

TRENDS AND PRACTICES IN HEALTHCARE SUBROGATION

Final Report

January 28, 2013

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SUMMARY

Healthcare subrogation may arise when someone with health insurance becomes injured in an accident for which someone else is liable. For example, a health insurance company may pay the injured's medical bills and attempt to recover its expenses from the liable party ("tortfeasor"). This may be possible through a subrogation claim against the tortfeasor or, if the victim already obtained compensation from the tortfeasor, by seeking reimbursement from the victim. Further, if third-party compensation is anticipated, an insurer may suspend benefit payments. This report explores healthcare subrogation practices and recoveries through any of the three avenues—subrogation, reimbursement, and savings of benefits in anticipation of third-party liability.

Economic literature suggests that, under certain stylized conditions, subrogation can help achieve a socially optimal outcome (Gomez and Penalva, 2008; Shavell, 1987; Sykes, 2001; CBO, 2003a).

Actuarial and accounting standards provide guidance to incorporate subrogation recoveries in estimates factored into premium rate-setting and financial reporting. According to the Actuarial Standards Board (ASB) and the Financial Accounting Standards Board (FASB), health insurance premiums should indirectly reflect subrogation recoveries (ASB, 2000, 2011; FASB, 1982). Under Statutory Accounting Principles (SAP), insurers may choose to factor subrogation estimates into unpaid claims liabilities and, if so, report the anticipated amount of future subrogation recoveries.

Public data on subrogation recoveries are extremely limited; however a review of a variety of data sources documented the following.

- Total subrogation recoveries for the overall industry in the early 2000s were estimated at approximately \$1 billion per year.
- Regulatory filings of six large health insurers in Ohio indicated that their subrogation recoveries ranged from 0.0% to 0.32% of incurred claims in 2009 (Ohio State Bar Association, 2010).
- Regulatory filings from eight Health Maintenance Organizations (HMOs) in Maryland suggested their subrogation recoveries averaged 0.28% of premium amounts in 2011 (Maryland Insurance Administration Annual Report, 2012; private communication with the Maryland Insurance Administration).
- Audit reports of 13 Federal Employees Health Benefits Program (FEHB) plans suggested subrogation recoveries of roughly 0.2% of benefit charges (Office of Personnel Management, Office of Inspector General, various years).
- Private health insurance companies' expenditures were \$849 billion in 2010 (National Health Expenditure Accounts, 2012). Under the assumption that private health insurers recovered between roughly 0.2% and 0.3% of benefit payments, this would suggest subrogation recoveries by private health insurers of between roughly \$1.7 billion and \$2.5 billion in 2010.

I. INTRODUCTION

Healthcare subrogation issues may arise when someone with health insurance becomes injured in an accident for which someone else is liable. In a common scenario, the health insurance company would pay the injured's medical bills and attempt to recover the expenses from the liable party ("tortfeasor"). This may be possible through subrogation, defined by the Merriam-Webster online dictionary as "the assumption by a third party (as a second creditor or an insurance company) of another's legal right to collect a debt or damages." The insurance company may also have a right of recovery or reimbursement of medical expenses after the injured party has collected funds from the tortfeasor.¹ Concerns over potential inequities created by situations involving subrogation of healthcare expense claims have prompted a debate over the laws and regulations covering healthcare subrogation. To illustrate subrogation and the concerns it raises, consider the following facts related to a current Supreme Court case, *U.S. Airways, Inc. v. McCutchen*:²

In 2007, a driver lost control of her car and struck James McCutchen's car. Mr. McCutchen required emergency surgery and later hip replacement surgery and physical therapy. The accident left him functionally disabled. Mr. McCutchen's U.S. Airways self-insured and administered health plan paid \$66,866 for his medical expenses, and his legal counsel recovered \$110,000 from multiple third parties to compensate for his injuries. After paying his attorneys' 40% contingency fee and legal expenses, Mr. McCutchen retained less than \$66,000. U.S. Airways claimed full reimbursement of the \$66,866 in a federal suit based on reimbursement language in the health plan, even though Mr. McCutchen had netted less than that amount from the settlement.

The recovery by the health insurer of medical expenses that it paid is an example of subrogation. Advocates of subrogation rights assert, among other arguments, that subrogation prevents double compensation for a loss and that subrogation recoveries help control health insurance premiums (e.g., Health Plan Week, 2010; Woody, 2011). In contrast, opponents argue that accident victims may receive only partial compensation of their losses due to subrogation (e.g., Baron and Lamb, 2012). Opponents have further argued that it is insurers, not insureds, who receive a windfall through subrogation because the insurer recoups its costs through

¹ While legally distinct, the two concepts have similar practical implications. This report discusses both subrogation and the right of recovery or reimbursement, using the terms interchangeably. Additionally, for the purposes of this report, an insurer refers to an insurance company or a self-insured employer. Furthermore, subrogation may also be pursued by healthcare providers who treated uninsured or underinsured patients and by such public programs as Medicare and Medicaid. While those are not the focus of this report, we briefly discuss subrogation by insurers in the public sector.

² Case facts obtained from Cornell University Law School LII Supreme Court Bulletin (<http://www.law.cornell.edu/supct/cert/11-1285>).

reimbursement even though the insured paid a premium for coverage (Baron and Druley, 2010).

Aggregate data on the amount of subrogation dollars recovered by insurance providers are sparse and not always consistently reported. By some estimates, in the early 2000s, insurance providers recovered approximately \$1 billion per year.³ This represents a small fraction of overall healthcare expenditures or private health insurers' expenditures, which amounted to \$2.6 trillion and \$849 billion in 2010, respectively (National Health Expenditure Accounts, 2012). As documented in this report, regulatory filings of six large health insurers in Ohio indicated that their subrogation recoveries ranged from 0.0% to 0.32% of incurred claims in 2009; regulatory filings from eight Health Maintenance Organizations (HMOs) in Maryland suggested their subrogation recoveries averaged 0.28% of premium amounts in 2011; and audits of 13 Federal Employees Health Benefits Program (FEHB) plans suggested subrogation recoveries of roughly 0.2% of benefit charges. Under the—admittedly crude—assumption that private health insurers recovered between roughly 0.2% and 0.3% of benefit payments, this would suggest subrogation recoveries by private health insurers of between roughly \$1.7 billion and \$2.5 billion in 2010.

The overall objective of this report is to document the extent to which health plans utilize subrogation to recover health benefits paid to plan participants. The report is organized as follows. Section II outlines the sources of information and the process by which those were obtained. Section III describes the subrogation process in the context of healthcare claims and reviews the economic, legal, and accounting/actuarial literature. Section IV summarizes quantitative data sources related to the prevalence of subrogation and the dollar amounts recovered. Section V concludes the report.

³ The estimates are based on annual subrogation recoveries of a large subrogation vendor and its estimated number of lives covered. They may be found in several amicus curiae briefs filed in support of subrogation rights and practices. See, for example, a brief by the American Association of Health Plans and others in *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002) (http://supreme.lp.findlaw.com/supreme_court/briefs/99-1786/99-1786.mer.ami.aahp.pdf) or a brief of America's Health Insurance Plans, Inc. and others in *Sereboff et al. v. Mid Atlantic Medical Service, Inc.* 547 U.S. 356 (2006) (http://www.americanbenefitscouncil.org/documents/sereboff_amicusbrief.pdf).

II. APPROACH

Overview

This section documents the various steps and data sources that were considered for this report. In general, our approach was iterative. We drew upon the technical knowledge of U.S. Department of Labor (DOL) attorneys and Deloitte subject matter specialists and searched public information sources as well as Deloitte's internal sources; these sources in turn provided leads for further investigation.⁴ As we synthesized and compared information during our literature review and data analysis, we consulted our subject matter specialists and searched for additional resources. With each iteration, we repeated this process as needed to refine our analysis.

Discussions with Subject Matter Specialists

Throughout the process, we interviewed subject matter specialists involved with Deloitte's Healthcare Practice, including prior health plan managers, subrogation specialists, tax specialists who prepare regulatory filings for health plans, health plan actuaries, health insurance company auditors, and employee benefit plan auditors. The subject matter specialists served such roles as:

- Informing our team on subrogation processes, accounting, premium-setting, and reporting
- Identifying sources of data on subrogation and guidance on subrogation practices
- Corroborating and/or questioning information sources that we considered
- Providing context on the healthcare and insurance regulatory environment
- Locating other subject matter specialists and sources

Review of Legal, Academic, and Trade Literature

We reviewed a broad spectrum of publicly available information sources. Among others, we consulted a trade association related to subrogation, the National Association of Subrogation Providers (NASP) and its 2010 Healthcare Benchmarking Study (NASP, 2010). We also identified websites for professionals and academics involved in the debate on subrogation, including those of Gary Wickert of the law firm Matthiesen, Wickert & Lehrer, S.C., and Roger Baron of the University of South Dakota School of Law. We reviewed Gary Wickert's book (Wickert, 2010), and several of Roger Baron's publications related to ERISA, subrogation, and reimbursement (Baron and Druley, 2010; Baron and Lamb, 2012; Baron, 2012).

⁴ As used in this document, "Deloitte" means Deloitte Financial Advisory Services LLP and other subsidiaries of Deloitte LLP. Please see www.deloitte.com/us/about for a detailed description of the legal structure of Deloitte LLP and its subsidiaries.

We performed a general literature search employing academic search engines (EconLit, MEDLINE, Microsoft Academic Search, and Google Scholar) as well as resources available internally to Deloitte. We reviewed academic articles uncovering many relevant information sources, which in turn led to additional information sources. Internally, we tapped a Deloitte specialty research team with access to paid subscription databases containing more than 35,000 academic journals and news and information sources, including some sources unavailable to the general public. Searching in these databases for articles related to our publicly accessed sources revealed several relevant academic articles; see Section III.

Data Sources

Below we introduce data sources which are discussed in further detail in the remaining sections of this report.

NASP Healthcare Subrogation Benchmarking Study

One of the few data sources available on healthcare subrogation comes from the NASP. In 2010, the NASP released its first “Healthcare Subrogation Benchmarking Study” (“NASP Study”; NASP, 2010). The NASP Study collected responses from a convenience sample of 14 member organizations that volunteered to complete the questionnaire. The NASP Study did not disclose the identities of its participants, but the study’s participants reportedly included health care providers, health benefit plans, and subrogation vendors acting on behalf of healthcare providers or health benefits plans.

The objective of the NASP Study was not to determine the prevalence of subrogation or estimate the aggregate amount of subrogation recoveries, but rather to “provide meaningful comparisons of participant’s [sic] performance and to identify best practices for maximizing subrogation recoveries.” Therefore, the NASP Study focused on business practices, such as outsourcing of subrogation, employee compensation and workload, training, and management reporting frequency. The study provides some limited insight into the extent of subrogation recoveries, such as average subrogation recovery amounts. However, given the small size and non-random nature of the sample, its results should be interpreted with caution. See Section IV of this report for further discussion.

Securities and Exchange Commission (SEC) Form 10-K Filings

A Form 10-K is an annual financial report filed with the SEC. We reviewed the most recent Form 10-K filings available for 10 large, publicly held insurance companies and the sponsors of 10 large health plans, but we were unable to locate any relevant quantitative subrogation data. Of the 20 Form 10-K filings we reviewed, only one contained a financial statement which mentioned subrogation recoveries, noting merely that they were incorporated in estimates for liabilities for unpaid claims and claim expenses. Our subject matter specialist in this area indicated that, generally, health care subrogation would not be large enough to appear as a financial statement line item, except possibly for companies that also offer property and casualty insurance. To better understand the accounting and actuarial practices related to subrogation, our subject matter specialists referred to guidance from the, Financial Accounting Standards Board (FASB), the Actuarial Standards Board (ASB),

and the National Association of Insurance Commissioners (NAIC) in the form of Statutory Accounting Principles (SAP). See the “Accounting and Actuarial Guidance” section later in this report for further details.

NAIC Annual Statements

Insurance companies are required to file annual statements (“NAIC Annual Statements”) with their state regulators and the NAIC, a body that coordinates with state insurance regulators. NAIC establishes annual statement forms to facilitate uniformity in financial information reported by insurance companies. While the NAIC Annual Statements do not provide a separate line item in the financial statements for subrogation, there is an accompanying note on “Anticipated Salvage and Subrogation.” See the section on “Accounting and Actuarial Guidance” for further discussion on the related accounting guidance. In the “Subrogation Prevalence and Recoveries” section, we provide observations on certain individual NAIC Annual Statements filed.

Federal and State Databases

We searched websites related to Federal and state agencies to locate possible subrogation regulatory reporting requirements. As detailed in the OPM Audits section, we located 13 Federal Employees Health Benefits Program (FEHB) plan audit reports on the website for the Office of Personnel Management (OPM), Office of the Inspector General (OIG). These OPM audit reports contain subrogation recovery data for the audited FEHB plan aggregated over several years. We also learned that Maryland and Ohio require certain insurance companies to report subrogation recovery amounts. We filed Public Information Requests with both the Maryland Insurance Administration (MIA) and Ohio Department of Insurance (ODI). ODI rejected our request for confidentiality reasons. However, as discussed later, we located a 2010 Ohio State Bar Association special task force report citing 2006-2009 subrogation recovery amounts for six insurance providers that provide health insurance in Ohio. MIA also rejected our initial request for confidentiality reasons, but later provided aggregate subrogation recoveries of Health Maintenance Organizations (HMOs) for each year from 2003-2011. See the “Subrogation Recovery Amounts for Maryland HMOs” section.

III. SUBROGATION BACKGROUND AND LITERATURE

This section starts with a description of the subrogation process as it may take place in practice. It then reviews the economic literature on subrogation and continues with an abridged discussion of the legal foundations of subrogation. It concludes with an overview of the accounting and actuarial standards governing the role of recovered funds in rate or premium setting.

Subrogation Process

While industry practices vary, the following is a stylized description of a few typical scenarios in which subrogation may take place.

Health plans may employ “Pay and Pursue” or “Pursue and Pay” subrogation recovery approaches. In the Pay and Pursue approach, health plans pay claims first and pursue potential third-party recovery later. Health plans using the Pursue and Pay approach stop paying claims when they become aware of a third party’s involvement; they then attempt to determine the third-party’s liability before making any (further) payments. Pre-pay denial would be based on an exclusion clause in the terms of the health plan (NASP, 2010).

Subrogation processes and practices vary by plan, but in general, they start with computerized algorithms to identify health claims which may involve third party liability. Diagnoses that may trigger an investigation include injury, poisoning, and diseases of musculoskeletal and connective tissue (NASP, 2010). Some plans employ text analyses of claims files and correspondence. Other information may also trigger a subrogation investigation, such as a subpoena related to an insured’s tort lawsuit requesting records of payment. Plans may also utilize external information, such as the Federal Employee Program Worker’s Compensation recovery files. An investigation typically takes place only if the health claims exceed a certain dollar threshold, such as \$500.

An investigation starts with a request to the insured for information about the nature of the claim and third-party involvement to identify potential third-party liability. If the insured does not respond, follow-up requests may be sent. If the insured still does not respond and the claim reaches a certain threshold (e.g., \$2,000), outside legal counsel may send a letter to the insured. A “roundtable” comprised of internal subrogation team members with various expertise areas may evaluate high-dollar or controversial claims to decide on strategy, scope, feasibility, and possible outcomes prior to retaining outside counsel or settlement authority (NASP, 2010). If third-party liability appears likely and a recovery is anticipated, a subrogation file is opened (NASP, 2010).

Subrogation cases may be pursued by the health plan itself through a separate subrogation department or a Coordination of Benefits (COB) department. A designated unit may address high-dollar claims, while internal or external attorneys may assist in investigating or litigating potential subrogation claims. Alternatively, the pursuit may be outsourced to a subrogation vendor or a third party administrator, again with the possible assistance of legal counsel. Also, plans may hire a subrogation vendor to perform a “sweep” or second pass to identify potential

subrogation claims after an internal department performs an initial scrub (NASP, 2010). Subrogation vendors typically work, at least in part, on a contingency fee and receive a percentage of recoveries. Plans and vendors often compensate their subrogation personnel in part based on recovery amounts. They may tie employees' bonuses to certain recovery goals (NASP, 2010).

An Economic Perspective on Insurance, Tort, and Subrogation

Personal injury subrogation arises from the interplay of tort liability and private insurance. This section discusses subrogation from an economic perspective. The economic perspective focuses on safety incentives and their social benefits measured against the social costs (e.g., insurance premiums and legal expenses). In contrast, a traditional legal perspective focuses on victim compensation and punishment of a wrongdoer as the primary goals of the insurance and the liability systems (Shavell, 2000). An economic perspective models human behavior by making simplifying assumptions, and therefore, theoretical market conditions may not match actual market conditions.

Victims of accidents caused by another party may be compensated for their injuries through insurance or through the liability system. The liability system compensates some accident victims when a tortfeasor (injurer) is found liable, but a tortfeasor may not always be found liable. The insurance system ensues because a risk-averse individual desires to transfer accident risk to an insurer by purchasing insurance. In fact, under a socially optimal situation, all risk-averse parties will completely avoid risk through insurance arrangements, and all parties will exercise care to minimize accidents (Gomez and Penalva, 2008; Shavell, 1987).⁵ This led Gomez and Penalva (2008) to ask "how to coordinate the insurance benefits... with tort liability awards if there is a liable injurer."

Generally, three compensation coordination methods exist:⁶

⁵ For any social welfare function, the socially optimal allocation of risk referred to here is the Pareto Optimal (feasible) allocation of risk (see Borch, 1962). When there is a positive probability of loss, the Pareto Optimal allocation of risk results from maximizing the insured and the insurer's expected utility of wealth. Determining the optimal insurance contract results from maximizing the insured's expected utility subject to the constraint that insurance premiums equal the insured's expected loss. This constraint implicitly assumes insurance policies are purchased in a competitive insurance market by a well-informed consumer, and that the insurance company's administrative costs are zero. Shavell's other assumptions include that risks facing insured parties are independent and that the level of potential loss is fixed. When administrative costs are included in the analysis, it becomes possible that socially appropriate and privately motivated use of the liability system will diverge, and Shavell concludes social intervention may be necessary to promote or discourage use of the liability system with, for example, small claims court or no-fault statutes (Shavell, 1987).

⁶ These are legal systems in various fields and to varying degrees can co-exist within the same systems.

1. Allowing accident victims to receive full insurance benefits and full tort liability awards ("double recovery"),⁷
2. Deducting insurance benefits from the tortfeasor's tort liability payment ("collateral benefits offset"), or
3. Requiring the victim to reimburse benefits received from the tort liability payment to the insurer ("subrogation").

Losses may be pecuniary (e.g., medical expenses, lost wages) or non-pecuniary (e.g., pain and suffering). Non-pecuniary losses will be addressed below; consider for now pecuniary losses only. Because a tortfeasor does not always compensate his victim fully, potential victims may purchase insurance. However, the presence of insurance can distort the tortfeasor's or the victim's incentives depending on how the tortfeasor's payment and the victim's insurance benefit are distributed. In a socially optimal outcome, the tortfeasor will pay an amount exactly equal to the victim's pecuniary (monetary) losses, which creates the tortfeasor's incentive to avoid causing injury. Also in the socially optimal situation, the victim will receive his exact pecuniary losses from the insurer's and tortfeasor's combined payments, and that does not distort the victim's incentive to avoid being injured (Shavell, 1987). When a liable tortfeasor has to pay a victim exact pecuniary damages, both the potential victim and the potential tortfeasor have incentives to reduce risk appropriately, leaving the question of how to coordinate insurance and tort payments.

Two of the possible compensation coordination methods distort the potential tortfeasor's or potential victim's incentives. The collateral benefits offset method deducts insurance benefits from the tortfeasor's liability. This reduces the incentives for potential tortfeasors to exercise care and prevent injuries; indeed, at least one empirical study has linked the movement away from the collateral source rule and the institution of the collateral benefits offset to increased accidental death rates (Rubin and Shepherd, 2007). Additionally, by using a victim's purchased insurance benefit to reduce the tortfeasor's liability, the collateral benefits offset method transfers the benefits of insurance coverage from the victim to the tortfeasor, and this leads to an actuarially unfair premium price (Gomez and Penalva, 2008; Sykes, 2001).⁸ Because the resulting premium price is unfair, victims purchase less than the socially optimal level of coverage (Gomez and Penalva, 2008). Similarly, double recovery creates an incentive for over-insurance because the insured is paying extra for a chance at receiving both insurance benefits and a tort liability award; therefore, double recovery could increase insurance premiums. Double recovery distorts a potential victim's incentives and increases his risk by forcing him "to engage in a gamble (where 'winning' will occur if he suffers a loss)." Like the collateral benefits offset method, victims will purchase less than the socially optimal level of coverage

⁷ A related concept is the collateral source rule, which prevents evidence of insurance payments to an injured party from being admitted into court. As defined by Black's Law Dictionary, "[t]he collateral-source (or collateral-benefit) rule is the doctrine that if an injured party receives compensation for its injuries from a source independent of the tortfeasor, the payment should not be deducted from the damages that the tortfeasor must pay; insurance proceeds are the most common collateral source." (Black's Law Dictionary 299 [9th Ed. 2009])

⁸ Insurance coverage with expected value less than the premium price is considered actuarially unfair.

because double recovery increases premiums above the optimal level (Shavell, 1987).

Economic theory suggests that, under certain assumptions, of the three possible accidents benefit and damage collection coordination methods, only subrogation can create the socially optimal outcome: the injurer will pay the victim or the insurer the exact losses caused, and the victim will not be able to collect more than his losses (Gomez and Penalva, 2008; Shavell, 1987). Even when the injurer does not cover the damages caused and the insured's losses aren't fully covered by insurance, providing insurers first-dollar recovery generates the optimal outcome in most circumstances (Sykes, 2001).⁹ This result follows from the logic that, if it is optimal for the victim to bear the risk of underinsurance when a third party cannot be found liable, the victim should bear the same risk when a third party can be found liable.

Accidents that cause non-pecuniary losses complicate the economic analysis. Non-pecuniary losses, such as pain and suffering, are often difficult to measure or verify, and for at least that reason, a consumer cannot purchase pain and suffering insurance in the marketplace (Sykes, 2001). Non-pecuniary losses will cause a divergence between optimal victim compensation and optimal injurer deterrence. Under suitable assumptions, the consumer will purchase insurance coverage equal to his expected pecuniary losses. When a victim receives payment for pecuniary accident losses only, non-pecuniary losses will cause a victim's overall utility to fall even though he possesses optimal insurance coverage. In other words, the individual will not be fully compensated ("made whole") for his loss (Shavell, 1987). Because pecuniary losses reflect only part of the accident's social cost, requiring the injurer to reimburse the insurance company for only the pecuniary losses will not sufficiently deter the injurer from causing future injuries. In the presence of non-pecuniary losses, optimal victim compensation payments differ from optimal injurer deterrence payments, and a socially ideal situation cannot be attained under the liability system (Shavell, 1987).

More recently, some academics have advocated unlimited insurance subrogation (UIS) that allows victims to completely transfer ownership of their future tort claims to insurers (Congressional Budget Office [CBO], 2003a; Rosenberg, 2002). Under UIS, the victim would be insured against all pecuniary losses, but the insurer would retain the victim's full right to sue a third party for both pecuniary and non-pecuniary losses. In a competitive market, the insurer's net proceeds from such cases would drive down premiums to below the expected pecuniary loss, thereby compensating insureds for potential future non-pecuniary losses (CBO, 2003a). UIS would improve the insureds' welfare by reducing insurance premiums and leveraging insurers' litigation and administration advantages from economies of scale (Rosenberg, 2002; CBO, 2003a).

⁹ A possible exception arises when the injury increases the marginal utility of money—loosely speaking, the victim's appreciation for money related to his ability to enjoy the goods and services that money can buy. See Sykes (2001) and Shavell (1987). The discussion in this section assumes that a victim's marginal utility of wealth is unaffected by any accident.

Legal Foundation for Subrogation

The legal foundation for subrogation of medical expenses by ERISA-covered health plans is subject to some debate. Baron and Lamb (2012) argued that healthcare subrogation was forbidden by the common law and was further uniformly prohibited by all state jurisdictions when ERISA was enacted in 1974. They also assert that ERISA's preemptive effect opened the door for healthcare subrogation. As a result, the authors noted, subrogation by ERISA health plans became enforceable in federal court. Baron and Lamb (2012) and Baron (2012) argued that subrogation is on less-than-solid legal footing because (1) no federal law explicitly authorizes subrogation, (2) subrogation proceeds tend to lag expenses by several years and do thus not benefit the pool of plan participants for whom the risk of loss had previously been actuarially determined, and (3) subrogation may violate a plan administrator's fiduciary duty to discharge its duties solely in the interest of the participants and beneficiaries for the exclusive purpose of providing benefits to participants and beneficiaries. Twice in the last decade the Supreme Court has ruled on ERISA plans' subrogation rights (*Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 2002; *Sereboff v. Mid Atlantic Medical Services, LLC*, 547 U.S. 356, 2006). At the time of this report's writing, the U.S. Supreme Court is reviewing a new challenge to ERISA plans' subrogation rights. This Supreme Court challenge asks whether ERISA authorizes courts to use equitable principles to rewrite contractual language and refuse to order participants to reimburse their plan for benefits paid even when the plan's terms give it an absolute right to full reimbursement (*US Airways, Inc. v. McCutchen* 663 F.3d 671, 3d Cir. 2011; Smith, 2012). Such equitable principles may include the made-whole and unfair enrichment doctrines. Wickert (2010) noted that the made-whole doctrine is the most common defense against health insurance subrogation and that some states, including Arkansas and Mississippi, forbid parties from negotiating away made-whole principles.

Wickert (2010) argued that subrogation rights may arise on three grounds:

1. Contractual subrogation – an insurer's right of subrogation based on a contract, agreement, or mutual engagement between the insurer and the insured, e.g., subrogation insurance policy plan language.
2. Equitable subrogation – a subrogation right that originates from "fairness" principles when one person pays the debt that should have been paid by another. Legal subrogation is a product of equity, and is not dependent on any contract, assignment, or privity.
3. Statutory subrogation – a subrogation right established by statute, including workers' compensation, hospital lien laws, and Medicare.

Many health plan policies contain language that establishes contractual subrogation. Statutory subrogation forms the basis for several types of subrogation that relate to medical claims (Wickert, 2010):

- Workers' compensation: each state has designed a workers' compensation system by statute, and each state's system enables the employer or its insurer to pursue subrogation recoveries against responsible third parties.¹⁰
- Hospital liens: some states, including Wisconsin and Florida, have adopted "hospital lien statutes" that grant a hospital treating an uninsured, or underinsured, injured patient a lien on a claim against the injurious tortfeasor or any other recovery resulting from the injury.
- Medicare: Under certain circumstances, Medicare provides secondary coverage. If the party that is primarily liable "has not made or cannot reasonably be expected to make payment", Medicare may make a conditional payment, for which it acquires a subrogation right (42 U.S.C. §1395y(b)(2)(B)(i) and (iv)). CBO estimated that the 2003 Medicare secondary payer provisions would save \$9 billion over ten years (CBO, 2003b).
- Medicaid: Federal law requires states to pursue reimbursement for medical assistance from third parties if certain conditions are met (42 U.S.C. §1396a(a)(25)(B)). The U.S. Supreme Court ruled that subrogation right applies to only the portion of the settlement that represented payment for past medical expenses (*Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268, 2006).
- Federal employees' health plans: the Federal Employees Health Benefit Act of 1959 (FEHBA), as amended, affects health coverage of federal employees in a similar manner as ERISA affects private sector health coverage. Similar to ERISA, FEHBA does not directly address subrogation or reimbursement rights, and FEHBA contains a broad preemption provision. Generally, federal health plans contain language defining their subrogation and reimbursement rights (Wickert, 2010). See Section IV of this report for OPM FEHB plan audits.

Accounting and Actuarial Guidance

One of the arguments in defense of subrogation is its potential for reducing health insurance rates or premiums. For example, in 2000, Maryland Senate Bill 903 was enacted into law, generally allowing subrogation for state workers' HMO health plans.¹¹ The law sought to remove the precedent set by a Maryland Court of Appeals decision *Victor G. Riemer et al. v. Columbia Medical Plan, Inc.* 358. Md. 222, 747 A.2d 677, 2000, which held that "an HMO may not pursue its members for restitution, reimbursement, or subrogation after the members have received damages from a third-party tortfeasor." CareFirst of Maryland and Mid-Atlantic Medical Services, Inc. had estimated that if the bill did not pass, the result would be an increase of 1%-2% in HMO premium increases for state workers in the plan (Miller and Bromwell, 2000).

Baron and Druley (2010) disputed the argument that subrogation may help lower health insurance premiums. They argued that "... due to the often-protracted nature

¹⁰ Note this relates to subrogation by the employer or its workers' compensation insurer; it is distinct from subrogation by health insurers of expenses for which the workers' compensation insurer is liable.

¹¹ Additionally, Maryland Senate Bill 903 authorized a Maryland HMO subrogation reporting requirement, discussed later in this report.

of litigation and settlement negotiations, the determination of whether there is a chance for subrogation occurs long after the event and long after the bills have been paid.” They concluded: “[s]ubrogation recoveries are not included in the factors that influence premium calculation.”

Discussions with Deloitte actuary and subrogation specialists indicated that subrogation recoveries would be indirectly factored into premium rate-setting because they contribute to net claims experience. Rates are set based on net claims cost, that is, claims paid net of subrogation, coordination of benefits, recovered overpayments to providers, risk-sharing arrangements, et cetera. Claims offsets are estimated based on historical lag patterns (“claim run-out”). Furthermore, we obtained actuarial guidance from the Actuarial Standards Board (ASB) and the Financial Accounting Standards Board (FASB) which indicates that subrogation is factored into actuarial practices and financial reporting under GAAP (generally accepted accounting practices). Under statutory accounting principles (SAP) from the NAIC, factoring subrogation estimates into liabilities for unpaid claims is optional. See below for detail on the guidance from these three sources.

The Actuarial Standards Board, which, according to its website “establishes and improves standards of actuarial practice,” in December 2000 adopted Actuarial Standard of Practice No. 5 (ASB, 2000, 2011) which covers health claims liabilities. Section 3.3.5 provides the following guidance:¹²

3.3.5 Coordination of Benefits (COB) or Subrogation—The actuary should take into account the relevant organizational practices and regulatory requirements related to COB or subrogation. In particular, the actuary should consider how these items are reflected in the data (for example, negative claims or income) and make appropriate adjustments for COB, subrogation, or other adjustments or recoveries.

The Financial Accounting Standards Board which, according to its website, since 1973 “has been the designated organization in the private sector for establishing standards of financial accounting that govern the preparation of financial reports by nongovernmental entities,” issued accounting guidance for insurance entities in Statement of Financial Accounting Standards No. 60 (FASB, 1982), including indication that subrogation should be reflected in claim liability estimates. Paragraph 18 addresses the accounting for a liability for unpaid claims in the following:

18. The liability for unpaid claims shall be based on the estimated ultimate cost of settling the claims (including the effects of inflation and other societal and economic factors), using past experience adjusted for current trends, and any other factors that would modify past experience... Changes in estimates of claim costs resulting from the continuous review process and differences between estimates and payments for claims shall be recognized in income of the period in which the estimates are changed or payments are made. Estimated recoveries on unsettled claims, such as salvage, subrogation, or a potential ownership interest in real estate, shall be evaluated in terms of their estimated realizable value and deducted from the liability for

¹² The 2000 standard was updated in 2011, without any change to Section 3.3.5.

unpaid claims. Estimated recoveries on settled claims other than mortgage guaranty and title insurance claims also shall be deducted from the liability for unpaid claims.

NAIC Annual Statements are prepared in accordance with NAIC's statutory accounting principles (SAP), which differ from GAAP. GAAP aims to provide investors and other users of financial information with an accurate and fair reporting of the condition and performance of an organization. SAP guidance comes from an insurance regulatory perspective to protect the interests of policyholders and avoid solvency problems by reporting liabilities and the adequacy of reserves. SAP can be considered generally more conservative than GAAP, as seen in the guidance for recording the liability for unpaid claims and losses. Under SAP, an insurance company may choose to deduct subrogation estimates from its liabilities for unpaid claims and losses. If so, those estimates are separately disclosed in a note to the financial statement. The following is an excerpt from Statement of Statutory Accounting Principles No. 55 "Unpaid Claims, Losses and Loss Adjustment Expenses" (SSAP 55):

If a reporting entity chooses to anticipate salvage and subrogation recoverables (including amounts recoverable from second injury funds, other governmental agencies, or quasi-governmental agencies, where applicable), the recoverables shall be estimated in a manner consistent with paragraphs 8 through 10 of this statement and shall be deducted from the liability for unpaid claims or losses.¹³

SSAP 55 further states that the entities' financial statements should include a disclosure related to the subrogation estimates deducted from the liability for unpaid claims and losses. This disclosure appears in Note 31 on "Anticipated Salvage and Subrogation."

¹³ Paragraphs 8-10 of SSAP 55 provide guidance related to claims estimates, such as using past experience and relevant modifications to calculate the liability for unpaid claims, various analytical and statistical techniques, and guidance to break down estimates by line of business.

IV. SUBROGATION PREVALENCE AND RECOVERIES

This section summarizes four sources of quantitative data on the prevalence of subrogation and the magnitude of subrogation proceeds. The first is a study of the NASP, based on a non-random, limited-size survey of its members. The second source consists of summary statistics on health insurers in the state of Ohio. The third includes aggregate subrogation recoveries for HMOs in Maryland. Finally, this section summarizes relevant statistics from OPM OIG audits of FEHB health plans.

NASP Healthcare Subrogation Benchmarking Study

As noted earlier, the NASP Study collected responses from a convenience sample of 14 member organizations that volunteered to complete the questionnaire. The study focused on subrogation best practices rather than on estimates of the extent of subrogation. The respondents consisted of nine “healthcare providers” and five healthcare subrogation vendors. Upon inquiry, a NASP representative clarified that “healthcare providers” included healthcare providers, health benefit plans, and carriers that act as both. The term “healthcare providers” does not include those who coordinate health benefits with other healthcare providers. This section follows the NASP definition of “healthcare providers.” Additionally, the NASP representative indicated that some respondents did not supply all the information requested. For example, a respondent may have supplied an overall recovery rate but not recovery rates by lines of business; therefore the overall figures may not tie out as averages of sub-categories.

Of the nine healthcare providers that participated in the study, seven (78%) processed subrogation files internally while the remaining two providers split subrogation files evenly between an internal team and external vendors. This suggests that approximately 11% of the study’s health providers’ subrogation cases were handled by external vendors. The study did not cover healthcare providers that contracted-out all subrogation cases.

As described previously, subrogation may be pursued on a “Pay and Pursue” or a “Pursue and Pay” basis. With Pay and Pursue, the health plan first pays the claim and later seeks reimbursement from the liable third party, whereas under Pursue and Pay, the health plan denies the claim until it can establish whether any third-party is liable. The majority of the respondents to the study (53.6%) indicated that their organization used only the Pay and Pursue approach, 7.1% used only Pursue and Pay, and 35.7% used a combination. The remaining 3.6% employed another method of subrogation pursuit.

In NASP terminology, the proceeds of a Pay and Pursue case (in which a bill was paid) are “recoveries” and the proceeds of a Pursue and Pay case (in which no money was paid upfront) are “savings.” For simplicity, the discussion below uses “recoveries” for either type of proceeds.

The NASP Study asked about the number and types of files that are opened for subrogation purposes. Only a small fraction of the requests that healthcare providers or subrogation vendors send to insured individuals ultimately resulted in the opening

of a file for subrogation purposes with the anticipation of a recovery. The fraction of files that resulted in recovery was also lower for Pay and Pursue cases (31.1%) than for Pursue and Pay cases (49.4%), as was the average recovery among files that were closed with a recovery: \$3,809 for Pay and Pursue cases and \$5,237 for Pursue and Pay cases.¹⁴ The reported recoveries are gross amounts, that is, without account of subrogation costs.

Table 1. Subrogation Rates and Recovery Metrics by Subrogation Approach

	Pay and Pursue	Pursue and Pay
Recovery per file closed	\$1,184	\$2,506
Recovery per file closed with recovery	\$3,809	\$5,237
Recovery rate per closed file	31.1%	49.4%

Source: NASP (2010).

Note: According to a NASP representative, the recovery rate for Pursue and Pay implied by recoveries ($2,506/5,237=47.9\%$) differs from the reported recovery rate (49.4%) because of incomplete item reporting.

Table 2 shows the relative importance of health benefit payors (lines of subrogation business) to study respondents, as measured by the fractions of opened subrogation files. The plurality of files (46.2%) related to self-funded health plans and 35.1% related to fully insured plans. Medicare and Medicaid accounted for 6.8% and 6.7% of opened files, respectively.¹⁵ Stop-loss and disability insurance files were relatively infrequent. The “other” category accounted for 4.6% of opened files; most of those related to federal health plans.

Table 2: Pursued Subrogation Files by Line of Business

Line of business	Fraction of opened subrogation files
Fully Insured	35.1%
Self-Funded/ASO	46.2%
Medicare	6.8%
Medicaid	6.7%
Stop Loss	0.2%
Disability	0.4%
Other	4.6%

Source: NASP (2010).

¹⁴ NASP (2010) reported both the unconditional and conditional recovery amounts. Their ratio should be equal to the recovery rate. However, the recovery rate for Pursue and Pay implied by recoveries ($2,506/5,237=47.9\%$) differs from the reported recovery rate (49.4%). A NASP representative explained that the discrepancy is due to incomplete item responses; one respondent was able to provide the closed files counts, but not the savings amount. The Pay and Pursue figures are internally consistent ($1,184/3,809=31.1\%$).

¹⁵ A NASP representative indicated that the Medicare and Medicaid lines of business were not defined for purposes of the NASP Study; therefore, the representative could not provide any information on what participants included in those categories.

Table 3 shows recovery rates and recovery amounts by subrogation approach and line of business. Among Pay and Pursue cases, the average recoveries per file closed with a recovery were similar for fully insured plans, self-funded plans, Medicare, and Medicaid. However, the recovery rates per file closed for fully insured and self-funded plans were roughly twice as high as those for Medicare and Medicaid, so that the average recoveries per file closed for the private sector plans were about twice as high as average recoveries for Medicare and Medicaid.

Table 3: Recovery Metrics by Subrogation Approach and Line of Business

	Fully Insured	Self-Funded	Medicare	Medicaid	Other	Overall
<i>Pay and Pursue</i>						
Recovery per file closed	\$1,500	\$1,662	\$814	\$734	\$2,040	\$1,184
Recovery per file closed with a recovery	\$3,492	\$3,586	\$3,293	\$3,482	\$1,269	\$3,809
Recovery rate per file closed	43.0%	46.2%	24.7%	20.9%	91.5%	31.1%
Recovery rate per pursued dollar	26.7%	33.5%	18.8%	27.9%	70.1%	N/A
<i>Pursue and Pay</i>						
Recovery per file closed	\$5,190	\$4,468	N/A	N/A	N/A	\$2,506
Recovery per file closed with a recovery	\$6,857	\$6,712	N/A	N/A	N/A	\$5,237
Recovery rate per file closed	73.8%	66.6%	N/A	N/A	N/A	49.4%
Recovery rate per pursued dollar	43.9%	47.1%	N/A	N/A	N/A	N/A

Source: NASP (2010).

Note: No statistics were available for stop-loss or disability insurance.

Note: According to a NASP representative, some implied recovery rates per file closed differ from reported recovery rates because of incomplete item responses. The same explanation was given for why the unconditional recovery for the Pay and Pursue "Other" category was greater than the conditional recovery.

Table 4 displays recovery/savings metrics by subrogation method and accident type. Note that higher dollar recoveries are correlated with lower recovery rates. Among Pay and Pursue cases, the recovery rate for motor vehicle accidents (62.1%) is much higher than those of other accident types. The average recovery per file that was closed with a recovery was higher for medical malpractice claims (\$24,800) and product liability claims (\$10,461) than for the other accident types (under \$4,000).

Table 4: Recovery Metrics by Subrogation Approach and Type of Accident

	Motor Vehicle Accident	Workers Comp	Medical Malpractice	Product Liability	Property Liability
<i>Pay and Pursue</i>					
Recovery per file closed	\$2,124	\$1,145	\$7,841	\$4,347	\$1,053
Recovery per file closed with a recovery	\$3,342	\$3,179	\$24,800	\$10,461	\$3,901
Recovery rate per file closed	62.1%	38.3%	32.4%	36.0%	27.8%
Recovery rate per pursued dollar	37.2%	37.3%	26.9%	31.4%	27.5%
<i>Pursue and Pay</i>					
Recovery per file closed	\$4,474	\$4,070	N/A	N/A	N/A
Recovery per file closed with a recovery	\$5,986	\$6,257	N/A	N/A	N/A
Recovery rate per file closed	74.7%	65.0%	N/A	N/A	N/A
Recovery rate per pursued dollar	47.2%	44.6%	N/A	N/A	N/A

Source: NASP (2010).

Note: According to a NASP representative, some implied recovery rates per file closed differ from reported recovery rates because of incomplete item responses.

The NASP Study replies also give an indication of the subrogation costs incurred by healthcare providers, which helps give a sense of the net gain of subrogation to healthcare providers. For example, for each full-time-equivalent employee, respondents reported that (gross) subrogation recoveries are about \$683,000 for healthcare providers and \$597,000 for subrogation vendors per year. Each full-time-equivalent employee handled, on average, about 549 subrogation files per year for healthcare providers and about 606 files per year for subrogation vendors.

Average external legal expenses, which do not include internal staff costs, were \$2,265 and \$1,082 per litigated case for healthcare providers and subrogation vendors, respectively. Healthcare providers litigated about twice as many subrogation files (31.7 per 1,000 files) as subrogation vendors (15.8 per 1,000 files).

In sum, the NASP Study provides unique information about healthcare subrogation business practices and recoveries. Unfortunately, given the small, voluntary sample, it does not permit generalizations about aggregate healthcare subrogation in the United States. Notably, it does not contain the information needed to estimate the total annual amount of health insurance subrogation recoveries.

Subrogation Recovery Amounts from the Ohio Subrogation Task Force Final Report

As noted above, the state of Ohio has compiled a database with insurer-level subrogation information.¹⁶ In 2010, using in part that database, the Ohio State Bar Association released a report from a special task force established for the purpose of determining whether a “new process for resolving disputes involving subrogation of

¹⁶ ODI rejected our request for such data on confidentiality grounds.

personal injury claims should be recommended” for the State of Ohio (Ohio State Bar Association, 2010). Ultimately, the group could not reach a consensus. The report cited subrogation recovery amounts for six insurance providers that provided health insurance in Ohio.

Table 5 summarizes the six insurance companies' subrogation recovery amounts and aggregate claims from 2006 to 2009. In that period, total subrogation recoveries for these carriers totaled \$71.5 million, corresponding to 0.26% of their total incurred claims. Community Insurance Co. reported the highest recovery share (0.82% in 2006 and 0.32% in 2009); all other companies reported 0.29% or less, with United Healthcare of Ohio, Inc. reporting no subrogation recoveries at all. The recovery rates have been rising or falling over time, without consistent time trend.

Table 5. Subrogation Recoveries as a Percentage of Total Incurred Claims (2006-2009)

Plan Name	Year	Total subrogation recovery (\$ millions)	Total claims incurred (\$ millions)	Ratio of recoveries to claims
Aetna Life Insurance Co.	2006	0.1	221.1	0.06%
	2007	0.3	316.3	0.09%
	2008	0.3	1,279.8	0.02%
	2009	0.4	1,435.9	0.03%
	Total	1.1	3,253.0	0.03%
Community Insurance Co.	2006	25.7	3,124.6	0.82%
	2007	8.7	3,325.8	0.26%
	2008	9.4	3,319.4	0.28%
	2009	10.8	3,333.1	0.32%
	Total	54.6	13,102.9	0.42%
Humana Health Plan of Ohio Inc	2006	0.5	206.6	0.23%
	2007	0.1	113.8	0.06%
	2008	0.0	230.5	0.01%
	2009	0.6	238.5	0.24%
	Total	1.1	789.4	0.14%
Medical Mutual of Ohio	2006	2.9	1,440.0	0.20%
	2007	3.2	1,496.4	0.21%
	2008	3.9	1,549.7	0.25%
	2009	4.6	1,557.3	0.29%
	Total	14.5	6,043.5	0.24%
United Healthcare Insurance Co. of Ohio	2006		337.1	0.00%
	2007		412.0	0.00%
	2008		432.8	0.00%
	2009		348.4	0.00%
	Total	0.0	1,530.4	0.00%
United Healthcare of Ohio Inc	2006		747.4	0.00%
	2007	0.1	587.7	0.01%
	2008	0.0	582.6	0.00%
	2009	0.0	634.1	0.01%
	Total	0.1	2,551.7	0.00%
Grand total		71.5	27,270.9	0.26%

Source: Ohio State Bar Association (2010).

To help corroborate the above figures, we obtained NAIC filings for five of the six health insurers listed in Table 5. The filings related to calendar years 2009 and 2010.¹⁷

- Community Insurance explained it that took into account estimated anticipated subrogation and other recoveries in its determination of the liability for unpaid claims and that it reduced its liability by \$10,798,000 at December 31, 2009. The Ohio State Bar Association (2010) report also listed \$10,798,000 in subrogation recoveries for 2009 (Table 5). The report interpreted that amount as subrogation recoveries *during* the year 2009, but the NAIC filing appears to suggest that the figure represents an estimate of anticipated subrogation recoveries *as of a specific date*, namely year-end 2009. It is unclear whether the amount was interpreted correctly. The NAIC-reported liability reduction on December 31, 2008 (\$10.6 million) differs from the subrogation recovery reported in the Ohio State Bar Association report (\$9.4 million).
- In its NAIC filing, Humana Health Plan of Ohio stated that anticipated salvage and subrogation was “Not applicable” for 2009, even though Ohio State Bar Association (2010) suggests that it recovered \$569,715 through subrogation during 2009. As previously noted, subrogation estimates may not be disclosed in the NAIC filing if it does not factor subrogation into its liability for unpaid claims and losses.
- In its NAIC filing, Medical Mutual of Ohio stated that, because of anticipated subrogation recoveries, it reduced its reserve for unpaid claims and claims adjustment expense by \$6.8 million at year-end of both 2009 and 2008. Ohio State Bar Association (2010) documented subrogation recoveries of \$3.9 million and \$4.6 million during 2008 and 2009, respectively.
- In its NAIC filing, UnitedHealthcare Insurance Co of Ohio reported that, as of year-end 2010 and 2009, it had no specific accruals established for outstanding subrogation, as it was considered a component of the actuarial calculations used to develop the estimates of claims unpaid and aggregate health claim reserves. This suggests that it may have pursued subrogation recoveries during 2009 and/or 2010, while Table 5 suggests that such recoveries were zero in 2009.
- Finally, in its NAIC filing for 2009, United Healthcare of Ohio stated that it did not anticipate subrogation recoveries.

Subrogation Recovery Amounts for Maryland HMOs

Maryland-based HMOs that include a subrogation provision in their contracts are required to report subrogation amounts in annual filings with the MIA.¹⁸ Citing confidentiality issues, the MIA declined to provide us with such filings, but instead made available annual aggregate subrogation amounts and the number of HMO companies included in those amounts. See Table 6.

¹⁷ SNL Financial, <http://www.snl.com/>.

¹⁸ Section 19-713(b)(2) of the Health - General Annotated Code of Maryland. This requirement resulted from the Maryland Senate Bill 903 discussed earlier in this report.

Table 6. Subrogation Recoveries and Premiums of HMOs in Maryland (2003-2011)

Calendar year	Number of HMO companies	Subrogation recoveries (\$ millions)	Premiums (\$ millions)	Ratio of recoveries to premiums
2003	9	4.8	N/A	N/A
2004	8	5.9	N/A	N/A
2005	8	5.5	1,939.1	0.28%
2006	8	5.8	2,075.3	0.28%
2007	8	5.0	2,017.5	0.25%
2008	8	6.7	2,153.3	0.31%
2009	8	10.3	2,208.2	0.47%
2010	8	9.1	2,769.7	0.33%
2011	8	8.1	2,907.4	0.28%

Sources: Maryland Insurance Administration Annual Reports (2004-2012) and private communication with the Maryland Insurance Administration.

Note: Premiums include Maryland commercial, Medicare, Medicaid, and Federal Employee Health Benefits premiums, and these could not be located for 2003 and 2004.

Table 6 also lists annual aggregate premium amounts, obtained from MIA Annual Reports (2004-2012). Both the subrogation and premium amounts refer to business in Maryland only and exclude amounts related to business in neighboring states. As shown in the table, subrogation amounts were between 0.25% and 0.47% of premiums from 2003 to 2011.

OPM Audit Reports

OPM administers the FEHB, and as a part of its FEHB administration, OPM's OIG audits plans and makes final audit reports available on its website. The purpose of the audits is to determine whether the plan in question was acting "in accordance with the terms of the contract" that was agreed to under the FEHB guidelines and restrictions (OPM, OIG, 2010d). In particular, the audits examine a plan's health benefit charges (claims payments), administrative expenses, and cash management. The health benefit charges section of the audit reports include specific subrogation recovery counts and dollar amounts, which are aggregated and reported based on the time period established in the audit (typically a five-year range).

Table 7 summarizes 13 FEHB plans ("Federal Employee Plans") for audit reports located on OPM's website. According to OPM, there were 207 Federal Employee Plans as of September 2011 (FEHB, 2011). In total, the 13 Federal Employee Plans recovered \$109 million in subrogation dollars over the audited periods. Additionally, eight of these Federal Employee Plan audit reports state the plan's total health benefit charges (primarily claim payments), and we calculate that these eight plans recovered 0.29% of health benefit charges through subrogation. Only one plan (Blue Cross Blue Shield of Arkansas) subrogated more than 0.34% of health benefit charges, and excluding that plan reduces the health benefit charge subrogation recovery rate to 0.18% among the other seven plans.

Table 7. Subrogation Recoveries by Federal Employee Health Plans Reported in OPM Audits

Time period	Plan name	State	Total health benefit charges amount * (\$ millions)	Subrogation recoveries (\$ millions)	Subrogated cases	Average subrogation recovery (\$)	Ratio of recoveries to health benefit charges
2003-2007	BlueCross BlueShield	AR	563.4	15.8	2,831	5,587	2.81%
2003-2007	Highmark BlueCross BlueShield	PA	1,026.9	0.3	228	1,425	0.03%
2004-2006	Health Care Service Corporation (BCBS)	OK	889.7	3.0	1,406	2,155	0.34%
2004-2008	Altius Health Plans	UT	440.6	0.4	97	4,161	0.09%
2004-2008	CareFirst BlueChoice	MD	234.7	0.2	93	2,011	0.08%
2004-2008	Carefirst BlueCross BlueShield	MD	6,810.1	13.9	5,636	2,473	0.20%
2004-2008	HealthPartners Bloomington	MN	433.2	0.8	967	833	0.19%
2005-9/2010	Independence BlueCross	PA	N/A	0.8	246	3,386	N/A
2005-2009	American Postal Workers Union	MD	2,567.6	3.5	819	4,216	0.13%
2005-6/2010	Optima Health Plan	VA	N/A	0.1	39	1,841	N/A
2006-7/2009	BlueCross BlueShield of Florida	FL	N/A	11.5	3,048	3,775	N/A
2006-6/2009	Wellpoint Inc.	OH	N/A	52.6	19,312	2,724	N/A
2006-2/2011	BlueCross BlueShield	SC	N/A	6.1	109,672	56	N/A

Source: OPM, OIG (various years).

* In addition to claim payments, the total health benefit charges in some reports appear to include other miscellaneous payments and credits, including subrogated amounts. N/A denotes cases in which the audit period used to determine total subrogation recoveries does not align with the period for which health benefit charges data are available.

NOTE: Several audits in the source were completely omitted from this table because they did not distinguish between specific subrogation details and general health benefit refunds.

V. CONCLUSION

Several recent court cases have highlighted concerns over healthcare subrogation. This report presents economic, legal, and actuarial perspectives on subrogation. Economic literature suggests that under certain conditions subrogation may improve economic outcomes, and actuarial accounting guidelines suggest that subrogation may lower health care premiums in the aggregate. However, the *U.S. Airways, Inc. v. McCutchen* case facts, and those of other similar litigation cases, highlight subrogation's potential to leave accident victims worse off than if they had not sued their tortfeasor. These concerns have brought legal challenges to subrogation across the country; in fact, the *U.S. Airways, Inc. v. McCutchen* case is only one of at least three cases to reach the Supreme Court in the last decade.

DOL's Employee Benefits Security Administration (EBSA) sought to determine the extent to which health plans utilize subrogation to recover health benefits paid to participants, and this report supported EBSA's efforts. We found that publicly available healthcare subrogation data are scarce, and therefore, we can make only crude estimates of subrogation's extent. To estimate the volume of subrogation recoveries, this report presents a number of observations on healthcare subrogation practices and recoveries. From the limited data available, we found evidence suggesting subrogation recoveries of between 0.0% and 0.3% of claims payments among six health insurers in Ohio, around 0.3% of premiums among eight HMOs in Maryland, and roughly 0.2% of health benefit charges among a dozen FEHB plans. To put these findings in perspective, consider that private health insurance expenditures amounted to \$848.7 billion in 2010 (National Health Expenditure Accounts, 2012). Under the assumption that private health insurers recovered between roughly 0.2% and 0.3% of benefit payments, this suggests subrogation recoveries by private health insurers amounted to between roughly \$1.7 billion and \$2.5 billion in 2010.

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Work for this report was performed in accordance with the Statement on Standards for Consulting Services issued by the American Institute of Certified Public Accountants (AICPA). Our services were provided under contract DOLJ089327415 from the U.S. Department of Labor.

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