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*Thanks for reading this edition of ClaimsBytes®. Please look
for our Winter edition for more important claims news.*

Sincerely,
The Graham Company Claims Services Department

Spring Claims Services' Workshop a Big Success!

The Graham Company Claims Services Department held its Spring Workshop on April 2, 2009 entitled "Know Your Rights! When Must You Pay and When Can You Deny a Workers' Compensation Claim?"

Given the current economic conditions, it is more important than ever for employers and insurers to aggressively manage Workers' Compensation claims.

Workshop attendees learned what an insurance company and its insureds can do to stop paying claims that they are not legally obligated to pay.

Our panelists were lawyers for each of the following four states: Pennsylvania, New Jersey, Delaware and Maryland. Due to the overwhelmingly positive response, we added a second Workshop on Friday, April 24, 2009.

If you would like a copy of the course materials, please contact your Graham Company Claims Consultant.



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EMERGENCY CLAIMS BYTES

The Graham Company recognizes that emergencies don't just happen during business hours. The Graham Company Claims Services Department stands ready to assist our clients 24 hours a day, 365 days a year. In the event of an emergency claim, please call The Graham Company at (215) 567-6300 or toll-free at (888) GRAHAM-C (472-4262). If you are calling after hours, you will receive instructions on how to reach The Graham Company's On-Call Emergency Claims Coordinator.

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Liability Bytes

New Medicare Reporting and Effect on Claims Settlement

The Medicare Secondary Payer Act, which has been in effect since the early 1980's, allows Medicare to always be a secondary payer. Thus, if there is any other primary payer (liability or workers' comp., self-insurance, etc.), Medicare is entitled to reimbursement of any they paid.

The problem for Medicare in the past was that the agency was unable to track settlements or determine whether or not there was another primary carrier. The agency was not active in recovering past conditional payments or providing for future needs because they were unable to track liability and workers' compensation settlements.

The solution to this problem was the SCHIP Extension Act, which was signed into law in December of 2007. This Act requires that all health carriers, liability carriers, workers' compensation carriers, no-fault carriers and self-insurers report cases involving Medicare beneficiaries, where they are considered primary payers.

It is important to note that if there is no responsibility to make medical payments in a case (property damage, indemnity only, etc.), no reporting is necessary with regard to Medicare. The only cases that must be reported involve Medicare beneficiaries (age 65 or collecting Social Security Disability benefits) that have an element of medical damage.

For workers' compensation cases, this essentially involves every case. Thus, workers' compensation carriers must report all of their open claims because each workers' compensation carrier has responsibility to pay the medical claim for the work-related injury.

For liability carriers, the reporting is a bit different. Since a liability carrier does not assume responsibility for any medical payments until they actually make a payment on a liability case (through settlement or verdict), reporting is not mandated until the case resolves. (In the case of a no-fault carrier, however, as soon as the no-fault carrier assumes responsibility for medical payments, the case must be reported.) For liability carriers, this reporting requirement is essential only in cases that deal with a Medicare beneficiary with elements of medical damage.

If a qualifying case is not reported by a carrier or self-insurer, there is a fine of \$1,000.00 per day per case that is not reported.

The first deadline for the reporting process was May 1, 2009. Beginning on this date and continuing through September 30th, each responsible reporting entity (insurance company or self-insurer responsible for payment) must register and begin the reporting process. For those of our clients who have large deductibles or self-insurance retentions, The Graham Company is arranging to have the insurance company or Third-Party Administrator acknowledge this SCHIP obligation and perform it for you.

On January 1, 2010, testing will begin for the exchange of claim information. Medicare's goal is to have actual reporting information accurately exchanged beginning on April 1, 2010. This phase will continue through March 31, 2010.

EFFECT ON SETTLEMENTS

The reporting requirements essentially give Medicare an ability to identify all settlements. As such, the agency will now be able to determine if they have made any conditional payments which should have been paid by another carrier. If that is the case, the carrier will receive a Medicare conditional payment letter requesting repayment. This will now happen on all settled cases.

A more subtle problem occurs if there are future medical payments or damages involved in the settlement. In workers' compensation cases, these future damages can be accounted for through the use of a Medicare set-aside. However, there is no such method available currently with regard to liability settlements. This author has spoken to the agency several times regarding this problem. The sources within the agency have explained that there are no plans to establish guidelines regarding the review of liability settlements. Currently, there are no guidelines in effect. All cases involving Medicare recipients must make provisions to protect Medicare's interests.

While the reporting Act does not require the parties to establish Medicare set-aside accounts in liability actions, the agency's interests still have to be taken into account. Since the agency will now be able to track all settlements, the agency would then have the information to either refuse to pay any future claims or indicate that no future claims will be paid until the settlement amount was accounted for. In other words, if you settle the liability claim that contained an element of future medical damages and the claimant later sent a bill to Medicare for those same injuries, Medicare would be able to come back to the carrier after the case was settled and request payment. **The case would not be finally closed.**

Currently, Medicare's policy is to allow voluntary review at the request of the parties. However, if the region does not have the manpower to review cases, there is no duty for them to do so. **If the agency will not review, it is up to the parties to initiate a method to guarantee that the case is closed.**

CONCLUSIONS

In summary, as a result of the new Medicare reporting requirements, this author believes that the cost of settlements will rise. Further, on every action, the following recommendations should be considered:

1. When a case is filed, the parties should immediately convey whether or not the plaintiff is a Medicare beneficiary.
2. If the claimant is a Medicare beneficiary, you must determine whether or not the case involves past conditional payments. If the case only involves past conditional payments, a letter to the MSPRC requesting the amount of conditional payments should be forwarded immediately.
3. If the case also involves future medical care, the situation becomes more difficult. If Medicare will review the case, a set-aside letter will be forwarded by the agency, thus binding them to an amount for future medical care. If the agency will not review it, it is incumbent upon the parties to take Medicare's future interests into account. This author recommends that a Medicare set-aside estimate be obtained and that a Medicare set-aside be incorporated into the settlement documents and perhaps judicial approval should be obtained as well.

The Medicare Secondary Payer Act and SCHIP Extension Act, when taken together, provide a powerful tool for Medicare to continue to collect payments from litigants in the workers' compensation and liability arenas. Having negotiated the guidelines with Medicare for Medicare set-asides in workers' compensation cases, and after reviewing all of the new legislation, as well as talking with the agency concerning their expectations, this author can confirm that Medicare will continue to be involved in settlements for the foreseeable future.

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This article is for information purposes only and cannot be relied on as legal advice. The author can be contacted at (570) 496-4601 or at jepocius@mdwvcg.com.



Legal Bytes

Update: New York Claim Reporting Requirements

In the last Claims Bytes Newsletter, we reviewed some recent changes to New York law regarding claim reporting requirements. The new law requires an insurance company to show prejudice in order for it to deny a claim based on late notice, if the insurance policy is issued after January 17, 2009.

The change in the law **only applies to policies that are issued or renewed after January 17, 2009.** In the event that you have a New York claim under a liability policy issued before January 17th of this year, the old “no prejudice” rule will continue to apply. The old “no prejudice” rule permits an insurer in New York to deny a late reported claim, even if it is not “prejudiced” by the delay. Therefore, you must still promptly report (“as soon as practicable”) any occurred claims as soon as you become aware of them.

In addition, the new law applies to claims made policies as well as occurrence policies. However, the new law does not change the effect of a claims made policy. Accordingly, if the policy requires the insured to report a claim before the end of the policy period (a “claims made and reported” policy), the insured must report that claim before the policy ends. What the new law changes is the effect of a late notice ***within*** the policy period. The new law would require the insurance company to accept the “late” reported claims under a claims made policy (unless it can prove prejudice), so long as the claim is reported within the policy period.

The best rule to follow when reporting occurrences and claims is to report them to The Graham Company as soon as you become aware of them.

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Risk Management Bytes

Downsizing Workforce Can Lead to Upsizing Claims

Times of economic slowdown can lead to layoffs, downsizing, elimination of overtime, reductions in payroll and even workplace closures - all of which can create an increase in your exposure for Workers' Compensation and Employment related claims.

We strongly recommended that employment counsel be consulted with respect to the various state and federal laws which may come into play with potential employment actions. The laws include, but are not limited to, the Worker Adjustment and Retraining Notification Act (WARN), The Americans with Disabilities Act (ADA), The Older Workers' Benefit Protection Act, and the Job Training Partnership Act. To assist you, The Graham Company has developed a program to assist clients in the prevention and management of potential Workers' Compensation and Employment Practices Liability claims resulting from workplace changes such as plant closures and layoffs. This program provides a framework for the management of pending claims as well as claims filed in response to workplace changes.

Considering that employee reaction is triggered once the closure or lay-off announcement has been made, the program has been split into two categories: Pre-Announcement Activities and Post-Announcement Activities.

Pre-Announcement Activities include information and guidance on activities such as selecting a Transition Team, establishing a game plan with specific timeframes for all future activity, updating personnel files to ensure that all employee records are current and complete, assembling complete job descriptions for all positions involved in the workplace change, performing a workplace inspection to identify and correct any potential hazards prior to the announcement, conducting noise studies and hearing tests provide a baseline in defense of potential hearing loss claims, and reviewing the company's loss history to identify and understand any claim trends or patterns as well as the potential impact to existing claims.

Post-Announcement Activities include information and guidance on activities such as offering outplacement services, aggressively managing employees on modified duty, conducting exit interviews, implementing appropriate security measures if needed, observing the departure of terminated employees to ensure safe departure from the premises, conducting weekly status conference calls with the Transition Team to ensure that all procedures are being followed as well as to monitor the status of any new claims, increasing the frequency of hazard inspections, and considering re-assigning and re-evaluating job functions to evenly distribute workflows as key positions are eliminated.

If you are considering a reduction in your workforce, your Graham Company Claims Consultant can and should be an integral part of your Transition Team. For more information on this program, please contact your Graham Company Claims Consultant.

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Legal Bytes

Watch Out for Federal RICO Claims For Improperly Denying Workers' Compensation Claims

I'll bet you never thought that you would be exposed to the same sort of liability that a Mafia Don faces for drugs, gambling and other bad activities. The United States Court of Appeals for the 6th Circuit in a case involving the Michigan Workers' Disability Compensation Act has determined that employers who "scheme" with their insurance carriers and/or physicians to wrongfully deny Workers' Compensation Claims can be sued under the Racketeer Influenced and Corrupt Organizations Act (RICO). RICO is a federal law that provides not only for criminal penalties, but also for a civil cause of action for actions performed as a part of an on-going criminal enterprise. The statute has been used to prosecute such infamous organizations as the Gambino Crime Family, the Hells Angels Motorcycle Club and the Latin Kings.

Michigan Trucking Company, Cassens Transport Co., a self-insured trucker, allegedly engaged in a pattern of "racketeering activity" to deny Workers' Compensation claims. Specifically, the Plaintiffs allege that Cassens and its third-party administrator, Crawford and Company, "deliberately selected and paid unqualified doctors...to give fraudulent medical opinions that would support the denial of Workers' Compensation benefits...".

Cassens Transport argued that the Michigan Workers' Compensation Statute should control and not RICO. The Court of Appeals was not convinced. The Court held that the Workers' Compensation Act would control if it was enacted for the purpose of regulating "the business of insurance." They found that it did not regulate the business of insurance and as such the RICO Claim was permissible.

What this means for employers and insurers going forward is questionable. At a minimum it means that employers and their insurers should take great pains to ensure that any Workers' Compensation denials are fully supported by the law as it applies to the facts of any particular claim. Overly aggressive approaches to claim denial should be carefully reviewed with an eye toward determining whether they are legally appropriate and defensible. Finally, any efforts to use physicians that are overly aggressive in favor of the employer (and therefore whose opinions are questionable) should be discouraged. Truly independent physicians who are looking out for the best interests of **both** the employer and the employee should be encouraged.

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Legal Bytes

Pennsylvania Superior Court: Failure to Preserve Critical Evidence Following Catastrophic Accidents May Impact Employer Immunity under the Pennsylvania Workers' Compensation Act

In an April 17, 2009 opinion in the case of *Minto v. J.B. Hunt Transport, Inc. et al.*, the Pennsylvania Superior Court held that an employer may be liable to a former employee for failing to preserve specific evidence during a post-accident investigation. This opinion not only reinforces the need to preserve critical evidence during a post-accident investigation, but also suggests that the exclusivity provision of the Pennsylvania Workers' Compensation Act may not shield employers from claims by employees or former employees related to the spoliation of evidence.

Marton Minto sustained serious injuries when the tractor-trailer he was driving on behalf of his employer, J.B. Hunt, ran off of the highway. J.B. Hunt conducted a post-accident investigation. Within 12 hours of the accident, they hired an accident investigator, took pictures of the truck and scene, and obtained a police report. A representative of J.B. Hunt also inspected the truck and accident scene. The vehicle was subsequently repaired 15 days later. Minto was fired by J.B. Hunt several months after the accident. He subsequently retained counsel who requested that J.B. Hunt preserve maintenance records, parts, and other documents related to the crash.

Minto filed a negligence and products liability suit against J.B. Hunt and the manufacturers of the truck and its component parts. The Complaint alleged that J.B. Hunt negligently destroyed and failed to preserve key parts of the tractor-trailer, including the seat-belts, brakes, and "black box" data and that this failure prejudiced Minto in his product liability suit against the other defendants.

J.B. Hunt filed a Motion for Judgment on the Pleadings, arguing that Minto's claims were barred by the exclusivity provision of the Workers' Compensation Act. The trial court granted J.B. Hunt's motion, and Minto appealed.

The narrow issue on appeal was whether the exclusivity provisions of the Act precluded Minto's claims against J.B. Hunt based on the facts pled in the Complaint. The Complaint did not allege damages against J.B. Hunt for the physical injuries Minto sustained as a result of the accident. Rather, Minto alleged economic damages as a result of J.B. Hunt's failure to preserve evidence after the accident. The Superior Court held that Minto's claims were not precluded by the exclusivity provision of the Workers' Compensation Act because the injury he is alleging did not "arise" in the course of his employment.

This holding could have a substantial impact on employers and insurers involved in post-accident investigations. Such entities may now need to obtain consent from the injured employee to repair or replace vehicles, equipment, or property involved in an accident. Failing to properly preserve these items, or communicate with an employee or his or her representative regarding the preservation of such items, could impact an employer's ability to use the Workers' Compensation Act as a shield in third party civil litigation.

If you have any questions regarding the potential impact of this decision or would like additional information about the implementation of a post-accident policy and procedure that considers the above issues, please contact Andrew J. Spaulding at 215-587-1160 or aspaulding@postschell.com, Joseph R. Fowler at 215-587-1003 or jfowler@postschell.com, or Michael J. Soska at 215-587-6636 or msoska@postschell.com.



Subrogation Bytes

Arbitration Forums, Inc.

In order to participate in Arbitration Forums, Inc. (often referred to as Inter-Company Arbitration), membership has become mandatory for those insureds who have large deductible programs managed by a Third-Party Administrator or self-insured retentions on their general liability, automobile liability or property insurance policies.

Arbitration Forums, Inc. is the Nation's largest not-for-profit resolution and recovery services organization. Annually they resolve nearly 500,000 disputes worth nearly 2.4 billion dollars in claims as a cost-effective alternative to litigation for the insurance industry. Founded in 1943, Arbitration Forums, Inc. has a membership of over 4,300 insurers and self-insureds. You may have heard of this type of Arbitration referred to as "Inter-Company Arbitration". This arbitration is utilized mostly for automobile and property damage claims where there are disputes in the liability of the claim. As long as the insurance company or client is a member of Arbitration Forums, Inc., the dispute can be resolved utilizing arbitration.

Arbitration Forums has advised that self-insureds and insureds with large deductibles/retentions need to be members in order to participate in this program whether or not the insured's carrier/TPA is a member. Membership to Arbitration Forums, Inc. is free and the only charge is a filing fee of \$40 when a dispute is sent to Arbitration Forums, Inc. The benefits of being a member to Arbitration Forums, Inc. are as follows:

1. Resolution of disputes takes only a fraction of the time compared to litigation
2. Dramatic reduction in legal costs/expense
3. No membership fees
4. A user-friendly process

All of Arbitration Forums, Inc. programs are designed with compulsory provisions requiring signatory members to forego the future litigation of disputes and have their differences settled within the forum. Compulsory arbitration is applicable to a maximum of \$100,000 for automobile and property losses. If you are interested in becoming a member of Arbitration Forums, Inc., please contact your Graham Company Claims Consultant who can assist you with this process. Arbitration Forums, Inc.'s website is www.arbfile.org.

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