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THE DEFENSE PERSPECTIVE

AND OBSERVATIONS OF THE

CALIFORNIA APPLICANTS'

ATTORNEYS ASSOCIATION

SUMMER CONVENTION, 2002

RESORT AT SQUAW CREEK
SQUAW VALLEY, CALIFORNIA

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2002 SUMMER CONVENTION OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION (June 20, 2002- June 23, 2002)

TO OUR CLIENTS:

We had the opportunity to attend the 2002 Summer convention of the California Applicants' Attorneys Association. The mood was upbeat, primarily because of the passage of Assembly Bill 749. Clearly, this was probably the most important current event as far as the convention delegates were concerned, and while we are going to bring you an overview of some of the more important and interesting points and issues discussed over the course of the convention, this is probably the best starting point:

I.

ASSEMBLY BILL 749

In the words of the panel delegates, this is the most significant piece of legislation regarding workers' compensation benefits to come along since the 1983 amendments (which essentially doubled the rates). Quite frankly, the panel members almost appeared to be in a state of unbelieving ecstasy with respect to the passage of this bill. Several of the panel members described it as better than anything that had previously been proposed since the Davis administration took office.

As we reported last Winter, although the legislative panel members reported that a bill was in the works, they were very tight lipped with respect to what it was about, almost giving the general audience the impression that there were not yet any concrete proposals. This, of course, was not true since a complex and comprehensive bill sailed through both houses of the legislature and was signed by the Governor only about three weeks later. We included a basic summary of the bill at the time of our last report to you, and to simplify things, a copy of the summary with respect to that bill that was included in our last report follows. Following that summary are some additional commentaries and supplements with respect to additional information picked up at the conference.

What we found very interesting was that, while the panel members seemed almost giddy about their good fortune and what this new legislation means to them, they were very tight lipped in terms of discussing it. They rather bluntly advised that there were a number of clean up bills which were making their way through the legislature (which was still in session for several months), and they did not want their remarks getting back to the legislature so as to form the basis for any clean up legislation which would limit the effect of the overall bill. They indicated the panel would

have more to offer in terms of what the membership would be able to accomplish with the new bill at the time of the Winter convention, 2003, basically at a time when it would be too late for the bill to be effectively limited by clean up legislation, but it is clear that they expect great things from this bill.

For your information, we present the following summary of AB 749, which was included in our prior package:

Assembly Bill 749 was signed by the governor on February 8, 2002. This bill does make some very substantive changes to existing law. We have had an opportunity to review the bill and, although this is not the place for a comprehensive analysis, a summary of the changes is as follows:

I. **Temporary disability** - The maximum temporary disability rate will rise over the next several years, to a maximum of $602.00 per week, commencing January 1, 2003, $728.00 per week commencing January 1, 2004, and $840.00 per week commencing January 1, 2005. As of January 1, 2006, and on January 1, of each year thereafter, the temporary disability rate will increase based upon the percentage increase in the state average weekly wage from the prior year.

II. **Permanent disability** - The rates change beginning January 1, 2003, and in that year, permanent disability below 70% will be paid from a minimum of $100.00 per week, to a maximum of $185.00 per week, while in cases at 70% or above, the permanent disability rate will stay to a maximum of $230.00 per week. Commencing January 1, 2004, the rates are a minimum of $105.00 per week, to $200.00 per week, for permanent disability less than 70%, and up to $250.00 per week, for disability of 70% or above. As of January 1, 2005, the

permanent disability rate will be a minimum of $105.00 per week, up to a maximum of $220.00 per week, for permanent disability less than 70%, and up to $270.00 per week for permanent disability of 70% and above. Commencing January 1, 2006, the minimum permanent disability rate will be $130.00 per week, up to a maximum of $230.00 per week for disability less than 70%, and up to $270.00 per week for disability of 70% and above (obviously, 100% total disability will continue to be paid at the temporary disability rate). In addition, one additional week will be added to each percent of permanent disability less than 20% (increasing the number of weeks for 1% of disability from 3-4 for disability under 10%, and from 4-5 for disability between 10-19.75%).

III. **Life pension** - The life pension will also essentially double as of January 1, 2006. At this time, the maximum average weekly wage for calculating the life pension is $257.69 per week (the life pension is calculated by multiplying 1.5% of the average weekly wage, times the percentage points in excess of 60). As of January 1, 2006, the maximum average weekly wage for this purpose will be raised to $515.38.

IV. **Death benefits** - Standard death benefits will all increase as of January 1, 2006 to $250,000.00 for one total dependent with no partial dependents, $290,000.00 for two total dependents regardless of the number of partial dependents, and $320,000.00 for three total dependents, regardless of the number of partial dependents. In the event of one total dependent and one or more partial dependents, the partial benefit will be determined by multiplying the annual support by four, but the total payment in no case can exceed $290,000.00. If there are nothing but partial dependents, then the dependency benefit is

determined by multiplying the amount of annual support by eight, although the total amount is not to exceed $250,000.00. If there are no total or partial dependents, then $250,000.00 is to be paid to the estate of the deceased employee (it would appear that the Death Without Dependents Unit is going to be looking for work).

With that being said, a total dependent is re-defined as being not only a minor child, but also a child who is mentally or physically incapacitated from earning. The law requiring payment of the death benefit to the minor child until he or she reaches the age of 18 remains unchanged, but the child who is physically or mentally incapacitated from earning is to be paid the death benefit until the death of that child (essentially, somewhat similar to a total disability case).

V. **Rehabilitation** - In the case of a represented employee, rehabilitation can be settled by a one-time payment, not to exceed $10,000.00.

VI. **Medical treatment** - The presumption of correctness in favor of the treating physician is eliminated, except in cases where the treating doctor was a pre-designated personal doctor. In this regard, however, Labor Code §4600.3, which relates to health care organizations, requires that an applicant be given a choice to either designate or change the health care organization and/or a personal physician at least annually. We have not really analyzed this sufficiently to determine whether or not this would apply in a case where an employer did not have an HCO.

VII. **Disclosure of medical information** - Labor Code §3762 has been loosened up some to allow the disclosure of medical information to the employer with the respect to the mental or

physical condition arising from the claim and the medical treatment provided, as well as medical information necessary to enable the employer to modify its work duties. Quite frankly, we continue to believe there are constitutional problems with this statute from an employer's standpoint, problems which become especially acute where the employer is self-insured (or has a large retention limit) and is funding the compensation through its own pocket, or in cases where the employer has been directly involved in the litigation by the employee by way of actions for Serious & Willful Misconduct or under Labor Code §132(a). If read literally, the statute would seriously hamper an employer's ability to defend itself. Certainly, if literally followed, the statute could cause difficulties in presenting a defense in a fully-insured case, where witness testimony from the employer would be required to rebut claims made by the employee.

Some additional comments are in order. With respect to the temporary disability rate, we know there has been litigation with respect to seasonal employees, and at least with respect to the law as it exists, the issue appears to have been put to rest by Jimenez v. San Joaquin Valley Labor, 67 C.C.C. 296 (2002), involving a seasonal farm worker who earned $405.00 per week from the August to October season, and had no wages at all during the off season. The Board found that applicant was entitled to temporary disability during the agricultural season based upon her earnings, but since she earned zero in the off season, that would be her temporary disability rate. Furthermore, the Board also found that rehabilitation maintenance benefits were to be paid at the same rate as temporary disability (subject to the $246.00 per week maximum), which meant that during the off

season, applicant's rehabilitation maintenance rate would be zero as well. Applicant attorneys screamed about this, the essential feeling being that participation in rehabilitation was somewhat similar to working, and that applicant should receive benefits for this participation.

As a practical matter, the point becomes academic for injuries occurring after January 1, 2003, since a minimum temporary disability rate of $126.00 per week will be in place, no matter what the earnings. In terms of those seasonal workers with zero off season earnings (as well as low wage earners whose average weekly wages are less than $126.00 per week), even with respect to injuries which occurred prior to January 1, 2003, once they have been disabled in excess of two years, Labor Code § 4661.5 will have the effect of raising them to the minimum temporary disability rate of $126.00 per week after that rate becomes effective on January 1, 2003.

On the high end of the scale (disabled workers with permanent disability of 100%, or who are entitled to life pensions), after January 1, 2004, a cost of living adjustment (we suspect this is only in connection with an increase, and that the cost of living adjustment could not be used to justify a decrease in the rate) is to be made with respect to all life pensions (including total disability pensions) for injuries incurred in the previous year. Thus, for example, assuming a 100% case as a result of an injury occurring in the year 2003, the life pension rate (which in a 100% case is the same as the temporary disability rate in effect at the time of the injury) would be $602.00 per week, but this amount would be subject to an upward adjustment as of January 1, 2004, and each year thereafter, based upon the cost of living index. This is the effect of Labor Code § 4659 (c).

No one is quite sure how the cost of living increase is going to work. The panel members assume that the Administrative Director will adopt rules and regulations with respect to how it is to

be determined, and then communicate it to the carriers who are obviously going to need this information.

Two other cases with respect to death claims will also be pretty much academic with respect to death cases which occur after January 1, 2003. In Smith v. WCAB (Walker), 67 C.C.C. _____ (2002), the carrier attempted to establish a partial dependency on behalf of the decedent's parents, so as to avoid payment of the full death benefit to the Death Without Dependents Unit. The attempt was rejected on the basis that decedent's contributions to the household were outweighed by the support that he actually received from his parents. With respect to deaths after January 1, 2003, Labor Code § 3501 (c) provides that, if there are no persons qualifying as either total or partial dependents, then the surviving parents of the deceased employee will be conclusively presumed to be wholly dependent upon the decedent for support.

This would also render academic a case such as Miller v. Fremont Compensation, 30 C.W.C.R. 100 (2002), where it was determined that, even though the decedent's parents did not qualify as dependents, they were entitled to pursue a cause of action directly against the employer for serious and willful misconduct, since the proceeds of a serious and willful misconduct award are not dependency benefits, accrued in favor of applicant immediately at the time of the accident, and are thus payable to his estate.

Additional items of interest relate to the expedited calendar for injury AOE/COE cases (Labor Code § 5502), which the panel members feel is a response to Allen v. State Compensation Insurance Fund, 29 C.W.C.R. 156, where a defendant was able to avoid an Expedited Hearing in an admitted injury case, because the injury with respect to the part of the body in issue was in dispute.

Also noteworthy is Labor Code § 4064 (b), which allows a previously unrepresented applicant, who had gone through the panel QME process, to start all over again and obtain a new QME if he becomes represented. The employer is permitted to obtain a new QME only if the represented applicant obtains a new QME, and while the panel members suggested that this provided a level playing field, it is obvious that the playing field is far from level.

Baseball arbitration (Labor Code § 4065) has been repealed, as has the blanket presumption in favor of the treating physician (Labor Code § 4062.9).

A pre-designated personal physician will still be entitled to the presumption, and certain suggestions by some of the delegates were made that this provision could be manipulated somewhat, but the physician is going to have to have a history of having provided medical care to the applicant.

In passing, we note the case of Gee v. WCAB, 67 C.C.C. 236 (2002), in which the Court of Appeal while smugly advising the Board that it erred in not applying the Labor Code § 4062.9 presumption in favor of applicant's treating physician, demonstrated a fundamental misunderstanding of the facts bordering on idiocy (we wonder why they do not do this in favor of carriers sometimes). In this case, applicant, while unrepresented, apparently requested and received an evaluation by a panel Qualified Medical Examiner. The Qualified Medical Examiner (Dr. Rhoads) decided that additional treatment was necessary, and became applicant's treating physician (the Court of Appeal seems to assume that this is acceptable under Rule 9785 and Tenet). It is unclear whether defendant acquiesced in this treatment, although the suggestion is that it did, at least up to the time the case became litigated.

In any event, applicant became represented, defendant obtained a qualified medical

examination (quite frankly, we are not quite sure how defendant accomplished this), and the matter proceeded to trial, where the trial judge relied upon defendant's QME as being better reasoned.

In essence, the Court of Appeal held that, the Labor Code § 4062.9 presumption of correctness in favor of the treating physician is a rule of substance, of which the trial judge must take judicial notice, so it does not have to be raised in the stipulations and issues (it was never referenced by the judge, and was raised for the first time on reconsideration). The court then found that the judge failed to apply the presumption of correctness to Dr. Rhoads, and remanded the case for this purpose.

The case is just plain wrong. The presumption of correctness applies to the treating physician only if the party against whom it is asserted obtained a qualified medical examination. In this case, applicant obtained a qualified medical examination through Dr. Rhoads, who became applicant's treating physician only after the qualified medical examination took place. As a matter of law, applicant could not claim the benefit of the presumption at this point. This is an extremely important point which the court appears to have missed entirely.

Before moving on, we note that CAAA is unhappy with the case of Smith v. WCAB (Lee), 67 C.C.C. 107 (2002), a case where a licensed sub-contractor misrepresented to a general contractor that it had workers' compensation insurance (the contractor apparently did not conduct an investigation beyond the sub-contractor's representation). Although a statute provided that the failure to maintain workers' compensation insurance would result in automatic suspension of the contractor's license, a notice from the State Contractors' License Board advising with respect to the lack of workers' compensation insurance was also required by the statute, and this advice letter had

not been sent. Under the circumstances, the court found that the sub-contractor remained licensed, and that the general contractor was not responsible in connection with applicant's industrial injury. CAAA is apparently going to pursue legislation which will provide that the license of an uninsured sub-contractor will be deemed suspended where there is a lack of workers' compensation insurance, irrespective of what notices have been sent (or not sent).

II.

TOXIC AND MULTIPLE INJURY CLAIMS

What probably causes as much concern with respect to the new legislation as anything else is the push to combine multiple injuries into one disability, or what appears to be a push by at least some attorneys to expand the envelope with respect to toxic or occupational diseases. The panel discussing the point at which an applicant becomes permanent and stationary began routinely enough. Basically, an applicant reaches a permanent and stationary status where he has made as full a recovery from his or her injury as he or she is likely to make. Estrada v. WCAB, 62 C.C.C. 1384 (1997). Courts have suggested that an applicant does not reach this state until all reasonable healing modalities have been attempted and all reasonable diagnostic testing has been completed, including the physician's evaluation of those tests. City of Glendale v. WCAB (Forrest), 47 C.C.C. 168 (1982); Allianz Insurance Company v. WCAB (Johnson), 47 C.C.C. 416 (1982). If a non-industrial condition must be treated before the industrial injury can be treated, then temporary disability must generally be paid during the period of time as such non-industrial treatment (Fremont Medical Center v. WCAB (Easley), 61 C.C.C. 110 (1996). It is noted that there is no maximum period of time for the payment of temporary total disability (in other words, it can be paid indefinitely if the

circumstances warrant), although there is a 240 week limitation with respect to temporary partial disability (Labor Code § 4656).

The panel members argue that where there is a prima facie case for rehabilitation, and applicant desires rehabilitation, there should really be no gap between the payment of temporary disability and rehabilitation maintenance benefits. They reference Gallagher Bassett Services v. WCAB (Lewis), 66 C.C.C. 520 (2001), which held that the carrier should bear the risk of delays by a treating physician in issuing a permanent and stationary report, and that the carrier must therefore pay VRMA at the temporary disability rate outside of the cap during the period of this delay, as standing for this proposition. We assume they would make this argument with respect to the gap which generally exists between the time a Notice of Potential Eligibility is sent to the applicant, and the return of the reply card (during which time permanent disability advances are generally pad).

The real sticky issues are probably going to occur in the cases of multiple injuries. We all understand Wilkinson v. WCAB, 42 C.C.C. 406 (1977), where the Supreme Court held that, where there are successive injuries to the same part of the body occurring with the same employer and becoming permanent and stationary at the same time, all of the injuries could be combined for disability rating purposes. Over the years, applicant's attorneys have attempted to expand upon this concept. A number of years ago, the big case was Department of Corporations v. WCAB (Daniell), 61 C.C.C. 1469 (1996), where it was held that various injuries to different parts of the body with different permanent and stationary dates, but with the same employer, could be combined. Daniell appears to have been discredited by a number of cases (for example, DeVera, 63 C.C.C. 1169; Bloom, 63 C.C.C.429; Ramirez, 66 C.C.C. 1128), and we have not really seen major pushes of the

Wilkinson envelope in recent times. Apparently, that is going to change. Siding with Daniell is Remick, 66 C.C.C. 1433, in which there were five injuries involving the left shoulder and elbow, arms, and legs, all becoming permanent and stationary at the same time, which were combined for a single disability.

The panel's opinion, based upon a re-examination of some of the earlier cases, is to the effect that the only limitation for combining disability at this point is that the injuries become permanent and stationary at the same time (in other words, the injuries can be to different parts of the body, and can be with different employers). They cite Rumbaugh v. WCAB, 43 C.C.C. 1399 (1978), a Court of Appeal decision, for the proposition that the same employer rule has been abandoned, the court suggesting that compensation for permanent disability should depend on disability, not the fortuitous identity of the employer (although Rumbaugh did require that the injuries be to the same parts of the body), and SCIF v. WCAB (Hurley), 42 C.C.C. 481 (1977), for the proposition that the injuries need not involve the same parts of the body. In examining Hurley, however, we do not believe it really stands for that proposition, as in this case applicant filed three separate Applications involving three different body parts, but only one cumulative trauma period. We think what Hurley really says is that there was really only one injury, a cumulative trauma injury, involving different body parts.

More recent than these cases appears to be Parker v. WCAB, 57 C.C.C. 608 (1992), a Court of Appeal decision which reiterated the Wilkinson rules of same part of the body, same employer, and same permanent and stationary date, although, the association is arguing that the conclusion here is erroneous. Notably, with the exception of Harold v. WCAB, 45 C.C.C. 77 (1980), the Supreme Court has not really spoken to these issues, and the Supreme Court's opinion in Harold appears to

have been more of a calculation issue. While the injuries in Harold apparently involved different parts of the body, but did become permanent and stationary at the same time and were apparently considered combined, the issue was primarily one of calculation, that is, what was the fairest way to subtract the extent of the previous disability, and the court determined that the fairest way was to subtract the number of weeks required by the previous disability.

If applicant's attorneys are successful in this push, the effect would be to significantly weaken the defense of apportionment as it relates to prior industrial injuries (the clear suggestion is that cases such as Harold be argued for the proposition that there is no apportionment, simply credit for the number of weeks paid).

This can probably be classified under the general category of maximizing benefits. Somewhat related to this concept is encouragement of the membership to explore with their clients the possibility of toxic exposures or occupational disease (in other words, if an applicant comes to the attorney with a back case, explore what other hazards he has been exposed to during the course of his work. The essential guiding light here is an old Supreme Court case, Bethlehem Steel Company v. Industrial Accident Commission, 8 Cal. 2d 61 (1943), which stands for the proposition that the disease contracted by an applicant and found to be industrial is not merely a hazard of the community, but that the employee was subjected to some special exposure in excess of that of the community, and it was that special exposure which led to the disease.

The problem here is that there are some fairly recent cases which suggest that the rule is being perverted by a rather amazing application of Labor Code § 3202 (liberal construction for the purpose of extending benefits for the protection of injured persons, sometimes otherwise stated as

giving applicant the benefit of the doubt), as a result of which the Boards seem to be accepting proof from applicants which can only be characterized as speculative, and which results in an illogical shift of the burden of proof to the defendants.

Some of the cases are grudgingly understandable: Liberty Mutual Insurance Company v. WCAB (Millay), 60 C.C.C. 134 (1995), in which applicant claimed exposure to 700 different types of toxic chemicals (evidence which was apparently un-rebutted), resulting in various physical symptoms; and McAllister v. WCAB, 33 C.C.C. 660 (1968), in which a fireman, who was exposed to smoke inhalation, contracted lung cancer; and perhaps even Rosas v. WCAB 58 C.C.C. 313 (1990), where a sewage worker, exposed for many years to raw sewage, contracted Hepatitis B.

The problem with cases like Rosas and McAllister is that they stand for the proposition that proof of medical certainty in these cases is not required, only proof of reasonable probability. This, unfortunately, has led to what appears to be some pretty insane results: Texaco Services, Inc. v. Workers' Compensation Appeals Board (Oblak), 67 C.C.C. 202 (2002), where applicant was given a total disability award based on the finding that his early onset Parkinson's disease was occasioned by his exposure to chemicals, based upon an opinion by applicant's doctor that, in the absence of anything else, the disease must have been caused by the chemicals (and in the face of medical evidence from Dr. O'Niell, an agreed medical examination quality doctor, to the effect that there was no scientific basis in the literature or elsewhere establishing a relationship between chemical exposure and Parkinson's disease); Raley's v. WCAB (Lohman), where applicant was given a 100% award based upon a claim that his multiple sclerosis was lit up by a post-surgical fever (the surgery was to an admitted knee injury), on the basis that, in the absence of the fever, no one could have

predicted when applicant's multiple sclerosis would have become disabling (apparently at least a concession here that multiple sclerosis in and of itself is non-industrial); Lumberman's Mutual Casualty Company v. WCAB (Cannington), 62 C.C.C. 527 (1997), in which it was found that applicant's belief that he was being exposed to dangerous microwaves at work aggravated his non-industrial leukemia and hastened his death; and Federal Insurance Company v. WCAB (John Doe), 60 C.C.C. 422 (1995), in which applicant's contraction of HIV was found industrial, even though the judge found that the one instance of actual potential exposure did not result in contraction (since applicant apparently had evidence of the virus prior to this exposure), but the finding was apparently based upon the "probability" that applicant's work with the sterilized, non-activated serum could have resulted in contamination.

The panel suggested that these types of issues be explored with respect to multiple occupations. Quite frankly, it does not appear that there is really a line to be drawn here. The Board's decisions suggest a willingness to consider an argument that, so long as an applicant was working at the time he contracted it, virtually any sickness or malady would be considered industrial. These types of cases are going to take on much greater significance given the benefit increases referenced in the first section of this report.

III.

CARRIER INSOLVENCIES AND CIGA

For reasons which escape us, the growing number of carrier insolvencies and near insolvencies do not seem to be making much of an impression on applicant's attorneys. One of the sections dealt with CIGA cases, and the attitude of the participants appeared to be that it did not

really make much difference whether the benefits were collected from a solvent carrier, or from CIGA. It was noted that one additional insurance carrier, Paula Insurance Company, became insolvent as of June 19, 2002.

CIGA is not an insurance company, although to a very large extent CIGA conducts business as if it were. It is not bound by the insolvent carrier's determination of coverage, but there must certainly be insurance coverage for CIGA to provide benefits and the Insurance Code provides that CIGA is only responsible for statutorily described covered claims. CIGA's primary impact is with respect to its relationship with other carriers (or other co-defendants for that matter), and the most significant issues relate to the Insurance Code exclusion from the definition of covered claims cases where there is the availability of other types of insurance (Insurance Code § 1063.1 (c) (9)). This most often arises in the context of a cumulative trauma claim where one or more carriers and/or employers share a portion of the period of injurious exposure with CIGA (see Industrial Indemnity v. WCAB (Garcia), 62 C.C.C. 1661). The issue is actually pretty clear where the period of injurious exposure is agreed upon, and a solvent carrier has coverage for a portion of this period. However, the issue has become contentious in cases involving temporary employers (basically, general special employment issues and a situation which arises in connection with specific injuries as well), and in cases involving self-insured employers. In these types of cases, CIGA takes the position that the special employer (the entity to which the temporary agency with the now insolvent insurance carrier has sent its employee to work) is jointly and severally liable for workers' compensation benefits, and that there is thus other insurance available; and that self-insurance is also the legal equivalent of other insurance within the meaning of Insurance Code § 1063.1 (c) (9). Obviously, this is only a

thumbnail sketch of the positions being taken, and both of these situations are presently the subject of extensive litigation. The general special employer issue appears to be set for trial in September, 2002, in connection with the consolidated Remedy Temp cases, presently being handled under Judge Mark Kahn, while the self-insured employer issue is presently before the 5th District Court of Appeals in Denny's v. WCAB (Bochman).

Other issues relate to CIGA's liability for claims by state agencies (excluded under Insurance Code § 1063.1 (c)(4)), and the most contentious of these cases involve Employment Development Department liens in cases where Thomas waivers have been approved. At this time, there does not appear to be much by way of appellate guidance here.

We note this same statute provides that CIGA is not responsible for claims of the federal government, but we are not sure that federal government agencies (such as Medi-Care) would feel bound by this California's statute (at least in cases where they have liens for benefits which were provided prior to settlement).

There was significant litigation with respect to CIGA's liability for pre-insolvency penalties and, at least at the Board level, applicant's attorneys feel that the issue has been resolved against CIGA (CIGA v. WCAB (Harris), 67 C.C.C. 171 and CIGA v. WCAB (Novak), 67 C.C.C. 315 (cases in which hearings were denied). Quite frankly, we do not know why the Supreme Court did not choose to take a look at this issue, as it does appear to be vitally important.

Of interest, is CIGA's ability to take a credit for payment made under uninsured or under-insured motorist claims (Insurance Code § 1063.2 (c)(1)), a situation which is exactly the opposite of that relating to other carriers.

IV.

MEDI-CARE CLAIMS

In connection with future medical care, the focus here is primarily on applicant's attorneys, rather than on the carriers. In connection with settlements dealing with prospective care, the problems arise in settlements which Medi-Care deems to represent an attempt to shift to Medi-Care the responsibility for payment of medical expenses which should legitimately be the responsibility of the employer. These are settlements which will not be recognized by Medi-Care, although the consequences of this appear to be borne pretty much solely by the applicant (and perhaps his attorney, in the event of a malpractice suit): Medi-Care will assume that the entire settlement amount was for future medical care, and will claim a credit for that amount. Obviously, all parties should be cautious in this regard, since there was at least one panel member who felt that there might be criminal fraud liability on the part of all of those involved who knowingly participate in the scheme to shift such payment liability to Medi-Care.

Normally, if such an illegitimate shifting attempt is not present, the Medi-Care Fiscal Intermediary Manual, part 3, section 3407.6 indicates that Medi-Care will defer to a reasonable settlement, and will in general accept a decision by a state workers' compensation agency on a contested claim, or a compromise settlement. If an award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work related injury or disease, Medi-Care payments for such services are excluded until medical expenses related to the industrial injury equal the amount of that award. However, it can also be stated the a portion of the future proceeds of the settlement could go to certain types of medical expenses which are not

covered by Medi-Care, and assuming that Medi-Care deems the settlement reasonable, this will not be challenged, and Medi-Care will not take a credit.

It is noted that there is no statutory authority for a "Medi-Care Set Aside Trust", and that these devices are simply one method by which an accounting of medical costs may be demonstrated to Medi-Care. In addition, there is no requirement that Medi-Care be contacted in advance of a settlement where an applicant is not yet receiving Medi-Care. The general rule is that, as long as the medical care settlement proceeds represent a reasonable sum based upon the evidence, and as long as those funds are first used before Medi-Care payment is sought, Medi-Care will be satisfied.

In a memorandum from the deputy director of the Center for Medi-Care Management dated July 23, 2001, Medi-Care recognizes different types of settlements, which are viewed differently. The ones that cause the most concern are the lump sum settlements, viewed as commutations (where there is really no dispute about the existence of industrial injury, although there may be a dispute with respect to either the extent of disability or the medical care required), or lump sum compromise settlements (which typically appear to be the Thomas type agreements). Medi-Care points out that set-asides are used only in the commutation type cases, and not in the compromise type cases, although certainly Medi-Care would consider taking some sort of credit in a large compromise type case.

In this memorandum, however, it was indicated that it is not in Medi-Care's best interests to review every workers' compensation settlement, and it was advised that applicants need only consider Medi-Care's interests when the applicant has a reasonable expectation of Medi-Care enrollment within thirty 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. The caveat is that injured individuals who are already Medi-Care beneficiaries must always consider Medi-Care's interests prior to settling their workers' compensation claim regardless of whether or not the total settlement amount exceeds $250,000.00.

From the carrier's standpoint, the primary area of attention must be where Medi-Care has made conditional payments which are arguably the responsibility of the carrier. This is the situation where Medi-Care has a direct right of action for reimbursement, including a right of action against the person responsible for primary payment (the workers' compensation carrier) (Regulation section 411.24 (e) and (f)). In the event a conditional payment has been made, and the reimbursement obligation is ignored at the time of settlement, there could be liability for double the amount of the payment.

V.

OTHER CASES

Perhaps one of the most significant cases, not only with respect to third party administrators, but also with respect to carriers whose insureds are subject to retention limits, is Coldiron v. Compuwar, 67 C.C.C. 289, which essentially stands for the proposition that it is a sanctionable offense for a third party administrator to fail to identify the actual insurance carrier (or, impliedly, self-insured employer) for which it administers. In this case, it was apparently assumed that the employer was self-insured right through trial and the issuance of two Findings and Awards. The trouble (which really seems to have been blown somewhat out of proportion) started when

defendant's counsel made a motion to amend the Findings and Award to name the actual insurance carrier (Reliance, now insolvent, the obligations of which by then had probably been assumed by CIGA). As a practical matter, this probably made no difference to applicant, since it does not appear from the case that there would have been any break in applicant's benefits (in other words, CIGA would have just continued paying). The Board, however, issued a Notice of Intent to Levy Sanctions and to hold a commissioner's conference, noting as issues not only the failure to properly identify the insurance carrier, but also suggesting that it was going to examine the issue of retention limits in connection with the requirement of the Labor Code that an employer either maintain workers' compensation insurance, or obtain a certificate of self insurance. Quite frankly, retention limits are no big secret, and have never been for years. We can not believe that the Board has not been aware of these arrangements and its sudden decision to subject them to scrutiny is somewhat disturbing.

In any event, you will be seeing from applicant's attorneys the following demands for information, and Coldiron would certainly suggest that this information should be provided promptly at the outset of every case:

(1) In the event of a third party administrator, the identification of the entity on behalf of whom the administrator is acting;

(2) The identification of the entity responsible for the payment of benefits;

(3) If there is a retention limit, that would indicate that there are two entities responsible for payment, first, the employer, and then an insurer, and in this case, these parties should be identified, as well as the nature of the retention limit.

Quite frankly, Coldiron is precedent for the proposition that a failure to provide the information referenced above is going to be sanctionable, and there is a suggestion by some panel members that liability for the actual benefits could be imposed upon the administrator if there is a failure to disclose.

Another important case with which applicant's attorneys are extremely unhappy is Lockheed Martin v. WCAB (McCullough), 67 C.C.C. 245 (2002), a Court of Appeal decision which holds that the psychiatric threshold set forth in Labor Code § 3208.3 (actual events of employment were predominant as to all causes combined of applicant's psychiatric injury) applies to all claims for psychiatric injury, including those which arise as compensable consequences of physical injury. The court felt that the actual language of the statute required this result, and suggested that, if there was unhappiness with the result, that the legislature should be consulted.

Also significant is the *en banc* Board decision in Navarro v. A&A Farming, 67 C.C.C. 145 (2002), holding that an employer who terminates health care benefits pursuant to an ERISA plan is not subject to a Labor Code § 132 (a) claim, since such a claim is preempted by a ERISA (which preempts any state laws relating to benefit plans).

In connection with employment terminations, an interesting, and what we think correctly decided case is Jersey v. John Muir Medical Company, which is a third party civil case decided by the First Appellate District of the Court of Appeal on April 16, 2002. In this case, a hospital employee who was assaulted by a patient, sued the patient for assault and, after refusing to drop the suit at the hospital's request, was fired by the hospital. The court noted that this was an at will employment, and that there was no public policy bar preventing the employer from firing the

employee for refusing the withdraw the suit, noting that in order for a termination to violate a public policy concern, it must be one which affects society at large rather than a purely personal or proprietary interest of the employee or employer.

Simply put, the employee in this case, by taking action adverse to a hospital's patient, acted in a manner adverse to her employer, the hospital.

In connection with civil cases, in Wright v. Beverly Fabric, 67 C.C.C. 51 (2002), an employee who came into work on her day off to sign a condolence card, attempted to assist in preventing a shelf in her employer's premises from collapsing, and was injured as the result. It was held that she could not sue her employer civilly, and her exclusive remedy was workers' compensation. Applicant's attorneys are very unhappy about this, but the decision only makes sense: she acted in a manner to advance her employer's interests. Although the panel was complaining that she might be precluded from collecting workers' compensation benefits (for unstated reasons, perhaps because she would be considered a volunteer or the like), these concerns are bogus. The Court of Appeal specifically stated that applicant's injury arose out of and in the course of her employment, and if that is the case, she is then entitled to workers' compensation benefits.

Finally, McDuffie v. Los Angeles Metropolitan Transit Authority, 67 C.C.C. _____ (2002), is instructive with respect to the appropriate procedure for accomplishing a Tyler augmentation of the medical record. First, the judge should instruct the parties to go back to their respective doctors for clarification. If this can not be done (or if the judge considers that neither physician is credible), then the parties should be requested to agree upon a doctor for the purpose of submitting the issues. Assuming the parties can not agree, then the judge may appoint an independent doctor (although the

Board does not really explain the procedure to be used by the judge in doing this). None of this is considered discovery, since it is the Board which is obtaining the evidence.

VI.

CONCLUSION

We hope you find the above referenced material to be helpful. Certainly, the suggestion here is that workers' compensation cases are going to become much more expensive in the future, and the cost of living increase applicable to total and partial disability life pensions after January 1, 2003, and temporary disability after January 1, 2006, are going to make calculating and reserving these claims somewhat more difficult.

As always, if you have any questions, please feel free to contact any of us here at the firm, and we will be more than happy to attempt to address your concerns or inquiries. If you wish, any of us would be happy to make a presentation with respect to any of the issues contained in this report, or any issues in which you might be interested.

Again, we hope this report has been helpful and of use to you, and we are happy to have been of service to you.

Very truly yours,

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