INSURANCE
FUNDAMENTALS

Workers' Comp

Practical Answers to the Most Common Workers' Comp Questions

THE NATIONAL ALLIANCE RESEARCH ACADEMY
RISK AND INSURANCE STUDIES

Workers' Comp

Practical Answers to the Most Common Workers' Comp Questions

by Christopher J. Boggs,
CPCU, ARM, ALCM, LPCS, AAI,
APA, CWCA, CRIS, AINS

THE NATIONAL ALLIANCE
RESEARCH ACADEMY
RISK AND INSURANCE STUDIES

Published 2018

Insurance Fundamentals:
Workers' Comp—Practical Answers to the Most Common Workers' Compensation Questions

Note: While the information in this publication is accurate, the summaries of coverages and interpretations, and any strategies or suggestions offered may not be complete or absolute. It is sold with the understanding that the publisher is not engaged in rendering legal or other professional services. The explanations and examples may not be applicable in all situations and jurisdictions. There are many ways to explain and interpret different risk exposures and coverages, and some agencies and brokers may have different opinions or interpretations that deviate from the perspectives contained in this work. Agency producers and customer service representatives should consult with insurance company personnel regarding specific coverage questions involving company-specific forms.

Court decisions and new policy versions may alter the intent of the policy form or coverage language. Although every reasonable effort has been made to verify the accuracy of the information in this book, readers are urged to check independently on matters of specific interest or concern. The National Alliance Research Academy makes no warranties or guarantees regarding the accuracy of the information contained in this publication.

ISBN 978-0-9980475-0-8

The National Alliance Research Academy
P.O. Box 27027
Austin, TX 78755-2027
academy@scic.com
TheNationalAlliance.com

The National Alliance Research Academy

The National Alliance Research Academy is a non-profit corporation, funded entirely through publication sales and affiliation dues. The Academy promotes and conducts practical research on all aspects of the risk management and insurance industries. As an extension of its robust research program, The Academy publishes monographs and studies that serve the needs of those who desire to share in the growth of the risk management and insurance industry.

The Academy serves as the research and development department of The National Alliance for Insurance Education & Research—the organization recognized across the nation as the best source for practical knowledge, continuing education credits, and designation opportunities for insurance and risk management professionals of every experience level. In addition, The Academy provides support to higher education through the University Associate Certified Risk Managers (UACRM) Program and the University Associate Certified Insurance Counselors (UACIC) Program, as well as assisting educational institutions in attracting new individuals into the insurance and risk management professions.

Academy Membership Categories

Research Associate: $1,000
For corporate entities or associations

With the support of Research Associates, The Academy is able to enhance the profession that we all serve. Contributions from Academy Research Associates help to support the research and publication activities of The Academy. In addition, these funds assist The Academy efforts to attract students to the insurance industry by offering career-oriented programs in cooperation with various educational institutions. We invite you to participate in this mission by becoming an Academy Research Associate. Benefits include:

- 10% discount on all Academy publications
- Tax-deductible contributions
- Two (2) complimentary copies of three (3) publications of your choice, and one (1) copy of each new publication as released

- Company name and logo included in the forefront of all new publications
- Company name and logo included on The Academy website
- Complimentary subscription to *Resources* magazine, a source of valuable technical information and articles of interest which also contains information regarding National Alliance programs
- Company recognition in The National Alliance's *Resources* magazine

Academy Fellowship: $20
For designated, dues-paying CICs, CRMs, CPRMs, CISRs, and CSRMs. Annual Academy dues are $20. Benefits include:

- A 10% discount on all Academy publications
- Complimentary subscription to *Resources* magazine, a source of valuable technical information and articles of interest which also contains information regarding National Alliance programs
- Opportunities to participate in upcoming studies and access podcasts which cover the key findings

Academy Associate: $35
For industry practitioners who are *not* designated, dues-paying CICs, CRMs, CPRMs, CISRs, and CSRMs. Annual Academy dues are $35. Benefits include:

- A 10% discount on all Academy publications
- Complimentary subscription to *Resources* magazine, a source of valuable technical information and articles of interest which also contains information regarding National Alliance programs
- Opportunities to participate in upcoming studies and access podcasts which cover the key findings

Visit TheNationalAlliance.com and click on "The Research Academy" (near the bottom of the home page) to learn more about membership.

Research Associates

The National Alliance Research Academy extends its gratitude to the Research Associates whose support made publication of ***Insurance Fundamentals: Workers' Comp*** possible:

American Automobile Association, Inc.

American Agents Alliance

Assurex Global

Bancorp South Insurance Services, Inc.

Bowen, Miclette & Britt

Brown & Brown, Inc.

Calhoun, Thomson+Matza, LLP

CRC Insurance Services, Inc.

Intergovernmental Pool Administration, Safety & Loss Control

Hylant

ISU Insurance Agency Network

Jerry Montgomery Memorial Research Fund

Keystone Insurers Group, Inc.

Marble Box

MarketScout, Inc.

McGriff
Insurance Services

McGriff, Seibles &
Williams

PATRA Corporation

Popular Insurance, LLC

State Auto
Insurance
Companies

Texas Capital Bank

United Valley
Insurance Services

USI

Westwood Trust

Zurich North America

Alabama IIA

IIAB of Arizona

PIIAC

PIA of Connecticut

IIAB of Delaware

Florida Association of Insurance Agents

PIA of Georgia

IIA of Illinois

IIA of Indiana

PIA of Indiana

Kansas Association of Insurance Agents

IIA of Kentucky

PIA of Kentucky

IIAB of Maryland

Massachusetts Association of Insurance Agents

Michigan Association of Insurance Agents

Minnesota Independent Agents and Brokers Association

Missouri Association of Insurance Agents

PIA of Nebraska and Iowa

PIA of New Jersey

PIA of New York

IIA of North Carolina

PIAA of Ohio

IIA of Oklahoma

IIAB of Pennsylvania

IIAB of South Carolina

Insurors of Tennessee

PIA of Virginia & DC

PIA of Washington/
Oregon

PIA of Wisconsin

About the Author: Chris Boggs

Christopher J. Boggs, CPCU, ARM, ALCM, LPCS, AAI, APA, CWCA, CRIS, AINS, is Independent Insurance Agents and Brokers of America (IIABA or the Big "I") Virtual University Executive Director. He joined the Big "I" team in November 2016. His current duties involve researching, writing, and teaching property and casualty insurance coverages and concepts to Big "I" members and others in the insurance industry.

During his career, which began in 1990, Boggs has authored nearly 500 insurance and risk management-related articles on a wide range of topics as diverse as Credit Default Swaps, the MCS-90, and enterprise risk management. Additionally, Boggs has written 13 insurance and risk management books:

- *The Insurance Professional's Practical Guide to Workers' Compensation: From History through Audit*—now in its second edition
- *Business Income Insurance Demystified: The Simplified Guide to Time Element Coverages*—now in its third edition
- *Property and Casualty Insurance Concepts Simplified: The Ultimate 'How to' Insurance Guide for Agents, Brokers, Underwriters and Adjusters*
- *Wow! I Never Knew That! 12 of the Most Misunderstood and Misused P&C Coverages, Concepts and Exclusions*
- *Insurance, Risk & Risk Management! The Insurance Professional's Guide to Risk Management and Insurance*
- *Workers' Compensation: How You Can Effectively Answer Your Clients 12 Most Commonly Asked Questions*
- *Glossary of Insurance Terms*
- *Choosing the Best Risk Financing Option*
- *Writing Property and Liability Coverage for Condos*
- *The Truth about Enterprise Risk Management*
- *The Experience Mod Worksheet*
- *What has ISO Done to us Now?*
- *Cancellations, Non-Renewals & Conditional Renewals: THE Insurance Professional's Guide to Statutory Insurance Carrier Notification Requirements for All 50 States!*
- *Insurance Fundamentals: Homeowners' Coverage—Managing Your Clients' Most Valuable Assets*

In addition to his responsibilities at the association, Boggs is a regular speaker at a wide range of industry events and has earned numerous professional accolades. His professional background includes work as a risk management consultant, loss control representative, producer, claims manager, journalist and columnist, and quality assurance specialist.

Foreward

Workers' Comp: Practical Answers to the Most Common Workers' Comp Questions provides a practical analysis and overview that educates the reader on answering sixteen of the most common questions asked about workers' compensation coverage. It also includes a glossary of key workers' compensation terms, as well as a state-to-state workers' compensation comparison chart. This information makes it an indispensable reference source.

The National Alliance Research Academy would like to thank the author, Christopher J. Boggs, for the time and effort that he spent in completing this publication. He used his extensive knowledge and experience in the insurance industry to write this practical guide that can be used to educate agency personnel about the underlying issues that impact coverage decisions and buying choices.

We want to be a part of the team that helps you to achieve your goals in the insurance and risk management industry. For information about other Academy publications and National Alliance program schedules, please visit our website: TheNationalAlliance.com. We also encourage your comments and recommendations for future editions of this publication.

Sincerely,

William T. Hold, Ph.D., CIC, CPCU, CLU
President, The National Alliance Research Academy

Table of Contents

Introduction

Workers' compensation, as a coverage, is simple. A worker gets hurt, the work comp policy pays—theoretically. That's the simple part. The more complicated areas of workers' compensation involve the state laws, legal doctrines, and unique requirements applicable to workers' comp.

Because what appears theoretically simple is actually quite complicated, our clients have many questions we must be able to answer. This book makes it easy for you to answer 16 of the most commonly asked workers' compensation questions. These 16 questions are:

1. What is workers' compensation?
2. Who is my insured responsible for covering under workers' compensation?
3. Who counts as an "employee"?
4. What injuries are covered ("compensable") under workers' compensation?
5. When is an illness, sickness, or disease covered under workers' compensation?
6. What benefits are provided by workers' compensation?
7. What is employers' liability and what types of claims are covered by this section?
8. What happens when employees travel to other states for work?
9. What is a premium audit and why is it necessary?
10. How is the workers' compensation classification code (or codes) determined?
11. What should the insured do to prepare for and ensure the best possible audit process and outcome?
12. What information is needed to prepare for the audit?
13. What pay/remuneration is INCLUDED within audited payroll?
14. What pay/remuneration is EXCLUDED from audited payroll?
15. What should be done following an injury to a worker?
16. How do I interpret the NCCI Experience Mod Worksheet?

Beyond the answers to these 16 questions, this book includes two appendices for quick reference:

- Appendix A – State-to-State Workers' Comp Comparison; and
- Appendix B – Glossary of Key Workers' Compensation Terms

Take the time to learn the answers to these questions to be ready to answer many, if not most, of your client's work comp questions with confidence. In fact, you may want to use this information to educate your prospects to increase your value compared to their current agent.

The Questions and Answers

Q. What is workers' compensation?

A. In simplest terms, workers' compensation benefits are statutorily mandated by the state. A workers' compensation insurance policy is designed and intended to provide your insureds a source of financing for the benefits required under workers' compensation laws to cover the costs associated with and arising from an injury to any worker for whom your insured may be statutorily responsible.

Workers' compensation coverage is known as a "sole remedy" coverage. The insured does not have to be legally liable or responsible for the worker's injury in order for coverage to apply. If the worker is considered an "employee" of the insured and the injury is compensable, workers' compensation pays all medical costs, a portion of lost wages, and other injury-related expenses.

Every state has adopted its own workers' compensation statute. While there are many state-to-state similarities in the management of workers' compensation, there are many differences that must be recognized. Requirements applicable in one state may not be applicable to a neighboring state.

Examples of areas where states may disagree include, but are in no way limited to:

- **The number of employees triggering the requirement that workers' compensation be carried.** Most states require workers' compensation if there are one or more employees (regardless whether classed as full or part time); but some states apply a different threshold (three, four or even five employees). Further, some states alter the number threshold based on specifics of the situation, such as classification or unique exposures.
- **The existence of a state fund.** Essentially, there are two types of state funds: 1) monopolistic state funds; and 2) competitive state funds. In monopolistic states, employers must purchase workers' compensation from the state fund. There are four monopolistic states. Competitive state funds compete against private insurers in that state. There are 18 competitive state funds currently in operation.
- **The jurisdiction over workers' compensation rules, rates, and forms.** Jurisdictional authority in most states is provided by the National Council on Compensation Insurance (NCCI). Within these states, NCCI develops forms,

rates, class codes, rules, experience modification factors, and workers' compensation manuals. However, 16 states maintain their own workers' compensation bureaus for the management of all aspects of their workers' compensation statutes. Many bureau states apply large parts of NCCI's rules, rates, and forms, but may differ in some key areas. States maintaining workers' compensation bureaus are: California, Delaware, Indiana, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Texas, Washington, Wisconsin and Wyoming.

- **Whether the upper tier is responsible for the employees of an uninsured lower tier contractor.** Forty-four states and the District of Columbia make an upper tier contractor legally responsible for the employees of a lower tier contractor if that lower tier contractor does not have its own workers' compensation policy. These are called "De Jure" employees (discussed in a later section). However, six states do not have such a requirement.
- **The percentage of payroll reimbursed by workers' compensation.** No state's workers' compensation laws allow for the employee to be indemnified for all lost wages. Only a percentage of lost wages is reimbursed. This percentage differs by state and ranges between 60 percent and 80 percent of the employee's average weekly wage (AWW), subject to a minimum and maximum.
- **How members and member/managers of an LLC are treated.** Limited Liability Companies (LLCs) are unique in their design, so they are treated differently in each state. Most states equate them to partnerships for workers' compensation purposes while a few states treat LLCs like corporations. The difference is how the member/managers are treated for workers' compensation. In most states, the member/managers are not automatically protected by workers' compensation; they must "opt in" if protection is desired. In a minority of states, LLCs are treated like corporations, and the members/managers are included in the protection and must "opt out" if they do not desire protection.
- **How the out-of-state worker exposure is managed.** Every state provides extraterritorial benefits, meaning the workers' compensation protection follows the employee when he/she leaves the state for work. However, some

states limit the amount of time that coverage is provided (the shortest is ten days), and some require certain conditions to be met.

- **Reciprocity differences.** The other side of extraterritoriality is reciprocity. Basically, reciprocity addresses how the state to which the worker travels to do work (on a temporary basis) views the extraterritorial benefits of the state from which the employee left. Some states don't reciprocate (meaning that state has to be listed as a "3.A." state). Some states fully reciprocate, and some have limited reciprocity (here is where the biggest problems exist).
- **The existence and operation of a Second Injury Fund.** Second Injury Funds were created to protect employers from the increased costs of injuries when a worker has a pre-existing injury. Second Injury Funds were essentially created after World War II to encourage employers to hire returning soldiers who had lost an arm, leg, eye, or suffered some other injury. Without these funds, employers may have been forced to pay a permanent total disability loss simply because of the combined effects of a previous injury and the work-related injury. About 30 states maintain a Second Injury Fund, and the other 20 have discontinued these funds.
- **Reported injuries.** Each state requires a different form and has different requirements regarding which injuries must be reported to the state (all injuries are to be reported to the insurance carrier).

Again, this is only a sampling of the differences between the states. The state-by-state spreadsheet in Appendix A lists a few more of these differences.

Q. Who is my insured responsible for covering under workers' compensation?

A. Your insureds are potentially responsible for protecting and providing workers' compensation benefits to up to four types of individuals (employees): direct employees; employees of uninsured subcontractors; "de facto" employees; and borrowed servants.

1. **Direct employees.** A "direct employee" is a person hired to perform certain services or tasks for a particular wage or salary under the direct control of another. Employees are generally hired to perform a specific job that is usual

and customary to the insured's business operation. Direct employees are easy to define since they are specifically listed on the insured's payroll records, it is their paychecks from which the insured deducts taxes, and it is to them that benefits may be provided.

2. **Employees of uninsured subcontractors.** Forty-four states and the District of Columbia statutorily require an upper tier contractor to provide workers' compensation benefits to the employees of an uninsured lower tier contractor. These are known as "de jure" employees. An "upper tier" contractor could be at any "level" in the hierarchy on the job site; the upper tier could be the general contractor or a trade contractor that contracts work to a lower tier (even contractors that are third, fourth or further downstream from the GC could be considered upper tier contractors). If the insured contracts another entity to do work, they could have "de jure" employees. De jure employees may be created during the policy period. For example, at the beginning of the job, the lower tier contractor has and provides proof that workers' compensation coverage is in place. During the policy period or time on the job site, the workers' compensation policy ceases to exist for a number of reasons. The employees of the now uninsured lower tier contractor become the de jure employees of the upper tier contractor.
3. **De facto employees.** Just because the insured calls someone an "independent contractor" does not necessarily make it so. Even if the individual is an "independent contractor" by IRS standards, they may still be considered an "***employee-in-fact***" under workers' compensation guidelines and laws. These "employees-in-fact" are also called "de facto employees." Four primary "tests" can be applied to determine whether a worker is truly an "independent contractor" or an "employee-in-fact" (a de facto employee) under workers' compensation. These four tests are:
    a. Does the contracting party control the worker's ways and means? Do they tell the contracted person what time to show up for work; when to go to lunch or when to go home? Further, do they tell the worker how to do the job? These are indications of control, and control is a key feature of an employment relationship. True independent contractors show up when they want, leave when they desire, and work according

to acceptable standards of quality. In essence, the contracting party has little control and provides limited direction.

b. Are the tools and materials supplied by the contracting party or the contracted party? True independent contractors supply their own tools and generally supply the materials necessary to perform their duties (nails, glue, etc.) and at their own expense (as part of the contract price). If the contracting party provides all or most of the tools and materials, they are asserting control and again, are more likely to be the de facto employer.

c. Does the "independent contractor" work for anyone else? True independent contractors work for many principals and general contractors. If this is not the case, then this individual is a "de facto employee" (employee-in-fact) regardless of what they are called or how they are paid.

d. Does the "independent contractor" carry his own insurance? If not, then it is very likely he/she is an "employee-in-fact" under workers' compensation laws. But even if he carries his own work comp, that does not guarantee the court won't find employer/employee status, especially if the work comp policy is a "ghost policy."

(**NOTE:** A "ghost policy" is a workers' compensation policy extending protection to no person. Examples often include: 1) a corporation purchases a policy but excludes the sole employee, the "owner" [corporate officer] of the corporation; 2) an LLC with no employees other than the members, and the members do not elect coverage or exclude themselves [depending on the state]; or 3) a sole proprietorship or partnership with no other employees where the owners do not "opt in" to coverage [or chose to opt out, depending on the state].)

4. **Borrowed servants** are direct employees of another entity but work under the insured's exclusive direction and control. Examples of borrowed servants might include (but are not limited to):

   a. Workers provided by temporary staffing firms.

b. A worker hired by his/her direct employer to work exclusively for another entity or person.

c. Employees of a professional employer organization (PEO). A PEO relationship creates "dual employment;" the contract between the PEO and the contracting party must address who: 1) is an employee of the PEO; and 2) who is responsible for providing workers' compensation benefits to the workers (specific endorsements are required).

(**NOTE:** Even if the insured is part of and insured by a PEO, a workers' compensation policy should still be procured to protect the insured's exposure for "miscellaneous" workers not included in the PEO arrangement, such as de jure employees and even de facto employees.)

Q. Who counts as an "employee"?

A. To understand who is considered the **employee** requires understanding who qualifies as the **employer**. There are three key points to consider when differentiating between an employer and an employee for workers' compensation purposes: 1) The employer is not required in most states to be protected by workers' compensation; 2) Employee status is affected by entity type; and 3) The employer is always a "person."

What is meant by the statement that the employer is always a person? Remember, in law there are two types of persons:

- natural persons; and
- legal persons.

A ***natural person*** is somebody who has flesh and blood, like you and me. You cut them and they bleed. Examples of natural person employers include sole proprietorships, partnerships, and in a majority of states, (33 or 34) LLCs.

Legal person employers are "persons" created by law. They're born by the filing of articles of incorporation or articles of organization. Examples include corporations, professional associations, and again, LLCs in 16 or 17 states.

Natural persons and legal persons are essentially equal under the law. They have the same rights and the same duties and responsibilities. They can hire, they can fire, they can own property, they can sell property, they can sue, and they can be sued.

With that as background, pinpointing who qualifies as an employee is easier. An employee is any ***natural person*** **not** considered the employer (i.e., sole proprietor, partner, or member of an LLC (in a majority of states). Consider the following organizations and consider who the employees are in each:

Sole Proprietorships:	Everyone but the sole proprietor
Partnerships:	Everyone but the partners
LLCs:	LLCs are a unique animal. Who is considered an employee differs by state. In a majority of states, employees include everyone but the members/managers. In a few states, everyone is an employee.
Corporations and Professional Associations:	Everyone is an employee (even the "owning" corporate officers).

Note: The above are the most commonly applied rules. A few states apply their own unusual rules.

Q. What injuries are covered ("compensable") under workers' compensation?

A. "Occupational" injuries are covered by the workers' compensation policy. An "occupational" injury is one that "arises out of and is in the course and scope of employment." These are three distinct tests and each must be satisfied:

1. "**Arise out of**..." indicates a causal connection between the furtherance of the insured's business and the injury. If the insured benefits in some way from the employee's activity, then the injury suffered by the worker in the pursuit of the activity is likely considered to have "arisen out of the employment." States apply one of three doctrines of "causal connection" in determining compensability:
    a. ***Increased Risk Doctrine:*** There is something about the employment that increases the chance of an injury when compared to the risk to the general public.
    b. ***Actual Risk Doctrine*** (closely related to the Increased Risk Doctrine): This is the risk of employment. The employment itself presents a risk of injury. The workplace creates the situation that results in injury.
    c. ***Positional Risk Doctrine:*** Simply being at work is enough to meet the "arising out of..." requirement.

2. "**In the course of**…" is a function of the timing and location. Did the injury occur during the worker's operations/ activities for the employer, regardless of the time of day, and at a location the employer could have expected the employee to be? If so, then the injury was in the course of employment; and
3. "**Within the scope of employment.**" This test more specifically defines the first two tests by: 1) analyzing the motivations of the worker; 2) analyzing the employer's direction and control over the actions of the worker; and 3) analyzing the employer's ability to foresee the activities of the worker. If the employee was acting under the employer's presumed direction, control, knowledge, and expectations, then the injury will likely be considered "occupational."

Injuries can "arise out of" and "be in the course of" employment **without** being "within the scope of" employment. Unless all three tests are satisfied, coverage can be denied! Let's look at an example.

A businessman is entertaining clients over dinner. At the table next to the businessman and his guests is a table full of long-time college buddies who like to drink—heavily.

As the evening progresses, the college buddies begin to get loud, disturbing the businessman and his guests. The businessman asks the group to be a little quieter, and they agree with apologies. But a few drinks later, the group is louder and less concerned with those around them.

Once again, the businessman asks them to keep it to a low buzz, but this time a nose-to-nose argument erupts—leading to a fight.

The businessman gets the worst of the fight (it's hard taking on three guys, even if they are drunk). Are his injuries compensable under workers' compensation? Let's look at each of the three requirements:

- "**Arising out of**": Was the businessman conducting business for the furtherance his employer and for the benefit of the employer? Yes, he was meeting with clients to cement a relationship towards a long-term relationship or more business.
- "**In the course of**": There is not much question here—the employee was where he was supposed to be (with

clients), doing what he was supposed to do (sell and build relationships), and in a place where his employer directed and/or expected him to be (a restaurant). He was in the course of employment.

- "**In the scope of employment**": This is where it all falls apart. Look again at the three parts of this requirement. Was the worker motivated to fight for the benefit of his employer? Hopefully not. Did the employer expect or direct the employee to fight? Again, likely not. If the employer could have foreseen the situation, would the "OK" to fight be given? This is unlikely. The employee was doing nothing for the benefit of or at the direction of the employer. He was not within the scope of employment.

Remember this: some injuries look "occupational" because of the location or surrounding events; but certain Injuries suffered at certain times or while participating in certain activities are considered "non-occupational" and are thus not compensable. Examples of generally non-occupational situations include:

1. **Injury suffered traveling to or home from work (known as the "coming and going rule").**

Injury suffered traveling to work or home from work is generally not compensable. Known as the **coming and going rule**, the reason the rule exists is because the employee is not furthering the employer's interest or serving the business's needs when traveling. The employee is serving his own purposes and furthering his own cause during this course of travel; namely, he is going to an employment situation where a paycheck is delivered for services rendered, going to lunch, or going home.

Exceptions to the coming and going rule do exist. Any time travel is an integral part of employment or such travel furthers the employer's business, the coming and going rule is superseded, making injury compensable. Examples of travel considered integral to the employment includes travel between job sites and travel to meet clients.

Other "special hazard" exceptions to the coming and going rule include:

- ***Employer-furnished transportation.*** If the employer undertakes to provide group transportation to and from the office or job site, injury suffered during the trip is compensable.

- ***The employee performs a beneficial errand for the employer.*** Going to the bank, the post office, or on any other errand to further the employer's business qualifies as a beneficial errand. If the errand requires the employee to deviate from her normal route, any injury suffered from the time the employee leaves the premises until she returns to her normal route is likely compensable. Errands taking the employee outside his normal ways and means are considered "for the benefit" of the employer—making injury compensable;
- ***Injury suffered by an "on call" employee.*** Doctors, medical personnel, emergency response personnel or those in employments who must be ready to respond when the "call" comes are considered to be within the course and scope of employment immediately upon responding to the call. The drive is considered part of furthering the employer's business—making injury compensable;
- ***If the employer reimburses or pays the employee's transportation costs,*** the trip is considered business-related and for the benefit of the employer. Injury suffered is compensable unless abandonment of employment is proven;
- ***Injury suffered once the employee enters the parking lot.*** Courts ascribe a reasonable time for employees to reach their assigned work station. During this time, the employee is considered to be in the course and scope of employment. "The clock" begins to tick (so to speak) when the employee arrives in the parking lot. The reverse is true; the employee is considered to be within course and scope until he leaves the parking lot. Injury suffered prior to and after leaving the parking lot is not covered (unless one of the other exceptions apply). The breadth of this special exception is applied differently by each state.

2. **Injury suffered while the employee is engaged in horseplay or a practical joke.**

Depending on the jurisdiction, injury to the perpetrator (the jokester) may likely be considered "non-occupational" and thus not compensable; however, the victim may be considered eligible for workers' compensation benefits. The court generally makes the final decision.

Prevailing opinion now centers on and applies a treatise known as "Larson's Workers' Compensation Law" (Larson). Larson applies a four-part test to the facts surrounding the

horseplay-associated injury to establish compensability. The four tests of fact are:

- **The extent and seriousness of the deviation.** Was the horseplay "reasonable" or did the parties go so far out of the way as to constitute unreasonable deviation?
- **The completeness of the deviation.** Was the horseplay commingled with the regular performance of duties or did it involve (and require) an abandonment of duty?
- **The extent to which the practice of horseplay has become an accepted part of the employment.** If horseplay, practical jokes, and hazing are common and not discouraged or forbidden by the employer, then it is reasonably judged to be part of normal employment and within course and scope.
- **The extent to which the nature of employment may be expected to include some horseplay.** If horseplay is an expected or accepted fact of the type of employment, it is considered part of the employment, leading to the potential that such injuries are considered to be part of the employment.

According to Larson, there is no requirement that all four tests be satisfied for a horseplay-related injury to be compensable: "It is now clearly established that the nonparticipating victim of horseplay may recover compensation."

3. **Injury suffered while participating in recreational activities.**

The facts surrounding the injury can move such injury from "non-occupational" to "occupational" and thus compensable under workers' compensation. Four tests are applied to the facts surrounding the injury to decide compensability:

a. ***Did the accident occur on the employer's premises?*** A "yes" response does not guarantee compensability. Key facts must be known before compensability can be decided, such as, is the employer directly benefiting from the activity? Making recreational facilities available does not make the employer liable. But neither is it required that the injury occur on the employer's premises for the injury to be compensable.

b. ***Was the event or team organized by the employer?*** Company-organized bowling or softball teams may

qualify under this provision. However, several employees deciding to form a team is wholly different from a team organized by the employer.

c. ***Did the employer pay for the activity?*** It is unclear if this guideline requires the employer to cover the total cost or if it can just be a subsidy.

d. ***Did the employer benefit?*** Advertising in the community, improved employee morale, or better teamwork are all possible benefits. An employer can "benefit" from these activities in more ways than tangible outputs.

Employee picnics, team building outings, and Christmas dinners are a few examples of other types of recreational and social activities that may lead to compensable injuries. State statutes should be reviewed regarding the issue of recreational activities. Some states have adopted relatively pro-employer statutes to limit compensability for activities in which employees are "expected" to participate. If asked, recommend that insureds make any recreational activities or outings truly optional.

Q. When is an illness, sickness, or disease covered under workers' compensation?

A. Like injuries—illnesses, sicknesses, and diseases must be "occupational" in nature to be covered by the workers' compensation policy. Two tests must be satisfied before an illness or disease can be considered occupational and thus compensable under workers' compensation:

1. The illness or disease must be "occupational," meaning that it arose out of and was in the course and scope of the employment; and
2. The illness or disease must arise out of or be caused by conditions "**peculiar**" to the work.

Whether an illness arises out of and in the course and scope of employment is a function of the employee's activities. The simplest test toward determining whether an injury "arises out of and in the course and scope of employment" is to ask: Was the employee benefiting the employer when exposed to the illness or disease? Be warned, this "test" is subject to the interpretations and intricacies of various state laws.

Qualifying as "occupational" is the low hurdle. The higher hurdle is whether the illness or disease is "**peculiar**" to the work. If the illness or disease is not peculiar to the work, it is not occupational and thus not compensable under workers' compensation. An illness or disease is "peculiar" to the work when such a disease is found almost exclusively in workers in a certain field, or there is an increased exposure to the illness or disease because of the employee's working conditions.

For example, black lung disease in the coal mining industry is a disease that is peculiar to the work of a miner. Coal miners are subject to prolonged exposure to higher-than-normal concentrations of coal dust, leading to black lung disease. This makes the disease **peculiar** to the coal mining industry.

Another example of an exposure "peculiar" to the work is a healthcare worker contracting an infectious disease such as HIV or hepatitis as a result of contact with infected blood. The worker's unusual or "peculiar" exposure to such diseases results in an illness that is occupational and compensable.

Other illnesses often related to work include: carpal tunnel syndrome, hearing loss from noisy operations, asbestosis, silicosis, contact dermatitis (chemicals) and even Lyme disease (for employees working in wooded areas).

Some illnesses less clearly attributable to conditions peculiar to the work include:

- ***Asthma:*** Often affects workers commonly around animal and plant products, wood dust, metals such as cobalt, cutting oils and irritants such as sulfur dioxide;
- ***Bronchitis:*** Common among employees working around high concentrations of acids, smoke, and nitrogen oxides;
- ***Hypersensitivity pneumonitis:*** Most often found in workers around moldy hay and cutting oils;
- ***Respiratory irritation and infections:*** Affects mainly office workers arising out of indoor air pollution (a.k.a. sick building syndrome);
- ***Skin cancer:*** Common in workers with long-term exposure to ultraviolet light (i.e., landscapers, construction workers, etc.);
- ***Brain and other tumors:*** Common among employees with long-term exposure to radiation;

- ***Coronary artery disease:*** Mostly attributable to employees exposed to carbon monoxide and stressful working conditions;
- ***Stress-related illnesses:*** Heart attacks, stroke, and other similar illnesses; and
- ***Eye and sight problems:*** Office-bound employees often experience eye and sight problems due to the need to focus on a computer screen for long periods.

Qualifying an illness or disease as occupational and, more importantly, peculiar to the work (and thus compensable) may ultimately require an industrial commission or court intervention to sort medical opinions from legal facts. No one "test" is available to declare an illness or disease compensable or non-compensable; each case is judged on its own merits and surrounding circumstances.

Concluding that an illness is occupational, peculiar to the work, and ultimately compensable is not necessarily based on the disease in question but on the facts surrounding the worker's illness. Factors investigated and considered by medical professionals and the court include:

1. The timing of the symptoms related to the work;
2. Co-workers showing similar symptoms;
3. The illness is common to the industry;
4. The employee has a predisposition to such illness; and
5. Personal habits and medical history of the worker.

Which policy responds to qualifying occupation illnesses and diseases?
If it is concluded that the illness or disease is "occupational," which policy responds? Because occupational illnesses and diseases generally have long "gestation" periods, employees may be exposed to the harmful condition for many years before the illness manifests. It is also possible that the employee doesn't contract the disease until years after the exposure ends.

Such long-term realities are managed by specific wording in the workers' compensation policy. The policy states that the workers' compensation policy in effect at the employee's last exposure is the policy that responds to the illness—even if the employee is working for another employer or retired at the time the disease manifests itself.

Q. What benefits are provided by workers' compensation?

A. Injuries or illnesses deemed "compensable" under any state's applicable workers' compensation law require prescribed benefits be paid to the injured employee. Benefit limits and duration vary by jurisdiction, but each state provides essentially the same three "classes" of benefits:

1. Medical benefits;
2. Disability/Indemnity benefits; and
3. Death Benefits.

Medical Benefits

Medical benefits are paid without a specified limit and generally with no applicable deductible (although some states allow a deductible option). Payments are made to the point that the injured employee is cured or has reached maximum relief. Bills for service go directly to the workers' compensation carrier, and payment is made directly to the healthcare provider; the employee's only responsibility is to follow the doctor's orders.

Although the medical care provided and billing are handled exclusively by the treating physician and the workers' compensation carrier, states differ regarding physician choice.

- Twenty-one states require the employee to use a physician chosen by the employer from among a list of "authorized" physicians.
- Twenty-nine states plus the District of Columbia allow the employee to choose the physician. Some require periodic consultation with an insurer-chosen physician.
- Nineteen of the "employee-choice" states limit the employee's options to physicians within a managed care type network.

Basic medical benefits are treated the same in every state. All statutes require medical costs, surgical fees, nursing care expense, and medication costs necessary to "effect a cure and give relief" be fully paid by the workers' compensation insurer. Additional medical benefits are the same in every state, but with jurisdictional nuances outside the scope of this text.

Disability/Indemnity Benefits

Injured employees may be totally unable to work or experience diminished earning capacity following the injury. Loss of income is a separate benefit paid at the direction of and in amounts mandated by a state's workers' compensation statutes.

Disability/indemnity benefits are subject to statutory minimum and maximum weekly payments, a maximum period of payments and/or a maximum amount of payments. These statutorily-defined limits are based on the **severity** of the injury and the expected **term** (length) of the resulting condition.

Injury severity is classified as either partial or total, and the injury term is assigned either a *temporary* or *permanent* status. Benefit payments are based on the combination of these conditions.

- **Temporary Partial Disability:** Defines an injury from which the employee is expected to completely recover in some period of time with no, or only minor, long-term effects.
- **Temporary Total Disability:** A full recovery from the injury is expected, but for some temporary period of time the employee is completely unable to work due to the injury.
- **Permanent Partial Disability:** The employee has suffered an injury from which he will never recover, but one that will not prevent him from returning to some type of work. Amputation of a body part or the loss of an eye or ear are examples of this classification.
- **Permanent Total Disability:** Recovery is not predicted; the employee is not expected to ever be able to return to work. Benefits paid will include medical bills to maximum cure and/or relief and lost wages.

Benefit payments are calculated based on the employee's "average weekly wages" (AWW) for the most recent 12-month period and are limited by minimum and maximum benefit amounts prescribed by the subject state.

Injured employees do not—*do not*—receive 100 percent of their average weekly wage during the period of disability; they receive a percentage of the AWW. The percentage differs by jurisdiction. Two reasons benefits are lower than the employee's AWW are: 1) benefits are not taxable; and 2) to encourage injured employees to return to work. A

majority of states require two-thirds ($66^{2}/_{3}$ percent) of the employee's average weekly wage be paid, but the benefit ranges anywhere between 60 percent and 80 percent of the employee's AWW. Disability benefits are usually adjusted annually to account for inflation and expected changes in income.

Injured employees must satisfy waiting periods before they are eligible to receive disability/indemnity benefits. "Elimination periods" range between three and seven days with each state incorporating a "retroactive provision" allowing the elimination period to be indemnified should the period of disability exceed a specified threshold. For example, consider a state with a seven-day elimination period and a 21-day retroactive provision. If the period of disability goes beyond 21 days, the policy retroactively indemnifies the employee for the first seven days, effectively providing coverage from the date of injury.

Death Benefits

Death benefits are the last of the three benefit classes dictated by workers' compensation statutes. This extends a limited amount toward funeral expenses plus a weekly benefit to eligible dependents. To collect death benefits from the workers' compensation policy: 1) death must occur within a limited period of time following the occupational injury, and 2) a request for death benefits must be made within a specified period following death.

Dependent benefits are also limited by statute. Some states pay benefits based on the employee's average weekly wages for the remainder of the surviving spouse's life, while others limit payment to a specified number of weeks. Provisions in other states pay until the spouse remarries or until a certain dollar amount is paid; there is truly no "standard" provision regarding spouses.

Benefits paid to or for surviving children are somewhat more uniform. Most states pay some specified amount until the child is 18. Some states provide additional benefits based on the child's education or ability status.

Death benefits, like the other workers' compensation benefits, are not nationally uniform so individual state laws must be studied to completely understand the specific state allowances.

Q. What is employers' liability and what type of claims are covered by this section?

A. Unlike workers' compensation, which is a sole-remedy, no-fault system of coverage governed and mandated by statute, employers' liability coverage fills the gap between the workers' compensation policy and the Commercial General Liability (CGL) policy. Employers' liability is neither required nor mandated by statute in any state. If the insured is domiciled in, or is required to purchase coverage in, a monopolistic state, employers' liability is not included in the workers' compensation policy and must be addressed separately.

Liability for employee injuries is essentially, totally excluded in the CGL (third-party-over claims, resulting from contractual risk transfer, are one exception). Further, workers' compensation covers medical, indemnity, and other expenses to, and for the benefit of, only the injured employee when the injury arises out of and was in the course and scope of employment. No one other than the employee receives payment or the benefit of payment under workers' compensation (except for the death benefit going to the family).

Employers' liability coverage fills the coverage gap between WC and CGL coverages, providing a source of funds for the person or entity financially or actually injured as a result of an injury to an employee. Additionally, employers' liability covers a worker when injured as a "consumer" rather than just an employee.

Four types of losses costs are covered by employers' liability:

1. ***Third-party-over actions*** (not to be confused with the third-party-over action covered by the CGL): Third-party-over coverage provided by the employers' liability section protects the **employer** against the legal liability assigned to it as a result of a financial injury suffered by an outside party arising out of injury to the employee. In simplified terms, the employee sues someone else as a result of the injury. If, during and after the suit, it is discovered that the employer was somehow negligent, and not the third party, the claim is turned over to the employer under employers' liability. For example, the employee is injured because the machine's safety devices are inoperative, leading the employee to sue the manufacturer. During investigation, it is discovered that the employer disabled the safety

devices to speed production. Upon this discovery, the manufacturer sues the employer for their negligent action. This is a third-party-over action covered by employers' liability;

2. ***Loss of consortium:*** Also known as loss of family services. When an employee is injured, the family is still hurt financially, even though workers' compensation pays medical and indemnity costs. The yard still must be cut, the house cleaned, and the children driven around. There may be a need to hire these services out, which increases the costs to the family. These increased costs are paid for under employers' liability;
3. ***Consequential bodily injury:*** For instance, one spouse brings a work-related disease home, and someone in the family contracts the disease. This is an over-simplified explanation of consequential bodily injury, but it makes the point; and
4. ***Dual capacity actions:*** If the employee is injured by a product manufactured by his employer, he may have a cause of action outside that granted him as an employee—he has the rights of a consumer. The classic example is a tire manufacturer delivery driver who is injured by a tire exploding while he is filling it with air. Of course, the tire was manufactured by his employer. He is covered under WC as a compensable injury, but he has also suffered an injury to which a consumer would be exposed. He holds two positions in the claim, and his position as a "consumer" is covered by employers' liability.

One caveat to employers' liability: the employer must be legally liable in causing the injury to the outside party (or employee in a dual capacity situation). While workers' compensation does not require fault, the employers' liability coverage is more like the CGL, requiring the employer be proven negligent in causing injury to the employee, leading to a financial loss for an outside party.

Q. What happens when employees travel to other states for work?

A. When employees travel to other states to work, the potential to create workers' compensation coverage gaps, up to and including no coverage (meaning your insured must pay the claim out of his/her own pocket), is very real. These coverage

gap problems arise at the junction of two key concepts: 1) Extraterritoriality and 2) Reciprocity.

Extraterritoriality relates to and is a function of the state from which the employee leaves to perform work, call this the "sending" state. The concept of reciprocity applies to the state to which the employee travels to work, call this the "receiving" state. Answers to specific questions must be known when looking at workers' comp coverage for traveling workers:

- ***Extraterritoriality:*** Does the "sending" state's workers' compensation coverage follow the employee when he/she leaves the state to work? If so, are there any specific limitations on the extraterritorial benefits?
- ***Reciprocity:*** How does the state to which the worker has traveled to work, the "receiving state," view the workers' compensation coverage from the "sending" state? Essentially, to answer the reciprocity question, you have to know the answer to two other questions: 1) Does the receiving state's workers' compensation law have jurisdiction over the employee's traveling into the state? and 2) Do the extraterritorial benefits of the workers' comp policy from the sending state satisfy the receiving state's workers' compensation statutes?

Extraterritoriality: Every state provides extraterritorial workers' comp benefits to employees traveling to another state for business purposes. However, some states limit the applicability of these "traveling" (or employee-following) benefits based either on the amount of time the employee is working in the other state, and/or whether the worker qualified as an "employee" in the sending state based on specific legal tests.

Although every state extends some level of extraterritorial protection, specific limitations may apply. For example, one state's extraterritorial protection is limited to ten days. On the eleventh day, extraterritorial protection ends.

Reciprocity: Although every state provides extraterritorial benefits to qualified employees, extraterritoriality laws don't consider the receiving state's laws. In practicality, extraterritorial benefits apply only when the receiving state recognizes the coverage. So, the important question is, what are the receiving state's reciprocity rules?

Some states simply don't care about another state's extraterritorial workers' comp coverage. If employees are working in non-reciprocating circumstances, or in non-reciprocal states, the employer must abide by, and is subject to, the workers' comp law of the state to which the employee(s) traveled to work.

Reciprocity statutes vary widely and fall into one of three "levels" or grants of reciprocity:

- **No reciprocity:** Non-reciprocal states are not concerned with the laws of any other state; employees working in nonreciprocal states must abide by its workers' comp law and are subject to that state's rules and rates.
- **Full reciprocity:** Fully reciprocal states generally maintain a list of states with which they have a reciprocity agreement, fully recognizing the other jurisdiction's laws—without limitation.
- **Limited reciprocity:** These are states that do reciprocate, but not in full. Four common reasons for non-reciprocity are:
  - ***The class of business:*** Construction is the most common class of business excluded from reciprocity. States that otherwise reciprocate refuse to recognize the "sending" state's workers' compensation coverage when the insured is in a construction class;
  - ***The number of employees:*** Some states reciprocate when the out-of-state employer sends only a limited number of workers into the state. These are generally states that have a number threshold greater than one for even an in-state employer to have workers' compensation. In these states, once the number of out-of-state workers eclipses a certain number, the state no longer reciprocates;
  - ***The length of time in the state:*** A few states recognize the sending state's coverage for a limited amount of time. Once the time limit is eclipsed, reciprocity ends; or
  - ***The lack of mutual reciprocity:*** These are quid pro quo states. Mutual reciprocity states recognize the sending state's benefits only if the sending state recognizes the receiving state's benefits when the roles are reversed (the sending state becomes the receiving state and vice versa). Imagine these states sticking their respective

tongues out at each other and saying, "You don't recognize our workers' compensation coverage so we aren't going to recognize yours. Take that!"

Ignore these extraterritorial and reciprocal exposures and the insured risks the complete loss of workers' comp protection. If the sending state's workers' comp policy does not, or cannot, respond, the insured may be responsible for paying all the benefits required by law out of its own pocket following a work-related injury.

No threat of "self-funding" exists when the sending and receiving states' extraterritorial and reciprocity provisions align. The sending state's workers' comp follows the worker, and the receiving state recognizes the coverage. Benefits are paid under the sending state's laws, and the receiving state asserts no authority over the situation. The out-of-state workers' comp exposures are covered.

However, when extraterritorial and reciprocal laws do not align, coverage for traveling employees requires specific action. Depending on the situation, workers' comp protection is extended to the employees in one of two ways when state laws don't sync:

- Adding the receiving state as an additional "Primary" state—also known as a "3.A." state; or
- Extending "Other State," also known as a "3.C." state or secondary state, status to the receiving state.

Deciding whether "3.A" or "3.C." is the appropriate option is simple: When the sending state's benefits do not apply in the receiving state, list the receiving state as a Primary (3.A.) state. Anytime there are known or suspected extraterritoriality or reciprocity issues, use "3.A." status.

"Other State" or "3.C." status is intended only as a safety net. What is meant by "safety net"? Essentially, a "3.C." listing is, or should be, limited to situations where there is no indication that the receiving state can or will assert authority over your worker; or when new temporary operations are begun during the policy period. "Other State" protection is an "uh oh" protection.

Assigning "3.A." Status

States that may require 3.A. status include:

- The employer's "home office" and branch office states;

- The employer's state of incorporation, if other than a home or branch office state;
- Any state where the employer hires temporary "employees" solely to perform operations in that state of hire;
- Any state where a subcontractor is hired to perform work on behalf of a general contractor if proof of workers' compensation is not provided (remember, *de jure* employees);
- Any state that has "significant contact" with an employee;
- The state in which the "contract of hire" was executed (even if the employee moves);
- Any state that does not reciprocate with any listed state;
- States with limited reciprocity provisions; and
- Monopolistic states that require a separate policy issued by the monopolistic state.

These are merely recommendations and not rules.

Using "3.C." Properly

Part Three – "Other States Insurance" dictates how the workers' compensation policy responds if an employee is injured in a non-"3.A." state, but, due to unexpected extraterritorial or reciprocity problems, is given the option to choose the benefits mandated by the state of injury rather than a listed "3.A." state.

Benefits extended to workers in "3.C." states comply with the statutory benefits required by the state where the employee is injured. Effectively the workers' compensation policy responds and pays benefits in listed 3.C. states, just as if the state was scheduled under 3.A.

"Other States" protection should be structured to include any state to which the insurance carrier is willing to extend coverage. If available, the preferred "3.C." wording is, "All states, territories and possessions other than 3.A. states and monopolistic states." However, some insurance carriers refuse to allow this breadth of protection for various reasons.

If the underwriter is unwilling to apply the overt "All states…" wording, build the "other states" coverage as broad as possible:

- Specifically schedule those states that qualify for "3.A." as per the previous recommendations, but which the underwriter would not allow;

- If not included in "3.A.," specifically list all bordering states;
- List all states to which employees regularly travel for training or meetings; and
- Complete the schedule by adding the terminology, *"All remaining states, territories and possessions other than 3.A. states, listed states and monopolistic states."*

Yes, the attempt is made to sneak the "All states…" wording back into the protection.

An underwriter might say, "We can't list _____ as a 3.C. state because we are not licensed there." This is a bogus claim. Underwriters may not want to list the state, but they CAN. Paragraph A.3. under *Part Three – Other States Insurance* reads: "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."

Other than not being licensed in the state, why would the carrier not be allowed to pay the injured worker directly? Just because they don't want to list a state doesn't mean they can't. But even though the facts are in the agent's favor, the underwriter may still refuse.

Requirements and Recommendations

Avoid the nightmares created by traveling employees; learn the extraterritorial laws of the "sending" state and understand the reciprocity laws of the "receiving" state.

Q. What Is a premium audit and why is it necessary?

A. Workers' compensation policies are designed to support and comply with the employers' state workers' compensation laws, and to provide the benefits prescribed by statute to any injured worker for whom the employer is responsible and whose injury or disease "arises out of and in the course and scope of" their employment.

Workers' compensation is generally priced based on the employer's classification and uses payroll as the basis for calculating premium (per $100 of payroll).

At the beginning of the policy term, the insured provides the estimated payroll for the coming policy year. Because payroll cannot be definitively known at the beginning of the

policy period, upon expiration the insurance carrier reviews, or "audits," the payroll records to confirm or ascertain the actual payroll for the policy period.

With this audited information, the final premium is determined. If the actual (audited) payroll is less than the amount estimated, a premium refund may be sent. Likewise, payroll greater than initially estimated results in an additional premium bill.

This process is misnamed. This process is not really a premium audit, but a payroll (or exposure) audit.

Although payroll is nearly always the basis of premium in workers' compensation, there are some operations that use a different basis for premium development:

- "Per capita" for domestic workers;
- "Upset payroll" for use in the pulpwood, logging, or lumbering industry if actual payroll records aren't available;
- Taxicabs: assigned payrolls per cab based on whether the cab is owner operated or leased to others;
- Aircraft: when an aircraft is owned by the insured—the charge is per seat. A special endorsement is required; and
- Subcontractor cost (if the subcontractor does not have its own workers' compensation and the payroll cannot be split out from total cost).

Q. How is the workers' compensation classification code (or codes) determined?

A. Beyond simply determining the correct payrolls, premium auditors also confirm that the operation and employees are classed correctly. Proper classification of the business and its internal operation is a key factor in determining premium.

The general rule of workers' compensation is that the insured's overall business activities are assigned one classification. The majority of employees are assigned to this one class code, rather than each employee being assigned a class code based on what he or she does. This single-code assignment is known as the "governing classification" or "single enterprise rule." (NOTE: The construction industry does not follow the "governing classification rule"; each job type is assigned to the applicable class code.)

The "governing classification" is generally based on the class code generating the largest payroll (which may not be the class code with the highest rates). This one code is intended to anticipate all the normal activities conducted by the business.

However, there are exceptions to this rule that may allow or cause certain employees to be assigned to different class codes with different rates (higher or lower than the governing classification rate). These exceptions are:

- **Standard Exceptions Classifications:** Employees exclusively engaged in clerical activities, drafting work, sales, or acting solely as drivers are NOT assigned to the governing classification. These workers are assigned their own code. But watch out, there are some exceptions to this exception, such as:
  - The employee can't be engaged in any other activity;
  - The employee must be physically separated from the operations; and
  - Some class codes include these standard exceptions within the governing code.
- **Interchange of Labor Rules:** This rule allows a single employee's payroll to be split between or among several codes. But the application of this rule varies by state; some states allow this split only when the employee is engaged in construction, erection, or stevedoring operations; other states allow this rule to apply to any type of business. Regardless of how the state's Interchange of Labor Rule applies, certain conditions must be met before payroll of a particular employee can be split:
  - All classifications must be appropriate for the work performed;
  - Payroll records must exist showing the actual dollar amount of the split—percentages are not allowed;
  - A division of payroll is NOT allowed with any of the "standard exception" classifications (see above); and
  - The operations/activities cannot be conducted on the same job site.
- **General Exclusion Classifications:** Some activities simply do not fit the activities contemplated by the "governing classification" because they are so far outside of normal or

expected activities. Essentially, these are the opposite of the "standard exception" classes. Any employees involved in aircraft operations; new construction or alteration; stevedoring; sawmill operations; or in an employer-owned daycare, are assigned the specified class code (and charged the rate) that appropriately describes and financially accounts for the activities.

- **Multiple Enterprise Rule:** If the insured conducts unusual operations, or engages in activities not customarily considered in, or by, the governing class code (known as a secondary operation), they may be eligible for the "multiple enterprise rule."

A secondary operation producing a basic **premium** equal to or higher than the governing class code (the code generating the highest payroll) premium automatically qualifies for separation under the multiple enterprise rule with the only requirement being segregation of payrolls.

If, however, the basic premium generated by the secondary operation is less than the governing class code basic premium, four tests must be satisfied before the insured can make use of the multiple enterprise rule. These are:

1. The operation is not commonly found within the operation of the subject insured's business;
2. The operations could each exist as a separate entity;
3. Financial records are kept separately for each operation; and
4. The operations are physically separated by means of a partition, wall, or placement in a separate building.

Q. What should the insured do to prepare for and ensure the best possible audit process and outcome?

A. A smooth audit is very important. To get the best results, the insured should apply the following guidelines; these "ABCs" make the audit process smoother and generally result in a better outcome.

- **Always be there:** Don't push responsibility for working with the auditor down to the lowest possible level employee; the higher the person is within the organization and the more familiar they are with the financials, the smoother

the audit will be. If the auditor can't get timely answers or must make assumptions, this will not produce good results.

- **Be prepared:** Have all the records ready before the auditor arrives. More detail on the needed information is found in the next section.
- **Get a copy of the auditor's work papers:** Don't let the auditor leave without getting a copy of the working papers. This will allow the insured and agent time to review the information collected and correct any errors BEFORE the audit is processed and billed. It's much harder to correct an audit after-the-fact. If the audit is not completed on-site, the insured should request this information in a written cover letter as part of the packet of information given to the auditor.
- **Don't answer more than is asked:** Expect the auditor to ask questions, that's his/her job. However, see that the insured only answers the questions asked; the insured should not offer more information than requested. Don't misunderstand—the insured should not hide material information and should be honest and up-front. Just warn the insured against allowing passion for the business and any future plans to lead the auditor down the wrong path.
- **Remember—treat the auditor well:** Treat the auditor as an honored guest, not as an intruder. The auditor is just doing his/her job, and making them comfortable will speed the process and will likely create an ally in the auditor (auditors often get treated poorly, so your insured's hospitality will be appreciated and he/she will stand out).
- **Know the rules:** When the insured understands the rules of classification, they will be prepared to "help" the auditor with the proper classifications.
- **Consider getting the auditor involved up front:** If the agent is not positive about a classification or there are options, get the auditor involved at the beginning of the policy period. Auditors are generally willing to provide their expertise in classifying the operation. And because they were involved from the beginning, the chance for surprises at audit time diminish greatly.

Q. What information is needed to prepare for the audit?

A. Some of the information required includes:

- **Payroll Records:** Payroll journal and summary; 941s, 1099 forms; state unemployment reports; an explanation and break out of overtime payments; and the general ledger.
- **Employee Records:** This should include a detailed description of job duties for each employee; the number of employees; and employee hire and fire dates.
- **Cash Disbursements:** Cost of and payments to subcontractors; cost of materials; and the cost of any casual labor.
- **Certificates of Insurance:** Supply current certificates of insurance covering the entire audit period, or the entire period of time the contractor has worked for the insured. If the subcontractor's policy renews in the middle of the audited policy period, make sure you request and receive a renewal certificate of insurance covering the remainder of the policy period.
- **OCIP Project Data:** If the insured has participated in any "wrap-up" program(s), the auditor needs this information to remove the payroll from the audit calculation.

Q. What pay/remuneration is INCLUDED within audited payroll?

A. Pay/remuneration included in the workers' comp audit is:

- Wages/Salaries;
- Commissions—If the employee is on a draw, and the draw is greater than commissions earned—use the entire amount of the draw;
- Bonuses—including stock bonus plans, unless the bonus is awarded for individual invention or discovery;
- Overtime—One-third of amount is subtracted from the total amount (one-half if it is double time pay);
- Davis-Bacon wages or wages from a similar prevailing wage law;
- Pay for holidays, vacations, or periods of sickness;
- Pay for time not worked (i.e., paid for an eight-hour day when only seven hours were worked);

- Pay for travel time to or from work or to specific job site;
- Employer payments of amounts otherwise required by law (i.e., Statutory insurance, Social Security, etc.);
- Contributions to a savings plan or vacation fund required by a union contract;
- IRS Qualified Salary Reduction Plan (i.e., 401K) (refers to the employee's contribution and any qualified agreement between the employer and the employee to pay into a retirement plan in lieu of direct wages);
- Employee Savings Plans—Only the amount given by the employee, not the employer's match, if any;
- Contributions to an IRA made by the employee;
- Payment on any basis other than time worked such as piecework, incentive plans, or profit sharing plans;
- Payment or allowance for tools;
- Car allowance;
- Value of housing/lodging;
- Value of meals if part of their pay;
- Substitutes for money (merchandise certificates, store credit, etc.);
- Expense reimbursements to employees to the extent that the employer's records do not substantiate the expense was incurred as a valid business expense; and
- Payment for filming of commercials (but not residual income).
- Expense reimbursements if the insured cannot substantiate the pay was for an expense reimbursement (why expense forms are necessary).

—basically, what the employee could lose if he/she can't work.

Q. What pay/remuneration is EXCLUDED from audited payroll?

A. Pay/remuneration excluded from the audit includes:

- Tips and other gratuities (subject to minimum wage exceptions);
- Group Insurance/Pension Plan contributions made by employer;

- Special rewards for individual invention or discovery;
- Severance pay;
- Pay for those on active military duty;
- Employee discounts;
- Expense reimbursements (if substantiated);
- Money for meals for overtime work;
- Work uniform allowance;
- Sick pay paid by a third party;
- Employer-provided perks (company autos, incentive vacations, memberships); and
- Employer contributions to salary reduction, employee savings plans, retirement, or cafeteria plans.

This may be the more important list. Knowing what should NOT be included in the audit makes finding audit errors easier.

Q. What should be done following an injury to a worker?

A. Although not an all-inclusive list, the following are the key steps the insured should take upon notification of an employee/worker injury:

1. Provide necessary emergency medical treatment to stabilize the worker and get appropriate medical attention;
2. Notify the agent/carrier by phone as soon as possible;
3. Complete the required first report of injury. The report should be given to the agent immediately after emergency needs are handled (and within time required). Each state requires a specific form;
4. Remember to complete the necessary OSHA forms;
5. Cooperate with the insurance carrier;
6. Send any legal papers received to the insurance carrier;
7. Do not interfere with the insurance carrier's ability to recover from an at-fault party;
8. Do not offer voluntary payments;
9. Keep in contact with the injured worker until he/she returns to work;
10. Talk with the claims adjuster to keep updated on the status of any/all claims including the amount of claims reserves;

11. Do not "approve" or offer advice to medical providers concerning coverage for any procedure. Refer them to the claims adjuster;
12. Workers' compensation injuries are NOT subject to HIPAA statutes, so you can receive updates on medical conditions;
13. If the insured has a return-to-work, light duty program in place, they should get the employee back to work as quickly as possible; and
14. If the employee refuses light duty when cleared to perform such duties, talk with the claims adjuster about the alternatives.

Q. How do I interpret the NCCI Experience Mod Worksheet?

A. The National Council on Compensation Insurance's (NCCI's) Workers' Compensation Experience Rating worksheet looks daunting at first. But once all the acronyms, shorthand, and calculations are decoded—it can be easily understood and explained.

This explanation skips self-explanatory terms such as Risk Name, Risk ID, and State and dives into the key factors.

Rating Effective Date: As the name suggests, this is the date the experience mod is effective (applicable to the insured). Historically, this is related to the *Anniversary Rating Date* (ARD), but NCCI ceased using the ARD as of May 1, 2017.

Production Date: This is the date the experience mod is calculated. But in preparation for this date, agents need to be aware of a much more important date, the Unit Statistical Report Date (the **Stat** Date). This is the date all loss information is sent to NCCI or state rating bureau—this includes paid and **reserved** loss information (all incurred losses). The "Stat" Date is approximately six months (180 days) prior to the Rating Effective Date. To best serve clients, request and gather from the insurance carrier all the loss information before the Stat Date. Stat dates are sometimes referred to as the "valuation date." Reviewing the loss information **before** the Stat Date gives the agent the opportunity to check and question reserves BEFORE they become part of the experience mod.

Experience Period: Although this term is not on the worksheet—specifically; this term describes the policy years used to develop the experience mod. Loss experience from three policy periods are included on the majority of experience mod worksheets. The years chosen are referred to as the "Experience Period." Calculating the experience period, and thus the policy periods used to develop the mod, is easy. The experience period comprises the three policy periods ending 12 months *before* the Rating Effective Date. For example:

Rating Effective Date:	June 1, 2018
Experience Period:	June 1, 2016 – **June 1, 2017**
(The policy terms used):	June 1, 2015 – June 1, 2016
	June 1, 2014 – June 1, 2015

Basically, the experience period comprises four years, but only the losses occurring during the three *oldest* years count in the mod calculation. Injuries occurring ***before*** June 1, 2014, and ***after*** June 1, 2017, do *not* count towards the workers' comp mod effective June 1, 2018.

The worksheet presents the experience period from oldest (top of the form) to newest (bottom of the form) **audited** policy years.

Information Recorded Within Each Policy Period of the Experience Period

Each policy period making up the experience period is presented separately. Several pieces of information are provided for each policy term. Following is a brief description of the information found within each reported policy year.

Code: This is the class code assignable to the insured. The number of class codes used is a function of several factors: 1) the governing class code, 2) exceptions to the governing class code rules, 3) the classifications of claims (see **IJ** below).

ELR: The "Expected Loss Rate." This is the amount of expected losses per $100 of payroll for the specific class code. Each state develops its own ELR for each class code. How the ELR is presented may differ depending on which bureau promulgates the worksheet (NCCI or state rate bureau). NCCI uses a decimal basis, whereas some states present the number without a decimal. NCCI may present the ELR as 2.35 while a particular state may use 235. If there is no decimal,

remember to input the decimal following the second number from the right (235 = 2.35 and 076 = 0.76). The ELR is applied to the payroll to develop expected losses.

D-Ratio: This ratio is used to develop the expected primary losses (Exp Prim Losses). Basically, it's the percentage of total expected losses that the bureau expects to fall below the relevant split point and thus be considered primary losses. Like the ELR, the D-Ratio is state-specific. The D-Ratio is similar to the ELR in that it may also be presented with or without a decimal; just remember to apply the same rule as presented under ELR when there is no decimal shown.

(**Note:** The ELR and D-Ratio factors used in the worksheet are those in effect ***when the experience mod is calculated***, NOT those in effect during the policy years of the experience period. All policy years are assigned the same ELR and D-Ratios. However, there are at least two states that do not apply this rule—Pennsylvania and Delaware. ELR and D-Ratios track by year in those states, not the factors in effect when the mod is calculated.)

Payroll: As the name suggests, this is the audited payroll assignable to the specified class code. If the payrolls are incorrect, expected losses are skewed, and the final mod may be incorrect. This is the reason a close review of the audits is required.

Expected Losses: Developed by applying the ELR to the payroll for each individual class code.

- (Class Code Payroll / 100) X ELR = Expected Losses

This is the total of expected losses for that class code for that given policy year. Ultimately all expected losses are added together, and the total is found in box **(D)** in the calculation section.

Exp Prim Losses: Expected Primary Losses are calculated after the Expected Losses are calculated. Again, this is the amount the bureau expects to fall within the classification of "primary losses" for that class code in a given year. All expected primary losses are added together, and the total is placed in box **(E)** as part of the mod calculation.

(***Primary vs. Excess Losses:*** To lessen the effect of a single large loss on the "mod," and enhance the fact that the loss occurred, losses are broken into two parts—"Primary" and "Excess." Primary losses are given more "weight" in the mod

calculation since there is no weighting or credibility factor applied to these losses in the final calculation. Excess losses are considered and applied as part of the "mod;" however, excess losses are subject to a "credibility" factor, lowering the amount of the excess loss that is considered in the calculation.)

Claim Data: Claims are presented in one of two ways, either as an individual claim (with the claim number provided) or as a group (using the number of claims in the group). Whether the claim can be grouped or must be presented individually is a function of the claim amount. Only small claims (generally below $2,000) can be grouped together. One important note regarding the information contained in the claims data column—it is NOT code specific. Just because claims data is in the same row as a specific class code, it does not mean the loss was to a person in that class code. In fact, the class code applicable to a specific claim is irrelevant because the experience mod calculation is ultimately a comparison of actual losses versus expected losses. This will make more sense as we progress.

IJ: The type, classification, or severity of the injury(ies) reported in the Claim Data column. Nine IJ codes are available:

1 – Death

2 – Permanent Total Disability

3 – Major Permanent Partial Disability

4 – Minor Permanent Partial Disability

5 – Temporary Total or Temporary Partial Disability

6 – Medical Only

7 – Contract Medical or Hospital Allowance

8 – Compromised Death—CA only

9 – Permanent Partial Disability

"Medical only" claims (IJ code 6) are often reduced in the experience mod calculation. Many states include only 30 percent of medical only claims in the experience mod calculation. These are called ERA states, or "Experience Rating Adjustment" states.

The ERA-approved states appear to currently include: Alabama, Alaska, Arkansas, Arizona, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, West Virginia, Wisconsin, and the District of Columbia.

OF: Indicates the status of the claim(s) presented under Claim Data. "O" indicates the claim is open. "F" means "final" or that the claim is closed.

Act Inc Losses: These are the total actual incurred losses taken directly from the insured's loss runs applicable to either the individually reported loss or grouped losses. Large actual incurred losses are capped in many states; each state develops its own maximum loss for individual and "group" (catastrophic) losses. Remember, incurred losses include the amount paid and the amount reserved. All Actual Incurred Losses are added together, and the total is found in box (H) in the mod calculation section.

Act Prim Losses: The insured's Actual Primary Losses are recorded in this column. Grouped losses are carried over in full; but large individual losses are subject to a "split point." Only the incurred loss amount up to the split point is included in this column. Until a few years ago, the split point was set at $5,000; meaning that only the first $5,000 of an individual loss was recorded. The split point is now designed to fluctuate, so confirm the current split point when reviewing the worksheet. Once all actual primary losses are developed, they are added together and recorded in box (I) in the calculate area of the form.

Compiling the Information to Calculate the Mod

Nearly all the information necessary to calculate the experience mod comes from the insured: class codes, payrolls, and losses. But to calculate the mod, NCCI or the state rate bureau must provide two factors or values: 1) the weighting factor (W) and 2) the ballast value (B).

Box (A) contains the weighting factor— also known as the credibility factor, and box (G) applies the ballast value.

Weighting Factor

The weighting (W) or credibility factor represents the authority's opinion regarding the credibility of the loss data as it relates to the ability to predict future losses. The higher the number, the more weight or credibility is given to the loss data; and, likewise, the lower the number, the less credible the past losses are as a factor for predicting future losses.

In general terms, the credibility factor is based directly, or indirectly, on the insured's premium or payroll amounts—specifically expected losses; expected losses are a function of the payroll and the expected loss ratio (ELR). The smaller the risk, the less weight is given to past and expected losses, resulting in a low weighting factor; conversely, the larger the risk, the greater the weight given to past and expected losses, resulting in a higher credibility factor.

Two functions served by the weighting factor are:

1. It is applied to excess losses (expected and actual), limiting the amount of each used in the calculation; and
2. Its inverse is used to develop the stabilizing value.

Ballast Value

The ballast value is based on the size of the risk; the larger the risk, the higher the ballast amount. Like the "W" factor, the ballast value is promulgated by the authority developing the mod or the mod factors. As its name suggests, the ballast value is designed to avoid too great of movement away from the center/base (a mod of 1.00). It is part of the stabilizing value, along with the inverse of the Weighting Factor, applied to both actual and excess values in the calculation.

Let's review "boxes" A – K to calculate the experience mod.

Box (A): The weighting factor as supplied by NCCI or other rating bureau.

Box (B): No one knows why this box exists; perhaps it is for symmetry. Supposedly, some states use this box for the ballast value, but other than that, it is left blank.

Box (C): Expected Excess Losses. Developed by subtracting **total expected** primary losses (EXP PRIM LOSSES) found in box (E) from total expected losses (Expected Losses) found in box (D). (D) – (E) = Expected Excess Losses (C).

Box (D): Total Expected Losses.

Box (E): Expected Primary Losses.

Box (F): Actual Excess. Developed by subtracting the actual primary losses found in box (I) from actual incurred losses presented in box **(H).**

Box (G): Ballast Value.

Box (H): Actual Incurred Losses. However, this amount may not be the total of the actual incurred losses (ACT INC LOSSES) presented during the experience period in ERA states. In ERA states, the medical only losses are reduced by 70 percent (only 30 percent of these losses count towards the total).

Box (I): Actual Primary Losses (ACT PRIM LOSSES). Like box (H), this is the total of the actual primary losses developed in the experience period section of the worksheet. And also, like box (H), the amount input in box (I) is actually the reduced total of primary losses if the risk is in an ERA state and there are medical only losses.

The only "boxes" not yet addressed are **(J)** and **(K).**

- **(J)** provides the ratable "**Actual** Total" losses; and
- **(K)** presents the ratable "Expected Total" losses.

So, the experience mod is a function of actual and expected. The ratable actual losses in **(J)** are divided by the ratable expected losses in **(K)** to develop the experience mod.

Now, let's calculate the mod!

NCCI's calculation is presented here; but not every state promulgates the experience mod the same as NCCI. Check your state for any variation. Here is the final calculation found at the bottom of the worksheet:

	Primary Losses		Stabilizing Value		Ratable Excess		Totals
Actual	(I)	+	C * (1 – A) + G	+	(A) * (F)	=	**(J)**
Expected	(E)	+	C * (1 – A) + G	+	(A) * (C)	=	**(K)**
						Exp. Mod =	**(J)** / **(K)**

Appendix A:

State-to-State Workers' Comp Comparison

State	WC Statute (& Year Adopted)	Employee Count (Non-Construction/ Construction)	State WC Fund	GC Resp. for Uninsured Subs (De Jure Emp.)	Jurisdiction
AL	Section 25-5 (1919)	5 / 5		Yes	NCCI
AK	Section 23.30 (1915)	1 / 1		Yes	NCCI
AZ	23.901 (1913)	1 / 1		Yes	NCCI
AR	11-9 (1939)	3 / 2		Yes	NCCI
CA	Division 1 & 4 (1911)	1 / 1	Competitive	Yes	WCIRB California
CO	Chapt. 8 (1915)	1 / 1	Competitive	Yes	NCCI
CT	Section 31 (1913)	1 / 1		Yes	NCCI
DE	Title 19 GS 2301 (1917)	1 / 1		No	Delaware Compensation Rate Bureau
FL	Section 440 (1935)	4 / 1		Yes	NCCI
GA	Chapt. 34-9 (1920)	3 / 3		Yes	NCCI
HI	Chapt. 386 (1915)	1 / 1	Competitive	Yes	NCCI
ID	Title 72 (1917)	1 / 1	Competitive	Yes	NCCI
IL	Section 305 (1911)	1 / 1		Yes	NCCI
IN	Title 22 (1915)	1 / 1		Yes	Indiana Compensation Rating Bureau
IA	Chapt. 65 (1913)	1 / 1		No	NCCI
KS	Chapt. 44-5 (1911)	1 / 1		Yes	NCCI
KY	Chapt. 342 (1916)	1 / 1	Competitive	Yes	NCCI
LA	Title 23 (1914)	1 / 1	Competitive	Yes	NCCI
ME	Title 39a (1915)	1 / 1	Competitive	No	NCCI
MD	Title 9 (1912)	1 / 1	Competitive	Yes	NCCI
MA	Chapt. 152 (1911)	1 / 1		Yes	The WC Rating & Inspection Bureau of Massachusetts
MI	Chapt. 418 (1912)	1 / 1 (under specific provisions: up to 3 emp.)		Yes	Compensation Advisory Organization of Michigan
MN	Chapt. 176 (1913)	1 / 1.	Competitive	Yes	Minnesota Workers Compensation Insurers Assoc.

State	WC Statute (& Year Adopted)	Employee Count (Non-Construction/ Construction)	State WC Fund	GC Resp. for Uninsured Subs (De Jure Emp.)	Jurisdiction
MS	Title 71 (1948)	5 / 5		Yes	NCCI
MO	Chapt. 287 (1926)	5 / 1	Competitive	Yes	NCCI
MT	39-71 (1915)	1 / 1	Competitive	Yes	NCCI
NE	Chapt. 48 (1913)	1 / 1		Yes	NCCI
NV	Chapt. 616 a–d & Chapt. 617 (1913)	1 / 1		Yes	NCCI
NH	RSA 281-A (1911)	1 / 1		Yes	NCCI
NJ	34-15 (1911)	1 / 1 (Statutorily elective, functionally compulsory)		Yes	New Jersey Compensation Rating & Inspection Bureau
NM	Chapt. 52 & 59 (1917)	3 / 1	Competitive	Yes	NCCI
NY	WKC Articles 1–11 (1913)	1 / 1	Competitive	Yes	New York Compensation Insurance Rating Board
NC	NCGS 97 (1929)	3 / 3 (1 if there is radiation present)		Yes	North Carolina Rate Bureau
ND	Chapt. 65 (1919)	1 / 1	Monopolistic	Yes	Workforce Safety & Insurance
OH	Chapt. 4121 & 4123 (1911)	1 / 1	Monopolistic	Yes	Ohio Bureau of Workers Compensation
OK	Title 85 (1915)	1 / 1	Competitive	Yes	NCCI
OR	Chapt. 656 (1913)	1 / 1	Competitive	Yes	NCCI
PA	Title 77 (1915)	1 / 1	Competitive	Yes	Pennsylvania Compensation Rating Bureau
RI	Chapt. 23 (1912)	1 / 1	Competitive	Yes	NCCI
SC	Title 42 (1935)	4 / 4 (1 if ionizing radiation present)		Yes	NCCI
SD	Title 62 & 58–20 (1917)	1 / 1		Yes	NCCI

State	WC Statute (& Year Adopted)	Employee Count (Non-Construction/ Construction)	State WC Fund	GC Resp. for Uninsured Subs (De Jure Emp.)	Jurisdiction
TN	Title 50, Chapt. 6 (1919)	5 / 1		Yes	NCCI
TX	Labor Code Title 5 (1913)	Coverage is Elective / 1	Competitive	Yes	Texas Department of Insurance
UT	Title 34A, Chapt. 2 (1917)	1 / 1	Competitive	Yes	NCCI
VT	Title 21, Chapt. 9 (1915)	1 / 1		Yes	NCCI
VA	65.2 (1918)	3 / 3		Yes	NCCI
WA	RCW 51 (1911)	1 / 1	Monopolistic	Yes	Washington Department of Labor & Insurance
WA-DC	Division 5	1 / 1			NCCI
WV	Chapt. 23 (1913)	1 / 1			NCCI
WI	Chapt. 102 (1911)	3 / 3			Wisconsin Compensation Rating Bureau
WY	27-14 (1915)	1 / 1	Monopolistic		Wyoming Workers' Safety & Compensation Division

Appendix B:

Glossary of Key Workers' Compensation Terms

Abandonment of Employment	Engaging in an activity clearly not intended for the advancement of the employer, nor directed or anticipated by the employer. Includes any activity in direct contradiction to the rules, requests, or expectations of the employer.
"Arising out of..."	A causal connection between the furtherance of the business and the injury. If the employer benefits in some way from the activity, the injury or illness suffered in the pursuit of that activity is considered to "arise out of" the employment.
Casual Labor	Work that is not within the usual course of trade, business, occupation, or profession of the "employer" (contracting party). The contractors hired perform duties not normally done by any employee; these laborers are doing work outside the hiring party's normal operational requirements. Essentially, a casual laborer is one that does not directly promote or advance the employer's business or operation and is generally not subject to workers' compensation law or eligible for benefits.
Coming and Going Rule	Injury suffered traveling to or home from work, or even while going to and returning from lunch, is generally not compensable. The logic behind the rule is that the employee is not furthering the employer's interest or serving the business's needs.
Contract of Hire	"Contract of hire" relates to extraterritorial jurisdictional issues and when to name a 3.A. state based on the employment contract. The state of hire is essentially the deciding factor. A majority of states statutorily subscribe to the contract or hire approach; however, court decisions in these states often apply the "significant contact" test.
De Facto Employee	De facto means "in fact or in reality." Employers may call a de facto employee an independent contractor when they are "in fact" an employee. The degree of control the employer has over the worker often influences the worker's classification as either a true independent contractor or a de facto employee.
De Jure Employee	De jure means "by right, according to the law." A de jure employee is an employee created by an act of law. In most states, injured employees of an uninsured subcontractor become the responsibility of the general contractor; they become the "de jure employees" of the general contractor by action of workers' compensation law.
Doctrinal Employer-Employee Relationship (Special Employer)	1) The employee (worker) made a contract of hire—express or implied—with the special employer In essence, did the **direct** employer volunteer or direct the employee to work for the **special** employer and did the employee agree to such assignment? 2) The work being done essentially is that of the special employer, and 3) The special employer has the right to control the details of the work.

Employee	A person hired to perform certain services or tasks for particular wages or salary under the control of another (the employer); or a worker hired to perform a specific job usual and customary to the employer's business operation in exchange for money or other remuneration.
General Contractor	An individual or entity with whom the principal/owner directly contracts to perform specified jobs. Some or all of the enumerated tasks are subsequently contracted to other entities (subcontractors) for performance. Three parties are required before any entity is considered a general contractor: a principal, an independent contractor, and a subcontractor hired by the independent contractor. The independent contractor's status changes to that of a general contractor when any part of the work is subcontracted to another entity.
General Exclusion Classifications	These are the opposite of "standard exception" classes. General exclusion class activities are completely unexpected and are not considered part of the analogy of the governing classification of most operations. Employees engaged in general exclusion activities require separation to allow the insurer to garner the usually higher premium for the increased exposure. Operations and activities falling within the general exclusion classification are: 1) employees working in aircraft operations; 2) employees performing new construction or alterations; 3) stevedoring employees; 4) sawmill operation employees; and 5) employees working in an employer-owned daycare.
General Inclusion Classifications	Some activities are considered an integral part of the business's operations, thus the payroll of individuals engaged in these activities is included in the governing classification. These activities include: 1) employees that work in a restaurant, cafeteria, or commissary run by the business for use by the employees (this does not apply to such establishments at construction sites); 2) employees manufacturing containers such as boxes, bags, cans, or cartons for the employer's use in shipping its own products; 3) staff working in hospitals or medical facilities operated by the employer for use by the employees; 4) maintenance or repair shop employees; and 5) printing or lithography employees engaged in printing for the employer's own products.
Ghost Policy	A "ghost" policy is a workers' compensation policy written for an unincorporated business with no employees and which does not extend coverage to the business's owner(s); or a policy written for an incorporated business that excludes all executive officers with no other employees.
Independent Contractor	An entity with whom a principal/owner directly contracts to perform a certain task or tasks. Independent contractors are generally engaged to perform operations not within the usual trade or business of the principal, and generally such tasks are contract-specific. All work required of the contract is performed by the independent contractor and employees.

Interchange of Labor Rule	The interchange of labor rule is an exception to the governing classification rule. Applicability of this rule varies by state; some states allow its use only in the construction, erection, or stevedoring classes of business while other states permit the interchange of labor rule to apply to any type of business operation. Interchange of labor rules allow a single employee's payroll to be split between or among several class codes that may be present within the operations. Certain requirements must be met before this rule can be applied.
"In the course..."	A function of the timing and location of the injury or illness. The implication is that the injury must occur during operations for the employer, or "during employment," and at the employer's location, or a location mandated or reasonably expected by the employer.
Legal Person	A "legal fiction." A person created (or born) by the filing of legal documents with the jurisdictional authority. Examples include corporations, professional associations, and LLCs in a few states.
Limited Liability Company (LLC)	An **LLC** is a hybrid legal entity combining the advantages (mostly tax-based) of a partnership and the liability protection offered by a corporation. Members are simply the owners of the LLC and may or may not participate in the day-to-day management of the company. Members involved in the management maintain a dual role as both members and managers.
Monopolistic States	Employers must purchase the workers' compensation policy from the state. Only four monopolistic states remain in operation: North Dakota, Ohio, Washington, and Wyoming. Employers' liability coverage is not offered in these states and this coverage must be procured by alternate means.
Natural Person	A flesh and blood human being. Sole proprietorships and partnerships are always natural person employers in workers' compensation. Managers and members of an LLC are viewed as natural persons in a majority of states, making these natural persons the employers in those states.
Occupational Injury	An injury arising out of and in the course and scope of employment.
Occupational Disease	Illness directly attributable to work conditions and exposures; such injury or illness must arise out of and in the course and scope of employment. To be considered "occupational" and therefore compensable, the disease must arise out of or be caused by conditions **peculiar** to the work. Medical opinion leading to the conclusion that an illness is work-related is not necessarily based on the disease but on the facts surrounding the patient's sickness.
Permanent Partial Disability	The employee has suffered an injury from which he will never recover, but one that will not prevent him from returning to some type of work. Amputation of a finger or leg or the loss of an eye or ear are examples of this injury classification.

Person	A person can be a natural person or a legal person. A natural person is a flesh and blood human. A legal person is created by articles of incorporation or other such legal documentation. Natural persons and legal persons are equal under the law. Both have the right to own property, sell property, hire, fire, sue, or be sued.
Permanent Total Disability	A disability from which recovery is not predicted; the employee is not expected to ever be able to return to work. Full paralysis, total blindness, and total loss of hearing are examples of such an injury.
Putative Employer	The special employer rather than the direct employer. Status as the "employer of record" at such a specific time is "put" upon the individual or entity based on several factors, the most obvious is the amount of control the person/entity has over the worker.
"Scope of employment…"	Refers to an analysis of the motivations of the employee, the employer's direction and control over the actions of the employee, and the employer's ability to foresee the activities of the employee. Employee actions which ultimately lead to an accident or injury must be motivated—in whole or in part—by the "desire" to further the interests of the employer. Motivation or desire can be out of fear that failure to perform will result in the loss of a job, or from a more altruistic desire to do well for the employer. The basis for the motivation or desire is irrelevant; it is the fact that the motivation exists that places it within the "scope of employment" and therefore, leads to compensability. Further, the actions must, to some extent, be at the presumed direction of the employer or potentially foreseen by the employer.
Significant Contact Test	This test is applied when making jurisdictional decisions to determine which state benefits the employee can access. Significant contact tests base these jurisdictional decisions around the **employee**. Three primary tests/questions work to determine which states need to be scheduled as primary, 3.A. states. These questions are: 1) Where does the employee live? 2) Where does the employee primarily work? And 3) In what state was the contract of hire made? If a "preponderance of contact" (or "significant contact") evidences a state not listed as a 3.A. state, there may be a gap in protection.
Situs	The first test before an employee can be considered a longshoreman or harbor worker. Situs requires that the employment be on, above, or below navigable waters and adjoining areas. However, working around or over water does not, in itself, qualify an individual for the benefits prescribed by the USL&HW (United States Longshore and Harbor Workers) Act. To qualify for such coverage requires satisfying the "status" test as well.

Standard Exception Classifications	Some duties/activities are considered so common to most business, and/or such duties may be so far outside the operational activities of the business, that employees engaged in these activities are considered exceptions to the governing classification rules. Payroll for these "standard exception" classes of employees is subtracted from the governing classification and assigned to the applicable standard exception code and rated separately from the governing class. The standard exception classes include: 1) Clerical Employees – Class Code 8810; 2) Clerical Telecommuter – Class Code 8871; 3) Drafting Employees – Class Code 8810; 4) Salespersons – Class Code 8742; and 5) Drivers – Class Code 7380. Standard exception classifications are not necessarily limited to these five class codes; some states utilize state-specific class codes that are also eligible for assignment as standard exceptions.
Status	To be considered a longshoreman or harbor worker requires that the employment involve the loading and unloading of ships, or the maintenance, repair, or dismantling of ships.
Temporary Partial Disability	A disability from which the employee is expected to completely recover in some period of time with little or no long-term effects. A broken arm is a good example of this type of injury. An employee suffering a temporary, partial disability can generally return to work under "light-duty" assignments until the "temporary" condition heals.
Temporary Total Disability	A full recovery from the injury is expected, but for a period of time the employee is completely unable to work due to the injury. These types of injuries might require bed rest or hospitalization while the employee recovers.

THE NATIONAL ALLIANCE
RESEARCH ACADEMY
RISK AND INSURANCE STUDIES

Workers' Comp—
Practical Answers to the Most Common Workers' Compensation Questions

Workers' compensation is mandated by the state and is considered a "sole remedy" solution. That *sounds* fairly straightforward. However, it gets complicated when statutes, common law, contracts, and the human element all join together—or in contention—to permit, reduce, or deny the results workers' comp was designed for—to provide a safety net for employees injured on the job.

"Because what appears theoretically simple is actually quite complicated, our clients have many questions we must be able to answer. This book makes it easy for you to answer 16 of the most commonly asked workers' compensation questions."

—Chris Boggs

Discover:

- The many differences between state workers' comp statutes—requirements applicable in one state may not be applicable in a neighboring state
- How a compensable injury must "arise out of and be in the course and scope" of the worker's employment—the gray areas and various interpretations of "course and scope"
- Who qualifies as an "employee," what injuries are compensable, and what benefits are available?
- How workers' compensation classification codes are determined—a key factor in determining premium
- How to interpret the NCCI Experience MOD Worksheet

Includes:

- State-to-State Workers' Comp Comparison Chart
- Glossary of Key Workers' Compensation Terms

ISBN 978-0-9980475-0-8
90000>
9 780998 047508
NationalAllianceBooks.com

P.O. Box 27027
Austin, TX 78755-2027
800-633-2165 • Fax 512-349-6194
TheNationalAlliance.com

4137-1118