OPINION OF TRUSTEES

In Re

Complainant: Employee
Respondent: Employer
ROD Case No: 81-496 - November 30, 1984

Board of Trustees: Harrison Combs, Chairman; John J. O'Connell, Trustee; Paul R. Dean, Trustee.

Pursuant to Article IX of the United Mine Workers of America 1950 Benefit Plan and Trust, and under the authority of an exemption granted by the United States Department of Labor, the Trustees have reviewed the facts and circumstances of this dispute concerning the level of health benefits for the Complainant's spouse. They hereby render their opinion on the matter.

Background Facts

The Complainant's spouse was hospitalized from August 14, 1983 through August 17, 1983. The hospital charges resulting from this admission totaled $1,290.08 and the physician's charge for her care during this admission was $255.00. The Complainant's spouse is employed and her employer's insurance is primary. However, it appears from the documentation received to date that the bills for the hospital and physician services were sent to both the primary insurer and the Respondent's carrier without indicating to either that there was other insurance involved.

As a result, the primary insurer paid $792.07 for the hospital claim and $204.00 for the physician's services, while the Respondent's carrier paid $1,237.58 for the hospital claim and $210.00 for the physician's services. The Respondent's carrier's payments resulted in a $739.57 overpayment on the hospital charge and a $159.00 overpayment on the physician's charge.

Each provider informed the Employee's spouse of an overpayment and advised her that it was holding a cheek for her. The Employee's spouse picked up both checks, and then contacted her employer's insurance carrier, who advised her in each case that the money was hers and she should keep it.

In April 1984 the Respondent's carrier began to contact the Complainant's spouse at her place of employment to request reimbursement of its overpayment to the hospital and physician provider. The Respondent's insurance carrier conceded that the overpayments had not been due to any fault on the part of the Employee or his spouse, but were caused by clerical error on the part of the providers who billed for services. The Employee and his spouse contacted the State Insurance Commission and claim that its representative advised them not to reimburse the money to the employer's carrier, since they were not liable.

The Respondent's carrier continues to request reimbursement of the overpayment made on the hospital and physician bills. The Employee and his spouse have requested that this matter be resolved as soon as possible, as they wish to stop the Respondent's carrier's demands for payment.

Dispute

Is the Complainant responsible for refunding the overpayments made by the Respondent's insurance carrier?

Positions of the Parties

Position of the Complainant: The Complainant contends that he is not responsible for refunding the overpayments made by the Respondent's insurance carrier.

Position of the Respondent; The Respondent Employer contends that the overpayments made by its insurance carrier should be reimbursed by the Complainant.

Pertinent Provisions

Article III A. 10. (f) of the Employer's Benefit Plan states:

(f) NON-DUPLICATION

The health benefits under this Plan are subject to a non-duplication provision as follows:

1. Benefits will be reduced by benefits provided under any other group plan, including a plan of another Employer signatory to the Wage Agreement, if the other plan:

    (i) does not include a coordination of benefits or nonduplication provision, or

    (ii) includes a coordination of benefits or non-duplication provision and is the primary plan as compared to this Plan.

2. In determining whether this Plan or another group plan is primary, the following will apply:

    (i) The Plan covering the patient other than as a dependent will be the primary plan.

(ii) Where both plans cover the patient as a dependent child, the plan covering the patient as a dependent child of a male will be the primary plan.

(iii) Where the determination cannot be made in accordance with (i) or (ii) above, the plan which has covered the patient the longer period of time will be the primary plan.

(iv) In the event a Pensioner or surviving spouse is covered under another group plan by reason of his or her employment, the other group plan shall be the primary plan for such Pensioner of surviving spouse and their eligible dependents.

3. As used herein, "group plan" means (i) any plan covering the individuals as members of a group and providing hospital or medical care benefits or services through group insurance or a group prepayment arrangement, or (ii) any plan covering individuals as employees of an employer and providing such benefits or services, whether on an insured, prepayment or uninsured basis.

4. If it is determined that benefits under this Plan should have been reduced because of benefits provided under another group plan, the Plan Administrator shall have the right to recover any payment already made which is in excess of the Plan's liability. Similarly, whenever benefits which are payable under the Plan have been provided under another group plan, the Plan Administrator may make reimbursement directly to the insurance company or other organization providing benefits under the other plan.

5. For the purpose of this provision, the Plan Administrator may, without consent of or notice to any Beneficiary, release to or obtain from any insurance company or other organization or person any information which may be necessary regarding coverage, expenses and benefits.

6. Any Beneficiary claiming benefits under this Plan must furnish the Plan Administrator such information as may be necessary for the purpose of administering this provision.

Discussion

Article III A. (10) (f) provides for non-duplication of benefits by an Employer Benefit Plan and another group plan in situations where benefits are provided by both plans. This non-duplication provision precludes duplicate payments for services and limits payments to the total allowable charges for covered services.

In this case, the secondary payer issued payment in an amount that in combination with the payment made by the primary payer, exceeded the total amount of billed charges, thereby resulting in an overpayment. The amount paid by the secondary payer, after the primary payer paid the benefits provided under its plan, exceeds the level of benefits provided under the Employer Benefit Plan. The Plan Administrator has identified overpayments in the amount of $739.57 and $159.00, respectively, for services provided by the hospital and physician.

Article III A. (10) (f) 4. establishes that if it is determined that benefits under this plan should have been reduced because of benefits provided by another group plan, the Plan Administrator shall have the right to recover any payments already made which are in excess of the Plan's liability. Therefore, the Respondent's Plan Administrator has the right to recover the overpayments in the amounts of $739.57 on the hospital charge and $159.00 on the physician's charge.

Opinion of the Trustees

The Respondents Plan Administrator has the right to recover the overpayments made by the Respondent's carrier on claims resulting from the Complainant's spouse's hospitalization from August 14, 1983, through August 17, 1983.