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Torts, Insurance & Compensation Law Section Journal

A publication of the Torts, Insurance & Compensation Law Section
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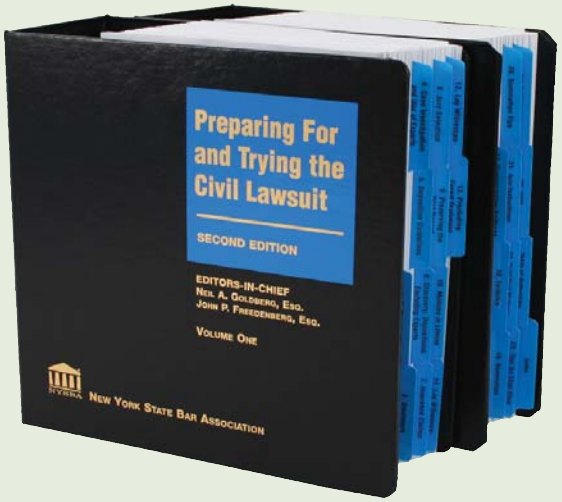

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A View from the Chair

Dear TICL Section Members:

Another great issue of the *TICL Journal*, thanks to Dave Glazer and all of our contributors. The variety of topics addressed by the articles is indicative of the strength of our Section. If you borrowed this from a colleague, consider joining our Section. We'd love to have you. If you'd like to be part of the *Journal*, please consider submitting an article for consideration.

We are preparing for back to school-and-our fall meeting, which will be held in music city, Nashville, Tennessee from November 9-12. We have lots of great CLE planned, including cyber crimes, driverless car technology, the art of mediation, mental wellness in the legal profession, premises liability, social media and trial tips. We also have lots of activities planned, including the Vandy/Kentucky football game with a Southern barbecue tailgate, a concert at the infamous Ryman Auditorium and plenty of time to explore the amazing city of Nashville. So pack your cowboy boots and plan to join us. November 10 is the Veterans Day holiday, so the courts and schools are closed, giving you the chance to network and mingle with old and new friends, enhance your career with cutting-edge CLE and explore Nashville without missing a day of court. You can register at www.nysba.org/TICLNashville17.

We are also looking forward to our annual Law School for Insurance Professionals—our Section's flagship program—focused on educating and networking with members of the insurance industry. The program will be held across the state in September and October.

It is hard to believe that our Annual Meeting is around the corner from January 22-26 in New York City. We hope to see you there. Registration will open shortly, so please check back for further information.

I hope to see you all in Nashville in November and at the Annual Meeting in January.

All the best,

Elizabeth Fitzpatrick

Upcoming TICL Events:

Torts, Insurance and Compensation Law Section Fall Meeting

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Must a No-Fault Carrier Reimburse a Health Insurer for Mistaken Payment?

By John Coco

In *Aetna Health Plans v. Hanover Ins. Co.,* the issue on appeal was whether a health insurer that pays for medical bills, which were the responsibility of the no-fault insurer, could maintain an action for reimbursement from the no-fault insurer.[1] The court held that within the framework of the Comprehensive Motor Vehicle Insurance Reparations Act, a health insurer could not maintain such a reimbursement claim.[2]

The Facts in *Aetna*

In April of 2008, Luz Herrera was injured while operating a vehicle insured by Hanover Insurance Company. Under Insurance Law § 5101, et seq. (the "No-Fault" Law), Hanover was liable to pay for medical expenses related to the accident. At that time, Herrera also had private health insurance provided by Aetna.[3]

Although medical bills should have been submitted to Hanover, the "no-fault" provider, the bills were mistakenly submitted to Aetna, which initially paid $19,649.10. Aetna thereafter requested reimbursement from Hanover but received no response. Aetna then filed a lien against Herrera's personal injury action. Hanover was not responsive to several attempts by Herrera's attorneys to rectify the mistaken payments, as they were ostensibly seeking to remove the lien that would ultimately reduce their client's recovery.[4] Herrera subsequently demanded arbitration, claiming that Hanover was responsible for payment of the lien. By this juncture, Aetna had paid an additional $23,525.73 toward Herrera's medical bills, totaling $43,174.83.

The Holding

In affirming the order of the Appellate Division, the majority held 5-2 that a health insurer is not a "provider of health care services" within the meaning of 11 N.Y.C.R.R. 65.3.11, specifically the section stating that "an insurer shall pay benefits for any…loss[,] other than death benefits, directly to the applicant or…upon assignment by the applicant…shall pay benefits directly to the providers of health care services."[5]

Although Aetna conceded that it is not a "health care provider" within the meaning of 11 N.Y.C.R.R. 65-3.11 (a), it argued that it stood in Herrera's shoes because Herrera assigned Aetna her no-fault rights.[6] The court disagreed with this argument for two reasons.

First, since Herrera's health care providers directly billed and received payment from Aetna, Herrera had already assigned her rights to Aetna, and therefore, had no further rights to assign.[7] Second, under the no-fault regulation, only the insured or a health care service provider may receive direct no-fault benefits. Accordingly, any purported assignment by Herrera to Aetna is ineffectual because Aetna is not a health care provider.[8]

Dissent: Equitable Subrogation

In his dissent, Judge Fahey opined that under these facts Aetna has a cause of action for "equitable subrogation."[9] Judge Fahey cited the following to establish the scope of equitable subrogation: the doctrine "is broad enough to include every instance in which one party pays a debt for which another is primarily answerable and which in equity and good conscience should have been discharged by the latter…"[10]

Simply stated, the core of the dissent was that Aetna should be reimbursed because it paid medical expenses for which Hanover was liable. Judge Fahey disagreed with the majority's rationale that the no-fault scheme precludes the plaintiff from pursuing this action, stating, "[t]rouble with respect to a *remedy* does not equate to trouble with respect to the *merits* of a cause of action."[11]

Judge Fahey further stated that although Aetna may be precluded from direct payment from Hanover under the no-fault regulations, Aetna could seek reimbursement from the medical service providers, who then could seek reimbursement from Hanover under their automobile insurance contract with Herrera. The medical service providers, if paid from both Aetna and Hanover for a single service, could then reimburse Aetna. Although this is a seemingly circuitous route for Aetna's recovery, Judge Fahey stated, "[a] meandering path to recovery does not mean that an equitable subrogation 'road' to plaintiff is closed here."[12]

Judge Fahey also reasoned that despite the complexity of the no-fault scheme, its intent included consumer protection. Here, Herrera had been harmed twice: first from the accident and second from a lien on her recovery, a result which the no-fault regulation was designed to avoid.[13]

Concurring Opinion

Judge Stein refuted the dissent in her concurring opinion, arguing that equitable subrogation did not apply in this situation. Judge Stein reasoned that the no-fault statutes and regulations provided no basis for a health maintenance organization (HMO) to recover from a no-

fault insurer and therefore, equitable subrogation did not apply.[14]

In addition to bolstering the majority's rationale, Judge Stein also referenced the State Insurance Department Office of General Counsel's informal opinion on precisely this matter. The opinion states that an "HMO is not entitled to subrogate its recovery pursuant to New York Insurance Law § 5105(a)…because it does not fit the definition of 'insurer' under the no-fault insurance law scheme." The Insurance Department's rationale is that an HMO can simply deny coverage for treatment that is covered by no-fault.[15]

Best Practices

Outside the scope of this decision remains the remedy for plaintiffs like Herrera who are faced with an erroneous lien against their recovery. No such lien is asserted when the no-fault insurer pays for medical treatment that arose from a motor vehicle accident where no-fault coverage applies. Myriad liens already diminish monetary recovery for many plaintiffs, and attorneys must contend with these liens to ensure that an improper lien never reduces his client's compensation.

While the scenario in *Aetna Health Plans v. Hanover* is often out of the attorney's control, it might be avoided by taking the following precautions:

- Notify the first party insurance carrier of the accident and injuries within 30 days of the accident (practically speaking, as soon as possible). Submission of an "Application for Motor Vehicle No-Fault Benefits" (form NF-2) satisfies this requirement.[16] A word of caution—do not rely upon other sources of information (e.g., a property damage claim arising from the same accident) to provide the no-fault carrier with notice of the accident and injuries. Seasoned personal injury attorneys will include the NF-2 form as part of their standard intake package for immediate filing. Upon receipt of the NF-2, the no-fault insurance carrier will generate a claim number and assign a no-fault adjuster.
- Immediately provide the no-fault claim number and adjuster's information to every Medical Service Provider (MSP) that has seen the client. If a client was hospitalized on the date of the accident, contact the hospital's billing department with the no-fault information, as a claim would not yet have been established.
- Advise the client to promptly provide any medical bills he receives for treatment related to the accident. Theoretically, if a client receives a medical bill then it was not properly submitted to no-fault. Forward such bills to the no-fault adjuster for payment.
- Direct the client to provide the claim number to every MSP she visits for injuries sustained in the accident. Impress upon the client the importance of providing this information to each MSP. The client possesses the most control in avoiding this situation.

Legislative Remedy

As previously mentioned, the *Aetna Health Plans v. Hanover* decision does not address the twice-harmed party, Luz Herrera. If a health insurer cannot recoup mistaken payments under these facts, it may assert a lien against the injury victim's recovery. The consumer protection oriented no-fault regulations certainly did not intend this result. While a detailed analysis of a new regulation or legislation is beyond the scope of this article, new law to preclude liens by HMOs where the no-fault insurer is liable could directly remedy this inequitable situation.

Injury victims are faced with the devastation of the accident and an often long road to recovery. Attorneys should take every precaution to avoid the imposition of unnecessary liens to prevent their clients from being twice victimized. New legislation addressing the scenario in *Aetna Health Plans v. Hanover* may protect an injury victim's monetary recovery from unnecessary and wrongful diminution.

John Coco is Chair of the Plaintiff's Personal Injury Committee at NCBA and founded the Law Offices of John Coco, PLLC, a personal injury firm. John can be reached at 516-224-4774 or jcoco@johncocolaw.com.

Endnotes

1. *Aetna Health Plans v. Hanover Ins. Co.,* 27 N.Y.3d 577 (2016).
2. Insurance Law § 5101 *et seq.*
3. *Aetna Health Plans v. Hanover Ins. Co.,* 27 N.Y.3d 579 (2016).
4. *Id. at* 579-80 (2016).
5. *Id.* at 582 citing *Health Insurance Plan of Greater New York v. Allstate Insurance Co.,* 2007 N.Y.Slip Op 33925(U) (Sup. Ct., NY Co. 2007); *see also* Gen. Counsel Opinion 1-28-2008).
6. *Aetna Health Plans v. Hanover Ins. Co.,* 27 N.Y.3d 583 (2016).
7. *Id.* at 582-83.
8. *Id.*
9. *Id.* at 587.
10. *Id.* at 588, citing *Gerseta Corp. v. Equitable Trust Co. of N.Y.,* 241 NY 418, 425-426 (1926).
11. *Aetna Health Plans v. Hanover Ins. Co.,* 27 N.Y.3d 588-89 (2016).
12. *Id.* at 589.
13. *Id.* at 589, citing *Presbyterian Hosp. in City of N.Y. v. Maryland Cas. Co.,* 90 N.Y.2d 274, 286 (1997), *rearg. denied* 90 N.Y. 2d 937 (1997), *Pommells v. Perez,* 4 NY3d 566, 570-571 (2005).
14. *Aetna Health Plans v. Hanover Ins. Co.,* 27 N.Y.3d 583 (2016).
15. *Id.* at 584-85. See 11 N.Y.C.R.R. 52.16 (c)(8).).
16. 11 N.Y.C.R.R. § 65-2.4(b).

Calculating Lost Profits—an Overview

By Stephen L. Ferraro

This article provides an overview of litigation matters involving commercial damages and represents the first in a series of articles devoted to the calculation of lost profits from the perspective of the forensic accounting expert.

"The method used for calculating lost revenue will vary depending upon the industry, the data available for the calculation, and the type of loss."

Commercial damages can occur in breach of contract and business tort cases and result in claims for lost profits or diminished business value. Intellectual property infringement cases, securities fraud and antitrust cases also can involve such loss claims. The measure of damages in commercial cases follows generally accepted methodologies. Financial models are prepared to provide an estimate of the economic damages experienced by the plaintiff resulting from the wrongful act of the defendant. To prove economic damages the plaintiff must successfully address the following legal principles:

- *The Proximate Cause Rule*: The recovery of damages for lost profits is subject to the general principle that damages must be proximately caused by the wrongful act of the defendant. This requirement is expressed in numerous cases and governs the recovery of all compensatory damages;
- *The Reasonable Certainty Rule*: A second requirement for the recovery of damages for lost profits is that the damages be proven with reasonable certainty. It requires that damages be capable of measurement based upon reliable factors without undue speculation. Again, this legal principle is expressed in a huge number of cases and is unquestionable;
- *The Foreseeability Rule*: There is a key question presented by cases looking for recovery of damages for lost profits on contract claims. The question is whether those damages were reasonably foreseeable as the expected and likely result of a breach of the contract at the time the contract was made.

These governing legal principles, which have been well established and reinforced by case law, should be woven into the financial analysis in a manner that shows their applicability to the case at hand. Specific supporting case law and practical approaches to demonstrate the relevance to financial models will be addressed in a future article.

Lost Net and Gross Profits

Lost net profits are determined by first estimating the lost gross revenue (or lost sales) due to a wrongful act or incident. The lost revenue is then reduced by the avoided (or saved) costs, which entails evaluating all the direct and other costs related to providing goods or services. This results in the lost net profits that would have been enjoyed had the loss of sales not occurred.

Some experts like to use lost gross margin or gross profits as the of measure of damages. This usually isn't the correct way to value damages. Gross margin only covers revenue reduced by cost of goods sold. This potentially overstates the damages because it fails to consider other costs of a business that may be associated to providing a good or service and, thus, avoided.

Lost Revenue

As mentioned earlier, the first, and usually primary, element of a lost profits calculation is the determination of the revenue lost due to the wrongful act or incident. The method used for calculating lost revenue will vary depending upon the industry, the data available for the calculation, and the type of loss. There are few typical methods for calculating lost revenue. A brief description of each follows:

- *The "Before and After" Method*: Under this approach, the expert compares the revenue of the business before and after the event. The underlying theory is that "but for" the event, the business would have experienced the same level of revenues and profits after the event as the business did before that event. Some consideration for other factors that could have affected the level of revenues is also warranted, such as the potential future impact of the trends in revenue in place prior to the event.
- *The "Yardstick" (or "Benchmark") Method*: Under this approach, the expert utilizes a "yardstick" to estimate what the revenues and profits of the affected business would have been. Examples of potential yardsticks that could be used include comparing the revenue trends and results of the business to a similar business; comparing to other unharmed locations of the business; utilizing the actual experience versus budgeted results or industry averages.
- *Contract Terms*: In some instances, the expert can reference a specific contract that may set forth terms which determine anticipated revenue levels. A model might be developed that calculates the

revenues and profits anticipated under the terms of the contract.

- *Defendant's Profits*: In cases involving unfair competition or intellectual property infringement, an accounting of the profits realized by the defendant may be used as the measure of damages. The plaintiff is entitled to receive the value of unjust enrichment of the defendant through disgorgement. We will provide much more information related to this method and measure of damages in a subsequent article.

Deductible Direct Costs and Other Expenses

To arrive at an accurate lost profit amount, the forensic accounting expert must determine and deduct the direct costs and other expenses associated with generating revenue. For example, many businesses incur direct material costs, labor costs, utilities, supplies, and other expenses to make and deploy their product and services. To the extent that the company lost sales, the company also did not incur the expenses associated with those sales. These avoided (or saved) costs need to be calculated and factored into the lost profits calculation.

"Because the damage award is intended to make the plaintiff whole, failing to discount future lost profits would result in a windfall to the plaintiff, since the award can be invested with a return earned on that investment."

It's important for the forensic expert to understand the company's cost structure, and the degree of detail required in estimating costs will vary from business to business. It is necessary to understand how the company's costs relate to the sales and what factors affect the costs and how. The accounting concepts involved in understanding and unraveling the cost structure are many, and require thoroughness on the part of the expert.

As with the calculation of lost revenues, it is always important for the expert to examine the calculated expenses for reasonableness. They must be satisfied that the numbers make sense considering the information available in the case.

Period of Recovery

Another important aspect of a damage calculation is correctly assessing the loss period. The loss period normally begins on the date the event occurred, which should be easy to determine. The ending date of the loss period may be more difficult to estimate. It will likely be based upon the date the business resumed to normal operating levels or the end of the term of a contract. The requirement for mitigation could also come into play in the determination of the loss period.

"A forensic accounting expert must calculate damages that are reasonable and that use reliable information and widely accepted methodology."

Other Important Calculation Considerations

Other areas relevant to the calculation of lost profits, that may need to be addressed by the forensic accounting expert, include the following:

- *Prejudgment Interest on Past Losses:* Generally, prejudgment interest is used to compensate the plaintiff for the interest not earned on the lost profits from the date of the incident to the date of the trial. Courts have considerable discretion in the calculation of prejudgment interest, including the interest rates to be applied and the manner of computing the interest.

- *Discounting of Future Lost Profits to Present Value:* When calculating lost profits, there is often both a historical element and a future element. The historical element would include lost profits that would have been earned from the date of the incident to the date of trial, while the future element would include lost profits that would have been earned from the date of the trial to some date in the future. It is necessary to state the future element of lost profits in terms of their present value. Because the damage award is intended to make the plaintiff whole, failing to discount future lost profits would result in a windfall to the plaintiff, since the award can be invested with a return earned on that investment. The challenge is to determine an appropriate discount rate that takes into consideration both the time value of money and risk.

- *Income Tax Treatment on Damages:* In general, lost profit damages are taxable as ordinary income to the plaintiff. Consequently, lost profit calculations are typically prepared on a pretax basis. Additionally, to the extent that the plaintiff received tax benefits because of losses triggered by the alleged bad act, such tax benefits are generally not considered in the calculation.

- *Mitigation of Damages:* The key to a successful defense is often proof that the plaintiff failed to mitigate damages. The burden of the mitigation requires that the plaintiff take appropriate steps to minimize damage allegedly caused by the defendant. The plaintiff has an obligation to act reason-

ably to mitigate its damages, but its failure to do so must be proved by the defendant.

- *Alternative Damage Measures Other Than Lost Profits:* In some cases, there could be different measures of damages other than lost profits. Two of the more common other measures pf damages include out-of-pocket costs and diminished business value.
- *Specialized Damage Areas:* Specialized areas of damage could include unestablished businesses, intellectual property infringement damages, antitrust violation damages, securities fraud damages, and the impact of internet business on damages.

Summary

The calculation of lost profits can be a very subjective, detailed and time-consuming process. It is necessary to be as thoughtful and accurate as possible when estimating lost sales and the related saved costs or expenses. Maybe most significant is the fact that this is not an exact process, and relies on significant estimates. A forensic accounting expert must calculate damages that are reasonable and that use reliable information and widely accepted methodology.

As mentioned, this article is intended to provide a basic overview of what we believe should be considered in the evaluation of a claim for lost profits. We hope it serves as a useful assessment tool if you are ever involved in the measurement of commercial damages. Please stay tuned for future articles that will go into much more detail and offer specific supporting case law with respect to what we feel are the most critical areas of consideration in lost profit cases.

Stephen Ferraro is a partner with Ferraro, Amodio & Zarecki, CPAs, based in Saratoga Springs, NY (FAZ). FAZ is a boutique Forensic CPA firm committed to supporting the legal community in the successful resolution of financial disputes, fraud and financial investigations, economic damage assessments and business valuations by delivering valuable expertise and related expert services at an appropriate cost. If you think you need assistance with a case or are interested in more information, please call Steve directly at (518) 288-2136.

Workers' Compensation Reform 2017: What? Again?

By Ronald Balter

Once again in 2017 the New York State Legislature was told that there is a crisis in workers' compensation and that more reforms were needed to save business from the high costs of workers' compensation.[1] This is a refrain that comes almost every year from the business community.[2] [3] [4] Although it is doubtful that workers' compensation is really a major cost to employers in New York State,[5] the legislature, as part of the budget for the fiscal year that began on April 1, 2017, passed amendments to the Workers' Compensation Law that are intended to greatly benefit business at the expense of injured workers by reducing the benefits available them.[6]

Although there were many amendments to the law many of them do not impact the day to day practice of workers' compensation law in front of the Workers' Compensation Board, as they deal with the right of the state to try to sell of the liabilities of the Special Funds Conservation Committee to a private insurance company, as well as setting up a drug formulary, rating insurance carriers' performance, the rate setting process and reviewing independent medical examinations in the workers' compensation system. This article will deal with the changes that impact the day to day practice of workers' compensation.

Labor Market Attachment

Over the last 15 years a doctrine known as Labor Market Attachment has been used by the defense bar to lower costs by suspending weekly benefits from injured workers who were deemed to have left the labor market on a voluntary basis.[7] This doctrine requires most injured workers who are partially disabled to conduct a job search, be in a training program, or enrolled full time in school, or they will lose their weekly benefits. The bill amended Workers' Compensation Law § 15(3)(w) to indicate that any claimant who has been classified as having a permanent partial disability and entitled to weekly benefits at the time they were classified will no longer be required to show an ongoing attachment to the labor market to continue to receive their weekly benefits. This amendment will ensure that a claimant with a permanent partial disability who is not working will be paid for the rest of their life if they were injured prior to March 13, 2007 or paid their entire capped period of benefits under §15(3)(w) of the Workers' Compensation Law based upon the amendments to the Workers' Compensation Law effective on that date.[8] Because this issue can no longer be litigated these cases should no longer be placed on the calendar by the Workers' Compensation Board, thereby freeing up the Workers' Compensation Board to resolve other issues for both the injured workers, employers and workers' compensation carriers.

There is one area where the issue of attachment possibly can remain an issue for injured workers. If one is found to have a permanent partial disability while working in excess of the average weekly wage before that would not be eligible for awards at the time of the classification. The question that the Workers' Compensation Board will have to resolve is whether or not when they make a claim for awards, and if they are found to be eligible and have awards made, will attachment be an issue for the length of the cap (or for life on the case prior to March 13, 2007) or will the new amendment end the issue in those cases?

Durational Caps

As stated above, prior to March 13, 2007 an injured worker who was out of work and found to have a permanent partial disability could have been paid benefits for the rest of their lives. The 2007 amendments limited the length of time an injured worker with a permanent partial disability can be paid. Depending upon the workers' loss of wage-earning capacity they could be paid anywhere from 225 weeks to 525 weeks after the date of classification. As a result of this, attorneys representing injured workers, acting in the best interest of their clients, sought to obtain benefits for a long as possible prior to a finding of a permanent partial disability. Employers and workers' compensation carriers obviously were opposed to the lengthening of the time between the date of accident and the date on which the claimant was found to have a permanent partial disability.

To reduce the time between an accident and when the durational caps begin to run for all accidents on or after April 10, 2017,[9] there will be a presumption that once a claimant is found to have a permanent partial disability the durational cap will have begun to run 130 weeks after the date of accident. However, that assumes that the claimant was paid some benefits for a partial disability, as the amendment states the presumptive date of reaching maximum medical improvement occurs when a workers' compensation carrier has paid benefits under Workers' Compensation Law § 15(5). Section 15(5) is the section for paying temporary partial disability benefits. If a claimant has only been paid at a temporary total disability[10] rate in the first 130 weeks, then the presumption should not come into play. Any benefits paid after 130 weeks will then likely count against the durational cap. This means that if the injured workers is found to have a permanent partial disability on the fourth anniversary of their accident, (approximately 208 weeks after the date of accident) the workers' compensation carrier would get a credit of 78 weeks against the durational cap and thereby reduce the amount of additional time and benefits payable to the claimant. For private workers' compensation carriers it will lower the value of the Aggregate Trust Fund deposit.

However, this starting date for the caps can be overcome by the injured worker. If the injured worker can produce a medical report that indicates that the claimant has not yet reached maximum medical improvement and the workers' compensation carrier has had a reasonable time to produce a report to the contrary, and if the Workers' Compensation Board determines that the claimant has yet to reach maximum medical improvement or the workers' compensation carrier produces a report that says the claimant has not yet reached maximum medical improvement, then there will be no credit against the durational cap until the claimant reaches maximum medical improvement and is found to have a permanent partial disability.

In giving the workers' compensation carrier credit for any benefits paid after 130 weeks from the date of accident the claimant's attorney must make sure that any periods of temporary total disability benefits do not count against the cap. The weeks payable under the durational caps are only those weeks when the claimant remains permanently partially disabled. If claimant prior to the 2017 amendments had been classified and had surgery, then the weeks after the surgery when the claimant was temporarily totally disabled post operatively did not count against the cap because when totally disabled the claimant was no longer permanently partially disabled. The argument to be made is that since Workers' Compensation Law § 15(3)(w) says that only permanent partial disability weeks count against the cap, the period of temporary total disability should not count against the cap. To rule that more than 130 weeks at temporary total disability should count against the durational cap would take a narrow interpretation of the Workers' Compensation Law contrary to the interpretation that the Workers' Compensation Law is to be liberally construed to accomplish its economic and humanitarian goals.[11]

What appears to be unfair is when a claimant does not have lost time until nearly 130 works post-accident. It appears that a claimant in that situation may almost immediately be using weeks against the durational cap despite being paid only a short period of time, as opposed to the injured worker who had been out of work since the date of accident. This anomaly may require a legislative fix so that the law commencing the cap does not begin until the injured worker has been paid workers' compensation benefits for 130 weeks.

First Responder Stress Claims

Ordinarily for a stress claim to be established the claimant must show that the amount of stress they were exposed to on the job was "greater than that of other similarly situated workers."[12] When a stress claim is filed on behalf of a police officer or firefighter subject to § 30 of the Workers' Compensation Law, an EMT, paramedic or other person certified to provide medical care in an emergency sustains stress from a "work-related emergency cannot be disallowed if the stress sustained is not greater than that which normally occurs in a normal work environment."[13] This modification to the Workers' Compensation Law is clearly intended to protect first responders who are exposed to levels of stress on a regular basis that results in stress-related conditions. One would think that such legislation would not be necessary. However, it was definitely needed. A police officer from the East Greenbush Police Department was involved in an active shooter situation where he was the "spotter" when the shooter was eventually shot and killed by fellow officers. The police officer who was the spotter eventually developed post traumatic stress disorder. After litigation his claim was disallowed by the Workers' Compensation Board and affirmed on appeal to the Appellate Division, Third Department.[14]

Scheduling of Hearings

At the onset of a workers' compensation claim there are times when the injured worker is out of work and not being paid benefits by the workers' compensation carrier. Attorneys representing the claimant will contact the Workers' Compensation Board for a hearing to be scheduled to get their clients the benefits they are entitled to receive. Previously, under the Workers' Compensation Law there was no time frame for the Workers' Compensation Board to respond and schedule a hearing to have benefits awarded to the claimant. The 2017 amendments added additional language to § 25(2)(a) requiring the Workers' Compensation Board to hold a hearing within 45 days of a request for a hearing when there is medical evidence in the Workers' Compensation Board's file and the claimant is out of work and not being paid any workers' compensation benefits. This addition will force the Workers' Compensation Board to place these cases on the calendar so that the injured worker will be paid his or her benefits. It will prevent the Workers' Compensation Board from stating that a hearing cannot be scheduled because the workers' compensation carrier has not yet filed certain forms.

It should also be noted that there is no limiting language as to when such a request can be used. Although, intended for use at the beginning of a case, there is no reason why it cannot be used later in a case such as when a claimant stops work for surgery and is not being paid, or if the injured worker is advised to stop working because of a worsening of his or her condition. So on any non-controverted claim, if the claimant is out of work and has the necessary medical evidence of a disability and not being paid, a hearing should be requested under this new provision of the Workers' Compensation Law.

On April 26, 2017 the Workers' Compensation Board issued Subject Number 046-937 explaining the requirements for when it is appropriate to use this new law. If attorneys representing the injured worker files a request under this provision, the Workers' Compensation Board has indicated that they will be penalized $500 under

Workers' Compensation Law § 114-a(3) and also will be denied a fee even if an award is made to their client.[15]

Safety Net Cases

In the 2007 amendments to the Workers' Compensation Law that created for the first time durational caps for injured workers who have a permanent partial disability, a safety net was created for those workers who sustained a loss of wage earning capacity in excess of 80 percent and who when the cap ran out (anywhere from 450 to 525 weeks after the finding of permanency) would have the right to apply for additional benefits within one year of the cap running out if they were still out of work at the end of the cap. If a finding of an "extreme hardship" was shown they would be reclassified by the Workers' Compensation Board as having either a permanent total disability or total industrial disability. Regardless of the reclassification the injured worker would be entitled to weekly workers' compensation benefits for life. The new amendments have reduced the threshold for those individuals who are found to have more than a 75 percent loss of wage earning capacity. The new amendments to the safety net provisions will increase the number of people eligible for the safety increases by lowering the threshold. It should also be noted that the 2017 amendments were effective 526 weeks after the 2007 amendments were effective, so it is unlikely that any person who had been found to have over an 80 percent loss of wage earning capacity would have even become eligible to apply for the extreme hardship benefits.

The Workers' Compensation Board in conjunction with the Commissioner of Labor is supposed to produce an annual report on claimants whose benefits had run out under the durational caps. This is a role reversal for the Workers' Compensation Board and the Commissioner of Labor, which hopefully will allow for the annual reports as required so that all parties to the system will be able to judge the impact of the cessation of weekly benefits after the durational caps have run out.

Decisions of a law judge at the Workers' Compensation Board are appealed to a Board Panel made up of three of the commissioners of the Workers' Compensation Board.[16] If one of the three commissioners dissents (except for referring a case to be evaluated by an impartial medical specialist) the losing party has the absolute right to request that the Board Panel decision be reviewed by the entire 13-member Workers' Compensation Board, if they desire. This right has now been expanded to those cases where, on appeal, even a unanimous Board Panel reduces an injured worker's loss of wage earning capacity to less than the safety net threshold. Hopefully, by creating additional cases subject to mandatory full board review hopefully there will be fewer cases in which a Board Panel reduces an injured worker's loss of wage-earning capacity out of the safety net.

For those claimants who become eligible to claim safety net benefits, the Workers' Compensation Board issued Subject Number 046-938 on April 26, 2017. The Workers' Compensation Board seeks to explain the process as to how claimants make a claim for extreme hardship benefits. To aid the Workers' Compensation Board in determining whether to award benefits it has created a new form C-35 that requests information from the injured workers on their financial status when they are making the claim and asks for supporting documents for all recurring expenses. In many of these cases the workers' compensation benefits will be a large percentage of the monies entering the household. The argument that should be made to a law judge and Workers' Compensation Board is would the loss of the percentage of money coming into their household from the workers' compensation benefits create an extreme hardship for the average person. If the answer is yes, then the claimant should be awarded extreme hardship benefits.

Scheduled Loss of Use Determinations

The most significant amendment to the Workers' Compensation Law was the addition of an additional subdivision to Workers' Compensation Law § 15(3). This new subdivision requires that the chair of the Workers' Compensation Board to consult with representatives of labor, business, medical providers, insurance carriers and self-insured employers to revise the Workers' Compensation Board's Impairment Guidelines as they apply to making awards for permanent impairments to the limbs, eyes and hearing loss.[17]

The chair is to report new Guidelines by September 1, 2017 and publish them for comment. The new Guidelines are to reflect advances in modern medicine since they were last written by the Workers' Compensation Board.[18] If final changes to the Guidelines are not able to be adopted by the Workers' Compensation Board, an emergency meeting of the Workers' Compensation Board on December 29, 2017 will be held to adopt the Guidelines based upon what was proposed by the chair on September 1, 2017, or Guidelines based upon the submission of guidelines created by a consultant to the Workers' Compensation Board as an emergency regulation for 90 days. The emergency regulation will have to be renewed every 90 days until such time as permanent new Guidelines can be adopted by the Workers' Compensation Board, because effective January 1, 2018 the existing Guidelines for determining a scheduled loss of use "shall have no effect."[19] The Workers' Compensation Board is also directed to train all appropriate staff on the new Guidelines so that they are timely and effectively implemented.

This is the most significant change in the amendments to the Workers' Compensation Law enacted by the legislature. Since the amendments enacted in 2007 the values of the scheduled loss of use have increased from what they were for injuries that occurred prior to

July 1, 2007. However, injured workers earning under $600 per week have not received any benefits from the amendments to the maximum weekly rates enacted a decade ago. Because business believes that claimants were getting huge windfalls because of the increased rates of weekly workers' compensation benefits, they have pushed to reduce the percentage of the scheduled loss of use findings based what they believe to be better results from surgeries today than when the Guidelines were originally written by the Workers' Compensation Board. Since the new Guidelines have to be based upon "advances in modern medicine that enhance healing and result in better outcomes" there may not be that much of a change, because although recoveries may be shorter today the damage done to a person by undergoing a medial meniscectomy is still the same. For the sake of injured workers, there is hope that the new Guidelines will not be draconian and will still allow for them to be properly compensated for their injuries as they impact their future earning capacity.

Quick Results

On May 15, 2017 Governor Andrew Cuomo announced that as a result of the amendments to the Workers' Compensation Law employers across New York State will realize a savings of $400,000,000 for policies and renewals that go into effect on or after October 1, 2017.[20] In response to this announcement the Business Council of New York announced that these savings were just the beginning of the savings[21] for employers in New York, hinting that they may push for more reforms to save business money.

Endnotes

1. Business Council announces coalition of leading statewide organizations calling for Workers' Compensation Reform, http://www.bcnys.org/whatsnew/2017/030817-Coalition-Workers-Comp-Reform.html.
2. 2016 http://www.bcnys.org/whatsnew/2016/030216-business-council-legislative-priorities.html.
3. 2014 http://www.bcnys.org/inside/gac/2014/Legislative-and-Regulatory-Agenda2014.html#workers-compensation-unemployment.
4. 2013 http://www.bcnys.org/inside/gac/2013-Legislative-Regulatory-Agenda.html#workers-compensation.
5. Workers' Comp Employer Costs, Worker Benefits at Historic Lows—Insurer Profits Rising, http://www.nyworkerscompensationalliance.org/1974.
6. Laws of New York 2017, Chapter 59, Section NNN.
7. See generally, *Zamora v. New York Neurologic Associates*, 19 N.Y. 3d 186 (2012).
8. Laws of New York 2007, Chapter 6.
9. The effective date of the bill enacting the amendments to the Workers' Compensation Law.
10. Temporary total disability benefits are paid under Workers' Compensation Law § 15(2).
11. *Smith v. Tompkins County Courthouse*, 60 N.Y. 939 (1983).
12. *Haynes v. Catholic Charities*, 135 A.D. 3d 1267 (2016).
13. Workers' Compensation Law § 10(3)(b).
14. *Cook v. East Greenbush Police Department*, 114 A.D. 3d 1005 (2014)
15. Whether or not the Workers' Compensation Board can prejudge the amount of the penalty and the denial of a fee are appropriate by issuing a Subject Number is questionable. Subject Numbers are only a pronouncement of how the Workers' Compensation Board intends to act or interpret a provision of the Workers' Compensation Law. They are neither a statute nor part of the Rules and Regulations of the Workers' Compensation Board. Both the actual statute involved and the Rules and Regulations of the Workers' Compensation Board will have to be interpreted on a case-by-case basis. Furthermore, there is no basis in § 114-a(3) of the Workers' Compensation Law to deny an attorney a fee for services rendered, even if a sanction is imposed under this provision of the Workers' Compensation Law.
16. Workers' Compensation Law § 23.
17. Workers' Compensation Law § 15(3)(a) through § 15(3)(v).
18. The current Guidelines issued in 2012 adopted the Guidelines in the same form as they were in the Workers' Compensation Board's 1996 Guidelines. Although they are called the 1996 Guidelines, they were in effect for many years prior to 1996.
19. Workers' Compensation Law § 15(3)(x).
20. https://www.governor.ny.gov/news/governor-cuomo-announces-new-york-employers-workers-compensation-premiums-will-be-reduced-about.
21. http://www.bcnys.org/whatsnew/2017/051517-workers-comp-reform-savings.html.

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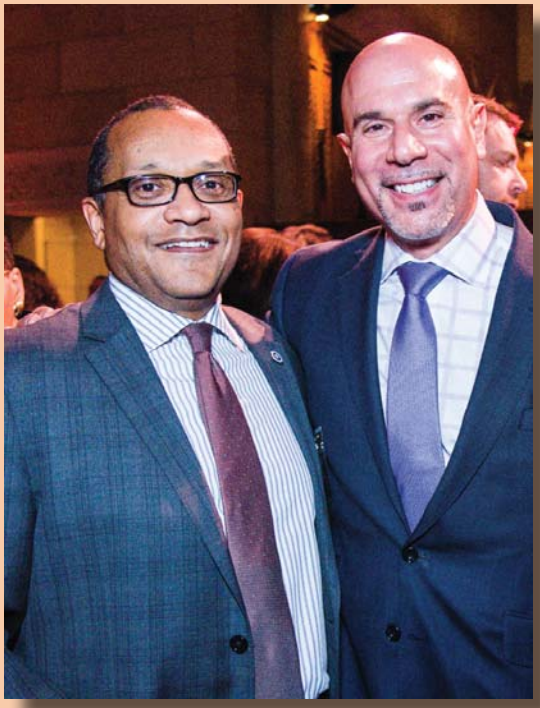

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Autonomous Transportation: A Brave New World

By Adam Dolan

The world is evolving. We're constantly creating and inventing new gadgets and tools that supposedly make our lives easier and more efficient. Cameras in our phones, fitness applications that track our physical activity, even vacuum cleaners that clean the house for us. And now we've developed self-driving cars. As we continue to advance and improve technology, what will that mean for the laws that govern our operation of motor vehicles? How will it impact case and statutory law? What about criminal implications? Where do we go from there? How do we apply the laws? What laws do we apply? How will a car that drives itself impact a drunk driving charge if the driver can legitimately say "I wasn't driving, the car was!"

Currently, New York State Vehicle and Traffic law defines a motor vehicle as "Every vehicle operated or driven upon a public highway which is propelled by any power other than muscular power."[1] Interestingly, a review of definitions listed within the New York State Vehicle and Traffic law does not include the term "operation." It does, however, contain the definition of "driver." Driver is defined as every person who operates or drives or is in actual physical control of a vehicle.[2] Right away, we can see a problem developing.

"After all, if we argue that a person within a vehicle isn't to blame for an accident due to the fact the vehicle was autonomous, then who is to blame?"

For clarification, perhaps the best place to look is within the criminal justice area of the law. After all, vehicular-based crimes all involve the element of "operation," so it makes sense that such a term would be defined within this area of the law. In New York, the term "operate" as used in Vehicle and Traffic Law is broader than term "drive" and extends to situation where the motorist begins to engage the motor for purpose of putting vehicle into motion.[3]

In Connecticut, "operation" refers to certain actions. They include any action that intentionally could set the motor power of the vehicle in motion. This can refer to doing something as simple as putting your car key in the ignition. Also, it might include starting the engine with a remote.[4]

In Massachusetts, a person "operates" a motor vehicle not only while doing all of the well-known things that drivers do as they travel on a street or highway, but also when doing any act that directly tends to set the vehicle in motion. A person is "operating" a motor vehicle whenever he or she is in the vehicle and intentionally manipulates some mechanical or electrical part of the vehicle— like the gear shift or the ignition—which, alone or in sequence, will set the vehicle in motion.[5] This can mean that an intoxicated individual found asleep behind the wheel of a parked car on a public road, with the key in the ignition and the engine on, can be found to have "operated" a motor vehicle.[6]

"By eliminating the human driver, autonomy could cut the operating costs of such systems by 70 percent."

So what does the rise of autonomous driving vehicle mean for both civil matters and criminal matters? What can a company expect if they purchase or create a fleet of self-driving vehicles? Will they need to still have an employee present within the vehicle for the purposes of transporting merchandise? What if that person is involved in an accident? Have we even arrived at the point where a company needs to start thinking about this? How realistic is it that self-driving vehicles can be used for long-distance travel?

Going one step further, will it be Vehicle and Traffic Laws that are automatically applied? What about products liability law? After all, if we argue that a person within a vehicle isn't to blame for an accident due to the fact the vehicle was autonomous, then who is to blame? The vehicle manufacturer? The software company that developed the code that "drives" the car? Is it a combination of both vehicle and traffic law and products liability law? Will this lead to an entirely new subsection of a law? How close are we to this even occurring?

In 2015 Delphi Automotive Plc went coast-to-coast using a self-driving Audi Q5.[7] Tesla Motors Inc., BMW, Ford and Volvo have also promised to have fully autonomous motor vehicles on the road by 2022.[8] Boston Consulting Group has predicted that the autonomous vehicle market will increase to $42 billion by 2025 and account for a quarter of global sales by 2035.[9] Uber is testing a number of autonomous Volvo XC90 SUVs. Ford stated its first self-driving cars will go to ride-hailing and ride-sharing services in 2021.[10] General Motors plans to test autonomous models with similar ride hailing fleets in Arizona.[11] Finally, on February 14, 2017, automakers General Motors and Toyota, along with ride sharing group Lyft, tried to get a little love from Congress by asking Congress to set nationwide self-driving car standards.[12]

"Without changes to those regulations, it may be years before the promise of today's technology can be realized and thousands of preventable deaths that could have been avoided will happen," said Mike Abelson, vice president of global strategy at GM, in written testimony.[13] "It is imperative that manufacturers have the ability to test these vehicles in greater numbers."[14]

"However, this section specifically excludes technology that already exists, such as active safety systems or driver assistance systems, including blind spot assistance, crash avoidance, emergency braking, parking assistance, etc."

Gill Pratt, CEO of the Toyota Research Institute, stated that there is a "patchwork of policy initiatives at the state level" and as more States develop such laws and regulations, additional impediments are being created towards the development of self-driving cars.[15] Autonomy also is getting a boost from U.S. regulators, who in December proposed new rules requiring cars to be embedded with computer chips to allow them to communicate with each other to help avoid accidents. Vehicle-to-vehicle communications, known as V2V, could arrive within five years and make driverless cars smarter and safer.[16]

"Every government agency we work with has been waiting for this rule," said Jim Barbaresso, national practice leader for intelligent transportation systems for consultant HNTB Corp.[17] For Delphi and its partners Mobileye NV and Intel Corp., the first application of their self-driving system could be an airport tram or a rental-lot bus. By eliminating the human driver, autonomy could cut the operating costs of such systems by 70 percent.[18]

Although the Department of Transportation released a set of general national guidelines for self-driving vehicles last September, language within the Federal Automated Vehicle Policy "provides unclear or even conflicting direction" to States on their role in regulating this next-generation technology, Pratt said.[19]

Why such a push? Why are companies seeking out clear directions before proceeding? The benefits of self-driving vehicles range from convenience and reduced congestion to fuel-efficiency gains. However, technology and automotive companies also claim there is a long-term promise of dramatic reductions in traffic accidents and road fatalities, which topped 35,000 in 2015.

This would seem to be a huge benefit for insurance companies. A reduction in traffic accidents and fatalities would lessen the impact on insurance companies bottom line. However, how do you account for the fact that not every car on the road will be self-driving? How do you apportion fault in an accident involving both a self-driving car and one driven by a person? And going back to one of my original questions—how do the laws as they are currently written provide for these scenarios? Whom do you hold responsible?

New York has started to try and figure that out. On January 10, 2017, the New York State Senate introduced bill A01037. The bill was an act to amend the vehicle and traffic law in relation to authorizing the testing and operation of autonomous motor vehicles upon public highways. It also sought to amend the General Obligations Law as it related to the liability of motor vehicle manufacturers for vehicles that were ultimately converted to autonomous motor vehicles.[20] The bill has been signed into law.

However, the bill, if it does pass, will add new sections to the Vehicle and Traffic Law that are designed to encourage the testing and ultimately the use of autonomous vehicles in New York State. Section 100-e is titled "Autonomous Technology." It discusses the technology that would be installed on a motor vehicle that has the capability to drive without the active control or monitoring by a human operator.[21] However, this section specifically excludes technology that already exists, such as active safety systems or driver assistance systems, including blind spot assistance, crash avoidance, emergency braking, parking assistance, etc.[22]

Section 100-f defines what an autonomous motor vehicle is and section 507-a defines the term "operation" for purposes of a motor vehicle.[23] For the purposes of this chapter, a person is deemed to be operating an autonomous vehicle in autonomous mode when that person causes the vehicle's technology to engage.[24] The bill also states that it is irrelevant whether the person is present within the vehicle at that time.[25]

For vehicle manufacturers, the section of largest import is Title 3, section 9-303. This section specifically addresses the liability of the original manufacturer of the technology, and the distributor or the dealer of the motor vehicle that was converted to an autonomous vehicle by a third party after delivery. The bill states that such manufacturers, distributors or dealers shall not be liable and shall have an absolute defense to and shall be discharged from any cause of action commenced by any person for damages due to an alleged defect caused by the conversion of such vehicle to an autonomous vehicle.[26] The section also provides a defense for these same parties for any cause of action for damages that is due to an alleged defect caused by any equipment installed in a motor vehicle by the person who converted such vehicle to an autonomous vehicle, unless the defect is alleged to have been present in the motor vehicle as originally manufactured.[27]

What we're seeing in terms of this bill, and what already exists within established case law, is that operation of the vehicle will remain a somewhat human responsibility. However, it will not take long for an individual to challenge the definition of "operation" given the nature of the vehicles. Unlike "operation" as it exists currently, the very purpose of autonomous vehicles is that a person does not have to drive. This may end up being a distinction raised in criminal matters and in civil matters if a person is accused of "operating" an autonomous vehicle that is involved in an accident or where a driver is found to be intoxicated. What it may also lead to is massive amounts of pre-trial litigation involving significantly greater amounts of electronic data discovery and much broader demands for electronically stored information, or ESI.

"Ultimately, given the way the laws have been drafted to date and those laws that are being proposed, it seems likely that liability will continue to ultimately rest with a vehicle's owner or its driver, barring some catastrophic software failure."

Despite these questions, and despite the high costs associated with developing this technology, the ultimate benefit would hopefully be the eventual demise of contested motor vehicle accident litigation. If all vehicles eventually become automated, with software that monitors speed, monitors traffic control devices, lane changing, stop and go traffic, the ability to prosecute a dubious claim involving a motor vehicle becomes exponentially more difficult. No longer would a plaintiff be able to claim that a car struck him while he was in a crosswalk, slammed into the rear of his vehicle at a high rate of speed, or sideswiped his or her vehicle without the other party simply retrieving the saved data, presenting it to the court and either disproving or proving plaintiff's contention.

Between budget approvals for further testing of autonomous vehicles,[28] to technology that continues to expand at breakneck speed, it is an exciting and interesting time in the transportation field. However, where as in the past, insurers were concerned mainly with the capabilities of their clients' drivers and their ability to avoid accidents, the proliferation of self-driving vehicles will add myriad new wrinkles to areas of insurance within the coming years. Normal straightforward liability and collision coverage for fleets will soon need to address whether the vehicles are self-driving or not; additional sections will need to be introduced that reflect the potential liability for the technology's manufacturer, its distributor, it's end-user. Ultimately, given the way the laws have been drafted to date and those laws that are being proposed, it seems likely that liability will continue to ultimately rest with a vehicle's owner or its driver, barring some catastrophic software failure. It's a fast moving world nowadays in transportation. As Ferris Bueller once said, "Life moves pretty fast. If you don't stop and look around once in a while, you could miss it." Insurers should be looking around. They're not going to want to miss this.

Endnotes

1. New York State VTL § 125.
2. *Id*. at § 113.
3. *People v Totman*, 208 A.D.2d 970, 971, 617 N.Y.S.2d 234, 235 (3rd Dept. 1994).
4. The issue of whether one operates a motor vehicle within the meaning of § 14-227(a) is to be determined on a case-by-case basis, making proof of operation…a factual determination." *Murphy v. Commissioner of Motor Vehicles*, 254 Conn. 333, 344-45, 757 A.2d 561 (2000). "There is no requirement that the fact of operation be established by direct evidence." *Id*. at 345.
5. *Commonwealth v. Ginnetti*, 400 Mass. 181, 184, 508 N.E.2d 603, 605 (1987); *Commonwealth v. Uski*, 263 Mass. 22, 24, 160 N.E. 305, 306 (1928).
6. *Commonwealth v. Sudderth*, 37 Mass. App. Ct. 317, 319-320, 640 N.E.2d 481, 482-483 (1994).
7. https://www.bloomberg.com/news/articles/2015-01-08/driverless-car-global-market-seen-reaching-42-billion-by-2025.
8. *Id.*
9. *Id.*
10. https://www.bloomberg.com/news/articles/2016-08-16/ford-aims-to-offer-fully-autonomous-ride-sharing-vehicle-by-2021.
11. *Id.*
12. http://www.forbes.com/sites/alanohnsman/2017/02/14/gm-toyota-and-lyft-urge-congress-to-set-nationwide-self-driving-car-standards/#594aac127144.
13. *Id.*
14. *Id.*
15. *Id.*
16. https://www.bloomberg.com/news/articles/2017-01-03/it-s-aye-robot-as-driverless-cars-finally-steer-near-showrooms.
17. *Id.*
18. *Id.*
19. *Id.*
20. State of New York, 2017 Regular Session, A01037 (N.Y. 2017-2018).
21. *Id.*
22. *Id.*
23. *Id.*
24. *Id.*
25. *Id.*
26. *Id.*
27. *Id.*
28. https://www.governor.ny.gov/news/governor-cuomo-announces-autonomous-vehicle-testing-begin-new-york-state.

Must I Set Aside? Part One

By Robert P. Mascali

Like Alice starts her journey through Wonderland, many attorneys involved in third-party liability litigation feel they are descending the rabbit hole into chaos and confusion when confronted by the question of whether a Medicare Set Aside Account/Arrangement (MSA) is required for future medical expenses as part of a potential settlement. And for the most part their wariness is justified because of the lack of firm guidance on this issue from the Centers for Medicare and Medicaid Services (CMS). The basic premise underlying the MSA is that once a claimant has received settlement funds from a third-party carrier that covers in part the costs of future medical treatment, the Medicare program wants to make sure that those funds are used to pay for those expenses before Medicare starts paying for them.

"However, CMS has promulgated several memos on the issue of the need for a MSA in worker's compensation cases and while not binding, they are clearly instructive in the third-party liability realm."

Some historical context is enlightening. Prior to the adoption of the Medicare Secondary Payer (MSP) Act,[1] Medicare was in fact the primary payer of all services covered by Medicare except where there was worker's compensation. Then in 1980 this new law made Medicare a secondary payer to certain insurance plans and programs for beneficiaries, including auto and other third party liability insurance plans. Enforcement did not begin until 2001 following the issuance of the Patel Memorandum[2] which set forth that compliance with MSP was required *in workers' compensation* cases. Thereafter in 2007, legislation was enacted[3] that required insurance companies and other payers to provide information to CMS in any settlement payment situation in which Medicare was, or could become, the secondary payer. This legislation got everyone's attention because if reporting was required, then CMS would have the mechanism in place to track who received settlement funds and whether Medicare's interest as a secondary payer was being protected.

In any third-party liability-based personal injury settlement where the claimant is on Medicare for whatever reason, some of the available settlement funds are used to reimburse Medicare for injury-related "conditional payments" that were made for *past* medical expenses. It then follows that if part of the settlement funds are to cover *future* medical expenses for which Medicare would, or may be, responsible, that there be a system in place to ensure that the funds are used for that purpose so that Medicare is not in effect paying for something for which the claimant already was compensated. Enter the MSA.

Recent years have seen many fits and starts from CMS as it grapples with how to implement and enforce this mandate, and many in the field now feel that the well-known financial pressures on the Medicare system and the obvious need to generate revenue to shore up the system suggests a strong possibility that CMS will look to third-party litigants for some monetary relief. In fact, CMS recently signaled that it will start taking a closer look at enforcing the MSP Statute on liability cases similar to what it does in workers' compensation claims. A CMS directive issued on February 6, 2017, effective October 1, 2017, provided that Medicare contractors will be able to deny payment for items and/or services that should instead be paid from some form of an MSA. Essentially Medicare has now made known its intention to amend its internal processes so that it can receive and track data related to liability cases. Simply stated, CMS is finally starting to build some teeth behind enforcement of the statute on liability cases, just like it has on workers' compensation claims. Therefore, for the personal injury bar the "do nothing" strategy is certainly no longer a viable option.

What are attorneys to do in the face of no formal guidance from CMS on these situations when confronted with the successful claimant who may have future medical expenses for which compensation has been received and who may incur medical expenses in the reasonably foreseeable future that will be submitted for payment to Medicare because of the age or status of the claimant?

This article will attempt to dispel some of the chaos and confusion and provide a ready source of information for the personal injury bar when determining whether a MSA is advisable, even if not currently required.

CMS Guidance in Workers' Compensation Matters

As stated above, there are no rules or regulations under the Medicare Secondary Payer Act for either third-party liability or workers' compensation cases. However, CMS has promulgated several memos on the issue of the need for a MSA in workers' compensation cases and while not binding, they are clearly instructive in the third-party liability realm. Specifically, in a workers' compensation case there is no MSA required where it is clear the award is only for past medical expenses, the treating doctor can certify that to a reasonable degree of certainty there will be no need for Medicare-covered expenses in the future, and that there is no attempt by the claimant to maximize other portions of the settlement to the damage of Medicare's

interests. On the other hand, CMS has established certain review thresholds which are only workload guides and do not mean a MSA is not required even if the threshold is not met in a particular situation. Those thresholds for review are as follows:

A. The gross settlement amount exceeds $25,000 and the claimant is currently eligible for Medicare; or

B. The gross settlement is for more than $250,000 and the claimant can reasonably be expected to become eligible for Medicare within thirty (30) months.

In these situations, it is the total amount of the settlement that is determinative and not merely the portion attributed to future medical expenses. In those cases where there is a structured settlement it is the stated value of the settlement, and not the actual cost of the structure, that is determinative. Finally, it is important to note that a claimant may not attempt to waive a right to future Medicare coverage to avoid the requirement to establish a MSA—at least in workers' compensation cases.

"The wise personal injury attorney should take this into consideration when discussing a prospective settlement and should advise the client of the pros and cons of establishing a MSA where there is reasonable likelihood that there will be future medical care that would be covered by Medicare."

Since 2002 there have been various policy pronouncements from federal officials in a series of conference calls with the insurance industry, handouts and policy memoranda, in which CMS has stated its position on the issue of how Medicare's interest are to be considered and protected in liability cases, while conceding that there is no formal guidance in place at the current time. In addition, there have been several reported decisions that have addressed the question of whether a MSA or some other arrangement is required in liability cases—with differing conclusions.

Cases of Interest

The 2015 case of *Aranki v. Burwell*[4] from the U.S. District Court in Arizona caused a considerable amount of discussion and possibly some unwarranted encouragement for those who continue to assert that MSAs are not necessary and that they are used by overly cautious attorneys for no reason. The court held in response to a petition from a plaintiff's counsel who could not get a response from CMS that the question of whether a MSA is necessary in a medical malpractice case not ripe for review as MSAs are not *required* for future medical expenses in third party liability cases. According to the Court:

> To comply with the provisions outlined in the MSP [Medicare Secondary Payer statute, in worker's compensation case CMS Mandates the creation of a 'Medicare Set Aside' account (41C.F. R.Sec.411). The purpose of a MSA is to allocate a portion of a worker's compensation award to pay potential future medical expenses resulting from the work-related injury so that Medicare does not have to pay. However, no federal law or CMS regulation requires the creation of a MSA in personal injury settlements to cover potential future medical expenses…There may be a day when CMS requires the creation of an MSA in personal injury cases, but that day has not arrived.

But is that really the "final answer"? Not really and here's why

It is beyond dispute that there is a clear federal mandate that parties to a personal injury settlement must consider the interests of Medicare [42 U.S.C. 1395y(b)(2)]. Furthermore, and possibly most importantly, there are potential penalties and the looming malpractice suit for an attorney who fails to set up a MSA when one is found to have been required and the client's future medical expenses are rejected by Medicare and there are now no funds available to pay them. While arguably penalties would not be assessed against an attorney, nor would a claimant prevail in malpractice where no firm guidance is in place on the issue, certainly no attorney wants to be that "test case."

In addition to *Aranki, infra*, other cases from state and federal district courts in recent years do offer some guidance for the personal injury bar. Specifically, the following issues have been considered and ruled upon:

1. If medical providers can attest there will be no future medical expenses related to the injury for which compensation is paid and Medicare acknowledges it has been reimbursed for all conditional payments related to the injury, no MSA is necessary (*Berry v. Toyota Motor Sales, U.S.A., Inc.*).[5]

2. If past and future injury-related expenses have been, and reasonably will be, paid by private insurance and considering the lack of CMS policy or guidance on the issue, no MSA is required (*Tye v. Upper Valley Medical Center*).[6]

3. Since currently Medicare does not require or approve MSAs they are not *required* as part of a personal injury settlement (*Warren Frank v. Gateway Ins. Co.*).[7]

4. While a court has held MSAs for future medical expenses are not required in a personal injury settlement, a court can also determine that a MSA is still appropriate for future medical expenses (*Big R Towing, Inc.v.Trans Am Trucking, Inc.*).[8]

5. A court has not only opined on the necessity for a MSA in a liability but went so far as to apply a percentage formula to determine a specific part of the settlement that should be set aside for future medical expenses (*Benoit v. Neustrom*).[9]

Conclusion

Given the inherent difference between workers' compensation cases which are based on a rigid formula for damage calculation and traditional third-party litigation which is much more flexible in allocation of damages, adherence to the experience in the workers' compensation field can go only so far. However, that is all we have at this time, and at some point it seems likely that the federal government will start to enforce compliance with the MSP in liability cases. The wise personal injury attorney should take this into consideration when discussing a prospective settlement and should advise the client of the pros and cons of establishing a MSA where there is reasonable likelihood that there will be future medical care that would be covered by Medicare.

The second part of this article will deal with the evaluation of the funding amount, the aspects of the administration of a MSA and other practical advice.

The opinions and statements in this article are those of the author only and do not necessarily reflect the views of his employer, The Center for Special Needs Trust Administration, Inc.

Endnotes

1. 42 U.S.C. § 1395y(b)(2); 42 CFR 46(d)(b).
2. *Medicare Set Aside Arrangements Transmittal* (Patel Memo) July 23, 2001.
3. 42 U.S.C. § 1305 (*Medicare, Medicaid and SCHIP Extension Act of 2007*).
4. 151 F. Supp. 3d 1038 (D. Ariz. 2015).
5. 2015 WL 158889.
6. 2014 WL 2957037 (Ohio S.C. 2014).
7. 2012 WL 868872.
8. 2011 WL 43219.
9. 2013 WL 1702120.

New York City's Fair Chance Act and the Real World Implications for Employers

By Karen Schnur

Introduction

On October 27, 2015, New York City's Local Law No. 63 (2015) or the Fair Chance Act ("FCA") went into effect.[1] This law follows the movement of Ban-the-Box that has taken the country by storm over the last decade, although more so recently.[2] The idea behind "banning the box," which prohibits employers from asking applicants about their criminal history on an initial employment application and delaying the background check inquiry until later in the hiring process, is that "employers [will] consider a job candidate's qualifications—without the stigma of a criminal record."[3]

As of May 2017, over 150 cities and counties throughout the United States, as well as 27 states, have implemented some version of Ban the Box legislation.[4] These policies can apply to public employers, private employers, and/or vendors, contractors and the issuance of licenses. Some jurisdictions have also included guidance and rules on how to use an applicant's criminal history in employment decisions.[5]

The FCA is one of the more expansive Ban-the-Box laws as it applies to private and public employers and vendors in New York City. It delays the time at which an employer can inquire about an applicant's criminal history or run a background check, incorporates pre-existing laws regarding the use of criminal records in hiring decisions, and requires particular analysis and notice to the applicant should the employer wish to withdraw its conditional offer based on the applicant's criminal record(s).[6]

This article provides an overview and highlights some of the major components of the FCA, while discussing the real world implications for New York City employers.

New York City's Fair Chance Act

The FCA's goal is to level the playing field and allow individuals who have a criminal history "to be considered for a position among other equally qualified candidates."[7] In order to effectuate this goal, the FCA amends the New York City Human Rights Law (NYCHRL) by making it an unlawful discriminatory practice for most employers to inquire about or consider the criminal history of job applicants[8] until after extending conditional offers of employment.[9] This includes prohibiting employers from "declar[ing], print[ing], or circulat[ing] or caus[ing] to be declared, printed, or circulated any solicitation, advertisement or publication, which expresses, directly or indirectly, any limitation, or specification in employment based on a person's arrest or criminal conviction."[10]

The FCA is not the first New York law that attempts to protect individuals with criminal records. On January 1, 1977, New York's Correction Law Article 23-A (Article 23-A) went into effect. It sought to protect against employment discrimination by laying out factors that must be considered when determining whether to deny employment based on an individual's criminal record. Article 23-A, Section 752 provides only two (2) bases under which an employer can deny employment.[11]

1. Where there is a direct relationship between the applicant's criminal record and prospective job; or
2. Where the company can show that employing the applicant "would involve an unreasonable risk to property or to the safety or welfare of specific individuals or the general public."[12]

However, New York City determined further protection was necessary as it found that employers were discriminating against applicants when they asked about their records before completing the initial stages of the hiring process. Previously, when the employer[13] learned of an applicant's conviction history and wanted to deny employment based upon a permissible Article 23-A basis, i.e., direct relationship or unreasonable risk, the employer had to simply consider the Article 23-A factors.[14] Notably, the FCA was implemented in order to expand upon Article 23-A. Now, following the Article 23-A analysis above, an employer must also follow the FCA's Fair Chance Process if it wants to withdraw the applicant's conditional offer.[15] This process requires the employer to:

1. **Disclose to the Applicant a Written Copy of Any Inquiry It Conducted into the Applicant's Criminal History.** This includes every piece of information the employer relied on to make its determination, along with the date and time the employer accessed the information. If an employer did an online search to obtain criminal histories, it must print out the pages it relied on, which must state the source. If oral information is relied upon, a written summary of the conversation must be provided to the applicant.[16]
2. **Provide Applicant with a Written Copy of Its Article 23-A Analysis.** This written analysis must include an evaluation of each Article 23-A factor and state which exception—direct relationship or unreasonable risk—the employer relies upon and the employer's conclusion. In addition, the applicant must

be informed of his or her time to respond, and the notice must request from the applicant evidence of rehabilitation and good conduct, with examples.[17]

3. **Allow the Applicant Time to Respond to the Analysis and Inquiry.** The applicant is entitled to no less than three (3) business days in order to respond. During that time, the employer is not allowed to fill the position. If during this time, the applicant provides the employer with additional information or informs the employer that there are errors in the information relied upon, the employer must again perform the Article 23-A analysis. In the case where there was an error in the criminal history results, the employer must follow the Fair Chance Process again, including holding the position for at least another three (3) days.[18] On the other hand, if the applicant provided additional information, but that information did not change the employer's analysis, the employer need only advise the applicant that it decided not to hire him or her.[19]

The New York City Commission on Human Rights (the "Commission") is responsible for enforcing the NYCHRL for private employers.[20] Thus, the Commission has the power and authority to enforce the FCA and assess civil penalties for violations. However, these civil actions are not the sole penalty for violating the FCA. Since applicants can also bring discrimination claims under the NYCHRL, employers are also potentially on the hook for dual payments—one to New York City in the form of a civil penalty, and the other to the aggrieved party in the form monetary damages.

What Does This Mean for NYC Employers?

Higher Costs

The FCA applies to all employers who have four (4) or more employees.[21] This means small "mom and pop" shops bear the same burdens as big box retailers. Accordingly, the costs associated with these new regulations will be felt by employers of all sizes.

First, there may be an increase in costs of the hiring process. Although the FCA makes it more difficult for employers to not hire someone with a criminal record, it is likely that employers will, at least at the beginning, and until they become more confortable with the law bear an increase in costs. Employers are likely to interview more individuals at the outset to have a larger pool should their first choice have a criminal record that prevents them from hiring the applicant because otherwise employers will have to start the interview process over if the applicant they chose is disqualified and his or her offer withdrawn. This is due to the later point in the hiring process at which employers can check an applicant's criminal history, and employers will want to protect themselves and the company by being able to quickly fill a position should the applicant's conditional offer be withdrawn.

Second, the time and resources needed to comply with the Fair Chance Process can be substantial. A written analysis accompanied by the documents relied upon must be provided to the applicant. But in order to satisfactorily do this, the analysis must be thorough, which will be time consuming. As explained in the Commission's FCA enforcement guide, "[b]oilerplate denials that simply list the Article 23-A factors violate the FCA. For example, an employer cannot simply say it considered the time since conviction; it must identify the years and/or months since the conviction. An employer also cannot list specific facts for each factor but then fail to describe how it concluded that the applicant's record met either the direct relationship or unreasonable risk exceptions to Article 23-A."[22] For a large company that may have many job openings at once and needs to perform multiple analyses simultaneously, it will feel these effects. The company may have to designate Human Resources (HR) personnel to this task alone, divert resources, or even hire additional employees. Small employers will also feel this burden because they usually do not have dedicated HR personnel, but rather the owners or other employees perform the hiring process tasks. Accordingly, if they now have to take on this additional work, their time and attention will be diverted from other business tasks, resulting in longer hours or other areas of the business suffering.

"But, if the New York City Council (or even New York State) also passes negligent hiring tort reform, this risk can be reduced or removed."

Third, a business's bottom line may be negatively impacted if a position that needs to be filled immediately is then kept vacant for at least three (3) days. This impact will be felt more so if the applicant provides additional information regarding his criminal history or errors in the report and additional time is spent on the updated analysis and Fair Chance Process, and/or the position has to be held open for at least another three (3) days.

Civil Penalties and Liability of the Employer for Violations of the FCA

Although compliance with the FCA may cost more in the short run, penalties for violations can be more costly in the long run. Under the FCA, an employer can be assessed a civil penalty for violations[23] irrespective of whether the employer takes an adverse action. For example, if a company prints or circulates a job posting, advertisement, etc. that states any limitation or specification regarding criminal history, including "no felonies" or "background check required," they can be fined, regard-

less if no adverse action follows. This is also true if the employer makes any statement or inquiry into an applicant's criminal history before extending a conditional offer of employment, *even if they still end up hiring the person*.[24] Moreover, if the employer fails to follow any part of the Fair Chance Process, that is a *per se* violation, and each step in the process is a separate chargeable violation.[25]

Moreover, an applicant who feels he was discriminated against in the hiring process due to his criminal record can also bring a claim under the NYCHRL, which can result in litigation costs and monetary settlements or judgments for the employer.

"There will still likely be cases where the aggrieved party will feel that an employer, after performing the Article 23-A factor analysis, should have reached the opposite conclusion and withdrawn the conditional offer through the Fair Chance Process."

For example, in November 2016, a nationwide company settled a criminal record discrimination case for $50,000 in damages to the complainant, $15,000 in civil penalties, and training for 10,000 employees on the New York City Human Rights Law and FCA. This settlement arose due to the employer's denial of employment to an applicant in the financial industry because of his conviction record, which consisted of four (4) minor traffic violations and a misdemeanor over a decade earlier.[26]

It therefore behooves New York City employers to familiarize themselves with the FCA and train their employees and hiring managers to avoid any potential issues or violations.

The Interplay Between the FCA and Negligent Hiring Lawsuits

There is some concern that Ban-the-Box laws, including the FCA, may end up increasing the risk of negligent hiring litigation. Since case law has not yet been established regarding negligent hiring in the context of the FCA, the effects are still unknown. But, based on New York's long history of ensuring the protection of people with criminal records through Article 23-A, and now the FCA, more individuals with criminal records will be hired in New York City. Thus, the potential for the number of negligent hiring lawsuits may increase, but cases with findings of liability could still potentially decrease.

In New York, an employer can be held liable for negligent hiring of an employee only if the employer knew or should have known of an employee's propensity for the conduct that caused the injury.[27] An employer also has a duty to investigate further into an employee's background, or to institute specific procedures for hiring employees, but only if the employer knew facts that would lead a reasonably prudent person to investigate the prospective employee.[28]

In *Ford v. Gildin*, Howard Taylor was hired as a porter in a residential building at the recommendation of his brother in 1964, four years after he completed his five-year sentence in prison after pleading guilty to manslaughter.[29] Plaintiff moved into the building in 1967, at which time she and Taylor became friends.[30] When her daughter, Timia, was born in 1974, she named Taylor as the godfather.[31] Taylor would spend time with Timia and would watch her unattended. Plaintiff sued for the negligent hiring of Howard Taylor when it was discovered in 1987 that Taylor had been sexually abusing Timia for the past five years.[32]

The court found, *inter alia*, that "it was not foreseeable, as a matter of law, that a person who had committed manslaughter some time prior to 1955 would molest a child 27 years later."[33] In fact, the court went further to state that were it to hold otherwise, "then all ex-offenders who had ever committed a violent crime would be rendered virtually unemployable, for to hire them would render the employer liable for an criminal act committed thereafter, no matter how long the passage of time after the prior offense, and no matter how different the subsequent offense was from the earlier one."[34] The court then referenced Correction Law §§ 753(1)(a) and 752, which state, respectively, New York State's public policy of encouraging the employment of individuals with one or more previous criminal convictions, and the illegality of denying employment to an individual based on his criminal conviction(s) unless there is a direct relationship or an unreasonable risk.[35] The court concluded that "[i]mposing liability upon an employer under the circumstances presented herein would have an unacceptably chilling effect on society's efforts to reintegrate ex-offenders into mainstream society, contrary to precedent and the explicitly stated public policy of this State."[36]

Ford is instructive on how New York courts would, or at least should, assess negligent hiring claims in the face of the FCA and the State's underlying public policy. If an employer runs a background check and finds a criminal record(s), performs the proper analysis using the Article 23-A factors, and determines that it cannot legally deny the applicant's employment, that should be sufficient, as a matter of law, to defeat a negligent hiring claim.

That being said, all risk cannot be reduced or removed unless the legislature or courts step in. There will still likely be cases where the aggrieved party will feel that an employer, after performing the Article 23-A factor analysis, should have reached the opposite conclusion and withdrawn the conditional offer through the Fair Chance Process. But, if the New York City Council

(or even New York State) also passes negligent hiring tort reform, this risk can be reduced or removed. Some examples include an affirmative defense that the employer complied with the FCA, a rebuttable presumption that the Fair Chance Process decision was proper, or even eliminating negligent hiring lawsuits based on an employee's criminal past as long as proper background checks are run and the FCA process is complied with. However, in the meantime the courts should look at the Fair Chance Process that the employer went through and give the employer deference when deciding negligent hiring suits.

Not only will the above safeguards provide employers with more incentive to comply with the FCA, it will also encourage employers to hire individuals with a criminal history, further supporting New York's public policy and the end goal of the FCA. But, until the time that safeguards are implemented, employers should be aware of the elements of a negligent hiring suit and make sure to fully document all decisions and the bases thereof when deciding to *hire* an applicant with a criminal record (not just when they choose to withdraw an applicant's conditional offer) in order to defend against a negligent hiring lawsuit should one be brought.

Endnotes

1. NYC Commission on Human Rights Legal Enforcement Guidance on the Fair Chance Act, Local Law No. 63 (2015), NYC Human Rights, https://www1.nyc.gov/assets/cchr/downloads/pdf/FCA-InterpretiveGuide-112015.pdf (last revised June 24, 2016) (hereinafter "Legal Enforcement Guidance").
2. Hawaii was the first state to adopt this type of legislation in 1998, Rodriguez, M and B. Avery (May 2017). "Ban the Box: U.S. Cities, Counties, and States Adopt Fair-Chance Policies to Advance Employment Opportunities for People with Past Convictions." National Employment Law Project Guide, http://www.nelp.org/content/uploads/Ban-the-Box-Fair-Chance-State-and-Local-Guide.pdf (last updated May 2017) (hereinafter "NELP Guide 2017"). Most other jurisdictions passed their laws or issued executive orders in the last ten years. *Id.*
3. *Id.* at p. 1; *see also* Legal Enforcement Guidance at p. 1.
4. *See* NELP Guide 2017.
5. *See*.
6. *See* Local Law No. 63 (2015).
7. Testimony of Gale A. Brewer, Manhattan Borough President, on Int. No. 318 to Prohibit Employment Discrimination Based on One's Arrest Record or Criminal Conviction at 2 (Dec. 3, 2014) (emphasis in original), available at: http://legistar.council.nyc.gov/LegislationDetail.aspx?ID=1739365&GUID=EF70B69C-074A-4B8E-9D36-187C76BB1098.
8. The Commission notes in its Legal Enforcement Guidance that when it uses the term "applicant," it is referring to both potential and current employees. *See* Legal Enforcement Guidance at p. 2. It also explains that "hiring process" includes hiring, termination, transfers and promotions. *Id.* However, for the purposes of this article, we focus on the effect of the FCA on potential employees.
9. N.Y.C. Admin. Code § 8-107(11-a)(a)(2). There are exceptions built into the FCA, including (1) actions of employers or their agents that are taken pursuant to any state, federal, or local law that requires criminal background checks for employment purposes or bars employment based on criminal history; (2) employers required by a self-regulatory organization to conduct a criminal background check of regulated persons (*i.e.*, financial services industry); (3) police and peace officers, law enforcement agencies, and other exempted city agencies; and (4) city positions designated by the Department of Citywide Administrative Services. *See* N.Y.C. Admin. Code § 8-107(11-a)(e)-(f); *see also* Legal Enforcement Guidance at pp. 10-12.
10. N.Y.C. Admin. Code § 8-107(11-a)(1).
11. N.Y. Correct. L. § 752.
12. N.Y. Correct. L. § 752(2).
13. Article 23-A applies to employers with 10 or more employees. *See* N.Y. Correct. L. § 750. The FCA expanded the number of employers that now have to comply with Article 23-A when it stated that the law does not apply to employers with fewer than four employees. *See* N.Y.C. Admin. Code § 8-102(5).
14. N.Y. Correc. L. §§ 752 and 753.
15. N.Y.C. Admin. Code § 8-107(11-a)(b).
16. *See* Legal Enforcement Guidance at p. 8.
17. *Id.* at pp. 8-9.
18. This is only in situations where the error is on the background report. However, where the information is different from what the applicant told the employer due to the applicant's misrepresentation, the employer need not evaluate the applicant's record under Article 23-A, and instead can choose not to hire the applicant based on his or her misrepresentation. *See* Legal Enforcement Guidance at p. 10.
19. *See* at pp. 9-10.
20. N.Y.C. Admin. Code § 8-107(11-a)(g).
21. N.Y.C. Admin. Code § 8-102(5).
22. Legal Enforcement Guidance at p. 9.
23. If an adverse action is taken, the applicant can also bring a charge for discrimination, at which point the company can also be liable to the complainant and be required to pay damages in addition to the civil penalties assessed.
24. Legal Enforcement Guidance at p. 4.
25. *Id.*
26. N.Y.C. Human Rights—Settlements, 2016 (accessed July 5, 2017), available at https://www1.nyc.gov/site/cchr/enforcement/2017-settlements.page.
27. *Doe v. Whitney*, 8 A.D.3d 610 (2d Dep't 2004); *T.W. v. City of New York*, 286 A.D.2d 343 (1st Dep't 2001).
28. *Boadnaraine v. City of New York*, 68 A.D.3d 1032, 1033 (2d Dep't 2009); *see also T.W.*, 286 A.D.2d 243.
29. 200 A.D.2d 224, 225 (1st Dep't 1994).
30. *Id.*
31. *Id.*
32. *Id.*
33. *Id.* at 227.
34. *Id.*
35. *Id.* at 227-28.
36. *Id.* at 229-30.

Book Review: *Business and Commercial Litigation in Federal Courts*, Fourth Edition

Edited by Robert L. Haig
Reviewed by David M. Gouldin and Jake H. Buckland

I had the privilege of providing a review of the multi-volume *Business and Commercial Litigation in Federal Courts* for the *TICL Journal* twice before: in its Third Edition in 2014, and in its Second Edition back in 2007. The Thomson Reuters publication is now in its Fourth Edition, and I am pleased to share with you my insights concerning the most recent publication.

Those of you who have delved into previous editions of this esteemed series are probably in universal agreement that *Business and Commercial Litigation in Federal Courts* is a pragmatic, yet learned and exhaustive, practice aid which would serve as a beneficial reference to any and all legal professionals.

As with the previous editions, Robert L. Haig continues to be the Editor-in-Chief, and is supported by many brilliant authors. Indeed, the Fourth Edition has 296 esteemed principal authors and covers 25 new and pertinent topics. As with prior editions, the roster of contributors includes many of the most prominent names in the commercial litigation field, incorporating works from both highly respected practitioners and jurists.

The bulk of the Fourth Edition retains its exhaustive chapters on all of the paramount aspects of commercial litigation and federal business, from filing a claim to enforcing a judgment. All of the instructional aspects of the first three editions are retained and thoroughly parsed. For example, David Brodsky, formerly of Latham & Watkins, writes about opening statements; William Frank, of Skadden, Arps, Slate, Meagher & Flom, writes about presenting the case-in-chief; Evan Chesler, of Cravath, Swaine & Moore, writes about trials, and William Maguire of Hughes Hubbard & Reed, writes about evidence.

But the breadth of this treatise goes far beyond these conventional commercial litigation topics. In this regard, chapters of note include "Civil Rights" (written by Judge Edmond Chang of the Northern District of Illinois), "Banking" (written by Owen Pell), "Immigration" (written by Thomas Ragland), "Marketing to Potential Business Clients" (written by Phil Kessler), and even some niche topics, such as "Fashion and Retail" (written by Howard Rubinroit).

Each of the authors explore their topics comprehensively and bring a tremendous amount of practical knowledge to their work. This includes many useful checklists and forms in a number of the chapters.

One of the concerns that a practitioner may have in purchasing this 15-volume publication is that even though the reader may be confident that answers to his or her questions are contained within such a comprehensive publication, finding those answers may be difficult due to the sheer volume of information. As with the third edition, I am happy to say that, in my opinion, access to the text pertinent to the reader's concerns is greatly facilitated by having a thorough and reader-friendly index for the entire work.

The editors at Thomson Reuters should be highly commended for their recognition of the importance of Volume 15, the tables and index for the 153 chapters which form the core of this work. It is an invaluable key to accessibility and the type of tool one would expect with a publication of this quality. Volume 15 provides the practitioner with thousands of citations to current cases, statutes and rules, all of which complement the many forms which provide a particularly helpful starting point when any lawyer is attempting to customize a particular agreement or pleading for a business or commercial matter on which he or she is working.

This series is a highly successful joint venture between Thomson Reuters and the American Bar Association Section of Litigation. For ease of use, the CD-ROM that comes with this publication contains many of the jury instructions, forms and checklists that are included in the printed volumes.

The scope of the coverage, the expertise and experience of the authors, and the ability of any lawyer to gain easy access through the thorough index to this library of information make this publication "a must" for any firm or individual with a substantial roster of federal commercial litigation and a wise investment for those whose practice is more state-oriented.

As I noted, the Fourth Edition contains 25 new chapters, which adds significant extra value for anyone who already owns an older edition and is contemplating purchasing the updated series. Bob Haig's objective was that the Fourth Edition of this treatise be a step-by-step practice guide that covers every aspect of a commercial case, from the assessment that takes place at the inception, through pleadings, discovery, motions, trial and appeal. Great emphasis is placed on strategic considerations specific to commercial cases.

I would strongly recommend this publication to anyone looking for a thorough and cohesive treatise on federal commercial litigation. It is an invaluable resource for new attorneys, who will easily find the guidance they need when representing clients in business or commercial cases including practical and strategic considerations; the current state of the law; legal theories; checklists and other practice aids. Seasoned attorneys will likewise find this treatise advantageous, in part for the reasons mentioned, but also because the 296 authors have so carefully studied and discussed the complex issues regularly faced by those who represent businesses of any size in federal court.

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