KEY ISSUES IN WORKERS' COMPENSATION DISPUTES

I. INTRODUCTION

Workers' compensation insurance spawns disputes between policyholders and insurers; and between insurers and reinsurers. While many arbitrators certified by ARIAS•U.S. have handled reinsurance disputes relating to workers' compensation, fewer certified arbitrators have experience handling direct insurance arbitrations under workers' compensation policies. This program discusses the key issues that are commonly the source of disputes in the direct insurance and reinsurance contexts.

II. WORKERS' COMPENSATION INSURANCE

The vast majority of employers in all states (except Texas) are required by law to carry heavily state-regulated workers' compensation insurance. Workers' compensation insurance is a state-mandated, no-fault system under which an employer provides benefits to an employee for injuries sustained on the job. Premiums vary by state and by each employee's job classification. In exchange for obtaining this insurance, employers generally are not subject to tort claims by employees for workplace injuries. Workers' compensation benefits are the employee's exclusive remedy for such injuries.

The standard Insurance Services Office Workers' Compensation and Employers Liability policy is well-understood. While the vast majority of insurance policies are guaranteed cost policies (*e.g.,* a policy where the insured's costs are guaranteed to remain at a stated manual rate), a larger, qualified employer may negotiate loss sensitive policies with its insurer where the employer shares in the risk associated with the losses through a large deductible, retrospective premium, self-insured retention or other like loss-sharing policy. In those instances, many insurers use a separate agreement to document how the employer will guarantee payment of, and

actually pay for, its loss sensitive obligations in a separate agreements referred to as a "program agreement, "deductible agreement" or a "retrospective premium agreement" (collectively, a "PA").[1] PAs are more common with large employers than with small ones, and unlike the standard form workers' compensation policy, PAs often contain arbitration clauses in their dispute resolution clauses.[2] The workers' compensation insurance contract and the PA operate in parallel, but the PA often is not an endorsement or attachment to the workers' compensation policy.

Premium rates for workers' compensation insurance vary depending on the employer's business, loss history (or experience modification) and the job function of each employee. Employees' functions correspond to "job classification codes," also called "class codes."[3] States that set workers' compensation insurance premium rates, have a rate that corresponds to each employee's class code. Where the state does not set the rates, insurers have rates that correspond to class codes. Premium rates are expressed in terms of dollars per $100 of payroll. An experience modifier (which is a multiplier) based on the employer's loss experience is applied to the basic premium rate. The last element the calculation is the employer's annual payroll, which is estimated for the policy period. The standard policy language requires, the insurer to audit the employer's actual payroll after the expiration of the policy and adjust the premium based on the actual payroll, number and class of employees and experience modifier. In guaranteed costs

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[1] Policyholders seeking to invalidate PAs call them "side agreements."

[2] Workers' compensation policyholders are not limited to individual employers. Consortia of employers or Professional Employee Organizations ("PEO") also purchase workers' compensation insurance. (A PEO is an independent business that assumes a separate company's employment obligations for a fee.)

[3] Job classification codes are very specific. *See* https://classcodes.com/numerical-ncci-code-list/

policies, an insured employer only pays estimated premiums and whatever premiums, if any, become due after an audit. Under loss sensitive programs, the insured employer usually pays an initial premium and thereafter will also pay retrospective premiums or its share of losses as bargained for when the policy was purchased, calculated periodically after the policy incepts.[4] Workers' compensation policies have a "long tail" in that they cover losses that can continue to develop over an extended period of years. Consequently, the adjustments for loss sensitive policies often continue over the course of many years.

Common features of PAs include:[5]

- Premium financing – PAs often operate as vehicles to finance premium payments. This is often done in two ways. First, a PA may provide for installment payments of basic premiums. Second, retrospective premiums and other loss sensitive payments, discussed below, often are included. Unlike other financing transactions, in which the lender may repossess the item that is financed, the workers' compensation insurance itself cannot return lost value to the insurer. This is why PAs often include collateral provisions, which are discussed below.
- Collateral – Some PAs require that the policyholder post collateral to secure the policyholder's premium payment obligation. PAs often provide that the insurer has exclusive and unilateral right to establish and adjust the amount of collateral the policyholder must post.

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[4] PAs may be used in connection with multi-line insurance programs as well. We focus here only on PAs used in workers' compensation insurance programs.

[5] All of these features may be incorporated into a workers' compensation insurance policy, as long as the policy form containing these features is approved by the insurance regulator of the state in which the policy is issued.

- Initial premiums – PAs generally provide that the policyholder must pay an initial premium when the policy incepts. This initial premium usually is the absolute minimum the policyholder must pay.

- Retrospective premiums – PAs generally provide for additional retrospective premiums to be paid based on a formula that principally focuses on incurred losses. Retrospective premiums are usually calculated periodically after the policy incepts. For example, a PA may provide that retrospective premiums will be calculated annually for three years following the policy's inception.

- Deductibles – Some PAs provide for high deductibles under which the policyholder retains responsibility for a substantial amount of risk.

- Audits – Workers' compensation policies provide that the insurer may audit the policyholder's books and records and interview the policyholder's management, to determine the actual exposure base, which is a function of number of employees the policyholder has and those employees' job classifications. PAs can set out more fulsome audit requirements (or a different audit schedule) than would otherwise apply under the policy. Review of the financial condition of the insured is also contemplated within PAs given the collateral requirements within many PAs. Accurate and complete audits are particularly critical for policyholders that perform task-based or seasonal work because the number of employees often fluctuates significantly. Premiums may be adjusted based on these audits.

- Miscellaneous payments – A PA may specify the types taxes, assessments or surcharges that the policyholder must pay in connection with a workers' compensation policy.

- Claim Handling Charges and Development Factors – A PA often outlines "development factors" and claim handling charges to be applied based on the losses incurred or paid for the policy term.

- Attorneys' fees – A PA may provide that the policyholder must pay the fees an insurer incurs in enforcing the policyholders' obligations under the PA.

- Interest - The PA may also provide that the policyholder must pay interest on any amounts the policyholder does not pay when they become due.

- Arbitration – Many PAs contain arbitration clauses.

- Cancellation – Some PAs provide that the insurance program may be cancelled if the policyholder breaches the PA.

Common disputes under PAs include:

- Propriety of PAs – If loss experience – and, by extension, retrospective premium or other loss-sensitive charges – are worse than expected, policyholders often seek to escape the liability by claiming that the PA is unenforceable if it is not approved by the state's insurance regulator. For example, at least one court has held that California bars PAs to the extent that they are not filed and approved by the California Department of Insurance. *See Am. Zurich Ins. Co. v. Country Villa Serv. Corp.*, 2015 U.S. Dist. LEXIS 89452, **695-**696 (C.D. Cal. 2015); Cal. Code Regs., tit. 10, § 2268(b) (An insurer shall not use a policy form, endorsement form, or ancillary agreement except those filed and approved by the Commissioner in accordance with these regulations.")

Although some policyholders have taken the same position in other jurisdictions, they have generally not fared as well. For example, a bankruptcy court concluded that it would be

unjust to allow a policyholder to escape its obligation to pay premiums under a PA after having received the benefit of the insurance, including workers' compensation coverage. *In re Stone & Webster, Inc.*, 547 B.R. 588, 603 (Bankr. D. Del. 2016); *see also Reliance Ins. Co. v. Woodward-Clyde Consultants*, 243 F. App'x 674, 675 n.3 (3d Cir. 2007); *In re Ionosphere Clubs, Inc.*, 85 F.3d 992, 998 (2d Cir. 1996).

Further, most courts have declined to deliver the policyholder a windfall by invalidating PAs on the ground that they are not regulatorily-approved. *See Stone & Webster*, 547 B.R. at 603 – 604. Those courts rely on the longstanding rule that failing to file a form does not render a contract unenforceable as between the parties. "The majority of jurisdictions addressing the effect of an insurer's failure to file an insurance policy form as required by a state statute have concluded that the failure to file . . . does not render it invalid." *John Beaudette, Inc. v. Sentry Ins.*, 94 F. Supp. 2d 77, 140 (D. Mass. 1999) (internal quotation omitted); *id.* at 140-41 (noting that the insurance commissioner, and not a private party, has the right to enforce the filing requirements, and therefore, the insurer's "apparent failure to file" the forms at issue did ***not*** render them "null and void" (emphasis in original)); *see also FDIC v. Am. Cas. Co.*, 975 F.2d 677 (10th Cir. 1992); *Highlands Ins. Co. v. Am. Marine Corp.*, 607 F.2d 1101 (5th Cir. 1979); *Cananwill, Inc. v. Emar Grp., Inc.*, 250 B.R. 533 (M.D.N.C. 1999).

- Arbitrability[6] - Where a PA contains an arbitration clause, a challenge to the PA's propriety as a matter of a particular state's insurance law must be arbitrated. *Home Quality Mgmt. v. Ace Am. Ins. Co.*, 381 F. Supp. 2d 1363, 1366-1367 (S.D. Fla. 2005) (question of

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[6] The State of Washington prohibits arbitration provisions in insurance contracts. RCW 48.18.200(1)(b). A Washington appellate court has held that PAs are "part and parcel" of a workers' compensation insurance policy and, therefore, may not require arbitration. *Oak Harbor Freight Lines, Inc. v. XL Ins. Am., Inc.*, 2017 Wash. App. LEXIS 1549 at *13 (Wash. Ct. App. 2017).

whether PA is enforceable under Florida law must be arbitrated); *accord, Matter of Argonaut Insurance Company v Grove Lumber & Building Supply Inc.*, 2008 N.Y. Misc. LEXIS 9418, 5-6 (N.Y. Misc. 2008); *and see, Buckeye Check Cashing, Inc. v. Cardegna*, 546 U.S. 440, 445-46 (2006) ("[U]nless the challenge is to the arbitration clause itself, the issue of the contract's validity is considered by the arbitrator in the first instance."). While the validity of a PA is a question for the arbitration panel, a policyholder's challenge to the *existence* of an agreement to arbitrate is for the court. *Cont'l Cas. Co. v. Staffing Concepts, Inc.*, 2011 U.S. Dist. LEXIS 153827, at *36 (M.D. Fla. Dec. 20, 2011).

- Employee classification – As shown above, employee classification significantly drives workers' compensation premiums. Obviously, the classifications with lower risks of employee injury yield lower premiums. Classification is a major area of dispute from several different perspectives. *See Premium Assignment Corp. v Utopia Home Care, Inc.*, 2010 N.Y. Misc. LEXIS 3107, *7-*8 (N.Y. Misc. 2010). The employer may claim that the insurer mis-classified its employees and, therefore, charged an inflated premium. The insurer may claim that the employer mis-identified the job functions of its employees and, therefore, paid too little premium. As most premium adjustments are primarily based on audits of the employer's records and interviews of the employer's management, unscrupulous employers may misrepresent the number of people they employed during the audit period and the functions those employees performed, among other things. Employers also may attempt to classify employees as "independent contractors,"[7] who are not subject to workers' compensation. As these audits are

[7] Whether an individual qualifies as an independent contractor generally depends on the degree to which the employer could control an individual's performance of his or her work. *See Travelers Prop. Cas. Co. of Am. v. Universal Drywall, LLC*, 85 Mass. App. Ct. 1125, 1125 (2014).

retrospective, employers who had few or no losses during audit period often bristle at paying for the coverage the insurer provided.

- Claim payment – Claim payment frequently is the subject of disputes in the workers' compensation context because claims drive retrospective premiums and the employer's experience modification factor. Employers often argue that insurers paid claims that should not have been paid or were overpaid, usually contending that the insurer failed to investigate the claims properly or was otherwise negligent in evaluating the claims. *See, e.g,. Northwinds Abatement v. Employers Ins.*, 69 F.3d 1304, 1306 (5th Cir. 1995). These types of disputes are fact-specific. Unlike reinsurance agreements, where insurer's claims-handling decisions usually receive deferential treatment under follow-the-fortunes clauses, little or no deference may apply to the same decisions in a dispute between the insurer and a policyholder -- though the policyholder alleging negligent claim-handling will likely bear the burden of proving that assertion. *See, e.g., Stone & Webster*, 547 B.R. at 608.

- Collateral – Policyholders often contend that the insurer is holding more collateral than is necessary to satisfy the policyholder's obligations. These cases also are very fact specific. The degree of deference accorded to the insurer's assessment of its collateral needs will usually depend on the language in the PA.

III. WORKERS' COMPENSATION REINSURANCE

Common Workers' Compensation Reinsurance Disputes

- Familiar issues – Almost all of the issues one encounters in connection with property-casualty reinsurance, including: notice; retention/aggregation; application of limits; number of occurrences/accidents/events; follow the fortunes; and compliance with the duty of utmost good faith, may arise in a workers' compensation reinsurance dispute. There are, however, two particular areas in which workers' compensation reinsurance disputes commonly arise.

- Mandatory commutations – Some workers' compensation reinsurance contracts contain mandatory commutation clauses that require the cedent and reinsurer to commute existing claims or all claims (i.e., projected to ultimate). (These clauses are most prevalent in high-layer workers' compensation contracts.) These provisions offer benefits to the cedent and the reinsurer. The reinsurer limits or terminates its going-forward liability and hedges against potentially catastrophic losses. The ceding company benefits by receiving cash up-front, which it can manage an use consistently with its priorities.

Mandatory commutation clauses are simple in concept but often complex in application. Fundamentally, the clauses generally require that the reinsurer pay the present value of existing losses and, in cases of total commutations, IBNR. As with most things, the devil is in the details. Better commutation clauses often specify in detail: the losses to be commuted; the discount rate; the medical escalation rate; mortality factors; the formula governing the commutation calculation; and other key inputs. Some clauses contain dispute resolution provisions under which an actuary or panel of actuaries will determine the amount the reinsurer must pay. Commutation clauses also may contain sunset provisions (discussed below).

Notwithstanding detailed and specific commutation clauses, disputes over: the scope of such clauses (some may arguably address commutation of known claims only); the manner in which the commutation calculation must be performed (including the order of operations to be applied); the collection and calculation of the data inputs for the commutation formula including medical escalation rates ; .

- <u>Sunset clauses</u> – Sunset clauses, depending on their wording, may bar claims that are not reported to the reinsurer by a specified date. The most notable decisions are sunset clauses are a series from the United States District Court for the District of New Jersey, in which Munich Reinsurance America, Inc. ("Munich") was the cedent and American National Insurance Company ("ANICO") was the reinsurer.[8]

In *Munich* line of cases, Munich reinsured the workers compensation liabilities of Everest National Insurance Company ("Everest") from 1998 to 2001. Munich retroceded some of this risk to ANICO under two agreements. Munich sued ANICO, claiming ANICO improperly failed to pay certain cessions.[9]

The Munich/ANICO retrocessional agreements contained a sunset clause that provided:

> Seven years after the expiry of this Agreement, the Company shall advise the Reinsurer of all claims for said annual period, not finally settled which are likely to result in a claim under this Agreement. No liability shall attach hereunder for any claim or claims not reported to the Reinsurer within this seven year period.

Munich I at __. The agreements contained the following loss notice provisions:

A. The Company [(Munich)] agrees to advise the Reinsurer [(ANICO)] promptly of all

[8] *See Munich Reinsurance Am., Inc. v. Am. Nat'l Ins. Co.,* 893 F. Supp. 2d 686 (D.N.J. 2012) ("Munich I"); *Munich Reinsurance Am., Inc. v. Am. Nat'l Ins. Co.,*936 F.Supp.2d 475 (D.N.J. 2013) ("Munich II"); and *Munich Reinsurance Am., Inc. v. Am. Nat'l Ins. Co.,* 999 F. Supp. 2d 690 (D.N.J. 2014) ("Munich III").

[9] ANICO counterclaimed for rescission, arguing that Munich withheld material facts from ANICO when the agreements were underwritten.

> claims coming under this Agreement on being advised by the Original Ceding Company, and to furnish the Reinsurer with such particulars and estimates regarding same as are in the possession of the Company. An omission on the part of the Company to advise the Reinsurer of any loss shall not be held to prejudice the Company's rights hereunder.
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> B. In addition, the following categories of claims shall be reported to the Reinsurer immediately, regardless of any questions of liability of the Company or coverage under this Agreement:
>
> 1. Any accident reserved at 50% of the reinsured attachment point;
> 2. Any accident involving a brain injury;
> 3. Any accident resulting in burns over 25% or more of the body; or
> 4. Any spinal cord injury.

Id. at 701.

Everest notified Munich of the workers' compensation claims at issue beginning in 2003, but Munich did provide notice to ANICO until 2008. When it did, Munich sent ANICO a lengthy spreadsheet that "listed all of the claims submitted by Everest to Munich," not only the claims that fell under the Munich-ANICO agreements (the "Omnibus Notice"). *Munich II* at 493. The Omnibus Notice "included the name of each insured, the date of loss, and the attachment point, however, the . . . [Omnibus Notice] did not delineate which of the claims were likely to result in a claim under the retrocessional agreements." *Id.* The Omnibus Notice also "was overbroad, and included claims arising from years outside the" scope of the applicable agreement." *Munich III* at 173. In response, the intermediary claimed that the Omnibus Notice "is not considered adequate notice of loss." *Munich II* at 492. Munich agreed. *Id.* This exchange did not, however, address whether the Omnibus Notice was sufficient for the reporting the sunset clause required.[10]

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[10] Discussing the sunset clause's purpose, the court said:

> On its face, the sunset provision here is straightforward: it prevents Munich from reporting claims *in perpetuam,* by excluding from coverage those claims not noticed within seven years following the expiration of each retrocessional agreement. . . . The

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Munich III followed a trial on the merits. It contains the court's ultimate conclusions about whether the Omnibus Notice sufficed for sunset reporting purposes. Distinguishing sunset reporting from everyday loss reporting, the court reasoned that sunset reporting must provide information that allows the reinsurer "to determine which claims appeared likely to impact . . . [its] coverage." *Id.* at 173. In the court's view, the Omnibus Notice did not contain sufficient information to make such a determination. *Id.*

The *Munich* cases show (at least in that court's view): (1) reporting losses and providing loss information for sunset purposes are distinct; and (2) reporting for sunset purposes must contain sufficient information to show whether that loss may reach the reinsurer's coverage.

> likely impetus behind . . . [the sunset clause] is to ensure that both parties have an accurate understanding of ANICO's exposure at the seven-year mark. Such an accurate appreciation of ANICO's economic liability would undoubtedly inform each party's position on commutation.

Id. at 495.