WORKERS COMPENSATION
2015 ISSUES REPORT

The nation’s most experienced provider
of workers compensation information,
tools, and services
Welcome to NCCI’s 2015 Issues Report


We are pleased to bring you an impressive collection of expert authors to discuss the latest trends and conditions driving results in the workers compensation industry.

This year’s Issues Report writers take a close look at the most discussed issues in the industry. Among the topics:

- Updated numbers and observations from NCCI’s annual State of the Line report
- A comprehensive overview of planned and completed state legislative activities
- An analysis of the latest conditions in the California workers compensation market
- A look into the future of the American workplace—and the ramifications of increased automation
- An examination of the continuing opt-out interest in some states

We think that you will find these articles both timely and insightful. And, of course, NCCI will continue to provide additional industry research, analysis, and issues overviews at ncci.com throughout the year.

Please enjoy the 2015 edition of NCCI’s Issues Report.

Stephen J. Klingel, CPCU, WCP
President and CEO
NCCI
Table of Contents

4 Outlook for 2015: Turbulence Ahead
   Stephen J. Klingel, CPCU, WCP
   President and CEO, NCCI

8 2015 Legislative and Regulatory Outlook
   Peter M. Burton, CPCU, AU
   Senior Division Executive, NCCI State Relations

11 RESEARCH BRIEF: The Impact of Claimant Age on Late-Term Medical Costs

12 Workers Compensation Opt-Out: Who’s Next?
   Nancy Grover
   Editor, *Workers’ Compensation Report*
   Program Director, National Workers’ Compensation and Disability Conference® & Expo

16 LEGAL BRIEF: Are Injuries Sustained During Social and Recreational Activities Compensable Under Workers Compensation?

18 Monitoring Reform in the California Workers Compensation System
   Alex Swedlow, MHSA
   President, California Workers’ Compensation Institute (CWCI)

22 LEGAL BRIEF: Undocumented Workers, Employers, and the Exclusive Remedy

24 The Future of Injury-Saving Technology
   Peter Rousmaniere
   Columnist, *WorkCompCentral*

28 Emerging Issues: Athletes and Workers Compensation
   Mona Carter
   Senior Division Executive, NCCI National Policy Development

31 RESEARCH BRIEF: NCCI Examines Medicare Set-Asides and Workers Compensation

32 LEGAL BRIEF: “You Can’t Make Me Pay for My Employees’ Illegal Drugs!”

34 Workers Compensation and the Oil and Gas Industry
   Len Herk
   Senior Economist, NCCI

39 LEGAL BRIEF: Home-Employee Dies on Treadmill; Widow Collects Benefits

40 LEGAL BRIEF: Sharing-Economy Workers and Workers Compensation Benefits

42 The Relationship Between Accident Report Lag and Claim Cost in Workers Compensation Insurance
   Thomas Sheppard
   Actuarial Consultant, NCCI

Please be sure to visit ncci.com for continual updates on the issues and articles contained in this *Issues Report*. 

Workers Compensation 2015 Issues Report 3
For many months now, stakeholders in the workers compensation system have benefitted from mostly positive conditions.

Industry costs have been largely contained, claim frequency has continued to decline, and the system in most states is operating efficiently. In short, the market has been operating as it should.

All good news … but unfortunately it's not the only news affecting our industry.

Today, the workers compensation system is being challenged by a number of external forces, including the courts, the press, and even the Occupational Safety and Health Administration (OSHA).

We’ve seen a number of court cases involving workers compensation. In Florida and Oklahoma, recent cases have focused directly on challenges to the fundamental principle of the exclusive remedy compact, which has been the bedrock of workers compensation.

In some quarters, there have also been calls for increases to benefit levels. While there is nothing inherently wrong with advocating for greater benefits, those decisions should not be made without a balancing consideration of increased costs and who will pay. To address the benefits concern, some are even calling for a new national commission on workers compensation—similar to the commission created in 1972.

These recent challenges are nothing new for an industry that has existed for more than 100 years. When the system has needed to change in the past, we have made the necessary changes to ensure that workers compensation insurance remains both viable and available. And we will meet the new challenges in the same way.

Thankfully, today we have a solid foundation of financial results on which to build a better system.
Updated Industry Results

NCCI’s preliminary analysis of statutory data for 2014 shows continued improvement in the combined ratio as well as another increase in premium volume.

More specifically, net written premium for workers compensation continued its upward trend, with 2014 marking the fourth consecutive year of premium increases.

NCCI’s preliminary estimate for 2014 net written premium is $38.5 billion. This represents growth of 4.6% over the 2013 premium level and a similar increase to the 4.5% growth observed in 2013.

NCCI’s preliminary estimate of the 2014 net combined ratio for workers compensation also suggests improvement. NCCI’s combined ratio estimate of 98, if realized, would be the industry’s first underwriting gain since 2006.

In terms of the residual markets managed by NCCI, Policy Year 2014 premium increased slightly from the prior year. Projections to ultimate, based on data valued as of December 31, 2014, show total premium volume of $1.2 billion for NCCI-serviced workers compensation residual market pools in Policy Year 2014.

Despite significant residual market premium growth over several of the most recent policy years, the projected underwriting results for these years are comparable to those experienced over the last decade and well below the debilitating levels of the early 1990s.

The Legislative Outlook

Last year was relatively quiet with respect to state legislative activity and rate/loss cost filings. In fact, countrywide approved workers compensation bureau rates/loss costs increased only 0.4% in 2014.

In terms of legislation, we saw new workers comp measures enacted in 39 states, but no significant reform movements. Where we did see legislative activity, it was usually related to workers compensation medical fee schedules. NCCI was a valuable resource to several states in their initiatives related to developing and revising medical fee schedules.

One issue that continues to draw attention is the interest in studying potential opt-out legislation in some states. With Oklahoma adopting opt-out last year, and Texas already a long-time practitioner, other states are watching this issue with interest. As late as February of this year, new legislation for an opt-out provision was being considered in Tennessee. NCCI will continue to monitor and report on the outcomes of these decisions. In this edition of Workers Compensation 2015 Issues Report, writer Nancy Grover takes a close look at the opt-out movement in her article, “Workers Compensation Opt-Out: Who’s Next?”

At the federal level, we continue to watch developments with regard to Social Security disability payments, Medicare secondary payer issues, and the Federal Insurance Office. These issues are discussed in the accompanying sidebar, “State-Federal Nexus: Federal Issues Impacting Workers Compensation.”

Looking ahead, we anticipate that 2015 will be a more active year for workers compensation legislation across a broad range of topics.

A comprehensive review of notable 2014 legislative activity, along with projections for anticipated 2015 initiatives, can be found in the “2015 Legislative and Regulatory Outlook” article by Peter Burton, NCCI senior division executive for state relations, in this Issues Report.

Finally, Alex Swedlow, president of the California Workers Compensation Institute, examines conditions for the state of California in his Issues Report contribution, “Monitoring Reform in the California Workers Compensation System.”

Improved Results/Continued Challenges

The market optimism that we expressed in mid-2014 was borne out in the full-year results—but we are now more cautious about the future direction of the workers compensation industry.

As noted above, we remain keenly aware of ongoing challenges that can disrupt the industry’s equilibrium—including continuing legal and press challenges, calls for increased benefit levels, and a workforce where workplaces are changing rapidly.

As we move toward midyear, NCCI will continue to monitor and report on all of the above. In May, we offer our comprehensive State of the Line report to announce the most recent numbers. And we invite you to visit ncci.com all year long for continual industry updates.

◆ Stephen J. Klingel, CPCU, WCP, was appointed president and chief executive officer of NCCI in 2002. Before joining NCCI, Mr. Klingel was a leader with the St. Paul Companies for more than 25 years.
The Extension of TRIA: Perseverance Rewarded

It is common for legislation in Congress to take a long and circuitous route on its way to the President’s desk.

That certainly was the case with the enactment of the Terrorism Risk Insurance Program Reauthorization Act (TRIPRA) of 2015. The legislative process that ultimately produced the latest version of TRIPRA had it all: ardent supporters, principled detractors, procedural machinations, the impact of unrelated amendments and, in the end, negotiation and compromise. That compromise resulted in the Terrorism Risk Insurance Act (TRIA) of 2002 extension legislation that continues the program for six years.

Lessons from the Past
Importantly, the extension of TRIA ensures that the impacts to the American economy and the insurance industry witnessed between the tragic events of September 11, 2001, and the original enactment of TRIA will not be repeated. Those harmful impacts were laid bare before public policymakers in the lead-up to the expiration of TRIA at the end of 2014, and played a significant role in garnering broad support in Congress.

No Fait Accompli
More than two years prior to TRIA’s expiration at the end of 2014, stakeholders began a coordinated effort to educate members of Congress and staff on the elements of TRIA and its positive impacts. This was imperative because nearly one-half of the representatives and senators who would determine the fate of TRIA were not in office when the Act was last extended in 2007. The economic downturn near the end of the last decade resulted in federal government intervention in several cornerstone American industries, making it vital to draw a clear distinction between TRIA and other programs. Key to that effort was the development of a targeted and refined communication strategy to be delivered by a broad base of industries affected by the terrorism risk.

The Power of Sound Research
Central to the successful extension of TRIA was the significant amount of resources dedicated by the insurance industry to educate and inform the debate. NCCI, insurance trade associations, insurance brokers, and other stakeholders all produced or commissioned research papers that made a solid public policy case for the importance of the continuation of TRIA against insured losses from acts of terror.

The epitome of high-quality research and analysis in support of TRIA’s extension was the RAND Corporation’s research effort. RAND produced TRIA-related public policy briefs that focused on the impact of large-scale terrorist acts on workers compensation insurance, the federal budget, and national security. Those briefs collectively presented an overwhelmingly compelling argument for the extension of TRIA and were widely cited during the legislative debate.

Certainty Obtained (Ultimately)
The two previous extensions of TRIA, in 2005 and 2007, conditioned the insurance industry to expect eleventh-hour Congressional action to extend the Act. Late December enactment had become the norm; and heading into the waning days of the 113th Congress, it appeared a similar scenario was taking shape.

Upon the return of Congress following the November 2014 midterm elections, a compromise between the House and the Senate to extend TRIA was reached expeditiously. As is often the case in the federal legislative process, however, even issues with strong bipartisan and bicameral support can get stymied.

The House of Representatives quickly cleared the compromise TRIA extension legislation and sent it to the Senate for consideration. But that legislation included provisions unrelated to TRIA, which some senators found objectionable. One amendment made clarifications to previously created National Association of Registered Agents and Brokers legislation, while another made amendments to the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010.

Opposition in the Senate ultimately halted enactment of the TRIA reauthorization legislation in December. The administration and legislative leadership in both chambers made strong commitments prior to the adjournment of the 113th Congress that a TRIA extension would be the first order of business upon reconvening the 114th Congress in January 2015.

Consistent with those commitments, both chambers passed TRIA extension legislation within days of the new Congress. A compromise produced legislation that gave the two main sides of the legislative debate a victory: the long-term extension of TRIA, along with changes that reduced the federal government’s exposure for insured losses resulting from large-scale acts of terror.
There are a number of federal legislative and regulatory proposals currently under consideration that could have a meaningful impact on the workers compensation industry. With significant and well-placed focus on the state workers compensation system, these federal proposals can, at times, get lost in the sea of public policy initiatives undertaken in individual states.

Presented below are a number of issues that will garner the attention of lawmakers and regulators this year.

**Social Security Disability Insurance**

The last two decades have seen a dramatic increase in the number of beneficiaries and related costs to the Social Security Disability Insurance (SSDI) program. Absent Congressional action, the SSDI trust fund is projected to become insolvent in 2016. In the last Congress, Representative Sam Johnson (R-TX) introduced legislation to address fraud, waste, and abuse in the SSDI program. That legislation allows states with reverse workers compensation offset laws to continue. Similar legislation is expected to be introduced during the current Congress, as well as legislation to address some of the fundamental drivers of SSDI insolvency.

The SSDI debate could be used by detractors of the state-based workers compensation system to push for an expanded federal role in workers compensation. Those detractors assert that the state-level workers compensation reforms instituted over the last several decades are significant drivers of the increase in the costs of the SSDI program.

**Medicare Secondary Payer Reforms**

A broad cross section of workers compensation insurance stakeholders have been working toward statutory improvements to Medicare secondary payer issues. In 2013, the Strengthening Medicare and Paying Taxpayers (SMART) Act was enacted; it brought about improvements to the Medicare conditional payment process. However, Medicare Set-Aside (MSA) provisions in the SMART legislation were removed prior to final passage.

Stakeholders continue to push for MSA reforms that would bring efficiencies and improvements to the process. One improvement is establishing time frames for the Centers for Medicare and Medicaid Services (CMS) to make MSA determinations. Another improvement provides for direct payment to CMS of set-aside amounts and creates a process to appeal CMS MSA determinations. MSA reform provisions could be included in legislation addressing the Medicare physician reimbursement formula, which will ultimately be considered in the current Congress.

**Longshore and Harbor Workers Compensation**

This Congress has reintroduced legislation that would provide clarification to the exemption from United States Longshore and Harbor Workers’ Compensation Act (USL&HW) for employers that perform certain activities on recreational vessels. Provisions included in the American Recovery and Reinvestment Act of 2009 extended the exemption to all recreational vessels, regardless of length. However, the definition of “recreation vessel” included in that legislation lacks clarity, and the Department of Labor did not permit the expanded exemption.

**Federal Insurance Office**

The most recent Federal Insurance Office (FIO) annual report indicated it had not taken any action in the past year to preempt state insurance law. The report is required to be submitted annually to Congress to provide an overview of insurance issues and highlight FIO activities.

The FIO continues to focus on international regulatory issues, which are central to its mission. Implementation issues related to the Terrorism Risk Insurance Program Reauthorization Act (TRIPRA) of 2015 will also be a significant focus of the FIO this year.
Legislative activity in 2014 for workers compensation, by most standards, was comparatively light.

The volume of legislation was fairly consistent, but the breadth and weight of proposals was not. While measures that could impact the workers compensation system were enacted in 39 states, there were no significant systemic reforms. Throughout the year, NCCI provided cost-impact analysis for over 100 measures, on topics ranging from attorney fees to medical cost-containment options to workplace bullying. There was also the standard complement of housekeeping-type measures to make administrative and procedural changes.

This reduced activity was due, in no small part, to the fact that it was an election year, coupled with declining loss costs generally relieving the pressure to make sweeping changes. NCCI anticipates that 2015 will be a more active year for workers compensation legislation.

**Election Results**

The 2014 midterm elections did produce some significant changes, including the thunderous victory that shifted control of both chambers of Congress to the Republicans for the first time since 2007. This echoed in the halls of state governments as well. With 72% of the governors’ offices in contention and over 6,000 legislative races across the country, there was plenty of opportunity for movement.

In the 36 governors’ races, 28 incumbents vied to maintain their jobs; and there were 8 open races, most of them due to term limits. Incumbents prevailed in all but 3 races, with Illinois’ Pat Quinn (D), Alaska’s Sean Parnell (R), and Pennsylvania’s Tom Corbett (R) meeting defeat. Corbett’s upset loss to Tom Wolf (D) signaled the Democrats’ only 2014 gain in the governors’ column. Alaska’s new governor, Bill Walker, ran as an Independent.

In the 8 open races, only 3 resulted in a party shift—all 3 in the Republican’s favor: Arkansas’ Asa Hutchinson (R), Maryland’s Larry Hogan (R), and Massachusetts’ Charlie Baker (R).
All in all, the Republicans picked up 4 governors’ seats (Arkansas, Illinois, Maryland, and Massachusetts) to the Democrats’ single seat (Pennsylvania), resulting in Republican control of 31 state governors’ offices.

**Regulatory Changes**

Insurance regulators are elected in a number of states, and 4 of those were on the ballot in 2014. Incumbents Dave Jones (D-CA), Ralph Hudgens (R-GA), and John Doak (R-OK) retained their positions, while Kansas welcomed newcomer Ken Selzer (R).

Changes in governors frequently result in changes in insurance regulators as well—especially with a new party in power. The 11 newly elected governors are all in a position to appoint new insurance regulators, and 6 of those governors—Bill Walker (I-AK), Asa Hutchinson (R-AR), Bruce Rauner (R-IL), Larry Hogan (R-MD), Charlie Baker (R-MA), and Tom Wolf (D-PA)—represent a change in party.

To date, insurance commissioners in Arkansas, Connecticut, Idaho, Illinois, Maryland, Massachusetts, Pennsylvania, South Dakota, Texas, and Wyoming have announced that they will be leaving office. And we anticipate additional new commissioners during 2015 as well.

Legislatures also experienced a significant shift in party dominance, with Republicans now controlling both chambers in 30 states, while 8 states now have divided legislatures. Democrats now hold majority in only 11 state legislatures—a net loss of 7 states in 2014. (Nebraska has a unicameral, nonpartisan legislature.)

Combining the results in the governors’ races with the legislative outcomes, a significant shift in power on a statewide basis is apparent. Prior to the election, the Republicans held sway in 23 states, the Democrats led in 15, and in 11 states the power was divided. The Republicans have maintained 23 states, but there are now 19 states with divided control, leaving the Democrats in power in just 7 state governments (California, Connecticut, Delaware, Hawaii, Oregon, Rhode Island, and Vermont).

While there were no measures on the 2014 ballot that would have had a direct impact on workers compensation, there were measures passed to increase the minimum wage (Alaska, Arkansas, Nebraska, and South Dakota) and to legalize recreational marijuana (Alaska, District of Columbia, and Oregon). Illinois passed a nonbinding measure that advises the legislature to increase that state’s minimum wage.

**States to Watch in 2015**

**Alaska**—Legislation has been introduced placing limitations on physician dispensing and repackaging of drugs, increasing permanent partial impairment benefits, and excluding individuals using their personal vehicles to provide services for a transportation networking company from the workers compensation definition of employee.

**Arizona**—House Bill 2346, which adds carriers and self-insurers to the list of entities that cannot be forced to reimburse an injured worker’s medical marijuana costs, was signed into law by Governor Ducey.

**Arkansas**—Legislation has been introduced to close the Death and Permanent Disability Trust Fund for new claims, effective July 1, 2015.

**Connecticut**—The legislature is again taking up the issue of severe mental and emotional impairment injuries for those witnessing a violent death or maiming, while the Workers’ Compensation Commission has implemented its first Medicare-based hospital fee schedule, effective April 1, 2015.

**Georgia**—Senate Bill 29, a rebuttable presumption bill calling for the expansion of firefighter occupational diseases, is being debated this session. House Bill 412, which expands benefits for injured workers and tightens the exclusive remedy provision, has received unanimous House and Senate approval and has been sent to the governor for signature.

**Hawaii**—The legislature is actively considering a measure (Senate Bill 1174) requiring mutual agreement of the employer and employee in the selection of an independent medical examiner. Senate Bill 675 creates a rebuttable presumption of compensibility for certain cancers and blood-borne infectious diseases in firefighters.

**Illinois**—Newly elected Governor Bruce Rauner has identified workers compensation reform as one of the priorities of his new administration. Narrowing the injury causation standard, strengthening the American Medical Association standards to determine level of disability impairment, and changing the medical fee schedule are all possible. Concurrently, initiatives have been introduced to create a competitive state fund, establish “hours worked” as the basis for developing premium for the construction industry, and create a task force to evaluate carriers’ reflections of NCCI’s rate recommendations.

**Kansas**—The Kansas Association of Insurance Agents (KAIA) is again expected to seek legislation to modify the state’s residual market mechanism.
Maine—The Workers’ Compensation Board is expected to establish a task force to study whether a drug formulary should be adopted in the Pine Tree State.

Maryland—Legislation (House Bill 468 and Senate Bill 465) to allow the former competitive state fund (now Chesapeake Employers’ Insurance Company) to become a private, nonstock, nonprofit insurer, and require it to become a member of NCCI after an eight-year transition has been sent to the governor for signature.

Missouri—As the only state without a prescription drug-monitoring program to control drug abuse, Missouri will mount another attempt to change that status this legislative session, with three bills addressing oversight of the prescribing and dispensing of certain drugs.

Montana—Legislation has been introduced recommending an increased oversight of its competitive state fund.

Nebraska—Legislative Bill 556 waives the workers compensation exclusive remedy provision and allows civil suits if a workplace injury was caused by willful employer negligence.

New Hampshire—Senate Bill 3, calling for a Medicare-based medical fee schedule and the need for continuing resource data to evaluate workers compensation choices, suffered defeat. Senate Bill 133, calling for the insurance department to collaborate with NCCI to include workers compensation medical data with its healthcare database, continues as a legislative initiative.

New Mexico—The New Mexico Association of Commerce and Industry once again took a run at reducing benefits for claimants who are intoxicated at the time of injury. While receiving significant support from committees of the Senate and House, the bill suffered a fatal unfavorable vote in the Senate Judiciary Committee.

Oklahoma—Even as the workers compensation exclusive remedy provision and the state’s opt-out legislation are being threatened in the Sooner State, the State Chamber of Oklahoma is seeking additional legislative funding to enhance reforms enacted in 2013 as well as calling for medical fee schedule changes and mandatory use of the Official Disability Guidelines.

Oregon—A number of bills have been introduced dealing with workers compensation medical billing and payments as well as the establishment of a task force to study worker misclassification.

South Dakota—Effective July 1, 2015, House Bill 1105 creates the rebuttable presumption of exemption under the Workers’ Compensation Act for a person who has signed an affidavit declaring that they work as an independent contractor.

Tennessee—The Association for Responsible Alternatives to Workers’ Compensation (ARAWC), in cooperation with the vice chair of the Senate Commerce and Labor Committee, has introduced legislation calling for a system alternative, allowing employers to opt out of the traditional workers compensation system. This initiative received a unanimous disapproval from the Tennessee Advisory Council, but continues to proceed forward with additional benefit enhancements in the Senate.

Utah—Legislation converting the competitive state fund to a for-profit, taxable insurer that may write business out of state has been sent to the governor along with an initiative creating a rebuttable cancer presumption for firefighters.

Virginia—In 2015, Governor McAuliffe signed into law several workers compensation measures. Among them are several clarifications to the definition of employee (House Bill 1285 and Senate Bill 745) and bills strengthening the exclusive remedy provision (House Bill 1486 and Senate Bill 770).

Washington—Two nearly identical measures (House Bill 1156 and Senate Bill 5420) were introduced early in the session proposing the creation of a task force to develop legislation aimed at opening the state workers compensation system to private insurance by July 1, 2017.

West Virginia—House Bill 2011, a measure to strengthen existing law that addresses recourse in the event of an injury or death resulting from an employer’s deliberate intent to harm a worker, was signed into law on March 31, 2015, by Governor Tomblin.

In summary, we are experiencing a robust agenda of state workers compensation legislation in 2015, along a broad range of topics. As always, NCCI will continue in its role of providing actuarial and technical support to assist all system stakeholders as these issues are debated.

Please note: The country’s regulatory and legislative environment changes quickly at both the federal and state levels. This article provides a snapshot of issues at the time of publication, May 2015.

◆ Peter M. Burton, CPCU, AU, is a senior division executive for NCCI’s state relations unit. Mr. Burton is responsible for all state, regulatory, and legislative issues for NCCI, and he manages the company’s state regulatory executive field personnel.
Recent NCCI research found that for workers compensation medical payments made between 20 and 30 years after an injury, the average annual payments for claimants younger than age 60 at the time of treatment are greater than the average annual payments for claimants older than age 60.

This study examines this difference by looking at the claims characteristics for injured workers in these age groups:
- Number of medical services and overall average prices paid for medical services
- Injury mix
- Prescription drug use

For this study, late-term medical care consists of all medical services provided during 2011 and 2012, for claims that occurred 20 to 30 years ago.

Key Findings
- The average annual late-term medical cost per claim generally decreases gradually with increasing claimant age.
- The number of services per claim is a larger contributor to age-related annual late-term medical cost differences than is cost per service.
- Average annual late-term medical costs per claim are about 60% higher for claimants born after 1950 than for older claimants. About 80% of this difference is explained by:
  - The mix of injuries being treated and, in particular, differences in the share of quadriplegic and paraplegic claims. This explains approximately 60% of the difference.
  - Use of prescription drugs and, in particular, differences in the use of narcotics. This explains approximately 20% of the difference.
With Oklahoma’s opt-out system entering its second year, the question on the minds of many workers compensation stakeholders is, Which state will be next? Nearly 30 Oklahoma employers had been approved for the opt-out system by the end of 2014, with many others taking a wait-and-see approach.

Industry groups and stakeholders were closely monitoring the situation to see which additional jurisdictions might be ripe for an opt-out approach. Based on the Oklahoma experience, a variety of factors weigh into the decision, and proponents and opponents are equally passionate about the idea.

The answer to Who’s next? came in February when Tennessee lawmakers introduced their own version of opt-out legislation.

**Alternative Systems**

Until 2013, Texas was the only state widely recognized as giving employers the choice of whether to subscribe to the workers compensation system. Nonsubscribers lose the exclusive remedy protection afforded those that do subscribe. Some nonsubscribers have developed their own occupational benefit plans, while others have no benefit programs for injured workers.

In its latest biennial report to the state legislature, the Texas Department of Insurance estimated about one-third of Texas employers—approximately 119,000—were nonsubscribers in 2014. Among those, about one-third offered a formal, alternative benefit plan.
Texas’s nonsubscribers system has been in place since the state adopted its workers compensation program in 1913. The effectiveness of the system is a matter of some debate. “Texas nonsubscription has moved from the Wild West of workers compensation to a widely accepted way of doing business,” said Bill Minick, president of PartnerSource, which advises on the feasibility, design implementation, administration, and funding for workers compensation alternative programs. “Over the past two decades, this alternative to workers compensation has achieved better medical outcomes for hundreds of thousands of injured workers and saved billions of dollars on occupational injury costs.”

Critics of the Texas system point to the 20% of employees—an estimated 1.9 million—who work for nonsubscribers, including roughly 5% of the workforce—470,000 workers—whose employers have no occupational benefit plans in place.

“The nonsubscribers system is still an open sore,” said Richard Levy, legal director for the Texas AFL-CIO. “We can’t even get standards that require reporting on outcomes among nonsubscribers or a prohibition on retaliation against workers injured on the job.”

With the workers compensation system scheduled to sunset in 2017, Levy said lawmakers in the current session will undertake a comprehensive review. “The fact that there are serious gaps is drawing the attention of legislators across the spectrum. As time goes on, I think that there’s going to be increasing pressure to address the nonsubscribers system.”

Oklahoma’s Opt-Out
Many of the concerns about Texas’s system were addressed in Oklahoma. Senate Bill 1062 was signed by Governor Mary Fallin in May 2013 and took effect February 1, 2014. Among its provisions was the Oklahoma Employee Injury Benefit Act, which allows employers deemed “qualified” to opt out of the state-based workers compensation system.

Unlike Texas’s system, Oklahoma employers must meet certain financial and other requirements to qualify, including a written benefit plan that provides coverage and benefit levels that meet or exceed the minimum requirements set forth in the law. Private employer plans must also comply with the Employee Retirement Income Security Act, a federal statute that sets minimum standards for a majority of the pension, welfare, and health plans offered through private industry. The plans provide the exclusive remedy for qualified employers.

The new law withstood a state Supreme Court challenge in 2013, but many stakeholders expect additional legal challenges. This was cited as one reason why only 29 employers have been certified for the opt-out system, rather than the 25% to 33% of employers some observers expected.

Another issue that may be deterring companies from choosing to opt out is what some believe is competition created by the opt-out system and improvements in the traditional system. Loss costs, for example, were reduced by 7.8% in January, marking the second consecutive year of decreases. Additionally, the law that enabled companies to opt out also changed the state-based workers compensation system from court-based to an administrative system.

“Under the old court system, judges would award impairment on body parts that were not originally reported and did not receive any medical treatment,” said Becky Robinson, assistant vice president and risk manager for Hobby Lobby Stores, Inc. “Under the new administrative system there is strict interpretation. The language does not allow impairment to a body part that has not been treated. The act is being interpreted fairly. That’s huge.”

Although Hobby Lobby had lobbied heavily for an opt-out provision in Oklahoma, it has not chosen that route at this time. But Robinson said the company is weighing its options. “It is kind of exciting to see that market develop, and it’s a market we will consider,” Robinson said. “We will look for opportunities where we see advantages for our employees.”

Employers that have opted out said the court-based system was just one reason they made the switch. Overall frustrations were key.

“Workers compensation costs kept rising and got completely out of control—a 50% increase one year, then 25%, and our losses weren’t that bad,” said Daryl Wigington, risk manager for the Ben E. Keith Company, which opted out as of December 1, 2014. “We had to do something.”
Wigington estimates the company will save at least 25% on its workers compensation costs.

“It gives us more control over the medical, so we’ll use the best doctors and get [injured workers] the quickest care they can, with the understanding that when they reach maximum medical improvement they will be ready to return to work,” Wigington said. “Also, we pay the wage benefit out of our payroll department, so there are no delays or going through insurance companies.”

Tennessee Joins the Party
In February, Tennessee Senator Mark Green and Representative Jeremy Durham proposed legislation to allow employers to opt out of the state’s workers compensation program and design individual plans.

The law aims to make workers comp more efficient and cut costs for payers by changing the way permanent partial disability benefits are calculated and creating a medical advisory committee in an effort to reduce medical costs, among other changes, Business Insurance reported.

The bill proposal would cap benefits to 156 weeks or three years unless medical expenses hit $300,000. The current program allows for coverage for as long as treatment is needed. Employers would have to prove it is financially able to establish its own program.

Why Opt Out?
Lower costs and better outcomes are cited as the main reasons employers opt out. Companies that are most likely to seek alternatives to the state-based workers compensation system are those that feel the traditional route is no longer effective.

“When the laws began in the early 1900s, it was a very different workforce—more focused on industrial jobs, and there were a lot more hazardous conditions,” said Richard Evans, executive director of the Association for Responsible Alternatives to Workers’ Compensation (ARAWC). “So the workers compensation statutes that were created, to a large degree with some modifications, are the same today but with a really different workforce.”

Evans said the “leaders” in nonsubscribers in Texas are generally from industries with fewer catastrophic injuries, such as retailers, restaurants, and hair care salons. Heavy manufacturers are often in the traditional workers compensation system due to their high exposure.

“Going from an industrial-based to a service-based [economy], you have a lot less exposure for those kinds of injuries,” he said. “I think it works well because you have an environment where people are getting hurt less.”

But employers involved in heavy manufacturing and other more hazardous industries may also opt out if their experience is better than average. Oil, gas, and transportation employers, for example, may want alternatives.

“A lot of companies you see opting out are those that think they can manage their risk better and don’t like that their premium rate is a blend of others,” said Brian Allen, vice president of government affairs at Helios. “You’ll see big regional companies opting out because they think they are getting saddled with the claims experience of other organizations. It’s a way to manage their own risk.”

Allen believes the appeal for alternative systems is centered on particular geographic areas. “I think it’s fair to say the further you get away from Texas the less buzz there is about the idea,” he said. “It seems to be regionally focused in the central southern area … there is virtually no talk of it in the Northeast—only in passing when they get frustrated, but no real serious talk about it.”

Political influences also play an important role in whether a particular jurisdiction is likely to embrace opt-out. States with strong organized labor influences, for example, may be less likely.

“There’s a feeling among labor advocates that injured workers may not get the same level of care and case management that they would otherwise get,” Allen said. “I don’t see the Northeast or California jumping on the opt-out bandwagon. I could see Florida, Georgia, Mississippi, Alabama, Arkansas, and some of the Midwestern states; and in some of the intermountain west states, Arizona and Utah, where the politics lend itself more to that kind of thinking. It will be driven a lot by the kind of industries in those states and the pressure on legislatures to do something different.”

Also driving the opt-out movement is the desire among some states to attract new businesses. That was one of the main considerations in Oklahoma, where workers compensation costs were among the highest in the nation.

Opt-Out Expansion Efforts
ARAWC is keenly aware of the nuances that affect a state’s decision to implement an alternative to its workers compensation program. The organization plans to undertake a strategic, long-term push in targeted states.
“We created ARAWC to be national,” Evans said. “Our mission is to take the option into as many states as possible over time. We will invest heavily in two states per year.”

Deciding the states to target will be based on a combination of factors, such as high workers compensation costs, cost drivers, the presence of ARAWC members, and the political environment.

“California and Florida have high workers compensation costs and a lot of interest in reigning in costs, but the political environment may not be right,” Evans explained.

Once the targeted states have been identified, proposals will be developed based on core principles unique to each state. Each state’s plan could be similar to that of Oklahoma or Texas or a hybrid between the two systems.

Opposition

Also weighing into ARAWC’s decision of whether to target a particular state is the expected pushback from various factions, such as unions, medical providers, and insurers. Evans said the group will meet with all stakeholders involved to try to make them comfortable with the idea.

Unions, for example, “oppose opt-out, but also criticize how poorly the workers compensation system works on benefits and the medical side,” Evans said. “What I think labor needs to really consider is, What are the positive impacts of being able to opt out? If employees can get better medical care and costs are reduced, then labor should support this—it’s money that can be spent on salaries, etc.”

How successful they will be is questionable. “The fundamental feature of these plans really is they privatize access to justice and privatize the definition of what justice is. They turn over so many features of the program to the sole discretion of the employer,” Levy said. “Fundamentally it’s a privatization of a function that belongs in the public sphere. It’s absolutely a very bad thing for workers moving forward.”

While several insurance carriers have developed policies that have been approved for Oklahoma employers that opt out, many are reluctant to embrace the idea of an alternative system. Among the insurance trade associations, the American Insurance Association (AIA) has been one of the most outspoken opponents of the Oklahoma opt-out proposals.

“I think the best overall way to characterize our opposition is our continuing belief that the state-based workers compensation system, now over 100 years old and having been tested for that protracted duration, has proven to be a very good means of compensating for industrial injury, providing injured workers with high-quality medical treatment, and getting them back to work,” said Bruce Wood, vice president and associate general counsel of AIA. “There’s never any system that’s perfect, and the workers compensation system in the aggregate certainly is not. Some states are more challenged than others, but the promise that is provided by the modern workers compensation system is optimal in contrast to those who are advocating a parallel universe that raises innumerable questions about benefit security and really, ultimately, the ability to effectively manage disability.”

For example, Wood questions the effectiveness of provisions that protect workers benefits. He also wonders whether the assessable base among self-insureds that opt out will be sufficient to pay benefits if necessary, and whether the medical care provided will be focused on getting employees back to work rather than just treating them.

“Nobody’s even raising the questions because the only thing employers say is simply they want to pay less. I get that: you want to be as efficient as possible. It’s a competitive marketplace,” he said. “But there are social questions and social costs involved without asking why one is paying less and what implications there might be for a program that allows you to pay less.”

Ultimately, Wood says it will be up to employers to decide whether they want to stay with the system that has been in place and tweaked for 100 years or go with something new. Employers, say proponents everywhere, should have that choice.

“We’re not trying to dismantle the state workers compensation system. This is really something that’s going to be a separate entity, a separate product, to compete with the workers compensation system—a genuine alternative to workers compensation,” Evans said. “We’re trying to create something entirely new that allows more flexibility and more contact between employers and employees. That’s what the system is supposed to be about—taking out some of the other so-called ‘stakeholders’ who’ve been in the workers compensation system.”

◆ Nancy Grover is a writer who covers the insurance, financial services, and healthcare industries. She is the editor of the Workers’ Compensation Report and program director for the National Workers’ Compensation and Disability Conference® & Expo. She can be reached at nancygrover@hotmail.com.
Picnics, holiday luncheons, appreciation banquets, sporting events, and family fun days are all common activities in the workplace these days as companies cultivate a work atmosphere that attracts and retains top talent. But is attendance at these types of events part of an employee’s job? And if an employee is injured at such social or recreational activities, is the injury compensable under workers compensation? The answers are not always so clear.

Traditionally, injuries occurring from social or recreational activities are excluded from workers compensation coverage. However, many states do provide coverage when it is determined that the social or recreational activity “arises out of” and is “in the course of employment.” To make this determination, courts often consider whether the facts surrounding the activity fit within one of the categories below from Larson’s Workers’ Compensation Law (Volume 2, Chapter 22).

1. It occurs on the premises during a lunch/recreation period as a regular incident of employment
2. The employer expressly or impliedly requires participation or makes the activity part of the services of the employee
3. The employer derives substantial direct benefit from the activity beyond improvement of employee health and morale

Though these Larson test elements are widely relied on and an important tool for the courts in many states, their application may not always be so straightforward, as seen in a recent case in South Carolina.

**Compensable Kickball in South Carolina**

In Whigham v. Jackson Dawson Communications, the South Carolina courts considered whether the claimant, Stephen Whigham, was due workers compensation benefits for injuries sustained while playing kickball in a team-building event. Whigham, a manager, conceived and organized the voluntary employee kickball game to further the company’s goal of creating an enjoyable work atmosphere. Whigham’s direct supervisor approved of the idea, instructing him to move forward with it. And the costs of the event were paid by the employer. On the last play of the kickball game, Whigham broke his leg, which required two surgeries and a possible knee replacement in the future.

Whigham went on to file a workers compensation claim for his kickball injury. The single workers compensation commissioner, the full commission, and the court of appeals all denied benefits, finding that the injury did not arise out of and in the course of employment because his attendance was not required and there was no benefit to the employer beyond employee morale.

The case was then presented to the South Carolina Supreme Court. Reversing the lower courts in a 3-2 decision, the Supreme Court ruled that the injury was compensable and did arise out of and in the course of employment. The Court’s analysis placed considerable emphasis on the second of the Larson test elements to determine whether the claimant was impliedly required to attend the event, thus becoming part of his employment services.
Regarding his presence at the event, Whigham testified that he considered his absence “a reflection of poor management.” His supervisor testified that he would have been “surprised and shocked” had Whigham not attended. The Court, therefore, decided that even though the event was generally voluntary and there was no direct mandate that he attend, the claimant’s participation was expected (read “required”) rather than voluntary. The Court reasoned:

This fact sets Whigham’s participation apart from that of all other employees. It is undisputed that Whigham felt compelled to go and his boss would have considered it a dereliction of duty to miss it. The only fair reading of [his boss’s] testimony is that he knew he did not have to expressly direct Whigham to attend the game because Whigham would already feel an obligation to be there.

As the Court’s analysis and ruling seem to be a relatively direct application of the Larson test and may even be common sense to some, is it a foregone conclusion that the outcome would be the same if heard by a different court? Maybe not, if the critiques set forth by the dissenting justices are given any weight.

The Dissent’s Take
The dissent, in its retort to the majority’s analysis, first points to the testimony below from Whigham to contend that the event was voluntary for all employees, including Whigham, and there was no pressure on him or anyone to play kickball:

Q: Was there any pressure on you or anybody that you know of that you’d better be playing kickball that day?
Whigham: No, there was not. There was never an ultimatum given to anybody...

Q: It was totally voluntary?
Whigham: Either that or working.

Q: Okay. But you would agree it was voluntary to go play kickball.
Whigham: Yes. It was not—it was not mandatory.

The dissent next took issue with the majority’s treating attendance at the event and participation in the kickball game as if they were one and the same activity. The dissent maintains that the two must be distinguished as separate activities, reasoning that even if the majority was correct and Whigham was impliedly required to attend the event, his injury was not contracted from organizing or attending the event. He was injured playing kickball, a voluntary activity over and above any attendance that may have been required.

The dissent also expressed concern with the majority’s analysis in that it “favors supervisors over other employees” by awarding benefits for a claimant in an organizational role but likely excludes benefits for other employees who may be hurt in a similar fashion from the same activity.

Conclusion
While this particular case is settled in South Carolina, it remains to be seen if similar cases heard by other courts will contain comparable analyses and outcomes. One thing is certain though: These cases are very fact-intensive and may be subject to differing interpretations, as highlighted by the dissent in Whigham. So, if you’re an employer who sponsors employee recreational or social activities and you want to limit your workers compensation exposure, make sure you have a solid understanding of how the law may be applied in your state.

◆ Adam Levell, Esq., is a counsel with NCCI’s Legal Division.
Every decade, the California workers compensation system undergoes a grand overhaul. The most recent reform, 2012’s Senate Bill 863, is intended to offset the cost of an $800 million permanent disability benefit increase by implementing more efficient, cost-effective medical delivery.

It’s too early to measure the impact of the permanent disability increase, but on the medical side there are some early returns:

- Medical liens, which totaled almost $1.2 million in 2012, declined more than 80% in 2014.
- A new ambulatory surgery center facility fee schedule lowered reimbursement levels by 29% despite significant reductions from network discounts.
- As the state began to transition to a Resource-Based Relative Value Scale (RBRVS) fee schedule in early 2014, the average number of treating physician reports fell 28%, and the average amount paid for those reports fell 30%.

In addition to reforms on liens, fee schedules, and other payment provisions, changes were also noted in claim frequency, severity, and premium rates.

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1 California Division of Workers’ Compensation, 2015.
2 David, Rena and Johnson, Gregory, Ambulatory Surgical Center Cost Outcomes: The Impact of California SB 863 Workers’ Compensation Reforms; CWCI and Workers’ Compensation Insurance Rating Bureau of California (WCIRB), February 2014; 2015 study is in press.
3 Jones, Stacy and David, Rena, Inpatient Utilization in the California Workers’ Compensation System (CWCI), December 2014.
Increased Claim Frequency
Bucking the national trend, indemnity claim frequency has continued to climb over the past three years, increasing 3.2% in 2012, 3.9% in 2013, and 0.9% in 2014. Increased frequency in California has been regional—primarily in and around Los Angeles, where frequency has risen 9% since 2010. In contrast, frequency in other parts of California declined slightly. Meanwhile, cumulative injury claims, which represented 8% of indemnity claims between 2005 and 2007, grew to 13% of lost-time cases in 2013. NCCI also reported that California has the highest permanent partial injury rate in the country.

#1 in Premium Rate
California has always been a high-cost state. And in 2014, it had the highest premium rates in the country, with a rate value 188% higher than the median state—the largest difference in 10 years. Some note that these rankings use Oregon’s distribution of top industries, which do not reflect California’s mix of industries. But Priven (2013) found that even when California’s mix is used, California’s 2012 ranking rises from the third highest to the second highest rate in the country.

Medical Severity
California’s cost per permanent partial injury at first report is $120,312—the eighth highest in the country. Medical costs alone average $78,178—fourth highest. Ultimate medical losses also develop more slowly in California, with only 11% of eventual medical benefits paid in the first year post injury vs. 31% in other states. At Year 4, the difference is 49% vs. 72%; at Year 8, the difference is 69% vs. 80%.

In the chart above, Medical benefits increased from 44% of all benefits in 1984 to 63% in 2013—a relative increase of 43%. Throughout that period, public policymakers modified the laws, regulations, and business practices that govern medical care delivery to injured workers.

Prior to 1993, California operated under a “free choice” model where injured workers selected physicians to treat their injuries, and treatment disputes were determined based on a preponderance of the evidence. In 1996, an en banc decision by the Workers’ Compensation Appeals Board (WCAB) confirmed that the injured worker’s primary treating physician (PTP) had a presumption of correctness on all treatment issues. This ruling also limited a payer’s ability to challenge the PTP unless they could prove the PTP’s opinion was erroneous, incomplete, or legally incompetent—a hurdle that was rarely met. This effectively created a separate standard of care for each physician.

Following this ruling, the estimated average ultimate cost of medical care on an indemnity claim surged, increasing 167%, from $13,137 in 1996 to $35,201 in 2002. Multiple studies linked this increase to the PTP presumption of correctness.

A Single Standard of Care
In 2003, state lawmakers reformed the workers compensation medical care delivery system by repealing the PTP’s presumption of correctness and implementing an objective standard of care determined by evidence-based medicine guidelines. The result was the creation of a Medical Treatment Utilization Schedule (MTUS), a dynamic compilation of treatment guidelines designed to create a single standard of care against which proposed treatment would be evaluated.

1 WCIRB, 2015.
4 2014 Oregon Workers’ Compensation Premium Rate Ranking Summary.
5 Priven, Mark, Bickmore Risk Services, CWCI 2013 Annual Meeting presentation.
6 WCIRB, 2015.
7 WCIRB, 2013.
10 Harris, Jeffrey S. and Swedlow, Alex, CWCI, January 2004. Harris, Jeffrey S., Swedlow, Alex; Gardner, Laura B.; Oster, Charlene; Crane, Rea, CWCI, February 2005. Swedlow, Alex; Gardner, Laura B.; Harris, Jeffrey S.; Crane, Rea, CWCI, September 2005.
The 2003–2004 reforms reinvigorated the role of the workers compensation judge and the WCAB as the final stop in medical dispute resolution and changed the medical management controls that were used. Recent CWCI studies show that the MTUS implementation and other medical reforms were associated with a brief reduction in treatment costs followed by a return to significant annual increases and an immediate and sustained increase in medical management (medical cost containment) expenses, which increased 195% between 2002 and 2010. Like group health and federal healthcare programs, the core of medical management consists of three components:

1. Medical bill review: using fee schedules to adjust physician bills to agreed-upon prices
2. Medical networks: channeling injured worker care when possible to pre-qualified physicians
3. Medical dispute resolution: reconciling the injured worker’s treatment plan with the standard of care and payer’s obligations

Fee Schedules and Networks
California is in the midst of implementing the RBRVS fee schedule which will be more aligned with other states and other systems. The schedule will be phased in over four years, so it will take time before a full accounting is possible. As noted above, however, data already shows reductions in medical report frequency and cost.

Medical Provider Networks (MPNs) have gained traction since being authorized by the 2004 reforms. Ireland (2014) found that as of 2013, 83% of California workers compensation treatment is provided by network providers, up 65% since 2004. A forthcoming CWCI study shows that while network providers are still associated with lower average claim costs than non-network providers, the differential is shrinking when compared with pre-MPN (2000–2003) managed claims.

Medical Dispute Resolution
Medical dispute resolution is an incremental process, shared by most healthcare delivery systems, in which claims examiners and/or case management nurses first review the physician’s request for treatment using support tools such as treatment guidelines. Requests that they cannot approve are elevated to a physician for utilization review (UR). Prior to 2012, if UR could not resolve the dispute, the matter was adjudicated before a workers compensation judge and ultimately decided by the appeals board. This required expert medical evidence, with each physician compiling his rationale and supporting documentation—a time-consuming, expensive process referred to as “dueling docs,” which led to arbitrary, inconsistent medical decisions.

Recent reforms changed everything. The California Legislature expressly stated the rationale for creating a new process, declaring:

That having medical professionals ultimately determine the necessity of requested treatment furthers the social policy of this state ....

That the performance of independent medical review … will be more expeditious, more economical, and more scientifically sound than the existing function of medical necessity determinations ....

The reforms mandated an independent medical review (IMR) process in which physicians rather than judges determine medical necessity. Today, two years into the reforms, there is a great debate about medical dispute resolution, centering on two issues:

1. The efficiency of UR
2. How to uphold the standard of care in determining the level, volume, and cost of care

UR Efficiency
One method of objectively measuring efficiency is to review independent audits. Each year, state regulators conduct random audits of claims organizations, monitoring UR timeliness and the content and distribution of materials to appropriate parties. David (2015) compiled outcomes of all

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18 Ibid.
2009–2013 audits (280 audits and 11,192 requests for authorization) to create an overall portrait of UR efficiency on three dimensions: timeliness, content, and distribution of documents. The average score across all dimensions was 97%.

<table>
<thead>
<tr>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>Total</th>
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<tr>
<td>Total Division of Workers’ Compensation UR Audits</td>
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<td>49</td>
<td>62</td>
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<tr>
<td>Requests for Authorization</td>
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<td>1,843</td>
<td>2,717</td>
<td>2,111</td>
<td>2,715</td>
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<tr>
<td>Overall Rating (Passing Grade = 85%)</td>
<td>96.6%</td>
<td>97.2%</td>
<td>97.1%</td>
<td>97.5%</td>
<td>97.1%</td>
</tr>
</tbody>
</table>

Upholding the Standard of Care

There is always some level of conflict among injured workers, physicians, and payers. Workers compensation lacks the supply and demand controls common to group health and federal programs (e.g., co-payments, deductibles, and contractual language specifying the types of covered care), so it has higher levels of conflict than those systems. Medical dispute resolution helps define the appropriate level and volume of care for injured workers. But how much conflict is there in California workers compensation? David (2014/2015) measured levels of requested and reviewed care at each step of the dispute resolution process. The results are summarized below.

| A | Treatment requests approved by adjuster/case nurse | 75% |
| B | Treatment requests elevated to UR | 25% |
| C | Elevated UR treatment requests approved by physician | 76.8% |
| D | Elevated UR treatment requests modified or denied by physician | 24.4% |
| E | Maximum % of elevated UR treatment requests that are denied/modified (B + D) | 5.9% |
| F | Elevated UR denials/modifications upheld by IMR | 91.4% |
| G | Elevated UR denials/modifications overturned by IMR | 8.6% |
| H | Maximum % of treatment requests overturned by IMR (E - G) | 0.5% |
| I | Maximum % of all treatment requests denied/modified by UR and IMR | 5.4% |
| J | Estimated % of approved treatment requests | 94.6% |

Twenty-five percent of treatment requests require elevated UR, and 23.4% of the elevated UR decisions modify or deny the treatment request. Thus, only 1 in 17 treatment requests (5.9%) are denied or modified by UR (and eligible for referral to an IMR physician). Among denied/modified treatment requests referred to IMR, 91.4% are upheld, while 8.6% are overturned. After accounting for the 5.9% of treatment requests that are denied/modified by UR and the 8.6% of those decisions overturned by IMR, the estimated approval rate for all medical treatment is estimated at 94.6%.

Conclusion

Data and patience are needed for a full accounting of any reform. With $8 billion in medical payments in 2013, California has many distinct stakeholders and vested interests that are seldom aligned. After two years, California can point to some significant successes, ongoing challenges, and debates. As the new permanent disability provisions begin to play out, the portrait will surely continue to change in anticipated and unanticipated ways.

◆ Alex Swedlow serves as president of the California Workers’ Compensation Institute (www.cwci.org), a non-profit organization dedicated to improving the operation of the California workers compensation system through research and education. Alex has over 25 years of experience in health services research, public policy analysis, and data development and has published numerous research studies in the areas of managed medical and disability systems, evidence-based medicine, pharmaceutical utilization, access to care, and return-to-work and key performance indicators of California workers compensation reform.
Good help is hard to find, as the truism goes. But what happens when that help is undocumented? With immigration taking center stage in the national arena, employers and practitioners should take note: A worker’s immigration status brings with it a multitude of considerations and unintended consequences, including potential impact to an employer’s rights and remedies under state workers compensation laws. Take, for example, a 2014 Wyoming Supreme Court case.

The Facts of the Case
In *Herrera v. Phillipps LLC*, Enrique Herrera was employed as a pipe fuser for Gilligan’s LLC. Herrera worked with a crew, supervised by Robert Phillipps, to clean a pipe by using a compressor to blow a cleaning plug through the pipe. When the cleaning plug became stuck, at Mr. Phillipps’ direction, the pipe was lifted from the ditch, and Herrera was instructed to hold the pipe. There was an explosion.

While other crew members ran, Herrera was left holding the pipe. Eventually Herrera laid the pipe down and ran too, but the pressurized pipe whipped around and injured him.

Herrera did not file for workers compensation benefits, alleging that Gilligan’s said it would not submit a workers compensation claim on his behalf but would pay for Herrera’s medical expenses and lost wages instead. Although Gilligan’s initially made payments, the payments eventually stopped.

In 2009, Herrera sued Gilligan’s LLC alleging, in part, negligence. Gilligan’s argued that Herrera was a covered employee under the Wyoming Workers Compensation Act and, as such, the company was immune from suit. Herrera countered that he was not an employee under the Act and that Gilligan’s was not entitled to immunity. Moreover, he asserted that the employer was aware that he was not authorized to work in the United States and, as such, Gilligan’s did not have a reasonable belief that he was authorized to work based on the documentation that the company possessed.

In 2011, Herrera filed a new lawsuit against Gilligan’s LLC and added Mr. Phillipps as a defendant. The district court consolidated both cases and ultimately granted summary judgment in Gilligan’s and Mr. Phillipps’ favor, finding that there was no fact issue and that Gilligan’s reasonably believed Herrera was authorized to work based on the documentation in its possession. Herrera appealed.

The Issue
At issue before the Wyoming Supreme Court was whether a fact issue existed regarding Gilligan’s reasonable belief, based upon the documentation in its possession, that Herrera was authorized to work in the United States.

The plaintiff argued that Gilligan’s did not have a reasonable belief that he was authorized to work based on documentation in its possession. Specifically, Herrera noted that the employer’s documentation consisted of an incomplete Form I-9. While Herrera had signed the first section of the Form I-9 certifying that he was authorized to work, the second section of the form, which Gilligan’s was supposed to
sign after reviewing certain specified documents relating to Herrera’s work authorization, was left blank and unsigned. Furthermore, Herrera testified in his deposition that the supervisor who drove him to the hospital asked, “You’re illegal, aren’t you?”

In support of the district court’s decision, Gilligan’s countered that it did have a reasonable belief, based on the documentation in its possession, that Herrera was authorized to work. First, the company noted that Herrera was included in its workers compensation account. Second, Herrera had signed the first section of the Form I-9, verifying that he was a lawful permanent resident. Finally, the defendant pointed to Herrera’s admission that he possessed a forged alien registration card and a Social Security card (although Herrera did not recall if he presented the forged documentation to Gilligan’s).

The Analysis
In its analysis, the Wyoming Supreme Court first considered the language in the Wyoming Workers’ Compensation Act, which in its definition of employee includes “aliens whom the employer reasonably believes, at the date of hire and the date of injury based upon documentation in the employer’s possession, to be authorized to work by the United States department of justice, office of citizenship and immigration services.” (Wyoming Statute §27-14-102(a)(vii).) There was no dispute that Herrera was not authorized to work in the United States, either when he was hired or when he was injured.

Focusing on the plaintiff, the Court opined that acceptance of Herrera’s argument would essentially require employers to have a fully and properly completed Form I-9 in order to prove, under the Act, that it had a reasonable belief that an employee was authorized to work. According to the Court, since the plain language of the statute made no such requirement, the Court was not willing to read one into the statute. Turning to the defendant’s argument, the Supreme Court noted that Gilligan’s argument showed that there was conflicting evidence as to whether it reasonably believed Herrera was authorized to work. As such, the district court should not have decided in Gilligan’s favor on summary judgment because there was an issue of fact in dispute. The Wyoming Supreme Court reversed the district court’s summary judgment and sent the case back for further proceedings.

Significantly, in its opinion, the Court stated that, at trial, the fact finder determined that the employer reasonably believed that Herrera was authorized to work, then Herrera was an employee as defined in the Act, and Gilligan’s would be immune from the plaintiff’s claims. However, if Gilligan’s did not have reasonable belief, then Herrera was not an employee under the Act, and the company would not be immune from Herrera’s claims.

The Conclusion
Phillips represents a cautionary tale. In a hiring process already fraught with the intersection of federal and state laws, employers and practitioners must understand what, if any, documentation is required and sufficient to verify an employee’s work status according to their state’s workers compensation laws. However, that alone will not suffice. Employers should not only ensure the adequacy of the verification process per their state’s law but also commit to following through with that process.

◆ Jennifer A. Chamagua, Esq., is a staff counsel with NCCI’s Legal Division.
Surging technology for American homes and businesses is profoundly changing employment, work design, and work injury risk.

The Second Machine Age, authored by two faculty members at the Massachusetts Institute of Technology, is an often-cited rallying cry for this 21st-century transformation. The authors tend to focus on computation, because breakthroughs in that arena enable robots, driverless vehicles, and machines that talk with us. “Our generation will see true artificial intelligence and digital connectivity of all humans,” they conclude.

They write, “Technological progress is going to leave behind some people, perhaps even a lot of people, as it races ahead…. there’s never been a better time to be a worker with special skills or the right education, because these people can use technology to create and capture value.” Count insurance professionals among these workers.

I decided to learn what this transformation means for underwriters, loss prevention, claims, and other insurance professionals. During a year-long investigation into the impact of these advances on the workers compensation industry, I conversed with a hundred technologists, insurance practitioners, and researchers. I read the most up-to-date studies. And I learned to see beyond the hype.

Let’s lay out, at the outset, the key facts I uncovered:

- First, technology, if defined broadly (as I do below), will drive down injury reduction rates at or above the pace the rates have declined since the early 1990s, which is about 3% a year.
- Second, injury-reducing technology is, for the most part, technology designed to boost productivity and quality; occupational safety is typically a happy by-product. This complicates the picture.
• Third, workers compensation carriers need to consider how to adapt. One can be a trendsetter and brand itself as such. Another can elect to be a middle or late adopter, fashioning a strategy with which it and its markets are comfortable. A logical strategy exists for every insurer, except for an insurer in denial.

• Fourth, injury-saving technology crosses over the entire insurer enterprise: loss prevention, claims, underwriting, product development, and distribution. The C-Suite will have its hands full fostering rewards from shared ownership.

• Finally, most workers compensation people don’t yet see this affecting their work even while it affects their personal lives.

Injury-Saving Technology Defined

News of driverless cars, robots, what some call “smart, connected products,” and other innovations assault the brain. For the time being, the following four overlapping categories can help sort out technologies of interest to the workers compensation community:

• Prediction. This includes devices and software designed to predict accidents. This technology is useful for avoidance, prevention, and insurance underwriting.

• Real-time monitoring, of which vehicle telematics is an example. The technology diagnoses worker behavior, work demands, and machinery in real time. For prevention and post-accident assessment (for example, to determine causation), its value is self-evident.

• Computer-controlled production. This is intended to help people deliver services or produce goods safely and productively. It helps in tasks such as sorting, packaging, and constructing. It reduces ergonomic and other risks.

• Autonomous robotics. This technology takes over onerous tasks. It is expanding beyond routine to nonroutine assignments. Robots will increasingly be used for physical functions involving strength, dexterity, environmental exposures, endurance, and other demands.

Experts in technology point out a crucial difference between emerging technology and the technology of the 20th century: the new technology thinks. This contrasts with much of 20th-century technology, which is mechanical in original design.

Inside the 21st-century robot or assistive resource is a computer, without which not much of anything can happen. Google’s self-driven car is a computer on wheels. Sometimes 21st-century technology doesn’t do anything but think, listen, report, and respond. That’s why it’s fair to include analytical products, such as vehicle telematics, as part of injury-saving technology.

How Big Can This Be?

It’s hard to see this coming, in part because the technologists and writers ignore the injury-saving implications of advances. An ambitious analysis completed in 2013 lets us conjecture about their work-injury impact.

Two Oxford University researchers, C.B. Frey and M.A. Osborne, examined 702 occupations in America and gave to each a factor that represents the potential for complete computerization.¹

To be clear, they did not address occupational injuries. Nor did they think through what a workforce would look like after aggressive computerization. It could be that jobs would be redesigned to retain a highly valued human element. An example from computer chess is noteworthy: The most proficient competitor in world-class chess today is not a computer but a human who consults multiple computers while in play. Imagine how self-driving cars will revolutionize mobility among the disabled and elderly for gainful work and (ready for more?) romance.

The Oxford researchers concluded that 47% of these 702 jobs are “in the high-risk category, meaning that associated occupations are potentially automatable over some unspecified number of years, perhaps a decade or two.” For them, the key advance in technology is the way robots can increasingly “perform a wider scope of nonroutine manual tasks.”

Borrowing their methods, I examined the largest 100 occupations in the United States, recorded for each the Bureau of Labor Statistics’ 2012 injury rate, and applied the factors developed by the Oxford researchers. I applied the BLS’s rate for injuries with at least six days’ duration of disability, which is a rough proxy for lost-time compensable workers compensation claims. (Each occupation has its own six-day plus rate.)

The table below summarizes the result. For the entire top 100 jobs, the number of claims would decline by 55%.

<table>
<thead>
<tr>
<th>Occupations</th>
<th>Before</th>
<th>After</th>
<th>Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>1,244,000</td>
<td>556,000</td>
<td>−55%</td>
</tr>
<tr>
<td>Construction</td>
<td>98,654</td>
<td>29,082</td>
<td>−71%</td>
</tr>
<tr>
<td>Healthcare</td>
<td>78,894</td>
<td>53,855</td>
<td>−32%</td>
</tr>
<tr>
<td>Hospitality</td>
<td>80,481</td>
<td>14,432</td>
<td>−82%</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>27,635</td>
<td>7,169</td>
<td>−74%</td>
</tr>
<tr>
<td>Transportation</td>
<td>155,843</td>
<td>61,691</td>
<td>−60%</td>
</tr>
</tbody>
</table>

*Note: This table reports only for occupations included in the top 100 in the United States. Occupation count is for all members of an occupation. For example, construction includes all carpenters regardless if in construction, farm, making, maintenance, etc.*

### Vehicle-Related Technology

Self-driving vehicles, collision avoidance technology, and telematics appear to have sprouted up suddenly. Take self-driving cars for the open road. In the mid-2000s, experts cautioned that it would take many years to solve a paradigmatic problem—how a self-driving car could handle a left turn. Within a few years, Google introduced its first generation of self-driving car; on its hood was a device capable of making over a million observations a minute.

But commercial fleet telematics has been around for some time, and fleet risk managers began piloting telematics technology more than a decade ago. A study released in 2014 found that drivers of trucks with a telematics device onboard had sharply fewer “unsafe events.” Drivers of trucks with sleeper cabs experienced a 55% reduction in “less severe” unsafe events and a 60% reduction in “more severe” unsafe events. And fuel economy improved by 5.4% for drivers of sleeper cabs and by 9.3% for drivers of day cabs. The results reflect how productivity and safety improvements often go hand in hand.

Collision avoidance technology is now a standard feature in some private car lines. Drivers experiment with it by aiming their new $30,000 sedans straight at cement barriers and driving forward. And cars are increasingly equipped with lane-change alert systems.

One needs to drill down into actual claims patterns to envision how the new technology can impact workers compensation. Accident Fund Holdings generously shared proprietary information from its extensive and very well-tended claims database about vehicle-related lost-time compensable claims.

### Patient Mobility Technology

Turn now to a classic 20th-century injury-saving technology: mechanical devices that help move patients in healthcare facilities. Accident Fund Holdings found that 23.9% of lost-time claims sustained by professional workers in hospitals and 20% of these employees in nursing homes arise out of patient lifting.

Patient mobility technology arose in the 1980s. Healthcare safety experts praise it. Since the mid-2000s, the technology has been relatively stable in terms of design and value proposition, so it is easy to understand. The Veterans Ad-
administration decided the technology produces a high ROI and spent $200 million acquiring the devices. NCCI confirmed in a special report the technology’s positive effect on workers compensation costs.

Yet most healthcare facilities either have not invested in it or their workers neglect to use it after considerable expense installing it. Most of the 17,000 long-term care facilities and 5,500 acute-care facilities do not have the equipment.

Is there a way for an insurer to leverage this technology into profitable workers comp insurance sales? Perhaps by helping to remove the impediments.

The consulting firm Atlas Lift Tech identifies a short list of barriers for facilities. They:

- Commit errors in their economic analyses of return on investment
- Fail to apply a comprehensive set of policies and procedures regarding use after installation
- May not assiduously train their new staff members
- Don’t get top management involved

Perhaps insurers that focus on the healthcare market—one of the few certain to grow—can design insurance policies that include more consultative support to clients and electronic monitoring of equipment use.

**We’re Still Human**

Injury-saving technology will deeply penetrate the American workforce. The pace of diffusion may be relatively fast compared to safety innovation in the past. That’s because management and employee ranks may see worksite innovations as similar or even identical to technology innovations they absorb into their personal lives, including possibly-upsetting compromises to privacy.

But there’s a big element of uncertainty among us humans in the face of change. Surreptitious observation of taxicab drivers in Munich, Germany, revealed that drivers who knew their cars had antilock brakes drove more recklessly than drivers who were told they did not have antilock brakes.

In sum, my year-long investigation concluded with a finding that was both frustrating and refreshing: *Technology may propose but humans dispose.*

◆ Peter Rousmaniere’s biweekly column on workers compensation appears in *WorkCompCentral*. He can be reached at pfr@rousmaniere.com.
In the spring of 2014, a ruling from the National Labor Relations Board (NLRB) shook the world of college athletics—and perhaps eventually the workers compensation insurance market.

The ruling from a Chicago-based NLRB regional director found that a group of Northwestern University football players were employees of the university and have the right to form a union and bargain collectively.

Interestingly, the Northwestern players are not seeking salaries. Instead, they want to use collective bargaining to:

- Significantly increase scholarships and coverage for sports-related medical expenses
- Minimize the risk of traumatic brain injury through measures such as reduced contact in practice
- Improve graduation rates with help from an "educational trust fund"
- Secure due process rights

The decision in favor of the athletes was based on a number of factors, including the time scholar athletes devote to football (as many as 50 hours some weeks), the control exerted by coaches, and scholarships, which were deemed a contract for compensation.

During the regional hearing, Northwestern attempted to rely on an earlier decision involving Brown University graduate assistants, in which the NLRB found that the graduate assistants are not employees of the university (Brown University, 342 NLRB 483 [2004]).

However, the NLRB regional director rejected this argument by distinguishing graduate assistants from football players. Graduate assistants receive academic credit for their additional activities, and their work supports their central purpose for attending
the university (education), while playing football does not support the central purpose of the university or that of students.

Understandably, Northwestern—with the backing of the National Collegiate Athletic Association (NCAA)—has appealed the decision to the full National Labor Relations Board in Washington, DC. Their argument is that college football players are primarily students, not employees. (Because the National Labor Relations Act excludes employees of federal, state, and local governments, the decision does not apply to public universities, and is only applicable to private universities such as Northwestern.)

So what’s the workers comp angle to all this?

Workers Comp Implications
In terms of college athletes being recognized as employees, there are several workers compensation implications, including:

- **Availability of Coverage**
  - Would comp carriers be interested in this new market?
  - Is workers comp the best means of providing coverage for college athletes?
  - Many schools already self-insure their workers comp exposures

- **Medical**
  - College athletes would be entitled to the same benefits as any other employees
  - There is a heightened emphasis on the long-term effects from head trauma

- **Indemnity**
  - Would this be the end of scholarships in favor of true “pay for play”?
  - Are college athletes subject to wage and hour laws? (The Fair Labor Standards Act [FLSA] would mandate that players be paid at least minimum wage, plus overtime, for any hours worked more than 40 per week.
  - What’s included/excluded when calculating payroll?

Steps Toward a Middle Ground?
Interestingly, while Northwestern and the NCAA vow to fight the regional NLRB ruling, there are steps being taken to address some of the health and compensation issues that may have been motivated by the actions of the Northwestern football players.

For example, the NCAA Division I Board of Directors voted to give five conferences—the Southeastern, Atlantic Coast, Pacific-12, Big Ten, and Big 12 Conferences—the right to award cost-of-living stipends, improve health insurance benefits, loosen rules on player contact with agents, and help players’ families with postseason travel expenses. While the new rules do not go nearly as far as the Northwestern decision, they do appear to be a step in the direction of payment for college athletes.

At the professional level, in 2014 a federal judge approved a multimillion-dollar settlement to compensate retired National Football League (NFL) players suffering from concussion-related injuries. The settlement does not require players who receive awards from the NFL fund to release any concussion claims against the NCAA or other amateur organizations.

Obviously, concussion claims are not limited to football injuries. In August 2014, soccer players and parents filed a lawsuit against Fédération Internationale Football Association (FIFA—the international soccer federation) and US-based soccer organizations in federal court. The lawsuit does not seek monetary damages but demands that FIFA adopt effective guidelines for dealing with soccer-related head injuries.

Similar concussion-related lawsuits have been filed against the National Hockey League (NHL), World Wrestling Entertainment (WWE), and the NCAA. The NCAA tentatively agreed to pay $70 million for diagnosing and testing student athletes, but a federal judge denied preliminary approval of the settlement and urged the parties to continue negotiating.

Examples of State Legislation Addressing Athletes and Workers Compensation
While the NLRB ruling continues to be challenged, a number of states have introduced legislation that attempts to address the questions surrounding athletes (both amateur and professional) and workers comp claims.

For example:
- **Iowa HB 40** would have amended the workers compensation law to state "[i]n the case of an employee injured in the course of performing as a professional athlete, the basis of compensation for weekly earnings shall be one-
fiftieth of the total earnings which the employee has earned from all employment for the previous twelve months prior to the injury."

The bill was introduced in 2013 but did not advance out of committee.

- **Louisiana** considered legislation in 2014 that would base the calculation of the average weekly wage for professional athletes in the state on the employee’s actual earnings at the time of his injury. The proponents of the Louisiana legislation argued that the amendment treats professional athletes like other workers in the state, while advocates for the players argued that the legislation would negatively impact those athletes injured outside of the NFL's regular season.

The bill passed the House but died in the Senate.

- **New York S 2357** would exempt members of a supervised collegiate summer baseball league from the definition of employee for purposes of workers compensation insurance.

The bill was introduced in 2015.

- **New York AB 1981/S 503** would amend the workers compensation law by establishing a mixed martial arts injury compensation fund for professional combative sports participants.

The bill was introduced in 2015.

- **Ohio** introduced legislation stating that college athletes are not employees under state law.

Ohio passed this legislation as part of the state’s budget bill (HB 483), effective September 15, 2014.

**Extraterritorial Laws**

In yet another wrinkle, a handful of states have enacted laws stating that employees injured while temporarily working for their employer in another state are to receive workers compensation benefits under their home state’s law. These laws impact NFL football players injured while playing in another state that has a more favorable workers compensation law.

- **Florida HB 723 (2011)**—Provides that Florida employees injured while temporarily working for their employer in another state are to receive benefits under Florida’s Workers Compensation Law. Employees who work in another state for no more than 10 consecutive days, or a maximum of 25 total days in a calendar year, are considered to be “temporarily working” in that state.

- **Tennessee HB 864 (2013)**—An employee is considered to be temporarily in a state working for an employer if the employee is working in a state, other than the state where the employee is primarily employed, for no more than 14 consecutive days, or no more than 25 days total, during a calendar year. Employees injured while temporarily working in another state are entitled to receive benefits under Tennessee’s Workers Compensation Law.

While a final decision is expected soon in the NLRB Northwestern case, the broader issues surrounding athletes as employees are expected to generate continued discussion in the months ahead. NCCI continues to monitor and study the implications of the NLRB ruling as well as the overall issue of athlete employees and their right to workers compensation benefits as determined by the states.

- Mona Carter is a senior division executive for NCCI’s Regulatory Services Division. She works with national organizations that include insurance carriers, insurance regulators, labor boards, legislators, insurance agents, and others that partner with NCCI in the workers compensation field.
Most Medicare Set-Asides Are for Claimants Who Are Medicare-Eligible at the Time of Settlement

Distribution of MSA Submissions by Medicare Status

NCCI Examines Medicare Set-Asides and Workers Compensation

Some workers compensation claimants are eligible for Medicare benefits or will become eligible in the near future. By law, Medicare is a secondary payer for work-related injuries—workers compensation should pay for medical services for such injuries. Workers compensation insurers (including self-insureds) are therefore required to protect Medicare’s interests when settling claims.

In 2013, the Centers for Medicare & Medicaid Services (CMS) approved $1.8 billion of workers compensation Medicare Set-Asides (MSAs). (An MSA is a fund established to pay future work-related-injury medical costs that might otherwise be paid by Medicare.)

Using a sample of proposed workers compensation settlements whose MSAs have been reviewed by CMS, this NCCI research report looks at:
- Demographics related to MSAs, such as:
  - The distributions of amounts of MSAs and total settlements that include MSAs
  - The distributions of ages of claimants
- Aspects of the CMS review process, such as:
  - The length of time from submission to CMS approval
  - The relation between submitted and CMS-approved MSA amounts

Key Findings
- After a period of dramatic lengthening, CMS’s processing time for MSAs has recently declined
- The ratio of CMS-approved MSA amounts to submitted MSA amounts has declined over time
- The differences between proposed and approved MSA settlements have been largely due to prescription drug costs
- Most MSAs are for claimants who are Medicare-eligible at the time of settlement
  - Most of these claimants are Medicare-eligible because they have been on Social Security Disability for at least two years
  - MSAs make up about 40% of total proposed settlements
  - Of this 40%, prescription drugs make up half
Oh, yes I can, said a New Mexico Court of Appeals.

In the summer of 2014, in Vialpando v. Ben’s Automotive Services, a New Mexico Court of Appeals upheld a workers compensation judge’s ruling that required an employer to reimburse the costs of an injured worker’s course of medical marijuana treatment. So how did the Court find that an employer can be compelled to pay for an injured worker’s marijuana treatment? Let’s take a closer look.

Conflicting Laws

The case involved three laws: (1) New Mexico’s Workers’ Compensation Act (WCA), (2) New Mexico’s Compassionate Use Act, and (3) the federal Controlled Substance Act (CSA). New Mexico’s WCA requires employers to provide injured workers “reasonable and necessary health care services from a health care provider.” New Mexico’s Compassionate Use Act permits the use of medical cannabis to alleviate symptoms caused by debilitating medical conditions. The federal CSA, however, makes the use and/or possession of marijuana illegal.

Argument #1: Reimbursing for medical marijuana treatment is tantamount to committing a federal crime

As one might surmise, the employer in Vialpando took the position that an order requiring it to reimburse an injured worker for a course of marijuana treatment was unenforceable and illegal under federal law. The Court acknowledged that the CSA prohibits the use and/or possession of marijuana. The Court also acknowledged that there was no exemption under federal law for medical uses of marijuana. The Court further recognized that the supremacy clause of the US Constitution requires the Court to resolve any conflict between a state and federal law in favor of the federal law. After making those initial findings, one would think the employer in Vialpando would prevail.

However, and significantly, the Court specifically pointed out that the employer was not attacking the constitutionality of the Compassionate Use Act. This leaves one to consider … if the employer had done so, would this case have had a different result? Rather, the Court noted, the employer’s position was that, by complying with the order to reimburse an injured worker for marijuana treatment, the employer was being ordered to commit a federal crime.

The Court found that it was bound to hear only those arguments presented before it and that it was not to assume or create arguments for any party. In doing so, the Court found that the employer had failed to present any federal law it would be violating by reimbursing the worker; and while it did not state so specifically, the Court did not think reimbursing the injured worker for marijuana treatment violated the CSA. Therefore, the supremacy clause was not implicated, so said the Court, because the employer failed to present any direct conflict between the Compassionate Use Act and the CSA.

The Court thereby found that the Vialpando case was distinguishable from Gonzalez v. Raich, in which the United States Supreme Court dealt with a direct conflict between the CSA and a state law that authorized marijuana.
use and cultivation for medical purposes. As such, the Vialpando Court dismissed the employer’s claim that reimbursing the injured worker would be a violation of federal law.

Argument #2: Reimbursing for medical marijuana treatment, if not a federal crime, is at the very least a violation of public policy

So how did the Court dispose of the employer’s argument that the order requiring it to reimburse an injured worker for his course of marijuana treatment is, at the very least, contrary to public policy? This was an easy one for the Court.

The Court merely recounted the federal government’s own enforcement philosophy as it relates to medical marijuana, and even recreational use of marijuana. The Court pointed to the Department of Justice’s announcement of its deferential enforcement policy regarding medical marijuana. The Court noted that the Department identified eight areas of enforcement priority (none of which concerned medical marijuana) and stated that outside those priorities, the Department would generally defer to state and local authorities. The Court went on to state that the Department even told the governors of two states that legalized the recreational use of marijuana that it would defer its right to challenge those laws.

Finally, the Court stated that New Mexico public policy was made clear in the Compassionate Use Act. New Mexico allows “the beneficial use of medical cannabis in a regulated system for alleviating symptoms caused by debilitating medical conditions and their medical treatments.” As such, the New Mexico Court of Appeals declined to reverse the order mandating reimbursement of medical marijuana treatment on the basis of public policy.

Vialpando provides some insight into how courts analyze medical marijuana reimbursement claims but also leaves questions

While Vialpando v. Ben’s Automotive is an instructive case for employers, reminding them to choose their arguments wisely, it leaves open the question of whether the New Mexico Court of Appeals would have decided this case differently had the Compassionate Use Act been attacked as unconstitutional. Time will tell if New Mexico courts will revisit the issue of whether employers and/or their insurers are required to reimburse an injured worker for a course of medical marijuana treatment. And, of course, the question also remains as to whether other state courts, where medical marijuana is lawful, will follow New Mexico’s lead.

◆ Kacy Marshall, Esq., is a senior counsel with NCCI’s Legal Division.

Medical Marijuana: Following an Ongoing Issue

Last year’s Issues Report included an article, “High Times in Workers Comp: The Impact of Medical Marijuana,” by Nancy Grover, which addressed the impact of medical marijuana in the workers compensation arena. One issue raised in that article was whether workers comp payers would be required to pay for medical marijuana for a claimant in a state where medical marijuana was legal. The article noted that most cases, at least as of last year when the article was published, have been unsuccessful in requiring workers comp payers to pay for the costs related to medical marijuana treatment.

The case of Vialpando v. Ben’s Automotive Services is a recent example of, and gives us a glimpse into, how at least one state court is analyzing state-permitted medical marijuana in the context of workers compensation and the federal law’s proscription against use and/or possession of marijuana.
Oil and gas issues, and particularly the practice of hydraulic fracturing ("fracking"), have received increased attention in state legislatures and the media over the past few years.

Fracking is a process for extracting oil and natural gas from low permeability source rock, typically shale. It involves pumping water, sand, and chemicals into a source rock formation under sufficient pressure to create fractures which increase permeability and enable the extraction of oil and natural gas. The fracking fluids flow back to the surface together with the hydrocarbons that are produced.

In addition to the economic and public health concerns that are typically raised in association with discussions about fracking, there is also a workers compensation element to be considered. The following offers a brief history and overview of the industry, along with some discussion of the workers compensation-related issues that bear watching if the industry continues to grow.

**History of Fracking**

The Schlumberger Oilfield Glossary provides the following definition of hydraulic fracturing:

A stimulation treatment routinely performed on oil and gas wells in low-permeability reservoirs. Specially engineered fluids are pumped at high pressure and rate into the reservoir interval to be treated, causing a vertical fracture to open. The wings of the fracture extend away from the wellbore in opposing directions according to the natural stresses within the formation. Proppant, such as grains of sand of a particular size, is mixed with the treatment fluid to keep the fracture open when the treatment is complete. Hydraulic fracturing creates high-conductivity communication with a large area of formation and bypasses any damage that may exist in the near-wellbore area.
Fracking has been around for decades, at least since the 1940s. But it wasn’t widespread until 2003, when energy companies began actively expanding oil and natural gas exploration, especially in Texas, Oklahoma, North Dakota, Pennsylvania, West Virginia, Wyoming, and Colorado. In 2004, an Environmental Protection Agency (EPA) study found that fracking was not a threat to underground drinking-water supplies. Shortly afterward, hydraulic fracturing was exempted from the Safe Drinking Water Act as part of the Energy Policy Act of 2005. These developments aided the rapid expansion of the fracking industry.

In October 2013, The Wall Street Journal reported that at least 15.3 million Americans live within a mile of a well that’s been drilled since 2000. For example, in Johnson County, Texas, a county south of Fort Worth, there were less than 20 oil and gas wells in 2000. However, at the time of the article, there were more than 3,900 wells in the county, and 99.5% of its 150,000 residents lived within a mile of a well. According to The Wall Street Journal, similar changes took place in parts of Colorado, Pennsylvania, and Wyoming.

In 2014, FracTracker, an independent oil and gas research group, utilized data available from individual state governments to count and map more than 1.1 million active oil and gas wells across 36 states.

Perceived Benefits of Fracking
The perceived benefits of fracking include:
• Jobs, economic stimulus, and increased energy security.
• According to the US Energy Information Administration, increased use of natural gas is improving the environment by helping reduce carbon dioxide emissions in the United States to their lowest levels since 1994. A modern natural gas-fired electricity power plant emits about half the carbon dioxide per kilowatt-hour as a coal-fired power plant.
• More plentiful and domestically produced oil and natural gas.

Perceived Dangers and Drawbacks
As the fracking industry grows, so does the level of controversy over the process. The primary concerns include:
• High consumption of water resources
• Potential impact on drinking water and surface water resources
• Generation of large volumes of wastewater, which must be disposed of safely
• Potential for stimulating earthquakes due to injection of wastewater deep underground

Because the fracking process requires large amounts of water and chemicals, there is the possibility of those chemicals leaching into underground water supplies. Additionally, it is difficult to check water supplies for the chemicals. The manufacturers of chemical compounds used for fracking assert that the ingredients are trade secrets, so it is difficult to determine which chemicals to test for and difficult to pinpoint the source of any contamination.

Furthermore, fracking can release cancer-causing chemicals such as benzene and methane during the drilling process. However, this is not unique to fracking and can occur with other types of drilling.

Workers Compensation Implications
The rapidly expanding fracking industry has increased demand for skilled employees in oilfield service industries, particularly well drilling and completion, transportation, and pipeline construction. This may result in an increase in frequency of claims due to an influx of new and inexperienced workers. In addition, the scope of the work is inherently dangerous, which may increase the severity of injuries. Furthermore, because drilling sites are often in remote locations, quick access to medical facilities may be limited.

According to the North Dakota Petroleum Council, since 2007, oil and gas job growth has tripled, workers compensation claims have quadrupled, and oil and gas truckers’ workers compensation claims have grown six-fold.

The Occupational Safety and Health Administration (OSHA) and National Institute for Occupational Safety and Health (NIOSH) have noted the following impacts from fracking:
• Growth in silica exposure
• Exposure to exhaust gases
• High and low temperature extremes
• High noise levels
• Overexertion and fatigue
• Increasing motor vehicle accidents and injuries
• Fires and explosions
The medical implications include:
• Stress on medical facilities
• Growth in emergency room visits
• Growing number of injuries to uninsured laborers, leading to growth in hospital debt
• Lack of trained medical staff
• Increase in severe injuries
• Inability to provide complete rehabilitation and other therapeutic care

Related Implications
Drilling escalation has increased motor vehicle traffic, especially for large vehicles and equipment, and there has been a growth in traffic accidents in drilling areas. For example, in May 2014, the Associated Press reported:
• In North Dakota, drilling counties’ population increased by 43% in the last decade; however, traffic fatalities increased 350%
• In a Texas drilling area, drivers were 2.5 times more likely to have a fatal accident than the statewide average for miles driven
• In West Virginia drilling areas, traffic fatalities increased 42% while the rest of the state decreased by 8%

According to OSHA, vehicle accidents are the biggest cause of fatalities to oil and gas workers. Furthermore, the velocity of growth exceeds the ability of governments to increase services and maintain essential infrastructure.

In addition, scientists are researching a possible link between fracking and earthquakes in states that are not known for seismic activity. Recent research published by the Seismological Society of America concludes that some earthquakes in Ohio during 2013 and 2014 coincided closely with hydraulic fracking in the same areas. Oklahoma is investigating the possible connection between fracking and tremors. In California, two earthquakes in March 2014, which registered 3.6 and 5.1 on the Richter scale, have raised concerns that fracking and tremors are related.

Workers Compensation Experience for the Oil and Gas Industry: PYE 2007–PYE 2011

Matching Class Codes With Industry Functions
NCCI does not capture experience for workers compensation fracking exposures per se. But, much of the recent growth in classifications related to oil and gas industries is due to fracking.

Exhibit 1 on page 37 shows data for workers compensation claims for classification codes relevant to the oil and gas industry over policy years ending (PYE) 2007 through 2011. Class codes are grouped according to major industry function: drilling and completion, production, and transportation.

The exhibit shows aggregate payroll for PYE 2011 by class and changes in aggregate payroll, frequency, severity, and total loss dollars from PYE 2007 to PYE 2011:
• Payroll is in millions of dollars and adjusted for wage changes through 2011
• The change in frequency is the change in the number of lost-time claims per million dollars of wage-adjusted payroll at first report
• The change in severity is the change in the average cost per lost-time claim, medical and indemnity combined, at first report
• The change in total loss dollars is the change in the total loss dollars at first report; this change can be derived from the changes in payroll, frequency, and severity

The exhibit also shows the loss elasticity for each class code, which is the ratio of the percentage change in total loss dollars to the percentage change in payroll. The loss elasticities reported here were estimated via linear regression of the logarithm of total loss dollars against the logarithm of payroll for the five years from PYE 2007 to PYE 2011. The estimated elasticities can be interpreted as averages over the time period, but do not necessarily match the ratios of percentage change in total loss to the percentage change in payroll between the terminal years PYE 2007 and PYE 2011.

Under Drilling & Completion, Class Code 6235 covers well drilling, and Class Code 6206 covers most fracking and pressure pumping operations; in both cases subject to the requirement that these are performed by a contractor other than the lease operator, which is standard practice in the
industry. And Class Codes 6213 and 6237 cover specialized measurement, repair, or workover functions, also as performed by contractors.

For the Lease Operator Group, Class Codes 1320 and 6216 capture a broad range of similar activities mostly related to production, and are distinguished by the worker’s relationship to the lease operator. Class Code 1320 applies to functions performed directly by the lease operator or principal contractor, while Class Code 6216 covers similar functions if performed by a specialist contractor. A specialist contractor is likely to have less familiarity with the well site than the lease operator.

The Pipeline Group consists of Class Codes 6233 and 7515, which pertain to pipeline construction and pipeline operation, respectively. The long-term development of oil and gas fields requires construction of pipelines from producing regions to end markets, although rail transportation may substitute during an oilfield’s early development.

Impact on Workers Compensation Loss Patterns: Pipelines a Big Driver

**Frequency and Severity:** All of the class codes for the oil and gas industry have relatively high frequency and severity rates per payroll. As in most other industries, claim frequency declined across most oil and gas class codes from PYE 2007 to PYE 2011. Severity increased for most oil and gas class codes. Some of the biggest increases in severity occurred in the Pipeline Group, both construction and operation. Interestingly, Oil or Gas Well Cementing (Code 6206) is the exception—frequency increased significantly but severity decreased slightly.

Loss Elasticity: Because the market for oilfield services related to drilling, completion, and transportation is national rather than regional or state-specific, and since the period from 2006 has shown a rapid industry expansion followed by a plateau around 2011, it makes sense to consider the relationship between losses and payroll for different class codes. A question is, have total loss dollars changed in proportion to payroll, or have they varied more or less than payroll since the beginning of the shale boom?

A simple metric for answering this question is the loss elasticity with respect to payroll, which is the ratio of the percentage change in total loss dollars to the percentage change in payroll over the relevant data period. Of course, the change in total loss dollars can be separated into the change in payroll, the change in frequency, and the change in severity. A loss elasticity of one is a useful benchmark: it signifies that total loss dollars changed in direct proportion to payroll for the affected class code. Similarly, loss elasticity greater than one indicates increased loss incidence in a class code where payroll has expanded. The elasticity metric will confound trend effects (e.g., frequency changes, with all else equal) with scale effects (e.g., payroll changes, with all else equal) if both are occurring simultaneously over the same time period.

However, as NCCI research has shown that loss trends in most industries are (mildly) negative, we would expect to observe long-term loss elasticities less than or equal to one for most class codes. Conversely, a loss elasticity significantly above one indicates that loss rates for a class code are particularly sensitive to payroll changes in that segment of the oilfield service industry. The elasticities discussed here are based on five years of experience for each class.

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**Exhibit 1: Oil and Gas Workers Compensation Experience**

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<td>Drilling and Completion</td>
<td>Oil or Gas Well—Drilling or Redrilling &amp; Drivers</td>
<td>6235</td>
<td>$1,246.6</td>
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<td>Oil or Gas Well—Cementing &amp; Drilling</td>
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<td>Oil or Gas Well—Instrument Logging or Survey Work &amp; Drivers</td>
<td>6237</td>
<td>1,474.7</td>
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<td>Lease Operator Group (Mostly Production)</td>
<td>Oil or Gas Lease Operator—All Operations &amp; Drivers</td>
<td>1320</td>
<td>$2,209.5</td>
<td>33.7%</td>
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<tr>
<td>Oil or Gas—Lease Work NOC—By Specialist Contractor &amp; Drivers</td>
<td>6216</td>
<td>2021.8</td>
<td>42.0%</td>
<td>-20.5%</td>
<td>-0.4%</td>
<td>12.4%</td>
</tr>
<tr>
<td>Pipeline Group</td>
<td>Oil or Gas Pipeline Construction &amp; Drivers</td>
<td>6233</td>
<td>$1,420.7</td>
<td>98.9%</td>
<td>-25.6%</td>
<td>66.0%</td>
</tr>
<tr>
<td>Oil or Gas—Pipeline Operation &amp; Drivers</td>
<td>7515</td>
<td>1,838.5</td>
<td>21.1%</td>
<td>-31.2%</td>
<td>83.8%</td>
<td>53.2%</td>
</tr>
<tr>
<td>Other Codes</td>
<td>Tool Mfg.—Agricultural Construction, Logging, Mining, Wells</td>
<td>3126</td>
<td>$1,515.3</td>
<td>12.0%</td>
<td>-24.3%</td>
<td>57.8%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$13,701.8</td>
<td>21.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Statistical data for all states where NCCI provides underwriting services, excluding WV*

Payroll is adjusted for wage changes through 2011.
Frequency is total-time claims at first report per $1M of wage-adjusted payroll
Severity is the average reported cost per backtime claim as of first report, medical and indemnity combined
While they reflect relationships between payroll changes and loss changes during this period of growth, they are not likely to be indicative of longer-term elasticities.

**Elasticity: Drilling and Fracking.** Loss elasticity for drilling (Code 6235) is close to one. Loss elasticity for Class Code 6206, including most fracking and pressure pumping services, is negative, indicating that total loss dollars increased as payroll decreased.

**Elasticity: Pipelines.** Loss elasticity is above one for both class codes in the Pipeline Group (6233, 7515). Note also that both pipeline codes experienced large payroll increases from PYE 2007–PYE 2011.

**Elasticity: Tool Manufacturing.** Class Code 3126, covering the manufacture of tools used in oilfield services as well as other sectors, has the highest loss elasticity of any class code surveyed here. However, Code 3126 is concentrated in Texas—81% of payroll and 75% of total loss dollars for PYE 2011 occurred in Texas—whereas every other class code in the table has a much more national employment footprint.

**Elasticity: Measurement, Repair, Workover Services.** The loss elasticity greater than one for Class Code 6213, which pertains to measurement, repair, or workover services distinct from drilling or fracking, is largely driven by exceptionally high losses in PYE 2011. If PYE 2011 constitutes an outlier, then the resulting high elasticity is an anomaly.

**Pipelines a Big Driver:** These observations suggest that a major driver for workers compensation losses via the shale boom is not drilling and fracking per se, but rather, associated employment growth in related sectors, especially pipelines, induced by oil and gas development.

In summary, for this group of nine classes, payroll went up 21% from PYE 2007 to PYE 2011, while total loss dollars rose 15%. For the combination of the two classes in the Pipeline Group, payroll rose 45% and losses increased 95%.

**Continued Expansion?** At the end of 2014 and beginning of 2015, gas and oil price drops were threatening profits from fracking, which is more expensive than conventional drilling. In November 2014, in fact, Reuters reported that permit applications to drill oil and gas wells in the United States declined almost 40%.

While some experts expect that the price drops will lead to less domestic production, others hold that the industry will continue to maintain and even increase production for at least several years.

Apart from the economic questions, workplace safety and workers compensation claims issues associated with the fracking industry will continue to be an area of broad industry interest.

**Len Herk** is a focus lead and senior economist for NCCI. His research to date has involved the Affordable Care Act, interstate variations in medical treatment and cost for workers compensation claims, quantitative comparison of alternative ratemaking methodologies, and internal rate of return models in the context of ratemaking. Len holds a PhD in economics from the University of Virginia and an MS in computational finance from Carnegie Mellon University. He has been published in the *Journal of Economic Theory* and the *RAND Journal of Economics*.

**NCCI National Policy Development Consultant Laura Kersey** and **NCCI State Relations Executive Mike Taylor** served as co-authors on this article.
Home-Employee Dies on Treadmill; Widow Collects Benefits

Thanks to the wonders of mobile technology, more workers have the capability to telecommute and perform at least a portion of their work duties from home. This arrangement can introduce new challenges, however, as illustrated by a Maine financial analyst who suffered a heart attack while walking on his treadmill and using his work Blackberry®. But can walking on a treadmill at home be considered within the course and scope of employment? In January 2015, the Supreme Judicial Court of Maine concluded “yes” in Estate of Sullwold v. Salvation Army.

Gregory Sullwold, employed as a portfolio specialist and comptroller, was responsible for overseeing $2.5 billion of investments for the Salvation Army’s Eastern Division. His employer supplied him with a BlackBerry® and other office supplies and permitted him to work from home. On the day of his death, Sullwold began working in his home office at about 8:30 a.m. At 3:30 p.m., he went for a walk on his treadmill; around 4:00 p.m., his wife found him unconscious with his BlackBerry® at his side. Emergency response personnel were unable to revive him.

Sullwold had a history of coronary artery disease and atherosclerosis. About 15 years prior to his death, he suffered a heart attack. Shortly before his death, Sullwold reported to his doctor that he experienced chest pain while walking his dog. Sullwold also suffered a panic attack, which he believed was caused by work overload. His wife and coworkers explained that Sullwold was stressed from frequent travel and working long hours, particularly during the 2008 Great Recession and its aftermath.

The Maine Workers’ Compensation Board awarded survivor benefits to Sullwold’s widow, determining that work stress was a major causal factor in his death. The appeals court upheld the hearing officer’s award.

On appeal to the Supreme Judicial Court of Maine, the Salvation Army argued that the hearing officer improperly applied the statutory presumption that Sullwold’s death arose out of and in the course of employment (39-A M.R.S. §327). (The Salvation Army also contended that it was not the proper party to rebut the presumption. On this issue, the Court agreed that the Salvation Army was not the proper party, but quickly dismissed the argument because the appellate court did not place this burden on the Salvation Army.)

“Rationally Possible” That Work-Related Stress Contributed Significantly to Workplace Death

Maine’s Workers’ Compensation Act provides, “In any claim for compensation, when the employee has been killed … there is a rebuttable presumption that the employee received a personal injury arising out of and in the course of employment …” (39-A M.R.S. §327). The Supreme Court explained that the presumption is properly invoked when the evidence presented to the hearing officer, combined with any facts the decedent may have reasonably presented if he were alive, could rationally result in an award of compensation. Claims that have a “rational possibility of success” receive the benefit of the presumption; “hopeless claims” do not.

The Supreme Court concluded that the evidence presented was sufficient to demonstrate that the claim had a rational potential for success and was not hopeless. At the time of death, Sullwold was walking on a treadmill, during working hours, in a place approved by his employer, while using a BlackBerry® provided by his employer. This evidence was sufficient to show there was a rational possibility that the injury occurred in the course of the employment. Additionally, the Court concluded that the hearing officer’s findings were correct: The evidence of work-related stress could rationally result in a determination that Sullwold’s employment contributed significantly to his fatal heart attack. Therefore, there was no error in the ruling that the death arose out of the employment.

Everything in Moderation, Including Moderation

So what did we learn from Estate of Sullwold v. Salvation Army? Working on a BlackBerry® while exercising was very significant. If Sullwold had simply put down his phone and focused solely on his workout, perhaps the hearing officer would have held that this was not a workplace injury. More importantly, Sullwold’s health feasibly may have improved if he reduced his stress at work by taking a break.

While mobile devices have certainly provided workers more flexibility to work while away from the office, like everything else, moderation in our lives is paramount. Time will tell whether employers institute more rules related to telecommuters’ work and break schedules.

◆ Evelyn M. Garbett, Esq., is a counsel with NCCI’s Legal Division.
Ride-sharing companies Uber and Lyft and other sharing-economy companies providing services from maid services to personal errands are constantly in the news these days. Most consumers who use these companies are unaware that the person who drives them across town or the one who cleans their apartment or picks up their dry-cleaning is not considered an employee by the companies who dispatch them through a mobile phone app or website. Instead, these companies consider the workers independent contractors.

But what happens when workers for these companies get injured while performing services? Based on their status as independent contractors, they do not receive workers compensation benefits.

FedEx characterized its drivers as independent contractors. The Operating Agreement with the drivers provided that, “the manner and means of reaching the results are within the discretion of the driver, and no officer or employee of FedEx … shall have the authority to impose any term or condition on the driver ….” One of the provisions in the Operating Agreement cited by the court stated:

No officer, agent or employee of FedEx … shall have the authority to direct the driver as to the manner or means employed. For example, no officer, agent or employee of FedEx … shall have the authority to prescribe hours of work, whether or when the driver is to take breaks, what route the driver is to follow, or other details of performance.

In addition to the Operating Agreement, FedEx’s relationship with its drivers was governed by various policies and procedures. FedEx had equipment and appearance standards requiring drivers to provide their own vehicles and have them marked with the FedEx logo. FedEx sold the drivers a “business support package,” which provided uniforms, scanners, and other necessary equipment. The
drivers were compensated according to a formula that included per-day and per-stop components. Although FedEx argued that the Operating Agreement and their policies and procedures created an independent contractor relationship with the drivers, the court countered, “California law is clear that the label placed by the parties on their relationship is not dispositive, and subterfuges are not countenanced.”

**Many Factors to Consider**

The court cited California’s right-to-control test, which requires courts to weigh a number of factors when determining employee status. “The principle test of an employment relationship is whether the person to whom service is rendered has the right to control the manner and means of accomplishing the result desired.” The California courts also consider whether the company has the right to terminate at will, without cause, and other secondary factors, including:

1. Whether the one performing services is engaged in a distinct occupation or business
2. The kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the principle or by a specialist without supervision
3. The skill required in the particular occupation
4. Whether the principal or the worker supplies the instrumentalities, tools, and the place of work for the person doing the work
5. The length of time for which the services are to be performed
6. The method of payment, whether by the time or by the job
7. Whether or not the work is a part of the regular business of the principal, and
8. Whether or not the parties believe they are creating the relationship of employer-employee

The court, relying on a quote from *Germann v. Workers’ Compensation Appeals Board* (1981), stated, “These factors ‘generally … cannot be applied mechanically as separate tests; they are intertwined and their weight depends often on particular combinations.’” The court concluded, based on the right-to-control test, that FedEx’s broad right to control the manner in which FedEx drivers performed their work strongly favored employee status and, therefore, the drivers were employees.

**Conclusion**

The perceived independent contractor status may not last forever for all sharing-economy companies and their workers. The FedEx case makes it clear that companies may claim workers are independent contractors; but as more jurisdictions across the country experience issues with sharing-economy companies, courts may eventually make the final determination based upon the facts surrounding the true relationship of the parties. If the workers are, in fact, employees and not independent contractors, the workers will be entitled to workers compensation and other employee benefits.

◆ Jeff Selbach, Esq., is a senior counsel with NCCI’s Legal Division.
In 2000, a study by The Hartford, using its own data, found that the average cost of a workers compensation claim generally rose as the delay in reporting the claim increased. Effectively managing a workers compensation claim ensures that the injured worker receives their benefits efficiently.

But an insurer cannot begin to manage a claim until notice is given that an injury has occurred. In this study we look at the relationship between report lag and claim cost using recent industrywide data.

**Key Findings**

- The median cost of claims reported between one day and two weeks after an accident is significantly lower than the median cost of claims reported either on the day of the accident (Day 0) or more than two weeks after the accident.
- The Hartford study found that injuries reported in Week 2 had a higher median cost than claims reported in Week 1. NCCI found a slightly different relationship, which depends on the nature of the injury. For sprains and strains and for contusions, the minimum median cost is for claims reported in Week 1. For fractures and lacerations, the minimum median cost is for claims reported in Week 2.
- Across three-day and seven-day waiting period states, the median claim cost for claims reported in Weeks 1 and 2 is lower than the median claim cost for claims reported on either the day of the accident or more than two weeks after the accident.
Data Description

This study uses NCCI’s Detailed Claim Information data Call (DCI), which includes data for 44 states. Reporting requirements for DCI were revised for claims reported to insurers beginning in September of 2009. This paper is the first use of this new version of DCI for NCCI research.

DCI is used for this research because it is the only source available to us that includes the date the claim was reported to the insurer. DCI also includes more claim detail than other available data sources.

Carriers are required to report all Fatal and Permanent Total claims in the DCI Call. Claims where only medical benefits are provided are not reported. Because certain information required in the DCI data Call is sometimes not captured in company claims systems, carriers are required to submit only a sample of other claims. For each state, NCCI specifies two sampling ratios—one for open claims and one for closed claims. To determine which claims to report under DCI, carriers select a random sample of their open and closed claims as of 18 months after report date, using the sampling ratios.

Terminology

• Claim Cost: We define claim cost as the case incurred amount reported in DCI. This amount includes lost-time benefits paid, medical costs paid, vocational rehabilitation expenses, and the case reserve. It reflects the insurance carrier’s best estimate of the amount required to settle the claim. Claim cost does not include loss adjustment expense.

• Report Lag: Report lag is the number of days between the date an accident occurs (accident date) and the date the insurer receives notice of the accident (report date). For example, if an accident occurs on January 15 and the insurer receives notice of the claim on January 18, this claim will have a report lag of three days. Similarly, a claim reported on the day of the injury has a lag of zero days. Both the accident date and the report date are reported in DCI.

• Jurisdiction State: The jurisdiction state of a claim is the state whose statutes determine the benefits to be provided to the injured worker. This could be the same state where the injured worker usually works (the exposure state) or the state where the worker was injured (the accident state).

• Lost-Time Claims: We refer to claims that include indemnity amounts as lost-time claims because indemnity benefits are associated with time away from work. Only lost-time claims are reported in DCI.

Methodology

Our study considers lost-time claims with two exceptions. We excluded occupational disease and cumulative injury claims because the accident date for such claims is defined differently from that for a traumatic injury. The cost of a workers compensation claim is related to how soon a worker returns to work and whether they have resulting disabilities that limit their earnings. Therefore, we excluded Fatal and Permanent Total claims since these workers do not return to work.

We used data from Report Years 2010 and 2011. These were the most recent complete years available at the time of the study. Although Report Year 2010 was available valued at 30 months after the report date, we used both years valued as of 18 months to have the data at a common maturity. The one exception to this is the comparison of Report Year 2010 at 18 and 30 months to determine whether claim maturity affects the results. Data for claims reported to insurers before September 2009 was not available in the current DCI format.

To use the DCI sample database to describe the total population of workers compensation traumatic injury claims, we applied a weight to each claim based on the sampling ratios. The sampling ratio is defined in the DCI reporting requirements and varies by injury type, claim status, and jurisdiction state. In general, the weight is the inverse of the sampling ratio. For example, if the sampling ratio for open claims in State A is 50%, then each open claim in State A receives a weight of 2. We also applied a factor to adjust for any carrier-specific departures from the prescribed sampling ratios.

We calculated weighted median claim costs for claims reported (1) the day of the accident, (2) in each of the first four weeks after the accident, and (3) after the fourth week. We selected the median as our measure of central tendency because it is less influenced by extreme values than the mean.

In an effort to find drivers of the differences in median costs by report lag, we split the data into various categories as noted below and illustrated in the next section.

• Overall claim costs
• Distribution of claims
• Percentage of claims by nature of injury
  - Sprains/strains
  - Fractures
  - Contusions
  - Lacerations
• Waiting period
• Share of medical
• Percentage with attorney involvement
• Percentage with lump-sum payments
• Closure ratio
• Paid-to-incurred ratios

Note that while we are able to identify correlations in the data, we are not able to determine cause-and-effect relationships. In particular, we cannot necessarily conclude that for two similar injuries, with one reported early and the other reported late, that:
1. The late reported claim will cost more than the early reported claim, or
2. The fact of late reporting will cause the cost of the second claim to be higher than it would have been had it been reported earlier

**Detailed Results**

**Overall Claim Costs**
The median cost per claim for claims reported on the day of the injury is about 25% more than the median cost for claims reported in Week 1, as shown in Exhibit 1. Claims reported on the day of the injury likely include very severe injuries that require immediate medical attention. Such claims often require extensive medical care and an extended recovery time away from work.

We found that median cost was lowest for claims reported in Weeks 1 and 2. Median claim cost rises for claims reported in Week 3 by about 35% relative to Week 2. In Week 4, the median cost rises another 12%. Median claim cost drops a bit for claims reported after Week 4 but is still higher than for those reported in Weeks 1 and 2.

Exhibit 2 shows that more than 80% of lost-time claims are reported within the first two weeks.

We investigated several different subcategories of claims to determine whether this pattern of claim cost variation by report lag was consistent across categories.

**Nature of Injury**
We looked at claims by the nature of injury for some of the most common natures of injury. Exhibit 3 shows that almost half of all lost-time claims are sprain or strain injuries. Other common injuries are fractures, contusions, and lacerations. Together, these four nature-of-injury classes account for over 70% of all claims.

For sprains and strains, the minimum median cost is for claims reported in the first week after injury, with the median cost for claims reported in the second week just slightly higher, as shown in Exhibit 4. Median cost increases as the report lag increases from Week 1 through
Week 4. Although our data only allows us to identify a correlation, not a causation, the results are consistent with the idea that early intervention after a workplace injury can lead to a lower claim cost. The median cost of a sprain or strain injury reported in Week 4 is about 70% higher than the cost of a similar claim reported in Week 1.

The pattern of median claim cost versus report lag for fractures contrasts with that for sprains and strains. As shown in Exhibit 5, the minimum median cost is for claims reported in Week 2. The median cost for claims reported in Week 3 is also low compared to other claims. One possible explanation is that the severity of fractures is more apparent to an injured worker than a sprain or strain, so workers with a fracture injury seek treatment relatively early. We recognize that fractures can take a wide variety of forms, with treatment for compound fractures being significantly different from treatment for hairline fractures. The DCI data does not separately identify the various types of fractures.

The relationship between report lag and median claim cost for contusions, displayed in Exhibit 6, is more similar to that of sprains and strains than it is to that of fractures. Median cost is high for claims reported immediately. It is at its lowest for claims reported in Week 1 and rises steadily as the report lag increases.

The median claim cost for lacerations is at its lowest for claims reported in Weeks 1 and 2. Exhibit 7 shows how costs rise quickly in Weeks 3 and 4, with the median cost in Week 4 more than twice the median for Week 2. The median cost for claims reported beyond Week 4 decreases, but the data is relatively sparse, with only about 5% of lacerations in this category.

Although there are different median cost levels between natures of injury, the pattern of relatively high cost for claims with no report lag, low relative cost in Weeks 1 and 2, and rising cost in Weeks 3 and 4 is consistent.
Waiting Period
We considered whether the waiting period (number of days of disability before indemnity benefits begin) for statutory benefits might influence the relationship between median claim cost and report lag. Most states have either a three-day or seven-day waiting period. Exhibit 8 shows the median cost per claim by report lag for three-day and seven-day waiting period states. We did not include Oklahoma because its waiting period changed between three days and seven days. For states with a three-day waiting period, the minimum cost is for claims reported in Week 1. In states with a seven-day period, the minimum cost is for claims reported in Week 2. In both cases, Weeks 1 and 2 have a lower median cost than the other report lag categories.

Exhibit 9 shows that a slightly higher share of claims is reported on the day of the accident in seven-day waiting period states, and there is a slightly lower share in Week 1. Through the end of Week 1, shares of claims reported are very similar between the two waiting periods, with 71.4% of claims reported for the three-day waiting period states and 72.6% for the seven-day waiting period states. This argues against there being any shifting of claims to later reporting with a longer waiting period.

Indemnity/Medical Split
The median medical cost share of case-incurred losses declines as the report lag increases. Exhibit 10 shows that the medical cost is about 60% of the total cost for claims reported in the first three weeks after the injury. For claims reported in Week 4, the medical share drops to 54% and declines further to 48% after Week 4. This indicates that the indemnity cost rises faster than the medical cost for claims reported after Week 3. One possible explanation is that it takes longer for a worker to return to work when the claim is reported after Week 3, resulting in a longer period of wage replacement benefits.

Attorney Involvement
Involvement of attorneys becomes more common as the report lag increases, as indicated in Exhibit 11. Claims reported immediately involve an attorney 13% of the time. This increases to 32% for claims reported after Week 4. This suggests that the complexity of resolving a claim increases as the report lag increases.
Use of Lump-Sum Payments
The share of claims involving lump-sum payments in the first 18 months is shown in Exhibit 12. The share varies between 13% and 18% through the first four weeks, then increases to 25% for claims reported after Week 4.

The share of total cost due to lump-sum payments tends to increase with report lag, as shown in Exhibit 13. Lump-sum payments are 31% of claim costs for claims reported on the day of the accident. For claims reported after Week 4, lump-sum payments are 59% of claim costs. While a claim can be settled with a lump-sum amount, not all lump-sum payments close a claim. A claimant may, for example, receive a lump-sum amount to catch up on periodic payments not previously received. This could explain at least some of the increase in the use of lump-sum payments as the report lag increases.

Closure Ratio
For the report lag ranges considered, the closure ratio—the ratio of the number of claims closed within 18 months of the report date to the total number of claims—is inversely related to the median claim cost. Exhibit 14 shows that the highest closure ratios are for claims reported in Weeks 1 and 2. Claims reported after Week 2 are less likely to be closed at 18 months than those reported in Weeks 1 or 2. This is another indication that claims reported after Week 2 take longer to resolve than claims reported in Weeks 1 or 2.

Paid-to-Incurred Ratio for Claims Open at 18 Months
The paid-to-incurred ratio on claims open at 18 months is shown in Exhibit 15. The ratio generally decreases with report lag. A lower paid-to-incurred ratio indicates that less of the expected final cost of the claim has been paid. This suggests that claims reported later take longer to resolve.
Aging of Claims to 30 Months

The results presented thus far have been based on Report Years 2010 and 2011 valued at 18 months. To test whether the patterns observed might change as a report year matures, we compared Report Year 2010 at 18 months to Report Year 2010 at 30 months.

The general pattern of lowest median costs for claims reported in Weeks 1 and 2 holds for claims evaluated at 18 months and for claims evaluated at 30 months, as shown in Exhibit 16.

Conclusion

This study included workplace injuries with lost work-time other than Fatal or Permanent Total claims and excluded claims for occupational disease or cumulative injury. For these claims, median costs are lowest for claims that are reported after the day of the accident but within two weeks of the accident. This pattern holds for all four of the most common types of injury (sprains and strains, fractures, contusions, and lacerations).

Claims reported on the day of the accident are some of the most costly claims. This is expected because serious injuries often require immediate medical care, which triggers notification to the insurer. Claims with more than a two-week delay in reporting are characterized by a lower medical share of total cost, greater attorney involvement, more use of lump-sum payments, lower paid-to-incurred ratio at 18 months, and a lower closure rate at 18 months. These characteristics suggest that claims with a delay of more than two weeks are more complex to settle, take longer to close, and involve a longer period before the injured worker can return to work.

◆ Additional NCCI authors who contributed to this report include Practice Leader and Senior Actuary Barry Lipton, Director and Senior Actuary John Robertson, and Senior Actuarial Analyst Nedzad Arnautovic.
NCCI MISSION STATEMENT

To foster a healthy workers compensation system by providing high quality information and analytical services that result in:

• Adequate loss costs/rates
• Objective reform evaluation
• Self-funded residual markets
• Tangible value for our stakeholders

NCCI VALUES STATEMENT

The following ethical and performance values guide our behavior and decision making at NCCI. We believe that the commitment of each employee to these values will continue to make NCCI a success.

• Integrity—Our actions are guided by the principles of honesty, fairness, and professionalism. We abide by all laws, regulations, and corporate policies. We foster an open environment and behave ethically in all we do.

• Respect—We show consideration for all people, value the differences among us, and deal with each other in a courteous way.

• Quality and Excellence—We strive constantly to improve our processes and products to remain the industry’s unimpeachable source for accurate, objective workers compensation information. We draw upon our individual strengths and collaborate to consistently meet and exceed the highest expectations of our stakeholders.

• Responsibility—We honor our commitments and are personally answerable for our actions. We actively give back to the communities in which we live and work.

• Commitment—We are driven to achieve our business objectives. We exhibit passion, focus, and intensity of effort in our work while simultaneously striving to achieve work/life balance.