IRMI®

Workshop A

Workshop A

# *WORKERS COMP TRENDS AND DEVELOPMENTS*

**Presented by**

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**Instructor**
**Florida Association of Insurance Agents**

**James Pocius**
**Shareholder**
**Marshall, Dennehey, Warner, Coleman & Goggin**

The workers compensation insurance market has experienced substantial changes in recent years. This session examines key workers compensation issues and challenges, including coverage availability and affordability, underwriting and claims practices, and litigation trends. Court cases will be used to heighten awareness and demonstrate trends in key areas, including workers compensation fraud, employee leasing, employment-related disease claims (e.g., smallpox), the erosion of immunity, and the disputed cost/benefit of settling lawsuits.

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# William H. Perkins
## Instructor
## Florida Association of Insurance Agents

Mr. Perkins is one of the speakers for Preconference Workshop 6, "Construction Insurance and Bonding Overview," which lasts all day on Monday, and he is also copresenting Workshop A, "Workers Comp Trends and Developments," on Tuesday. He has been an instructor for the Tallahassee-based Florida Association of Insurance Agents (FAIA) since June 1993. His teaching responsibilities at the FAIA are concentrated on commercial insurance with interests in maritime compensation, employment practices liability, and fee-based income for insurance agents. Prior to joining the FAIA, Mr. Perkins was an agent for 12 years in his father's Orlando agency, during which he was an active member of the Independent Insurance Agents of Central Florida, serving as a board member, chairing its education committee, and serving as a guest lecturer at the University of Central Florida's Small Business Development Center. He recently spoke at the Independent Insurance Agents and Brokers of America InfoXchange on the topic, "How To Insure the Maritime and Longshore Exposure." Textbooks in which he has been involved include *Advanced Maritime Insurance*, *Longshore and Harbor Workers Compensation Act and Jones Act*, *Employment Practices Liability*, and various works concentrated on business insurance topics. He graduated from Loyola University of the South in 1980 and holds the Accredited Advisor in Insurance designation.

Mr. Perkins was named IRMI's Words of Wisdom (WOW) speaker at the 21st IRMI Construction Risk Conference. This is Mr. Perkins's fifth year to speak at the Construction Risk Conference; he also was a speaker on employment practices liability at the Independent Insurance Agents of America's 104th Annual Convention.

# James Pocius
## Shareholder
## Marshall, Dennehey, Warner, Coleman & Goggin

Mr. Pocius is copresenting Workshop A, "Workers Comp Trends and Developments," on Tuesday. As a shareholder in the Scranton, Pennsylvania, office of Marshall, Dennehey, Warner, Coleman & Goggin and a member of the firm's workers compensation department, he supervises the workers compensation attorneys in the firm's Scranton, Allentown, Williamsport, and Harrisburg offices. His practice is dedicated to the full-time litigation of workers compensation claims, federal black lung claims, and employers liability claims exclusively on behalf of insurance companies and self-insureds. His experience includes full file development and litigation in the United States District Court for Middle District of Pennsylvania, Court of Common Pleas, Third Circuit Court of Appeals, Federal Black Lung Administrative Law Judges, Workers Compensation Judges, and Appellate Courts in the Commonwealth of Pennsylvania.

Prior to joining Marshall, Dennehey, Warner, Coleman & Goggin, he was in private practice specializing in defense of civil litigation, workers compensation, and federal black lung. He was associate solicitor of the City of Scranton from 1988 until 1990. He was associate professor at Marywood College, teaching workers compensation in the ABA-approved legal program from 1987 until 1997. He has also served as an associate attorney with Lenahan & Dempsey, P.C., in Scranton; as a legal clerk to the Honorable James J. Walsh, Judge of the Court of Common Pleas of Lackawanna County; and as a member of the legal staff at Dollar Savings Bank in Pittsburgh.

In addition to numerous in-service presentations dealing with workers compensation and federal black lung issues for various employers, insurance companies, and self-insured administrators in the Scranton area, Mr. Pocius has addressed the Pennsylvania Bar Institute and the CPCU Society on several occasions. He has also been a speaker for the American Bar Association, the National Workers Compensation and Disability Conference, and the Lorman Business Institute. He wrote "Attorney's Fees and Penalties" and was coauthor of "Offsets under Act 57" for the Pennsylvania Bar Institute. His article, "Interaction between the Pennsylvania Workers Compensation Act and the Heart and Lung Act," was published in the *Pennsylvania Bar Association Quarterly* and "Subrogation in Workers Compensation" was published by the Pennsylvania Defense Institute. He was coauthor of "Analysis of the Federal Coal Mine Safety Act," written for International Risk Management Institute's *IRMI's Workers Comp: Coverage, Laws, and Cost Containment*; "Defining the ADA," for the *Pennsylvanian* magazine, and "Litigation in Workers Compensation Claims," for the American Bar Association national magazine, *Compleat Lawyer*. Mr. Pocius is also responsible for multiple articles published in the *Defense Digest* on behalf of Marshall, Dennehey concerning various workers compensation issues.

He earned his juris doctor degree from the Dusquesne University School of Law in Pittsburgh in 1978, and his bachelor of science degree in pre-law from Pennsylvania State University in State College in 1974. He was selected for the Dusquesne Law Review, was a student representative from Dusquesne Law School to the American Bar Association, and was news editor for the law school magazine, *Jurist*.

He is a member of the American Bar Association and the bar associations of Pennsylvania and Lackawanna County, and the Pennsylvania Defense Institute.

# *WORKERS COMP TRENDS AND DEVELOPMENTS*

***William H. Perkins***
***Florida Association of Insurance Agents***

***James Pocius***
***Marshall, Dennehey, Warner, Coleman & Goggin***

## I. Trends

The presenters will briefly outline the current conditions of the workers compensation market and legal challenges.

A. Availability issues

B. Affordability issues

C. Underwriting and claims practices

D. Litigation trends

E. Forecast

## II. Topics

Each of the following topics will include a review of court decisions that addresses the topic and provides an interesting and/or provocative insight into the question. The presenters will then provide legal and/or insurance tips that would/could assist in managing or mitigating the problem highlighted by the topic.

A. Workers compensation fraud: Does crime pay?

B. Employment-related diseases

1. Smallpox vaccinations: prevention or claim?

2. Asbestos: More of the same?

C. Slip sliding away: The erosion of immunity

D. To settle or not to settle: Is that the question?

E. Employee leasing: Does PEO spell disaster?

## III. Tips

Each of the topics discussed during the presentation will conclude with a series of legal and/or insurance tips that are meant to be practical tools that can be employed to aid the insured in managing their workers compensation exposures. Some examples of these tips include:

A. Legal

1. Witness management
2. How to prepare the employer
3. How to perform a good initial interview
4. Prompt claims handling
5. Partnering with the carrier

B. Insurance

1. Qualities of a quality carrier
    a. Underwriting practices
    b. Claims administration
2. Qualifying a qualified agent/broker
3. Knowing right from wrong: Finding the right job for the right job

# WORKERS COMP TRENDS AND DEVELOPMENTS

***William H. Perkins***
***Florida Association of Insurance Agents***

# TRENDS

## Workers Compensation Market Results

### Premium Volume Increases

The ’90s witnessed workers compensation net written premium steadily decline from a high of $31 billion early in the decade to $22.2 billion at the end. The new millennium saw the first increase in net written premium when in CY 00 there was an increase of $2.6 billion followed by increases of $1.2 billion and $3 billion in 2001 and 2002 respectively.[1]

### Improved Pricing

Other improvements experienced since 2000 include increases in the countrywide average approved rates/loss costs. In 2002 the average increase was nearly 5 percent and the same average has been seen in states during the first half of 2003.[2] Significant rate/loss cost increases have been witnessed in the states of South Carolina (+17.5), Missouri (+13.8), Florida (+13.7),[3] Montana (+13.8) and California (+10.5 percent).

### Indemnity and Medical Severity Increases

The early ’90s saw an annual average rate of change in workers compensation indemnity costs of .3 percent from 1991 to 1995. Since then, the annual average cost of indemnity claims has continued to increase to an average of 6.8 percent since 1996. There are two principle reasons for this change. Medical claims costs are increasing at a double digit pace over the past couple of years, largely due to increased medical severity and increased prescription drug costs. In fact, during the last two years medical claim cost severity increased by 10.7 percent and 12 percent respectively. According to the U.S. Department of Commerce, prescription drug expenditures have outpaced consumer expenditures on other related medical care since 1995. In some years, the difference is a factor of three.[4]

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[1] 1990–2001 Workers Net Written Premium, A.M. Best
[2] State of the Line: Analysis of Workers Compensation Results, NCCI
[3] Rate reduction of 14 percent effective October 1, 2003, due to benefit changes
[4] State Advisory Forum, NCCI

## Frequency Declines

Lost time claims are down once again in 2002 by approximately 4.5 percent. The reason for this decline is attributable largely to improvements in the workplace, technology and economic incentives. These include:

- Continued emphasis on workplace safety
- Increased use of robotics
- Increased use of modular design and construction techniques
- Increased use of power-assisted processes
- Advances in ergonomic design
- Widespread use of cordless tools
- More and better job training
- Improved fraud deterrents[5]

## Residual Market Growth

The premium size of residual markets increased to $1.2 billion, up from $632 million in 2001. While experiencing an increase in writings, combined loss ratios have remained steady during the last four years. This is due to appropriate rate changes and adoption of special programs such as assigned risk rate differentials, removal of premium discounts, surcharges (ARAP) and loss sensitive rating. Despite these improvements, residual underwriting results remain negative.

## Workers Compensation System Reform

Major changes have occurred within the state's legislative environment. During the last electoral season, 24 new governors were elected to state houses and several states saw changes in the party in power. Within the first three months of 2003 there were 18 new insurance commissioners elected or appointed to the head regulator's position. The affect of prior legislation permitting term limits has resulted in the loss of institutional knowledge and the introduction of novice lawmakers.

This year has seen legislative changes in two of the largest workers compensation states. In California, reform to the system has been a topic of many of that state's gubernatorial candidates. There was a great deal of debate in the legislature about the amount of money that would be realized in the form of cost savings to California's employers as a result of the senate and assembly bills. Some have suggested a savings of five to six billion dollars, yet critics cite California's official rate making entity, the Workers' Compensation Insurance Rating Bureau (WCIRB) indicating that its preliminary review shows costs are still projected to increase despite legislative reforms. Most of the savings associated with SB 228 and AB 227 were from the medical side of workers compensation system. Changes are anticipated next year, among them are revisions to:

- Permanent disability
- Employer choice of physician
- Amend vocational rehabilitation program

[5] Ibid

In Florida, a governor's task force made up of select members from employers, consumer advocates and legislative representatives worked diligently for nearly a year and envisioned significant revisions resulting in their proposal that came to be known as Fair Care. A companion group largely represented by industry officials, crafted its' own list of recommendation changes. In the end and following generally accepted law-making principles, compromise led to changes to several areas that were approved during a special legislative session. The restructuring resulted in expansion of the residual market to include a subplan that includes capped rates, revisions to benefit and medical issues, increased anti-fraud provisions and litigation reform including stricter compensability standards and restricted eligibility for exemptions.

## Insurer Financials

Increased claim costs and a weakened investment climate combined to downgrade many insurers. Some downgrades may foreshadow potential insolvency and those carriers remaining may experience additional financial stress. The after affects of D&O claims arising from corporate scandals, revisited asbestos exposures and the lingering claims of 9/11 have all contributed to insurer's review of their reserving practices. According to NCCI estimates, workers compensation reserves were deficient by a projected $18 billion for CY '02. While high, this reflects an improvement over 2001 when reserve deficiencies were at $21 billion. It has been reported that several independent research and investment firms have counseled reserve deficiencies will continue to be an industry issue.

# TOPICS

## Terrorism

Described by an industry official as "the highest profile issue facing the workers' compensation market,[6]" terrorism is a threat that poses many difficulties for the workers compensation industry. Unlike other property and casualty lines of business, workers compensation does not have the choice to exclude terrorism. Because of the mandatory nature of workers compensation, residual markets will provide a means of coverage when underwriting practices result in the lack of availability in the voluntary market. Additionally, workers compensation cannot put a limit on benefits like other forms of insurance. To do so would require statutory changes in each of the states' workers compensation legislation. This exposure and uncertainty of its magnitude imposes tremendous risk to the workers compensation system. With the passage of the Terrorism Risk Insurance Act of 2002 (TRIA), a good first step was taken in the right direction but the journey is not without its share of challenges.

First, TRIA is not a long-term solution. It was enacted November 26th, 2002 and is scheduled to expire December 31st, 2005. This three year backstop does allow insurers to develop sufficient capacity for future terrorists acts but its' short duration does not allow insurers the security of a long-term strategic solution. Second, while TRIA is designed to respond to terrorist attacks of foreign origin, it does not protect insurers from exposures of domestic terrorism. Third, a potentially large financial obligation could arise from assessments due to insolvencies caused by terrorism.

Modeling has been used to estimate the impact of a terrorist attack on the workers compensation system. One such program is currently in place[7] and indicates workers compensation losses alone would have a devastating impact and is a problem for all regions of the country. Obviously, not an understate-

[6]Stephen Klingel, President and CEO, NCCI Holdings Inc., *Critical Issues Facing Workers Compensation*
[7]NCCI and EQECAT

ment and despite the current efforts at improving homeland security paired with the benefits afforded under TRIA, the industry still faces challenges such as:

- Acquiring adequate terrorism reinsurance at affordable prices
- Guaranty fund assessments for insolvencies
- Ongoing threat of domestic terrorism

## Smallpox Vaccinations

The threat of bioterrorism led to President Bush to announce the establishment of the Smallpox Vaccination Program on December 13, 2002. In addition to all military personnel being vaccinated against smallpox, the vaccine was made available on a voluntary basis to medical professionals and emergency personnel and response teams that would be the first on the scene in a smallpox emergency. Four months after the introduction of the program, three persons (two civilian and one military) died from heart attacks attributed to the smallpox vaccine and another 50 adverse reactions to the vaccine were reported by the Centers for Disease Control and Prevention. These so called “first responders” would not enjoy the same degree of medical aid afforded to the military as they are mostly civilians working for local police, fire and public health agencies. Because of the uncertainty involving coverage under workers compensation or health insurance covering smallpox injuries, the call for 450,000 first responders to be vaccinated by the end of February 2003 has resulted in fewer than 30,000 volunteers as of the end of March.

As for state workers compensation, an AFL-CIO survey[8] reveals that only 14 states clearly guarantee coverage of smallpox as of April 2003. They are:

| | |
|---|---|
| Alabama | New Jersey |
| Arizona | North Dakota |
| Colorado | Ohio |
| Idaho | Texas |
| Kentucky | Washington State |
| Maine | West Virginia |
| New Hampshire | Wisconsin |

Five states (California, Georgia, Indiana, Massachusetts, Mississippi) confirmed coverage based on case law, nine states (Arkansas, Connecticut, Delaware, Florida, Illinois, Maine, Michigan, Missouri, Montana) indicated no coverage and eight states (Illinois, New York, Nebraska, New Mexico, Oklahoma, Pennsylvania, Tennessee, Virginia) surveyed responded by saying some workers compensation insurers in the state. Twelve states (Alaska, Iowa, Kansas, Louisiana, North Carolina, Oregon, Rhode Island, Vermont, Virginia, Wyoming) are still reviewing coverage for smallpox under workers compensation. While some authorities disagree if coverage is provided on the basis there was no injury because the vaccination is a “prophylactic exercise”[9] nonetheless, some form of protection is called for.

Initially, some vaccination-related liability protection was available to vaccine manufacturers and institutions that administer the vaccine under section 304 of the Homeland Security Act but that did not ad-

[8] www.aflcio.org/yourjobeconomy/safety/smallpoxcomp
[9] *Business Insurance*

dress the compensation for "first responders" who are subsequently injured or disabled by the vaccine. This exposure led to the passage of the Smallpox Emergency Personnel Protection Act, which passed on April 30th, 2003. While those eligible include "first responders" the benefits are secondary to any available workers compensation, health or disability insurance.

## The Graying Workforce

For demographic and economic reasons the relative number of older workers will increase in the next two decades. The likelihood of increased workplace injuries could have a marked affect on the severity of occupational injuries.

This will have an impact on the workers compensation system and will be of special concern in states with an aging population.

It's not uncommon to learn of older workers (between the ages of 55-65) taking longer to heal after an injury and undoubtedly this will have an impact on medical and disability costs. Statistics maintained by NCCI indicate the older the injured worker the more work days are lost to work-related injury or illness. Based on data taken from 2001, employees 65 and older show a 40 percent increase in the median number of days lost compared to workers ages 55 to 64.

Common injuries experienced by older workers are those associated with driving and falling. Reduced vision impairs ability to see detail (either directly or peripherally), depth perception and color contrasts. Muscular and skeletal limitations such as limited flexibility, reduced strength and diminished reaction time as well as mental and neurological conditions such as short-term memory loss and increased sensitivity to noise and sudden movement will be challenges for managing an aging workforce. Combined with common health problems, the result of employing older workers can mean exposures to higher frequency and/or severity claims that will inevitably have a negative impact on workers compensation costs.

The challenge for employers is to find methods of effectively hiring and training older workers and promoting workplace safety that considers the special needs of this demographic group. By enhancing the workplace experience, the employee will not only benefit the employer, but will improve their own well-being and provide a necessary service to the world of work.

# TIPS

## Evaluating Insurers

Financial stability is often considered first among several criteria used to evaluate insurance companies. One of the most respected sources of insurer financial information is the Key Rating Guide published by the A.M. Best Company. This guide summarizes financial information and rates more than 2,600 property and casualty carriers over a five-year period. The ratings are based on a number of factors that affect the financial stability of the insurer such as underwriting competence, management efficiency, reserve practices, adequacy of net resources and investment policies. In addition to A.M. Best, other insurer rating services include Standard & Poor's, Duff & Phelps, Moody's Investment Service, Fitch Ratings and Weiss Research. Because so many insurers are having their ratings downgraded, it is advisable to check the latest ranking on a regular basis. Additionally, each state has regulatory responsibility for insurers authorized to do business in their state and their oversight and can often provide valuable information on the financial standards of a particular insurer. In some cases carriers do not fall under the full jurisdiction of the state and these carriers are sometimes referred to as excess and surplus (E&S) carriers or unauthorized insurers. Such classification does not imply limited financial resources; in fact

in many cases these insurers are better financially than those under the full scrutiny of the regulator. In cases involving a carriers' insolvency, some protection may be provided by a state guaranty fund. Such funds are often responsible only for authorized carriers and then may limit benefits to policyholders based on state laws. In any case, review of the financial standards of an insurer by using one of the suggested rating organizations is a sound business practice.

A second important factor to investigate an insurer is the quantity and quality of the services provided. For instance, what type of loss control and auditing services are provided? Does the carrier maintain a staff of specialized technical personnel to conduct inspections and advise insured's on how to manage insurance costs? Underwriting skills and flexibility plus familiarity with the insured's business operations are essentials in maintaining a professional insurance program. Does the carrier operate within a limited geographic area or can it provide protection on a national and international basis? Careful analysis of the carrier's experience in providing insurance for a particular class of business both from a historical perspective and where possible, their commitment to this class of business in the future are key decision points in the evaluation of an insurer.

The prompt investigation and payment of claims is another key factor in evaluating an insurer. Consideration should be given to if the insurer uses staff adjusters or hires independent adjusters to settle losses. The advantage of using staff adjusters suggests better knowledge of company coverage forms and procedures that could prove invaluable at claim time. In some cases, insured's selection of counsel is a distinct advantage over a carrier that does not provide such flexibility. Access to claims officials and prompt response time to claims questions are positive signs of a carrier's dedication to professional claims handling.

# *WORKERS COMPENSATION EMERGING TRENDS*

***James Pocius***
***Marshall, Dennehey, Warner, Coleman & Goggin***

1. Federalization of Workers Compensation

   A. Medicare interference with Workers Compensation

   B. The Federal Privacy Act

2. Erosion of Employer Immunity

## Federal Control of Workers Compensation Systems

1. Medicare's requirement that they approve settlements

2. The HIPPA law and its effect on workers compensation

## Medicare Set-Aside Arrangements

I. Section 1862 (b) 2n (Social Security Act) requires that Medicare payment may not be made for any item or service to the extent of that payment has been made or can reasonably be expected to be made under a workers compensation law or plan.

II. Medicare's authority to review workers compensation cases:

   A. 42CFR411.46 requires Medicare to exclude its payments when an individual receives a workers compensation settlement award that is intended to compensate the individual for future medical expenses required because of work-related injury or disease.

      1. Controversy over commutation or Compromise and Release.

   B. Medicare set-aside arrangements apply to workers compensation settlements that involve a commutation aspect (defined by the agency as payment of future medical benefits)

      1. Medicare set-aside arrangements are independent of Medicare liens for past injury related services.

      2. Any identified claims for past injury related services must be reimbursed to the Medicare trust fund.

      3. COBC must be contacted at 1-800-999-1118.

III. Circumstances which Medicare approval is required:

A. Claimants who are entitled to Medicare regardless of the settlement amount (based on age or based on Social Security Disability)

B. Claimants with a reasonable expectation of Medicare enrollment within 30 months of the settlement date and a total settlement of greater than $250,000.00.

1. If Claimant is less than 65 years old and has been receiving Social Security Disability Benefits for two years or more, they have automatically become entitled to Medicare.

2. If the Claimant is 65 years or older, they are entitled to Medicare.

IV. Medicare set-aside basics:

A. Set-aside funds may only be used to pay for injury-related services that would otherwise be covered by Medicare.

B. Set-aside funds should be sufficient to last the reminder of the Claimant's estimated life expectancy.

C. If the Claimant only requires prescription medication; a set-aside arrangement is still required for doctor visits to get prescriptions filled.

V. Common Medicare covered services:

A. Doctors

B. Diagnostic tests

C. Steroid injections

D. Hospitalization

E. Surgery

F. Morphine pumps

G. TENS stimulators

VI. Services that are not covered by Medicare:

A. Prescription medication

B. Dentures

C. Glasses

D. Hearing aids

E. Physical rehab after MMI is achieved (for specific Medicare covered questions call 1–800–633–4227)

VII. Processing of cases:

A. Turnaround time 90-120 days

B. Submissions, each office is different and unless a submission is correct, Medicare may return it to you.

# Medical Privacy Regulations
# Problems in Workers' Compensation
# Related to the Medical Privacy Act

The Medical Privacy Act or HIPPA was enacted in 1996. This law directed the health and human service administration to issue medical privacy regulations. The final regulations were published on December 28, 2000 and the amendments were adopted on August 14, 2002. An effective date of the Act for compliance was set on April 14, 2003.

Medical privacy was an issue because electronic storage and transmittal and retrieval of medical records magnified the risk of exposure, embarrassment or employment discrimination.

There was partisan interest for this bill and the healthcare industry favored uniform national privacy regulations in place of 50 different state requirements.

In Workers' Compensation cases, there is a legitimate need to be able to obtain medical information concerning any Claimant. The need for this information includes the processing of the Workers' Compensation claim, providing disability evaluations, facilitating return to work following the injury, carrying out Utilization Reviews of medical treatment (under the appropriate state regulations), complying with Workers' Compensation reporting requirements, investigating suspected fraud, securing reimbursement from secondary injury funds, subrogation against Third Party recoveries, and conducting public policy research.

All health plans and medical providers are covered under the HIPPA framework. However, Workers' Compensation is not a health plan. The employer/insurer and Workers' Compensation third party administrators are not covered entities that must safeguard medical information. However, the Workers' Compensation systems have been adversely affected by the access rules.

There is a specific (but less than clear) exemption for Workers' Compensation participants from patient authorization requirements where disclosure is required by law. Further, under this law, disclosure is limited to the minimum amount necessary as determined by the ***provider.***

We now must get patient permission to obtain, use or exchange Medicare, personnel or health information. Thus, the first problem in Workers' Compensation, even though we are exempt, is that most providers are requiring patient permission to obtain medical records.

The next problem is that even with the consent, disclosures are limited to the minimum amount necessary. Who is to determine the minimum amount? The Claimant may determine that the minimum amount was the first visit with regard to the alleged work injury. However, past medical records are often the best way to find out if the Claimant really had a work injury or whether or not Claimant may be exaggerating his/her symptoms.

The federal law specifically indicates that any covered entity (any health provider or doctor) must safeguard personal health information. Personal health information was defined very broadly as information relating to past or present or future physical or mental health, or provision of health care to an individual, or payment for health care".

With regard to Workers' Compensation, does the law really require a Claimant's authorization to disclose medical information in a Workers' Compensation case?

Section 164.512 states that "a covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to Worker's Compensation or other similar

programs, established by law, that provide benefits for work-related injuries or illness without regard to fault".

Unfortunately, there is no definition of authorized in the Act and it is not clear how the federal government will interpret that word. In addition, as a practical matter, all of the health care agencies and providers that this author deals with require an authorization from the Claimant. This is despite the fact that the preamble to the law reiterates various provisions in the existing rule and reinforces the intent not to interfere with Workers' Compensation disclosures. Currently, Eric Oxfeld, the President of the UWC, a lobbying organization for employer's and businesses in Washington, has indicated to the author that there are only three people assigned to enforce the law at the present time. Therefore, you will not see much government enforcement presently.

The next problem with this law is that there is a minimum necessary standard. The problems with this minimum necessary standard are several. Initially, the Federal Government is ill equipped to decide what is necessary under 50 different state Workers' Compensation laws. In addition, there is a patient incentive to with hold relevant information if it will improve their status in the Workers' Compensation system.

There is also an open invitation to fraud in the environment with doctor shopping and attorney choice of physicians.

This law also causes delay in litigation with regard to full disclosure. It is also costly to comply. Since the government will eventually determine what the minimum necessary standard is, and, since the providers are requiring authorization, etc., this added burden to obtain medical records adds a cost to the Workers' Compensation system. However, the preamble to the law also indicates that the government will actively monitor the effects of the rule to assure that it does not have any unintended negative effects that disturb the existing Workers' Compensation system. The government further indicates that if the privacy rule is being misused and misapplied to interfere with the smooth operation of the Workers' Compensation systems, it will consider proposing modifications to the rule to clarify the application of the minimum necessary standard. This author would suggest that all employer's write to the HHS and indicate that the law is interfering with the smooth operation of the Workers' Compensation system.

The next problem with the Privacy Act is that the patient has the right to review the records and revise them before providing them to opposing counsel in the discovery request. The doctor may be also re-review the note and add or subtract items before supplying the records. To this author, as an employer representative, this is an open invitation to fraud. Obviously, the doctor can change the history of the Claimant or the past medical history of the Claimant or treatment records before providing the records; the complexion of a Workers' Compensation case could change completely.

With regard to amendments to the HIPPA law, amendments are only allowed every 12 months. This author strongly urges that employers and carriers must monitor the situation and be ready with examples of problems. Further, you should encourage your state regulators to modify laws or regulations to expressly require disclosures by providers.

Respectfully Submitted,

______________________________

By: James E. Pocius, Esquire

# Workers' Compensation and Medicare Conflict over Settlements

Recently, within the last several years, conflict has arisen between Medicare and the Workers' Compensation systems in the 50 States. The conflict arose in 1980. At that time a series of acts were passed by the Federal Government to insure that Medicare was only secondarily responsible for paying medical expenses for individuals covered by Medicare who were covered by any other type of private insurance.

In 1986 the statute was amended to add a private right of action against primary payers for the recovery of funds by Medicare. In Workers' Compensation terms, this meant that if Medicare paid a bill on a Workers' Compensation case that should have been paid by a first party insurer Workers' Compensation, Medicare had the right to try to recover their funds.

If Medicare has, by mistake, made any payment, it can recover by bringing an action against "any entity responsible for making primary payment." (42 CFR 411.24(e)).

The Agency can also collect double damages if it actually has to file a suit. The term "any entity" includes a third-party administrator, doctor, carrier or the participants in the litigation including the Claimant's Attorney.

Medicare has a subrogation right to collect these monies that can waive the right if it is "in the best interest of the program." Medicare can also seek to recover conditional payments within three years beginning on the date on which the item or service is provided. Medicare is empowered to collect work from any Workers' Compensation first party payer in all 50 States. (42 CFR 411.40).

These regulations, which empower Medicare to make recoveries in subrogation situations were interpreted by the Agency in 2000 and 2001 to mean that every Workers' Compensation settlement had to be approved by Medicare. Further, it appeared that the agency did not have the manpower to approve every single Workers' Compensation case which arose across the country. This created a log jam. States such as Pennsylvania, Michigan and Florida, which have a fast track in order to resolve Workers' Compensation settlements had a real conflict with the 6 to 9 month waiting period. In addition, one must also consider that other states, which do not allow Workers' Compensation participants to settle the medical parts of their claim were not affected by Medicare's stance.

During March of 2001 this author became involved in a series of meetings with Medicare through a delegation from the Commonwealth of Pennsylvania in an attempt to resolve the conflict between the systems. The actual wording of the regulations has added to the controversy and has exacerbated the conflict.

42 CFR 411.46 seems to contain contradictory paragraphs. Paragraph (a), entitled "Lump-sum commutation of future benefits, states "if it is stipulated that the amount paid is intended to compensate the individual for all future medical expenses required for the work-related injury, Medicare payments are excluded until medical expenses related to the injury equal the lump sum. Medicare payments are excluded until medical expenses related to the injury equal the lump sum.

Thus, in commutations, Medicare will not pay for the treatment of the work-related condition until the settlement amount has been consumed.

However, in Paragraph (d) of the same section, entitled "Lump Sum Compromise Settlement" the regulation indicates "if a lump-sum compromise settlement forecloses the possibility of future payment of workers' compensation benefits, medical expenses incurred after the date of settlement are payable by Medicare".

Even after the author reviewed these two sections a number of times, it still appeared that there was a distinct conflict between paragraph (a) and paragraph (d).

Further confusion was generated by the next Section (42 CFR 411.47). This regulation attempted to explain the apportionment of a lump sum compromise settlement of a Workers' Compensation claim.

Paragraph (a)(1) indicates that if a compromise settlement allocates a portion of the payment for medical expenses and also gives reasonable recognition to the income replacement element, that apportionment may be accepted as a basis for determining Medicare benefits.

The next Paragraph (a)(2) basically states that if no recognition is given to the medical portion of a claim, the agency will use a mathematical formula to determine the amount of medical set-off. The author notes that neither of these paragraphs mention a Medicare set-aside trust. Further, they do not indicate that every Workers' Compensation settlement requires the approval of Medicare.

During discussions with Medicare, the Agency took the position that in order to settle a Workers' Compensation case, an amount of the settlement had to be allocated to an interest-bearing account in order to pay for possible future Medicare expenses.

The participants were actually asked to predict how much medical expense would be related to Medicare for the future lifetime of the Claimant and that set aside an amount to cover that projection.

Unfortunately, Medicare had no guidelines with which to make this prediction. There was nothing in any of the regulations which provided guidance or provided support for the agencies position. It is possible that Medicare has exceeded the authority of its regulations in this area. There is nothing in any regulation to indicate that Medicare has the right to request its subrogation interest be protected before bills are actually paid.

The agency also took the stance that every case had to be approved by Medicare. Thus, even if a Claimant was not receiving Medicare benefits and would not qualify for Medicare benefits for 20 years, Medicare still took the position that they would want to approve every settlement. Similarly, even if people were receiving Medicare benefits based on age and not on injury the agency took the position that any Workers' Compensation settlement had to be approved. Further, in cases where there were small amounts of money involved ($5,000.00-$10,000.00). Medicare still wished to have approval on these cases. These interpretations essentially caused resolutions in Workers' Compensation cases where the parties wished to resolve the medical portion of their claim, to grind to a halt. Further, the avalanche of cases into the Medicare system also caused the agency to become powerless to issue approvals.

This author, along with the delegation from the Pennsylvania Department of Labor addressed these problems to U.S. Senator Arlen Specter. The Senator arranged a meeting with Medicare on May 24, 2001. In that meeting, the problem concerning Medicare approval of Worker's Compensation cases was discussed. The conflicts and the regulations were pointed out and this author and the Pennsylvania representatives requested changes with regard to the Agency's position.

One of our primary requests was that a monetary limit be placed on Workers' Compensation cases as well as a time limit. In other words, if a Claimant was not going to qualify for Medicare payment for 30 or 40 years, Medicare should not be interested in the Workers' Compensation settlement. They would not have a subrogation interest. Similarly, in cases where future medical benefits would be a minor consideration, Medicare should not be interested in the settlement because there would not be a large amount of subrogation interest.

After this meeting, a Guidance was issued by Medicare (on 7-23-01). While the Guidance has raised many questions it has also answered some of the questions and solved some of the initial problems.

The Agency provided that unless a Claimant is actually receiving Medicare benefits, Medicare's interests should only be considered "when the injured individual has a reasonable expectation of Medicare enrollment within thirty (30) months of the settlement date and the anticipated total settlement amount for future medical expenses and disability lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.00." Thus, if a Claimant has applied for Social Security Disability Benefits but has not yet received them no Medicare approval is required unless the settlement is over $250,000.00. Similarly, if the Claimant is too young to qualify for Medicare based on age and has not applied for Social Security Disability there is no reason to seek approval from Medicare because the Claimant would not have a reasonable expectation of receiving Medicare benefits in thirty (30) months.

Problems still arise when a Claimant is actually receiving Medicare benefits either based on age or through Social Security Disability. Currently, the agency wishes to approve every Worker's Compensation settlement that involves a Claimant who is receiving Medicare benefits for any reason. Thus, there is no monetary limit in these type of cases. Even if the case has settled for $5,000.00-$10,000.00 you must seek Medicare approval. Often, this provides an obstruction to settlement especially if the settlement involves only medical expenses.

This author continues to work with the officials at Medicare in an attempt to redefine the parameters for Claimants who are receiving Medicare benefits. However, no official position has been yet announced by the Medicare agency. We are hoping to hear from Medicare at some time within in the next three to four months. Hopefully, as times goes on, this procedure will become streamlined and less of a problem for all of the parties involved.

Respectfully submitted,

By: ____________________________________
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## Erosion of the Employer Immunity Doctrine (States Surveyed: California, Illinois, Florida, and Pennsylvania)

1) Dual employment doctrine.

2) Public policy exceptions.

3) Intentional Torts

## Top Ten Tips for Your Next Deposition

1) Think before you speak.

2) Do not volunteer information.

3) Only comment on what you have seen or heard.

4) Do not guess and do not explain your thought process as to how you reach the answer to a question.

5) Do not testify as to what other people know.

6) Do not let the examiner put words in your mouth.

7) If you are finished with an answer and your answer is complete and truthful, you do not have to expand upon.

8) If an objection is made to a question, listen to the objection very carefully.

9) If an examiner appears confused about your profession and its' technical aspects, do not attempt to educate him/her.

10) If you do not remember something, say so!