

Resolving Longshore Claims Through Settlements and Stipulations: Overview of Current Issues and Developments in Administrative Law Judges' Decisions¹

By Yelena Zaslavskaya
Senior Attorney for Longshore
Office of Administrative Law Judges
U.S. Department of Labor, Washington, D.C.

[This article is also scheduled to be published in the Benefits Review Board Service Longshore Reporter (July 2014). It was prepared by Ms. Zaslavskaya in her capacity as a member of the Advisory Board of the BRBS Longshore Reporter, and it does not constitute the official opinion of the Department of Labor or the Office of Administrative Law Judges.]

Many disputed Longshore claims² referred to the Office of Administrative Law Judges (OALJ) for a formal hearing are ultimately resolved through the settlement process under Section 8(i) (33 U.S.C.S. § 908(i)) and pertinent regulations, or through the issuance of a compensation order based on the parties' stipulations. This commentary highlights several recent ALJ decisions, and a few very recent Benefits Review Board decisions, addressing various issues that tend to arise when parties seek to resolve a case through settlement or stipulations. Because appeals are relatively unlikely in this context, the Benefits Review Board (BRB) and the courts have a limited opportunity to provide guidance to adjudicators and practitioners. Thus, a look at how these issues are handled by the ALJs may be particularly informative.

Determining the Adequacy of a Settlement Amount

Section 8(i) provides for the approval of settlements unless inadequate or procured by duress. 33 U.S.C.S. § 908(i)(1);³ 20 C.F.R. § 702.243(f), (g). The recent Board decision in *Richardson v. Huntington Ingalls, Inc.*, 48 BRBS __ (May 26, 2014), affirming the ALJ's approval of a settlement application over the objections of the Director for the Office of Workers' Compensation Programs (OWCP), highlights the challenges attendant to the determination of "adequacy" and illuminates the standard to be applied in reviewing settlement applications.

¹ The author would like to thank all Administrative Law Judges who helped in the preparation of this commentary by bringing to the author's attention the issues and decisions discussed herein. This article is current through the date of its submission for publication on 6/2/14.

² This commentary applies to claims arising under the Longshore and Harbor Workers' Compensation Act (LHWCA, 33 U.S.C.S. § 901 *et seq*) and its Extension Acts.

³ Prior to the 1984 Amendments, § 8(i)(A) provided that whenever the deputy commissioner determined that it was in the "best interests" of an employee, he could approve a settlement discharging employer's liability for compensation notwithstanding the provisions of §§ 15(b) and 16.

In this case, the employer initially paid the claimant temporary total disability (TTD) benefits for a shoulder injury, which it later converted to partial disability benefits.⁴ The parties eventually executed a settlement agreement, which was disapproved by the District Director on adequacy grounds. After the case was referred to the OALJ, the parties submitted an amended settlement which provided for \$140,500 in disability compensation (\$500 more than the original amount), \$10,000 in future medical costs, plus attorney's fees not to exceed \$10,000.

Both parties and the OWCP Director submitted briefs to the ALJ. Claimant urged approval of the settlement on the grounds that: (1) she was concerned that she might fail to reach her actuarial age and, if so, her heirs would lose the benefit of the remainder of any lump sum; (2) a lump sum payment would help her support her family and meet many current debts and obligations; (3) since she has returned to work, any increase in pay would decrease her future benefits; and (4) she was fully aware of the full value of her claim. The employer asserted that, if the case went to hearing, it would be able to substantiate a reduction in benefits. The OWCP Director urged the ALJ to reject the settlement because the parties had failed to establish its adequacy. The claimant's post-injury wage (\$7.25/hour) was consistent with the employer's vocational evidence. Applying that earning capacity and using the claimant's actuarial life expectancy and an 8% discount rate, the Director calculated a minimum adequate amount of \$306,000. The Director further asserted that the claimant did not provide sufficiently specific information pertaining to her personal circumstances to justify the discounted settlement amount; if such information was of a "sensitive nature," she could communicate it by telephone to the District Director and shield it from unnecessary disclosure.

The ALJ was not persuaded by the Director's contentions and he approved the settlement. He stated that "[t]he ultimate issue here involves the statutory role of the Department of Labor (DOL) in administering claims under the Act and the tension between the paternalistic role taken by the DOL and the normal assumption that counsel advising claimants are competent and ethical." Order at 4. The ALJ rejected the Director's position that, as a statutory second guesser, the Department must substitute its judgment for that of the claimant and her attorney, and he concluded that "even in its paternalistic context, the Act does afford a presumption of effective assistance of counsel." *Id.* at 6. He reasoned that, by providing for automatic approval of any settlement application by a represented claimant, if no action is taken within 30 days, Section 8(i)(1) "clearly indicates that applications submitted by counsel are entitled to some level of deference not due those submitted by *pro se* claimants." *Id.* at 5. The ALJ further observed that second-guessing decisions claimant makes on the advice of counsel implies that counsel is incompetent or unethical. In discussing the standard of review to be applied by the U.S. Department of Labor in reviewing settlements, the ALJ contrasted an abuse of discretion standard with *de novo* review that would allow the DOL to exercise veto power over the choices made by a claimant on the advice of counsel. The ALJ noted several concerns associated with the latter approach. In particular, the DOL normally does not have the same information as the claimant and his or her attorney. While the general reasons given by the claimant in this case could be offered in support of virtually every settlement, revealing more specific information may cause an employer to take money off the table. The ALJ added that shielding such information from employer with *ex parte* communications is not an option for an ALJ. He

⁴ *Richardson v. Huntington Ingalls, Inc.*, 48 BRBS 107(ALJ), 2013-LHC-01317 (June 24, 2013 "Order Approving Settlement").

further observed that assessment of the litigation risk and expected value is extremely subjective, and that “[t]he individuals with the best assessment of litigation risk are Claimant and her counsel and, as with the life expectancy and future earnings issue, I do not believe Claimant or her counsel are obliged to explain to the Department the detailed specifics of the assessment of why she thinks she might lose her case.” *Id.* at 6. The ALJ concluded that the settlement application was submitted by claimant on the advice of counsel after consideration of the risks of litigation and her personal circumstances, and he approved it as adequate and not procured by duress. The Director appealed.

Noting that the ALJ’s approval of a settlement is reviewed under an abuse of discretion standard, the Board affirmed the ALJ’s order. The Board addressed and rejected the arguments advanced by the Director in support of his position that the settlement is inadequate; in so doing, it rejected the Director’s interpretation of *Oceanic Butler, Inc. v. Nordahl*, 842 F.2d 773, 21 BRBS 33(CRT) (5th Cir. 1988), controlling precedent in this case arising in the Fifth Circuit. The Board initially rejected the Director’s contention that the ALJ erred in deferring to claimant’s counsel as he was required to independently assess adequacy, regardless of claimant’s representation by counsel. It also rejected the Director’s related contention that the ALJ could not properly distinguish between represented and unrepresented claimants in determining the amount of specific information necessary to demonstrate adequacy. The Board concluded that the ALJ reasonably determined that the provision in the statute, 33 U.S.C.S. § 908(i)(1), and regulation, 20 C.F.R. § 702.243(b), which deems a counsel-negotiated settlement “approved” effectively includes a presumption that counsel is competent and ethical. Consistent with this provision, the ALJ held that a represented claimant is not required to substantiate the reasons stated for the compromise with the same specificity as might be required of an unrepresented claimant; general assertions may be sufficient if the claimant is represented by counsel who is presumed to be competent and ethical. The Board also noted the ALJ’s assessment that claimant and her counsel were in the best position to assess her risks of litigation. The Director has not shown that the ALJ’s interpretation is unreasonable or inconsistent with *Nordahl*. The Board concluded that

[a]s claimant is represented by counsel who explained the pros and cons of her choices, and as the Act contains an automatic approval provision for settlements when claimants have legal representation, absent a specific disapproval of the settlement, it was reasonable for the [ALJ] to conclude that claimant is entitled to rely on the advice of her attorney. Thus, the [ALJ] did not abuse his discretion in giving weight to the opinions of claimant and her counsel when ascertaining the settlement’s adequacy.

Richardson, 48 BRBS ___, slip op. at 9 (citation omitted).⁵

Next, the Board rejected the Director’s “primary” contention that the ALJ was required to perform an actuarial analysis to arrive at a starting point for assessing adequacy. While the court

⁵ The BRB contrasted this holding with *Bomback v. Marine Terminals Corp.*, 44 BRBS 95 (2010) (ALJ summarily approved settlement without discussing whether amount for future medical benefits was adequate; BRB vacated and remanded). The BRB noted that when medical benefits are involved, adequacy in § 702.243(f) specifically requires ascertaining the cost and necessity of future medical benefits. *Id.*, slip op. at 9-10, n.11. Here, the Director did not challenge the settlement provisions pertaining to medical benefits and attorney’s fee.

in *Nordahl* noted that determination of adequacy largely depends on actuarial tables, the regulations and case law it cited do not support this statement; e.g., only § 702.243(g) mentions actuarial tables and, then, only under certain circumstances not applicable in this case. Further, the court's statements "requiring" an actuarial analysis were non-binding *dicta* and were not applied in addressing adequacy.

Finally, the Board rejected the Director's assertion that the parties did not provide sufficient evidence for determining adequacy. The Director asserted that claimant's concerns regarding early demise and possible increase in earnings were unsupported by facts; and that claimant's reason for wanting a lump sum to help her pay debts might indicate that she agreed to the settlement amount under financial duress, especially because the type and amount of those debts were not specified. The Board observed that the settlement agreement addressed the regulatory factors for determining adequacy set forth in § 702.243(f), including probability of success if the case were litigated. The ALJ properly determined that there was risk to claimant in proceeding with litigation; he discussed employer's evidence indicating claimant's physical evaluation efforts were sub-maximal, as well as employer's assertions that it would have developed evidence showing that claimant could return to her usual work or had fewer restrictions, or that additional employment opportunities were available. The Board concluded that

[i]n light of employer's litigation strategy, claimant's acknowledgements thereof, and the fact that the [ALJ] found them credible, it is unreasonable for the Director to make judgments on the evidence as it stands to presume that claimant's success is assured and that the risk to claimant of litigating her claim is slight. The [ALJ] also noted claimant's concerns about not living until the expected age, having debts to pay, and earning increased wages in the future that would decrease her entitlement to benefits, and he rejected the Director's assertions that claimant's statements cannot be accepted without further 'specific substantiation' or some 'confidential concession.' He found that claimant and her attorney are in the best position to assess her litigation risks, her life expectancy, and her future earnings, and that neither is 'obligated to explain to the Department the detailed specifics of the assessment of why she thinks she might lose her case.' The [ALJ's] conclusion is rational.

As employer and claimant argue, the Director fails to recognize that the settlement here is a compromise between the parties that acknowledged their disputed issues – it is not employer's agreement to pay claimant a discounted portion of what claimant could obtain were she to succeed on every aspect of her claim and live to or beyond expectations. Claimant and her attorney have assessed the situation and arrived at a mutually acceptable solution, the parties' settlement addressed the factors required by the regulation, and the [ALJ] accepted claimant's generalized reasons for her decision, considering the risk of litigation.

Slip op. at 13-14 (citations to record omitted).

The Board thus concluded that the ALJ reasonably found the settlement to be adequate and not procured by duress, and affirmed the ALJ's approval of the settlement.

Prospective Medicare Set-Aside (MSA) Provisions and Finality of Settlements

It is not uncommon for the parties to submit a § 8(i) settlement application for disability and medical benefits, while their proposed MSA is pending review by the Centers for Medicare and Medicaid Services (CMS).⁶ In some cases, the parties include in their settlement application a provision that allows employer/carrier the option to void the settlement of medical benefits if the CMS requires an MSA in an amount greater than the employer/carrier would then be willing to pay. The ALJ decisions reflect different approaches to such prospective MSA provisions. In some cases, the ALJs have approved such provisions, as long as employer/carrier remained liable for medical benefits in the event that the CMS were to find the proposed MSA inadequate and the employer/carrier declined to fund a larger set-aside amount. *See, e.g., Harris v. Serv. Employees Int'l, Inc.*, 2010-LDA-00401/00402 (Sept. 21, 2010 “Decision and Order Approving Revised Settlement and Awarding Attorney Fees”).⁷ By contrast, in *Kent v. Georgia Pacific*, 2011-LHC-01474 (Nov. 16, 2012 “Settlement Rejection and Call for the Views of the Director, OWCP”), the ALJ rejected such provision, while offering the Director an opportunity to state his views on this issue.⁸ The ALJ determined that this provision is in tension with the concept of finality of Section 8(i) settlements, stating that “[t]he settlement provisions of the Act and regulations proceed on the assumption that a settlement is a final disposition. A settlement that an adjudicator approves will ‘discharge the liability of the employer or carrier, or both,’ [33 U.S.C.S. § 908(i)(3)] something the text of the proposal contemplates.”⁹ The ALJ noted that the parties “offered thoughtful arguments for their proposal” and he sought “[t]o afford the parties the opportunity for some authoritative review of their current proposal” by calling for the views of the OWCP Director. The ALJ stated that he would reconsider his rejection if the Director were to find the settlement provisions acceptable.

The Director responded, agreeing with the ALJ’s rejection of the settlement application.¹⁰ Specifically, the Director identified two problems with the provision in question. First, he opined that “[t]he proposed settlement agreement must be rejected because it does not constitute

⁶ The OWCP Procedure Manual states that: “[t]he [District Director] has no authority to require the parties to a section 8(i) settlement to obtain Medicare pre-approval, nor to deny the settlement as inadequate absent such pre-approval.” Available at: www.dol.gov/owcp/dlhwc/lsproman/proman.htm#03-0501-12. The Board adopted this position in *Bomback v. Marine Terminals Corp.*, 44 BRBS 95 (2010) (stating that “even if Medicare is applicable, there is no requirement that the adjudicatory officer require the parties to obtain Medicare pre-approval nor can she deny the settlement as inadequate for failure to obtain such approval,” citing the OWCP Procedure Manual).

⁷ In *Harris*, the ALJ stated that “[a] provision allowing for a prospective Medicare Set-Aside is not *per se* invalid, as long as the amount of compensation and medical benefits due Claimant is certain, and Employer/Carrier remain liable for medical care in the event that CMS finds the proposed MSA inadequate and Employer/Carrier decline to fund a larger set-aside amount.”

⁸ *See also Fairchild v. Homeport Insurance Co.*, 2009-LHC-00830/00831 (Oct. 22, 2009 “Order Disapproving Settlement Agreement”).

⁹ Pertinent footnote incorporated in brackets; additional footnote omitted.

¹⁰ *See* Letter from Associate Solicitor Rae Ellen James, dated 4/15/13.

a final agreement with regard to future medical benefits.” He elaborated that the provision at issue

. . . renders non-final the parties' resolution of liability for medical benefits, as they have reserved the right to reopen the agreement for the purpose of modifying it at some future date. Because the terms of the agreement provide for reopening and modification, the agreement cannot be approved under section 8(i).

Because approval of the settlement agreement would not finally discharge the liability of the Employer, it does not constitute a settlement that can be approved under section 8(i). See 33 U.S.C. § 908(i)(3); *Lawrence v. Toledo Lake Front Docks*, 21 BRBS 282, 283 (1988) (compensation order could not be considered a settlement under section 8(i) because it did not provide for complete discharge of employer's liability for payment of compensation). Thus, the proposal cannot be approved as a settlement of the claim under section 8(i). (Additional citation omitted)

Second, the Director opined that “Employer’s promise to pay the Claimant’s future medical benefits is illusory,” and therefore the proposed settlement agreement “fails to constitute a binding, enforceable agreement under general principles of contract law,”¹¹ citing *Restatement of Contracts, Second*; *Ridge Runner Forestry v. Veneman*, 287 F.3d 1058, 1061 (Fed. Cir. 2002). According to the Director,

[h]ere, the Employer has reserved for itself a choice of alternative performances. It has, in effect, promised either to pay the claimant the amount approved by CMS or to refuse to pay the amount approved by CMS. This leaves the choice of whether the Employer will pay the approved amount entirely up to the Employer. Thus, the Employer’s alleged promise is illusory, and cannot be the basis for an enforceable contract between the parties. (Citations omitted)

The ALJ did not reach the merits of these arguments, as the matter was ultimately remanded to the District Director.¹²

Structured Settlements and Assignment of Employer/Carrier’s Payment Obligation to a Third Party

Section 8(i) settlements may be in the form of a lump sum settlement or a structured settlement, *i.e.*, one that provides for continuing periodic payments.¹³ In the broader workers’

¹¹ The Director observed that the Board and the courts have recognized that contract principles apply to section 8(i) settlement agreements in the absence of superseding provisions in the Act, citing *Oceanic Butler, Inc. v. Nordahl*, 842 F.2d 773, 780-781, 21 BRBS 33(CRT) (5th Cir. 1988) (recognizing that where Act is silent on an employer's right to withdraw from an 8(i) agreement, employer could have reserved right by means of a contractual provision).

¹² The ALJ’s 11/21/13 order of remand stated that “[t]he parties have submitted an application to approve a settlement to the District Director and he issued a compensation order on July 13, 2013 that settles the claim for medical benefits before this matter was administratively remanded to OWCP. I concur with his order.”

¹³ See *Poole v. Ingalls Shipbuilding, Inc.*, 27 BRBS 230 (1993).

compensation context, structured settlements are often funded by an annuity purchased from a life insurance company and held for the claimant's benefit by employer/carrier.¹⁴ Alternatively, employer/carrier may wish to assign its periodic payment obligation under a structured settlement to a third party.¹⁵ If a "qualified assignment" is made in accordance with Section 130 of the Internal Revenue Code (IRC), all payments made to claimant are tax-exempt.¹⁶ The qualified assignment is achieved by the employer/carrier assigning its future payment obligation to a third party, typically an affiliate of a life insurance company, which, in turn, insures its risk by purchasing an annuity from its parent. It thus allows employer/carrier to eliminate a liability from its books.¹⁷ Qualification of the assignment is also important to assignment companies because without it the amount they receive to induce them to accept periodic payment obligations would be considered income for federal income tax purposes.¹⁸

Several states' workers compensation statutes regulate structured settlements by annuity.¹⁹ As one commentator observed, "[t]he major concern reflected by statutes that do regulate [such] settlements by annuity is contingent liability in the event that the annuity payer becomes insolvent or otherwise defaults on its responsibility to pay."²⁰ That same concern arises in connection with structured settlements under the LHWCA.²¹ Some states have enacted rules and regulations that provide for contingent liability of employer/insurer in case the annuity carrier or an entity to which the annuity has been assigned is unable to fulfill its obligations;²² and some also provide that the employer/carrier shall be the owner of the annuity policy.²³ Further, according to one survey, several states view the anti-assignment provisions set forth in

¹⁴ See David Torrey, *Compromise Settlements under State Workers' Compensation Acts: Law, Policy, Practice, and Ten Years of the Pennsylvania Experience*, 16 Widener L.J. 199, 375-82, 16 WIDLJ 199 (2007).

¹⁵ *Id.* at 377-78.

¹⁶ *Id.* at 377, citing 26 U.S.C.S. §130(c).

¹⁷ *Id.* at 377-80 (discussing positive and negative implications of qualified assignments).

¹⁸ en.wikipedia.org/wiki/Structured_settlement

¹⁹ 16 WIDLJ at 379-80.

²⁰ *Id.* at 370-80. The courts are mindful of the risks associated with the use of annuities to fund settlement obligations. See generally *Gilliland v. E.J. Bartells Co., Inc.*, 270 F.3d 1259, 35 BRBS 103(CRT) (9th Cir. 2001).

²¹ See generally *id.* at 380, citing John E. Kawczynski, *The Longshore and Harborworkers' Compensation Act and Its Extensions: Background and the Law of Compromise Settlements*, Workers' Compensation L. Sec. Newsl. (Pa. B. Ass'n), Jan. 2006, at 46, 53.

²² *Id.* at 380; see, e.g., Virginia Workers' Compensation Commission, Rules, Regulations, & Policies ("Structured or Deferred Settlements for Payment Under an Annuity"), available at: www.workcomp.virginia.gov/portal/vwc-website/HelpfulResources/RulesRegulations/POReq#1 (last visited 3/28/14).

²³ See Virginia Workers' Compensation Commission, Rules, Regulations, & Policies, *supra*.

their respective workers' compensation statutes as precluding qualified assignments, while several others evidently perceive no such conflict.²⁴

Presently, there appears to be little guidance on the issue of structured settlements in the LHWCA context.²⁵ It is, evidently, the Director's position that "[s]hould the carrier or any other party designated to make the continuing payments fail to make the payments, liability to make the payments shall revert to the original [employer/carrier]."²⁶ In some cases, the ALJs have rejected settlements that provided for assignment of the employer/carrier's obligation to make periodic payouts to a third party financial institution while attempting to release or discharge the employer/carrier from any future liability under the Act. *See McShane v. Ports America*, 2013-LHC-01850/01851 (Dec. 17, 2013 "Order Rejecting Settlement Agreement");²⁷ *see also Brenner v. AIS Constr.*, 2010-LHC-01391 (June 14, 2011 "Order Tentatively Disapproving Settlement");²⁸ *Goble v. Oshkosh Truck Co.*, 2009-LDA-00071 (Feb. 4, 2009 "Order Disapproving Settlement Agreement").²⁹ In other cases, the ALJs have required evidence of the

²⁴ Stephen J. Dionisio, *Munich Reinsurance Am., Inc., Workers' Compensation Claim Settlements*, pp. 39-43 (2001), available at www.amre.com/content/rl/workers_compensation.pdf (last visited March 2009); *see also* 16 WIDLJ at 382.

²⁵ The OWCP Procedure Manual (3-501) contains the following rather incongruous statement:

A settlement may also be "structured" in that payment of the agreed settlement may extend over the lifetime of the claimant and may even involve the use of annuity policies issued by life insurance companies to provide continuing payments. It is recommended that the following or similar language be contained in all structured settlement orders to assure that only upon the continued payment to the claimant of the agreed upon settlement shall the liability of the EC be discharged: 'Upon payment of the aforesaid monies, the employer and carrier shall be forever discharged and released of any further liability for payment of compensation to the employee under the Longshore and Harbor Workers' Compensation Act'. Should the carrier or any other party designated to make the continuing payments fail to make the payments, liability to make the payments shall revert to the original EC.

www.dol.gov/owcp/dlhwc/lsproman/proman.htm#03-0501-04

²⁶ *See* OWCP Procedure Manual (3-501), *supra*.

²⁷ In *McShane*, the ALJ stated that: "[t]he Settlement Agreement provides for the funding of an annuity which would relieve Respondents of any liability for payments to be paid by the annuity insurer. I advised the parties that that provision is unacceptable and that Respondents cannot be relieved of the liability for paying the annuity amounts in the event, though unlikely, that the annuity insurer fails to make the payment." A revised settlement, which addressed the ALJ's concerns, was ultimately approved in this case.

²⁸ In *Brenner*, the ALJ tentatively disapproved the settlement application as it provided for assignment of employer/carrier's obligation to fund an MSA to an annuity seller. Thereafter, the parties evidently submitted a revised settlement that was approved by the ALJ.

²⁹ In *Goble*, the originally submitted settlement provided for a "qualified assignment" to an annuity company of the employer's payment obligation such that "[a]ssignee shall be the sole obligor with respect to the Periodic Payments obligation, and that all other releases with respect to the Periodic Payments obligation that pertain to the liability of the Employer and the Carrier shall thereupon become final, irrevocable and absolute." In response to the ALJ's 2/4/09 order, the parties submitted a revised agreement, which provided that "[i]f the annuity company shall fail to pay benefits as stated herein, the responsibility to pay the benefits stated herein shall revert to the Employer and Carrier." In his 3/27/09 "Notice of Deficiency and Order to File Briefs," the ALJ noted that this provision appeared to conflict with the terms of an addendum containing annuity terms, which provided for "complete[] release and

ability of a third party financial institution to satisfy the payment obligations under the § 8(i) settlement. *See, e.g., Barr v. Bath Iron Works Corp.*, 2014-LHC-00261/00646/00647 (Feb. 21, 2014 “Decision and Order Approving Settlement and Canceling Hearing”).³⁰

Attorney’s Fees as a Factor in Determining Adequacy of Settlement Amount

As the following cases demonstrate, the amount allocated in a settlement application to attorney’s fees may raise a concern regarding the adequacy of the settlement amount. In *MacKenzie v. Civilian Police Int’l*, 2012-LDA-00237 (Mar. 7, 2013 “Order Denying Application For Approval of Settlement”), the parties’ proposed settlement provided for a payment to claimant of \$200,000.00 for all past and future benefits of any kind, \$100,000.00 in attorneys’ fees and costs, and \$30,000.00 for a BCBS lien. The parties informed the ALJ that the carrier “had its figure for settlement” and was less concerned with the division of the proceeds between claimant and his attorney. The ALJ then issued a notice of deficiency regarding “considerable attorneys’ fees” and requested an explanation of why a co-counsel was necessary in this case. Claimant’s counsel responded that unique medical issues presented by this case exceeded his expertise. The ALJ, however, rejected this explanation in light of the counsel’s extensive expertise and ability in handling disability claims. The ALJ concluded that while the total sum is adequate, “the division of settlement proceeds between Claimant and his lawyers has resulted in an excessive amount to counsel and an inadequate amount to Claimant.” The ALJ ultimately approved a revised settlement, whereby employer paid \$235,000.00 to the claimant, \$65,000.00 to the claimant’s counsel, and \$30,000 for the BCBS lien. *Cf. Cooper v. Service Employees Int’l*, 2012-LDA-00428 (Mar. 7, 2013 “Order Approving Settlement”) (use of co-counsel to attend local depositions justified, as it saved claimant’s attorney travel time and costs).

Itemization of Past Medical Expenses Under Section 702.242(b)(7)

20 C.F.R. § 702.242(b)(7) provides that a complete settlement application that covers medical benefits must include “an itemization of the amount paid for medical expenses by year for the three years prior to the date of the application;” this requirement may be waived for “good cause.” In *Hoke v. DynCorp Int’l*, 2012-LDA-00467 (Jan. 6, 2014 “Order Disapproving Settlement Application”), the ALJ rejected the parties’ settlement application due to various deficiencies, including failure to comply with § 702.242(b)(7). The parties sought reconsideration of this finding on the grounds that the claim was originally controverted in its entirety and therefore “no annual itemization of paid medical expenses was included because

discharge [of] the Employer and the Carrier from the Periodic Payments obligation assigned to [annuity company].” The parties declined the ALJ’s invitation to brief this issue and instead amended the settlement to provide for a lump sum payment without an annuity.

³⁰ In approving the settlement application in *Barr*, the ALJ observed that “[t]he parties were represented by experienced counsel and agreed to resolve their differences through the use of a structured settlement,” and that “[e]mployer has provided an affidavit from the structured settlement broker attesting to the financial strength rating ascribed to the annuity company, as well as the guarantee provisions.” In the attached affidavit, the structured settlement broker stated, *inter alia*, that the structured settlement had been placed with Liberty Life Assurance Company of Boston, which is “ranked highly for financial strength” by A.M. Best (“A” rating) and Standard & Poor’s (“A-” rating) and is backed by a written guarantee from its parent company, Liberty Mutual Insurance Company.

none of Claimant's medical bills were paid by Employer/Carrier and because 20 C.F.R. § 702.242(b)(7) requires only the amounts *paid* in the claim." The ALJ rejected this limiting interpretation of the regulation, and concluded that the parties seeking to settle past medical expenses must provide an itemization of all medical treatment expenses paid in the past three years, whether paid by Employer/Carrier, Medicare, other health plans or by Claimant, as well as information regarding any unpaid medical bills. *See* 20 C.F.R. §§ 702.242(b)(7), 702.243(f); *see also* OWCP Procedure Manual at 3-501.³¹ The ALJ noted that the parties' interpretation would only require information as to amounts actually paid by employer, regardless of the facts of a particular case and whether or not the claim was accepted as compensable. The ALJ concluded that the law and the regulations do not support this interpretation. Further, on the fact of this case, the fact that the claim was controverted did not obviate the need for complete information as to past medical expenses, in light of conflicting evidence as to the work-relatedness of the claimant's injuries.

Stipulations Seeking to Bypass Section 22 Modification

In *Mitri v. Global Linguist Solutions*, 2012-LDA-00578 (July 12, 2013 "Order Denying Director's Motion for Reconsideration"), the OWCP Director requested reconsideration of an ALJ decision and order awarding TTD benefits based on the parties' stipulations. As formulated by the ALJ, the issue on reconsideration was whether a judge can approve stipulations for the payment of ongoing TTD compensation that permit the employer and carrier unilaterally to terminate or reduce compensation upon:

- the claimant's return to (full duty) work, or
- a physician's finding the claimant has reached maximum medical improvement, plus a labor market survey that show available work within the claimant's permanent restrictions

without first obtaining an order under § 22 of the LHWCA (33 U.S.C.S. § 922) to modify the interim order. The Director contended that the stipulation is contrary to law, because the sole way to terminate or decrease compensation the employer/carrier has been ordered to pay is through a modification proceeding under § 22. The parties countered that the stipulations represented a "bargained-for exchange."

³¹ The OWCP Procedure Manual states:

[i]f the settlement application covers medical benefits, an itemization of the amount paid for medical expenses by year for the three years prior to the date of the application shall be included. A statement in the application to the effect that the employer/carrier has not paid for any medical treatment in the past three years is not sufficient. The parties should be required to provide an itemization of all medical treatment expenses paid in the last three years, whether paid by employer/carrier, Medicare, other health plans or by the claimant, as well as itemization of all unpaid medical bills.

At the outset, the ALJ recognized that “[e]fficiency favors the stipulations” -- the stipulations obviated the need for a trial on the TTD issue, the claimant promptly received benefits, and the parties memorialized how they would deal with changes in the claimant’s medical condition or work status in the future. Further, the stipulations did not preclude the claimant from returning to the OALJ for a full adjudication. Nevertheless, the ALJ ultimately agreed with the Director’s view that the stipulations are improper. The ALJ observed that § 15(b) of the LHWCA (33 U.S.C.S. § 915(b)) limits the parties’ freedom of contract in stating that “no agreement by an employee to waive his right to compensation under this Act shall be valid,” and he noted that this limitation “has nothing to do with efficiency.” The ALJ further reasoned that

[s]trictly speaking the Stipulations only vary the time of payment; the Claimant hasn’t waived the right to receive whatever compensation the statute sets. Section 22 delays the Employer/Carrier’s opportunity to reduce compensation until the district director or an [ALJ] entered a modification order. The Stipulations accelerate the reduction, yet preserve the Claimant’s right to challenge it. This time delay, in the Director’s view, plus dispensing with the normal modification procedure, is impermissible under § 22.

While the ALJ agreed with the Director’s interpretation of the Act, he strategically denied the Director’s motion for reconsideration, stating that the only practical way for the Board to reach this recurrent issue would be for the Director to seek review of this denial by the Board. The Director’s appeal of the ALJ’s order is presently pending review by the Board.

Stipulations Consistent with Law Are Binding

In *Beach v. Ceres Marine Terminals, Inc.*, BRB No. 13-0507 (May 16, 2014) (unpub.), the Board discussed the effect of stipulations executed by claimant and employer. The parties filed stipulations with the District Director seeking to modify a prior ALJ award, and the District Director ultimately issued a compensation order based on the stipulations.³² Claimant appealed the compensation order, challenging the date his disability was found to be partial. The Board stated that stipulations are offered in lieu of evidence and therefore may be relied on to establish an element of the claim; it noted the Fourth Circuit’s statement that, when it comes to a stipulated fact, one party need offer no evidence to prove it and the other is not allowed to disprove it. Stipulations are generally binding upon those who enter into them, but are not binding if they evince an incorrect application of law. In affirming the District Director’s order, the Board reasoned that

[w]e reject claimant’s assertion that the stipulation that claimant is partially disabled is not binding because employer’s labor market survey is deficient. The evidence of suitable alternate employment and the degree of claimant’s loss of wage-earning capacity are facts to which the parties stipulated. Whether employer’s evidence would be sufficient to establish suitable alternate employment if the claim were adjudicated is not relevant to the district director’s acceptance of the stipulation as between the private

³² The District Director initially declined to accept stipulations as they related to employer’s Section 8(f) application; she then approved the amended stipulations that addressed concerns related to § 8(f) relief.

parties. Moreover, the stipulation does not involve an incorrect application of law. Thus, claimant is bound by the stipulation that he is partially disabled.

Slip op. at 4 (citations and footnotes omitted).

As the foregoing discussion demonstrates, review of settlements and stipulations in Longshore claims may require the ALJs to interpret the law and regulations, as well as exercise their discretionary authority. Notably, the cases discussed above reflect the ALJs' willingness to invite the views of the parties, and at times the views of the OWCP Director, when presented with challenging issues in this context.