PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D89

PROVIDER - Seniors Management 95 Workers Compensation Group

Provider Nos. Various

vs.

INTERMEDIARY - Blue Cross and Blue Shield Association/ Horizon Blue Cross and Blue Shield of New Jersey

DATE OF HEARING-
November 18, 1999

Cost Reporting Period Ended -
December 31, 1995

CASE NO. 98-1396G

INDEX

ISSUE:

Was the Intermediary=s adjustment to worker=s compensation expense proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Seniors Management, Inc. (AProvider@) is a Florida based corporation that owns and/or operates thirteen skilled nursing facilities (ASNF@). Seven of the thirteen facilities which are located in either the state of Pennsylvania, New Jersey, or Florida, are represented by the Provider in this appeal.[1]

For the cost reporting period ended December 31, 1995, the Provider charged its worker=s compensation costs to the Administrative and General (AA&G@) cost center within its Medicare cost reports. These costs were then allocated to the Provider=s revenue producing cost centers on the basis of accumulated cost to determine program reimbursement. Horizon Blue Cross and Blue Shield of New Jersey (AIntermediary@) reviewed the cost reports and reclassified the Provider=s worker=s compensation expenses from A&G to the Employee Benefits cost center. Here, the costs were allocated to the revenue producing cost centers on the basis of direct salaries, reducing the Provider=s program reimbursement by $117,445.[2]

The Intermediary issued a Notice of Program Reimbursement reflecting the subject reclassification in each of the subject cost reports.[3] On March 5, 1998, the Provider appealed each reclassification to the Provider Reimbursement Review Board (ABoard@) pursuant to 42 C.F.R. '' 405.1835-.1841, and met the jurisdictional requirements of those regulations.

The Provider was represented by Kimberly A. Bane, Esquire, of Cozen and O=Connor. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross and Blue Shield Association.

PROVIDER=S CONTENTIONS:

The Provider contends that the Intermediary's reclassification of worker=s compensation expense from the A&G cost center to the Employee Benefits cost center is improper. The Provider asserts that program regulations, manual instructions, and case law support its position that worker=s compensation is an A&G expense which is allocated over all allowable costs.[4]

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1 Provider Position Paper at 1. Intermediary Position Paper at 1.

2 Id.

3 Exhibit P-A.

4 Provider Position Paper at 2.

The Provider cites Longwood Management Corporation v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 99-D34, April 6, 1999, Medicare & Medicaid Guide (CCH) & 80,177, decl=d rev. HCFA Administrator, June 4, 1999 (ALongwood@),[5] where the Board found that worker=s compensation costs should be classified as an A&G expense rather than an employee benefit. The Provider explains that the very same issue that was decided in Longwood is presented in the instant case.[6]

In particular, the Provider explains that the Board found the characteristics of worker=s compensation insurance to differ significantly from the characteristics of employee fringe benefits, but analogous to other types of insurance that are typically classified as A&G such as casualty insurance and malpractice insurance.[7] The Provider Reimbursement Manual, Part I (AHCFA Pub. 15-1@) ' 2161.A.2 specifically defines worker=s compensation as a form of liability insurance.[8] This definition suggests that worker=s compensation insurance is purchased primarily for the benefit of the employer, for example, to protect the employer against potential losses due to worker=s injuries. Conversely, employee fringe benefits Ainure primarily to the benefit of the employee.@ HCFA Pub. 15-1 ' 2144.2.[9] Also, HCFA Pub. 15-1' 2144.4 lists examples of fringe benefits, and notably, worker=s compensation is absent from this list. Although the list is not all inclusive, the Board found particularly significant the fact that all of the benefits numerated such as contributions to pension plans, health insurance, or life insurance, directly and primarily benefit the employee.[10]

The Provider asserts that the Board found further support for classifying worker=s compensation costs as A&G expenses in federal case law.[11] The Provider cites In re HLM Corporation v. Ramette, 62 F.3d 224, 226 (8th. Cir. 1995) (AIn re HLM Corp@) where the court stated: [w]hile workers= compensation programs are certainly designed to benefit employees, the institution of a workers= compensation insurance program helps Aemployers safeguard their statutory obligations@ by insuring the employer from its liability to provide workers' compensation benefits. Additionally, because the

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5 Exhibit P-E.

6 Transcript (ATr.@) at 8 and 11.

7 Tr. at 28-31.

8 Exhibit P-F.

9 Exhibit P-G.

10 See also Provider=s Post Hearing Brief at 2.

11 Provider Position Paper at 3.

employee would still be entitled to such benefits even if the employer were illegally uninsured, the employer=s participation in a workers= compensation insurance fund cannot be understood as a true Abenefit.@ A true Abenefit@ would be one more commonly associated with, for example, employee life insurance benefits, where unless an employer offered a life insurance benefit plan the employee would not necessarily have coverage. Id.[12]

Accordingly, the Provider maintains that because the employer benefits more than an employee from worker=s compensation insurance, such expenses should be classified with all other types of liability insurance as A&G costs instead of employee benefit costs.

The Provider contends that the differences between worker=s compensation and traditional employee benefits are recognized by other federal programs.[13] In the context of the Employee Retirement Income Security Act ("ERISA"), worker=s compensation does not relate to employee fringe benefits and, therefore, does not come under ERISA's employee benefit and welfare plans. As a result, courts have held that state-mandated worker=s compensation insurance plans are not preempted by ERISA. See District of Columbia v. Greater Washington Board of Trade, 506 U.S. 125, 131 (1992).[14]

The Provider also contends that the fact that worker=s compensation payments are statutorily mandated as opposed to contractually mandated further supports its classification of worker=s compensation payments as A&G costs. The individual facilities participating in this group are located in either New Jersey, Pennsylvania or Florida. In each of these states employers must maintain worker=s compensation insurance for their employees in order to do business. See N.J. Stat. '' 34:15-71; 34:15-72 (1998); 77 P.S. ' 501 (1998); 31 Fla. Stat. ' 440.38 (1998).[15] Fringe benefits, on the other hand, are generally bargained for between employers and employees as part of a collective bargaining arrangement where employees may relinquish certain claims for wages in exchange for receiving fringe benefits. See In re Allentown Moving & Storage Inc., 208 B.R 835 (E.D. Pa. 1997), aff=d. 214 B.R. 761 (E.D. Pa. 1997) (holding that since worker=s compensation benefits were a statutory requirement and not obtained through collective bargaining, premiums could not be considered contributions to an employee benefit plan).[16]

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[12] Exhibit P-H.

[13] Provider Position Paper at 4. Provider=s Post Hearing Brief at 5.

[14] Exhibit P-I.

[15] Exhibits P-J, P-K, and P-L, respectively.

[16] Exhibit P-M.

In sum, the Provider maintains that worker=s compensation insurance, as defined by HCFA Pub. 15-1, is a liability insurance.[17] As such, it possesses characteristics that are very similar to other liability insurance, specifically malpractice and casualty insurance, that fall under the A&G cost category. Although the Medicare statute and regulations do not explicitly state whether worker=s compensation should be treated as an A&G cost or as an employee benefit cost, federal courts have encountered this issue outside the context of Medicare, and concluded that worker=s compensation insurance should not be categorized as an employee benefit.

The Provider rejects the Intermediary=s reliance upon the Board=s decision in Bryn Mawr Terrace Convalescent Center v. Blue Cross and Blue Shield Association/Veritus Medicare Services, PRRB Dec. No. 99-D59, August 19, 1999, Medicare & Medicaid Guide & 80,323, decl=d rev. HCFA Administrator, October 4, 1999 (ABryn Mawr@) to help support its position.[18] The Provider argues that Bryn Mawr deals with the reclassification of FICA taxes which is an entirely different type of expense than worker=s compensation. The Provider asserts, therefore, that the rationale used by the Intermediary to reclassify FICA taxes as an employee benefit does not justify a similar reclassification of worker=s compensation expenses to the employee benefits cost center.

To the contrary, however, the Provider maintains that Longwood speaks directly to the issue of worker=s compensation, and supports its classification of such expenses as A&G costs. As noted, HCFA Pub. 15-1 ' 2144.2 states that fringe benefits inure primarily to the benefit of the employee. Similarly, all of the examples of fringe benefits listed in HCFA Pub. 15-1 ' 2144.4, which notably does not include worker=s compensation, directly relate to the benefit of the employee. Respectively, FICA taxes primarily, if not exclusively, benefit the employee. FICA taxes are paid by employers on behalf of employees to secure the employee's right to Social Security, old age or disability benefits. FICA credits accrued during the tenure of an individual's employment are portabe, job to job.

The Provider rejects the Intermediary=s reliance upon a letter issued by the Director, Office of Chronic Care and Insurance Policy, Health Care Financing Administration (AHCFA@), dated March 25, 1996, as authority for its reclassification of worker=s compensation to employee benefits.[19] The Provider asserts that the letter=s focus is Skilled Nursing Facility Requests for Exceptions to Routine Costs Limits. It does not state HCFA's position regarding the classification of worker=s compensation. Consequently, the Intermediary's reliance upon the letter is misplaced.

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[17] Provider Position Paper at 5.

[18] Supplement to Provider=s Position Paper at 2. Provider=s Post Hearing Brief at 7.

[19] Supplement to Provider=s Position Paper at 5. Provider=s Post Hearing Brief at 8. Exhibit I-3.

The Provider also rejects the Intermediary=s reliance upon Medicare=s cost reporting instructions to support its position.[20] Specifically, the Intermediary explains that HCFA Pub. 15-2, which provides the cost reporting instructions for SNF cost reports, requires worker=s compensation expense to be classified as an employee benefit. However, this argument was previously found uncompelling by the Board in Longwood. Moreover, it is well-settled that instructions that are created to assist intermediaries to complete Medicare reimbursement forms do not have the binding effect of regulations as they have not been subject to official comment and rulemaking. National Medical Enterprises v. Bowen, 851 F.2d 291, 292 (9th. Cir. 1988)(finding that Part II of HCFA Pub. 15 does not establish Medicare policy and, therefore, requires no particular deference). Rather, they are intended to function merely as a guide for intermediaries in applying the Medicare statute and reimbursement regulations. Phoenix Baptist Hospital v. Heckler, 767 F.2d 1304, 1307 (Cir. 1985); John Muir Memorial Hospital Inc. v. Schweiker, 664 F.2d 1337, 1339 (9th. Cir. 198 1).[21]

Finally, the Provider contends that worker=s compensation costs are indirect/overhead costs; therefore, they should be classified as A&G expenses as are all other such costs, and apportioned to the revenue producing cost centers based upon accumulated cost. The Provider asserts that the Intermediary's objection to this apportionment is in error.[22] Specifically, the Intermediary argues that worker=s compensation should be classified as an employee benefit where it would be apportioned on the basis of salaries; where there is no salary amount in a revenue producing cost center there would be no employee benefit allocation. The Intermediary maintains that this apportionment is the only way to match costs appropriately.

However, the question of apportionment was answered at the time worker=s compensation costs were found to benefit the Provider (employer) rather than the employee. Once this determination was made, it was appropriate to apportion worker=s compensation expenses like any other A&G cost. The method of allocation flows from the characterization of the expense. The apportionment question, therefore, only becomes relevant if worker=s compensation costs had been determined to be employee-related expenses.

Notably, in making its apportionment argument the Intermediary erroneously presupposes that worker=s compensation expenses are costs which benefit the employee. This assumption, however, is contrary to the Longwood decision, which makes clear that worker=s compensation expenses primarily benefit the employer.

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[20] Id.

[21] See Supplement to Provider=s Position Paper at Exhibits A-C.

[22] Supplement to Provider=s Position Paper at 6. Provider=s Post Hearing Brief at 5 and 9.

The Provider adds that worker=s compensation insurance costs should be classified as A&G expenses as they are necessary and indirect costs of providing services to all patients including Medicare patients. In St. James Hospital v. Heckler, 760 F.2d 1460 (7th. Cir. 1985), the court noted that the Department of Health & Human Services recognized this indirect benefit to all patients by requiring participating providers to maintain minimum insurance coverage.[23] Program instructions at HCFA Pub. 15-1 ' 2160.A require providers to maintain an adequate insurance program to protect against likely losses, particularly for losses so great that their financial stability would be threatened. As such, worker=s compensation insurance expenses are indirect costs of providing health care to Medicare patients, which belong in the A&G cost center rather than in the employee benefits cost center.

The Provider explains that federal cases involving Medicare reimbursement have also delineated worker=s compensation expense along with fire, accident and malpractice insurance costs, as examples of indirect, A&G expenses. The provider cites Hadley Memorial Hospital, Inc. v. Schweiker, 689 F.2d 905, 907 (10th. Cir. 1982) (explaining that general and administrative cost centers include Asuch items as costs of admissions, billing, workers= compensation, fire, casualty, accident and malpractice insurance@), and Minnesota Hospital Association v. Bowen, 703 F. Supp. at 782 (discussing the differences between direct and indirect costs and identifying worker=s compensation as an example of an indirect cost).[24]

In response to the Board's inquiry, the Provider determined that Generally Accepted Accounting Principles ("GAAP") do not recommend a specific classification of worker=s compensation costs within an entity=s financial statements. The Provider asserts, however, that all insurance costs are typically treated as operating expenses according to GAAP.[25]

And finally, the Provider asserts that the Intermediary's reliance upon the American Hospital Association=s Chart of Accounts ("Chart of Accounts") to support its reclassification is inappropriate.[26] The Provider argues that the Chart of Accounts, which considers worker=s compensation to be an employee fringe benefit, is directed to hospitals, not SNFs. Accordingly, SNFs are not required to rely on the Chart of Accounts when preparing their cost reports. Moreover, the Chart of Accounts does not represent Medicare policy and, therefore, should not be construed as persuasive or authoritative.

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[23] Supplement to Provider=s Position Paper at Exhibit D.

[24] Provider=s Post Hearing Brief at 6. Exhibits P-19 and P-20.

[25] Provider=s Post Hearing Brief at 7.

[26] Provider=s Post Hearing Brief at 9.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that its reclassification of worker=s compensation insurance expense is proper. The Intermediary explains that the underlying problem with treating worker=s compensation as an A&G expense rather than an employee benefit is Acost-shifting,@ i.e., a circumstance where the Medicare program improperly assumes costs attributable to non-Medicare patients.[27]

Specifically, the Intermediary asserts that worker=s compensation is a salary generated expense much like FICA taxes, which should be apportioned to Medicare on the basis of gross salaries. Using gross salaries as the allocation base properly matches costs with the activities which benefited from them as required by 42 C.F.R. ' 413.24(d)(1), which states: A[a]ll costs of non-revenue producing cost centers are allocated to all cost centers that they serve.@ Id. The Intermediary cites the Board=s decision in Bryn Mawr, finding that gross salaries, as an allocation base, properly matches employment taxes to the activities which benefited from them.[28]

The Intermediary explains the problem with classifying worker=s compensation as an A&G expense is that A&G expenses are apportioned to Medicare on the basis of accumulated cost rather than salaries. This means, that if worker=s compensation were apportioned as an A&G expense, some revenue producing cost centers would receive an allocation of worker=s compensation even though they had no salaries. The Intermediary notes that a review of the seven cost reports at issue in this case reveals that no salary expenses were incurred for laundry, housekeeping, and therapy services. Accordingly, the Intermediary maintains that since there were no salaries in these cost centers, allocating any of the salary-related worker=s compensation expense to these cost centers would violate 42 C.F.R. '413.24(d)(1), i.e., they should receive no allocation of worker=s compensation insurance expense since they were in no way served by that cost.

The Intermediary believes a key factor in this matter is that SNFs commonly staff routine service areas with employees while staffing their therapy departments, to a significant degree if not entirely, with contractors. Using data from the Florida Club Care Center (AFlorida Club@), one of the individual facilities included in this appeal, the Intermediary shows how the use of contractor staff and the allocation of worker=s compensation as an A&G expense produces an excess allocation of costs to the Medicare program:[29]

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[27] Tr. at 14. Intermediary=s Supplemental Position Paper at 3.

[28] Tr. at 12. Intermediary Position Paper at 7.

[29] Tr. at 15. Intermediary=s Post Hearing Brief at 3.

Worker=s Compensation Cost	$ 104,872
Salaries in Routine Areas	$1,899,180 (64.2%)
Salaries in Therapy Departments	$43,317 (1.5%)
Salaries-General Services	$1,017,966 (34.3%)
Accumulated Costs - Routine	$ 3,013,695 (78.8%)
Accumulated Costs - Therapy	$ 850,451 (22%)
Medicare Utilization - Routine	8.8%
Medicare Utilization - Therapy	81%

Analysis shows that Florida Club paid $104,872 in worker's compensation for its employees. If this expense is apportioned based upon gross salaries, approximately 64 percent would be charged to routine cost areas which have a Medicare utilization rate of 8.8 percent, and less than 2 percent would be charged to the therapy cost centers which have a Medicare utilization rate of 81 percent. However, if the worker=s compensation costs in this example are allocated on the basis of accumulated costs as part of A&G, approximately 22 percent of approximately $70,000 in worker's compensation cost (after an allocation to general services) would be apportioned to the therapy cost centers in spite of the fact that they had virtually no employees. This apportionment results because the therapy departments accumulated cost of $850,451 includes a significant amount of contractor payments, which is compared to routine service accumulated cost of $3,015,695.

The Intermediary asserts that in this example, which is representative of each of the individual facilities= operations in this appeal, the allocation of worker=s compensation as part of A&G would also result in a Adouble allocation.@[30] That is, Florida Club staffed its therapy departments pursuant to a contract with CMS Therapies, Inc. (ACMS@). According to the contract, Florida Club=s payments to CMS cover the worker's compensation risk for the therapy workers, as follows:

(a) Facility's Insurance. Facility shall obtain and maintain at its sole expense adequate professional and public liability insurance coverage in the amount of at least $1,000,000 per occurrence and $2,000,000 in the aggregate, which insurance shall cover Facility and its employees, students and volunteers. Facility shall provide workers compensation and unemployment insurance coverage to its employees at levels in compliance with applicable state statutes.

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[30] Intermediary=s Post Hearing Brief at 5.

(b) Contractor's Insurance. Contractor shall obtain and maintain at its sole expense adequate professional and public liability coverage in the amount of at least $1,000,000 per occurrence and $2,000,000 in aggregate, which insurance shall cover Contractor and its employees. Contractor shall provide workers compensation and unemployment insurance coverage to its employees at levels in compliance with applicable state statutes.

Therapy Services Agreement at Article V.[31]

Accordingly, the Intermediary concludes that the apportionment of the $104,872 in worker's compensation as an A&G expense duplicates costs already in the therapy departments while providing no coverage to them.

The Intermediary contends that its position regarding cost-shifting, or that Medicare=s cost apportionment process requires worker=s compensation to be classified as an employee benefit, is supported by authorities both within and outside of the Medicare program.[32]

First, the Intermediary asserts that its position is supported by the definition of Afringe benefits@ found at HCFA Pub. 15-1 ' 2144.1, which states:[33]

> [a]mounts paid to, or on behalf of, an employee, in addition to direct salary or wages, and from which the employee, his/her dependent . . . or his/her beneficiary derives a personal benefit before or after the employee's death.

HCFA Pub. 15-1 ' 2144.1.

With respect to this definition, the Intermediary argues that worker=s compensation insurance premiums are similar to medical health insurance premiums, which are a benefit paid on behalf of an employee. The amount of the premiums are based on the number of employees or their salary amounts. Moreover, an employee is the true recipient of this benefit when receiving compensation for time away from work due to injury. Since worker=s compensation insurance benefits may be received by an employee or his dependents before his/her death (for example, during the recovery period for an on-the-job injury), the expense related to worker=s compensation insurance is appropriately considered a fringe benefit.

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[31] Exhibit I-7.

[32] Tr. at 15.

[33] Intermediary Position Paper at 4.

The Intermediary acknowledges that an employer benefits from the existence of worker=s compensation insurance but maintains that the employer is not the beneficiary. According to the insurance industry a "beneficiary" is that person, persons, or entity who stands to receive the cash remuneration of an insurance policy should the conditions of its execution be met. For example, while a whole community may benefit from each homeowner insuring his or her home against fire loss, the beneficiaries of a given policy are the owners of the specific house insured. Likewise, while an employer may benefit by having its employees covered by worker=s compensation insurance, as the Provider suggests, the actual beneficiaries are the employees and their families.

Next, the Intermediary asserts its position is supported by HCFA Transmittal 378 (HCFA Pub. 15-1 ' 2534.5.B), which pertains to SNF exception requests. Essentially, the Intermediary argues that the transmittal requires worker=s compensation costs to be included in employee benefits for the purpose of performing peer group comparisons.[34] See letter issued by Director, Office of Chronic Care and Insurance Policy, HCFA, March 25, 1996 (Exhibit I-3).

The Intermediary asserts its position is also supported by Medicare=s cost reporting instructions.[35] Specifically, the instructions for completing the SNF Medicare cost report, HCFA Pub. 15-2 ' 1611.2, explain that FICA tax and worker=s compensation should be reclassified to the fringe benefits cost center. (Exhibit I-4). Further, the instruction for completing the wage index survey lists these expenses as fringe benefits. Id. With respect to the instant case, the Intermediary maintains that it dutifully followed the SNF Medicare cost reporting instructions when it reclassified worker=s compensation expense to the fringe benefits cost center.

Finally, the Intermediary rebuts the Board=s reasoning in Longwood absent a decision from the HCFA Administrator affirming the Board=s position. The Intermediary=s rebuttal is as follows:[36]

Cost-Shifting

The underlying problem is an improper assignment of costs to the Medicare program resulting from improper cost classification.[37] A specific cost category is being charged twice to certain ancillary

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[34] Tr. at 65. Intermediary Position Paper at 5.

[35] Tr. at 60. Intermediary Position Paper at 6.

[36] Intermediary=s Supplemental Position Paper at 2.

[37] Intermediary=s Supplemental Position Paper at 3.

services offered by the Provider. Those ancillary services have a higher Medicare utilization than routine or inpatient services. Therefore, the Medicare program picks up a disproportionate amount of the subject costs.

Protecting the Medicare program and other payors from cost-shifting is an integral part of the statutory definition of reasonable costs (42 U.S.C. 1395x(v)(1)(A)). Medicare regulation 42 C.F.R. ' 413.9 twice articulates the anti-cost-shifting concept:

> (b)(1) The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program.
>
> (c)Application. (1) It is the intent of Medicare that payments to providers of services should be fair to the providers, to the contributors to the Medicare trust funds, and to other patients.

42 C.F.R. ' 413.9(b)(1) and (c).

The Board=s discussion of the provider=s position acknowledged the existence of a cost distortion problem. In part, the Board states:

> [t]he Providers observe that the Intermediary asserts that if workers' compensation insurance costs are classified to the A&G cost center, such costs would be apportioned to the ancillary services cost centers where contracted personnel may be used. The Intermediary's allocation of workers' compensation insurance costs would be to cost centers that are not being served by the costs since contracted personnel may not participate in workers' compensation claims. However, the actual number of contracted personnel used by the Providers for the ancillary services cost centers are notably fewer in number compared to the total number of Provider employees. This alleged cost reporting inconsistency has a very limited impact on the Providers when compared to the importance of applying uniform cost-finding principles.

Longwood at 6.

The Board's discussion of the intermediary=s position also articulates the distortion problem:

> [t]he Intermediary contends that a review of Worksheet A of the Medicare cost reports for the Providers who are included in this group appeal show that ancillary therapy services are furnished entirely by contracted personnel. Contracted personnel are covered for workmen=s compensation purposes by their employers. There is no reason for the Providers= to cover contracted personnel for work-related injuries because any such insurance requirement would already have been met by the contractor's liability insurance. Accordingly, the intermediary argues that the allocation of workers' compensation insurance costs as part of administrative and general costs will result in the allocation of these costs to all the ancillary cost centers. That has nothing to do with ancillary services which are furnished entirely by contracted personnel.

Longwood at 9.

Respectively, the Intermediary maintains that in Longwood, as well as the instant case, management made a business decision to staff its therapy departments with workers who were employed by another entity--a contractor. In turn, that contractor deployed therapists who furnished patient care services at the Provider. The Provider's payment to the contractor for the therapist services covered the contractor's exposure for worker=s compensation claims resulting from the therapist being injured on the job at the Provider=s facility.

Fringe Benefits

A step-by-step review of HCFA Pub. 15-1 does not support the Board's conclusion that worker=s compensation is not a fringe benefit.[38] The basic definition of Afringe benefits@ found at HCFA Pub. 15-1 ' 2144.1 states:

> [f]ringe benefits are amounts paid to, or on behalf of, an employee, in addition to direct salary or wages, and from which the employee, his dependent (as defined by IRS), or his beneficiary derives a personal benefit before or after the employee's retirement or death.

Id.

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[38] Intermediary=s Supplemental Position Paper at 7.

With respect to this definition, the Intermediary asserts that worker=s compensation insurance costs are incurred because of the presence of employees and payment of salary or wages. Moreover, an employee derives a personal benefit from the existence of worker=s compensation protection.

In addition, the Intermediary contends that the rationale for worker=s compensation is generally understood, and offers the following definition from Blacks Law Dictionary, 6th. Edition, 1990 (Exhibit I-9):

> Workers' Compensation Acts. State and federal statutes which provide for fixed awards to employees or their dependents in case of employment related accidents and diseases, dispensing with need by employee to bring legal action and prove negligence on part of the employer. Some of the statutes go beyond the simple determination of the right to compensation and provide insurance systems, either under state supervision or otherwise. The various state acts vary as to extent of workers and employment covered, amount and duration of benefits, etc.
>
> The effect of most workers' compensation acts is to make the employer strictly liable to an employee for injuries sustained by the employee which arise out of and in the course of employment, without regard to the negligence of the employer or that of the employee. Where the statute applies, it has been uniformly held that this remedy is exclusive and bars any common-law remedy which the employee may have had, the compensation scheduled under the act being the sole measure of damage.

Id.

The purpose of fringe benefits is further defined at HCFA Pub. 15-1 ' 2144.2, stating:

> [f]ringe benefits inure primarily to the benefit of the employee. However, there may also be some intrinsic benefits to the provider, such as increasing employee work efficiency and productivity, reducing personnel turnover, or increasing employee morale.

Id.

In all, the Intermediary contends that trying to decide whether the presence of worker=s compensation laws and mandated coverage primarily benefit the employee or the employer is an exercise in the

esoteric. If the reference point is an employee who would be without a common-law remedy because of his own negligence, it is the employee who is the primary beneficiary of worker=s compensation. If the reference point is an employer who was clearly negligent but had damages limited, the answer would be different.

Also, the fact that worker=s compensation is not included in the list of fringe benefits found at HCFA Pub. 15-1 ' 2144.4 is not fatal to the argument that worker=s compensation can be fairly considered a fringe benefit. The omission from the list can just as well be attributed to the fact that the inclusion would be obvious. Moreover, this interpretation draws support from HCFA Pub. 15-1 ' 2122.3, which states:

> [e]mployment-related taxes, i.e. FICA, workers' compensation and unemployment compensation, which are paid by a provider on behalf of a provider-based physician, are considered business expenses of the employers and not fringe benefits (' 2108.3C1 [& 5886]). Hence, they are includible in their entirety as part of the administrative cost of the Provider, without allocation to the physician's professional component, and reimbursable to the provider on a reasonable cost basis.

Id.

Notably, for one class of employee, provider-based physicians, there is a specific manual directive regarding the treatment of worker=s compensation and payroll expenses. However, there are no reported cases interpreting this provision and the history and purpose is not clear from its context. Therefore, if it was such a clearly undisputed concept that worker=s compensation was a business expense (an A&G cost), there would be no need for this provision. Simply, the manual creates an exception, and Medicare=s cost reporting instructions implement the general rule.

Non-Medicare Case Precedent

The Board mistakenly relied upon the provider's citation to In re HLM Corp., 62 F.3d, 224 (8th. Circuit, 1995).[39] The issue in that case was whether an employer's debt to its worker=s compensation insurer had a priority level equal to contributions to an employee benefit plan. The worker=s compensation insurer was trying to rise above the status of an uninsured creditor. The District Court analysis, which was affirmed by the 8th. Circuit, focused on the specific issue and objectives of bankruptcy priorities, concluding that:

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[39] Intermediary=s Supplemental Position Paper at 10.

> [b]oth ' 507(a)(4)'s plain language and its legislative history, as reflected in the House and Senate Reports, demonstrate that contributions to an Aemployee benefit plan@ are not the same as employer's workers' compensation premium payments. This construction of the phrase "employee benefit plan" is also consistent with the purposes of the Code. Section 507(a)(4) was adopted specifically to place non-monetary compensation owed by a debtor to its employees on the same level as wage compensation. As discussed, workers' compensation insurance payments are not a wage substitute. More generally, the Code was promulgated to ensure the fair and uniform treatment of creditors. To that end, preferential treatment is given to unsecured creditors only in exceptional circumstances.

In re HLM Corp., 62 F.3d, 224 (8th. Circuit, 1995) (emphasis added).

The Intermediary asserts there is no parallel between accurate cost finding and cost reimbursement and bankruptcy priorities. Therefore, In re HLM Corp. has no relevance to the subject issue.

The Board also agreed with the provider's ERISA argument distinguishing worker=s compensation from other types of employee benefits and welfare plans. However, the ERISA distinction is not based on intellectual resolution of the debate over whether worker=s compensation is a fringe benefit or a general liability insurance or an A&G cost. The distinction follows the fact that worker=s compensation programs, however they are financed, are extensively monitored and controlled by other government entities. There is no need for federal protection or preemption that ERISA provides for less regulated employee benefit programs.

Self-Insurance

The argument endorsed by the Board that HCFA Pub. 15-1 ' 2161 defines worker=s compensation as a form of liability insurance does not win the Provider=s case.[40] The significant presence of contract workers who generate no direct worker=s compensation exposure has to be considered. If a provider, as an employer, has substantially all of its staff in an employer/employee basis (i.e. nurses, maintenance crew, therapists, x-ray technicians, and any other job category) then all departments contribute to the cost of worker=s compensation on a relatively consistent basis. Under this scenario, it is arguable whether or not worker=s compensation costs need to be allocated to the revenue producing cost centers based on a payroll statistic. However, if certain cost centers, because of a business decision, are staffed with contracted workers who do not contribute to the worker=s compensation expense and exposure of the Provider/employer, then any arguments for not using the payroll statistic collapse.

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[40] Intermediary=s Position Paper at 12.

Chart of Accounts

The AHA=s Chart of Accounts has taken a clear position on the classification of payroll expenses.[41] The accounting policy for fringe benefits states:

> [a]ll employee fringe benefit expenses are to be assigned to the functional reporting center to which the employee=s salary or wages are assigned. Fringe benefits may include the employer=s share of employee hospitalization insurance, medical and dental benefits, Workmen=s Compensation, employee group insurance, Social Security taxes (FICA), unemployment compensation, annuity premiums, past several benefits and pensions.

AHA Chart of Accounts at 97 (emphasis added).[42]

Notably, the Chart of Accounts has long been a useful source of information regarding cost classification questions. In previous appeals the HCFA Administrator has considered the Chart of Accounts for other cost subject matters. See St. Joseph=s Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 85-D62, June 12, 1985, Medicare & Medicaid (CCH) ¶ 34,852, rev=d. HCFA Administrator, August 13, 1985, Medicare & Medicaid (CCH) ¶ 34,922, and Frankford Hospital Association v. Blue Cross and Blue Shied Association, PRRB Dec. No. 85-D101, September 4, 1985, Medicare & Medicaid (CCH) ¶ 35005, rev=d. HCFA Administrator, November 11, 1985, Medicare & Medicaid Guide (CCH) ¶ 35,061.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 1395x(v)(1)(A)	-	Reasonable Cost

2. Regulations - 42 C.F.R.:

§§ 405.1835-.1841	-	Board Jurisdiction

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[41] Intermediary=s Supplemental Position Paper at 13.

[42] Exhibit I-10.

' 413.9(b)(1) - Cost Related to Patient Care, Definitions-Reasonable Cost

' 413.9(c) - Cost Related to Patient Care, Application

' 413.24(d)(1) - Adequate Cost Data and Cost Finding, Cost Finding Methods, Step-Down Method

3. Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

' 2122.3 - Employment-Related Taxes--Provider-Based Physicians

' 2144 et seq. - Fringe Benefits

' 2161.A.2 - Insurance Costs, Purchased Commercial Insurance, Liability

' 2534.5.B - Determination of Reasonable Costs in Excess of Costs Limit or 112 Percent of Mean Cost, Uniform National Peer Group Comparison

4. Provider Reimbursement Manual, Part II (HCFA Pub. 15-2):

'1611et seq. - Cost Report Instructions, Skilled Nursing Facilities, Worksheet A-6, Reclassifications

5. Case Law:

Longwood Management Corporation v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 99-D34, April 6, 1999, Medicare & Medicaid Guide (CCH) **&** 80,177, decl=d rev. HCFA Administrator, June 4, 1999.

In re HLM Corporation v. Ramette, 62 F.3d 224 (8th. Cir. 1995).

District of Columbia v. Greater Washington Board of Trade, 506 U.S. 125 (1992).

In re Allentown Moving & Storage Inc., 208 B.R 835 (E.D. Pa. 1997), aff=d. 214 B.R. 761 (E.D. Pa. 1997).

Bryn Mawr Terrace Convalescent Center v. Blue Cross and Blue Shield Association/Veritus Medicare Services, PRRB Dec. No. 99-D59, August 19, 1999, Medicare & Medicaid Guide & 80,323, decl=d rev. HCFA Administrator, October 4, 1999.

National Medical Enterprises v. Bowen, 851 F.2d 291 (9th. Cir. 1988).

Phoenix Baptist Hospital v. Heckler, 767 F.2d 1304 (Cir. 1985).

John Muir Memorial Hospital Inc. v. Schweiker, 664 F.2d 1337 (9th. Cir. 1981).

St. James Hospital v. Heckler, 760 F.2d 1460 (7th. Cir. 1985).

Hadley Memorial Hospital, Inc. v. Schweiker, 689 F.2d 905, 907 (10th. Cir. 1982).

Minnesota Hospital Association v. Bowen, 703 F. Supp. 780 (D. Minn. 1988).

St. Joseph=s Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 85-D62, June 12, 1985, Medicare & Medicaid (CCH) & 34,852, rev=d. HCFA Administrator, August 13, 1985, Medicare & Medicaid (CCH) & 34,922.

Frankford Hospital Association v. Blue Cross and Blue Shied Association, PRRB Dec. No. 85-D101, September 4, 1985, Medicare & Medicaid (CCH) & 35005, rev=d. HCFA Administrator, November 11, 1985, Medicare & Medicaid Guide (CCH) & 35,061.

5. Other:

N.J. Stat. '' 34:15-71; 34:15-72 (1998).

77 P.S. ' 501 (1998).

31 Fla. Stat. ' 440.38 (1998).

HCFA Letter, Director, Office of Chronic Care and Insurance Policy, March 25, 1996.

Chart of Accounts for Hospitals issued by the American Hospital Association.

Blacks Law Dictionary, 6th. Edition, 1990.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties= contentions, evidence presented, testimony elicited at the hearing, and post-hearing submissions, finds and concludes as follows:

The Board finds there are two aspects to the subject issue. The first aspect is whether the cost of worker=s compensation insurance should be classified as an A&G expense or whether it is an employee benefit. The second aspect is whether or not that classification results in an improper allocation of costs; that is, allocating worker=s compensation costs on the basis of accumulated cost as an A&G expense or on the basis of salaries as an employee benefit.

Respectively, the Board finds that worker=s compensation insurance is a type of liability coverage whose costs are appropriately classified as an A&G expense. The Board finds that worker=s compensation insurance is primarily purchased to protect an employer (Provider) from potential losses due to workers= injuries as compared to a fringe benefit that would inure primarily to an employee.

The Board finds that program instructions at HCFA Pub. 15-1 ' 2161.A.2 supports its position. In part, the manual states:

> Liability.-- This insurance includes professional liability (malpractice, error in rendering treatment, etc.), unemployment compensation, worker=s compensation, automobile liability, etc.

HCFA Pub. 15-1 ' 2161.A.2 (emphasis added).

Also regarding this matter, the Board finds that the amount of worker=s compensation cost incurred by any given employer is not based solely upon salaries as argued by the Intermediary. Rather, the cost of such coverage is determined to a large extent on the amount of risk involved with employee activities, i.e., the potential for employee injuries and the severity of such injuries should they occur.

Moreover, the Board finds no authoritative basis within Medicare regulations, program policies, or GAAP supporting the classification of worker=s compensation insurance costs as an employee benefit. The Board acknowledges the Intermediary=s reference to Medicare=s cost reporting instructions classifying worker=s compensation insurance costs as a fringe benefit. However, the Board is not compelled by this argument. Essentially, the Board finds that Medicare reimbursement policy is reflected in Part I of the Provider Reimbursement Manual, as is HCFA Pub. 15-1 ' 2161.A.2, quoted above. Cost reporting instructions, which are separately maintained in Part II of the manual, may provide some guidance towards reimbursement policy but only if no other more authoritative source is available. The Board notes the Provider=s reference to National Medical Enterprises v. Bowen, 851

F.2d 291, 292 (9th. Cir. 1988)(finding that Part II of HCFA Pub. 15 does not establish Medicare policy and, therefore, requires no particular deference).

In all, with respect to the classification of worker=s compensation insurance cost as an A&G expense, the Board reaches the same findings and conclusions as it did in Longwood.

With respect to the allocation of worker=s compensation insurance costs, the Board finds that Medicare=s cost finding process dictates the basis upon which any cost will be divided among the other cost centers. Since worker=s compensation insurance costs are appropriately charged to the A&G cost center, they are appropriately allocated on the basis of accumulated cost. Importantly, the Board also finds no impropriety with this process.

As noted by the Intermediary, allocating worker=s compensation insurance costs on the basis of accumulated cost results, in some instances, in greater program payments than if it were allocated on the basis of direct salaries. However, this effect does not warrant a change in a cost=s classification since restricting program payments is not the intent of Medicare=s cost finding process.

The Board finds that Medicare=s cost finding process is designed to be fair and equitable to both the program and providers. It is not, however, designed to be a perfect process, meaning that every type of cost would be apportioned to Medicare with absolute precision. Clearly, there are far too many variations of provider costs and potential allocation bases to reach such result. Instead, the process recognizes that some A&G costs may be disproportionately allocated in favor of Medicare while others would be disproportionally allocated in favor of other payors. For example, the cost of malpractice insurance is attributable far more greatly to non-Medicare patients than to covered patients, yet this cost is apportioned through the A&G cost center. Conversely, the cost incurred by providers to produce their Medicare cost report is also dispersed as an A&G expense, although its purpose is almost exclusively for the benefit of the program.

The Board rejects the Intermediary=s argument regarding In re HLM Corp.. Specifically, the Intermediary contends that the court=s findings in that case fail to support the classification of worker=s compensation insurance costs as an A&G expense. The Intermediary bases this argument on the fact that the issue in that case was employer debt rather than Medicare cost finding. The Board finds, however, that the nature of the case is not the relevant factor--it is what the court says that is most important. In this regard, the Board notes the court=s language, as follows:

> [w]hile workers= compensation programs are certainly designed to benefit employees, the institution of a workers= compensation insurance program helps Aemployers safeguard their statutory obligations@ by insuring the employer from its liability to provide workers compensation benefits. Additionally, because the employee would still be entitled to such benefits even if the employer were illegally uninsured, the

> employer=s participation in a workers= compensation insurance fund cannot be understood as a true Abenefit.@ A true Abenefit@ would be one more commonly associated with, for example, employee life insurance benefits, where unless an employer offered a life insurance benefit plan the employee would not necessarily have coverage.

In re HLM Corp.

The Board also rejects the Intermediary=s reliance upon the findings and conclusions in Bryn Mawr. The issue in that case involved employment taxes which are characteristically different from worker=s compensation insurance. Clearly, the arguments in Bryn Mawr are not on point.
Also, the Board rejects the Intermediary=s reliance upon the AHA=s Chart of Accounts to support its argument that the cost of worker=s compensation insurance should be classified as an employee benefit. The Board agrees that the Chart of Accounts may be a useful source of information regarding cost classifications in some instances. However, it has no applicability in situations where Medicare policy has been established, as in the instant case, at HCFA Pub. 15-1 ' 2161.A.2.

Finally, the Board disagrees with the Intermediary=s rebuttal of its findings and conclusions in Longwood because the Administrator of HCFA did not formally affirm that decision. The Board believes the Administrator=s decision not to review that case is indicative of her general agreement with the resolution of the issue.

DECISION AND ORDER:

The Intermediary=s adjustments reclassifying worker=s compensation insurance costs from the A&G cost center to the employee benefits cost center are improper. The Intermediary=s adjustments are reversed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq.
Martin W. Hoover, Jr. Esq.
Charles R. Barker
Stanley J. Sokolove

Date of Decision: September 06, 2000

FOR THE BOARD:

Irvin W. Kues
Chairman