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BROKEN BARGAIN--HAWAII WORKERS' COMPENSATION SYSTEM

The Dark Side of Paradise

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I. INTRODUCTION

Hawaii's Workers' Compensation Law (Chap. 386 H.R.S.) was established in 1915 as a "social contract" whereby injured workers gave up the right to sue their employers for on-the-job injuries in return for medical care, temporary disability payments, permanent partial impairment, vocational re-training, and other benefits. The law was significantly revised in 1963, and subject to various changes over the years. The law was intended as a humanitarian system for the greatest possible medical and vocational rehabilitation of the injured worker and his or her rapid return to the work force in a cost-efficient manner.

Hawaii's system is basically a "private payer" system whereby the employer self-insures or purchases insurance from an insurance carrier to meet its obligation to provide protection to its workers for on the job injuries. A government-administered Special Compensation Fund paid by an employer tax limits the amount an employer is required to pay for pre-existing injuries, and situations of concurrent employment (i.e., where the injured worker was employed at more than one employer at the time of injury).

The number of reported on-the-job injuries has been about 25,000+ per year based on most recent available statistics. About 10% of these injuries have involved hearings in the Disability Compensation Division for contested issues.¹

There have developed many obstacles to payment of injured workers' benefits after filing of claims which have led to an adversarial process of increased litigation and frustration of the intent of the law. In response to these challenges, the Hawaii Injured Workers' Alliance was formed in 2004

by injured workers, health care providers, labor representatives, and attorneys representing claimants.

This brief essay is not intended as a comprehensive treatise of all of the nuances of the law or all of the issues facing injured workers, but to highlight the areas of difficulty and generally propose reforms to expedite benefit processing, reduce adversarial delays, and restore workers' faith in the system.

II. CHALLENGES FACING THE INJURED WORKER

A. "INSURANCE MEDICAL EXAMINATIONS"

The present law , 386-79 H.R.S. is appropriately entitled: "Medical Examinations by **Employer's Physician**", i.e., the employer's insurance company selects the physician. The present law has developed into an unfair and biased system whereby:

1. A small group of reliably-biased physicians are repeatedly hired by the employer have been willing to repeatedly endorse the insurance companies' positions against the injured worker to cut off temporary disability, deny medical treatment, and deny work connection, most commonly by alleging poorly documented or non-existent pre-existing injury or medical conditions, refusal to diagnose documented injuries, or declaring needed treatment as unnecessary.

2. Enriched this small group of physicians by lack of scrutiny or limitation on the amount paid for examination reports at rates which are multiples of fees limited to the Medicare Fee schedule for treating physicians. (One physician reportedly earned \$1,000,000 in one year for his reports for HEMIC, and others are known to limit their practice exclusively to such work).

3. Encouraged delay by insurers and the Disability Compensation Division by multiple, repetitive examinations, despite the statutory limitation of sec. 386-79 of "one per case unless good and valid reasons exist." Objections by injured workers and their attorneys to multiple examinations are routinely ignored.

4. Enhanced the financial advantage of the insurers against the injured worker by the ability to pay for medical opinions, whereas the worker and attorneys are limited in resources to pay for additional medical support to rebut the hired guns of the insurance carriers.

PROPOSED SOLUTIONS:

1). Senate Bill 1157 & House Bill 1196 (2011 Legislative Session) have been introduced and will require mutual consent by both the insurance company and the injured worker for the selection of

a medical examiner. A similar bill was previously passed into law on two occasions by the Legislature, but were twice vetoed by former Governor Linda Lingle.

2). Several presumptions have been built into the law to provide greater legal benefit to the injured worker under sec. 386-85, H.R.S. (principally, that a claim is covered work injury). The addition of another presumption in law could require that the treating providers reports and opinions be given greater weight than the opinions of the “independent” insurance examiner.

B. OBSTACLES AND DELAYS IN MEDICAL TREATMENT

The present practice for allowance of medical treatment under our Workers’ Compensation law, Chap. 386 as it has been administratively structured has become dysfunctional as delays by insurance carrier objection and the need for hearing and ruling on the objection is typically 60-90 days or more despite recent changes in the law. It is well known that Hawaii suffers from a shortage of medical providers and lack of specialists. To compound the shortage of physicians, most of the medical profession has dropped out of the Worker’s Compensation system out of frustration and lack of adequate financial compensation.

The few medical professionals willing to treat injured workers are constantly hamstrung by the inability to readily conduct diagnostic testing or obtain a consultation under the workers compensation system with a specialist in the field to further determine treatment and diagnostic recommendations.

There are now frequent insurance carrier objections to requests for treatment, diagnostic testing or consultation. It was estimated by one member of the Labor and Relations Appeals Board that about 50% of appeals presently before the Board are now related to the denials of treatment plans under current law and practice.

These objections to treatment are frequently being made by insurance personnel without medical training, minimal medical knowledge, and often without medical evidence. Moreover, many medical providers will hesitate to provide the diagnostic testing or consultation under private medical insurance when confronted with a denial by a worker’s compensation insurance company. The result is delay in medical services for the injured worker and delayed return to the work force.

PROPOSED SOLUTIONS:

1). House Bill 463 (Legislative Session 2011) has been introduced and was passed by the Legislature in its present form in 2009 and vetoed by former Governor Linda Lingle. This bill will allow one-time automatic referral for consultation and diagnostic testing without insurance carrier approval.

2). Disallowing or restricting unilateral decision-making and objection as to reasonableness and necessity of medical and related treatment by non-medical insurance adjusters. A proposal to

abolish the Medical Fee Scheduled in its present form is being discussed among practitioners. Some states do not require insurance pre-approval for medical providers to perform treatment.

3). Requiring workers compensation carriers to advise a treating medical doctor or specialist that they may proceed to treatment, and guaranteeing payment by the carrier for all treatment up to the date of a decision by the Director of Labor and Industrial Relations. This is already provided under sec. 386-26 (c) as amended, 2005. Furthermore, if treatment is not paid by the workers' compensation carrier the medical billing will be paid by any available private medical insurance.

4). Enactment of a presumption under sec. 386-21 H.R.S. (Medical and Rehabilitation Benefits) that any treatment recommendation, consultation, and referral to a specialist by the attending health care provider be presumed as reasonably necessary for the injured workers greatest possible rehabilitation and return to work.

C. ADVERSARIAL PROCESS AND DELAYS

Injured workers and legal practitioners representing them have experienced more frequent objections to coverage for injuries, treatment plans, vocational rehabilitation programs, and other benefits. The most recent available statistics show that the number of hearings at the initial administrative level of the Disability Compensation Division was about 2500 per year from 2006-2008. At the appeals level of the Labor and Industrial Relations Appeals Board there have been well over 500 appeals per year, or 20% of all decisions rendered at the initial level of hearing. ⁱⁱ

Attorneys representing injured workers have recently reported increased attendance at hearings because of the greater number of objections, particularly in the area of treatment plans. The greater reliance by the insurance carriers on their insurance examiners have also led to greater difficulty in obtaining coverage for work injuries and re-opening of cases.

There has also been increased use of aggressive insurance tactics such as denials of coverage without evidentiary documentation and without medical support. Injured workers have increasingly had to resort to the civil courts to file cases of bad faith insurance handling. However, such cases are expensive, time-consuming, and require specialized expertise, and are therefore generally limited to the most egregious situations.

The need for legal intervention at the initial administrative level is also costly and time consuming for injured workers who are usually unable to work and can ill afford to have a portion of benefit compensation paid for legal representation. The number of attorneys willing to accept workers' compensation cases is also diminishing in part due to an artificially low rates set by the Disability Compensation Division and arbitrary fee reductions.

PROPOSED SOLUTIONS:

1. Requiring the employer to pay the claimant's attorney fees where the employer unsuccessfully challenges work connection (compensability), any non-payment of disability or other benefits, or is over-ruled on a treatment objection. Such fee-shifting is required under the federal workers compensation in the Longshore and Harbor Workers Compensation Act (LHWCA), 33 USCA § 928 (a), and has significantly reduced litigation and challenges by the insurance carriers.

2. HB 464 (Legislative Session 2011). This previously introduced bill will amend §386-86 (a) HRS, and require an employer to submit a written report to the Director of Labor and Industrial Relations within 30 days of denial. An extension of time to submit a report is prohibited. The present law as applied allowed almost indefinite extensions of time, where the employer requested time to "investigate" a claim. Most frequently, no actual investigation takes place and an insurance medical examination is scheduled to provide an after-the-fact justification for denial of a claim. Often, nothing is done to process the claim until the frustrated injured worker retains counsel and requests a hearing on the refusal to recognize a claim. It is known that many injured workers become discouraged and fail to pursue claims and forego benefits otherwise payable by law.

3. Adopting a rational and market-based attorney fee structure, such as by removal of fee approval authority from the Disability Compensation Division (by non-legally-trained hearing officers) and adoption of prevailing civil rates for legal fees with adequate controls by setting maximum caps on fees, such as by percentage of recovery of benefits, or restriction to fees for contested cases. This automatic control on fees could work effectively if fee-shifting were adopted, as discussed above. Fair and adequate compensation would encourage representation for injured workers.

4. SB 2167 (Legislative Session 2009). Proposed to expressly allow attorney fees to be awarded as part of "whole costs" where there is found to be an unreasonable defense or prosecution of a claim. This proposal was made to overturn the present policy of the current Labor and Industrial Relations Appeals Board misinterpreting §386-93 (a) as disallowing attorney fees. A new bill is expected to be introduced in the 2011 session.

5. Requiring the payment of temporary total disability to an injured worker until a decision by the Director of Labor and Industrial Relations is filed, if work connection is challenged.

6. Requiring prompt decisions by the Labor and Industrial Relations Appeals Board, either by adoption of a 30-day deadline for the issuance of an abbreviated decision following a hearing, and by funding staff positions for full-time hearing officers.

7. Practitioners frustrated by the delays are discussing a partial return to the civil system by allowing the injured worker an option to withdraw a claim from the workers' compensation system and file a civil suit against a negligent employer. Mandatory arbitration under Hawaii's Court Annexed Arbitration Program would encourage mediation and settlement of claims.

III. CONCLUSION

Hawaii's Workers' Compensation system cries out for effective changes as well as review toward wholesale reform so that the social promise made of fair, efficient, and expedited return to the workforce without extended adversarial process can be restored, as it was originally intended when it was enacted nearly a hundred years ago.

ⁱ Workers' Compensation Data Book, Dept. of Labor and Industrial Relations, 2006-2008

ⁱⁱ The Appeals Board Index, Aug. 2010

