NEW MEADOWS ABATEMENT

v.

MAINE EMPLOYERS' MUTUAL INSURANCE COMPANY, *et al.*

DOCKET NO. INS-99-16

DECISION AND ORDER

This adjudicatory proceeding arises out of a petition filed by New Meadows Abatement, pursuant to 24-A M.R.S.A. §§ 12-A, 229, and 2320 and Bureau of Insurance Rule 450, Article I, § 4(B), requesting that the Superintendent order New Meadows' workers' compensation insurer, Maine Employers' Mutual Insurance Company ("MEMIC"), to lower its workers' compensation premium. According to New Meadows, $81,998 in workers' compensation benefits paid in the past and anticipated to be paid in the future to A.H., a former New Meadows employee, were erroneously included in New Meadows' experience rating. New Meadows contends that MEMIC negligently failed to controvert this claim and then negligently failed to mitigate losses, inappropriately inflating New Meadows' experience rating from 0.88 to 1.17.

As explained more fully below, New Meadows has failed to prove that MEMIC's handling of this claim resulted in any material overpayment at all, let alone an overpayment resulting from reliance upon inaccurate information within the meaning of Bureau of Insurance Rule 450. The Petition must therefore be denied.

Factual and Procedural Background

The Petitioner, New Meadows Abatement, is an asbestos and lead paint abatement contractor in Bath, Maine. At 7:00 in the morning on July 8, 1996, one of the Petitioner's crews resumed work on a school project in Topsham after a four-day July 4 weekend. New Meadows' owner and president, Bruce Brawn, went to visit that site shortly after work started. He recalls arriving there at approximately 7:10, and hearing from a school district consultant who was supervising the work that the New Meadows foreman had driven A.H. to the hospital with a foot injury.

Later, Mr. Brawn spoke with the foreman, who explained that when he, A.H., and a third New Meadows employee had arrived to set up that morning, they saw that the protective plastic sheeting had come loose from the wall, and A.H. had been assigned to climb an 8-foot stepladder and put it back up. Mr. Brawn testified that the foreman "told me that [A.H.] had told him that [A.H.] climbed up the ladder, and the ladder base – again, [A.H.] leaned the ladder up against the wall, the ladder base slipped out from the wall. I call it kicking out, and then

she jumped off the ladder onto the floor.... *(I Tr. 32)* I did not think much of the accident to begin with because it was just labeled as a sprain. *(I Tr. 34)*"

On July 24, Administrative Assistant Sally Berry phoned a First Report of Injury on behalf of New Meadows to the Workers' Compensation Board, reporting that the injury had taken place at 8:00 the morning of July 8, and that "EE [employee] did not open the ladder and leaned it against the wall. The ladder started to fall and the EE fell with it. EE landed on her foot and sprained it."

The claim file notes of adjuster Betsy Audette, who testified at length at the hearing, show that on July 24, she spoke with Berry and noted "No question on claim. Good EE as far as she knows. Witnesses to the incident include the supervisor [and coworker] .... She is supposed to RTW [return to work] next Monday." Audette tried to call A.H., but the phone was no longer in service, so she sent a letter instead, and interviewed A.H. in person on July 29. The descriptions of the events given by the employer and employee were consistent, so Audette did not conduct followup interviews with the witnesses. Therefore, she was unaware that when she asked whether anyone else was there at the time of the incident, and was given the same two names by Berry and by A.H., neither of those "witnesses" was actually in the same room.

A.H.'s return to work was delayed and sporadic. On October 4, after consulting with an outside attorney, Mr. Brawn wrote MEMIC expressing concern with A.H.'s lack of progress, questioning whether she was really making a good faith effort to return to work, and inquiring about the standards for terminating benefits for refusal to work. Meanwhile, A.H. remained under medical supervision, and on November 21 was scheduled for surgery, which took place on December 19. After her recovery from surgery, problems continued, and in September of 1997 Audette referred A.H. for vocational rehabilitation, noting that "EE isn't really motivated to job search on her own, she would benefit from assistance." The vocational rehabilitation program was not productive.

A second surgery was performed on June 1, 1998, and the treating physician cleared A.H. for return to work effective September 4. On October 22, MEMIC filed a notice of discontinuance of benefits. A.H. contested the discontinuance, but on December 15, 1998, a Workers' Compensation Board hearing officer denied her request for a provisional order reinstating benefits pending final review of the discontinuance. A mediation session on January 27, 1999 resulted in an agreement to pay partial incapacity benefits based on a minimum-wage earning capacity, and to provide further retraining assistance, and a consent decree was entered on April 8.

Meanwhile, New Meadows had consulted with another outside attorney, and in March of 1999, sent MEMIC a critique of its handling of this claim, with a list of 15 proposed action steps. After consultations between New Meadows, its counsel, and MEMIC, they developed an action plan which included a specific

modified-duty job offer which had been pre-cleared with A.H.'s treating physician.

New Meadows made a written job offer effective May 10. A.H. accepted the offer. There were some questionable minor injury reports, and New Meadows offered work modifications to accommodate the alleged new injuries. On July 19, MEMIC again discontinued benefits, effective August 9, and no further wage loss benefits have been paid on this claim. Meanwhile, on June 18, New Meadows sent A.H. a warning that her attendance was unsatisfactory. A.H. was laid off toward the end of that summer; although she was recalled in early September, she immediately filed a new workers' compensation claim, which MEMIC regards as suspicious and has controverted.

New Meadows filed its Petition for revision on its experience rating on September 17, 1999. The Superintendent held an adjudicatory hearing on January 14, 2000,[1] which was continued for a second day of testimony on January 24. The parties filed their briefs on March 13, and the record closed on March 15 upon submission of corrections to the Petitioner's brief. An order was issued on April 14 denying the Petition and extending until today the deadline for issuance of the Decision and Order explaining the factual and legal basis for that denial.

The Experience Rating Framework

The principal reason this matter is before the Superintendent for adjudication under the Maine Insurance Code, rather than being a private contractual dispute, is because all workers' compensation insurers in Maine are required, pursuant to 24-A M.R.S.A. § 2382-D, to adhere to a uniform experience rating plan. The disagreement between the parties as to the applicable standard of review revolves largely around the nature and purpose of that law.

Experience rating is based on the principle that policyholders at higher risk should pay higher premiums for coverage, and that one way to measure who is at higher risk is by looking at their loss history. This is practiced in many lines of insurance, and is subject to varying degrees of regulation depending on conditions in a particular market. Except for certain lines of health insurance in which experience rating is forbidden by law, workers' compensation is the line of business in which experience rating is most strictly regulated.

For workers' compensation insurance, all price differentials between employers must, "after allowing for practical limitations ... reflect equitably the differences in expected losses and expenses." 24-A M.R.S.A. § 2382(4). In particular, experience rating must be based on a statewide experience rating plan developed by the designated workers' compensation advisory organization and filed with the Superintendent pursuant to 24-A M.R.S.A. § 2382-C(5)(C).[2] The

terms of that plan as approved and interpreted by the Superintendent have the same force and effect as rules adopted by the Superintendent. *Imagineering, Inc. v. Superintendent of Insurance,* 593 A.2d 1050 (Me. 1991). Detailed constraints on the permissible terms of such a plan are set forth in 24-A M.R.S.A. § 2382-D and in Bureau of Insurance Rule 450. In particular, there must be a mechanism by which employers can appeal to the Superintendent for the correction of an incorrect loss report "if the insured can demonstrate that the information used by the insurer in estimating the incurred loss was incorrect." Rule 450, Article I, § 4.

There is widespread folklore that experience rating is a mechanism for insurers to shift the cost of workers' compensation benefits from themselves back to employers. It is not.

Nevertheless, there is a kernel of truth in this legend. Experience rating does mean that each time there is a compensable injury in the workplace, the employer's premiums for the next three years will be higher than they would have been in the absence of the injury. Increasing an employer's experience modification factor from 0.88 to 1.17, for example, results in a premium increase of almost 33%. This creates a strong financial incentive for employers to maintain safer workplaces, and is an important reason why experience rating for workers' compensation insurance is not only permitted but required. *See* 24-A M.R.S.A. § 2382-D(1)(B) & (C) (requiring the uniform experience rating plan to contain "Incentives for loss prevention" and "Sufficient premium differentials to encourage safety").

But the Petitioner fundamentally misconstrues how experience rating works in arguing that these incentives create "an inherent conflict between the insurer's role to administer a claim and the insured's obligation to pay whatever costs the insurer may incur." *(Pet. Br. at 4)* The cases the Petitioner cites involve a different type of insurance contract, called "retrospective rating," in which much of the risk of loss under the policy is transferred back to the insured. For example, in *Deerfield Plastics Co. v. Hartford Insurance Co.,* 536 N.E.2d 322, 404 Mass. 484 (1989), after a workers' compensation claim was filed against Deerfield, Deerfield was required to pay Hartford the full amount of the "reserve" established by Hartford as its estimated cost of the claim, 536 N.E.2d at 322 n.1, and subsequently when the claim was settled, to make an additional payment reflecting the difference between the initial reserve and the actual cost.[3]

Here, by contrast, the policy is a standard policy and the costs incurred by the insurer are paid in full by the insurer, out of the insurer's own funds.[4] Experience rating may allow the insurer to recapture some of these costs indirectly, at some later date, through higher premiums paid by the employer. But any such indirect recovery is speculative, since the employer may not be insured with the same carrier, and may not even be in business. Furthermore, the cumulative premium surcharges attributable to a particular

claim will not in any event be enough to reimburse the carrier for the cost of the claim. This does not, of course, mean that insurers will never cut corners on claims handling, only that the Petitioner has significantly exaggerated any structural incentives that may exist for them to do so.

Unfortunately, the same risks that cause employers to purchase insurance in the first place will also cause unlucky employers to have loss histories that overstate their true risk, and lucky employers to have loss histories that understate their true risk. This disparity will to some extent even out over time, and the rating plan contains safeguards designed to prevent isolated losses from having a disproportionate impact upon the employer's premium, but there is no way to eliminate the element of chance entirely from the experience rating process. Out of the imperfect alternatives available, the decision has been made that the fairest and the most accurate is to use an objective standard that considers all incurred claims, without any effort to evaluate the degree to which the employer is or is not at fault. This makes sense conceptually, as the insurance policy must respond to the unavoidable hazards of the workplace as well as to preventable losses.

On the other hand, an experience rating plan does not fairly measure a "difference among risks that may have a probable effect among losses or expenses," as required by 24-A M.R.S.A. § 2303(1)(G), if the underlying losses on which the adjustment is based were created by the insurer's own actions. "When the cause of a particular claim payment is not an unsafe workplace, or even the element of chance that experience rating reduces but cannot eliminate, but rather is the insurer's own doing, the insurer cannot lawfully use its own mistake as the basis for raising its policyholder's premium." *Industrial Roofing Corp. v. NCCI,* No. INS-93-73 (Me. Bur. Ins., October 12, 1993), *citing L.N. Violette, Inc. v. Northern MGA,* No. INS-92-85 (Me. Bur. Ins., July 22, 1992)

The balance between the goals of fairness and objectivity is codified in the provisions of Rule 450 which override more restrictive provisions of NCCI's national rating plan and require an insurer's loss reports to be disregarded for experience rating purposes to the extent "that the information used by the insurer in estimating the incurred loss was incorrect and the insurer knew or should have known at the time of the required valuation date that the information was incorrect." Rule 450, Article I, § 4(A).

This means that general allegations that an insurer has over-reserved or overpaid a claim as a result of poor judgment do not state a claim for relief under Rule 450. Correction of an experience modification requires specific proof of reliance on incorrect information. *MGA Insurance Services v. Superintendent of Insurance,* No. CV-93-606 (Me. Superior Ct., Kennebec County, October 17. 1994); *Bryant Steel Works v. MGA Insurance Services,* No. INS-97-6 (Me. Bur. Ins., August 20, 1997); *Gillespie Farms v. MEMIC,* No. INS-95-29 (Me. Bur. Ins., June 11, 1997) (granting relief with respect to a claim for an injury that

was erroneously reported by the insurer as a claim against the wrong policy, and that was settled for an amount that included an allowance for surgery when the case file showed no indication that surgery had been recommended).

In this case, although New Meadows does allege that MEMIC accepted the claim in reliance on incorrect information about the circumstances and extent of the claimant's injury, New Meadows has not proven that allegation, nor has New Meadows proven that any of the challenged actions by MEMIC had any material impact on the cost of the claim.

> Devices for ameliorating the effects of an unusually severe claim are built into the experience rating formula, and it would be unfair to apply a different standard to [this employer] than the formula applies to every other employer in Maine. It is insufficient, therefore, for the employer to demonstrate that a loss was due to events beyond its control. There must also be persuasive evidence that a significant contribution to the losses came from events within the insurer's control.

C.H. Stevenson, Inc. v. NCCI, Nos. INS-93-67*, vacated on other grounds sub nom. MGA v. Superintendent, supra.* No such persuasive evidence has been presented here.

Failure to Present Expert Testimony

As a threshold matter, MEMIC contends that the Petition must be denied as a matter of law because New Meadows did not present expert testimony as to the proper standards for adequate claims handling. However, such issues are within the expertise of this agency. As the Petitioner notes, the Superintendent has adopted performance standards in Bureau of Insurance Rule 440, Article IV, which have been used as a basis for review in earlier experience rating cases.[5] The Petitioner has also presented evidence relevant to the standard of care through the testimony of MEMIC's own adjusters.

Furthermore, as noted above, the ultimate issue is not the adequacy of claims handling *per se,* but rather the more objective standard of whether the incurred loss report was tainted by the insurer's reliance on inaccurate information. The Petition will therefore be decided on the weight of the evidence which has been adduced.

Application to the Facts of This Case

Although New Meadows alleges numerous irregularities in MEMIC's handling of the claim, they can be reduced to three potential sources of overpayment of the claim:

- acceptance of a claim that was invalid to begin with, and should not have been paid at all;
- unnecessary prolongation of the claim, particularly by failure to pursue sufficiently aggressive return to work efforts; and
- payment of benefits on a year-round basis, when A.H. should have been treated as a seasonal employee.

It should be noted that there are some serious questions whether many of the allegations can be tied to claims of reliance on "inaccurate information" within the meaning of Rule 450, particularly with regard to the delays in return to work. However, a more fundamental defect in the Petition is that it is impossible to prove that a claim has been overpaid as the result of reliance on inaccurate information without proving that the claim has been overpaid, and the Petitioner simply has not proven that the claim has been overpaid.

The issue with the greatest impact, obviously, is New Meadows' allegation that the claim was fraudulent and should never have been paid at all. Reviewing the weight of the evidence, however, I find that the suspicions of fraud are pure hindsight. There is considerable evidence of questionable conduct by A.H. later in the course of the claim – I would say downright fraudulent in some cases, except that A.H. was not called as a witness and has not been offered any fair opportunity to rebut. However, the record also shows both New Meadows and MEMIC taking appropriate countermeasures – they were not always as swift in their impact as New Meadows would have preferred, but that is result of the fact that A.H. <u>did</u> have documented medical problems which <u>did</u> impose work restrictions. She appears to have exaggerated both the severity of her condition and the extent of her work restriction, but that is not enough to call into question the existence of her work-related injury or the findings of the treating physicians and MEMIC's own independent examiner.

It is true that the accident allegedly occurred on Monday morning after a holiday weekend, and happened to someone who later turned out to display many questionable character traits. But this is exactly the sort of accident that could happen on in the course of setup after a long holiday weekend. Mr. Brawn has offered persuasive testimony that the accident occurred as a result of poor safety practices that he and his supervisors have often warned against, but there is a reason for this warning, and the fact that there is a name for this type of accident is evidence that it has occurred before.

Although there was nobody in the room when the accident allegedly occurred, the foreman and another coworker were close at hand, probably easily within earshot, and they did not question at the time that the accident had taken place. The first documented instance of New Meadows questioning the circumstances of the accident was almost two years later, in Mr. Brawn's March 1998 letter to MEMIC which is submitted as New Meadows Exhibit 16. Even then, he does not say that the accident did not happen, only that it could not have happened as A.H. said it did because she had recently told the rehab provider she fell "from 8 or 9 feet," and the ceiling in the room was only 8 feet.

However, the differences between "falling from 8 feet" and from an 8-foot ladder, or the differences between "falling from a ladder" and jumping from a falling ladder, are insufficiently material to call into question whether the accident happened.

MEMIC's adjusters have testified that even if they knew then what they know now, they would not have sufficient grounds to deny the entire claim as fraudulent. I find their conclusions reasonable and credible.

It should be noted further MEMIC's initial payments on this claim were not a decision by its personnel, but rather were required because New Meadows failed to provide timely notice of injury.

The most significant costs of the claim all relate directly or indirectly to the surgeries. As a practical matter, once it is acknowledged that the surgeries were medically necessary and arose out of A.H.'s work-related condition, the periods of incapacity before and after those surgeries must also be compensable.[6] Here, the record shows that MEMIC did pursue a second opinion, and did consider the circumstances of the surgery and verify the reputation of the treating physician before deciding to accept it. This is not a case where the insurer "never investigated or litigated these issues, choosing at several junctures to accept the claim at face value over the policyholder's objections."*C.H. Stevenson, Inc. v. NCCI,* No. INS-93-67 (Me. Bur. Ins., November 17, 1993)

The effect of the remaining issues is in any event relatively minor, and I find that with regard to the pace of return to work efforts and the question of A.H.'s year-round status, MEMIC likewise acted appropriately. The payments made were the result of the constraints posed by the nature of the claim, not of any actions by MEMIC and certainly not of any reliance on incorrect information.

Order and Notice of Appeal Rights

It is therefore *ORDERED* that the Petition to revise New Meadows' experience modification factors is *DENIED.*

This Decision and Order is a final agency action of the Superintendent of Insurance within the meaning of the Maine Administrative Procedure Act. It is appealable to the Superior Court in the manner provided in 24-A M.R.S.A. § 236 (2000) and M.R. Civ. P. 80C. Any party to the hearing may initiate an appeal within thirty days after receiving this notice. Any aggrieved non-party whose interests are substantially and directly affected by this Decision and Order may initiate an appeal on or before June 12, 2000. There is no automatic stay pending appeal; application for stay may be made in the manner provided in 5 M.R.S.A. § 11004.

[1]Pursuant to 24-A M.R.S.A. § 210, the Superintendent has appointed Bureau of Insurance Attorney Robert Alan Wake to serve as hearing officer, with full decisionmaking authority.

[2]The National Council on Compensation Insurance ("NCCI") has been designated by the Superintendent pursuant to 24-A M.R.S.A. § 2382-B as the advisory organization responsible for the administration of the workers' compensation experience rating plan. NCCI was named as a party to this proceeding but elected not to participate actively.

[3]In *Deerfield,* the effect of the disputed claim on future premiums under the experience rating plan was also taken into account, 536 N.E.2d at 325, but only as an additional element of damage once it was found that the claim had been wrongfully settled using funds held by the insurer in a quasifiduciary capacity. Actually, if Deerfield continued to be retrospectively rated, the interest on the incremental premium would have been a more appropriate measure of additional damage than the full incremental premium.

[4]The conflict of interest observed in the residual market under the former "Fresh Start" framework was a different one. There, claims management was provided by "servicing carriers" at the servicing carrier's expense, whereas claims were paid out of the funds of the Residual Market Pool, in which the servicing carrier's share of the assessments funding the marginal losses was insignificant relative to the share borne by the other carriers in the Pool and by employers. Under the current law, in both the voluntary and the residual market the insurer is responsible for 100% of both losses and loss adjustment incentives.

[5]*See, e.g.,Gillespie Farms v. MEMIC,* No. INS-95-29 at 5. However, as MEMIC notes, Rule 440 is not as directly on point in this case, because Rule 440 by its terms is only binding on servicing carriers for the former residual market mechanism, such as the predecessor insurer whose actions were in question in *Gillespie Farms.* Voluntary market insurers and MEMIC are not subject to Rule 440, so the Rule is of value only to the extent that particular standards may have validity as sound practice guidelines for all insurers.

[6]As a strict matter of law, it would have been theoretically possible to deny or reduce benefits for a week or two immediately before the surgery, but such a move would have accomplished little in the short run and been counterproductive in terms of long-range case management.

PER ORDER OF THE SUPERINTENDENT OF INSURANCE

MAY 1, 2000

ROBERT ALAN WAKE
DESIGNATED HEARING OFFICER