From John Burton's Workers' Compensation Resources

WORKERS' COMPENSATION POLICY REVIEW

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In This Issue:

FEATURED TOPICS

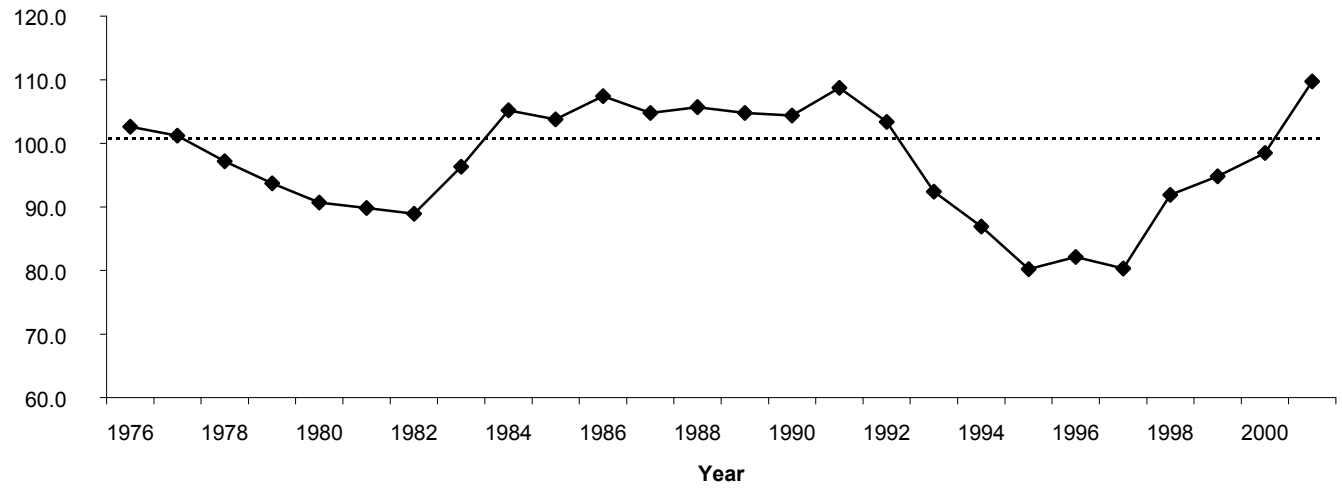
Summary of the Contents

Workers' compensation underwriting results have recently deteriorated, as discussed in the article by Elizabeth Yates and John Burton. The overall operating ratio for years 1976 to 2001 is shown in Figure A. In essence, the higher the overall operating ratio, the worse the underwriting experience, and when the ratio is greater than 100, carriers lose money even when investment income is considered. Between 1993 and 2000, the overall operating ratio was less than 100, which represented an impressive period of prosperity. But the poor results in 2001 were perhaps even more impressive, with the overall operating ratio soaring to 109.7, the highest figure in at least 25 years.

California has enacted significant reforms in the workers' compensation program for the first time since 1993. Glen Shor and Suzanne Marria describe and analyze the changes, which include substantial increases in cash benefits, increased emphasis on return to work and rehabilitation programs for injured workers, and enhanced enforcement of coverage requirements for employers. One key to the success of some of the reforms is an effective state workers' compensation agency, and the authors identify the problems caused by the reductions in agency resources as a result of the state's financial crisis.

Workers' compensation is normally the exclusive remedy for an injured employee against the employer. Most states, however, allow the employee to bring a tort action against the employer when the injury is a result of an intentional act of the employer. A recent New Jersey Supreme Court decision has clarified that state's application of the intentional harm exception to the exclusive remedy doctrine by allowing a tort suit to proceed to trial for an employee who was injured after the employer disabled the safety guard on a rolling mill – except during OSHA inspections.

Figure A
Overall Operating Ratio as a Percent of Premiums, 1976-2001



JACKSON HOWARD BUNN, JR.

Howard Bunn died July 29, 2002 at the North Carolina Memorial Hospital in Chapel Hill from complications related to diabetes. He was born in Zebulon, North Carolina on October 18, 1937.

Howard received his bachelor's degree in 1959 and his law degree in 1963 from Wake Forest University. After practicing law for seven years, he was appointed in 1970 by Governor Robert Scott to serve as Chairman of the North Carolina Industrial Commission.

Howard moved to Washington, D.C. in 1974 when he was appointed by the U.S. Secretary of Labor to serve as the Executive Director of the Interdepartmental Workers' Compensation Task Force. He lived in the Chicago area from 1977 to 1993, where he continued his employment in workers' compensation, first as Vice President of the National Association of Independent Insurers and later as a private consultant.

In 1993 Howard returned to North Carolina, where he was again appointed as Chairman of the Industrial Commission, this time by Governor Jim Hunt, where he served until his retirement in 1999.

Howard was a frequent speaker at workers' compensation conferences, and he was co-founder of the annual National Symposium on Workers' Compensation. He also served as a member of the Advisory Board for the *Workers' Compensation Policy Review*.

Howard is survived by his wife, Kay Wiggs Bunn, a daughter and two sons, his former wife, six grandchildren, and three stepchildren. A memorial service was held for Howard on August 1 at the Zebulon Baptist Church.

I first met Howard 1972 when he was Chairman of the North Carolina Industrial Commission. He invited me to meet the Governor and members of the legislature to help persuade them to improve the state's workers' compensation law in response to the recommendations of the National Commission on State Workmen's Compensation Laws. He introduced me to southern hospitality on that trip, including memorable visits to restaurants specializing in southern cooking and to his favorite jazz spots. We became life-long friends during that visit.

He and Bob Collyer subsequently started the National Symposium on Workers' Compensation, which they directed for about 15 years. I spoke at every one of the annual meetings of the National Symposium, and those occasions helped cement my friendship with Howard. Later, when Ed Welch and I took over as co-directors of the National Symposium, Howard was our most regular attendee, which allowed me to entertain him at my home and try to persuade him that northern hospitality was not an oxymoron.

I remember highs and lows of Howard's life. Among the former are my recollections of Howard's interest in jazz, which included our exchanges of records and CDs we especially liked. He was particularly proud to give me a copy of a CD featuring his son, a professional musician. I also remember Howard's championing the deregulation of workers' compensation insurance markets – at a time before this was acceptable to some segments of the insurance industry, and as a result his stand jeopardized the financial status of the National Symposium. I recall his mentoring young persons interested in workers' compensation and his continuing interest in improving the program. And, at the bottom line, I always enjoyed my time with Howard. We could always find something interesting to discuss and could challenge each other in a friendly way.

Too soon. Too young. May he rest in peace.

John Burton

Workers' Compensation Underwriting Results Deteriorate

by Elizabeth Yates and John F. Burton, Jr.

The underwriting results for the workers' compensation insurance industry have rapidly deteriorated since the halcyon days of the mid- to late-1990s, according to results recently released by A.M. Best. The overall operating ratio is the most comprehensive measure of underwriting experience for insurance carriers. The overall operating ratio is measured as expenses minus investment income as a percentage of premiums. When the overall operating ratio is greater than 100, carriers lose money even when investment income is considered. Conversely, an operating ratio of less than 100 indicates that the industry is profitable when investment income is included.

Underwriting Results Vary

The overall operating ratio for the workers' compensation industry for 1976 to 2001 is shown in Figure A and Table 1, and the cyclical nature of profitability in the industry is evident. Two years of losses in 1976-1977 were followed by six years of profits through 1983. The operating ratio was below 90 in 1981 and 1982, indicating that carriers had profits that exceeded $10 for every $100 of premiums in those years.

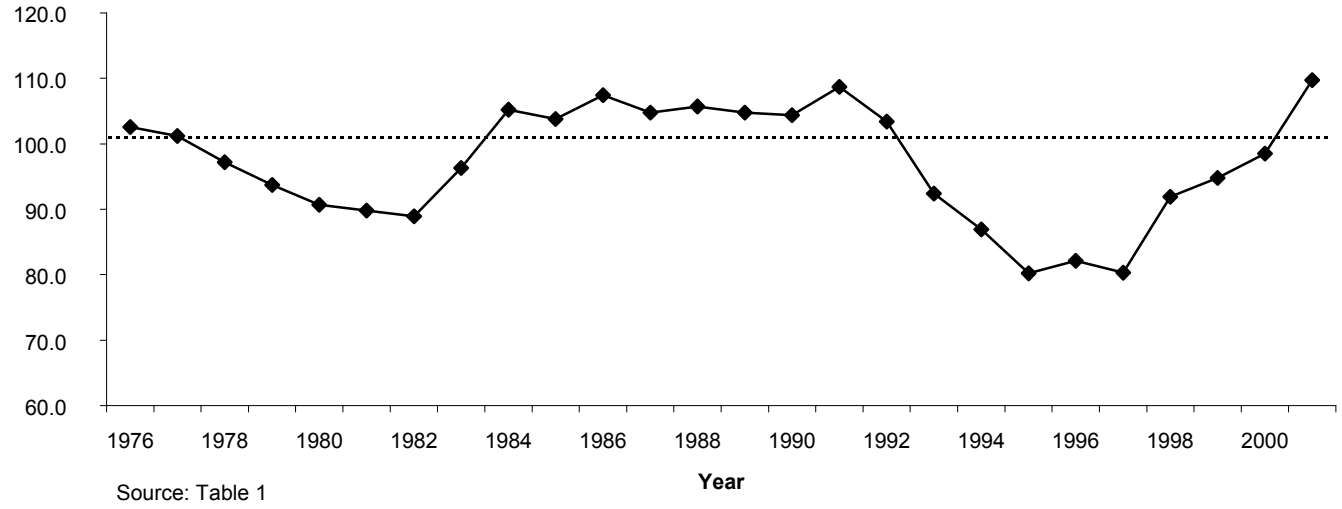
...the overall operating ratio of 109.7 in 2001 indicates the underwriting losses in that year were worse than in any other year for which data are available.

The workers' compensation insurance industry was then unprofitable in every year from 1984 to 1992. During this nine-year stretch of unfavorable results, carriers lost from $3.40 to $8.70 for every $100 of workers' compensation premiums. One result of this unfavorable experience is that the workers' compensation industry took the lead in "reform" efforts that reduced benefits and tightened eligibility standards in many states.[1] Because insurance regulators, who refused to allow insurance rates to increase as rapidly as losses, were a major source of the underwriting losses in many jurisdictions, workers' compensation carriers pursued and achieved deregulation of the workers' compensation insurance markets in many states.[2]

The results of deregulation and the various reforms of workers' compensation in the early to mid-1990s are evident in the underwriting results from 1993-2000, when the overall operating ratio was less than 100 in every year. This was the longest string of profitable years for the workers' compensation insurance industry in the last half-century (and perhaps in the history of workers' compensation). The best years were 1995 to 1997, when on average carriers had profits of more than $19.00 per $100 of premium.

The underwriting experience of workers' compensation carriers steadily deteriorated after 1997. In-

Figure A
Overall Operating Ratio as a Percent of Premiums, 1976-2001



Source: Table 1

Table 1 Workers' Compensation Insurance Underwriting Experience, 1973-2001

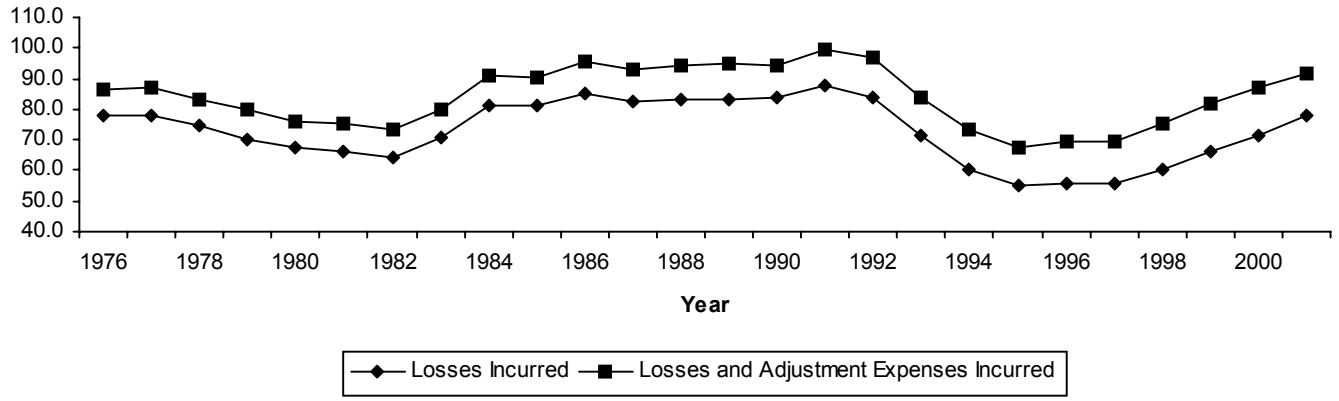
Year	Losses Incurred* (1)	Loss Adjustment Expenses* (2)	Losses and Adjustment Expenses Incurred* (3)	Underwriting Expenses Incurred** (4)	Dividends to Policyholders* (5)	Combined Ratio After Dividends (6)	Net inv. Gain/Loss and Other Income* (7)	Overall Operating Ratio (8)
1973	68.5	8.5	77.0	19.8				
1974	71.6	8.7	80.3	19.6				
1975	74.0	8.2	82.2	18.9	6.3	107.4		
1976	78.2	8.4	86.6	17.6	5.4	109.6	6.9	102.6
1977	78.0	8.9	86.9	16.7	5.1	108.6	7.4	101.2
1978	74.4	8.7	83.0	16.4	5.6	105.0	7.8	97.2
1979	70.4	9.2	79.6	16.8	6.5	103.0	9.2	93.7
1980	67.6	8.4	76.1	17.4	8.0	101.4	10.8	90.7
1981	66.1	9.0	75.1	19.0	8.7	102.8	13.0	89.8
1982	64.3	9.1	73.4	20.6	9.9	103.9	15.0	88.9
1983	70.6	9.2	79.9	22.0	10.6	112.5	16.2	96.3
1984	81.0	9.8	90.8	21.2	9.9	121.9	16.7	105.2
1985	81.0	9.5	90.5	19.0	9.3	118.8	15.0	103.8
1986	85.4	10.2	95.5	18.0	7.6	121.1	13.7	107.4
1987	82.2	10.9	93.1	18.0	6.4	117.6	12.8	104.8
1988	83.4	10.8	94.2	17.8	6.4	118.4	12.7	105.7
1989	83.3	11.4	94.7	17.4	6.1	118.2	13.4	104.8
1990	83.8	10.7	94.6	17.6	5.1	117.4	13.0	104.4
1991	87.8	11.5	99.3	18.5	4.9	122.6	14.0	108.7
1992	83.9	13.2	97.1	19.8	4.6	121.5	18.1	103.4
1993	71.6	12.4	84.0	20.4	4.7	109.1	16.7	92.4
1994	60.3	13.1	73.4	21.7	6.3	101.4	14.5	86.9
1995	55.2	12.5	67.7	23.3	6.0	97.0	16.8	80.2
1996	55.8	13.7	69.5	25.4	4.8	99.7	17.6	82.1
1997	55.6	13.8	69.4	25.9	5.4	100.7	20.4	80.3
1998	60.2	15.3	75.5	26.7	5.3	107.6	15.7	91.9
1999	65.9	15.8	81.7	28.0	5.6	115.3	20.5	94.8
2000	71.2	15.9	87.1	26.5	4.5	118.2	19.6	98.5
2001	78.1	13.8	91.9	26.2	3.6	121.7	12.0	109.7

Source:
Best's Aggregate & Averages Property/Casualty, 2002 and prior Editions, © A.M. Best Company - used with permission.

Notes:
Losses Incurred (also termed the pure loss ratio) (1) plus Loss Adjustment Expenses (2) equals Losses and Adjustment Expenses Incurred (3). Losses and Adjustment Expenses Incurred (3) plus Total Underwriting Expenses Incurred (4) plus Dividends to Policy Holders (5) equals Combined Ratio after Dividends (6). Combined Ratio after Dividends (6) minus Net Investment Gain/Loss and Other Income (7) equals Overall Operating Ratio (8). As of 1992, the methodology for allocating investment income changed slightly; as a result, 1992-2001 numbers in the last two columns are not directly comparable to those for earlier years.

* Percentage of net premiums earned
** Percentage of net premiums written

Figure B
Losses Incurred and Losses and Adjustment Expenses Incurred as Percent of Premiums, 1976-2001



deed, between 1997 and 2001, the overall operating ratio jumped almost 30 points, which is the most rapid rate of deterioration during the period covered by the data in Figure A (namely 1976 to 2001). Moreover, the overall operating ratio of 109.7 in 2001 indicates the underwriting losses in that year were worse than in any other year for which data are available.

A full explanation of the recent deterioration in the underwriting experience is beyond the scope of this article.[3] However, there is one fundamental difference between the adverse experience of the late 1980s and early 1990s and the deteriorating profitability since 1997. In the earlier period, benefits paid to workers were increasing rapidly, while that has not been true in recent years. In 1984, benefits paid to workers were 1.21 percent of payroll and continued to climb until 1992, when they peaked at 1.68 percent of payroll. Since then, benefits as a percent of payroll have declined every year through 2000 (the latest year with data), when they were 1.03 percent of payroll.[4]

Components of the Overall Operating Ratio

The loss ratio is incurred losses as a percentage of premiums.[5] When premiums drop more rapidly than losses (or when premiums increase less rapidly than losses), the loss ratio will increase. As shown in Figure B and Table 1 (column 1), the loss ratio increased rapidly from 55.6 percent in 1997 to 78.1 percent in 2001.

The total of incurred losses and incurred loss adjustment expenses is also shown in Figure B and in Table 1 (column 3). The difference between the two lines in Figure B is incurred loss adjustment expenses, which are also shown in Table 1 (column 2). Loss adjustment expenses include the cost of processing claims. From 1973 to 1985, loss adjustment expenses

Figure C
Underwriting Expenses Incurred as a Percent of Premiums, 1976-2001

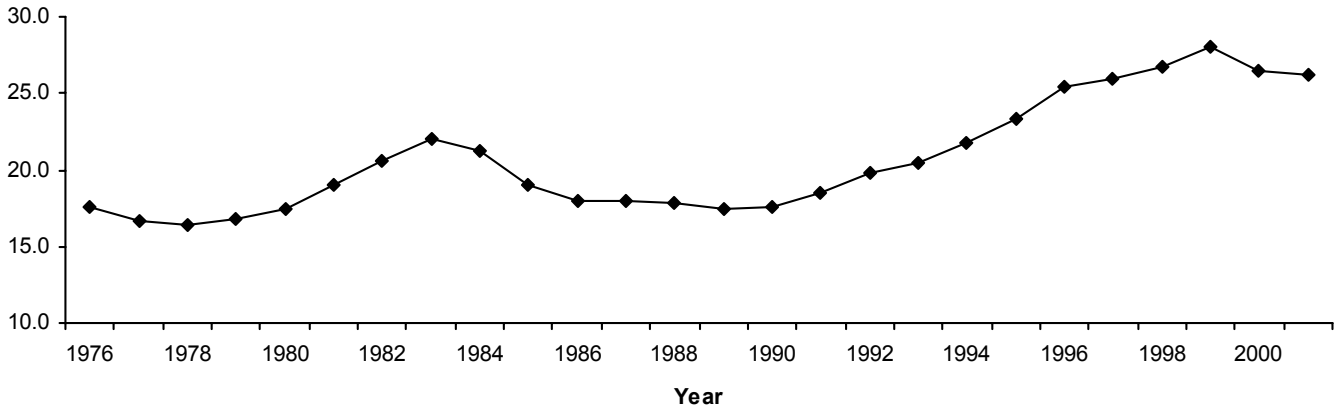
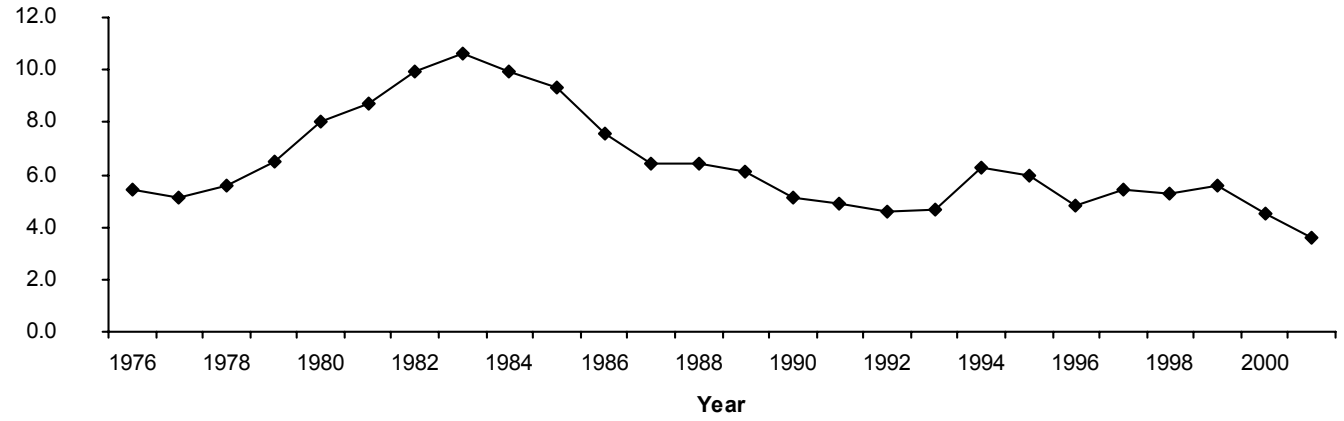


Figure D
Dividends to Policyholders as Percent of Premiums, 1976-2001



were always less than 10 percent of premium, but they have been at least 10 percent since 1986 and they averaged over 15 percent in 1998 to 2001. The higher costs in the last decade reflect in part the more intensive efforts to manage health care costs for disabled workers.

Underwriting expenses incurred as a percent of premiums are shown in Figure C and Table 1 (column 4). These expenses, which include commissions and broker fees, have also generally increased over time. Between 1973 and 1992, underwriting expenses were greater than 20 percent of premium only thrice; since 1993, underwriting expenses have been 20 percent or greater in every year and averaged 27 percent in 1998 to 2001.

Dividends as a percent of premiums are presented in Figure D and Table 1 (column 5). Prior to deregulation of the workers' compensation insurance markets in recent decades, carriers were limited in their ability to compete by lowering insurance rates at the beginning of the policy period. However, both mutual and stock companies could compete by offering policies that paid dividends to policyholders after the policy period. In the early 1980s, dividends ranged from 8.0 to 10.6 percent of premiums. Since 1990, dividends have never exceeded 6.3 percent of premiums, and dividends averaged less than five percent of premiums in 1998 to 2001.

The combined ratio after dividends is presented in Figure E and Table 1 (column 6). The combined ratio is the sum of the loss ratio (column 1), loss adjustment expenses (column 2), underwriting expenses (column 4), and dividends (column 5). When the combined ratio exceeds

Figure E
Combined Ratio After Dividends as Percent of Premiums, 1976-2001

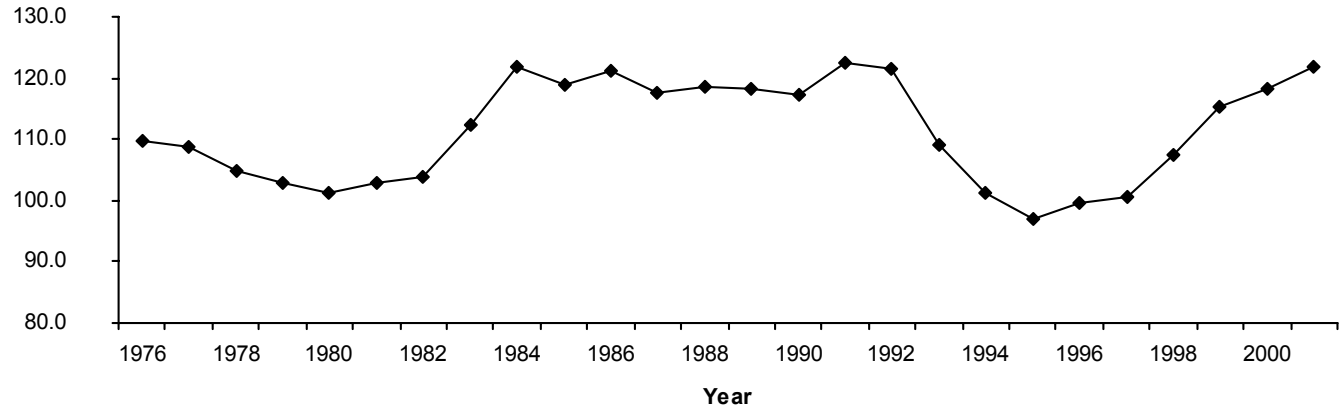
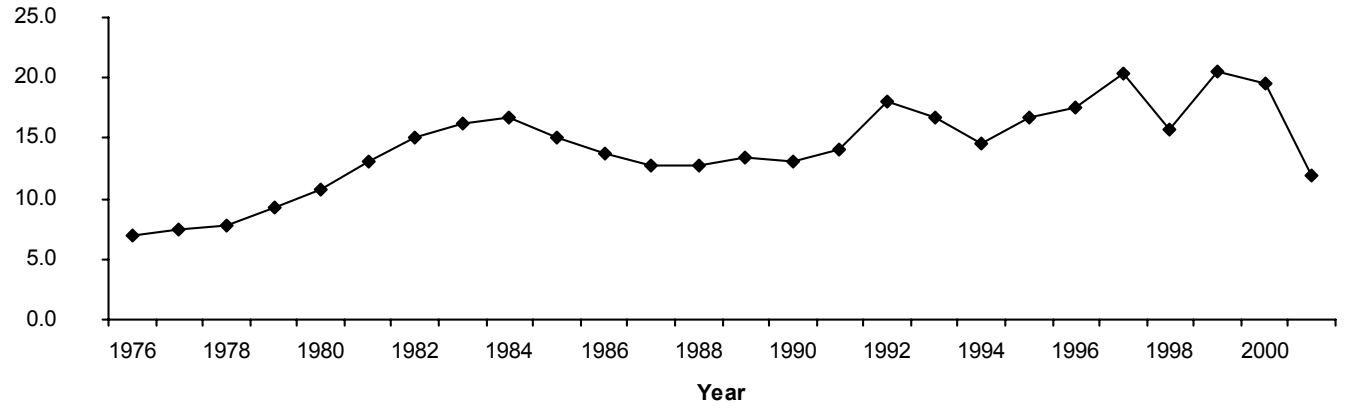


Figure F
Net Investment Gain/Loss and Other Income as Percent of Premiums, 1976-2001



100 percent, insurers lose money on their underwriting experience because premiums are not adequate to cover losses and expenses. As shown in Figure E, the combined ratio exceeded 100 percent in every year between 1975 and 1994, and was greater than 110 percent in every year from 1983 to 1992. The combined ratio then dropped sharply to 1992 until reaching a low of 97.0 in 1995. The combined ratio deteriorated (increased) in every year after 1995, reaching 121.7 percent in 2001 and averaged 118 percent in 1998 to 2001. Restated, for every $100 of premium received by workers' compensation carriers in 1998 to 2001, there were $118 of losses, loss adjustment expenses, underwriting expenses, and dividends.

The combined ratio after dividends provides an incomplete report on the underwriting experience in the workers' compensation insurance market, however, because no account is taken of investment gains (or losses) and other income received by workers' compensation carriers. Net investment gains (or losses) and other income as a percent of premium ("net investment income") are shown in Figure F and Table 1 (column 7). Since 1980, net investment income has been at least 10 percent of premium, and since 1990 net investment income has been at least 13 percent of premium in every year but one. Of current concern to workers' compensation carriers is that 2001 was the year when net investment income dropped to the lowest rate since 1980. The net investment income of 12.0 percent of premium in 2001 represented a drop from an average of 20 percent in 1999 and 2000 and reflected the low interest rates and dismal stock market performance last year.

Analysis

The overall operating ratio of workers' compensation is compared

Figure G
Overall Operating Ratio as Percent of Premiums,
Workers' Compensation and Commercial Lines, 1985-2001

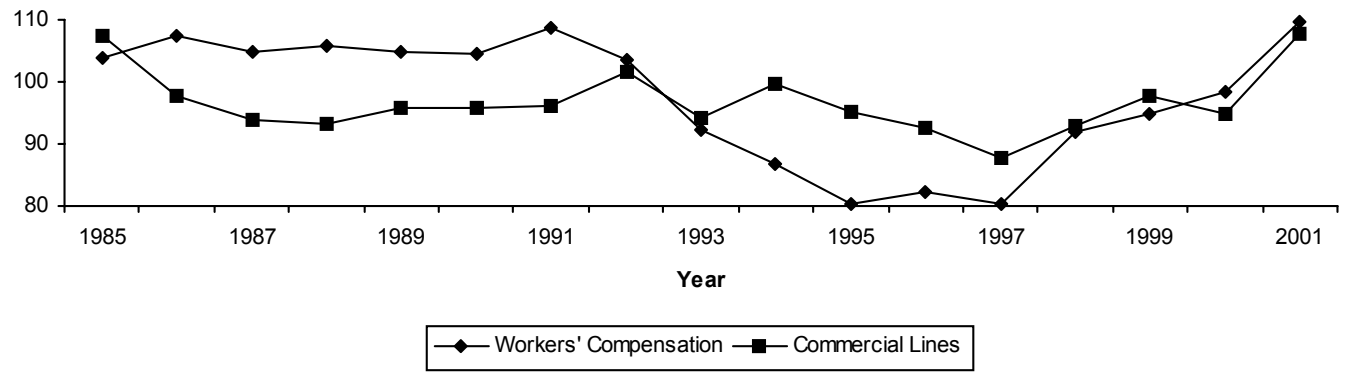


Table 2
Underwriting Experience,
Workers' Compensation and Commercial Lines
1991-2001

Year	Overall Operating Ratio-Workers' Compensation	Overall Operating Ratio-Commercial Lines
1976	102.6	
1977	101.2	
1978	97.2	
1979	93.7	
1980	90.7	
1981	89.8	
1982	88.9	
1983	96.3	
1984	105.2	
1985	103.8	107.5
1986	107.4	97.7
1987	104.8	93.9
1988	105.7	93.2
1989	104.8	95.7
1990	104.4	95.9
1991	108.7	96.0
1992	103.4	101.5
1993	92.4	94.2
1994	86.9	99.6
1995	80.2	95.1
1996	82.1	92.6
1997	80.3	87.9
1998	91.9	93.0
1999	94.8	97.6
2000	98.5	94.8
2001	109.7	107.8

Source:
Best's Aggregate & Averages Property/Casualty, 2002 and prior Editions, © A.M. Best Company - used with permission.

Notes:
The Overall Operating Ratio is the total of all underwriting expenses and income from investments as a percentage of premiums.
"Commercial Lines" includes all insurance lines except passenger auto and homeowner multiples peril insurance.

to all commercial lines of insurance for 1985 to 2001 in Figure G and Table 2. The comparison reinforces the impression of the volatility of the underwriting results in the workers' compensation insurance industry. The workers' compensation industry had smaller losses (a lower operating ratio) than other commercial lines in 1985; workers' compensation had losses (overall operating ratios were in excess of 100) while other commercial lines were profitable (overall operating ratios were less than 100) from 1986 until 1991; workers' compensation had greater losses than other commercial lines in 1992; workers' compensation was more profitable (a lower overall operating ratio) than other lines from 1993 to 1999; workers' compensation was profitable but less so than other lines in 2000; and workers' compensation had losses that exceeded those in other commercial lines in 2001.

The rapid deterioration in the underwriting results in workers' compensation insurance since 1997 is obviously a great concern to workers' compensation insurance carriers, especially because the 2001 overall operating ratio is the highest in at least 25 years. But not just workers' compensation carriers should be concerned, because the results are likely to be higher premiums and increased difficulties in finding workers' compensation policies in the voluntary markers for employers, and more resistance to paying marginal and even legitimate claims for employees.

The worse scenario is that the insurance industry will react to the deteriorating underwriting experience by attempting to launch a new wave of reforms reminiscent to those of the early and mid-1990s, when benefits were reduced in some states and eligibility rules to receive any workers' compensation benefits were tightened in many states.[6] Although it probably will be harder for carriers to enlist employers in a new reform effort since employers have experienced declining workers' compensation costs in most recent years,[7] the incentives for reform could rapidly strengthen if the underwriting losses translate into higher premiums; if the slack economy leads to a significant increase in claims for cash benefits from injured workers who are unable to return to their jobs; and if the surge in medical costs in the general health care system spills over into rapid acceleration of health care costs in workers' compensation. We will monitor these possible developments in the *Workers' Compensation Policy Review*.

ENDNOTES

1. The reform efforts are examined in Spieler and Burton (1998).

2. The deregulation of the workers' compensation insurance market is examined in Thomason, Schmidle, and Burton (2001a: 39-43).

3. The deterioration in the overall operating ratio in recent years appears to be due to a combination of declining premium and adverse developments in some of the components of expenses and income that constitute the overall operating ratio. One possible explanation of dropping premium is that the high profitability of the industry in the mid- and late 1990s attracted more capital to the workers' compensation industry, which in turn led to increasing competition. As a result of deregulation, the competition was less constrained than in the period of administered pricing, which facilitated vigorous price competition in recent years. Thomason, Schmidle, and Burton (2001b: 5) report that the most comprehensive form of deregulation – lost cost systems that do not require prior approval by regulators of rates promulgated by carriers – is, on average, associated with about an 11 percent reduction in the employers' costs of workers' compensation insurance.

4. The 1984 result for benefits paid to workers as a percent of payroll is from Thomason, Schmidle, and Burton (2001a: Table A.1). The 1992 and 2000 results are from Mont, Burton, Reno, and Thompson (2001: Table 13).

5. Incurred losses include paid losses plus reserves for future losses for injuries or diseases that have already occurred. An extended discussion of Insurance Terminology is included in Thomason, Schmidle, and Burton (2001a, Appendix B).

6. The surge in workers' compensation costs and the unfavorable underwriting results from 1985 to 1991 and the resulting developments in the "neo-reform era" beginning in 1992 are discussed in Burton (2001).

7. Private sector employers' expenditures on workers' compensation dropped from 2.99 percent of payroll in 1994 to 1.92 percent of payroll in 2001 before increasing somewhat to 1.96 percent of payroll in 2002 (Burton 2002, Figure A).

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John Burton's Workers' Compensation Resources currently provides two services to workers' compensation aficionados. The first is this bi-monthly publication, the *Workers' Compensation Policy Review*. The second is a website at www.workerscompresources.com. Access to the website is currently free. Portions of the site will soon be available to subscribers only.

The website offers several other valuable features:

- Summaries of the contents of *Workers' Compensation Policy Review* and an Author's Guide for those interested in submitting articles for consideration of publication.
- An extensive list of international, national, and state or provincial conferences and meetings pertaining to workers' compensation and other programs in the workers' disability system.
- News updates of current events in workers' compensation.
- Posting of Job Opportunities and Resumes for those seeking candidates or employment in workers' compensation or related fields.
- The full text of the *Report of the National Commission on State Workmen's Compensation Laws.* The report was submitted to the President and the Congress in 1972 and has long been out of print.

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California Passes Workers' Compensation Reform: Implementation is Next Challenge

by Glenn Shor and Suzanne Marria

BACKGROUND

Significant workers' compensation reform was enacted in California for the first time since 1993 in a bill signed by Governor Gray Davis on February 15, 2002. The law makes changes in several areas including:

- Benefits for Injured Workers
- Return to Work
- Vocational Rehabilitation
- Medical care and cost containment
- Audit of claims payment activity of insurers and third party administrators
- Enforcement of insurance coverage requirements and action against illegally uninsured employers
- Establishment of a governor-appointed position of Court Administrator

The signing of the bill came after four sessions of intense legislative action and the veto of three prior omnibus reform bills by the governor. Each bill had been rejected as not providing a balance between benefit increases and system savings. A review of the veto messages depicts the search for that balance.

What Took So Long?

In vetoing SB 320 in 1999, the governor found that the bill, "while seeking to increase benefits for injured workers, fails to meet the test of moderation. While I recognize that some benefits for injured workers have fallen behind the cost of living in recent years, SB 320 increases benefits far beyond what I believe California employers can absorb without negatively impacting the economy."

In 2000, the veto message for SB 996 again stressed the impact on the economy. "(The) proposed reforms to the workers' compensation system ... are not sufficient to support such a large benefit increase without having an adverse impact on the California economy." But the message went further. "All parties have come to recognize that the benefit paid to injured workers in California has not been increased in many years and needs to be increased. I intend to sign a bill that incorporates reasonable benefit increases and additional system reforms to ensure that California's system of workers' compensation operates in a fair and cost efficient manner."

In vetoing SB 71 in 2001, the governor specified that any comprehen-

About the Authors

Glenn Shor is Chief of Policy and Legislation for the California Division of Workers' Compensation (DWC). He previously worked in the state's occupational health program, and was research director for the Workers' Compensation Rate Study Commission. His career in workers' compensation began at the U.S. Department of Labor in 1978, co-authoring a study on occupational disease compensation.

Glenn holds a masters degree and a Ph.D. in public policy analysis from the University of California at Berkeley. His dissertation looked at the evolution of workers' compensation policy in California from 1910 to 1990. He serves as liaison to the Commission on Health and Safety and Workers' Compensation, and to the Department of Insurance and Workers' Compensation Insurance Rating Bureau. He serves on the Workers' Advocacy Advisory Committee to the Secretary of Energy, and is a member of the National Academy of Social Insurance. He also participates in various committees of the IAIABC, and as a member of NIOSH and NIEHS review committees. He is an active member of the Workers' Compensation Research Group, and the American Public Health Association's Occupational Health and Safety Section.

Suzanne Marria serves as the Acting Chief Deputy Director of the Department of Industrial Relations in California. The department has statewide jurisdiction for labor standards enforcement (minimum wage, hour and labor standards), occupational safety and health, workers' compensation, apprenticeship standards, labor statistics and research, and state mediation and conciliation services. DIR is a core part of the California Labor and Workforce Development Agency.

An attorney by profession, Suzanne practiced in various parts of the department's occupational health and safety and the workers' compensation programs between 1984 and 1998, at which time she was appointed as the department Assistant Director. From 1988 to 1990, she worked in house with the Air Transport Employees, Local Lodge 1781 of the International Association of Machinists and Aerospace Workers, which represents mechanics and ground workers at the United Airlines maintenance and flight facilities in the Bay Area.

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sive bill would have to satisfy four goals:
1) Provide a significant benefit increase for injured workers;
2) Promote early and sustained return to work within the person's medical and work restrictions;
3) Implement effective medical cost containment measures while assuring the quality of care provided; and
4) Target benefit dollars to achieve the best outcomes for injured workers.

The governor offered to work collaboratively in the 2001 veto message. "If we work together, the legislature, my staff and the interested parties can craft a comprehensive bill reaching all four goals before the 2002 legislative session begins." Threats of a ballot initiative if legislation was not forthcoming also pushed action by the legislature.

AB 749

The bill that emerged from this discussion to become AB 749 addressed each of the four goals in the governor's 2001 veto. It provided a significant benefit increase, promoted return-to-work programs, created new mandates on medical cost containment, and targeted benefits. The passage and signing was the product of a long process of negotiation and education that went on through multiple and thorough legislative hearings, excellent legislative and executive branch staff work, and research and analysis done inside the workers' compensation system.

A labor-management oversight body created in the 1989 reform and modified in the 1993 act, the Commission on Health and Safety and Workers' Compensation (CHSWC), pursued its mandate to conduct continuing oversight of the workers' compensation system. Its members, staff, research consultants and advisory boards released reports on system trends and operations, and collaborated with the Division of Workers' Compensation (DWC), the Workers' Compensation Insurance Rating Bureau (WCIRB), and other entities on several large projects. Many of their issue papers and recommendations helped inform the Legislature and the public, and set the stage for further negotiation.

Prior reforms had also changed the charter of the WCIRB in several ways. After reforms in 1989, 1993 and 1994, the Bureau's mandate included issuing a very useful annual overview of costs and trends in workers' compensation. The organization also opened up its own process with appointment of outside public members (representing unions and employers) to the Governing Board, by providing independent actuarial resources to the public members, and by including researchers from outside the insurance industry on study panels. Collaboration of researchers and analysts from the Commission, the Bureau, the Department of Industrial Relations (DIR), the DWC, and from stakeholder representatives assisted in building consensus on overall baseline assumptions and methodologies for costing out benefit changes during final negotiations for AB 749.

The legislation provides an opportunity for California's system to realize improved outcomes in four key areas: adequately compensating workers for losses due to job related disability; improved opportunity for returning injured employees to work; keeping employers' costs in check; and assuring that all employers follow the law and provide coverage for all eligible workers.

Table 1 - Distribution of States' Benefits as Indexed against State Average Weekly Wage (SAWW)	
Number of States	% of SAWW
1	200%
2	150%
1	133%
2	110%
1	105%
25	100%
4	90%
2	85%
3	75%
3	67%

Source: U.S. Department of Labor State Workers' Compensation Laws, January, 2002, Table 6.

Implementation Challenges

Passage of the bill is a first step in meeting the goals. Some provisions require little if any regulatory or administrative action. But others alter the state's priorities and require significant research and development to progress towards these performance objectives. Many cannot be designed or implemented without adequate staff and other resources.

During 2001, state tax and investment revenues dropped as the economy faltered, and many general fund agencies were slated for cuts. In January 2002, the Governor's proposed 2002-2003 budget (released prior to passage of the workers' compensation legislation) included a DWC funding cut of $7.1 million and 90 positions (approximately 10 percent of total staff). Just weeks later the Legislature passed and the Governor signed AB 749. By the spring, it became clear that the state's budget deficit for 2002-03 had ballooned to $24 billion. All state agencies were

Figure 1
Maximum Benefits for Total Disability
and State Average Weekly Wage in California
1982-1999

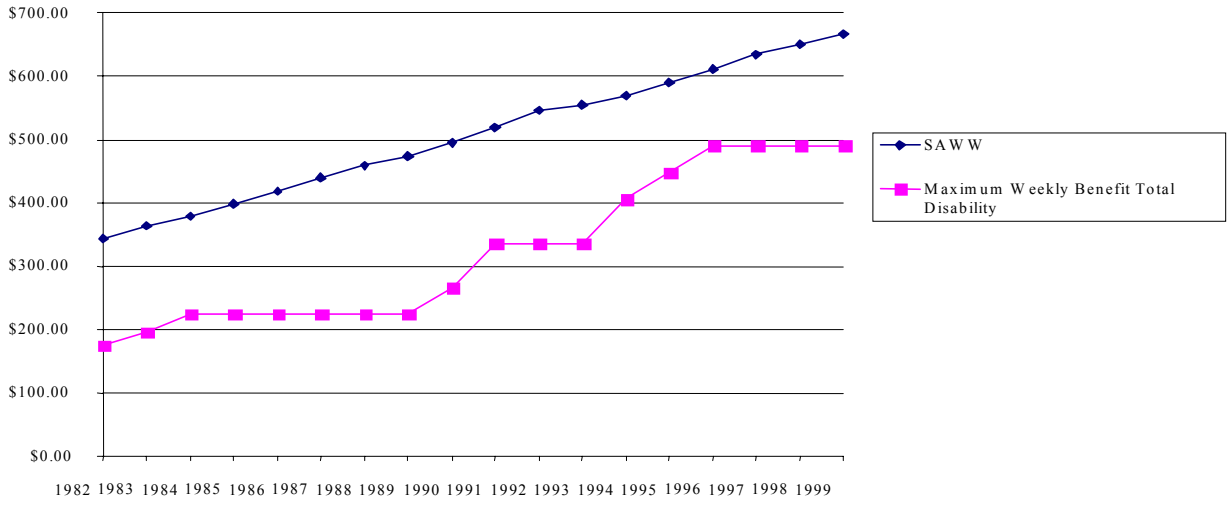
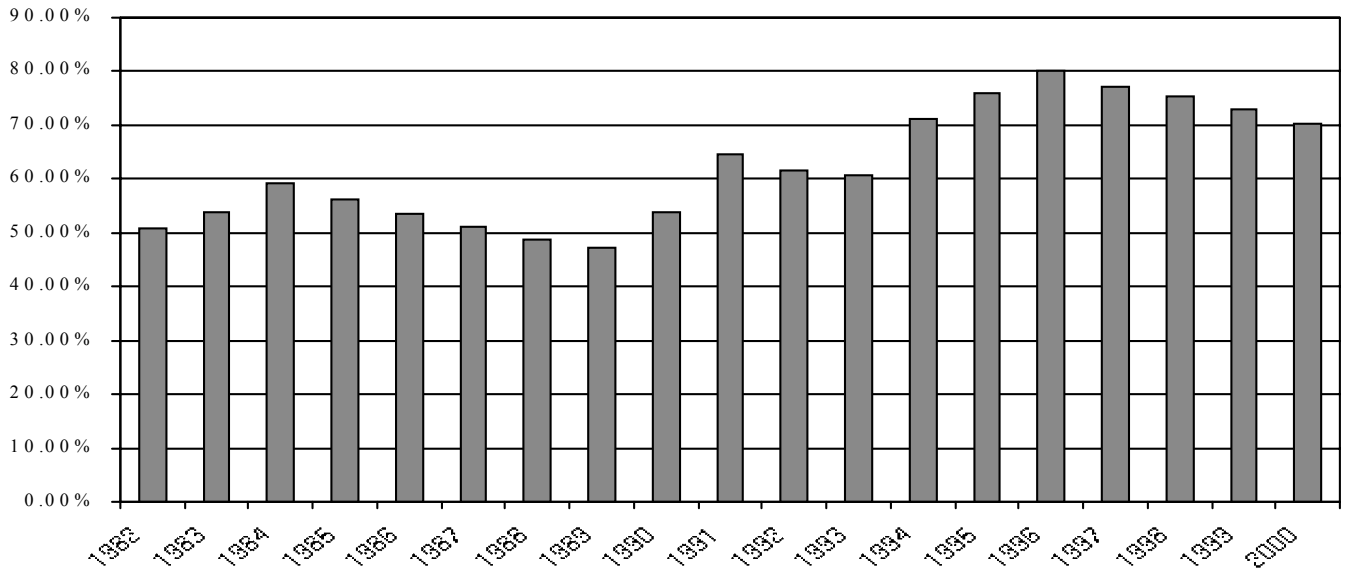


Figure 2
Maximum Benefit as a Percentage
of State Average Weekly Wage in California,
1982 - 2000



mandated to submit significant further cost-cutting recommendations.

The pressure to cut state expenditures was concurrent with new workload for the DWC. Much of the statute takes effect for injuries occurring on or after January 1, 2003. Other changes, including fee schedule development and new program innovation, have delayed starts. Passage of the bill raised some hopes that resources to implement the new provisions would follow. As the Legislature conducted its hearings and review of the Governor's budget proposal, the Senate and Assembly allocated over $7 million in increased funding for the planning and first six months of implementation of the workers' compensation act during the 2002-03 budget year. As passed, the budget augmented funding for administration of the workers' compensation system by $4.6 million, with another $1 million earmarked for further fraud prevention activities, and nearly $2 million for research and education about injury prevention programs and workers' compensation. Each of these augmentations was tied directly to funds needed to implement mandates in AB 749.

Despite employer and union support for funding the early implementation, due to State budget deficiencies, the extra money for implementation was line-item vetoed. The 2002-03 California budget battle was the longest in state history; passage finally came 61 days into the fiscal year (which begins July 1), on the last day of the legislative session. The final budget is a combination of program reductions, revenue enhancements, and hopeful projections of future revenues. Even with these factors, a balanced budget required further cuts. To achieve final passage of the nearly $100 billion package, the legislature and governor agreed that a further $750 million and 1,000 state positions would be cut by the governor without specific legislative guidance or any new revenue generating mechanisms. Some of the cuts hit DWC and the CHSWC hard; in the budget signed on September 5, the augmentations for workers' compensation administration and research and education were stricken. Subsequently, the $1 million to fund the Division of Labor Standards Enforcement's increased efforts against uninsured employers was stricken.

With the short-term loss of augmented funds for administration, program development, audit and enforcement, and research and education, there are now substantial obstacles to full implementation of the reforms proposed in the new laws. Without structural changes, budgetary and staffing restrictions will impede the mission of the Division to achieve reasonable timeframes for processing cases and for fulfilling the promises of monitoring the system, running an effective and efficient system, and implementing services to control costs.

On December 6, 2002, as part of a $10.2 billion spending reduction proposal over the following 18 months, the Governor proposed changing the California workers' compensation system funding base from its current 80% general fund/20% user fund formula, to a 100% user funded system. The Governor called a special session of the legislature, to convene December 9, 2002, to consider this and other proposals to meet the State's budget deficit which most commentators project at above $21 billion, and some are estimating to become closer to $30 billion.

WHAT WAS PASSED?

The following sections describe the legislative changes and programs enacted under AB 749, and when appropriate by the technical "clean-up" bill, AB 486, signed September 30, 2002.[1]

Benefits for Injured Workers

Background. Since the original program inception in 1913, California has set workers' compensation cash benefits through legislative action that requires a new law every time benefits are changed. As in most states, benefits are computed at 66 2/3 percent of a worker's pre-injury earnings with the maximum amount depending on the date of injury. California's maximum workers' compensation benefit for temporary disability is $490 per week for injuries that occur between January 1, 1996 and December 31, 2002.

Figures 1 and 2 compare the state's average wage with mandated benefit levels. The state average weekly wage for 1982 to 2001 rose gradually and steadily, while maximum weekly benefits for temporary disability rose, but sporadically. Maximum benefit levels have been consistently less than the average state wage, and in those years without legislative changes, real benefits diminish.

Figure 2 shows the roller coaster portion of wages replaced by workers' compensation for workers injured in different years who received the maximum weekly benefit. Equity issues arise with such a changing benefit. While benefits edge up in years of legislative passage, they fall back after that.

Benefit Indexing. Most states have adopted some variant of the recommendations contained in the 1972 *Report of the National Commission of State Workmen's Compensation Laws* for temporary disability benefit levels. The National Commission recommended that states automatically increase maximum weekly benefits in proportion to increases in state average weekly wages (SAWW). As of 2002, only six states besides California did not automatically index benefits to wages.[2] In 44 jurisdictions (43 states plus D.C.) maximum TTD benefits are automatically pegged to some percentage of the SAWW, as shown in Table 1.

The National Commission made 19 essential recommendations, one of which was that the maximum weekly benefit for TTD benefits be at least 100 percent of the state's average

weekly wage. The National Commission also made 65 "non-essential" recommendations, one of which was that the maximum weekly benefit for TTD benefits be at least 200 percent of the SAWW. On January 1, 2002, maximum TTD benefits in California replaced less than 70 percent of California's SAWW.

The benefit package passed in AB 749 brings California more in line with the majority of states. After incremental increases to maximum temporary total disability (TTD) and permanent total disability (PTD) benefit levels in 2003, 2004, and 2005, the new statute then links the state's TTD and PTD maximum benefits automatically to changes in the average weekly wage. Former Undersecretary of Labor Arthur Larson, commenting on the 1972 National Commission, saw the trend toward indexing as a positive step.

> The important new fact of life, then, which more than any other development is responsible for the difference between the issues of the last (1970s) decade and those of the next, is that for the first time in the history of workers' compensation, the main struggle for amelioration does not take the form of a never-ending battle to push benefits and coverage standards to a higher level. In the past, the larger part of the efforts of those striving to improve compensation went into tedious tussles every year or two over a $3 or $5 raise in the weekly benefit. Except in a few states, this is all behind us. Benefit levels are generally adequate, and what is more, they are going to stay adequate, effortlessly, because of automatic escalation.[3]

Minimum Benefit. AB 749 makes another significant and controversial change in temporary disability benefits, bringing back the minimum benefit for temporary disability. California had had a minimum temporary disability benefit that could exceed actual earnings for low-wage workers from 1983 until 1991 when actual earnings became the minimum for those earning less than $126 per week. AB 749 reinstates a minimum weekly temporary disability of $126 for those earning under $189 per week.

Permanent Disability Benefits.[4] Changes in maximum permanent disability benefits remain subject to legislative action (that is, will not be automatically adjusted by indexing to another measure, such as changes in the SAWW). However, the new legislation contains several areas of revision for the next few years.

Injured workers who are permanently disabled -- those who have losses of actual earnings or of earnings capacity after maximum medical recovery -- are entitled to receive permanent disability benefits. A worker who is determined to have a PTD receives the temporary disability benefit for life. For injuries before 2004, workers determined to have permanent partial disability receive weekly benefits for a period that increases with the percentage of disability, from 3 weeks for a 1 percent permanent disability up to 694.25 weeks for a 99.75 percent disability. Permanent partial disability benefits are also payable at two-thirds of the injured worker's average weekly wages, but are subject to a much lower maximum. For injuries occurring July 1, 1996 through December 31, 2002, the benefit payments are $140 per week for disabilities less than 14.75 percent, $160 for disabilities rated at 15 percent to 24.75 percent, $170 for disabilities rated at 25 percent to 69 percent, and $230 per week for disabilities rated at 70 percent to 99.75 percent. Those with a permanent partial disability of 70 percent or more also receive a small life pension -- a maximum of $153.65 per week -- following the final payment of permanent partial disability benefits.

The percentage of permanent disability is determined by using the Permanent Disability Rating Schedule (PDRS) and a physician's assessment of the injured worker's permanent disability, work restrictions and functional limitations. The final permanent disability rating, expressed as a percentage, reflects the evaluation of the injured worker's diminished capacity to compete for and maintain employment in the open labor market. The schedule specifies standard percentage ratings for permanent impairments and limitations, and provides for the modification of these standard ratings based on the injured worker's age and occupation. The standard rating is adjusted for age by lowering the rating for younger workers and increasing it for older workers on the theory that it is easier for younger people to adjust to a permanent handicap. The standard rating is adjusted for occupation by increasing the rating if the permanent impairment or limitation will be more of an impediment in performing the worker's occupation, and lowering the rating if it will have a lesser impact.

AB 749 raises permanent disability payments in two ways, with an increase in the maximum weekly benefit for injuries in 2003, and a further increase in the number of weeks paid per percent of disability in 2004 and beyond.[5] The Appendix details these changes, along with other changes in the benefit package.

Death Benefits. In the event a worker is fatally injured, reasonable burial expenses, up to $5,000, are paid. In addition, the worker's dependents may receive support payments for a period of time. These payments are generally payable in the same manner and amount as temporary disability benefits, but the minimum rate of payment is $224 per week. The total aggregate amount of support payments depends on the number of dependents and the extent of their dependency. For fatalities through December 31, 2005, the maximum payment (where three or more total dependents are eligible) is $160,000, though additional benefits are pay-

able if there continue to be any dependent children after the basic death benefit has been paid.

Under AB 749, maximum survivors' benefits for work-related fatalities will be doubled for all the various categories of dependents beginning in 2006. Beginning in 2004, $250,000 in benefits will be paid to the estate of a fatally injured worker when there are no dependents.[6] It is likely this section will be challenged on constitutional grounds that only dependents may be compensated for fatalities. Under case law interpreting Article 14, section 4 of the California Constitution, payments in "death without dependents" cases are paid to the state for use by the second injury fund.[7]

Return-to-Work Program

AB 749 created two types of Return-to-Work (RTW) programs. An intended Return to Work consultation service of the DIR is meant to provide direct information and assistance to employers attempting to implement RTW programs. A separate but connected set of reimbursements to employers for utilizing return-to-work practices and making investments in worksite changes is intended by the legislation, but will require an annual appropriation for implementation. Three kinds of reimbursements are established by the act and are available to employers: wage subsidies, reimbursement for costs of workplace modifications, and premium rebates for returning workers to work.

Consultation Program of Policy and Education on Return to Work. The legislation intends that the DIR will create a program to inform, show, and assist employers and injured workers to experience the mutual benefits of early and sustained return to work within medical work restrictions. The program responsibility includes development and distribution of educational materials, especially easily understandable print and electronic materials. The program is expected to serve employers, health care providers, employees, and labor unions by discussing and promoting appropriate early RTW, assessing functional abilities and limitations, appropriate work restrictions, job analyses, worksite modifications, assistive devices, and resources available. The legislation also establishes training programs for employer and employee organizations and health care providers, to emphasize and address accommodation of injured worker and prevention of re-injury

Reimbursements from RTW Fund (LC 139.48). When implemented, direct financial incentives may inspire some RTW programs. AB 749 mandates that starting in mid-2004, the Administrative Director (AD) shall pay wage reimbursement, workplace modification expenses, and premium reimbursement as allowed under the law. All employers, except public agencies, may apply for reimbursement for wages of injured employees who return to modified or alternate work while on temporary disability. Reimbursement of up to 50 percent of wages for up to 90 days, or until full duties are resumed, or until the person becomes "permanent and stationary," whichever is first, would come from the RTW Fund. All employers (including public agencies) may also be reimbursed $1,250 for worksite modification for temporarily disabled workers and $2,500 for modification for qualified injured workers (QIW), a California notation of vocational rehabilitation status. In addition, employers are eligible for workers' compensation insurance premium reimbursements, in effect canceling out the premium costs of returned workers. Small employers (with 100 or fewer employees) can get 100 percent of premium paid for each employee returned to work for up to two years, while medium and large employers (more than 100 employees) get up to 50 percent of premium paid for each employee returned to work for up to two years. This provision extends an existing incentive that can reimburse employers for workers' compensation premium costs when they re-employ injured workers.[8]

All the reimbursement programs are operable as of July 1, 2004 and sunset four and one-half years later on January 1, 2009. Payments made from the Return-to-Work Fund are intended to be funded by increased workers' compensation insurance premium taxes.[9]

Impact Study on RTW (LC 139.49). An evaluation of the return-to-work program is required by the Act. The AD must contract with an independent research organization and report findings by January 1, 2008. The study is mandated to include at least two years' RTW program data including reporting on:

- Effectiveness of wage, workplace modification, and premium reimbursements
- Participation rates by insured and self-insured
- Rates of use of modified and alternative work before and after RTW program
- Evaluate whether there has been any increase in sustained RTW
- Assess impact on injured workers
- Determine the cost effectiveness of program and potential future funding mechanisms.

Vocational Rehabilitation (LC 4646b and c)

Under current law, settlement of vocational rehabilitation benefits is disallowed except in cases where a judge has determined "that there are good faith issues which, if resolved against the employee, would defeat the employee's right to all compensation."[10] Under the new act, employers and injured workers represented by an attorney may settle prospective rights to vocational rehabilitation for cases with dates of injury on and after January 1, 2003. The attorney must fully disclose the settlement to the worker and explain the nature of rights and privileges being waived. Settlement is allowed of a one-time payment of up to $10,000 for use in

self-directed vocational rehabilitation plans. Under the law, the settlement is submitted to and must be approved by the Rehabilitation Unit (RU) of the DWC; the RU can only disapprove the settlement on finding that vocational rehabilitation services are needed to return the injured worker to suitable gainful employment.

Medical Care

AB 749 contains several opportunities for understanding the costs and utilization of medical care, doing outreach to treating physicians, altering the control of medical treatment, streamlining the methods of billing and payment, and controlling medical costs. Seven issues affect the provision of medical care:

- Repeal of the "presumption of correctness" of treating physicians (LC 4062.9)
- Study of medical treatment and quality in workers' compensation (LC 127.6)
- The production and dissemination of educational materials for treating physicians (LC 4062.9)
- Specific revisions of the pharmaceutical fee schedule (LC 5307.2)
- Development of a new outpatient surgery facility fee schedule (LC 5307.21)
- Health Care Organization (HCO) Reform Rules (LC 4600.3)
- Mandate to establish standardized medical billing procedures and establish regulations to required acceptance of electronic billing (LC 4603.4)

Repeal of Treating Physician Presumption (LC 4062.9). The law passed in 1993 established a presumption of correctness of the opinion of the treating physician in a compensation case. While the provision was intended to allow those closest to the care to control its course, payors and others observed that there was an unintended consequence of raising costs of medical care. Under AB 749, for injuries after January 1, 2003, the presumption of correctness now only applies where the injured worker predesignates a personal physician or personal chiropractor prior to the injury date.

New Medical-Legal Reports (LC 4061e, 4062b, 4064b, 4067). AB 749 expands access to paid supplemental medical-legal reports under certain circumstances. For those injured on or after January 1, 2003, and who become represented by an attorney after receiving a qualified medical examiner (QME) report, an additional medical/legal evaluation report (AME or QME) is admissible and is at employer expense. If a represented worker gets an additional report, the employer is also entitled to obtain and pay for an additional report for consideration in the case.

Medical Treatment and Quality Study (LC 127.6). Much of the increase in workers' compensation costs during the past few years has been attributed to increases in utilization and cost of medical care. Technology used in the care of injured workers is rapidly increasing and changing. Organization of the care has also changed, in some ways in response to unanticipated payment incentives. Recent research has identified medical cost containment as a supplementary cost driver. Under the law, the AD, in consultation with the Industrial Medical Council, the CHSWC, other state agencies, and researchers in health care delivery and occupational treatment, is to begin study of several aspects of medical care:

- Factors leading to increases in costs and utilization of medical treatment and case management in workers' compensation
- Case management that achieves early and sustained RTW
- Performance measures for medical treatment reflecting patient outcomes
- Physician utilization, quality of care and outcome measurement data
- Patient satisfaction.

The study is to begin by July 2003, and a report to the Legislature is due a year later.

Fee Schedule Reforms

The law contains two areas of responsibility in setting medical fees. The first mandates design and implementation of a pharmaceutical fee schedule and the second contains permissive language on establishing a fee schedule for outpatient surgery facilities.

Pharmacy Schedule (LC 5307.2). The pharmaceutical fee schedule mandated by AB 749 requires a single dispensing fee for generics and brand name products, a preference for generics unless otherwise specified by the primary treating physician, and a provision that, by mutual agreement, providers and payors may contract out of the Fee Schedule (LC 4600.2). The act requires that the schedule establish reasonable maximum fees for medicines and medical supplies while providing access to a pharmacy within reasonable geographic distance of the injured worker's residence. To set the schedule, the AD is permitted to consult relevant studies, practices in other states, or other payment systems.

Outpatient Surgery Facility Fee Schedule (LC 5307.21). A more difficult path to negotiate concerns the setting of outpatient surgery facility fees. Under the law, the AD, after holding public hearings, is given the sole authority to adopt and revise biennially a schedule. In developing the schedule, the AD is expected to include all facility charges, except MD/surgeon fees. The schedule is intended to promote payment predictability, minimize administrative costs, ensure access, be sufficient to cover costs of each surgical procedure, and assure access to quality care.

Prior to adopting the schedule, the AD is to formally analyze one year of published data from the Office of Statewide Health Planning and Development (OSHPD); data from existing outpatient surgery providers; payment data; cost data; information on access data (including date of injury,

date surgery recommended, and date of procedure); and information on outcome of the surgery. The adoption process is expected to rely upon getting OSHPD and stakeholder input, but many obstacles block an early resolution of this process.

Health Care Organization (HCO) Reforms (LC 4600.3)

Oversight of organized health care delivery systems became part of California's workers' compensation system in 1993 with a limited program. Under the law, a health care entity, such as a workers' compensation insurer; PPO, HMO, or provider group, can be certified by the Managed Care unit of DWC as a Health Care Organization (HCO). The HCO certification indicates that the entity has the financial and organizational resources, and the professional staffing and procedures to provide an occupational medicine and disability case management approach to providing medical care in workers' compensation cases. They must also record and report to DWC specified data about case costs and utilization, RTW rates, time in medical treatment, and other factors. The HCO program has taken several years to grow to be a significant part of the workers' compensation medical care arena, but with recent changes and other contributory factors, HCO enrollments are up to almost half a million covered employees and the program seems poised for significant growth.

AB 749 loosens the enrollment process. Through 2002, employers wanting to use an HCO had to offer a choice of at least two HCOs to its workers. Effective January 1, 2003, only one HCO option is required for certification. Employees will be given written affirmative choice annually to select an HCO or to predesignate a personal physician, personal chiropractor, or personal acupuncturist. Where a worker makes no affirmative choice of treating provider in case of injury, the HCO will furnish care. Under the HCO program, the employer's control of medical treatment is set at 90 days (if no non-occupational health care coverage from employer) or 180 days (if employer provides non-occupational health care coverage as well).

Other HCO changes in AB 749 were intended to make the program more accessible to employers and encourage other health care entities to become participants. Group-health side Health Maintenance Organizations (HMOs) certified by the Department of Managed Health Care (DMHC) can be "deemed" an HCO if in good standing with DMHC and upon demonstrating to DWC the HMO meets the requirements for occupational treatment and disability case management required of other HCOs. These include: (1) providing required medical and health service access and occupational medicine staffing(2) providing cooperative programs with employers, employees and medical providers to promote workplace health and safety and early return to work, and (3) recording and reporting data on medical costs and utilization, rates of RTW, time in medical treatment, and other effectiveness measures required by the AD.

Medical Confidentiality (LC 3762c). The general rule for medical confidentiality under the amendments contained in AB 749 is that the workers' compensation insurer, third party administrator (TPA), and benefit staff for self-insured employers, respectively, are prohibited from disclosing or causing disclosure of "medical information" about an employee who filed for workers' compensation. The following exceptions apply:

- Medical information limited to diagnosis for physical or mental condition claimed and medical treatment provided for this condition
- Medical information about claimed injury necessary for employer to have to modify work duties

"Medical information" includes any individually identifiable information regarding medical history, mental or physical condition, or treatment. (Civ. Code section 56.05)

Audits of Insurance Companies and Third Party Administrators (LC 129 and 129.5)

The Division's Audit Unit is charged with reviewing claims administration practices of the literally hundreds of claims adjusting locations that process workers' compensation claims for California. The Unit uses random and targeted on-site audits to review timeliness and accuracy of claims payments, the timeliness and activity of sending required notices to injured workers about changes in their benefits, and cites and penalizes claims administrators for poor compliance with the law. The Unit has typically done between 30 and 60 audits of claims adjusting locations per year, a rate that leads to random audits about once every 10 years.

The changes in the law require each claims adjusting location (CAL) to be audited every five years. A simplified first stage profile audit review (PAR) is intended to review files more quickly by focusing only on a limited number of key violations. Only if a location fails the simplified PAR audit, based on performance measures jointly developed by DWC and the Commission, would a location be subject to a full compliance audit (FCA) based on all violations. Locations would still be subject to the full FCA audit if targeted for audit based on complaints or previous audit performance. No penalties are assessed if the CAL met or exceeded the minimum standards established by the AD. Those adjusting locations not passing the full compliance audit are subject to significantly increased penalties, not to exceed $40,000 for any single violation. Any subject failing this audit is to be audited again within two years. A "targeted profile audit review" or full compliance audit may be conducted at any time based

on information from specified parties. Any CAL who fails to meet the full standards in two consecutive full audits shall be rebuttably presumed to cause injury. The AD is obligated to refer these CALs to the Insurance Commissioner (for insurers) or Director of the DIR (for self-insurers or their TPAs) to determine whether license revocation should occur. The legislative changes also provide for allowing $100,000 civil penalty upon finding consistently poor claims adjusting performance.[11] Audit subjects who receive penalty assessments may request a WCAB hearing within seven days after receipt of notice, and the Board must issue findings within 30 days of hearing.

Other changes in the law include that penalties collected are to be deposited into the Workers' Compensation Administrative Revolving Fund. The AD is required to publish a listing of all carriers audited during the prior year ranked by performance. Under the law, the Uninsured Employers Fund of DIR is also to be audited every five years.

Targeting Illegally Uninsured Employers

Research studies and pilot programs have confirmed that many employers are in violation of the mandatory requirement that they be covered for workers' compensation through insurance or a certified self-insurance plan. AB 749 contains new language giving the Department increased responsibility to establish and maintain a program for targeting unlawfully uninsured employers. The program includes procedures for ensuring that employers with payroll but no record of workers' compensation insurance are contacted and if no valid reason for the lack of record of coverage is found, that the employer be inspected on a priority basis.

Prior research studies of the CHSWC and preliminary work by the DWC confirm that large percentages of employers are fraudulently going without such insurance. Significant increases in the premium rates for workers' compensation insurance over the past three years have exacerbated the problem, leading to increased costs to the state in paying for medical and indemnity benefits of uninsured employers (approximately $25 million last year) and leaving such injured employees without access to timely and adequate benefits.

As passed by the Legislature, the budget contained a $1 million augmentation to the budget of the Labor Commissioner for implementing increased activities at preventing illegal uninsurance by employers. The money was earmarked for monitoring and enforcement activities. The field enforcement activities would include follow-up inspections and sanctions. Funding was also to be available to assist in coordinating interagency labor law enforcement efforts. However, in the final budget for 2002-03, the $1 million appropriation for this program was dropped. As with many other aspects of the law, the search is on for resources to accomplish the goals. (See also section on Anti-Fraud Resources, below.)

Court Administrator as Trial Court System Manager

AB 749 creates the position of Court Administrator, a person appointed by Governor, confirmed by the Senate, and who serves at the pleasure of the DWC Administrative Director. The functions of the Court Administrator include:

- Administering the workers' compensation adjudicatory process at the trial court level, and supervising workers' compensation administrative law judges (WCALJs)

- Promoting uniformity and expedition of proceedings before workers' compensation judges and ensuring that the WCALJs adhere to deadlines and manage procedural matters at the trial level.

- Making recommendations to the AD concerning revisions to existing regulations governing judicial ethics for WCALJs.

- Adopting uniform rules of practice and procedure governing trial level proceedings of the WCAB. A violation of these uniform procedures could subject a WCALJ to disciplinary action.

Other Issues

Carve-outs (LC 3201.5, 3201.7; 3201.9, Insurance Code Section 11741). Under existing law, California allows unionized construction employers to submit, in partnership with the unions representing employees, plans to "carve out" an alternative dispute resolution system that does not require case filings through the WCAB. After several years of legislative discussions over whether to expand carve outs into other unionized industries, AB 749 provided for an expansion of the program to the timber and aerospace industries. The bill also requires an evaluation of the carve out programs' long-term experience. Section 3201.9 establishes another research effort to allow carve out case data to be followed beyond the injury year by requiring annually updated information on injuries and the claims process. In AB 486, limitations were placed on the ability to expand the program into the non-construction sectors by mandating that only unions with affiliates that had negotiated a construction carve out program prior to 2003 would be eligible.

Under AB 749, the Insurance Commissioner is precluded, for a period of three years, from disapproving a rate established by any insurer for any policy issued in regard to alternative dispute resolution processes described in LC Section 3201.5. The same provision was extended to non-construction carve outs in AB 486.

Loss Control (LC 6354.5 and 6354.7). Workers' compensation reforms in 1989 and 1993 gave Cal-OSHA the responsibility for certifying the operation of insurance carrier

loss control persons. Under the mandate of AB 749, the requirements for workers' compensation insurance carriers to provide loss control services remain. However, DIR certification of these programs will no longer be required; an ombudsperson will oversee the process. In the past, this monitoring and certification function was paid through an insurer assessment; the assessment is earmarked under AB 749 for increased health and safety education programs.

Anti Fraud Resources and Uses. Annually under the new law, the DWC is mandated to provide employers, claims administrators, attorneys and physicians with notices that warn the parties against committing workers' compensation fraud, and that specify the penalties for such fraud. Funding for this effort is to come from the Fraud Assessment Commission. (LC 3822)

For the first time, anti-fraud resources from the annual assessment may be used against illegally uninsured employers by Department of Insurance fraud bodies and local district attorneys. Several county district attorneys, the recipients of half of the money collected through employer anti-fraud assessments each year, plan to start the new year with a significant push in this new target area.

The large expenditures (currently over $30 million per year) on anti-fraud activities have attracted a range of critics and those who question the effectiveness of the program. The bill requires the Bureau of State Audits to evaluate the effectiveness of the program by May 1, 2004. The evaluation will look at the Fraud Assessment Commission, the Bureau of Fraudulent Claims, the Department of Insurance, DIR, as well as local law enforcement in investigating and prosecuting workers' compensation fraud and willful failure to secure workers' compensation.

Insurance Code Changes. AB 749 allows the State Compensation Insurance Fund (SCIF) to commission an independent study to determine the feasibility of issuing bonds or securities. It also adds members to the SCIF Board, specifically the Speaker of the Assembly and the President of the Senate.

Insurers are authorized to reflect the changes in benefit levels in the bill by surcharging policies in force through January 1, 2003. (Ins.C. 11737f)

Other Workers' Compensation Measures Passed in 2002

Under current law, the costs of claims payments for insolvent insurers may be assessed against other operating workers' compensation insurers through an assessment for the California Insurance Guarantee Association (CIGA). The maximum annual assessment to fund the CIGA work has been increased from one percent of premium per year to two percent per year.

While the bill increases benefits and thereby raises employer costs, it also contains potentially significant improvements in system operation, if ultimately implemented wisely.

Current law contains several presumptions for specific occupational illnesses among industrial groupings. For instance, certain injuries among some public sector employees, like cancer among firefighters exposed to toxic chemicals and gases on the job, are presumed to arise out of employment. During 2002, presumptions of work-relatedness were added in a few more areas, including injuries to public safety employees from exposure to a biochemical substance (AB 1857) and injuries to specified peace officers and members of the California Conservation Corps who contract Lyme Disease while working in high risk areas (AB 2125).

What Was Left Out of the New Law?

The cost to employers for workers' compensation insurance has fluctuated wildly in California for 20 years. The "open rating" premium rate setting process implemented after the last set of reform measures in 1993 has now entered the phase of the insurance cycle where employer costs of workers' compensation insurance are rising significantly, following early years of heavy discounting of rates. The extreme underpricing of that era by some companies led to several insolvencies, especially when other sources of favorable underwriting results (high investment returns and low reinsurance rates) went sour in 2001 and 2002. The insurance market is again in distress in California. With rates rising dramatically, and the availability of insurance decreasing for employers because of tough underwriting standards, there will likely be increased demands for new or recycled cost-cutting devices.

Other consequences of the insurance insolvencies are challenging the system as well. Valid information for experience modification plans has been a casualty of some large insurer failures; many employers whose carriers became insolvent are now finding it difficult to verify their loss experiences. The entire basis for insurance ratemaking is based on access to complete, valid, and verifiable data on exposure, losses, and expenses. There will be increased focus on insurance reform, and the ratemaking and pricing processes. Rising costs of medical care, while addressed by certain promises in the bill, needs greater attention. Parsing out the problems particular to workers' compensation from those attacking all other insurance mechanisms is difficult but potentially rewarding work.

Finally, infrastructure repair is essential for the administrative bodies engaging in dispute resolution and injured workers support services. Improved and integrated data and information systems can assist in under-

standing, monitoring, and taking action when appropriate, and gives policymakers better information for decisions. It is also necessary to have dependability and stability in funding court systems.[12]

Summary and Conclusions

AB 749 and the accompanying clean-up bill contain many changes to present law. Potentially important changes to workers' compensation policy are in a multitude of places: initiating new programs while eliminating old ones, increasing benefits and indexing some of them to a wage index, developing further medical cost controls, and making several changes in the structure of workers' compensation judicial oversight. While the bill increases benefits and thereby raises employer costs, it also contains potentially significant improvements in system operation, if ultimately implemented wisely. Many of these can reduce overall system cost.

The new responsibilities are currently up against forces that would significantly decrease the Division's ability to do even its present work. As a program with operating expenses mostly funded by general revenues in a financially strapped state, further budget reductions seem inevitable without the development of alternative funding mechanisms. With a stable and dependable funding source and adequate resources to accomplish its mission, the Division of Workers' Compensation will be able to implement the new programs mandated by AB 749 that can help employers control their compensation costs as workers in California receive their first benefit increase since 1996.

ENDNOTES

1. This analysis also comments on changes made to the initial passage of AB 749 through a "clean-up" bill, numbered AB 486. Nearly all work in the companion bill is technical in nature or attempts to correct errors in drafting. Only one significant change, adding increased programs to fight insolvency of self-insurance funds, is included.

2. These are Alaska (current benefits at about 112 percent of SAWW), Minnesota (at 105 percent), Tennessee (98 percent), Arizona (at 61 percent), Georgia (at 58 percent) and New York (at 53 percent of current SAWW.) Sources: US. Department of Labor, AFL-CIO, US Chamber of Commerce. U.S. Chamber of Commerce, "2002 Analysis of Workers' Compensation Laws" copyright 2002, Washington DC; U.S. Department of Labor, Employment Standards Administration, Office of Workers' Compensation Programs, "State Workers' Compensation Laws, January 2002"; AFL-CIO, "2002 Workers' Compensation and Unemployment Insurance under State Laws, January 1, 2002."

3. Arthur Larson, "Tensions of the Next Decade" in John F. Burton, Jr., editor, *New Perspectives in Workers' Compensation* (Ithaca, NY: , ILR Press, 1988, p. 22.)

4. Introductory section on permanent disabilities is drawn from description in Workers' Compensation Basics, Division of Workers' Compensation Website, November 2002 (http://www.dir.ca.gov/DWC/basics.htm).

5. Disability payments for permanent disability are calculated through a formula establishing the number of weeks of payment per disability percentage. Currently, injured workers receive get 3 weeks of benefit payment for each percentage of disability under 10 percent and 4 weeks of payment for each percent between 10 and 20 percent. Under this formula, a person with a 5 percent disability gets 15 weeks of payment. A 15 percent disability would receive 50 weeks (10x3 plus 5x4). Under the bill, the number of weeks per point of disability goes up to 4 weeks for less than 10 percent disability, and 5 weeks for 10 to 20 percent, respectively, as of 2004. Under the new formula, a 5 percent disability would get 20 weeks of payment, and a 15 percent disability would receive benefits for 65 weeks, for injuries on or after January 1, 2004.

6. AB 486, Laws of 2002, amending Labor Code Section 4702(a)(6).

7. "The Legislature shall have power to provide for the payment of an award to the state in the case of a death, arising out of and in the course of the employment, of an employee without dependents, and such awards may be used for the payment of extra compensation for subsequent injuries beyond the liability of a single employer for awards to employees of the employer." California Constitution, Article 14, Section 4. See also *Yosemite Lumber Co. V. Industrial Accident Commission (1922) 187 Cal. 744. See also, Ops. Cal. Legis. Counsel, No. 13279 (June 18, 1998) Workers' Compensation (A.B. 1732 (1997-1998 Reg. Sess.), pp.5-7).*

8. The reimbursement is payable for up to two years after refund of workers' compensation premium per Labor Code 4638.

9. Section 86 of the Act noted "...the intent of the Legislature that all reimbursement expended by the Administrative Director of the Division of Workers' Compensation for the administration of the workers' compensation Return-to-Work Program established in Section 139.48 of the Labor Code shall be funded from the funds collected in the annual premium tax, collected under Section 12201 of the Revenue and Taxation Code, which is directly attributable to the compensation benefit rates and amounts set forth" in the Act.

10. Labor Code Section 4646.

11. A civil penalty may be imposed upon finding, after hearing, that an employer, insurer, or third-party administrator for an employer has knowingly committed or performed with sufficient frequency so as to indicate a general business practice any of the following:

(1) Induced employees to accept less than compensation due, or made it necessary for employees to resort to proceedings against the employer to secure compensation.

(2) Refused to comply with known and legally indisputable compensation obligations.

(3) Discharged or administered compensation obligations in a dishonest manner.

(4) Discharged or administered compensation obligations in a manner as to cause injury to the public or those dealing with the employer or insurer.

12. The Chief Justice of the California Supreme Court recently noted that stable funding is a primary key to promote justice. "...In 1997, the adoption of a system for state funding of the trial courts provided a stable and dependable source of income for the courts, as well as the means to have policy drive the administration of justice and promote equal access to justice. Prior to the enactment of that legislation, the courts often found themselves struggling simply to make ends meet." Ronald George, Chief Justice, California Supreme Court, "A Final Piece of the Puzzle." State Bar of California, *California Bar Journal* November 2002, p. 8.

APPENDIX

BENEFIT PACKAGE IN AB 749

Class of Benefits	2002	2003	2004	2005	2006
Temporary Disability					
Minimum	Actual Wages	126	126	126	126*
Maximum	490	602	728	840	840*
				* increased by change in SAWW	
Permanent Disability Minimums					
< 15%	70	100	105	105	130
15-24.75	70	100	105	105	130
25-69.75	70	100	105	105	130
70-99.75	70	100	105	105	130
Permanent Disability Maximums					
< 15%	140	185	200	220	230
15-24.75	160	185	200	220	230
25-69.75	170	185	200	220	230
70-99.75	230	230	250	270	270
Weeks of Disability per 1% of PD Within Percentage Range					
0-9.75	3	3	4	4	4
10-19.75	4	4	5	5	5
20-24.75	5	5	5	5	5
25-29.75	6	6	6	6	6
30-49.75	7	7	7	7	7
50-69.75	8	8	8	8	8
70-99.75	9	9	9	9	9
Death Benefit Maximums					
Single total dependent	125,000	125,000	125,000	125,000	250,000
No total dependents and one or more partial dependents	125,000	125,000	125,000	125,000	250,000
Single total dependent and one or more partial dependents	145,000	145,000	145,000	145,000	290,000
Two total dependents	145,000	145,000	145,000	145,000	290,000
Three or more total dependents	160,000	160,000	160,000	160,000	320,000
Life Pension					
Weekly Wage to determine maximum life pension benefits	257.69	257.69	257.69	257.69	515.38

The Intentional Injury Exception to the Exclusive Remedy Doctrine

by John F. Burton, Jr.

Workers' compensation statutes in all jurisdictions incorporate the workers' compensation principle, which has two elements.[1] Workers benefit from a no-fault system, which enables them to receive benefits in many situations in which tort suits against their employers would be unsuccessful because the employers were not negligent. Employers benefit from limited liability, which means that the cash and medical benefits provided in the workers' compensation statutes are the exclusive remedy of employees against their employers for workplace injuries and diseases. The workers' compensation benefits are often less than a plaintiff in a successful tort suit would receive since, for example, the cash benefits replace only a portion of lost wages, and there are no payments for pain and suffering.

There are, however, several exceptions to the exclusive remedy doctrine that allow injured workers to bring tort suits against their employers. One of these exceptions occurs when there is an intentional injury of the employee by the employer. This commentary provides an introduction to the intentional injury exception by providing an overview of the various approaches used by the states to the exception, by tracing the evolution of the doctrine in Michigan, and by examining developments in New Jersey, including a recent Supreme Court case.

Approaches to the Intentional Injury Exception

When will an employee be able to bring a tort suit against the employer because the employer engaged in activity that at least arguably represented an injury to the employee? There are at least four possible answers to this question.[2]

(1) There is no intentional injury exception.

Larson and Larson (2002, §103.01) identify several states that do not recognize the intentional injury exception to the exclusivity of the workers' compensation remedy, including Alabama, Indiana, and Pennsylvania.

(2) The exception requires an actual intent to injure.

Larson and Larson (2002, §103.03) indicate the "almost unanimous rule" is that the intentional injury exception requires misconduct of the employer that represents "a conscious and deliberate intent directed to the purpose of inflicting an injury." Thus "accidental injuries caused by the gross, wanton, willful, deliberate, intentional, reckless, culpable, or malicious negligence, [or] breach of statute" are not sufficient to satisfy the intentional injury exception. Since there appears to be some overlap in these excerpts from the same sentence in the Larsons' treatise of what would and would not constitute an exception based on actual intent, the authors later in the section provide further clarification: the actual intent to injure exception only applies when there was "deliberate infliction of harm comparable to an intentional left jab to the chin."

Larson and Larson (2002, §103.03) cite a number of cases that illustrate conduct that does not represent the kind of actual intention to injure that would allow an exception to the exclusive remedy doctrine, including: knowingly permitting a hazardous work condition to exist; knowingly ordering an employee to perform an extremely dangerous job; willfully violating a safety statute; refusing to respond to an employees' medical needs and restrictions; and withholding information about worksite hazards. These decisions are from Missouri, California, Illinois, and New York.

(3) The exception requires employer conduct that is substantially certain to cause injury or death.

There are almost a dozen jurisdictions that allow injured employees to bring tort suits against employers when the employers' conduct was substantially certain to cause the injury, according to Larson and Larson (2002 §103.04). The states cited by Larson and Larson as adopting the broader definition of intentional injury include Florida, Michigan, New Jersey, North Carolina, and West Virginia.

Although Larson and Larson suggest that this standard subjects employers to common law suits for actions that "might under ordinary circumstances be viewed as gross negligence," the states listed by the authors involve decisions that appear to require more than gross negligence. Thus, the West Virginia decision cited by the Larsons as the first decision to depart from what they characterized as the "pure intent" standard, *Mandolidis v. Elkins Industries, Inc.*, 161 W. Va. 695, 246 S.E.2d 907 (1978), allowed tort suits for employer behavior that involved "willful, wanton, and reckless behavior."[3]

Whatever the merits of the substantially-certain approach to the exclusive remedy provision, the authors of the leading legal treatise express reservations, particularly because the approach could undermine the requirement that the employer must have subjectively intended the injury to have occurred in order to be subject to tort suits. Thus, Larson and Larson (2002, §103.04[4]) provide this admonition:

> In jurisdictions that have adopted the "substantial certainty" theory, courts sometimes have failed to examine what the employer believed and simply looked to the hazard condition to determine whether harm was "substantially certain" to occur. Because of this potential for abuse, it is advisable for states to avoid this superficially attractive test.

(4) The exception requires employer conduct that is negligent, wanton, reckless, or (arguably, even) grossly negligent.

I am unaware of any jurisdiction that allows an employee to bring a tort suit against an employer because the employer engaged in conduct that was merely negligent, wanton, or reckless. Moreover, despite the assertion by Larson and Larson to the contrary, I am unaware of cases in which gross negligence made an employer subject to a tort suit (short of facts that indicated the employer was actually aware the employee was exposed to conditions that made it substantially certain the employee was going to be injured, which I consider involving more than gross negligence).

The Intentional Injury Exception in Michigan

The ability of injured workers to successfully use the intentional injury exception depends in part on the language in the particular state's workers' compensation statute. Michigan provides a good example of how that language can change over time. The Michigan Supreme Court in *Beauchamp v. Dow Chemical Co.*, 398 N.W.2d 882 (Mich. 1986), held that an intentional tort provided an exception to the exclusive remedy doctrine, and that "intention" included any injury in which the employer intended an act and believed that the injurious consequence was "substantially certain" to occur.

The Michigan legislature reacted in 1987 by amending the workers' compensation statute to provide that an intentional injury occurs only when "the employer had actual knowledge that an injury was certain to occur and willfully disregarded that knowledge." MICH. COMP. LAWS §418.131(1). The Michigan Supreme Court interpreted this language in *Travis v. Dreis & Krump Manufacturing Co.*, 551 N.W.2d 132 (Mich. 1996). Travis had been assigned to work on an unfamiliar machine that her supervisor knew (but did not tell her) had a history of unpredictable malfunctions. The tool room supervisor had told the supervisor that the machine needed to be shut down and fixed or rebuilt, or that someone would be hurt. After this conversation, some repairs were made on the machine and the supervisor believed it was functioning properly. However, the machine malfunctioned and Travis suffered amputation of two fingers and multiple crushing injuries to both hands. The trial court granted summary disposition of the case because it could not find that the facts constituted an intentional injury, and the Michigan Supreme Court agreed because the 1987 legislation requires an "extremely high standard" of showing that an injury was "certain" to occur. Id. at 143.

An alternative set of facts further clarifies the meaning of "certain" in Michigan. An employee's job included pouring wet scrap metal objects into a furnace containing molten aluminum. The employee warned the employer about the dangerous circumstances under which he was required to work and the lack of protective devices. He suffered minor burns from this task and was sent home. He was then called back the same day to perform the same job function, and was severely burned this time. The Michigan Supreme Court held this employer conduct constituted an intentional injury under the 1987 Michigan legislation, *Golec v. Metal Exch. Corp.*, 551 N.W.2d 132 (Mich. 1996), because of the actual knowledge of a specific injury which had already been proven "certain" to occur.

The Intentional Injury Exception in New Jersey

The meaning of the intentional injury exception in New Jersey has benefited from progressive revelations in state supreme court decisions. *Millison v. E.I. du Pont De Nemours & Co.*, 101 N.J. 161, 501 A.2d 505 (1985), involved two counts alleging that the employer had engaged in conduct that resulted in an intentional injury to the employees. In the first count, the employer was charged with intentionally exposing the workers to asbestos and with deliberately concealing from employees the health hazards associated with asbestos exposure. In the second count, du Pont was alleged to have fraudulently concealed from the workers the fact that company medical exams revealed certain workers had already contracted asbestos-related diseases. As part of the second count, the workers further alleged that, rather than provide medical treatment for these ailing employees, the employer sent them back into the workplace where their diseases were aggravated by additional asbestos exposure.

The New Jersey workers' compensation statute provides that when an employee qualifies for workers' compensation benefits, ordinarily the employee is barred from the pursuit of other remedies, but that an exception to the exclusivity provision is available when the worker can prove an "intentional wrong." The court noted that previous New Jersey decisions had provided an exception to the exclusive remedy only when there was a deliberate or actual intent to injure the worker, and quoted from the Larson treatise to illustrate the meaning of this standard: there must be a "deliberate infliction of harm comparable to an intentional left jab to the chin."

The court recognized that if the intentional wrong exception is interpreted too broadly,

> this single exception would swallow up the entire "exclusivity" provision of the Act, since virtually all employee accidents, injuries, and sicknesses are a result of the employer or a co-employee intentionally acting to do whatever it is that may or may not lead to eventual injury or disease.

Millison v. E.I. duPont De Nemours & Co., 101 N.J. 161, 177, 501 A.2d 505 (1985),

The court chose a standard for what constitutes an intentional injury that was easier to meet than the actual intent to injure approach espoused by Larson but that also insured "that as many work-related disability claims as possible be processed exclusively within the Act." In order to achieve this middle ground, the court adopted the intent analysis of Dean Prosser, who had indicated that:

> the mere knowledge and appreciation of a risk – something short of substantial certainty – is not intent. The defendant who acts in the belief or consciousness that the act is causing an appreciable risk of harm to another may be negligent, and if the risk is great the conduct may be characterized as reckless or wanton, but it is not an intentional wrong . . . .
> *Id.*

The court further clarified its position by referring to the Restatement of Torts, which indicates that the:

> meaning of intent is that actor desires to cause consequences of his act or is substantially certain that such consequences will result from his actions.
> *Id.* at 178.

The New Jersey court thus adopted the "substantially certain" standard for determining when the employer's conduct constituted an intentional injury. The court also added a second component to the level of risk exposure that will satisfy the intentional injury exception, namely

> the context in which that conduct takes place: may the resulting injury or disease, and the circumstances in which it is inflicted on the worker, fairly be viewed as a fact of life of industrial employment, or is it rather plainly beyond anything the legislature could have contemplated as entitling the employee to recover only under the Compensation Act?
> *Id.* at 178-79.

However, as soon as the OSHA inspector left, the safety guard would again be disabled. The employer conceded that the guard was removed for speed and convenience.

Using the two components involved in the intentional wrong exception (namely the employer's conduct and the context in which that conduct takes place), the New Jersey Supreme Court concluded that count one of the workers' complaints must fail. The court indicated that mere knowledge and appreciation of a risk, and even the strong probability of a risk resulting in harm, does not constitute employer conduct that represents an intentional harm. Moreover, the legislature was aware of occupational diseases as a fact of industrial employment when the workers' compensation statute was enacted, and therefore the context indicated that occupational diseases would be encompassed by the workers' compensation exclusive remedy provision.

The court decided, however, that count two did provide an exception to the exclusive remedy provision. The court distinguished between employer conduct that tolerates workplace conditions that result in injuries and diseases and conduct that actively misleads employees who have already contracted those diseases, and concluded that the latter type of behavior represents intentional harm. Moreover, the court concluded that such "intentionally-deceitful action goes beyond the bargain struck by the Compensation Act. . . . The legislature, in passing the Compensation Act, could not have intended to insulate such conduct from tort liability." In short, the second count satisfied both the conduct and context components of the intentional injury exception to the exclusive remedy provision.[4]

The New Jersey Supreme Court recently revisited the intentional injury exception to the exclusive remedy provision in *Laidlow v. Hariton Machinery Co.*, 170 N.J. 602, 790 A.2d 884 (2002). Laidlow worked for the company from 1978 until 1992, when he was injured when his hand was pulled into a rolling mill. The rolling mill had been purchased in 1978 and the company arranged to have a safety guard installed. However, the safety guard was "never" engaged, and from 1979 to Laidlow's accident, the guard was always "tied up" and inoperative. The only exception was when the OSHA inspectors came to the plant, when Laidlow's supervisor, Portman, would instruct the employees to release the wire holding up the safety guard. However, as soon as the OSHA inspector left, the safety guard would again be disabled. The employer conceded that the guard was removed for speed and convenience.

Although the employer operated the mill without the safety guard for about 12 or 13 years, there were no accidents before 1992. However, on prior occasions, both Laidlow and a fellow worker had close calls when they were able to pull their hands out

of the machine just in time to escape injury. Those incidents had been reported to the employer. Moreover, in the period immediately prior to his accident, Laidlow had spoken to Portman three times about the safety guard, but Portman had never restored the guard. Also, a professional engineer retained by Laidlow certified that the employer knew there was a "'virtual' certainty of injury" to Laidlow or other workers from operation of the mill without a guard.

The trial court concluded that the facts alleged by Laidlow failed to demonstrate an intentional wrong. Accordingly, the court granted the employer's and Portman's motions for summary judgment. The Appellate Division (New Jersey's first level of appeals court) affirmed the dismissals in a split decision.

The New Jersey Supreme Court reversed the judgment of the Appellate Division and remanded the case for trial. In the decision, the court clarified its holding in the 1985 *Millison* case. A key passage (at 613) is:

> What is critical, and what often has been misunderstood, is that we cited Professor Larson and the cases relying on his approach for informational, not precedential, purposes. Millison, in fact, specifically rejected Professor Larson's thesis that in order to obtain redress outside the Workers' Compensation Act an employee must prove that the employer subjectively desired to harm him. In place of Larson's theory, we adopted Dean Prosser's broader approach to the concept of intentional wrong.
>
> Under Prosser's approach, an intentional wrong is not limited to action taken with a subjective desire to harm, but also includes instances where an employer knows that the consequences of those acts are substantially certain to result in such harm.

The New Jersey Supreme Court also clarified the additional requirements for the intentional wrong exception to the exclusive remedy provision in New Jersey (Id at 614-15).

> In addition to adopting Prosser's "substantial certainty" test relative to conduct, in *Millison* we added a crucial second prong to the test:
>
> Courts must examine not only the conduct of the employer, but also the context in which that conduct takes place: may the resulting injury or disease, and the circumstances in which it is inflicted on the worker, fairly be viewed as a fact of life of industrial employment, or is it rather plainly beyond anything the legislature could have contemplated as entitling the employee to recover only under the Compensation Act? . . .
>
> In other words, under *Millison*, if only the conduct prong is satisfied, the employer's action will not constitute an intentional wrong . . . . That standard will be met only if both prongs of *Millison* are proved.

The court was not persuaded that the absence of prior accidents obviates a possible finding of "substantial certainty" by the jury.

The court then applied these principles to the facts involving the suit by Laidlow. The court said that a directed verdict was inappropriate because the facts could have led a jury to conclude that the employer was aware of the virtual certainty of injury from the unguarded rolling mill. The court was not persuaded that the absence of prior accidents obviates a possible finding of "substantial certainty" by the jury. Rather, the other facts – such as the purchase of the safety guard, the reports of close calls, the activation of the safety guard when the OSHA inspectors appeared, and the three requests from Laidlow to his supervisor to restore the guard – could have served as the basis for a jury's determination that the employer's conduct was substantially certain to cause death or injury.

As to the second prong of the intentional harm exception – the context indicates the employer conduct was beyond anything the legislature could have contemplated as confining the employee to recover only under workers' compensation – the New Jersey Supreme Court indicated that this determination was for the court to make. And the court indicated that if Laidlow's allegations were proved, the context prong could be met.

> Indeed, if an employee is injured when an employer deliberately removes a safety device from a dangerous machine to enhance profit or production, with substantial certainty that it will result in death or injury to a worker, and also deliberately and systematically deceives OSHA into believing that the machine is guarded, we are convinced that the Legislature would never consider such actions or injury to constitute simple facts of industrial life. On the contrary, such conduct violates the social contract so thoroughly that we are confident that the Legislature would never expect it to fall within the Workers' Compensation bar.

> Our holding is not to be understood as establishing a per se rule that an employer's conduct equates with an "intentional wrong" . . .whenever that employer removes a guard or similar safety device from equipment or machinery, or commits some other OSHA violation. Rather, our disposition in such a case will be grounded in the totality of the facts contained in the record and the satisfaction of the standards established in Millison and explicated here. *Id.* at 622-23.

CONCLUSIONS

As with many aspects of workers' compensation programs, there are differences among states in the extent to which the exclusive remedy provision protects employers from tort suits for an intentional injury to the employee. A few states do not recognize the intentional injury exception regardless of the circumstances; most states confine the exceptional injury exception to misconduct that represents a deliberate attempt to inflict an injury on the workers (the Larson view); and about a dozen states allow an exception to the exclusive remedy provision when the employer conduct is substantially certain to cause injury or death (the Prosser view).

Despite the fears expressed by Larson and Larson about the threats to the exclusive remedy provision from use of the exception when the employer conduct is substantially certain to cause injury or death, the states that adopted that approach, such as New Jersey, appear to have effectively limited that exception to extreme circumstances that do not threaten the integrity of the exclusive remedy doctrine. The New Jersey Supreme Court has clearly indicated that gross negligence, or willful or wanton behavior, are not sufficiently egregious behavior to warrant tort suits.

Whether the two-prong approach used in New Jersey is a good idea is less obvious. The distinction seems strained between the content of the employer's conduct, which is assessed by the jury to determine if there is evidence of behavior "substantially certain" to harm the employee, and the context for the employer's conduct, which is assessed by the courts to determine if the circumstances that resulted in the injury are beyond anything the legislature could have contemplated as entitling the employee to recover under workers' compensation. Generally the employer conduct that satisfies the content requirement should also satisfy the context requirement, and so the two prongs are largely redundant. To the extent the prongs produce different results, the context requirement seems to be a way for the New Jersey courts to nullify content decisions by the jury that the courts do not like. In essence, the best solution appears to be the "substantially certain" approach used in New Jersey to determining what employer actions represent an intentional injury without the second New Jersey "prong" involving a judicial determination of context.

ENDNOTES

1. Workers' compensation statutes were enacted in most states between 1910 and 1920. Prior to these statutes, workers injured on the job were required to sue their employers in tort suits based on negligence. While successful suits could result in substantial awards, including full losses of wages and payments for payment and suffering, employees were generally unsuccessful because of the necessity to establish employer negligence and because of several defenses that negligent employers could invoke to avoid liability. The history of the emergence of workers' compensation in response to the deficiencies of the negligence law approach is briefly recounted in Burton and Mitchell (2002).

2. The four possible answers discussed in the text could be subdivided into additional answers.

3. The West Virginia legislature amended the workers' compensation statute in response to the decision in *Mandolidis v. Elkins Industries, Inc.*, 161 W. Va. 695, 246 S.E. 2d 907 (1978), which in turn led to other West Virginia Supreme Court decisions. "The West Virginia Story" is recounted in Larson and Larson (2002, § 103.04[3][a]).

4. Several years after the *Millison* case was decided, Arthur Larson (1988) analyzed several cases in which deceit or fraud are used as a basis for tort suits that arguably constitute exceptions to the exclusive remedy provision. Larson distinguished between single-injury cases and dual-injury cases. In single-injury cases, the employer deceives the worker about the hazards of the job, such as chemical exposure, and the worker is injured as a result. Larson indicates that this kind of effort to avoid the exclusive remedy provision almost always fails because the deceit merges into the compensable injury itself. In dual-injury cases, the employer deceives an employee after the injury has occurred, with the result that the employee suffers a second harm. While not all courts have adopted the dual-injury approach and allowed the employees to bring tort suits, Larson cites the *Millison* decision as providing important support for the doctrine. While Larson indicates that the key to recovery in these fraud or deceit cases is whether there is a single injury or a dual injury, Willborn, Schwab, and Burton (2002, 974-975) argue that a more useful distinction is whether the fraud or deceit preceded the injury to the worker (in which case the worker cannot recover in a tort suit) or whether the injury precedes the fraud or deceit (in which case a tort suit is possible.)

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