

CHAPTER 17

CHARGING OF CLAIM COSTS

#113.00 INTRODUCTION

The general practice followed by the Board is that the cost of any compensation paid out on a claim is charged to the class or subclass of employers of which the worker's employer is a member. These costs are not paid directly by the employer. Rather, the employer will, through the assessment rate, pay a proportion of the total costs incurred on all claims made by employees of all the employers in the subclass. The proportion paid is the proportion which the employer's payroll bears to the total payrolls of all employers in the subclass. This may be adjusted through a system of experience rated assessments.

In certain cases, the class or subclass consists of one major employer so that the employer does directly pay the costs of the claim. Examples are the Canadian National Railway, Air Canada, Canadian Pacific, and the Provincial Government. These are termed deposit classes.

Generally speaking, whether or not an employer was at fault is not a material factor when determining how the costs of a claim are to be charged. The general practice set out above applies both when the employer's negligence or misconduct caused an injury and when the injury was due to circumstances beyond the employer's control.

There are certain provisions in the *Act* which result in exceptions to the above rule. An individual employer or the class or subclass may be relieved of the costs of compensation incurred on a particular claim. Alternatively, an individual employer may be charged with costs additional to the employer's ordinary liability as a member of a class or subclass. None of these special relieving or charging provisions apply to claims by Federal Government employees.

The amount of costs attributed to an employer are disclosed to an employer in the cost statements which are sent regularly. These list the claims concerned and the amount of costs incurred on each.

EFFECTIVE DATE: December 31, 2003 (as to the third paragraph which incorporates portions of, and replaces, policy item #115.20 "*Significance of Employer's Conduct in Producing Injury*" of this manual.)

#113.10 Investigation Costs

Costs may be incurred prior to making a decision on a claim in investigating the validity of the claim or in paying benefits pursuant to an interim adjudication. Where the decision is ultimately in the worker's favour, these costs are charged to the employer's class in the normal way. Where the decision is unfavourable to the worker, these costs will not be charged to the employer's class, but will be spread across all classes. They are treated in effect as an administration cost.

The same rule also applies where:

1. A claim is accepted in error or benefits paid in error;
2. A decision is reversed by the Review Division or Workers' Compensation Appeal Tribunal;
3. There is a reconsideration by the Board.

The employer's class is relieved where the original decision was favourable to the worker and benefits were paid pursuant to it. Conversely, the class will be charged with costs already incurred where the previous decision was unfavourable to the worker.

For another situation where the class of employers is relieved of costs as investigation costs, see the policy on suffering an occupational disease at policy item #26.10.

EFFECTIVE DATE: June 1, 2009 – Delete references to Medical Review Panel, officer, Manager and Director.
HISTORY: March 3, 2003 – Insert reference to the Review Division, the Workers' Compensation Appeal Tribunal and to reconsideration by a Manager or Director.
APPLICATION: Applies on or after June 1, 2009

#113.20 Occupational Diseases

The long period of exposure required for the development of some occupational diseases raises special problems in connection with the charging of claim costs. The position is the same as for injuries when the exposure has been with one employer only, but there are commonly situations where the relevant exposure has occurred during employments with two or more employers. The general rules followed in these cases are as follows:

1. Until September 27, 2002, all wage-loss and health care benefits are charged to the class of the employer at the time the claim was submitted for the first 13 weeks. Effective September 28, 2002, all

wage loss and health care benefits are charged to the class of the employer at the time the claim was submitted for the first 10 weeks.

2. Until September 27, 2002, an assessment of the worker's work exposure history is then made and an apportionment of the costs incurred beyond 13 weeks, including the amount of any permanent disability award reserve, is carried out. The class of the employer at the time the claim is submitted will be charged with the portion of costs incurred after the 13 weeks, which is attributable to the worker's employment with the employer, provided that that portion exceeds 20% of the total amount. The balance will not be charged to any particular class but will be spread across all classes of industry.

Effective September 28, 2002, an assessment of the worker's work exposure history is then made and an apportionment of the costs incurred beyond 10 weeks, including the amount of any permanent disability award reserve, is carried out. The class of the employer at the time the claim is submitted will be charged with the portion of costs incurred after the 10 weeks, which is attributable to the worker's employment with the employer, provided that that portion exceeds 20% of the total amount. The balance will not be charged to any particular class but will be spread across all classes of industry.

3. Until September 27, 2002, where any portion attributable to any employer at the time the claim is submitted is less than 20%, the costs incurred following 13 weeks are not charged to any employer's class, but will be spread across all classes of industry. To ensure procedural fairness in the event of a request for review or an appeal in such situations, decision letters and review and appeal information is sent to the employers' association that best represents the appropriate class and subclass of industry.

Effective September 28, 2002, where any portion attributable to any employer at the time the claim is submitted is less than 20%, the costs incurred following 10 weeks are not charged to any employer's class, but will be spread across all classes of industry. To ensure procedural fairness in the event of a request for review or an appeal in such situations, decision letters and review and appeal information is sent to the employers' association that best represents the appropriate class and subclass of industry.

4. The apportionment is made by comparing the number of years of exposure with the employer at the time the claim is submitted with the worker's total exposure. No account is taken of varying degrees of exposure which may have occurred at different times.

EFFECTIVE DATE: March 3, 2003 (as to references to review)
APPLICATION: Not applicable.

#113.21 *Silicosis and Pneumoconiosis*

When, in the case of silicosis or pneumoconiosis claims, there is exposure to silica or other dust in more than one subclass of industry within the Province, costs are normally apportioned on the basis of employment records confirming the exposure. Occasionally, it is difficult to be precise about exact periods of exposure because absolute confirmation of employment is not always available many years after the fact. This is because employers may no longer be in business or the worker is unable to provide a complete resume of employment. Under the circumstances, there may be a few cases where it is unfair to simply use employment records for the charging of costs, particularly if there is other substantive evidence available to support exposure to silica dust in a certain class or classes of industry. The Board is therefore responsible for handling silicosis or pneumoconiosis claims discretion in the apportionment of costs where it appears that the sole use of employment records will produce an inequitable result.

The guidelines set out below are followed:

1. Cost for silicosis or pneumoconiosis claims will normally be apportioned on the basis of confirmed periods of employment in industries where there is exposure to silica or other dust.
2. Where confirmed employment records are unavailable, but there is other substantive evidence to support periods of exposure to silica or other dust, the Board has discretion to apportion costs on the basis of the best evidence available.
3. Where a worker is entitled to compensation for silicosis or pneumoconiosis under the terms of section 6 of the *Act*, the costs will be charged to the appropriate class or classes of industry within the province of British Columbia as provided by the *Act*.

EFFECTIVE DATE: June 1, 2009 – Delete references to Board officer.
APPLICATION: Applies on or after June 1, 2009

#113.22 *Hearing-Loss Claims*

Section 7(7) of the *Act* provides that “Where a worker suffers loss of hearing caused by exposure to causes of hearing loss in 2 or more classes or subclasses of industry in the Province, the board may apportion the cost of compensation among the funds provided by those classes or subclasses on the basis of the duration or severity of the exposure in each.”

The procedure followed to implement this provision is set out below.

1. An assessment is made of the worker's work exposure history and an apportionment made as between the various employers concerned of the cost of compensation paid out. The apportionment is made by allocating to each period of employment a factor varying in accordance with the loudness of the noise experienced and multiplying this by the number of years exposed in each employment. The resulting figures for each employment are totalled and the percentage attributable to each is calculated by reference to this total.
2. The costs of a claim are attributed to individual employers in accordance with their percentage where those percentages are 20% or greater. Where the percentages of any employers are less than 20%, the equivalent percentages of the costs of the claim are not attributed to any particular employer, but are still charged to the appropriate class of industry.
3. Where the total exposure in this province is 5% or less, the claim is disallowed. Where the total exposure in this province is 90% or greater, the Board accepts responsibility for the whole hearing loss.
4. Where there is only one employer, but (because of non-occupational or out-of-province exposure) responsibility is less than 20%, the full costs of the claim are nevertheless attributed to that employer. (1)

#113.30 Interjurisdictional Agreements

Section 8.1(1) provides as follows:

"The board may enter into an agreement or make an arrangement with Canada, a province or the appropriate authority of Canada or a province to provide for

- (a) compensation, rehabilitation and health care to workers in accordance with the standards established under this Act or corresponding legislation in other jurisdictions,
- (b) administrative co-operation and assistance between jurisdictions in all matters under this Act and corresponding legislation in other jurisdictions, or
- (c) avoidance of duplication of assessments on workers' earnings."

The agreement entered into contains provisions to deal with situations where an injury, or exposure to the causes of an occupational disease occurs in another province or territory. In addition, it contains a system to permit the Board to help another Board's workers or dependants and a method of resolving disputes between Boards.

An employer who carries on business in this province may be required to register with this Board as an employer even though carrying on business and is registered as an employer with the Board in another province or territory. (2)

Where an employee of such an employer suffers from an injury or occupational disease and is eligible to claim compensation in this and another province or territory, the employer's class will be charged with the costs of the claim subject to adjustment resulting from any reimbursements received or made under the terms of the Interjurisdictional Agreement.

#114.00 PROVISIONS RELIEVING CLASS OF COSTS OF CLAIM

#114.10 Transfer of Costs from One Class to Another

Section 10(8) provides as follows:

"The provisions of this Part are in lieu of any right of action that the employer of the injured or deceased worker is or may, in respect of the personal injury or death of the worker, be entitled to maintain against another employer within the scope of this Part, or an independent operator to whom this Part applies by direction under section 2(2)(a); but where the board considers that

- (a) a substantial amount of compensation has been awarded as a result of the injury or death of the worker; and
- (b) the injury or death was caused or substantially contributed to by a serious breach of duty of care of an employer or an independent operator to whom this Part applies by direction under section 2(2)(a) in another class or subclass,

the board may order that the compensation be charged, in whole or in part, to the other class or subclass; but the provisions of this subsection do not affect any right which an employer may have against another employer, or an independent operator to whom this Part applies by direction under section 2(2)(a), arising out of their indemnity agreement or contract."

This provision permits the Board to transfer the costs of a claim from the class of the worker's employer to the class of another employer in certain circumstances. The requirements of such a transfer are discussed below.

#114.11 *The Amount of Compensation Awarded Must Be Substantial*

The Board has interpreted the word "substantial" as referring to a specific dollar amount. The amounts are set out below:

January 1, 2011 – December 31, 2011	\$44,214.24
January 1, 2012 – December 31, 2012	\$45,494.72

If required, earlier figures may be obtained by contacting the Board.

Effective June 30, 2002, the dollar amount will be adjusted on January 1 of each year. The percentage change in the consumer price index determined under section 25.2 of the *Act*, as described in policy item #51.20, will be used.

#114.12 *Serious Breach of Duty of Care of Another Employer Must Have Caused or Substantially Contributed to Injury*

"Duty of care" has the same meaning as it does in the law of tort. It is therefore relevant to consider what conclusions a court of common law would come to if a claim for damages for personal injury were brought by the worker against the other employer. The basic question considered is whether there was a failure to take reasonable care. The mere fact that the employer may have violated the Occupational Health and Safety Regulation is not sufficient since it often imposes strict liability.

The doctrine of vicarious liability has no application to section 10(8), and a transfer of costs is only available where the breach of duty of care consisted of acts or omissions by management personnel who can be identified as the employer, and not to cases where the breach of duty consists only of the act or omissions of other workers.

If there has been a breach of duty of care by the employer, the next question to be considered is whether it was a "serious" one. The word "serious" refers to the culpability of the employer's behaviour rather than the consequences of that behaviour. Regard will be had to the probability of injury resulting from the breach and the predictable gravity of the likely consequences of such an injury.

The fact that the worker was negligent does not necessarily mean that the employer's breach of duty did not cause or substantially contribute to the injury. Lapses of attention are a normal part of ordinary human behaviour that should be foreseen and guarded against.

#114.13 *Discretion of the Board*

The Board has a discretion where the requirements set out in policy items #114.10 – 12 are satisfied to transfer all or part of the cost of a claim. In exercising this discretion, the Board takes no account of any contributory negligence by the worker.

#114.20 **Depletion or Extinction of Industries or Classes**

Section 39(1)(b) requires the Board to “provide a reserve in aid of industries or classes which may become depleted or extinguished; ...”

Employers may apply to have the costs of a claim transferred from their class to that fund. This provision is very rarely used.

#114.30 **Disasters or Other Circumstances which Unfairly Burden a Rate Group**

Section 39(1)(d) requires the Board to “provide a reserve ... to meet the loss arising from a disaster or other circumstances which the Board considers would unfairly burden the employers in a class.”

Costs will not be charged to the fund created by section 39(1)(d) because there is an unfair burden on an individual employer. The unfair burden must be on a rate group or industry group of employers.

Each deposit account employer forms a classification unit, which is treated as a self-funded rate group by itself. This does not automatically mean that a burden on the deposit account employer is a burden on the rate group. The relief available to deposit accounts under section 39(1)(d) is limited to the same sorts of situations as for other employers.

The Federal Government does not contribute to the Accident Fund, therefore no relief of costs under this section can be made where the Federal Government is recorded as the injury employer.

EFFECTIVE DATE: March 1, 2005

HISTORY: Updates language, consistent with rate-making system in *Assessment Manual*; incorporates portions of, and replaces, policy item #114.50 *Sections 39(1)(d), 39(1)(e) and Federal Government Claims* of this *Manual*.

This policy continues the substantive requirements as they existed prior to the effective date.

APPLICATION: Applies to all decisions on and after March 1, 2005

#114.40 Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability

1. Overview

Section 39(1)(e) requires the Board to “provide and maintain a reserve for payment of that portion of the disability enhanced by reason of a pre-existing disease, condition or disability”. Under this section, eligible claims costs are redirected from an employer’s experience rating and rate group to the section 39(1)(e) reserve.

The intent of section 39(1)(e) is to give reassurance to potential employers that in employing workers with pre-existing diseases, conditions or disabilities, they will not incur undue costs in respect of possible future injuries that are enhanced as a result of the pre-existing diseases, conditions or disabilities.

Where a claim is accepted under the *Act* for a personal *injury*, mental stress or occupational disease, the Board provides cost relief under section 39(1)(e) for any portion of a compensable *disability* that is enhanced by reason of a pre-existing disease, condition or disability. Section 39(1)(e) cost relief decisions do not impact a worker’s entitlement to compensation.

The Board is responsible for initiating section 39(1)(e) cost relief considerations with or without a specific request or application by an employer, and to decide upon the applicability of the section on a claim.

This policy applies to all employers, including deposit class employers, except for the Federal Government. As the Federal Government does not contribute to the Accident Fund, no relief of costs under this section can be made where the Federal Government is recorded as the injury employer.

2. Eligibility

Cost relief consideration does not occur on claims where wage loss ended and/or a permanent disability award was established on or before December 31, 1993.

Where benefits were paid between January 1, 1994 and September 27, 2002, an employer was eligible for cost relief consideration under section 39(1)(e) in two situations:

- a) on all claims where there had been 13 or more weeks of temporary total and/or temporary partial disability benefits paid;
- b) a permanent disability award had been granted.

Where benefits are paid on or after September 28, 2002, an employer is eligible for cost relief consideration under section 39(1)(e) in two situations:

- a) on all claims where there has been 10 or more weeks of temporary total and/or temporary partial disability benefits paid;
- b) a permanent disability award has been granted.

Cost relief can be considered on claims where the pre-existing disease, condition or disability arose from an earlier compensable injury or disease with the same employer, where the date of injury or disease, for the injury or disease on which relief is sought, is on or after July 1, 1998. The date of the disease, for the purpose of this paragraph, is the date that the first claim document is registered at the Board.

3. Evaluation Process

Any impact of the pre-existing disease, condition or disability on the occurrence of the compensable *injury* is irrelevant to the question of whether cost relief will be granted for the enhanced *disability*.

Three questions are considered when evaluating the application of section 39(1)(e).

1. *Was there a pre-existing disease, condition or disability, and if so, to what extent?*

A “pre-existing” disease, condition or disability is one that exists before the compensable injury and is established by a confirmed diagnosis or medical opinion. It does not have to be symptomatic prior to the compensable incident, nor does there have to be previous medical treatment or disability related to the pre-existing disease, condition or disability, for it to be considered for the purposes of relief of costs under section 39(1)(e).

If a worker suffers a compensable personal injury (including mental stress or occupational disease), and there is no evidence of any pre-existing disease, condition or disability, section 39(1)(e) does not apply. The fact that a disability has been enhanced by factors other than a pre-existing disease, condition or disability is not a ground for relief under section 39(1)(e).

1. Was the worker's compensable disability enhanced by reason of a pre-existing disease, condition or disability, and if so, to what extent?

“Enhanced” can mean either the prolongation of recovery or the extent to which the compensable disability is made worse, due to the pre-existing disease, condition or disability.

Evidence that may be considered in determining the degree of prolongation or worsening of a disability includes:

- medical opinion regarding the “normal” recovery time for the particular type of injury;
- medical opinion regarding the “normal” post-surgical recovery time;
- the requirement of additional health care services (physiotherapy, hospitalization, etc.); and
- medical evidence contained on the claim.

All relevant factors are considered in the decision-making process.

Where the severity of the compensable accident, incident or exposure was relatively minor, but there is evidence that the recovery period was prolonged, or the temporary or permanent disability was made worse, by reason of a pre-existing disease, condition or disability, cost relief under section 39(1)(e) will clearly be applicable.

2. How severe was the incident initiating the claim in question?

Where there is confirmation of a pre-existing disease, condition or disability of a minor degree, but the incident which precipitated the compensable claim was of a severe nature, cost relief under section 39(1)(e) will not normally be applicable.

Since section 39(1)(e) specifically refers to the enhancement of “disability”, it has no application in fatal cases or in cases where only health care benefits are payable.

4. Determining Amount of Cost Relief

After it has been determined that a pre-existing disease, condition or disability has enhanced the compensable disability, the Board then determines the amount of cost relief to be granted to an employer.

The grid below is one tool that may be used to determine the amount of cost relief to be granted to an employer. It plots the medical significance of the pre-existing disease, condition or disability against the severity of the accident, incident or exposure resulting in the compensable disability.

Medical Significance of Pre-existing Disease, Condition or Disability	Severity of Accident, Incident or Exposure	Percentage of Cost Relief
Minor	Minor	50%
	Moderate	25%
	Major	0%
Moderate	Minor	75%
	Moderate	50%
	Major	25%
Major	Minor	90-100%
	Moderate	75%
	Major	50%

Medical Significance

A determination of the medical significance of the pre-existing disease, condition or disability is based on a review of the medical evidence and, where applicable, an opinion from the Board.

Severity

The severity of the accident, incident or exposure is generally determined by a review of the factual evidence, including the mechanics of the injury, the activity the worker was undertaking at the time of the injury and the conditions of the worksite.

The following definitions will assist in assessing the severity of the accident, incident or exposure:

- “Minor” severity is expected to cause either no disability or a minor disability.
- “Moderate” severity is expected to cause a disability.
- “Major” severity is expected to cause serious disability or probable permanent disability.

Percentage

How much disability stems from the compensable injury and how much from the enhancement of the disease, condition or disability and, therefore, to what extent costs should be charged under section 39(1)(e) can never be more than an estimate and will always be difficult to determine.

There may be circumstances where the evidence points to a different percentage being relieved than those suggested in the grid. It is more likely that the grid would be used where the distinction between the effects of the pre-existing disease, condition or disability and the compensable injury are not easily made.

In cases of continuing wage-loss and health care benefits, it may be appropriate for the Board to determine that after a particular point in time, all the costs are charged under section 39(1)(e). Alternatively, it may also be determined that a percentage is relieved from a certain time onwards.

A decision on cost relief related to the payment of temporary disability wage loss benefits is distinct and separate from a decision on cost relief for a permanent disability award arising out of the same claim.

No minimum period of temporary disability is required in order for cost relief to be considered on a permanent disability award.

In respect of permanent disability awards, it is necessary for the Board to establish a percentage of cost relief to be granted based on the applicable medical evidence. It is noted that 100% cost relief cannot be granted for a permanent disability award, as this would imply that no portion of the permanent disability resulted from the work-related injury.

5. Timing of Cost Relief Decisions

Where an employer is eligible for cost relief consideration on a claim, the decision is made at the earliest of:

- a) there being sufficient evidence to make a determination on whether the compensable disability was enhanced by reason of a pre-existing disease, condition or disability; or
- b) the conclusion of temporary disability compensation; or

c) after six months of wage loss has been paid.

Cost relief decisions may be deferred beyond six months of wage loss payment when the impact of the pre-existing disease, condition or disability on the compensable disability is not yet clear, or major diagnostic procedures have been scheduled that would clarify the existence, and/or extent of any pre-existing disease, condition or disability.

6. Communication of Cost Relief Decisions

The Board notifies the eligible employer of all section 39(1)(e) cost relief decisions.

If there is a disagreement with such a decision, the employer may request a review by the Review Division. Unexercised appeal rights on relief of cost decisions made before March 3, 2003 are appealed directly to the WCAT and not to the Review Division.

EFFECTIVE DATE: March 1, 2005

CROSS-REFERENCES: Medical Evidence (policy item #97.30)
Appeal and Review Rights (section 41(1)(a)(i), *Workers Compensation Amendment Act (No. 2), 2002, S.B.C. 2002, c. 66*)

HISTORY: Housekeeping amendment effective April 8, 2005. Combines and replaces policy items #114.40A, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*, #114.40B, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*, #114.43, *Procedure Governing Applications under Section 39(1)(e)*, and #114.50, *Sections 39(1)(d), 39(1)(e) and Federal Government Claims of this Manual*.

Incorporates policy previously set out in Panel of Administrators' Resolution No. 1998/04/23-03 *Re: Section 39(1)(e)*. Section 39(1)(e) cost relief consideration does not occur on claims where wage loss ended and/or a permanent disability award was established on or before December 31, 1993. On or after July 1, 1998, section 39(1)(e) cost relief consideration is available for claims in which the pre-existing disease, condition or disability arises from an earlier compensable injury or disease with the same employer as the compensable injury or disease for which relief is sought.

Incorporates portions of, and retires from policy status, *Workers' Compensation Reporter* Decision No. 271, [1971] 4 W.C.R. 10.

Further amendments clarify the evaluation process for allocating cost relief.

This policy continues the substantive requirements as they existed prior to the effective date.

APPLICATION: Applies to all decisions on and after March 1, 2005

#114.41 *Relationship Between Sections 5(5) and 39(1)(e)*

It is important to distinguish between the provisions of section 5(5) and section 39(1)(e), as discussed in policy items #44.00 and #114.40. Section 5(5) deals with the situation where a disability resulting from a work injury is superimposed on a pre-existing disability in the same part of the body and increases that disability. (As outlined in policy item #44.31, section 5(5) can also apply if a permanent disability award is being assessed on a loss of earnings basis under section 23(3) of the *Act* and the disability is deemed to be partly the result of a disability in another part of the body.) It may result in a reduction in the amount of compensation paid to the worker.

Section 39(1)(e) is concerned only with the rate group to which the costs of the claim are to be charged and cannot affect the entitlement of the worker. It can apply in cases where section 5(5) does not apply and the whole of the worker's disability results from the injury or, if section 5(5) does apply, to the portion of disability for which the Board is responsible. It provides relief for the rate group of the worker's employer when the disability or portion of disability accepted under the claim is worse because of a pre-existing disease, condition or disability than it otherwise would be. That condition might well be in a different part of the worker's body.

EFFECTIVE DATE: March 1, 2005

HISTORY: Updates language, consistent with rate-making system in *Assessment Manual*.

This policy continues the substantive requirements as they existed prior to the effective date.

APPLICATION: Applies to all decisions on and after March 1, 2005

#114.42 *Application of Section 39(1)(e) to Occupational Diseases*

Section 39(1)(e) will not be applied to occupational disease claims simply because the disease results from exposure in several different employments. That situation is dealt with in policy item #113.20. However, there may be cases where the disability caused by an occupational disease was enhanced by a pre-existing condition. Section 39(1)(e) can be applied in such cases if the criteria outlined in policy item #114.40 are met.

#115.00 **PROVISIONS CHARGING INDIVIDUAL EMPLOYERS**

One provision of this nature has been discussed in policy item #94.15. Section 54(8) permits the Board to charge an employer with the costs of a claim where late in submitting a report of injury to the Board.

Other provisions of this nature are discussed below.

#115.10 **Failure to Register as an Employer at the Time of Injury**

Where an employer is an employer to which the *Act* extends compulsory coverage, failure to register with the Board as an employer will not prejudice any claim by the employees unless the provisions set out in the policy in Item AP1-1-4 of the *Assessment Manual* apply. However, the employer may be faced with paying the costs of the claim under section 47(2), which provides as follows:

An employer who refuses or neglects to make or transmit a payroll return or other statement required to be furnished by the employer under section 38(1), or who refuses or neglects to pay an assessment, or the provisional amount of an assessment, or an instalment or part of it, must, in addition to any penalty or other liability to which the employer may be subject, pay the Board the full amount or capitalized value, as determined by the Board, of the compensation payable in respect of any injury or occupational disease to a worker in the employer's employ which happens during the period of that default, and the payment of the amount may be enforced in the same manner as the payment of an assessment may be enforced.

Section 38(1) provides that "Every employer must

- (a) keep at all times at some place in the Province, the location of which the employer has given notice to the Board, complete and accurate particulars of the employer's payrolls;

- (b) cause to be furnished to the Board
 - (i) when the employer becomes an employer within the scope of this Part; and,
 - (ii) at other times as required by a regulation of the Board of general application or an order of the Board limited to a specific employer, an estimate of the probable amount of the payroll of each of the employer's industries within the scope of this Part, together with any further information required by the Board; and
- (c) furnish certified copies of reports of the employer's payrolls, at or after the close of each calendar year and at the other times and in the manner required by the Board."

The Board may, under section 47(3), if satisfied that the default was excusable, relieve an employer in whole or in part from liability under section 47(2).

The Board has decided that section 47(2) applies to claims for fatalities.

The charge made under section 47(2) is in addition to any ordinary assessments which the employer may be liable to pay for the period prior to the occurrence of the injury.

Policy item #113.30 dealt with the rules followed in charging the costs of claims where an employer is carrying on business in two or more provinces and is required to register in both. Where such an employer is not registered in this province at the time of an injury, there may be personal liability for the costs of the claim under section 47(2) in any situation where, under the provisions of the Interjurisdictional Agreement or otherwise, the employer's class would ordinarily be charged.

EFFECTIVE DATE: March 18, 2003 (as to numerical reference to the policy in Item AP1-1-4 in the *Assessment Manual*)
APPLICATION: Not applicable.

#115.30 Experience Rating Cost Exclusions

Section 42 provides as follows.

The Board shall establish subclassifications, differentials and proportions in the rates as between the different kinds of employment in the same class as may be considered just; and where the Board thinks a particular industry or plant is shown to be so circumstanced or conducted that the hazard or cost of compensation differs from the average of the class or subclass to which the industry or plant is assigned, the Board must confer

or impose on that industry or plant a special rate, differential or assessment to correspond with the relative hazard or cost of compensation of that industry or plant, and for that purpose may also adopt a system of experience rating.

The Board has adopted an experience rating plan (ER) under this section. The plan compares the ratio between an employer's claim costs and assessable payroll with the ratio between the total claim costs and assessable payroll of the employer's rate group. Subject to maximums, discounts are assigned for favourable ratios and surcharges for unfavourable ratios. The discount or surcharge takes the form of a percentage increase or decrease in the usual assessment rate. Details of ER can be found in the policy in Item AP1-42-1 of the *Assessment Manual*.

As a general rule, all acceptable claims coded to a particular employer are counted for experience rating purposes. It makes no difference whether the injury was or was not the employer's fault. There are, however, some types of claim costs which are excluded from consideration. These are:

1. Costs recovered by way of a third party action (see policy item #111.25, *Pursuing of Subrogated Actions by the Board*).
2. Investigation and/or compensation costs paid out prior to the disallow of a claim or reversal of a decision by the Board, or the Workers' Compensation Appeal Tribunal (see policy item #113.10, *Investigation Costs*).
3. Costs transferred to the rate group of another employer under section 10(8) (see policy item #114.10, *Transfer of Costs from One Class to Another*).
4. Costs assigned to the funds created by section 39(1)(d) and (e) (see policy item #114.30, *Disasters or Other Circumstances which Unfairly Burden a Rate Group*, and policy item #114.40, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*).
5. Occupational disease claims which on average require exposure for, or involve latency periods of, two or more years before manifesting into a disability. The diseases presently excluded on this ground are:

Non-traumatic hearing loss, excluding hearing loss resulting from other injuries

Silicosis

Asbestosis

Other diagnosed pneumoconioses, for example, anthracosis and siderosis

Pneumoconioses not specifically diagnosed

Heart disease

Cancer

Hand-arm vibration syndrome, vinyl chloride induced Raynaud's phenomenon, disablement from vibrations

(see policy item #113.20, *Occupational Diseases*)

6. Until September 27, 2002, costs after 13 weeks where section 5(3) applies (see Item C3-14.10, *Serious and Wilful Misconduct*). Effective September 28, 2002, costs after 10 weeks where section 5(3) applies (see Item C3-14.10, *Serious and Wilful Misconduct*).
7. Costs from accidents substantially due to personal illness, e.g. epilepsy (see Item C3-16.00, *Pre-Existing Conditions or Diseases*).
8. Injuries covered by Items C11-88.10, *Work Assessments*, C11-88.40, *Training-on-the-Job*, and C11-88.50, *Formal Training*.
9. The situations covered by policy item #115.31, *Injuries or Aggravations Occurring in the Course of Treatment or Rehabilitation*, and policy item #115.32, *Claims Involving a Permanent Disability Award and a Fatality*, below.
10. The situation covered by policy item #115.33, *Claims Relating to Subsequent Non-Compensable Incidents*.

The decision whether a claim falls within one of the exclusions will usually be made by the Board. In the case of third party actions (Exclusion 1), a Board solicitor makes the decision.

EFFECTIVE DATE: August 1, 2010
HISTORY: June 1, 2009 – Delete references to the Review Division, Medical Review Panel and the Worker and Employer Services Division.
March 1, 2005 – Updates language as to the use of the phrase “rate group”, consistent with rate-making system in *Assessment Manual*; updates and incorporates cross-references to policy items #113.20 and C11-88.10, to make all items consistent and accurate. This policy continues the substantive requirements as they existed prior to the effective

date. Applied to all decisions on or after March 1, 2005.

March 18, 2003 – “Discount”, “Surcharge” and the numerical reference to the policy in Item AP1-42-1 in the *Assessment Manual* were incorporated.

APPLICATION:

This policy applies to all decisions made on or after August 1, 2010.

#115.31 *Injuries or Aggravations Occurring in the Course of Treatment or Rehabilitation*

Where there is an aggravation of an injury or a subsequent injury arising out of treatment for the primary injury, and the aggravation or subsequent injury is acceptable on the claim, compensation costs resulting from this secondary problem will be charged in the usual way. Exclusion from the employer’s experience rating will only occur where:

1. the original injury was one that would not have been expected to result in death or permanent disability, and
2. the aggravation or subsequent injury occurred beyond the operations of the employer, and if the worker required transportation to a hospital or other place of medical treatment, after the employer had fulfilled the obligations under section 21(3) (see policy item #82.40), and
3. the aggravation or subsequent injury resulted in permanent disability or death.

The application of relief is limited to the permanent disability award reserve established for a fatality or permanent disability.

Consideration is automatically given by the Board to excluding the costs from experience rating in these cases. No request from the employer is required. The employer will be advised of the decision in writing and of the relevant review and/or appeal rights.

EFFECTIVE DATE:

June 1, 2009 – Delete reference to Board officer.

HISTORY:

March 3, 2003 – Amendments to delete references to the Review Board and the Appeal Division.

APPLICATION:

Applies on or after June 1, 2009

#115.32 *Claims Involving a Permanent Disability Award and a Fatality*

ER does not include the actual cost of the fatal claims experienced by an employer. Rather, it includes for each claim the average cost for all fatal claims in the year.

A worker in receipt of a permanent disability award may die as a result of the injury or disease accepted under the claim. If pensions are payable to dependants, the cost otherwise included in ER may be reduced to the extent set out below:

1. Where the average cost of a fatal award is the same or less than that of the permanent disability award, the total cost of the fatal award is excluded.
2. Where the average cost of a fatal award is greater than that of the permanent disability award, a portion of the cost of the fatal award equal to the reserve charged to the employer for the permanent disability award is excluded.

#115.33 *Claims Relating to Subsequent Non-Compensable Incidents*

A worker may continue to receive temporary wage-loss benefits where recovery from a compensable disability is delayed due to a subsequent non-compensable incident.

As set out in policy item #34.55, the Board estimates when the worker would have reached maximum medical recovery. The Board continues to pay wage-loss benefits for the period that the Board estimates the worker would have taken to reach maximum medical recovery from the compensable injury had the subsequent non-compensable incident not occurred.

When the estimated date for terminating wage-loss benefits arrives, if the worker is still disabled, the Board makes a new decision as to whether the disability is due to the compensable injury or the subsequent non-compensable incident. If the disability is due to the compensable injury, wage-loss benefits may be continued.

Where the delay in recovery is due to the subsequent non-compensable incident, the cost of compensation associated with the delay in recovery beyond the estimated date for terminating temporary wage-loss benefits is excluded from the employer's experience rating. These costs will also not be charged to the employer's rates group, but will be spread across all rate groups.

Claims costs associated with a permanent disability award would not be relieved under this policy.

EFFECTIVE DATE: August 1, 2010
APPLICATION: This policy applies to all decisions made on or after August 1, 2010.

NOTES

- (1) See policy item #31.20
- (2) See Item AP1-38-4 of the *Assessment Manual*
- (3) ~~See policy item #112.30~~ **DELETED**
- (4) ~~See policy item #82.40~~ **DELETED**
- (5) ~~See policy item #82.40~~ **DELETED**
- (6) ~~S.96(6) and 96(7)~~ **DELETED**