

QUARTERLY NEWSLETTER

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LB 588: CHANGES TO THE WORKERS' COMPENSATION ACT –

How It Impacts You

BY DARLA S. IDEUS AND CAROLINE WESTERHOLD

As reported in our July Quarterly Newsletter, LB 588, driven in large part by the business group Nebraskans for Workers' Compensation Equity and Fairness, was approved by the Governor on May 24, 2007. LB 588 requires the establishment of a Diagnostic Related Group In-Patient Hospital Fee Schedule (DRG Fee Schedule) which is expected to result in significant savings to carriers and employers. LB 588 also changes the compensation payable to an employee who injures more than one scheduled member in one accident. How each of these changes may impact carriers, claims handlers, and employers is discussed in more detail below.

The New DRG In-Patient Hospital Fee Schedule

The DRG Fee Schedule applies to in-patient discharges from large hospitals on or after January 1, 2008. It is intended to cover at least 90 percent of all workers' compensation in-patient hospital claims. The DRG Fee Schedule does not include Rehabilitation Diagnostic Related Groups. Claims for in-patient trauma services will not be included until January 1, 2010. The new DRG Fee Schedule provides for reimbursement to large hospitals at the rate of 150 percent of Medicare. While the DRG Fee Schedule is expected to result in significant savings for carriers and employers, it imposes certain requirements upon them as well. In order to benefit from the anticipated savings, carriers and employers need to comply with certain deadlines and reporting requirements.

First, there is a "prompt payment" provision. Payors must notify the provider within **fifteen business days** after receiving a claim regarding what information is necessary to process the claim. Failure to notify the provider within fifteen business days assumes the payor has all the information needed to pay the claim. Payors must pay providers pursuant to the DRG Fee Schedule within **thirty business days** after receipt of all information necessary to process the claim. Failure to pay the claim within this time frame obligates the payor to pay the hospital its "normal billed charges."

Payment of a claim means the receipt of funds by the provider. If a claim or payment is submitted electronically, the claim or payment is presumed to have been received on the date of the electronic verification receipt. If a claim or payment is submitted by mail, it is

presumed to have been received five business days after being placed in the United States mail with first class postage prepaid.

Second, LB 588 imposes reporting requirements upon payors. It requires hospitals, workers' compensation insurers, risk management pools, and self-insured employers to report claim and stop loss threshold counts by Diagnostic Related Group to the court in a format approved by the court. The first such report is due **October 15, 2008**, and shall include payment data from January 1, 2008, through June 30, 2008. Billing data must be retained beginning January 1, 2008, so that the appropriate report can be generated. Beginning in 2008, on or before **August 1** of each year, each reporter must provide a technical contact to the court and on or before **September 1** of each year, each reporter must provide to the court a "test file."

A carrier or employer may still contract with a provider for hospital services different than the DRG Fee Schedule provided the agreement is in writing and mutually agreed upon prior to the date services are provided.

For a list of covered hospitals and for more information regarding the specific requirements of the DRG claims report, visit the court's website at <http://www.wcc.ne.gov>.

Two Scheduled Members in One Accident

Included among the changes under LB 588 is a provision which changes the compensation payable to employees who injure two or more scheduled members in one accident. This provision, which also becomes effective January 1, 2008, provides that an employee may be entitled to compensation based upon her loss of earning power, rather than the schedule of benefits, where the payments per the schedule of benefits "do not adequately compensate the employee" and the employee's loss of earning capacity is at least 30 percent. The Workers' Compensation Court will only assess the employee's loss of earning capacity if the employee requests it. It is unlikely employers may invoke this section.

Several questions remain unanswered, including whether the employer is obligated to pay the costs

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associated with a loss of earning capacity assessment. We suspect employers will likely be obligated to pay the assessment costs if employees, as in the traditional context, possess evidence that the employee was involved in an accident which injured more than one member and resulted in a permanent loss of use to more than one member.

The Bill does not define the meaning of the term does “not adequately compensate.” This would appear to be an element of the employee’s burden of proof to establish an entitlement to permanent disability based upon the employee’s loss of earning capacity rather than the schedule of benefits. We suspect this burden will be satisfied if the value of the employee’s permanent benefits based upon her loss of earning capacity exceeds the value of the employee’s permanent benefits payable under the schedule of benefits.

However, in those cases where an employer or carrier wishes to dispute the employee’s entitlement to benefits, or the employer’s obligation to pay for a loss of earning capacity assessment, disputing that the schedule does “not adequately compensate” may provide some leverage to resolve such claims.

We suspect this section will be invoked by employees after the employer has paid out the permanent disability benefits per the schedule. The question will then likely be, what credit is the employer entitled to against its obligation to pay out a loss of earning capacity as a result of its payment of the benefits per the schedule? The statute does not directly address this issue, but we suspect Nebraska courts will give an employer a dollar-for-dollar credit for benefits paid per the schedule to be applied towards the value of the benefits due per the employee’s loss of earning capacity.

The most likely claim that will give rise to requests to apply this section is the ubiquitous repetitive trauma claim affecting both upper extremities. Keep in mind that it is the employee’s burden to prove that injuries to both scheduled members were a result of “the same accident.” In the context of repetitive trauma claims, the timing of the accident is not straight forward, but is most likely a function of when an injury caused the employee to “discontinue employment” and seek medical attention. If the employer or carrier can show that the date that one scheduled member injury necessitated initial medical care and time off from work is a different date than when the other scheduled member injury initially necessitated medical care and time off from work, the employer may be able to successfully avoid the application of this section.

MEET OUR NEW PARTNERS

Baylor Evnen is pleased to announce three new partners. **Mark Hunzeker’s** real estate practice focuses on land use and zoning for developers and businesses, as well as lobbying for his clients’ interests in the Legislature and City Hall. Mark serves as counsel to the Homebuilders Association of Lincoln and is a member of the Legal Action Network for Development Strategies (LANDS), an attorney network of the National Association of Homebuilders. He has served as a member of the Nebraska Power Review Board for the past 12 years. A native of Fullerton, Nebraska, Mark earned a bachelor of science degree from the University of Nebraska and a doctorate of jurisprudence, with distinction, from the University of Nebraska College of Law.

With a wealth of litigation experience in eminent domain/condemnation, real estate and commercial disputes, **Bill Blake** is a frequent lecturer on these topics. Before beginning private practice in Lincoln, he worked for the City of Lincoln as Chief Assistant City Attorney. Bill is currently chair of the Compendium Sub-Committee

of the Condemnation Committee for the American Bar Association Litigation Section, and editor of the 50 State Eminent Domain Compendium. Born and raised in Lamoni, Iowa, Bill attended Graceland College, where he earned a bachelor of science degree, magna cum laude. He received a doctorate of jurisprudence from the University of Nebraska College of Law.

Representing clients in business entity and transactional work, **Peter Katt’s** practice is intensely focused on Nebraska real estate, including valuation and taxation issues, land use and zoning, and lobbying. Peter is past president of the Lincoln Independent Business Association (LIBA) and is still an active member. He is a past member of the Lincoln Public School Board and served six years on the Board of Directors for the Indian Center. Originally from Kenosha, Wisconsin, Peter received a bachelor of arts degree from Doane College in Crete, Nebraska, and a doctorate of jurisprudence from the University of Nebraska College of Law.



Mark Hunzeker



Bill Blake



Peter Katt

NEW ASSOCIATES JOIN FIRM

With history as a law clerk for the firm, **Derek Zimmerman** joins Baylor Evnen as an attorney handling general litigation and insurance defense. Derek graduated with high distinction from the University of Nebraska College of Law where he was a Robert G. Muchemore Scholarship recipient. He graduated from the University of Nebraska-Lincoln, also with high distinction, with a major in business administration. While attending Nebraska College of Law, Derek received a CALI award for excellence in Individual Income Taxation and Trial Advocacy.

John Heieck joins the firm as a litigator, building on his trial advocacy and mock trial team experience in law school. John graduated from Creighton University School of Law, cum laude, with a concentration in litigation. He received a bachelor of arts, magna cum laude, from the University

of Notre Dame with a major in English literature. Prior to attending law school he worked as an insurance claims adjuster in Boston and, more recently, he was a law clerk in Omaha prior to graduation. Raised in Omaha, the son of a surgeon, John's practice involves injury cases with disputed medical issues.

Mark Buckwalter joins the firm as a member of the Commercial Practice Group, focusing on land use and zoning. He provides support to attorneys involved in entity formation and issues of corporate governance. Mark graduated from the Nebraska College of Law, with distinction, after graduating from Utah State University, cum laude, with a major in political science. While attending Nebraska College of Law, Mark received three awards for legal research and writing, including the Nebraska State Bar Foundation Silver Quill Award.



Derek Zimmerman



John Heieck



Mark Buckwalter

GIVE ME MY MONEY BACK – ERISA-Governed Health Plans and Subrogation

BY JAMES D. HAMILTON



James D. Hamilton

The Employee Retirement Income Security Act (ERISA) is the federal law that governs most employee benefit plans. If an individual receives health insurance through a plan offered by his employer, it is likely an ERISA-governed plan.

A dispute frequently occurs when an employee who is covered by an ERISA-governed health plan (the Plan) receives medical treatment for which the Plan pays but for which a third party is liable. Should the employee recover from the third party, is the Plan entitled to reimbursement? If the Plan is entitled to reimbursement, how is the amount of reimbursement determined?

In a recent decision, *Admin. Committee of Wal-Mart Stores, Inc. v. Shank*, the 8th Circuit Court of Appeals handed down a decision that has raised the ire of the Plaintiffs' bar. The Court in *Shank* concluded that ERISA governed health plans can recover "dollar for dollar" in subrogation all amounts paid on behalf of a covered employee for which a third party is

liable when the Plan language provides for such recovery and the elements of an equitable restitution claim are met.

In *Shank*, a Wal-Mart employee, Deborah Shank, was severely injured in a car accident. Wal-Mart's health plan paid \$469,216 for her care. Shank filed suit against the wrongdoer, eventually settling for \$700,000. After attorney's fees and costs were deducted, \$417,477 remained and was placed in a special needs trust for Shank. Wal-Mart's Plan filed suit under Section 502(a)(3) of ERISA seeking recovery of the funds it had spent for her care. Section 502(a)(3) of ERISA authorizes a civil action by a Plan participant, beneficiary, or fiduciary to either enjoin any action or practice which violates any of the terms of the Plan or to obtain "other appropriate equitable relief" to redress the violation or enforce the terms of the Plan. Named in the suit were Shank, her husband as trustee, and the trust itself.

The district court ruled for Wal-Mart, and imposed a constructive

trust on the settlement proceeds for the full amount the Plan had paid. The Shanks appealed to the 8th Circuit. At issue was whether the Plan was seeking "appropriate equitable relief" as authorized under Section 502(a)(3) in seeking dollar-for-dollar recovery when Shank had clearly not been fully compensated.

First, the Court acknowledged that "equitable relief" pursuant to Section 502(a)(3) includes a claim for restitution "where the [Plan] seeks to recover 'specifically identifiable' funds, that are due pursuant to the plain language of the Plan, that are within the Defendant's 'possession and control.'"

Next, the Court addressed whether a dollar-for-dollar reimbursement was "appropriate." Shank argued that the "made-whole" doctrine should be applied. Under the "made-whole" doctrine the Plan would not have been permitted to enforce its contractual right to reimbursement unless Shank had first been fully

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compensated for her injuries. In the alternative, Shank contended the Court should adopt a pro-rata share requirement, under which the Plan would receive only partial reimbursement equal to the share of Shank's settlement that compensated her for her medical expenses.

The Court, however, declined to adopt either proposal and held that the Plan's full dollar-for-dollar recovery according to the plain language of the terms of the Plan was "appropriate relief" within the meaning of ERISA. In declining to adopt the "made-whole" doctrine or the pro-rata approach, the Court stressed the importance of the contractual language of an ERISA plan when evaluating its rights to reimbursement.

The Court noted that one of the primary purposes of ERISA is to ensure the integrity of written plans and to protect the expectations of participants and beneficiaries. In *Shank*, that meant protecting the expectations of the parties based upon Plan language that clearly set forth the Plan's right to "... recover or subrogate 100 percent of the benefits paid by the Plan. . . . to the extent of . . . [a]ny judgment, settlement, or any payment made These rights apply regardless of whether such payments are designated as payment for . . . [m]edical benefits [or] [w]hether the participant has been made whole. . . ."

The Court's conclusion in *Shank* appears to have the greatest impact on claimants. If the language of a Plan provides for 100 percent recovery, a claimant may be liable to the Plan

for every dollar it paid provided the elements of an equitable restitution claim are met.

At the very least, *Shank* illustrates that it will likely be to the claimant's advantage to determine and attempt to negotiate the Plan's interest at the outset of settlement negotiations with a third party.

Shank is also important, however, to participants, beneficiaries, and fiduciaries seeking to recover on behalf of a Plan. *Shank* makes it clear that the language of the Plan determines the extent of the Plan's interest. The case may make it more difficult for Plan fiduciaries to negotiate, as a compromise may be difficult to justify to its members and beneficiaries. An ERISA-governed plan has even more clout, and less reason to compromise, in the situation where there is a trust separate from general assets to latch on to. This may also be instructive in structuring settlements where subrogation has not been addressed. Presumably, absent identifiable funds, the ERISA plan may still subrogate but would have to obtain a judgment and enforce collection on assets that are more difficult to find and liquidate.

Last, the effects of *Shank* will likely be felt by those liability insurers providing coverage for the third-party tort-feasor as well as workers' compensation carriers who are ultimately liable for medical expenses conditionally paid by an ERISA plan. In 1995 the 8th Circuit clarified in *Witt v. Allstate Ins. Co.* that Section 502(a)(3) of ERISA does not create any action against the insurer for a third-party tort-feasor when that

insurer fails to take into account the ERISA plan's subrogation interest, even if the insurer was on notice of the subrogation interest. The Court extended this same logic to workers' compensation insurers who likewise settle claims without making provision for reimbursement to an ERISA plan. *Shank* does not change this result. The Court in *Witt*, however, did not address whether the ERISA plan has other causes of action against the third-party insurer which are not based in ERISA.

Even though Section 502(a)(3) of ERISA does not create a cause of action against third parties and carriers, *Shank* will likely impact settlement negotiations with these carriers.

Claimants may be more leery about settling their claims without providing for a negotiated reimbursement to an ERISA plan at the outset. This will likely increase the settlement value of the claim. Should the issue arise, claims handlers will want to confirm the existence of an ERISA plan and its language. Also be aware of the potential to negotiate with an ERISA plan its interest. Finally, be aware that ill-prepared claimants, poor preparation on this point, or failure to address the subject in a release or settlement agreement may derail a settlement at a critical time.

While *Shank* has been met with much disdain by the Plaintiffs' bar because it may cut into the overall recovery, it could also prove to be a thorn in the side of the other parties typically involved in these subrogation disputes due to the complications that may now arise in settlement.

NOTES FROM THE FIRM

Randy Goyette has been elected to the Nebraska State Bar Association House of Delegates. **Bill Blake** is also a member of the House of Delegates.

In September, **Dallas Jones** was elected Chairman of the Lancaster County Republican Party. He will serve a two-year term.

Also in September, at a meeting of the International Association of Industrial Accident Boards and Commissions (IAIABC), **Jill Schroeder** participated in a panel discussion of hot topics concerning coordination of benefits with Medicare in workers' compensation settlements. The panel discussion was hosted by the American Law Firm Association, which is a global network of 125 independent law firms, and of which Baylor Evnen is a member. Through the panel discussion, information was disseminated about procedures currently used by Medicare in workers' compensation claims, proposed federal legislation affecting coordination between workers' compensation and Medicare, and Medicare's "workload review thresholds." For more information regarding current Medicare regulations, contact Jill.

At the Annual Meeting of the Nebraska Defense Counsel Association in October, **Stephanie Stacy** spoke on the topic of avoiding discovery sanctions. She was also re-elected to serve on the Board of Directors.

Caroline Westerhold has been selected to participate in the 2007-2008 Leadership Lincoln Fellows Program. Leadership Lincoln seeks to develop a diverse pool of available leaders to help improve the overall quality of life in Lincoln and Lancaster County through the Fellows Program.

To find additional newsletter articles, go to our website at www.bayloreven.com.

This Baylor Evnen publication provides substantive information and reflects the firm's opinions and views on current issues. The content is not legal advice. It cannot replace consultation with an attorney on specific matters, nor does it create an attorney-client relationship.



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