A Reference and Guide

Peter M. Lencsis

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Peter M. Lencsis

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Introduction

Workers compensation in the United States is a combined governmental and private insurance program that provides benefits to most workers who suffer work-related injuries and disabilities. In 1995 there were approximately 3.6 million disabling workplace injuries in the United States, and private workers compensation insurance accounted for approximately $30 billion of a total of $131 billion that U.S. insurance companies collected in commercial property and casualty premiums. It represented a larger portion of that $131 billion than any other kind of commercial liability insurance, such as general liability or automobile. If state-sponsored insurance funds and employers' self-insurance programs are also taken into account, workers compensation in the United States currently represents a total expenditure of approximately $42 billion per year, roughly the same amount as the gross domestic product of Egypt or Ireland.

Workers compensation is a no-fault social insurance concept, similar to no-fault automobile insurance, that mandates the payment of statutorily defined medical, disability, and other benefits to injured employees without regard to fault as a cause of the accident in question. Tort actions against employers are almost entirely eliminated. In general terms, workers compensation laws make employers liable for accidental injuries to employees that arise out of and in the course of their employment (and for certain job-related diseases), regardless of the presence of fault on the part of the employee or the employer, and regardless of the absence of fault. In

exchange for this no-fault liability, which frequently makes employers liable for unavoidable accidents and other situations in which they would have no liability under tort principles, employers' liabilities to employees are limited to fixed statutory amounts that may not actually represent full compensation for lost wages and ordinarily provide no compensation at all for pain and suffering or other non-economic damages. This limited liability is usually referred to by calling workers compensation the employee's exclusive remedy against the employer. In most states, the liability is enforced by an administrative agency rather than the courts, so that entitlement to workers compensation is determined without litigation in the usual sense.

Originally called workmen's compensation laws, and, as that name suggests, many of the statutes enacted in the early part of this century applied only to workers (mostly men) engaged in hazardous employments, such as heavy manufacturing, mining, and construction. Today the terms "workmen" and "workman" are inappropriate in this field not only because females represent a large portion of the workforce but also because men and women in most kinds of employments, manual and non-manual, are usually covered by the laws. Probably the most nearly correct term to use today would be "employees' compensation," because coverage of the laws is invariably limited to persons who have the legal status of employees; that term is not used, however, because it is suggestive of salary and fringe benefit structures.

Another component of the tort-versus-compensation trade-off is the requirement that employers purchase and maintain insurance to cover all of their workers compensation liability exposures (something like compulsory automobile insurance) unless they can qualify as self-insurers on the basis of their extraordinary financial ability. Premium rates for different categories of employment are determined by the collection and analysis of detailed statistics with reference to the expected losses or claims for each category.

This introductory description might suggest a fairly simple workers compensation system, but that misimpression is easily dispelled by a few more general observations about workers compensation. There are many different, nonuniform workers compensation laws in the United States — state, territorial, and federal. The state and territorial laws, which exist in every state, Puerto Rico, and the U.S. Virgin Islands, are especially nonuniform in terms of which kinds of employments are covered, and with regard to dollar amounts of wage loss benefits payable for different kinds and degrees of disability. Many questions arise under these laws, related laws, and other kinds of insurance policies as to what payments are

due from workers compensation as opposed to general liability insurance, health insurance, disability insurance, automobile no-fault, Social Security, Medicare, and other sources.

The federal laws cover special kinds of employments such as seamen, longshore and harbor workers, interstate railroad employees, underground coal miners, and federal employees. The coverage of state laws versus federal laws, and of one state law versus another state law, is frequently a constitutional issue as well as one of statutory interpretation. Exactly which kinds of employees are covered for what kinds of accidents and while performing what duties under any particular statute is a matter of considerable complexity in itself.

Furthermore, even when a person engaged in a particular kind of work and injured by a particular kind of accident is clearly covered under a statute, there may be a question whether that person is an employee (versus an independent contractor, not covered by the statutes). The same kinds of issues that arise in taxation, unemployment compensation, and employment discrimination law present themselves in this regard. Also, the standard and fairly innocuous sounding definition of job-related accidents — those arising out of and in the course of employment — has developed over time into a rather abstruse concept relating to accident causation, subject to different interpretations by different courts, administrative agencies, and scholars.

In addition to the workers compensation laws themselves and the liabilities they create, this book describes the insurance and self-insurance vehicles that have been created to pre-fund those liabilities (in notable contrast to Social Security and Medicare) and to guarantee or virtually guarantee that injured workers and the survivors of deceased workers will receive the compensation due to them regardless of the financial vicissitudes of the responsible employers or even of those employers' insurance carriers. In addition to guaranteeing the payment of benefits, the insurance mechanisms in particular (which account for most of the funding of the system) are designed to pass through the costs of job-related accidents and illnesses to employers and their customers or constituencies in an equitable fashion, somewhat like taxes, and with a degree of detail that is reminiscent of taxation schemes. The development and application of workers compensation premium classifications and rates is a highly technical subject that mirrors in its complexity the coverage and benefit structures of the various state and federal laws.

This text is intended for educational and reference use by managers responsible for human resource and risk management matters, by insurance and legal professionals, and by students of insurance. The basic

organization of the book involves four parts: Chapters 1 through 3 deal with the various statutory and other liability exposures that employers encounter; Chapter 4 outlines benefits and claims; Chapters 5 through 7 deal with coverages and security mechanisms; and Chapter 8, which is devoted to important current topics, includes the role of managed care in workers compensation and the possibility that, in the near future, by the elimination of the dichotomy between work-related and non-work-related injuries and diseases, workers compensation will cease to be a system in itself and will become an integrated part of a larger or universal social security program.

This book is dedicated to the author's partner, Robert K. Gale, M.D., and his patients, past and present.

Note: The National Council on Compensation Insurance, Inc. and a number of other insurance organizations have adopted the practice of spelling the terms "workers compensation" and "employers liability" without any apostrophes. That practice is generally followed in this book.

1

History of Workers Compensation Laws

THE LAW OF TORTS AND NEGLIGENCE IN THE EMPLOYMENT CONTEXT

From a legal point of view, the background against which workers compensation must be viewed is the law of torts and negligence and a basic understanding of that background is, therefore, essential to an understanding of workers compensation. The Anglo-American law of torts and negligence developed over centuries and is largely the product of judicial decisions, which is an unusual phenomenon as compared with the legal systems of Continental Europe, which are based upon legislated codes. Tort and negligence concepts are part of the common law of England, which was retained after the American Revolution as the basic foundation of American jurisprudence.

A tort is usually defined as a civil wrongdoing that gives rise to a cause of action, or claim, for money damages. The cause of action is, of course, asserted in an action or lawsuit and the case is tried before a jury. (The practice of using jury trials in civil and criminal cases also developed in England over a period of centuries and is a complex subject in itself.) Tort law is divided into three categories: intentional torts (assault, battery, defamation, false imprisonment, invasion of privacy, and so forth); negligence; and strict liability, which includes liability for ultrahazardous activities and certain kinds of products liability.[1]

For the purposes of this book, negligence is the most important of these concepts, and it may be defined as a failure to use reasonable care to prevent injury (physical or otherwise) to another person, which proximately causes injury to that other person. Liability for negligence can be direct or vicarious (indirect). Vicarious liability is the result of the doctrine of *respondeat superior,* which states that a principal or employer is generally liable for the acts of his or her agent or employee, so long as the acts are within the scope of the principal-agent or employer-employee relationship.

Reasonable care is a somewhat artificial concept based upon what a theoretical exemplary or model citizen would do in the circumstances being considered. The "reasonable person" has been described as "a prudent and careful person, who is always up to standard" and as "a personification of a community ideal of reasonable behavior, determined by the jury's social judgment."[2] In any negligence case, the jury's functions are to determine: first, what happened; then, whether the various parties acted as reasonable persons under the circumstances; and finally, if there was negligence, to award an amount of money damages to compensate the injured party.

Compensation by the payment of damages is an effort to make the plaintiff whole, that is, to restore the plaintiff as nearly as possible to his or her condition before the accident. It therefore includes reimbursement for all out-of-pocket expenses such as those for medical treatment, payment for lost wages, and payment for pain and suffering. This last category requires the jury to determine what amount of money is sufficient to compensate the plaintiff for past and future physical and mental suffering and loss of the quality and enjoyment of life.

The whole subject of negligence, damage awards, and jury trials as applied to personal injury cases has become quite controversial in recent years, as evidenced by the automobile no-fault movement that began in the 1970s and the tort reform trend of the 1980s and 1990s. As discussed below, these innovations modify the tort system but they do not fundamentally or broadly replace it. Workers compensation, in contrast, derives from the first two decades of this century and represents a radical departure from the tort system on a nearly universal scale for a particular class of personal injuries, namely those that are work-related.

The industrial revolution of the eighteenth and nineteenth centuries had two aspects that eventually led to the abandonment of negligence concepts and actions for damages by employees against employers. First, industrial work was much more dangerous than agricultural or mercantile work had been in previous centuries. Machines, factories, railroads, and the

other accoutrements of the industrial age exposed workers to new and heightened dangers. Second, society became generally more concerned with the welfare of the unfortunate, and it became socially unacceptable for injured and disabled workers in particular to be left without medical care or a source of income. Therefore, first in Germany and then in England and the United States, concepts of fault gave way to no-fault compensation principles in the employment context.

Under the traditional rules of negligence, if the injured party (the plaintiff in a lawsuit) had been the least bit negligent in trying to prevent injury to himself, even if the defendant was overwhelmingly negligent in comparison, the action would fail under the rule of "contributory negligence."[3] If the plaintiff knew that he was being exposed to a dangerous condition, but nevertheless allowed himself to be so exposed, the case would fail under the rule of "assumption of risk."[4] Both of these rules applied in the employment context as well as others, so that an injured employee could easily be found guilty of contributory negligence or of assuming the risk with regard to many kinds of workplace accidents.

Employees were also subject to the "fellow servant" rule, which said that, despite *respondeat superior*, there could be no recovery against the employer for the negligence of a fellow employee. (The origins of this rule are somewhat obscure, but one theory is that the risk of a fellow employee's negligence was a risk "assumed" by the injured employee. Another theory holds that judges invented the rule because they simply did not favor lawsuits by employees against employers.)[5] Whatever its origins, the fellow servant defense was fatal in a large number of cases, because in ordinary circumstances the plaintiff's case would be based upon the employer's vicarious liability for another employee's negligence. The rule was later softened to some extent by the "vice-principal" corrolary, which held the employer liable if the fellow servant in question was a high-ranking or supervisory employee.[6]

These three rules, which automatically cause the plaintiff to lose his or her case, are called defenses to a claim based upon negligence (just as, for example, self-defense and insanity are defenses to a charge of murder). They are sometimes called, from the plaintiff's point of view, the unholy trinity of common-law defenses to negligence. Even if all three could be avoided in a particular case, an injured employee still faced two major, practical hurdles in recovering any damages: expense and delay. Contingent fee arrangements with attorneys are a relatively recent development, and as of the early part of this century, an injured employee, or any injured person of modest means, might not be able to afford to pay attorney fees in advance of obtaining a recovery. Also, even if the plaintiff could afford

to bring a lawsuit, it would take a considerable amount of time, sometimes years, to reach a conclusion. There would be no funds available to pay medical or living expenses during the period immediately following an accident, when they might be needed most.

Of course, suing one's current employer is and always was a rather delicate matter, to say the least. An action based on negligence implies fault, moral and otherwise, on the part of the employer. In the absence of an employment contract or collective bargaining agreement, there was nothing to prevent a litigating employee from being discharged or from being refused reinstatement after a period of disability in retaliation for the employee's legal action impugning the integrity of the employer. Also, factual questions of fault in the employment context often involve the need for co-employees to serve as witnesses, which in turn leads to conflicting testimony and resulting friction among members of the work force.

The rules of negligence apply between strangers as well as between a business and its customers, between a business and its employees, and in other situations in which the parties have a pre-existing relationship. For example, a driver of an automobile has a duty to act with reasonable care toward the drivers and occupants of other vehicles on the road, even if they are complete strangers (or, for that matter, even if they are personal enemies). Similarly, the owner of a supermarket or department store has a duty to keep the aisles or sales areas properly lighted and the floors clean so that customers, whether first-time or not, do not fall and injure themselves. An employer generally has a duty to use reasonable care to prevent injuries to his or her employees. This duty can be broken down into more specific duties, such as: to provide a reasonably safe workplace and reasonably safe tools and equipment; to warn of unexpected dangers associated with the work, such as dangerous machines or chemicals; to provide a sufficient number of suitable fellow employees; and to make and enforce suitable workplace rules.[7]

All of these duties have been established by court decisions over a period of decades or longer, and are referred to as common law (as opposed to statutory) duties or responsibilities. A breach of any of these duties, combined with proximate cause and actual injury, creates common-law liability for negligence. (Proximate cause is a fairly complex notion in itself, but basically it means that the injury must not be too remote from what the defendant did or failed to do, or in other words, that it must be "foreseeable" from the defendant's point of view.)[8] In the absence of a workers compensation law, an employee injured by negligence attributable to his or her employer (that is, either the direct negligence of an

individual employer, or the negligence of another employee or employees for whose acts the employer is responsible under the rule of *respondeat superior*) can recover damages, including past and future medical expenses, lost income, and pain and suffering.

These kinds or categories of damages require some further discussion, because the essence of the workers compensation idea is the substitution of limited compensation for common-law damages. As mentioned above, damages, also called money damages, are intended to restore the plaintiff, as completely as the payment of money can, to the position he or she would have been in if the injury had not occurred. These damages are called compensatory, as opposed to punitive damages, which are intended to punish the defendant for intentional wrongdoing or especially irresponsible conduct.

Full damages recoverable by a severely injured person with a high pre-accident earning capacity can easily run into the millions or tens of millions of dollars. Extremely high jury verdicts in personal injury cases are well publicized. The situation under workers compensation is much different because, although medical expenses are fully recoverable, juries are not involved in determining entitlement to or the amount of compensation; lost income is compensated subject to strict dollar limitations; and pain and suffering are generally not compensated *at all*.

STATUTORY NO-FAULT LIABILITY AS A SUBSTITUTE FOR TORT REMEDIES

The invention of workers compensation as it has existed in this country since about 1910 involves a classic social trade-off or, to use a Latin term, a *quid pro quo*. Something is given in exchange for something else. What is given to the injured employee is the right to receive certain limited benefits regardless of fault, that is, even in cases in which the employee is partially or entirely at fault, or when there is no fault on anyone's part. What is taken away is the employee's right to recover full tort damages, including damages for pain and suffering, in cases in which there is fault on the employer's part.

What is given includes something very valuable: the certainty that funds will be available to pay the benefits by virtue of compulsory insurance coverage (or approved self-insured status) for all employers. Therefore, stated differently, what is given is guaranteed partial compensation, and what is taken away is non-guaranteed full compensation for occupational injuries. Of course, the term "compensation" must be used somewhat loosely in this regard, to include what amounts to gratuitous benefits

in cases in which the employee would have no right to damages under common-law principles.

The abolition of the employee's common-law remedies against his or her employer is referred to as the exclusive remedy rule, which is discussed fully in Chapter 3. It can also be described an an immunity conferred on the employer. Workers compensation becomes the employee's exclusive or sole remedy against the employer for injuries within the scope of the law (an extensive subject in itself, also discussed in Chapter 3). Significantly, compensation does not prevent the employee from suing parties other than the employer, although overlapping recoveries are normally not permitted.

GERMANY, ENGLAND, AND THE UNITED STATES BEFORE 1910

Workers compensation as it ultimately materialized in the United States had two sets of origins in the laws of Germany and of England.[9] The English legal background was the traditional body of negligence law as applied to the master-servant relationship. Modifications in the law of negligence, particularly the defenses available to an employer in a negligence case, were made through "employer's liability" acts, which were intended to prevent harsh results in negligence cases. The German legal background, on the other hand, involves a much more radical departure from negligence concepts in that it introduces the innovative principle of shared social responsibility for industrial accidents. In Germany we find the origins of the distinctive idea that accidents connected with employment should be compensated regardless of the presence or absence of negligence or other fault.

A concept quite similar to workers compensation had been the subject of legislation in Germany, or more specifically in what was then called Prussia, as early as 1838.[10] That legislation was in the nature of a strict or absolute liability law applicable only to railroads, which provided that railroad employers were responsible for all accidents that were neither unavoidable nor the worker's fault. The legislation was later extended to other kinds of industrial employment, but only if negligence on the employer's part could be shown.

In 1884, in recently-unified Germany under Bismarck, a true no-fault law called the Accident Insurance Law was enacted.[11] The original German plan was intended in part as a response to socialistic tendencies within the labor movement. It involved contributions by employers and employees to various industry-specific accident insurance funds under the

supervision of the government. Requiring contributions from employees was related to the earlier practice of member contributions to benefit funds sponsored by trade guilds, and it is a feature that the German system retains to this day (see below). The now-familiar basic structure of benefits, consisting primarily of all medical expenses and two-thirds of lost wages, was part of the original German plan.

Meanwhile, in England the common-law defenses of employers had been modified to some extent in 1880 by an Employers' Liability Act, which provided that supervisory workers were not to be considered fellow servants for purposes of applying the fellow-servant defense.[12] Similar laws were also enacted in various states of the United States. Following the German example, the English Parliament then adopted a true no-fault law called the Workmen's Compensation Act of 1897, in which the phrase "arising out of and in the course of employment" was first used to describe the kinds of employment-related accidents that were covered.[13] The English law originally applied only to hazardous employments and contained no insurance or funding requirements. It was extended to most other kinds of employment in 1906 and became the model for New York and, in turn, other U.S. jurisdictions.

NEW YORK AND OTHER U.S. JURISDICTIONS (1910–1949)

Prior to 1910, Maryland, Montana, and Massachusetts had enacted workers compensation laws that were limited to certain industries or that applied only if agreed to by the employer and employee.[14] These laws were of little importance. Also, at President Theodore Roosevelt's request, Congress enacted a workers compensation law for a limited class of federal employees in 1908.[15] That law was later expanded to cover all federal civilian employees and is now known as the Federal Employees' Compensation Act. Congress also enacted the original Federal Employers' Liability Act, a comparative-negligence law applicable to railroad employees, in 1906. It was held to be unconstitutional inasmuch as it applied to wholly intrastate commerce,[16] so another Federal Employers' Liability Act limited to railroads engaged in interstate commerce was enacted in 1908 and has remained in effect since then.[17]

In 1910, following a study by the legislatively-mandated Wainwright Commission, New York was the first U.S. jurisdiction to enact a widely applicable, mandatory workers compensation law (which was nevertheless limited to enumerated "hazardous" employments).[18] The basic features of that law — a requirement that statutory benefits be paid

regardless of fault and the elimination of the employee's tort cause of action against the employer — were the same as those that are contained in other states' laws today. The law of 1910 in effect required employers to pay money to injured workers in circumstances in which they previously had no obligation to pay, and this sudden alteration of the property rights of employers led to a constitutional challenge in the state courts. At the same time that it enacted a mandatory law, the New York legislature also enacted a contractual-elective law applicable to most employments, but it was never utilized to any appreciable extent.[19] (A contractual-elective law allows the employer and each employee to agree in advance that compensation, rather than tort, will apply. Optional-elective laws, discussed below, give the employer an option to accept or reject the compensation scheme as to all employees.)

In the case of *Ives* v. *South Buffalo Railway*,[20] decided in 1911, the New York Court of Appeals (the state's highest court then and now) decided that the entire mandatory workers compensation law of 1910 was unconstitutional and invalid because, in taking away employers' money when they had done nothing wrong, it deprived them of property without "due process of law," as guaranteed by the Fourteenth Amendment of the federal constitution and by the New York State Constitution. Judge Werner, who authored the court's unanimous opinion, did not hesitate to describe the new law as "radical" and "revolutionary." Ironically, the very day after the *Ives* decision was rendered, a tragic fire in a New York City garment factory called the Triangle Waist Factory killed approximately 150 workers. The publicity and public sentiment that resulted from the fire is generally associated with proposals for, and the eventual enactment of, an amendment to the New York State Constitution, now known as Article 1 Section 19, effective in January 1914. That amendment provides in part that: "Nothing contained in this constitution shall be construed to limit the power of the legislature to enact laws . . . for the payment . . . of compensation for injuries to employees or for death of employees resulting from such injuries without regard to fault as a cause thereof . . . or to provide that the right of such compensation, and the remedy therefor shall be exclusive of all other rights and remedies for injuries to employees or for death resulting from such injuries."[21] The mandatory workers compensation law was then reenacted with some changes, to become effective in July 1914. The changes included a provision requiring employers to meet their obligations either by purchasing insurance (from a private insurer or from the newly-created State Insurance Fund) or by qualifying as a self-insurer. The new law was upheld by the Court of Appeals in 1915.[22] In the meantime, in view of constitutional doubts raised by the *Ives* decision,

nine states, including Iowa, enacted elective laws, and only one state, Washington, enacted a mandatory law in 1911.[23]

The final hurdle was the challenge presented to the 1914 law in the case of *New York Central Railroad* v. *White*,[24] decided by the United States Supreme Court in 1917. In that case and two other cases decided on the same day,[25] the court upheld the New York law, the Iowa elective law, and the Washington mandatory law under federal constitutional standards. The central point of the *White* decision was that New York could constitutionally change common-law rules of liability so long as the change was accompanied by a substitution of other just rules in their place. The court found that the new scheme was a "just settlement of a difficult problem"[26] which, judged in its entirety, did not offend constitutional principles of fairness and justice. Largely as a result of the *White* decision, 42 states had enacted workers compensation laws by 1920, and every state then in the union had such a law by 1949.[27]

In the early years of workers compensation, constitutional "cold feet" caused many state legislatures in the first instance to enact workers compensation laws that were either limited to certain hazardous employments or elective on the part of employers. The limitation to hazardous employments, such as mining or factory work, was thought to be dictated by the principle that each state's police power includes the power to regulate matters concerning public health and safety. If the safety of workers in dangerous occupations could be regarded as the primary subject matter of the legislation, it was thought, then the legislation was more likely to be valid.

Secondly, many states' laws initially provided that each employer was free to make an election, accepting or rejecting the no-fault compensation system as to its own employees. If the employer accepted the system, its liability to all employees was limited to the statutory benefits; if it rejected the system, it could be sued for damages on the basis of negligence, and the common-law defenses would not apply. Laws of this variety were thought to represent a less radical change from common-law principles and, therefore, to be more likely to withstand constitutional challenge.

Gradually, as the laws were amended over the years, virtually all employments came to be covered, whether hazardous or not (except for the commonly excepted categories of agricultural workers and domestic servants), and almost all of them became mandatory. Significant vestiges of the elective law concept have remained in New Jersey (where the law is, nevertheless, as a practical matter, mandatory), South Carolina (where the law was elective until 1997), and Texas.[28]

THE NATIONAL COMMISSION ON STATE WORKERS' COMPENSATION LAWS (1972)

One of the results of the federal Occupational Safety and Health Act of 1970[29] was the creation of a temporary National Commission on State Workers' Compensation Laws, whose purposes were to study possible inadequacies in existing state laws and to make recommendations for changes. It is commonly observed that the National Commission's findings led to refinements in the U.S. system rather than radical changes (such as the establishment of a federal compensation law of universal application or the elimination of private insurance coverage).[30] The National Commission issued a report that contained 84 recommendations, of which 19 were called essential. Among the essential recommendations were the following: mandatory, as opposed to elective, application of all state laws; coverage of all employers, regardless of the number of employees; coverage of all employees, including at least some farm workers and domestic workers, and all government employees; coverage for all work-related diseases; income benefits based upon at least 66-2/3 percent of pre-accident wages; maximum weekly benefits based upon at least 66-2/3 percent of the state average weekly wage; lifetime benefits for total disability; and no time or dollar limits upon medical or rehabilitation benefits.

In a similar vein, shortly thereafter the federal government created an Inter-Agency Workers' Compensation Task Force, which issued its own report in 1976. That report also suggested a need for extensive reforms at the state level, with federal monitoring and technical assistance. Largely as a result of these reports, many state laws were substantially amended to an extent that may be statistically characterized as a national, overall 64 percent acceptance of the 19 essential federal recommendations as of 1988.[31]

WORKERS COMPENSATION IN OTHER NATIONS

According to a study by the American Insurance Association,[32] 136 countries around the world had a workers compensation system of one kind or another as of 1989. It appears that workers compensation is viewed as a necessary, basic social welfare arrangement, even in many countries that have no other forms of social benefits. Some of these systems, especially in highly developed countries, are integrated in varying degrees with broader social security or welfare programs, to such an extent that workers compensation ceases or virtually ceases to exist as a

distinct program. In most countries other than the United States, Canada, and Australia, there is a single, national workers compensation program (or component of other national programs). In the three countries mentioned, which have federal systems of government, workers compensation is decentralized, that is, it is generally organized at the state, provincial, or territorial level rather than at the national level, and its details differ considerably from one state, province, or territory to another.

Major differences exist among the systems worldwide, especially with regard to the presence or absence of an exclusive remedy provision (which, when it exists, prevents lawsuits against employers — see Chapter 3) and the use of private insurance coverage as opposed to public insurance or funding, or the integration of workers compensation into much broader social programs. The New Zealand system of "accident compensation" is unique and arguably the most advanced because it applies to almost all accidents, including automobile accidents, accidents in public places and at home, as well as medical "misadventure" (malpractice). For illustrative purposes, following is a synopsis, based mostly on the above-mentioned American Insurance Association report, of the system currently or recently in place in seven selected countries.

Canada

Each Canadian province has its own workers compensation law and provincial insurance fund. There is no private insurance company involvement. Provincial health care systems are used to provide medical treatment, with reimbursement being made to the provincial systems by the workers compensation boards. An unusually high level of income-replacement benefits is provided: 90 percent of pre-accident wages (nontaxable) is commonly paid, and employers frequently add another 10 percent or more on a voluntary basis. Workers compensation is generally the employee's exclusive remedy.

Germany

An unusual feature of the German system is its decentralization, not geographically, but with respect to different industry and trade groups. (This feature is reminiscent of the medieval trade guilds that provided insurance-like benefits to their members and members' families.) The overall system has three components corresponding to agricultural enterprises, marine enterprises, and general industry and commerce. Within the largest, general component are 36 different "institutes," which operate on

a nonprofit basis, are internally governed jointly by employer and employee representatives, and are relatively free of external governmental regulation.

The exclusive-remedy rule is applicable. The system covers students and family helpers as well as all private employees, and (unlike the situation in the United States) employees are covered while commuting to and from work. The first 18 days of medical care are provided by the national health care system, and then the applicable institute assumes responsibility. Similarly, employers continue to pay wages for six weeks, and thereafter the institute pays 80 percent of pre-accident wages.

Japan

Japan has a national program called Workmen's Accident Compensation Insurance. A national insurance fund provides most benefits, but private insurance companies sell enhancements to employers, often as a result of collective bargaining by employee groups. These enhancements typically relate to compensation for unearned bonuses, which are a large part of employee compensation packages in Japan. Also, employers purchase employers' liability insurance from private insurers because of the absence of an exclusive-remedy rule — employers are liable directly to employees for gross negligence, and the national fund can seek recovery from employers in cases of even ordinary negligence.

Commuting risks are covered, as in Germany. In general, benefits are denied if the employee is guilty of gross negligence. Back injuries are not covered by workers compensation but are covered by national health insurance whether job-related or not.

United Kingdom

The British system is considered somewhat complicated and unusual. It is a combination of an "Industrial Injury Scheme" and other forms of social insurance. Financing is based on contributions from employers, employees, and the government and is part of the overall social security system.

There is an "alternative remedy" rule that allows employees to recover damages from their employers, with certain reductions on account of social benefits received. As a result, there is considerable tort litigation over employment-related accidents, and a significant private market for employers' liability insurance.

France

France, like the United Kingdom, has a national system that is part of the overall social security plan. One general system covers most employees, and there are smaller, separate systems for agricultural, railroad, mining, and other kinds of employment. Private insurance is not used.

Income benefits can be significantly different for work-related disabilities as compared with those that are not work-related. For example, a worker may receive 100 percent of lost wages for a work-related permanent total disability, and only 50 percent if the disability is not work-related. Also, medical benefits for work-related conditions are paid from the first franc, whereas national health insurance generally has cost-sharing features.

Australia

Like the United States, Australia has a system that is operated at the state and territorial level. There is considerable variety from one state or territory to another, and there are special federal programs for maritime and governmental employees. The system tends to be state-run, without private insurance, in the states of New South Wales, South Australia, and Victoria, whereas private insurers are primarily involved in the other states and territories. The exclusive remedy rule was traditionally not applied, but in recent years many aspects of the tort system have been eliminated.

New Zealand

New Zealand may be thought of as the world capital of no-fault compensation, at least in terms of a trend or movement. Beginning in 1974, not only job-related accidents but also automobile and most other accidents at home and away from home, and even medical malpractice, came to be covered by the quasi-governmental Accident Compensation Corporation. Tort litigation over accidents was almost entirely eliminated.

Funding comes from various sources, including motor vehicle fees, employer contributions, and general taxation. Pay-as-you-go is used instead of pre-funding, and great emphasis is placed on accident prevention and rehabilitation of injured persons. Public hospitals are utilized to provide medical treatment, and awards may be granted for permanent disability as well as for pain and suffering.

AUTOMOBILE AND OTHER NO-FAULT EXPERIMENTS; TORT REFORM

The universal acceptance of workers compensation in the United States, combined with the proliferation of automobile accident cases in the latter part of the twentieth century, inspired many state legislatures to adopt automobile no-fault laws of various kinds beginning around 1970. The academic side of the no-fault movement is traditionally identified with Professors Keeton and O'Connell and their celebrated publication of 1965, entitled *Basic Protection for the Traffic Victim: A Blueprint for Reforming Automobile Insurance.* The Keeton-O'Connell point of view is essentially a rejection of the litigation system and especially jury trials in the context of routine and essentially unavoidable accidents, particularly minor ones that present an opportunity for injured persons to exaggerate their injuries. The tort system is considered defective because it involves unreliable fact-finding by unsophisticated jurors, delay, and waste in the form of attorneys' fees, especially plaintiffs' attorneys' contingent fees.

The currently existing automobile no-fault laws contain elements of no-fault compensation, but almost without exception they do not come close to any typical workers compensation law in eliminating common-law liabilities. They exhibit an almost bewildering variety, and no two states have laws that are exactly alike, or even nearly so, but in general they can be broken down into two categories, each of which has two subcategories: mandatory no-fault laws with verbal thresholds or monetary thresholds and optional or add-on laws with verbal thresholds or monetary thresholds.

A threshold means that the law permits the recovery of damages, but only after an injury threshold (that is, a degree of severity) has been met. These thresholds, in turn, are of two kinds: verbal thresholds and monetary or dollar thresholds. A verbal threshold specifies in words the kinds of injuries that are considered severe enough to warrant a lawsuit (for example, death, fractures, losses of limbs). A monetary threshold measures severity in terms of actual medical expenses, setting a dollar amount (such as $10,000), after reaching which the injured person may sue. Mandatory laws do not permit any suits until the threshold is exceeded. Optional or add-on laws permit an injured person to accept no-fault benefits and, at the same time, to sue for additional damages in excess of the applicable threshold. Workers compensation laws, by contrast, involve no thresholds and are almost always mandatory.

Currently there are automobile no-fault laws in approximately half of the states.[33] None of them is a pure no-fault law, like a workers

compensation law, in the sense of providing a complete replacement of tort liability with comprehensive benefits. Michigan is the only state that provides unlimited medical benefits, but it does not provide unlimited disability benefits. The other states provide even more limited benefits. For example, New York provides a combined total of $50,000 in medical benefits and a maximum $2,000-per-month income replacement benefit for up to three years.[34] No-fault benefits are usually paid by the insurer of the automobile in which the injured person was riding at the time of the accident, whether as driver or passenger, or by the insurer of the vehicle that strikes a pedestrian. Actions against persons other than drivers and owners of insured vehicles (such as automobile manufacturers, municipalities) are usually permitted.

Two states, Florida and Virginia, have adopted no-fault laws of limited scope for medical malpractice claims involving birth-related neurological injuries.[35] They are strictly optional regardless of the extent of the injury. There is also a federal law establishing a compensation fund for adverse medical reactions caused by childhood vaccines.[36] These state and federal laws are not utilized very much, and it can be fairly said that the no-fault concept has not been successful in the medical or products liability field. Many would say that it has not been truly successful in the automobile area, either.

In a number of other countries, including Israel and Sweden, and in the Canadian provinces of Quebec, Manitoba, and Saskatchewan, pure automobile no-fault involving private insurance does currently exist.[37] In other countries, including Denmark, France, Germany, the Netherlands, and Switzerland, the social insurance system effectively replaces lawsuits over automobile injuries.[38] New Zealand uniquely represents the zenith of no-fault principles: as discussed above, its national accident compensation system applies to virtually all accidents, whether work-related, automobile-related, or otherwise.

What is generally called tort reform (by its advocates) is not a movement in the direction of no-fault compensation, but, as the name indicates, a reform or modification of the tort system with its essential features retained. Tort reform measures, which are usually proposed by business and institutional interests and opposed by trial lawyers, commonly include: damage "caps," or limitations on awards for pain and suffering, and other non-economic damages, sometimes expressed as a dollar amount such as $300,000, and sometimes as a multiple of the particular plaintiff's economic damages; elimination or modification of the rule of "joint and several liability," which makes a relatively innocent co-defendant as liable as other defendants; and abolition of the "collateral source"

rule, under which payments received by a plaintiff from medical insurance and other sources are disregarded in calculating damages.

NOTES

1. PROSSER & KEETON ON TORTS, 5th ed. (St. Paul, Minn.: West, 1984) (hereafter PROSSER & KEETON), Sec. 7.
2. Id., Sec. 32.
3. Id., Sec. 65.
4. Id., Sec. 68.
5. Id., Sec. 80.
6. Id.
7. LARSON, WORKMEN'S COMPENSATION (New York: Matthew Bender, 1996) (hereafter LARSON), Sec. 4.30.
8. PROSSER & KEETON, Sec. 42.
9. MILLUS & GENTILE, WORKERS' COMPENSATION LAW AND INSURANCE, 2d ed. (New York: Roberts, 1980) (hereafter MILLUS & GENTILE), pp. 15–19.
10. Id., p. 15.
11. Id., pp. 16–17.
12. Id., p. 13.
13. LARSON, Sec. 6.10.
14. MILLUS & GENTILE, pp. 20–21.
15. Id., p. 32.
16. Howard v. Illinois, 207 U.S. 463 (1918).
17. 45 U.S.C. Secs. 51–60.
18. MILLUS & GENTILE, p. 25.
19. Id.
20. 201 N.Y. 271 (1911).
21. See the full text in Appendix Part VI.
22. Jensen v. Southern Pacific Railroad, 215 N.Y. 514 (1915).
23. MILLUS & GENTILE, pp. 30–31.
24. Hawkins v. Bleakly, 243 U.S. 210 (1917); Mountain Timber Co. v. Washington, 243 U.S. 219 (1917).
25. 243 U.S. 188 (1916).
26. 243 U.S. 193.
27. MILLUS & GENTILE, p. 32.
28. See Chapter 8 for a discussion of elective laws.
29. P.L. 91-596.
30. DECARLO & MINKOWITZ, WORKERS COMPENSATION INSURANCE AND LAW PRACTICE (Fort Washington, Pa.: LRP Publications, 1989), p. 12.
31. Id., p. 21.
32. Unpublished and undated memorandum of the American Insurance Association, College of Insurance Library, New York.

33. 1997 PROPERTY/CASUALTY FACT BOOK (New York: Insurance Information Institute, 1997), p. 116.

34. N. Y. Ins. Law Sec. 5102.

35. See Fla. Statutes Sec. 768.13(2)(b); Va. Statutes Sec. 38.2-5000.

36. 42 U.S.C. Sec. 300aa-10 et seq.

37. JOOST, AUTOMOBILE INSURANCE AND NO-FAULT 2D (Deerfield, Ill.: Clark Boardman Callahan, 1992), Sec. 7:3–7:8.

38. Id., Sec. 7:4.

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Federal Workers Compensation and Related Laws

This chapter refers to federal laws that are related to workers compensation laws. Some of the federal laws discussed in this chapter are not workers compensation laws in the usual sense of a no-fault, limited-benefit compensation remedy, although they are somewhat similar to workers compensation laws. As will be seen, the Federal Employers' Liability Act (FELA) and the Jones Act are based upon the principle of comparative negligence. The remedies available to seamen under the general maritime law are unique and, although they are not based primarily upon negligence, they are substantially different from no-fault compensation. The Federal Employees' Compensation Act (FECA), the District of Columbia Workers Compensation Law, the United States Longshore and Harbor Workers' Compensation Act (the USL&H Act or "Longshore Act"), and the three extensions of the Longshore Act applicable to certain civilian employees outside the United States are true no-fault laws. The Black Lung Act is a unique and strange hybrid between a no-fault occupational disease law and a social welfare program.

THE FEDERAL EMPLOYERS' LIABILITY ACT

The FELA was enacted by Congress in 1908.[1] Its name does not give much of a hint as to what it is about, except that it is a federal law. It applies to employees of interstate railroads, or more exactly, to employees

of any "common carrier by railroad while engaging in commerce between any of the several States or Territories."[2] It does not provide a no-fault remedy or prescribe any particular benefits for injured employees; instead it establishes a rule of comparative negligence in place of contributory negligence: "the fact that the employee may have been guilty of contributory negligence shall not bar a recovery, but the damages shall be diminished in proportion to the amount of negligence attributable to such employee."[3] It also expressly abolishes the rule of assumption of risk with respect to interstate railroad employees[4] and has been construed to abolish the fellow-servant rule as well.[5]

In 1908 comparative negligence was a rather revolutionary development. Today, primarily as a result of legislative action, it has replaced contributory negligence in most tort contexts, such as automobile accidents, in many states. Current-day comparative negligence laws are of two kinds: pure comparative negligence (under which any percentage of plaintiff's negligence, such as 90, 50, or 10 percent, reduces the plaintiff's award by the applicable percentage) and modified comparative negligence (under which 50 percent, or in some states anything more than 50 percent, of negligence on the part of the plaintiff results in no recovery at all). The FELA is a pure comparative negligence law.

An injured employee subject to FELA, then, can sue for full tort damages, including pain and suffering, but must prove at least some negligence attributable to the employer. Perhaps surprisingly, as a result of the way the FELA has been applied by the courts, a very small amount or "featherweight" of negligence is sufficient to make out a case, so much so that the quantity of negligence necessary has been reduced almost to the "vanishing point."[6] As a practical matter, then, unless a significant percentage of comparative negligence can be proven, the FELA operates much like a no-fault law, but with full tort damages available. As one might expect, the FELA involves court litigation and jury trials.

THE MERCHANT MARINE ACT OF 1920, DEATH ON THE HIGH SEAS ACT, AND GENERAL MARITIME LAW

What is commonly referred to as the Jones Act is actually Section 20 of an extensive piece of federal legislation known as the Merchant Marine Act of 1920,[7] which had to do with various aspects of the shipping business. The Jones Act, simply stated, is a duplicate or copy of the FELA made applicable to a completely different class of employees, namely "seamen" (a term that is not defined in the statute). It states that: "Any

seaman who suffers personal injury in the course of his employment may, at his election, maintain an action for damages at law . . . and in such action all statutes of the United States modifying or extending the common-law right or remedy in cases of personal injury to railway employees [that is, the FELA] shall apply."[8] The first part of this statute, permitting an action "at law," is necessary because, prior to the Jones Act, sick or injured seamen were entitled only to specialized maritime law, as opposed to common-law, remedies.

There are many decided cases, including decisions of the United States Supreme Court, regarding the issue of who is a seaman. Generally, a seaman who is covered by the Jones Act is the same as the "master or member of a crew" of a vessel, who is excluded from coverage by the USL&H Act. According to the latest pronouncement by the Supreme Court, to be a seaman one must have duties that contribute to the function of a vessel or the accomplishment of its mission, and have a connection to a vessel in navigation that is substantial in duration and nature.[9] So, for example, it was a jury question as to whether an electronic communications specialist employed by a passenger cruise line, who spent a large amount of his time in the firm's offices on land, and who was injured while on board one of the line's cruise ships, was or was not a seaman.

In addition to the Jones Act, seamen have two non-statutory remedies for personal injuries under an ancient body of quasi-international law known as the general maritime law or admiralty law. The first of these remedies is usually called "maintenance and cure," although its full technical name should probably be "transportation, wages, maintenance, and cure." Basically, a seaman who is injured or becomes ill from any cause (other than gross misconduct) while in the service of a vessel or answerable to the call of duty is entitled to remain on the vessel to the end of the voyage, to receive his wages to the end of the voyage, and to receive food, lodging, medicine, and medical care to the end of the voyage, or to the point of maximum possible cure.[10]

The second maritime law remedy is an action for breach of the implied warranty of seaworthiness, usually abbreviated to "unseaworthiness." This remedy, which also applies to passengers, is available whenever it can be proven that the injury was caused by a condition of the vessel or its equipment which, in retrospect, shows the vessel was not reasonably fit for the intended voyage.[11] Unseaworthiness may consist in a major design defect or in something relatively trivial, like a slippery deck. Damages for unseaworthiness can include medical expenses, lost income, and pain and suffering.

The Death on the High Seas Act (DOHSA)[12] provides a remedy "in admiralty" (as opposed to a remedy "at law") to the deceased person's personal representative (executor or administrator) for the benefit of certain surviving family members. It applies whenever the death of a seaman or a passenger has been caused by a "wrongful act" on the high seas, defined as those areas beyond one marine league (or three miles) from the United States coastline. Wrongful act includes negligence and unseaworthiness. Damages under DOHSA are based upon pecuniary losses only, and pure comparative negligence applies. DOHSA also applies to deaths on the high seas as a result of airplane crashes.

A seaman for whom causes of action exist under two or more of the various theories discussed in this section does not, of course, obtain duplicate or multiple recoveries. It is nevertheless common for an injured seaman to assert several different maritime causes of action for the same injury as alternative avenues of recovery.

THE UNITED STATES LONGSHORE AND HARBOR WORKERS' COMPENSATION ACT

The history of the USL&H Act,[13] and its interplay with state laws, is long and complex. This law is sometimes especially difficult to apply because it involves issues of state versus federal jurisdiction arising under Article III, Section 2, of the United States Constitution, which provides that the authority of the federal courts includes "all cases of maritime and admiralty jurisdiction." In very simplified terms, this means that only the federal government can make certain kinds of laws regulating activities, including employments, that take place on or near navigable waters that are federal. Therefore, in certain cases the USL&H Act supersedes or preempts state laws, including state workers compensation laws.

In 1917, the Supreme Court held that the New York Workers Compensation Law could not be applied to a worker who fell off a gangplank ten feet from the dock in New York harbor, because the waters of the harbor were within the federal maritime jurisdiction established by the Constitution.[14] Workers injured within the maritime jurisdiction who were not seamen were therefore left without any no-fault or similar remedy. The USL&H Act became law in 1927 and has been amended in significant ways many times since then.

As opposed to the activities of seamen, which are governed by the above-discussed remedies, the USL&H Act involves the loading, unloading, building, repairing, and dismantling of ships by various categories of

workers who are collectively covered under it. The act provides a detailed panoply of generous but limited benefits, including medical, wage-loss, and survivors' benefits, structured in a way very similar to most state workers compensation laws. (This is not at all surprising when one considers that the New York Workers Compensation Law historically served as a model for the USL&H Act and for other state laws, in many respects.) Coverage of employees and accidents, however, is quite specialized under the USL&H Act. The usual rule is that both the status test and the situs test must be satisfied in order for a particular accident involving a particular employee to be covered.[15]

The status test has to do with the kind of work being done. The statute specifies that the employee (as opposed to the employer generally) must be "engaged in maritime employment," which specifically includes work as a longshoreman or other person engaged in longshoring operations and work as a harbor worker, including a ship repairman, shipbuilder, or ship breaker (one who is engaged in scrapping a vessel).[16] There are various detailed exceptions to this status test, such as: persons performing clerical or security work; persons employed by a club or restaurant; certain persons employed by a marina; persons temporarily doing work for suppliers, transporters, or vendors; persons working on recreational vessels less than 65 feet in length; persons loading, unloading, or repairing a vessel under 18 tons net; and the master and members of a crew of any vessel, regardless of the kind of work they are doing.[17]

The situs test concerns the place where the accident or injury occurs, and especially its exact location relative to the water. In general the injury must be sustained "upon the navigable waters of the United States (including any adjoining pier, wharf, dry dock, terminals, building way, marine railway, or other adjoining area customarily used by an employer in loading, unloading, repairing, dismantling, or building a vessel)."[18] Three issues that frequently arise under this part of the statute are: what are "navigable waters," what are "waters of the United States," and what is an "adjoining area." Navigable waters usually means waters that can serve as an avenue for marine commerce (that is, the passage of vessels) at least part of the time. "Waters of the United States" is usually interpreted to mean bodies of water that provide, or at least form part of, an avenue for commerce between two or more states or between a state and the high seas (so that a wholly intrastate body of water like the Great Salt Lake would not qualify). There are many cases defining what is and what is not an "adjoining area," but they generally agree in holding that the place must not be too remote from places where actual maritime activities take place. The geographical zone of uncertainty, in which state and federal laws may

both apply (and the injured employee may be entitled to opt for one or the other), is sometimes called the "Twilight Zone."[19]

The maximum wage-loss benefits available under the USL&H Act are quite high relative to those provided under most state laws. As of 1996, for example, the weekly maximum was $801.06 as compared with $400.00 under the New York law and $490.00 under the California law.[20] (See Chapter 4 for a comparison of state maximum benefit levels.)

EXTENSIONS OF THE UNITED STATES LONGSHORE AND HARBOR WORKERS' COMPENSATION ACT

There are three fairly obscure federal statutes that extend the application of the USL&H Act, not with regard to the status or situs requirements discussed above, but with regard to the Act's basic no-fault nature and the benefits provided. In other words, these statutes extend the coverage and benefits of the USL&H Act to different kinds of workers, as though they were longshore or harbor workers. These extensions, which are of some importance if only because they are specifically referred to in the standard workers compensation insurance policy (see Chapter 9), are as follows.

The Defense Base Act[21] applies to civilian employees of the United States armed forces on bases outside of the United States, its territories and possessions (such as the naval base in Guantanamo Bay, Cuba).

The Nonappropriated Fund Instrumentalities Act[22] applies to civilian employees of armed forces instrumentalities, such as post exchanges and recreational facilities, which are not supported by funds appropriated by Congress but rather by their own revenues.

The Outer Continental Shelf Lands Act[23] generally makes U.S. laws applicable to certain minutely defined areas where oil, natural gas, mineral deposits, or other natural resources lie submerged under the Atlantic Ocean and the Gulf of Mexico. The portion of the Outer Continental Shelf Lands Act applicable to employee injuries pertains to civilian employees of contractors performing work on drilling platforms and similar projects on the outer continental shelf.

THE FEDERAL EMPLOYEES' COMPENSATION ACT

All civilian employees of the federal government are covered by the FECA[24] (definitely not to be confused with the FELA). The basic formula of coverage under the FECA is that benefits are payable by the United States for "the disability or death of an employee resulting from personal

injury sustained while in the performance of his duty, unless the injury or death is — (1) caused by willful misconduct of the employee; (2) caused by the employee's intention to bring about the injury or death of himself or of another; or (3) proximately caused by the intoxication of the employee."[25] Certain war-related risks are covered regardless of whether the injury or death was sustained while the employee was in the performance of his or her duty. The FECA applies, however, only to civilian employees, not to members of the armed forces, who are covered under an entirely separate and elaborate system of military and veterans' benefits and pensions.

One curious aspect of the FECA, as compared with the USL&H Act or state compensation laws, is that eligibility determinations in individual cases are made administratively by the Department of Labor with virtually no judicial review. Thus, there is practically no law at all interpreting the act (for example, with respect to the meaning of the phrase "in the performance of his duty").

THE DISTRICT OF COLUMBIA WORKERS COMPENSATION LAW

Because the District of Columbia is subject to Congressional legislative authority under the Constitution, a discussion of its workers compensation law is included in this chapter. From 1928 until 1982, employees of private (non-governmental) employers in the District of Columbia were subject to the benefit structure of the USL&H Act as it existed from time to time. In 1982, a separate workers compensation law for such private employments was enacted by the local government of the District.[26] Most employees of the District itself are covered under the FECA and under a local enactment that provides certain alternatives.[27] Other than the fact that its wage-loss benefit levels are high relative to most states (like those provided by the USL&H Act), there is nothing else especially distinctive about the D.C. compensation law as compared with most state laws.

THE FEDERAL BLACK LUNG PROGRAM

The Federal Coal Mine Health and Safety Act of 1969[28] (often called the Black Lung Act insofar as it applies to occupational disease) was, according to conventional analysis, emotionally inspired by a coal mine explosion that occurred in Farmington, West Virginia, on November 20, 1968, as a result of which 78 miners died. The rational inspiration for the act was the perceived inadequacy of most state workers compensation

laws as they applied to dust-related occupational diseases. It was once widely believed that such diseases were so endemic or unavoidable with respect to certain occupations that making them compensable would require insurance premiums so high that the employers in question would be put out of business. Therefore, many state laws contained rather invidious obstacles to the adequate compensation of dust-related diseases, such as artificially or unrealistically short time limits on the presentation of claims or strictly limited benefits.

The Black Lung Act emerged from Congress in 1969 and was extensively amended in 1972, 1977, and 1981. It has been aptly described, in its various incarnations, as "an extraordinarily complicated and controversial statute."[29] Despite its name, it is not merely a law regulating safety in coal mines but includes a federal workers compensation program of sorts for miners who are "totally disabled" or who die on account of coal-dust respiratory diseases contracted in mines, specifically the disease called pneumoconiosis or "black lung disease." The following is a necessarily brief and oversimplified description of an extremely complicated program.[30]

In general, the law makes certain responsible operators liable to provide monthly cash benefits (and medical benefits in some cases) to miners who are totally disabled because of pneumoconiosis contracted in coal mine employment and to their survivors in certain fatality cases. A miner is someone who works or worked in or around a coal mine or coal preparation facility, or a coal mine construction or transportation worker if he or she was exposed to coal dust. Pneumoconiosis is a label used to describe many different lung diseases that impair respiration. Its existence can be established by X-ray studies, by autopsy or biopsy, or by a physician's opinion regardless of a negative X-ray (in which case blood gas studies or other tests are required). A miner may be conclusively presumed to be totally disabled by pneumoconiosis if he or she has "complicated pneumoconiosis" (indicated by an X-ray with a one-centimeter or greater opacity) or has had 15 years of underground coal mine employment and has a totally disabling respiratory ailment.

An operator is generally someone who is the owner or lessee or other person who operates, controls, or supervises a coal mine, or an independent contractor engaged in construction or maintenance or the transportation of coal. A "responsible operator" is generally an operator who can be located and who most recently employed the miner for a cumulative period of one year, which consists of at least 125 working days. Responsible operators generally became obligated to provide benefits in 1974 and later years and were required to carry insurance. The presumptions and other

criteria used in deciding entitlement to benefits were changed a number of times over the years and have resulted in a most challenging puzzle, to say the least.

The original program included a Part B and a Part C, which were supposed to place responsibility for claim payments on the Social Security Administration and on "adequate" state workers compensation programs, respectively. Part B allowed claims to be filed, based on any past exposure, through 1972. For claims filed after December 31, 1972, Part C was to be responsible. In 1972, however, Congress enacted the Black Lung Benefits Act of 1972, which extended federal financing of Part C through 1974 and placed responsibility for post-1974 claims on the coal industry, or on the Department of Labor in cases where a responsible operator could not be located.

The Black Lung Benefits Reform Act of 1977 and the Black Lung Benefits Revenue Act of 1977 liberalized certain disability criteria, imposed an excise tax on coal to fund certain benefits, and created a Black Lung Disability Trust Fund. The Trust Fund was created because no state program had been found "adequate," and in any event responsible operators could not be located in most instances. The 1981 amendments included another Benefits Revenue Act, which increased the tax on coal, and Benefits Amendments, which made further complicated changes in the disability criteria and presumptions.

Black Lung benefits are currently payable at monthly rates that range from $455.10 to $890.20, plus a cost-of-living adjustment and a dependent allowance of up to 100 percent for three or more dependent relatives.[31] The program cost $10.7 billion in benefits (not including costs of administration) from 1974 through 1996.[32]

SOCIAL SECURITY AND MEDICARE

The federal Social Security system comprises various programs, including Old Age, Survivors, and Disability Insurance and Medicare. The disability insurance component of Social Security provides monthly cash benefits, based in part upon prior income, to covered employees in cases of total disability, which is defined as the inability to engage in any substantial gainful activity by reason of a physical or mental impairment that is expected to result in death or to last for a continuous period of at least twelve months.[33] The maximum monthly benefit for total disability is currently $1,462 for an individual and $2,193 for a family, subject to cost-of-living increases, but average benefits are considerably less.[34]

The federal law makes no distinction between disabilities that are work-related and those that are not. Therefore, many state laws provide that there will be an offset of federal Social Security disability payments against workers compensation payments for the same disability.[35] As to states where such offset provisions do not exist, the Social Security law itself contains a "reverse offset" provision under which Social Security and workers compensation benefits combined cannot exceed 80 percent of pre-disability earnings.[36]

Medicare is a federal health insurance program for persons who have reached the age of 65 years and for certain categories of disabled persons. It consists of a Part A, which is mandatory and covers hospital expenses, and a Part B, which is voluntary (but heavily subsidized and almost always elected) and covers physicians' fees and other outpatient services. In general, Medicare coverage is the primary payer (that is, it pays first) as compared with private health insurance, but the law provides that it is generally secondary with respect to expenses covered by workers compensation.[37]

NOTES

1. 45 U.S.C. Secs. 51–54. See text in Appendix Part I.
2. Id., Sec. 51.
3. Id., Sec. 53.
4. Id., Sec. 54.
5. Jamison v. Encarnacion, 281 U.S. 635 (1930).
6. See, for example, Ulfik v. Metro-North Commuter R.R., 77 F.3d 54 (CA2, 1996).
7. 41 Stat. 988, Ch. 250.
8. 46 U.S.C. Sec. 688.
9. Chandris, Inc. v. Latsis, 115 S.Ct. 2172 (1995).
10. See LARSON, WORKMEN'S COMPENSATION (New York: Matthew Bender, 1996) (hereafter LARSON), Sec. 90.
11. Id.
12. 46 U.S.C. Sec. 761 et seq.
13. 33 U.S.C. Sec. 901 et seq.
14. Southern Pacific Railway Co. v. Jensen, 244 U.S. 205 (1917).
15. See LARSON, Sec. 89.27.
16. 33 U.S.C. Sec. 902 (3).
17. Id., Sec. 902 (3)(A)-(H). Exclusions (A) through (F) apply only if the respective workers are covered under a state compensation law.
18. Id., Sec. 903.
19. See LARSON, Sec. 89.24 et seq.

20. U.S. CHAMBER OF COMMERCE, 1997 ANALYSIS OF WORKERS' COMPENSATION LAWS (Washington, D.C.) (hereafter 1997 ANALYSIS), pp. 26–31.
21. 42 U.S.C. Sec. 1651 et seq.
22. 5 U.S.C. Sec. 8171 et seq.
23. 43 U.S.C. Sec. 1333(b).
24. 5 U.S.C. Sec. 8102 et seq.
25. Id., Sec. 8102.
26. D.C. Code, Part V, Title 36.
27. 5 U.S.C. Sec. 8101(1)(D).
28. 30 U.S.C. Sec. 801 et seq.
29. LARSON, Sec. 4190.
30. See generally 30 U.S.C. Secs. 901–962.
31. Supra note 20 at p. 3.
32. Id.
33. 42 U.S.C. Sec. 423(d).
34. 1997 ANALYSIS, p. 3.
35. Supra note 20.
36. 42 U.S.C. Sec. 424a.
37. 42 U.S.C. Sec. 1395y(b)(2).

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3

Coverage of State and Federal Workers Compensation Laws

LIABILITY FOR COMPENSATION: ACCIDENTS "ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT"

Most state laws use exactly the same words, or almost exactly the same words, to describe those injuries that are compensable: such injuries must be caused by accidents "arising out of and in the course of employment."[1] It is fairly obvious that these words mean the accident must be job-related in some way. Given the tremendous variety of circumstances involved in the millions of industrial accidents that have occurred over the years, however, these few innocent-sounding words have given rise to a large body of law produced by administrative agencies and courts as they review the peculiarities of individual cases. Professor Larson's treatise observes that "[f]ew groups of statutory words in the history of law have had to bear the weight of such a mountain of interpretation as has been heaped upon this slender foundation."[2]

It must be emphasized that the formula has two different parts, both of which must be satisfied if the accident is to be compensable. Even though "arising out of" and "in the course of" may sound virtually the same, they definitely have not been interpreted that way by most agencies and courts. "Arising out of" is a requirement of causation in fact by an employment-related risk, whereas "in the course of" is a requirement of causation in time, place, and circumstances of employment.

"Arising out of" means that the accident must be caused by a risk that is "closely," "directly," or "distinctly" associated with the employment. Larson uses the terms "employment risk," "neutral risk," and "personal risk" to illustrate the spectrum of possibilities that exists with regard to the causation of an accident.[3] If the risk is closely, directly, or distinctly associated with the employment (perhaps all three mean approximately the same thing), it is an employment risk and the accident is always compensable. If the risk is not associated with the employment but with the employee's own personal activities, it is a personal risk and the accident is never compensable. If the risk does not clearly originate either in employment or in personal activities, it is a neutral risk, and further, finer distinctions must be made to determine whether the accident is compensable.

For example, being hit on the head by a falling brick while working as a bricklayer on a construction site is an employment risk because it is definitely associated with that employment. Being struck by lightning or a stray bullet while working in the same job is a neutral risk because it is something to which all persons in the area are exposed to some degree, regardless of whether they are working at the same job, or at another job, or not working at all. Being assaulted by one's personal enemy (not a co-worker) at the job site is a personal risk, because it has nothing to do with the employment itself, but simply occurs at the place of employment. (An altercation with a co-worker is a different matter, and is normally considered job-related, especially if the argument concerns some aspect of the work.) Neutral risks include "Acts of God," such as adverse weather conditions, as well as human acts (sometimes called "street risks") such as explosions and criminal assaults.

Over the years, the courts have adopted at least three different standards or tests (as categorized and described by Larson, whose treatise has been very influential on the courts) for deciding which neutral risks should give rise to compensation and which should not. Under the increased risk test, the accident is compensable if the risk to the injured employee was quantitatively greater than the risk to the general public. (A virtually obsolete test called the peculiar risk test used the standard of a risk qualitatively greater than the risk to the general public.) The actual risk test (more liberal) grants compensation whenever the risk is actually a risk of the employment at the time and place in question, regardless of its quantity as compared with the risk to the general public. The positional risk test (the most liberal) grants compensation so long as the employee was placed by the employment in the time and place of the accident, even if the risk had nothing to do with the employment.[4] Courts in

different states apply different tests, sometimes using these labels and sometimes not using them. (For example, New York almost certainly applies the positional risk test, but without using that label.)

In addition to satisfying the "arising out of" requirement, the accident must satisfy the "in the course of" requirement. This means that the accident must happen while the employee is engaged in the duties of employment, during the hours of employment, and at a proper place of employment when the accident occurs. The requirement is similar to, but not quite the same as, the "scope of employment" test, which is used in tort law to determine when an employer is vicariously responsible for the torts of the employee. In most states, commuting to and from work is not in the course of employment, nor are deviations, which occur when an employee takes a detour or break from the trip or duties that he or she should be engaged in, so long as the deviation is substantial.[5] As an example, crossing the street to buy a candy bar is probably not a substantial deviation for a messenger assigned to travel a distance of several blocks, but going many blocks in the opposite direction to buy a television probably would be. The distance, the length of time, and the motivation for the deviation all usually are considered relevant factors.

Other employee activities that usually are considered inside the scope of employment are: routine activities during business travel, even during non-working hours; authorized breaks and rest periods, including use of the washroom; other reasonable activities involving the personal comfort of the employee; altercations between employees; "horseplay" and "skylarking" (horseplay is playful activity by two or more persons, whereas skylarking is basically the same thing done by one person); recreational and social activities, such as sports and parties, if the employer is substantially involved in sponsoring the activity; and actions taken in response to emergencies, such as rescuing people from dangerous situations.[6]

There are common-sense rationales behind most of these rules. For example, an employee on a business trip is basically acting for the employer's benefit from the beginning to the end of the trip, and cannot possibly avoid such personal activities as eating, washing, and dressing, which in rare cases can cause injuries. Normal activities that provide an employee with rest and comfort during working hours enable the employee to be more productive and therefore benefit the employer. Having fun at work or otherwise is a normal part of human nature and is not to be penalized unless it is extreme. The basic principle to be applied in this area is the standard of what is normal or at least tolerable, and therefore to be expected, versus what is abnormal, intolerable, or extreme.

Brief synopses of three New York cases (two of which involve crimes) will serve to illustrate the application of the coverage formula. The first case, *Malacarne* v. *City of Yonkers Parking Authority*,[7] involves a question of "arising in the course of employment." Maurice Malacarne was employed as a part-time parking lot attendant at a race track called Yonkers Raceway. One of his duties was to deposit the cash receipts at a bank across the street shortly before closing time, at around 11:00 p.m. One evening, he left work about 45 minutes early before the track had closed in order to attend a party at his brother-in-law's house, which was about a half-hour drive from the race track. After parking his car near his brother-in-law's house, he was shot and killed by an unknown assailant. His possessions, including a substantial amount of cash, were not taken. There was some testimony by relatives to the effect that the decedent, before he died, made a statement that the assailant had asked him for the "money bag."

Compensation was awarded by the Workers' Compensation Board, and ultimately the case was appealed to the Court of Appeals. That court held that, even if the "money bag" testimony was credible, there was not sufficient evidence to show that the decedent's course of employment on that evening extended to his personal trip to the vicinity of his brother-in-law's house. For example, there was no reason to suppose that a robber would follow him for such a distance, when the track had not closed and the receipts were customarily deposited at a bank across the street. In effect, the court held that retail employees who sometimes handle their employer's cash off the premises are not covered during their personal time simply because a criminal might suspect that they have money in their possession.

Another case involving the "course of employment" is *Neacosia* v. *New York Power Authority*,[8] in which the employee was a security officer at a nuclear power plant. He was supplied with uniforms by the employer but was required to keep them clean. Dry cleaning was not particularly required. The employer recommended certain dry cleaners in the vicinity and maintained accounts at these establishments so that the charges could be paid directly by the employer. On one evening after work, after leaving some shirts and trousers at one of the recommended dry cleaners, the employee was on his way home by the regular route and was severely injured in an automobile accident.

Compensation was awarded. On appeal, the Court of Appeals held that, despite the general rule that commuting time is not covered, the "special errand" exception applied and compensation was payable. The special errand rule had previously applied only when errands during personal

time were required as a condition of employment, but the court extended it to situations where the employer does not require the activity but both encourages the activity and derives a benefit from it.

The third case, considered by some to be notorious, is *Richardson* v. *Fiedler Roofing, Inc.*[9] Richardson was employed as a laborer by a roofing company and on the date of the accident was on a customer's rooftop waiting with a co-worker for certain roofing material to arrive. He and his co-worker climbed over a party wall and onto the roof of an adjacent building in order to steal some copper downspouts, which were valuable as scrap metal. Richardson slipped and fell seven stories to his death, leaving five minor children (a circumstance that should not be relevant but is mentioned in the court's opinion). Once again, compensation was awarded and an appeal ensued.

The Court of Appeals affirmed the award, primarily because it was "common practice" in the roofing industry for laborers to steal and sell copper roofing materials. Richardson's employer in particular knew of the practice, had never disciplined or discharged an employee for such a theft, and in fact had previously paid building owners for property stolen by its employees. Based upon these rather extreme facts, the court was able to conclude that Richardson was not engaged in a deviation from employment while attempting the theft, and was in the course of his employment. The court also noted that the New York Disability Benefits Law, which is part of the Workers' Compensation Law but provides non-occupational disability benefits, contained an exception relative to illegal acts, whereas the main portion of the Workers Compensation Law did not.

Although there is much case law in this area, many states also have special provisions in their workers compensation statutes that deal with one or more "arising out of" or "in the course of" situations of the kind discussed in this section. Some of these provisions are of very limited application. For example, the New York law provides that any injury sustained by an emergency medical technician while rendering assistance at the scene of an accident shall be considered compensable, regardless of whether the technician is on-duty or off-duty.[10]

Larson also expounded a "Quantum Theory" whereby the strong presence of an "arising out of" component can make up for the relative absence of an "arising in the course of" component in a given claim situation.[11] In other words, according to Larson, if the risk that caused an injury was very closely associated with the employment, a compensation board or a court may be inclined to find the injury compensable, even if the "course of employment" aspect of the claim is weak or virtually absent (such as where the employee is arguably engaged in a deviation).

Likewise, where the "arising out of" aspect is weak but the accident clearly happened during the time, and in the place and circumstances of work, the claim for compensation may also be upheld. The point of Larson's theory is that there is a certain minimum quantity or "quantum" of work connection that must be satisfied, and that there may be some spillover from one part of the formula to the other, even though that is not technically proper.

EMPLOYERS' "DEFENSES" TO CLAIMS FOR COMPENSATION

Considering the social purposes of workers compensation, there are very few things that an employee can do that will prevent compensation from being available. (Those things that will are sometimes called the employer's "defenses" to a claim, even though that term is more appropriate in a tort context.) In the first place, being negligent or even reckless to a certain point is not a disqualification. Even a violation of the employer's rules or procedures is usually not a bar unless the violation is so severe that it amounts to a deviation that takes the employee out of the course of employment.

An employee is usually disqualified, however, if he or she is injured while engaged in a criminal act (but see below), if the injury was self-inflicted, or if the employee committed or attempted to commit suicide. Intoxication by alcohol or illegal drugs may also bar compensation, but on this point some states are much more lenient than others. For example, in New York the claim is not barred unless intoxication was the "sole cause" of the accident;[12] in Florida the claim is barred if the injury was "occasioned primarily" by intoxication, and there is a rebuttable presumption that it was so occasioned if the employee had a blood alcohol content of 0.10 percent or more.[13]

In most cases involving alcohol or drugs, and even more so in cases of criminal acts, self-inflicted injury, and suicide or attempted suicide, it could be argued that either there was no accident (in the sense of an unexpected event from the employee's point of view) at all, or that, if there was an accident, it did not arise out of or in the course of employment, but purely out of the employee's own personal designs and motivations. In this sense, the disqualifications are in the nature of interpretations of the law, rather than special rules of exception or exclusion.

OCCUPATIONAL DISEASES

In most states, the standard for compensability of occupational diseases is somewhat different from the standard applicable to accidental injuries. A commonly used formula is the rule that the disease must be caused or arise "due to the nature of the employment."[14] This may sound like, but is not the same as, either "arising out of" or "arising in the course of" employment, or those two concepts combined. Instead, it is usually interpreted to mean that the disease must be more than causally related to the employment — it must, in addition, have something to do with the particular or peculiar nature of the employment (for example, tuberculosis contracted by a nurse in a hospital where tuberculosis is a special hazard, as opposed to influenza contracted by an office worker in an office, which is not especially a hazardous place with regard to influenza).

In addition to this general standard, some occupational disease laws link certain diseases to certain industrial processes (such as anthrax with the handling of wool, or arsenic poisoning with the use of arsenic for industrial purposes) and create a presumption that the existence of the disease coupled with exposure to the process constitutes a compensable occupational disease.[15] Further proof is not needed in such cases.

Many, if not most, occupational diseases are contracted as a result of exposure to harmful agents (microbes, poisons, or other substances) over a substantial period of time, even many years in some cases. The time of contracting of the disease, in turn, can be much earlier than the time when it manifests itself through symptoms. Because of the inherent uncertainty and the long delays involved, it sometimes becomes difficult or impossible to determine at exactly what time or times a workers compensation liability arises and who the responsible employers (and insurers) are. To relieve the afflicted employee from having to bear the burden of proving actual causation in fact and in time by a particular employment or employments, most occupational disease laws provide that the liability at least initially falls (regardless of when the disease was actually contracted or manifested) upon the employer in whose employment the employee sustained the last exposure to the agent that gave rise to the disease.[16] In some states, that employer or its insurer can then seek an apportionment of liability from previous employers in whose employment the employee in question was also exposed.[17]

THE EXCLUSIVE REMEDY RULE AND EXCEPTIONS

As discussed in the Introduction, one of the cornerstones of workers compensation is the rule that compensation as set forth in the statute is the sole or exclusive remedy of the employee — and of any other related persons who might have a claim for damages on account of his or her injury — against the employer. This rule breaks down into three major principles. First, if the injury or disease is compensable, there is no right on the part of the employee or related persons to sue the employer for damages, even if it might be preferable from the employee's point of view to seek damages in a lawsuit on the basis of fault. This first principle may be thought of as the second edge of the double-edged sword that is workers compensation.

Second, the rule takes away from persons other than the employee, namely family members and other dependents, rights that they would have outside the employment context, such as causes of action for loss of services and consortium, or for wrongful death in fatality cases. Loss of services and consortium refers to the household assistance, companionship, and intimacy of which family members are deprived when an employee is injured or killed. Wrongful death is a statutory tort that results in the deceased person's family members receiving damages for their economic losses. The rationale for taking away these rights is the fact that workers compensation benefits indirectly accrue to the benefit of such persons in non-fatality cases, and accrue directly in fatality cases (see Chapter 4).

Third, and perhaps unexpectedly, the rule does not prevent the employee or his family members from suing anyone other than the employer (and usually co-employees as well). This principle will be more fully discussed in the section that follows.

THIRD-PARTY ACTIONS AND SUBROGATION

With some variations from state to state, an employee who is entitled to and is receiving workers compensation benefits can bring an action for damages against responsible parties (called third parties) other than the employer, such as the manufacturer of a defective machine that injures the employee, or the owner or driver of a vehicle that strikes the employee.[18] An injured employee may even sue multiple parties who are alleged to be responsible for the injury, and in such a case the various third parties will normally assert claims against each other (technically called claims for indemnification or contribution), seeking to negate their individual

responsibilities or to apportion the responsibility in shares among themselves.

To prevent overlapping recoveries once the employee obtains a recovery from one or more third parties, the employer or its insurance carrier is entitled to recover the amount of compensation paid out of the tort recovery; this is usually accomplished by the statute's creation of a lien against the recovery, that is, a paramount legal right in favor of the employer or carrier.[19] Furthermore, if the employee for some reason does not pursue a viable claim against a third party or parties within certain time limits, most laws give the employer or carrier a right of subrogation.[20]

Subrogation is a principle of equity that generally applies whenever one person has performed another person's obligation, not gratuitously or obtrusively. In simple terms it means that the employer or carrier who has paid the employee "stands in the shoes" of the employee for purposes of bringing such an action itself. The lien also applies to the recovery in such a case, with the excess (or a portion of the excess) of the recovery over the amount of compensation belonging to the employee.

For example, in New York, an injured employee is generally permitted to commence an action against a third party within six months after an award of compensation is made. If he or she does so, the employer's carrier has a lien on any recovery obtained in the action, after attorneys' fees and expenses, to the extent of the compensation paid. If the injured employee does not commence an action within the six-month period, following written notice from the carrier to the employee at least 30 days before the expiration of the six-month period, the employee's claim is deemed to be assigned to the carrier. If the carrier then recovers from a third party any amount in excess of the compensation paid to the employee plus the expenses of obtaining the third-party recovery, the carrier is entitled to retain one-third of that excess and the remainder belongs to the employee.[21]

COVERED EMPLOYERS AND EMPLOYEES

Although employee status is usually indispensable to a claim for compensation, not all employers and not all employees are subject to workers compensation laws. There are some common threads that run through the various states' laws, but there is still a great deal of nonuniformity in this regard from one state to another. Noncovered employments represent a relatively small part of the total, but they are important nonetheless, especially with regard to employers liability insurance, discussed in Chapter 7. The most common classes of noncovered employees are casual workers

(those who work only occasionally or intermittently for a given employer), domestic servants, and agricultural workers. Other fairly common categories of noncovered employees are real estate salespersons (who are often at least arguably independent contractors anyway) and certain employees of religious, charitable, and other nonprofit organizations.[22]

In this regard, it is helpful to think in terms of a "covered employer" being liable to a "covered employee" for compensation. If either is not covered under a particular state's law, there is no obligation or right with respect to compensation (and no exclusive remedy rule, so the usual tort rules apply between the parties). To make matters a bit more complicated, coverage or non-coverage for an employer or an employee may be a matter of choice rather than the automatic result of the statute. In other words, in many cases certain employers may "opt in" or "opt out" of coverage, and so may certain employees. The exact manner in which the opting must take place is usually prescribed in the law. For example, in one state an employer may be able to opt for coverage for its otherwise non-covered employees simply by purchasing a workers compensation policy that covers them, whereas in another state the employer may have to file an appropriate election form with the state workers compensation agency.

EMPLOYEE VERSUS INDEPENDENT CONTRACTOR STATUS

Strictly speaking, workers compensation should probably be called "employees' compensation" because it invariably provides benefits only to employees, not to anyone who is simply working. Determinations of employee status, versus independent contractor status, are a perennial problem in workers compensation and other areas of the law, such as vicarious tort liability, labor laws, Social Security, and unemployment compensation. In most of these contexts, the basic common-law principles of agency are still applied: in other words, an employee of an employer for workers compensation and other purposes is basically the same as a common-law servant of a master, who will cause the master to be responsible for the servant's acts that are within the scope of the servant's duties.[23]

A warning is warranted at this point. The reader should not confuse acting within the scope of employment, which is an agency concept relevant to tort liability, with accidents that occur in the course of employment, which is a workers compensation concept discussed earlier in this chapter. The ideas are quite similar but not the same. For example, a criminal act may be in the course of employment, but it will almost certainly never be within the scope of employment.

There are numerous criteria for determining whether a person (the worker) is an employee-servant or an independent contractor of another person (the principal).[24] They generally include the following, which are taken from the *Second Restatement of Agency* (a compilation by legal scholars of prevailing principles of agency law set forth in decisions of U.S. courts):

the amount of control exercised by the principal over the details of the work;

whether the worker is engaged in a distinct occupation or business;

whether the kind of work is usually done with or without supervision;

the amount of skill required;

who supplies the equipment and the workplace;

the length of time that the work involves;

whether payment is determined by the amount of time spent or is based on the completed job;

whether the work is part of the principal's regular business;

what legal relationship the parties intend to create (note: this is not at all conclusive); and

whether the principal is in business.[25]

Larson argues that the tests for determining employee status should not be based solely or primarily upon the common-law rules governing vicarious tort liability.[26] He maintains that, because the primary purpose of workers compensation is to afford benefits to injured workers who cannot provide for themselves, it should be largely immaterial whether a given worker is injured while acting as an employee or as an independent contractor. Instead, the law should require an inquiry into all the circumstances of the work to determine whether a particular injury should be compensated as an expense of the "employer's" enterprise. Nevertheless, Larson recognizes that one of the attributes of a true independent contractor may be the ability to maintain insurance for injuries and illnesses, or otherwise to provide in advance for one's own needs in periods of disability.

Another test sometimes used in making the employee-versus-independent contractor distinction is the "relative nature of the work" test.[27] Under this test, the worker is more likely to be considered an independent contractor if he or she holds himself or herself out to the public as being engaged in a separate and distinct business (as opposed to being devoted mainly or exclusively to the business of the person for whom the work is

done). For example, under this test a worker who cuts lumber for a single property owner on a regular basis and as his sole means of support should probably be considered an employee, whereas another worker who does such work for the same owner only occasionally (and also does work for others) should be considered an independent contractor, even if the working conditions, methods of payment, and so forth, are otherwise the same in both instances.

Of the various criteria, undoubtedly the single most important is the degree of control exercised over the person in question. Larson's treatise uses a worker in a garment factory as an example of an employee, as contrasted with a tailor who is an independent contractor.[28] Both individuals do the same work, that is, they create items of clothing, but under very different circumstances. Larson amusingly suggests that if the tailor's customer (as opposed to an employer) were to tell the tailor when to start and end the workday and how much time to take for lunch, the customer would be promptly thrown out of the shop. Another good example is a taxicab driver (an independent contractor) as compared with a personal chauffeur (an employee). (The question of a cab driver's status as either an employee or independent contractor vis-à-vis the owner of the cab is more problematic and depends upon the circumstances of each case or special provisions in some statutes.)

EMPLOYEES OF UNINSURED SUBCONTRACTORS

As discussed below and in Chapter 6, most employers are required to purchase workers compensation insurance to cover all of their liabilities under an applicable workers compensation law. Such insurance can often be very expensive, especially in the case of dangerous employments like construction and demolition. Premiums can equal or even exceed the employer's payroll in some extreme cases. There is therefore a temptation on the part of some employers, especially small firms that do not have much net worth, to do without the insurance and risk the consequences if an injury happens.

To protect injured workers who might be left without any source of funds to pay their benefits, most laws provide that the employees of an uninsured subcontractor will be considered employees of the contractor who engaged that subcontractor, for purposes of workers compensation coverage.[29] As a corollary, the contractor becomes liable to pay premiums to its carrier for the subcontractor's employees. In this way, contractors are strongly motivated to make certain that their subcontractors have the required insurance at all times.

Partly because of the imprecise way that some of the laws are drafted, the question is sometimes raised whether an owner of premises can be a "contractor" who then becomes liable for compensation to employees of an uninsured entity that is hired to perform work, such as construction or maintenance, on the premises. Most courts nevertheless find that a mere owner of premises is not a contractor who subcontracts work to another, because in such a case there is no contractual work obligation to be turned over to a subcontractor.[30]

EXTRATERRITORIAL APPLICATION OF STATE LAWS

Within a federal system of government like that of the United States, every state or local law is necessarily limited in terms of the geographical scope of its application. To use an absurd example, the State of New York cannot require people who drive cars in California to purchase New York drivers' licenses because the California drivers have no connection with New York. New York can, however, make its laws apply to California residents when they come into New York or establish some business or other presence within New York.

A given state's workers compensation law ordinarily says that a covered employer, as defined, is liable to pay compensation to a covered employee, as defined, and so forth, but it may or may not say what has to happen or exist in that state in order for the law to apply at all. Although there is considerable variation from one state to another, usually there are three possible situations, either set forth in the statute or formulated in case law, that will constitute a sufficient nexus to make a given state's law applicable to an injury: if the accident happens within the state; if the employment was primarily "localized" within the state, even if the injury occurs outside the state; and if the contract of hire was made within the state, that is, if the employer and employee finally agreed upon the fact and the terms of the employment within the state.[31]

The third nexus situation is sometimes more complicated. To cite just one interesting example, in Pennsylvania the local contract of hire can be the basis for jurisdiction, but only if, in addition, the employment was not localized in any state, or it was principally localized in a state where the employee is not covered under the workers compensation law, or the local contract of hire was made for employment outside of the United States and Canada.[32]

Deciding which workers compensation law or laws apply to a given accident can be important for at least two reasons. First, the law of a given

state may not apply to the accident at all if, for example, the employer or the employee is not covered at all, or if there is an "arising-out-of" or "in-the-course-of" problem, or a disqualification such as intoxication. (In such cases, the employee might want to consider a negligence action for damages, if there is a factual basis for it.) Second, the maximum amount of income benefits available to employees varies considerably from one state to another, sometimes by a magnitude of 100 percent or more (see Chapter 4). All other factors being equal, an injured employee will normally seek coverage under the state law that provides the highest income benefits.

OTHER ASPECTS OF COMPLIANCE WITH WORKERS COMPENSATION LAWS

"Compliance" with a workers compensation law is a special term that refers to things an employer must do or refrain from doing under the law, other than paying benefits for compensable accidents. First and foremost, the employer must comply by either purchasing insurance to cover its entire liability under the law or by qualifying as a self-insurer under the applicable rules. These alternative requirements are covered in detail in Chapter 6.

In most states an employer must post a prescribed notice in a conspicuous place, such as an employee bulletin board, in each place of employment.[33] The notice is usually a fairly large poster that is directed to employees and advises them that they have the right to receive compensation in certain instances. It also usually advises them of the name of the employer's current carrier and provides further information about how to make a claim.

Employers are often required to make a written report of every significant employee injury to the workers compensation administrative agency. For example, in New York an employer must report to the Workers Compensation Board, within ten days, every injury that has caused or will cause a loss of working time beyond the day on which the accident occurred or required or will require medical treatment beyond routine first aid, or more than two treatments of first aid.[34]

Another typical aspect of compliance is the obligation on the part of the employer to refrain from discriminating in any way against an employee who has claimed compensation or has been a witness in a compensation case.[35] Finally, many laws provide that an employer may not enter into any agreement with an employee regarding a waiver or surrender of compensation benefits (and that any such agreement will be unenforceable)[36]

or obligating the employee to contribute to the payment of insurance premiums.[37]

NON-OCCUPATIONAL DISABILITY BENEFIT LAWS AND COVERAGES

Currently the states of California, Hawaii, New Jersey, New York, and Rhode Island require most employers to provide employees with public or private insurance against loss of income during limited or short-term disabilities (usually six months or less) that do not arise out of and in the course of employment, such as in the case of routine, non-occupational illnesses. In New York, this requirement is contained in a separate article of the Workers Compensation Law entitled "Disability Benefits," and the coverage, which can be sold by the State Insurance Fund or by private liability or life-health insurers, is commonly called "DBL" or Disability Benefits Law coverage. Benefits under the New York law are payable at the rate of one-half of prior wages and are currently limited to a maximum of $170 per week.[38] Private insurance or self-insurance may also be used in Hawaii. In California, New Jersey, and Rhode Island disability benefits are provided under state-administered programs and are financed by employment taxes.

NOTES

1. See, for example, N. Y. W. C. Law Sec. 10(1).
2. LARSON, WORKMEN'S COMPENSATION (New York: Matthew Bender, 1996) (hereafter LARSON), Sec. 6.10.
3. Id.
4. Id., Secs. 620–50.
5. LARSON, Sec. 19.00 et seq.
6. Id., Sec. 21.00 et seq.
7. 391 N.Y.S. 2d 402 (1976).
8. 626 N.Y.S. 2d 44 (1995).
9. 502 N.Y.S. 2d 125 (1986).
10. N. Y. W. C. Law Sec. 10(2).
11. LARSON, Sec. 29.10.
12. Supra note 1.
13. Fla. Stat. Sec. 440.09.
14. See, for example, N. Y. W. C. Law Sec. 39.
15. Id.
16. Id., Sec. 44.
17. Id.

18. Id., Sec. 11.
19. Id., Sec. 29(1).
20. Id., Sec. 29(2).
21. Id.
22. U.S. CHAMBER OF COMMERCE, 1997 ANALYSIS OF WORKERS' COMPENSATION LAWS (Washington, D.C.) (hereafter 1997 ANALYSIS), pp. 7–12.
23. LARSON, Sec. 43.00.
24. Id., Sec. 43.10.
25. Id.
26. Id., Sec. 43.40.
27. Id., Sec. 43.50.
28. Id., Sec. 43.20.
29. See, for example, N. Y. W. C. Law Sec 56.
30. LARSON, Sec. 43.19.
31. Id., Sec. 87.00 et seq.
32. 77 Pa. Stat. Sec. 411.2.
33. N.Y. W. C. Law Sec. 51.
34. Id., Sec. 110.
35. Id., Sec. 120.
36. Id., Sec. 32.
37. Id., Sec. 31.
38. Id., Sec 204.

4

Benefits and Claims

MEDICAL BENEFITS

Virtually all workers compensation laws have one feature in common: they provide medical benefits that are unlimited in dollar amount and in time. In this respect, workers compensation laws do provide full compensation for employee injuries, because the amount of damages that would be awarded in a negligence action would be calculated with reference to medical care required over a lifetime, without any dollar limits. Medical benefits can be a very costly component of a claim from the insurer's or self-insured employer's point of view, because such expenses can run into the millions of dollars for even one injured person in unusual cases.

Although the term "medical" might strictly mean only services provided by physicians and hospitals, medical benefits in most states include the services of dentists, chiropractors, podiatrists, psychologists, and other health care professionals. Medical benefits include not only reimbursement for professional services and hospital stays, but also items of expense associated with various kinds of health care, such as diagnostic tests, wheelchairs and crutches, prosthetic devices, other medical appliances, and medications.[1]

There are, however, some restrictions on the amounts payable for medical expenses. First, in roughly half of the states, the injured employee does not have complete freedom of choice with regard to doctors, hospitals, or other health care providers.[2] In some of these states, the employer

is entitled to designate the provider at all stages of treatment, and in other states the employer may initially designate providers, subject to the employee's right to change providers later during the course of treatment, for personal or other reasons.

In many states, medical benefits are further restricted by the use of fee schedules for physicians and other practitioners. A good illustration is the New York fee schedule,[3] which assigns different "unit values" to many different specified services in seven major categories (medicine, physical therapy, occupational therapy, anesthesia, surgery, radiology, and pathology) that correspond closely to procedural classifications established by the American Medical Association for health insurance purposes. Each unit value in each of the major categories is multiplied by a regional conversion factor (expressed in dollars and cents) corresponding to a geographical region of the state, in order to determine the maximum permissible fee. For example, in Region 4, which includes New York City, an open or closed reduction of a fracture of the femur is currently assigned 12.5 unit values, which, multiplied by the Region 4 surgery factor of $229.04 gives a maximum fee of $2,863.00. Some states (especially those where medical costs do not vary much between urban, suburban, and rural locales) do not use regional variations and may therefore simply state a dollar amount as the maximum fee alongside the description of each service in the schedule.

INCOME (DISABILITY) BENEFITS

The second most important category of benefits is variously referred to as income, disability, indemnity, or wage-loss benefits. As part of the workers compensation compromise, an injured worker is entitled to cash benefits to replace his or her lost income, generally for an indefinite period if the disability lasts that long. However, not all workers will receive full compensation in this regard because income benefits are always subject to maximum amounts, which provide more than a subsistence level of income in most cases but will not fully replace workers' income in certain cases. For example, in New York the maximum weekly income benefit is currently $400,[4] even if the worker's pre-accident wages were, for example, $1,000 per week or more.

Income benefits are usually calculated at two-thirds, or 66-2/3 percent, of pre-accident wages, subject to a maximum that varies by state.[5] In some states, like New York, the maximum is a fixed dollar amount, which remains the same until the legislature changes it. In most states, unlike New York, the maximum is a function of an average wage that is derived

from labor statistics compiled on an annual or other periodic basis, such as the "Statewide Average Weekly Wage." Table 4.1 shows the maximum amounts currently in effect in the various states. Benefits under the United States Longshore and Harbor Workers' Compensation Act are capped at $801.06 per week, based upon 200 percent of the National Average Weekly Wage.[6] This is higher than the current maximum under any state law except for Iowa's.

TABLE 4.1
Maximum Weekly Income Benefits

State	Dollar Maximum	Percent of Statewide Average Weekly Wage
Alabama	458.00	100
Alaska	700.00	
Arizona	327.95	
Arkansas	348.00	85
California	490.00	
Colorado	468.44	91
Connecticut	678.00	100
Delaware	372.23	66-2/3
District of Columbia	748.83	100
Florida	479.00	100
Georgia	275.00	
Hawaii	501.00	100
Idaho	389.70	90
Illinois	781.17	133-1/3
Indiana	428.00	
Iowa	873.00	200
Kansas	326.00	75
Kentucky	447.03	100
Louisiana	349.00	75
Maine	441.00	90
Maryland	553.00	100
Massachusetts	585.66	100
Michigan	533.00	90
Minnesota	615.00	
Mississippi	270.67	66-2/3
Missouri	513.01	105
Montana	384.00	100

Table 4.1 (cont.)

State	Dollar Maximum	Percent of Statewide Average Weekly Wage
Nebraska	427.00	
Nevada	492.24	150
New Hampshire	756.00	150
New Jersey	480.00	75
New Mexico	363.60	85
New York	400.00	
North Carolina	512.00	110
North Dakota	387.00	100
Ohio	521.00	100
Oklahoma	426.00	100
Oregon	518.69	100
Pennsylvania	542.00	100
Puerto Rico	65.00	
Rhode Island	503.00	100
South Carolina	450.62	100
South Dakota	375.00	100
Tennessee	415.87	86-4/5
Texas	491.00	100
Utah	379.00	85
Vermont	655.00	150
Virgin Islands	287.00	66-2/3
Virginia	466.00	100
Washington	633.90	120
West Virginia	441.61	100
Wisconsin	509.00	100
Wyoming	433.33	

Source: U.S. Chamber of Commerce, *1997 Analysis of Workers' Compensation Laws* (Washington, D.C.: U.S. Chamber of Commerce, 1997), pp. 26–31.

Income benefits may be payable for total disability (usually defined as a complete loss of wage-earning capacity, not just with reference to medical or physical incapacity) or for partial disability (that is, a reduction in wage-earning capacity due to the injuries sustained). Benefits are further categorized as temporary when an end to the period of disability is foreseeable and as permanent when the disability is expected to endure indefinitely or for the employee's remaining lifetime.

SCHEDULED AWARDS FOR SELECTED INJURIES

Scheduled amounts payable for certain injuries are not to be confused with fee schedules. Fee schedules relate only to medical and other services, whereas scheduled injury awards are fixed amounts payable to the injured worker for the loss or loss of use of certain body parts and functions. They represent payment for a presumed permanent disability, regardless of any actual lost wages, and they include some component of an award for pain and suffering, or the closest thing to such a component that exists in the workers compensation field.

Scheduled awards are almost universally payable for the loss (that is, traumatic or surgical amputation) or loss of use of an arm, leg, hand, foot, thumb, finger, or toe, or more than one of the foregoing, for the loss of eyes or vision, and for loss of hearing.[7] A few states (Florida, Maine, Minnesota, Montana, Nevada, Vermont, and Wyoming) do not use scheduled awards but pay benefits according to the actual degree of impairment of the injured worker in each case. Maximum scheduled awards vary tremendously by state: loss of a leg, for example, may be worth $208,690 in Pennsylvania but only $31,200 in Colorado. There are even more extreme discrepancies: loss of an arm is compensated at a maximum of $405,407 under the Federal Employees' Compensation Act, but under the Puerto Rico law the maximum is $12,000.

Some laws provide for the award to be paid in a lump sum under some circumstances, but more commonly the award is paid out over a number of years. For example, in New York the loss of an arm generates payment at the rate of 66-2/3 percent of prior wages for 312 weeks or six years; for a leg, 288 weeks; for a thumb, 75 weeks; and for a toe other than a great toe, 16 weeks.[8] Some states also provide a scheduled award for facial disfigurement (such as a $20,000 maximum in New York).[9] The states differ in their treatment of temporary disability together with a scheduled award: depending on the state, it may be paid in addition to the scheduled award without limitation, or with limitations, or it may be deducted from the scheduled award.[10]

SURVIVORS' AND FUNERAL EXPENSE BENEFITS

Because workers compensation represents a substitute for tort remedies, it must provide benefits to surviving spouses and dependent relatives of workers who die as a result of work-related accidents, because these survivors suffer a real financial loss and would ordinarily have had a right to damages under tort law. (Technically, in a fatality case the applicable

state law may provide for the "survival" of the decedent's claim as an asset of the estate, or for an independent "wrongful death" claim that belongs directly to the surviving relatives.) Survivors' benefits currently comprise approximately 14 percent of all income benefits paid.[11]

Benefits are usually paid at the same rate as would apply if the worker were totally disabled. Payments to a spouse may be for as long as the spouse's lifetime, but it is very common for the spouse's benefits to terminate with a lump-sum payment of two years' compensation upon his or her remarriage,[12] the somewhat dubious rationale being that remarriage signals the end of the spouse's period of financial distress. Benefits to surviving children usually end at age 18 or 19, with an extension to age 23, 24, or 25 if the child is still a full-time student.[13] Different states provide for different adjustments when a spouse and one or more children survive the deceased worker.

Each state's law also provides a funeral expense or burial allowance for a deceased worker, which ranges from $1,000 to more than $7,000, depending upon the state.[14]

REHABILITATION BENEFITS

Rehabilitation of injured workers is normally divided into two categories: physical or medical rehabilitation, which refers to the regaining of full use of the body, and vocational rehabilitation, which refers to retraining and counseling in connection with the resumption of employment. The costs of rehabilitation of injured workers are frequently compensable in addition to medical benefits per se.

Many states specifically require carriers to provide one or the other,[15] or both kinds of rehabilitation, but it is usually in the carrier's best interest to do so anyway in order to limit the amount of wage-loss and other benefits payable. Many states also impose an obligation upon an injured employee to accept certain rehabilitation services as a condition to the continued receipt of full compensation benefits.[16] As in many other areas of workers compensation, each state has requirements regarding rehabilitation that are somewhat different.

COORDINATION WITH OTHER PRIVATE AND SOCIAL INSURANCE COVERAGES

From the point of view of a claimant who is injured or sick, there are various sources of potential recovery in addition to or instead of state or federal workers compensation benefits. These sources include the following:

non-occupational disability benefits under a mandatory state disability benefits law (see Chapter 3); private health insurance (individual or group); private disability income insurance (individual or group); Social Security, including Medicare and Medicaid; and automobile no-fault benefits, if an automobile accident is involved.

Most health insurance (that is, medical expense reimbursement) policies and plans contain exclusions or carve-out provisions applicable to work-related accidents and medical expenses payable under workers compensation laws. (If they did not, they would overlap unnecessarily with mandatory workers compensation insurance.) Therefore, at least in normal circumstances when an accident is easily recognized as being work-related or not, there will be no coverage under a major-medical or similar health insurance policy. Similarly, many long-term disability policies (which pay a percentage of pre-disability wages if the insured person is unable to work because of sickness or accident following a waiting period of several weeks or months) contain "setoff" or "offset" provisions that reduce the disability payments by the amount of workers compensation and Social Security payments being received. The coordination of Social Security benefits with workers compensation insurance is discussed in Chapter 2.

Most automobile no-fault laws (see Chapter 1) apply in employment contexts, but they usually provide that workers compensation is the primary source of benefits for accidents that are covered both by workers compensation and automobile no-fault. The availability of tort remedies against third parties in cases where workers compensation applies is also discussed in Chapter 3.

NON-TAXABILITY AND PROTECTION FROM CREDITORS

Workers compensation benefits, both medical and wage-loss, have traditionally been exempt, and remain exempt, from federal income taxes.[17] Because an employee's income is normally replaced only to the extent of two-thirds or some other fraction of his or her pre-accident wages, the various workers compensation laws in effect anticipate that this reduced amount will not be taxable. Workers compensation benefits are also sometimes exempt from state personal income taxes.

Finally, because one of the humanitarian purposes of workers compensation is the prevention of destitution, workers compensation income benefits are invariably made exempt under state laws (as are pension benefits, disability insurance benefits, and similar forms of income) from the

claims of creditors of the recipient.[18] These exemptions usually apply to creditors who obtain a money judgment for contractual debts or for other reasons, such as negligence in an accident situation.

ADMINISTRATIVE BOARDS AND COMMISSIONS; TIME LIMITATIONS

The substitution of a no-fault remedy and statutory benefits for negligence and damages is the major part of the workers compensation innovation. That substitution does not, however, eliminate the problems presented when there are disputed facts relative to a claim for compensation (such as what an employee was doing at the time of an injury), or when there are disputes over interpretation of the workers compensation law itself (such as whether, given certain facts, an injury arose out of and in the course of employment).

The delay and expense associated with lawsuits, attorneys, and courts are among the evils that workers compensation is intended to remedy. Because disputes over factual matters and the interpretation of laws will always arise, workers compensation seeks to remove the adjudicative process from the courts to administrative agencies which are, at least in theory, specialized and streamlined, and, therefore, better able to process claims in an efficient manner. These administrative agencies (see Table 4.2) are part of the executive branch of government rather than the judicial branch.

There are major differences between the administrative claim process and litigation in the courts. First and foremost, the administrative process dispenses with juries and places the responsibility for deciding issues of fact as well as issues of law with an administrative judge or panel of judges. Access to the appellate courts is normally available only for a review of legal issues decided by the administrative judges, not factual issues. (In technical terms, there is usually no *de novo* review of factual matters.) Second, the intricate and formal rules of evidence, such as hearsay rules, which were developed over many years especially for jury trials, are normally not fully applicable, and judges' factual decisions will not be overturned by appellate courts as long as they are based on a certain amount, sometimes called a residue, of admissible evidence.

As shown in Table 4.2, the state agencies responsible for workers compensation claims have many different kinds of names. Claims under the Federal Employers' Liability Act are handled by the Division of Federal Employees' Compensation, and United States Longshore and Harbor

TABLE 4.2
Workers Compensation Administrative Agencies or Officials

State	Agency or Official
Alabama	None (Courts)
Alaska	Workers' Compensation Board
Arizona	Industrial Commission
Arkansas	Workers' Compensation Commission
California	Division of Workers' Compensation
Colorado	Division of Workers' Compensation
Connecticut	Workers' Compensation Commissioners
Delaware	Industrial Accident Board
District of Columbia	Office of Workers' Compensation
Florida	Division of Workers' Compensation
Georgia	Board of Workers' Compensation
Hawaii	Director of Labor and Industrial Relations
Idaho	Industrial Commission
Illinois	Industrial Commission
Indiana	Workers' Compensation Board
Iowa	Industrial Commission
Kansas	Division of Workers' Compensation
Kentucky	Department of Workers' Claims
Louisiana	Office of Workers' Compensation Administration
Maine	Workers' Compensation Board
Maryland	Workers' Compensation Commission
Massachusetts	Department of Industrial Accidents
Michigan	Bureau of Workers' Disability Compensation
Minnesota	Workers' Compensation Division
Mississippi	Workers' Compensation Commission
Missouri	Division of Workers' Compensation
Montana	Department of Labor and Industry
Nebraska	Workers' Compensation Court
Nevada	Division of Industrial Relations
New Hampshire	Division of Workers' Compensation
New Jersey	Division of Workers' Compensation
New Mexico	Workers' Compensation Administration
New York	Workers' Compensation Board
North Carolina	Industrial Commission
North Dakota	Workers' Compensation Bureau
Ohio	Bureau of Workers' Compensation
Oklahoma	Workers' Compensation Court
Oregon	Workers' Compensation Division
Pennsylvania	Bureau of Workers' Compensation

Table 4.2 (cont.)

State	Agency or Official
Rhode Island	Division of Workers' Compensation
South Carolina	Workers' Compensation Commission
South Dakota	Division of Labor and Management
Tennessee	Courts and Workers' Compensation Division
Texas	Workers' Compensation Commission
Utah	Industrial Commission
Vermont	Commissioner of Labor and Industry
Virginia	Workers' Compensation Commission
Washington	Department of Labor and Industries
West Virginia	Workers' Compensation Division
Wisconsin	Workers' Compensation Division
Wyoming	Division of Workers' Compensation

Source: U.S. Chamber of Commerce, *1997 Analysis of Workers' Compensation Laws* (Washington, D.C.: U.S. Chamber of Commerce, 1997), pp. 69–76.

Workers' Compensation Act claims are administered by the Division of Longshore and Harbor Workers' Compensation, both of which agencies are within the United States Department of Labor.

CONTROVERTED CASES AND APPEALS

In New York, the Workers' Compensation Board consists of 13 members appointed by the governor with the advice and consent of the state senate. A decision of a majority of the members constitutes a decision of the board. At least four of the members must be attorneys. The board is divided into four panels, with at least one attorney member on each panel. The chairman of the board may appoint referees (more commonly called administrative judges) to conduct hearings and render decisions.[19]

The procedure followed in New York, which is fairly representative, is as follows. A controverted case is initially assigned to an administrative judge for a hearing. A physical examination of the claimant may be performed by a physician employed or designated by the board. The hearing is to be conducted in an orderly manner in order to ascertain the substantial rights of the parties, but technical rules of evidence and formal rules of procedure are not binding.

Considering the remedial purposes of the law, the claimant is provided by statute with certain generous presumptions, which basically put the

burden on the employer or carrier to submit evidence. The presumptions apply "in the absence of substantial evidence to the contrary" and include the following:

that the claim comes within the provisions of the Workers' Compensation Law (that is, that there was an accident arising out of and in the course of employment);

that sufficient notice of the claim was given (see the discussion of time limitations below);

that the injury was not the result of the employee's intention to injure himself or herself, or another person;

that the injury was not caused solely by the employee's intoxication; and

that the medical and surgical reports submitted by the claimant are prima facie evidence of the matters contained in them.[20]

An appeal from the administrative judge's decision may be taken in certain cases to a board panel, and then from the panel to the entire board. Judicial review of legal questions only (not *de novo* findings of fact) is available in the Appellate Division for the Third Department (Albany) and ultimately in the Court of Appeals.[21]

Most tort actions brought in regular courts are governed by statutes of limitation that specify that, for example, an action for personal injuries based on negligence must be commenced, usually by service of a summons and complaint on the defendant, within a certain number of years, such as three or four. Because workers compensation claims are not part of the tort system and are not usually handled in regular courts, most state laws provide for administrative time limitations within which an employee's claim must be presented to the employer and, in controverted cases, to the compensation board or other responsible agency.

The New York law, for example, contains several different time limitations. First, written notice of a compensable injury or death must be given to the employer within 30 days after the accident or death, and failure to meet this requirement will render the claim unenforceable unless "sufficient reason" for the failure is shown, the employer or its agents knew of the accident anyway, or there is no prejudice to the employer.[22] Second, a claim for compensation must be filed with the chairman of the Workers Compensation Board within two years after the accident or death, and in the case of an occupational disease, within two years after the claimant "knew or should have known" that the disease was due to the nature of the employment.[23]

After a claim is closed by denial of benefits or by a final payment, it will be considered for payment as a "reopened claim" only if an application is made within seven years after the accident or death, if compensation was previously denied, or within seven years after the accident or death and within three years after the last payment of compensation, if compensation was previously awarded.[24] In such cases, payments are made out of the Fund for Reopened Cases (see Chapter 7), rather than by the carrier or employer.

Most states require notice to the employer within a relatively short time, such as 7 to 90 days, after the accident (subject to being excused for good reasons), and filing of a claim with the responsible agency within a longer period, such as one to three years. These time limitations may be contrasted with various states' statutes of limitation applicable to tort actions, which frequently allow actions to be brought at later times, even as long as five or six years after an accident.

SETTLEMENTS AND COMPROMISES

Only a small percentage of workers compensation cases are controverted — perhaps 10 percent or fewer.[25] Nevertheless, in view of the great volume of cases arising every year, there are still tens or hundreds of thousands of contested matters. Such controversies may relate to the compensability of the accident in the first instance, the amount of benefits payable (for example, with respect to the extent of a partial disability), the persons entitled to benefits (between and among survivors), or two or more such aspects of any given case.

In most states, cases cannot be settled for less than the full amount of compensation prescribed by statute, but a minority of jurisdictions do allow compromises and settlements. Lump-sum settlements are thought to conflict with the benevolent purposes of workers compensation by presenting less-than-thrifty workers or their survivors with an opportunity to squander cash awards, but they are sometimes permitted. In almost all instances, settlements of any variety are subject to the approval of the workers compensation administrative agency.

ATTORNEY INVOLVEMENT AND ATTORNEYS' FEES

Although one of the original purposes of workers compensation laws was to reduce the expense and delays associated with attorneys and trials, attorneys have always been involved in workers compensation to some

extent. A claimant is usually entitled to be represented by an attorney in dealings with the employer or carrier and in proceedings before the compensation board or commission. Likewise, the employer or carrier is normally entitled to legal representation with regard to claims of injured employees.

The salient provision of most workers compensation laws with respect to attorneys is the requirement that attorneys' fees be approved in advance of payment by the compensation judge or administrative agency in accordance with regulatory guidelines. The states have varying standards applicable to the amount of attorneys' fees that can be approved by the agency or judge. In some states, the fees must be proportionate to the award of compensation; in other states they must be in proportion to the time or skills expended; and some states impose combinations of these kinds of requirements. New York requires that fees be "commensurate with the services rendered," but not based solely on the amount of compensation awarded.[26]

In some states, attorneys' fees are payable out of the award of compensation benefits; that is, a payment or payments will be deducted from the benefits payable to the claimant and directed to the claimant's attorney. In some of these states, there is no award of attorneys' fees unless there is an award of compensation. In another group of states, attorneys' fees may be awarded in addition to the amount of compensation payable.

NOTES

1. See, for example, N. Y. W. C. Law Sec. 13.
2. U.S. Chamber of Commerce, 1997 Analysis of Workers' Compensation Laws (Washington, D.C.) (hereafter 1997 Analysis), pp. 39–41.
3. N. Y. Workers' Compensation Board Rules and Regulations, Part 329.
4. N. Y. W. C. Law Sec. 15(6).
5. Supra note 2 at pp. 26–31.
6. Id., p. 31.
7. Id., pp. 34–36.
8. N. Y. W. C. Law Sec. 15(3).
9. Id., Sec. 15(3)(t).
10. Supra note 7.
11. 1997 Analysis, p. 25.
12. Supra note 1 at pp. 36–37.
13. Id.
14. Id., p. 36.
15. Id., pp. 43–45.
16. Id.

17. Internal Revenue Code Sec. 104(a)(1).
18. See, for example, N. Y. W. C. Law Sec. 33.
19. Id., Secs. 140-157.
20. Id., Sec. 21.
21. Id., Sec. 23.
22. Id., Sec. 18.
23. Id., Sec. 28.
24. Id., Sec. 25-a.
25. LARSON, WORKMEN'S COMPENSATION (New York: Matthew Bender, 1996), Sec. 82.10.
26. Supra note 3 at Sec. 300.17(d).

5

Special Funds and Residual Markets

SECOND INJURY FUNDS

Second injury funds are a subject unique to the field of workers compensation. They first became popular after World War II, as a way of encouraging employers to hire veterans who had physical impairments and of providing benefits to impaired employees in situations in which the benefits might otherwise be inadequate (for example, if a worker with only one arm lost his or her second arm, and was paid only for the loss of one arm). As their name suggests, they involve situations in which an employee suffers a second injury that compounds a first or previous injury.

In general, a state-administered fund is established by broad-based assessments to relieve employers and individual carriers from at least part of the cost of each compensable second injury that involves a permanent disability. The second injury is usually compensated in a way that does not penalize the employee on account of the previous injury. In this way, at least theoretically, workers receive greater protection, and employers should be less reluctant to hire impaired workers, because they are relieved from at least part of the increased risk of resulting compensation liability.

There is a great deal of variation from one second injury fund to another, but commonly the employer's or carrier's responsibility for compensation payments (medical and indemnity) ceases after 104 weeks, and the fund's responsibility begins at that time.[1] Another very common method is to calculate the fund's liability based upon the difference between the

compensation that would have been payable for the second injury alone, if the employee had not had a previous injury, and the compensation actually payable for the employee's permanent disability resulting from the combined effects of the injuries.[2] In some states, the employer or carrier makes all payments to or for the claimant, and is reimbursed by the fund for the fund's share; in other states, the fund actually takes over a direct payment function. (This latter approach may lead to inefficiencies, as discussed below.)

In addition to the variations with regard to the fund's liability versus the employer's or carrier's liability, there are various methods of determining exactly what constitutes a first injury and a second injury, and different rules as to whether the employer's knowledge of the previous condition is a prerequisite to the liability of the fund. In the original model law, the first injury had to be the loss of a specific body member, but over time most of the laws were changed to accommodate other kinds of permanent impairments. In most states, the second injury no longer has to be a permanent and total disability. Instead, the second injury is usually described as one that, combined with the first, causes a disability that is "substantially greater" than what the second injury alone would have produced. The New York statute is particularly precise on this issue. It applies when there is a "permanent physical impairment" followed by a "subsequent disability" resulting in a "permanent disability caused by both conditions that is materially and substantially greater than that which would have resulted from the subsequent injury . . . alone."[3]

With regard to the issue of employer knowledge, in 1969 New York's statute (which at the time said nothing about the issue) was interpreted by the Court of Appeals as including such a requirement,[4] but the law was amended in 1987 to provide that employer knowledge or lack of knowledge is irrelevant.[5] Many states, however, either by court decision or specific statutory provision, continue to require proof that the employer had knowledge of the prior injury. In some states a record of such knowledge can be administratively registered with a state agency in advance of any injury, in order to eliminate later problems of proof.

Methods of funding the second injury funds (which are often called something else, such as Special Disability Fund in New York) are extremely varied, and no two states are exactly alike in this area. In some states carriers are assessed based upon their workers compensation premiums and in other states based upon their claim payments during specified time periods. Other sources of revenue may be added to the funds, such as specified lump-sum amounts in fatality cases in which the deceased employee left no dependents entitled to benefits.

Generally, each second injury fund is financed, unlike the rest of the workers compensation system, on a pay-as-you-go basis. Funds needed to pay claims in a current period are raised currently and are not withdrawn from amounts previously set aside and invested. This aspect of the second injury funds, especially when combined with direct payment of claims by the funds themselves, has been blamed for multi-billion-dollar unfunded liabilities in certain states and has caused second injury funds to be regarded with disfavor. The states of Connecticut and Florida have recently closed their second injury funds on a prospective basis, and the liability of the New York fund has been limited to compensation payable after five years, rather than two years, as was previously the case.

UNINSURED EMPLOYER FUNDS

Even though most employers in most states are legally required to purchase workers compensation and to maintain it in force continuously as long as they have any employees subject to the workers compensation law, as with any law there are inevitably instances of noncompliance. As discussed in Chapter 6, if an employer fails to obtain or to maintain workers compensation insurance and a compensable accident occurs, the injured employee is usually entitled to payment of full statutory benefits directly from the employer (who may or may not be financially capable of making such payments). As an alternative, the injured employee usually has an option to sue the employer for damages if negligence or other fault is present, and the employer is deprived of the common-law defenses. (Of course, an employer who fails to maintain workers compensation coverage will invariably not have employers liability coverage either, because they are almost always sold together.) Assuming that the employee seeks no-fault benefits, and that the employer is, as might be expected in many cases, not financially responsible, there is an obvious need for another source of the benefit payments.

A number of states, including New York,[6] provide such a source in the form of a special fund called an Uninsured Employers Fund, or something similar, which satisfies the statutory benefit obligations of uninsured employers. The financing of the fund may be provided from various sources, such as fines and assessments against all uninsured employers who are found to be such, compensation awards in no-dependency death cases (where there is no living person eligible to receive survivor benefits), and recoveries by the fund from uninsured employers, who remain liable for the benefits paid by the fund on their account.

INSURANCE GUARANTY (SECURITY) FUNDS

Insurance guaranty funds are very roughly the equivalent of federal deposit insurance in the field of banking, the major difference being that the insurance guaranty funds are organized and operate at the individual state level only. Guaranty funds, which now exist in all 50 states for many kinds of life-health and property-casualty insurance, provide a source of funds to pay valid and covered claims against insurers that have become insolvent. (The term "bankrupt" is not used because insurance companies are not subject to the federal Bankruptcy Code.)[7] Each state has a life-health fund and a separate property-casualty fund. A few states, including New York, have a workers compensation fund (sometimes called a security fund) that is separate from the life-health fund and the general property-casualty fund.

Each fund generally applies to covered claims of residents of the state, but in the case of workers compensation the fund usually applies to the portion of any policy under which payments are due by virtue of the state's workers compensation law (see Chapter 7). Most claims other than workers compensation claims are subject to a monetary limit, which is commonly $300,000 ($1 million in New York), but in all states workers compensation claims are covered without limit. Many of the funds apply to claims for unearned premiums as well as claims for policy proceeds and benefits.

Each fund is financed by assessments as needed on an ongoing basis against all remaining solvent insurers in the state based upon their current (usually the prior year's) share of the total state premiums for the category of insurance in question. For this purpose, within the property-casualty funds, insurance is usually divided into the categories of automobile, workers compensation, and "all other." Therefore, for example, if a given guaranty fund needs $10 million in 1997 to pay workers compensation claims of an insolvent insurer (which may arise out of accidents that happened at any time before the insolvent insurer stopped doing business), and XYZ Insurance Company wrote 10 percent of the statewide workers compensation premiums in 1996, XYZ will be assessed $1 million toward the financing of the fund for 1997. (This method is to be contrasted with the assigned risk deficit assessment system, discussed later.)

SELF-INSURER GUARANTY FUNDS

In connection with the requirements for qualified self-insurers, many state laws provide for a funding mechanism to pay claims that are left

unpaid by self-insured employers who become insolvent and whose statutory deposits or other forms of security are also inadequate.[8] Commonly, the funding is provided by assessments, as needed, against all self-insured employers in the state. There may be a formal fund similar to a guaranty fund or simply an assessment mechanism set forth in the statute, which is binding upon self-insurers in exchange for the privilege of being self-insured.

MISCELLANEOUS FUNDS

New York and some other states have workers compensation funds for various specialized purposes. These miscellaneous funds are frequently interrelated in ways that involve a flow or spillover of money from one fund to another as cash requirements dictate from time to time.

For example, New York has an unusual fund called the Aggregate Trust Fund, into which carriers are required to pay the present value of certain long-term claims, such as those for permanent total disability.[9] The monies paid into the fund are administered by the State Insurance Fund and paid out in the same manner as if the carriers were still handling the claims, and the carriers are relieved of further legal responsibility. The rationale for such a fund is the additional measure of financial security provided to claimants and to the insolvency guaranty fund by the removal of the risk of insolvency of the responsible carrier.

New York also has a Reopened Case Fund, also called the Fund for Reopened Cases, which pays valid claims in cases that have remained administratively closed for certain time periods.[10] Generally the fund becomes involved when a claim is made and seven years have passed since the accident without payment of compensation, or seven years have passed since the accident and, in addition, three years have passed since the last payment of compensation. The fund also becomes involved when a death results from an accident after the passage of the foregoing time periods. Financing is provided by assessments against carriers and self-insureds, and by certain no-dependency fatality awards (that is, cases in which the employee is fatally injured but leaves no spouse or dependents entitled to survivor benefits).

RESIDUAL MARKET (ASSIGNED RISK) PLANS AND POOLS

Individuals and businesses are required to purchase certain kinds of property-casualty insurance, including automobile liability and workers

compensation, under many state laws and some federal laws. As discussed in Chapter 6, workers compensation insurance is required in almost all states (with the notable exception, for the time being at least, of Texas) for an employer who has the number and kinds of employees that make it subject to the workers compensation law. Because of these mandatory insurance requirements, and also to provide property insurance in certain high-risk areas such as inner cities and coastal zones, most states have assigned risk or "residual market" plans of one kind or another.

The basic concept underlying any assigned risk plan is the sharing in an equitable fashion, among all licensed insurers within a state, of the pool or residue of risks that individual carriers do not wish to insure in the usual manner (in the "voluntary market") because of their undesirable underwriting characteristics. In the case of workers compensation insurance, these characteristics may involve poor claim history, deficient safety conditions in workplaces, the small size of the business to be insured, or even the low level of approved rates generally in effect for the compensation line of business (usually called rate inadequacy). Each state that does not have a state insurance fund (see Chapter 6) has some form of workers compensation assigned risk plan under which virtually any employer, regardless of its desirability or undesirability as an insurance risk, can automatically obtain coverage through a central facility upon payment of the required premium.

Assigned risk plans generally, and workers compensation plans in particular, are to be contrasted with the utilization of unlicensed U.S. or non-U.S. insurers for unusual or very large risks — that is, so-called "surplus lines" insurers who are able to write otherwise-unavailable coverages, without being licensed in a given state, through the medium of a specially licensed surplus lines broker. Surplus lines companies are normally disqualified from writing workers compensation insurance because employers are usually required to insure their compensation liability with a licensed carrier only (so that the carrier will be properly regulated in general and required to be a member of the state's guaranty fund, as discussed previously).

The simplest version of an assigned risk plan involves a central administration facility, cooperatively run and financed by all carriers licensed in the state, that receives applications for coverage and randomly assigns them to particular carrier members based upon a quota system. Each carrier's quota, usually measured by premium, is determined by that carrier's most recent share of the statewide voluntary market for the line of insurance involved. For example, if XYZ Insurance Company wrote 10 percent of the voluntary automobile business in State W in 1996, it would

normally receive applications representing 10 percent of the assigned risk premium in 1997. Each carrier writes the assigned policies for its own account, and it may or may not have reinsurance on such policies, depending upon what it can negotiate in the reinsurance marketplace.

Automobile liability insurance provided under assigned risk plans is normally limited to relatively small amounts, such as $10,000 per person or $20,000 per accident. Workers compensation insurance, as discussed in Chapter 7, is normally unlimited in amount, and even a policy with a very small premium can potentially generate claims in the millions of dollars. Reinsurance through a professional reinsurer (normally essential for a workers compensation insurer) may not always be available for assigned risk business because it is understandably perceived as being of low quality. Therefore, the workers compensation assigned risk plans are usually structured together with a reinsurance pool comprised of all the members of the plan, that is, all licensed carriers.

The National Workers Compensation Reinsurance Pool (NWCRP) is to some extent an offshoot of the National Council on Compensation Insurance (see Chapter 6), which acts as the administrator of the pool and whose members are generally the same as the pool members. The pool, through its members, provides reinsurance to the limited numbers of servicing carriers who are selected to write all of the assigned risk policies within the various states that are covered by the pool, of which there are currently 25.[11] There are separate, statutory pools in Alabama, Maine, and New Mexico, but the effect of the NWCRP is very much the same because its operations and finances are segregated by state.

The operation of a combined plan and pool can be illustrated by a simplified, theoretical example. Assume that there are 100 carriers writing business in State A, ten of which write five percent each, for a total of 50 percent, and the remainder of which together write the remaining 50 percent. The total voluntary market is $100 million in premium, and the assigned risk market is approximately $10 million. Five of the ten major carriers are selected to serve as servicing carriers. Each of them will receive approximately 20 percent of the applications, or $2 million in premium.

The servicing carriers write and service the policies and retain a predetermined amount of premium, in the neighborhood of 30 percent, as a servicing fee to cover the expenses of underwriting, claim administration, and related functions. The remainder is distributed to all the members of the pool (including the servicing carriers themselves, in their capacity as pool members) in exchange for reinsurance of 100 percent of the losses (claims) incurred under the assigned policies. The losses for a given

policy year (all policies issued or renewed during a given calendar year) are shared in proportion to each carrier's voluntary market share for the corresponding calendar year.

For example, if Carrier Member D wrote 1 percent of the voluntary market in 1995, it would absorb 1 percent of the losses on assigned risk policies issued or renewed on any date during calendar year 1995. Because assigned risk rates are not usually high enough to subsidize all losses, it can be expected that each member will become liable for its share of claims in an amount somewhat more than the amount of premium that it has received, but at least the losses generated by the assigned risk business are evenly distributed among a large number of carriers, none of which suffers extremely adverse effects.

Prior to 1993, each carrier doing business within any of the NWCRP states was required to make an election whether to join the pool for all pool states or to receive direct assignments in all pool states. In 1993 the all-or-nothing requirement was eliminated, and carriers could thereafter decide on a state-by-state and year-by-year basis whether to participate in the pool or to accept direct assignments. For many years the servicing carriers were paid a uniform percentage of premium as determined by the Board of Governors of the NWCRP, but recently a competitive bidding process has been introduced, and now carriers must compete with each other for the opportunity to act as servicing carriers. The servicing carriers have traditionally been and currently remain subject to an ongoing auditing process to insure the completeness and integrity of their work.

A distinctive feature of most assigned risk plans is the automatic "postmark binding" of coverage. Each plan usually specifies than any employer who is "in good faith" entitled to coverage, but unable to obtain it in the voluntary market, will be covered under the plan. Only such things as nonpayment of past premiums or willful disregard of safety requirements will constitute a lack of good faith. Because there is virtually no discretion on the part of the plan administrator to issue or refuse to issue a policy, coverage can become effective on a date to be selected by the employer, which may be as early as 12:01 A.M. on the date after the mailing of the application, together with the appropriate premium, to the plan administrator.

Both the amount of premiums and the amount of deficits involved in the operations of the NWCRP and other residual market pools peaked in the early 1990's but have declined dramatically in more recent years, as shown in Table 5.1. The reasons usually cited for this improvement are: workers compensation statutory reforms, including benefit reductions, which have led to lower claim costs for employers and their carriers;

improved rate adequacy, especially with respect to assigned risk rates, combined with special assigned risk rating plans; the introduction of competitive bidding by potential servicing carriers with respect to their servicing allowances; and anti-fraud and managed care initiatives.[12]

TABLE 5.1
Combined Residual Market Pool Financial Results 1985–96

Year	Total Premium ($ billion)	Underwriting Gain or Loss ($ billion)	Combined Ratio
1985	1.2	–1.0	179
1986	2.1	–1.5	170
1987	2.6	–1.9	174
1988	2.8	–2.0	170
1989	3.5	–2.3	165
1990	3.9	–1.8	135
1991	4.4	–1.4	117
1992	4.8	–0.8	116
1993	4.1	–0.3	107
1994	3.1	–0.04	101
1995	2.0	0.02	99
1996	1.1	–0.05	105

Source: National Council on Compensation Insurance, Inc., *1997 NCCI Issues Report* (Boca Raton, Fla.: National Council on Compensation Insurance, Inc., 1997), pp. 12–13.

NOTES

1. DeCarlo & Minkowitz, WORKERS COMPENSATION INSURANCE AND LAW PRACTICE (Fort Washington, Pa.: LRP Publications, 1989), p. 196.
2. Id., p. 198.
3. N. Y. W. C. Law Sec. 15(8)(d).
4. Bellucci v. Tip Top Farms, 301 N.Y.S.2d 14 (1969).
5. Supra Note 3.
6. N. Y. W. C. Law Sec. 26-1(2).
7. 11 U.S.C. Sec. 109(b)(2).
8. See, for example, Fla. Stat. 440.385.
9. N. Y. W. C. Law Sec. 28.
10. Id., Sec. 25-1(3).
11. NCCI RESIDUAL MARKET TODAY, October–December 1997, pp. 14–21.
12. 1997 NCCI ISSUES REPORT (Boca Raton, Fla.: NCCI, 1997), p. 6.

6

Insurers and Self-Insurers

INDIVIDUAL AND GROUP SELF-INSURANCE

The term "self-insurance" may mean nothing more than engaging in a business or profession without certain kinds of property or liability insurance, or it may mean something more substantial, such as internally establishing a plan or program to set aside funds to pay for expected future losses due to accidents and other occurrences that may give rise to liability or losses. In the contexts of automobile insurance and workers compensation, self-insurance means even more than such a voluntary program. In many states, the same laws that generally make automobile liability and workers compensation insurance mandatory also provide alternative formal methods for self-insurance under regulatory control.

The question whether to purchase workers compensation insurance or to self-insure involves tax and other financial considerations. One disadvantage of self-insurance is that reserves set aside to pay for future claim payments may not be currently deductible as business expenses, whereas insurance premiums (which dispose of the same liabilities) may be. The supposed advantages of self-insurance include the avoidance of producers' commissions and insurers' overhead and profit factors. Self-insured employers are also normally in control of claim payments (either directly or through an administrator) and are therefore at least theoretically in a position to achieve savings on claim costs.

A formal self-insurance program for a very large employer may occasionally involve pure self-insurance, where no insurance company or policy is involved, but most workers compensation self-insurance programs involve at least some elements of excess insurance, as discussed below. They also frequently involve requirements pertaining to deposits of cash or securities or other methods of guaranteeing payment of benefits in the event of the insolvency of the self-insured entity. All states except North Dakota and Wyoming currently allow some form of self-insurance for workers compensation liabilities.[1]

The term "group self-insurance" may sound a bit contradictory, but it is nevertheless commonly used to describe an alternative to individual self-insurance. It involves an arrangement whereby a group of employers, usually in the same industry, distribute and share losses among themselves according to an agreed-upon formula, or even under contracts or policies issued by the group to its members, somewhat like a mutual insurance company. Of the states that allow self-insurance of any kind, approximately 32 states and territories allow group self-insurance in one form or another; the remainder allow only individual employers to be self-insured.[2]

The New York requirements for self-insurance, for example, are fairly detailed.[3] An employer seeking to be self-insured is required to deposit with the chairman of the Workers' Compensation Board either securities, cash, an irrevocable letter of credit issued by an approved bank, a bond written by a licensed surety company, or a combination of the foregoing, in amounts determined by the chairman to be adequate to secure the self-insurer's obligations. The regulations specify that the combined deposit shall not be less than the lesser of (a) and (b), where (a) is the statutory maximum weekly amount of compensation for total disability (currently $400) times 52, times 30 (a total of $624,000 under current law) and (b) is 1.5 times the self-insurer's retention under its excess insurance, but not less than $200,000. Unless specially waived, there is an accompanying requirement that the self-insurer maintain catastrophe excess insurance, covering all losses arising out of any one accident, in an amount satisfactory to the chairman. The foregoing requirements also apply to group self-insurers in New York.[4]

Self-insurance and group-self insurance both require substantial claim and other administrative work to be performed on behalf of the self-insured entities. Many self-insured employers do not wish to perform these functions internally. An independent third-party administrator retained to perform some or all of these functions for a negotiated fee may be either an insurance company, which provides administrative services

only and does not take on any insurance risk, or it may be a purely administrative organization (such as a claim adjusting company) that has satisfied any applicable licensing requirements.

As discussed in Chapter 5, workers compensation benefits, even for a single injured employee, are theoretically unlimited, and in exceptional cases (especially those involving brain injuries, paralysis, and the like) they actually do amount to millions of dollars. An accident such as a fire or an explosion involving many employees at one location can be financially catastrophic for even the largest and best-capitalized self-insured employer. Therefore, most self-insured employers ordinarily find it advisable to purchase some form of excess coverage. Very often, the purchase of specified amounts of excess insurance is required by the state agency that permits employers to become and remain self-insured, in addition to other financial requirements for self-insurance.

Like any excess insurance, this coverage may be thought of as a policy with a very large deductible, such as $100,000 or $500,000. The use of the term "excess" in this context is potentially confusing because normally an excess liability coverage applies "on top of" a primary insurance coverage; in the case of workers compensation, there is no primary coverage per se, but self-insurance instead. In any event, it definitely makes no sense to talk about primary versus excess workers compensation coverage, because any such primary coverage would invariably be unlimited (see Chapter 7) and the excess coverage would therefore be superfluous.

Excess liability insurance of most kinds, including workers compensation, is usually written either on a specific basis, an aggregate basis, or a combined specific-and-aggregate basis. The first category means that the excess insurer pays when claims arising from any one particular accident exceed a predetermined amount, called a retention. The second means that the excess coverage applies only when all claims in the aggregate during a given year exceed the retention (which would normally be higher than under a specific excess policy). Excess coverage may also be provided on a combined specific-and-aggregate basis, such as a $500,000 retention per accident, combined with an aggregate retention of $2,000,000 per policy year. In simple terms, under such an arrangement the employer will never have to pay more than $500,000 for any one accident or more than $2,000,000 for all claims arising during the year.

Excess workers compensation insurance is sometimes confused with reinsurance, especially because some professional reinsurers that usually sell only reinsurance (to other insurance companies) also sell excess workers compensation insurance to self-insurers. It must be remembered that reinsurance involves a transfer of risk from one commercial insurer

to another; a self-insurer is not a commercial insurer. Nevertheless, it may be appropriate in some cases involving group self-insurance to describe what is essentially excess coverage as reinsurance.

STATE INSURANCE FUNDS

As of 1997, six states (Nevada, North Dakota, Ohio, Washington, West Virginia, and Wyoming) and the Commonwealth of Puerto Rico have state insurance funds that are called "monopolistic" (or sometimes more politely called "exclusive"), because they are generally the only permitted source of insurance for an employer's liability under the respective state workers compensation law.[5] In other words, with a few exceptions relative to federal coverages and the like, private insurance companies are not involved in workers compensation in these jurisdictions. In these jurisdictions, it is probably fair to say that workers compensation is more like a governmental benefit program funded by taxes (sometimes called contributions rather than premiums) than anything else.

The monopolistic state insurance funds (whose names do not always sound either like insurance underwriting entities or like funds of any kind) are shown in Table 6.1.

TABLE 6.1
Monopolistic State Insurance Funds

State Industrial Insurance System (Nevada)
North Dakota Workers Compensation Bureau
Ohio Bureau of Workers Compensation
Washington Industrial Insurance State Fund
West Virginia Workers Compensation Fund
Wyoming Workers Compensation Fund

The extraterritorial effect of state workers compensation laws, discussed in Chapter 3, gives rise to special problems when a monopolistic state is involved. For example, if a New York-based employer insures, with a private insurer, its liability under the New York workers compensation law and under the laws of all other states that allow private insurance (probably by purchasing "Other States" coverage, as discussed in Chapter 7), that employer would still have no coverage for an employee

who might be injured while temporarily working in a monopolistic state or passing through that state on business. Most of the monopolistic state laws therefore provide that they do not apply to an out-of-state employee who is temporarily in the state.

As of 1997, 20 states (see Table 6.2) have governmental or quasi-governmental insurance entities, usually called state insurance funds, that provide an optional source of workers compensation insurance and are therefore at least theoretically in competition with private carriers. Most of these state funds are not permitted to refuse coverage to an employer, no matter how undesirable the risk, so long as past and current premiums

TABLE 6.2
Competitive State Insurance Funds

Name of Fund	Estimated Market Share (Percent of Statewide Premiums)
Arizona State Compensation Fund	46
California State Compensation Insurance Fund	22
Colorado Compensation Insurance Authority	47
Hawaii (not yet operative)	
Idaho State Insurance Fund	50
Kentucky Employers Mutual Insurance Authority*	8–9
Louisiana Workers Compensation Corporation*	40
Employers Mutual Insurance Company (Maine)*	45
Maryland Injured Workers' Insurance Fund	26
State Fund Mutual Insurance Company (Minnesota)	20
Missouri Employers Mutual Insurance Company*	7
State Compensation Insurance Fund (Montana)	55
New Mexico Mutual Casualty Company*	30
The State Insurance Fund (New York)	48
The State Insurance Fund (Oklahoma)	50
SAIF Corporation (Oregon)	35
State Workmen's Insurance Fund (Pennsylvania)	15
Beacon Mutual Insurance Company (Rhode Island)*	85
Texas Workers Compensation Insurance Fund*	31
Workers Compensation Fund of Utah	50

*Created or organized since 1991.

Source: *IRMI's Workers Comp: A Complete Guide to Coverage, Laws, and Cost Containment* (Dallas, Tex.: International Risk Management Institute, 1996), pp. V.P.1–V.P.19.

are paid. In this regard they are referred to as "insurers of last resort" and they take the place of an assigned risk plan or pool.

State insurance funds are normally restricted in terms of the coverages they can legally write. In particular, most of them can write only workers compensation coverage under the law of their own state, not for exposures in other states. If an employee is injured in another state, coverage will usually extend only to the benefits provided under the law of the home state. Most of the state funds write employers liability insurance as an adjunct to workers compensation insurance, and some of them provide federal coverages as well. Some of the funds deal with and pay commissions to producers, and others do not.

It has always been customary to call these entities competitive state insurance funds, but in recent years several states have created or sponsored the creation of entities that are in certain respects private companies that nevertheless function in ways similar to what might be called a traditional state fund. The state insurance funds and their respective market shares are shown in Table 6.2. Seven of these entities, those marked in Table 6.2 with an asterisk, have been created or organized since 1991. In most of these seven cases, the fund was designed as an alternative to a very large assigned risk plan that generated large losses for insurance company members and, in effect, tended to drive private carriers out of the state. In order to preserve a system that allows for private insurers, these states replaced their assigned risk plans with a state-sponsored fund or company.

State funds have certain understandably limited operating characteristics in comparison with insurers, and particularly in comparison with insurers that are licensed in multiple states. First, state funds generally do not sell or service policies through agents or brokers and, therefore, generally do not pay commissions, although some funds (such as New York's) allow the insured to designate a broker-representative.[6] Second, as might be expected, state funds usually provide coverage only for liability under their own state's workers compensation; this is usually coupled with employers liability insurance, as in private coverages.[7] Out-of-state injuries are usually covered, but only to the extent of the benefits provided under the law of the home state.

COMMERCIAL INSURERS

There were 870 private commercial insurers (many of which operate in commonly owned and managed groups) actively writing workers compensation insurance in the United States as of 1996.[8] The 20 largest

company groups (measured by 1996 nationwide written premium) are shown in Table 6.3. The companies writing workers compensation insurance, like property-casualty insurers generally, may be organized as stock, mutual, or reciprocal insurers. The stock form is essentially the same as that of most business corporations, which simply means that in concept the company is owned and controlled by its stockholders or shareholders. Mutual insurers are, at least theoretically, owned and controlled by their policyholders. Reciprocal insurers are similar to mutuals in that the policyholders insure each other through an "attorney-in-fact" who is authorized to bind them to contracts of inter-insurance.

Writing workers compensation insurance within any one state potentially involves three distinct activities: writing policies voluntarily,

TABLE 6.3
Leading Commercial Insurers

Insurer Group	1996 Premiums (millions of dollars)
American International Group	1,720
CNA Insurance Group	1,701
Liberty Mutual Group	1,598
Travelers PC Group	1,228
Hartford Insurance Group	1,161
Kemper Insurance Companies	1,096
Zurich Insurance Group (US)	928
Nationwide Group	871
Fireman's Fund Companies	563
Business Insurance Group	481
Fremont General Group	447
Talegen/TRG Insurance Groups	433
American Financial Group	397
CIGNA Group	392
Orion Capital Companies	382
General Accident Insurance Group	320
Reliance Insurance Group	304
Chubb Group	299
FCCI Insurance Group	286
St. Paul Companies	285

Source: *Best's Aggregates and Averages*, 1997 ed. (Oldwick, N. J.: A. M. Best, 1997), p. 258.

participating in the state's mandatory residual market as an assigned carrier or as a member of a pool that reinsures assigned risks, and possibly participating in the residual market as a volunteer servicing carrier. In the simplest case, a carrier will write a certain amount of voluntary premium and pay assessments based on its market share to cover losses generated by insureds in the state's assigned risk pool; as an alternative the carrier might agree to accept direct assignments, as is commonly the case in the field of automobile insurance. Many large insurers wish to participate as servicing carriers, which basically involves earning a fee for issuing policies and paying claims that are completely reinsured by a pool consisting of all licensed carriers in the state. Assigned risk plans and pools are discussed more fully in Chapter 5.

The subject of captive insurers is very extensive in itself, but for purposes of this book it may be generally described as the use by a non-insurance business enterprise or group of enterprises of an insurance company owned by the enterprise or group to insure the exposures of the enterprise or group. Captives allow for the same potential savings as self-insurance (avoidance of the costs attributable to producer commissions and insurance company profits), but they are usually created as an alternative to self-insurance for tax reasons. Premiums paid to captives may be currently tax-deductible business expenses, whereas claim payments to injured employers or others are not usually deductible until actually paid out, which may take many years; in most cases, it is to the employer's benefit to have tax deductions earlier rather than later.

Many captives are organized in offshore jurisdictions, such as Bermuda, but the laws of a few states, such as Vermont, also allow for captive formation. Captives are usually not licensed in multiple states, because they transact business only with their owners and not with the general public. This creates a distinct problem under the workers compensation laws of many states, which require employers to be covered by a carrier licensed in the state in question. (The states understandably wish to regulate workers compensation insurers for the benefit of claimants, in particular as regards coverage of claims against insolvent carriers by state guaranty funds.) Therefore, it is fairly common for a licensed, non-captive insurer to act as a "front" for an unlicensed captive in writing workers compensation insurance. In a fronting arrangement, the fronting carrier writes the policy and pays claims, but all or virtually all of the insurance risk is reinsured by the captive. The practice of fronting is generally thought to be on the borderline of legality at best, because it involves an avoidance of state licensing laws, but as a practical matter it is tolerated in many instances.

REGULATION OF POLICY FORMS AND RATES GENERALLY; THE MCCARRAN-FERGUSON ACT AND ANTITRUST LAWS

Prior to 1944 it was taken for granted by knowledgeable people in business and government that the insurance industry was properly regulated by the state insurance departments and that, in particular, the federal antitrust laws did not apply to insurance companies because of their special place in the scheme of things. This belief was formally based upon a Supreme Court decision of 1869[9] that held that insurance was not interstate commerce, as referred to in the Constitution, but something more lofty, and that Congress therefore did not have the constitutional power to regulate it.

As a result, property-casualty insurance companies had formed what might unflatteringly be called "cartels." They joined associations and agreed as members of the associations to use the same or virtually the same premium rates and, in some cases, agents' commission rates. To an extent, these arrangements made economic sense because the rates were derived from the companies' actual overall claim experience, and the use of uniform "adequate" rates tended to guarantee that individual companies would always collect enough in premiums to pay their claims. This activity would, however, normally constitute illegal price fixing if the antitrust laws applied.

Suddenly in 1944, the Supreme Court changed its mind and declared in a famous case, *United States* v. *South-Eastern Underwriters Association*,[10] that insurance was commerce and that the association and its members could be prosecuted for federal antitrust violations. Perhaps even more momentously, the decision coincidentally meant that a very large part of state insurance regulation — anything that interfered with the theoretical (but mostly unexercised) power of Congress to regulate insurance as interstate commerce — was invalid. The insurance industry asked Congress to remedy this intolerable situation, and in 1945 Congress enacted the McCarran-Ferguson Act.[11] In simple terms, the Act restored the status quo as it existed before *South-Eastern Underwriters* with a few modifications. State insurance regulation in general was validated, but the federal antitrust laws were made applicable to the extent that the business of insurance was not regulated by the states.

There have been proposals over the years to repeal or substantially amend the McCarran-Ferguson Act, but it still remains in its original form. In terms of insurance rates and policy forms, it means that insurance companies can, in a limited sense, set prices by making their rates in a

collective fashion, so long as they do so under the active supervision of a state insurance department pursuant to a state law that regulates rates and forms. There are, as might be expected, laws regulating rates and forms in all states. As might not be expected, every law is somewhat different, although there are similarities.

FINANCIAL AND MARKET CONDUCT REGULATION

In simplified terms, all of insurance regulation can be broken down into financial regulation and market conduct regulation. Financial regulation, also called solvency regulation, refers to the supervision by the state insurance departments of all states in which the insurer is licensed of the insurer's financial condition so that it remains solvent and able to pay all valid claims indefinitely. Market conduct refers to the regulation of an insurer's marketing, underwriting, and claim practices to assure that they are fair and equitable to policyholders, beneficiaries, and claimants.

Financial regulation is accomplished primarily by requiring insurers to disclose their internal financial condition annually on a standard form of annual statement, by examining their books and records periodically, by restricting them to certain kinds and mixes of investments, and by requiring them to keep adequate reserves, that is, estimates of future liabilities, on their balance sheets. Market conduct regulation includes policy form and rate filing requirements and periodic examinations to ascertain whether insurers are using approved rates and forms and otherwise complying with the insurance law and regulations as they apply to sales and claim practices.

In the context of workers compensation insurance, solvency regulation is a critical concern because employers are compelled by law to buy insurance; employees are required to accept compensation benefits over time from their employer's carrier, rather than sue their employer and obtain a judgment, the proceeds of which they could invest for themselves; and a workers compensation claim may be payable over many years or even decades after an accident occurs. In recognition of these realities, the regulatory laws usually provide, in addition to other solvency safeguards, unlimited guarantees of workers compensation claim obligations from the state guaranty funds (see Chapter 5). Rate regulation is also especially important in workers compensation because the profitability of most employer enterprises, large and small, is directly affected by changes in rates.

RATE REGULATION; THE NATIONAL COUNCIL ON COMPENSATION INSURANCE AND OTHER RATING OR ADVISORY ORGANIZATIONS

For many years the standard kind of rate regulatory law applicable to workers compensation insurance (and other lines of liability insurance) provided that insurers could make their rates and file them for approval independently, or through a licensed rating organization that was authorized to develop rates and make filings on behalf of its members.[12] In this regard, rates meant full "manual" rates (those set forth in the manual used by all companies, usually without modification) including rate components (called "loadings") for expenses and profit. Rating organizations were used to a great extent for this purpose until recently (see the section on competitive rating below).

The largest such organization, and the only one operating on a multistate basis, is the National Council on Compensation Insurance, Inc. (NCCI), which recently became a not-for-profit corporation rather than an unincorporated association as it was for many years. The NCCI currently has approximately 700 members and performs rating and other functions in approximately 30 states. Despite its name, it is not associated at all with the federal government and does not operate in all or even nearly all states. Largely due to historical happenstance, there are independent (that is, single-state) rating or advisory organizations in 12 states that take the place of the NCCI in most respects, as shown in Table 6.4. Because of the structure of their rating laws, Texas and the District of Columbia have no rating or advisory organization, nor do the six monopolistic-fund states (see above), where private workers compensation insurance is not used.

The currently used ratemaking methodology for workers compensation is basically a standard or generally accepted casualty-actuarial technique.[13] (Actuaries who practice in this area are usually qualified as fellows or associates of a national professional organization called the Casualty Actuarial Society.) The most fundamental premise of ratemaking is that the premium rates for a given set of policies (such as all policies issued or renewed in 1997 in the state of Florida) should be adequate to pay for all future losses, insurer expenses, and insurer profit with respect to those policies. If in fact the rates turn out to be more than adequate, the insurers are entitled to keep the difference; by the same token, if they turn out to be less than adequate, the insurers cannot surcharge the policies or otherwise recoup their losses (although rates for future policy years can be calculated accordingly).

TABLE 6.4
Independent Rating Organizations

Workers Compensation Insurance Rating Board (California)
Delaware Compensation Rating Bureau
Hawaii Insurance Rating Bureau
Indiana Compensation Rating Bureau
Workers Compensation Insurance Rating Bureau of Massachusetts
Minnesota Compensation Rating Bureau
New Jersey Compensation Rating and Inspection Bureau
New York Compensation Insurance Rating Board
North Carolina Rating Bureau
Pennsylvania Compensation Rating Bureau
Virginia Compensation Rating Bureau
Wisconsin Compensation Rating Bureau

The basic steps used in traditional ratemaking are as follows, and a theoretical, simplified illustration of how they might be applied is shown in Table 6.5.

1. Calculate the required overall state premium level (that is, the total amount of money expected to be needed to pay claims in the state arising out of a given policy year) by using financial data (insurers' results for workers compensation in the aggregate) and unit statistical plan data (which includes individual policy information). These sets of data are organized by policy year and calendar/accident year. The policy year method (for all policies issued or renewed in 199x) yields one set of premium and loss data and the calendar/accident year method (for all premiums written and all accidents occurring in 199x) yields another set of premium and loss data.
2. Adjust the data for loss development and trending. Basically this means using historical data with technical modifications as a prediction of what future claims will be.
3. Calculate an average cost ratio by adding the policy year cost ratio to the calendar/accident year cost ratio and dividing the total by 2.
4. Calculate a target cost ratio, which is 100 percent minus the percentage of premium allocated to expenses and profit (such as 30 percent).
5. Divide the average cost ratio by the target cost ratio. The resulting positive or negative percentage is the change needed in the overall state premium level.

6. Distribute the overall percentage change, first to each of the major industrial groups (manufacturing, contracting, and all other) and then, within certain "swing limitations" (such as 15 or 20 percent plus or minus), to the individual classifications within each group. (These limitations are necessary so that individual employers within a given classification do not experience sudden, dramatic changes in premiums, up or down.) Based upon the relative amounts of payroll represented by the various groups and classifications, the overall percentage change should take place even though individual class rates undergo different percentages of change.

TABLE 6.5
Simplified Illustration of Statewide Rate Level Calculation for Policy Year 199Y

Policy year 199x premiums = $505,000,000
Policy year 199x losses = $475,000,000

Calendar/accident year 199x premiums = $515,000,000
Calendar/accident year 199x losses = $488,000,000

Policy year 199x cost ratio = losses/premiums = 0.941
Calendar/accident year 199x cost ratio = 0.948
Average cost ratio = 0.9445

Target cost ratio = 100% − 28% = 72%

Average cost ratio ÷ target cost ratio = 0.9445/0.72 = 1.31

Rate increase to be distributed to classifications = 31%

COMPETITIVE RATING VERSUS ADMINISTERED PRICING

In the late 1940s, after passage of the McCarran-Ferguson Act, most states enacted rating laws based upon model legislation called All-Industry rating laws produced by the National Association of Insurance Commissioners. These laws were of two kinds: one for fire and marine insurance and another for casualty (that is, liability) and surety insurance. The casualty and surety law covered the workers compensation line and, like the fire and marine version, provided for insurers or rating organizations to file full manual rates, including expense and profit loadings, with the respective state insurance departments for approval prior to use.

In ordinary practice, filings were made by the NCCI or by local rating organizations on behalf of their members; individual members were then

free, under the rating laws and under the membership rules, to file for upward or downward deviations. They were also unrestricted, either by the rating laws or by the membership rules, in paying dividends (which in practical terms amount to a premium reduction), subject to whatever special provisions the laws might contain regarding regulatory approval of dividends. This system is variously known (with different degrees of expressiveness and precision) as "administered pricing," a "prior approval" system, or the use of "bureau rates."

Beginning in the 1980s, some states amended their rating laws to provide in various ways for what is generally called competitive rating.[14] Obviously, this label suggests that the old system, whether called administered pricing or something else, was not competitive or not competitive enough. Competitive rating generally involves a separation between the mostly historical "loss cost" component of rates, and the profit and expense components. The rationale for competitive rating is twofold: historical loss data, gathered from many or all companies doing business in a given state, is the best indicator of what future claims will cost and the expense and profit components of individual companies' rates should be determined by those companies individually, not on a collective basis, so that companies are forced to compete with each other in regard to things other than deviations and dividends.

In a competitive rating environment, the role of the rating organization (probably called an advisory organization or a rate service organization instead) is limited to collecting historical (that is, actual) loss information, applying actuarial techniques called "loss development" and "loss trending" to the loss information, and producing either advisory loss costs or advisory "pure premiums." After the loss costs or pure premiums are disseminated, each individual insurer must make a filing adopting them with or without modifications and supplying the insurer's own proposed expense and profit factors or multipliers. Table 6.6 shows a separation of states into the general categories of administered pricing and competitive rating.

Even in competitive rating states, rates for assigned risk workers compensation policies are usually the result of a separate administered pricing system, whereby the rating organization files final rates for use by all assigned risk carriers. In addition to experience rating, special assigned risk rating plans may apply in certain states (see Chapter 5).

TABLE 6.6
States by General Category

Administered Pricing		
Arizona	Iowa	New Jersey
Delaware	Kansas	New York
Florida	Massachusetts	North Carolina
Idaho	Mississippi	Tennessee
	Montana	Wisconsin
Competitive Rating		
Alabama	Louisiana	Oregon
Arkansas	Maine	Pennsylvania
Colorado	Maryland	Rhode Island
Connecticut	Missouri	South Carolina
District of Columbia	Nebraska	South Dakota
Hawaii	New Hampshire	Texas
Illinois	New Mexico	Utah
Indiana	Oklahoma	Vermont
Kentucky		Virginia

Source: *IRMI's Workers Comp: A Complete Guide to Coverage, Laws, and Cost Containment* (Dallas, Tex.: International Risk Management Institute, 1996), p. XI.C.4.

NOTES

1. U.S. Chamber of Commerce, 1997 ANALYSIS OF WORKERS' COMPENSATION LAWS (Washington, D.C.), pp. 4–7.
2. Id.
3. N. Y. W. C. Law Sec. 50(c).
4. N. Y. Workers Compensation Board Rules and Regulations, Parts 315–316.
5. IRMI'S WORKERS COMP: A COMPLETE GUIDE TO COVERAGE, LAWS, AND COST CONTAINMENT (Dallas, Tex.: International Risk Management Institute, 1996), p. V.B.1.
6. Id., p. V.O.1 et seq.
7. Id.
8. BEST'S AGGREGATES AND AVERAGES 1997 (P-C) (Oldwick, N.J.: A. M. Best, 1997), p. 371.
9. Paul v. Virginia, 8 Wall. 168 (1868).
10. 322 U.S. 533 (1944).
11. 15 U.S.C. Sec. 1011 et seq.
12. See, for example, N. Y. Ins. Law Art. 23.

13. See generally NCCI RATEMAKING: THE PRICING OF WORKERS COMPENSATION INSURANCE (Boca Raton, Fla.: National Council on Compensation Insurance, 1993).

14. SURVEY OF WORKERS COMPENSATION LAWS (Schaumburg, Ill.: Alliance of American Insurers, 1995), pp. 55–56.

7

Insurance Coverages and Premiums

THE STANDARD WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

Workers compensation can be thought of, for most practical purposes, as a social welfare program (combined with aspects of tort reform) that is coincidentally administered largely through the private sector. For purposes of insurance coverage, however, workers compensation laws are regarded as sources of liability and are treated very much like other liability exposures. In other words, workers compensation insurance is most definitely a branch of casualty or liability insurance, rather than a kind of accident-health insurance or employee benefit program. Significantly, the federal Employee Retirement Income Security Act, which comprehensively regulates all employee benefit plans including retirement plans, does not apply under ordinary circumstances to workers compensation insurance or self-insurance plans.[1]

Following the model of most liability insurance policies, the workers compensation policy has two distinct but closely interrelated aspects: the insurer agrees to indemnify the insured, or to pay money on the insured's behalf, on account of liabilities covered by the policy, and the insurer also agrees to defend the insured at the insurer's expense, against claims, proceedings, and lawsuits pertaining to those liabilities. The liabilities in question are, of course, those that have to do with employees' work-related accidents and illnesses. These liabilities are carefully carved out of the

coverages of other standard liability policies (such as Insurance Services Office [ISO] policies), so that in the vast majority of instances there are no gaps and no overlaps.

The standard policy invariably used by almost all carriers is called the Workers Compensation and Employers Liability Policy. The basic policy itself consists of five pages of text and an information page (see Appendix, Part X) and may include any of hundreds of standard endorsements that are filed by the National Council on Compensation Insurance (NCCI) for approval by the various insurance departments. The approved forms are compiled in a manual, called the Forms Manual for Workers Compensation and Employers Liability Insurance, which all NCCI members use to some extent.

The basic policy is divided into a General Section, which includes certain definitions, and six numbered Parts:

(1) Workers Compensation Insurance;
(2) Employers Liability Insurance;
(3) Other States Insurance;
(4) Your [the Insured's] Duties If Injury Occurs;
(5) Premium; and
(6) Conditions.

The most important provisions of the policy are contained in Parts One and Two, which correspond to insurance for workers compensation statutory benefits, and common-law and other damages, respectively. Part Three is an expansion or extension of Parts One and Two, and the remaining parts are fairly standard provisions that have close counterparts in most other kinds of liability policies.

The crucial sentence in Part One (the promise to indemnify) provides "We [the insurer] will pay promptly when due the benefits required of you [the insured] by the workers compensation law." Workers compensation law is defined in the General Section as the particular law of "each state or territory listed in Item 3A of the Information Page." This means that, in general, insurance is provided for the entire liability of the insured, as it exists from time to time under certain specified state workers compensation laws. In conceptual terms, the state laws, all changes in those laws, and all decisions interpreting those laws, are incorporated by reference, as though they were written into the policy. This generally holds true regardless of the kind or kinds of work the insured is engaged in, the place or places where the work is done, or the identity or number of the employ-

of the employees in question. In sum, these provisions taken together fulfill the insured employer's obligation to insure its entire liability under a given workers compensation law or laws.[2]

Part Three is unique in the field of liability coverages. It provides coverage for specified states, listed in Item 3C of the Information Page, where the insured does not have employees or operations (referred to as "work") at the commencement of the policy, in case a situation arises later that would expose the insured to statutory liability in any such state. (Such a situation might include an accident that befalls an employee while temporarily traveling on business or setting up a new office in such a state.) Technically this is accomplished by saying that if the insured begins "work" in one of the 3C states and does not have other insurance or self-insurance for that state, "*all provisions of the policy* will apply as though that state were listed in Item 3A of the Information Page"[3] (emphasis added). By reason of this provision, Part Two also applies to 3A states, as discussed below.

There is no premium for Other States coverage unless and until the insured begins work or operations in a state other than a 3A state, at which time the insured is required to advise the insurer so that the policy can be changed.[4] To provide very broad coverage, an insurer may agree to list in Item 3C all states other than the 3A states and the monopolistic fund states.

Part Two is radically different from Parts One and Three, because it is insurance not against statutory liability for benefits but against common-law or other liability for damages. Part Two of the policy provides that: "We [the insurer] will pay all sums you [the employer] must pay as damages because of bodily injury to your employees . . . provided that these damages are the direct consequence of bodily injury that arises out of and in the course of the injured employee's employment by you." Part Two applies to employees whose employment is "necessary or incidental" to the insured's work in a 3A or 3C state.[5] The liabilities in question may be based upon federal law or may relate to accidents that "fall through the cracks" of the state workers compensation laws and their exclusive remedy provisions. The latter cases are of five basic kinds:

where the injured employee, such as an agricultural or domestic employee, is simply not covered by the applicable workers compensation law, and is, therefore, allowed to sue the employer;

in Federal Employers' Liability Act (FELA), Jones Act, and maritime cases where the claim is for damages under common law or admiralty law, rather

than for statutory benefits (although coverage for these claims must be "added back" by endorsement, as discussed below);

(in a few states, including New York) where the employer is liable, not directly to an employee, but for contribution or indemnity to a third party (such as a product manufacturer or an owner of premises) whom the employee has sued for damages (so-called "third-party-over" actions);

(in even fewer states, if any) where the employer can be sued based upon a "dual capacity" or "dual persona" theory, for example, where the employer is also the manufacturer of a defective product that injures the employee; and

(also in very few states, if any) where a family member or dependent of the employee may have a viable claim for loss of consortium or services, or wrongful death, if such claims are not totally eliminated by the exclusive remedy rule.[6]

A most important feature of Part Two as compared with Parts One and Three is the limitation of the amount of insurance under Part Two in most states. The standard limits are $100,000 for bodily injury per accident, $100,000 for bodily injury by disease per employee, and $500,000 for bodily injury by disease per policy.[7] Higher limits are available for an additional premium. By reason of special regulatory requirements and endorsements, Part Two coverage currently has no monetary limits with regard to employees covered by the workers compensation law in the states of Massachusetts, Missouri, New Jersey, and New York.

A highly technical but sometimes important aspect of Part Two is the exclusion it contains relative to "liability assumed under a contract." This exclusion directly dovetails with the coverage of contractually assumed liability, including such liability in connection with employees, which is provided under the ISO's standard Commercial General Liability (CGL) policy. Because the CGL policy excludes all liability on account of employee injuries except assumed liability, it is commonly said that there is a "cross-over" between the two policies in this regard.

The currently used standard policy is the 1992 version. The immediately previous version, of 1984, was very similar except that federal coverages (for FELA, Jones Act, United States Longshore and Harbor Workers' Compensation Act, and so forth), which are excluded in the body of the 1992 version[8] (and now must be "added back" by endorsement if they are desired), had to be excluded by endorsement in the 1984 version. The 1992 version also includes an employment practices exclusion[9] that was not present in the 1984 version (but could be added by endorsement).

Prior to the 1984 version was the 1954 version, which perhaps surprisingly is still of importance with respect to cases that arose before 1984

(that is, where an injury took place before 1984). The most important differences between the 1954 and 1984 and 1992 versions are the following:

what is called Part One or 3A coverage in the 1984 and 1992 policies was called Coverage A or "1(a)" coverage in the 1954 policy, and Part Two coverage was called "1(b)" coverage (these older terms are still sometimes used in insurance circles, even with respect to current claims); and

the approximate equivalent of Part Three of the 1984 and 1992 policies was not part of the standard 1954 policy but was provided by an optional "Broad Form All States Endorsement" (Part Three coverage is sometimes still referred to as "All States" or "Broad Form" coverage).

ENDORSEMENTS

The official NCCI endorsements fall into two major categories, general endorsements and state endorsements. General endorsements, in turn, are broken down into federal, maritime, miscellaneous coverage and exclusion, premium, and retrospective rating. Similar breakdowns are applicable to the collections of endorsements prepared by the independent rating bureaus. State endorsements relate to such matters as deductibles, cancellation and non-renewal, special rating plans, and employee leasing. Some of the more important endorsements within the miscellaneous category are the Alternative Employer Endorsement (for use in connection with temporary workers), the Designated Workplace Exclusion Endorsement (used in connection with large construction projects), and the Voluntary Compensation and Employers Liability Coverage Endorsement (which provides that the insurer will offer the equivalent of statutory benefits to non-covered domestic employees or to employees temporarily working in foreign countries).

As discussed above, as a result of the 1992 changes to the standard policy, FELA and Maritime Coverage endorsements must now be added to the policy if these coverages are to be provided. Prior to 1992 these coverages were automatically included within the general language of Part Two and had to be excluded by endorsement if warranted by the underwriting circumstances.

CLASSIFICATIONS AND RATES; PAYROLL AS THE BASIS OF PREMIUM

Part Five of the standard policy is entitled Premium. Its most important provision is the following: "All premium for this policy will be

determined by our [the insurer's] manuals of rules, rates, rating plans and classifications. We may change our manuals and apply the changes to this policy if authorized by law or a governmental agency regulating this insurance."[10] In this context, the reference to "our manuals" is a somewhat complicated subject. It may refer either to the particular insurer's own customized manual of rates for various states, containing rates approved only for its own use, or it may refer to a rating organization's manual, or parts thereof, which contains rates that are approved for use by all member insurers. In either case, legally speaking the rates in the applicable manual are incorporated by reference into the insurance policy; that is, the insured agrees to pay premiums that can only be calculated by reference to a document other than the policy itself, which document is subject to change from time to time. (This state of affairs is roughly analogous to a citizen's obligation to pay taxes in accordance with the tax laws in effect from time to time.)

As discussed in Chapter 6, full or partial rates for workers compensation insurance, after receiving any required insurance department approvals, are compiled in manuals, the most important of which is the multi-state *Basic Manual of Workers Compensation and Employers Liability Insurance*, prepared and published by the NCCI. The *Basic Manual* generally applies in 37 jurisdictions (the District of Columbia and all states except the "independent bureau" states of California, Delaware, Hawaii, Michigan, New Jersey, New York, Pennsylvania, Texas, and the six monopolistic states) and has three major parts: Rules, Classifications, and Rates and State Exceptions. As might be expected, it is updated on an ongoing basis as rate revisions and other changes occur.

Parts 1 and 2 of the *Basic Manual* apply generally in all states in which the manual applies. Part 3 contains a separate listing of rates for each state, applicable to each of approximately 600 employer classifications, and special classifications and rules (the "State Exceptions") applicable to each state. Each classification is described by at least a name, such as "Airplane Manufacturing," and sometimes by additional wording (such as "Ammonium Nitrate Manufacturing — 4811 — Includes dehydration and graining. Manufacturing of ammonia and nitric acid to be separately rated as 4812 ammonia manufacturing and 4815 acid manufacturing respectively"). The NCCI also publishes the *Scopes of Basic Manual Classifications*, which is technically not a manual incorporated into the policy, but is nevertheless used in many instances as though it were. The *Scopes* contains more detailed descriptions of the classifications.

Rates are expressed in the manual as dollars and cents per $100 of payroll. For example, in Arizona the rate for Classification Code 3830,

Airplane Manufacturing, as of 1993 was $1.55, meaning $1.55 per $100 of payroll. The classifications, set out in Part 2, are assigned four-digit code numbers between 0000 and 9999. The NCCI classifications are similar to, and are sometimes cross-referenced with, those promulgated by the ISO for CGL insurance (the CGL classification codes). The NCCI codes are somewhat difficult to compare or cross-reference with the codes promulgated by the federal government (Standard Industrial Classification codes) because the two sets of codes have different purposes.

The most important rule pertaining to classifications provides that: "The object of the classification system is to group employers into classifications so that the rate for each classification reflects the exposures common to those employers. Subject to certain exceptions described later in this rule, it is the business of the employer within a state that is classified, not the separate employments, occupations or operations within the business."[11] In other words, as stated in another section of the Rules: "The object of the classification procedure is to assign the *one basic classification which best describes the business of the employer* within a state"[12] (emphasis added). Additional basic classifications may be assigned only if there are separate enterprises, having separate payroll records, conducted in different physical locations without interchange of labor.

The exceptions referred to are of three kinds, bearing slightly confusing labels: standard exceptions, general inclusions, and general exclusions.[13] A standard exception is, in simple terms, a special classification for a distinctive occupation that is nevertheless common to many different kinds of businesses: clerical office employees; drafting employees; drivers, chauffeurs, and helpers; and salespersons, collectors, and messengers. General inclusions mean certain kinds of operations that could be considered separate businesses but are so common that they should not be. They include commissaries and restaurants for the insured's employees, manufacture of containers for the insured's products, hospitals and medical facilities for the insured's employees, maintenance and repair of the insured's buildings and equipment, and printing or lithographing on the insured's products. No separate code numbers are needed for these operations.

Whereas the standard exceptions exist because many businesses include routine, non-manual occupations, the general exclusions exist because certain businesses include particularly unusual occupations. They are: aircraft operations; new construction and alterations by the insured's employees; stevedoring; sawmill operations; and employer-operated day care service. These operations are classified separately using the appropriate classification descriptions and codes.

Premium for each classification is almost always based upon the employer's actual total payroll, also called remuneration, for that classification during the policy period.[14] Remuneration is defined in the *Basic Manual* as money or substitutes for money, including a long list of particular items and excluding another long list of items. Among the items included are: wages, salaries, commissions, bonuses, and overtime pay (but not shift differentials or overtime pay that is separately recorded); holiday, vacation, and sick pay; Social Security contributions that the employees would otherwise have to make themselves; the value of housing, meals, and merchandise received by employees as part of their pay; and payments for salary reduction, retirement, or cafeteria plans that are deducted from employees' pay.[15] Some of the excluded items are: tips and gratuities; employer payments to group insurance or group pension plans; severance pay; work uniform allowances; and the value of "perks" such as automobiles, club memberships, and tickets to entertainment events.[16]

Because highly-compensated executive officers are nevertheless subject to the same maximum wage-loss benefits as other employees, in most states there is a payroll limitation for such officers.[17] This means that only a certain portion of the officer's remuneration, such as $1,500 or $2,000 per week, will be counted as payroll for premium calculation purposes. Similar limitations are sometimes applied to the payroll of professional athletes and other highly-compensated employees.

PREMIUM CALCULATION GENERALLY

The calculation of premium can be described by the following formulas, which involve various terms of art that may be somewhat arbitrary-sounding, but nevertheless have clearly defined meanings.

Payroll for each classification times manual rate for the respective classifications equals manual premium.

Manual premium (adjusted for minimum premium), plus or minus schedule rating credits or debits, times experience modification, equals standard premium.

Standard premium, minus premium discount, plus expense constant, equals total estimated annual premium.

The final policy premium for a given policy year is adjusted by using the actual payrolls and classifications, based upon an audit after the policy year ends, instead of the estimated payrolls and initially assigned classifications.

Obviously these terms require further explanation. The manual rate for a given classification is either the rate specified in a rating organization's

manual (in administered pricing states), or the filed and approved rate for an individual carrier (in competitive pricing states). Even in an administered pricing state, the manual rates for a particular carrier may be adjusted upward or downward by a deviation filing (see below).

Minimum premium is a dollar minimum (such as $500) for any policy, regardless of how small the estimated payroll. A minimum premium for each governing classification in each state is shown in the *Basic Manual*. Schedule ratings, which are permitted in only a few states, are discretionary percentage credits based upon an underwriter's subjective evaluation of certain safety and risk factors. A typical schedule rating credit (for example, for superior safety devices) would be 5 to 10 percent, with no more than a total of 20 or 25 percent for all credits combined. The experience modification is a multiplier, such as 1.15 or 0.95, determined by a fairly complicated formula and based upon the employer's prior claim history (see below). Premium discount (which can vary by state) is a volume discount applied to bands of premium; an example is shown in Table 7.1. It reflects the fact that larger policies involve economies of scale that require the insurer to collect less premium in order to be adequately compensated for its services.

The expense constant, in states where it is applicable, is a flat dollar amount, such as $100, that reflects the expenses of underwriting, preparing, and issuing the policy. It is often referred to appropriately as a policy fee and is charged because a policy with relatively small premiums may cost as much to underwrite and prepare as larger-premium policies.

TABLE 7.1
Sample Premium Discounts

Standard Premium (dollars)	Stock (percent)	Non-stock (percent)
First $5,000	—	—
Next $95,000	10.9	3.5
Next $400,000	12.6	5.0
Over $500,000	14.4	7.0

DEVIATIONS, DIVIDENDS, AND OTHER RATING COMPONENTS

The traditional but gradually disappearing environment of administered pricing includes two features — deviations and dividends — that

give it a competitive rather than a monopolistic aspect, despite the fact that rates are determined by rating bureaus and are at least initially uniform from one carrier to another. Most casualty rating laws provide that members of rating bureaus may file for permission to deviate from the bureau's manual rates, and that no insurer shall be restricted by membership in a rating bureau or otherwise in the payment of dividends.[18]

A deviation usually refers to a uniform percentage increase or decrease, such as 10 or 15 percent, applicable across-the-board to the rates for all classifications in effect for a given period of time. Deviation filings are commonly made by insurance company subsidiaries within a group, with the result that one subsidiary may offer "preferred" rates (a downward deviation), another may offer "substandard" rates (an upward deviation), and yet another may offer standard rates (no deviation). Filings for permission to deviate must ordinarily contain actuarial justifications for the deviation requested.[19]

Dividends (that is, policyholder dividends) in the context of insurance pricing are not to be confused with stockholder or shareholder dividends. Policyholder dividends are a partial refund of premium paid for a given period of coverage, as declared by the insurer's board of directors at the conclusion of the period of coverage and applicable to all policies within a particular, specified class (such as all policies with a policy loss ratio of less than 75 percent). Somewhat like shareholder dividends, which of course represent a distribution of earnings to shareholders, policy dividends are not guaranteed. Nevertheless, an insurer's history of dividend payments is usually a reliable indicator of what will be paid in the future and is commonly relied upon by many insurance purchasers.

Even if rates are initially fixed and uniform from one insurer to another, the escape hatches represented by deviations and dividends do allow for considerable competitive pressure on prices. For example, an insurer that can demonstrate that its overhead expenses are less than average can usually qualify for a downward deviation filing, even for standard business, and will presumably draw customers away from higher-expense insurers by doing so. Still, there is a definite trend across the nation for states to adopt a competitive pricing system of one kind or another, under which insurers must determine in advance a profit and expense component for their own rates, even though the loss component is determined by collective industry statistics.

EXPERIENCE RATING

Experience rating is governed in NCCI states by the *Experience Rating Plan Manual.* (In other states, it is governed by applicable parts of the local rating organization's manual.) The manual sets forth detailed rules and a basic arithmetic formula for calculating insureds' experience ratings, together with various values that must be used in applying the formula. In simplified terms, an experience rating is a number, such as 0.75 or 1.25, that is to be applied as a multiplier to the dollar amount of premium, before application of the premium discount. The multiplier is a quotient that equals adjusted actual losses divided by expected losses (losses in this context means the dollar amount of claims). The full-blown formula for calculating an experience rating, expressed in actuarial notation, is:

Experience Rating =

$$[Ap + WAe + (1\text{-}W)Ee + B] / [Ep + WEe + (1\text{-}W)Ee + B]$$

where:

Ap	=	Actual Primary Losses
Ae	=	Actual Excess Losses
Ep	=	Expected Primary Losses
Ee	=	Expected Excess Losses
W	=	Weighting Value
B	=	Ballast Value.

(*Note*: With regard to the discussion that follows, the reader should be warned that the mathematics involved in experience rating is highly specialized and not comprehensible to the average person or even to the average workers compensation expert.)

The actual losses used in the calculation are those incurred in a three-year period that ends one year before the effective date of the policy to which the experience rating will apply. (By necessity, reserves for unpaid losses, in addition to paid losses, will be part of the calculation.) These actual losses are first "adjusted" by being broken down into primary (up to $5,000) and excess (over $5,000) portions. This is done because the larger, excess dollar amounts are not as statistically significant; the result is that experience rating gives more weight to accident frequency than to severity. The next step is to apply tabular weighting and ballast values, as

shown above, to both the numerator and the denominator of the fraction that produces the experience rating. A weighting value, which can range from 0.07 to 0.63, depending upon the amount of expected losses, assigns a percentage weight to be given to excess losses in the calculation. The ballast value, which begins at 7,500 and increases as expected losses increase, is designed to prevent severe fluctuations in individual experience ratings and, in simple terms, to keep them within ranges that do not make premiums either very high or very low.[20]

Expected losses are calculated in a separate process, using tables of expected loss rates and discount ratios for each classification. The applicable expected loss rate for each classification is multiplied times the payroll for that classification to produce its expected losses; the discount ratio is then applied to expected losses to produce the amount of expected primary losses. Finally, the amount of expected primary losses is subtracted from expected losses to arrive at expected excess losses.

Experience rating does not apply to all policies. According to the individual states' eligibility rules (which, contrary to their label, dictate which policies are subject to mandatory experience rating), policies become eligible when premiums for a given policy year reach a dollar threshold, such as $5,000 or $7,000, set forth in the state rate pages of the *Basic Manual* and in the *Experience Rating Manual*. The rules are slightly vague with regard to the number of years of past claim experience that must be used in the calculation of a modification, but in most cases three years' worth of experience is used.[21]

Experience rating operates somewhat differently on a multi-state policy than on a single-state policy. A so-called "interstate" experience modification involves, first, a determination of which states are, according to the filed and approved rating plans, subject to interstate rating and which require an individual state modification. With respect to coverages in the states of California, Delaware, New Jersey, and Pennsylvania, a separate intrastate experience rating applies.[22] In the other states, where interstate rating is permitted, weighted-average ballast and weighting values are used; they are obtained by multiplying the expected losses for each state by the ballast and weighting values, and dividing the respective products by total expected losses.

RETROSPECTIVE RATING

Retrospective rating is a somewhat misleading term, especially when used in contrast with experience rating. Both kinds of rating plans are retrospective, but in different ways. Instead of using the loss experience for

a past policy period or periods to modify the premium on a current policy, retrospective rating uses the actual experience for the current policy period to modify the standard premium for the same period. Unlike experience rating, retrospective rating is completely optional for the insured and the carrier, and there are various kinds of retrospective rating plans that are subject to negotiation between the parties.

It is helpful to think of retrospective rating as a risk management technique that represents a blend or hybrid of insurance (usually referred to in this context as "guaranteed cost insurance") and self-insurance. In that regard, it is usually appropriate only for relatively large businesses or organizations. Use of retrospective rating will usually generate either a return premium or an additional premium after the policy period ends, but the final premium will be subject to a minimum and a maximum, such as 50 percent and 150 percent of the standard premium. Retrospective adjustments of premium, up and down, usually take place at annual intervals for an agreed-upon number of years as losses develop following the end of the policy period, after which there are no further adjustments regardless of further claim developments.

Certain standardized retrospective rating plans are covered in the NCCI's *Retrospective Rating Plan Manual for Workers Compensation and Employers Liability Insurance*, and the NCCI also publishes standardized policy endorsements that are used as attachments to a standard policy in order to implement these plans. Under the NCCI formulation, the basic formula for retrospective rating is:

Retrospective Premium = [Basic Premium + Converted Losses + Excess Loss Premium (Optional) + Retrospective Development Premium (Optional)] x Tax Multiplier

Basic premium equals standard premium times a basic premium factor that includes allowances for insurer expenses (but not unallocated loss adjustment expenses or taxes) and profits, and a net insurance charge based upon the maximum and minimum retrospective premiums selected. Converted losses equal incurred losses times a loss conversion factor that covers unallocated loss adjustment expense.

Excess loss premium refers to a separate charge for an optional feature whereby the insured and insurer agree that individual losses (claims) will not enter into the retrospective premium calculation beyond a certain dollar amount, which may range from $25,000 to an amount equal to 50 percent of standard premium. Retrospective development premium is a factor that may be used to create artificially higher premium charges at

earlier adjustments, rather than at later adjustment when losses have more fully developed. (It, therefore, does not favor the insured, and was originally intended to be a mandatory feature of retrospective rating.) Finally, a tax multiplier is applied to allow for premium taxes, assessments, and other charges that the insurer must bear but that are not provided for elsewhere in the formula.

Under the NCCI's standardized rules, a retrospective rating plan can be based upon either one year or three continuous years of coverage. It is generally recognized that the results of a three-year plan are more stable because they are based upon larger and therefore more actuarially credible numbers. A one-year plan lacks this stability but allows the insured more flexibility in changing from one plan to another.

STATISTICAL PLANS AND REPORTING

Much of the information needed to calculate experience ratings in particular, and part of the information used to calculate rates in general, is supplied to rating organizations by insurers through the use of unit statistical reports. Each insurer is required to submit a report of premiums and losses (claim payments and reserves for future payments) for each policy at the end of the policy year and subsequently at annual intervals, for as many as four years. These reports include the following details:

name of insured,
state or states covered,
policy effective date and expiration date,
risk (insured) identification number,
classification code or codes,
payroll for each code,
manual rate and premium for each code,
claim numbers,
accident date of each claim (or number of claims under $2,000),
incurred losses, separated into indemnity and medical, and
claim open or closed.

In order to calculate an individual employer's experience rating for a given policy, the payroll and loss information for prior years is transferred to a special form used for each annual calculation. The data collected from unit statistical reports regarding payroll and losses within individual

classifications are used to distribute overall state rate changes within those individual classifications, subject to swing limits and other factors, as discussed in Chapter 6.

NOTES

1. 29 U.S.C. Sec. 1003(b)(3).
2. NCCI GUIDE TO THE WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY (hereafter, NCCI GUIDE) (Boca Raton, Fla.: National Council on Compensation Insurance, 1992), p. 5.
3. Id., p. 15.
4. NCCI BASIC MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE (hereafter BASIC MANUAL) (Boca Raton, Fla.: National Council on Compensation Insurance, 1995), Rule II (C)(4).
5. NCCI GUIDE, p. 15.
6. Id., pp. 10–11.
7. BASIC MANUAL, Rule VIII (A).
8. FORMS MANUAL FOR WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE (Boca Raton, Fla.: National Council on Compensation Insurance, 1992), Part Two, Sec. C (8).
9. Id., Part Two, Sec. C (7).
10. Id., Part Five, Sec. A.
11. BASIC MANUAL, Rule IV (A).
12. Id., Rule IV (D) (1).
13. Id., Rule IV (B) (2–4).
14. Id., Rule V (A).
15. Id., Rule V (B) (2).
16. Id., Rule V (B) (3).
17. Id., Rule V (F).
18. N. Y. Ins. Law Sec. 2313(m).
19. Id., Sec. 2339.
20. NCCI ABC'S OF REVISED EXPERIENCE RATING (Boca Raton, Fla.: National Council on Compensation Insurance, 1993), p. 15.
21. NCCI EXPERIENCE RATING PLAN MANUAL (Boca Raton, Fla.: National Council on Compensation Insurance, 1980 et seq.), Part One, Sec. (II)(D).
22. Supra note 20 at p. 5.

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8

Current Trends and Issues in Workers Compensation

PROFITABILITY OF WORKERS COMPENSATION INSURANCE

Volatility of profits and earnings is an accepted part of the property-casualty insurance business. According to a prevalent theory, there is a perennial underwriting cycle that causes premiums to rise and fall, and thereby causes insurers' aggregate profits to do the same, over periods of several years. The cycle has much to do with competitive rate cutting by insurers during periods of profitability, which leads to reduced prices and profitability, followed by price increases and a lower volume of business. The results of this price competition are sometimes described in terms of fluctuating capacity, which means the total amount of capital available for insurance underwriting activities (including reinsurance on an international scale), and the associated hardness or softness of the market, meaning high rates or low rates, respectively.

Rates for many lines of business, especially workers compensation and automobile, are also influenced by regulatory factors. Regulators tend to keep rates low for political reasons until the market contracts (that is, insurers stop writing business voluntarily) to a point where rate increases must be allowed so that the public's demand for insurance coverages — particularly legally required coverages — can be fully met. As profitability increases, rate increases are again restricted, and the cycle repeats itself.

Whether the underwriting cycle is real or imaginary, workers compensation as a line of insurance does in fact go through periods of fluctuating profitability. Of course, workers compensation is a relatively "long-tail" line of business in which claims are paid out over many years or even decades, so that most statistics for recent years involve a substantial amount of reserving or estimation as to the ultimate payout. In any event, the statistics recently gathered for workers compensation as a separate line of insurance indicate that it was very unprofitable as of 1991 but has become very profitable based upon the latest statistics available in 1997 (see Table 8.1).

A combined loss ratio as referred to in Table 8.1, as opposed to a pure loss ratio, means that the insurance company expenses (underwriting, claims, commissions, general overhead, and the like) are factored into the calculations. A combined loss ratio of 100 percent or even more will almost certainly still produce a profit because many of the "losses" in question (both medical and income benefits) are payable over a long period of time, and the insurer in question can earn investment income on the reserves held to fund future benefits. A combined loss ratio less than 100 percent means that the business is definitely profitable.

The reasons usually cited for the current upswing in workers compensation profitability are: the restoration of rate adequacy in many states; legal reforms, which in many instances are simply reductions in or restrictions upon benefits (such as maximum income benefits); increased

TABLE 8.1
Underwriting Results

Year	Premiums (thousands of dollars)	Annual Change in Premiums (in percent)	Combined Ratio
1990	30,957,411	9.6	112.2
1991	31,258,040	1.0	117.8
1992	29,702,707	-5.0	116.9
1993	30,320,541	2.1	104.3
1994	28,895,217	-4.7	95.1
1995	26,171,373	-9.4	91.0

Note: Combined Ratio = Earned Premiums / (Incurred Losses + Expenses)

Source: *1997 Property/Casualty Fact Book* (New York: Insurance Information Institute, 1996), p. 27.

use of managed care techniques (see below), such as discounted-fee provider groups and heightened rehabilitation efforts; fraud detection and prevention with regard to both claims and premiums; and the relief provided by the establishment of new state insurance funds in states where the residual market deficits were previously severe.

MANAGED CARE IN WORKERS COMPENSATION

The term "managed care" in the general context of health care and insurance has become virtually a household expression as of 1997. It is undeniably a controversial subject, and because the term itself is something of a euphemism, it is placed in quotation marks in the title of this section. Managed care can be most generally defined as the use of controls or incentives to reduce the cost of medical care, theoretically without impairing the quality of that care. In practical terms, managed care often refers to the provision of prepaid health services by specially licensed entities called health maintenance organizations and by various other kinds of provider organizations or networks. Although the terminology used in this field is not always consistent, the term "preferred provider organization" is commonly used to describe a network of doctors and hospitals that contract with insurers to provide care to a defined insured population at discounted rates or subject to other restrictions.

Managed care can also refer to the use of increasingly stringent coverage and claim payment controls, such as prospective and retrospective utilization review (which basically means questioning doctors' judgments and motivations) in the context of more traditional medical insurance plans that indemnify the insured for doctors' and hospital bills. These controls may include requirements pertaining to second opinions, the use of "gatekeepers" who restrict access to specialists, pre-authorization of hospital admissions and surgical procedures and, in general, the negotiation of treatment modalities and prices in advance between insurers and health care providers.

Managed care has understandably created controversy or dislike among many members of the general public (not to mention health care providers) to the extent that managed care plans deny to their members certain treatments, services, or reimbursements to which the members feel they are entitled. From a patient's point of view, managed care may represent no more than a pretext for the self-interested denial of expensive or aggressive forms of treatment. Federal and state legislation in this area is rapidly developing to guarantee what are thought to be basic rights, such as

48-hour-minimum maternity stays in hospitals and strict time limitations upon the making of utilization or claim decisions.

The principal avenues for the use of managed care initiatives under workers compensation laws — fee schedules and provider choice restrictions — have actually been in place for decades and may be thought of in a sense as predecessors of modern managed care. The use of fee schedules has become an accepted part of non-workers compensation medical practice in the past two decades by virtue of the Medicare fee schedules and the prevalent use of schedules in preferred provider organization arrangements. Workers compensation fee schedules continue to represent a stabilizing influence upon the cost of medical services covered by compensation laws.

More contemporary managed care techniques, often labeled "reforms," usually take the form of increased statutory restrictions upon injured employees' choice with regard to health care providers, but these newer techniques are not always fully utilized even where permitted. In instances where employers, either directly or through their insurers or third-party administrators, have the right to direct employees to particular providers or networks, they often choose not to, so as to avoid creating an adversarial atmosphere that may discourage employees from returning to work and thereby prolong disability claims. (Recall also that in most states, employers may not discharge, demote, or otherwise discriminate against employees who assert workers compensation claims.)

Similarly, the use of health maintenance organizations or other integrated managed care organizations that involve capitative or per-case rates of reimbursement may be counterproductive in the workers compensation context, because aggressive forms of treatment (which are more likely to promote an earlier recovery from disabled status) are disfavored in such environments. It is becoming apparent that managed care concepts developed for the field of employee benefits are not always fully adaptable to workers compensation because, in the first place, compensation cases sometimes involve employer fault, which creates a legal and emotional tension between the parties, and in the second place, because compensation cases are ordinarily bifurcated into medical and disability income components. A technique that successfully controls one component may interfere with the control of the other component, and the control of either component may have a generally negative effect upon employee relations.

ELECTIVE WORKERS COMPENSATION LAWS

As of 1996, the three states of New Jersey, South Carolina, and Texas had, at least theoretically, elective rather than mandatory workers compensation laws. In other words, in these three states a given employer and a given employee were not inescapably bound to the no-fault and exclusive-remedy features of workers compensation, but under defined circumstances involving some kind of choice on someone's part, they might be subject to common-law or modified common-law liability concepts instead. The South Carolina law is simply no longer elective as of July 1, 1996.

The New Jersey law has been technically elective on the part of employers and employees since it was enacted in 1911. It provides that an employer and employee who enter into a contract of hire will be deemed to have accepted the no-fault law unless either elects otherwise in writing. If either elects not to be bound by that law, the employer will be subject to liability for negligence and the traditional common-law defenses will not apply; instead, the employer will be liable for negligence unless the employee is guilty of "willful negligence" as defined in the statute. It further provides that, just as an employer who is subject to the no-fault law must insure its statutory liability under the law, an employer who is not subject to the law must insure its modified common-law liability. As a practical matter, no such liability insurance currently is, or apparently ever has been, available in New Jersey, because the New Jersey Insurance Department has never approved any policy forms or rates for such a coverage (possibly because there is no statistical basis for making rates). Therefore, absent such approval, New Jersey is for all practical purposes not an elective state.

In Texas, the last of the three states, the situation is radically different. Currently, Texas law (which has undergone sweeping changes in the past decade) provides that either an employer or an individual employee may reject the application of the no-fault remedy in advance of an injury, by executing certain election forms. If the employer rejects the law — which must be done on a blanket basis, as to all employees — it can be sued for negligence and the common-law defenses are not available. There is no requirement that the employer purchase employers liability coverage in such cases.

If an employee rejects the law, he or she can sue the employer for negligence, but the common-law defenses are available to the employer. As a result, employers in Texas currently have available a substantial variety of risk management options, including standard workers compensation

insurance and many exotic varieties of employers liability insurance. Of course, they also have the option of "going bare," and in the case of small incorporated employers or others who can effectively shield themselves from personal-injury judgments, the sanctioning of that option may be viewed as the total demise of the workers compensation social idea or ideal, albeit on a local scale.

ALTERNATIVE WORKERS COMPENSATION INSURANCE PRODUCTS

In at least half of the states, employers are required to purchase a single policy in which their entire state workers compensation liability is insured, and in most other states it is standard practice for one insurer to issue one policy to cover the employer's entire liability. It is almost universally understood, in both groups of states, that the policy in question will be a liability or casualty insurance policy, issued by a company licensed to write liability insurance in general, and to write the distinct species of liability insurance known as workers compensation insurance in particular. Viewed in reverse, so to speak, these requirements and customs give rise to the possibility that in some instances, more than one policy may be used, and the policy or policies need not be of the commonly accepted liability variety.

In a few southern states, the possibility has become a reality in very recent years, due to certain highly unorthodox regulatory developments. Given the close resemblance between workers compensation benefit structures and various kinds of life, accident, and health insurance coverages (together with annuity or life-income features), creative carriers have, with regulatory accommodation, devised packages of different coverages of the life-health variety, sometimes combined with liability coverages, as alternatives to, or substitutes for, traditional workers compensation policies. For example, in Alabama, Georgia, and Louisiana, life-health insurance companies have been permitted to write policies that are combinations of accidental death, disability, and medical expense insurance (tailored to conform to the benefit requirements of the applicable workers compensation statute), sometimes to be sold together with employers liability policies issued by affiliated or non-affiliated liability insurers. In the absence of an affiliation, the liability insurer would normally be a joint venturer, or involved in a "strategic alliance" or similar group enterprise with the life insurer.

These arrangements have been motivated in substantial part by the absence or relative laxity of rate regulation applicable to the life-health

products being sold and by the apparent inapplicability of workers compensation residual market assessments (see Chapter 5). In other words, when the regulatory environment restricts workers compensation rates and where residual market charges are heavy, insurers can avoid both problems simply by writing a look-alike substitute for workers compensation insurance. This is quite apparently a loophole situation that may afford a temporary opportunity for some venturous insurers, but should not and probably will not be allowed to continue for very long. In any case, the great reduction in the residual market burden as of 1997 would appear to remove much of the incentive for such schemes.

EMPLOYEE LEASING

Employee leasing first became popular in the 1980s. It involves an arrangement whereby workers, who are paid as employees of one business entity known as a leasing firm, are furnished to another entity known as a customer or client firm for a fee that is based upon the wages paid to the workers. Employee leasing may involve temporary or permanent and full-time or part-time employees. One reason for the existence of employee leasing is the elimination of payroll and payroll-related processing and recordkeeping functions within the customer firm. Although many or most employee leasing arrangements are legitimate, they can and have been used as methods for improper or even illegal avoidance of taxes and insurance premiums.

For example, Employer X, which has a high debit experience modification (see Chapter 7), might contract with a leasing firm to hire all of Employer X's employees and simultaneously lease them back to Employer X for a monthly fee computed with reference to the employees' wages and related costs, including insurance premiums. Assuming that the leasing firm has a substantially lower debit modification than Employer X, or even a credit modification, there is an immediate saving in workers compensation premiums, which can be passed on to Employer X because the employees are now (at least ostensibly) employees of the leasing firm and their payroll will be part of the basis of premium of the leasing firm's policy. A leasing firm might even be newly and specially created for the sole purpose of hiring and re-leasing the employees of Employer X, in which case the new firm would begin with a unity (1.00) modification. A premium saving could also be accomplished, regardless of experience rating, if the leasing firm had a governing classification with a lower rate than Employer X.

Special rules regarding employee leasing are contained in the National Council on Compensation Insurance's *Basic Manual* and in the manuals of many independent rating bureaus. They usually provide that common-law rules (especially the right-to-control test) are used to determine who is the employer for workers compensation premium purposes, so that in many instances employee leasing will be disregarded and the leased workers' payroll will be charged to (that is, treated as that of) the actual employer, that is, the entity for whom and under whose supervision the work is done. If the customer firm does not provide the payroll information, the entire consideration paid under the leasing agreement will be treated as payroll.

TELECOMMUTING

Telecommuting is the name currently given to certain kinds of home-based, clerical work or employment, usually through the medium of a personal computer and modem or other electronic communication devices installed in the worker's residence and connected with the employer's office-based organization. Telecommuting has yet to become a prevalent form of work, but it is steadily increasing in popularity, especially in certain parts of the country, such as California. It satisfies environmental concerns because it reduces the level of automobile and other commutation within a community, reduces employers' workplace-related overhead expenses, and satisfies many workers' desires to remain at home for parenting and other domestic purposes.

Telecommuting raises certain problems that are interesting, but as yet mostly unresolved, with regard to workers compensation. First is the two-part question whether — and if so, exactly when — a telecommuter is a covered employee within the meaning of a given workers compensation law. Under traditional rules (see Chapter 3), an employee is basically the same as a common-law servant, who is subject to direction and control by the employer or master as to the manner and details of performing the work, not just as to the results. Obviously a worker who never even enters the employer's workplace is not subject to such direction or control in any traditional sense. The extent to which the employer uses electronic monitoring of the worker and the amount of time, if any, spent by the worker on the employer's premises may be especially relevant in this regard. It might be that the worker would be considered an employee at certain times (while under supervision) and an independent contractor at other times, perhaps even during the same workday or workweek.

Second, the question is bound to arise as to exactly what activities in the home workplace can give rise to a compensable claim. For example, if a worker is having lunch or caring for a child at home during working hours, is an accident (such as a slip and fall) to be considered as arising out of and in the course of employment? Stated differently, what accidents can be said to arise out of telecommuting employment, and when does the course of such employment begin and end? Paradoxically, the relatively safe, clerical work being performed by the typical telecommuter is to be contrasted with the possibility of accidents connected with personal activities.

Third, given the likelihood that, in many instances, a telecommuter will be hired and paid by a company whose offices are in a state other than the state of the telecommuter's residence, the question of the applicability of different states' workers compensation laws would inevitably arise (see the discussion of extraterritorial laws in Chapter 3). For example, if a worker had been interviewed and hired in New York, but worked at least partly at home in New Jersey, in the event of a compensable accident in New Jersey either the New York law or the New Jersey law might be a basis for claiming benefits. This problem spills over into the area of premium calculation, because either New York or New Jersey rates must be applied to each worker's payroll, with the choice presumably depending upon which state's law is more likely to afford a basis for claims. Especially with regard to this last problem, it appears that special underwriting rules and perhaps even statutory changes will become necessary.

"TWENTY-FOUR-HOUR" COVERAGE: THE DEMISE OF WORKERS COMPENSATION AS A SEPARATE SYSTEM?

As discussed in Chapter 1, workers compensation was one of the first social welfare programs in Europe and the United States when it was invented in the latter part of the nineteenth century and the early part of the twentieth century. At that time, employee benefit plans as we now know them, providing pensions and medical, disability, life, and accidental death insurance, among other benefits, were virtually nonexistent. Workers compensation, therefore, represented, in a certain sense, one of the first forms of employee benefits to the extent that it covered accidents involving no fault on anyone's part, or the fault of the injured employee.

The basic concept underlying the newly-emerging trend toward "24-hour" coverage (sometimes called integrated coverage or integrated benefits) is the elimination of the distinction between work-related

accidents and illnesses and those that are not work-related for the purpose of integrating workers compensation with one or more voluntary employee-benefit coverages. A typical combination or integration might be medical coverage for non-occupational injuries (whether at home, automobile-related, or otherwise) added onto workers compensation to provide 24-hour medical coverage for accidents. Twenty-four–hour concepts generally are a step in the direction of universal or nearly universal health insurance provided through the employment relationship. They also represent a tendency in the direction of providing wage-replacement benefits for all disabilities in amounts substantially above the relatively low or subsistence level currently provided by the disability component of the Social Security program.

Theoretically, there are eight different categories of coverages that can be provided in many different possible combinations, based on three sets of dichotomies, as follows:

work-related versus non-work related,
accident-only versus illness-only, and
medical benefits versus income benefits.

That is to say, combinations of the following different coverage categories are possible:

work-related, accident-only, medical benefits,
work-related, accident-only, income benefits,
work-related, illness-only, medical benefits,
work-related, illness-only, income benefits,
non-work related, accident-only, medical benefits,
non-work related, accident-only, income benefits,
non-work related, illness-only, medical benefits, and
non-work related, illness-only, income benefits.

Traditional workers compensation (including occupational disease) involves only items 1 through 4 combined. Traditional employee benefits involve one or more of the remaining items, typically items 5 and 7 in the case of employers who provide traditional, comprehensive health insurance but not disability income insurance. The broadest possible 24-hour coverage would presumably involve all eight items combined.

It is commonly observed that there are various substantial barriers or obstacles to the development of 24-hour coverage plans. These barriers are usually described as institutional or organizational and legal or regulatory. Institutional barriers (which have legal and regulatory aspects also) arise out of the pronounced division of the entire insurance business in the United States into the two domains of life-health insurance and property-casualty insurance. A given insurance company (considered as a distinct legal entity) that is licensed to write workers compensation insurance, a variety of casualty or liability insurance, is almost invariably not licensed to write life insurance or certain kinds of medical or disability insurance, and vice versa. Even when life-health and property-casualty companies are commonly owned and managed in groups, there are very distinct operating boundaries between the two kinds of companies and major discrepancies between the kinds of coverages provided.

For example, workers compensation medical benefits are dictated by state law and are usually unlimited in time and total amount, but they are often subject to state-specific fee schedules (see Chapter 4). This benefit structure is to be contrasted with the multitude of customized health insurance policies and plans provided on a voluntary basis to employees and other groups, normally not on a state-specific basis per se but governed by different state regulatory standards (for example, mandated mental health or maternity benefits). If the two medical coverages were to be integrated (so that there were no appreciable differences between benefits for a work-related accident or illness and a non-work-related accident or illness) a threshold issue would be the question of which coverage is to be made more like the other. This in turn presents a legal issue with regard to the necessity for changes either in the workers compensation law, or the laws and regulations applicable to group health coverages, or both.

Another distinct problem of a legal nature is the well-established exclusive remedy aspect of workers compensation (see Chapter 3). Benefits for compensable accidents are to be paid on a predetermined and guaranteed basis, potentially for a lifetime, in exchange for the protection from lawsuits granted to the employer. Such a trade-off does not exist in the arena of voluntary benefits, where employers are generally free to change benefit plans and coverages from time to time, and where negligence is not an issue at all. If, for example, medical benefits for accidents were provided under a single plan to employees, regardless of work-connection, should the employer retain the exclusive-remedy protection? Presumably it should, but only with respect to medical-expense elements of damages and not, for example, with respect to wage-loss elements.

An especially thorny issue is the extremely far-reaching applicability of the federal Employee Retirement Income Security Act of 1974 (ERISA), and in particular its preemption provisions. ERISA generally regulates pension plans and other employee benefits, including health insurance plans, but not any plan that is maintained solely for the purpose of complying with applicable workmen's compensation laws. It preempts (that is, supersedes) state laws that relate to the plans that it regulates, even if they do not conflict with its requirements. It does not, however, preempt state laws that regulate insurance. Taken together, these provisions mean that a state may regulate workers compensation insurance, but only if it is provided under a "plan" (an ERISA term of art) that is maintained solely for workers compensation purposes. If other elements, or even traces of them, should creep into such a plan, it might completely remove the employee-benefit aspects of workers compensation from the regulatory purview of the applicable state or states.

Conclusion

The author uses the following list of basic principles as a guide for students of workers compensation at The College of Insurance in New York City. It is reproduced here because it serves as a convenient summary and reminder of the most important concepts in this field of study.

The human costs associated with work-related accidents and illnesses should be passed on to consumers through the prices of goods and services. Determinations of fault with respect to the causation of such accidents are unnecessary and wasteful.

A covered employer is liable to pay a covered employee (or survivors) statutory benefits on account of bodily injury or death by accident arising out of and in the course of employment or by disease contracted because of the nature of the employment, in either case without regard to fault.

Adequate benefits include medical expenses without limitation and limited indemnity for loss of wage-earning capacity or death.

The employee's (or survivors') right to such benefits is the employee's (and survivors') exclusive remedy against the employer, that is, it completely replaces common-law rights and remedies. It does not replace such rights and remedies against persons other than the employer, but double recoveries are not permitted.

Each covered employer must insure its entire workers compensation liability with an authorized insurer or qualify as a self-insurer. The penalties for non-compliance may include fines, imprisonment, injunction against doing business,

loss of immunity against common-law actions, and loss of the employer's traditional defenses in such actions.

The workers compensation insurer becomes obligated to pay all benefits required of the insured employer under the workers compensation law. Disputes regarding entitlement to benefits are resolved by an administrative agency subject to limited judicial review.

The insured employer is obligated to pay premiums to the insurer in accordance with the standard policy, which incorporates filed and approved manuals of rates, rules, classifications, and rating plans.

The workers compensation rating system should be self-sustaining on a pre-funded basis, including a reasonable profit for insurers, and equitably distribute among all insured employers the cost of providing benefits.

All good-faith employers should be able to obtain workers compensation insurance from a reliable source.

The payment of workers compensation benefits by insurers should be guaranteed completely and as securely as possible.

Glossary

Actual Risk Theory: a legal theory that an accident is compensable if the risk was an actual risk of the employment, whether or not it was greater than the risk to which the general public was exposed

Administered pricing: setting of full manual rates by a rating organization, subject to insurance department approval, for use by all of the organization's insurer members (sometimes also called "prior approval")

Admiralty: the special body of quasi-international law applicable to vessels, cargo, and seamen, as opposed to the common law

Advisory organization: an organization that compiles statistics and develops advisory rates or loss costs for use by its insurer members

Assigned risk plan: a mechanism for providing insurance to employer-applicants who cannot obtain it in the voluntary market

Assumption of risk: a legal doctrine that takes away an injured person's rights to recover damages when he or she knowingly assumed the risk that caused the injury

Ballast Value (B Value): a mathematical stabilizing value used to prevent extreme fluctuations in experience ratings

Basic Manual: a multi-state manual of rates, rules, and classifications for workers compensation insurance, published by the National Council on Compensation Insurance

Black Lung benefits: cash benefits provided to certain disabled coal miners under a complex federal program

Casualty Actuarial Society: the professional society of actuaries who work in the property-casualty field

Classification: a premium category to which an insured employer is assigned, based on the nature of the work undertaken

Comparative negligence: a legal doctrine that reduces the amount of damages an injured person can recover when he or she has failed to exercise reasonable care to avoid injury

Compensable: giving rise to a valid claim for workers compensation benefits

Competitive rating: setting of advisory rates or loss costs by an advisory association for adaptation by individual insurers

Competitive state insurance fund: a governmental or quasi-governmental entity that sells workers compensation insurance in competition with private insurers

Contributory negligence: a legal doctrine that completely takes away an injured person's right to recover damages when he or she has failed to exercise reasonable care to avoid injury

Controverted claim: a claim for workers compensation benefits that is being contested in whole or in part

Death on the High Seas Act (DOHSA): a federal law that gives a person's estate the right to recover damages for that person's death on board a vessel in certain circumstances

Defense Base Act (DBA): a federal law that extends the United States Longshore and Harbor Workers' Compensation Act to civilian employees of the armed forces on defense bases in other countries

Deviation: (a) a departure from the course of employment; or (b) the use by an insurer of rates that are higher or lower than manual rates

Disability: reduction or elimination of income caused by an accident or illness

Disability benefits law: a state law that mandates short-term, non-occupational disability benefits for certain employees

Discount Ratio (D Ratio): a component of the experience rating formula that determines the percentage of losses that are expected to be "primary" rather than "excess"

Dividend (policyholder): a refund of a portion of premium to an insured after the corresponding policy has expired

Employee: one who performs work for another under a contract of hire, subject to the other person's direction and control; synonymous with a common-law "servant"

Employers liability insurance: insurance against damages payable by an employer to an employee for bodily injury or disease

Excess insurance: liability insurance that applies only when the limits of a primary policy have been exhausted

Expected Loss Ratio (ELR): a component of the experience rating formula that is multiplied by payroll to obtain Expected Losses

Experience modification or rating: adjustments of premium for a current policy based upon the insured's claim experience during earlier periods of coverage

Extraterritorial effect: applicability of a given state's workers compensation law to employers in other states

Federal Employees' Compensation Act (FECA): a federal workers compensation law applicable to civilian employees of the federal government

Federal Employers' Liability Act (FELA): a federal law that makes comparative negligence applicable in actions by interstate railroad employees against their employers

Fellow servant rule: a legal doctrine that takes away an injured person's right to recover damages when he or she has been injured by a fellow worker's negligence

Guaranty fund: a fund created by state law to cover the policy obligations of insolvent insurers

Income benefits: benefits payable on account of disability (also called disability benefits)

Increased Risk Theory: a legal theory that an accident is compensable if the risk of injury was increased by the employment, as compared with the risk to which the general public was exposed

Indemnity benefits: the same thing as income benefits or disability benefits

Independent contractor: one who performs work for another, but not as an employee or servant

Jones Act: a federal law that makes the provisions of the Federal Employers' Liability Act applicable to seamen

Larson, Arthur: a law professor at Duke University (d. 1992) who wrote a classic multi-volume treatise entitled *Workmen's Compensation*

Loadings: actuarial provisions for expenses and profit within a rate

Longshore Act — see United States Longshore and Harbor Workers' Compensation Act

Loss costs: parts of premium rates attributable only to claim payments, not to expenses or profits

Maintenance and cure: a traditional maritime remedy that generally provides a sick or injured seaman with transportation, wages, and food to the end of the voyage or beyond, and with medical treatment to the point of maximum cure

Managed care: cost controls in the provision of medical or disability benefits

Manual Premium: premium based upon payrolls and manual rates, before experience rating, premium discounts, or other adjustments

Maritime law: same as admiralty law

Medical benefits: payment for medical, dental, and other professional care and treatment required as a result of a compensable accident

Merchant Marine Act of 1920 — see Jones Act

Monopolistic state insurance fund: the governmental insurance fund for workers compensation established under the laws of a state that does not permit private insurance (also called "exclusive" state fund)

Mutual insurer: an insurer legally considered to be owned by its policyholders

National Association of Insurance Commissioners (NAIC): an organization composed of the insurance regulatory officials of all U.S. jurisdictions, which has no official power but in fact performs many important functions in the field of insurance regulation

National Council on Compensation Insurance (NCCI): a multi-state rating organization and assigned risk administrator

National Workers Compensation Reinsurance Pool (NWCRP): a reinsurance pool that covers assigned risk policies in many states

Negligence: failure to exercise reasonable care to prevent injury to another

Neutral risk: a risk that is neither personal to an employee nor distinctly job-related

No-fault law: a law applicable to bodily injuries that (a) provides benefits through insurance policies without regard to fault and (b) at least partially restricts lawsuits

Nonappropriated Fund Instrumentalities Act (NAFIA): a federal law that extends the United States Longshore and Harbor Workers' Compensation Act to civilian employees of instrumentalities of the U.S. armed forces

Occupational disease: a disease that arises because of the nature of a particular employment

Other States Coverage: the workers compensation coverage provided under Part Three of the standard policy for states where the insured does not have operations

Outer Continental Shelf Lands Act (OCSLA): a federal law that extends the United States Longshore and Harbor Workers' Compensation Act to employees working on the continental shelf

Payroll: salaries, wages, and other specified remuneration paid to employees, which serve as the basis of premium

Personal injury: in the context of workers compensation, the same thing as bodily injury

Personal risk: a risk of injury that is part of an employee's personal life and not job-related

Positional Risk Theory: a legal theory that an accident is compensable if the employment caused the employee to be in the position where the accident occurred

Premium audit: an insurer's examination of an insured's books and records after a policy expires to determine the proper final premium

Premium discount: percentage volume discounts applicable to various bands of premium

Pure premiums: the same as loss costs

Quantum Theory: the late Professor Larson's theory to the effect that the strong presence of either of the two components of "arising out of" and "in the course of employment" can compensate for the relative absence of the other

Rating organization: an organization of insurers that collects statistics and develops premium rates or components of rates

Reciprocal insurer: an arrangement whereby businesses insure each other's risks through an attorney-in-fact

Rehabilitation benefits: medical and vocational rehabilitation provided to an employee under a workers compensation law

Reinsurance: the passing off of all or part of an insurance risk by one insurer to another insurer

Residual market: the market consisting of assigned risk insureds that insurers will not voluntarily cover

Retrospective rating: adjustment of premium within certain limits, based upon the insured's claim experience within the policy period

Scheduled injury: a traumatic injury, such as loss of an arm or leg, for which a specified amount of compensation is payable regardless of disability

Second-injury fund: a fund financed by insurers within a given state that pays certain claims attributable to employees' second or subsequent injuries

Self-insurance: retention of liability risk by an employer, with or without excess insurance

Social Security: a well-known federal program that provides old age, survivors, and disability insurance, Medicare, and Medicaid

Standard Industrial Classifications: classifications of various kinds of businesses, as determined by the U.S. Department of Labor and used for statistical purposes

Standard Premium: premium as modified by the applicable experience modification, before premium discount

State Average Weekly Wage (SAWW): the statistically-determined average wage in a given state, which is often a basis for calculating maximum disability benefits

Stock insurer: an insurer legally owned by its stockholders

Stop-gap endorsement: an endorsement that covers certain liabilities under the workers compensation law of a monopolistic state

Stress claim: a claim for mental injury caused by stressful conditions of employment

Subrogation: the right of an insurer to recover all or part of a claim payment from a responsible third party

Survivors' benefits: income benefits payable to survivors of a deceased employee

Third-party action: a lawsuit by an injured employee against a responsible party other than the employer

Third-party-over action: the part of a lawsuit regarding an employee injury in which claims are asserted against an employer by a defendant, such as a manufacturer

Traumatic claim: a workers compensation claim involving an accidental injury, as opposed to an occupational disease

24-hour coverage: the expansion of workers compensation coverages or similar coverages beyond the usual places and hours of employment

United States Longshore and Harbor Workers' Compensation Act (USL&H Act): a federal workers compensation law applicable to certain longshore, shipbuilding, and related activities

Voluntary compensation: an optional coverage under which the insurer will offer the equivalent of workers compensation benefits to an injured employee who is not covered by the workers compensation law

Voluntary market: the usual market for a particular line of insurance, consisting of insurers that write policies voluntarily or decline to write them, based upon their own underwriting criteria

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Appendixes

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I

Federal Employers' Liability Act 45 U.S.C. Secs. 51–54 (1908, as amended)

Sec. 51. Liability of common carriers by railroad, in interstate or foreign commerce, for injuries to employees from negligence; employee defined

Every common carrier by railroad while engaging in commerce between any of the several States or Territories . . . shall be liable in damages to any person suffering injury while he is employed by such carrier in such commerce, or, in case of the death of such employee, to his or her personal representative, for the benefit of the surviving widow or husband and children of such employee; and, if none, then of such employee's parents; and, if none, then of the next of kin dependent upon such employee, for such injury or death resulting in whole or part from the negligence of any of the officers, agents, or employees of such carrier, or by reason of any defect or insufficiency, due to its negligence, in its cars, engines, appliances, machinery, track, roadbed, works, wharves, or other equipment.

Any employee of a carrier, any part of whose duties as such employee shall be the furtherance of interstate or foreign commerce; or shall, in any way directly or closely and substantially, affect such commerce as above set forth shall, for the purposes of this chapter, be considered as being employed by such carrier in such commerce and shall be considered as entitled to the benefits of this chapter.

Sec. 53. Contributory negligence; diminution of damages

In all actions on and after April 22, 1908 brought against any such common carrier by railroad under or by virtue of any of the provisions of this chapter to recover damages for personal injuries to an employee, or where such injuries have resulted in his death, the fact that the employee may have been guilty of contributory negligence shall not bar a recovery, but the damages shall be diminished by the jury in proportion to the amount of negligence attributable to such employee; Provided, that no such employee who may be injured or killed shall be held to have been guilty of contributory negligence in any case where the violation by such common carrier of any statute enacted for the safety of employees contributed to the injury or death of such employee.

Sec. 54. Assumption of risks of employment

In any action brought against any common carrier under or by virtue of any of the provisions of this chapter to recover damages for injuries to, or the death of, any of its employees, such employee shall not be held to have assumed the risks of his employment in any case where such injury or death resulted in whole or in part from the negligence of any of the officers, agents, or employees of such carrier; and no employee shall be held to have assumed the risks of his employment in any case where the violation by such common carrier of any statute enacted for the safety of employees contributed to the injury or death of such employee.

II

Merchant Marine Act of 1920
(Jones Act)
46 U.S.C. Sec. 688

Sec. 688. Recovery for injury to or death of seaman

Any seaman who shall suffer personal injury in the course of his employment may, at his election, maintain an action for damages at law, with the right of trial by jury, and in such action all statutes of the United States modifying or extending the common-law right or remedy in cases of personal injury to railway employees shall apply; and in case of the death of any seaman as a result of any such personal injury the personal representative of such seaman may maintain an action for damages at law with the right of trial by jury, and in such action all statutes of the United States conferring or regulating the right of action for death in the case of railway employees shall be applicable. Jurisdiction in such actions shall be under the court of the district in which the defendant employer resides or in which his principal office is located.

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III

Death on the High Seas Act
46 U.S.C. Sec. 761 et seq.
(1920)

Sec. 761. Right of action; where and by whom brought

Whenever the death of any person shall be caused by a wrongful act, neglect, or default occurring on the high seas beyond a marine league from the shore of any State, or the District of Columbia, or the Territories or dependencies of the United States, the personal representative of the decedent may maintain a suit for damages in the district courts of the United States, in admiralty, for the exclusive benefit of the decedent's wife, husband, parent, child, or dependent relative against the vessel, person, or corporation which would have been liable if death had not ensued.

Sec. 762. Amount and apportionment of recovery

The recovery in such suit shall be a fair and just compensation for the pecuniary loss sustained by the persons for whose benefit the suit is brought and shall be apportioned among them by the court in proportion to the loss they may severally have suffered by reason of the death of the person by whose representative the suit is brought.

Sec. 763. Contributory negligence

In suits under this chapter the fact that the decedent has been guilty of contributory negligence shall not bar recovery, but the court shall take into consideration the degree of negligence attributable to the decedent and reduce the recovery accordingly.

IV

United States Longshore and Harbor Workers' Compensation Act 33 U.S.C. Sec. 901 et seq. (1927, As Amended Through 1984)

Sec. 902. Definitions

When used in this chapter —

(2) The term "injury" means accidental injury or death arising out of and in the course of employment, and such occupational disease or infection as arises naturally out of such employment or as naturally or unavoidably results from such accidental injury, and includes an injury caused by the willful act of a third person directed against an employee because of his employment.

(3) The term "employee" means any person engaged in maritime employment, including any longshoreman or other person engaged in longshoring operations, and any harbor-worker including a ship repairman, shipbuilder, and ship-breaker, but such term does not include —

(A) individuals employed exclusively to perform office clerical, secretarial, security, or data processing work;

(B) individuals employed by a club, camp, recreational operation, restaurant, museum, or retail outlet;

(C) individuals employed by a marina and who are not engaged in construction, replacement, or expansion of such marina (except for routine maintenance);

(D) individuals who (i) are employed by suppliers, transporters, or vendors, (ii) are temporarily doing business on the premises of an employer described in

paragraph (4), and (iii) are not engaged in work normally performed by employees of that employer under this Act;

(E) aquaculture workers;

(F) individuals employed to build, repair, or dismantle any recreational vessel under sixty-five feet in length;

(G) a master or member of a crew of any vessel; or

(H) any person engaged by a master to load or unload or repair any small vessel under eighteen tons net;

if individuals described in clauses (A) through (F) are subject to coverage under a State workers' compensation law.

(4) The term "employer" means an employer any of whose employees are employed in maritime employment, in whole or in part, upon the navigable waters of the United States (including any adjoining pier, wharf, dry dock, terminal, building way, marine railway, or other adjoining area customarily used by an employer in loading, unloading, repairing, or building a vessel).

Sec. 903. Coverage

(a) Disability or death; injuries occurring upon navigable waters of United States.

Except as otherwise provided in this section, compensation shall be payable under this Act in respect of disability or death of an employee, but only if the disability or death results from an injury occurring upon the navigable waters of the United States (including any adjoining pier, wharf, dry dock, terminals, building way, marine railway, or other adjoining area customarily used by an employer in loading, unloading, repairing, dismantling, or building a vessel).

Sec. 904. Liability for compensation

(a) Every employer shall be liable for and shall secure the payment of compensation to his employees of the compensation payable under sections 907, 908, and 909 of this title.

(b) Compensation shall be payable irrespective of fault as a cause for the injury.

V

Federal Employees' Compensation Act 5 U.S.C. Sec. 8102 et seq.

Sec. 8102. Compensation for disability or death of employee

(a) The United States shall pay compensation as specified by this subchapter for the disability or death of an employee resulting from personal injury sustained while in the performance of his duty, unless the injury or death is —

(1) caused by willful misconduct of the employee;

(2) caused by the employee's intention to bring about the injury or death of himself or of another; or

(3) proximately caused by the intoxication of the injured employee.

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VI

New York State Constitution Article 1, Section 18

Nothing contained in this constitution shall be construed to limit the power of the legislature to enact laws for the protection of the lives, health, or safety of employees; or for the payment, either by employers, or by employers and employees or otherwise, either directly or through a state or other system of insurance or otherwise, of compensation for injuries to employees or for death of employees resulting from such injuries without regard to fault as a cause thereof, except where the injury is occasioned by the wilful intention of the injured employee to bring about the injury or death of himself or of another, or where the injury results solely from the intoxication of the injured employee while on duty; or for the adjustment, determination and settlement, with or without trial by jury, of issues which may arise under such legislation; or to provide that the right of such compensation, and the remedy therefor shall be exclusive of all other rights and remedies for injuries to employees or for death resulting from such injuries; or to provide that the amount of such compensation for death shall not exceed a fixed or determinable sum; provided that all moneys paid by an employer to his employees or their legal representatives, by reason of the enactment of any of the laws herein authorized, shall be held to be a proper charge in the cost of operating the business of the employer.

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VII

New York Workers' Compensation Law

Sec. 10. Liability for compensation [Accidental Injuries]

1. Every employer subject to this chapter shall in accordance with this chapter . . . secure compensation to his employees and pay or provide compensation for their disability or death from injury arising out of and in the course of the employment without regard to fault as a cause of the injury, except that there shall be no liability for compensation under this chapter when the injury has been solely occasioned by intoxication from alcohol or a controlled substance of the injured employee while on duty; or by the wilful intention of the injured employee to bring about the injury or death of himself or another.

Sec. 11. Alternative remedy

The liability of an employer prescribed by the last preceding section shall be exclusive and in place of any other liability whatsoever, to such employee, his personal representatives, spouse, parents, dependents or next of kin, or anyone otherwise entitled to recover damages, at common law or otherwise on account of such injury or death, except that if any employer fails to secure the payment of compensation for his injured employees and their dependents as provided in section fifty of this chapter, an injured employee, or his legal representative in case death results from the injury, may, at his option, elect to claim compensation under this chapter, or to maintain an action in the courts for damages on account of

such injury; and in such an action it shall not be necessary to plead or prove freedom from contributory negligence nor may the defendant plead as a defense that the injury was caused by the negligence of a fellow servant nor that the employee assumed the risk of his employment, nor that the injury was due to the contributory negligence of the employee.

Sec. 13. Treatment and care of injured employees

(a) The employer shall promptly provide for an injured employee such medical, surgical, optometric or other attendance or treatment, nurse and hospital service, medicine, optometric services, crutches, eye-glasses, false teeth, artificial eyes, orthotics, functional assistive and adaptive devices and apparatus for such period as the nature of the injury or the process of recovery may require. . . . All fees and other charges for such treatment and services shall be limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living. . . . The chair [of the Workers' Compensation Board] shall establish a schedule for the state, or schedules limited to defined localities, of charges and fees for such medical treatment and care, to be determined in accordance with and to be subject to change pursuant to rules promulgated by the chair. . . . The amounts payable by the employer for such treatment and services shall be the fees and charges established by such schedule.

Sec. 15. Schedule in case of disability

The following schedule of compensation is hereby established:

1. Permanent total disability. In case of total disability adjudged to be permanent, sixty-six and two-thirds per centum of the average weekly wages shall be paid to the employee during the continuance of such total disability. Loss of both hands, or both arms, or both feet, or both legs, or both eyes, or of any two thereof shall, in the absence of conclusive proof to the contrary, constitute permanent total disability. In all other cases permanent total disability shall be determined in accordance with the facts.

2. Temporary total disability. In case of temporary total disability, sixty-six and two-thirds per centum of the average weekly wages shall be paid to the employee during the continuance thereof, except as otherwise provided in this chapter.

3. Permanent partial disability. In case of disability partial in character but permanent in quality the compensation shall be sixty-six and two-thirds per centum of the average weekly wages and shall be paid to the employee for the period named in this subdivision, as follows:

Member lost	Number of weeks' compensation
a. Arm	312
b. Leg	288
c. Hand	244
d. Foot	205
e. Eye	160
f. Thumb	75

[Shorter periods are provided for fingers and toes.]

m. Loss of hearing. Compensation for the complete loss of hearing of one ear, for sixty weeks, for the loss of hearing of both ears, for one hundred and fifty weeks.

w. Other cases. In all other cases in this class of disability, the compensation shall be sixty-six and two-thirds per centum of the difference between his average weekly wages and his wage-earning capacity thereafter in the same employment or otherwise, payable during the continuance of such partial disability.

5. Temporary partial disability. In case of temporary partial disability resulting in decrease of earning capacity, the compensation shall be two-thirds of the difference between the injured employee's average weekly wages before the accident and his wage earning capacity after the accident in the same or other employment.

6. Maximum and minimum compensation for disability. Compensation for permanent or temporary total disability due to an accident or disablement from an occupational disease that occurs . . . on or after July first, nineteen hundred ninety-two, shall not exceed four hundred dollars per week.

Sec. 16. Death benefits. If the injury causes death, the compensation shall be known as a death benefit and shall be payable in the amount and to or for the benefit of the persons following:

1. Funeral expenses. [Omitted.]

1-c. [Spouse and no children] If there be a surviving spouse and no child of the deceased under the age of eighteen years or under the age of twenty-three years if enrolled and attending as a full-time student in an accredited educational institution . . . and no child of any age dependent blind or physically disabled, and the death occurs on or after January first, nineteen hundred seventy-eight, to such spouse sixty-six and two-thirds per centum of the average wages of the deceased during widowhood or widowerhood with two years' compensation, in one sum, upon remarriage.

2-a. [Spouse and one child] If there be a surviving spouse and a surviving child under the age of eighteen years or under the age of twenty-three years if enrolled and attending as a full time student in an accredited educational institution and such enrollment and full time attendance is certified by such institution or a surviving child of any age dependent blind or physically disabled and the death occurs on or after January first, nineteen hundred seventy-eight, to such spouse thirty-six and two-thirds per centum of the average wages of the deceased during widowhood or widowerhood with two years' compensation in one sum, upon remarriage; and thirty per centum of such wages to such child under the age of eighteen years or under the age of twenty-three years if enrolled and attending as a full time student in an accredited educational institution and such enrollment and full time attendance is certified by such institution or a surviving child of any age dependent blind or physically disabled; in case of the subsequent death of such surviving spouse the surviving child shall have his compensation increased to sixty-six and two-thirds per centum of such wages and the same shall be payable so long as he is under the age of eighteen years or under the age of twenty-three years if enrolled and attending as a full time student in an accredited educational institution and such enrollment and full time attendance is certified by such institution or a surviving child of any age dependent blind or physically disabled; upon statutory termination of compensation payable to such child, the compensation of the surviving spouse shall be increased to sixty-six and two-thirds per centum of such wages with two years' compensation, at such rate, in one sum, upon remarriage. Upon remarriage of such surviving spouse, the surviving child shall continue to receive thirty per centum of such wages.

[Spouse and two or more children] If there be a surviving spouse and two or more surviving children . . . and a death occurs on or after January first, nineteen hundred seventy-eight, to such spouse thirty-six and two-thirds per centum of the average wages of the deceased during widowhood or widowerhood with two years' compensation in one sum upon remarriage; and thirty per centum of such wages to such children . . . share and share alike. [Further details omitted.]

[Other provisions relating to benefits for surviving children when there is no surviving spouse, and benefits for dependent grandchildren, brothers and sisters, parents, and grandparents in cases where there is no surviving spouse and no surviving children, are omitted.]

Sec. 39. Right to compensation [Occupational Diseases]

If an employee is disabled or dies and his disability or death is caused by one of the diseases mentioned in subdivision two of section three, and the disease is due to the nature of the corresponding employment as described in such subdivision in which such employee was engaged and was contracted therein, he or his dependents shall be entitled to compensation for the duration of his disablement or for his death in accordance with the provisions of articles two and three of this chapter.

Sec. 44. Liability of employer [Occupational Diseases]

The total compensation due [under Sec. 39] shall be recoverable from the employer who last employed the employee in the employment to the nature of which the disease was due and in which it was contracted. If, however, such disease (except silicosis or other dust disease and compressed air illness or its sequelae) was contracted while such employee was in the employment of a prior employer, the employer who is made liable for the total compensation as provided by this section, may appeal to the [Workers' Compensation] board for an apportionment of such compensation among the several employers who since the contraction of such disease shall have employed such employee in the employment to the nature of which the disease was due.

Sec 50. Security for payment of compensation

An employer shall secure compensation to his employees in one or more of the following ways:

1. By insuring and keeping insured the payment of such compensation in the state fund; or
2. By insuring and keeping insured the payment of such compensation with any stock corporation, mutual corporation or reciprocal insurer authorized to transact the business of workmen's compensation insurance in this state.
3. By furnishing satisfactory proof to the chairman [of the Workers' Compensation Board] of his financial ability to pay such compensation for himself, in which case the chairman shall require the deposit with the chairman of such securities as the chairman may deem necessary . . . or the deposit of cash or the filing of irrevocable letters of credit issued by a qualified banking institution . . . or the filing of a bond of a surety company authorized to transact business in this state, in an amount to be determined by the chairman, or the posting and filing as aforesaid of a combination of such securities, cash, irrevocable letters of credit and surety bond.

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VIII

Ives v. *South Buffalo Railway Company* 201 N.Y. 271, 94 N.E. 431 (1912)

Werner, J. In 1909 the legislature passed a law (Chap. 518) providing for a commission of fourteen persons . . . "to make inquiry, examination and investigation into the working of the law in the State of New York relative to the liability of employers to employees for industrial accidents, and into the comparative efficiency, cost, justice, merits, and defects of the laws of other industrial states and countries, relative to the same subject, and as to the causes of the accidents to employees." . . . As the result of its labors the commission recommended for adoption the bill which, with slight changes, was enacted into law by the legislature of 1910, under the designation of article 14-a of the Labor Law. This act is modeled on the English Workmen's Compensation Act of 1897, which has since been extended to cover every kind of occupational injury.

The statute, judged by our common-law standards, is plainly revolutionary. Its central and controlling feature is that every employer who is engaged in any of the classified industries shall be liable for any injury to a workman arising out of and in the course of the employment by "a necessary risk of danger of the employment or one inherent in the nature thereof; . . . provided that the employer shall not be liable in respect of any injury to the workman which is caused in whole or in part by the serious and willful misconduct of the workman." This rule of liability, stated in another form, is that the employer is responsible to the employee for every accident in the course of the employment, whether the employer is at fault

or not, and whether the employee is at fault or not, except when the fault of the employee is so grave as to constitute serious and willful misconduct on his part. The radical character of this legislation is at once revealed by contrasting it with the rule of the common law, under which the employer is liable only when the employer is guilty of some act or acts of negligence which caused the occurrence out of which the injuries arise, and then only when the employee is shown to be free from any negligence which contributes to the occurrence.

[The commission's report] is based upon a most voluminous array of statistical tables, extracts from the works of philosophical writers and the industrial laws of many countries, all of which are designed to show that our own system of dealing with industrial accidents is economically, morally and legally unsound. Under our form of government, however, courts must regard all economic, philosophical and moral theories, attractive and desirable though they may be, as subordinate to the primary question whether they can be moulded into statutes without infringing upon the letter or spirit of our written constitution. In that respect we are unlike any of the countries whose industrial laws are referred to as models for our guidance.

This legislation is challenged as void under the fourteenth amendment to the Federal Constitution and under section 6, article 1 of our State Constitution, which guarantee all persons against deprivation of life, liberty or property without due process of law. . . . When our Constitution was adopted it was the law of the land that no man who was without fault or negligence could be held liable in damages for injuries sustained by another. That is still the law, except as to the employers enumerated in the new statute. . . . It is conceded that this is a liability unknown to the common law and we think it plainly constitutes a deprivation of liberty and property under the Federal and State Constitutions.

IX

New York Central Railroad Co. v. *White*
243 U.S. 188, 37 S.Ct. 247 (1917)

Mr. Justice Pitney delivered the opinion of the court:

A proceeding was commenced by defendant in error before the Workmen's Compensation Commission of the State of New York, established by the Workmen's Compensation Law of that state, to recover compensation from the New York Central & Hudson River Railroad Company for the death of her husband, Jacob White, who lost his life September 2, 1914, through an accidental injury arising out of and in the course of his employment under that company. The Commission awarded compensation in accordance with the terms of the law; its award was affirmed, without opinion, by the appellate division of the supreme court for the third judicial department, whose order was affirmed by the court of appeals, without opinion. . . . Federal questions having been saved, the present writ of error was sued out by the New York Central Railroad Company, successor, through a consolidation of corporations, to the rights and liabilities of the employing company.

The errors specified are based upon these contentions: (1) that the liability, if any, of the railroad company for the death of Jacob White, is defined and limited exclusively by the provisions of the Federal Employers' Liability Act [FELA] of April 22, 1908 . . . and (2) that to award compensation to defendant in error under the provisions of the Workmen's Compensation Law would deprive plaintiff in error of its property

without due process of law, and deny to it the equal protection of the laws, in contravention of the 14th Amendment.

[The Court first concluded that the deceased, a night watchman, was not engaged in interstate commerce at the time of the accident, so that the FELA did not apply.]

We turn to the constitutional question. The Workmen's Compensation Law of New York establishes forty-two groups of hazardous employments, defines "employee" as a person engaged in one of these employments upon the premises, or at the plant, or in the course of his employment away from the plant of his employer, but excluding farm laborers and domestic servants; defines "employment" as including employment only in a trade, business, or occupation carried on by the employer for pecuniary gain, "injury" and "personal injury" as meaning only accidental injuries arising out of and in the course of employment, and such disease or infection as naturally and unavoidably may result therefrom; and requires every employer subject to its provisions to pay or provide compensation according to a prescribed schedule for the disability or death of his employee resulting from an accidental personal injury arising out of and in the course of the employment, without regard to fault as a cause, except where the injury is occasioned by the wilful intention of the injured employee to bring about the injury or death of himself or of another, or where it results solely from the intoxication of the injured employee while on duty, in which cases neither the injured employee nor any dependent shall receive compensation. By Section 11, the prescribed liability is made exclusive, except that, if an employer fails to secure the payment of compensation as provided in Section 50, an injured employee, or his legal representative, in case death results from the injury, may, at his option, elect to claim compensation under the act, or to maintain an action in the courts for damages, and in such an action it shall not be necessary to plead or prove freedom from contributory negligence, nor may the defendant plead or prove as a defense that the injury was caused by the negligence of a fellow servant, that the employee assumed the risk of his employment, or that the injury was due to contributory negligence. Compensation under the act is not regulated by the measure of damages applied in negligence suits, but, in addition to providing medical, surgical, or other like treatment, it is based solely on loss of earning power, being graduated according to the average weekly wages of the injured employee and the character and duration of the disability, whether partial or total, temporary or permanent; while in case the injury causes death, the compensation is known as a death benefit, and includes funeral expenses, not exceeding $100, payments to the surviving wife (or dependent husband)

during widowhood (or dependent widowerhood) of a percentage of the average wages of the deceased, and if there be a surviving child or children under the age of eighteen years, an additional percentage of such wages for each child until that age is reached.

The scheme of the act is so wide a departure from common-law standards respecting the responsibility of employer to employee that doubts naturally have been raised respecting its constitutional validity. The adverse considerations urged or suggested in this case and in kindred cases submitted at the same time are: (a) That the employer's property is taken without due process of law, because he is subjected to a liability for compensation without regard to any neglect or default on his part or on the part of any other person for whom he is responsible, and in spite of the fact that the injury may be wholly attributable to the fault of the employee; (b) that the employee's rights are interfered with, in that he is prevented from having compensation for injuries arising from the employer's fault commensurate with the injuries actually sustained, and is limited to the measure of compensation provided by the act; and (c) that both employer and employee are deprived of their liberty to acquire property by being prevented from making such agreement as they choose respecting the terms of the employment.

In support of the legislation, it is said that the whole common-law doctrine of employer's liability for negligence, with its defenses of contributory negligence, fellow servant's negligence, and assumption of risk, is based upon fictions, and is inapplicable to modern conditions of employment; that in the highly organized and hazardous industries of the present day the causes of accident are often so obscure and complex that in a material proportion of cases it is impossible by any method to ascertain the facts necessary to form an accurate judgment, and in a still larger proportion the expenses and delay required for such ascertainment amount in effect to a defeat of justice; that, under the present system, the injured workman is left to bear the greater part of industrial accident loss, which, because of his limited income, he is unable to sustain, so that he and those dependent upon him are overcome by poverty and frequently become a burden upon public or private charity; and that litigation is unduly costly and tedious, encouraging corrupt practices and arousing antagonisms between employers and employees.

In considering the constitutional question, it is necessary to view the matter from the standpoint of the employee as well as from that of the employer. For, while plaintiff in error is an employer, and cannot succeed without showing that its rights as such are infringed, . . . the exemption

from further liability is an essential part of the scheme, so that the statute, if invalid as against the employee, is invalid as against the employer.

The close relation of the rules governing responsibility as between employer and employee to the fundamental rights of liberty and property is, of course, recognized. But those rules, as guides of conduct, are not beyond alteration by legislation in the public interest. No person has a vested interest in any rule of law, entitling him to insist that it shall remain unchanged for his benefit.

This court repeatedly has upheld the authority of the states to establish by legislation departures from the fellow-servant rule and other common-law rules affecting the employer's liability for personal injuries to employees. . . . A corresponding power on the part of Congress, when legislating within its appropriate sphere, was sustained in Second Employers' Liability Cases [regarding the constitutionality of the "Second" FELA of 1908].

It is true that in the case of the statutes thus sustained there were reasons rendering the particular departures appropriate. Nor is it necessary, for the purposes of the present case, to say that a state might, without violence to the constitutional guaranty of "due process of law," suddenly set aside all common-law rules respecting liability as between employer and employee, without providing a reasonably just substitute. . . . The statute under consideration sets aside one body of rules only to establish another system in its place. If the employee is no longer able to recover as much as before in cases of being injured through the employer's negligence, he is entitled to moderate compensation in all cases of injury, and has a certain and speedy remedy without the difficulty and expense of establishing negligence or proving the amount of damages. Instead of assuming the entire consequences of all ordinary risks of the occupation, he assumes the consequences, in excess of the scheduled compensation, of risks ordinary and extraordinary. On the other hand, if the employer is left without defense respecting the question of fault, he at the same time is assured that the recovery is limited, and that it goes directly to the relief of the designated beneficiary. . . . The act evidently is intended as a just settlement of a difficult problem, affecting one of the most important social relations, and it is to be judged in its entirety.

[W]e recognize that the legislation under review does measurably limit the freedom of employer and employee to agree respecting the terms of employment, and that it cannot be supported except on the ground that it is a reasonable exercise of the police power of the state. In our opinion it is fairly supportable on that ground.

Judgment affirmed.

X

Workers Compensation and Employers Liability Policy

INFORMATION PAGE

Insurer: Policy No.:

1. The Insured: ____ Individual ____ Partnership
   Mailing Address: ____ Corporation or __________
   Other workplaces not shown above:

2. The policy period is from _________ to __________ at the insured's mailing address.

3. A. Workers Compensation Insurance: Part One of the policy applies to the Workers Compensation Law of the states listed here:

B. Employers Liability Insurance: Part Two of the policy applies to work in each state listed in Item 3.A. The limits of our liability under Part Two are:

Bodily Injury by Accident $ _________ each accident
Bodily Injury by Disease $ _________ policy limit
Bodily Injury by Disease $ _________ each employee

C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here:

D. This policy includes these endorsements and schedules:

4. The premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All information below is subject to verification and change by audit.

Classifications	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium

Total Estimated Annual Premium $

Minimum Premium $ Expense Constant $

Countersigned by _____________

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XYZ INSURANCE COMPANY

In return for the payment of premium and subject to all of the terms of this policy, we agree with you as follows:

GENERAL SECTION

A. The Policy

This policy includes at its effective date the Information Page and all endorsements and schedules listed there. It is a contract of insurance between you (the employer named in Item 1 of the Information Page) and us (the insurer named on the Information Page). The only agreements relating to this insurance are stated in this policy. The terms of this policy may not be changed or waived except by endorsement issued by us to be part of this policy.

B. Who Is Insured

You are insured if you are an employer named in Item 1 of the Information Page. If that employer is a partnership, and if you are one of the partners, you are insured, but only in your capacity as an employer of the partnership's employees.

C. Workers Compensation Law

Workers Compensation Law means the workers or workmen's compensation law and occupational disease law of each state or territory named in Item 3.A. of the Information Page. It includes any amendments to that law which are in effect during the policy period. It does not include any federal workers or workmen's compensation law, any federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits.

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D. State

State means any state of the United States of America, and the District of Columbia.

E. Locations

This policy covers all of your workplaces listed in Items 1 or 4 of the Information Page; and it covers all other workplaces in Item 3.A. states unless you have other insurance or are self-insured for such workplaces.

PART ONE
WORKERS COMPENSATION INSURANCE

A. How This Insurance Applies

This workers compensation insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. Bodily injury by accident must occur during the policy period.
2. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

B. We Will Pay

We will pay promptly when due the benefits required of you by the workers compensation law.

C. We Will Defend

We have the right and duty to defend at our expense any claim, proceeding or suit against you for benefits payable by this insurance. We have the right to investigate and settle these claims, proceedings or suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance.

D. We Will Also Pay

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding or suit we defend:

1. reasonable expenses incurred at our request, but not loss of earnings;
2. premiums on appeal bonds to release attachments and for appeal bonds in bond amounts up to the amount payable under this insurance;
3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

E. Other Insurance

We will not pay more than our share of benefits and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that may apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance will be equal until the loss is paid.

F. Payments You Must Make

You are responsible for any payments in excess of the benefits regularly provided by the workers compensation law including those required because:

1. of your serious and willful misconduct;
2. you knowingly employ an employee in violation of law;
3. you fail to comply with a health or safety law or regulation; or
4. you discharge, coerce or otherwise discriminate against any employee in violation of the workers compensation law.

If we make any payments in excess of the benefits regularly provided by the workers compensation law on your behalf, you will reimburse us promptly.

G. Recovery From Others

We have your rights, and the rights of persons entitled to the benefits of this insurance, to recover our payments from anyone liable for the

injury. You will do everything necessary to protect those rights for us and to help us enforce them.

H. Statutory Provisions

These statements apply where they are required by law.

1. As between an injured worker and us, we have notice of the injury when you have notice.
2. Your default or the bankruptcy or insolvency of you or your estate will not relieve us of our duties under this insurance after an injury occurs.
3. We are directly and primarily liable to any person entitled to the benefits payable by this insurance. Those persons may enforce our duties; so may an agency authorized by law. Enforcement may be against us or against you and us.
4. Jurisdiction over you is jurisdiction over us for purposes of the workers compensation law. We are bound by decisions against you under that law, subject to the provisions of this policy that are not in conflict with that law.
5. This insurance conforms to the parts of the workers compensation law that apply to:
   a. benefits payable by this insurance;
   b. special taxes, payments into security or other special funds, and assessments payable by us under that law.
6. Terms of this insurance that conflict with the workers compensation law are changed by this statement to conform to that law.

Nothing in these paragraphs relieves you of your duties under this policy.

PART TWO
EMPLOYERS LIABILITY INSURANCE

A. How This Insurance Applies

This employers liability insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. The bodily injury must arise out of and in the course of the injured employee's employment by you.
2. The employment must be necessary or incidental to your work in a state or territory listed in Item 3.A. of the Information Page.

3. Bodily injury by accident must occur during the policy period.
4. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.
5. If you are sued, the original suit and any related legal actions for damages for bodily injury by accident or disease must be brought in the United States of America, its territories or possessions, or Canada.

B. We Will Pay

We will pay all sums you legally must pay as damages because of bodily injury to your employees, provided the bodily injury is covered by this Employers Liability Insurance.

The damages we will pay, where recovery is permitted by law, include damages:

1. for which you are liable to a third party by reason of a claim or suit against you by that third party to recover the damages claimed against such third party as a result of injury to your employee;
2. for care and loss of services;
3. for consequential bodily injury to a spouse, child, parent, brother or sister of the injured employee;

provided that these damages are the direct consequence of bodily injury that arises out of and in the course of the injured employee's employment by you; and

4. because of bodily injury to your employee that arises out of and in the course of employment, claimed against you in a capacity other than as employer.

C. Exclusions

This insurance does not cover:

1. liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;
2. punitive or exemplary damages because of bodily injury to an employee employed in violation of law;

3. bodily injury to an employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your executive officers;
4. any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;
5. bodily injury intentionally caused or aggravated by you;
6. bodily injury occurring outside the United States of America, its territories and possessions, and Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;
7. damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions;
8. bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 USC Sections 901–950), the Nonappropriated Fund Instrumentalities Act (5 USC Sections 8171–8173), the Outer Continental Shelf Lands Act (43 USC Sections 1331–1356), the Defense Base Act (42 USC Sections 1651–1654), the Federal Coal Mine Health and Safety Act of 1969 (30 USC Sections 901–942), any other federal workers or workmen's compensation law or federal occupational disease law, or any amendments to these laws;
9. bodily injury to any person in work subject to the Federal Employers' Liability Act (45 USC Sections 51–60), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of and in the course of employment, or any amendments to those laws;
10. bodily injury to a master or member of the crew of any vessel;
11. fines or penalties imposed for violation of federal or state law; and
12. damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 USC Sections 1801–1972) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

D. We Will Defend

We have the right and duty to defend, at our expense, any claim, proceeding or suit against you for damages payable by this insurance. We have the right to investigate and settle these claims, proceedings and suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance. We have no duty to defend or continue defending after we have paid our applicable limit of liability under this insurance.

E. We Will Also Pay

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding or suit we defend:

1. reasonable expenses incurred at our request, but not loss of earnings;
2. premiums on appeal bonds to release attachments and for appeal bonds in bond amounts up to the amount payable under this insurance;
3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

F. Other Insurance

We will not pay more than our share of damages and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that may apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance will be equal until the loss is paid.

G. Limits Of Liability

Our liability to pay for damages is limited. Our limits of liability are shown in Item 3.B. of the Information Page. They apply as explained below.

1. Bodily Injury by Accident. The limit shown for "bodily injury by accident — each accident" is the most we will pay for all damages covered by this insurance because of bodily injury to one or more persons in any one accident.

A disease is not bodily injury by accident unless it results directly from bodily injury by accident.

2. Bodily Injury by Disease. The limit shown for "bodily injury by disease — policy limit" is the most we will pay for all damages covered by this insurance and arising out of bodily injury by disease, regardless of the number of

employees who sustain bodily injury by disease. The limit shown for "bodily injury by disease — each employee" is the most we will pay for all damages because of bodily injury by disease to any one employee.

Bodily injury by disease does not include disease that results directly from a bodily injury by accident.

3. We will not pay claims for damages after we have paid the applicable limit of our liability under this insurance.

H. Recovery From Others

We have your rights to recover our payment from anyone liable for an injury covered by this insurance. You will do everything necessary to protect those rights for us and to help us enforce them.

I. Actions Against Us

There will be no right of action against us under this insurance unless:

1. You have complied with all the terms of this policy; and
2. The amount you owe has been determined with our consent or by actual trial and final judgment.

This insurance does not give anyone the right to add us as a defendant in an action against you to determine your liability. The bankruptcy of you or your estate will not relieve us of our obligations under this Part.

PART THREE
OTHER STATES INSURANCE

A. How This Insurance Applies

1. This other states insurance applies only if one or more states are shown in Item 3.C. of the Information Page.
2. If you begin work in any one of those states after the effective date of this policy and are not insured or self-insured for such work, all provisions of this policy will apply as though that state were listed in Item 3.A. of the Information Page.

3. We will reimburse you for the benefits required by the workers compensation law of that state if we are not permitted to pay the benefits directly to persons entitled to them.
4. If you have work on the effective date of this policy in any state not listed in Item 3.A. of the Information Page, coverage will not be afforded for that state until we are notified within thirty days.

B. Notice

Tell us at once if you begin work in any state listed in Item 3.C. of the Information Page.

PART FOUR
YOUR DUTIES IF INJURY OCCURS

Tell us at once if injury occurs that may be covered by this policy. Your other duties are listed here.

1. Provide for immediate medical care and services required by the workers compensation law.
2. Give us or our agent the names and addresses of the injured persons and of witnesses, and other information we may need.
3. Promptly give us all notices, demands and legal papers related to the injury, claim, proceeding, or suit.
4. Cooperate with us and assist us, as we may request, in the investigation, settlement or defense of any claim, proceeding or suit.
5. Do nothing after an injury occurs that would interfere with our right to recover from others.
6. Do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE
PREMIUM

A. Our Manuals

All premium for this policy will be determined by our manuals of rules, rates, rating plans and classifications. We may change our manuals and apply the changes to this policy if authorized by law or a governmental agency regulating this insurance.

B. Classifications

Item 4 of the Information Page shows the rate and premium basis for certain business or work classifications. These classifications were assigned based on an estimate of the exposures you would have during the policy period. If your actual exposures are not properly described by those classifications, we will assign proper classifications, rates and premium basis by endorsement to this policy.

C. Remuneration

Premium for each work classification is determined by multiplying a rate times a premium basis. Remuneration is the most common premium basis. This premium basis includes payroll and all other remuneration paid or payable during the policy period for the services of:

1. all your officers and employees engaged in work covered by this policy; and
2. all other persons engaged in work that could make us liable under Part One (Workers Compensation Insurance) of this policy. If you do not have payroll records for these persons, the contract price for their services and materials may be used as the premium basis. This paragraph 2. will not apply if you give us proof that the employers of these persons lawfully secured their workers compensation obligations.

D. Premium Payments

You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid.

E. Final Premium

The premium shown on the Information Page, schedules, and endorsements is an estimate. The final premium will be determined after this policy ends by using the actual, not the estimated, premium basis and the proper classifications and rates that lawfully apply to the business and work covered by this insurance. If the final premium is more than the premium you paid to us, you must pay the balance. If it is less, we will refund the balance to you. The final premium will not be less than the highest minimum premium for the classifications covered by this policy.

If this policy is canceled, final premium will be determined in the following way unless our manuals provide otherwise:

1. If we cancel, final premium will be calculated pro rata based on the time this policy was in force. Final premium will not be less than the pro rata share of the minimum premium.
2. If you cancel, final premium will be more than pro rata; it will be based on the time this policy was in force, and increased by our short rate cancelation table and procedure. Final premium will not be less than the minimum premium.

F. Records

You will keep records of information needed to compute premium. You will provide us with copies of those records when we ask for them.

G. Audit

You will let us examine and audit all your records that relate to this policy. These records include ledgers, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data. We may conduct the audits during regular business hours during the policy period and within three years after the policy period ends. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

PART SIX CONDITIONS

A. Inspection

We have the right, but are not obligated to inspect your workplaces at any time. Our inspections are not safety inspections. They relate only to the insurability of the workplaces and the premiums to be charged. We may give you reports on the conditions we find. We may also recommend changes. While they may help reduce losses, we do not undertake to perform the duty of any person to provide for the health or safety of your employees or the public. We do not warrant that your workplaces are safe or healthy or that they comply with laws, regulations, codes or standards. Insurance rate service organizations have the same rights we have under this provision.

B. Long Term Policy

If the policy period is longer than one year and sixteen days, all provisions of this policy will apply as though a new policy were issued on each annual anniversary that this policy is in force.

C. Transfer Of Your Rights And Duties

Your rights and duties under this policy may not be transferred without our written consent.

If you die and we receive notice within thirty days after your death, we will cover your legal representative as insured.

D. Cancelation

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancelation is to take effect.
2. We may cancel this policy. We must mail or deliver to you not less than ten days advance written notice stating when the cancelation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
3. The policy period will end on the day and hour stated in the cancelation notice.
4. Any of these provisions that conflict with a law that controls the cancelation of the insurance in this policy is changed by this statement to comply with the law.

E. Sole Representative

The insured first named in Item 1 of the Information Page will act on behalf of all insureds to change this policy, receive return premium, and give or receive notice of cancelation.

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About the Author

Peter M. Lencsis is an attorney in private practice in New York City. Formerly Vice President and General Counsel of Greater New York Mutual Insurance Company and Senior Staff Counsel to the National Council on Compensation Insurance, he has contributed to many legal treatises in his field and serves as an adjunct professor at the College of Insurance, New York City. His first book, *Insurance Regulation in the United States*, was published by Quorum in 1997.