

## Strengthening payment integrity: subrogation and injury coverage coordination

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## Introduction

Economists at the Centers for Medicare & Medicaid Services (CMS) reported that in 2009, total health expenditures reached \$2.5 trillion, which translates to \$8,086 per person or 16.2 percent of the nation's Gross Domestic Product (GDP).<sup>1</sup> The growth is significant but not nearly as dramatic as it had been in previous years. Even so, virtually every stakeholder in health care continues to feel the pinch.

Health plans have taken several steps to minimize the impact of escalating costs. Perhaps most notably, they have begun designing new plans that give consumers more decision-making power—and, presumably, discretion—as to the quality of care they receive.

Claims management, particularly management of accident-related health claims, gets less attention as an area of potential cost savings. It's true that industrywide, these claims account for a small percentage of health plans' total claims volume. According to a recent survey conducted by America's Health Insurance Plans (AHIP), 14 percent of claims were pended or delayed in 2006.<sup>2</sup> Of those, health plans reported that 9 percent were delayed because of coordination of benefits or coverage determination. Some health plans identified possible third-party liability as a reason for pended claims, but the overall percentage is unclear in the survey, as these claims are grouped into the "Other" category, which includes delaying payment for scenarios such as incorrect provider ID, Medicare as primary payer, or high-dollar claims.

Perhaps the survey didn't capture the whole story. It is unclear how precisely health plans were able to recognize accident-related claims that may have been the responsibility of an auto insurance, personal injury protection, workers' compensation, or some other policy. If accident-related claims went unnoticed, health plans probably processed them like any other claim. Lack of awareness may have accounted for the low percentage of claims reported in the AHIP survey as pended due to possible third-party liability. One company's claims data suggests that it also may be costing health plans significant dollars. OptumInsight client data show that accident-related claims make up 8 to 10 percent of health plans' claims volume. When those claims were directed to their rightful payer, recovered from a liable third party, health plans preserved a collective \$267.1 million in 2009. The gap between the AHIP survey and the OptumInsight data raises an important question: What if health plans don't know what they don't know?

It costs plans money to investigate a claim. According to the 2006 AHIP survey, pended claims were delayed for eight to 14 days. The value of these claims may seem minimal, but like all increments of a process, they add up. Health plans reported in the survey that on average, pended claims requiring manual or other review cost health plans \$2.05 to process, compared to \$0.85 for a clean claim that was received and processed electronically without extra review. But more importantly, the amount

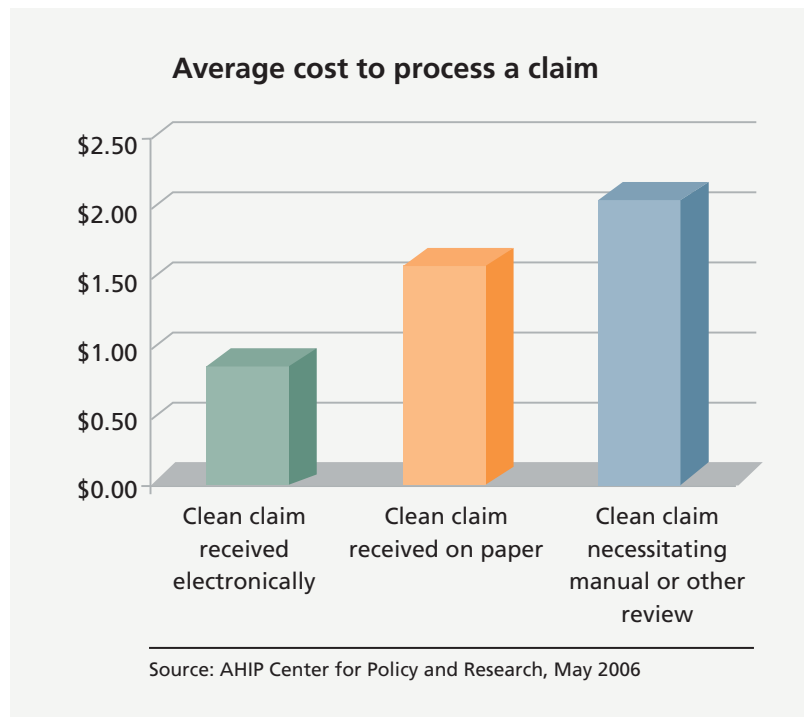
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There are more than 20,000 injury and disease classification codes, or ICD-9 codes. As many as 3,700 of them suggest a connection to an accident.

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<sup>1</sup> Centers for Medicare & Medicaid Services, "National Health Expenditures 2009 Highlights," <http://cms.hhs.gov/NationalHealthExpendData/downloads/highlights.pdf>

<sup>2</sup> AHIP Center for Policy and Research, "An Updated Survey of Health Care Claims Receipt and Processing Times," May 2006, available at <http://www.ahipresearch.org/pdfs/PromptPayFinalDraft.pdf>. Data for pended or delayed claims was not included in the 2009 update. To view the AHIP Center for Policy and Research's most recent survey data, "Update: A Survey of Health Care Claims Receipt and Processing Times, 2003," visit <http://www.ahipresearch.org/pdfs/SurveyHealthCareJan252010.pdf>.

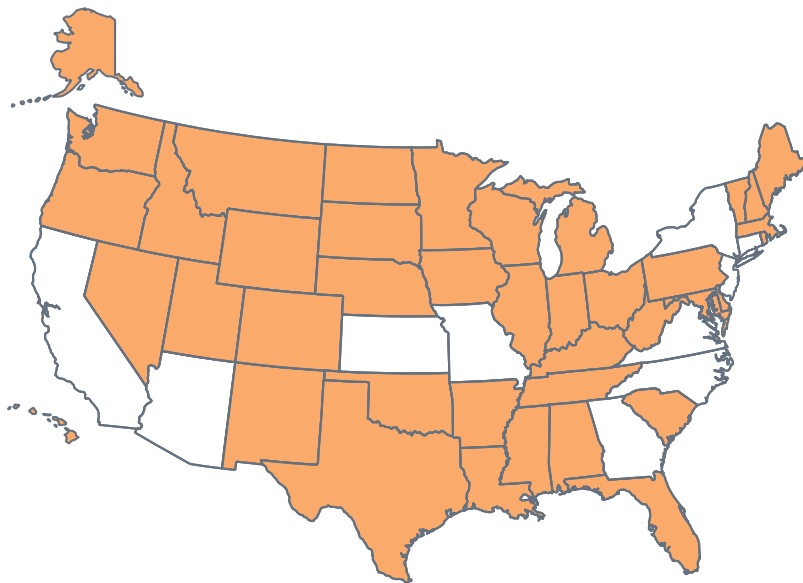


spent on investigating a claim may pale to the amount gained by recovering money paid out on an accident-related claim that was someone else's responsibility, or, ideally, identifying the correct payer and preventing the health plan's payment in the first place. Obviously, if the plan can reduce the cost of investigation through sophisticated automation, the benefit of pending the claim will increase.

Enter subrogation and injury coverage coordination (ICC). Both processes are intended to save health plans money—potentially millions of dollars annually—by preventing payment on claims that are someone else's primary responsibility to pay or by asserting the plans legal rights of subrogation recovery. When health plans save money, so, too, do employers and consumers through lower premiums and lower out-of-pocket expenses.

## Recovering claims through subrogation

A technical definition of subrogation is the substitution of one person in place of another, with reference to a lawful claim, demand, or right, so that the one who is substituted succeeds to the rights of the other, in relation to the debt or claim and its rights, remedies, or securities. In layman's terms, subrogation means that a health plan can be reimbursed by the party whose insured was deemed responsible for the accident or injury. For example, auto liability insurance or workers' compensation coverage would pay for medical claims resulting from an accident, thus saving the medical insurance carrier from incurring excessive costs. Subrogation is different from "the right of reimbursement," in which the injured person has already recovered payment from the third party and the plan then asserts a claim against the member to recover the benefits of which the plan advanced or paid. While, an important distinction, this paper uses the term subrogation to broadly describe all aspects of third party liability recovery.




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### State policies on subrogation among fully insured health plans

- State laws permit subrogation or right of reimbursement
- State laws bar subrogation or right of reimbursement

States allowing subrogation subject to change. Please check with your legal department and/or your state insurance commissioner.

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Some health plans pursue subrogation internally, but many are instead turning to business process outsourcing due to the complexity of state and common laws surrounding recovery. Vendor partners with subrogation experience and expertise and advanced analytics systems can relieve pressure on plan adjusters by doing the initial sifting and then flagging claims with potential third-party responsibility. A health plan may choose to turn its daily claims data over to a vendor partner with the expertise, tools, and technology to mine the data and investigate the claims for treatments common to auto- or workers' compensation-related accidents.

There are more than 20,000 injury and disease classification codes, or ICD-9 codes. As many as 3,700 of them suggest a connection to an accident. Health plans may pay those claims without necessarily knowing whether they truly are responsible. For example, a provider may submit claims coded for a patient's general back pain. If the back pain stems from an overambitious golf outing, the claim likely belongs to the health plan. If it resulted from a car accident, the health plan ought to coordinate benefits to prevent payment or initiate subrogation efforts to recover its money from the relevant auto insurance carrier.

A health plan may also find that skills needed to properly pursue subrogated claims do not neatly fit into their existing organizational structure. Depending on plan type, applicable laws fall under state or federal jurisdiction, and navigating the subrogation legal landscape may be a complex and costly proposition. For example, state law and regulation would not impact self-funded ERISA-qualified plans, and may or may not impact fully insured ERISA-qualified plans. For self-funded ERISA-qualified plans and some fully insured ERISA plans, federal law will control their interpretation and enforcement. Also, subrogation laws change regularly in response to various constituencies and interests working to modify and/or adjust current state laws. Having a vendor partner deeply knowledgeable in the legal and industry impacts can help health care partners contain overall medical costs.<sup>3</sup>

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<sup>3</sup> This OptumInsight paper focuses on the laws and regulations that impact health plans subject to state legal regulation: fully insured plans and self-funded non-ERISA plans. The legal issues that impact self-funded ERISA-qualified plans and some fully insured ERISA plans are not addressed in this paper.

Some health plans rely on their own staff to recoup paid claims that were later discovered to be the responsibility of another carrier. With a steady flow of incoming claims that need to be processed and paid, recovery isn't the best use of adjusters' time. One survey found that just 3 percent of claims handlers' working time was spent working to recover claims.<sup>4</sup> Sophisticated analytics systems can help distinguish between the two cases by identifying not only common accident-related codes, but also patterns of those codes—and cost thresholds—over time to alert health plans to possible subrogation cases. Once a case is identified, the health plan can begin investigating, usually through letters or phone calls, the cause of the claim and determine financial responsibility. If another payer is found to be accountable, the health plan can assert a subrogation claim and pursue reimbursement.

## Front-end claim identification

Injury coverage coordination (ICC) intends to protect health plans from unnecessarily paying accident-related claims at all. This can be a daunting task given the millions of claims plans receive daily. Most claims require several days of processing even without taking time to search for a possible connection to an accident. The 2009 AHIP survey found that health plans processed nearly 74 percent of electronic and paper claims within seven days and 97 percent within 30 days.<sup>5</sup> State laws and insurance companies' desire to stay competitive have inspired faster turnaround times, which, indeed, have improved in recent years thanks to electronic adjudication. Sometimes lost in the desire to close claims quickly, however, is time allowed to scrutinize them for signs that they are linked to an accident and possibly someone else's financial responsibility. *Insurance Journal* noted that health plan adjusters' job performance is often measured by how long it takes them to close a claim: "...there is a great pressure to close files and move on to the next claim as quickly as possible."<sup>6</sup>

ICC investigates potential accident claims prior to payment, ideally just prior to issuing a check on the original claim. A provider submits a claim to a patient's health plan. The health plan follows its normal procedures—verifying eligibility, determining coverage, and preparing to pay the provider as negotiated through their network contract. ICC kicks in at the point the plan is ready to cut a check on what may be an accident-related claim.

The first evidence of a possible ICC claim comes in the box on the claims form that notes whether an injury was caused by an accident. If that information is not readily apparent, a good analytics system operates the same way it does in subrogation cases. It mines claims for ICD-9 codes that suggest a possible connection to a car- or work-related accident. Instead of triaging claims until a certain quantity or cost threshold is met, ICC jumps right into investigation mode when the system flags a questionable claim.

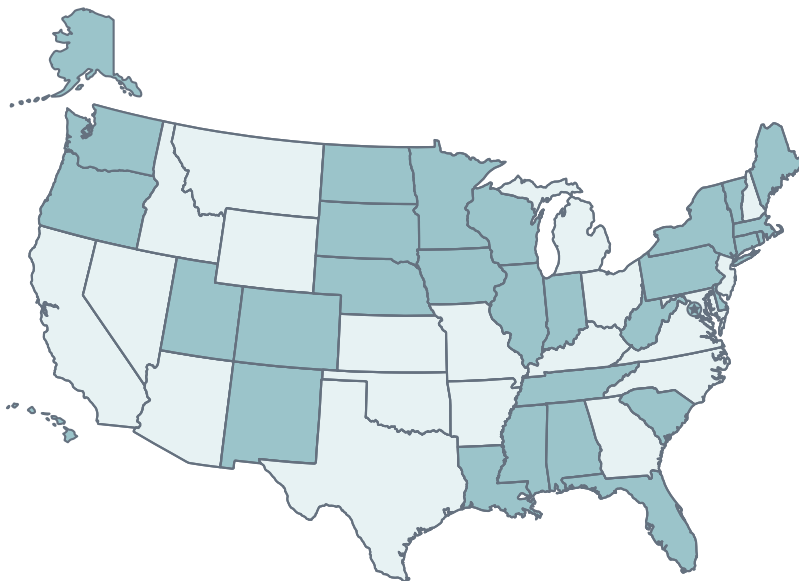
All of this has to be done quickly because of state prompt-pay laws, insurer policies, or provider policies that set minimum timelines for claim payment and levy penalties for missing them. Rather than initiating a letter campaign, an ICC telephone campaign is initiated to call the insured directly to get more details about whether the claim originated from an accident-related injury. If the insured doesn't reply to repeated telephone messages and letters within a certain timeframe, a health plan may choose to deny the claim for lack of response.

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<sup>4</sup> *Insurance Journal*, Feb. 9, 2004

<sup>5</sup> AHIP Center for Policy and Research, May 2009

<sup>6</sup> *Insurance Journal*, Feb. 9, 2004




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**State policies on injury coverage coordination among fully insured health plans**

- State laws are open to ICC
- State laws limit ICC

States allowing injury coverage coordination subject to change. Please check with your legal department and/or your state insurance commissioner.

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Once other coverage is identified, ICC “actively coordinates” with the other insurer, confirming that they have a copy of the bills in question and sufficient coverage available to pay the claims. Because of this “active coordination” method, members may find injury coverage coordination quite palatable, however, because they stand to pay less out of pocket under auto or workers’ compensation policies than under their health plan. Likewise, providers may prefer to be paid through auto or workers’ compensation policies because, as mentioned earlier, they likely can collect more for the same claim than they would from a health plan with whom they agreed upon discounts.

Another advantage to ICC is that it establishes a case history so that if subsequent claims come in and are found to be related to the same accident, they can be routed to the appropriate carrier without having to re-investigate.

Not all states are friendly to ICC, however. Some prohibit coordinating with auto carriers. Others forbid telephone calls to plan members, leaving mail as the only communication avenue, an avenue that may be too slow to work in a world of prompt payment requirements.

**Getting the most out of subrogation and ICC**

Health plans are increasingly looking to outside help for administrative functions, including claims adjudication and payment. Subrogation, and to a greater extent, injury coverage coordination (ICC), are relatively new strategies for improving payment integrity. Both work best when powered by a fast, thorough, agile investigation system. Here are some traits to look for when considering outsourcing these important—and potentially money-saving—tasks.

**The right expertise**

Successful subrogation and ICC depend on three key steps: 1) Identification of potential accident-related claims, 2) Timely and complete investigation into payment responsibility, and 3) Effective case management, including negotiation, settlement, legal guidance, and recovery. Within these steps are technical tasks, including review and evaluation of accident details, contract language, law, insurance coverage and other theories of liability to assess the probability of successful recovery. Look for a service that can execute on both identification and investigation. Companies with expertise in data mining and analytics can accelerate and streamline both processes.

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**Combination services**

Some companies specialize in subrogation. A few are wading into ICC. Look for a company that offers both. Injury coverage coordination allows health plans to direct claims to the proper third-party payer before they ever send out a check. If time limitations preclude identification and investigation before payment, subrogation services can serve as a backup. With the help of biostatistician-developed data-mining criteria, analytics systems can sift through vast stores of claims data—before or after a health plan has paid a claim—to find the ones that belong to someone else.

**Turnaround time**

Look for a company that can be quick without hurrying. Many claims management companies tout their turnaround times as the industry's fastest. Sometimes fastest isn't best. A cursory subrogation investigation that recovers \$10,000 in 10 days isn't nearly as valuable as the 20-day investigation that finds multiple related claims totaling \$100,000.

**Legal experience**

Subrogation and ICC laws vary by state, so legal experience is crucial. Attorneys who specialize in these services can help navigate state laws, advise investigators, negotiate with insurers' or members' attorneys, and, if needed, litigate.

**Communication**

Health plans may not have the time or expertise to investigate accident-related claims on their own, but that doesn't mean they don't want to stay informed on recovery and payment-prevention efforts. A company with solid analytics can deliver daily guidance on a claim-by-claim basis, as well as monthly performance reports on anything from active cases to negotiation progress to projected and actual recovery results.

**Conclusion**

While accident-related claims make up a relatively small proportion of health plans' total claim volume, health plans can save money by paying closer attention to them and directing them to the rightful payer through solutions such as injury coverage coordination and subrogation.

A good analytics program, such as Optum's SubroAnalytics®, in addition to experienced recovery analysts and legal counsel, can strengthen the efficacy of the capture of potential third-party claims both before and after a health plan has paid them. Pre-payment identification, such as injury coverage coordination, is ideal because it saves plans money by preventing errant payments in the first place, as well as avoiding costs associated with trying to recover payments from a third party. Providers also benefit because they can get paid more for their services from an auto or workers' compensation payer that is not bound by the network discounts afforded to health plans. Finally, plan members benefit because ICC likely reduces their out-of-pocket expenses.

Even if prompt-pay policies impose too tight of a timeline for health plans to identify and investigate accident-related claims before payment, plans may opt to recover their money through subrogation. Either one or both approaches strengthen payment integrity, and, potentially, a health plan's bottom line.

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