Workers Compensation Focus

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Chapter 1 THE TRADE OFF

Workers' compensation is state-supervised insurance that provides compensation medical care for employees who are injured in the course of employment, in exchange for mandatory relinquishment of the employee's right to sue his or her employer for the tort of negligence. The trade off between assured, limited coverage and lack of recourse outside the worker compensation system is known as "the compensation bargain."

While plans differ between jurisdictions, provision can be made for weekly payments in place of wages. Thus it is that workers' compensation functions as a form of disability insurance. That is, compensation for economic loss, reimbursement or payment of medical and like expenses (functioning in this case as a form of health insurance), and benefits payable to the dependents of workers killed during employment (functioning in this case as a form of life insurance).

Damages for pain and suffering and punitive damages for employer negligence are generally not available in worker compensation plans. Proponents of workers' compensation believe the system improves working conditions and provide an economic safety net for employees. At the other end of the spectrum opponents criticize these laws for removing or restricting workers' common-law rights such as suit in tort for negligence. This is done in order to reduce governments' or insurance companies' financial liability.

Workers' Compensation Statutes

Workers' compensation laws are designed to protect employees and their families from the financial consequences of accidental injury, disease, or death arising out of and in the course of employment. Prior to the enactment of these statutes, there were many obstacles to an employee's collecting from an employer for injury on the job. Today, every state has enacted a workers' compensation law.

The laws vary on occupations covered and benefits to be paid. All the laws, however, provide that the employee need not establish the employer's negligence or that the employee was free from negligence. The only requirement is that the injury occurs on the job during the course of employment. If so, the employer is liable. This is an example of strict liability or liability regardless of fault. Some statutes give the employer the option of electing to be sued by employees. In those states, the employee must show employer negligence but is free from the common law defenses of contributory negligence and assumption of risk.

Under workers' compensation acts, employees obtain cash payments for loss of income as well as reimbursement for medical expenses. Some laws provide for the establishment of state workers' compensation funds, and others require private insurance coverage to be obtained by the employer. Under some state laws, employers may "self-insure" if they meet certain qualifying financial standards.

In the past, workers' compensation laws have been criticized because of the number of occupations left uncovered as well as for poor administration of the programs. Because the statutes were designed to remedy recognized defects in the common law, the courts tend to construe the statutes liberally and, whether deciding coverage or the scope of employment, courts tend to find in favor of injured employees. Reform of the benefits has been proposed and the enactment of a federal workers' compensation act may be the ultimate result if all states do not bring their workers' compensation statutes up to a minimum standard.

Safety by Statute

Today, all state workers compensation statutes cover most public and private employment, and the interests protected are those of the workers exposed to work-related illness or injury as well as the members of their families who otherwise would be responsible for medical bills and would suffer loss of income when a worker was disabled or killed. Some statutes include within the scope of their coverage civilian volunteers such as volunteer fire fighters or auxiliary police officers; some statutes specifically exclude domestic servants and farm workers from the operation of the law.

Federal statutes provide similar kinds of benefits to certain types of employees including longshoremen and harbor workers, railroad workers, sailors, and others. The effect of a compensation statute on the employee is to take away his or her common-law rights against the employer and to substitute a remedy that requires the employer to pay certain benefits as specified during disability, awards for permanent disability, and in the case of death, a death benefit to dependents. When workers are excluded from the law, they retain their common-law rights to sue the employer. When afforded, the right to compensation becomes the employee's exclusive remedy (except in states that permit the employee to reject the statute prior to an accident and thus retain the right to sue). Under common law, the injured worker would be subject to the usual delays of litigation and would receive no money unless and until the case was tried or settled in favor of the injured employee.

The effect of a workers' compensation law on the employer is to relieve the employer of the duty to respond in damages that might have otherwise been imposed for failure to meet the common-law duties to the employee. Simultaneously, the employer becomes obligated for the statutory compensation benefits regardless of fault. The statutes require that weekly payments be made promptly, with the first payment usually being due at the end of the second week of disability.

Chapter 2 EXPLANATION OF THE POLICY

The workers compensation policy is a financial contract between a policyholder and an insurer. The insurer agrees to pay in the event that the worker insured suffers a type of loss named in the policy. The protection remains in force for a specified "policy term," typically six months or a year, after which the policy is renewed in order to continue the coverage.

Policy Layout

The policy is laid out in the following manner-

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

The workers compensation insurance policy consists of one section and six parts. In return for the payment of the premium and subject to all terms of the policy, the insurer agrees with the insured as follows:

GENERAL SECTION

This section indicates that the insurance policy, the Information Page (which follows the policy) and all endorsements and schedules in effect on the inception date represent the contract of insurance between the insured employer and the insurance company. Defines who the insured is and explains how the workers compensation insurance and employers liability laws of the state apply. It also explains the meaning of workplace locations and defines "State" to mean states of the United States and the District of Columbia.

A. The Policy- The policy includes at its effective date the Information Page and all endorsements and schedules listed. It is a contract of insurance between the insured (the employer named in Item 1 of the Information Page) and the insurer (named on the Information Page). The only agreements relating to the insurance are stated in the policy, there are no verbal or ‘side’ agreements. The terms of the policy may not be changed or waived except by endorsement issued by the insured to be part of the policy.

B. Who is Insured- The entity is an insured if it is an employer named in Item 1 of the Information Page. If that employer is a partnership, and if in individual is one of its partners, he or she is insured, but only in the capacity as an employer of the partnership’s employees.

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

D. State- ’State’ in this context means any state of the United States of America, and the District of Columbia.

E. Locations- The policy covers all of the employers workplaces listed in Items 1 or 4 of the Information Page; and it covers all other workplaces in Item 3 A states unless the employer has other insurance or is self-insured for such workplaces.

PART ONE WORKERS COMPENSATION INSURANCE

This section explains how the workers compensation insurance provided applies and outlines the payments the workers compensation insurance company is obligated to make. These include benefits required by law, costs of defense of suits brought against the insured for benefits paid by the insurance and additional costs incurred as a result of a claim or legal action. It explains what happens if other insurance covers the same claim and outlines the payments the insured must make. It also outlines the procedures in the event of any recoveries from others and summarizes the statutory provisions that apply in the event of loss.

A. How the Insurance Applies- The workers compensation insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

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

B. The Insurer Pays- Prompt payment must be made when due for the benefits required of the employer by the workers compensation law.

C. The Insurer Defends- The insurer has the right and duty to defend at its own expense any claim, proceeding or suit against the insured for benefits payable by the workers compensation insurance policy. The insurer has the right to investigate and settle such claims, proceedings or suits. The insurer has no duty to defend a claim, proceeding or suit that is not covered by the policy.

D. The Insurer Also Pays- The insurer also pays costs, in addition to other amounts payable under the insurance, as part of any claim, proceeding or suit defended by the insurer:

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

E. Other Insurance- The insurer will not pay more than its share of benefits and costs covered by the insurance and other insurance or self-insurance. Subject to any limits of liability that may apply, all shares are be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance are to be equal until the loss is paid.

F. Payments the Insured Must Make- The insured is responsible for any payments in excess of the benefits regularly provided by the workers compensation law including those required because:

1. Of the insured's serious and willful misconduct;
2. The insured knowingly employs someone in violation of law;
3. The insured fails to comply with a health or safety law or regulation; or
4. The insured discharges, coerces or otherwise discriminates against any employee in violation of the workers compensation law.

If the insurer makes any payments in excess of the benefits regularly provided by the workers compensation law on the insured's behalf, the insured will reimburse the insurer promptly.

G. Recovery From Others- The insurer has the rights of the insured, and the rights of persons entitled to the benefits of the insurance, to recover payments from anyone liable for the injury.

The insured must do everything necessary to protect those rights and to help enforce them for the insurer.

H. Statutory Provisions- These statements apply where they are required by law.

1. As between an injured worker and the insurer, so it is that the insurer has have notice of the injury when the insured has notice.
2. Default or bankruptcy or insolvency of the insured or the insured's estate does not relieve the insurer of its duties under the insurance contract after an injury occurs.
3. The insurer is directly and primarily liable to any person entitled to the benefits payable by the insurance policy. Those persons may enforce the insurer's duties; so may an agency authorized by law. Enforcement may be against the insurer or against the insured and the insurer.
4. Jurisdiction over the employer is jurisdiction over the insurer for purposes of the workers compensation law. The insurer is bound by decisions against the insured under that law, subject to the provisions of the policy that are not in conflict with that law.
5. The insurance conforms to the parts of the workers compensation law that apply to:
    a. benefits payable by the insurance;
    b. special taxes, payments into security or other special funds, and assessments payable bythe insurer under that law.
6. Terms of the insurance that conflict with the workers compensation law are changed by the statement to conform to that law.

Nothing in these paragraphs relieves the insured of its duties under the policy.

PART TWO EMPLOYERS LIABILITY INSURANCE

This section explains what employers liability insurance is, how it applies, and outlines the payments for which the insurance company is responsible. It provides a detailed list of exclusions and circumstances where coverage does not apply. It outlines the circumstances under which the insurance company defends the insured for suits brought due to damages paid by the insurance and details the additional costs the insurer pays as part of any legal action it defends. It explains what happens if other insurance covers the same claim and defines the meaning of the terms and limits that apply to the coverage. It also outlines the obligations of the insured in the event of recoveries from others responsible for a covered loss and summarizes the requirements of each party before an action can be brought against the insurance company.

A. How the Insurance Applies

The employer's liability insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. The bodily injury must arise out of and in the course of the injured employee's employment by the insured.
2. The employment must be necessary or incidental to the employer's work in a state or territory listed in Item 3 A of the Information Page.
3. Bodily injury by accident must occur during the policy period.
4. Bodily injury by disease must be caused or aggravated by the conditions of employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

5. If the employer is sued, the original suit and any related legal actions for damages for bodily injury by accident or by disease must be brought in the United States of America, its territories or possessions, or Canada.

B. Insurer Will Pay

The insurer pays all sums that legally must be paid as damages because of bodily injury to company employees, provided the bodily injury is covered by the Employers Liability Insurance.

The damages the insurer pays, where recovery is permitted by law, include damages:

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

   provided that these damages are the direct consequence of bodily injury that arises out of and in the course of the injured employee's employment by the insured; and
4. because of bodily injury to the insured's employee that arises out of and in the course of employment, claimed against the insured in a capacity other than as employer.

C. Exclusions-

The insurance does not cover:

1. liability assumed under a contract. The exclusion does not apply to a warranty that the employer's work will be done in a workmanlike manner;
2. punitive or exemplary damages because of bodily injury to an individual employed in violation of law;
3. bodily injury to an employee while employed in violation of law with employer's actual knowledge or the actual knowledge of any of the insured's executive officers;
4. any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;
5. bodily injury intentionally caused or aggravated by the insured;
6. bodily injury occurring outside the United States of America, its territories or possessions, and Canada. The exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;
7. damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions;
8. bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 the USC Sections 901–950), the Non-appropriated Fund Instrumentalities Act (5 the USC Sections 8171–8173), the Outer Continental Shelf Lands Act (43 the USC Sections 1331–1356), the Defense Base Act (42 the USC Sections 1651–1654), the Federal Coal Mine Health and Safety Act of 1969 (30 the USC Sections 901–942), any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws;
9. bodily injury to any person in work subject to the Federal Employers' Liability Act (45 the USC Sections 51–60), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of or in the course of employment, or any amendments to those laws;
10. bodily injury to a master or member of the crew of any vessel;
11. fines or penalties imposed for violation of federal or state law; and

12. damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 the USC Sections 1801–1872) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

D. The Insurer Defends- The insurer has the right and duty to defend, at its own expense, any claim, proceeding or suit against the insured for damages payable by the insurance. The insured has the right to investigate and settle these claims, proceedings and suits.

The insured has no duty to defend a claim, proceeding or suit that is not covered by the insurance. Also, the insured has no duty to defend or continue defending after they have paid the applicable limit of liability under the policy.

E. Insurer Also Pays- Costs to also be paid by the insurer, in addition to other amounts payable under the coverage, as part of any claim, proceeding, or suit defended by the insurer:

1. reasonable expenses incurred at the insurer's request, but not loss of earnings;
2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the limit of the insurer's liability under the insurance;
3. litigation costs taxed against the insured;
4. interest on a judgment as required by law until the insured offers the amount due under the coverage; and
5. expenses incurred by the insurer.

F. Other Insurance- The insurer does not pay more than its share of damages and costs covered by the policy and other insurance or self-insurance. Subject to any limits of liability that apply, all shares are to be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance and self-insurance will be equal until the loss is paid.

G. Limits of Liability- The insurer's liability to pay for damages is limited. The limits of liability are shown in Item 3 B of the Information Page. They apply as explained below.

1. Bodily Injury by Accident. The limit shown for "bodily injury by accident—each accident" is the most the insurer pays for all damages covered by the insurance because of bodily injury to one or more employees in any one accident.
    i. A disease is not bodily injury by accident unless it results directly from bodily injury by accident.
2. Bodily Injury by Disease. The limit shown for "bodily injury by disease—policy limit" is the most the insurer pays for all damages covered by the insurance policy and arising out of bodily injury by disease, regardless of the number of employees who sustain bodily injury by disease. The limit shown for "bodily injury by disease—each employee" is the most the insurer pays for all damages because of bodily injury by disease to any one employee.
    i. Bodily injury by disease does not include disease that results directly from a bodily injury by accident.
3. The insurance carrier does not pay any claims for damages after they have paid the applicable limit of liability under the insurance.

H. Recovery From Others- The insurer has the rights of the insured to recover payments from anyone liable for an injury covered by the policy. The insured must do everything necessary to protect those rights for the insurer and to help the insurer enforce them.

I. Actions Against the insurer There is no right of action against the insurer under the insuring agreement unless:

1. The insured has complied with all the terms of the contract; and

2. The amount owed by the employer has been determined with the insurer's consent or by actual trial and final judgment.

The policy does not give anyone the right to add the insurer as a defendant in an action against the insured to determine the insured's liability. The bankruptcy or insolvency of the insured or his or her estate does not relieve the insurer of its obligations under this Part.

PART THREE

In this section is outlined how this coverage applies when one or more states are listed in the space provided for this coverage on the Information Page. Coverage applies to any state listed on the Information Page but does not apply to any other state unless the insured reports the start of any work in that state within 30 days of it beginning. The insured is required to immediately inform the company of the commencement of operations in any state listed in this section on the Information Page.

OTHER STATES INSURANCE

A. How The Insurance Applies-

1. Other states insurance applies only if one or more states are shown in Item 3.C. of the Information Page.
2. If the insured begins work in any one of those states after the effective date of the agreement and are not insured or are not self-insured for such work, all provisions of the policy apply as though that state were listed in Item 3.A. of the Information Page.
3. The insurer must reimburse the insured for the benefits required by the workers compensation law of that state if the insurer is not permitted to pay the benefits directly to persons entitled to them.
4. If the insured has work on the effective date of the policy in any state not listed in Item 3 A of the Information Page, coverage will not be afforded for that state unless the insurer is notified within thirty days.

B. Notice

There is an obligation under the contract to tell the insurer at once if the insured begins work in any state listed in Item 3 C of the Information Page.

PART FOUR

This part lays out the duties and responsibilities of the insured with respect to both the injured employee and the company if an injury occurs that may be covered by the insurance policy.

EMPLOYER DUTIES IF INJURY OCCURS

Employer must tell the insurer at once if injury occurs that may be covered by the insuring agreement. The insured's other duties are listed here.

1. Provide for immediate medical and other services required by the workers compensation law.
2. Give the representing agent or the insured the names and addresses of the injured persons and of witnesses, and other information that may be needed.
3. Promptly give the insurer all notices, demands and legal papers related to the injury, claim, proceeding or suit.
4. Cooperate with and assist the insurer as requested, in the investigation, settlement or defense of any claim, proceeding or suit.

5. Do nothing after an injury occurs that would interfere with the insurer’s right to recover from others.
6. Do not voluntarily make payments, assume obligations or incur expenses, except at the insured’s own cost.

PART FIVE—PREMIUM

This part explains the insurance company's use of its manuals, rules, rates, rating plans and classifications to determine the premium charged. Method used to determine the classifications and outlines how remuneration is used as the basis for premium development in most cases. Requires the insured to pay premiums when due and provides details on how the final premium is determined. Provides details of the records the insured must maintain and the manner in which premium audit uses those records.

A. Manuals- All premium for the policy are determined by the insurer’s manuals of rules, rates, rating plans and classifications. The insurer may change manuals and apply the changes to the insuring agreement if authorized by law or a governmental agency regulating the insurance contract.

B. Classifications- Item 4 of the Information Page shows the rate and premium basis for certain business or work classifications. These classifications were assigned based on an estimate of the exposures the insured would have during the policy period. If the insured’s actual exposures are not properly described by those classifications, the insurer assign proper classifications, rates and premium basis by endorsement to the contract.

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

1. All the insured’s officers and employees engaged in work covered by the insurance contract; and
2. All other persons engaged in work that could make the insurer liable under Part One (Workers Compensation Insurance) of the policy. If the insured does not have payroll records for these persons, the contract price for their services and materials may be used as the premium basis. Paragraph 2 does not apply if the insured provides proof that the employers of these persons lawfully secured their workers compensation obligations.

D. Premium Payments- The employer must pay all premium when due. The insured pays the premium even if part or all of a workers compensation law is not valid.

E. Final Premium- The premium shown on the Information Page, schedules, and endorsements is an estimate. The final premium is determined after the policy ends by using the actual, not the estimated, premium basis and the proper classifications and rates that lawfully apply to the business and work covered under terms of the agreement. If the final premium is more than the premium the employer paid to the insurer, the employer must pay the insurer the balance. If it is less, the insurer must refund the balance to the insured. The final premium will not be less than the highest minimum premium for the classifications covered by the contract.

If coverage is canceled, final premium must be determined in the following way unless the insurer’s manuals provide otherwise:

1. If the insurer cancels, final premium is to be calculated pro rata based on the time the policy was in force. Final premium will not be less than the pro rata share of the minimum premium.

2. If the insured cancels, final premium will be more than pro rata; it is based on the time the insuring agreement was in force, and increased by the short-rate cancelation table and procedure. Final premium will not be less than the minimum premium.

F. Records- The insured must keep records of information needed to compute premium. The insured is to provide the insurer with copies of those records when the insurer asks for them.

G. Audit- The insured must let the insurer examine and audit all the insured's records that relate to the insurance agreement. These records include ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data. The insurer may conduct the audits during regular business hours during the policy period and within three years after the policy period ends. Information developed by audit is used to determine final premium. Insurance rate service organizations have the same rights as the insurer under this provision.

PART SIX—CONDITIONS

This part outlines the right of the company to inspect workplaces at any time and clarifies that those inspections are not an obligation, nor serve as safety inspections. It explains that the insured cannot transfer any of its rights or duties without the written consent of the insurance company. The section details how the policy may be cancelled by both party, and how long-term policies are handled. Also requires the first named insured on the Information Page to act on behalf of all insured's with respect to all policy transactions.

A. Inspection- The insurer has the right, but is not obliged to inspect the insured's workplaces at any time. The insurance company's inspections are not safety inspections. They relate only to the insurability of the workplaces and the premiums to be charged. The insurer may give the insured reports on the conditions found. The insurer may also recommend changes. While they may help reduce losses, the insurer does not undertake to perform the duty of any person to provide for the health or safety of the insured's employees or the public. The insurer does not warrant that the employer's workplaces are safe or healthful or that they comply with laws, regulations, codes or standards. Insurance rate service organizations have the same rights the insurer has under this provision.

B. Long Term Policy- If the policy period is longer than one year and sixteen days, all provisions of the insurance contract apply as though a new policy were issued on each annual anniversary that the policy is in force.

C. Transfer of Rights and Duties- Rights or duties under the insurance contract may not be transferred without written consent of the insurance company. If the insured dies and the insurer receives notice within thirty days after his or her death, the insurer covers the insured's legal representative as insured.

D. Cancelation-

1. The insured may cancel the policy. The insured must mail or deliver advance written notice to the carrier stating when the cancelation is to take effect.
2. The insurer may cancel the policy. Insurer must mail or deliver to the insured not less than ten days advance written notice stating when the cancelation is to take effect. Mailing the notice to insured's mailing address shown in Item 1 of the Information Page is sufficient to prove notice.
3. The policy period ends on the day and hour stated in the cancelation notice.
4. Any of these provisions that conflict with a law that controls the cancelation of the insurance in the policy is changed by the contract's wording on this matter shall comply with the law.

E. Sole Representative- The insured first named in Item 1 of the Information Page acts on behalf of all insureds to change the insurance agreement, receive return premium, and give or receive notice of cancelation.

INFORMATION PAGE

The information page contains data as follows-

Insurer name Policy number

1. The Insured's name and address and whether an individual, partnership or corporation

A listing of other workplaces

2. The policy period is stated. Policy Period is considered coincide with the time (Eastern, Central, etc.) at the insured's mailing address.

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

B. Employers Liability Insurance: Part Two of the policy applies to work in each state listed in Item 3.A. The limits of the insured's liability under Part Two are then categorized-

Bodily Injury by Accident $ _____ each accident

Bodily Injury by Disease $ _____ policy limit

Bodily Injury by Disease $ _____ each employee

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

D. The policy endorsements and schedules are named in this section as well as being attached to the policy

4. The premium for the policy is determined by the insurers Manuals of Rules, Classifications, Rates and Rating Plans. All the following categories of information shown as being required are subject to verification and change by audit.

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

GENERAL INFORMATION PAGE NOTES

1. Insurance carriers may show a renewal agreement statement on the standard Information Page when a policy is renewed. The carrier must show "Renewal Agreement" or a like heading along with the title "Information Page" if a renewal agreement statement is shown on the Information Page.

2. Insurance carriers showing a renewal agreement statement on the Information Page or entering into a renewal agreement not shown on the Information Page can list any or all endorsements in Item 3.D., elsewhere on the Information Page or in an Information Page Schedule. A carrier is not required to attach such listed endorsements to the Information Page and Policy if the endorsements have already been provided to the insured by that carrier.

3. These General Information Page Notes do not affect the standard Information Page entry requirements shown in the Information Page Notes.

Chapter 3 POLICY ENDORSEMENTS

An endorsement is a written change attached to a policy to add or subtract specific insurance coverages.

Common Endorsements

In workers' comp insurance, the most common endorsements are notice of material change, waiver of subrogation, longshore and officer/owner exclusions. The description of several endorsements follow.

Notice of material change

Description: Request for the carrier to provide advance notice of material change (cancellation or reinstatement of policy) to a named third party. **Insurer must receive a separate request for each policy, each year.**

Details: Name and complete mailing address of the third party
Time limits, if applicable

Waiver of subrogation

Description: Request for the carrier to forego its statutory right to recover the cost of claims from third parties who are legally liable
Details: Can be specific or blanket. For specific waivers, insurer needs the name and complete mailing address of the third party, as well as the payroll and class codes applicable to work done for the third party. For blanket waivers, the insurer does not need specific information; however, blanket waivers do not apply automatically to all third parties. The insured must have a written contract with the third party requiring a waiver of subrogation, or the insured preserves the right to recover. Blanket waivers roll over to the renewal policy. Insured must request any specific waiver for each applicable policy period.
Time limits, if applicable
Fee determination & calculation: Blanket waivers usually cost two percent of the policy premium before application of credits/debits. Specific waivers cost five percent of the premium associated with the payrolls/class codes for the work to be done at that job site.

Limited reimbursement for employees injured in other jurisdictions

Description: This endorsement provides limited reimbursement to employers for employees injured while working temporarily in other states. The insurer does not require a supplemental application.
Details: This endorsement does not apply to ongoing operations in other states or people hired in other states, and it is often not available for certain specific states for which the state of jurisdiction does not have reciprocity. If the employee is injured in another state and the employee elects in writing to pursue another jurisdiction's benefits, the endorsement provides for reimbursement to the policyholder for any benefits they are required to pay under the other jurisdiction's workers' comp laws.
If the employee is eligible to receive benefits in another jurisdiction, the insurer will reimburse the employer the amount they are required to pay in that jurisdiction. The reimbursement

provided by this type endorsement is very limited. Reimbursement applies only to home state employees who meet the eligibility requirements.
Time limits, if applicable: None
Fee determination & calculation: No charge

Longshore

Description: Provides federal statutory coverage under the Longshore & Harbor Workers' Comp Act (L&HW)
Details: Insured must request the L&HW-2001 endorsement on the policy and list all applicable class codes with the L&HW coverage indicated.
Time limits, if applicable: None
Fee determination & calculation: Based on the amount of payroll subject to the federal act. There is a minimum $100 charge.

Outer Continental Shelf

Description: Extends Longshore coverage for employee injuries occurring as a result of operations conducted on the Outer Continental Shelf (OCS) for the purpose of exploring for, developing, removing or transporting by pipeline the natural resources, or involving rights to the natural resources, of the subsoil and seabed of the OCS.
Details: Insured must request the OCS-2001 endorsement on the policy and list all applicable class codes with the OCS coverage indicated.
Time limits, if applicable: None
Fee determination & calculation: Based on the amount of payroll subject to the federal act

Jones Act/maritime

Description: The insurance provided by the Jones Act (maritime) endorsement is limited. This coverage applies only to in-state employees as generally defined in insurance/labor code, whose principal location of employment is in the state of origin or has significant contacts with that state. Federal law, which includes Jones Act coverage, is subject to court interpretations and statutory revisions. This endorsement amends Employer Liability Coverage, Item 3.B, to include maritime employments (masters or members of the crews of vessels) with bodily injury by accident or disease with a maximum limit, usually $25,000.

Officer/owner exclusions

Description: Allows named individuals who are qualifying sole proprietors, owners, partners or officers to choose to be excluded from workers' compensation coverage.
Details: To qualify for exclusion, the officer must have at least a 25 percent ownership interest in the insured entity and be named as an officer in the company's bylaws (or have the title of president, vice president, secretary or treasurer). A corporate executive officer of the named insured with less than 25 percent equity ownership in the named insured may be excluded from coverage at the insurer's option.
The insurer generally needs the name, title and ownership of each officer. They also need the name of each owner and partner, and we need to know if they choose to be excluded from coverage. If included, their payroll MUST be listed at the flat rate based on the Texas Average Weekly Wage calculation. This rate is updated effective each October 1. In a community

property state, the insurer also needs to know if the spouse of a partner works in the business. If so, the spouse may choose to be excluded.
Fee determination & calculation: No charge. Payroll for any excluded, named individuals will not be included in premium calculations

The list of policy endorsements follows. Some seem arcane, but each has an application.

Defense Base Act Coverage Endorsement This endorsement applies only to the work described in the Schedule or described on the Information Page as subject to the Defense Base Act. The policy applies to that work as though the location included in the description of the work were a state named in Item 3.A. of the Information Page.
Federal Coal Mine Health and Safety Act Coverage Endorsement This endorsement applies only to work in a state shown in the Schedule and subject to the Federal Coal Mine Health and Safety Act of 1969 (30 USC Sections 931–942). Part One (Workers Compensation Insurance) applies to that work as though that state were shown in Item 3.A. of the Information Page.
Federal Employers' Liability Act Coverage Endorsement This endorsement applies only to work subject to the Federal Employers' Liability Act (45 USC Sections 51–60) and any amendment to that Act that is in effect during the policy period.
Longshoremen's and Harbor Workers' Compensation Act Coverage Endorsement This endorsement applies only to work subject to the Longshore and Harbor Workers' Compensation Act in a state shown in the Schedule. The policy applies to that work as though that state were listed in Item 3.A. of the Information Page.
Nonappropriated Fund Instrumentalities Act Coverage Endorsement This endorsement applies only to the work described in the Schedule or described on the Information Page as subject to the Nonappropriated Fund Instrumentalities Act. The policy applies to that work as though the location shown in the Schedule were a state named in Item 3.A. of the Information Page.
Outer Continental Shelf Lands Act Coverage Endorsement This endorsement applies only to the work described in Item 4 of the Information Page or in the Schedule as subject to the Outer Continental Shelf Lands Act. The policy will apply to that work as though the location shown in the Schedule were a state named in Item 3.A. of the Information Page.
Terrorism Risk Insurance Extension Act Endorsement Under the Terrorism Risk Insurance Act of 2002 and the Terrorism Risk Insurance Extension Act of 2005 (hereinafter both Acts are referred to as "TRIA"), insurers must provide clear and conspicuous disclosure to the policyholder of the premium charged (on a separate line item in the policy) for insured losses covered by the Terrorism Insurance Program ("Program") established by TRIA and the Federal share of compensation for insured losses under the Program. An insurer's receipt of payment from the Federal government under the Program is contingent upon the insurer's compliance with the policyholder disclosure requirements. Given the importance of the policyholder disclosure, both the Terrorism Risk Insurance Extension Act Endorsement (WC 00 01 13) and the Terrorism Risk Insurance Act Endorsement (WC 00 04 20) include a *Policyholder Disclosure Notice*.
Maritime Coverage Endorsement The Endorsement provides voluntary compensation insurance for **employees** for whom workers' *compensation insurance* coverage is not required by law. Under many state statutes, the types of employees for whom workers' compensation insurance is not required by law include certain masters and seamen, certain salespersons, certain taxicab operators, and a person whose employment is not in the usual course of the trade, business, profession or occupation of his employer ("exempt employees"). The Endorsement may be used only to provide voluntary compensation insurance for those employees for whom workers' compensation insurance coverage is not required by law.
Voluntary Compensation Maritime Coverage Endorsement The Endorsement provides voluntary compensation insurance**,** which is distinct from *workers' compensation insurance.* This Endorsement can be used to provide employees with voluntary compensation coverage, but not

workers'compensation coverage. voluntary compensation provides coverage for workers for whom workers' compensation coverage is not required by law… Voluntary Compensation Insurance enables the employer to offer the equivalent of workers' compensation and employers' liability coverage for these types of employment. It is permitted for volunteers only where allowed by state law.
Designated Workplaces Exclusion Endorsement This endorsement removes coverage for injuries sustained at workplaces listed in the endorsement. Commonly used on contractors' policies to exclude coverage with respect to projects on which the contractor is covered under an ongoing, or rolling, controlled/consolidated insurance program
Employers Liability Coverage Endorsement This endorsement is used to provide employers liability insurance in any state, including monopolistic state fund states, where the policy does not provide workers compensation insurance.
Joint Venture as Insured Endorsement An endorsement that clarifies that a joint venture can be a named insured. Joint ventures should be insured under separate workers' compensation policies whenever practical when there are separate payrolls or when the division of individual employee payroll can be readily determined. The "Joint Venture as Insured Endorsement" should be included in any policy which includes a joint venture as a named insured.
Medical Benefits Exclusion Endorsement A number of states permit an employer to exclude medical benefits coverage from their workers' compensation policy. This allows the employer to pay these cost directly. This is accomplished through the use of the "Medical Benefits Exclusion Endorsement". Excluding medical benefits from the workers' compensation policy may provide an opportunity for more efficient medical management of workers' compensation claims.
…..And so on; Other endorsements are listed below.
Insurance Company as Insured Endorsement
Alternate Employer Endorsement
Partners, Officers and Others Exclusion Endorsement
Rural Utilities Service Endorsement
Sole Proprietors, Partners, Officers and Others Coverage Endorsement
Voluntary Compensation and Employers Liability Coverage Endorsement
Voluntary Compensation and Employers Liability Coverage for Residence Employees Endorsement
Waiver of our Right to Recover from Others Endorsement
Workers Compensation and Employers Liability Coverage for Residence Employees Endorsement
Domestic and Agricultural Workers Exclusion Endorsement
Labor Contractor Endorsement
Labor Contractor Exclusion Endorsement
Employee Leasing Client Exclusion Endorsement
Multiple Coordinated Policy Endorsement
Residual Market Multiple Company Endorsement
Residual Market Limited Other States Insurance Endorsement
Aircraft Premium Endorsement
Anniversary Rating Date Endorsement
Experience Rating Modification Factor Endorsement
Pending Rate Change Endorsement
Policy Period Endorsement
Premium Discount Endorsement
Rate Change Endorsement
Contingent Experience Rating Modification Factor Endorsement
Notification of Change in Ownership Endorsement
Assigned Risk Adjustment Program Endorsement

Assigned Risk Loss Sensitive Rating Plan Notification Endorsement
Assigned Risk Mandatory Loss Sensitive Rating Plan Endorsement
Premium Due Date Endorsement Instructional
Domestic Terrorism, Earthquakes, and Catastrophic Industrial Accidents Premium Endorsement
Foreign Terrorism Premium Endorsement
Retrospective Premium Endorsement One Year Plan
Retrospective Premium Endorsement Three Year Plan
Retrospective Premium Endorsement Long-Term Construction Project
Retrospective Premium Endorsement Aviation Exclusion
Retrospective Premium Endorsement Changes
Retrospective Premium Endorsement Non-Ratable Catastrophe Element or Surcharge
Retrospective Premium Endorsement Short Form
Retrospective Premium Endorsement One Year Plan - Multiple Lines
Retrospective Premium Endorsement Three Year Plan - Multiple Lines
Retrospective Premium Endorsement Long-Term Construction Project - Multiple Lines
Retrospective Premium Endorsement Flexibility Options
Benefits Deductible Endorsement
Policy Information Page Endorsement
Issuing Agency/Producer Office Address Endorsement

Chapter 4 STATE WORKERS' COMPENSATION COVERAGE REQUIRMENTS

This Section is adapted form a Texas Department of Insurance Workers' Compensation Research Group report.

- Texas is the only state that allows any private sector employer the option of not purchasing workers' compensation coverage for employees (also known as "nonsubscription" to the Texas workers' compensation system).

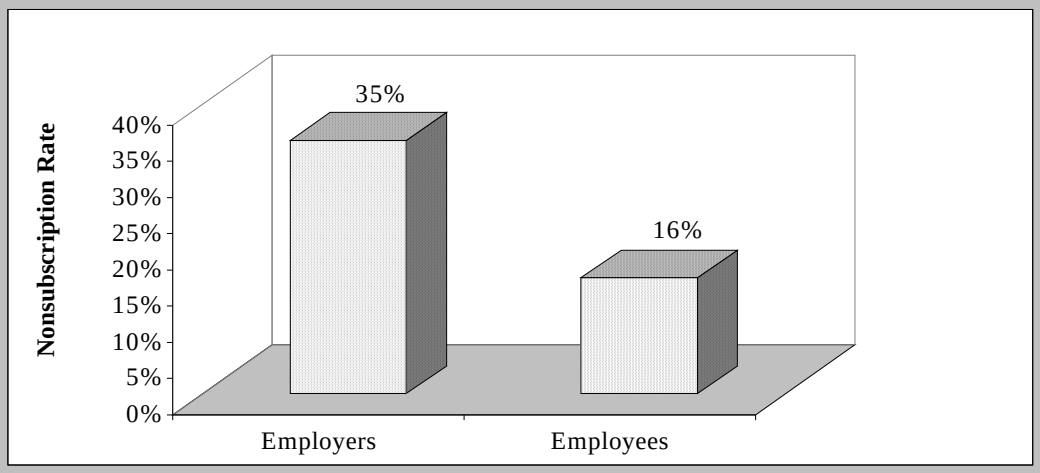
- Although most states have mandatory workers' compensation coverage requirements, certain states do not require workers' compensation coverage for particular industries. For example, in states such as Georgia, Kansas, Missouri, Nebraska, and Wyoming, workers' compensation coverage is elective for certain agricultural employers.

- Approximately 14 states with compulsory workers' compensation laws provide exemptions for small private sector employers. **See Table 1.**

    - Four of these states exempt employers with fewer than five employees;
    - Two of these states exempt employers with fewer than four employees;
    - Seven of these states exempt employers with fewer than three employees; and
    - One state exempts employers with one employee.

- As of 2001 (the most recent estimates to date), an estimated 35 percent of year-round Texas employers (approximately 114,000 firms) did not carry workers' compensation coverage. These firms employ approximately 16 percent of the Texas workforce (approximately 1.4 million workers). **See Figure 1.**

Figure 1 2001 Nonsubscription Rates



For the Texas Workers' Compensation System

Source: *Survey of Employer Participation in the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation and the Public Policy Research Institute at Texas A&M University, 2001.

Note: The sample was limited to only year-round employers, which were active in four consecutive quarters 1/1/2000 - 12/31/2000. Firms that hire only seasonal employees were excluded from the analysis

- Among industry types, nonsubscription rates are highest among employers in the retail trade (48 percent), services (38 percent), and manufacturing (36 percent) sectors and lowest among employers in the mining (12 percent) and wholesale trade (25 percent) sectors. **See Figure 2.**

- Larger employers are significantly less likely to be nonsubscribers, compared to smaller employers. Almost half (47 percent) of the smallest employers in the state (i.e., one to four employees) are nonsubscribers to the workers' compensation system, compared to just 14 percent of employers with 500 or more employees.

- According to the 2001 nonsubscription study completed by the Research and Oversight Council on Workers' Compensation (ROC), the most frequent reasons nonsubscribing employers cited for not purchasing workers' compensation coverage were:

    - the cost of workers' compensation premiums; and
    - that some employers felt there were too few employees to warrant purchasing the coverage.

- Over half of the nonsubscribing employers surveyed by the ROC in 2001 (56 percent) indicated that they pay occupational benefits to employees injured on the job. Of the nonsubscribers who indicated that they pay benefits to injured workers:

- Eighty-two percent indicated that they pay some or all medical expenses for injured workers; and
- Sixty-nine percent indicated that they pay income benefits to injured workers.

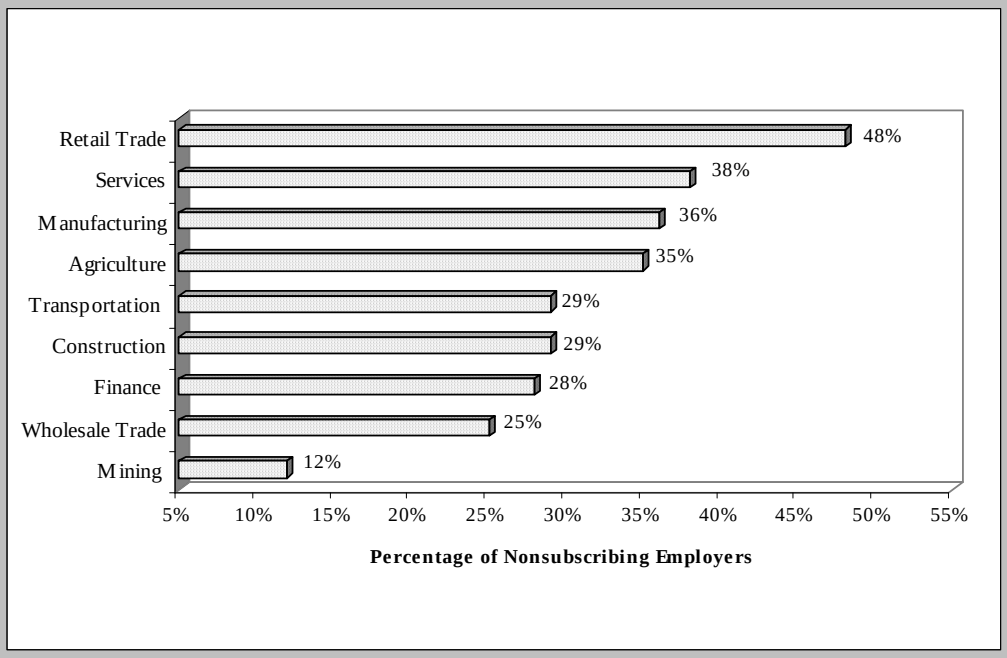


Figure 2 Employer Nonsubscription Rates by Industry

Source: *Survey of Employer Participation in the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation and the Public Policy Research Institute at Texas A&M University, 2001.

Statutory Limitations on Medical Benefits

- The vast majority of states (45 states, including Texas) do not place any statutory limitations on medical benefits, including the length of time an injured worker may receive medical care related to an on-the-job injury or the total amount of money that can be spent on medical care related to an on-the-job injury.

- Of the remaining five states:
  - Two states (Florida and Montana) require injured workers to pay a co-payment for medical services under certain circumstances;
  - One state (Tennessee) places limits on psychological treatment if not based on a referral from a physician;
  - One state (Ohio) specifies that once the injured worker has received Temporary Total Disability benefits (i.e., income benefits) for ninety days, the worker must be evaluated by the exclusive state fund to determine continued eligibility for income benefits and the appropriateness of the medical treatment being provided; and
  - One state (Arkansas) ends employer liability for medical care after six months if the worker has never lost time away from work, returned to work for at least six months, or a maximum of $10,000 has been paid, unless the employer agrees to extend the time and dollar limits.

- It is important to note that although most states do not place limits on an injured worker's access to medical care for a work-related injury, many states limit the usage of specific medical services (e.g., limitations on the number of chiropractic manipulations that can be billed per patient) through statutory provisions or state-adopted treatment guidelines.

Table 1 State-by-State Comparisons Statutory Workers' Compensation Coverage Requirements for Private Sector Employers

Elective Coverage for Private Employers	Mandatory Coverage for All Private Employers	Mandatory Coverage for Private Employers with 3 or More Employees	Mandatory Coverage for Private Employers with 4 or More Employees	Mandatory Coverage for Private Employers with 5 or More Employees
New Jersey*	Alaska	Arkansas	Rhode Island	Alabama
Texas	Arizona	Georgia	South Carolina	Mississippi
	California	Michigan	Florida	Missouri
	Colorado	New Mexico		Tennessee
	Connecticut	North Carolina		
	Delaware	Virginia		
	Hawaii	Wisconsin		
	Idaho			
	Illinois			
	Indiana			
	Iowa			
	Kansas			
	Kentucky			
	Louisiana			
	Maine			
	Maryland			
	Massachusetts			
	Minnesota			
	Montana			
	Nebraska			
	Nevada			
	New Hampshire			
	New York			
	North Dakota			
	Ohio			
	Oklahoma			
	Oregon			
	Pennsylvania			
	South Dakota			
	Utah			
	Vermont			
	Washington			
	West Virginia			
	Wyoming			

Source: U.S. Department of Labor, Office of Workers' Compensation Programs, January 2003; the U.S. Chamber of Commerce, 2003 Analysis of Workers' Compensation Laws, 2003; and various state workers' compensation agency websites, 2004.

Note: * New Jersey has a single law, which includes two alternatives for employers: 1) purchase a standard workers' compensation insurance policy; or 2) get approval to self-insure from the state and purchase a form of employers' liability insurance based on traditional common law remedies. Due to the restrictive nature of the statute, virtually all New Jersey employers have opted to purchase a workers' compensation insurance policy.

Certain states do not require workers' compensation coverage for particular industries. For example, in states such as Georgia, Kansas, Missouri, Nebraska, and Wyoming, workers' compensation coverage is elective for certain agricultural employers.

Statutory Provisions Relating to Choice of Treating Doctor

- Texas is currently one of 30 states that allow injured workers to choose their initial medical provider (often referred to as the "treating doctor" in statute). **See Table 2.**
    - One of these employee-choice states allows injured workers to choose their treating doctors if workers can demonstrate that they or a family member have a record of previous treatment with a particular doctor.
    - Three of these employee-choice states require injured workers to choose their treating doctor from a list maintained by the employer.
    - Four of these employee-choice states, including Texas, require injured workers to choose their treating doctor from a list prepared by the state agency charged with administering the workers' compensation system.
    - Five of these employee-choice states allow injured workers to select their treating doctor if their employer or insurance carrier does not have a managed care plan for work-related injuries; however, if a managed care plan exists, the injured worker must choose a treating doctor inside the network.[1]
    - Seventeen of these employee-choice states provide that injured workers have unlimited initial choice of treating doctor.
- Of the twenty states that allow employers to choose the treating doctor:
    - Three states allow the state administrative agency to authorize a change of doctor based on a request by the injured worker;
    - Seven states specify that the employer may choose the treating doctor for a specified period of time (usually spelled out in statute), after which injured workers may change to a treating doctor they select; and
    - Ten states allow employers to designate the injured worker's treating doctor.

[1] These states include Connecticut, Montana, New Hampshire, North Dakota, and Oregon.

Table 2 State-by-State Comparison Statutory Provisions Relating to Initial Choice of Treating Doctor

States with Employee Choice of Treating Doctor			States with Employer Choice of Treating Doctor		
Employee Has Initial Choice of Treating Doctor	Employee Selects from List Prepared by State Agency	Employee Selects from List Maintained by Employer	Employer Has Initial Choice of Treating Doctor	Employer's Choice of Doctor May Be Changed by State Agency	After Specified Period of Time, Employee Has Choice of Treating Doctor
Alaska	Connecticut	Georgia	Alabama	Arkansas	California**
Arizona	Nevada	Tennessee	Florida	Colorado	Maine
Connecticut*	New York	Virginia	Indiana	Idaho	Michigan
Delaware	Texas		Iowa		New Mexico
Hawaii			Kansas		Pennsylvania
Illinois			Missouri		Utah
Kentucky			New Jersey		Vermont
Louisiana			N. Carolina		
Maryland			Oklahoma		
Massachusetts			S. Carolina		
Minnesota					
Mississippi					
Montana*					
Nebraska					
New Hampshire*					
North Dakota*					
Ohio					
Oregon*					
Rhode Island					
South Dakota					
Washington					
West Virginia					
Wisconsin					
Wyoming					

Source: U.S. Department of Labor, Office of Workers' Compensation Programs, January 2003; the U.S. Chamber of Commerce, 2003 Analysis of Workers' Compensation Laws, 2003; and various state workers' compensation agency websites, 2004.

Note: * In these states if an employer and/or insurance carrier has a managed care arrangement for workers' compensation, then injured workers are required to choose a treating doctor from within the employer's or carrier's network.

** If an employer has designated at least two Health Care Organizations (HCOs), then the timeframe that an employer has to choose the treating doctor is normally extended.

Types of Income Benefits Available in Texas and Other States

- The Texas Workers' Compensation Act of 1989 established five types of income benefits payable under the law:

    - o Temporary Income Benefits (TIBs) – paid during the period of temporary disability (lost time from work) while the worker is recovering from an on-the-job injury;
    - o Impairment Income Benefits (IIBs) – paid to injured workers for permanent impairment sustained as a result of the on-the-job injury (impairment evaluations are currently based on the *Guides to the Evaluation of Permanent Impairment*, 4th Edition, published by the American Medical Association);[2]
    - o Supplemental Income Benefits (SIBs) – paid to injured workers for ongoing disability after IIBs have been exhausted, with all eligibility for SIBs ending at 401 weeks after the date of injury;[3]
    - o Lifetime Income Benefits (LIBs) – paid for the life of the injured worker for specific catastrophic injuries (e.g., total and permanent loss of sight in both eyes) as set forth in Section 408.161 of the Texas *Labor Code*;
    - o Death Benefits (DBs) and Burial Benefits – paid to the deceased workers' spouse or eligible beneficiaries as a result of a death from a compensable injury.

- The terminology used to describe workers' compensation income benefits in Texas differs from that of other states. For example, in most states, an injured worker who has lost time from work typically receives Temporary Total Disability (TTD) benefits, while in Texas the same worker receives Temporary Income Benefits (TIBs).

- If a worker has an injury that results in a permanent impairment, that worker generally receives Permanent Partial Disability (PPD) benefits in other states, while in Texas the same worker receives Impairment Income Benefits (IIBs) and possibly Supplemental Income Benefits (SIBs). If a worker sustains a catastrophic injury in other states, that worker may be eligible to receive Permanent Total Disability Benefits (PTD), while in Texas; the same worker may be eligible to receive Lifetime Income Benefits (LIBs).

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[2] Injured workers in Texas receive three weeks of IIBs for each percentage point of impairment assigned. For example, an injured worker with a 5 percent impairment rating would receive 15 weeks of IIBs. See Section 408.121, Texas *Labor Code*.

[3] SIBs are available only to injured workers who have exhausted their IIBs, who receive an impairment rating of at least 15 percent, and who sustain ongoing disability (i.e., an inability to work or to earn their pre-injury wage as a direct result of an on-the-job injury). See Section 408.142, Texas *Labor Code*.

Waiting Periods and Retroactive Periods for Income Benefits

- Overall, most states require injured employees to wait either 3 days or 7 days before receiving income benefits (22 states have a 3-day waiting period; 1 state has a 4-day waiting period, 5 states have a 5-day waiting period and 22 states, including Texas, have a 7-day waiting period). **See Table 3.**

- Many states allow injured employees to recoup their income benefits for the waiting period after a specified period of time set by statute (this is often referred to as the "retroactive period"). Most states have a statutory retroactive period of 14 days (4 states have no statutory retroactive period; 11 states have a 5-10-day retroactive period; 22 states have a 14-day retroactive period; 8 states have a 21-day retroactive period; 3 states, including Texas, have a 28-day retroactive period and 2 states have a 42-day retroactive period). **See Table 4.**

Table 3 State-by-State Comparisons of Statutory Waiting Periods

January 2003

3 Days	4 Days	5 Days	7 Days
Alabama	North Dakota	Idaho	Arizona
Alaska		Massachusetts	Arkansas
California		Mississippi	Florida
Colorado		Nevada	Georgia
Connecticut		Montana	Indiana
Delaware			Kansas
Hawaii			Kentucky
Illinois			Louisiana
Iowa			Maine
Maryland			Michigan
Minnesota			Nebraska
Missouri			New Jersey
New Hampshire			New Mexico
Oklahoma			New York
Oregon			North Carolina
Rhode Island			Ohio
Utah			Pennsylvania
Vermont			South Carolina
Washington			South Dakota
West Virginia			Tennessee
Wisconsin			Texas
Wyoming			Virginia

Source: U.S. Department of Labor, Office of Workers' Compensation Programs, January 2003; the U.S. Chamber of Commerce, 2003 Analysis of Workers' Compensation Laws, 2003; and various state workers' compensation agency websites, 2004.

Table 4 State-by-State Comparisons of Statutory Retroactive Periods

January 2003

No Retroactive Period	5-10 Days (# of days in parentheses)	14 Days	21 Days	28 Days	42 Days
Hawaii	North Dakota (5)	California	Alabama	Alaska	Louisiana
Oklahoma	Nevada (5)	Colorado	Massachusetts	New Mexico	Nebraska
Rhode Island	Connecticut (7)	Illinois	Florida	Texas	
Montana	Delaware (7)	Iowa	Georgia		
	Vermont (7)	Maryland	Indiana		
	West Virginia (7)	New Hampshire	Kansas		
	Wisconsin (7)	Oregon	North Carolina		
	South Dakota (7)	Utah	Virginia		
	New Jersey (7)	Washington			
	Wyoming (8)	Indiana			
	Minnesota (10)	Mississippi			
		Arizona			
		Arkansas			
		Kentucky			
		Maine			
		Michigan			
		South Carolina			
		Pennsylvania			
		Ohio			
		New York			
		Tennessee			
		Missouri			

Source: U.S. Department of Labor, Office of Workers' Compensation Programs, January 2003; the U.S. Chamber of Commerce, 2003 Analysis of Workers' Compensation Laws, 2003; and various state workers' compensation agency websites, 2004.

Temporary Total Disability (TTD) Benefits

Statutory Compensation Rates for Temporary Total Disability (TTD) Benefits

- TTD benefits (referred to as Temporary Income Benefits or TIBs in Texas) are the most common type of income benefit paid to injured workers. These benefits are generally paid while the injured worker is off work due to an on-the-job injury. Most states, including Texas, pay TTD benefits as a percentage of the worker's gross earnings (i.e., pre-tax earnings).

- Thirty-five states pay TTD benefits based on 66-2/3 percent of the injured worker's gross average weekly wage (AWW), which is lower than the 70 to 75 percent of the average weekly wage paid in Texas (5 states, including Texas, pay TTD benefits at a rate equal to 70 percent of the AWW).[4] **See Table 5.**

- Six states pay TTD benefits based on after-tax earnings (usually at a rate equal to 75-80 percent of a worker's spendable wages).

[4] Weekly Temporary Income Benefits (TIBs) are paid to injured workers in Texas at a rate of 70 percent of the gross average weekly wage (AWW) if they earn more than $8.50 per hour. If the employee earns less than $8.50 per hour, TIBs are paid at a rate of 75 percent of the gross AWW for the first 26 weeks of disability and 70 percent thereafter.

- The remaining states pay TTD benefits at various percentages of a worker's gross average weekly wage (e.g., Massachusetts - 60 percent of the AWW, Idaho - 72 percent of the AWW).

Table 5 State-by-State Comparisons of Temporary Total Disability (TTD) Benefit Rates and Benefit Duration as of January 2003

State	TTD Weekly Compensation Rate (as a % of the worker's average weekly wage)
Alabama	66 2/3%
Alaska	80% of after tax earnings
Arizona	66 2/3%
Arkansas	66 2/3%
California	66 2/3%
Colorado	66 2/3%
Connecticut	75% of after tax earnings
Delaware	66 2/3%
Florida	66 2/3%
Georgia	66 2/3%
Hawaii	66 2/3%
Idaho	67%
Illinois	66 2/3%
Indiana	66 2/3%
Iowa	80% of after tax earnings
Kansas	66 2/3%
Kentucky	66 2/3%
Louisiana	66 2/3%
Maine	80% of after tax earnings
Maryland	66 2/3%
Massachusetts	60%
Michigan	80% of after tax earnings
Minnesota	66 2/3%
Mississippi	66 2/3%
Missouri	66 2/3%
Montana	66 2/3%
Nebraska	66 2/3%
Nevada	66 2/3%
New Hampshire	60%
New Jersey	70%
New Mexico	66 2/3%
New York	66 2/3%
North Carolina	66 2/3%
North Dakota	66 2/3%
Ohio	72% for first 12 weeks, 66 2/3% thereafter
Oklahoma	70%
Oregon	66 2/3%

Table 5
State-by-State Comparisons of Temporary Total Disability (TTD) Benefit Rates and Benefit Duration, *continued* as of January 2003

State	TTD Compensation Rate (as a % of the worker's average weekly wage)
Pennsylvania	66 2/3%
Rhode Island	75% of after tax earnings
South Carolina	66 2/3%
South Dakota	66 2/3%
Tennessee	66 2/3%
Texas	70% for workers who earn over $8.50/hr; 75% for all others
Utah	66 2/3%
Vermont	66 2/3%
Virginia	66 2/3%
Washington	60-75% depending on marital status and # of dependents
West Virginia	70%
Wisconsin	66 2/3%
Wyoming	66 2/3% of actual monthly wages

Source: U.S. Department of Labor, Office of Workers' Compensation Programs, January 2003; the U.S. Chamber of Commerce, 2003 Analysis of Workers' Compensation Laws, 2003; and various state workers' compensation agency websites, 2004.

Permanent Partial Disability (PPD) Benefits

Statutory Eligibility Requirements for Permanent Partial Disability (PPD) Benefits

- Permanent Partial Disability (PPD) benefits (referred to as Impairment Income Benefits - IIBs or Supplemental Income Benefits – SIBs in Texas) are paid to injured workers who have suffered either a permanent impairment or a disability as a result of a work-related injury.[5]

- Forty-two states, not including Texas, pay PPD benefits for the loss of use of particular body parts according to a set benefit schedule.[6] For example, an injured worker who loses the use of a foot in a state with a PPD benefit schedule is compensated for a number of weeks proportional to the degree of impairment or disability the injured worker sustained. **See Table 6.**

[5] "Permanent Impairment" is the permanent loss of physical functioning that directly results from a work-related injury (usually measured by an impairment rating, which represents the percentage of a person's whole body that is impaired as a result of the injury), while "Disability" refers to the economic consequence of a work-related injury (i.e., loss of income or loss of ability to work).

[6] Prior to the 1989 reforms, Texas used a PPD benefit schedule for certain types of injuries.

- All states with benefit schedules also pay PPD benefits for unscheduled injuries. To determine PPD benefits for injuries that are not part of a state's benefit schedule, states use one or more of the following four basic methods (**see Table 7**).[7]

    - Nineteen states, including Texas, use the impairment approach, which only includes the actual physical and psychological loss produced by the injury. In these states, impairment is generally measured by an impairment rating, which is generally assigned by a doctor using the American Medical Association's *Guides to the Evaluation of Permanent Impairment* or another rating guide.[8]

    - Thirteen states use a loss of wage-earning capacity approach to determine unscheduled PPD benefits. This approach estimates the impact of the injury on an injured worker's future wages, often using factors such as age, education, training and skills, the worker's impairment rating and existing labor-market conditions.

    - Ten states use a wage-loss approach, which determines PPD benefits using the difference between the worker's pre- and post-injury wages.

    - Eight states use a bifurcated approach. For workers who have returned to work at or near their pre-injury wage, PPD benefits are determined based on their impairment rating, while other workers' PPD benefits are determined on their loss of wage-earning capacity.

[7] See Barth, Peter and Michael Niss. *Permanent Partial Disability Benefits: Interstate Differences*, Workers' Compensation Research Institute, Cambridge, Massachusetts, 1999.

[8] In Texas, doctors assign impairment ratings to injured workers using the American Medical Association's *Guide to the Evaluation of Permanent Impairment*, fourth edition as mandated by Section 408.124 of the Texas *Labor Code*.

Table 6 States That Use Benefit Schedules to Pay Permanent Partial Disability (PPD) Benefits for Certain Injuries

State	Benefit Schedule Linked to Worker's Pre-Injury Wages	Partial Loss of Use of Body Part Rated Based on	
		Impairment	Disability
Alabama	X	X	
Arizona	X	X	
Arkansas	X	X	
California	X		X
Colorado		X	
Connecticut	X	X	
Delaware	X	X	
Georgia	X	X	
Hawaii		X	
Idaho		X	
Illinois	X		X
Indiana		X	
Iowa	X		X
Kansas	X	X	
Louisiana	X	X	
Maine	X	Not applicable	
Maryland	X	X	
Massachusetts		X	
Michigan	X	Not applicable	
Minnesota		X	
Mississippi	X		X
Missouri	X		X
Nebraska	X	X	
New Hampshire	X	X	
New Jersey	X	X	
New Mexico	X		X
New York	X	X	
North Carolina	X	X	X
North Dakota		X	
Ohio		X	
Oklahoma	X	X	
Oregon		X	
Pennsylvania	X	Not applicable	

Table 6
States That Use Benefit Schedules to Pay Permanent Partial Disability (PPD) Benefits for Certain Injuries, *continued*

State	Benefit Schedule Linked to Worker's Pre-Injury Wages	Partial Loss of Use of Body Part Rated Based on	
		Impairment	Disability
Rhode Island	X	X	
South Carolina	X		X
South Dakota	X	X	
Tennessee	X		X
Utah	X	X	
Virginia	X	X	
Washington		X	
West Virginia	X	X	
Wisconsin	X	X	

Source: Barth, Peter and Michael Niss. *Permanent Partial Disability Benefits: Interstate Differences,* Workers' Compensation Research Institute, Cambridge, Massachusetts, 1999.
Note: Maine, Michigan and Pennsylvania do not schedule partial losses. In Maryland, where impairment is below a certain level, the condition is evaluated on a disability basis. New York pays benefits for certain scheduled losses with impairment ratings at or above 50 percent. In North Carolina, the worker chooses whether the loss is rated as an impairment or a disability.

Table 7 Methods States Use to Pay Permanent Partial Disability (PPD) Benefits for Unscheduled Injuries

State	PPD Benefits Based on			
	Impairment	Loss of Wage-Earning Capacity	Wage Loss	Bifurcated Approach
Alabama				X
Alaska	X			
Arizona			X	
Arkansas				X
California		X		
Colorado	X			
Connecticut	X			
Delaware	X			
Florida	X			
Georgia	X			
Hawaii	X			
Idaho		X		
Illinois		X		
Indiana	X			
Iowa		X		
Kansas				X

Table 7: Methods States Use to Pay Permanent Partial Disability (PPD) Benefits for Unscheduled Injuries, *continued*

State	PPD Benefits Based on			
	Impairment	Loss of Wage-Earning Capacity	Wage Loss	Bifurcated Approach
Kentucky				X
Louisiana			X	
Maine			X	
Maryland		X		
Massachusetts			X	
Michigan			X	
Minnesota	X			
Mississippi		X		
Missouri		X		
Montana				X
Nebraska		X		
Nevada	X			
New Hampshire			X	
New Jersey	X			
New Mexico		X		
New York		X		
North Carolina				X
North Dakota			X	
Ohio			X	
Oklahoma	X			
Oregon		X		
Pennsylvania			X	
Rhode Island			X	
South Carolina		X		
South Dakota	X			
Tennessee				X
Texas	X			
Utah	X			
Vermont	X			
Virginia	X			
Washington	X			
West Virginia	X			
Wisconsin				X
Wyoming		X		

Source: Barth, Peter and Michael Niss. *Permanent Partial Disability Benefits: Interstate Differences*, Workers' Compensation Research Institute, Cambridge, Massachusetts, 1999.

Note: In Connecticut, Minnesota, North Carolina, and Virginia, almost all losses are scheduled.

Statutory Compensation Rates for Permanent Partial Disability (PPD) Benefits

- Most states, including Texas, pay PPD benefits as a percentage of the worker's gross earnings (i.e., pre-tax earnings).

- Twenty-nine states pay PPD benefits based on 66-2/3 percent of the injured worker's gross average weekly wage (AWW), which is lower than the 70 percent of the average weekly wage paid in Texas for IIBs.[9] **See Table 8.**

- Five states pay PPD benefits based on after-tax earnings (usually at a rate equal to 75-80 percent of a worker's spendable wages).

- The remaining states pay PTD benefits at various percentages of a worker's gross average weekly wage (e.g., New Hampshire - 60 percent of the AWW, West Virginia - 70 percent of the AWW).

Table 8 State-by-State Comparisons of Permanent Partial Disability (PPD) Benefit Rates and Benefit Duration, as of January 2003

State	PPD Weekly Compensation Rate (as a % of the worker's average weekly wage)
Alabama	66 2/3%
Alaska	* See Note
Arizona	55%
Arkansas	66 2/3%
California	66 2/3%
Colorado	* See Note
Connecticut	75% of after tax earnings
Delaware	66 2/3%
Florida	50% of workers' weekly TTD benefits
Georgia	66 2/3%
Hawaii	66 2/3%
Idaho	No statutory provision
Illinois	60%
Indiana	66 2/3%
Iowa	80% of after tax earnings
Kansas	66 2/3%
Kentucky	66 2/3%

[9] In Texas, an injured worker begins to receive Impairment Income Benefits (IIBs) once the worker reaches Maximum Medical Improvement (MMI) and receives an impairment rating by the worker's treating doctor or the Texas Workers' Compensation Commission (TWCC) Designated Doctor. For each percentage of impairment, the injured worker receives 3 weeks of IIBs paid at a rate of 70 percent of the worker's gross average weekly wage (AWW). If a worker has an impairment rating of 15 percent or higher, has not returned to work or has returned to work, but is earning less than 80 percent of the worker's pre-injury weekly wage, then the injured worker may be eligible to receive Supplemental Income Benefits (SIBs). SIBs are paid quarterly to injured workers at a rate of 80 percent of the difference between 80 percent of the worker's pre- and post-injury weekly wages.

Table 8
State-by-State Comparisons of Permanent Partial Disability (PPD) Benefit Rates and Benefit Duration, *continued* as of January 2003

State	PPD Compensation Rate (as a % of the worker's average weekly wage)
Louisiana	66 2/3%
Maine	80% of after tax earnings
Maryland	66 2/3%
Massachusetts	60% of the difference between worker's average weekly wage before and after injury
Michigan	80% of after tax earnings
Minnesota	66 2/3%
Mississippi	66 2/3%
Missouri	66 2/3%
Montana	66 2/3%
Nebraska	66 2/3%
Nevada	No statutory provision
New Hampshire	60%
New Jersey	70%
New Mexico	66 2/3%
New York	66 2/3%
North Carolina	66 2/3%
North Dakota	No statutory provision
Ohio	No statutory provision
Oklahoma	70%
Oregon	66 2/3%
Pennsylvania	66 2/3%
Rhode Island	75% of after tax earnings
South Carolina	66 2/3%
South Dakota	66 2/3% for scheduled injuries & 50% for non-scheduled injuries
Tennessee	66 2/3%
Texas	IIBs – 70%; SIBs – 80% of the difference between 80% of the worker's average weekly wage before and after injury
Utah	66 2/3%
Vermont	66 2/3%
Virginia	66 2/3%
Washington	No statutory provision
West Virginia	70%
Wisconsin	66 2/3%
Wyoming	66 2/3%

Source: U.S. Department of Labor, Office of Workers' Compensation Programs, January 2003; the U.S. Chamber of Commerce, 2003 Analysis of Workers' Compensation Laws, 2003; and various state workers' compensation agency websites, 2004.

Statutory Caps on Income Benefits

For Temporary Total Disability (TTD) Benefits:

- Out of fifty states, Texas ties for 34th in terms of statutory maximum weekly payments for TTD benefit payments at $537 week. This level is lower than both the national average of $624.16 and the national median of $588. The $537 limit is considerably lower than the nation's highest TTD benefit level of $1,103 in Iowa and considerably higher than the nation's lowest TTD benefit level of $331.06 in Mississippi. **See Table 9.**

- Of the 44 states that use a percentage of the State Average Weekly Wage (SAWW) to set the maximum TTD benefit payment, the vast majority (50 percent, Texas included) currently set the maximum TTD benefit payment at 100 percent of the SAWW.[10] **See Table 9.**

- Of the 42 states that have a statutory minimum weekly payment amount for TTD benefits, Texas ranks 23rd with a minimum TTD benefit level of $81 per week. The highest minimum TTD weekly benefit level was $374.99 in Pennsylvania and the lowest was $20 in Florida and Arkansas. **See Table 10.**

[10] SB 1574 (78th Legislature, regular session, 2003) statutorily set the state average weekly wage (SAWW) for fiscal year 2004 at $537 and for fiscal year 2005 at $539. Prior to SB 1574 the SAWW was based on the annual average weekly wage of manufacturing production workers in Texas as calculated annually by the Texas Workforce Commission (TWC). Early in the 78th session it was discovered that the methodology that TWC used to calculate this rate had changed and as a result, the cap on workers' compensation income benefits would have increased by an estimated $40 in FY 2004, creating an estimated additional cost to the system of about $5.6 million a year. In response to the need for a statutory change to avoid an unintended increase in the cap on benefits and the short time available for consideration of a new benchmark, SB 1574 set the SAWW for fiscal year 2004 at $537 (the same as in FY 2003) and for FY 2005 at $539. However, it was anticipated that the 79th Legislature would re-examine this issue and set a new benchmark for calculating the SAWW.

Table 9 State-by-State Rankings of Temporary Total Disability (TTD) Benefit Maximums
January 2003
(rankings are from highest to lowest maximum weekly TTD benefit payments)

Rank	State	Maximum Weekly TTD Benefit Payment	Maximum TTD Compensation Rate (as a % of the State Average Weekly Wage)
1	Iowa	$1,103	200%
2	New Hampshire	$1,018.5	150%
3	Illinois	$998.12	133 1/3%
4	Connecticut	$909	100%
5	Massachusetts	$882.57	100%
6	Washington	$868.68	120%
7	Oregon	$865.78	133%
8	Vermont	$865	150%
9	Alaska	$814	120%
10	Minnesota	$750	No provision
11	Maryland	$722	100%
12	Rhode Island	$702	110%
13	Virginia	$681	100%
14	Pennsylvania	$675	100%
15	North Carolina	$674	110%
16	Wisconsin	$669	110%
17	Colorado	$659.12	91%
18	Michigan	$653	90%
19	Missouri	$649.32	105%
20	Ohio	$644	100%
21	New Jersey	$638	75%
22	Florida	$608	100%
23	California	$602	No provision
24	Tennessee	$599	100%
25	Indiana	$588	No provision
26	Nevada	$580.72	100%
27	Hawaii	$580	100%
28	Kentucky	$571.42	100%
29	Alabama	$569	100%
30	South Carolina	$563.55	100%

Table 9 State-by-State Rankings of Temporary Total Disability (TTD) Benefit Maximums January 2003, *continued*
(rankings are from highest to lowest maximum weekly TTD benefit payments)

Rank	State	Maximum Weekly TTD Benefit Payment	Maximum TTD Compensation Rate (as a % of the State Average Weekly Wage)
31	Utah	$562	100%
32	Nebraska	$542	100%
33	New Mexico	$540.07	100%
34	North Dakota	$537	110%
34	Texas	$537	100%
35	Oklahoma	$528	100%
36	Wyoming	$527	100% of State Average Monthly Wage
37	West Virginia	$526.81	100%
38	Delaware	$491.57	66 2/3%
39	Maine	$491.35	90%
40	South Dakota	$482	100%
41	Idaho	$474.3	90%
42	Montana	$473	100%
43	Arkansas	$440	85%
44	Kansas	$432	75%
45	Louisiana	$416	75%
46	Georgia	$400	No provision
46	New York	$400	No provision
47	Arizona	$374.01	No provision
48	Mississippi	$331.06	66 2/3%

Source: U.S. Department of Labor, Office of Workers' Compensation Programs, January 2003; the U.S. Chamber of Commerce, 2003 Analysis of Workers' Compensation Laws, 2003; and various state workers' compensation agency websites, 2004.

Table 10 State-by-State Rankings of Temporary Total Disability (TTD) Benefit Minimums
January 2003
(rankings are from highest to lowest minimum weekly TTD benefit payments)

Rank	State	Minimum Weekly TTD Benefit Payment	Minimum TTD Compensation Rate (as a % of the State Average Weekly Wage)
1	Pennsylvania	$374.99	50%
2	North Dakota	$293	60%
3	Vermont	$288	50%
4	South Dakota	$241	50%
5	Ohio	$214.67	33 1/3%
6	New Hampshire	$203.70	30%
7	Connecticut	$181.80	20% of maximum benefit payment
8	Michigan	$181.24	No provision
9	Massachusetts	$176.51	20%
10	Virginia	$170.25	25%
11	New Jersey	$170	20%
12	Delaware	$163.86	33 1/3%
13	Alabama	$156	27.5%
14	West Virginia	$144.2	33 1/3%
15	Hawaii	$137	25%
16	Minnesota	$130	No provision
17	California	$126	No provision
18	Kentucky	$114.28	20%
19	Louisiana	$111	20%
20	Alaska	$110	No provision
21	Illinois	$100.90	No provision
22	Tennessee	$89.85	No provision
23	Texas	$81	15%
24	Idaho	$79.05	15%
25	South Carolina	$75	No provision
26	Indiana	$50	No provision
27	Oregon	$50	No provision
28	Maryland	$50	No provision
29	Nebraska	$49	No provision
30	Utah	$45	No provision

Table 10
State-by-State Rankings of Temporary Total Disability (TTD) Benefit Minimums as of January 2003, *continued*
(rankings are from highest to lowest minimum weekly TTD benefit payments)

Rank	State	Minimum Weekly TTD Benefit Payment	Minimum TTD Compensation Rate (as a % of the State Average Weekly Wage)
31	Washington	$43.17	No provision
32	Georgia	$40	No provision
33	New York	$40	No provision
34	Missouri	$40	No provision
35	New Mexico	$36	No provision
36	North Carolina	$30	No provision
37	Wisconsin	$30	No provision
38	Oklahoma	$30	No provision
39	Kansas	$25	No provision
40	Mississippi	$25	No provision
41	Florida	$20	No provision
42	Arkansas	$20	No provision

Source: U.S. Department of Labor, Office of Workers' Compensation Programs, January 2003; the U.S. Chamber of Commerce, 2003 Analysis of Workers' Compensation Laws, 2003; and various state workers' compensation agency websites, 2004.

Statutory Time Limitations on Income Benefits

For Temporary Total Disability (TTD) Benefits:

- Texas is one of 18 states that limits the maximum duration of Temporary Total Disability (TTD) benefits to less than the full duration of the injured worker's disability (i.e., the total amount of time an injured worker is off work due a work-related injury). The remaining 33 states pay TTD benefits for the full duration of disability. **See Table 11.**

- Three states, including Texas, limit the duration of TTD benefits to 104 weeks. For the remaining fifteen states with set limits on TTD benefit duration, the maximum numbers of weeks TTD benefits are paid ranges from 156 weeks in Massachusetts and Oklahoma to 500 weeks in Indiana, South Carolina, and Virginia.

For Permanent Partial Disability (PPD) Benefits:

- Texas is one of 29 states that place statutory time limitations on Permanent Partial Disability (PPD) benefits. These statutory time limitations range from a low of 260 weeks in Massachusetts to a high of 1,500 weeks in North Dakota; however, most statutory time limitations, including Texas' 401 week time limit on PPD benefits, range from 300 weeks to 600 weeks. **See Table 11.**

Table 11 State-by-State Comparisons of Temporary Total Disability (TTD) and Permanent Partial Disability (PPD) Benefit Durations

January 2003

State	Maximum TTD Benefit Duration	Maximum PPD Benefit Duration
Alabama	Duration of disability	300 weeks
Alaska	Duration of disability	No statutory provision
Arizona	Duration of disability	Duration of disability
Arkansas	450 weeks	450 weeks
California	Duration of disability	No statutory provision
Colorado	Duration of disability	Duration of disability
Connecticut	Duration of disability	520 weeks
Delaware	Duration of disability	300 weeks
Florida	104 weeks	No statutory provision
Georgia	400 weeks	Based on statutory schedule
Hawaii	Duration of disability	No statutory provision
Idaho	Duration of disability	500 weeks
Illinois	Duration of disability	500 weeks
Indiana	500 weeks	No statutory provision
Iowa	Duration of disability	500 weeks
Kansas	Duration of disability	415 weeks
Kentucky	Duration of disability	425 weeks
Louisiana	Duration of disability	520 weeks
Maine	Duration of disability	364 weeks or duration of disability if impairment rating exceeds 13.2%
Maryland	Duration of disability	Duration of disability
Massachusetts	156 weeks	260 weeks
Michigan	Duration of disability	Duration of disability
Minnesota	104 weeks	No statutory provision
Mississippi	450 weeks	450 weeks
Missouri	400 weeks	400 weeks
Montana	Duration of disability*	350 weeks
Nebraska	Duration of disability	300 weeks
Nevada	Duration of disability	Duration of disability
New Hampshire	Duration of disability	262 weeks
New Jersey	400 weeks	600 weeks
New Mexico	Duration of disability	500 weeks if disability is less than 80%; 700 weeks if greater than 80%
New York	Duration of disability	Duration of disability

Table 11
State-by-State Comparisons of Temporary Total Disability (TTD) Benefit Rates and Benefit Duration, *continued* as of January 2003

State	Maximum TTD Benefit Duration	Maximum PPD Benefit Duration
North Carolina	Duration of disability	300 weeks
North Dakota	Duration of disability	1,500 weeks
Ohio	Duration of disability	No statutory provision
Oklahoma	156 weeks	500 weeks
Oregon	Duration of disability	No statutory provision
Pennsylvania	Duration of disability	500 weeks
Rhode Island	Duration of disability	312 weeks
South Carolina	500 weeks	340 weeks
South Dakota	Duration of disability	Duration of disability
Tennessee	400 weeks	400 weeks
Texas	104 weeks	401 week
Utah	312 weeks	312 weeks
Vermont	Duration of disability	No statutory provision
Virginia	500 weeks	500 weeks
Washington	Duration of disability	No statutory provision
West Virginia	208 weeks	No statutory provision
Wisconsin	Duration of disability	1,000 weeks
Wyoming	Duration of disability	No statutory provision

Source: U.S. Department of Labor, Office of Workers' Compensation Programs, January 2003; the U.S. Chamber of Commerce, 2003 Analysis of Workers' Compensation Laws, 2003; and various state workers' compensation agency websites, 2004.

State Workers' Compensation System Administrative Structures

- Nineteen states, including Texas, have set up a separate state agency to administer the state's workers' compensation system. The remaining thirty-one states have workers' compensation division attached to a larger state agency (generally the equivalent of a division of the Texas Workforce Commission or the Texas Department of Insurance). **See Table 12.**

- A majority of states (27 states) utilize a single commissioner, administrator or presiding judge to oversee the administration of the state's workers' compensation system. Generally these are also the states that have a workers' compensation division attached to a larger state agency.

- The remaining twenty-three states, including Texas, have governing boards that range from three full-time members to sixteen part-time members. The majority of these governing boards are appointed by the Governor of the state.

Table 12 Organizational and Administrative Structures of State Workers' Compensation Systems

All 50 States

State	Organizational Structure	Name	Administrative Structure
Alabama	Division	Department of Industrial Relations	Single administrator
Alaska	Division	Department of Labor & Workforce Development	Twelve member board appointed by the Governor that serves 6 year terms.
Arizona	Division	Industrial Commission of Arizona	Five member commission appointed by the Governor. Commission chairman appointed by Governor for 5 year term.
Arkansas	Separate Agency	Workers' Compensation Commission	Three full time members appointed by the Governor for terms of six (6) years.
California	Division	Department of Industrial Relations	Single administrator
Colorado	Division	Department of Labor & Employment	Single administrator
Connecticut	Separate Agency	Workers' Compensation Commission	Sixteen Workers' Compensation Commissioners nominated by the Governor to serve for 5 year terms.
Delaware	Division	Department of Labor	Ten Board Members each of whom shall be appointed by the Governor for a term of six years.
Florida	Division	Department of Insurance	Single administrator
Georgia	Separate Agency	State Board of Workers' Compensation	Three members who shall be appointed by the Governor for a term of four years.
Hawaii	Division	Department of Labor & Industrial Relations	Single administrator
Idaho	Separate Agency	Industrial Commission	Three members, to be appointed by the Governor, with the approval of the senate for six year terms.
Illinois	Separate Agency	Industrial Commission	Seven members that are appointed by the Governor.
Indiana	Separate Agency	Workers' Compensation Board	Seven members, not more than four from the same political party, appointed by the Governor, one of whom is designated as chairman.
Iowa	Division	Iowa Workforce Development	Single commissioner appointed by the Governor for a six year term.
Kansas	Division	Kansas Department of Human Resources	Single administrator
Kentucky	Division	Department of Labor, Office of Workers' Claims	Single Commissioner under the direction of the Secretary of the Labor.

State	Organizational Structure	Name	Administrative Structure
Louisiana	Division	Department of Labor	Single administrator
Maine	Separate Agency	Workers' Compensation Board	Eight member board selected by the Governor.
Maryland	Separate Agency	Workers' Compensation Commission	Ten Commissioners appointed by the Governor for a twelve year term.
Massachusetts	Separate Agency	Department of Industrial Accidents	Single Commissioner appointed by the Governor serving same term as the Governor.
Michigan	Division	Bureau of Workers' & Unemployment Compensation	Single administrator appointed by the Governor.
Minnesota	Division	Department of Labor & Industry	Single Commissioner appointed by the Governor
Mississippi	Separate Agency	Workers' Compensation Commission	Three Commissioners appointed by the Governor for 6 year terms.
Missouri	Division	Department of Labor & Industrial Relations	Seven Commissioners appointed by the Governor.
Montana	Division	Department of Labor & Industry	Single administrator.
Nebraska	Separate Agency	Workers' Compensation Court	Seven Judges appointed by the Governor for six year terms.
Nevada	Division	Department of Business & Industry	Seven member board appointed by the Governor.
New Hampshire	Division	Department of Labor	Single administrator
New Jersey	Division	Department of Labor	Presiding judge/director
New Mexico	Separate Agency	Workers' Compensation Administration	Workers' Compensation Director appointed by the Governor to serve a five year term.
New York	Separate Agency	Workers' Compensation Board	Thirteen member board appointed by Governor and confirmed by the Senate to serve seven year terms.
North Carolina	Separate Agency	Industrial Commission	Seven member board appointed by Governor for six year terms. Chairman also appointed by Governor.
North Dakota	Separate Agency	Workforce Safety and Insurance	Ten-member Board of Directors appointed by the Governor to serve staggered four year terms.
Ohio	Separate Agency	Bureau of Workers' Compensation	Single administrator
Oklahoma	Division	Department of Labor	Single commissioner who is elected every four years.

State	Organizational Structure	Name	Administrative Structure
Oregon	Division	Department of Consumer & Business Services	Five member board appointed by Governor to serve four year terms.
Pennsylvania	Division	Department of Labor & Industry	Single administrator appointed by Governor.
Rhode Island	Division	Department of Labor & Training	Single administrator
South Carolina	Separate Agency	Workers' Compensation Commission	Seven Commissioners appointed by the Governor for six year terms.
South Dakota	Division	Department of Labor	Single administrator
Tennessee	Division	Department of Labor and Workforce Development	Single administrator
Texas	Separate Agency	Workers' Compensation Commission	Six Commissioners (3 employee and 3 employee representative) appointed by the Governor to serve staggered six year terms.
Utah	Division	Industrial Commission	Single Commissioner to serve at pleasure of the Governor.
Vermont	Division	Department of Labor & Industry	Single administrator
Virginia	Separate Agency	Workers' Compensation Commission	Three Member Board chosen by General Assembly for six year terms.
Washington	Division	Department of Labor and Industries	Single administrator
West Virginia	Division	Bureau of Employment Programs	Three Commissioners appointed by the Governor.
Wisconsin	Division	Department of Workforce Development	Single administrator
Wyoming	Division	Department of Employment	Single administrator

Source: U.S. Department of Labor, Office of Workers' Compensation Programs, January 2003 and various state workers' compensation agency websites, 2004.

Chapter 5 THE DEFENSE BASE ACT (DBA):

The Federally Mandated Workers' Compensation System for Overseas Government Contractors

September 15, 2008

Summary

This report is by the Congressional Research Service with a September 15, 2008 release date. Many overseas federal contractors are covered by the Defense Base Act (DBA), which mandates that they provide workers' compensation insurance for their employees. As the U.S. military has increased operations in Iraq, the size of the DBA program has grown, and in 2007 over $170 million in cash and medical benefits were paid to nearly 12,000 DBA claimants who were injured or killed while working under contract to the federal government.

Congress has become increasingly concerned with the costs involved in the DBA program because the federal government usually reimburses its contractors for their DBA premiums. The Department of State (DOS) and the U.S. Agency for International Development (USAID) have seen some cost savings since adopting a single-source model for their DBA insurance in which contractors for each agency are required to purchase insurance from a single company selected by the agency. The U.S. Army Corps of Engineers (USACE) is currently testing such a model for its DBA system. For the rest of the Department of Defense (DOD), however, including the Army's large Logistics Civil Augmentation Program (LOGCAP) contract, individual contractors are free to select their own DBA insurers and negotiate their own rates. The House of Representatives has included a provision in its version of the FY2009 Defense Authorization bill that would require DOD to change the way its contractors provide DBA coverage for their workers. In addition, the House Committee on Oversight and Government Reform held hearings in 2008 on the DBA. Current DOD DBA policies have also been criticized by the Government Accountability Office (GAO) and the Army's own auditors. It is expected that cost issues associated with the DBA will continue to be the subject of congressional attention for the remainder of the 110th Congress and beyond.

This report provides an overview of the DBA and the systems used to provide DBA insurance at DOS, USAID, DOD, and USACE. Also included are criticisms of the current DOD DBA policy raised by GAO and Army auditors as well as responses to those criticisms by DOD and USACE. The report concludes with a discussion of several DBA reform options suggested by the House of Representatives in recent legislation. This report will be updated to reflect any legislative changes. A list of acronyms used in this report follows-

Appendix: List of Acronyms
AIG: American International Group
ALJ: Administrative Law Judge
CBO: Congressional Budget Office
CFR: Code of Federal Regulations
CPA-IG: Inspector General for the Coalition Provisional Authority

CRS: Congressional Research Service
DBA: Defense Base Act
DFEC: Division of Federal Employees' Compensation, Department of Labor
DLHWC: Division of Longshore and Harbor Workers' Compensation, Department of Labor
DOD: Department of Defense
DOL: Department of Labor
DOS: Department of State
FECA: Federal Employees' Compensation Act
GAO: Government Accountability Office
IG: Inspector General
LOGCAP: Logistics Civil Augmentation Program
LHWCA: Longshore and Harbor Workers' Compensation Act
OIF: Operation Iraqi Freedom
OWCP: Office of Workers' Compensation Programs, Department of Labor
SIGIR: Special Inspector General for Iraq Reconstruction
USAAA: U.S. Army Audit Agency
USACE: U.S. Army Corps of Engineers
USAID: U.S. Agency for International Development
USO: United Service Organizations
WHCA: War Hazards Compensation Act

Workers' Compensation in the United States

Over 130 million private and public sector employees in the United States are covered by some form of workers' compensation (Ishita Sengupta, Virginia Reno, and John F. Burton, Jr., *Workers' Compensation: Benefits, Coverage, and Costs, 2005,* (Washington: National Academy of Social Insurance 2007), p. 9. Hereafter cited as Sengupta et al., *Workers' Compensation,* 2007). Although the details of the various state and federal workers' compensation systems differ, all workers' compensation systems in the United States provide for limited wage replacement and full medical benefits for workers who are injured or become ill as a result of their work and survivors benefits to the families of workers who die on the job. In most cases, workers' compensation is mandated by state law and administered by state agencies. However, for some classes of workers, workers' compensation is mandated by federal law and provided or administered by the federal government. **Table 1** provides summary data on workers' compensation in the United States.

Table 1. Workers' Compensation Coverage, Benefits, and Costs for the United States, 2005	
Covered workers (in millions)	128.1
Covered wages (in billions of $)	5,212
Total benefits paid (in billions of $)	55.3
Medical benefits paid (in billions of $)	26.2
Cash benefits paid (in billions of $)	29.1
Employer costs (in billions of $)[a]	88.8

Source: Ishita Sengupta, Virginia Reno, and John F. Burton, Jr., *Workers' Compensation: Benefits, Coverage, and Costs, 2005,* (Washington: National Academy of Social Insurance 2007), p. 2.
a Employer costs include costs paid for workers' compensation insurance or costs paid for benefits and administration by self-insured firms.

The workers' compensation system is a no-fault system that pays workers for injuries or illnesses related to employment without considering the culpability of any one party. In exchange for this no-fault protection and the guarantee of benefits in the event of an employment-related injury, illness, or death, workers give up their rights to bring actions against employers in the civil court system and give up their rights to seek damages for injuries and illnesses, including pain and suffering, outside of those provided by the workers' compensation laws. With limited exceptions, injuries, illnesses, or deaths that are the result of accidents or incidents that occur in the workplace or that are the result of activities related to employment are covered by workers' compensation. Common exceptions to coverage include injuries caused by the willful misconduct of an employee, the drug or alcohol use of an employee, or "acts of God." Traditionally, only injuries or deaths that resulted from specific accidents were covered by workers' compensation. Modern workers' compensation systems now generally provide coverage for illnesses or other conditions, such as hearing loss, that are the result of prolonged exposure to a dangerous workplace environment.

State and federal laws differ on how private employers may meet their responsibilities to insure against the economic losses to employees from workplace injuries and illnesses. In nearly every state and federal system, firms can self-insure or purchase workers' compensation insurance from private providers or, in some states, from state funds. In five states, firms are required to purchase workers' compensation from state funds. Federal agencies that provide workers' compensation for their employees essentially self insure and are responsible for 100% of the cost of all benefits paid.

Federal Workers' Compensation

Workers' compensation policy is largely determined by the individual states. Each state and the District of Columbia, with the exception of Texas, has its own basic workers' compensation policy that mandates that private-sector employers and state and local government agencies insure against the financial damages caused by employment-related injuries and illnesses and provide no-fault cash and medical benefits to employees who are injured, killed, or become sick on the job. The Texas workers' compensation system is not mandatory for private-sector employers in that state. However, private-sector employers who do not participate in the workers' compensation system can be sued for damages by employees injured on the job.

The federal government has only a limited role in the workers' compensation system and administers workers' compensation programs for federal employees and several limited classes of private-sector workers. In 2005, state workers' compensation programs paid $52.1 billion, or 94.2%, of the $55.3 billion in total cash and medical benefits paid by the workers' compensation system; federal workers' compensation programs paid $3.2 billion, or 5.8%, of total workers' compensation benefits (Sengupta et al., W*orkers' Compensation,* p. 19.).

With limited exceptions, the federal government has traditionally left workers' compensation law and policy to the states. However, the federal government has intervened in workers' compensation policy in three cases. First, the federal government administers a workers compensation program for most federal employees under the Federal Employees' Compensation Act (FECA). Second, the federal government administers workers' compensation

programs for the longshore and harbor and railroad industries because of the interstate nature of those industries. Third, the federal government administers limited workers' compensation systems for coal miners with black lung disease and energy workers with cancer and other diseases caused by exposure to radiation and other toxic substances because state workers' compensation systems have proven unable to provide adequate coverage for these conditions.

The Defense Base Act (DBA)

The Defense Base Act (DBA) requires that many federal government contractors and subcontractors provide workers' compensation insurance for their employees who work outside of the United States. The provisions of the Defense Base Act (DBA) are provided in statute at 42 U.S.C. §§1651-1654 and as part of the Longshore and Harbor Workers' Compensation Act (LHWCA) at 33 U.S.C. §§ 901-950. Regulations implementing the DBA are provided in Parts 701-704 of Title 20 of the Code of Federal Regulations (CFR) and in the Federal Acquisition Regulation at 48 C.F.R. §§ 28.305, 52.228-3, and 52.228-4.

Under the provisions of the DBA, overseas federal military and public works contractors are subject to the same workers' compensation rules, including the same insurance requirements and same schedules of benefits for affected workers, as maritime firms covered by the Longshore and Harbor Workers' Compensation Act (LHWCA). DBA insurance is provided by private companies or through self-insurance and the DBA program is administered by the Department of Labor (DOL). Like all workers' compensation systems, the DBA provides no-fault coverage and is an exclusive remedy to injured workers. Injured workers and the survivors of workers killed on the job are entitled to benefits for employment-related injuries, illnesses, and deaths regardless of fault and are not permitted to sue their employers or the federal government for any types of damages caused by employment-related incidents. Prior to the start of Operation Iraqi Freedom (OIF) in 2003, DBA benefits were paid to several hundred claimants per year. OIF was accompanied by an increase in the number of DBA cases and the total amount spent on DBA claims. The number of DBA cases continues to grow with the caseload increasing more than six-fold between 2004 and 2007 and with 2007 having the largest caseload of the entire OIF period. The average amount of compensation and medical benefits paid per claim in 2007, however, was at the lowest level since 2003. DOL reports that the increase in cases in 2007 was due, in part, to greater compliance efforts that resulted in firms reporting a greater number of claims that involved only minor medical care and no lost work time (*Defense Base Act Insurance: Are Taxpayers Paying Too Much?: Hearing Before the House Committee on Oversight and Government Reform,* 110th Cong., (2008), statement of Shelby Hallmark, Director, Office of Workers' Compensation Programs, Department of Labor. Hereafter cited as Hallmark testimony, 2008). **Table 2**, below, provides an overview of DBA claims paid between 1997 and 2007.

Legislative History

The Defense Base Act, P.L. 77-208, was enacted in 1941 and extended workers' compensation coverage under the Longshore and Harbor Workers' Compensation Act (LHWCA) to persons working on American military bases that were either acquired by the United States from foreign countries or that were located outside of the continental United States. Coverage was extended to public works contractors working outside of the United States in 1942 with the enactment of the War Hazards Compensation Act, P.L. 77-784, which also established the War Hazards Compensation Act (WHCA) program. The most significant amendments to the DBA were enacted in 1958 and extended coverage to non-citizens, to persons working on projects funded under the Mutual Security Act of 1954, and to persons working to provide morale and welfare

services, such as through the United Service Organizations (USO) to the armed forces. These amendments also further defined the types of work covered under the DBA to include service contracts. P.L. 85-477 extended DBA coverage to contracts under the Mutual Security Act of 1954 and to morale and welfare workers; it also further defined public works contracts and extended coverage to service contracts. P.L. 85-602 extended DBA coverage to non-citizens. In 2006, Congress directed the Department of Defense (DOD) to examine ways it could improve its DBA procedures (P.L. 109-163). Legislation passed by the House of Representatives in 2008 would require DOD to establish a single DBA strategy and provides a list of options for DOD to consider when designing this strategy (H.R. 5658; as of this report, the Senate has not taken any action on this bill).

Table 2. Total Defense Base Act (DBA) Payments, 1997 to 2007

Year	Cases Paid	Cash Benefits for Wage Loss and Survivors ($)	Medical Benefits for Covered Injuries and Illnesses ($)	Total Benefits ($)	Average Benefits per Case ($)
1997	432	4,905,081	1,203,217	6,108,298	14,140
1998	423	5,497,439	2,194,012	7,691,451	18,138
1999	269	3,724,290	1,727,703	5,451,993	20,268
2000	309	6,268,112	2,314,654	8,582,766	27,776
2001	516	7,212,869	2,198,061	9,410,930	18,238
2002	430	5,480,592	2,101,403	7,581,995	17,633
2003	688	7,885,666	3,452,728	11,338,394	16,480
2004	1,592	19,432,369	10,647,020	30,079,389	18,894
2005	3,080	36,140,994	23,656,467	59,797,461	19,415
2006	5,039	66,973,732	48,781,929	115,755,661	22,972
2007	11,887	100,319,949	69,815,704	170,135,653	14,313

Source: *Defense Base Act Insurance: Are Taxpayers Paying Too Much?: Hearing Before the House Committee on Oversight and Government Reform,* 110th Cong., (2008), statement of Shelby Hallmark, Director, Office of Workers' Compensation Programs, Department of Labor.

Basic Provisions of the Defense Base Act (DBA)

The DBA extends the provisions of the LHWCA to federal contractors working outside of the United States. The LHWCA is a federal law that requires that private sector firms provide workers' compensation coverage for their employees engaged in longshore, harbor, or other maritime occupations (11 33 U.S.C. §§ 901-950). Workers' compensation insurance under the LHWCA can be provided either by a private carrier approved by the DOL or through a self-insurance system. Injured workers covered by the LHWCA and DBA are entitled to full medical benefits to treat their injuries provided by a physician of their choice. Injured workers are also entitled to cash disability benefits to replace a portion of their lost wages. The basic weekly LHWCA and DBA disability benefit is equal to two-thirds of a worker's pre-disability weekly

wage. Under the LHWCA and DBA, benefits for total disability are capped at 200% of the national average weekly wage; benefits for partial disability are capped on the basis of a schedule of impairments. For example, a covered worker is entitled to receive benefits for a maximum of 312 weeks if he or she loses an arm at the shoulder and 160 weeks if he or she loses an eye. The complete schedule of maximum partial disability benefits is provided in law at 33 U.S.C. § 908(c). Benefits are also paid to survivors of covered workers killed on the job.

DBA Eligibility

Section 1 of the DBA applies the basic workers' compensation protections and benefits of the LHWCA to the following four categories of private-sector employees working as federal contractors:

- employees who work on U.S. military, air or naval bases outside of the United States, including bases located in U.S. territories;
- employees who work on public works projects outside of the United States under contract to any federal agency;
- employees who work outside of the United States on projects funded by the federal government under the provisions of the Mutual Security Act of 1954 that provide for the sale of military equipment or services to American allies (The Mutual Security Act of 1954 was replaced by the Foreign Assistance Act, codified at 22 U.S.C. § 2151 et seq., in 1961. For additional information on the Foreign Assistance Act, see CRS Report RL34243, *Foreign Aid Reform: Issues for Congress and Policy Options,* by Susan B. Epstein and Connie Veillette).
- employees who work for American firms providing morale, welfare, or similar services to the armed forces outside of the United States.

Work performed under a grant from the federal government is not covered by the DBA. The U.S. Court of Appeals for the Second Circuit held in *University of Rochester v. Hartman*, 618 F. 2d. (2nd Cir. 1980), that an employee injured in Antarctica while working on a scholarly research project funded through a grant from the National Science Foundation was not covered by the DBA. DOL has adopted a position, which it claims is consistent with this decision, that work done pursuant to a federal grant is not covered by the DBA.

DBA Insurance

The DBA is a privatized workers' compensation insurance program. Benefits are not paid by the federal government but rather are the responsibility of a covered worker's employer. Employers subject to the DBA can purchase insurance from a private provider approved by the DOL or, with the permission of DOL, self-insure. Firms that fail to provide compensation for their injured employees covered by the DBA can be subject to criminal prosecution and the firm and its officers can be subject to civil suits brought by the injured workers.

Insurance Through Private Carriers. Contractors covered by the DBA may purchase workers' compensation insurance from private carriers approved by the DOL. Currently, the major providers of DBA insurance coverage are ACE-USA, American International Group (AIG), and CNA.1515 Department of Labor, *Defense Base Act: Workers' Compensation for Employees of U.S. Government Contractors Working Overseas,* page 2, available on the website of DOL at [http://www.dol.gov/esa/owcp/dlhwc/ExplainingDBA.pdf]. A complete list of authorized DBA carriers is available on the website of DOL at [http://www.dol.gov/esa/owcp/ dlhwc/lscarrier.htm].

Self-Insurance. Insurance prices can be quite variable, moving between "hard market" periods with higher premiums and difficulties for consumers finding insurance and "soft market" periods

with low premiums and relatively easy availability. Particularly when faced with high premiums, some insurance consumers choose not to purchase insurance from an insurance company but instead choose to "self-insure." Self-insurance is a very broad term, possibly covering any situation in which an entity chooses to retain a risk rather than purchasing insurance. Self insurers can cover a spectrum from (1) entities who essentially ignore a risk and take few, if any, steps to financially prepare for a loss; to (2) entities who consider and evaluate risks, while perhaps setting up some sort of savings or reserve accounts to pay for future losses; to (3) entities who set up a legally licensed insurance company, known generally as a captive insurer, to whom actuarially determined premiums are paid but ownership of the insurer is retained by the insured, so both profits and risks are also retained by the insured.

Because the DBA mandates workers' compensation insurance for federal contractors overseas, the first self-insurance option, essentially ignoring the risk, is generally not an option. Under the DBA, however, employers do have the option to self-insure if they meet certain financial criteria and are approved to do so by DOL. The DOL's Procedure Manual outlining the authorization of self-insurers is available on the website of the DOL at http://www.dol.gov/esa/owcp/dlhwc/lspm/lspm7-400.htm]. The full regulations for self-insurers can be found at 20 CFR §§ 703.301-703.313. Under the federal regulations, self-insurers are not required to go so far as to set up captive insurers in order to self-insure. Nearly 170 employers are listed by DOL as authorized self-insurers. See the website of the DOL at [http://www.dol.gov/esa/owcp/dlhwc/lscarrier.htm]. Firms may also self-insure under most state workers' compensation laws, and according to the Self-Insurance Institute of America, more than 6,000 corporations and their subsidiaries self-insure their workers' compensation risks (Self-Insurance Institute of America, *Workers' Compensation Programs*, available on the website of the Self-Insurance Institute of America at [http://www.siia.org/i4a/pages/index.cfm?pageid=3284]).

Many self-insurers still purchase some form of insurance, typically a "catastrophic" policy that would take effect if extraordinarily high losses occurred, and federal rules actually require such a policy. Many self-insurers also hire third-party administrators, who undertake much of the administrative burden of dealing with claims but without assuming any of the financial risk. Choosing to self-insure is a decision taken on a wide variety of business grounds. In general, those self-insuring are seeking to reduce insurance costs and ensure the availability of insurance. Self-insurance can reduce costs through three primary mechanisms. First, any profits that would have flowed to the insurer could be captured by the self-insurer; second, the self-insurer may be able to save on administrative costs, either by undertaking the administration in-house or finding a more efficient third-party administrator; and third, if the self-insurer is a relatively low-risk, its costs would be lower if it were not pooled with other, higher risk parties.

DBA Waivers

The Secretary of Labor may, at the request of a federal agency, grant a waiver that exempts a firm from the DBA if the firm can demonstrate that an alternative workers' compensation system that provides benefits in the case of disability or death is in place to cover the firm's employees. DBA waivers do not apply to American citizens or nationals or to persons hired within the United States.

DBA Benefits for Foreign Nationals

The DBA covers all eligible federal contractors, including non-U.S. citizens and foreign nationals. Foreign nationals receive the same DBA benefits as U.S. citizens or nationals with two exceptions. First, benefits for the survivors of a foreign national who was not a resident of

the United States or Canada are only available to the worker's surviving spouse and children or, if there is no spouse or children, the worker's surviving father or mother, provided that the worker supported the father or mother for at least one year before the worker's death. The eligibility for survivors benefits for foreign nationals is more limited than that for American citizens and nationals. Survivors benefits in the case of the death of an American citizen or national can be paid to the worker's spouse, children, siblings, parents, grandparents, or grandchildren. Second, permanent disability benefits or survivors benefits payable for foreign nationals who are not residents of the United States or Canada may be commuted from installment payments to a single lump-sum payment equal to one-half of the present value of the future compensation. The decision to commute benefit payments for foreign nationals is made by the Secretary of Labor and can be requested by the insurance carrier responsible for paying benefits.

DBA Administration

The DBA is administered by the DOL, Office of Workers' Compensation Programs (OWCP), Division of Longshore and Harbor Workers' Compensation (DLHWC). DBA claims are processed through one of ten regional offices, with all claims originating in Iraq and Afghanistan processed through the New York office.

Dispute Resolution. An applicant dissatisfied with the decision made on his or her DBA claim may request a hearing before a DOL Administrative Law Judge (ALJ). The decision of a DOL ALJ can be appealed to the DOL Benefits Review Board, and the decisions of this board may be appealed to the U.S. District Court. In addition to this formal process for adjudicating claims, the DOL has an informal dispute resolution process that seeks to bring the worker and his or her insurer or employer together either over the telephone or in an informal conference to resolve the dispute before an ALJ hearing is required. DOL reports that 8.2% of all DBA cases originating in Iraq or Afghanistan between 2001 and 2005 involved claims disputes (Hallmark testimony, 2008).

War Hazards Compensation Act (WHCA)

The War Hazards Compensation Act (WHCA) supplements the DBA by providing a form of reinsurance for injuries and deaths to contractors directly related to military conflict (42 U.S.C. § 1701 et seq.) If an employee's injury or death is caused by a war hazard, the workers' compensation benefits are provided not by the insurer or employer but by the federal government. Under the provisions of the WHCA, an injury or death is considered to have been caused by a war hazard if it occurred during-

- a war in which the United States is engaged;
- an armed conflict in which the United States is engaged, whether or not war has been formally declared; or
- during a war or armed conflict between military forces of any origin in a country in which a covered employee is working.

and if the injury or death was caused by

- the discharge of any weapon by a hostile force or in combating an attack;
- the action of a hostile force or person, including an insurrection or rebellion against the

- the discharge of any munitions intended for use against a hostile force;
- the collision of vessels in convoy, or the operation of vessels or aircraft without running

- the operation of vessels or aircraft in a hostile zone or engaged in war activities.

For the purposes of the WHCA, a covered employee includes any person covered under the DBA, any person working outside of the United States under a personal services contract with the federal government, and any person working as a civilian employee paid by nonappropriated funds under the jurisdiction of the Department of Defense, such as an employee of a military post exchange or officer's club. Generally, an insurance carrier or self-insured employer will first pay DBA benefits to an injured worker or his or her survivors and then seek reimbursement from DOL under the WHCA Insurers and employers may be reimbursed for benefits paid and itemized and non-itemized administrative costs associated with the claim. Non-itemized administrative costs are capped by regulation at 15% of the total value of the benefits due on a claim (20 C.F.R. § 61.104). A claim is not reimbursed under the WHCA if the insurance carrier charged an additional premium, referred to as premium loading, to cover the specific war hazard that caused the injury or death. WHCA benefits are paid out of the Employees' Compensation Fund, which also pays workers' compensation benefits for federal employees under the Federal Employees' Compensation Act (FECA). The Federal Employees' Compensation Act (FECA) is codified at 5 U.S.C. § 8101 et seq. The WHCA is administered by the DOL OWCP Division of Federal Employees' Compensation (DFEC), and the DFEC makes determinations on whether claims should be paid under the WHCA. WHCA claims make up a relatively small percentage of the total DBA claims that originate in Iraq and Afghanistan. Between 2003 and the end of March 2008, over 27,000 DBA claims have been filed for cases originating in Iraq and Afghanistan. However, during that same time period, 252 WHCA claims have been Filed (Hallmark testimony, 2008). Thus, even in two military operations in which the United States is fighting insurgent enemy forces without clearly established front lines and in which contractors are playing significant roles, WHCA claims make up less than 1% of all DBA claims filed. Among the WHCA cases that have been paid since 2003, a total of $5,207,461 has gone for compensation and benefits, whereas $7,610,260 has gone to reimburse insurers for itemized and non-itemized administrative expenses associated with these claims.

Selection of Defense Base Act (DBA) Providers

Although many federal agencies have had or currently have overseas contracts subject to the DBA, the Departments of State (DOS) and Defense (DOD) and the U.S. Agency for International Development (USAID) are the major DBA contractors operating in Iraq and Afghanistan. These agencies take different approaches to contracting for insurance services under the DBA. DOS and USAID have awarded competitive contracts through the use of blanket contracts, with fixed rates, to a single provider for each agency. In contrast, under the DOD approach private contractors negotiate individually with private insurers. Over time, evidence has shown that rates for DBA insurance charged to DOD have been significantly higher than DBA insurance rates for DOS and USAID (*Defense Base Act Insurance: Are Taxpayers Paying Too Much?: Hearing Before the House Committee on Oversight and Government Reform,* 110th Cong., (2008), statement of John K. Needham, Director, Acquisition and Sourcing Management Issues, Government Accountability Office. Hereafter cited as Needham testimony, 2008).

Much of the recent attention focused on the DBA program has been due to the media reports of the experience of contractors in combat operations in Iraq and Afghanistan. According to testimony at a recent congressional hearing on the DBA, 90% of DBA business is for DOD contracts (*Defense Base Act Insurance: Are Taxpayers Paying Too Much?: Hearing Before the House Committee on Oversight and Government Reform,* 110th Cong., (2008), statement of Hon. Henry Waxman, Chairman). The DBA program came to the attention of the media in part because of a lawsuit filed against Blackwater Worldwide by the families of four contractor

employees killed in Iraq in March 2004. Blackwater Worldwide had asserted that it was immune from any civil litigation because the contractor employees were working under a contract with DOD and thus covered by the exclusive remedy of the DBA. This case, as well as a countersuit against the plaintiffs filed by Blackwater Worldwide, is pending [as of this report]. The U.S. District Court case involving Blackwater's petition for arbitration is currently stayed pending an appeal before the U.S. Court of Appeals (*Blackwater Security v. Nordan*, No. 07-1508 (4th Cir.)); a related case is also pending in the Superior Court of Wake County, North Carolina (*Nordan v. Blackwater Security Consulting*, No. 07CVS7061).

Department of State (DOS) and the U.S. Agency for International Development (USAID)

Before 1990, DOS required contractors to obtain DBA insurance independently, resulting in a variety of rates on the basis of company size, claims history, and work site. This arrangement proved particularly onerous for small businesses with limited overseas experience. Such companies found it difficult to obtain insurance, and when insurance was possible, they paid significantly higher premiums. However, a DOS Inspector General (IG) found that costs could be reduced through the use of a blanket contract to a single provider. In 1991, DOS competitively awarded a multiyear contract to CIGNA Property and Casualty Insurance Company. As a result, in 2000 DOS conducted a competition for a follow-on, multi-year contract. Four companies competed: CIGNA, AIU, Ace International, and CNA. CNA was competitively awarded the DOS contract in 2001 and has held the contract since that time. DOS issued a formal notice in April 2008 of its intent to solicit bids for a permanent contract for DBA insurance (*Defense Base Act Insurance: Are Taxpayers Paying Too Much?: Hearing Before the House Committee on Oversight and Government Reform,* 110th Cong., (2008), statement of William Moser, Deputy Assistant Secretary of State for Logistics Management, Department of State). USAID, like DOS, has a single insurer program that requires all contractors performing work overseas to purchase DBA insurance from a specific insurance carrier at a set rate. USAID's current rate for DBA insurance is the lowest among the three agencies, at $1.58 per $100 of salary costs. This is a single rate for DBA coverage for all USAID contractors worldwide (Needham testimony, 2008).

Department of Defense (DOD)

The Department of Defense (DOD) permits its overseas contractors to purchase DBA insurance from any insurance company approved by DOL. In 1996, DOD studied the DBA issue and compared its rates with a sampling of rates paid by DOS and USAID. At that time, DOD officials concluded that their rates were lower, in most cases, than rates paid by DOS and USAID, and that DOD contractors as a whole did not report difficulty in securing appropriate DBA insurance coverage for their employees. Furthermore, DOD rejected the use of a single payer insurance system, reportedly because of the opinion that such a system would not provide enough incentives for companies to improve safety practices to keep rates more competitive.

Government Accountability Office (GAO) Audit and Review of the DBA Program.

Largely in response to congressional concerns, the Government Accountability Office (GAO) conducted an audit and review of the entire DBA program in April 2005. (Government Accountability Office, *Defense Base Act Insurance: Review Needed of Cost and Implementation Issues*, GAO 05-280R, (Washington: GPO 2005), p. 1). GAO reports that over 100 Members of Congress requested a review of a number of Iraq-related issues, including issues involving the DBA. The Comptroller General initiated this review under his statutory authority and the objectives of this review were, according to the final report, "to identify the cost to the Federal government for all insurance coverage purchased under DBA and to assess the Act's implementation."

GAO reviewed DBA claims for DOS, USAID, DOD, and other federal agencies that have issued contracts for Iraq reconstruction and to support deployed forces. In its investigation, GAO reported significant problems with its ability to determine the total cost of the program because it was difficult to gather and analyze data on large numbers of contractors and multiple layers of subcontractors. GAO found it difficult to analyze wide variations in the amounts federal government agencies were paying for DBA insurance or explain inordinate delays in the processing of claims. GAO also reported that it could not calculate the impact that DBA insurance costs had on reconstruction activities in Iraq. GAO found that DOD contractors were being charged premiums that ranged between $10 and $21 per $100 of employee salary. Thus, if an employee earned $100,000 a year, DBA insurance costs could run as high as $21,000.

Congressional Response to GAO's Audit of the DBA Program.
Largely as a result of the GAO report, Congress, with the passage of the National Defense Authorization Act for FY2006, P.L. 109-163, directed DOD to conduct a full review of its DBA program. Section 1041 of P.L. 109-163 requires that this review address-

- cost-effective options for acquiring DBA insurance;
- methods for coordinating DBA data collection efforts among agencies and contractors;
- improved communication and collaboration within and among agencies on DBA insurance implementation; and
- actions to be taken to address difficult DBA issues including cost, data, enforcement, and claims processing.

Section 1041(c) of the law also required DOD to submit to Congress a report on the results of its review of the agency's DBA policies and procedures.

DOD's Response to GAO's Audit of the DBA Program.
In response to the requirements of Section 1041(c) of P.L. 109-163, DOD issued a report to Congress on its DBA activities in February 2007 (Department of Defense. *Report to Congress: Review of DBA Insurance pursuant to the National Defense Authorization Act for Fiscal Year 2006,* February 27, 2007, p. 5. Hereafter cited as DOD, *Report to Congress,* 2007). DOD's report discussed DBA related data collection efforts among various federal government agencies. According to the DOD report, since 2003, DOL has provided the Special Inspector General for Iraq Reconstruction (SIGIR) with quarterly reports of DBA claims activity in Iraq. The Special Inspector General for Iraq Reconstruction (SIGIR) replaced the Inspector General for the Coalition Provisional Authority (CPA-IG) in 2004 with the enactment of the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005, P.L. 108-375. As provided for in P.L. 108-106, the SIGIR provides for independent and objective audits, analyses, and investigations into the use of U.S.-appropriated resources for Iraq relief and reconstruction. The SIGIR, Stuart W. Bowen, Jr., was appointed as CPA-IG on January 20, 2004. He reports to both DOS and DOD, provides quarterly reports and semi-annual reports to Congress, and has offices in Baghdad and Arlington, VA. For a summary of the history of U.S. reconstruction assistance in Iraq, see CRS Report RL31833, *Iraq: Recent Developments in Reconstruction Assistance*, by Curt Tarnoff.

According to the report, while DOL has statutory responsibility for administering the DBA claims processing for all agencies, federal agencies do not undertake independent efforts to collect specific DBA data. According to the report, "such data collection efforts would be expensive and would divert already limited contracting resources, without any clear benefit to the procurement process" (DOD, *Report to Congress*, 2007, p. 3). The report later asserts that DOD does not view any additional independent data collection efforts on its part as necessary stating that DOL

already provides for sufficient collection of DBA data and is responsible for monitoring the processing of DBA claims. DOD also stated that its personnel with responsibilities for overseas contracting are already aware of the DBA and its various requirements (Id. p. 4).

U.S. Army Corps of Engineers (USACE) Pilot Program.

Shortly after the 2005 GAO report, DOD began working closely with the U.S. Army Corps of Engineers (USACE) to conduct a competition to award a contract for a pilot DBA project based on the DBA programs already in place at DOS and USAID. CNA was the only company to submit a proposal and was awarded the contract. The contract was awarded in November 2005 and coverage began in December 2005 with coverage extending through March 2008. DOD's report to Congress discussed the early results under the USACE pilot program. After the first six months of the pilot program, USACE reported that estimated savings to the federal government on DBA insurance costs already had exceeded more than $19 million (Id. p. 5). On the basis of these results, the pilot program was extended through September 2008. The Department of the Army announced that a new contract will soon be competitively awarded for a permanent single-insurer program. At the May 15, 2008, hearing of the House Committee on Oversight and Government Reform on the DBA, Richard Ginman of the Office of the Deputy Undersecretary of Defense for Acquisition, Technology and Logistics, projected that continued success with the USACE pilot program would, in all likelihood, make it a permanent DOD program stating:

> Although the contract for the pilot program is continuing, the USACE in February 2008 decided to make the program permanent. A goal of the pilot program was to provide data to build and present to our office and the Army, a formal business case to determine if the pilot should be expanded Army or DoDwide. To help USACE develop such a case, the Army Audit Agency recently agreed to the Army's request (through the Deputy Assistant Secretary of the Army, Policy and Procurement) to review the results of the two-year pilot program to determine if it warranted permanent placement at the USACE and warrant further extension in the Army. Once Army Audit's review is complete, USACE will develop the business case and we will review the results to determine the Department's next steps.

From *Defense Base Act Insurance: Are Taxpayers Paying Too Much?: Hearing Before the House Committee on Oversight and Government Reform,* 110th Cong., (2008), statement of Richard Ginman, Deputy Director for Defense Procurement and Acquisition Policy, Office of the Deputy Under Secretary of Defense for Acquisition, Technology and Logistics.

GAO Re-Examination of the DBA Program.

The GAO examined the DBA program again in 2008 and reported that although DOD's single insurer pilot program through USACE has reduced DOD's DBA rates, DOD has not implemented a department-wide program to reduce rates. GAO also concluded that DOD lacks reliable data on the total amount of funds spent on DBA insurance claims across the agency (Needham testimony, 2008).

Costs to the Federal Government

Although the DBA requires that federal contractors working overseas either purchase workers' compensation insurance for their employees or self-insure, the costs of this insurance is usually passed along to the federal government as a cost item in the contract. If the agency is purchasing services under a cost-plus contract, the contractor receives a set percentage of the total cost of all items, including DBA insurance, billed to the federal government. In cost-plus contracts, the contractor's fees rise with contract costs. There is no incentive for the contractor

to limit the government's costs. Because DOD requires that nearly all of its contractors purchase DBA insurance separately, it is not possible to compare its overall DBA costs with those of DOS and USAID. However, it is possible to compare the costs of DBA insurance purchased through the USACE pilot program with the costs of DBA insurance paid by DOS and USAID contractors. In 2008, USAID contractors paid the lowest DBA insurance premiums at $1.58 per $100 in payroll for all workers. Contractors in the USACE pilot program paid lower premiums than did DOS contractors on their service workers. **Table 3**, below, provides DBA insurance premiums for contractors in the USACE pilot program, DOS and USAID.

DBA Costs Associated with the Department of the Army's Logistics Civil Augmentation Program (LOGCAP) Contract

The Logistics Civil Augmentation Program (LOGCAP) was established by the Department of the Army on December 6, 1985, with the publication of Army Regulation 700-137. LOGCAP is an initiative to manage the use of civilian contractors who perform services in support of DOD missions during times of war and other military mobilizations. For a detailed discussion of the origin, background, and current issues with the Department of the Army's LOGCAP program, see CRS Report RL33834, *Defense Contracts in Iraq*, by Valerie Bailey Grasso.LOGCAP contracts are intended to augment combat support and combat service support to military forces. Prior to OIF, LOGCAP contracts have been awarded for work in Rwanda, Haiti, Saudi Arabia, Kosovo, Ecuador, Qatar, Italy, southeastern Europe, Bosnia, and South Korea. Under LOGCAP, private sector contractors are used to provide a broad range of logistical and other support services to U.S. and allied forces during combat, peacekeeping, humanitarian and training operations.

Table 3. DBA Insurance Premiums for the U.S. Army Corps of Engineers (USACE) Pilot Program, the Department of State (DOS), and the U.S. Agency for International Development (USAID), 2008

Agency	Insurer	Premium for Service Workers (rate per $100 in salary)	Premium for Construction Workers (rate per $100 in salary)
USACE Pilot Program	CNA	$3.50	$7.25
DOS[a]	CNA	$3.87 to $6.45	$5.00 to $8.34
USAID	CNA	$1.58 (for all workers)	

Source: Congressional Research Service (CRS) table compiled from *Defense Base Act Insurance: Are Taxpayers Paying Too Much?: Hearing Before the House Committee on Oversight and Government Reform,* 110th Cong., (2008), statements of James Dalton, Chief of Engineering and Construction, U.S. Army Corps of Engineers; William Moser, Deputy Assistant Secretary of State for Logistics Management, Department of State; and John Needham, Director, Acquisition and Sourcing Management Issues, Government Accountability Office.
a. DOS contractors pay separate premiums of $10.30 for security services without aviation and $17.50 for security services with aviation.

Although the LOGCAP program began in 1985, the program has been the subject of intense scrutiny since the start of OIF. The LOGCAP troop support contract in Iraq has been the subject of several congressional hearings. The contract is the largest single contract for combat operations in Iraq to date. Policymakers continue to express concern over the reported lack of

oversight of LOGCAP contracts in Iraq for several reasons, including the expense and difficulty of managing large-scale logistical support contracts; allegations and reported instances of contract waste, fraud, abuse, and financial mismanagement; and questions regarding DOD's ability and capacity to manage such contracts. See the Special Inspector General for Iraq Reconstruction, *Quarterly Report to Congress, April 30, 2008*.

Congressional concerns over the DBA insurance program have been driven, in part, by the lack of transparency and oversight of the overall costs incurred under the LOGCAP program. Recent assessments from the GAO, DOD's Inspector General (IG), and the SIGIR reveal a lack of federal oversight, management, and accountability for funds spent for Iraq contracting. An audit conducted by the DOD IG revealed that the federal government failed to substantiate the disbursement of at least $7.8 billion of $8.2 billion dollars spent for goods and services in Iraq. In a May 22, 2008, congressional hearing before the House Oversight and Government Reform Committee, DOD officials revealed estimates that the Army disbursed $1.4 billion in commercial payments that lacked the minimum supporting justification and documentation for a valid payment, such as certified vouchers and invoices. In one reported instance, a $320 million payment in cash was made without justification beyond a signature (*Accountability Lapses in Multiple Funds for Iraq*: *Hearing Before the House Committee on Oversight and Government Reform,* 110th Cong. (2008), statement of Mary L. Ugone, Deputy Inspector General for Auditing, Office of the Inspector General, Department of Defense).

U.S. Army Audit Agency (USAAA) Report on DBA Insurance under LOGCAP.

In early 2007, an audit of the DBA program was initiated by the U.S. Army Audit Agency (USAAA) due to several factors, including the growing complexity of the DBA program, rising program costs, wide fluctuations in insurance rates, and the federal government's efforts to reduce and avoid future program costs. In September 2007, the USAAA released its audit report. The USAAA does not publicly release its audit reports. However, the House Committee on Oversight and Government Reform has posted a copy of this report, *Audit of Defense Base Insurance for the Logistics Civil Augmentation Program, Audit of Logistics Civil Augmentation Program Operations in Support of Operation Iraqi Freedom*, on its website at [http://oversight.house.gov/documents/20080515102103.pdf].

Army auditors found that KBR, the LOGCAP contractor, paid approximately $284.3 million in DBA premiums during the period from FY2003 through FY2005. These premiums rose steadily each fiscal year from approximately $4.7 million in FY2003 to approximately $164.7 million in FY2005. During the period covered by the USAAA audit and this report, KBR was the exclusive LOGCAP contractor under a contract referred to as LOGCAP III. On April 17, 2008 the Department of the Army announced that it was awarded its latest LOGCAP contract, known as LOGCAP IV, to KBR, DynCorp International, and Fluor Corporation. As a result of these premiums, the auditors concluded that DBA insurance represented a "significant and recently increasing cost element" of the overall LOGCAP contract.4646 U.S. Army Audit Agency, *Audit of Defense Base Insurance for the Logistics Civil Augmentation Program, Audit of Logistics Civil Augmentation Program Operations in Support of Operation Iraqi Freedom*, Audit Report A-2007-0204-ALL, September 28, 2007, p. 5. Hereafter cited as USAAA, Audit of Defense Base Insurance.

USAAA found that whereas total LOGCAP DBA costs rose between FY2003 and FY2005, DBA premiums for Iraq and Kuwait as a percentage of total payroll increased from FY2003 to FY2004 and then declined in FY2005 and FY2006. The audit also found that these rate fluctuations appeared inconsistent with the risks associated with providing DBA insurance for this contract.

In addition, the audit found that the LOGCAP contractor reported accident rates that were lower than the U.S. private industry average yet it was paying higher than industry-average worker's compensation premiums. **Table 4** provides the LOGCAP DBA premiums for Iraq and Kuwait for the period between FY2002 and FY2006.

Table 4 Defense Base Act (DBA) Premiums for the Logistics Civil Augmentation Program (LOGCAP) Contract in Iraq and Kuwait, FY2002 to FY2006

Fiscal Year	Premium (rate per $100 in salary)	Percent Change in Premium from Previous Fiscal Year
2002	3.75	NA
2003	3.75	0.0%
2004	16.20	332.0%
2005	13.80	(14.8%)
2006	8.50	(38.4%)

Source: U.S. Army Audit Agency, *Audit of Defense Base Insurance for the Logistics Civil Augmentation Program, Audit of Logistics Civil Augmentation Program Operations in Support of Operation Iraqi Freedom*, Audit Report A-2007-0204-ALL, September 28, 2007, p. 5.
Notes: Parentheses indicate a decrease from the previous fiscal year. Data does not include subcontractors.

Army auditors found that the Department of the Army paid "substantially" more in DBA premiums than was expected to be paid out in DBA claims. The auditors found that while $284.3 million in DBA premiums were paid under the LOGCAP contract between FY2003 and FY2005, just under 26% of these premiums went to pay the $73.1 million in DBA claims and potential future claims arising from cases during this period. **Table 5** provides data on LOGCAP DBA premiums and potential claims for the period between FY2003 and FY2005. One explanation offered by the USAAA for what it deemed as these "excessive" premiums was the practice of basing DBA premiums on total payroll costs, including costs such as overtime pay and hazard pay while basing DBA benefit amounts, usually two-thirds of pre-injury wages, only on base pay. In his testimony before the House Oversight Committee, Joseph Mizzoni of the USAAA characterized the premiums paid by KBR for LOGCAP DBA insurance as "excessive" (*Defense Base Act Insurance: Are Taxpayers Paying Too Much?: Hearing Before the House Committee on Oversight and Government Reform,* 110th Cong., (2008), statement of Joseph Mizzoni, Deputy Auditor General for Acquisition and Logistics, U.S. Army Audit Agency). In its response to the USAAA audit report, the U.S. Army Sustainment Command stated that KBR, the LOGCAP contractor, does not pay an overtime rate (USAAA, *Audit of Defense Base Act Insurance,* p. Enclosure 5).

Auditors found that between January 1, 2003, and September 30, 2005, KBR paid $23.1 million in premiums on the special incentive payments made to its employees for the hazard pay component of its payroll (USAAA, *Audit of Defense Base Act Insurance*, p. 11). In addition, DBA benefits, but not the wages used to calculate DBA premiums, are capped, and thus a portion of the total premium is paid on salary above the cap that will not be replaced by DBA disability benefits. Because of this, KBR is essentially paying insurance on payroll that does not need to be insured because it can not, by law, be replaced under the provisions of the DBA.

Table 5. Defense Base Act (DBA) Premiums and Claims for the Logistics Civil Augmentation Program (LOGCAP) Contract in Iraq and Kuwait, FY2003 to FY2005			
Fiscal Year	**Premiums Paid ($)**	**Potential Claims ($)**	**Potential Claims as Percentage of Premiums Paid (%)**
2003	4,671,775	9,882,515	211.5
2004	114,992,588	25,329,820	22.0
2005	164,657,004	37,905,929	23.0
Total	*284,321,367*	*73,118,264*	*25.7*

Notes: Potential claims do not include claims under the War Hazards Compensation Act (WHCA) reimbursed by the federal government.
Source: U.S. Army Audit Agency, *Audit of Defense Base Insurance for the Logistics Civil Augmentation Program, Audit of Logistics Civil Augmentation Program Operations in Support of Operation Iraqi Freedom*, Audit Report A-2007-0204-ALL, September 28, 2007, p. 8.

Options for Congress

Current military operations in Iraq and Afghanistan have brought increased congressional attention to several issues surrounding the DBA. Concerns have been raised over the overall cost and variability of DBA premiums paid, the basis for DBA premiums, the costs of the program to the federal government, the manner in which contractors select their DBA providers, and the coordination of the DBA with the WHCA. In 2006, Congress enacted language in the Defense Authorization Act that required the DOD to review its DBA procedures and to work with the DOS and USAID to find ways to more effectively provide DBA insurance to overseas military Contractors (P.L. 109-163). On May 15, 2008, the House Oversight and Government Reform Committee held a hearing on DBA issues that focused on DBA costs involved in the LOGCAP contract as well as the possibility of the DOD adopting a single-source model for DBA insurance similar to what is currently used by DOS, USAID, and USACE as part of its pilot program (*Defense Base Act Insurance: Are Taxpayers Paying Too Much?: Hearing Before the House Committee on Oversight and Government Reform,* 110th Cong., (2008)).

H.R. 5658, the Duncan Hunter National Defense Authorization Act for 2009, as an Outline for Possible DBA Reform

In May 2008, the House of Representatives passed H.R. 5658, the Duncan Hunter National Defense Authorization Act for 2009. Included in this bill is language requiring DOD to adopt a department-wide DBA insurance procedure that will minimize costs, ensure that premium prices are tied to expected claims, minimize risk to DOD, and provide for a competitive DBA marketplace. Although this legislation does not require DOD to adopt any specific DBA strategy, Section 850(c) of the bill does outline several policy options that DOD is required to consider when formulating its overall DBA strategy. These policy options fall into three broad categories of DBA reform that are similar to those mentioned in reviews of the DBA performed by the GAO, the Congressional Budget Office (CBO), the USAAA, and the House Oversight and Government Reform Committee. The three categories of policy options are-

- using a single contracted source, or a limited set of contracted sources, for all DOD DBA contracts, similar to the model used by DOS, USAID, and the USACE pilot program;

- using a rating system to set premiums based on past claims incurred, similar to the experience rating systems used in many private insurance lines; and
- having the federal government self-insure for all DBA costs similar to what is currently done with the workers' compensation for injuries and death related to war hazards under the WHCA and workers' compensation for federal employees under the FECA program.

Single-Source Contract for DBA Insurance

Currently, DOS and the USAID use a single-source contract to provide DBA insurance for their contractors. Under this model, all agency contractors purchase DBA insurance from a single source selected through a competitive bidding process. USACE is currently testing this model for its contracts as part of a pilot program. This process allows a single insurer to pool the risks of multiple contractors and contracting activities with the goal of using this pooled risk to reduce the premiums paid by all contractors.

As shown in **Table 3**, above, USAID, DOS, and USACE have experienced cost savings by single-sourcing DBA insurance. Currently, premiums under the USAID DBA contract are lower than those paid by DOS and USACE contractors as well as those paid by KBR under the LOGCAP contract. In addition, a report issued by the Majority Staff of the House Oversight and Government Reform Committee found that underwriting gains were significantly higher for major DBA contracts independently negotiated than for the single-source contracts used by DOS and USAID (House Committee on Oversight and Government Reform, Majority Staff, *Supplemental Information on Defense Base Act Insurance Costs,* Memorandum to Committee Members, May 15, 2008. Available on the website of the House Committee on Oversight and Government Reform at [http://oversight.house.gov/documents/20080515102024.pdf]). The Congressional Budget Office (CBO) estimates that adopting a singlesource model for all DOD DBA insurance would result in savings of $33 million dollars in the first year and a 10-year cost savings of $362 million (Congressional Budget Office, *Budget Options*, (Washington: GPO 2007), p. 35. Hereafter cited as CBO, *Budget Options).* Although there are indications that adoption by DOD of a single-source model for DBA insurance could result in cost savings, the size and complexity of the DOD and its contracts may result in difficulties in that agency adopting the system used by the smaller DOS and USAID. It is not known if a single insurer would be willing or able to take on all of the DOD's DBA business. USAAA reports that only one insurance carrier bid to provide coverage under the LOGCAP contract, and an earlier effort by DOD to find a single carrier for all DBA contracts in Iraq resulted in no carriers placing bids. (USAAA, *Audit of Defense Base Act Insurance,* p. 6). Additionally, it is not known whether contractors would accept not being able to select their own insurance carriers to cover their employees. USACE reports that even with a single source for all DBA insurance under its pilot program, the agency is still required to provide administrative support and bear administrative costs (*Defense Base Act Insurance: Are Taxpayers Paying Too Much?: Hearing Before the House Committee on Oversight and Government Reform*, 110th Cong., (2008), statement of James Dalton, Chief of Engineering and Construction, U.S. Army Corps of Engineers). The CBO concurs with this assessment and notes that although it estimates overall cost savings if DOD were to adopt a single-source model for DBA insurance, these cost estimates do not take into account the costs to DOD involved in setting up and administering the system and that these costs "could greatly diminish savings" (CBO, *Budget Options,* p. 35).

Experience Rating for DBA Insurance

In its audit of DBA insurance for the LOGCAP contract, USAAA concluded that the premiums being paid by KBR did not reflect either the expected claims to be paid or the risks involved in the covered activities, especially given KBR's relatively low accident rates. USAAA also found that LOGCAP DBA rates were subject to large annual fluctuations and were a major component of the overall cost of the LOGCAP contract. The use of experience ratings, in which current premiums are based on past claim rates, could bring DBA premiums more into line with the risks faced by DBA contractors. Experience rating is common in the insurance industry and is a feature of many workers' compensation systems governed by state laws. Under an experience rating system, a base premium can be increased if a customer has a history of claims that indicate a greater risk to the insurer or be lowered if the claims history indicates a reduced insurance risk. The proprietary nature of individual insurance arrangements between contractors and carriers and that neither DOL nor any of the contracting agencies has any authority to regulate DBA claims makes it difficult assess what factors are currently used to set current DBA premiums. In an October 2006 report, the SIGIR criticized KBR for its labeling of nearly all of the data on its LOGCAP operations as proprietary and stated that this practice constituted an "abuse" of the Federal Acquisition Regulation (Special Inspector General for Iraq Reconstruction, *Interim Audit Report on Inappropriate Use of Proprietary Data Markings by the Logistics Civil Augmentation Program (LOGCAP)* Contractor, SIGR-06-035, October 26, 2006.

There may be difficulties in using experience ratings to determine DBA premiums. The fluctuations in the price of premiums charged under the LOGCAP program may indicate difficulties in accurately estimating insurance risk in a war zone. One such difficulty involves the determination of whether a claim should be paid under the DBA or the WHCA. For example, USAAA reports that KBR's insurance broker was concerned with the probability of increased DBA claims due to a plane crash and the current DOS insurance contract allows for higher premiums for security contracts that involve aviation (USAAA, *Audit of Defense Base Act Insurance,* p. 7). However, under some circumstances a plane crash would be covered not by the insurer under the DBA but rather by the federal government under the WHCA. In addition, in response to USAAA's audit of the DBA insurance under the LOGCAP contract, the U.S. Army Sustainment Command stated that it "may prove difficult to find insurance carriers who use retrospective rating plans in determining DBA insurance premiums for countries where war risk hazards have been recognized by the DOS" (Id., p. Enclosure 6).

Federal Self-Insurance

The DBA is a privatized workers' compensation system in which individual contractors either purchase insurance from private carriers or self-insure. However, because the terms of many federal contracts allow the contractors to bill the federal government for the cost of DBA insurance, DBA insurance costs are often ultimately paid by the federal government. One option for DBA insurance reform would be to eliminate the private nature of DBA insurance and have the federal government act as the sole DBA insurer and pay 100% of all DBA administrative and claim costs. Having the federal government self-insure for DBA insurance would be similar to the way workers' compensation insurance is handled for injuries and deaths caused by war hazards under the WHCA and for federal employees under the FECA program. There are several potential advantages to having the federal government self insure for DBA hazards. First, rather than paying insurance premiums, the federal government would only be responsible for paying the actual cost of claims and administration. Given that claims make up just over 25% of total costs paid for DBA insurance under the LOGCAP contract, the federal government could potentially see cost savings through self-insurance. In addition, issues involving premium

loading and the charging of DBA insurance premiums on non-covered components of payroll such as hazard pay would be eliminated if the federal government self-insured. Second, the use of the federal government as self-insurer would eliminate the need to distinguish between DBA and WHCA claims, because every claim would be paid by the federal government. There is evidence that the current process, in which the federal government identifies WHCA claims after they have been paid as DBA claims and then reimburses insurers for claim and administrative costs, results in the federal government paying significant amounts that do not go directly to claimants. Over the past five years under the WHCA, the federal government has paid more in reimbursements to insurers for administrative expenses ($7,610,260) than it has paid in compensation to claimants ($5,207,461). Having the federal government self-insure for DBA hazards would change the historic private nature of the DBA program and place the program at odds with the privatized LHWCA program. In addition, federal self-insurance for DBA claims would go against current trends in state workers' compensation programs. Exclusive state funds, in which the state pays all workers' compensation claims, are being replaced either by state funds that compete on the open market with private carriers, or by systems in which all workers' compensation insurance is provided privately.

Chapter 6 A POLICY CASE STUDY

This section is an Arkansas case involving workers compensation, a big retailer, and a cast of participants whose motives are at cross purposes.

WAL-MART STORES, INC. v. CRIST

United States District Court, Western District of Arkansas, Fayetteville Division

July 6, 1987

WAL-MART STORES, INC., PLAINTIFF,
v.
LEWIS R. CRIST, RECEIVER FOR TRANSIT CASUALTY COMPANY IN RECEIVERSHIP, DEFENDANT.
WAL-MART STORES, INC., THIRD-PARTY PLAINTIFF ON COUNTERCLAIM, V. ALEXANDER & ALEXANDER, INC., THIRD-PARTY DEFENDANT ON COUNTERCLAIM.

Stuart Cotton, Rein, Mound & Cotton, New York City, Robert Robinson, Hatfield, Robinson, Hodges, Marshall, Jordan & Shively, Little Rock, Ark., and Robert R. Rhoads, Asst. General Counsel, Bentonville, Ark., for Wal-Mart Stores, Inc.

W.H. Sutton and C. Tab Turner, Friday, Eldredge & Clark, Little Rock, Ark., for Lewis R. Crist.

Philip J. Walsh, Wilson, Elser, Edlman & Dicker, New York City, and Patrick J. Goss, Wright, Lindsey & Jennings, Little Rock, Ark., for Alexander & Alexander, Inc.

The opinion of the court was delivered by: H. Franklin Waters, Chief Judge.

MEMORANDUM OPINION

I. The Litigation

This is exceptionally complex litigation between Wal-Mart Stores, Inc., one of the largest retail concerns in the country, and the Receiver of an insolvent insurance carrier, Transit Casualty Company, which wrote workers' compensation insurance covering Wal-Mart's employees in eighteen states in which Wal-Mart then had facilities.

The litigation started as a declaratory judgment action filed by Wal-Mart against Transit (prior to it being declared insolvent) seeking to enforce the provisions of an agreement that it says it entered into with Transit through one of Transit's agents, calling for Transit to provide workers' compensation coverage in those states for two separate policy periods, one commencing February 1, 1983, and ending January 31, 1984, and the second beginning February 1, 1984, and ending January 31, 1985. It is alleged that this agreement called for Wal-Mart to pay premiums not to exceed $3,500,000 for each policy year for such coverage.

Transit answered, substantially denying the allegations of the complaint, and alleging that the agreement which Wal-Mart seeks to enforce in this litigation is contrary to law and, thus, unenforceable. It counterclaimed, seeking to recover, in addition to the $7,000,000 in premiums already paid by Wal-Mart for the coverage, additional premiums approximating $20,000,000.

In its reply to the counterclaim, Wal-Mart denied its allegations, and affirmatively pled that, in the event the agreement referred to is contrary to law, then Transit is barred from recovery on its counterclaim because it is in pari delicto. Subsequently, Wal-Mart amended its complaint to include allegations in relation to certain retroactive coverage that it says it contracted for which it claims Transit had, since the original complaint was filed, ceased performing the obligations required by such coverage. In addition, Wal-Mart brought into the lawsuit, as a third-party defendant, Alexander & Alexander, Inc., (A & A) an insurance brokerage firm which it claims provided consulting services during the period relevant to this litigation. It seeks recovery from A & A of any amounts that it is required to pay to Wal-Mart.

Approximately sixteen months after the original complaint was filed, and after numerous amended pleadings and various motions were filed and disposed of, the Circuit Court of Cole County, Missouri, acting on a petition for liquidation of Transit filed by the Acting Director of the Division of Insurance, Department of Economic Development, State of Missouri, found Transit to be insolvent and appointed a Receiver for it. After a short stay of all litigation, this matter was allowed to proceed with Transit's interests being pursued by the Receiver, Lewis R. Crist, who was also at the time Director, Division of Insurance, Department of Economic Development, State of Missouri.

After substantial additional pretrial motions, including a motion for partial summary judgment, were filed and disposed of by the court, the matter was tried. Initially, a jury was selected at the request of one or more of the parties, and the case was tried to that jury for a period of approximately four and one-half days. At that time, all parties advised the court that they would waive a jury and would agree to have the matter tried and decided by the court. Whereupon, the jury was excused, and testimony was completed in two and one-half additional trial days.

The matter was taken under advisement so that the attorneys for the parties could file briefs in

relation to the issues. The attorneys for the parties, all of whom performed admirably during the trial of this complex litigation, also favored the court with excellent post-trial briefs. In addition, an amicus curiae brief was filed in behalf of the Director of the Missouri Division of Insurance and was joined in and adopted by the State of Texas acting through its Attorney General. The court has considered the briefs, and after a careful consideration of the evidence received at the trial, is prepared to rule.

II. The Facts

Transit Casualty Company was, at least when compared to other insurance carriers, a relatively small insurance carrier which, during the 1960s and 1970s, specialized in transportation related insurance, insuring primarily truck and bus operations. However, it had authority to write most types of insurance in most of the states.

By the late 1970s, because of changes in the transportation industry and increased competition from other carriers, Transit was "watch[ing] [itself] go out of business," according to Robert J. Olson, an officer with the company at the time. In approximately 1981 Transit's management decided to "get into the captive movement" and use captive insurance companies to reinsure Transit policies. In this manner, Transit hoped and intended to write insurance policies in lines of business in which it had not previously been involved and in which its employees had little if any experience. The officers of the company decided to proceed into those areas in that manner because, according to Olson, the idea was "that you don't have an insurance risk, you have a credit risk."

Because Transit had little if any experience in this area of insurance, its management decided that it needed to create a relationship with someone or some entity that did. Negotiations began with Donald F. Muldoon who had prior experience with the types of insurance that would be involved, particularly in "captive programs." These discussions resulted in the formation of a company known as Donald F. Muldoon & Co., Inc. (Muldoon), which was established in 1981 to "do fronting" for Transit. Transit retained a 24% ownership interest in Muldoon.

In January of 1982 Transit and Muldoon entered into a "Managing Agency Agreement" which substantially gave Muldoon the authority to issue any Transit policy which Transit was authorized to issue in any state in which it was qualified to issue insurance policies. The agreement contained certain limitations which do not appear to be material to the issues in this case, except that the agreement provides that Muldoon had the authority to issue coverages on behalf of the company using "policies, contracts, certificates, utilizing rates and forms, endorsements and binders on behalf of the company which have been approved by the company and which have been approved by and/or conform with any applicable state insurance department laws and regulations." The agreement provided that Muldoon would "observe and comply with all insurance laws, rules and regulations of all states and the District of Columbia wherein any business is transacted for and on behalf of the company."

The Managing Agency Agreement authorized Muldoon to request, from time to time, that certain sub-agents be appointed with substantially the same authority as Muldoon in relation to the production and issuance of Transit insurance policies. Shortly after Muldoon was appointed Transit's managing agent, a former Alexander & Alexander, Inc., employee introduced Donald F. Muldoon to Carlos Miro[11], himself a former A & A employee. Mr. Muldoon recommended Miro, then doing business as Miro & Associates Risk Management, Inc. (Miro), to become a

[11] Carlos I Miro was subsequently involved in various insurance fraud schemes. Ed. note

sub-agent of Transit. Miro was appointed a sub-agent and a "Managing Agency Agreement" (Wal-Mart Ex. 19) was entered into between Donald F. Muldoon & Co., Inc., and Miro & Associates, Inc. The agreement authorized Miro to

> solicit and bind only the types and lines of business as hereinafter stated, under the terms and conditions of this agreement, subject to and in accordance with the insurance laws and regulations of each state, and in accordance with rates, filings, forms, policy limits, underwriting guidelines governing acceptance of such business, and procedures, all as directed, filed and promulgated by the company from time to time; and to issue policies and certificates of such insurance on forms provided by the company, utilizing rates filed by the company pertaining to such coverages; and to amend such policies by endorsements authorized by the company; and to cancel such policies.

Muldoon provided Miro with blank policy forms to issue on Transit's behalf, and all of Miro's business was to be written or fronted on Transit policies and reinsured with Miro's captive reinsurers. For providing its insurance policies, name, filings, and, in effect, guaranty, Transit was to receive a fronting fee of 9% of the premium paid.

Under the agency agreement, Transit had the right to audit its agent's records and it recognized that there was a danger that the agent would exceed its authority. Accordingly, Transit had the right to cancel coverages if an audit revealed that an agent had exceeded its authority.

After Muldoon's appointment as Transit's managing agent, and Miro's appointment as a sub-agent, the Transit captive program grew very fast. According to Olson, in 1981 premiums from the program went from "zero to $40,000,000; and in 1982 it exceeded $100,000,000." By 1983, Miro was Muldoon's biggest premium producer. All of the policies issued by Miro on Transit paper were to be 100% reinsured. If the program had functioned as designed, there was minimal retained risk for Transit so long as reinsurance remained in place with solvent reinsurers.

Wal-Mart Stores, Inc., one of the largest retailers in the country, is headquartered in Bentonville, Arkansas. During 1980-1981 Wal-Mart was self-insured for its workers' compensation and general liability risks in all states in which it did business except the state of Texas and three or four southern states in which it had a limited number of employees. During that period of time it paid a monthly fee of $6,000 (later reduced to $3,000) to Alexander & Alexander, Inc., to act as its insurance consultant.

In April, 1980, John Sooter, an accounting graduate from the University of Arkansas in 1970, was appointed Wal-Mart's Director of Risk Management. Prior to that time, he had been an internal auditor for Wal-Mart and before joining Wal-Mart was an internal auditor for Standard Oil of Indiana (later Amoco Production Company) and Pan-American Petroleum Corporation of Tulsa, Oklahoma. While Sooter, probably understandably, attempted to denigrate his ability and experience as a Risk Manager, the court believes that, at the time of his appointment to the Risk Management job, he was a sophisticated businessman and accountant. In addition, the court finds that he practically had at his beck and call, for $6,000 per month, the substantial insurance experience present within Alexander & Alexander. The evidence indicates that the individual from Alexander & Alexander who primarily consulted with him was George Hallinan, Vice President, a person with in depth experience in almost all phases of the insurance business for approximately thirty years.

In late 1982, Sooter asked Hallinan to obtain quotes for the Texas workers' compensation coverage which was up for renewal or replacement in a few months. In November of 1982 Hallinan brought to Sooter two quotes for the Texas coverage. One was from the Hartford

Insurance Company and one was from Transit through Miro. Sooter was certainly sophisticated enough to recognize a "good deal" when he saw one. When he saw the quote on the Texas worker's compensation coverage, he immediately asked Hallinan to determine if Miro would be interested in bidding on the workers' compensation coverage for all states, replacing the self-insurance which Wal-Mart had in the other states. After being contacted by Hallinan, Miro indicated that he would gladly provide such quotes.

While it is not apparent from the evidence that Miro used much of the information to make the quote that he made, it appears from the evidence that he at least had access to Wal-Mart's payroll figures for the previous five years and also loss history for the self-insured states. This loss history was provided by a subsidiary of Alexander & Alexander, Alexsis, which had provided the adjusting services for Wal-Mart during the period that its workers' compensation coverage was self-insured.

In mid-January of 1982, Sooter, Hallinan and Pete Proffer, of Alexsis' St. Louis office where Wal-Mart's self-insured claims files were kept, attended a meeting in Miro's Dallas office. The meeting was also attended by two of Miro's employees who had also previously been employees of A & A.

It was obvious that Miro was the decision maker in the group. Certain testimony in relation to Miro is illuminating. When Sooter was asked if Miro was a "young man," he replied: "He appears to be a very young man. I don't believe he is quite as young as you would think he was if you saw him." Then later in his testimony he said: "He was just confident. He felt like he was intelligent and everybody around him thought he was intelligent and he was a very good speaker and just displayed a good bit of confidence." When he was asked if it was fair to say that he was "a pretty slick guy," he said, "I'd say he was pretty slick, yes. . . . Towards the end he had developed quite a staff and I don't know a number, but they started out with one little corner in an office building and they ended up with at least half of the floor of an office building."

At this Dallas meeting, and a subsequent one, Miro presented to Wal-Mart a quote which is set forth in Plaintiff's Exhibit 1. The court believes that the evidence shows, without question, that Miro proposed to write all of Wal-Mart's workers' compensation coverage in all of the states where it did business for a flat and guaranteed premium of $3,500,000. This premium, the court believes the evidence clearly shows, was not to be affected in any way by any factors other than an increase or decrease in Wal-Mart's payroll from the estimated figure of $547,000,000. The court believes that the evidence indicates that no one at either meeting, probably including Miro, really understood anything Miro said about how the $3.5 million premium was calculated, or the figures in Plaintiff's Exhibit 1, except for the bottom line figure. Everyone knew that he was bidding $3.5 million to provide the coverage, and that appears to be all that Sooter of Wal-Mart and his consultant, Hallinan, were interested in. The testimony indicates that, apparently after arriving at the $3.5 million figure, Miro did some calculation on a Casio calculator and arrived at a "composite rate" of .63985 per $100 of payroll, determined simply by dividing $3,500,000 by $547,000,000 and multiplying the quotient by 100. The court believes that the evidence indicates that the premium of $3.5 million was "pulled out of the air" and that the composite rate was a mere mathematical calculation which could have been made by anyone with a calculator and rudimentary knowledge about how to use it. The evidence does not indicate that the other figures and calculations shown in Plaintiff's Exhibit 1 had anything to do with the rate to be charged and the premium to be paid by Wal-Mart for this substantial insurance coverage. At least, no witness was able to explain to the court any other method for calculating the composite rate, and Plaintiff's Exhibit 1 appeared to be largely meaningless to the witnesses who testified,

and is certainly meaningless to the court, even after several days of testimony. Unfortunately, Mr. Miro was no longer in the United States at the time of the trial, and did not testify.

During the Dallas meeting, either Miro was asked if he would be interested in bidding on what became known as the "tail coverage" or he volunteered to do so. In any event, Miro was asked to also cover, through Transit insurance policies, Wal-Mart's liability for workers' compensation benefits for the period from February 1, 1980, to January 31, 1983, when Wal-Mart was self-insured. In other words, Miro was asked to cover for a period of three years any Wal-Mart liability for workers' compensation benefits, whether they were known or unknown. In addition, he was asked to provide general liability coverage covering claims resulting from incidents which occurred from February 2, 1980, to October 15, 1981, again, whether they were known or unknown.

Miro agreed to provide this "tail coverage" for $2,852,000, the aggregate amount of "reserves" which Alexsis had established on incurred and reported claims (known claims). Apparently nothing was charged for incurred but not reported (unknown) claims. Miro said he could do that because he would invest the premiums in "Euro dollars." Although Alexsis, through Proffer, offered to make the claims files available, Miro indicated that he had worked with Alexsis during his tenure with A & A and that he was "familiar with Alexsis and had no problem with their reserves."

In short, the court is convinced that the evidence shows, whether right or wrong, that Miro, in behalf of Transit, agreed to provide workers' compensation insurance coverage for Wal-Mart's employees in all states for a guaranteed premium of $3,500,000, to be affected by absolutely nothing except increases or decreases in Wal-Mart's payroll. In the event of an increase or decrease, the premium would be adjusted using the "composite rate" of .63985, the figure calculated on his Casio. In addition, the "tail coverage" would be supplied for a guaranteed premium of $2,852,000, irrespective of what the losses turned out to be (and as will be indicated below, they turned out to be disastrous).

During the second meeting, Miro signed a binder using the figures in his proposal, gave it to Sooter, and they shook hands on the "deal." Thus, the court is convinced that the evidence indicates that Miro agreed to provide, and Wal-Mart quickly agreed to accept, a "deal" in which both the workers' compensation coverage and the tail coverage would be provided for a guaranteed premium of $6,352,000. It appears to the court that loss experience played little if any part in development of the premium, and the "deal" was that it would play no part in what Wal-Mart ultimately paid for its coverage. In other words, if its loss history was substantially greater than that of others in the industry (which turned out to be the case), Wal-Mart still would pay no more than the agreed amount for its coverage.

After the meeting in which the "deal" was made, Miro prepared and forwarded to A & A, Wal-Mart's consultant, the insurance policies received as Plaintiff's Exhibits 2 and 3. The workers' compensation policy (Plaintiff's Ex. 2) was issued to Wal-Mart by Miro utilizing Transit policy forms on file with the appropriate state regulatory body. The policy contained a detailed provision for the computation of premiums based on state rates from National Council of Compensation Insurers (NCCI) manuals on file. This policy listed the sixteen states in which Wal-Mart at the time did business and purported to break Wal-Mart's payroll down into the various job classifications provided for in the NCCI manual on file with most states. The NCCI rate was applied to the purported payroll, by classification, and a total premium of $3,967,064 was calculated. Not surprisingly, sufficient discounts were applied on the declarations page to reduce the premium to exactly $3,500,000, the amount earlier agreed to. This workers'

compensation policy also covered the tail coverage in relation to compensation benefits. In addition, the general liability policy (Plaintiff's Ex. 3) was prepared and issued providing the retroactive general liability coverage which Miro had agreed to provide.

These policies, after having been forwarded to A & A, were accepted by them and forwarded to Sooter at Wal-Mart. Sooter reviewed them and placed them in the book where he kept all policies.

As indicated above, the workers' compensation policy appears, on its face, to be a standard policy using manual rates, and appears regular on its face. In fact, the policy when issued contained an endorsement, signed by Paul Stanley, an officer for A & A, Wal-Mart's consultant, which provided that: "It is agreed that the premium for the policy is subject to an experience modifier not available at the time of policy issuance. Such experience modification, when determined, if different from the modification shown on the policy, will be stated in an endorsement issued to form a part of the policy." It should be noted that even though Sooter and officials of A & A contend that this was not part of the "deal" (and the court believes that it was not), this endorsement was signed by an officer of A & A and included in the policy which was subsequently forwarded to Sooter at Wal-Mart.

Sometime after the policy arrived, Sooter or one of his employees noted that, when the payroll figures shown in the policy and purportedly used to calculate the premium were added, the total was considerably less than the estimated payroll of $547,000,000. (The court believes the total of these figures is slightly in excess of $249,000,000.) When this was noted, Sooter contacted Hallinan at A & A and was told that "there was no problem." Hallinan told Sooter not to be concerned because it was "a really common practice" to depress payrolls to come up with an agreed upon premium. One of Miro's employees later confirmed that Miro had "backed into" the premium by depressing the payroll. In other words, it appears to the court that Hallinan knew at the time that what Miro had actually done was arrive at the bottom line and then plug into the formula provided for in the policy whatever figures were necessary to arrive at the bottom line. It is also obvious that Hallinan accepted this as being a "common practice" and told Sooter that there was nothing wrong with it. The policy as written was accepted by Sooter upon the recommendation of Hallinan, his $6,000 per month consultant.

As indicated, in contracting to provide the tail coverage Miro had "purchased" the Wal-Mart reserves and had covered all of Wal-Mart's liability for the prescribed time, whether known or unknown, for the total of the reserves that had been set up by the adjuster. As indicated, this proved to be disastrous. Approximately 185 new claims were reported to Wal-Mart after the "purchase" and Alexsis created approximately $666,000 in additional reserves for these new claims. In addition, there were adverse developments on several major cases including one in which a Wal-Mart customer had been hit above the eye while using an exercise machine in a Wal-Mart store. Alexsis had reserved that incident at $750 and Miro had "bought it" for that. It later resulted in a judgment of $135,000. A subrogation suit later recovered $88,000 which was paid into the registry of the court pending the outcome of this case.

Another case involved a "slip and fall" in front of a Wal-Mart store. It was initially reserved for $4,000, and was accepted by Miro at that figure, but later resulted in a $200,000 verdict.

When things began to "go bad" in relation to the tail coverage, Muldoon in behalf of Transit had an independent adjuster, Wendell Donahue, review the Alexsis files. He found many files in which a zero reserve was shown. He inspected 170 claims in which the reserve was over $5,000, and found that 103 of them were severely under reserved.

In late August of 1983, Sooter, Hallinan, Miro and one of Miro's employees met in Bentonville to discuss the possibility of providing Wal-Mart with a Transit general liability policy effective October 1, 1983. Miro was very interested and sent a written proposal offering general liability coverage. He also offered, as part of the package, to renew the workers' compensation coverage for a maximum premium of $3,500,000. Hallinan sent a letter to Sooter confirming Miro's renewal proposal for "the same guaranteed maximum premium." There were to be no other adjustments to this figure. Hallinan later confirmed in an October 14, 1983, letter to Miro Wal-Mart's "firm order" to renew the workers' compensation policy on the "same terms, conditions and premium as the current policy." In December of 1983, Sooter, Proffer and Hallinan met with Carlos Miro and some of his employees in Miro's Dallas office and Miro confirmed the renewal. Sooter was asked to prepare an estimated payroll for the renewal period. He first provided an estimate of $551,000,000, which he later revised to $630,000,000.

In January of 1984, Robin Page, one of Miro's employees, wrote to Hallinan suggesting that the workers' compensation premium for the second policy be increased to a little more than $4,000,000 for the coming year to reflect the increased payroll. Page wanted to apply the same "composite rate" of .6398 calculated by Miro at one of the early meetings as outlined above. When that "composite rate" was applied to the estimated payroll of $630,000,000, it resulted in a premium of $4,031,623.

Hallinan and Sooter discussed the proposal. They believed that Miro had already agreed to the same maximum premium, $3,500,000. This led to a June 12, 1984, meeting in Kansas City. Page, Hallinan and Sooter attended. By this time, Wal-Mart had calculated its actual 1983-84 payroll and reported a figure lower than the $547,000,000 estimate. This would result in a return premium to Wal-Mart of slightly in excess of $362,000. It turned out that Sooter's estimate of the 1983-84 payroll was much too low, but that was not discovered until several months later. In any event, based on what he apparently believed to be the lower total payroll, Sooter agreed to forego the return premium which he believed was due Wal-Mart if Miro would agree that the index figure or "composite rate" for the workers' compensation renewal be lowered to provide for a $3,500,000 maximum premium based on the $630,000,000 estimated payroll. The new "composite rate" would be .55555 per $100 of payroll which, not surprisingly, is the result when $3,500,000 is divided by $630,000,000 and the quotient multiplied by 100. Again, it was that simple. Miro and Wal-Mart negotiated a guaranteed premium and the "composite rate" was changed as necessary to reflect it. The rate had nothing to do with Wal-Mart's loss experience which, by that time, everyone involved knew, or should have known, had been dismal. Miro prepared and forwarded to Hallinan the renewal policy (Plaintiff's Ex. 9) and Hallinan delivered it to Sooter. Again, it appears to be a standard workers' compensation policy listing the states in which Wal-Mart had employees, and reflecting standard NCCI rates. The purported payroll was broken down into job classification categories, and the rate for those categories applied. The premium purportedly developed through this method was reduced by sufficient discounts to arrive at the agreed $3,500,000 premium. Again, the policy called for an experience modifier endorsement to be attached. Although Sooter says that he did not add the payroll figures shown, it is clear, that by this time, everyone concerned knew that those figures meant nothing other than they were the figures necessary to "back into" the agreed premium. In fact, the total of the payroll figures used in the policy appears to be $263,788,776 on a payroll that was estimated by Wal-Mart to total for the policy year $630,000,000. This policy was forwarded by Hallinan, with its obvious deficiencies and misstatements, to Sooter, apparently because Hallinan believes, according to his testimony, that such misstatements and untruths are common practice in the insurance industry. The policy was accepted by Hallinan and Sooter.

In July of 1984, shortly after the second policy was issued, Hallinan's assistant sent Sooter endorsements No. 9, 10, 11 and 12 for the second year policy, and endorsement No. 16 for the first year policy. Endorsements No. 9 and No. 16 contained experience modifiers prepared by NCCI showing how Wal-Mart's loss experience compared with like employers in similar industries. The endorsement for the first year policy showed an experience modifier of 1.70, and for the second year, 1.73. This means that, according to NCCI, Wal-Mart's loss experience was 70% and 73% greater than the industry average. This means, if the provisions of the policies are complied with, that the premium would have to be adjusted upward 70% for the first policy, and 73% for the second. Of course, it is Hallinan's and Wal-Mart's contention that the "deal" was that these experience modifiers would play no part in arriving at the premium to be paid by Wal-Mart. This is true even though they were sent to Wal-Mart by one of Hallinan's employees and included in the policies as the policies clearly provide that they should be.

During early 1984, apparently at Transit's request and demand, White & White Inspection Services, an independent auditing firm, was hired to audit the Wal-Mart payroll. In the fall of 1984, White & White concluded its audit and notified Miro of an increase in 1983 payroll from the purported $243,000,000 shown on the policy to $549,000,000. Miro applied this difference in payroll to the state rates on file in the various jurisdictions, applied the experience modifier received earlier from NCCI of 1.70, and after applying applicable discounts, reached an additional premium figure of $6,028,894.

Between September and December of 1984, three meetings were held among Wal-Mart, Miro and A & A personnel concerning payment of this additional premium. It appears that Miro advised Sooter and Hallinan that he knew that the additional $6,000,000 premium was not really owed since the policy had been sold for a guaranteed premium of $3,500,000, but that, in order to satisfy certain statutory requirements, and to satisfy Transit, it was going to be necessary for it to be billed and shown as paid. He suggested that the way that this could be done would be for his company to bill Wal-Mart and for Wal-Mart to then pay the bill by wire transferring $6,000,000 to Miro at the Dallas bank with which it did business. These funds would then be transferred to Lafayette Re, which was Miro's reinsurance company owned by him, domiciled either in the Cayman Islands or on the Isle of Man. Lafayette Re would then retransfer the $6,000,000 to Wal-Mart as a "dividend." He said that since all of the parties involved did business with the same Dallas bank, this could be done in one day. Surprisingly, and in fact astoundingly, Sooter of Wal-Mart, after consulting with another officer of Wal-Mart, agreed that "this would be no problem" if they could be assured that their funds would not be at risk. There is a great deal of testimony by both Sooter and Hallinan about this proposed transaction, but it is not at all clear from this testimony what they believe or wish the court to believe the purpose of this fake transfer was. Hallinan, for several pages of the transcript, testified that they only were told that the transfer was necessary to satisfy statutory requirements but they didn't know what those requirements were. Finally, in answer to the court's questions, after ducking and dodging for almost three transcript pages (pp. 6-160-6-162), Hallinan finally admitted that he saw no purpose for this illusory transfer other than to attempt to "fool someone." He finally admitted that he knew of no one that Miro, he, and Sooter would have any reason to "fool" other than Transit and regulatory authorities.

Sooter's testimony on this subject is not substantially more enlightening. Although he agrees that he and his superior, also an officer of Wal-Mart, decided "that should we be given the proper assurances that the money would flow through as described back to us that it probably wouldn't present a problem," he professes not to know what the purpose of the sham $6,000,000 transfer was. The best that he could do was to say that they (Miro and Hallinan) told him that it was something that had to be done.

The fictitious transfer was not made because Miro's house of cards came tumbling down before it could be. Transit and Wal-Mart received word that Alexsis had not been reimbursed for claims paid by it in several weeks and was owed approximately $700,000. Transit subsequently cancelled Miro's authority and drew down the letter of credit that was established to guarantee the obligations of his reinsurance company. According to the testimony, the letter of credit was only $1.3 million.

In November-December of 1984, Transit learned that the reinsurers that had been paying claims under the Miro program had stopped making payments. On December 4, 1984, Miro's agency was terminated by Transit.

On January 2, 1985, Muldoon sent an invoice for $13,000,000 additional premium for the Wal-Mart coverage to Hallinan. Hallinan did not forward the bill to Wal-Mart, or even tell Wal-Mart personnel about it. Instead, he returned it to Muldoon, advising that it was not in compliance with the "deal."

In mid-January of 1985, Alexander & Alexander advised Sooter that there would be a meeting in the New York offices of Muldoon. At the meeting, George Bowie, Chairman of the Board of Transit, announced that Wal-Mart owed Transit an additional $13,000,000 in premiums and that additional amounts would probably be owed in the future. He produced the invoice earlier sent to Hallinan, with a copy of the letter to Hallinan attached and demanded that the bill be paid in two weeks.

Sooter of Wal-Mart, after overcoming the shock occasioned by the bill and the fact that Hallinan had not told him of the earlier billing, returned to Bentonville, Arkansas, to consult with other officers of Wal-Mart. Bowie was advised by Wal-Mart personnel that the senior officers that would be required to make the decision were not in the office, and they requested additional time to advise Bowie of their decision. However, rather than advise Bowie of their decision, Wal-Mart quickly filed this action in Arkansas in an obvious attempt to prevent suit from being filed against it in some other jurisdiction.

The Receiver claimed during the trial that total losses paid on the two workers' compensation policies and the tail coverage policy approximated $30,000,000, with approximately $21,000,000 of this being paid on the workers' compensation policies alone. Sooter testified (Tr. 2-68) that he believed this figure was too high, but admitted that payments on the policy were "somewhere in the neighborhood of sixteen to seventeen million dollars."

In respect to Sooter's sophistication in relation to insurance matters, he admitted (Tr. 2-70) that he had monitored the Texas self-insurance program for approximately three years. He recognized that that coverage required an audit and an adjustment of the premium based on the experience modifier. Wal-Mart had additional premiums to pay after the audits and application of the experience modifier, and he agreed that he saw such modifiers for each of the years on the Texas policy, but says that he had only a "vague understanding" of what an experience modifier was and how it applied. Then, with further cross-examination, it became obvious that he was fully aware of the purpose of these modifiers, and how they affected the premiums that Wal-Mart was required to pay on the Texas policy.

The court is particularly troubled by some of the testimony of Mr. Hallinan. Although, as indicated, he had over thirty years of experience in the insurance industry and, at least during part of the period, was receiving $6,000 a month to consult with Wal-Mart, he professed to have an amazing lack of knowledge about insurance matters. In addition, the court had a distinct feeling that Mr. Hallinan's testimony was less than credible. To see why, one only needs to read

his cross-examination at Tr. 6-49 through Tr. 6-56. It took over six pages of transcript to get him to finally admit that the purpose of depressing the payrolls as was done on both of the policies issued was to show regulatory authorities something that didn't exist. In other words, if the estimated payrolls of $547,000,000 on the first policy and $630,000,000 on the second policy were shown, it would be obvious to authorities with whom the policies had to be filed that the "deal" did not comply with requirements of law. After a great deal of sparring with the attorney examining him, the following question was asked and the following answer given:

Q. All right. Now, Mr. Hallinan, isn't it a simple fact that since your testimony is that the way the rate structure is shown in the policy is not the way you're actually going to calculate policy premium has nothing to do with the way you're actually going to calculate the premium?
That the only reason it was put in there with the wrong payroll is so that the state regulatory authorities would read it and say, well, that looks about right on a 3.5 million dollar premium?
A. That's right.

Mr. Hallinan also testified that a "deal" for a $3.5 million premium on a payroll of $547,000,000 does not conform to state regulatory requirements, although it, again, took some "doing" to get him to say that. At Tr. 6-75 the following testimony is shown:

Q. (By Mr. Sutton) Mr. Hallinan, you have referred to a contracted for maximum premium. And I don't know whether you claim that's what was done in this case or not; do you?

A. Yes. There's an indication that a maximum premium would be available.

Q. And did you tell us on your deposition that that kind of a proposal does not conform to state regulations on standard workmen's compensation policies?

A. In this particular instance it is a different agreement.

Q. It does not conform to state regulatory authorities, does it?

A. Well, you're — it does conform to state regulatory requirements under the terms of the agreement.

Q. Which one? The one that was filed with the state regulatory authorities?

A. Well, yes.

Q. But a contract for a flat 3.5 million dollar premium on a payroll of 532 or 547 or 549 million dollars —

A. Right.

Q. — does not conform to the state regulatory authorities, does it, sir?

A. Not under that situation.

THE COURT: I'm not understanding. What did you say?
Not under that situation?

THE WITNESS: Right.

THE COURT: Are you saying it does or it doesn't. I don't know what that answer means.

THE WITNESS: It doesn't.

THE COURT: It doesn't. All right.

There is other testimony, coming from the mouths of Wal-Mart's consultants, that the "deal" was not filed with regulatory authorities but the sham policies with depressed payrolls were filed instead because those involved recognized that the "deal" would not be approved. At Tr. 6-163, Hallinan agreed that "you could not file in any state a 3.5 million dollar premium showing a $547,000,000 payroll." Paul F. Stanley, a vice president with Alexander & Alexander, with thirty-three years of insurance experience, the last twenty-two with Alexander & Alexander, was asked why "deals" such as the one in question in this case, were not filed with regulatory authorities. Although he did not appear to want to answer the question during the trial, it was obvious during impeachment by counsel for Transit, that he had testified in a deposition as follows:

Q. Have you ever asked an underwriter why they don't put the agreement in the policy?

A. As I believe I stated earlier, my assumption would be that the agreement is not entirely according to the filings that they have in all the statements [sic].

(Based on additional passages that were read from the deposition, it appears obvious that "statements" should read "states.") Then, in answer to questions asked by the court, Mr. Stanley testified:

A. . . . All right. In this case I'm convinced the evidence shows that the first premium, the premium for the first policy, the '83-'84 was — at least I think there's plenty of evidence to indicate that Mr. Miro at least agreed with Wal-Mart and with A & A that the premiums would be $3.5 million. They then, I suspect used the $547 million payroll, divided that into 3.5 and came up with .6398. At least it looks like that's what happened.

A. Right.

Q. It looks like .6398 had no relation to anything. Have you heard the testimony and had you looked at the file to see if that's a fact?

A. I've looked at the file. I don't recall the composite rate, but that's the way a composite rate of that sort would always be done, divide the premium by the estimated exposure.

Q. In other words, you do whatever you want to arrive at what you think you can sell this policy for and then you — your composite rate is nothing more than the premium divided by the payroll.

A. That's correct.

Q. That's correct, and then in — or the next policy, '84-'85 I guess it would be, after a lot of negotiation the evidence shows having to do with whether or not some returned premium was due Wal-Mart, they said okay, we'll let you have it for the same 3.5, and I guess not too surprisingly they've merely — and I've done that on my calculator — they merely divided 3.5 by $630 million and says oh, that's 555555 ratio and that's what the composite rating is going to be. Is that the way you understand this was done in this case?

A. Yes, sir.

Q. All right. Forgetting again about what's "right" and "wrong", do you believe that the filing of any state allows a premium — or the law of any state allows a premium to be arrived at in those kinds of ways? In other words, take any state — let's take Arkansas for example. If you told Arkansas that's the way we arrived at this rate by filing, what do you think would happen?

A. I don't think that would be satisfactory to the regulators in Arkansas.

Q. Would it be satisfactory based on your 30 some years of experience — would that be satisfactory anywhere?

A. No, I doubt that it would, sir.

Q. Every state requires that you charge a premium for the business you write in that state based on the statute and on the filings that are on file. Is that correct?

A. Yes, sir.

Q. All right.

A. Again, within whatever latitude your accepted filings in that state gives you.

Q. Sure, sure, sure.

A. Yes, sir.

Q. In other words, if the evidence shows that in Arkansas for '83 and '84 they had deviations or a deduction, I'm not sure which one it was, but a deviation of 25% on file, what you'd have to do in order to be legal in Arkansas is apply the manual rates times the individual classifications of the payroll, apply the experience modifier to that and then deduct 25%.

A. That's correct.

Q. In other words, if you don't come up with a premium of at least that much you're not legal in Arkansas.

A. If you don't — yes, sir, that's correct.

Q. All right. The same kinds of things are done in all of the other states, or say at least similar things. You may have different filings as I understand it in other states, but the same kind of arithmetic has to be done in other states. Is that correct?

A. Yes, sir and as I understand the way it's done it's the composite of all those under the various filings that end up being — they are used to back into the premium that was quoted to the client. Obviously if the premium quoted to the client is lower than the composite of all those can be justified, then the insurance underwriter who did it has a problem, but I've never in my experience had an underwriter come back and tell me that was the case.

The testimony of Jan Taylor, an employee of the Arkansas Department of Insurance since 1979, was particularly helpful to the court. At the time of her testimony, Ms. Taylor was the Director of the Division of the Arkansas Department of Insurance responsible for reviewing contracts that property and casualty insurers issue in Arkansas, including workers' compensation insurance.

Among other things, Ms. Taylor described that workers' compensation insurance is social insurance and is regulated by the state of Arkansas, although controls had been reduced somewhat in recent years. However, it was her testimony that her department still had the responsibility of reviewing and approving or disapproving rate rule and form filings made by insurance carriers who desired to write insurance in Arkansas. She testified that Arkansas is a "prior approval state" which means that an insurance carrier must have prior approval of its rates and policies before issuing such policies in Arkansas. She testified that it was the department's duty to see that filings made and policies issued and rates agreed upon were not excessive, unfairly discriminatory, or inadequate. She said that the department had a duty to attempt to prevent carriers from treating one insured "different from another insured."

Ms. Taylor was asked: "What types of things have to be approved before they are used for workers' compensation in Arkansas?" Her answer was:

Every aspect of workers' compensation has to receive approval. Some of it can be done by the National Council on Compensation Insurance for their companies like coming up with a new job classification, but that does receive prior approval. The prices going to be charged to the insurer has to receive, we're talking about the front end price going out according to the risk, has to receive prior approval. Any sort of departure from anything previously on file has to receive approval.

She described that companies issuing policies in Arkansas could choose to adopt rates promulgated by the National Council on Compensation Insurance. She described the function of this Council as follows:

A. Because of the social nature of workers' compensation and because there are so many jobs performed by workers across the United States it's important for insurance companies who provide workers' compensation insurance to employers to have some kind of credible data so that they can use it as a point to determine how much they need to charge when they're going to issue policies to Dillards who has some clerical workers and has some retail salespersons, they have some drivers. All of these job classifications for across the United States are all reported together so if this is Class A-120 for instance, we'll have the experience of everybody that falls into that across the United States from all the insurance companies writing that. They take that and they weigh each one for the various states, in other words we may have an awful lot of credibility, we have a lot of clerical workers in Arkansas. There are some classes that we have very little credibility for and an insurance company that wants to come in and write this in a state will need some idea how much they need to charge for that classification. The National Council collects the data and promulgates the rate that's going to be used for every job classification basically.

THE COURT: You say there's something over 600 jobs in the classes?

BY MR. TURNER:

Q. Now in Arkansas it's my understanding that they're not required to follow the National Council on Compensation, is that right?

A. Yes.

Q. Now if an insurance company desires to adopt what the National Council has promulgated as far as these national rates go, in other words if they want to use what the National Council has promulgated, how would they go about doing that in Arkansas?

A. They would generate a letter to the insurance department saying they're going to use the rates and rating plans on file by the National Council.

Q. Now let's go back to the years of 1983 and 1984. Are you familiar enough with filings that were in Defendant's Exhibit # 3 and could you tell the jury during that period of time whether Transit Casualty was a member of the NCCI in Arkansas.

A. Yes, they were a member of NCCI.

Q. Okay. Now once you become a member of the National Council in Arkansas, and you're writing workers' compensation insurance, and you want to modify this rate which is made by the National Council, you want to change it say from 110 to 115, can an agent for an insurance company or an insurance company just begin applying a different rate or must they first notify the Insurance Commissioner's office?

A. If they're going to use a member of NCCI and they have filed to use NCCI and they're not going to use $1.10 which is what NCCI had for that class code, they would have to file a request to use something other than $1.10.

Ms. Taylor testified that Transit had on file the deviations and scheduled rating plans introduced as Plaintiff's Exhibits 27, 28 and 29, with the effective dates shown, but that if any of these were to apply to a specific policy, it should be shown on the policy issued.

In answer to questions by Transit's counsel, Ms. Taylor said that she knew of no basis for writing workers' compensation insurance and calculating the premium other than on the basis of the expected payroll. The premium is calculated by breaking the estimated payroll down into the various job classifications, and then for NCCI companies, applying the rate for each job classification to the payroll for that category. To that is applied, at a subsequent time, the experience modifier developed by the NCCI. At Tr. 3-149, she testified:

Q. In those seven years, Ms. Taylor, have you ever had the opportunity or the occasion to run into a situation where a workers' compensation policy which is standard, has got the NCCI rates, it's got the appropriate payroll and it's got the experience modifier attached to it and endorsement and it's got everything that complies with what these statutory requirements are and that policy has been furnished to the insured but there's been some kind of side deal cut that alters the premium. Have you ever run into that?

A. I assume you mean a side deal — no.

Q. And that's not something that you would consider as being to the insurance department something that's common in the insurance industry, would you?

A. As far as we know?

Q. As far as you know.

A. I would have to say no.

Q. In fact is a side deal — if the determined premium is different than what's been furnished to the insurance commissioner's office and the rates used are not on file, those are incorrect, are they not?

A. Using a rate other than that filed is incorrect.

She said that she had never seen a "composite rate" used in workers' compensation insurance. In respect to the "deal" which Miro made with Wal-Mart, she testified:

Q. Okay. Now, when we're talking about a composite rate we're talking about a rate for job classifications kind of like this rate right here for clerical, are we not?

A. I'm not sure what you're talking about in workers' compensation. I assume you are talking about combining all of the factors that go into it and using a composite rate.

Q. Okay. If you combined all of the factors for let's say clerical and I think you mentioned some number about in the different classifications there are but if you combined all of those average numbers, would that in some way reflect what it should reflect when you use them in the correct way by listing them separately? Do you understand my question?

A. No, I don't.

Q. Okay. I'm having a hard time. What I'm trying to say is if you use 100 classifications and 100 manual rates you come to some figure and then you used a composite rate and came to some figure, that messes up the whole procedure, does it not?

A. I don't think we would accept that.

Q. Okay. Now, let me show you a formula which has been called a rating formula as we've been discussing. On this blow up right here — can you see that from there? I can bring it closer.

A. It's alright.

Q. It says right here, earned premium equals chargeable losses minus investment income over one minus six cost factor. Let me ask you if you have ever seen in your experience in the workers' comp. department down in Little Rock — have you ever seen a formula for workers' compensation rating anything like this?

A. No. Those things are used by the National Council to come up with the manual rate but their fixed cost factor — the earned premium of the losses, investment income, but not for developing a premium on an individual risk.

Q. If this formula right here, prior to either one of these policies being issued, if that formula had been submitted to your office to be approved on behalf of Wal-Mart — I mean on behalf of Transit Casualty for the Wal-Mart account, would it have been approved?

A. I don't think — I would say that we would have a lot of reservations, that we would probably spend quite a bit of time looking at it. It would not have been automatically approved, no.

Q. Out of the three standards that you described to us earlier today —

A. Uh-huh.

Q. — the unfairly discriminatory, inadequate and excessive, could you tell me what problems you would have with that formula right there?

A. I think you might have all three of them with that formula. Unfairly discriminatory because, you know, I assume it would be for one insured, and excessive because.....
— do you want me to go ahead?
Excessive because the — I can't really see it but I believe it has a fixed cost factor in the investment income. I'm not sure how you would pro rate that out for Transit Casualty when they're already included in the manual rates, the figures that are used by the National Council and could be inadequate, I don't know, it just depends on what numbers they plugged there and how they segregated that account out.

The "proof" in relation to the amounts owed according to the policies of workers' compensation insurance as issued came from Frank R. Watkins who until June of 1986 was with Transit Casualty Company or its Receiver. When Transit was a solvent company, he was a Vice President in the Underwriting Department and, among other things, it was his duty to calculate premiums on workers' compensation policies. He prepared defendant's exhibit 40 which is a summary of his calculations showing the amounts that the Receiver claims Wal-Mart owes on the two policies. He says that he reviewed Transit's filings in all applicable jurisdictions and applied deviations on file. In fact, he testified that he applied the 15% deviation in Arkansas which was filed a few days before the initial policy was issued, even though it was not shown on that policy by Miro. In addition, he applied the relevant experience modifiers and discounts and computed the premiums shown on defendant's exhibit 40 using standard underwriting guidelines. Although Wal-Mart, through its attorneys, contends that these figures are not accurate, no evidence was offered by it to refute them.

Calculated in the manner described by Watkins, he testified that Wal-Mart owed an additional premium of $9,696,845 on the first policy, when the payroll determined by the White & White audit is used, and $7,505,378 if the payroll that Wal-Mart contends was the correct one is used. On the policy for the second year, he testified that the additional premium due is $9,266,766. Thus, according to these figures, Wal-Mart either owes an additional premium of $16,772,144 if the Wal-Mart payroll figures are used for the first year and the White & White audit figures for the second, or $18,963,611 if the White & White payroll audit figures are used for both years.

III. Did Carlos Do It?

As indicated by the facts set forth in the preceding section, the evidence shows that Carlos Miro agreed with Wal-Mart to provide workers' compensation coverage for Wal-Mart in all of the states in which it did business for a flat and guaranteed premium of $3,500,000, to be affected by no other factors, for both of the years in question. It is also clear that, rather than show the "deal" entered into, undoubtedly, as will be discussed below, because it was obviously not in compliance with the law of any state, Miro prepared and forwarded to Hallinan for his review and

acceptance standard worker's compensation insurance policies showing premium calculations which, if one was not aware of the depressed payroll shown, would comply with the laws of the states in which Wal-Mart had employees. Hallinan reviewed the policies, accepted them, and forwarded them on to John Sooter of Wal-Mart. This was done by Miro and accepted by Hallinan and, in fact, Sooter, even though none of the three believed for one moment that the policy correctly reflected the "deal." Hallinan apparently accepted it and sent it on to Wal-Mart because he believed that this was "common practice." In other words, his excuse was that "everybody does it."

Prior to and during the trial, Transit contended that Wal-Mart was bound by the terms of the insurance policies delivered and accepted, and it objected on the basis of the parol evidence rule to any evidence being offered and received to show the "deal." At the start of the trial, the court ruled that the parol evidence rule did not apply, and, after hearing the evidence, the court is even more convinced that it does not. The court does not believe that anyone involved in the transactions or, in fact, anyone in the courtroom during the trial, really believes that the policies reflected the arrangement reached by the parties. The policies delivered were shams to show someone (and it must have been regulatory authorities) that policies had been issued which complied with the law of the states in which they had to be filed and reviewed.

Arkansas law permits parol evidence to show, among other things, that the written agreement is not really the agreement of the parties and what the parties in fact intended their agreement to be. (See L.L. Cole & Son, Inc. v. Hickman, 282 Ark. 6, 665 S.W.2d 278 (1984); Jefferson Square, Inc. v. Hart Shoes, Inc., 239 Ark. 129, 388 S.W.2d 902 (1965); Kyser v. T.M. Bragg & Sons, 228 Ark. 578, 309 S.W.2d 198 (1958).) Parol evidence is always permitted where "there is a question of whether the parties intended to integrate their entire agreement into the document involved in the case." Starling v. Valmac Industries, Inc., 589 F.2d 382, 386 (8th Cir. 1979), citing Farmers Coop. Ass'n v. Garrison, 248 Ark. 948, 454 S.W.2d 644 (1976), citing 3 Corbin on Contracts § 573 (1960); see also 30 Am.Jur.2d Evidence § 1034 (1967).

In this respect, Transit contends that the "sham theory" which allows parol evidence to show that the writing is a "sham" is not applicable where parol evidence is offered to negate a legal contract and prove the terms of an illegal contract where the "real agreement" was made for the illegal or immoral purpose of deceiving or misleading public authorities or is contrary to public policy. See Bank of America Nat. Trust & Sav. Assoc. v. Gillaizeau, 593 F. Supp. 239 (S.D.N.Y. 1984); Bersani v. General Accident F. & L. Assur. Co., 36 N.Y.2d 457, 369 N.Y.S.2d 108, 330 N.E.2d 68 (N.Y. 1975); Kergil v. Central Oregon Fir Supply Co., 213 Or. 186, 323 P.2d 947 (1958); 30 Am.Jur.2d Evidence § 1034 (Supp. 1986). While this argument is not without merit, the court believes that that contention can be more logically and properly discussed in the section below which discusses the enforceability of the "deal." As indicated, the court believes that the evidence was admissible. The question of whether it should be considered by the court to prove an illegal or immoral contract or one against public policy is another question.

In short, the court is convinced that, in fact, Carlos Miro did exactly what Wal-Mart charges him with doing. He agreed to provide Wal-Mart's workers' compensation coverage for two years at a flat $3,500,000 per year, to be affected by nothing. In addition, he provided retroactive coverage, agreeing to pay any workers' compensation claims, whether known or unknown, arising in any of the Wal-Mart locations during the period from February 1, 1980, to January 31, 1983. He agreed to accept this liability, both known and unknown, for the amount of reserves set up by Wal-Mart's adjusters at the time the known claims were filed. In addition, he agreed to insure general liability claims at any Wal-Mart location, both known or unknown, which resulted from any incident occurring between February 1, 1980, and January 31, 1983.

Thus, the answer to the question posed at the beginning of this section, "Did Carlos Do It," is unquestionably "yes."

IV. Did Carlos Have Authority To Do It?

There is no question but that Carlos Miro was an agent of Transit Casualty Company with the power to issue Transit policies. In fact, the evidence shows that he was provided by Muldoon, acting in Transit's behalf, blank pre-numbered policies to use for that purpose. An agreement was entered into between Miro and Muldoon acting in behalf of Transit. (Plaintiff's Ex. 19). Article I, subparagraph (a), specifically sets forth the actual authority granted by Transit to Miro. He was authorized to issue policies of insurance "subject to and in accordance with the insurance laws and regulations of each State, and in accordance with rates, filings, forms, policy limits, underwriting guidelines governing acceptance . . . all as directed, filed, and promulgated by the Company . . . utilizing rates filed by the Company."

The court believes that it is abundantly clear from the evidence in this case that Miro acted well outside the bounds of the actual authority granted to him. Unquestionably, he agreed to provide workers' compensation coverage which, in the court's view, as will be discussed below, is not in accordance with the insurance laws and regulations of any state in which Wal-Mart did business, and, the rates used clearly were not filed in any state and, in fact, could not be. Both of the officers of Wal-Mart's $6,000 per month consultant who testified, with combined experience in the insurance industry of over sixty years, said that the "deal" could not have been filed and approved in any state of which they were aware.

Since Miro exceeded his actual authority, the question then becomes whether he had apparent authority to enter into the "deal." This court had occasion to consider the issue of apparent authority in Scholtes v. Signal Delivery Service, Inc., 548 F. Supp. 487 (W.D.Ark. 1982). In that case, we said that, in Arkansas, apparent authority is defined as follows:

> Apparent authority is such authority as a principal proclaims or permits, such authority which a principal by lack of care causes or allows, or such authority as a reasonably prudent man using diligence and discretion would naturally suppose. (citations omitted). The principal's liability attaches regardless whether the authority was actual or apparent, so long as the third party acts in good faith.

Id. at 495. See also Arkansas Valley Feed Mills, Inc. v. Fox De Luxe Foods, Inc., 171 F. Supp. 145 (W.D.Ark. 1959), aff'd, 273 F.2d 904 (8th Cir. 1960); Mack v. Scott, 230 Ark. 510, 323 S.W.2d 929 (1959).

Thus, the law in Arkansas is that a showing of "apparent authority" requires both (1) conduct by the principal and (2) a reasonable belief by the third party dealing with the agent that the agent has the authority to do what he is doing. In this case, it is true that Transit made blank policies available to Miro and authorized him to issue them so long as he complied with the conditions set forth in the agreement discussed above. That is clear. The hard question is whether that conduct by Transit would cause a reasonable person to believe that Miro had authority to issue policies of workers' compensation insurance using a rate structure that even Wal-Mart's "experts" did not believe could be openly filed in any state.

It should be remembered that the insured in this case is Wal-Mart. We are not talking about a mom and pop five and dime on the corner of First and Main. Instead, we are talking about a company which, according to the authors of the popular book, In Search of Excellence — Lessons from America's Best-Run Companies, "is the mass retailing success story of the late 1970s and the early 1980s." T. Peters & R. Waterman, Jr., In Search of Excellence — Lessons from America's Best-Run Companies, 191-192 (1982). We are talking about a corporation that

everyone in northwest Arkansas knows started as a small discount operation in northwest Arkansas and during the succeeding few years developed into one of the top three or four retailers in America. This is a corporation that almost anyone writing on modern day success stories includes in the story. It is considered, as evidenced by the discussion of Wal-Mart in the book cited above, to be one of the best-run businesses in all of this country and, in fact, there is rarely a discussion in books, magazines and newspapers about modern day business success stories that Wal-Mart and its founder, Sam Walton, are not given prominent and laudatory discussion.

Not only is Wal-Mart one of the best-run companies in America, the evidence in this case indicates that it had a whole department with a director that did nothing but look out after Wal-Mart's insurance interests. While Sooter, during the course of the trial, appeared to be attempting to convince the court that he knew little about insurance, the court does not believe for a moment that he was not a sophisticated and astute businessman knowledgeable in the area of insurance. If he was not, he would not have been Director of the Risk Management Division of Wal-Mart. Paul Stanley, Vice President of Wal-Mart's consulting firm, thought that he was. In a deposition given, a portion of which was read to him during the cross-examination of him at the trial, he said, "I would say in every case — we are dealing with rather sophisticated people such as Mr. Sooter and other risk managers and I can't get into their heads. . . ."

The evidence in this case indicates that Sooter had been the Director of the Risk Management Department of Wal-Mart for almost two and one-half years at the time of the negotiation of the first contract. The evidence indicates that Wal-Mart, prior to the Miro policy being issued, had been self-insured in most states and had a standard policy in the state of Texas. During the two and one-half years that Sooter had been the Director of Risk Management, he had monitored and been responsible for the proper operation of not only the self-insurance program but also the Texas program insured by a standard policy. He admitted, somewhat reluctantly, that he was aware of experience modifiers and how they were applied to calculate premiums. He was responsible for the self-insurance program so he must have been aware of Wal-Mart's loss history. The court simply does not believe that he really believed at the time that he entered into the "deal" with Miro that it was permissible and would be accepted in any state in which Wal-Mart did business. If he had believed that that was the case, why did he accept a policy of insurance that clearly did not set forth the agreement that he contends he reached? Why did he accept a policy that had depressed payrolls? Was it because Hallinan told him that that is "common practice" and not to worry about it? If that is the case, was that reasonable for a man of Sooter's business experience and expertise? The court believes that mom and pop on the corner would know that they should question a policy of insurance which doesn't even come close to properly setting forth the agreement that was reached in relation to the insurance coverage. As indicated, the "deal" was that the insurance would be provided for $3.5 million per year, not affected by anything. The policy that Sooter got and accepted clearly provided otherwise. It was clearly a standard policy, and it provided that the premiums would be calculated using the NCCI manual rates and would be adjusted by experience modifiers.

Sooter's testimony is that he made one deal but that he received and accepted something entirely different. Someone with much less business experience and business acumen than that displayed by Sooter should have worried about that even if his expert told him not to.

An event occurred during the second policy year which the court believes indicates that Sooter and the A & A people knew that the "deal" was not one that would, in the words of one of the A & A executives "pass muster" in any state. The court has reference to the $6,000,000 sham transfer that was agreed to and did not take place only because Miro's activities were

discovered and the house of cards that he, Wal-Mart and Hallinan built came tumbling down before the transfer could take place.

Wal-Mart, in its brief, contends that this was a "non-event" and should have no bearing on the outcome of this case. The court disagrees. It is recognized that the transfer did not, for the reasons stated, take place, but the court is convinced that the fact that Wal-Mart's executives agreed to the transfer speaks volumes about their knowledge of whether the deal was a proper one insofar as state regulatory authorities were concerned. At Transit's insistence, Miro had the Wal-Mart account audited by White & White. The audit, when policy provisions were applied, showed that Wal-Mart owed an additional premium in excess of $6,000,000. Miro said to Hallinan and Sooter that he had a plan to get around this problem. His plan was that a sham transfer of $6,000,000 would take place. Miro would bill Wal-Mart for the additional premium and Wal-Mart would wire transfer $6,000,000 to Miro & Associates in Dallas which would then transfer the money to its reinsurance company which was domiciled either on Cayman Island or the Isle of Man. That reinsurance company would, the same day, transfer the funds back to Wal-Mart. Astoundingly, Sooter and his boss, an executive with Wal-Mart, agreed to this fake transfer and it is obvious that their only concern was that their funds not be "at risk."

The court believes that anyone reading the portion of Sooter's and Hallinan's testimony on this transfer would have to believe that they must have known more about the purpose of this than they now would like to admit. Their testimony is that Miro simply told them that it was to satisfy a "statutory requirement." They say that they did not know what that meant and they waited for Miro's lawyer to tell them, but he never did. The court simply does not believe that. The court is convinced that astute and experienced businessmen of the caliber of John Sooter and George Hallinan must have known that this could have no other purpose than to "fool someone." In fact, under questioning by the court, Hallinan admitted as much. What other purpose could it have had? If Sooter and Hallinan really believed that the deal was a legal one, why the sham transfer? Could it have had any other purpose than to attempt to show someone that something occurred which didn't? Since the answer to that question is obvious, who could Sooter, Hallinan and Miro have been intending to "fool"? Could it have been anyone other than either Transit or state regulatory authorities? Hallinan agreed that it could not. The court can see no other explanation for this unexplainable conduct than that Sooter and Hallinan must have known that their "deal" did not comply with the law of any state and that that fact must be "covered up."

Even if it is assumed, for the sake of argument, that John Sooter did not know this, an assumption that stretches this court's credulity considerably past the breaking point, it is clear that the consultants which he paid, at least during part of the relevant period, $6,000.00 per month did. They said that they did. (Hallinan Tr. 6-163 and Stanley Tr. 7-128). It has long been the law in Arkansas that "the principal is affected with notice of all his agent knows in the line of his duty or the scope of his powers." Whitehead v. Wells, 29 Ark. 99 (1874), and other cases cited in West's Arkansas Digest Key No. 177(1). It is also well settled that a third person, by undertaking to deal with a purported agent, is put on inquiry as to the extent and scope of the agent's authority and must use due care to discover the authority or else suffer the consequences if it is exceeded. See also International Harvester Co. v. McLaughlin, 182 Ark. 1122, 34 S.W.2d 452 (1931); J.T. Fargason Co. v. Dudley, 173 Ark. 1148, 294 S.W. 6 (1927); Hadley Milling Co. v. Kelly, 117 Ark. 173, 174 S.W. 227 (1915); and 2A C.J.S. Agency § 168 (1972).

Applying the law, and considering what the court is convinced John Sooter knew and what the law imputes to him from Hallinan's and Stanley's knowledge, the court finds that it was not reasonable for him to believe, if he in fact did, that Miro had the authority to issue policies of

insurance which would not comply with the filing requirements of any state. Thus, Miro did not have either actual or apparent authority to make the "deal" that he made with Wal-Mart.

The court is further convinced that John Sooter either knew or certainly should have known that he did not. The evidence, in the court's view, indicates that Sooter quickly recognized what a deal he was getting when he received the bid on the Texas only insurance. He promptly asked Hallinan to have Miro bid on all of their coverage. There is nothing wrong with that, but Sooter, like most of us, should have learned long ago that, whether it is a man in a pickup truck wanting to pave your driveway or roof your house, or someone on the telephone trying to sell you a lot in Florida, if the deal sounds "too good to be true," it probably is.

Did Carlos have authority to do it? The answer is "no" and it was not reasonable for Sooter and Hallinan to think that he did.

V. Is The "Deal" Enforceable?

Workers' compensation insurance is social insurance not only required but also controlled by legislative enactments in every state. It has the salutary purpose of protecting employees, employers and the public by providing a means by which injured workers may be compensated during the period of their inability to work caused by the injury so that they may continue to exist and feed their families. The public is protected because, hopefully, this prevents injured workers from becoming wards of the state maintained at the expense of the public. Besides, it is the "right thing to do."

An overriding and compelling state interest has been recognized for many years and is well expressed in Employer's L.A. Corp. v. Success-Uncle Sam Cone Co., 124 Misc. 614, 208 N.Y.S. 510 (1925). That court said:

> It should be borne in mind that the policy of the state, as expressed in sections 67 and 141 of the Insurance Law, is to remove the matter of rates, premiums, and classifications from the field of private bargaining and agreement. Section 67 of the Insurance Law does this by providing that no rates shall take effect until approved by the superintendent of insurance, and thus limits the power of the insurance company and the insured to contract on the basis of one rate alone — the rate approved by the superintendent of insurance. This policy has a threefold purpose: First, to protect injured workmen and the dependents of those killed in industrial accidents, by insuring the financial stability of companies writing compensation insurance. This means the maintenance of adequate reserves on the basis of a sound and scientific system of rates carefully supervised by the state. Secondly, it has for its purpose the protection of employers against excessive rates, and it is the state's duty to afford this protection because employers for the most part are compelled by law to carry workmen's compensation insurance; they have no choice in the matter, except that certain large employers may under prescribed conditions carry their own insurance. And finally this policy was designed to guard against rebates, discriminations, and favoritism in rates, the effect of which would be harmful to employers as well as to injured workmen.

Id. 208 N.Y.S. at 512. See also Public Service Mut. Ins. Co. v. Rosebon Realty Corp., 39 Misc.2d 663, 241 N.Y.S.2d 555 (1963).[12]

[12] See also American Mut. Liability Ins. Co. v. Plywoods-Plastics Corp., 81 F. Supp. 157 (E.D.S.C. 1948); Contractor's Safety Assoc. v. California Comp. Ins. Co., 48 Cal.2d 71, 307 P.2d 626 (1957); Key System Transit Lines v. Pacific Employers Insurance Co., 52 Cal.2d 800, 345 P.2d 257 (1959); Great American Ins. Co. v. Nova-Frost, Inc., 362 N.W.2d 358 (Minn.App. 1985); Employer's Liability Assur. Corp. v. Arthur Morgan Trucking Co., 236 Mo.App. 445, 156 S.W.2d 8 (1941); Public Service Mutual Ins. Co. v. Rosebon Realty Corp., 39 Misc.2d 663, 241 N.Y.S.2d 555 (1963); Warm Springs Forest Products Ind. v. Employee Benefits Ins. Co., 74 Or. App. 422, 703 P.2d 1008 (1985); Mountain Fir Lbr. Co. v. Employee Benefits Ins. Co., 296 Or. 639, 679 P.2d 296 (1984); Glenn H.

Although there is some dispute about what law applies in determining whether the insurance contracts in this case are enforceable, the court believes that the law in Arkansas on this subject is substantially similar to the law in each of the other states in which Wal-Mart did business during the relevant period. In addition, as already indicated, the court is convinced that the evidence shows that the "deal" entered into in this case would not be acceptable in any relevant state. Since that is true, it is not necessary for the court to determine whether the law of Arkansas or some other state applies. A choice-of-law analysis cannot begin until a specific issue has been found where laws conflict. Snow v. Admiral Ins. Co., 612 F. Supp. 206, 208-10, (W.D.Ark. 1985). Absent a real issue of conflicting laws, a court need not determine what "contacts" are relevant to a choice-of-law analysis. Acting otherwise would be responding to a "false conflict." See generally Restatement (Second) of Conflicts §§ 181-188 (1971).

Every relevant state requires that employers who meet certain criteria make provisions to protect their workers in the event of injury. Arkansas, nor any other state, gives the employers a choice about whether they desire such protection. They must have it. Likewise, the states do not give the employers a choice as to the amount of coverage that they will have. Instead, the law requires, not only that they provide such protection, but the level of protection that must exist. The law specifically sets forth the benefits that are payable in relation to injuries, and the employer may not choose to provide something different. For example, he cannot say that he does not believe that his clerical workers, or some other class of workers, are not substantially at risk, so he won't make provisions to protect them. He must protect each worker at the level of protection required by the law of the applicable state.

Not only do the states provide that the employer must have such protection, every state, in one manner or another, provides what the employer will pay for it. In most instances at least, and the court believes in every state in which Wal-Mart did business during the relevant period, the amount that the employer pays for the insurance must be first approved in some manner by regulatory authorities. In other words, the employer is required by the state to carry insurance, and the state dictates the rates to be charged. It is true that, in recent years, more leeway has been granted in this respect, but the fact appears to be that every state relevant to the issues in this case still maintains substantial control over the making and charging of rates for workers' compensation insurance.

For example, in Arkansas, Ark.Stat.Ann. § 66-3120 (Repl. 1980) requires all workers' compensation carriers to file rates, forms, rating plans and manuals with the Arkansas Insurance Commissioner's office for prior approval. The statute mandates that any rate or method of premium development for workers' compensation be on file with and approved by the Insurance Commissioner's office before it is offered. As Ms. Taylor testified, the purpose of this is to protect workmen and the public by ensuring that carriers do not unfairly discriminate between employers or charge excessive or inadequate rates. The court believes that it is obvious that this is a legitimate concern of the regulatory authorities.

Obviously, in order to protect the workmen and the public, the insurance provided must be "fair." It would not be "right" to allow an employer such as Wal-Mart, because of its immense size and bargaining power, to obtain insurance for an inadequate rate. Obviously, someone must pay under those circumstances, and it has to be either the public or other employers. The regulatory authorities are concerned that the rates be adequate because, if they are not, the insurance

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McCarthy, Inc. v. Knox, 186 S.W.2d 832 (Tex.Civ.App. 1945); Associated Employer's Lloyds v. Dillingham, 262 S.W.2d 544 (Tex.Civ.App. 1953).

carrier providing the coverage often "goes broke" as Transit did, leaving someone else "holding the bag."

As indicated, Wal-Mart appears to contend that Arkansas law should not be applied to this matter in determining whether the "deal" is enforceable, but fails to say what law should be applied. In fact, all states listed in the insurance policies issued have similar legislation to that of Arkansas.[13]

In Arkansas, and it appears in the other states relevant to the issues, an employer may choose NCCI to establish the basic formula for determination of the premiums. According to Ms. Taylor, NCCI promulgates standard rates for over 600 job classifications. As Ms. Taylor explained, if an employer chooses to use NCCI rates, it must do so unless prior approval is obtained from the regulatory agency. If a policy is issued under these conditions, the premium to be charged is determined by breaking the estimated payroll down into the relevant job categories, and then applying by a simple mathematical calculation the NCCI rates to the estimated payroll for each category. If the employer is large enough, an experience modifier is later established by the NCCI to reflect each insured's actual experience in the various states. If the insured's experience modifier is greater than 1.00, the insured is required to pay additional premiums to cover its bad loss experience. The obvious intention of this is to encourage loss prevention techniques and to promote equality among insureds. Logically, if Wal-Mart's loss experience is 70% or 73% worse than the average, Wal-Mart should pay more. If it does not, someone does and obviously, in most cases at least, it has to be the employers who do a better job in containing losses than Wal-Mart does. Ultimately, of course, the public pays. This system insures that other employers and the public are not required to pay the "tab" because a particular employer is a sharper negotiator or has more bargaining power than others and is, thus, able to "beat down" the premium.

In Arkansas, and other states, the final step in premium development is a premium discount which is applicable if the premium developed is of sufficient amount. According to Ms. Taylor, these discounts are intended to provide credits to large insureds to recognize legitimate cost savings based upon lower per capita handling costs.

Employers who choose to use NCCI are also permitted, under proper circumstances, to take advantage of certain retrospective rating plans provided by NCCI. There are five retrospective rating plans provided, and they are based on the standard formula, but permit credits based on the insured's actual loss experience. The maximum premium is still calculated utilizing the standard formula, but it is reflected as a percentage of a standard premium. These plans still have requirements for maximums and minimums, and they utilize manual rates and experience modifiers and must be reflected in the policy and an applicable endorsement approved by the regulatory authority. They must be applied to legitimate estimated payrolls and cannot be manipulated, as was done in this case, to arrive at a premium already agreed to.

In recent years at least, Arkansas, and most other states, have relaxed the regulation of workers' compensation rates to some extent. In most states, an insurance company may

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[13] Ala.Code § 27-13-29 (1975); Ark.Stat.Ann. § 66-3120 (Repl. 1980); Fla.Stat.Ann. § 627.091 (West 1984); Ga.Code Ann. § 34-9-130 (1982); Ill.Ann.Stat. ch. 73, ¶ 1065.4 (1965); Ind.Code § 27-7-2-10 (Burns 1986); Iowa Code Ann. § 515A.6 (1949); Kan.Stat.Ann. § 40-1113 (1986); Ky.Rev.Stat.Ann. § 304.13-040 (1980); La.Rev.Stat.Ann. § 22-1407 (West 1978); Miss.Code Ann. § 83-3-107 (1972); Mo.Rev.Stat. § 287.320 (Supp. 1986); Neb.Rev.Stat. § 44-1403 (1984); N.M.Stat.Ann. § 59A-17-10 (1978); N.C.Gen.Stat. § 58-124.20 (1982); Okla.Stat.Ann. tit. 36, § 901 et seq. (1976); S.C.Code Ann. § 38-43-330 (Law.Co-op 1984); Tenn.Code Ann. § 56-5-306 (Supp. 1986); Tex.Ins.Code Ann. § 5.60 (Vernon 1981).

deviate from the manual rates and rating plans by filing a proposed deviation or modified rating plan to be approved by the Insurance Commissioner's office. However, these plans cannot be discriminatory and the regulatory authorities in the states review them to ensure that they are not. Once approved, the deviation or modification can be utilized to develop premiums if it is reflected in the policy itself. According to Ms. Taylor, if such plans are not approved, the carrier is required to use the standard formula discussed above.

Ms. Taylor testified that, according to the department's records, Transit was a member of NCCI and had the plans or deviations introduced as Plaintiff's Exhibits 27, 28 and 29 on file with the effective dates shown. However, Ms. Taylor advised that if these deviations or plans were to be used, it should be shown on the policy. In this respect, the court believes that the evidence shows, unequivocally, that no one who had anything to do with developing the premiums in this case relied to any degree on these deviations or plans. It seems to be Wal-Mart's position that the insurer could have if it had wanted to, but the fact remains that it did not, and no one has any reason to believe that it did. The "deal" was that the premium would be $3.5 million, irrespective of any other factors.

It was Ms. Taylor's testimony, and it appears to be true in every other state, that after the initial premium is calculated as outlined above, the final premium to be paid by the insured is subject to adjustment by audit following the policy period. If the estimated payroll is less than the audited payroll, the insured pays additional premiums based on the applicable state rates, experience modifiers and discounts.

Arkansas has a statute which, in the court's view, makes it clear that a policy of insurance issued must reflect the true "deal" made between the insured and the insurance carrier. Ark.Stat.Ann. § 66-3019 has been called an anti-rebate statute, but in the court's view, it is much more than that. As indicated above, the court believes that, in Arkansas, and most other states, the legislature not only provides what coverage the employers of the state will have, but also what they must pay for it. This statute very effectively carries out this legislative purpose. It provides in pertinent part:

> (1) No property, casualty or surety insurer or any employee thereof, and no broker, agent, or solicitor shall pay, allow, or give or offer to pay, allow or give, directly or indirectly, as an inducement to insurance or after insurance has been effected, any rebate, discount, abatement, credit or reduction of the premium named in a policy of insurance, or any special favor or advantage in the dividends or other benefits to accrue thereon, or any valuable consideration or inducement whatever not specified in the policy, except to the extent provided for in an applicable filing with the Commissioner as provided by law.
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> (2) No insured named in a policy, nor any employee of such insured, shall knowingly receive or accept, directly or indirectly, any such rebate, discount, abatement, credit or reduction of premium, or any such special favor or advantage or valuable consideration or inducement.

The court believes that this statute was intended to and clearly and unambiguously does provide what the insurer will charge for an insurance policy, and what the insured must pay for it. It leaves no alternative. It says that the insurance carrier must charge the premium shown on the policy and that the insured will not knowingly pay anything other than the premium shown unless there are applicable filings authorizing a premium other than that shown.

In this case, the policies in question showed a premium which, at least on its face, complied with state law. The fact is that we now know that it didn't because Miro depressed the payrolls and Sooter and Hallinan, although recognizing it, accepted it because it was "common practice." But

the fact is that the policies, as issued and accepted, provide for the proper manner for calculating the premiums to be charged. These policies clearly and unambiguously say that it is recognized that the premiums shown on the face of the policies are estimated only, and that the final premium will be determined by an audit and an application of experience modifiers when available.

Thus, Ark.Stat.Ann. § 66-3019 directs Transit to charge the premium shown on the policies, and gives it no alternative but to do so. Similarly, this statute directs that Wal-Mart will not knowingly receive or accept any reduction in the premium shown on the policy unless there is a filing authorizing such reduction. For the reasons already stated, the court believes that Sooter was knowledgeable in insurance matters, and certainly his consultants were. The court does not believe that Wal-Mart, through its employees and consultants, can close their eyes and ears, as did the "three wise monkeys" in ancient Japan and say "we hear no evil, see no evil, and speak no evil." For the reasons already stated, the court is convinced that Wal-Mart and its consultants knew that this deal was too good to be true, and it cannot now say that it did not "knowingly" accept a reduction in premium that was not authorized by law.

Every state in which Wal-Mart had workers covered by the relevant policies has statutes similar to Ark.Stat.Ann. § 66-3019.[14]

In their briefs, the attorneys for the parties have very well set forth their views on whether the "deal" was legal or illegal and, if illegal, what should flow therefrom. Not surprisingly, Wal-Mart contends that, in the first place, the "deal" was legal, but if it was not, then the court should walk away from this matter, leaving the parties where it found them. On the other hand, Transit contends that only the "deal" was illegal, and that it clearly was, but that the court should still enforce the policies as issued and require the premiums which are set forth in the policies to be paid.

The court believes that it is necessary that the premiums be paid, and it is not certain that it must get into the "thicket" which conflicting authorities have created in relation to illegal contracts. In our case, Wal-Mart received exactly the coverage required by Arkansas and apparently the other states. Thus, the coverage complied with the various statutes. The policies, as issued, said that specified rates would be paid for this insurance. The premiums so calculated would seem to comply with the law of Arkansas and every other relevant state and, unless criteria not present in this case are present, the law of those states requires that the premium set forth on the policy be paid. Thus, it would not appear to be necessary to determine whether the "side agreement" was legal or illegal. The law provides the coverage to be maintained and the price that is to be charged and paid for it. In view of this, the court believes that Wal-Mart is required to pay the premiums called for in the insurance policies issued. The law requires that.

Wal-Mart, during the trial, and in its briefs filed in its behalf by its attorneys, has indicated that that would not be "fair" because that is not what they contracted for. Yet, they have failed to show what they could have obtained the required insurance for from another provider, and this

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[14] See Ala.Code § 27-12-14 (1975); Ariz.Rev.Stat.Ann. § 20-449 (1975); Fla.Stat.Ann. § 626.9541(1)(n) (West Supp. 1987); Ga.Code Ann. § 33-9-36 (1982); Ill.Ann.Stat. ch. 73, ¶ 763 (1965); Ind.Code Ann. § 27-1-20-30 (Burns 1986); Iowa Code Ann. § 507B.4 (Supp. 1987); Kan.Stat.Ann. § 40-941 (1986); Ky.Rev.Stat.Ann. § 304.12-090 (1980); La.Rev.Stat.Ann. § 22-1214 (West 1978); Miss.Code Ann. § 83-3-121 (1972); Mo.Rev.Stat. § 379.356 (Supp. 1986); Neb.Rev.Stat. § 44-361 (1984); N.M.Stat.Ann. § 59A-16-15 (1978); N.C.Gen.Stat. § 58-44.5 (1982); Okla.Stat.Ann. tit. 36, § 1204 (1976); S.C.Code Ann. § 38-55-130 (Law.Co-op 1984); Tenn.Code Ann. § 56-8-104(8) (1980); Tex.Ins.Code Ann. § 21.21 § 4(8) (Vernon 1981).

certainly should have been relevant, at least in relation to the third-party complaint which Wal-Mart filed against Alexander & Alexander. The court believes that it did not make this proof because there is none available which would indicate that any insurer anywhere in the country would have provided Wal-Mart with workers' compensation coverage which even came close to Miro's "deal." The court simply does not believe that any competent insurer would knowingly agree to provide Wal-Mart, or any other employer, with insurance covering employees in which there is a guaranteed cap on the premium to be charged. As in this case, this leaves the insurer in an unbelievably untenable position. Such an agreement could cause him to "go broke" as Transit did. In this case, the Receiver for Transit claims that over $21,000,000 in claims have been paid, and that before incurred but not reported claims have been identified and paid, they expect that total claim payments will exceed $30,000,000. Wal-Mart disagrees with this, but Sooter admitted during his testimony that he believes claims of 16 to 17 million dollars had been paid. It is certainly difficult to believe that any competent insurer would take on such an obligation, with no control over the results, nor would any reasonable employer believe that one would. It should be remembered that Transit, nor, in fact, Miro, A & A, or any other party except Wal-Mart, had nothing to do with the atrocious loss history that Wal-Mart had. That was something in the control of none of the participants other than Wal-Mart. What occurred is a perfect example of why the law of every state, and any reasonable insurer, requires that loss history have some effect on the premiums to be paid.

Thus, for these reasons, the court is convinced that the law of every state requires that Wal-Mart pay the insurance premiums called for in the policies of insurance issued, and it is not necessary to determine whether the side agreement, or the entire agreement, was legal or illegal.

Be that as it may, if it is necessary to make such a determination, the court is convinced, for the reasons already set forth, that the side agreement was unenforceable and void. See American Mutual Liability Ins. Co. v. Plywoods-Plastics Corp., 81 F. Supp. 157 (E.D.S.C. 1948); Key System Transit Lines v. Pacific Employers Ins. Co., 52 Cal.2d 800, 345 P.2d 257 (1959); Contractor's Safety Assoc. v. California Comp. Ins. Co., 48 Cal.2d 71, 307 P.2d 626 (1957); Warm Springs Forest Products Ind. v. Employee Benefits Ins. Co., 74 Or. App. 422, 703 P.2d 1008 (1985), aff'd, 300 Or. 617, 716 P.2d 740 (1986); Mountain Fir Lbr. Co. v. E.B.I. Co., 296 Or. 639, 679 P.2d 296 (1984); Biggs v. Reliance Life Ins. Co., 137 Tenn. 598, 195 S.W. 174 (Tenn. 1917); Associated Employers Lloyds v. Dillingham, 262 S.W.2d 544 (Tex.Civ.App. 1953); Glenn H. McCarthy, Inc. v. Knox, 186 S.W.2d 832 (Tex.Civ.App. 1945).

In this respect, Wal-Mart earnestly contends in its briefs that the Arkansas case of Pyramid Life Ins. Co. v. Patten, 194 Ark. 987, 110 S.W.2d 526 (1937), is on point and represents not only the Arkansas rule, but the prevailing view. The court is convinced that a mere reading of that case shows that it is not, in fact, on point and is not, in fact, controlling to the least degree. The court was applying a 1937 statute that is not even similar in most respects to the one applicable to this case. At 194 Ark. 989, 110 S.W.2d 526, the court said:

> The statute, supra, does not appear to be aimed at those receiving life insurance policies, but rather against companies and their agents. It does not prohibit any person from receiving a rebate, and it does not declare any policy to be void where a rebate is given or accepted. It does prescribe the penalty for the violation of the law, and, under ordinary rules of construction, such penalty is exclusive. To give to the statute the effect contended for by appellant would be to enable it to take advantage of its own wrong. . . . Unless a statute prohibits the insured from receiving a rebate and denounces a penalty for its violation, it clearly appears that such statute is designed to regulate insurance companies and not to punish the public who deals with them. In the statute under consideration, no reference is made to the insured, no provision

is made for avoiding the policy, and it is clearly not the legislative intent that violations of the rebate law do more than inflict the punishment named therein.

The statutory scheme discussed in the Patten case is clearly different from the plan now in existence in Arkansas. Now, as discussed above, the law of Arkansas provides how premiums are to be calculated and does not allow rates or formulas for rates to be used that have not received prior approval from the Insurance Commissioner. In addition, as the court in Patten pointed out, there was then no statute that even, to the slightest degree, seemed to apply to the insured. That is no longer the case. Now, as discussed above, Arkansas law directs that no insurer knowingly receive any premium other than one properly approved and shown on the policy.

In fact, not only is the Patten case not on point, there is other Arkansas authority which holds that an agreement which violates an anti-rebate statute similar to the one now in existence in Arkansas is unenforceable. In Schneider v. O'Neal, 145 F. Supp. 120 (E.D.Ark. 1956), aff'd in part and rev'd in part, 243 F.2d 914 (8th Cir. 1957), Judge Trimble held that an agreement to give a rebate to a car dealer on insurance provided to the dealer in violation of the Arkansas rebate statute then in existence, and similar to the present one, is unenforceable.

VI. Doctrines of Waiver, Estoppel, and In Pari Delicto.

Wal-Mart contends that the Receiver should not recover because Transit has waived its right to do so, or is estopped from doing so. Based on the facts which the court believes exist in this case, as outlined in detail above, the court simply does not believe that the evidence supports the tests laid down for estoppel in cases such as Askew Trust v. Hopkins, 15 Ark. App. 19, 688 S.W.2d 316 (1985). In Arkansas, waiver is used interchangeably with estoppel, and for a waiver to be binding it must operate by way of estoppel. Continental Ins. Co. v. Stanley, 263 Ark. 638, 569 S.W.2d 653 (1978). The evidence simply does not support a finding that Transit or the Receiver knowingly waived any right granted to it by the insurance policies or is estopped from exercising those rights.

Wal-Mart also contends that the court should apply the doctrine of pari delicto[15] and leave the parties where it finds them. According to this doctrine, in a case where the court finds that the parties are in pari delicto, it will not allow itself to be made the instrument of enforcing obligations arising out of an agreement which is illegal. Wommack v. Maner, 227 Ark. 786, 301 S.W.2d 438 (1957); 17 Am.Jur.2d Contracts § 216. The obvious purpose of the rule is to discourage illegal agreements and it extends to any agreement which is illegal, immoral, against public policy, or prohibited by statute. Ganntt v. Ark. P. & L. Co., 189 Ark. 449, 74 S.W.2d 232 (1934); Tate v. Gould, 175 Ark. 306, 299 S.W. 24 (1927).

Because of the reasons for the rule, the court is convinced that it should not be applied in a case such as this one. To apply the rule in this case would not further the public interest and would not discourage illegal, immoral, and against public policy contracts. Instead, it would encourage them and allow Wal-Mart to walk away from this matter after having received 15 to 30 million dollars in benefits after paying premiums that are a fraction of that. As indicated, the "deal" which Wal-Mart received in this case was not in compliance with the law of any state, and Wal-Mart and its consultants didn't believe that it was. Why then should the court apply a rule that

[15] *In Pari Delicto*- Latin for “in equal fault”. It refers to an exception to the general rule that illegal transactions or contracts are not legally enforceable; thus, where the parties to an illegal agreement are not in pari delicto, the agreement may nevertheless be enforceable at equity by the innocent or less-guilty party [ed. Note].

has salutary purposes in such a way as to fly directly in the face of the laudable reasons for the rule?

Other courts have held that estoppel, waiver, mistake or other affirmative defenses of that nature are not available in workers' compensation cases brought to recover premiums based on rates promulgated and on file with the applicable insurance department. See Walker v. Bituminous Casualty Corp., 74 Ga. App. 517, 40 S.E.2d 228 (1946); Travelers Indemnity Company v. Collier, 205 Okla. 247, 237 P.2d 153 (Okla. 1951); Silver Threads, Inc. v. Insurance Company of North America, 530 S.W.2d 874 (Tex.Civ.App. 1975); Associated Employers Lloyds v. Dillingham, 262 S.W.2d 544 (Tex.Civ.App. 1953); Traders and General Ins. Co. v. Frozen Food Express, 255 S.W.2d 378 (Tex.Civ.App. 1953); Brown and Root v. Traders and General Ins. Co., 135 S.W.2d 534 (Tex.Civ.App. 1939).

In any event, the court is convinced that this is not a case in which Transit is attempting to enforce an illegal agreement. Instead, Wal-Mart is. Wal-Mart brought this lawsuit asking the court to enforce the "side agreement." If it is not enforced by the court, Wal-Mart is bound by the policies issued and accepted which require payment of additional premiums. As indicated above, there is a line of cases that hold that the court should not allow or consider parol evidence to show what the "deal" was when its purpose was illegal or made to deceive and mislead public authorities. See cases cited at page 39 of this opinion. If Wal-Mart is permitted to avoid its obligation to pay workers' compensation premiums according to state rates for the very substantial benefits that it received, it has successfully enforced an illegal contract made to deceive public authorities and has frustrated the purpose of premium regulations.

On the other hand, Transit does not seek to enforce an illegal contract. Its counterclaim is based on the policies which were issued, delivered and accepted by Wal-Mart. The policies are standard workers' compensation policies with premiums based on estimated payrolls, state rates, and experience modifiers promulgated as contemplated by the law of each of the states in which the policies were to apply. The policy form was approved and on file with the Arkansas Insurance Department at least as early as 1980 and contained the standard formula used throughout the country to determine the premium to be charged. The policies are completely separate and independent from the "side agreement" and the Receiver requires no aid nor reference to such illegal agreement in calculating the additional premiums owed. Thus, requiring Wal-Mart to pay the premiums called for in the valid policy is not an enforcement of an illegal contract, and in doing so, the court is only doing what the law of Arkansas and every other relevant jurisdiction requires.

For these reasons, the court finds it unnecessary to discuss the very complicated area of the law relative to whether a trustee or receiver may be prevented from enforcing a contract provision because of the acts of the bankrupt prior to the insolvency.

VII. Tail Coverage

The court has been asked by Transit to declare the tail coverage to be null and void because of misrepresentations made by and in behalf of Wal-Mart. The court finds that the evidence adduced at the trial simply does not support this. Unlike the workers' compensation insurance policies, the court can find no provision of law which does not permit that type of insurance. Apparently, the law allows anyone to insure about anything that they can find an insurance carrier to insure. If news media reports are accurate, that ranges from parts of a woman's anatomy to whether it will rain at a particular sporting event. The court can find no basis to hold that the tail coverage was not in compliance with law, and the evidence simply does not support a finding that Wal-Mart or its agents misrepresented the facts resulting in the incredibly bad deal that Miro made in behalf of Transit. Instead, the evidence is that the claims files in the Alexsis

office were offered to Miro, but that he declined to consider them. Incredibly, he decided that, because he was familiar with Alexsis, he would accept reserves established by its employees and would charge nothing for incurred but not reported claims, apparently because he was going to invest the premiums received in "Euro Dollars," whatever that means.

In this respect, it is appropriate for the court to say that the evidence reflects that there is more than enough fault to go around in this case. Transit and its managing agent, Muldoon, were guilty of very ample malfeasances. They loosed this disaster (Miro) waiting to happen on the public and on themselves with almost no control of it. The court has not ruled as it has because it finds the employees of Transit or Muldoon blameless by any means. Instead, the court is convinced that, for the reasons discussed, the law and public policy demand that Wal-Mart pay an adequate premium for the insurance it received and that it not be allowed to use its tremendous influence and bargaining power to require other employers or other members of the public to pay millions of dollars for claims paid to its injured employees.

The court finds the tail coverage to have been properly issued within the actual or apparent authority of Miro, and that policy is enforceable according to its terms.

VIII. Third Party Complaint Against Alexander & Alexander

Wal-Mart brought Alexander & Alexander into this lawsuit, asking that, in the event that judgment was rendered against it, Alexander & Alexander be ordered to reimburse it. The court finds, without question, that Wal-Mart's consultant did not serve it well. There is little question that Stanley and Hallinan, with a combined experience in the insurance business of over sixty years, should have known that this "deal" was too good to be true, and that it did not comply with the law of any jurisdiction. The court is convinced that, in fact, they did know that. For whatever reason, they did not, according to the evidence, advise Wal-Mart of this, and they are unquestionably derelict in their duties in not doing so.

After having said that, the court frankly doesn't know what it can do about it. What are Wal-Mart's damages? In the court's view, they were not proved at the trial. For the reasons indicated, the court is convinced that Wal-Mart is being required to pay for the coverage what the law requires it to pay. There was no evidence which indicates that, if Wal-Mart had been properly advised by Hallinan and Stanley, it could have gotten like coverage for some specified amount. As indicated, the court is overwhelmingly convinced that no other sane insurer would make the deal that Miro made. For this reason, there is no basis for the court to determine that Alexander & Alexander owes to Wal-Mart the difference between the premiums that it will be required to pay according to the policy, and the $3.5 million which Miro agreed to accept.

Likewise, there is no evidence from which the court could find that Wal-Mart could have received the same coverage for anything less than the amount that it is required to pay as a result of this lawsuit. It is true that some of Wal-Mart's witnesses testified that they believed that deals calling for premiums less than the manual rates could have been obtained, but there was no evidence from which the court can find that that is true nor certainly any evidence which indicates, even if true, what that coverage would have cost.

Since this is true, there is absolutely no basis for this court to award a judgment in favor of Wal-Mart against A & A on any basis other than pure speculation. The law simply does not allow that.

IX. Conclusion and Judgment

For the reasons set forth above, the court finds that Wal-Mart should be required to pay the premiums called for in the two workers' compensation policies of insurance discussed in detail above. Randy Watkins testified at the trial and submitted defendant's exhibit 40 as a summary of premium calculations which he made. The calculations, according to his testimony, were based on audits performed by White & White and John Sooter and rates contained in the 1983-84 NCCI manual. He reviewed Transit's filings for all applicable jurisdictions and applied appropriate deviations, experience modifiers and discounts, and computed the premium according to standard underwriting guidelines.

While Wal-Mart contends in its brief that his testimony was not adequate on damages, they failed to refute it during the trial to any degree, and did not offer evidence of their own. For this reason, the court believes that Mr. Watkins' testimony does correctly set forth the premiums that are due on the policies in question for the coverage provided.

Exhibit 40 contains two separate calculations for the premium for the policy year 1983-84. The reason for this undoubtedly was that, as the court recalls, while Wal-Mart's attorney did not object to the introduction of the first White & White audit, he contended that the payroll information was not correct. For this reason, Watkins also calculated the premiums for that year based upon what John Sooter said the payrolls were. There is a difference of in excess of $2,000,000 caused by this. However, because Wal-Mart's attorneys did not stipulate that the figures in the first audit were accurate, and because the White & White auditors were not called to testify, those figures, in the court's view, would be "hearsay." For this reason, the court will accept the premium determined on the basis of Sooter's estimate of the payroll for the first policy year.

This means that Wal-Mart owes total premiums for two years in the amount of $16,772,144.00. Such judgment will bear prejudgment interest from the date on which it was possible to calculate the premiums due. See Bank of Mulberry v. Fireman's Fund Ins. Co., 720 F.2d 501 (8th Cir. 1983), and cases cited in that decision.

Because the Receiver is in a better position than the court to determine on what date pre-judgment interest should commence, and because of the matter of certain funds being paid into the registry of the court, the court directs that Receiver's counsel prepare and forward to the court, within ten (10) days of the receipt of this opinion, a judgment in compliance with the court's decision. In respect to the pre-judgment interest issue, the court directs that the Receiver cite the court to the evidence in the record which establishes the date on which such interest should commence.

(This decision was appealed. The decision was upheld by Eight Circuit Court of Appeals 08/26/88.)

Chapter 7 HISTORICAL PERSPECTIVE

As an aid to understanding the workers' compensation issue, this section presents a past perspective on the subject; Selected Chapters Adapted from "Workmen's Compensation and Industrial Insurance- Under Modern Conditions" Vol I by James Harrington Boyd (1913).

This chapter offers a unique historical perspective on workman's compensation insurance. At that time the idea of workman's compensation was new and 'progressive.' The author points up the Socialist/Communist movement in Germany. The reader will keep in mind that the content was written on the eve of the Great War, before the Bolshevik revolution. Considering a historical background is helpful in understanding today's views on workers' compensation (or any other subject, for that matter).

I Distinctions Between Common-Statutory Law

§ 1. The common law system of employer's liability

Today, at common law, the employer's duty to his employé[16] is to use ordinary and reasonable care for the safety of his employé while he is performing his work. That duty includes:

(a) The duty to provide a reasonably safe place to work.
(b) The duty to provide reasonably safe tools and appliances.
(c) The duty of being reasonably careful in hiring agents and servants fit for work they are to do.
(d) The duty of providing suitable and reasonable rules for carrying on the work.
(e) The duty to warn and instruct youthful and inexperienced servants as to the dangers of the employment.

If a workman be injured by reason of the failure of these duties he may recover from his employer full compensation for his injuries, the amount of damages to be determined by a jury in the usual legal proceedings. Such a right of action is based upon the negligence or fault of the employer. This is the fundamental principle of the present common-law system brought down from the common law of England and which no statute of States or the Federal Government had changed up to the time of the enactment of compensation acts.
The employer has, 4owever, certain defenses to any action brought at common law, as it now exists, by an employé who has been injured in the due course of his employment, and which constitute a special body of so-called judge made law.

(1) THE DEFENSE OF CONTRIBUTORY NEGLIGENCE.

Contributory negligence is the negligence of a servant which is a contributing and proximate cause of his injury, and the burden is generally upon the employé in any action for compensation for injuries received to prove not only the negligence of the employer, but that he himself was exercising ordinary care and was free from negligence, directly contributing to the injury. The reasons for this rule are thus stated by Judge Thompson: "The rule that contributory

[16] Used in place of today's "employee."

negligence but a recovery is said to be founded on (1) the mutuality of the wrong; (2) the impolicy of allowing a party to recover for his own wrong; (3) the policy of making personal interests of parties depend on their own prudence and care." (1 Thomp. Neg. (2d ed.), § 168). The employé injured by his employer's neglect is therefore placed in the same position as a stranger so injured.

(2) THE FELLOW SERVANT RULE.

The fellow servant rule, as announced in the earlier decisions of our Supreme Courts, precludes the recovery by one servant for any injury occasioned by the negligence of another engaged in the same general business, if there had been ordinary care and diligence observed by the master in the selection of servants (Columbus, C. & I. C. R. Co: v. Troesch, 68 III. 545). This fellow servant rule is a special rule which applies only to the status of employment and has its origin in a decision by Lord Abinger in the Court of Exchequer in 1837, in the case of Priestly v. Fowler (3 M. & W. 1), and finally settled in England by the House of Lords in 1858 in Barstonhill Coal Co. v. Reid (3 Macq. House of Lords Cases, 266). It was followed in all of the states of the union up to the time of the enactment of employers' liability laws.

The Priestly case, decided by Lord Abinger, was not a case of injury in a hazardous employment such as a factory or a railroad, but a simple case where a butcher's helper was injured by a wagon driver hired by the same employer. The judge regarded it a hardship to hold the butcher liable for the injury which had no real relation to any fault of the butcher, because the helper could have guarded against the injury as well as the butcher. This hardship appealed to Lord Abinger and he decided in favor of the butcher. Lord Abinger's opinion reads as follows:

> It is admitted that there is no precedent for the present action by a servant against a master. We are, therefore, to decide the question upon general principles, and in doing so we are at liberty to look at the consequences of a decision the one way or the other.
>
> If the master be liable to the servant in this action the principle of that liability will be found to carry up to an alarming extent. He who is responsible by his general duty, or by the terms of his contract for all the consequences of negligence in a matter in which he is the principal, is responsible for the negligence of all his inferior agents. If the owner of the carriage is therefore responsible for the sufficiency of his carriage to his servant, he is responsible for the negligence of his coach maker, or his harnessmaker or his coachman. The footman, therefore, who rides behind the carriage, may have an action against his master for a defect in the carriage, owing to the negligence of the coach- maker or for a defect in the harness, arising from negligence of the harnessmaker, or for drunkenness, neglect or want of skill in the coachman; nor is there any reason why that principle should not, if applicable in this class of events, extend to many others. The master, for example, would be liable to the servant for the negligence of the chambermaid, for putting him into a damp bed; for that of the upholsterer for sending him a crazy bedstead; whereby he was made to fall down while asleep and injured himself; for the negligence of the cook in not properly cleaning the copper vessels used in the kitchen; of the butcher, in supplying the family with meat of a quality injurious to the health; of a builder for a defect in the foundation of the house, whereby it fell and injured both the master and the servant by the ruins.
>
> The inconvenience, not to say the absurdity, of these consequences affords sufficient argument against the application of this principle to the present case. But, in truth, the mere relation of the master and the servant never can imply an obligation on the part of the master to take more care of the servant than he may reasonably be expected to do of himself. He is no doubt bound to provide for the safety of his servant, in the course of his employment, to the best of his judgment,

information and belief. The servant is not bound to risk his safety in the service of his master, and may, if he thinks fit, decline any service in which he reasonably apprehends injury to himself; and in most of the cases in which danger may be incurred, if not all, he is just as likely to be acquainted with the probability and extent of it as the master. (Priestley v. Fowler, 3 M. & W. 1)

3. THE DEFENSE OF ASSUMPTION OF RISK.

The so-called "assumption of risk rule" is closely related to the fellow servant rule, the former rule really embracing the latter. Under this principle every risk which an employment involves after a master has done everything that he is bound to do for the purpose of securing the safety of his servants (including the employment of other servants) is assumed, as a matter of law, by each of those servants. The risks which are thus considered to have been assumed, are those which are commonly described as "ordinary." It is the settled doctrine of the law that the servant may reasonably be presumed to foresee that he will be exposed to the ordinary risks of the business in which he engages, although it may involve unusual or extraordinary hazards. The courts are wont to say that there is an "assumption of the risk," or an "implied contract," however, in the average case and that is merely a formula of words which the rule of the law happens to take. Even in dangerous employments there is usually no contract between the employer and the workman concerning the risk. Hazard of an employment does not fix the price of wages, they are fixed by competition.

The common law system of employers' liability has been developed along the same lines in the United States and Great Britain, during the period in which modern manufacturing with its factory system was replacing hand labor. It has been well said that "the development has been profoundly influenced by the belief of the courts that the necessity of profit in industrial enterprises demanded protection even at the expense of damage to certain industries. (See Report of the Employer's Liability Commission of Ohio, Part I, p. XVIIL)

§ 2. The system of employer's liability prior to the insurance and compensation acts.

The [common law] system of liability of employers in the States of the United States and the United States, speaking generally, is founded upon fault. That is, an employé who is injured while employed can only recover damages from his employer when the jury finds that the employer was negligent and that his negligence caused the accident. Even then the employé may not recover in case he was negligent and his negligence contributed to the cause of the injury, or the negligence of a fellow workman caused the injury, or he assumed that risk while working.
For injury due to the inherent hazards of the employment and accidents due to an act of God or for which the blame can not be fixed, the employer is not liable. These fundamental principles of the common law were accepted and enforced by all the courts of this country until the enactment of Workmen's Insurance and Compensation Laws by Montana, New York, Washington, Ohio, Wisconsin, Massachusetts, Ne\v Jersey, Illinois, Kansas, California, Michigan, Nevada, New Hampshire, Rhode Island, Maryland, Arizona and the Federal Government.

Prior to the enactment of Workmen's Insurance and Compensation Acts, the legal relation of the employer and his employés in the States and the United States were governed by the common law as modified by statutory liability laws.

Although there have been enacted, chiefly during the last ten years, Employer's Liability Laws by the United States and many of the States, they have not essentially changed the fundamental principles of the common law in this respect. The legal relation of employer and employé at common law in both England and United States prior to 1837 in no way differed from that of a stranger and there were no special rules respecting employers' liability. If A was injured on account of B's neglect and not by his own fault, B was bound to compensate A whether A was an employé or not. Since 1837 the Courts have made special rules respecting the liability for accidents in employment. The reason which the courts have assigned for this special body of judge made law is that they are exercising their duty in interpreting the contract of employment. 'It is to be noted that this body of purely judge made law was in process of making for about seventy years before compensation acts of any kind were passed in the States of the United States, or by the Federal government.

§ 3. The distinguishing characteristics of employer's liability laws

It should be noted, that for two hundred and fifty years after]; the Magna Charta was adopted, it was the law of England that one was liable to those injured by his acts or by the acts of persons or things for which he was responsible whether the cause of the injury was attributable to the fault of the defendant or not. The first suggestion that freedom from fault might excuse in such a case was made in 1466, but this rule did not become fully settled in England until 1891. In America there were decisions to this effect from 1820 and after, the most important decisions having been made between 1830 and 1850 (See "The New York Workmen's Compensation Act Decision" by Dean James Parker Hall, In *The Journal of Political Economy*, Vol. XLV, No. 8, October, 1911, p. 698).

In a later chapter on The Economic Basis of Workmen's Insurance and Compensation Acts (Chapter V), it is shown that an injured workman does not on the old idea of fault have a cause of action, in theory, against his employer, in to exceed eighteen per cent of all the cases, taken collectively, and in practice this per cent falls below twelve per cent. Impressed by this hardship upon injured workmen and their dependents, congress and the legislatures of some thirty of the States of the United States have enacted, within the last ten years, a number of employer's liability acts which have largely abrogated the common law defenses, set out in the preceding section. The following States have by statute abrogated the defense of fellow servant either by general statute or in particular industries (usually railroads): Arkansas, Colorado, Florida, Georgia (since 1855), Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, Nevada, North Carolina, North Dakota, Oklahoma, South Dakota, Texas, Wisconsin The best available summary of the laws of the other states appears In the Bulletin of the United States Bureau of Labor, No. 74 of January, 1908. The Colorado statute is the most striking example of this class since it completely eliminates the defense of fellow servant in every employment (this statute has been upheld as constitutional in Vindicator Min. Co. v. Firstbrook, 36 Colo. 498).

In the following States the defense of fellow servant is modified without being abrogated: California, Mississippi, Maryland, Ohio, Oregon, South Carolina, Utah, Virginia. In some or all of the States named, modifications of the common law have been adopted along the following lines (by statutes or by decision as to the common law):

(1) Adopting the doctrine of comparative negligence which allows a recovery notwithstanding contributory negligence, provided it is less in degree than the negligence of the master.
(2) Changing the burden of proof of contributory negligence, from the plaintiff to the defendant, which has always been the rule in the Federal Courts and some States.
(3) Taking away the defense of the assumption of risks when the risk assumed was caused by the fault or negligence of the employer.

§ 4. The modern conception of employer's liability

The old methods of manufacture, and even many of the old industries, have become obsolete and have been superseded by rapid, complicated and hazardous methods growing out of improvements directed towards the cheapening of products, and the ancient relation of employer and employé, under which the employé generally worked beneath the eyes of the employer, has ceased to exist. In modern times, the employer has little personally to do with the employé, and necessarily their mutual personal interest is no longer the same. Notwithstanding the great changes in the character of the employment and in the hazards, there has been for years practically no change in the law governing the relation; so that thoughtful persons are almost unanimously of the opinion that the law now governing employer and employé, with respect to injuries done to the latter, in hazardous industrial occupations, is unjust to both employer and employé and a source of unfair oppression to the employer and a cause of unmerited hardship to the employé.

Many suggestions have been made as to a remedy, but commissions on Employer's Liability are strongly of the opinion that the industry itself should bear the burden and not the employé. The industry now bears the burden of the wearing out and destruction of machinery necessarily resulting from its use, and civilization now demands that the industry bear also the burden of the wearing out and destruction of the efficiency of the human machines without which the industry could not survive. In bringing this about, radical changes in the law governing employer and employé must be made. When a man's life is lost, or his efficiency decreased through injury in his employment, humanity demands that his dependents in case of his death, and he himself in case of injury, shall be cared for. This care must be given either by the community at large, or by the industry in which he was engaged when injured. We have not progressed so far in this country that the State will care for everybody except for charity's sake; but as the injured employé must be cared for, and as the ancient legal fiction of assumption of the risk in the dangerous employment of modern industry is unjust to the employé, it seems fitting that some device spreading this burden throughout the whole industry shall be created, and the employer protected from oppression by law suits and prolonged litigation, and the employer relieved from the necessity of seeking redress in the courts for loss of ability to earn a livelihood, of which he has been deprived by accident. N or is this in any sense charity, but only simple justice.
A change in the law should insure to the employé quick, practically immediate relief by way of support and medical attendance, coupled with an assurance of future support.

Some objection might be made to imposing this obligation upon the industry, upon the ground that the employé should bear his share of the burden, in view of the fact that such a scheme Is practically in the nature {)f accident insurance; but it seems more feasible to impose the whole burden upon industry because, like all the other losses growing out of depreciation in machinery and in the plant and other expenses, this added charge will be taken care of in the prices obtained by the employer for the products of the industry (Report of Employer's Liability Commission of Ohio, Part I, p. XV).

§ 5. The distinguishing characteristics of workmen's compensation acts

During the years 1910, 1911, 1912, there have been passed Workmen's Compensation Acts in eleven states of the United States and by the United States government as follows:

- The New York Law enacted in session of 1910 and held unconstitutional March 24, 1911;
- The New Jersey Law approved April 4, 191 I, and took effect July 4, 1911;

- The Wisconsin Law passed session of 1911 and became operative September 1, 1911;
- The California Law enacted session of 1911 and became operative September 1, 1911;
- The Kansas Law enacted by the session of 1911 and took effect January 1, 1912;
- The Illinois Law passed at the session of 1911 and became operative May 1, 1912;
- The Michigan Law passed at the session of 1912 and took effect September 1, 1912;
- The Arizona Act took effect September 1, 1912.
- The Nevada Law passed at session of 1911 and became operative July 1, 1911;
- The Ne\v Hampshire La\v approved April 15, 1911, and took effect January 1, 1912;
- The Rhode Island and Providence Plantation Law approved April 29, 1912, and took effect October I, 1912, and
- The Federal Compensation Acts of May 30, 1908; March 4, 1911; March 11, 1912, to provide compensation to injured government employés on and after August 1, 1908.

The employer is personally liable for the compensations to be paid an injured worker under both systems, Employers' Liability Laws and Workmen's Compensation Acts. In the case of Compensation Acts, however, the only negligence recognized on the part of either the employer or employé, speaking generally, is that of willful negligence. Where the employer is guilty of this form of negligence, he is penalized; where the willful negligence is that of the employé, he is denied his compensation or is penalized or has his compensation reduced. In compensation acts the amount of the compensation is determined within a maximum and minimum limit by specified schedules of compensation fixed in the law and are graded on a basis of a certain percentage of the loss or impairment of the injured worker's average weekly wage. Jury trials are either largely or wholly eliminated, and the compensation, to which the injured worker is entitled under the act is determined by a board of arbitration, a judge of some court or a board of awards created or specified by the act.

§ 6. The distinguishing characteristics of workmen's industrial insurance laws

Workmen's Industrial Insurance Acts have been passed in five States as follows:

- The Ohio Act enacted in May, 191 I, and became operative January 1, 1912;
- The Washington Act was passed March, 1911, and became operative October 1, 1911:
- The Massachusetts Law approved July 28, 1911, and took effect July 1, 1912; and
- The Montana Mining Law approved March 4, 1909, and declared unconstitutional by the Supreme Court of Montana, November, 1911.
- The Maryland Act, became operative April IS, 1912.

The enactment of Compensation Acts and Workmen's Industrial Insurance Laws, in particular, introduce remedies for the compensation of injured workmen, which on principle are new to the jurisprudence of the United States. There are fundamental differences between the principles of Workmen's Industrial Insurance and those of Employer's Liability Laws or Compensation Acts of the type of the English, New York or Wisconsin Acts. The injured workman's claim under a state insurance act is against a fund which is created by contributions paid by employers, employés and the State or by any of them, in the form of an insurance premium which is collected t by the taxing power of the State through the exercise of its police power. The employer's liability to his employés on account of personal injuries occurring in the due course of their employment is discharged when he has paid the premiums provided by the act. The right of trial by jury is entirely eliminated in such cases, excepting the case where the employé is denied compensation of any kind and in that case he may sue the board of administration created by the act and have his case tried before a jury as heretofore but can not sue his employer. No

negligence of any kind is recognized either on the part of the employer or employé, speaking generally, excepting the willful negligence on the part of either. In case the employer caused the accident by willful act or by disregarding Factory Inspection acts and orders, he is subjected to some kind of penalty, and in case the injured worker willfully caused the accident for the purpose of obtaining compensation, he is denied any compensation or has it reduced or is penalized. The compensation is paid in installments and based upon a certain percentage (usually 50 to 60 per cent) of the impairment of wages caused by the accident. The act usually fixes the length of time that such compensation may run and also a maximum and minimum total compensation. In the enactment of these statutes the State exercises its police power for the protection of the peace, safety and general welfare of the public.
The primary object of industrial insurance for workmen is to provide a reasonable compensation which shall be paid without fail and at a minimum cost of administration, to the injured worker and his dependents, at stated intervals, so that his dependents shall not, in case they are minors, suffer in attaining a normal development which is necessary for self-support, and in order that neither the injured workman or his dependents shall become public charges, by reason of bodily injuries which the worker received in the due course of his employment. From the standpoint of the public, the effect of a serious bodily injury received by such a workman is the same whether the cause of the injury is attributable to the negligence of the employer or to that of his employé, or that of a fellow-workman, or is caused by an act of God. It is assumed that the case is very rare that either the employer or his employé will willfully cause an injury covered by such a law.

II Historical Sketch of Development…

§ 7. Inception of movement for these laws

The movement for the enactment of more just and humane laws to take the place of the outgrown common-law remedy for the compensation of workmen for injuries received in the course of their employment became widespread in the United States about the beginning of this century. The movement received its first legislative recognition in New York when the Legislature of that state passed an act which authorized the appointment of a commission "to inquire into the working of a law in the State of New York relative to the liability of employers to employés for industrial accidents and into the comparative efficiency, cost, justice, merit and defects of the laws in other states and countries relative to the same subject and as to causes of accidents to employés."

Pursuant to the statute a commission of fourteen members was appointed in May, 1909, three from the Senate, five from the Assembly and six from industrial and professional walks of life, all of whom were eminently qualified for the work to be done. This commission made its report to the legislature in March, 1910, and the bills reported by the commissioner were virtually adopted by the legislature with but few dissenting votes, there being only four dissenting votes in the House against it. The bill is in the form of a compulsory workmen's compensation law affecting eight classes of hazardous employments. A copy of the law and the opinion of the Court of Appeals holding the act unconstitutional are given in a later chapter. The conclusions of the report of the New York commission respecting the important economic and sociological principles of law involved in their investigations are fully set forth in this opinion.

§ 8. Previous investigation of the problem

Every civilized nation in Europe and many other nations in other parts of the world except the United States have discarded the old system of Employer's Liability based upon fault and substituted a system under which every industry bears the burden of relieving the distress caused by injuries to workers in any given industry practically without litigation. The German system of insuring the workers in all of its industries against sickness, accidents and old age, was inaugurated during the period from 1883 to 1887. Great Britain enacted her Compensation Act in 1897 and the same was amended and broadened in its scope in 1900, 1906 and supplemented in March, 1912 by David Lloyd-George's Insurance Law against sickness, old-age and out-of-work. The prime mover in the adoption of the German system was Prince Bismarck. In England these laws were ably championed by Lord Salisbury and Mr. Chamberlin.

The subject first attracted the attention of legislative agents in the United States in 1893 when the investigation of the German system by John Graham Brooks was published in The Fourth Special Report of the Commissioner of Labor of the United States, Carroll D. Wright. In 1898 William Franklin Willoughby published a careful study of foreign industrial insurance, and in 1900 the report of the Commissioner of Labor of New York (Senate Documents, 123d Session, 1900, Vol. 10. Part II, written by Adna F. Weber) contained an intelligent study and report upon the experience of European nations with this kind of insurance and compensation for injured workers. The Commission which was appointed to investigate the subject in Massachusetts in 1904, recommended the adoption of a plan modeled after the English Compensation Act of 1897, but the bill reported by the commission was not passed. A commission in Illinois recommended a workmen's compensation law of a similar nature in 1907. This bill in like manner failed of passage. A commission was appointed in Connecticut in 1908 to investigate the same subject but it was unable to reach any definite conclusions. During the year 1910 congress and the legislatures of Massachusetts, Minnesota, New Jersey, Connecticut, Ohio, Illinois, Wisconsin, Montana, and Washington authorized the creation of commissions to investigate employers liability laws and the various plans for the compensation of injured workmen, with the result that commissions were appointed in all of these states and by July, 1911, were engaged in their investigations.

§ 9. The Chicago conference of employer's liability and workmen's compensation commissions

In 1910 there was held in Chicago a Conference of Commissioners on Compensation for Industrial Accidents from United States government, Illinois, Massachusetts, Minnesota, Montana, New Jersey, New York, Ohio, ,Washington, Wisconsin, Connecticut and the committee on Uniform State Laws and United States Bureau of Labor. This conference met November 10, 1910, and remained in session for three days. Its officers were H. V. Mercer, of Minneapolis, chairman, and Amos T. Sanders, Clinton, Mass., secretary. The various commissions and their membership were as follows:

[Attendees names omitted- space considerations]

§ 10. Subjects discussed

The work of this conference covered seven sessions during which were discussed the following fourteen propositions relating to workmen's compensation:

1. What employments shall the act cover?
2. Shall all injuries be covered, irrespective of negligence?
3. Shall all persons engaged in such employments be included?

4. Shall compensation be paid in a lump sum or in installments?
5. Amount and duration of compensation?
6. Length of waiting period?
7. Shall dependents include aliens and illegitimate relations?
8. Shall employés contribute?
9. Shall it be permissible for employers to substitute voluntary schemes?
10. Method of determination of controversies?
11. Nature of scheme: Compensation, insurance, or State insurance,
    (a) Voluntary,
    (b) Compulsory?
12. Repeal of other laws?
13. Constitutionality?

§ 11. Conclusions of the Chicago conference

The conclusions of this conference were drafted into a law, the fundamental provisions of which may be briefly stated as follows: The act provides a compulsory and exclusive remedy, with a waiting period of two weeks during which time the injured workman may be allowed compensation by way of medical attendance and hospital bills and funeral expenses not to exceed $100.00; it covers all hazardous employments and the compensation to be paid to injured workers or dependents is based upon 50% of the loss of wages caused by the injury without regard to fault or negligence excepting malicious negligence, payments to be made monthly and to continue so long as the disability lasts, not to exceed three hundred weeks, and lump sum payments to be made at the discretion of the Board of Advisors; the compensation in any case not to be more than $10.00 per week and in case of death or total disability not less than $5.00 per week; in case of death the compensation to dependents shall continue not longer than three hundred weeks and in case of total disability so long as total disability lasts not to exceed 300 weeks.

§ 12. The work of the State commissions

Since the Chicago Conference of Commissions and during the year 1911 and the first six months of 1912 the legislatures of the states of Ohio, Washington and Massachusetts have enacted Workmen's Industrial Insurance Laws and New Hampshire, New Jersey, Illinois, Michigan, Wisconsin, Kansas, Nevada, Rhode Island and California have enacted Workmen's Compensation Acts. During the spring of 1909 the Montana legislature enacted an Insurance Compensation law affecting the employés of mines only. Similar commissions are now at work on the recommendation of compensation acts in other states and are required to report to their respective legislatures.

§ 13. Executive recommendations

Since 1908, the subject of workmen's compensation has received frequent consideration from Congress with respect to the employés of employers who are engaged in interstate commerce and in the government service. President Roosevelt on January 31, 1908, sent a message to the Congress in which he advocated the passage of such laws to bring relief to injured workers in such employments and indicated at the same time the duty of the legislatures of the several States in this respect. In that message the President said, "I also very urgently advise that a comprehensive act be passed providing for compensation by the government to all employés injured in the government service" * * * and further, "The same broad principle which should

apply to the government should ultimately be made applicable to all private employers. Where the nation has the power it should enact the laws to this effect. Where the States alone have the power they should enact the laws" * * * The Federal Workmen's Compensation Act affecting employés of the Government service was passed by Congress and approved by President Roosevelt, May 80th, 1008. Governor Hughes, of New York in his 1909 annual message advocated the enactment of like legislation for the protection of injured employés.

§ 14. The Federal employers' liability and workmen's compensation commission

This Commission authorized and created pursuant to a joint resolution of Congress, conducted extensive investigations during the year 1910 and 1911 and inquired into the economic conditions affecting employés of railroads engaged in interstate commerce only. The commission conducted hearings in Washington and Chicago and made their report to Congress in December, 1911, and recommended a workmen's compensation law obligatory and exclusive in nature affecting the employés of railroads engaged in interstate commerce only.

III Brief Historical Review of the German Plan (Omitted)

IV Origin and Development of Compulsory Industrial Insurance for Workmen in Germany (Omitted)

V Economic Basis of Compulsory Industrial Insurance

§ 33. Statement of problem from the economic standpoint

It is proposed in this chapter to present the economic basis for the substitution of a new remedy, namely, compulsory industrial insurance for working- men, or workmen's compensation acts, in lieu of the common and statutory liability law remedies, as a means for compensating workmen who are injured in course of their employment. It will be shown not only that the common (and liability) law remedy in its present form does not furnish compensation of any kind in to exceed 12% of the cases of injuries to employés, and even in those cases in which compensation is paid, the compensation paid does not on the average exceed one-fifth of what is regarded as adequate compensation, but also that no modification of the common law remedy can be made whereby these results will be materially improved. Hence that the old common law remedy must be abandoned and a new remedy substituted therefor.

§ 34. Statistical studies exhibiting effects of old and new systems of compensation

In the evolution of economic and sociological problems of a nation, already largely industrialized, gross inequalities in the material condition of the different classes of its citizens arise, and when the public mind becomes conscious of the hardships flowing from these inequalities, the legislative and judicial arms of the state are called upon to regulate, to equalize, and to adjudicate equitably such economic abuses and hardships. The first steps to be taken in adjusting and relieving society of the said abuses are to inquire into and determine what the exact causal facts are, from which flow these abuses, before the legislative and judicial arms of

the State can formulate and apply a just and equitable remedy. It is the determination of the causal facts of these economic abuses and the magnitude- of their evil effects that constitute the most difficult step to accomplish, and upon the clear determination of which the legislatures and the courts of last resort insist first upon knowing, before they will enact and sustain the putting into operation of an adequate remedy for the injurious economic abuses involved in this problem.

Therefore, the discussion of "what provisions can be made for workingmen and their dependents, to avoid the economic insecurity which accompanies the modern wage system," resolves itself into the following plan:

(A) The location and determination of the causal facts and their fundamental characteristics which pro- duce the economic insecurity of workingmen, and characteristics which accompany the modern wage system, shall first be analyzed.

(B) The remedy to cure these economic inequalities and in what way the legislative and judicial authorities of the States can put the proposed remedy into operation and perpetuate the same.

§ 35. Statistical experience under compulsory State insurance in Germany

In 1887 there were insured against sickness and accidents in Germany 3,861,560 workingmen among 319,453 establishments, (Fourth Special Report of the Commissioner of Labor, 1893, p.82) and the number of notices of accidents was 106,001. A special analysis of the different elements of the causes of these accidents will be found in the following section.

	Persons Insured
In 1907, these were Insured In Germany against accidents:	
Industrial, building, and marine trade associations (associations, 66; establishments, 637,118)	9,018,367
Agriculture and forestry trade associations (associations, 48; establishments, 637,118	11,189,071
State executive boards (boards, 5350	964,589
total	21,172,027
In 1897 there were insured in Germany against accidents in the same associations and 409 State executive boards, in round numbers	18,500,000

§ 36. The question of fault and prevention of accidents-Compensation-German statistics

The following table shows the accident statistics of industries for the three years, 1887, 1897 and 1907, under the German law:

By fault of-	1887 Per cent	1897 Per cent	1907 (46,000 accidents) Per cent
Employer	20.47	17.30	16.81
Employé	26.56	29.74	28.89
Both parties	8.01	10.14	9.94
Due to negligence of the parties	55.04	57.18	55.64
Due to inevitable risks of the industries and other causes	44.96	42.82	44.36
	100.00	100.00	100.00

This table, covering a period of 20 years of experience, shows not only the elements of fault which enter into the problem, but also supplies a valuable basis for further improvement of preventive measures, since from 55 to 57 per cent of all accidents are due either to the fault of the employer, employé, or their combined negligence. It is of interest in this connection that the tables of the Minnesota and Wisconsin labor departments ascribe from 40 to 50 per cent of all industrial accidents, on the average, as due solely to the inevitable risks of the business. The Austrian tables show 70 per cent are attributed to this cause (Report of the New York Commission, p.255). It is first to be noted that this table represents the experience of the operation of the compulsory German State Insurance Law, for a period of 25 years, under the operation of which, from 4,000,000 to 21,000,000 workingmen and their dependents engaged in all possible industrial, governmental, and agricultural occupations of a great nation, with respect to the determination of the element of fault entering into the causes of accidents to workmen. We shall define the natural hazard of any occupation by the equation:

Inevitable risk + combined negligence of both employer and employé = natural hazard.

From this table it follows:

	1897	1897	1907
Fault of both parties	8.01	10.14	9.94
Inevitable risks	44.96	42.82	44.36
Natural hazard	62.97	52.96	54.30
Average, 53.41 per cent			

During the period 1887-1897 there were put under the operation of the German law the workingmen employed in the occupations of agriculture, forestry, building trades, to the number of 12,250,000, who heretofore were not insured (Frankel and Dawson, Workingmen's Insurance In Europe, p. 101). This large class of workingmen were the most ignorant and poorest trained of all the workingmen insured under the law. It will be seen that the per cent of the causes of accidents attributable to the negligence of the employé increased from 26.56 per cent in 1887 to 29.74 per cent in 1897, an increase of almost 3 per cent. During the next decade, 1897-1907, this element of fault fell from 29.74 per cent to 28.89 per cent while the number of such workingmen remained practically at the 12,000,000 mark. This is due to a gradual improvement of the ways and means of preventing accidents so carefully studied in Germany. The superior intelligence of the employers made a more marked improvement in the reduction of the element of fault due to the employer's negligence. Thus the causes of accidents attributable to the employer in 1887 was 20.47 per cent; in 1897 it fell to 17.30 per cent; and during the next decade it fell to 16.81 per cent in 1907. But, notwithstanding these improvements in the reduction of the element of fault, yet the per cent of the causes of accidents due to natural hazard remains practically constant, as shown, at 53.41 per cent.

This leads us to the first fundamental conclusion of primary evidence in our problem:
That no matter how careful the employer is, or how careful the employé may be, or how high the efficiency of the State may rise in the application of ways and means in the prevention of accidents, the natural hazard remains practically constant. That on the average from 52 per cent to 53 per cent of the causes of all accidents are due to the natural hazard of the business.

1.) This is the first element of insecurity of workingmen under the modern wage system, for the reason that an injured workman can not recover at all in an action at law for damages on

account of an accident received while working for his master until he can prove that his master was negligent and that such negligence was a contributing cause to his injury. The object of giving an injured workman a cause of action for injuries is not only to compensate the workman especially in the case of death or total disability, but principally to furnish some compensation to his dependents, who might become public charges when their means of support are cut off by such an accident. The entire equity side of our courts has been built up on the theory that justice should be done between man and man when the common law does not furnish any remedy or does not furnish an adequate remedy. Here in this problem there is the one element alone of 52 per cent of all cases of injury for which the common law does not presume to furnish any relief at all- none for the injured workman and none for the dependents who, in most of such cases, must be supported by the community in which they live.

2.) This leads us to the second 'fundamental conclusion of primary evidence in our problem. The table shows that the element of the causes of accidents which were attributable to the workingmen's own negligence (taking the workmen of a State or Nation as a whole) is on the average: 1/3 (26.56 per cent + 29.74 per cent + 28.89 per cent) = 28.39 per cent). The effect on dependents is just the same whether the cause of the injury was due to the negligence of the employé, to that of the employer, or to the natural hazard of the business. The common law in theory denies the injured workman relief in all of these cases, to-wit, 28.39 per cent, and, further, there is no cause of action at all in the 53.41 per cent of the cases due to the natural hazard. Or in the combination of the two elements, natural hazard and negligence of the workmen, that is, in 81.80 per cent of the cases of injury the common law does not presume to furnish any compensation either to the workman or his dependents.

3.) The third conclusion of primary evidence in our problem relating to the economic insecurity of the workingman under the modern wage system in the United States is:
That the per cent of cases of injuries to working- men, the causes of which are attributable to the negligence of the employer, is on the average but 18.20 per cent of the cases.

It is susceptible of proof that the foregoing elements of negligence of employer, employé, and natural hazard are practically the same in the United States as they are in Germany.
It will be hereafter shown in presenting the "Statistical experience of workingmen under the common law and liability laws in the United States," that while in theory the common-law remedy furnishes compensation in 18.20 per cent of cases of injuries to working men, that, however, in practice that compensation in any amount is paid in less than 6 per cent to less than 12½ per cent of the cases, and then only in amounts about one-fifth of adequate compensation.

§ 37. Experience in New York

During the years 1906, 1907 and 1908, ten insurance companies, which keep employers' liability records, doing business in New York, received in premiums from-

Employers	$23,524,000
Paid to injured employés	8,560,000
Waste	$14,964,000

(First report of the Employers Liability Commission, New York. p.31.)

Nothing could more strikingly set forth the waste of the present system. Only 36.34 per cent of what employers pay in premiums for liability insurance is paid in settlement of claims and suits.

Thus, for every $100 paid out by employers for protection against liability to their injured workmen, less than $37 is paid to those workmen; $63 goes to pay the salaries of attorneys and claim agents whose business it is to defeat the claims of the injured, to the cost of soliciting business, to the cost of administration, to court costs, and to profit.
Out of this 36.34 per cent the injured employé must pay his attorney. The same report shows that the attorney gets 26.13 per cent of what is paid to the injured employé. This investigation covers 46 cases where the recovery was above $1,500 each. In small recoveries the attorney fees take a larger proportion. This report shows that not more than somewhere between 20 and 25 per cent of the money paid by the employing class goes actually into the pockets of injured workmen for their dependent families in death cases.

§ 38. The Pittsburgh survey

The investigation -recently conducted in Allegheny county, Pa., under the direction of the Pittsburgh survey showed that out of 355 cases of men killed in industrial accidents, all of whom were contributing to the support of others and two-thirds of whom were married, 89 of the families left -received not more than $100, and 61 families received something more than this $100. In other words, 57 per cent of these families were left by their employers to bear the entire burden of income loss and granting that all unknown claims would be decided for the plaintiffs, then only 26 per cent received in compensation for the death of a regular income provided more than $500, a sum which would approximate one year's income of the lowest paid of the workers killed (*In Work Accidents and their Cost* by Crystal Eastman, Charities and the Commons, March, 1909). The proportion of the loss borne by employers in injury cases does not differ greatly from that in death cases. Thus, out of 288 injury cases, of the married men alone, 56 per cent received no compensation; of single men contributing to the support of others, 69 per cent received no compensation; of single men without dependents, 80 per cent received no compensation.

§ 39. The Wisconsin bureau of statistics

The great financial losses borne by the workmen are set forth by the Wisconsin bureau of labor and statistics in the following report of 306 non-fatal cases of injuries:

	Cases	Per Cent
Received nothing from employer	72	23.5
Received amount of doctor bill only	99	32.4
Received amount of part of doctor bill only	15	4.9
Received something in addition to doctor bills	91	29.7
Received something but not doctor bills	29	9.5
Total	306	100.0

In other words, we may say that in two-thirds of the cases part or all of the doctor bills were paid, but in less than one-third was anything more paid, and in about one-fourth of the cases nothing whatever was paid. Of 131 non-fatal cases in Wisconsin, concerning which reports were secured by factory inspectors, the following disposition was made:

	Cases	Per cent
Received nothing from employer	23	21.37
Received doctor bills only	56	42.75
Received something- doctor bills	10	7.63
Received something, but not doctor bills	34	25.96
Not settled	3	2.29
Total	131	100.00

§ 40. The report of the Illinois commission

The employers' liability commission of the State of Illinois has recently made a report of its investigation of industrial accidents and employers' liability at a cost of $10,000. The summary which follows is taken from statistics prepared by Edwin B. Wright, Secretary of the Commission.

More than 5,000 individual accidents were investigated and recorded, together with comparative figures and analysis. A few words as to what the report shows may be of value:

- Six hundred and fourteen fatal accidents are recorded. The families of 214 of these workers received nothing in return for the loss of the bread-winner.
- One hundred and eleven damage suits are pending in court. Twenty-four cases have been settled through court proceedings. Two hundred and eighty-one families settled direct with the employer.
- Skilled railroad employés, in settlement for death claims, averaged about $1,000; steel workers, $874; railroad laborers, $617; skilled building tradesmen, $348; skilled electric railway employés, $310; unclassified workmen, $311; miscellaneous trades, $292; packing- house employés, $234; general laborers, $154; mine workers, $155; electric railway laborers, $75; teamsters, none; building laborers, none.

A further summary may be offered. Of every 100 industrial accidents, 15 go to court-7 are lost and 8 are won. Ninety-two injuries out of every one hundred receive no compensation. This includes both fatal and non-fatal accidents. Another interesting feature is this: A thorough search through the record reveals 53 fatal cases of recent date. In fatal cases the usual defenses of the employer-the fellow-servant doctrine, assumption of the risk, etc. - did not apply or there would not have been a recovery at all.

For these-the very pick of industrial cases-the average recovery for death was only $1,877.36. Of this an average amount of $750.95 was paid to attorneys or expended in court fees, etc., leaving an actual payment of $1,126.41 to the family of the dead worker. Thirty- four widows were compelled to seek employment and 65 children left school to help keep the wolf from the door.

§ 41. Ohio statistics

The following table shows the results of investigations of the economic effects of industrial accidents on workingmen and their dependents, for the period of 1905-1910, in Cuyahoga county (Cleveland), Ohio, prepared under the direction of the author for the Ohio legislature (See Report of the Employers' Liability Commission of Ohio, Pt. I, pp. XXXV-XLIV).

Table Showing Per Cent Receiving Settlement in Fatal Cases

Civil status of decedent	Number of cases taken from coroner's records	No. receiving settlement through probate court	No. settling without going to probate court	No. security awards in court of common pleas	Per cent. Securing settlement.	Per cent. Not securing settlement.
Married	115	37	10	1	41.7	58.3
Single	60	14	____	1	25.0	75.0
Total	175	51	10	2	36.0	64.0

A settlement was made with the dependents in 36 per cent of all the cases, and in 42 per cent of those in which the decedent left a widow. In practically all of these cases an amicable settlement

was made with the representative of the deceased, appointed by the probate court, either out of court in the first instance or after the institution of a suit.

§ 42. Average amount received in settlement in Ohio under old system

An examination of 285 fatal cases proved that the average amount paid per case was $838.61. In 176 of these cases the decedent left a widow, and the average settlement was $1,056. The exact figures are given in the following table:

Table Showing Average Amount Received in Death Cases

Civil Status of Decedent	Number of Cases	Average Amount Received
Married	176	$1,056.51
Single	109	485.87
Total	285	$838.61

The amount received varied from funeral expenses to $5,000. In the case of the dependents of 109 single workingmen killed, the average amount received was $485.87.

TABLE SHOWING AVERAGE AMOUNT OF SETTLEMENT OF FATAL CASES WITHIN SPECIFIED LIMITS, AS DISCLOSED BY COURT RECORDS.

Range of Amount of Settlement	Court in which Settlement was Made	No. of Cases	Average Amount of Settlement
Up to $300	Common please court	15	$178.93
	United States circuit court	4	187.50
	Probate Court	116	161.05
	Total	135	$163.83
$300 to $1,000	Common pleas court	14	$542.85
	United States circuit court	10	587.54
	Probate court	83	507.78
	Total	107	$519.81
$1,000 to $2,000	Common pleas court	8	$1,231.25
	United States circuit court	14	1,290.00
	Probate court	49	1,270.59
	Total	71	$1,269.98
$2,000 to $4,000	Common pleas court	6	$2,241.67
	United States circuit court	7	2,364.28
	Probate court	29	2,704.13
	Total	42	$2,581.13
$4,000 and over	Common pleas court	1	$4,500.00
	United States circuit court	6	5,419.17
	Probate court	8	4,687.74
	Total	15	$4,991.66
	Total in common pleas court	45	$915.20
	Total in United States circuit court	40	1,775.26
	Total in probate court	285	838.61
	Total	370	$949.19

First. That the total amount of compensation received by the dependents of 313 workingmen out of a total number of 370 killed (or 87.86 per cent) of those receiving settlement is $165,905.35, which is only 47.81 per cent of the total amount, $351,200.35, paid to the dependents of the 370 workingmen killed; that the total amount of compensation received by the dependents of 57 of these 370 workingmen killed (or 12.14 per cent of those receiving settlement) is $183,295, which is 52.19 per cent of the total amount paid the dependents of the 370 workers.

Second. That on the average in Ohio, taking the best 15 cases out of the 370 families left dependent by death of the breadwinners, receive on the average $4,- 991.66. Deducting now (see next section) 25 per cent for attorney fees and $300 for doctors' bills, funeral expenses, and interest due to delays in making settlements (assuming that the largest damages are paid to the earners of the largest wages), we have $3,443.75 as the maximum compensation paid under the present sys- tem on an average for each of the best 4 cases out of 100 families left dependent when the head of the family is killed in industrial employment. The obligatory industrial insurance act passed by both houses of the Legislature of Ohio in May, 1911, provides a maximum of $3,400 and a minimum of $1,500, and doctors' bills and hospital expenses not to exceed $200 in all cases.

§ 43. Attorney fees under old system in Ohio

It was intended to give in the following table an accurate idea of what per cent of the amount of settlement is retained by the plaintiff's attorney as remuneration for his services. Specific amounts were ascertained in so few cases however that the table as given will be misleading unless taken with a few grains of allowance. The great majority of the cases included in it were settled either out of court or before going to trial. The average for these cases is shown to be about 24 per cent and this includes both fatal and non-fatal cases. The table shows that approximately one-fourth of the amount received was paid out as plaintiffs' attorney fees and as court costs.

TABLE SHOWING ATTORNEY FEES UNDER OLD SYSTEM IN OHIO

Court	Number of cases in which amount of fees was ascertained	Total amount of settlement	Total amount of attorney’s fees	Per cent
Common pleas	53	$78,500	$20,650.82	26.3
United States circuit court	13	56,850	14,100.00	24.6
Probate Court	88	97,862	19,918.73	20.3

§ 44. Social and economic results of accidents

An individual investigation to determine the social and economic conditions of families deprived by industry of their breadwinners was made in 86 cases. The results, as compiled in the following table, show that nearly 56 per cent of the widows were compelled to go to work, and at an average weekly wage of $5.51. Altogether in these homes there were 178 children, about 70 per cent of whom were under twelve years; 59 per cent of the others were forced to go to work. The wretched condition in which some of these families were found can not be depicted by means of tables.

TABLE SHOWING SOCIAL AND ECONOMIC CONDITIONS OF WIDOWS AND CHILDREN.

WIDOWS

	Number	Number compelled to go to work	Per cent of those visited	No. compelled to work whose wages were ascertained	Per cent of those who worked	Average weekly wages
Widow's homes visited	86	48	55.8	38	79.2	$5.51

CHILDREN

Ages	Number	Number to go to work	Per cent
Under 12	124		00
12 to 18	45	27	60
18 to 21	9	5	55
Total	178	32	

Fifty-six per cent of the widows visited and 18 per cent of the children were forced to go to work to earn a livelihood as a result of the industrial accidents.

§ 45. Liability Insurance Statistics in Ohio

In making settlements of 65,800 accidents covering a period of about eight years, in Cleveland, Ohio, the Aetna Liability Insurance Co. made payments of any kind in only 6 per cent of the cases (See Report of Ohio Employers' Liability Commission, Pt. II, p. 208).

§ 46. German statistics analyzed

In 1887 there were insured in Germany 3,861,560 workingmen among 319,453 establishments, and the number of notices of accidents was 106,001. The German analysis of the 15,970 accidents which incapacitated workmen for more than 13 weeks shows:

CAUSES OF ACCIDENTS IN 1887

Attributable causes	Per cent	Number
Fault of employer:		
Insufficient apparatus for protection	10.64	1,700
Defective arrangement for carrying on business	7.03	1,122
Lack of directions or improper ones	2.09	334
Total	19.76	3,156
Fault of injured:		
Awkwardness or inattention	16.49	2,634
Disobedience to orders	5.17	825
Heedlessness	1.98	316
Failure to make use of protective apparatus	1.76	281
Unsuitable clothing	.24	38
Total	25.64	4,094
Fault of the employed and injured	4.45	711
Fault of third person, particularly a co-laborer	3.28	524
No fault which can be assigned	3.47	554
Inevitable risk when at work	43.40	6,931

(Fourth Special Report of the Commissioner of Labor, 1898, p. 88)

That 19.76 per cent of the 15,970 or 3,156 injuries were attributable to the fault of the employers. That 25.64 per cent of the 15,970, or 4,094 injuries, were attributable to the fault of the injured. That 54.60 per cent of the 15,970, or 8,720 injuries, were attributable to the combined fault of the injured and employer, and inevitable risk when at work (Fourth Special Report of the Commission of Labor, 1893, p. 83).

Thus 8024 per cent of 15,970, or 12,814 injuries were attributable to the fault of the employé and the inherent dangers of the industry. Now, 18.51 per cent of these 12,814 were killed, 2,372; 17.70 per cent of these 12,814 were totally disabled, 2,268; 50.88 per cent of these 12,814 were partly disabled, 6,520.

Of these 12,814, 12.91 per cent were incapacitated for a time longer than 13 weeks, 1,654. It follows, therefore, that out of 15,970 employés whose injuries lasted more than 13 weeks, the common law remedies would give 3,156 employés such compensation as a jury would assess after a trial and all appeals were settled (Schonberg, Hanbuch, Vol. II, XXII, pp. 737-748). But the common law does not pretend to compensate dependents of the 2,372 killed in these accidents where the cause of death could not be attributed wholly to the fault of the employer. Nor does the common law pretend to compensate the 2,268 injured workmen who were disabled for life, the fault not being attributable to the employer. Nor does the common law offer any remedy for compensating the 6,520 injured workmen who were partially disabled, the fault thereof not being traceable to the employer.

RESULTS OF ACCIDENTS IN 1887.

Results	Per cent	No.
Death	18.51	2,956
Incapacity for a time longer than 13 weeks	12.91	2,061
Lasting incapacity for work:		
Entire	17.70	2,827
Partial	50.88	8,126
Total	68.58	10,953

§ 47. Classification of causes of accidents in Germany

A classification of the causes of accidents to 46,000 employés collected by the German imperial insurance office for the year 1907 shows the following results (Bulletin Bureau of Labor, January, 1908).

1. Due to negligence or fault of employer	16.81
2. Due to joint negligence of the employer and injured employé	4.66
3. Due to negligence of co-employés (fellow servants)	5.28
4. Due to “acts of God”	2.31
5. Due to fault or negligence of employé	28.89
6. Due to inevitable accidents connected with the employment	42.05
Total	100.00
These figures grouped to correspond to those for one year, 1887 are;	
1. Cause of accident attributable to employer	10.81
2. Cause of accidents attributable to employé	28.89
3. Due to the inherent risks of the business	54.30
Total	100.00

The agricultural laborers were admitted to insurance after 1887, and the act was made to cover a large additional class of less intelligent laborers.

§ 48. Miscellaneous data

The 19,000,000 workingmen who earn on an average less than $500 per annum with their families, represent a population of 60,000,000 people. Every civilized nation has decided that the product of labor of a given generation must support all during that time (F. A. Walker, The Wage Question, p. 34). Looked at from a purely commercial standpoint, that of rearing of men and women for the purpose of productive laborers the elements of cost and waste have been studied with accurate results. There is the rearing of the children to the age of self- support with the result that 13 per cent die during that period; during the assumed productive life of wage earners it is estimated that the loss from death is 25 per cent, in the United States. The loss through sickness is 6 per cent (C. S. Loch, Insurance and Savings, p. 50). Then you must add the cost, in money and time of accidents and the support of the aged. Under these conditions, it is claimed that the contract of labor through some inadvertence is made as though sickness, accident, invalidity, and old age had been permanently banished from the earth; that the daily wage is sufficient only for daily necessities; that a man entitled to support for a lifetime unwillingly consents to a wage based upon a portion of that lifetime, for the competition in the field of labor is among the strong, the able-bodied, the efficient. We are surprised when told that Germany's poorer classes, though less favored by circumstances, maintain a higher level of well-being and far higher level of vitality than those of the United States and England (A. Shodwell, Industrial Insurance, Vol. 2, p. 468).

We can derive no comfort from the statistics of savings-bank deposits. Take Massachusetts, where there seems to be an average deposit of about $300. Investigation shows that, while far the largest number of deposits belong to the wage-earning class, the deposits of thirteen-fourteenths of the whole number are but slightly larger than those of the remaining one-fourteenth; that in a typical bank the average deposit of wage-earners was less than $75.28 (Massachusetts Bureau of Labor Statistics, Third Annual Report,. pp. 304-313; Fourth Annual Report, p. 192).

In England, “it took 25 years of legislation to restrict a child of 9 to 69 hours per week." (Hutchison and Harrison, p.21). "It took 75 years to ascertain that the factory act, instead of weakening, had strengthened her in the world's rivalry." (Thrall, social England, Vol. VI, p. 825). The assumption of any function by the State, like: that of compulsory public education, is based upon higher grounds than compassion for a class. On what grounds does the State regulate the cholera, bubonic plague, and build and maintain institutions for paupers and for the insane? Why not begin higher up and prevent pauperism and assist those who do work of the nation and must fight its battles, who can not protect themselves from having an eye put out or an arm or leg cut off or their lives crushed out?

The fourth element which enters into the determination of the economic insecurity of workingmen under the modern wage system is the following: While, theoretically, injured workmen have a cause of action at law against their employers in 18.19 per cent of the cases of injuries to them, we learn further from this table that the per cent of accidents the causes of which are attributable to the combined negligence of the employer and employé is 9.94 per cent, and from the German statistics we learn that the portion of this 9.94 per cent which is due to the negligence of fellow servants is 5.28 per cent. But in the cases which come under the fellow-servant rule the injured workmen can not recover. Subtracting 5.28 per cent from the 18.19 per cent there is left only 12.91 per cent of the cases in which injured workmen can theoretically recover under the common and liability laws for personal injuries received while at work (see table § 47).

§ 49. Statistical results of the per cent of workingmen who receive compensation under the common law and liability laws

Prior to the adoption of compulsory State insurance in Germany, under the operation of common and liability laws injured workingmen received compensation in only 10 per cent of the cases. (Fourth Special Report of Commissioner Wright, 1893). By reference to the preceding tables of results in the different States and making allowance for the rotting of evidence between the time of the accident and that of the trial of the case, the statistics of the practical operation of the workingman's ability to recover compensation in the United States verifies the German statistics that he can theoretically recover in from 6 to 12 per cent of the cases.

The fifth element which enters into the determination of the "economic insecurity of workingmen under the modern wage system" is gathered from the miscellaneous data. The preceding section shows:

(a) That in the rearing of children to the age of self-support 13 per cent dies during that period;

(b) That in the United States during the assumed productive life of wage earners it is estimated that the loss from death is 25 per cent;

(c) That the loss of wages through sickness of workingmen is 6 per cent, saying nothing about the cost of supporting the aged, etc.

Lastly, there is still the very important sixth element of the said insecurity-that is, the average compensation received by the dependents of a workman killed while at work under the present wage system.

Take the most favorable cases, called court cases; for example, in the Ohio table in a preceding section, the average compensation received by the family of the worker in fatal cases is $949. Deducting 25 per cent for attorney fees and $212 for funeral expenses and the costs of delay of settlement, and you have a net compensation of $500. Under the Ohio law, just passed, the workman receiving the average wages of $12 per week would receive $2,400. (In the opinion of the writer the scientific and economic value to society of the statistical results which are set forth in Section 36 are, of all the economic statistics known to the writer, of the greatest importance; and that the conclusions derived by means thereof are new discoveries in the field of political economy.) Thus the small per cent who receive any compensation under the present wage system receive on the average about one-fifth of what is regarded as a reasonably adequate compensation.

§ 50 Fundamental economic conclusions

The foregoing statistical studies show conclusively that {and to what extent) the social and economic order of the people of the United States is gravely threatened in the permanency of its security by the economic insecurity of the workingmen which accompanies the modern wage system under the operation of the prevailing common and liability laws through which workingmen must seek compensation when they are injured in the due course of their employment. Further, it should be said that the ultimate object of compulsory State insurance for workingmen is to conserve the normal capacity of the average worker of all the classes of workingmen and to maintain the same at the highest possible efficiency.

§ 51. Remedies proposed-German and English plans

The German plan of insurance against accidents had paid out $802,000,000 during the last 20 years ending in 1904. Of this total sum $555,750,000 was paid on account of sick insurance, $232,750,000 on account of accidents, and $13,500,000 on account of invalidism and old age. To the fund necessary to make these payments the employer contributed $424,500,000. The employés contributed $377,000,000 and the Imperial Government paid a portion of the cost of administration and a small portion of the funds necessary to take care of invalidism and old age (50 marks in each case insured).

The general rules are, in respect to the raising of the insurance fund, that the employés should pay two- thirds of the fund necessary to take care of sick insurance, which lasts for 13 weeks, and the employers pay one-third. In the case of accident insurance the employers pay about 85 per cent and the employés 15 per cent. In the case of invalidism and old-age insurance the Imperial Government pays $12.50 for each person insured, and the remainder of the fund is paid half and half by the employers and employés. The German plan in 1907 had 27,172,000 working- men insured against sickness, accidents, and old age out of a population of 62,000,000 people.

Now, briefly, the English plan, which in 1908 had 13,000,000 workingmen insured, is the following:
In case of death, the compensation paid is at most three years' wages, at £300, or $1,460, with a minimum payment of three years' wages at £150, or $730. In case of disability which lasts longer than one week the compensation paid is one-half week's average wage, not to exceed $4.87, as long as the disability lasts. Responsibility for the payment of the compensation rests solely on the employers, and they are not required to insure. In both the German and English plans the rules of contributory negligence, assumption of risk, and the fellow- servant rules are abolished, and the only kind of negligence recognized is that of malicious negligence on the part of the employer or employé. The common law does not presume to furnish a plan of relief except where it can be proven that the defendant is at fault; therefore the common law does not presume to furnish any relief for something like 80 per cent of all workingmen injured and killed in the United States, and the lowest estimate of the number of persons injured and killed in the industrial accidents in 1909 is 536,000 people.

In the battle of Gettysburg, which lasted three days in actual fighting, there were killed and wounded and missing 43,500 soldiers, and if, therefore, you were to have a battle of Gettysburg in one of each of 12 divisions of the United States, one in one month, say, in the neighborhood of Boston, and the next month in the neighborhood of New York City, a third at Washington, a fourth at New Orleans, a fifth at Cincinnati, one at Pittsburgh, a seventh at Chicago, one at St. Louis, one in Minneapolis, one in Denver, one at Portland, Ore., and wind up at the end of the year at San Francisco, you would not create quite the damage and destruction which takes place in the conduct of our industries for one year; yet the common law does not pretend to furnish any relief or remedy, except in those cases in which the employer is negligent, and the best figures indicate that it does not exceed 20 per cent of all injuries, and even the part of that relief which reaches the employés is less than one-fifth of what the employers payout to protect themselves against the liability arising out of injuries to workingmen in industrial accidents.

§ 52. Specific provision against the economic insecurity of workingmen in the United States

Legislative agents and those best informed on the subject of compensating the workingmen injured in the due course of their employment agree that the most just and efficient remedy is that known as industrial insurance along the lines of the German plan, or a workman's compensation act along the lines of the British act. Perhaps the most concrete illustration of the adaptation of the German plan of industrial insurance to the- compensation of injured workmen now in operation in the United States is the Ohio workman's compensation act. The following statistical data is taken from the- report of the experts for the Ohio commission which was prepared by Emile E. Watson, investigator in chief (Report of the Employers' Liability Commission of Ohio, Pt. I p. xxxv.) The facts and the Ohio law are fairly typical of the conditions and the proposed remedies in respect to industrial insurance as they exist today in the United' States. They are of the highest scientific importance. The results are briefly summarized in the following paragraphs (See tables in §§ 41-46);

1. (a) Under the old system the Ohio workman who was killed while at his employment got an average: settlement of $958x36+100, or $344.88.

(b) Under the new workmen's compensation plan he will receive an average settlement of $2,444.

2. (a) Under the former system the widow and the children of the injured are obliged to pay 24 per cent of this $344.88 to lawyers and to the courts.

(b) Under the workmen's compensation plan they will receive all the $2.444, not having to pay a penny for attorney or court costs.

3. (a) Under the old system only 36 per cent of those workingmen who were killed while at their work received anything at all, leaving 64 per cent absolutely without compensation.

(b) Under the workmen's compensation plan every workingman killed, not by his own willful carelessness, or in other words, by suicide, will receive full compensation, meaning that from 80 to 95 per cent are to receive compensation.

4. (a) Under the old system, of this 36 per cent who actually received anything at all 60 per cent got somewhere between $50 and $500, and 12 per cent of those injured got more than 50 per cent of the total amount that was paid out for injuries.

(b) Under the new system not only will the 80 to 95 per cent receive on an average of $2,444 each, but the difference in wages; for instance, where the workman receives a wage of $2 a day and is killed, his widow and children will receive a compensation of $2,444, whereas the widow and children of the workman who receives $3 a day will get $3,400.

5. (a) Under the old system, where the workman was killed the widow and children of the 36 per cent who got anything at all had to wait from one to five years before they got it, in which period the widow buried her husband, the wages of the husband stopped coming in on Saturday night, and the mother was forced from her home to the washtub, *or* the scrub rag, and part of the children were taken from school to live a life of slavery and drudgery; they were forced to live in hovels because rent was cheap there, and in this way tuberculosis and other diseases were contracted.

(b) Under the workmen's compensation plan there is no delay whatever- the $2,444 (the average compensation received) being paid at once. As a rule this amount is not to be paid in a lump sum, but in the same manner as the husband received his regular weekly wage. In this way the widow will not be forced to lower the standard of living for herself and her children, and she will be shielded from the washtub and the scrub rag and be enabled to keep her children in school until she has educated them.

6. (a) The old system results in 56 per cent of the widows and 18 per cent of the children of the injured workman going to work in order to earn a livelihood, because of the great mass who receive nothing and because of the court delay and costs involved to those who actually do receive something.

(b) The work- men's compensation plan will result in not more than 10 per cent of the mothers and 4 per cent of the children going to work as a result of the death of the broad winner, because there will be from 80 to 95 per cent who will receive compensation of a uniform nature-an average compensation of $2,444- without any costs and without any delay in securing the same.

Every employer covered by the act, who fails to come under this workmen's compensation plan is denied the protection of the fellow-servant, contributory negligence, and assumed risk doctrines.
The employé who is working under an employer who has come under the compensation plan is required to accept terms of settlement as prescribed by the compensation plan. The State is made custodian of a fund which is created for the purpose of taking care of an claims which arise under the workmen's compensation plan. The employer contributes ninety and the employé ten per cent of this fund.

§ 53. Argument for joint contribution by employer and employé

The argument for making both employer and employé a party to this fund is that both parties may stand in vital relation to it, every employer will take it as his business to force the careless employer to most carefully protect his men because to the extent that accidents are increased or diminished his premium is increased or diminished; likewise the employé, being a party to this fund, makes it his business to whip his fellow-workingmen into exercising care, because to the degree that the workingman is careless his premium is increased. Broadly speaking, the end sought to be attained by all constitutions, statutes and court decisions is the correction of economic inequalities which arise during the process of the evolution of organized society.

That these new remedies do no violence to existing constitutions Is well shown by Mr. Justice Marshall In his concurring opinion In the case of Borgnls v. Falk Co., 147 Wisconsin 327,133 N. W. 224-5, which sustained the constitutionality of the Wisconsin act. He says:

"So, In short, I think the law In question Is a reasonably appropriate means to effect a constitutional purpose; that the Constitution needs no bending whatever In order to sustain It In Its essential features, and none would be proper If the contrary were the case.

The foregoing I can but regard out of harmony with this, In Its letter: 'Changed social, economic and governmental conditions and ideals of the time, as well as the problems the changes have produced, must largely enter Into the consideration and become influential factors in the settlement of problems of construction and interpretations’- so far as It Is pregnant with the thought that the fundamental law Is judicially changeable. The words 'problems' of 'construction' and 'interpretation' I think were unfortunately used, If the thought was merely of problems of whether new enactments to cope with new conditions are within or without the legitimate field of legislative activity, having regard to appropriateness of means to effect a constitutional end. The latter might be, as I have suggested, at one time and not a half century theretofore, because changed conditions may render an end legitimate, within the unchangeable scope of the fundamental law, which earlier was not, or the selected means to effect that end might be reasonably appropriate at one time, though not so a century, more or less, theretofore.
…..
"True, the old remedies for losses mentioned have been Inefficient and wasteful. They are, economically speaking, unscientific and have always been. It is more apparent now than formerly by reason of greater and more numerous modern activities and methods, that is all. In truth, the Infirmity from an economic standpoint, and from the standpoint of man's duty to his fellowmen, has always existed, though the quantum of regrettable results and useless waste has greatly

increased by the multiplication of human activities and physical instrumentalities. So it will be seen, I think, that while particular means may be reasonably appropriate to a legitimate purpose under some conditions characterizing a particular period, and not have been at a prior time, no change in the Constitution Is involved in remedying the misfit. The end being proper the legitimacy of means may be dependable upon conditions, the question turning more on matter of fact than anything else. The change of mere means does not require a fundamental change, so long as legitimacy of end and reasonable appropriateness of means shall be kept efficiently in view."

VI New York Workmen's Compensation Act Omitted

VII Montana Workmen's Compensation Act Omitted

VIII An Analysis of the Principles of the Legal Basis of the Laws

§ 65. Introductory

It is the purpose of this chapter to present and discuss the objections most frequently urged against insurance and compensation laws when their validity is called in question in courts of law. The matter for this chapter is largely founded on the brief used by the author in his presentation of the case of the Ohio Industrial Insurance law In behalf of the State before the Ohio Supreme Court. It is thought to cover all questions that have been raised against these laws in all the states where their validity has been litigated.

§ 66. The nature and remedial provisions of insurance laws

Workmen's insurance acts greatly resemble each other in their provisions. The Ohio act, which may be taken as a type of these laws, provides:

(1) That all workmen injured shall be compensated at the rate of 66 2/3 per cent of his loss of wages for not longer than 300 weeks, and not more than $12 per week; in case of death where there are dependents, the compensation shall not be less than $1,500 nor exceed $3,400, plus doctor bills not to exceed $200 and funeral expenses to a maximum amount of $150; and in no case shall the compensation for any injury exceed $3,400, except in the case of total disability.

(2) That any employer of five or more persons shall pay monthly into the state fund, the premium based upon the pay roll and hazard of his business, sufficient to pay his pro rata share of the compensation awarded to workmen against the fund.

(3) That every employer of five or more persons who fails to pay said premiums shall not avail himself of any of the so-called common-law defenses in case he is sued by a workman who is injured while in his employ.

(4) That every workman must accept the compensation provided by the act, in lieu of all rights and remedies heretofore existing, excepting the case where he may be denied any relief whatever, or where he may be injured through a willful act of the employer, or through the employer's violation of a statute or ordinance, in which case he may elect to sue his employer at law or take under the compensation act.

(5) That in case a workman, covered by the act, is totally disabled he shall be compensated at the rate of 66 2/3 per cent of his average weekly wage, in no case at less than $5 per week, nor at more than $12 per week, and the compensation shall be paid as long as total disability lasts.

§ 67. Nature of the obligation imposed

The relation imposed by these laws is purely economic in character as distinguished from the creation of a new right in the employé sounding in tort. The new obligation of the employer to his employés is rather a wage obligation in the nature of an undertaking thrust upon the employer, as a part of the contract of employment, to become a party to an insurance policy created by law and to be entered into as additional consideration for services rendered by the employé. The obligation falls within the domain of contract and thus involves a sphere of constitutional law pertaining to the subject of the regulation of contracts. The true theory in all cases is that the compensation is in fact a tax levied by the state, both upon the employer and employés, and accepted by the employé class for the public welfare. This is necessarily so, for were the new obligation of the employer deemed to be created with the sole object of establishing in the employé a new private right and remedy in substitution of his former right to sue in tort for damages, then an industrial insurance law would be as unfair to the employé as to the employer. This proposition is true, because in lieu of a possible opportunity formerly belonging to the injured employé to be made whole in a sum for damages fully commensurate with his peculiar loss, he would be compelled, under an insurance or compensation act to accept a stipulated amount admittedly having no relation to his injury, but measured on the basis of his relative economic position in the community, viz.:-the amount of his wage. This is not a just basis to compensate the employé for his injury, if his new right is to be classified in the same category in which his old right belongs, viz.:-a means to redress a private wrong. The reason for such a law must be to- require the employé to accept, against his former precarious right to adequate damages, the entirety, not only for himself, but also for all members of his class, of receiving in case of injury, a stipulated sum computed not independently as to each party injured on the basis of loss peculiar to his own personal injury but relatively as to all in accordance with their respective earning capacities. Hence its sole justification must be the public welfare, and whatever its form be it must in substance result as to the parties involved in the arbitrary levying and administration of a tax fund.

On the above theory it is argued that the positions of the employer and employé should be so altered that no new statutory privity of relationship be created between them, as was the case under the New York law (Yves v. South Buffalo R. Co. 201 N. Y. 271. 94 N. E. 431, 34 L R. A. (N. 8) 162n), but rather that each be required independent of the other to perform a new duty toward the state, namely, the employer and employé, each, by paying an adequate tax to the state, and the employé by surrendering a chose in action to the state; that these respective duties, however, can be constitutionally required of each only -upon some direct compensatory return of an economic character moving to each. Distinction is here made, between a law (for instance the New York statute) :such as gives in fact a right in A to appropriate directly by new right and remedy the property of B and a law which leaves A and B in respect of their personal relations as they were before, but requires each for the needs of the public welfare, and in exchange for specific benefits respectively received, to surrender to the state certain rights and likewise to look to a state agency alone for the returning benefits.

Another limitation also inheres in this theory of the appropriation of the property rights of the two classes involved, namely, that since the tax is not levied on all in the state but that certain classes of citizens are alone selected a corresponding benefit or return must be traced to them for their property and rights to be so appropriated. This constitutional limitation requires that any scheme of industrial insurance or workmen's compensation shall be what it purports to be, namely, an actual readjustment of the social relations of the classes involved in it by making such scheme a substitute for and exclusive of all other present methods of protecting personal injuries; for if there exist in any plan of compensation the recognition of the right of the employé

to either exercise his option to sue at law for personal injuries, or to take his insurance, by this very token is it declared that the intention of such a law is not to bring about such an economic reform, for still would there exist all the evils now inherent in the present method of redressing personal injuries; in consequence such a plan would disclose, as was suggested by the New York Court of Appeals in the *Ives* case but the creation of a new remedy in the employé, additional to those now vested in him and unconstitutional in character, to redress a private wrong. The very essence of any scheme of industrial insurance or workmen's compensation to be constitutional requires that it be exclusive in character. The tax levied must be for a public purpose and the act to be valid must be a proper exercise of the police power.

Upon the assumption that such taxation would be for a public purpose, the brief then considers the limitations prescribed by the Seventh Amendment, being that provision of the Constitution which preserves the right of trial by jury in suits at common law. All attempts to demonstrate that in so far as a state agency is concerned any controversies arising between such agency and any of the parties of the tax or as to the distribution of the same, would not fall within the scope of the seventh amendment and may therefore be adjudicated by such statutory remedy or summary procedure as the state may prescribe.

§ 68. Nature of the obligation imposed-German view

The American insurance acts are adaptations of the German industrial insurance law against accidents, enacted in 1884, which all European countries have adopted in a more or less modified form. Dr. Laband, in analyzing industrial insurance legislation of Germany and other European countries, uses language which is equally applicable to the American acts (See *Droit Public de l'Imperlal Allemand*, IV, 12). He says:

> "The Imperial legislation starts from this idea-that the undertaker of an enterprise who employs workmen in order to appropriate to himself the economic value of the fruits of their labor owes them not only the agreed wages for this labor, but ought also to bear with them the risks of accident resulting from this labor. This conception has not taken the shape of a principle of private law which governs the relations resulting, in a judicial sense, from the labor contract; it has become one of the tasks laid upon the state to take care of the victim of an industrial accident, or of those he leaves behind him; and this task is accomplished with the means and according to the forms dictated by public law. The right of the workman to the solicitude of the state is therefore wholly independent of an agreement relating to his work and the clauses it contains; he enjoys this right even when there is no agreement of this sort and this convention can neither modify this or deprive him of it. So, this right is not founded on a fault committed by the master or any of his employés, and even a fault of the workman does not affect it at all unless he has intentionally caused the accident. The obligation to aid the workman is not a legal obligation, or what is called a 'state obligation' of the master towards his workmen, for master and workmen are not set against one another like debtor and creditor, and they are powerless to vary the right of one to aids and the obligations of the other to give them. The workmen or their survivors receive the aids which come to them by an intermediary that the Empire or the State has delegated to perform this duty, an intermediary who has with them no private legal relation, who simply performs a public administrative function, confided to him by imperial order, when he determines the indemnity to be given to the workmen or effects its payment."

§ 69. The relationship between employer and employé under common law and modern liability acts

There is this distinction between the legal principles applicable to the common law of torts and the more recent employer's liability acts and those applicable to industrial insurance and compensation acts. The body of law applicable to the former pertains entirely to the redress of private wrongs. The liability results in the payment of damages to the employé intended to be commensurate with and to reimburse him for the injury suffered. The sole object of laws of this form is to regulate private rights, to readjust the relationship between individuals and to restore the parity presumptively existing between them.

§ 70. The relationship between employer and employé under insurance and compensation acts

The obligations of industrial insurance and workmen's compensation acts accrue from contingencies not dependent upon or within the control of the parties and thus have no relationship whatever to the conduct of the parties; hence these obligations are not based upon wrongs. It follows then that they must pertain to the subject of government regulations, and are in the nature of economic provisions taking the form of indirect taxation levied to regulate occupations, for on what other basis would the government be justified in writing into the labor contract against the will of the parties, an insurance policy?

Were this not so, industrial insurance or workmen's compensation would be, without basis of justice or equity from the standpoint of both the employé and employer, for the theory of such laws is that compensation is not to be commensurate with injury but is based upon wages, thereby substituting for the former obligations based upon tort, which offered damages commensurate with injury, a purely arbitrary sum. Such a scheme has no relation to the adjustment of private wrongs. If it be justifiable it must be on the sociological theory of the right of the state to levy a tax for the purpose of protecting from an economic standpoint the community as a whole. It follows, therefore, whether compensation be paid by the state as insurance in the form of a tax levied upon all citizens of the state, or be paid through the intermediary of assessments levied by industrial associations, or be paid in the form of compensation from the employer to the employé, it has all the inherent attributes of money raised by the appropriation of private rights in the form of a tax for the benefit of the common good (R. J. Carey Brief on the power of Congress In respect of Industrial Insurance and the Law of Workmen's Compensation).

It would, therefore, seem that in an analysis of constitutional limitations it would be futile to look for analogy to the decisions which pertain to the regulation of the private relations between the parties. Hitherto, for this purpose there have been drawn into discussion of this subject-

- Cases which hold a statute constitutional making a railroad company liable for injury though without fault (Chicago, etc., R. Co. v. Zernlcke, 183 U. S. 582, 46 L. ed. 839).
- Cases holding statutes constitutional which make railroad companies responsible for fires set by engines though without fault (St. Louis, etc., R. Co. v. Mathews, 165 U. S. 1, 41 L. ed. 611).
- Cases holding subcontractors' lien laws constitutional (Jones v. Great Southern, etc., Co., 83 Fed. 370).

Or such familiar illustrations as the ancient law of deodands or the liability of the husband for the tort of the wife, or the liability of the master for the acts of his servant. [A deodand is a thing forfeited or given to God, specifically, in law, an object or instrument which becomes forfeit

because it has caused a person's death. The English common law of deodands traces back to the 11th century and had been applied, on and off, until Parliament finally abolished it in 1846. Under this law, a chattel (i.e. some personal property, such as a horse or a hay stack) was considered a deodand whenever a coroner's jury decided that it had caused the death of a human being. In theory, deodands were forfeit to the crown, which was supposed to sell the chattel and then apply the profits to some pious use.] But it is to be noted that all the statutory or common law duties interpreted in these decisions pertain solely to the protection of private rights.

§ 71. Validity as to employer-Deprivation of defenses

It is clearly within the power of a State Legislature to deprive the employer of the three so-called common law defenses, to-wit, the defense of the fellow servant rule, the defense of the assumption of the risk and the defense of contributory negligence. This proposition is amply sustained by authority. The supreme judicial court of Massachusetts, addressing itself to this matter in a case involving the compensation law of that state, said:

> "The rules of law relating to contributory negligence and assumption of the risk and the effect of negligence by a fellow servant were established by the courts, not by the Constitution, and the Legislature may change them or do away with them altogether as defenses (as it has to some extent in the employer's liability act) as in its wisdom in the exercise of powers intrusted to it by the Constitution it deems will be best for the 'good and welfare of this commonwealth.' See Missouri Pacific Railway v. Mackey, 127 U. S. 205, 32 L. ed. 107; Minnesota Iron Co. v. Kline, 199 U. S. 593, 50 L. ed. 322. The act expressly provides that it shall not apply to injuries sustained before it takes effect. If, therefore, a right of action which has accrued under existing laws for personal injuries constitutes a vested right or interest, there is nothing in the section which interferes with such right or interests. The effect of the section is not to authorize the taking of property without due process of law, as the Court of Appeals of New York held was the case with the statute referred to in the preamble to the questions submitted to us, and which in consequence thereof was declared by that court to be unconstitutional. Ives v. South Buffalo Railway, 201 N. Y. 271, 94 N. E. 431, 34 L. R. A. (N. S.) 162n. Construing the section as we do and as we think that it should be construed, it seems to us that there is nothing in it which violates any rights secured by the State or Federal Constitutions." (In re Opinion of Justices, 209 Mass. 607, 96 N.E. 308)

To a similar effect is a late decision of the Wisconsin Supreme Court:

"The two defenses [the defense of the assumption of risk and negligence of a fellow servant which the legislature has thus attempted to take away are not entrenched behind any express constitutional provision, nor were they originally created by legislative action. They were both evolved by the courts. * * *

"It is frankly admitted by appellant that it is within the legislative power to make this change with regard to the hazardous trades, but not with regard to what are called the non-hazardous trades. But why not? There are, of course, some occupations which are exceptionally hazardous, and it may well be that it would be within legislative discretion to classify these very hazardous occupations and remove the defenses to them, while retaining them as to others less hazardous. Indeed, that very thing has been done and has been approved by the courts in this and many other states, especially in the case of railroads and to some extent with other industries (Minnesota Iron Co. v. Kline, 199 U. S. 593, 26 Sup. Ct. 159; 50 L. ed. 322; sec. 1816, Stats. (1898), as amended by ch. 254, Laws of 1907; Kiley, etc., C. M. & St. P. R. Co., 142 Wis. 154, 125 N. W. 464; sec. 1636j, Stats. (1898); sec. 1636jj, Stats. (ch. 303, Laws of 1905)).

"But because there is room for classification it does not follow that legislation without classification is unconstitutional. There are hazards in all occupations; indeed they follow every man from the cradle to

the grave. What constitutional requirement, either express or implied, clothes these court-made defenses with exceptional sanctity as to the less hazardous industries, and wards off from them the sacrilegious hand of the legislature? We are referred to none, and we know of none. It is admitted in the Ives case, supra that both the fellow-servant defense and the contributory-negligence defense, being of judicial origin may be changed or abolished by the legislature. See also the opinion of the Justices of the Massachusetts Supreme Court on the Personal Injuries act of 1911, 96 N. E. 308. We see absolutely no ground for the contention that these defenses may be lawfully abrogated as to the more hazardous industries, but must be forever held sacred as to the less hazardous industries. There may be a less persuasive reason for the change in the case of the latter class of industries, but this does not deprive the Legislature of the power to make it," (Borgnls v. Falk, 147 Wis. 327, 133 N. W.209. See also Yves v. South Buffalo R. Co., 201 N. Y. 271).

§ 72. Validity as to employé

Workmen's insurance and compensation acts take away from the employé his common-law right of action against his employer for nonfatal injuries caused by the employer's negligence. As to fatal injuries, a cause of action against an employer was unknown to the common law, is a statutory creation, and consequently (since the Constitution of the state contains no inhibition) is subject without question to repeal by the Legislature. The proposed act carefully saves any right of action on account of an injury received prior to the date named for it to become operative, upon the employers and employés affected by it. The question involves not the taking away of a vested right of action, but the changing of the law in respect of expectancies and possibility of action in which the party has no present interest. At an early day the Legislature of Pennsylvania passed a statute abolishing the doctrine of *respondeat superior* in the case of persons injured on or near railroads and not in the employ of the railroad company. Of this law the Supreme Court said:

> "The law says that the legal principle of *respondeat superior* shall have no place in this particular relation; that as a matter of public policy for the good of all, those who voluntarily venture into employment alongside of the servants of a railroad company shall have just the same remedies for injuries happening in the employment that these have, and none other. In doing this no fundamental right of the person thus voluntarily venturing is cut off or struck down. The liability of the company for the acts or omission of others, though they be servants, is only an offspring of the law. The negligence which injures is not theirs in fact, but is so only by imputation of law. The law which thus imputes it to the company for reason of public policy can remove the imputation from the master and let it remain with the servant whose negligence causes the injury." (Kirby v. Pennsylvania R. Co., 76 Pa. 506)

The Supreme Court of the United States had before it the same statute and sustained it, saying: "If it be conceded, as contended, that the plaintiff in error could have recovered but for the statute, it does not follow that the legislature of Pennsylvania, in preventing a recovery, took away a vested right or a right of property. As the accident from which the cause of action is asserted to have arisen occurred long after the passage of the statute, it is difficult to grasp the contention that the statute deprived the plaintiff in error of the rights just stated. Such a contention in reason must rest upon the proposition that the state of Pennsylvania was without power to legislate on the subject,-a proposition which we have adversely disposed of. This must be, since it would clearly follow, that if the argument relied upon were maintained, that the state would be without power on the subject. For it can not be said that the state had authority in the premises if that authority did not even extend to prescribing a rule which would be applicable to conditions wholly arising in the future." (Martin v. Plttsburg, etc., R. Co., 203 U. S. 284, 51 L. ed. 184, 27 S. Ct. 100, S. A. & E. Ann. Cas 87)

A right of action of a third person against a master for negligence of his servant was a common-law right of action. (Middleton v. Fowler, 1 Salk. 282; Blackstone's Com. 48l; Gray v. Portland Bank, 3 Mass. 364, 3 Am. Dec. 156; Harlow v. Humiston, 6 Cow. 189)

§ 73. Validity as to employé- Vested rights in remedies withdrawn.

"Vested rights," says Judge Cooley, "can not be taken away by legislative enactments, but a right can not be considered a vested right unless it is something more than such a mere expectation as may be based upon the anticipated continuance of the present general laws. The Legislature may change such general laws constitutionally except as to a right of interest that may have already accrued or become perfected. * * * In organized society every man holds all he possesses, and looks forward to all he hopes for through the aid and under the protection of the laws; but as changes of circumstances and of public opinion, as well as other reasons affecting the public policy, are all the while calling for changes in the laws, and as these changes must influence more or less the value and stability of private relations and strengthen or destroy well-founded hopes, and as the power to make very many of them could not be disputed without denying the right of the political community to prosper and advance, it is obvious that many rights, privileges, and exemptions that usually pertain to ownership under a particular state of law, and many reasonable expectations, can not be regarded as vested rights in any sense." Says the Supreme Court of the United States in Munn v. Illinois, 94 U. S. 113, 24 L. ed. 77:

> "A mere common-law regulation of trade or business may be changed by statute. A person has no property, no vested interest, in any rule of the common law. That is only one of the forms of municipal law, and is no more sacred than any other. Rights of property which have been created by the common law can not be taken away without due process; but the law itself, as a rule of conduct, may be changed at the will or even at the whim of the legislature, unless prevented by constitution limitations. Indeed the great office of statutes is to remedy defects in the common law as they are developed, and to adapt it to changes of time and circumstances." (Munn v. Illinois, 94 U. S. 113, 24 L. ed. 77. Applied to the relation of master and servant In Vindicator Consol. Gold Min. Co. v. Firstbrook, 36 Colo. 498, 86 Pac. 313, 10 A. & E. Ann. Cas. 1108)

Some of the states in their Constitutions, in substance, contain the provision of Magna Charta, that "every man shall have a remedy for injury done him in person, property, or reputation." Nevertheless, the principle last above stated has been sustained in states having such a constitutional provision (Templeton v. LInn County, 22 Ore. 313, 51 L. R. A. 780, 29 Pac. 795; William v. Galveston, 41 Tex. Civ. App. 63, 90 S. W. 505).

"Conceding that a cause of action for personal injuries is property, the cause of action, i.e., the property must exist before one can be deprived of it at all. A statute which abrogates a cause of action for personal injury before such cause of action has arisen or before the injury occurs, or requires certain things to be done by the injured party as conditions precedent to a cause of action, does not deprive the injured party of his property rights without due process of law. * * * In other words, the legislature may create a right of action which never existed, if in doing so it does not affect rights which vested prior thereto. A party injured after the legislature has taken away the right of action for personal injuries can no more complain of it than a party against whom a right of action is given for an injury resulting in death, can of such a legislative enactment. For the one party is no more injuriously affected by such legislation than the other. In the one case what was before actionable ceases to be so; in the other, what was not before actionable becomes so" (Sawyer v. El Paso, etc., R. Co., 49 Tex. Civ. App. 106, 108 S. W. 718).

§ 74. Validity as, to the State-Public interest

Workmen's insurance and compensation acts generally provide for the creation of a new department for their administration, the expenses of which are borne by the state. The usual limitation on the right of the state to expend the moneys of the state is that the expenditure shall be for a public purpose. It is clear that it is a public purpose to pay the salaries and defray the office, traveling and court expenses of state officials, and other, expenses of a state department charged with the administration of a branch of the police power of the state, just as the state bears without question the expense of administration of other departments, e. g., the railroad commission, mine, factory, grain and hotel inspection, all operating under the police power.

§ 75 The problem of industrial insurance

The inquiry at the outset of the discussion would seem to be: Has the state the power to regulate industries for the purpose of protecting the economic welfare of the community by levying a tax in the form of an insurance obligation upon the same for the benefit of the employés injured while employed in such industries? And again, if the state has a right to levy such a tax may it as part of the private rights appropriated by it for the benefit of the common good, take from the employé the right now belonging to him to redress his personal injury caused by the default of his employer by recovering damages from the latter?

§ 76. Whether these laws infringe constitutional limitations

The insurance and compensation acts are generally contested on the ground that they are violative of recognized constitutional limitations, in that they authorize the taking of property without due process of law, they lack uniformity of operation, they curtail unlawfully the administration of judicial authority, they authorize the taking of private property for private use, they authorize the taking of private property for public use, they delegate legislative powers, they impair the obligation of contracts between employer and employé, they amount to an unreasonable exercise of the police power.

§ 77. Insurance acts sustainable against constitutional objections under analogous decisions

It is believed that insurance acts are already well grounded as against the foregoing constitutional objections in four distinct lines of cases in American jurisprudence. These cases are

(a) The bank depositors guarantee act cases;
(b) The sheep-dog law cases;
(c) The cases which justify the enactment of a law which authorizes the creation of a fund to be disbursed by a state commission in the erection and operation of a state asylum for inebriates;
(d) The cases which uphold statutes imposing a liability upon fire insurance agents, of the nature of a tax, based upon the amount of insurance effected by them, for the creation of a fund to care for and cure sick and injured firemen.