CAIIA Status Report

JANUARY 2010

Business Insurance

Written by Roberto Ceniceros

Deadline looms for firms to register claims data

Effort to curb Medicare costs raises questions

Insurers and self-insured employers face a Dec. 31 deadline to register with a federal agency, but numerous questions remain about what workers compensation and liability claims data must be fed into the Medicare system, several experts say.

Advertisement

Insurers and self-insured employers identified as responsible reporting entities must register with the U.S. Centers for Medicare & Medicaid Services by year-end to comply with Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007.

The mandates stem from Medicare secondary payer laws and ongoing efforts allowing CMS to track medical claims payments to make certain that insurers and employers paying claims do not shift costs to Medicare.

Starting in the first quarter of 2010, the law also requires claims payers to provide CMS with test data files for liability, workers compensation and no-fault claims that have a medical-expense component and involve Medicare-eligible or potentially Medicare-eligible beneficiaries.

The reporting and data feed requirements reach across the entire liability industry, said Roy Franco, director of risk management strategies for supermarket chain Safeway Inc. in Pleasanton, Calif.

Even directors and officers liability coverage would be affected if, for example, an employment practices claim contained a psychological damages component, said Mr. Franco, who also is a member of the Risk & Insurance Management Society Inc.'s external affairs committee and is co-chairman of the steering committee for the Medicare Advocacy Recovery Coalition, a diverse coalition that formed in 2008 because of the 2007 law.

Insurers and self-insured employers failing to comply face fines of up to $1,000 per claim per day for failing to comply with the law.

But precisely how CMS will define "noncompliance" and apply fines re-

continued on page 3

PUBLISHED MONTHLY BY
California Association of
Independent Insurance Adjusters

An Employer Organization of Independent Insurance Adjusters

Inside This Issue

***Status Report* Now Available by E-mail**

If you would like to receive the *Status Report* via e-mail please send your e-mail address to *info@caiia.org*.

CAIIA Newsletter
CAIIA Office
P.O. Box 168
Burbank, CA 91503-0168
Web site - http:\\www.caiia.org
Email: info@caiia.org
Tel: (818) 953-9200
(818) 953-9316 FAX
Editor: Sterrett Harper
Harper Claims Service, Inc.
Tel: (818) 953-9200

California Association of Independent Insurance Adjusters, Inc

PRESIDENT'S OFFICE
P.O. Box 5154
Cerritos, CA 90703
562-802-7822
Email: info@caiia.org
www.caiia.org

PRESIDENT
Sam Hooper
hooper@hooperandassociates.com

IMMEDIATE PAST PRESIDENT
Pete Vaughan
pvaughan@pacbell.net

PRESIDENT ELECT
Phil Barrett
barrettclaims@sbcglobal.net

VICE PRESIDENT
Jeff Caulkins
jeff@johnrickerby.com

SECRETARY TREASURER
William "Bill" McKenzie
walshadj@sbcglobal.net

ONE YEAR DIRECTORS
Kearson Strong
kearson@claimssonsultinggroup.com

Jenee Child
info@sequioapros.com

Rick Beers
NCI63@sbcglobal.net

TWO YEAR DIRECTORS
Tanya Gonder
Tanya@casualtyclaimsconsultants.com

Scott Hannaford
Hannaford@comcast.net

Art Stromer
artstromer@hotmail.com

OF COUNSEL
Nancy DePasquale
WILLIS & DePASQUALE, LLP
725 W. Town & Country Rd., Ste. 550
Orange, CA 92868
714-544-6000 • Fax 714-544-6202
ndepasquale@wdlegal.net

PRESIDENT'S MESSAGE

Relationship Building: Customer Service

When does your client need your report?

A.15 Days after receipt of the assignment

B.Per the DOI Fair Claims Practices Regulations

C.30 Days after receipt of the assignment

D.The day of the assignment

E.Per your organization's policies & procedures

F.All of the above

While all may apply; the key word is "need". Like our other CAIIA members, I have recognized over the years the client's need for information is implicitly recognized no later than at the time of the assignment. Therefore in this context, "D" would apply. This is when the actual need is communicated.

Certainly, we want to comply with the DOI Regulations, and any minimum requirements of the client. Moreover, exceeding the client's requirements should be the service provider's goal.

As a prior company staff adjuster and claims manager, I hired those vendors whose comprehensive reports were received before my file came up on diary. Consequently, I continued to provide repeat business to those companies or individuals. More often than not, the IA's employed were CAIIA members (or other vendors associated with a CAIIA member)

Our members' common use of digital photography, digital statements, electronic document reproduction and email submissions facilitates faster reporting. Therefore it comes as no surprise the industry continues to seek out companies, or individuals listed in the CAIIA Directory and Website.

SAM HOOPER
President - CAIIA 2009-2010

Business Insurance

Written by Roberto Ceniceros

continued from page 1

mains among many significant unknowns, said Katie A. Fox, compliance and resolution unit manager in Parker, Colo., for MedInsights Inc., a managed care services unit of GAB Robins Group of Cos.

Documentation does not exist explaining whether fines would be triggered only when entities fail to submit an entire claim file, or if such a fine could be imposed for providing a claim file that lacks certain data, experts say.

"We know that there is a $1,000 per day (fine), but when and where and what triggers the $1,000 per day" are not known, said Ms. Fox, who also is co-chair of MARC's steering committee. "We are all interested in understanding that level of financial impact."

There is a lack of clarity about how reporting to CMS will be carried out by a broad array of liability insurance entities, including captive insurers and risk-sharing pools, several sources said. Insurance industry providers have added to the confusion because they have misunderstood or misinterpreted reporting requirements, they added.

"It has been very confusing," said Steve Bent, executive director of the Texas Assn. of Responsible Nonsubscribers, an Austin-based group of employers that provide workplace injury benefits. "It seems like it would be difficult for (CMS) to address all (liability claims) situations. But on the other hand, it sure is difficult for everybody to prepare to comply when some of the answers are still up in the air."

CMS has cooperated with stakeholders and has worked to improve the process and address questions, Mr. Bent and other industry sources said.

CMS, which did not respond to an interview request, may be overwhelmed with implementing the program across the numerous types of coverage arrangements within the liability industry, the sources added.

Still unresolved are reporting claims involving multiple insurers and mass tort cases with multiple claimants about which settlement payers usually know little.

MARC, which formed to improve the Medicare Secondary Payer program, sent letters to CMS in August and again in October that asked for additional clarity and recommended that directions on complying with the reporting requirements be improved.

MARC asked for more information on "how the Section 111 reporting system will treat all types of captives," because some captive definitions that CMS has relied on "may not be accurate and, in any event, do not completely address the common captive situations which occur."

MARC also recommended that CMS help self-insurance pools to resolve claims without the involvement of the participating pool member.

For mass tort cases, MARC suggested that funds typically established by trial courts and handled by administrators retained by plaintiffs attorneys act as the RRE, rather than the insurer or self-insurer covering the claims.

In response, CMS created a mass tort group comprised of industry representatives to help "hash out the areas of ambiguity," Ms. Fox said.

A CMS "user guide," containing input from the tort group and other improvements hopefully will be available soon, but little time remains as the deadlines approach, several sources said.

Another unresolved issue is who the RRE is when a fronting policy, foreign insurer or employer is involved, said Jeffrey Hames, assistant vp and implementation project manager in Memphis, Tenn., for Sedgwick Claims Management Services Inc.

Even the Dec. 31 deadline for registering as an RRE is ambiguous, Mr. Hames said.

CMS initially set June 30 as the deadline for RREs to register, documents show. That was extended to Sept. 30 and then to the end of this year when CMS recognized many self-insurers and insurers were awaiting information before registering.

But CMS has not produced official written communication stating that it extended the deadline to Dec. 31, Mr. Hames said. Instead, CMS first articulated the "unofficial" extension indirectly during one of several telephone conference calls held to answer questions.

"They didn't extend the registration deadline," Mr. Hames said. "What they said is, "We won't penalize anyone as long you can make sure you have registered

Continued on page 4

Business Insurance

Written by Roberto Ceniceros

Continued from page 3

in enough time to get us a test file in the first quarter of 2010.' Then they said in another town hall call (that) their expectation is that you would complete registration by Dec. 31."

Many questions raised in those meetings remain unanswered and affect how insurers and self-insureds program their computer systems to report data, sources said.

Although many clients launched compliance efforts early on, other entities "have not registered yet because they are still waiting for information from CMS," Mr. Hames said.

There are exemptions for small employers.

With so much uncertainty, however, CMS is likely to show leniency during the early phases of implementation, sources said.

Unofficially, indications are that entities can avoid the potential penalties by making a good-faith effort to comply, Mr. Bent said.

Coverage Alert

Submitted by McCormick Barstow, LLP - Fresno, CA

Where an insurer's decision to terminate benefits is wrong but reasonable and made with proper cause, the genuine dispute doctrine applies and the insurer cannot be held liable for bad faith

Bosetti v. United States Life Ins. Co. in the City of New York, 175 Cal.App.4th 1208 (2009)

BACKGROUND FACTS Bosetti's job as an assistant director of adult education was eliminated for economic reasons. After learning that her employment would be terminated, she saw a doctor for depression and was placed on temporary disability. The disability extended in excess of two years and included a physical component as well as an emotional one. Benefits provided by Bosetti's employer under a U.S. Life disability policy were terminated after two years. Bosetti brought suit against U.S. Life, seeking additional benefits and alleging bad faith. U.S. Life sought and obtained summary judgment. Bosetti appealed.

THE COURT'S RULING The Court of Appeal ultimately determined that Bosetti had raised a triable issue of fact as to whether her benefits were properly terminated. Applying the genuine dispute doctrine, however, the court determined that U.S. Life was entitled to summary adjudication on the bad faith claim. In reaching this determination, the court first recognized that an insurer cannot benefit from the genuine dispute doctrine where the investigation of the claim is not full, fair and thorough, nor can it insulate itself from liability for bad faith conduct by simply hiring an expert to create a "genuine dispute." The court further concluded, however, that an insurer's bad faith must be determined solely by the standard of objective unreasonability as opposed to a subjective good faith requirement. U.S. Life had assumed that Bosetti's mental symptoms were irrelevant to a determination of disability after two years. This position was supported by case law. Although the Court of Appeal disagreed with the case law, it could not find that the insurer's reliance on the then sole California case to address the issue was unreasonable. The court found that while Bosetti could point to evidence that her benefits should not have been terminated, U.S. Life could point to evidence, as well as its reliance on then existing California law, that its decision was reasonable and made with proper cause. Since there was a genuine dispute as to Bosetti's entitlement to extended benefits, U.S. Life was entitled to summary adjudication on the bad faith cause of action.

THE EFFECT OF THE COURT'S RULING Although a prior California Court of Appeal decision, *Brehm v. 21st Century Ins. Co.* (2008) 166 Cal.App.4th 1225, indicated that in order to establish an absence of bad faith as a matter of law, an insurer must establish both objectively reasonable conduct as well as good faith subjective intent, the court disagreed with this analysis finding that there is no subjective good faith requirement in order for an insured to rely on the genuine dispute doctrine. Instead, the court concluded that bad faith must be determined solely by objective unreasonability.

Weekly Law Resume

Prepared by Low, Ball & Lynch, Attorneys at Law, San Francisco, CA

Torts - Non-Resident Landowner Not Entitled To Damages For Discomfort and Annoyance

Kelly v. CB&I Constructors, Inc., Court of Appeal, Second District (November 19, 2009)

An occupant of land may recover damages for annoyance and discomfort that result from a trespass on the occupant's land. This case analyzes whether damages for annoyance and discomfort may be awarded to a non-resident owner.

Plaintiff Martin Kelly owned a 34 acre ranch in the hills of Northern Los Angeles County. The property had three houses. The ranch also included pastures, a vintage barn, other structures, 150 to 200 oak trees, and a running stream. Kelly lived at the ranch for 23 years. In the mid-1990's, he moved away from the property. Kelly planned to return to the ranch, however, and maintained the ranch as his permanent resident address. He also kept tools and equipment at the ranch.

In 2002, Defendant CB&I Constructors, Inc. (CB&I) erected a municipal water tank approximately 15 miles from Kelly's property. Sparks ignited a large brush fire which spread over 20,000 acres. Much of Kelly's property was damaged or destroyed. Erosion caused by the fire contributed to subsequent mudslides, which further damaged the property. Kelly sued CB&I and others for negligence and trespass. The case proceeded to trial. During the liability phase, CB&I was found 90% responsible. During the damage phase, Kelly was awarded over $4.7 million, which included $543,000 for discomfort, annoyance, inconvenience and mental anguish.

CB&I appealed on several grounds. One contention on appeal was that Kelly was not entitled to recover annoyance and discomfort damages, because he did not live at the property at the time of the fire. The Court of Appeal did not question that a non-resident owner might suffer mental or emotional distress from damage to his property. Annoyance and discomfort damages, however, are distinct from general damages for emotional distress. Consistent with prior holdings, including Kornoff v. Kingsburg Cotton Oil Co. (1955) 45 Cal. 2d 265, the Fourth District held that annoyance and discomfort damages are intended to compensate a plaintiff for the loss of his occupation and enjoyment of the property. The Court held that Kelly, who was not an occupant, could not recover for these harms. The fact that Kelly kept possessions at the property and intended to move back to the property did not sway the Court of Appeal. The judgment was therefore reversed insofar as it awarded Kelly $543,000 in damages for annoyance and discomfort. In all other respects, the judgment was affirmed.

COMMENT

This decision is consistent with prior cases upholding an award of annoyance and discomfort damages only to plaintiffs that are personally in immediate possession of property at the time of loss.

Civil Procedure - Collateral Source Rule - Reduction of Medical Bills

Rebecca Howell v. Hamilton Meats & Provisions, Inc., Court of Appeal, Fourth District (November 23, 2009)

The courts have been going back and forth over the last several years over what amount a plaintiff is entitled to recover for medical expenses. This battle has been between recovery of the full amount of the medical bills or only the amount the providers have agreed to accept in payment.

Rebecca Howell was seriously injured when the vehicle she was driving was struck by a truck driven by one of Hamilton Meats & Provisions, Inc's vehicles. Howell was insured through PacifiCare. Howell underwent two spinal fusions, as well as surgical procedures for harvesting grafts. Before surgery, she executed an agreement with Scripps Memorial Hospital and CORE Orthopedic Medical Center to be fully liable for all charges. However, PacifiCare paid a reduced amount and Scripps and CORE wrote off the balance.

At trial, Hamilton sought to limit the evidence of the amount of recoverable medical bills to those paid for by insurance or by Howell. The trial court denied Hamilton's motion. Following trial, Hamilton filed a motion to reduce the special verdict for past medical expenses to the amount paid by insurance. The trial court granted the motion and reduced the special damages by the amount written off by the institutions. Howell appealed.

The Court of Appeal reversed. The Court stated that a person is entitled to be compensated for all monetary losses, including all medical expenses. This includes expenses paid by a collateral source, such as an insurance company. In this case, Howell was personally liable for the full amount of medical bills as a result of the contract she signed with the medical institutions. Even though a portion of the bills was written off, the Court stated that the extinguishment of a portion of Howell's debt to the medical institutions was a benefit to Howell. This benefit was a collateral source benefit within the meaning of the collateral source rule, because it was conferred on her as a direct result of her own thrift and foresight in procuring private health insurance through a source wholly independent of the tortfeasor. The tortfeasor was not entitled to receive the benefit of her thrift.

The Court distinguished Hanif v. Housing Authority (1988) 200 Cal.App.3d 635, by stating in Hanif the plaintiff had in-

continued on page 6

continued from page 5

curred no personal liability for the full amount of the medical bills. As to Nishihama v. City and County of San Francisco (2001) 93 Cal.App.4th 298, the Court disagreed with the holding of that case. The Court stated Nishihama was based on an analysis of lien rights rather than what amount the plaintiff and her insurer incurred in medical bills. As such, it failed to correctly analyze the collateral source rule. The Court suggested the Legislature should look at the collateral source rule and develop new rules for the handling of these problems. In this case, the Court was convinced the reduction violated the collateral source rule and needed to be reversed.

Finally, the Court indicated it did not believe a trial court was authorized to hear and grant a post-trial motion to reduce a recovery of economic damages. The Court therefore ordered the matter reversed and remanded with directions to reinstate the full amount of the economic award.

COMMENT

In this case, the plaintiff was fully liable for the entire medical bill. Whether that will be an important distinction in future cases remains to be seen.

Torts - Grocery Truck Driver, Parked On Emergency Shoulder, Not Negligent For Collision

Cabral v. Ralphs Grocery Company, Court of Appeal, Fourth District (November 10, 2009)

This case deals with the essential elements of a negligence case - duty and causation - in determining the liability of a defendant. Adelelmo Cabral was driving a pick-up truck eastbound on Interstate 10 in Southern California. The evidence showed that he was traveling 70-80 mph and may have fallen asleep at the wheel. Mr. Cabral's vehicle veered off the freeway to the right, and onto a shoulder, where it struck a Ralphs Grocery Store (Ralphs) big-rig driven by Hen Horn. Mr. Horn had parked in an emergency parking area to eat lunch.

Mr. Cabral was killed in the accident. His wife filed a wrongful death action against Ralphs and Mr. Hen, alleging that Mr. Hen was negligent in parking in the emergency parking area, 16 feet off the roadway. The case proceeded to trial. The jury returned a verdict for plaintiff, finding Mr. Cabral 90% at fault; and Mr. Horn 10% at fault. Plaintiff was awarded $475,298.40 in damages. Ralphs appealed. The Fourth District Court of Appeal reversed.

On appeal, Ralphs contended that as a matter of law, Mr. Horn owed no duty to Mr. Cabral to avoid stopping in the emergency parking area and that Mr. Horn's alleged negligence did not proximately cause the accident. Plaintiff responded that Mr. Horn owed a duty to other motorists and that Horn breached that duty by unsafely parking in the emergency parking area - contrary to company rules, in order to eat lunch. Plaintiff further argued that it was foreseeable that another motorist would veer off the freeway and crash into a vehicle parked on the shoulder.

The Court of Appeal sided with Ralphs. In so doing, the Fourth District acknowledged that, as a general rule, a person is liable for injuries caused by his or her failure to use reasonable care. In determining whether to depart from that general rule, courts analyze a number of factors, including the foreseeability of the harm. With regard to foreseeability, the Court held that its task was not to decide whether a particular plaintiff's injury was reasonably foreseeable in light of a particular defendant's conduct, but to evaluate generally whether the category of negligent conduct at issue would likely result in the kind of harm that took place.

Under these facts, the Court of Appeal held that a reasonable person would not conclude that Horn's act of stopping on the side of the freeway, 16 feet from the far right lane, in a dirt area, would subject motorists using the freeway to an unreasonable risk of harm. The Court found it significant that there was no evidence of prior similar accidents presented at trial. The fact that it was possible that the accident could happen was not sufficient. As such, the Court held that as a matter of law, Mr. Horn owed no duty in this situation.

Even if Ralphs and Mr. Horn owed Mr. Cabral a duty, the next question for the court of Appeal was whether Horn breached that duty. Again, the Court agreed with the Defendants. In order to find negligence, a plaintiff must present substantial evidence of a causal connection between a defendant's negligent act and plaintiff's injuries. Here, the Fourth District ruled that the evidence presented (primarily through expert testimony), was speculative and largely inadmissible. Further, the Court held that from a public policy standpoint- liability was too attenuated. Vehicles stop along the side of the road everyday for legitimate reasons. Citing decisions from other states, the Court held this was not a direction California should be going. The judgment was therefore reversed.

COMMENT

This case should prove very helpful for counsel defending questionably foreseeable accidents. While anything is possible, the Court of Appeal makes clear that more is needed to create a duty between a plaintiff and a defendant.

EDUCATION - REACHING FOR THE STARS

Attendee Registration Form

April 5-7, 2010 Long Beach Convention Center * Long Beach, California

Questions, please call: 888.811.6930 or email: info@combinedclaims.com

REGISTRATION INFORMATION:

Please fill out this registration form completely. One registration form per person. Photocopies accepted.

Name:_____

Title: _____

Company: _____

Address:_____

City, State, Zip:_____

Email:_____

Phone: _____

Fax: _____

Conference registrations include continental breakfast, breaks and lunch on the day(s) you are attending as well as admission to all sessions, handouts, and a conference program.

CONFERENCE FEES:

Conference registration is discounted for certain fields in the insurance and claims industry. The nature of my work is:

- ❑ Adjuster
- ❑ Appraiser
- ❑ Insurance Carrier
- ❑ Private Investigator
- ❑ Risk Management
- ❑ Attorney

Yes, I work in the fields checked above. Please register me for the following rate:

- ❑ Two Day Conference Registration $190.00
- ❑ One Day (Tuesday, April 6, 2010) $95.00
- ❑ One Day (Wednesday, April 7, 2010) $95.00

No, I do not work in the fields listed above. Please register me for the following rate:

- ❑ Two Day Conference Registration $400.00
- ❑ One Day (Tuesday, April 6, 2010) $200.00
- ❑ One Day (Wednesday, April 7, 2010) $200.00

❑ Please send me golf tournament information.

SESSION SIGN-UP:

For purposes of seating/handouts, please select the sessions and events you plan on attending.

TUESDAY, APRIL 6, 2010

9-10:15AM

- ❑ GENERAL SESSION - The Star in You

11-NOON

- ❑ Track 1 Percutaneous Discectomy
- ❑ Track 2 Plain English Guide to Soil Problems
- ❑ Track 3 Insurance Claim and Fraud Trends

NOON-1:30PM

- ❑ Lunch in the Exhibit Hall
  Keynote Speaker: Ed Hochuli, NFL Referee

1:30-2:30PM

- ❑ Track 1 Recent Developments in California Law
- ❑ Track 2 Ethical Decision Making
- ❑ Track 3 The Ideal Interview

3:15-4:15PM

- ❑ Track 1 A Primer on Racially-Based Lawsuits
- ❑ Track 2 Subrogation Potential by First Responders
- ❑ Track 3 Auto Accident Reconstruction

WEDNESDAY, APRIL 7, 2010

9-10:00AM

- ❑ Track 1 Liability Claims Involving Public Entities
- ❑ Track 2 Anatomy of an Arson
- ❑ Track 3 Increasing Salvage Returns

10:45 - 11:45AM

- ❑ Track 1 California Fair Claims Practices Act
- ❑ Track 2 Water Damage Restoration
- ❑ Track 3 A Mock Trial That's Out of this World - Part 1

11:45AM - 1:30PM

- ❑ Lunch with award presentations in the Exhibit Hall

1:30 - 2:30PM

- ❑ Track 1 Developing Good Team Communication
- ❑ Track 2 Vendors and Experts on Property Claims
- ❑ Track 3 A Mock Trial That's Out of this World - Part 2

2:45 - 3:45PM

- ❑ CLOSING SESSION - Insurance Fraud Arson
  Special Prize Drawing for Attending This Session

PAYMENT - CHECKS, AMERICAN EXPRESS, MASTER CARD AND VISA ACCEPTED.

Mail form and check or credit card information to: CCC - 1880 Radcliff Ct - Tracy, CA 95376 or by fax to 888.969.6922

❑ By Credit Card Authorization for payment in the amount of $ _____

Credit Card Number: _____ Exp Date: _____ Security Code:_____

Billing Address: _____

Name on Card: _____

❑ By Check Check Number: _____ in the amount of $_____

QUESTIONS, PLEASE CALL: 888.811.6930 OR EMAIL: INFO@COMBINEDCLAIMS.COM

The Importance of Walking!!

Walking can add minutes to your life. This enables you at 85-years-old to spend an additional 5 months in a nursing home at $7000 per month.

My grandpa started walking five miles a day when he was 60. Now he's 97-years-old and we don't know where the hell he is.

I like long walks, especially when they are taken by people who annoy me. . .

The only reason I would take up walking is so that I could hear heavy breathing again.

I have to walk early in the morning, before my brain figures out what I'm doing.

I joined a health club last year, sent about 400 bucks. Haven't lost a pound. Apparently you have to go there.

Every time I hear the dirty word 'exercise', I wash my mouth out with chocolate.

I do have flabby thighs, but fortunately my stomach covers them.

The advantage of exercising every day is so when you die, they'll say, "Well, she looks good, doesn't she?".

If you are going to try cross-country skiing, start with a small country.

I know I got a lot of exercise the last few years, . . . just getting over the hill.

We all get heavier as we get older, because there's a lot more information in our heads. That's my story and I'm sticking to it.

AND . . .

Every time I start thinking too much about how I look, I just find a Happy Hour and by the time I leave I look just fine!

You could walk this over to your friends . . . or just e-mail it!