SB

322

(File 16)

Introduced: 1/11/88
Referred: Labor and Commerce

5-1514A

BY THE LABOR AND COMMERCE COMMITTEE

IN THE SENATE

SENATE BILL NO. 322

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to workers' compensation; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. LEGISLATIVE INTENT. (a) It is the intent of the legislature that AS 23.30 be interpreted so as to assure the quick, efficient, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of AS 23.30.

(b) The legislature declares that the workers' compensation laws must not be construed by the courts in favor of any party. It is the specific intent of the legislature that workers' compensation cases be decided on their merits, except when otherwise provided by statute. It is also the intent of the legislature that the board possess the greatest possible authority in the exercise of its fact finding responsibilities and that the board's decisions be conclusive if supported by any evidence.

(c) It is the intent of the legislature in amending AS 23.30.175 regarding benefits payable to recipients not residing in the state to

(1) recognize the levels of workers' compensation benefits brought about by the high cost of living that exists in the state as compared to other localities;

(2) reduce disincentives to return to work; and

(3) remove obstacles to the utilization of vocational rehabilitation that may be brought about by the payment of workers' compensation benefits at the high levels provided by the Alaska workers' compensation

law to individuals residing in localities with living costs lower than those in Alaska.

* Sec. 2. AS 23.30.005(h) is amended to read:

(h) The department may adopt identical rules for all panels, and procedures for the periodic selection, retention, and removal of rehabilitation specialists or physicians under AS 23.30.041 and 23.30.095, and may adopt regulations to carry out the provisions of this chapter. Process and procedure under this chapter shall be as summary and simple as possible. The department, the board or a member of it may for the purposes of this chapter subpoena witnesses, administer or cause to be administered oaths, and may examine or cause to have examined the parts of the books and records of the parties to a proceeding that relate [WHICH RELATED] to questions in dispute. The superior court, on application of the department, the board or any members of it, shall enforce the attendance and testimony of witnesses and the production and examination of books, papers, and records.

* Sec. 3. AS 23.30.005 is amended by adding a new subsection to read:

(m) If a regulation adopted by the department and approved by a majority of the full board is determined to be invalid by the state supreme court, the department shall immediately adopt new regulations that conform to the department's statutory authority as interpreted by the court.

* Sec. 4. AS 23.30.020 is amended by adding a new subsection to read:

(b) An employee who knowingly makes a false statement as to the employee's physical condition on an employment application or preemployment questionnaire may not receive benefits under this chapter if

(1) the employer relied upon the false representation and this reliance was a substantial factor in the hiring; and

(2) there was a causal connection between the false

representation and the injury to the employee.

* Sec. 5. AS 23.30.040(b) is amended to read:

(b) If an employee suffers a compensable injury that results in temporary total disability, temporary partial disability, permanent partial disability, or permanent total disability, the employer or insurance carrier shall contribute to the second injury fund. The contribution shall be made annually at the time of the report filing required by AS 23.30.155(m) [BY ONE YEAR FROM THE DATE OF THE INJURY OR ON TERMINATION OF THE EMPLOYEE'S CLAIM, WHICHEVER IS SOONER. IF THE CLAIM IS NOT TERMINATED WITHIN ONE YEAR, SUBSEQUENT CONTRIBUTIONS SHALL BE MADE YEARLY UNTIL THE TERMINATION OF THE EMPLOYEE'S CLAIM]. The amount of the contribution is the product of the compensation to which the employee is entitled for temporary total disability, temporary partial disability, permanent partial disability, or permanent total disability and the applicable contribution rate set out in column A of this subsection. Payment need not be made to the second injury fund if the total contribution under this subsection is less than $20. By December 15 of each year the commissioner shall determine and make available to the public the applicable contribution rate for the following calendar year according to the reserve rate of the second injury fund in column B of this subsection:

Column A	Column B	
Second Injury Fund	Reserve Rate	
Contribution Rate	At Least	But Less Than
(Percent)	(Percent)	(Percent)
6	0	50
5	50	75
4	75	100
3	100	125

2	125	150
1	150	175
0	175	

* Sec. 6. AS 23.30.041 is repealed and reenacted to read:

Sec. 23.30.041. REHABILITATION OF INJURED WORKERS. (a) The board shall select and employ a reemployment services administrator. The board may authorize the reemployment services administrator to select and employ additional staff. The reemployment services administrator is in the partially exempt service under AS 39.25.120.

(b) The reemployment services administrator shall perform the following functions:

(1) enforce regulations adopted by the board to implement this section;

(2) recommend regulations for adoption by the board that establish performance and reporting criteria for rehabilitation specialists;

(3) enforce the quality and effectiveness of reemployment benefits provided for under this section;

(4) review on an annual basis the performance of rehabilitation specialists to determine continued eligibility for delivery of rehabilitation services;

(5) submit to the department, on or before January 1 of each year, a report of reemployment benefits provided under this section for the previous fiscal year; the report must include a general section and sections related to each rehabilitation specialist used under this section; the report must also include for each section a statistical summary of all rehabilitation cases, including

(A) the estimated and actual cost of each active rehabilitation plan;

(B) the estimated and actual time of each rehabilitation plan;

(C) a status report on all individuals completing or terminating a reemployment services program including a return to work date;

(D) the cost of reemployment services;

(6) maintain a list of rehabilitation specialists who meet the qualifications established under this section;

(7) promote awareness among physicians, adjustors, injured workers, employers, employees, attorneys, training providers, and rehabilitation specialists of the reemployment program established in this subsection.

(c) If an employee suffers a compensable injury that may permanently preclude an employee's return to the employee's occupation at the time of injury, the employee or employer may request an eligibility evaluation for reemployment benefits. The reemployment services administrator shall, on a rotating basis, select a rehabilitation specialist from the list maintained under (b)(6) of this section to perform the eligibility evaluation.

(d) Except as provided in (e) of this section, an employee shall be eligible for benefits under this section upon the employee's written request and by having a physician predict that the employee will have permanent physical capacities that are less than the physical demands of the employee's job as described in the United States Department of Labor's "Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles" for

(1) the employee's job at the time of injury; and

(2) other jobs that exist in the labor market that the employee has held within 10 years before the injury or that the

employee has held following the injury for a period long enough to obtain the skills to compete in the labor market, according to specific vocational preparation codes as described in the dictionary of occupational titles.

(e) An employee is not eligible for reemployment benefits if

(1) the employer offers employment within the employee's predicted post-injury physical capacities at a wage equivalent to at least 60 percent of the worker's gross hourly wages at the time of injury and the employment prepares the employee to be employable in other jobs that exist in the labor market; or

(2) the employee has been previously rehabilitated in a former workers' compensation claim and returned to work in the same or similar occupation in terms of physical demands.

(f) When an employee is found eligible for reemployment benefits and desires to use these benefits, the employee shall select a rehabilitation specialist who shall provide a complete reemployment services plan. If the employer disagrees with the employee's choice of rehabilitation specialist to develop the plan and the disagreement cannot be resolved, then the reemployment services administrator shall assign a rehabilitation specialist. The employer and employee each have one right of refusal of a rehabilitation specialist. The reemployment plan must include the following:

(1) an occupational goal in the labor market;

(2) a plan to acquire the occupational skills to be employable;

(3) the cost estimate of the reemployment plan, including provider fees; the amount of tuition, books, tools, and supplies; transportation; temporary lodging; or job modification devices;

(4) the estimated length of time that the plan will take;

(5) the date the plan will commence; and

(6) the time of medical stability as predicted by the physician.

(g) Reemployment benefits shall be selected from the following in a manner that ensures remunerative employability in the shortest possible time:

(1) on the job training;

(2) vocational training;

(3) academic training;

(4) self-employment; or

(5) a combination of (1) - (4) of this subsection.

(h) The employee, rehabilitation specialist, and the employer shall sign the reemployment services plan.

(i) After the injured worker has elected to participate in reemployment benefits, noncooperation by the worker shall result in the termination of reemployment benefits on the date of noncooperation. Noncooperation means failure to

(1) keep appointments;

(2) maintain average grades;

(3) attend designated programs;

(4) maintain contact with the rehabilitation specialist;

(5) cooperate with the rehabilitation specialist in developing a reemployment plan and participating in activities relating to reemployability on a full-time basis;

(6) comply with the employee's responsibilities outlined in the reemployment plan; or

(7) participate in any planned reemployment activity as determined by the reemployment services administrator.

(j) Reemployment benefits are subject to the following time

limits:

(1) benefits related to the reemployment plan may not extend past two years from date of plan acceptance, at which time the benefits expire, except at the discretion of the employer;

(2) election of the eligibility evaluation by the employee for reemployment benefits must occur within 60 days of the employer's notice of injury unless the reemployment services administrator determines that unusual and extenuating physical limitations of the employee preclude the employee from making a timely request;

(3) the determination of the employee's eligibility for reemployment benefits shall occur no later than 30 days following the date of evaluation referral, except under circumstances that are determined to be unusual and extenuating by the reemployment services administrator, who may grant up to an additional 30 days;

(4) within 10 days after the employee has been determined eligible for reemployment benefits, the employee and employer shall select a rehabilitation specialist to deliver reemployment services;

(5) a reemployment plan must be formulated and approved by the parties within 90 days of the determination of eligibility;

(6) the reemployment plan shall be initiated when the employee is considered physically able to engage in the plan by the employee's physician;

(7) if the employer and employee fail to agree on a reemployment plan, either party may submit a reemployment plan for approval to the reemployment services administrator; the reemployment services administrator shall approve or deny a plan within 14 days after the plan is submitted; within 10 days of the decision, either party may seek review of the decision by requesting a hearing under AS 23.30.110; the board shall uphold the decision of the administrator

unless evidence is submitted supporting an allegation of abuse of discretion on the part of the administrator; the board shall render a decision within 30 days after completion of the hearing.

(k) The cost of the reemployment plan incurred under this section shall be the responsibility of the employer, but may not exceed $10,000. If an employee reaches medical stability before completion of the plan, temporary total disability benefits shall cease and permanent impairment benefits shall then be paid at the employee's temporary total disability rate. If the employee's permanent impairment benefits are exhausted before the completion or termination of the reemployment plan, the employer shall provide wages equal to 60 percent of the employee's spendable weekly wages but not to exceed $525, until the completion or termination of the plan. A permanent impairment benefit remaining unpaid upon the completion or termination of the plan shall be paid to the employee in a single lump sum. The fees of the rehabilitation specialist or rehabilitation professional shall be paid by the employer and may not be included in determining the cost of the reemployment plan.

(l) Only a rehabilitation specialist may accept case assignments as a case manager and sign eligibility determinations and reemployment plans. A person who is not a rehabilitation specialist may perform rehabilitation casework if the work is performed under the direct supervision of a rehabilitation specialist employed in the same firm and location.

(m) In this section

(1) "employability" means possessing the ability but not necessarily the opportunity to engage in employment that is consistent with the employee's physical status imposed by the compensable injury or disease;

(2) "labor market" means a geographical area that offers employment opportunities in the following priority:

(A) area of residence;

(B) area of last employment;

(C) the state;

(D) other states;

(3) "physical capacities" means objective and measurable physical traits such as ability to lift and carry, walk, stand or sit, push, pull, climb, balance, stoop, kneel, crouch, crawl, reach, handle, finger, feel, talk, hear or see;

(4) "physical demands" means the physical requirements of the job such as strength, including positions such as standing, walking, sitting, and movement of objects such as lifting, carrying, pushing, pulling, climbing, balancing, stooping, kneeling, crouching, crawling, reaching, handling, fingering, feeling, talking, hearing, or seeing;

(5) "reemployment benefits" means eligibility determination, plan development, and plan cost not exceeding $10,000, exclusive of provider fees;

(6) "rehabilitation specialist" means a person who is a certified insurance rehabilitation specialist or a person who has equivalent or better qualifications as determined under regulations adopted by the department;

(7) "remunerative employability" means having the skills that allow a worker to be compensated with wages or other earnings equivalent to at least 60 percent of the worker's gross hourly wages at the time of injury; if the employment is outside the state, the stated 60 percent shall be adjusted to account for the difference between the applicable state average weekly wage and the Alaska

average weekly wage.

* Sec. 7. AS 23.30.055 is amended to read:

Sec. 23.30.055. EXCLUSIVENESS OF LIABILITY. The liability of an employer prescribed in AS 23.30.045 is exclusive and in place of all other liability of the employer and any fellow employee to the employee, the employee's legal representative, husband or wife, parents, dependents, next of kin, and anyone otherwise entitled to recover damages from the employer or fellow employee at law or in admiralty on account of the injury or death. <u>The liability of the employer is exclusive even if the employee's claim is barred under AS 23.30.-020(b).</u> However, if an employer fails to secure payment of compensation as required by this chapter, an injured employee or the employee's legal representative in case death results from the injury may elect to claim compensation under this chapter, or to maintain an action against the employer at law or in admiralty for damages on account of the injury or death. In that action the defendant may not plead as a defense that the injury was caused by the negligence of a fellow servant, or that the employee assumed the risk of the employment, or that the injury was due to the contributory negligence of the employee.

* Sec. 8. AS 23.30.095(a) is amended to read:

(a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. However, if the condition requiring the treatment, apparatus, or medicine is a latent one, the two-year period runs from the time the employee has knowledge of the nature of the employee's disability and its relationship to the

employment and after disablement. It shall be additionally provided that, if continued treatment or care or both beyond the two-year period is indicated, the injured employee has the right of review by the board. The board may authorize continued treatment or care or both as the process of recovery may require. When medical care is required, the injured employee may designate a licensed physician inside the state where the employee resides to render the care. The employee may not make more than one change in the employee's choice of attending physician without the written consent of the employer. Referral to a specialist by the employee's attending physician is not considered a change in physicians [EXCEPT IN CASES WHERE, IN THE JUDGMENT OF THE BOARD, CARE OR TREATMENT OR BOTH CAN BEST BE ADMINISTERED BY THE SELECTION OF ANOTHER PHYSICIAN]. Upon procuring the services of a physician, the injured employee shall give proper notification of the selection to the employer within a reasonable time after first being treated. Notice of a change in the attending physician shall be given before the change [IF FOR ANY REASON DURING THE PERIOD WHEN MEDICAL CARE IS REQUIRED THE EMPLOYEE WISHES TO CHANGE TO ANOTHER PHYSICIAN, THE EMPLOYEE MAY DO SO IN ACCORDANCE WITH REGULATIONS ADOPTED BY THE BOARD].

* Sec. 9. AS 23.30.095(c) is amended to read:

(c) A claim for medical or surgical treatment is not valid and enforceable against the employer unless, within 14 days following treatment, the physician giving the treatment or the employee receiving it furnishes to the employer and the board notice of the injury and treatment, preferably on a form prescribed by the board. The board shall, however, excuse the failure to furnish notice within 14 days when it finds it to be in the interest of justice to do so, and it may, upon application by a party in interest, make an award for

the reasonable value of the medical or surgical treatment so obtained by the employee. A claim for a course of treatment requiring continuing and multiple treatments of a similar nature is not valid unless the treatments are carried out under a written treatment plan prescribed before the commencement of treatment, completed and signed by the attending physician, and mailed to the employer within one week of the beginning of treatment. The treatment plan must include objectives, modalities, and frequency of treatment. The initial treatment plan may not include more than 20 visits in the first 60 days. If more than 20 visits are required within the first 60 days, or more than four visits a month after the first 60 days, the physician shall document the need for services in excess of the guidelines in the written treatment plan.

* Sec. 10. AS 23.30.095(e) is amended to read:

(e) The employee shall, after an injury, at reasonable times during the continuance of the disability, if requested by the employer or when ordered by the board, submit to an examination by a physician or surgeon of the employer's choice [AUTHORIZED TO PRACTICE MEDICINE UNDER THE LAWS OF THE STATE IN WHICH THE EMPLOYEE MAY BE FOUND], furnished and paid for by the employer. An examination requested by the employer not less than 14 days after injury, and every 30 days thereafter, shall be presumed to be reasonable, and the employee shall submit to the examination without further request or order by the board. Facts relative to the injury or claim communicated to or otherwise learned by a physician or surgeon who may have attended or examined the employee, or who may have been present at an examination are not privileged, either in the hearings provided for in this chapter or an action to recover damages against an employer who is subject to the compensation provisions of this chapter. If an employee

refuses to submit to an [ANY] examination provided for in this section, the employee's rights to compensation shall be suspended until the obstruction or refusal ceases, and the employee's compensation during the period of suspension may, in the discretion of the board or the court determining an action brought for the recovery of damages under this chapter, be forfeited. The board in any case of death may require an autopsy at the expense of the party requesting the autopsy. An autopsy may not be held without notice first being given to the widow or widower or next of kin if they reside in the state or their whereabouts can be reasonably ascertained, of the time and place of the autopsy and reasonable time and opportunity given the widow or widower or next of kin to have a representative present to witness the autopsy. If adequate notice is not given, the findings from the autopsy may be suppressed on motion made to the board or to the superior court, as the case may be.

* Sec. 11. AS 23.30.095(f) is amended to read:

(f) All fees and other charges for medical treatment or service [ARE LIMITED TO THE CHARGES THAT PREVAIL IN THE SAME COMMUNITY FOR SIMILAR TREATMENT OF INJURED PERSONS OF LIKE STANDARD OF LIVING AND] shall be subject to regulation by the board but may not exceed usual, customary, and reasonable fees for the treatment or service in the community in which it is rendered, as determined by the board.

* Sec. 12. AS 23.30.095(j) is repealed and reenacted to read:

(j) The board may appoint a medical services review committee, or contract with an existing organization in the state or another state, to assist and advise the board in matters involving the appropriateness, necessity, and cost of medical and related services provided under this chapter.

* Sec. 13. AS 23.30.095 is amended by adding a new subsection to read:

(k) In the event of a medical dispute regarding determinations of causation, medical stability, degree of impairment, functional capacity, the amount and efficacy of the continuance of or necessity of treatment, or compensability between the employee's attending physician and the employer's independent medical evaluation, a second independent medical evaluation shall be conducted by a physician or physicians selected by the board from a list established and maintained by the board. The cost of the examination and medical report shall be paid by the employer. The report of the independent medical examiner shall be furnished to the board and to the parties within 14 days after the examination is concluded. The opinion of the independent medical examiner shall, in the absence of clear and convincing objective evidence to the contrary, be presumed to be correct. A person may not seek damages from an independent medical examiner caused by the rendering of an opinion or providing testimony under this subsection, except in the event of fraud.

* Sec. 14. AS 23.30.105(a) is amended to read:

(a) The right to compensation for disability under this chapter is barred unless a claim for it is filed within two years after the employee has knowledge of the nature of the employee's disability and its relation to the employment and after disablement. However, the maximum time for filing the claim in any event other than arising out of an occupational disease shall be four years from the date of injury, and the right to compensation for death is barred unless a claim therefor is filed within one year after the death, except that if payment of compensation has been made without an award on account of the injury or death, a claim may be filed within two years after the date of the last payment of benefits under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215. It is additionally provided that,

in the case of latent defects pertinent to and causing compensable disability, the injured employee has full right to claim as shall be determined by the board, time limitations notwithstanding.

* Sec. 15. AS 23.30.120 is amended by adding a new subsection to read:

(c) The presumption of compensability established in (a) of this section does not apply to a mental injury resulting from work-related stress.

* Sec. 16. AS 23.30.125 is amended by adding a new subsection to read:

(f) Subject to an employer's or employee's burden of proof, a finding of fact made by the board as a part of a compensation order is conclusive if supported by any evidence.

* Sec. 17. AS 23.30.130(a) is amended to read:

(a) Upon its own initiative, or upon the application of any party in interest on the ground of a change in conditions, including, for the purposes of AS 23.30.175, a change in residence, or because of a mistake in its determination of a fact, the board may, before one year after the date of the last payment of compensation benefits under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215, whether or not a compensation order has been issued, or before one year after the rejection of a claim, review a compensation case under [IN ACCORDANCE WITH] the procedure prescribed in respect of claims in AS 23.30.110. Under [IN ACCORDANCE WITH] AS 23.30.110 the board may issue a new compensation order which terminates, continues, reinstates, increases, or decreases the compensation, or award compensation.

* Sec. 18. AS 23.30.155(c) is amended to read:

(c) The employer shall notify the board and the employee on a form prescribed by the board that the payment of compensation has begun or has been increased, decreased, suspended, terminated, resumed, or changed in type. An initial report shall be filed with the

board and sent to the employee within 28 days after the date of issuing the first payment of compensation. If at any time 21 days or more pass and no compensation payment is issued, a report notifying the board and the employee of the termination or suspension of compensation shall be filed with the board and sent to the employee within 28 days after the date the last compensation payment was issued. A report shall also be filed with the board and sent to the employee within 28 days after the date of issuing a payment increasing, decreasing, resuming, or changing the type of compensation paid. If the employer fails to notify the board and the employee within the 28 days prescribed by this subsection for reporting, the employer shall pay a civil penalty of $100 for the first day plus $10 for each day thereafter that the employer failed to give notice. Total penalties under this subsection [SECTION] may not exceed $1,000 for a failure to file a required report. Penalties assessed under this subsection are eligible for reduction under (m) of this section.

* Sec. ~~19.~~ AS 23.30.155(d) is amended to read:

(d) If the employer controverts the right to compensation the employer shall file with the board and send to the employee a notice of controversion on or before the 21st day after the employer has knowledge of the alleged injury or death. If the employer controverts the right to compensation after payments have begun, the employer shall file with the board and send to the employee a notice of controversion within seven days after an installment of compensation payable without an award is due. When payment of temporary disability benefits is controverted solely on the grounds that another employer or another insurer of the same employer may be responsible for all or a portion of the benefits, the most recent employer or insurer who is party to the claim and who may be liable shall make the payments

during the pendancy of the dispute. When a final determination of liability is made, any reimbursement required, including interest at the statutory rate, and all costs and attorneys' fees incurred by the prevailing employer, shall be made within 14 days of the determination.

* Sec. 20. AS 23.30.155(m) is repealed and reenacted to read:

(m) By March 1 of each year the employer shall file a verified annual report on a form prescribed by the board stating the total amount of all compensation by type, medical, and related benefits, vocational rehabilitation expenses, legal fees, and penalties paid on all claims during the preceding calendar year. If the annual report is timely and complete when received by the board and provides accurate information about each category of payments, the commissioner shall review the timeliness of the employer's reports filed under (c) of this section. If the employer filed at least 99 percent of the reports on time, the penalties assessed under (c) of this section shall be waived. If the employer filed at least 97 percent of the reports on time, 75 percent of the penalties assessed under (c) of this section shall be waived. If the employer filed 95 percent of the reports on time, 50 percent of the penalties assessed under (c) of this section shall be waived. If the employer's reports have not been filed on time at least 95 percent of the time, none of the penalties assessed under (c) of this section shall be waived. The penalties that are not waived are due and payable when the employer receives notification from the commissioner regarding the timeliness of the reports.

* Sec. 21. AS 23.30.175 is repealed and reenacted to read:

Sec. 23.30.175. RATES OF COMPENSATION. (a) The weekly rate of compensation for disability or death for a recipient residing in the

state may not exceed $700 and initially may not be less than $110. However, if the board determines that the employee's spendable weekly wages are less than $110 a week as computed under AS 23.30.220, or less than $154 a week in the case of an employee who has furnished documentary proof of the employee's wages, it shall issue an order adjusting the weekly rate of compensation to a rate equal to the employee's spendable weekly wages. If the employee's spendable weekly wages are greater than $154, but 80 percent of the employee's spendable weekly wages is less than $154, the employee's weekly rate of compensation shall be $154. Prior payments made in excess of the adjusted rate shall be deducted from the unpaid compensation in the manner the board determines. In any case, the employer shall pay timely compensation.

(b) The following rules apply to benefits payable to recipients not residing in the state at the time compensation benefits are payable:

(1) the weekly rate of compensation shall be calculated by multiplying the recipient's weekly compensation rate calculated under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215, by the ratio of the cost of living of the locality in which the recipient resides to the cost of living of the state;

(2) the calculation required by (1) of this subsection does not apply if the recipient is absent from the state for medical or rehabilitation services not reasonably available in the state;

(3) if the average weekly wage of the recipient and the resulting compensation rate is determined under AS 23.30.220(a)(2), the calculation required by this subsection applies only to the portion of the recipient's weekly compensation rate attributable to wages earned in the state;

(4) application of this subsection may not reduce the weekly compensation rate to less than $154 a week, except as provided in (a) of this section.

(c) The board shall provide by regulation for the determination of living costs for the state and other localities in which recipients reside and for the annual redetermination of these costs.

* Sec. 22. AS 23.30.180 is amended to read:

Sec. 23.30.180. PERMANENT TOTAL DISABILITY. In case of total disability adjudged to be permanent 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the total disability. Loss of both hands, or both arms, or both feet, or both legs, or both eyes, or of any two of them, in the absence of conclusive proof to the contrary, constitutes permanent total disability. In all other cases permanent total disability is determined in accordance with the facts. In making this determination the market for the employee's services shall be

(1) area of residence;

(2) area of last employment; and

(3) the state.

* Sec. 23. AS 23.30.180 is amended by adding a new subsection to read:

(b) Failure to achieve remunerative employability as defined in AS 23.30.041(m)(7) does not, by itself, constitute permanent total disability.

* Sec. 24. AS 23.30.185 is amended to read:

Sec. 23.30.185. COMPENSATION FOR TEMPORARY TOTAL DISABILITY. In case of disability total in character but temporary in quality, 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the disability. Temporary total disability benefits may not be paid for any period of disability

occurring after the date of medical stability. Temporary total disability benefits may not be paid for more than two years regardless of continuance of the disability.

* Sec. 25. AS 23.30.190 is repealed and reenacted to read:

Sec. 23.30.190. COMPENSATION FOR PERMANENT PARTIAL IMPAIRMENT. (a) In case of impairment partial in character but permanent in quality, and not resulting in permanent total disability, the compensation is $240,000 multiplied by the employee's percentage of net permanent impairment of the whole person, and payable in a single lump sum, except as otherwise provided in AS 23.30.041, but the compensation may not be discounted for any present value considerations. Net permanent impairment is to be determined by multiplying the employee's actual degree of permanent impairment by the appropriate adjustment factor, as follows:

Degree of Actual Impairment	Adjustment Factor
0 - 5 percent	0
6 - 10 percent	0.2
11 - 15 percent	0.4
16 - 20 percent	0.6
21 - 25 percent	0.7
26 - 30 percent	0.8
31 percent and greater	1.0

(b) All determinations of the existence and degree of permanent impairment shall be made strictly and solely under the whole person determination as set out in the American Medical Association Guides to the Evaluation of Permanent Impairment, except that an impairment rating may not be rounded to the next five percent. The board may adopt and use a supplemental schedule only for injuries that cannot be rated by the use of American Medical Association guidelines.

(c) An employee with an actual permanent impairment as determined under (b) of this section may not receive less than $250 for the impairment.

(d) The impairment rating determined under (a) of this section shall be reduced by a permanent impairment that existed before the compensable injury. If the combination of a prior impairment rating and a rating under (a) of this section would result in the employee being considered permanently totally disabled, the prior rating does not negate a finding of permanent total disability.

* Sec. 26. AS 23.30.200 is amended to read:

Sec. 23.30.200. TEMPORARY PARTIAL DISABILITY. In case of temporary partial disability resulting in decrease of earning capacity the compensation shall be 80 percent of the difference between the injured employee's spendable weekly wages before the injury and the wage-earning capacity of the employee after the injury in the same or another employment, to be paid during the continuance of the disability, but not to be paid for more than <u>two</u> [FIVE] years. <u>Temporary partial disability benefits may not be paid for a period of disability occurring after the date of medical stability, unless otherwise provided under AS 23.30.041.</u>

* Sec. 27. AS 23.30.200 is amended by adding a new subsection to read:

(b) The wage-earning capacity of an injured employee is determined by the actual spendable weekly wage of the employee if the actual spendable weekly wage fairly and reasonably represents the wage-earning capacity of the employee. The board may, in the interest of justice, fix the wage-earning capacity that is reasonable, having due regard to the nature of the injury, the degree of physical impairment, the usual employment, and other factors or circumstances in the case that may affect the capacity of the employee to earn wages in a

disabled condition, including the effect of disability as it may naturally extend into the future.

* Sec. 28. AS 23.30.220(a) is amended to read:

(a) The spendable weekly wage of an injured employee at the time of an injury is the basis for computing compensation. It is the employee's gross weekly earnings minus payroll tax deductions. The gross weekly earnings shall be calculated as follows:

(1) The gross weekly earnings are computed by dividing by 100 the gross earnings of the employee in the two calendar years immediately preceding the injury.

(2) If the employee had no earnings during the two calendar years preceding the injury or was voluntarily absent from the labor market for 18 months or more of the two calendar years preceding the injury [THE BOARD DETERMINES THAT THE GROSS WEEKLY EARNINGS AT THE TIME OF THE INJURY CANNOT BE FAIRLY CALCULATED UNDER (1) OF THIS SUBSECTION], the board shall [MAY] determine the employee's gross weekly earnings for calculating compensation by considering the nature of the employee's work and work history, but compensation may not exceed the employee's earnings at the time of injury.

(3) If an employee when injured is a minor, an apprentice, or a trainee in a formal training program, as determined by the board, whose wages under normal conditions would increase during the period of disability, the projected increase may be considered by the board in computing the gross weekly earnings of the employee.

(4) If the employee is injured while performing duties as a volunteer ambulance attendant, policeman, or fireman, the gross weekly earnings for calculating compensation shall be the minimum gross weekly earnings paid a full-time ambulance attendant, policeman, or fireman employed in the political subdivision where the injury

occurred, or, if the political subdivision has no full-time ambulance attendants, policemen, or firemen, at a reasonable figure previously set by the political subdivision to make this determination but in no case may the gross weekly earnings for calculating compensation be less than the minimum wage computed on the basis of 40 hours work per week.

* Sec. 29. AS 23.30.225 is amended by adding a new subsection to read:

(c) If employer contributions to a qualified pension or profit sharing plan have been included in the determination of gross earnings and the employee is receiving pension or profit sharing payments, weekly compensation benefits payable under this chapter shall be reduced by the amount paid or payable to the injured worker under the plan for any week or weeks during which compensation benefits are also payable. The amount of the reduction may not in any week exceed the increase in weekly compensation benefits brought about by the inclusion of employer contributions to a qualified pension or profit sharing plan in the determination of gross earnings.

* Sec. 30. AS 23.30 is amended by adding a new section to read:

Sec. 23.30.247. DISCRIMINATION PROHIBITED. (a) An employer may not discriminate in hiring, promotion, or retention policies or practices against an employee who has in good faith filed a claim for or received benefits under this chapter. An employer who violates this section is liable to the employee for damages to be assessed by the court in a private civil action.

(b) This section may not be construed to prevent an employer from basing hiring, promotion, or retention policies or practices on considerations of the employee's safety practices or the employee's physical and mental abilities; nor may this section be construed so as to create employment rights not otherwise in existence.

(c) This section may not be construed to prohibit an employer from requiring a prospective employee to fill out a preemployment questionnaire or application regarding the person's prior health or disability history as long as it is meant to either document written notice for second injury fund reimbursement under AS 23.30.205(c) or to determine whether the employee has the physical or mental capacity to meet the documented physical or mental demands of the work.

* Sec. 31. AS 23.30.265(15) is amended to read:

(15) "gross earnings" means periodic payments, by an employer to an employee for employment before any authorized or lawfully required deduction or withholding of money by the employer, including compensation that is deferred at the option of the employee, and excluding irregular bonuses, reimbursement of expenses, expense allowances, and any benefit or payment to the employee that is not <u>fully</u> taxable to the employee during the pay period<u>, except that the total amount of contributions made by an employer to a qualified pension or profit sharing plan during the two plan years preceding the injury, multiplied by the percentage of the employee's vested interest in the plan at the time of injury, shall be included in the determination of gross earnings</u>; the value of room and board <u>if taxable</u> to the employee may be considered in determining gross earnings; however, the value of room and board that would raise an employee's gross weekly earning above the <u>state</u> [ALASKA] average weekly wage at the time of injury may not be considered;

* Sec. 32. AS 23.30.265(17) is amended to read:

(17) "injury" means accidental injury or death arising out of and in the course of employment, and an occupational disease or infection which arises naturally out of the employment or which naturally or unavoidably results from an accidental injury<u>; "injury"</u> [,

AND] includes breakage or damage to eyeglasses, hearing aids, dentures, or any prosthetic devices which function as part of the body and further includes an injury caused by the wilful act of a third person directed against an employee because of the employment; "injury" does not include mental injury caused by mental stress unless it is established that (A) the work stress was extraordinary and unusual in comparison to pressures and tensions experienced by individuals in a comparable work environment, and (B) the work stress was the predominant cause of the mental injury; the amount of work stress shall be measured by actual events rather than misperceptions by the employee; a mental injury is not considered to arise out of and in the course of employment if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, termination or similar action, taken in good faith by the employer;

* Sec. 33. AS 23.30.265 is amended by adding a new paragraph to read:

(34) "medical stability" means the date after which further objectively measurable improvement from the effects of the compensable injury is not reasonably expected to result from additional medical care or treatment, notwithstanding the possible need for additional medical care or the possibility of improvement or deterioration resulting from the passage of time; medical stability shall be presumed in the absence of objectively measurable improvement for a period of 45 days; this presumption may be rebutted by clear and convincing evidence.

* Sec. 34. AS 23.30.210 is repealed.

* Sec. 35. TRANSITIONAL PROVISIONS. Notwithstanding AS 23.30.040(b), as amended by sec. 5 of this Act, and AS 23.30.155(m), as amended by sec. 20 of this Act, on or before March 1, 1989, each employer that is subject to those sections shall file a report and make the appropriate contribution

for all claims existing as of December 31, 1988. The period covered in the report shall be from the date of the termination report or the last anniversary report filed, if one has been filed, through December 31, 1988.

* Sec. 36. APPLICABILITY. This Act applies only to injuries sustained on or after July 1, 1988.

* Sec. 37. This Act takes effect July 1, 1988.

* Sec. 3. AS 23.30.005 is amended by adding a new subsection to read:

(m) If a regulation adopted by the department and approved by a majority of the full board is determined to be invalid by the state supreme court, the department may adopt new regulations that conform to the department's statutory authority as interpreted by the court. These new regulations shall apply both retrospectively and prospectively.

* Sec. 5. AS 23.30.041 is repealed and reenacted to read:

Sec. 23.30.041. REHABILITATION OF INJURED WORKERS. (a) The board shall select and employ a reemployment services administrator. The board may authorize the reemployment services administrator to select and employ additional staff. The reemployment services administrator is in the partially exempt service under AS 39.25.120.

(b) The reemployment services administrator shall perform the following functions:

(1) enforce regulations adopted by the board to implement this section;

(2) recommend regulations for adoption by the board that establish performance and reporting criteria for rehabilitation specialists;

(3) enforce the quality and effectiveness of reemployment preparation benefits provided for under this section;

(4) review on an annual basis the performance of rehabilitation specialists to determine continued eligibility for delivery of rehabilitation services;

(5) submit to the Department of Labor on or before January 1 of each year, a report of reemployment benefits provided under this

section for the previous fiscal year; the report must include a statistical summary of all rehabilitation cases, including

(A) the estimated and actual cost of each active rehabilitation plan;

(B) the estimated and actual time of each rehabilitation plan;

(C) a status report on all individuals completing or terminating a reemployment services program including a return to work date;

(D) the cost of reemployment preparation services;

(6) maintain a list of rehabilitation specialists meeting the qualifications established in this section;

(7) promote awareness among physicians, adjusters, injured workers, employer, employees, attorneys, training providers, and rehabilitation specialists of the reemployment program established in this subsection.

(c) If an employee suffers a compensable injury that may permanently preclude an employee's return to the employee's occupation at the time of injury, the employee or employer may request an eligibility evaluation for reemployment benefits. The employee must request an eligibility evaluation within 90 days after the employee gives the employer a notice of injury unless the reemployment services administrator determines the employee has unusual and extenuating physical limitations that prevent the employee from making a timely request. The reemployment services administrator shall, on a rotating and geographic basis, select a rehabilitation specialist from the list maintained under (b)(6) of this section to perform the eligibility evaluation.

(d) Within thirty days after the referral by the administrator, the rehabilitation specialist shall perform the eligibility evaluation and issue a report of findings. The reemployment services administrator may grant up to an additional 30 days for performance of the eligibility evaluation upon notification of unusual and extenuating circumstances and the rehabilitation specialist's request. Within 14 days after receipt of the report from the rehabilitation specialist, the reemployment services administrator will notify the parties of the employee's eligibility for reemployment preparation services. Within 10 days after the decision, either party may seek review of the decision by requesting a hearing under AS 23.30.110. The hearing shall be held within 30 days after it is requested. The board shall uphold the decision of the administrator except for abuse of discretion on the administrator's part.

(e) An employee shall be eligible for benefits under this section upon the employee's written request and by having a physician predict that the employee has permanent physical capacities that are less than the physical demands of the employee's job as described in the United States Department of Labor's "Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles" for

(1) the employee's job at the time of injury; and

(2) other jobs that exist in the labor market that the employee has held or received training for within 10 years before the injury or that the employee has held following the injury for a period long enough to obtain the skills to compete in the labor market, according to specific vocational preparation codes as described in the dictionary of occupational titles.

(f) An employee is not eligible for reemployment benefits if

(1) the employer offers employment within the employee's predicted post-injury physical capacities at a wage equivalent to at least 60% of the employee's gross hourly wages at the time of injury and the employment prepares the employee to be employable in other jobs that exist in the labor marker;

(2) the employee has been previously rehabilitated in a former workers' compensation claim and returned to work in the same or similar occupation, in terms of physical demands, as the employee held at the time of the prior injury; or

(3) at the time of medical stability no permanent impairment is identified or expected.

(g) Within 10 days after the employee receives the reemployment services administrator's notification of eligibility for services, the employee shall notify the employer in writing of his selection of a rehabilitation specialist who shall provide a complete reemployment services plan. If the employer disagrees with the employee's choice of rehabilitation specialist to develop the plan and the disagreement cannot be resolved, then the reemployment services administrator shall assign a rehabilitation specialist. The employer and employee each have one right of refusal of a rehabilitation specialist.

(h) Within 90 days after the rehabilitation specialist's selection in (g) of this section, a reemployment plan must be formulated and approved. The reemployment plan must contain at least the following:

(1) an occupational goal in the labor market;

(2) a plan to acquire the occupational skills to be employable;

(3) the cost estimate of the reemployment plan, including provider fees; the amount of tuition, books, tools, and supplies; transportation; temporary lodging; or job modification devices;

(4) the estimated length of time that the plan will take;

(5) the date the plan will commence; and

(6) the estimated time of medical stability as predicted by the physician.

(i) Reemployment benefits shall be selected from the following in a manner that ensures remunerative employability in the shortest possible time:

(1) on the job training;

(2) vocational training;

(3) academic training;

(4) self-employment; or

(5) a combination of (1) - (4) of this subsection.

(j) The employee, rehabilitation specialist, and the employer shall sign the reemployment services plan. If the employer and employee fail to agree on a reemployment plan, either party may submit a reemployment plan for approval to the reemployment services administrator; the reemployment services administrator shall approve or deny a plan within 14 days after the plan is submitted. Within 10 days after the administrator files the decision, either party may seek review of the decision by requesting a hearing under AS 23.30.110. The standards and time periods allowed for review are the same as those in (d) of this section.

(k) Benefits related to the reemployment plan may not extend beyond two years from the date of plan acceptance or approval, at which time benefits expire. If an employee reaches medical stability before completion of the plan, temporary total disability benefits

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shall cease and permanent impairment benefits shall then be paid at the employee's temporary total disability rate. If the employee's permanent impairment benefits are exhausted before the completion or termination of the reemployment plan, the employer shall provide wages equal to 60% of the employee's spendable weekly wages but not to exceed $525, until the completion or termination of the plan. A permanent impairment benefit remaining unpaid upon the completion or termination of the plan shall be paid to the employee in a single lump sum. The fees of the rehabilitation specialist or rehabilitation professional shall be paid by the employer and may not be included in determining the cost of the reemployment plan.

(l) The cost of the reemployment plan, not including the fees of the rehabilitation specialist or the benefits provided in (1) of this section, shall be the responsibility of the employer, but may not exceed $10,000.

(m) Only a rehabilitation specialist may accept case assignments as a case manager and sign eligibility determinations and reemployment plans. A person who is not a rehabilitation specialist may perform rehabilitation casework if the work is performed under the direct supervision of a rehabilitation specialist employed in the same firm and location.

(n) After the employee has elected to participate in reemployment benefits, noncooperation by the employee shall result in the termination of reemployment benefits on the date of noncooperation. Noncooperation means but shall not be limited to, failure to

(1) keep appointments;

(2) maintain at least average grades;

(3) attend designated programs;

(4) maintain contact with the rehabilitation specialist;

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(5) cooperate with the rehabilitation specialist in developing a reemployment plan and participating in activities relating to reemployment of a full-time basis;

(6) comply with the employee's responsibilities outlined in the reemployment plan; or

(7) participate in any planned reemployment activity as determined by the reemployment services administrator.

If the employer believes the employee has not cooperated, it may terminate reemployment services and wages under (1) of this section. However, upon the request of either party, the reemployment services administrator shall decide whether the employee cooperated. A hearing before the administrator shall be held within 30 days after it is requested. The administrator shall issue a decision within 14 days after the hearing. Within 10 days after the administrator files the decision, either party may seek review of the decision by requesting a hearing under AS 23.30.110. The standards and time periods allowed for review are the same as those in (d) of this section.

(o) In this section

(1) "employability" means possessing the ability but not necessarily the opportunity to engage in employment that is consistent with the employee's physical limitations resulting from the compensable injury.

(2) "labor market" means a geographical area that offers employment opportunities in the following priority:

(A) area of residence;

(B) area of last employment;

(C) the state;

(D) other states.

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(3) "physical capacities" means objective and measurable physical traits such as ability to lift and carry, walk, stand or sit, push, pull, climb, balance, stoop, kneel, crouch, crawl, reach, handle, finger, feel, talk, hear, or see.

(4) "physical demands" means the physical requirements of the job such as strength, including positions such as standing, walking, sitting, and movement of objects such a lifting, carrying, pushing, pulling, climbing, balancing, stooping, kneeling, crouching, crawling, reaching, handling, fingering, feeling, talking, hearing, or seeing.

(5) "rehabilitation specialist" means a person who is a certified insurance rehabilitation specialist, a certified rehabilitation counselor or a person who has equivalent or better qualifications as determined under regulations adopted by the department.

(6) "remunerative employability" means having the skills that allows a worker to be compensated with wages or other earnings equivalent to at least 60 percent of the employee's gross hourly wages at the time of injury, if the employment is outside the state, the stated 60 percent shall be adjusted to account for the difference between the applicable state average weekly wage and the Alaska average weekly wage.

*Section 18. AS 23.30.155(c) is amended to read:

(c) The <u>carrier or independent adjuster</u> [EMPLOYER] shall notify the board and the employee on a form prescribed by the board that the payment of compensation has begun or has been increased, decreased, suspended, terminated, resumed, or changed in type. An initial report shall be filed with the board and sent to the employee within 28 days

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after the date of issuing the first payment of compensation. If at any time 21 days or more pass and no compensation payment is issued, a report notifying the board and the employee of the termination or suspension of compensation shall be filed with the board and sent to the employee within 28 days after the date the last compensation payment was issued. A report shall also be filed with the board and sent to the employee within 28 days after the date of issuing a payment increasing, decreasing, resuming, or changing the type of compensation paid. If the [EMPLOYER FAILS TO NOTIFY THE] board and the employee are not notified with the 28 days prescribed by this subsection for reporting, the carrier or independent adjuster [EMPLOYER] shall pay a civil penalty of $100 for the first day plus $10 for each day thereafter that [THE EMPLOYER FAILED TO GIVE] notice was not given. Total penalties under this subsection [SECTION] may not exceed $1,000 for a failure to file a required report. Penalties assessed under this subsection are due and payable and eligible for reduction under (m) of this section.

*Section 20. AS 23.30.155(m) is repealed and reenacted to read:

(1) On or before March 1 of each year the carrier or independent adjuster shall file a verified annual report on a form prescribed by the board stating the total amount of all compensation by type, medical and related benefits, vocational rehabilitation expenses, legal fees and penalties paid on all claims during the preceding calendar year.

(2) If the annual report is timely and complete when received by the board and provides accurate information about each category of payments, the commissioner or his designee shall review the timeliness of the carrier or independent adjuster's reports filed during the

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preceding year as required by (c) of this section. If the carrier or independent adjuster timely filed at least 99% of the reports for the preceding year, the penalties assessed under (c) of this section shall be waive. If the carrier or independent adjuster timely filed at least 97%, of the reports for the preceding year, 75% of the penalties assessed under (c) of this section shall be waived. If the carrier or independent adjuster timely filed 95% of the reports for the preceding year, 50% of the penalties assessed under (c) of this section shall be waived. If the carrier or independent adjuster's reports for the preceding year were not timely filed at least 95% of the time, none of the penalties assessed under (c) of this section shall be waived. The penalties that are not waived shall be due and payable within 28 days after the Commissioner of Labor mails the notice of the penalties due.

(3) If the annual report is not filed by March 1 of each year, the carrier or independent adjuster shall pay a civil penalty of $100 for the first day plus $10 for each day thereafter.

(4) If the payment under (2) of this subsection is not paid timely, the carrier or independent adjuster shall pay a civil penalty of 20% of the penalties due plus interest at the rate prescribed by AS 45.45.010.

*Section 21. AS 23.30.155 is amended by adding a new subsection to read:

(n) If the employer does not have a carrier or independent adjuster, (c) and (m) of this section apply to the employer.

NOTE: ALL SUBSEQUENT SECTIONS SHOULD BE RENUMBERED.

Rev. 2/8/88

John D. Herring
6939 Gemini
Anchorage, Ak.
99504

January 16, 1988

Senator Tim Kelly
P.O. Box V
Juneau, Ak. 99811

Attention : Senator Kelly

Subject : Response to Workers Compensation Letter

Dear Senator Kelly,

This letter responds to your information letter on the subject.

In my opinion and experience :

General :

1. People respond to imposed systems to maximize benefits to themselves ;
2. Governments efforts and programs are always subverted by a majority of its recipients consistent with maximization of benefits to themselves ;
3. Bureaucracies operated by the State of Alaska lack the ability to objectively serve the clientele requiring their services. Dealing with State Welfare agencies is degrading, humiliating, frustrating and dehumanizing experience. A minimum amount of exposure should be necessary for any program you are currently considering.
4. Rehabilitation Services are needed in many cases but most of the time people are merely going through steps to achieve maximum benefits from the system ; Avoid creating a system that requires those seeking "Workmans' Comp." to needlessly waste the State's resourses.
5. Benefits paid by any welfare system should be "life sustaining" only; once a person is on the system they should continue without bureaucratic checking, discontinuities and meddling, thus preserving the individuals self respect. Set time limits and schedules of payments consistent with minimum survival in the least expensive location in America.
6. Build in mandatory delays for all benefits when legal remedies are sought. Assure that legal cost are subtracted from money due any Workmans' Comp. recipient.

Vocational Rehabilitation Services :

1. Most injuries do not require nor benefit from Vocational Rehab. services. It should be strictly optional and requested.
2. It should never be part of the system to get Workmans' Comp. benefits.
3. Rehabilitation services should be continued as long as an individual is benefiting from the service. Investing in Human beings is the best use of State's funds.
4. The goals of the administrators should be to build and maintain an individuals self respect, as well as to build meaningful skills.

Medical :

1. The state should have a medical doctor (IME)
2. Set maximum dollar values allowed to correct any injury or loss of limb. Give the Workmans' Comp. recipient that amount and let he or she do what they want with the money. Never try to set standards of medical service, number of visits, number of doctors or anything that degrades the "human spirit".

Compensation :

1. The sum of $2,500 per month should never be exceeded. Also avoid setting class distinction for skill classes. The payment of $1.100.00 per week is ludicrous and represents an unnecessary incentive to join the Workmans' Comp. system.
2. Lower the minimum to $100.00 per month for some classes of injuries.
3. Create a board to investigate accidents. When unnecessary risks were required by any employer then set up an additional process to go after the employer for compensation.

Other :

1. Disallow all claims for mental injury. Such claims should be settled in a civil court between the employer and employee. The state should request Federal support to allow OSHA to investigate working conditions which lead to mental breakdown and determine if federal guidelines can assist in the evaluation of risk in the work place.

2. Employers should never be prevented from evaluating the possibility that a prospective employee may wish to place himself in a position to again receive an injury and again bilk the system.

In Conclusion :

- Tim, I believe that you have a tough job ahead and hope you refuse to pass restrictive legislation which will act to increase the power of bureaucrats over needy people. I hope you respond to this crisis of esculating Workmans' Comp. insurance cost in such a manner that will make it less lucrative. I hope you leave needy individuals in a position to maintain their self respect and in a position to respect the State of Alaska and its Policies.

I look forward to seeing you again soon.

Respectfully yours,

John D. Herring

John D. Herring

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Cominco Alaska

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Senator Tim Kelly
Chairman
Senate Labor & Commerce Committee
Alaska State Legislature
P. O. Box V
Juneau, Alaska 99811

February 18, 1988

Dear Senator Kelly:

We wish to notify you of our support of the efforts both you and your committee are putting into the Workers' Compensation legislation this session. Workers' Compensation rates are now a major crisis.

It will clearly be difficult to withstand pressures to alter the original bill as different interest groups seek to protect their particular niche in the system.

We understand the chiropractic profession is now making just such an organized attempt to pressure the Committee to make changes in the bill changes which we understand not to be at all of concern to a legitimate chiropractic doctor. The current visitation language, for example, seems to adequately handle unusual chiropractic requirements with the provision that excess visitations simply require written justification by the physician.

We urge you not to waiver under pressure from groups such as this. Our only hope of any rate decrease this year is to adhere as closely as possible to the work accomplished by the joint task force.

Thank you for your efforts.

Sincerely,

W. R. Hargrave

W. R. Hargrave
President

WRH:fr

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January 18, 1988

Senator Tim Kelly
P.O. Box V
Juneau, Alaska 99811

Dear Senator Kelly:

I'm taking this opportunity to respond in a letter to your questionnaire dated January 7, 1988. I'm not sure whether I have what you would call an expertise in Workmen's Compensation, however, I've certainly had a great deal of experience treating patients affected by it and because of that have some definite opinions. I'd like to address several issues mentioned in your questionnaire and then move on to some more general thoughts.

With respect to the length of time a person is unable to work before being considered permanently disabled, I think there ought to be perhaps a set limit of about two years but a mechanism for reviewing cases after that time such as is done with the V.A. Many patients who are unable to work at two years do in fact become employable subsequent to that time.

Regarding the number of visits to a doctor or a chiropractic I would think that if a patient saw a physician approximately once a week for two months on the average that would be more than sufficient. However, I'm not sure whether your question refers to physical therapy treatments as those often are recommended two to three times a week over an extended time period and on some occasions perhaps even on a daily basis. That is to say, I would suggest that the number of visits to a physician or chiropractor to be roughly once a week whereas treatments for physical therapy perhaps should have a greater number of visits or else be considered in a separate category.

I would agree that Compensation should be reduced if a person moves to an area with a lower cost of living. I'm not at all sure how one assesses the actual cost of living in a fair and equitable manner but the concept of reduced payments seems reasonable.

It has long been my observation that the mandatory rehabilitative service clause in the Workmen's Comp Act is quite costly. Many patients are quite capable of making their own alternate plans and actually resent the interference by the rehabilitative people whom they feel are simply agents of the insurance carrier. What I have seen happen all to often is that the rehab counselor will meet with the patient, develop a spectrum of unrealistic expectations based on testing, then lead the patient to believe that these

Senator Tim Kelly
P.O. Box V
Juneau, Alaska 99811

plans are feasible. The patient will then begin to make arrangements to pursue these at which point a conference occurs between the rehabilitative counselor and the funding insurance company and it becomes apparent that the insurance company has no intention of spending the money needed to complete the rehabilitation at which point the patient is markedly disillusioned and the rehab person becomes ineffective as they have lost their client's trust. I certainly think that rehab services are inappropriate in any instance where the patient has a reasonable chance of returning to the original employment however long that might take. I would also agree that $10,000 on a rehab plan seems generous.

Now addressing your medical proposals, I would say that they sound reasonable. I'd like to suggest that in many instances patients will progress from practitioner to practitioner on the basis of referrals. I would hope that the policy on changing practitioners would not apply in that case. What I'm referring to is the instance in which a family practitioner or a chiropractor might refer a patient to an orthopedic surgeon who might then later refer the patient on to a neurosurgeon or perhaps a rehabilitative specialist. I would agree however that doctor shopping is a frequent and undesirable occurrence and is often occasioned by attorneys who are advising their patient to find a physician who is willing to maximize the injury and thus the ultimate award rather than cure the underlying problem.

Thank you so much for allowing me to express my opinion at length. I'm not sure what your stand is or has been on tort reform but I would like to suggest that a significant portion of my overhead as a medical practitioner is medical malpractice insurance. I hope you are willing to support meaningful tort reform including collateral source disclosure, contingency fee limitation and each and several liability as another way to help reduce the overall cost of medical care.

As I suggested at the start of my letter, I'm not an expert on Workmen's Compensation but have had considerable experience with it. If my further involvement or consideration of the Workmen's Compensation program would be of assistance to you, please contact me.

Best wishes for a Happy New Year.

Yours respectfully,

R.W. Garner MD

R. W. Garner, M.D.

RWG:mck
cc: Senator Dick Eliason
cc: Senator Bettye Fahrenkamp
cc: Senator Rick Uehling
cc: Senator Mike Szymanski

337-6619

Submitted by:
Charles Kirchbaum D.
As Testimony Before
Jt. Labor + Commerce
Comm. Hearing
1/29/88

WCCA BILL

SECTION A.S. 23.30.095(a):

(1) DELETE underlined passage beginning page 12, line 7 through line 11, starting with "The employee".

RATIONALE: This passage is objectionable for several reasons:

(a) because there is an insufficient definition of "attending physician";

(b) because there is an insufficient definition of "specialist";

(c) because there is no indication of when a physician becomes an "attending" physician as opposed to an examining or consulting physician; and,

(d) because there is no real indication of how a choice of a different specialty is treated. For instance, if employee's attending physician is a GP and he has a broken leg and decides that a orthopedist would be better able to treat him, does that decision count as a change? Or, the employee has a lower back injury, choses to try an osteopath or a chiropractor instead of his GP, does that decision count as a change when he is not merely changing from one doctor to another but is actually seeking a different type of treatment?

If the passage must remain in, here is a suggested change:

> The employee may not make more than one change <u>of attending physician within the employee's attending physician's discipline or speciality</u> without the written consent of the employer.

We would suggest that A.S. 23.30.265 be amended to include the following definitions.

> An attending physician is the physician of the patient's choice responsible for the provisions of primary health care.
>
> A specialist is a physician to whom the patient is referred by the attending physician for the provision of secondary care and/or consultation.

(2) Keep language that will be deleted (bracketed langauge on page 12, line 11 through line 13). There does not appear to be any justification for taking away the boards authority to make exceptions to this rule in the appropriate cases.

(3) Amend the language in the next sentence, page 12, line 13, starting "Upon procuring" to read:

> Upon procuring the services of an <u>attending</u> physician, etc.

<u>SECTION A.S. 23.30.095(c)</u>:

(1) DELETE the added language (underlined and appearing on page 13, line 2 through line 13).

RATIONALE: This passage is ill considered:

(a) because there is no definition of what is considered "continuing and multiple treatments" and health care providers must necessarily guess;

(b) because there is no designation of who will approve the plan and what standards will be employed and upon what facts or basis the review will rest;

(c) because the process of review will occur simultaneously with the provision of treatment and, according to the current language, the health care provider must bear the financial risk of disapproval;

(d) because there are no provisions for amendment of the plan should the need arise; and,

(e) because the provision imposes maximum limits arbitrarily.

Generally, it appears to us that these provisions will probably result in an increase in litigation and resulting costs rather that a decrease since so much is left unstated.

If the reason for this amendment is to guard against unreasonable or unnecessary treatment, there are already regulations in place and the employer can, with most health care professions, submit perceived abuses to the appropriate peer review committees.

If the reason for this provision is, as some of our members strongly suspect, an indirect attack on Chiropractic, it is not in fact cost effective and is, to say the least, discriminatory.

SECTION A.S. 23.30.95(e): DELETE ADDED LANGUAGE (UNDERLINED AND APPEARING ON Pg 13 LINES 8 AND 21-24) LEAVE OLD LANGUAGE

(1) Proposed amendment deleting requirement that examining physician be authorized to practice is inappropriate and suspect. Therefore, bracketed section on page 13, line 18 through line 19, should be RETAINED.

How is either the Board or the employee able to rely upon the competence of a report or examination if there is no requirement that the physician doing the examining be appropriately licensed? Does the legislature really intend to require that the employee must submit to an examination by someone who may not be capable of meeting license requirements?

(2) The creation of a presumption of reasonableness of requiring examinations every 30 days appears to be irrational. It seems obvious that the added language could easily be used by the employer to harass an employee in cases where either (1) the condition is stable enough that monthly examinations are unnecessary, and/or the examination technique used is painful and the likelihood of substantial changes in condition would not, in the absence of an adversary relationship, be normally considered justified. In addition, should the employee not be able to work at his/her old job, a requirement for monthly examinations by the former employer's doctor may well interfere with the ability of the employee to secure other employment.

(3) **Although there are fairly draconian provisions within this section for employee non-cooperation, there are no provisions for (i) advance (reasonable) notice requirement by the employer; or, (ii) a means by which the employee can contest the necessity and/or reasonableness of the monthly examinations prior to their imposition.**

SECTION A.S. 23.30.95(f):

DELETE (UNDERLINED) changes.

AMEND LANGUAGE

RATIONALE: The present section, prior to amendment, limited fees charged for medical treatment and services to charges that generally prevailed in the community. (See bracketed section, page 14, lines 18 through 19). The new section (underlined, page 14, line 20 through line 22) adds to the Board's responsibility the necessity to determine whether or not the charge, which may well be customary in the community, is reasonable (underlined).

That being true, the phrase that the Board may regulate fees and charges contained within this section would become a reality since the Board would have authority under this section to override free market considerations, including local economics and the effects of local competition and declare that charges that were in fact usual and customary but, in the Board's opinion, unreasonable.

The proposed change is actually unnecessary since normal free enterprise processes supply reasonableness of price through market place competition.

The purposes behind this section are two-fold. First, the legislature is rightly concerned over the incurring costs of workmens' compensation insurance to employers. Second, paying inappropriately high charges to a physician will encourage bias that inevitably leads to increased litigation. Assuming that these provisions are laudatory, the measure only goes half way in treating the problems. The other half of the costs associated with workmens' compensation cases arises from the p½hysician retained by the employers to examine the employeess. The costs associated with those physicians contribute to the burgeoning costs of insurance in the same manner as those of the employer's physician. Additionally, the issues of bias for over compensated physicians are not confined to either side.

Finally, the present language limits comparison to an obviously vague and confusing standard of "treatment of injured persons of "like standard of being". That portion should have the confusing language removed. Therefore, we suggest that the language of A.S. 23.30.095(f) be as follows:

> All fees and charges for treatment, service or examinations by physicians for either party should be limited to charges that prevail in the same community for similar treatment, services or examination of injured persons and shall be subject to regulation by the Board.

SECTION A.S. 23.30.95(j):

DELETE changes. AMEND CURRENT LANGUAGE.

The most offensive of the added language is contained on page 14, lines 25 through 26, which allows for an out-of-state organization to advise the Board on the appropriateness and necessity for and costs of medical treatment of Alaskan workmen by Alaskan physicians. A host of questions arise by this wording. If an out-of-state organization is appointed, how well qualified are they to judge these issues? Could they pass the relevant Alaska boards? Are they in fact licensed physicians/health care providers? Are they anything more than claim adjusters? How is an out-of-state organization going to determine appropriateness of treatment without recourse to examining the patient or taking additional xrays or additional studies? Why is an out-of-state organization needed when there are peer review committees set up within the various disciplines for these purposes now?

Regarding costs, once again, how is an out-of-state organization going to determine appropriate levels of costs? If for instance, the person making the determination on appropriateness of costs lives in and is familiar with medical costs in some small town in Illinois, will that familiarity influence the advice he gives to the Board on treatment rendered in Alaska where the cost of everything is higher?

Based upon the recommendations that are made to the Board, the Board will be determining whether an employer should pay a bill for services that have already been rendered. Because it has the power to approve of the withholding of payment, the employee and the local physician in Alaska rendering treatment to him is at a distinct disadvantage in challenging the advice of an out-of-state organization.

If the advice is unsound, but because of economics, remains unchallenged, the Board's decision will eventually begin to influence the manner in which Alaskan physicians treat injured workmen since their choices will essentially be to either adopt an approved (but unsound) procedure or to refuse to treat the injured workman. Additionally, injured employees may not seek appropriate treatment since they might end up having to pay for it themselves, which will either add to the term of the injury or begin to increase costs of employee medical insurance plans.

We suggest the following language REPLACE Section (j):

> The board may appoint a medical services review board consisting of physicians licensed in the state and employer and employee representatives to assist and advise the Board in matters involving the costs of health care services. The medical services advisory board shall conduct anonymous surveys biannually to determine usual and customary costs of treatment and procedures, and in the case of unusual situations, may conduct special surveys to determine usual and customary costs for treatment of procedures not normally encountered. If the Board shall determine that a physician or health care provider has inappropriately or unnecessarily provided treatment, or has habitually and substantially exceeded the usual and customary charges in the community in which treatment was rendered, the committee shall refer the matter to the peer review committee of the health care provider's discipline and advise the Board to disapprove the charges in question.

SECTION A.S.23.30.095(k):

(1) AMEND proposed language.

RATIONALE: The clear import of this section is to provide the Board with an independent source to turn to when a dispute arises between the parties' experts. Unfortunately, the proposed section as it's presently worded does not go far enough to insure the independence of the source. Additionally, it fails to guard against "apples and oranges" comparisons that so often create or increase litigation before the Board. Finally, the proposed section creates an inappropriately limited standard of review which is inconsistent with current diagnostic techniques.

First, in order to insure the independence of the review, the selection of a physician or health care provider should be from a rotating list so that there can be no question as to impartiality in the selection process.

Second, both parties should have the right to object to one selection within a reasonable time period so that questions of bias may be minimized.

Third, the lists that are resorted to by the Board should be kept by discipline and specialty and the selection made should conform to the discipline or specialty of the health care provider of the employee. Otherwise, there is every likelihood that the Board will become embroiled in jurisdictional disputes between disciplines and specialties that will provide no meaningful comparison.

Fourth, limiting the standard required to overcome the presumption to objective evidence deselects critical subjective findings that often times form the backbone of a valid diagnosis.

Fifth, although shielding the independent physician from liability for ordinary negligence is a good idea, making his liability dependent upon proving fraud goes too far. As a result, it is our feeling that the limits of liability should extend to fraud's cousin, misrepresentation, and to gross negligence in order to ensure an appropriate level of reliability in the findings of the independent physicians.

We would suggest the following language be substituted for the proposed language:

> In the event of a dispute regarding determinations of causation, stability, degree of impairment, functional capacity, the amount and efficacy of the continuance of or necessity of treatment, or compensability between the employee's attending physician and the employer's medical evaluation, an independent medical evaluation shall be conducted by a physician or physicians of the same discipline and specialty of the employee's attending physician.
>
> Such physicians shall be licensed in the State of Alaska or the state that treatment was rendered and selected from a list established with the aid and advice of the medical advisory board, and maintained by the Board. Both the employee and employer shall have the right to challenge one

appointment. In the event of a challenge, the next physician on the list will be appointed. The contents of the list and the order of its contents shall be kept confidential by the Board. The report of the independent medical examiner shall be furnished to the Board and both parties within 14 days after the examination is concluded. The opinion of the independent medical examiner shall, in the absence of clear and convincing evidence to the contrary, be presumed to be correct. A person may not seek damages from an independent medical examiner caused by the rendering of an opinion or providing testimony under this subsection, except in the case of fraud, misrepresentation or gross negligence.

SECTION A.S. 23.30.155(c):

DELETE Added language.

RATIONALE: As will be explained more fully when Subsection (m) is discussed, the exception being grafted onto this section is, in essence, gutting the penalty provisions by allowing an employer to escape the penalties by simply performing once a year ministerial acts that have nothing to do with the merits of a particular controversion, or for that matter, to do with a habitual practice of unjustifiably controverting employee claims. As a result, it is our suggestion that the amenditory language be deleted.

SECTION A.S. 23.30.155(m):

DELETE changes.

RATIONALE: This section as it is proposed, essentially vacates the penalty provisions in subsection (c) by allowing an employer to avoid penalties for failure to timely notify the employee and the board of changes it unilaterally makes to the employee's compensation, or whether or not the employer intends to controvert at all. In essence this provision allows, on a sliding scale, an employer to escape substantial penalties if it performs the ministerial acts that, under the present and proposed statute, it must perform.

For the employee who is caught within the exception's parameters, however, there is little relief. If the filing requirements did not incorporate notifications to the employee and were, in fact, only ministerial, there might be

some justification for the proposal, although it is not readily apparent even in that situation. However, the reports do require notification to the employee and, in the absence of receiving timely reports, the employee may well make decisions that he might not should he receive a timely notification that the employer was either going to controvert, suspend or terminate his compensation. In essence then, the employer is, according to this section, allowed to escape penalties for failing to comply with the employee notification provisions in Subsection (c).

SECTIONS A.S. 23.30.185, A.S. 23.30.200:

DELETE proposed language unless the term medical stability is changed as noted below.

RATIONALE: Obviously, the employers and their carriers are seeking to place a limit upon TTD and TPD payments. However, they are basing the proposed limit upon an unrealistic and unfair standard, "medical stability". As will be demonstrated below, the definition for the term "medical stability" is suspect.

SECTION A.S. 23.30.265 (34):

AMEND proposed language.

RATIONALE: According to the proposed language, an employee's medical condition is "stable" after the date that no further objectively measurable improvement is reasonably expected to result from additional medical care or treatment. This definition has several flaws.

The section is used in conjunction with two other sections, AS 23.30.185 and AS 23.30.200 which deal with payments for temporary disability records to those sections, payments will be cut off once medical stability is reached. Therefore, for both parties the definition of medical stability becomes paramount. However, under AS 23.30.265(34) the definition is highly suspect. According to the proposed language, medical stability is measured solely upon the question of whether further care or treatments will result in improvement and specifically disallows consideration of improvement generated by the natural healing process of time. Therefore, it is

easily conceivable that an injured employee who is temporarily disabled and unable to be gainfully employed, and who will get better over time, would lose his temporary benefits because the health care providers could not provide treatment or care that would improve upon the natural healing process. In essence, the injured employee would be penalized because of the impotence of current science to help him.

Second, once again the standards for making the determination based solely upon objective findings when modern diagnostic techniques use a combination of objective and subjective techniques. As a result, the employee and all of the physicians coming into contact with him are artificially limited to decision making that bears no relationship to how medical decisions are normally made.

SECTION ENTITLED LEGISLATIVE INTENT, SUBSECTION (b):

AMEND proposed language.

RATIONALE: In decreeing that the Board has increased powers, there must be some authority for decision making concerning his medical treatment left to the injured employee. Therefore, there should be some provision contained within the statute that it is not the legislature's intent that the employee's right to chose who his health care provider will be will not be restricted unreasonably.

We suggest that the following language be added to subsection (b):

> With the exception of the provisions contained in A.S. 23.30.095(a), nothing contained within this section shall empower either the board or any party to interfer with or infringe upon the employee's right to select the type of health care and the person to provide it for the treatment of his injuries. Any employer or its representative that violates this section is guilty of practicing discrimation against the employee and subject to the provisions of A.S. 23.30.247.

Miscellaneous: I didn't have a chance yet to gratf in some changes that will try to limit what the employer/insurance carriers pay for their expert. I also need to go through the IME language dealing with the experts hired directly by the employers to perform examinations and try to exclude references to that process as an IME since the employer's experts are no more "independent" than the employee's experts. I'll try to complete those tasks by tomorrow.

I didn't do a cheat sheet yet but will be prepared to verbally discuss the manner in which the testimony will be presented at our meeting and, if it is felt that a sheet would be helpful, I'll prepare and deliver one to you.

PLD

January 14, 1988

Senator Tim Kelly, Chairman
Senate Labor and Commerce Committee
Representative Dave Donley, Chairman
House Labor and Commerce Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Kelly, Representative Donley and members of your committees:

As Co-chairmen of the Management/Labor ad hoc committee we are pleased to present our proposal for changes to the current workers' compensation act. Our proposals represent the culmination of more than a years effort by hundreds of professionals from many different walks of life. It is not intended to be a final solution to the high cost of workers' compensation in Alaska, but represents instead our most recent step in our ongoing effort to improve the benefit levels for injured workers while at the same time reducing the cost that must be borne by Alaskan employers.

BACKGROUND

PRE AD HOC COMMITTEE

In 1968, the Alaska weekly maximum workers' compensation benefit was $113. By 1974, the maximum weekly compensation rate rose to $175. During this period of time, Congress established the National Commission of State Worker's Compensation Laws to "undertake a comprehensive study and evaluation of State workmen's compensation laws, in order to determine if such laws provide an adequate, prompt and equitable system of compensation."

In a pro-labor atmosphere and in reaction to some of the National Commission's findings, the Alaska legislature in 1975 amended the Alaska Workers' Compensation Act (Act) by providing a gradual phase-in of the 200% of state average weekly wage maximum, doubling the scheduled permanent partial disability maximum in the Act, and eliminating the $30,000 limit on unscheduled permanent partial disability.

Management bitterly contested the 1975 labor-sponsored amendments. As a result, little thought was given by labor management or the legislature to workers' compensation as an effective delivery system. Only a portion of the 1972 Commission's recommendations were enacted, but due to the changes that were adopted, workers' compensation insurance premiums increased 35.2% in 1975, 13.0% in 1976, and 5% in 1977.

In 1977, management successfully sponsored legislation reinstating a limit on "unscheduled" permanent partial disability -- this time at $60,000. Other meaningful changes were impossible to achieve and in 1979, a pro-management group, the Alaska Conference of Employers (ACE), was established to study the problems and recommend legislative changes necessary to reduce the high cost of workers' compensation in Alaska. The employers also created another group, the Workers' Compensation Committee of Alaska (WCCA) and charged that group with the task of placing the recommendations of the ACE study into legislation. The pressure of these two management groups led to the creation of the 1980 Legislative task force to study the Alaska workers compensation system and recommend changes. The committee, co-chaired by Senator Terry Stimson and Representative Brian Rogers, included representatives from labor, management, and the insurance industry. Ultimately the joint effort failed at the close of the 1981 legislative session and no corrective legislation was recommended.

At that time, WCCA commissioned a study by Darvi Cody and Associates on the problems with workers' compensation in Alaska and their recommendations for changes. This study was presented to Representative Terry Martin in January, 1982 with the recommendation that the suggested changes be incorporated into legislation.

With the Cody study, the opportunity for the classic management vs labor confrontation on workers' compensation presented itself. This time however, logic prevailed. Labor, represented by the AFL-CIO, and management, represented by WCCA called for a joint public meeting for the purpose of selecting representatives to sit on an "ad hoc committee" to recommend changes to the Alaska workers' compensation statutes.

THE LABOR/MANAGEMENT AD HOC COMMITTEE

The first order of business for the new ad hoc committee was to formulate the objectives of the group. The following were adopted at the first meeting:

1. Provide an effective system for the delivery of benefits and services.

2. Discourage fraudulent claims and fraudulent statements to obtain or deny workers' compensation benefits.

3. Provide an effective deterrent for those employers failing to provide required workers' compensation insurance;

4. Increase incentives and decrease disincentives for returning to work after an injury;

5. Encourage safety;

6. Provide for effective rehabilitation of an injured worker;

7. Redistribute dollars from those workers not severely injured to those seriously injured workers who have lost the ability to be gainfully employed as a result of their injury;

8. Reduce or minimize the impact of workers' compensation premiums on the employer;

9. Continue to study the Alaska workers' compensation system to identify problems and recommend solutions; and,

10. Stabilize the atmosphere for discussing proposed changes to the Alaska Workers' Compensation Act.

Due to time problems, the Ad Hoc committee agreed to limit its initial efforts to:

1. Providing for the early identification of injured workers who potentially need rehabilitation;

2. Providing for the early return to direct employment;

3. Providing incentives to return to work and reduce disincentives to return to work;

4. Providing for appropriate criminal penalties for willful misrepresentation of facts for the purpose of obtaining or denying benefits; and,

5. Providing a mechanism for cease and desist orders to be issued against uninsured employers.

The Ad Hoc committee was successful in having its legislation agenda passed in 1982 and 1983.

Since 1983, the Ad Hoc committee has continued to meet to work on problems that became apparent or problems that were created by the court system in their interpretation of the statute. For

the most part, however, the committee dealt primarily in relatively minor problems and had not undertaken an in-depth review of the system and its evolution since the legislation passed in 1982 and 1983.

CURRENT EFFORTS OF THE AD HOC COMMITTEE

The cost increase for workers compensation announced in November of 1986 caused the ad hoc committee to reexamine the problems with the system and the need for changes. It was apparent that the system had deteriorated significantly since the last major modifications in 1983. The quality of service to the injured worked had decreased and the cost to the employer had increased. In fact, from 1983 to 1986, the incurred cost of workers compensation increased from $70.3 million to $100.1 million while employment in the state decreased. Since the incidence rate of injuries remained relatively constant during this period, it was apparent that the cost per claim had more than doubled.

In this setting, the ad hoc committee decided that the best approach was a complete examination of the current statute. In order to establish priorities, both management and labor met with their respective constituents and developed a list of issues that needed attention. These lists were then compared, merged and a plan of action developed. Since the problems were complex, it was decided to concentrate on the issues of vocational rehabilitation, medical services, compensation and benefits in 1987 and defer other items until 1988.

The current members of the ad hoc committee are:

Robert Anders - Co-chair and labor member of the Workers' Compensation Board; business agent - Operating Engineers

Mary Pierce - Co-chair and management member of the Workers' Compensation Board; Executive Director, Medical Indemnity Corporation of Alaska

Richard Cattanach - Vice President, Finance, Unit Company

Kevin Dougherty - AFL-CIO

David Cottstein - Director of Distribution, Tarr Cottstein, Inc.

Ralph Lewis - Vice President - Teamsters Port of Alaska

Ralph Minoo - Safety Engineer, Teamsters Local 959

Stephen Rehnberg, MA - Vice President, Finance, Tyndquist Corporation

Joseph Thomas - Business Agent, Laborers Union

Kenneth Weist - Business Agent, Roofers

During the past year, the ad hoc committee met weekly in an attempt to define the various problems and explore potential solutions. The advice and suggestions of hundreds of professionals were sought. Medical doctors, chiropractors, vocational rehabilitation providers, lawyers, and others knowledgeable in workers' compensation were consulted and provided input to either the ad hoc committee or a WCCA study committee. During the entire process, the committee sought the advice and counsel of the Division of Workers' Compensation and at least one member of the division was in attendance at all the committee meetings.

Briefly, the proposed legislative changes for 1988 can be outlined as follows:

Vocational Rehabilitation

1. Change the current system from being mandatory to voluntary;

2. Limit the program to those injured workers prevented from performing the duties of their profession;

3. Limit rehabilitation programs to two years;

4. Limit rehabilitation plan costs to $10,000;

5. Pay a permanent partial disability or a total permanent disability at the total temporary disability rate until plan completion or termination. The remainder, if any, is to be paid in a lump sum;

6. Establish employability, not employment, as the goal of rehabilitation;

Medical

1. Subject medical payments to the usual, customary and reasonable fees charged in an area;

2. Allow the injured worker to make one change in treating physician before seeking the consent of the employer;

3. Limit treatment plans to no more than 30 visits within 60 days;

4. In the case of a dispute, allow the board to appoint an independent medical examiner whose opinion shall, in the absence of clear and convincing objective evidence to the contrary, be presumed to be correct;

Compensation

1. Change the maximum weekly benefit from $1108 to $700, and increase the minimum from $110 to $154;

2. Allow an employees vested pension contributions to be considered in determining the weekly wage;

3. Limit the controversy in the determination of weekly earnings by clarifying the process for such determinations;

4. Adjust the weekly compensation benefits for differences in the cost of living for claimants residing outside Alaska;

Benefits

1. Schedule all injuries and base disability benefits on the "whole man" concept;

2. Increase the permanent partial disability benefit for the more severely injured worker;

3. Limit temporary total disability benefits to two years;

Other

1. Provide legislative intent language for the courts and future legislatures;

2. Bar workers' compensation claims if the employee falsified his application and the falsification contributed to a subsequent injury

3. Establish criteria for stress claims;

4. Prohibit discrimination of an employees who files a workers compensation claim;

5. Assure the maintenance of workers' compensation payments to employees when questions exist as to the ultimate responsibility for liability;

It is the belief of the ad hoc committee that the changes recommended should lead to an improved delivery system for workers' compensation at a lower cost to Alaskan employers. We believe that the savings will come primarily from a reduction in the amount of litigation, a reduction in the number of injured workers entering vocational rehabilitation programs, and a reduction in expenditures for medical care. These cost savings

should not however negatively impact the quality or quantity of services available to an injured worker. Rather, it is our belief that the injured worker will be able to avail themselves of better services in a more timely manner.

Determining the cost impact of the proposed changes will be difficult and will require a certain amount of faith. An evaluation of the cost savings due to a reduction in litigation, the impact of a voluntary vocational rehabilitation system, the acceptance of a usual, customary, and reasonable limit on medical expenses, the limitation on medical utilization, scheduling some injuries that are currently unscheduled, and other similar items will be difficult if not impossible. Quantification and estimation necessary for a precise actuarial determination of the impact of these recommendations is not possible and accordingly will require assumptions as to what "might be". The net result will only be as good as the assumptions that were used to determine what "might be". It may be necessary for the legislature to accept, as management and labor has, that the changes should logically lead to lower costs in the system with no adverse impact on the injured worker. If the legislature is to make this commitment of faith, we would like to see them at this time as we measure the actual results of our changes and work with us to continue to make modifications when and where it is [illegible].

Sincerely,

Robert Anders

Mary Pierce

WCCA

Worker's Compensation Committee of Alaska, Inc., 11401 Olive, Anchorage, AK 99515

Rep. Dave Donley and Sen. Tim Kelly
House and Senate Labor and Commerce Committee Chairs
Juneau, Ak.

Gentlemen:

I want to take this opportunity to thank you both for the tremendous support you two have shown in the recent months and reiterate our support for the task force. I have been asked many times whether the WCCA would have a separate agenda for the session. The answer is emphatically, no.

The efforts of the very best people we could find in Alaska from the ranks of management and organized labor have contributed to our effort. The WCCA believes that effort has produced an impressively thorough, first look at the major cost components of the Alaska worker's compensation system.

In our legislation you will find answers to the problems of soaring unregulated medical costs, unrealistic Alaska benefits and the failure of private vocational rehabilitation. It attempts to look at the history and the future of worker's compensation in Alaska in addressing the intent of the law and the new frontier of claims -- stress. Underlying all of the features of this bill is the effort to reduce the needless dispute and litigation that seems to haunt the system. But perhaps its most redeeming quality is that it represents the thoughts, hard work and aspirations of the two most important parties in the system: those who pay and those who benefit.

We were warned we should not leave the bill at the doorstep of State agencies. We took that message to heart and produced a piece of legislation without a single fiscal note attached that will significantly reduce the cost of worker's compensation insurance for all Alaska employers.

My constituency anxiously awaits the outcome of your efforts in Juneau and trusts you will help us honor the agreement between labor and management that produced this extraordinary document.

Sincerely,

Steve Haag

THE ALASKA CHAPTER

ASSOCIATED GENERAL CONTRACTORS OF AMERICA, INC.

SKILL
RESPONSIBILITY
INTEGRITY

BOX 92500 • ANCHORAGE, ALASKA 99509
TELEPHONE (907) 561-5354

3201 SPENARD ROAD
ANCHORAGE

WILLIAM E. SCHNEIDER
EXECUTIVE DIRECTOR

January 15, 1988

Representative Dave Donley
Chairman, House Labor & Commerce Committee
Alaska State Legislature
P.O. Box V (M.S. 3100)
Juneau, AK 99811

Dear Representative Donley:

On behalf of the membership of the Associated General Contractors of Alaska, we strongly support the recommendations of the Management/Labor ADHOC Committee For Workers' Compensation Reform.

Your efforts in this critical area are appreciated by all of those individuals who make their living in the construction industry.

We encourage you and your fellow representatives to expeditiously pass this legislation.

Sincerely,

ASSOCIATED GENERAL
CONTRACTORS OF ALASKA

William E. Schneider
Executive Director

THE ALASKA CHAPTER
ASSOCIATED GENERAL CONTRACTORS
OF AMERICA, INC.

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1201 FRENARD ROAD
ANCHORAGE
WILLIAM E. SCHNEIDER
EXECUTIVE DIRECTOR

January 15, 1988

Senator Tim Kelly
Chairman, Senate Labor & Commerce Committee
Alaska State Legislature
P.O. Box V (M.S. 3100)
Juneau, AK 99811

Dear Senator Kelly:

On behalf of the membership of the Associated General Contractors of Alaska, we strongly support the recommendations of the Management/Labor ADHOC Committee For Workers' Compensation Reform.

Your efforts in this critical area are appreciated by all of those individuals who make their living in the construction industry.

We encourage you and your fellow senators to expeditiously pass this legislation.

Sincerely,

ASSOCIATED GENERAL
CONTRACTORS OF ALASKA

William E. Schneider
Executive Director

ALASKA STATE AFL-CIO

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Anchorage, Alaska 99501
(907) 258-6284

509 1st Ave.
Fairbanks, Alaska 99701
(907) 456-2030

MANO FREY
Executive President

TO. ALL HOUSE AND SENATE MEMBERS
FROM. MANO FREY, EXECUTIVE PRESIDENT
RE: WORKER'S COMPENSATION

The Joint Labor-Management Task Force has worked for more than a year negotiating changes to the current Worker's Compensation Law that would result in premium reductions to the employer; and, at the same time, maintain fairness in compensating the injured worker.

The legislation now being considered is a result of the task forces' efforts. It certainly does not attempt to address every complaint or concern regarding the current worker's compensation statute, but it does accomplish the stated goal of providing some necessary relief to the employer while providing benefit safeguards for the employee. In addition, reforms are included to several areas of the law that caused abuse and hardship to the employees in the past.

I strongly urge your support for this bill.

FAIRBANKS BUILDING
& CONSTRUCTION TRADES COUNCIL
AFL-CIO

North of the 63rd Parallel
315 5th Avenue
Fairbanks, Alaska 99701-4686
(907) 456-4248
(907) 456-1208

JIM CARROLL
President

JOHN GIUCHICI
Secretary/Treasurer

January 14, 1983

Bob Anders
Labor and Management Ad Hoc Committee

Dear Bob,

The Fairbanks Building and Construction Trades Council voted to Endorse your workers compensation bill. We have some concerns about some areas of the bill but, feel in the long run it will be beneficial to lowering the high insurance rates.

Fraternally Yours

J.N. Carroll
President

WESTERN ALASKA BUILDING and CONSTRUCTION TRADES COUNCIL

AFFILIATED WITH

A.F.L.-C.I.O.

BUILDING AND CONSTRUCTION TRADES DEPARTMENT

Phillip A. Thingstad
PRESIDENT
407 Denali Street
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ANCHORAGE, ALASKA 99501

SECRETARY
407 Denali Street
ADDRESS
ANCHORAGE, ALASKA 99501

January 14, 1982

Alaska State Legislators

Dear Ladies and Gentlemen.

This letter accompanies a proposed piece of legislation, one in which alot of time and effort was put into by both Labor and Management in an attempt to help close the loopholes and solve many of the problems of the Workers Compensation Law.

The Bi-partisan work put into this proposal was extensive and a very good product was the result, one in which all appear to be happy with as it will help the workers as well as the employers. The only people who oppose such legislation are the "Out of State" insurance companies and the lawyers, both of whom make a great deal of money off the current ambiguous law.

The Western Alaska Building and Construction Trades supports, with great enthusiasm, this possible revamping of the Workers Compensation Law.

Sincerely,

Phil Thingstad/lk

Phil Thingstad
President
Western Alaska Building
and Construction Trades

PT/lk
Attachment

GUIDE TO

INSURANCE REHABILITATION SPECIALISTS

CERTIFICATION

CERTIFICATION OF INSURANCE REHABILITATION SPECIALISTS COMMISSION

A DIVISION OF

BOARD FOR REHABILITATION CERTIFICATION

1156 SHURE DRIVE, SUITE 350
ARLINGTON HEIGHTS, ILLINOIS 60004

SECTION 3. CRITERIA FOR ELIGIBILITY:

To be eligible to sit for the CIRS examination, an applicant must meet ALL requirements in ONE of the categories listed below. Education and employment experience requirements must have been fully satisfied by the application deadline date **(JANUARY 1, OR JULY 1)**. Applications not meeting the eligibility criteria of one of the following categories at the application deadline date will be referred to the Credentials Committee for review to determine eligibility. Please be reminded, the application processing fee is non-refundable. Read categories carefully. **CIRSC will charge a $20.00 handling fee for any check returned for non-sufficient funds.**

CATEGORY ONE

Degree or Certification or License:	Current Registered Nurse (RN) Valid Certified Rehabilitation Counselor (CRC) or Master's degree or Doctorate degree in: Rehabilitation Counseling, Rehabilitation Administration, Work Adjustment, Vocational Rehabilitation, Job Placement, or Psychology.
Acceptable Employment Experience Required: (See definition Section 4)	A minimum of two years full-time (or the equivalent) employment providing direct or indirect rehabilitation services to a disabled population receiving benefits from a disability compensation system.

CATEGORY TWO

Degree Required:	Bachelor's, Master's, or Doctorate in any other discipline.
Acceptable Employment (See definition Section 4)	A minimum of four years of full-time (or the equivalent) employment providing direct or indirect services to a disabled population receiving benefits from a disability compensation system.

JOHN H. LEWIS
Post Office Box 330550
Coconut Grove, Florida 33233
(305) 443-8111

Education: B.S.B.A., University of Florida, 1963
J.D., Duke University School of Law, 1967

Experience: Assistant to Dr. Arthur Larson
Larson's The Law of Workmen's Compensation
1965-1974

Instructor In Law
University of Miami School of Law
1973

Chief Counsel and Associate Executive Director, National Commission on State Workmen's Compensation Laws, 1971-1972

Florida Governor's Task Force on Workmen's Compensation, Vice-Chairman, 1972-1973

Florida Workmen's Compensation Advisory Council, Chairman, 1974-1977, Vice-Chairman, 1977-1980

Legal Advisor, Florida Self-Insurance Rules Advisory Committee, 1976-1977

Research Analyst, Interdepartmental Workers' Compensation Task Force, 1975-1976

Consultant: U.S. Senate, U.S. Department of Labor, Alaska State Legislature, Pennsylvania State Legislature, Alaska Workers' Compensation Board, Rhode Island Department of Business Regulation, Delaware State Chamber of Commerce, Louisiana Association of Business and Industry, Alaska State A.F.L.-C.I.O, California Workers' Compensation Institute, Office of the

Governor-State of Rhode Island, Massachusetts House of Representatives, Kentucky Legislative Research Commission, Maryland State Chamber of Commerce, California State Senate, National Conference of State Legislatures, The Government of the Territory of American Samoa, Oregon Workers' Compensation Department, Michigan Department of Labor-Department of Commerce, Office of Inspector General-U.S. Department of Labor, Minnesota Department of Labor and Industry, Maine Bureau of Insurance, United States General Accounting Office, Office of the Governor-State of Illinois.

Practice of law, 1967-80, with emphasis on civil litigation and workers compensation matters.

Reports and Articles:

A Workmen's Restoration System, Supplemental Studies for the National Commission on State Workmen's Compensation Laws, 1972.

An Analysis of State Workers' Compensation Agency Activities, Report for the Interdepartmental Workers' Compensation Task Force, 1977.

An Analysis of the Alaska Workers' Compensation System, Report for the Alaska State Legislature, 1982.

Cost Implications of the Hawaii Workers' Compensation System: An Analysis of Cases, Costs and Law, 1984.

The Alaska Workers' Compensation Law: Fact-Finding, Appellate Review, and the Presumption of Compensability, Alaska Law Review, Volume 2, June 1985, Number 1 (With Arthur Larson).

Permanent Partial Disability Benefit Recipients In The Kentucky Workers' Compensation System, Report for the Kentucky Legislative Research Commission, 1985.

Major Issues In The Oregon Workers' Compensation System, Report for the Oregon Workers' Compensation Department, 1987.

WCCA CONTRIBUTORS

A & B Tool
Acme Fence
Alaska Airlines
Alaska Business Insurance
Alaska Cleaners
Alaska National Insurance
Alaska Oil Marketers Association
Alaska Pulp
Alaska Sales and Service
Alaska State Medical Association
Alaska Timber Insurance Exchange
Alyeska Air Service
Anchorage Refuse
Anglo Alaska Petroleum
ARCO
Arctic Foundations
Arctic Slope Region, Inc.
ARECA Insurance Management
Associated General Contractors - Alaska Chapter
Bailey's Rent All
Carr Gottstein
Collins & Associates
Central Plumbing and Heating
Cimarron Holdings
Comprehensive Rehabilitation Services
D.J.'S Alaska Rentals
Doyon Drilling
Ensearch
Enstar
GCI
Hickel Investment
Holland America
K & L Distributors

Kenai Pennisula Borough
Klukwan
Lynden
Marathon Oil
Mark Air
Mechanical Contractors of Fairbanks
Midas Muffler
Municipality of Anchorage
National Bank of Alaska
Newberry Alaska
Northern Adjustors
Northern Air Cargo
Pacific Movers
Professional Trust Administrators
R G & B Contractors
Rain Proof Roofing
Reeve Aleutian
Rental Association of Alaska
Saupe Enterprises
Smyth Moving
Spenard Building Supply
Standard Alaska Production
Steel Fabricators
TOTE
Telhoven
Universal Motors, Inc.
UNOCAL
Usibelli Coal
VECO

ALASKA STATE SENATE

SENATOR TIM KELLY
ANCHORAGE/EAGLE RIVER
CHAIRMAN

SENATOR DICK ELIASON
SITKA
VICE CHAIRMAN

LABOR AND COMMERCE COMMITTEE

MEMBERS
SENATOR BETTYE FAHRENKAMP
FAIRBANKS

SENATOR RICK UEHLING
ANCHORAGE

SENATOR MIKE SZYMANSKI
ANCHORAGE

February 1, 1988

MEMORANDUM:

To: All Legislators

From: Sen. Tim Kelly TDK

My office has been receiving postcards in opposition to the proposed worker's compensation bill. This campaign has been organized by some of the chiropractors within Alaska and some misinformation is being distributed as shown by the attached fliers. I've enclosed a copy of my reply for your information.

Please keep in mind that the organized labor - management task force that developed this proposal was not just concerned with cutting overall costs, but are attempting to cut back on excessive services and litigation while getting more of the program dollars into the hands of the more substantially injured.

P.O. BOX V, JUNEAU, AK 99811 (907) 465-3822 • P.O. BOX 210001, ANCHORAGE, AK 99521 (907) 278-3284

ALASKA STATE SENATE

SENATOR TIM KELLY
ANCHORAGE/EAGLE RIVER
CHAIRMAN

SENATOR DICK ELIASON
SITKA
VICE CHAIRMAN

LABOR AND COMMERCE COMMITTEE

MEMBERS
SENATOR BETTYE FAHRENKAMP
FAIRBANKS

SENATOR RICK UEHLING
ANCHORAGE

SENATOR MIKE SZYMANSKI
ANCHORAGE

January 28, 1988

Scott McVey
7340 Hillside Way
Anchorage, Ak. 99516

Dear Scott,

I appreciate you taking the time to send me a card with your thoughts on the worker's compensation bill before us.

After receiving a number of cards, we have reviewed the flier suggesting the postcards and making comments about the legislation. I am somewhat disappointed to see that a good portion of the information given you about the legislation is inaccurate. To clarify the situation, I want to give you some additional information.

This bill was developed by a task force made up of 5 representatives of organized labor and 5 representatives of management. Both groups realized that a solution to the current problem needed to be found and that an agreement had to be negotiated. After several months of work, this agreement was reached and the same bill was introduced in both the House and the Senate to use as a starting point.

First let me highlight a few points that the bill does for Alaskan workers.

* There is a significant increase in the payment for permanent partial disabilities. This assures that the more substantially injured workers receive greater benefits.

* The minimum weekly benefit is being raised and the maximum weekly benefit is being reduced. Only about 3 percent of the cases will be effected by the reduction and a much larger number of workers will get increased benefits. This section will actually increase in dollar amounts, the overall wage benefits to injured workers.

* The bill requires that pensions and benefits be included in calculating a workers' average weekly wage instead of just wages and salaries.

P.O. BOX V, JUNEAU, AK 99811 (907) 465-3822 • P.O. BOX 210001, ANCHORAGE, AK 99521 (907) 278-3284

* An injured worker will immediately receive benefits if an argument breaks out over which carrier will be responsible. Currently a worker can go for months without benefits.

* Vocational rehabilitation will become voluntary under the bill. The injured worker has a choice of whether or not to enter a vocational rehabilitation program,and will no longer be forced to "play the game" just to continue receiving benefits.

* Discrimination against a worker who has filed a worker's compensation claim will be prohibited under this new law.

There has been some other misunderstandings that need to be clarified.It has been said that the cost of vocational rehabilitation can't exceed $10,000. In truth, only the cost of the plan for rehabilitation can't exceed that amount. There isn't a cap on the cost of the rehabilitation itself.

It is not the insurance company who must approve additional changes of doctors, but the worker's employer. Referrals to other doctors by a primary physician don't count as a change of doctors. Additional changes of doctors can be made if the worker's employer approves.

The area of only allowing 20 visits in 60 days has also been mis-stated. After the 60 day period 4 visits per month are allowed. If more than the 20 are needed, they are allowed if they are justified in the written plan.

Under the current system, less than 40 cents out of every dollar paid in worker's compensation premiums actually goes to the injured worker. The bill being worked on is designed to give more of the money to the injured workers and less money to the people in the middle. The idea behind worker's compensation is to provide a system to ensure that an injured worker gets the appropriate care and compensation. It is my intention to support a bill that is fair to both the injured worker and the employer, after all, that's who the system was designed to protect in the first place.

Hopefully, I have cleared up some of your concerns. Please be assured that I won't support a bill that I feel is unfair to injured workers.

Best Regards

TIM KELLY
State Senator

Chiropractors Handout

BIG NEWS ABOUT THE NEW WORKER'S COMPENSATION BILL RECENTLY INTRODUCED! FOLLOWING ARE A FEW OF THE HIGH POINTS:...

* An insurance rehabilitation specialist will have total control over your rehabilitation. You will have almost no say. Also, you can only be rehabilitated once in your life, regardless of how many injuries you suffer. And it can't cost more than $ 10,000.00.

* You can only receive 20 treatments in 60 days, regardless of how extensively you are injured!

* After 14 days, the insurance company can make you go to their doctor, even if you are happy with your doctor, regardless of your wishes.

* The insurance company can use "lower 48" companies to determine fees, making you responsible for the difference!

* Permanent disability benefits will have a limit, no matter how extensively you are injured.

* Once you have stopped improving, or if your condition is expected to get worse without continued care, you can receive no additional medical care, regardless of how extensively you are injured, unless you prove it to the Board, which could take months, or longer.

* Your doctor has 1 week to submit his treatment schedule to the insurance company, and they have 2 weeks to accept or deny it. Therefore, if they do not like you, your doctor, or his plan of treatment, they can deny the entire claim without penalty.

* You can only change doctors once without written approval from the insurance company.

* If there is a dispute between you and the insurance company, they can stop all benefits to you, regardless of your condition, until you take it to a Board hearing. You are guilty until you prove yourself innocent!

* Independent Medical Examinations (IME) performed on chiropractic patients can be done by orthopedic surgeons biased against chiropractors. The IME doctor is not held liable for his report.

For all of this (and more), the insurance companies are not required to report how much they set aside in reserves, how much is spent on injuries, or how much was collected in premiums. Therefore, they can charge whatever they want, regardless of how it may strangle our economy.

We urge you to phone your representatives and strongly oppose this Bill. It is highly discriminatory, and will seriously jeopardize your ability to seek health care as an injured worker. Employers, demand that the insurance companies justify these exorbitant rates which they charge us. This is Alaska. We all live and work here. LET'S MAKE IT SAFE, AND FAIR.

SAMPLES FOR POSTCARDS

1. I have seen House Bill (H.B.) 352 concerning the workers' compensation. I feel it severely compromises the injured worker's rights. Please do not pass this bill in its present form.

2. House Bill (H.B.) 352 benefits only the insurance carrier. I am strongly opposed to the passage of this bill the way it currently is.

3. I have seen House Bill (H.B.) 352. I don't support it. Please don't pass it.

4. I believe the new workers compensation bill is unfair to the injured worker and takes away his freedom of choice. Please don't pass this bill.

WHAT YOU SHOULD KNOW ABOUT THE PROPOSED WORKERS' COMPENSATION LEGISLATION

The proposed law now before the legislature came about as a result of a year long effort conducted by a statewide labor- management task force.

If passed, the new law would do the following:

1. Increase disability benefits for seriously injured workers.
2. Increase temporary total disability benefits for workers employed in low-paying jobs to match at least minimum wage.
3. Provide for voluntary rehabilitation for workers who want to prepare for future employment.
4. Encourage cooperation between injured workers and rehabilitation counselors.
5. Establish minimum qualification standards for rehabilitation counselors, and offer a referral service to workers and employers.
6. Allow physicians to charge only "reasonable" fees for specific services.
7. Provide for unbiased and cost-effective settlements in medical disputes.
8. Encourage patients to seek quality medical care that promotes recovery rather than dependency.
9. Require health-care providers to show cause for continuous multiple treatments. It does not, however, limit treatment if it can be proven to promote recovery.
10. Make it unlawful for an employer to discriminate against a job applicant who has previously filed for workers' comp benefits.
11. Protect workers from loss or delay of benefits in the event of a dispute where an insurance carrier is ultimately liable.
12. Allow for the reduction of benefits for workers who relocate to an area with a lower cost of living.
13. Set a standard under which stress claims may be judged valid.
14. Allocate a greater portion of worker compensation dollars directly to injured employees.
15. Provide for a cost-effective, equitable program that provides incentives to injured workers to return to work.

We are representative of the companies and organizations that support this legislation because it is fair to injured workers, cost effective for employers and will save jobs in Alaska.

SCOTT WETZEL SERVICES
ALASKA AIRLINES
WESTMARK HOTELS
ANGLO ALASKA PETROLEUM
CARR-GOTTSTEIN
CIMARRON HOLDINGS
NORTHERN ADJUSTORS
ALASKA STATE MEDICAL ASSN
HOLLAND AMERICA
NORTHERN AIR CARGO
ALASCOM
TOTEM OCEAN TRAILER EXPRESS
ANCHORAGE REFUSE
ALASKA CLEANERS
KLUKWAN, INC.

HICKEL INVESTMENT
REEVE ALEUTIAN
NATIONAL BANK OF ALASKA
GCI
CENTRAL PLUMBING AND HEATING
SPENARD BUILDING SUPPLY
SAUPE ENTERPRISES
ALASKA OIL MARKETERS ASSN.
ALASKA PULP CORPORATION
RAIN PROOF ROOFING
USIBELLI COAL MINE
ALASKA STATE CHAMBER OF COMMERCE
RESOURCE DEVELOPMENT COUNCIL
ACME FENCE
PACIFIC MOVERS

SMYTH MOVING SERVICES
BAILEY'S RENT ALL
MIDAS MUFFLER
ALYESKA PIPELINE SERVICE COMPANY
ALASKA CHAPTER OF RISK AND INSURANCE MANAGEMENT SOCIETY
ALASKA SALES AND SERVICE
PETER KIEWIT AND SONS
ASSOCIATED GENERAL CONTRACTORS
ALASKA STATE HOMEBUILDERS
BARRATT INN
BUILDING INDUSTRY ASSOCIATION OF ANCHORAGE
WILDER CONSTRUCTION COMPANY, INC
HOFFMAN CONSTRUCTION COMPANY OF ALASKA

ALASKA STATE AFL-CIO
WESTERN ALASKA BUILDING AND CONSTRUCTION TRADES COUNCIL
FAIRBANKS BUILDING AND CONSTRUCTION TRADES COUNCIL
CARPENTERS LOCAL 2162
CARPENTERS LOCAL 1281
PUBLIC EMPLOYEES UNION LOCAL 71
INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS LOCAL 1547
LAUNDRY AND DRYCLEANING LOCAL 333
LABORERS INTERNATIONAL UNION LOCAL 341

LABORERS INTERNATIONAL UNION LOCAL 942
PAINTERS AND ALLIED TRADES LOCAL 1140
PAINTERS AND ALLIED TRADES LOCAL 1555
INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL 302
UNITED TRANSPORTATION UNION LOCAL 1626
UNITED FOOD AND COMMERCIAL WORKERS LOCAL 1496
ROOFERS AND WATERPROOFERS LOCAL 190
TEAMSTERS UNION LOCAL 959
SHEETMETAL WORKERS LOCAL 23
FIREFIGHTERS LOCAL 1264
BRICKLAYERS LOCAL 1

8/

Alaska Cabaret, Hotel,
Restaurant & Retailers Association

P.O. Box 104839 • Anchorage, Alaska 99510
225 Cordova, Building B, Suite 305 • (907) 272-8133

February 11, 1988

The Honorable Senator Tim Kelly,

The Alaska Cabaret, Hotel, Restaurant and Retailers Association (CHARR), would like to extend its support to the passage of SB222 and HB352, the Workmen's Compensation legislation. We feel that this legislation will go far in correcting the inequities in the present system.

Charlie H. Selman

Charlie Selman
President

H. C. PRICE
CONSTRUCTION CO.

471 W. 36th, Suite 201, Anchorage, Alaska 99503
Telephone (907) 561-4400, Telecopy (907) 563-3255
Telex 090-25370

9/

February 10, 1988

Senator Tim Kelly
Senate Labor and Commerce Committee
Room 101, Capitol
P. O. Box V
Juneau, AK 99811

Subject: Senate Bill No. 322
Workers' Compensation Reform

Dear Senator Kelly:

I would like to express my support for the passage of the subject bill without modification. As an employer of hundreds of Alaskan construction workers, and as a member of WCCA who helped define employers' concerns to the Ad Hoc Committee, I can affirm my belief that passage of this bill into law will reduce my Workers' Compensation costs by at least 15%.

While Workers' Compensation is a necessary safety net for all workers, the ambiguities and loopholes in the current law make it difficult for the injured worker who truly needs it and easy for the free-loader who wants to take advantage of the system.

Very truly yours,

Wesley P. Nason
Vice President and
General Manager

WPN:cmb

cc: WCCA
Lynn Phillips
2204 Cleveland
Anchorage, AK 99517

February 5, 1988

Dear Senator Kelly:

I am sick and tired of hearing complaints from chiropractors and lawyers on why we shouldn't change dramatically our workers compensation laws. The current law costs way too much and does not even do a good job of rehabilitating injured workers and getting them back to work. In fact, it creates a dependency on welfare and discourages people from working. The legislation you have in front of you, as I understand it, will reduce costs to employers while at the same time it takes better care of the more seriously injured workers, and provides incentives to go back to work. Anybody who opposes that kind of reform must either profit from the current system or should have their head examined.

Thank you.

Sincerely,

Jerry Barnes

Jerry Barnes
14727 Park Hills Circle
Anchorage, AK 99516

February 5, 1988

Senator Tim Kelley, Chairman
Senate Labor and Commerce Committee
Alaska State Legislature
P.O. Box V (M.S. 3100)
Juneau, Ak. 99811

Dear Senator Kelley:

Re: S.B. 322

I strongly support the recommendations of the Management/ Labor ADHOC Committee for Workers' Compensation Reform.

I encourage you and your fellow senators to pass S.B. 322.

Sincerely,

Jack Holland

Swanson General
CONTRACTORS, INC.

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February 10, 1988

Alaska State Senate
Labor and Commerce Committee
P.O. Box V Room 101
Juneau, Alaska 99811

Attention: Senator Tim Kelly, Chairman

Reference: Senate Bill 322

Our company has performed as a general and electrical contractor in the State of Alaska since 1974. We deal almost exclusively in remote site projects for various agencies of the State and Federal Governments.

Although we have experienced relatively few Workers Compensation claims over the years, we have seen our rates climb dramatically, especially in the past two years.

I have read House Bill #352 which amends the Workers Compensation laws now in effect and I feel that it would produce some very real cost savings to employers as well as establishing a more equitable system for employees with work related injuries and illnesses.

Having attended one public hearing on the bill I am aware of its shortcomings and am confident the legislative process will fine tune the bill before signing it into law.

The bottom line is that we must have a Workers Compensation reform bill with some teeth in it passed during this legislature. The small businesses of Alaska are struggling to stay afloat now without the added burden of repeated insurance rate increases of 20% a year or more.

While we're at it, let's get some legislation moving on tort reform so General Liability Insurance rates can be brought back to a reasonable level.

Sincerely,

Valerie Maxim

Valerie Maxim
Administrator

11221 OLIVE LANE • ANCHORAGE, ALASKA 99515 • (907) 344-0022 • LIC. NO. AA3354

LYNDEN INCORPORATED

3027 Rampart Drive
Anchorage, Alaska 99501
(907) 279-7501

February 9, 1988

Senator Tim Kelly
Alaska State Legislature
P.O. Box V (MS 3100)
Juneau, Alaska 99811

Dear Senator Kelly:

Lynden has experienced the same sky-rocketing Workmens' Compensation premiums as have other Alaska businesses within the past two years. These spiraling costs are crippling the Lynden companies and threatens the livelihood of our employees.

We would like to strongly encourage your support of SB 322 as a first step in correcting the serious deficiencies in which exist in the present program. Your support in getting this Bill passed will be greatly appreciated by Lynden

Very truly yours,

LYNDEN INCORPORATED

Jim Jansen
President & CEO

JJ:am

February 5, 1988

Dear Senator Kelly:

You have before you an important piece of legislation regarding workers compensation. If it passes it will go a long way in reducing costs and taking more appropriate care of our injured workers instead of all the doctors, lawyers, chiropractors, and rehabilitators the current system is designed to reward. I would strongly urge you to support HB 352 in an effort to stem the losing tide of worker compensation premium costs in Alaska. It has the broad support of management and labor, and even though not everybody is happy with it, I believe it will do the job we want our comp system to do for us.

Please support the effort put forth by labor and management, and help our economy at the same time.

Thank you.

Respectfully,

Larry Peck
3136 Doil Drive
Anchorage, Alaska 99507

February 5, 1988

Dear Senator Kelly:

I am writing in strong support of the workers compensation reform package you are currently considering. I understand that a labor and management group has developed a progressive reform bill that cuts away a lot of abuse on both sides and reduces the amounts going to lawyers, doctors, chiropractors, and rehabilitators. Hurray..

The firm I work for has escalating workers compensation costs that I know it cannot afford. I hope you can do something about this. If not, I know a lot of businesses such as ours will continue to suffer a continuation of these high costs that it cannot afford. Please do not give in to the special interest groups on this one. Our economy cannot afford that anymore.

Thank you.

Most Sincerely,

Sam Deakin
12641 Foster Road
SRA Box 2385-D
Anchorage, Ak 99507

February 5, 1988

Senator Tim Kelley, Chairman
Senate Labor and Commerce Committee
Alaska State Legislature
P.O. Box V (M.S. 3100)
Juneau, Ak. 99811

Dear Senator Kelley:

Re: S.B. 322

I strongly support the recommendations of the Management/ Labor ADHOC Committee for Workers' Compensation Reform.

I encourage you and your fellow senators to pass S.B. 322.

Sincerely,

Roger Morris

February 4, 1988

Dear Senator Kelly:

I understand that there is currently legislation under review to revamp our workers compensation laws. I cannot think of anything else the state could do to help our economy that won't cost the state one red cent. In fact I bet the state will save money along with every other business in the state. From what I know the bills in the Senate and House Labor and Commerce committees will cut costs, and do a better job of taking care of the more injured workers while giving them an incentive to go back to work. Those who argue against the bill must not either understand it or probably make money on it.

Please take a strong stand in support of this legislation and don't give in to those few who want to profit at the expense of the many.

Thank you.

Most Sincerely,

Linda K. Bowers

Linda Bowers
3441 Wiley Post Loop
Anchorage, Ak 99503

RENT-ALL
Bailey's

DOROTHEA J. LOVEJOY
OWNER

3671 OLD SEWARD HIGHWAY
ANCHORAGE, ALASKA 99518
(907) 344-6535

FEBRUARY 9, 1988

STATE HOUSE LABOR & COMMERCE
P. O. BOX V
JUNEAU, ALASKA 99811

ATTENTION: TIM KELLY

DEAR MR. KELLY:

AS A SMALL BUSINESS OWNER IN ANCHORAGE, ALASKA, PROVIDING A NECESSARY COMMUNITY SERVICE, AND HAVING THE DISTINCTION OF BEING AN ESTABLISHED BUSINESS SINCE 1956, WE ARE VITALLY CONCERNED ABOUT THE MAJOR ISSUE OF WORKERS COMPENSATION INSURANCE AND THE SKYROCKETING INSURANCE RATES THAT SERIOUSLY AFFECT OUR OPERATIONAL ABILITY.

THIS LETTER IS A SINCERE EFFORT TO URGE YOU TO APPROVE AND PASS HOUSE/SENATE BILL NO.322 AS IT HAS BEEN AGREED UPON BY THE LABOR MANAGEMENT TASK FORCE.

THANK YOU FOR YOUR EFFORTS AND YOUR CONSIDERATION IN THIS MATTER.

SINCERELY,
BAILEY'S RENT-ALL, INC.

Dorothea J. Lovejoy

DOROTHEA J. LOVEJOY
OWNER

DJL:S

February 9, 1988

Senator Tim Kelley, Chairman
Senate Labor and Commerce Committee
Alaska State Legislature
P.O. Box V (M.S. 3100)
Juneau, Ak. 99811

Dear Senator Kelley:

Re: S.B. 322

I strongly support the changes to the workers' compensation statutes as outlined in Senate Bill No. 322.

I hope you will agree and provide the necessary support for passage of this important legislation.

Sincerely,

Leonard Jablonski

OLSEN LOGGING COMPANY
P.O. BOX 950
PETERSBURG, ALASKA 99833

(907) 772-3148

TO

All Legislators

Pouch V

Juneau, Ak. 99811

DATE February 8, 1988

SUBJECT Reform Worker's Compensation

Dear Sirs,

We urge you to support the worker's comp : reform legislation as proposed by the labor- management task force. Any major changes will kill the bill this session and every business in Alaska needs that bill to pass for both the benifit of the employers and employees. Save jobs !

Olsen & Sons Logging Ltd.

Olsen Logging Company

By: Gladys M. Olsen

February 4, 1988

Dear Senator Kelly:

I work for a company that has seen its workers compensation costs go up year after year. If you can do anything about it, I wish you would. I have heard that our compensation system is one of the worst in the country. I believe it.

Please do what you can.

Thank you.

Sincerely,

Mary Jean Anderson
4725 Mills Drive
Anchorage, AK 99508

February 9, 1988

Senator Tim Kelley, Chairman
Senate Labor and Commerce Committee
Alaska State Legislature
P.O. Box V (M.S. 3100)
Juneau, Ak. 99811

Dear Senator Kelley:

Re: S.B. 322

I strongly support the changes to the workers' compensation statutes as outlined in Senate Bill No. 322.

I hope you will agree and provide the necessary support for passage of this important legislation.

Sincerely,

Jo Ann Stromberg

Jo Ann Stromberg

Taylored

CONSTRUCTION SERVICES, INC.

DESIGN • REMODELS • ADDITIONS

8

Senator Kelly
P.O. Box V
Juneau, Alaska 99811

Feb. 15, 1988

Dear Senator Kelly:

I'm writing as a small business person who is trying to stay alive in these tough economic times. While we are able to bring most of the overhead cost for our business under control the one that needs to be brought back to a reasonable cost can only be corrected with your help of legislative action.

Workers Compensation Rate for construction has risen over 50% in the last two years - while the construction industry has been the hardest hit industry in the State's recession. It is literally forcing companies to get rid of any employees and use only subcontractors.

On top of the rising cost, in my business I have been able to watch the devastating results of a bogus claim by an employee who was hurt on the weekend working on his own home. He made more than any of the carpenters which I had working because of the tough economic times. Tell me, what incentive did he have to go back to work. Especially when he moved back to North Dakota and lived comfortably on the income from workers compensation paid at the Alaska level. After a settlement in March because he can never work as a carpenter again, I recently got word that he is framing in Oregon now. So take the 50% increase of workers compensation for carpentry and add a modification factor of 1.39 because of the incidence above.

I understand that the major opposition to the compromise bill negotiated between labor and management is coming from the chiropractor community and the claimants attorneys. I can certainly see why they have an interest in the bill as the people whose pockets are affected but what about those who are paying for the cost and are being forced out of business for this large contingency at the feeding trough. I would love to have someone pay for me to see a chiropractor every week. It is a real addiction that makes one feel relaxed.

I urge you to take quick action to protect Alaskan jobs and businesses by swift action on the labor-management workers compensation reform bill.

Sincerely,

Elaine Taylor

Elaine Taylor

2028 OTTER • ANCHORAGE, ALASKA 99504 • (907) 349-7564

LARRY BUCHHOLZ DBA I.D.E.A.
Injured or Displaced Employees of Alaska
801 West Fireweed Lane, Suite 200-B
Anchorage, Alaska 99503
(907) 273-3730

February 19, 1988

Dear Friend:

The attorneys who represent injured workers for workers' compensation claims in Alaska have asked me to contact you to inform you of how proposed legislation amending the Alaska Workers' Compensation Act will affect your interests.

The proposed legislation reduces all the wrong things -- it reduces your medical benefits, your time loss benefits and your vocational rehabilitation benefits.

Please complete the enclosed card and mail today. Time is of the essence, because introduction of the proposed legislation in the Alaska Legislature is scheduled to occur on February 26.

You may also object to particular aspects of the proposed legislation by telephoning the Legislative Affairs Office (phone number 561-7007) and dictating a free public opinion message to any or all legislators and the governor.

By protecting the interests of injured workers, you will protect yourself. Thank you.

Very truly,

I. D. E. A.

By: _____
Larry Buchholz

LB/jce

Dear Representatives and Senators:

H.B. 352/S.B. 322 effectively destroy the protection afforded injured workers by the Alaska Workers' Compensation Act. This no fault system of private insurance is shifting the burden onto injured workers and social welfare programs by reducing time loss benefits, virtually eliminating vocational rehabilitation and restricting medical coverage.

Please reconsider your support and I would appreciate your conveying my concerns to my local legislators by sending them a copy of this card.

Thank you.

Name _____ Signature _____

Address _____ Date of Injury: _____

Senate Labor & Commerce Committee
House Labor & Commerce Committee
P.O. Box V
Juneau, AK 99811

VECO INTERNATIONAL, INC.
5151 Fairbanks Avenue
Anchorage, Alaska 99502

February 16, 1988

Honorable Tim Kelly, Senator
Chairman Senate Labor and Commerce Committee
Alaska State Senate
Pouch Y
Juneau, Alaska 99811

Dear Senator Kelly,

This firm has been watching with great interest the activities of the Legislature, the Governor and the Governor's Oversight Committee and the several employer and employee interest groups that have been actively involved in either drafting or commenting upon the legislation to modify the Workers' Compensation Act, Senate Bill 322 and House Bill 352.

Veco is a large employer and, because of the nature of its work, is one of the largest payors of workers' compensation benefits in the state. We have watched with alarm the cost of our workers' compensation premium and the cost of our claims rise steadily and significantly, despite a continuing decline in the number of injuries sustained by our workforce. Accordingly, although we have remained relatively uninvolved in the process leading to the proposal of the subject legislation, Veco is and will remain vitally interested in the outcome.

Although we have taken a less visable role in the drafting of proposals to your committee, we have been carefully monitoring the legislative hearings, the work of the Oversight Committee and the work of WCCA. We have also been engaged in independent review of the bill in order to determine the impact the proposals are likely to have on our specific claims.

As a result, and because you are now about to begin mark-up of the bill, we wish you to consider our very serious concerns.

First, it is the position of our company that, as a general proposition, the bill provides a framework for meaningful improvement in the way the compensation benefits are delivered. We do like many aspects of the bill. We do find, however, that some of the most important provisions have been drafted in such a way as to create more ambiguity, and thus foster more litigation, than is warranted by the expected savings from a change in concept or definition of benefit.

Secondly, we are alarmed to learn from work done by two actuarial firms, the rating bureau used by the insurance industry and an independent actuarial firm hired by the State, that the bill will not only not save any significant cost, but could end up costing employers more. Such a finding makes the bill totally unacceptable, even if there are concepts that are desireable.

Our inquiries lead us to believe that the current system has been subjected to substantial increase in cost for three principle reasons:

1. Unwarranted utilization of the rehabilitation benefits driving up both rehabilitation costs and extending the times for payment of lost time benefits;

2. ambiguities in the current law which give rise to litigation, particularly in such areas as calculation of average wages;

3. Increases in permanent partial disability awards, particularly for unscheduled injuries (backs and necks).

The bill you have before you makes a good faith attempt to address these issues and in many ways does a good job.

We believe there are three principle areas where the bill is deficient and which have to be changed if the bill is to be adopted.

1. The language in the intent section is drafted as to not cure the problem which the intent language was written to address.

Our view is that the language has to more clearly specify that the courts should strictly construe the interpretations of the law such that the benefits are not increased except by specific act of the legislature. On the other hand, factual questions ought to be decided based on the weight of the evidence, but, if there is reasonable disagreement on the weight of the evidence to favor the employee.

We have enclosed alternative proposed language for the intent section.

2. It is incomprehensible that the legislature would even consider this bill unless changes are made which, according to responsible actuarial indications will save some money for employers. We have targeted an overall hard dollar savings of 15% as our goal for any meaningful legislation.

It is our understanding that the firm of Milliman and Robertson, the firm hired by the State and reporting to the Governor's Oversight Committee, is currently working on a proposed revision to the permanent partial impairment section of the bill, the section that revises 23.30.190, such that an overall savings of 15% could be realized. We urge you to include their recommendations in your bill when they become available. We understand that their work will be transmitted to Alaska in the next day or so.

3. The rehabilitation provisions, while being the area of most concern from both a cost and administrative viewpoint, is also the area where we believe inartful drafting leaves the way open to unnecessary litigation.

We have included with this letter, a proposed alternative draft of 23.30.041.

Its salient differences from the current draft are as follows:

a. Our proposal clarifies and limits the authority of the rehabilitation administrator. We do not believe it is necessary or appropriate that an essentially independent structure for rehabilitation be created in the division of workers' compensation. The rehabilitation aspects of a claim should be handled to the greatest extent possible in the context of the existing administrative adjudicatory structure, yet permitting use of specialists in the rehabilitation disciplines.

b. The procedure for obtaining initial eligibility determinations is greatly simplified. Our review indicates that the basic eligibility test in the proposed bill is a good one, but the procedure for determining the eligibility is unncessarily complex.

c. It is vital that the formal and full evaluation process allow for the rehabilitation specialist to find that a plan may not be appropriate. Our draft includes a procedure for finding that no plan is warranted, even for those found preliminarily eligible, if the plan would not accomplish anything for the employee.

d. Another principle change deals with the process for resolving disputes over the rehabilitation plan. We are deeply concerned that the bill includes a provision giving the rehabilitation administrator absolute and non-reviewable authority to make decisions. The hearing officers who decide far more consequential issues do not have such authority.

4.There is in the bill a much improved control over the medical delivery aspects of the workers' compensation system. We believe, however, that the independent medical examiner called for in the newly added 23.30.095(k) must be a medical doctor. We support the proposition that alternative health care providers should be allowed and paid for by the system to the extent they are effacacious, but the IME is called upon to make judgements that we believe ought not to be made by any of the several health care provider professionals that come under the act's definition of "physician". This one section should limit IME participation to "Doctor of Medicine".

Senator Kelly, there are several parts of the bill which we do not comment on because they are acceptable to us. In fact some are very important and if they were to be taken out would cause us to rethink our posture on the bill; the limit on stress claims, the two year limit on temporary benefits and the limits on medical costs and services are all important.

There are several changes favoring employees in the bill which were negotiated by the Ad Hoc Task Force and we are prepared to accept these changes if the overall cost of the system is brought under control.

Thank you for your consideration of our views.

Yours cordially,

John Kerrigan
Vice-President

PROPOSED CHANGES TO INTENT LANGUAGE OF
HB 352/SB322

Section 1 (b)

It is the specific intent of the legislature that the definition of rights and obligations under this act be strictly construed in accordance with the clear and unambigious language of this act. If there is any ambiguity, it is the intent of the legislature that the act be interpreted so that there shall not be any change, extension or broadening of rights of the employees or obligations of the employers except by act of the legislature.

It is further the intent of the legislature that the system, including the process of administrative hearings for resolving factual disputes, be fair and afford due process, but expidiciously settle factual differences. Accordingly, unless specifically provided otherwise in the act, factual disputes that cannot be resolved by the weight of the evidence, should be resolved by according favor to the position of the injured worker.

PROPOSED CHANGES TO 23.30.041

23.30.041 (a) The department shall select and employ a rehabilitation administrator, who shall be a part of the Division of Workers' Compensation and who shall have such additional staff as required to carry out the purposes of this section. The rehabilitation administrator is in the partially exempt service under AS 39.25.120.

(b)The rehabilitation administrator shall implement the provisions of this section, and study the issue of rehabilitation, both physical and vocational, on a continuing basis.

(c) If an employee suffers a compensable injury that may permanently preclude an employee's return to the employee's job at the time of injury, the employee or employer may request the treating doctor of medicine or independent medical examiner selected pursuant to AS 23.30.xxx to determine what the physical capacities of the employee will be when the employee reaches medical stability. The only capacities which may be determined pursuant to this paragraph are those required to make the determinations under paragraph (d).

(d) An employee shall be eligible for a full evaluation pursuant to paragraph (f) of this section if the capacities of the employee at medical stability determined pursuant to paragraph (c) are found to be less than the physical demands as described in the United States Depadrtment of Labor's "Selected Characterisitics of Occupations defined in the Dictionary of Occupational Titles" for:

(1) the employee's occupation at the time of injury; and

(2) other occupations that exist in the labor market that the employee has held within 10 years before the injury; and

(3) occupations that the employee has held following the injury for a period long enough to acquire the vocational preparation required for those occupations as specified in the "Selected Characteristics of Occupations defined in the Dictionary of Occupational Titles".

(e) An employee is not eligible for an evaluation pursuant to paragraph (f) if:

(1) the employer offers, or obtains for, employee remunerative employment the physical demands of which are not more than the physical capacities of the employee determined to exist at medical stability and the employment is in an occupation that generally exisits in the labor market; or

(2) the employee has received rehabilitation benefits in connection with a prior industrial injury under this or any similar section of a Workers' Compensation Act, but, following the receipt of the benefits, was employed at the same or similar occupation as the occupation at the time of the prior injury.

(3) the employee has been paid any or all of his permanent impairment award pursuant to AS 23.30.190.

(f) When an employee is found eligible for and desires to have a full evaluation for rehabilitation the employee shall so notify the employer and the employee and the employer jointly shall select a rehabilitation specialist who shall provide a full re-employment evaluation, and, if appropriate, a complete re-employment service plan. If the employee and the employer cannot agree on a rehabilitation specialist, but not before thirty days after the employee notifies employer of his desire to have an elibibility for an evaluation, either party may request the rehabilitation administrator to assign a rehabilitation specialist. The employer and the employee each have the right to reject the assignment by the rehabilitation administrator for cause and shall have the right to one pre-emptive rejection.

(g) The full evaluation and rehabilitation service plan must include the following:

(1) an inventory of the employee's technical skills, physical capacities, intellectual capacity, academic achievement, emotional condition and familial support.

(2) a determination of the occupation which the plan establishes as the goal.

(3) a finding that:

i. the occupation established as the goal for the plan is one for which adaquate employment opportunity exists the labor market; and

ii. the employee's technical skills, physical capacities, intellectual capacity, academic achievement, emotional condition and familial support at commencement of the plan are such that the employee can reasonably be expected to satisfactorily complete the plan and perform in the new occupation; and,

iii. the plan can be completed within the time an cost limitations imposed by this section.

(4) a detailed description and schedule of the plan.

(5) the cost estimate of the plan including provider fees, the amount of tuition, books, tools, supplies, transportation, temporary lodging or job modification devices.

(6) the date the plan will commence.

(7) the time that the employee will be medically stable as determined by the treating doctor of medicine or independent medical examiner.

(h) [(g) in the bill as currently drafted.]

(i) If the rehabilitation specialist finds that any one of the required findings in subsection (g) (3) is not true, then the employee shall not be entitled to a re-employment plan and the rehabilitation specialist shall provide a report to the employee and the employer stating that fact including the reasons and information upon which such finding is made.

(j) [same as (i) in current draft of the bill.]

(k) The following time limitations shall apply to the entitlements and the obligations of this section:

(1)The reemployment plan must be scheduled so that it can be completed and the occupational goal achieved within two years from date of plan approval.

(2)-(6) [same as (2)-(6) in current draft of bill except change "reemployment services administrator" to "rehabilitation administrator" so that consistent terms are used throughout.]

(7) If the report or plan of the rehabilitation specialist is not approved by either the employer or the employee, either may petition the rehabilitation administrator for a modification of the report or plan in a manner set forth in the petition. If no petition is filed within ten days of submission of the report or plan to the employee and employer, the report or plan is deemed approved. If a petition is filed, the non filing party shall have ten days to file a response. The administrator shall conduct a pre-hearing conference with the parties to resolve differences. If the approval of both partis cannot be obtained at the pre-hearing conference, then the administrator shall prepare a report within ten days following the conference with a recommendation as to the report or plan that ought to be approved. The petition, response and report of the administrator shall be deemed the filing of a claim and notice of claim referred to in AS 23.30.110(a) and (b). The Board shall notice a hearing as provided in AS

23.30.110(c) and proceed pursuant to AS 23.30.110 to resolve the matter.

(l)-(m) [as (k)-(l) in the current bill.]

(m) In this section:

(1) [as (1) in current bill.]

(2) "labor market" means the geographic areas where the employee lived and where the employee worked at the time of injury, unless, subsequent to the date of injury, the employee permanently changed residence from Alaska to outside the state, in which case the labor market is also anywhere in the state of new residence.

(3) "physical capacities" and "physical demands" means the physical capacities and physical demands as those terms are used in the Department of Labor "Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles".

(4) [included with (3).]

(5)-(7) [as (5)-(7) in the current bill.]

(8) "occupation" means the generic classification of work as described in the Dictionary of Occupational Titles.

COMMUNITY
CHIROPRACTIC CLINIC

550 EAST TUDOR ROAD
ANCHORAGE, ALASKA 99503
TELEPHONE (907) 562-5366

Senator Jan Faiks
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99881

RE: Proposed Workers' Compensation Law

Dear Senator Faiks:

I am forwarding additional information regarding the proposed Workers' Compensation bill. I was surprised that you have not been fully informed on this issue when we discussed the bill at Mr. Neil Berg's home. Mr. Mitch Gravo, our lobbyist, confirmed he had not discussed the issue with you from our view-point.

There are numerous provisions in the new bill we feel would be detrimental to the intent of the Workers' Compensation Law, as well as unfair to the injured worker when it comes to the management of the patient's injury. The employer will also incur an increased potential for litigation which will ultimately increase Workers' Compensation cost.

Senator Kelly and the group supporting him simply are not telling the whole story. The Senator has repeatedly demonstrated he is not interested in what the public or anyone else thinks about this bill. I guess he feels he has the huge financial power-brokers of this state behind him and he does not need to concern himself with the general public's view.

The chiropractic profession, nor anyone else I know are against some changes in the Workers' Compensation Law. Appropriate changes would be beneficial to the system. What we are emphatically stating is; this "proposed bill is a "bad bill" in many respects (see attached material). Most

important, the bill will not accomplish the initial intent that started this legislation, "Cost Reduction".

Senator Kelly <u>should not</u> be allowed to co-chair the Free Conference Committee on this legislation as he is clearly not open to good suggested changes. I respectfully request you to reconsider Senator Kelly's appointment to this committee.

I have enclosed documents and letters to further inform you on a different point of view. Please give your immediate attention to this matter.

If you have further questions, please contact Mr. Mitch Gravo in Juneau or myself at 562-5366. Thank you.

Sincerely,

Adrian G. Barber, D.C.
AGB/jc

enclosures:

cc: Governor Steve Cowper
Senator Tim Kelly
House Judicial Committee
House Labor and Commerce Committee

Bill would cut employee insurance coverage costs

By LARRY PERSILY
The Associated Press

JUNEAU — Employers are expected to save millions of dollars in premiums and insurance companies may save millions of dollars in claims under a rewrite of workers' compensation laws passed Thursday by the Senate.

The measure is intended to reduce the increasing cost of workers' compensation coverage, while also providing some help to injured workers.

The bill (SB322) passed the Senate 15-0 and now moves to the House.

Alaska employers paid $153 million in workers' compensation premiums in 1986, said Don Koch, special deputy for the state Division of Insurance. That cost increased in 1987, he said, but an exact figure is not available.

Insurance companies paid out more than $150 million in claims in 1986, Koch said.

Anchorage pays out $2 million to $3 million a year in claims, said Harry Sjoberg, the municipality's risk manager. He said the city expects in time to save more than $500,000 a year if the bill becomes law.

"There could be less litigation because of it," he said, and stress-related claims and vocational rehabilitation costs to employers would be reduced under the bill.

The municipality covers its own employee claims up to $500,000, and buys insurance to handle claims over that amount, Sjoberg said.

In passing the bill, senators approved a letter of intent asking the Division of Insurance to request insurance companies to adjust their rates to reflect changes in the law.

The letter of intent, which does not have the force of law and only expresses the wishes of legislators, said the bill is expected to reduce workers' compensation costs at least 2 percent.

The bill would prevent workers' compensation benefits for stress unless it was "extraordinary and unusual in comparison to pressures and tensions experienced by individuals in a comparable work environment."

Stress-related claims were cited at legislative committee hearings as a growing problem. "Workers' compensation was not designed to deal with stress," an attorney told lawmakers last month. He said stress may be pre-existing or caused by factors outside the work place.

Briefcase

Alaska job-related injuries drop

Job-related injury and illness rates in Alaska dropped nearly five percent in 1986, according to the U.S. Bureau of Labor Statistics. Latest statistics also show the rate of injuries and illnesses for the nation remained unchanged from last year. The rate in Alaska declined from 10.7 to 10.2 percent in 1986. The incidence rates represent the annual number of recordable private sector occupational injuries and illnesses per 100 full-time workers. About one out of every 10 workers in Alaska suffered an on-the-job injury or illness during 1986.

DISCUSSION DRAFT

COST ANALYSIS OF THE ALASKA WORKERS' COMPENSATION PROGRAM

Milliman & Robertson, Inc. (M&R) was retained by the Alaska Division of Insurance to perform the following tasks:

1. To provide a breakdown of current costs of the Alaska workers' compensation program.

2. To identify those elements driving the recent large rate increase indications.

3. To review and comment on SB322/HB352 as it pertains to the costs of the Alaska workers' compensation program.

4. To analyze local Alaskan data relevant to estimating the likely cost impact of SB322/HB352, the major source of this data being the Alaskan Workers' Compensation Information Handling System (WCIHS).

5. To review the National Council on Compensation Insurance (NCCI) preliminary evaluation of SB322/HB352 and where appropriate, modify the NCCI estimate using relevant local data.

6. To provide a likely cost estimate of the impact of SB322/HB352.

This report summarizes our findings.

1: BREAKDOWN OF CURRENT COSTS

In its most recent rate filing, the NCCI provides the following breakdown of the "average" premium dollar in Alaska:

NCCI Definitional and System Change Estimates

In their preliminary evaluation, the NCCI included an adjustment of -4% to account for aspects of the proposed law not explicitly evaluated. We understand the -4% was selected by judgment.

Using data from the WCIHS, we were able to provide some quantitative measure of the impact on the provisions of the new law relating to claimants living out of state.

Claimants Living Out of State

As discussed earlier, based on the distribution of claimant's ZIP codes in the WCIHS data base, approximately 30% of claimants now receiving temporary total, fatal, or permanent partial benefits reside out of state.

We judgmentally estimate that benefits for out of state claimants are reduced by 25% under the proposed law and that 20% of all claimants are affected. This implied a 5% (= 20% x .25) reduction in temporary total, fatal, and permanent total benefit costs.

The assumption that 20% of claimants will receive reduced benefits rather than 30% as indicated by the WCIHS data is to recognize that if the new law is implemented, the percentage of out of state claimants is likely to drop as claimants lose an incentive to leave Alaska.

6: M&R ESTIMATED COST IMPACT OF SB322/HB352

We estimate the following impact on costs:

	Fatal	Perma-nent Total	Permanent Partial Temp-orary	Permanent Partial Award	Temp-orary Total	Medical	Total
A: Cost Under Current Law	3.0%	13.4%	20.1%	30.1%	5.1%	28.3%	100.0%
Proposed Law Change							
B: Revision To PP Award	1.000	1.000	1.000	1.180	1.000	1.000	
C: Weekly Benefit Maximum	0.996	0.999	0.950	1.000	0.995	1.000	
D: Out of State Claimants	0.950	0.950	1.000	1.000	0.950	1.000	
E: Duration of Temp-orary Benefits	1.000	1.000	0.800	1.000	1.000	1.000	
F: Overall Impact (AxBxCxD)	0.946	0.949	0.760	1.18	0.945	1.000	
G: Cost Under Proposed Law (AxF)	2.8%	12.7%	15.3%	35.5%	4.8%	28.3%	99.4%

We thus believe the proposed law is likely to have little overall impact on total costs. We note the following:

1. If the proposed permanent partial award maximum were reduced to $200,000, we estimate there would likely be little overall change in permanent partial award costs from present levels, and overall costs of the program would be reduced by about 6%.

2. We believe we have implicitly factored into our estimates all aspects of SB322/HB352 identified earlier as impacting costs.

3. The estimates above anticipate strict adherence to the provisons of SB322/HB352.

4. We again stress that the proposed reform of permanent

Letters to the Editor
Anchorage, Times
P.O. BX. 40
Anchorage, AK. 99510

March 8, 1988

Dear Editor:

I would like to respond to Mr. Larry Taylor's letter regarding the pending Workers' Compensation legislation. I believe he has not had an opportunity to clearly evaluate the facts of this bill. I personally have been involved in this particular legislation and feel it is grossly unfair to the injured worker. Most importantly, though, is the fact that the injured worker is guilty until proven innocent. If there is a dispute between the employee and the employer, all benefits can be legally stopped (or controverted) until the Board can decide. This can leave the injured worker without any financial support for months (or longer) until he can get a board hearing. I have literally seen legitimately injured workers lose all their savings, their cars, and their homes waiting for a board hearing. So, let us look at who stands to benefit the most from this bill. If you think the injured worker will benefit from this bill, you are wrong. Sure, the minimum benefits have been raised to meet minimum wage, but the maximums have been decreased way out of proportion. Choice of physicians has been decreased, amount of treatment has been limited and must be approved by the insurance company, insurance companies can use out of state organizations to determine fees (making the worker responsible for the difference), and the list goes on. The injured worker cannot by any stretch of the imagination benefit from this legislation as a whole. How about the provider? You made mention that the chiropractors and the claimants' attorneys are the ones making such wonderful livings from the Workers' Compensation system. I cannot speak for the attorneys, but I can tell you that approximately 11% of our practice is Workers' Compensation patients, and we have one of the largest clinics in Alaska. It is not by any means the major portion of our business. Nor do I appreciate the implication that we as a class are anything less than ethical regarding injured workmen. Our fees are our fees, and they are no different if you were hurt on the job or carrying out the garbage. As a matter of fact, studies from around the country have shown that chiropractic is twice as effective as medical care for work related injuries, and many foreign governments have come to the same conclusions, finding chiropractic both effective and cost effective. In a study yet to be released by the

Italian Medical Community, that spanned two years and 17,142 patients, they found that chiropractic care saved 75.55% of days absent from work and 83.6% of hospital admissions. Any implication that chiropractic is not effective or would not save the employer valuable time lost from work can only be based on ignorance of the facts and bias.

So, let us turn our attention to the employer. Unfortunately, the employer does not stand to gain from this legislation either. As your letter implies, the emphasis is on containing your costs. Will that really be accomplished? Neither of the two actuarial studies performed showed any significant cost savings, and during a teleconference held in Anchorage, an unidentified insurance representative stated that there would be no cost savings. This could actually increase costs due to litigation, and therefore increased premiums.

Let us finally consider the insurance industry, and I include the self-insureds. In my opinion, these are the ones who stand to gain the most. In 1945, the United States legislature passed the McCarran-Ferguson Act, which gave the insurance industry legal ability to monopolize. This has made it difficult if not impossible for state regulatory agencies (ie-Division of Insurance) to obtain accurate information by which to base rates. Therefore, insurance consumers (you and I) are forced to pay rates that are determined by a what-the-market-can-bear attitude. In this proposed legislation, fines for late payments to injured workers can even be avoided by simply providing custodial reports on time (which are already required by law). And the self-insureds are no better. Because of their status, they can avoid some of the laws that apply to the insurance companies, while also avoiding payment of the premium tax which insurance companies are required to pay. That means they enjoy the benefits of the Workers' Compensation system while providing absolutely no support for it.

Mr. Taylor, I have to admit that I empathize with you. I also pay Worker's Compensation premiums for my employees. It is the law. But what is so frustrating is to be forced to buy insurance and having absolutely no input as to its cost. I agree that there needs to be changes to the current law, but not necessarily the ones proposed. We have been led to believe that the "insurance crunch" is our own fault and that we need to do something about it, but I really think this is the smoke from another fire. Nowhere in this bill does it say anything about mandating a premium reduction. If insurance coverage is to be required by law, maybe they should be regulated similar to the public utilities. It is your responsibility (and mine) to demand justification for these outrageous premiums, and not just "costs are going up". Insurance companies are getting rich thanks to you and me, and we should have some input into the

process (other than paying into it). I simply do not think the injured worker should be left holding the bag. I hope you will take a second look at the proposed legislation with a more objective eye. I am not opposed to it because it will affect my practice. The impact will be minimal. I am opposed to it because it is arbitrary, it is restrictive to the injured worker, and because it is wrong.

Respectfully,

David J. Mulholland, D.C.
Community Chiropractic Clinic, Inc.

cc: Governor Steve Cowper
Dr. Trevor Ireland, D.C.
Dr. Charles Krichbaum
Alaska State Legislature, et al

Chiropractors' Recommendations for changes to the original WCCA Bill

SECTION A.S. 23.30.095(a):

(1) DELETE underlined passage beginning page 12, line 7 through line 11, starting with "The employee".

RATIONALE: This passage is objectionable for several reasons:

(a) because there is an insufficient definition of "attending physician";

(b) because there is an insufficient definition of "specialist";

(c) because there is no indication of when a physician becomes an "attending" physician as opposed to an examining or consulting physician; and,

(d) because there is no real indication of how a choice of a different specialty is treated. For instance, if employee's attending physician is a GP and he has a broken leg and decides that a orthopedist would be better able to treat him, does that decision count as a change? Or, the employee has a lower back injury, choses to try an osteopath or a chiropractor instead of his GP, does that decision count as a change when he is not merely changing from one doctor to another but is actually seeking a different type of treatment?

If the passage must remain in, here is a suggested change:

The employee may not make more than one change <u>of attending physician within the employee's attending physician's discipline or speciality</u> without the written consent of the employer.

We would suggest that A.S. 23.30.265 be amended to include the following definitions.

> An attending physician is the physician of the patient's choice responsible for the provisions of primary health care.
>
> A specialist is a physician to whom the patient is referred by the attending physician for the provision of secondary care and/or consultation.

(2) Keep language that will be deleted (bracketed langauge on page 12, line 11 through line 13). There does not appear to be any justification for taking away the boards authority to make exceptions to this rule in the appropriate cases.

(3) Amend the language in the next sentence, page 12, line 13, starting "Upon procuring" to read:

> Upon procuring the services of an <u>attending</u> physician, etc.

<u>SECTION A.S. 23.30.095(c)</u>:

(1) DELETE the added language (underlined and appearing on page 13, line 2 through line 13).

RATIONALE: This passage is ill considered:

(a) because there is no definition of what is considered "continuing and multiple treatments" and health care providers must necessarily guess;

(b) because there is no designation of who will approve the plan and what standards will be employed and upon what facts or basis the review will rest;

(c) because the process of review will occur simultaneously with the provision of treatment and, according to the current language, the health care provider must bear the financial risk of disapproval;

(d) because there are no provisions for amendment of the plan should the need arise; and,

(e) because the provision imposes maximum limits arbitrarily.

Generally, it appears to us that these provisions will probably result in an increase in litigation and resulting costs rather that a decrease since so much is left unstated.

If the reason for this amendment is to guard against unreasonable or unnecessary treatment, there are already regulations in place and the employer can, with most health care professions, submit perceived abuses to the appropriate peer review committees.

If the reason for this provision is, as some of our members strongly suspect, an indirect attack on Chiropractic, it is not in fact cost effective and is, to say the least, discriminatory.

SECTION A.S. 23.30.95(e):

(1) Proposed amendment deleting requirement that examining physician be authorized to practice is inappropriate and suspect. Therefore, bracketed section on page 13, line 18 through line 19, should be RETAINED.

How is either the Board or the employee able to rely upon the competence of a report or examination if there is no requirement that the physician doing the examining be appropriately licensed? Does the legislature really intend to require that the employee must submit to an examination by someone who may not be capable of meeting license requirements?

(2) The creation of a presumption of reasonableness of requiring examinations every 30 days appears to be irrational. It seems obvious that the added language could easily be used by the employer to harass an employee in cases where either (1) the condition is stable enough that monthly examinations are unnecessary, and/or the examination technique used is painful and the likelihood of substantial changes in condition would not, in the absence of an adversary relationship, be normally considered justified. In addition, should the employee not be able to work at his/her old job, a requirement for monthly examinations by the former employer's doctor may well interfere with the ability of the employee to secure other employment.

(3) Although there are fairly draconian provisions within this section for employee non-cooperation, there are no provisions for (i) advance (reasonable) notice requirement by the employer; or, (ii) a means by which the employee can contest the necessity and/or reasonableness of the monthly examinations prior to their imposition.

SECTION A.S. 23.30.95(f):

DELETE (UNDERLINED) changes.

AMEND LANGUAGE

RATIONALE: The present section, prior to amendment, limited fees charged for medical treatment and services to charges that generally prevailed in the community. (See bracketed section, page 14, lines 18 through 19). The new section (underlined, page 14, line 20 through line 22) adds to the Board's responsibility the necessity to determine whether or not the charge, which may well be customary in the community, is reasonable (underlined).

That being true, the phrase that the Board may regulate fees and charges contained within this section would become a reality since the Board would have authority under this section to override free market considerations, including local economics and the effects of local competition and declare that charges that were in fact usual and customary but, in the Board's opinion, unreasonable.

The proposed change is actually unnecessary since normal free enterprise processes supply reasonableness of price through market place competition.

The purposes behind this section are two-fold. First, the legislature is rightly concerned over the incurring costs of workmens' compensation insurance to employers. Second, paying inappropriately high charges to a physician will encourage bias that inevitably leads to increased litigation. Assuming that these provisions are laudatory, the measure only goes half way in treating the problems. The other half of the costs associated with workmens' compensation cases arises from the physician retained by the employers to examine the employeess. The costs associated with those physicians contribute to the burgeoning costs of insurance in the same manner as those of the employer's physician. Additionally, the issues of bias for over compensated physicians are not confined to either side.

Finally, the present language limits comparison to an obviously vague and confusing standard of "treatment of injured persons of "like standard of being". That portion should have the confusing language removed. Therefore, we suggest that the language of A.S. 23.30.095(f) be as follows:

> All fees and charges for treatment, service or examinations by physicians for either party should be limited to charges that prevail in the same community for similar treatment, services or examination of injured persons and shall be subject to regulation by the Board.

SECTION A.S. 23.30.95(j):

DELETE changes. AMEND CURRENT LANGUAGE.

The most offensive of the added language is contained on page 14, lines 25 through 26, which allows for an out-of-state organization to advise the Board on the appropriateness and necessity for and costs of medical treatment of Alaskan workmen by Alaskan physicians. A host of questions arise by this wording. If an out-of-state organization is appointed, how well qualified are they to judge these issues? Could they pass the relevant Alaska boards? Are they in fact licensed physicians/health care providers? Are they anything more than claim adjusters? How is an out-of-state organization going to determine appropriateness of treatment without recourse to examining the patient or taking additional xrays or additional studies? Why is an out-of-state organization needed when there are peer review committees set up within the various disciplines for these purposes now?

Regarding costs, once again, how is an out-of-state organization going to determine appropriate levels of costs? If for instance, the person making the determination on appropriateness of costs lives in and is familiar with medical costs in some small town in Illinois, will that familiarity influence the advice he gives to the Board on treatment rendered in Alaska where the cost of everything is higher?

Based upon the recommendations that are made to the Board, the Board will be determining whether an employer should pay a bill for services that have already been rendered. Because it has the power to approve of the withholding of payment, the employee and the local physician in Alaska rendering treatment to him is at a distinct disadvantage in challenging the advice of an out-of-state organization.

If the advice is unsound, but because of economics, remains unchallenged, the Board's decision will eventually begin to influence the manner in which Alaskan physicians treat injured workmen since their choices will essentially be to either adopt an approved (but unsound) procedure or to refuse to treat the injured workman. Additionally, injured employees may not seek appropriate treatment since they might end up having to pay for it themselves, which will either add to the term of the injury or begin to increase costs of employee medical insurance plans.

We suggest the following language REPLACE Section (j):

> The board may appoint a medical services review board consisting of physicians licensed in the state and employer and employee representatives to assist and advise the Board in matters involving the costs of health care services. The medical services advisory board shall conduct anonymous surveys biannually to determine usual and customary costs of treatment and procedures, and in the case of unusual situations, may conduct special surveys to determine usual and customary costs for treatment of procedures not normally encountered. If the Board shall determine that a physician or health care provider has inappropriately or unnecessarily provided treatment, or has habitually and substantially exceeded the usual and customary charges in the community in which treatment was rendered, the committee shall refer the matter to the peer review committee of the health care provider's discipline and advise the Board to disapprove the charges in question.

SECTION A.S.23.30.095(k):

(1) AMEND proposed language.

RATIONALE: The clear import of this section is to provide the Board with an independent source to turn to when a dispute arises between the parties' experts. Unfortunately, the proposed section as it's presently worded does not go far enough to insure the independence of the source. Additionally, it fails to guard against "apples and oranges" comparisons that so often create or increase litigation before the Board. Finally, the proposed section creates an inappropriately limited standard of review which is inconsistent with current diagnostic techniques.

First, in order to insure the independence of the review, the selection of a physician or health care provider should be from a rotating list so that there can be no question as to impartiality in the selection process.

Second, both parties should have the right to object to one selection within a reasonable time period so that questions of bias may be minimized.

Third, the lists that are resorted to by the Board should be kept by discipline and specialty and the selection made should conform to the discipline or specialty of the health care provider of the employee. Otherwise, there is every likelihood that the Board will become embroiled in jurisdictional disputes between disciplines and specialties that will provide no meaningful comparison.

Fourth, limiting the standard required to overcome the presumption to objective evidence deselects critical subjective findings that often times form the backbone of a valid diagnosis.

Fifth, although shielding the independent physician from liability for ordinary negligence is a good idea, making his liability dependent upon proving fraud goes too far. As a result, it is our feeling that the limits of liability should extend to fraud's cousin, misrepresentation, and to gross negligence in order to ensure an appropriate level of reliability in the findings of the independent physicians.

We would suggest the following language be substituted for the proposed language:

> In the event of a dispute regarding determinations of causation, stability, degree of impairment, functional capacity, the amount and efficacy of the continuance of or necessity of treatment, or compensability between the employee's attending physician and the employer's medical evaluation, an independent medical evaluation shall be conducted by a physician or physicians of the same discipline and specialty of the employee's attending physician.
>
> Such physicians shall be licensed in the State of Alaska or the state that treatment was rendered and selected from a list established with the aid and advice of the medical advisory board, and maintained by the Board. Both the employee and employer shall have the right to challenge one

appointment. In the event of a challenge, the next physician on the list will be appointed. The contents of the list and the order of its contents shall be kept confidential by the Board. The report of the independent medical examiner shall be furnished to the Board and both parties within 14 days after the examination is concluded. The opinion of the independent medical examiner shall, in the absence of clear and convincing evidence to the contrary, be presumed to be correct. A person may not seek damages from an independent medical examiner caused by the rendering of an opinion or providing testimony under this subsection, except in the case of fraud, misrepresentation or gross negligence.

SECTION A.S. 23.30.155(c):

DELETE Added language.

RATIONALE: As will be explained more fully when Subsection (m) is discussed, the exception being grafted onto this section is, in essence, gutting the penalty provisions by allowing an employer to escape the penalties by simply performing once a year ministerial acts that have nothing to do with the merits of a particular controversion, or for that matter, to do with a habitual practice of unjustifiably controverting employee claims. As a result, it is our suggestion that the amenditory language be deleted.

SECTION A.S. 23.30.155(m):

DELETE changes.

RATIONALE: This section as it is proposed, essentially vacates the penalty provisions in subsection (c) by allowing an employer to avoid penalties for failure to timely notify the employee and the board of changes it unilaterally makes to the employee's compensation, or whether or not the employer intends to controvert at all. In essence this provision allows, on a sliding scale, an employer to escape substantial penalties if it performs the ministerial acts that, under the present and proposed statute, it must perform.

For the employee who is caught within the exception's parameters, however, there is little relief. If the filing requirements did not incorporate notifications to the employee and were, in fact, only ministerial, there might be

some justification for the proposal, although it is not readily apparent even in that situation. However, the reports do require notification to the employee and, in the absence of receiving timely reports, the employee may well make decisions that he might not should he receive a timely notification that the employer was either going to controvert, suspend or terminate his compensation. In essence then, the employer is, according to this section, allowed to escape penalties for failing to comply with the employee notification provisions in Subsection (c).

SECTIONS A.S. 23.30.185, A.S. 23.30.200:

DELETE proposed language unless the term medical stability is changed as noted below.

RATIONALE: Obviously, the employers and their carriers are seeking to place a limit upon TTD and TPD payments. However, they are basing the proposed limit upon an unrealistic and unfair standard, "medical stability". As will be demonstrated below, the definition for the term "medical stability" is suspect.

SECTION A.S. 23.30.265 (34):

AMEND proposed language.

RATIONALE: According to the proposed language, an employee's medical condition is "stable" after the date that no further objectively measurable improvement is reasonably expected to result from additional medical care or treatment. This definition has several flaws.

The section is used in conjunction with two other sections, AS 23.30.185 and AS 23.30.200 which deal with payments for temporary disability records to those sections, payments will be cut off once medical stability is reached. Therefore, for both parties the definition of medical stability becomes paramount. However, under AS 23.30.265(34) the definition is highly suspect. According to the proposed language, medical stability is measured solely upon the question of whether further care or treatments will result in improvement and specifically disallows consideration of improvement generated by the natural healing process of time. Therefore, it is

easily conceivable that an injured employee who is temporarily disabled and unable to be gainfully employed, and who will get better over time, would lose his temporary benefits because the health care providers could not provide treatment or care that would improve upon the natural healing process. In essence, the injured employee would be penalized because of the impotence of current science to help him.

Second, once again the standards for making the determination based solely upon objective findings when modern diagnostic techniques use a combination of objective and subjective techniques. As a result, the employee and all of the physicians coming into contact with him are artificially limited to decision making that bears no relationship to how medical decisions are normally made.

SECTION ENTITLED LEGISLATIVE INTENT, SUBSECTION (b):

AMEND proposed language.

RATIONALE: In decreeing that the Board has increased powers, there must be some authority for decision making concerning his medical treatment left to the injured employee. Therefore, there should be some provision contained within the statute that it is not the legislature's intent that the employee's right to chose who his health care provider will be will not be restricted unreasonably.

We suggest that the following language be added to subsection (b):

> With the exception of the provisions contained in A.S. 23.30.095(a), nothing contained within this section shall empower either the board or any party to interfer with or infringe upon the employee's right to select the type of health care and the person to provide it for the treatment of his injuries. Any employer or its representative that violates this section is guilty of practicing discrimation against the employee and subject to the provisions of A.S. 23.30.247.

Miscellaneous: I didn't have a chance yet to gratf in some changes that will try to limit what the employer/insurance carriers pay for their expert. I also need to go through the IME language dealing with the experts hired directly by the employers to perform examinations and try to exclude references to that process as an IME since the employer's experts are no more "independent" than the employee's experts. I'll try to complete those tasks by tomorrow.

I didn't do a cheat sheet yet but will be prepared to verbally discuss the manner in which the testimony will be presented at our meeting and, if it is felt that a sheet would be helpful, I'll prepare and deliver one to you.

PLD

Insured Against Full Competition

SUMMARY: Premiums for personal and commercial insurance coverage have increased at double-digit rates for a number of years. Now comes a sustained effort by a large coalition of bankers and consumers to strip the industry of the monopolistic control handed to it by a 1945 act of Congress. Pending in Congress is a bill that would subject insurers to the same antitrust laws that govern other businesses.

Millions of Americans are acquainted with the practices. The insurance agent says premiums have risen again, then refuses to sell personal umbrella coverage unless the customer buys a package of insurance that includes a homeowners policy and insurance covering all the family cars. Some agents even insist on auto liability coverage far above that of established state minimums. It does little good to go to another agent. Insurance agents legally can collude, deny insurance coverage and charge identical prices without fear of antitrust prosecution that could lead to jail terms. Besides all that, their commissions are identical.

Elsewhere, among uncounted commercial enterprises ranging in size from a local candy store to a nuclear power plant operator, among professionals such as doctors and among political subdivisions of all sizes, liability insurance premiums rise so high that businessmen flee their trades and professionals abandon their practices. Among communities that are unable to afford or are denied insurance, a public swimming pool is closed, athletic events are canceled and policemen are not hired out of fear of uninsured liability.

There is nothing new about the high price of casualty insurance and refusals of coverage. Premiums for both personal and commercial coverage have rocketed at double-digit rates for a number of years. In 1986, for example, the net premiums of property and casualty insurance companies rose to $176.5 billion, up 22.4 percent from the $144.1 billion of 1985, according to the Insurance Information Institute. An increase of similar magnitude occurred the year before.

What is new about the insurance crisis, a term used by critics as well as insurance spokesmen, is a sustained effort by a large and unusual coalition that includes the American Bankers Association and the Consumers Union of the United States, to strip the insurance industry of legal monopoly power handed to it in 1945 with passage of the McCarran-Ferguson Act. The act exempts the insurance industry from prosecution under antitrust law, which forbids such practices as price-fixing, raising prices in concert and denying coverage.

In a real sense, the act was passed as a favor. Before its passage, the states were the exclusive regulators of insurance, chiefly because insurance was not considered commerce. But in 1944, the Supreme Court ruled that insurance was in fact commerce. That meant it could be regulated by Congress as well as the states, which in turn meant the industry was subject to antitrust law. Congress saw the decision as threatening the traditional power of the states to regulate insurance and feared that the uniform pricing permitted by states would bump up against the strictures of the Sherman Antitrust Act. An insurance company obeying a state order could be found guilty of antitrust violation, went the reasoning. The result was McCarran-Ferguson.

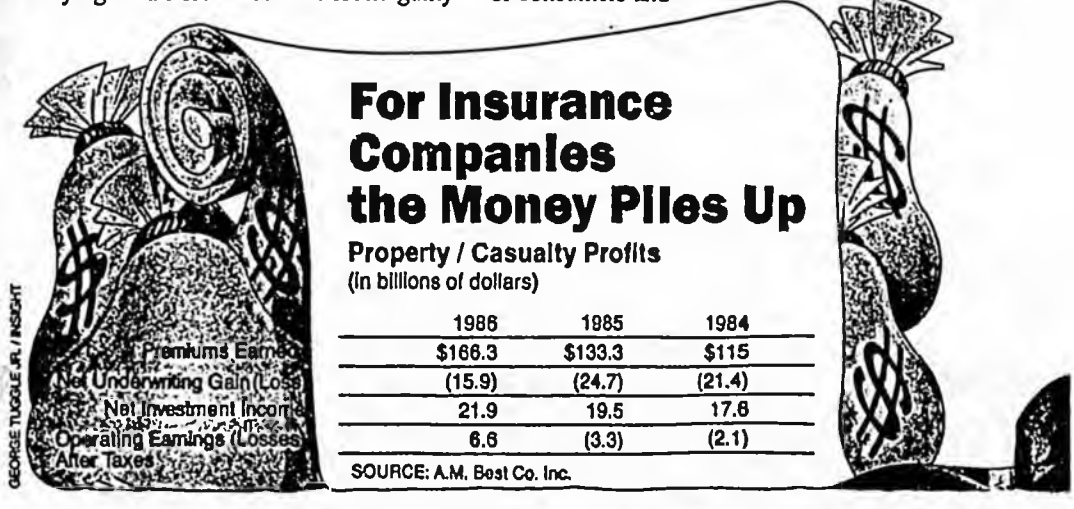
SHEPARD SHERBELL / PICTURE GROUP

Edwards: The industry fixes rates.

Today, however, critics say that the act's purpose has been subverted. Where a state plays no role in pricing, as in California (where State Farm Mutual Automobile Insurance Co. and Allstate Insurance Co. exchange rating data), the McCarran-Ferguson Act, "intended to protect state regulation from antitrust laws," protects "the unregulated from those laws," says John K. Van de Kamp, California's attorney general.

After a number of attempts during the last decade or more, attempts easily held off by the insurance industry, McCarran-Ferguson has come under serious and lasting attack. One of the attacks is led by Rep. Don Edwards, a member of the Judiciary Subcommittee on Monopolies and Commercial Law. The California Democrat wants to repeal the exemption with his proposed Fairness in Insurance Act of 1987, leaving the states to regulate insurance and thus subjecting insurance companies to antitrust law. Currently, a mere cameo appearance by a state insurance official confers immunity on decisions that would be deemed anticompetitive in other industries. Nor is there any appeal possible, since the shield of antitrust immunity prevents customers of insurance companies from going to court for relief.

Edwards says his bill, which wound its way through a series of subcommittee hearings last year, "would restore the application of the federal antitrust laws." He says, "The insurance industry can legally fix prices, allocate markets, limit or deny certain types of coverages at will and engage in a host of other activities that would be criminal offenses for other businesses. The time has come for Congress to heed the call of consumers and



GEORGE TUGGLE JR. / INSIGHT

For Insurance Companies the Money Piles Up

Property / Casualty Profits
(in billions of dollars)

	1986	1985	1984
Premiums Earned	$166.3	$133.3	$115
Net Underwriting Gain (Loss)	(15.9)	(24.7)	(21.4)
Net Investment Income	21.9	19.5	17.6
Operating Earnings (Losses) After Taxes	6.6	(3.3)	(2.1)

SOURCE: A.M. Best Co. Inc.

the states to repeal this $400 billion industry's antitrust exemption."

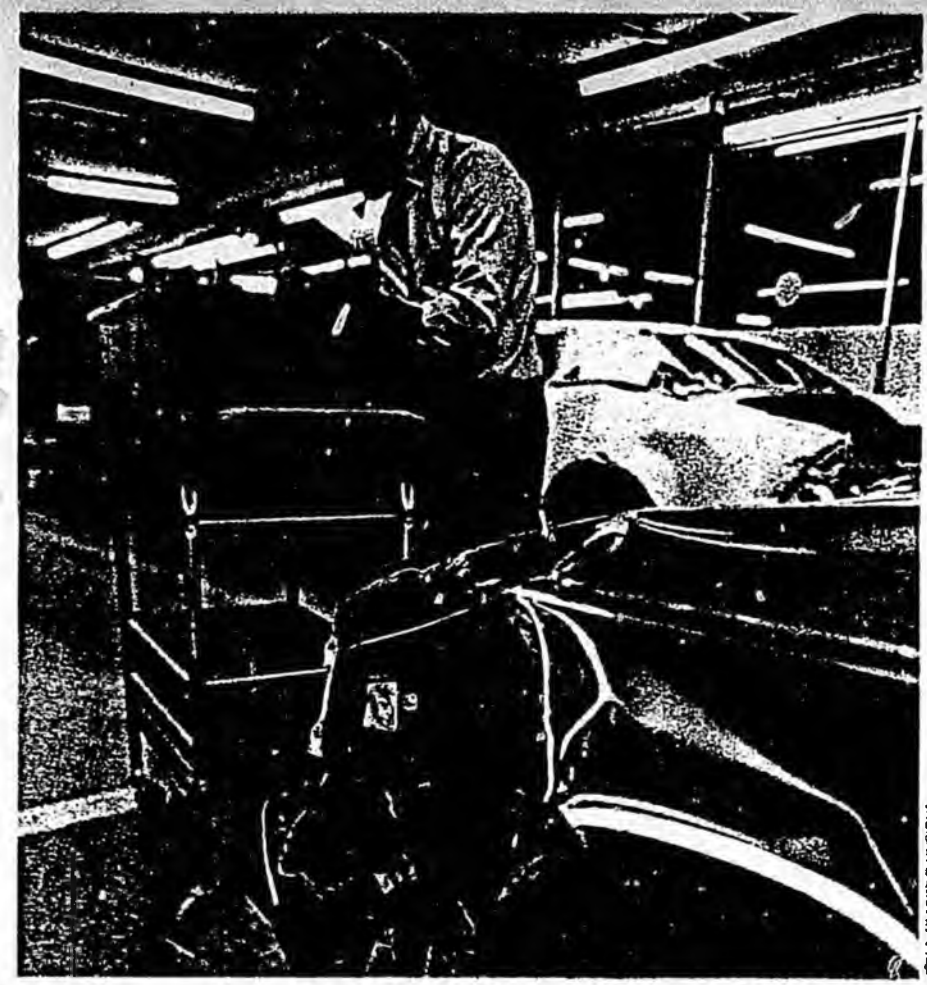
On the floor of the House, Edwards charged, "The insurance industry does legally engage in price-fixing. Tying arrangements — tying coverage in unprofitable lines to a required purchase of coverage in a profitable line — are legally used. Coverage is limited or denied at will. Customers and territories are divided up with impunity and rates openly shared among competitors."

Within the industry and among its watchdogs, Edwards's bill and a similar one introduced in the Senate by Ohio Democrat Howard M. Metzenbaum have energized a debate over an issue that has been raised before without much success, even as other major financial service industries lost antitrust exemptions and were thrust kicking and screaming into a competitive world. Just a few years ago commercial banking was deregulated (and now wants permission to sell casualty insurance).

In 1975, the New York Stock Exchange reluctantly gave up the right to fix brokers' commissions. The fierce price competition that followed spawned an industry of discount brokers. During President Ford's tenure, some administration members concluded that price competition in the insurance industry would be beneficial to consumers, and a national commission suggested to President Carter that broad antitrust immunity for the insurance industry should be repealed.

Repeal this time around is still uncertain, though Edwards believes his bill "has a very good chance of passage." His proposal has attracted supporters with clout that for the first time may match the legendary political clout of the insurance industry. Rep. Peter W. Rodino Jr., for example, a New Jersey Democrat and chairman of the Judiciary Committee, weighed in with supporting words when Edwards introduced his bill last year.

In New Jersey, where personal and commercial insurance premiums are among the highest, and both no-fault and tort (fault) systems apply in auto accident liability, hundreds of thousands of the state's 4 million automobiles are uninsured, despite state law requiring coverage. Among the reasons is high cost. At the same time, the owners of 2 million autos, rejected by the industry for a mixed bag of reasons, buy



JON A. HILDEBRAND / INSIGHT

Appraiser inspects damaged car; some rates are far above state minimums.

especially expensive insurance from a Joint Underwriting Association composed of reluctant insurance companies and forced into being by the Legislature. The association is underfunded by $1 billion, and the state is levying a surcharge on auto owners who do buy insurance to bridge the $1 billion gap. Conceivably, with repeal of McCarran-Ferguson, both the insurance companies and the state could be targets of lawsuits by insurance buyers.

The Edwards bill also has attracted the support of the National Association of State Legislatures and the National Association of State Attorneys General. The Justice Department, though opposing exemptions generally, is unsure about supporting repeal, says Kenneth G. Starling, deputy assistant attorney general of antitrust. Repeal may benefit consumers, he says, but he worries over tearing away an antitrust shield "that's grown up intertwined with a lot of state regulation."

Among the states, the National Association of Insurance Commissioners opposes repeal, but opposition is not unanimous. In New Jersey, Commissioner Kenneth D. Merin says, "We don't oppose repeal, but we feel that it doesn't approach the problems of affordability and availability that have surfaced in the past few years." In California, Michael J. Strumwasser, special assistant attorney general, says the state "strongly supports repeal. The act . . . is an accident of history, adopted when people didn't understand the relationship between antitrust and business. This is an industry beset by excessive cooperation, with lemminglike behavior which can be tracked to a culture of collusion."

California's insurance commissioner, in fact, recently prohibited the Insurance Services Office, the industry-owned ratemaking body, "from promulgating final rates," though the state will permit distribution of data used in the organization's ratemaking computations. "We think there will be a diversity in price," says Strumwasser. Most of the organization's critics say it uses operational costs of the most inefficient companies as a base for arriving at its "advisory" prices. This soaks up 40 to 50 cents of every premium dollar formulated. The advisory prices also include estimates of inflation, litigiousness, fees of the industry's defense lawyers, general expense, profit and contingencies.

Within the Reagan administration, Federal Trade Commission Chairman Daniel Oliver, an opponent of "trade restraints" of all kinds, has attacked the reasoning that leads to creating any legal monopoly: a trade-off permitting monopolistic behavior in exchange for some sort of redeeming social benefit. In a speech last year before the Reinsurance Association of America, whose members insure insurers' risks, Oli-

"When insurance companies report an underwriting loss in a particular year, that does not mean that they actually paid out more than they took in."

BRAD CRISE / INSIGHT

Hunter, a critic of insurance practices, with complaints from upset consumers

ver said lawsuits charging "anticompetitive activities lacking any redeeming social benefit" have been "dismissed on McCarran-Ferguson grounds alone."

Among other voices supporting repeal is that of Robert Hunter, president of the National Insurance Consumer Organization. Hunter has been an opponent of casualty insurance management practices at least since the 1970s and explains the high premiums of insurance companies partly in terms of boom-and-bust cycles.

In one part of the cycle, he says, insurance companies compete recklessly against each other with severe price-cutting to build market share. During bull markets in stocks or during periods of double-digit interest rates, investing the premiums of customers generates returns great enough to overcome the effects of price-cutting.

"But when market breaks come," says Hunter, "one or two companies will lead the others back to inflated [Insurance Services Office] rates. When that happens you see the remarkable increases you've seen in the last few years." Hunter says that more than $63 billion in increases have been levied against insurance company customers. "They blame the higher premiums on the legal system, but the total cost of the legal system is $30 billion a year. So it's something more than that." Hunter adds that those companies that did, in fact, gain market share during the period of price-cutting several years ago, "are reaping bushels of money today."

He also questions the honesty of the financial reporting of the industry, which distributes a confusing array of revenue, earnings and other operating data that does not adhere to common accounting practices found in other industries' corporate reports. "When insurance companies report an underwriting loss in a particular year," he says, "that does not mean that they actually paid out more than they took in. It means that they estimate they will eventually pay out more than they took in that year." But after all claims against policies issued in a given year are resolved, he says, "even when there's an underwriting loss, the companies almost always take in much more than they pay out."

In addition, Hunter questions reports of profits. Last year, for example, he disputed the industry's report of $11.5 billion in net profits for 1986, an all-time high, saying they were much higher. "The industry's true profits," he says, "were $23.4 billion. One reason is accounting that recorded $2.2 billion of dividends paid to policyholders as losses. Nor did the industry include $4.5 billion in unrealized capital gains. The industry also "took a current loss for the full amount reserved to pay future claims," says Hunter. If reserves had been reduced by the investment income they were likely to earn until they were used to pay claims, "insurers' gains would have been another $5.2 billion higher."

Hunter also accuses the industry of not paying taxes. Citing the General Accounting Office, he says property and casualty insurance companies paid no federal income tax for the years 1975 through 1984, despite net gains of $75.2 billion. The reason is dual accounting. In one ledger, an insurance company invests and earns interest on premiums kept aside for claims, say for as long as eight years, a length of time associated with malpractice payments. In another ledger, says Hunter, the company deducts the entire amount for tax purposes in the first year it is received.

A fact sheet distributed by Hunter's organization says that six of the largest U.S. insurance companies (Allstate Insurance Co., Fireman's Fund Corp., Hartford Fire Insurance Co., Crum and Forster Inc., Home Beneficial Corp. and CNA Financial Corp.) paid no federal income taxes for the years 1980 through 1984, despite net gains of more than $5.2 billion after underwriting losses of $8.3 billion and investment gains of $13.5 billion.

Efforts to repeal the McCarran-Ferguson Act have not gone unanswered, of course. The Coalition of State Regulation of Insurance, whose 18 members include the most powerful industry associations, alliances and institutes, has reacted with detailed and lengthy arguments. The coalition says that the McCarran-Ferguson Act places responsibility for regulation of the insurance industry primarily in the hands of the states. That was true before enactment, it is true now and would still be true if repeal occurred, the group argues.

The coalition also says it has only limited exemption, since McCarran-Ferguson forbids boycotts, coercion and intimidation. The industry also worries over a lack of data relative to losses and underwriting not being distributed among all companies, thus crippling small companies without the resources to do in-depth research.

Supporters of repeal say that all companies will still have access to industry-wide loss data. Repeal will inhibit price-fixing, and only inefficient companies will be at a disadvantage. To the argument of the coalition members that repeal will prevent the formation of pools to insure large or specialized risk, the response is that lawful joint ventures can be formed for the tasks. Nor will big companies necessarily get bigger, as the coalition suggests. "If this were true," says Hunter, "big companies would be working to repeal the antitrust exemption."

— Christopher Elias

THE CHIROPRACTIC REPORT

An international review of professional and research issues, published bimonthly.

Editor: David Chapman-Smith, Toronto January 1988 Vol. 2 No. 2

Professional notes:

Medicine Deserts Bedrest

The times they are a'changin. It was always going to happen, but medicine is now moving sharply towards the chiropractic model of management of back pain. There are two important recent reviews of which you should be aware.

The Biopsychosocial Model

'A New Clinical Model for the Treatment of Low Back Pain' Waddell G, Spine (1987) 12(7):632-644. **PN 1**

This article will be highly influential within medicine. It is by Gordon Waddell, a well-published British orthopaedic surgeon from the Western Infirmary, Glasgow. It won the prestigious 1987 Volvo Award in Clinical Sciences, and is thus accepted in medicine as a foremost international spinal research contribution for 1987.

On considerable clinical and research evidence Waddell says:

a) "The main theme of management must change from rest to rehabilitation and restoration of function".

b) There is "a fundamental antithesis between the passive and active approaches" to treatment of back pain.

c) "There is no evidence that rest has any beneficial effect on the natural history of low back pain. On the contrary, there is strongly suggestive evidence that rest, particularly prolonged bed-rest,

continued on insert page 1.

Cost Effectiveness of Chiropractic – the evidence

A. Introduction

1. In a paper entitled 'Health Economics and Chiropractic'[1] Professor John Dillon, a prominent Australian economist, studies modern health care economics and concludes:

- "Undoubtedly, in terms of economic appraisal of the current health scene ... chiropractic is in a very strong position. Compared to medical services, it is an extremely cheap avenue of health care for those who seek it. Unlike primary medical practice, it does not spiral costs into the system through ancillary and specialist services, hospitalization and pharmaceutics. On average, a dollar spent on a chiropractor's services causes no further costs".
- "... until very recently and unlike medical services ... chiropractic has stood the market test of exhibiting a growing demand for services without the inducement of price subsidies, health insurance coverage and tax deductibility. ... Far more, therefore, than the demand for medical services, the demand for chiropractic services reflects an expressed need in the community".
- "... in terms of meeting the not insignificant need felt by many members of the community to have an occasional friendly chat with a professional practitioner about their health, chiropractic beats medicine hands down".

2. In terms of cost-effectiveness a chiropractor can best be compared with a dentist. Both see the patient directly, and generally provide all necessary diagnosis and treatment themselves.

The essentials of chiropractic practice are the same worldwide. Treatment is conservative without the cost of drugs or surgery. Principal treatment approach is joint adjustment, comprising a wide range of specific manipulative techniques, with adjunctive use of remedial exercises, nutritional therapy and advice, soft tissue and pressure techniques, traction and electrotherapy. These are self-contained inexpensive approaches to care.

3. Recent government inquiries in Australia (1986)[2] and Sweden (1987)[3] have found chiropractic treatment effective and cost-effective, and recommended increased government funding for chiropractic services.

This report looks at the evidence of cost-effectiveness, emphasizing acute and chronic back pain including workers' compensation figures, neck pain/migraine/headache, and prevention.

Most talk of cost-effectiveness is at the community level – costs to insurance companies, WCBs, government and society. A final section looks at chiropractic cost-effectiveness from the patient's point of view.

B. Back Pain

4. Surveys of chiropractic practice in a number of countries confirm that approximately 90% of chiropractic patients have headache, neck and back pain as chief presenting complaints - 50-60% have acute or chronic back pain.[4,5]

5. In the western world 80% of the population will experience disabling low-back pain during their lives. At any given time 6.8% of the adult U.S. population is experiencing a bout of back pain that has been continuing for more than two weeks.[6]

30% of WCB claims by injured workers are for back pain (more than twice the percentage of any other complaint) and, because of the acknowledged poor medical management of this complaint and the huge cost of chronic cases, these 30% of claims generate 60% of total WCB compensation costs.[7]

6. In 1985 U.S. workers compensation boards disbursed $6 billion for low-back pain.[8] The estimated total annual cost of back pain in the U.K. in 1982 was £1,000 million.[9]

7. No one knows the true cost and, as the manager of a large U.S. insurance association has confessed, "the insurance industry should be and is being criticized for an obvious lack of statistical data on the costs of back related injuries. What we have, however, is scary".[10]

8. The high cost of medical management of low-back pain is a major subject in the scientific literature in recent years, which reveals:

a) Surgery and chemonucleolysis have been subject to high failure rates and unacceptable costs, and are now used rarely, with under 1% of patients.[11]

b) Bedrest, which promotes 'illness behaviour' and huge compensation costs has now been proven ineffective. It has been a general medical first response to back pain. It is being outspokenly rejected by leaders in medicine – most notably in recent months by

Gordon Waddell, in work which won the 1987 Volvo Prize for spinal clinical research.[11] (See professional notes).

c) The basic approach to treatment now recommended is on a chiropractic model – early active treatment to restore spinal function and prevent onset of illness behaviour.

C. Acute Back Pain

9. Research from chiropractic[12 13] and medicine[14 15] reports a greater than a 90% success rate with skilled specific spinal manipulation for treatment of acute back pain. There is such broad acceptance of effectiveness with acute pain that the major research effort has been directed at chronic back pain.

10. A prominent finding of great importance with respect to cost is the speed of relief. This has been confirmed by recent research in both England[16] and the United States[17]. In the U.S.study, from the University of North Carolina:

a) There were 54 patients with acute low-back pain, one group with duration of pain under two weeks, the other with pain from 2-4 weeks.

b) The purpose of the study was to compare two active forms of manual therapy – mobilization ("use of insufficient force to move the facet joints" – i.e. moving the vertebra more slowly through a lesser range of movement as commonly practised by physiotherapists) with spinal manipulation (by a medical physician, but using the controlled low-amplitude high-velocity thrust basic to chiropractic practice - the physician claimed his technique was the "one used by chiropractors").

c) Outcome was monitored by questionnaire immediately after treatment and every three days for two weeks.

d) "The vast majority" of patients in both treatment groups "improved dramatically" over the two weeks follow-up period.

However, the group that had suffered acute back pain for slightly longer – the patients with pain for 2-4 weeks – did much better with manipulation than mobilization. Speed of response was commented on particularly. The advantage of manipulation "was most striking midway through the first week" and was statistically significant.

11. Accordingly chiropractic spinal adjustive techniques are effective and, since they produce a generally quick response, are also cost-effective. This is both in terms of both direct costs (treatment) and indirect costs (compensation, lost production, lost opportunity).

D. Chronic Low-Back Pain

12. While there is no real debate concerning cost-effectiveness with acute pain, there has been concerning chiropractic treatment of chronic low-back pain. That is rapidly being laid to rest by recent research arising from the new era of cooperation between chiropractic and medicine.

13. Compelling evidence of effectiveness and cost-effectiveness comes from Kirkaldy-Willis, an orthopaedic surgeon, and Cassidy, a doctor of chiropractic, who have been researching chiropractic treatment of chronic low-back and leg pain for the past 10 years. Their striking results have been published in a number of prominent texts[18 19] and journals[20 21]. Consider the population of 171 patients examined by consulting chiropractors in a hospital setting and found to have posterior joint syndrome and/or sacroiliac joint syndrome:[20]

a) These were patients who had been *totally disabled* by chronic low-back pain ("constant severe pain") *for an average of 7.6 years*.

b) Over that period they had proved unresponsive to a wide variety of medical treatments. No details of cost are given – obviously direct and indirect costs will have been substantial.Patients were now being referred, or re-referred, to the hospital back pain clinic for further investigation with a view to initial or further surgery.

c) Following a "2-3 week regime of daily chiropractic manipulation", 87% returned *"to full function with no restrictions for work or other activities"*.

d) Importantly, that success rate was maintained at 12 months follow-up. Additionally, no patient was made worse.

Quite simply workers compensation and insurance fund managers should be swept off their feet by those figures from internationally respected researchers. They should be establishing studies in their own jurisdictions to see if they can repeat such startling success with such an intractable problem.

14. Interesting evidence is now emerging from the United States, as the health care system reacts to years of unacceptable cost increases and is producing new health care partnerships and delivery systems.

15. In a trial study[22] Silverman, a Florida chiropractor, was sent a consecutive series of 100 patients with persistent low-back or neck pain by AV-MED, a large South Florida health maintenance organization (HMO). Faced with fixed funding per patient, and prohibitive rates and costs of surgery, Dr. Herbert Davis, AV-MED's medical director, agreed to a study wherein the next 100 patients requiring hospital evaluation with a view to surgery would first be sent for chiropractic evaluation and, if appropriate, care. Comments are:

a) The patients had already been seen by 1.6 MDs on average.

b) 2% had already been hospitalized.

c) 12% had been confirmed medically as requiring surgery.

d) Chiropractic care consisted of spinal adjustment supplemented with physical therapy modalities, remedial exercise programs and advice.

e) Average number of visits per patient was 12.1, *average cost per patient $326.76*.

f) This was total cost – there were no referred costs for outside diagnostic investigations, other health care practitioners, or hospitalization.

g) No patient, including the 12 medically diagnosed as needing surgery, required surgery.

International Meetings

Cervical Spine and Upper Extremity
April 27-30, 1988
Nashville Tennessee
Contact:
ACA, Combined Council Forum
1701 Clarendon Blvd.
Arlington VA 22209
(703) 276-8800

Chiropractic USA
June 16-19, 1988
Las Vegas Nevada
Contact:
The American Chiropractor
P.O. Box 350
LEO Indiana 46765.
(219) 423-1432

International Chiropractic Congress
October 2-9, 1988
Sydney, Australia
Contact:
John Sweeney, D.C.,
Australian Chiropractors' Association
459 Great Western Highway,
Faulconbridge
N.S.W. 2776, Australia.

American Back Society: Spring Symposium
May 12-14, 1988
Orlando, Florida (Disney World)
Contact:
A.B.S.,
2647 East 14th Street, Suite #401,
Oakland, California, 94601
(415) 536-9929

Spinal Disorders 1988: Current Solutions
June 26 to July 1, 1988
Gothenburg, Sweden
Contact:
Alf L. Nachmeson, M.D.,
Department of Orthopaedics
Sahlgren Hospital
S-413 45 Gothenburg, Sweden.

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h) At six months follow-up 86% had used no further chiropratic or medical services.

i) AV-MED advised an average cost of neck/back surgery at the time as $20,000. *Accordingly AV-MED considers it saved approximately $225,000 (medical and surgical costs, less cost of chiropractic care) on the 12 confirmed surgical cases alone.*

Following the trial AV-MED established a corporate policy *requiring all patients to receive chiropractic assessment before referral to hospital for back and neck pain.*

16. Impartial clinical evidence of cost-effectiveness is emerging from U.S. hospitals now that many hospitals have chiropractors on staff.

In the recently decided Wilk Case Dr. Per Freitag, a Chicago orthopaedic surgeon, gave testimony comparing the progress of hospitalized back pain patients in the two hospitals at which he is a consultant, the John F. Kennedy Hospital in Chicago where patients receive combined chiropractic and medical management, and the Lutheran General Hospital in Park Ridge, which has no chiropractors on staff.

He reported that with chiropractic care at JFK the term of hospitalization of his orthopaedic patients was cut by half. "An average of .... six or seven days in hospital (at JFK). At Lutheran General Hospital the same type of orthopedic patients spend an average of 14 days".[23]

17. There are two points to be made here:

a) Hospital bed costs are reduced by 50%

b) Overall costs are reduced by far more because of the consevative low cost nature of chiropractic care. A number of costly examinations and surgeries will have been avoided by sending these patients first to conservative chiropractic care. (See Silverman (para 15 above), and Kirkaldy-Willis and Cassidy (para 13)).

18. In the United Kingdom Breen reported a survey of British chiropractic practice in 1977.[4] Data was obtained over a one year period. Specific information on cost was reported.

a) 1595 patients (53.4%) presented with low-back pain. One in two had chronic back pain (complaint for over 1 year), one in three had experienced back pain for over 5 years, and only one in four was seen within 3 months of onset of pain.

b) The 'average patient' from this group made a preliminary visit for examination and assessment including x-rays, and then 6 treatment visits – 7 visits total.

c) Costed on chiropractic fees at May 1976 (when survey results were analyzed) the total cost for chiropractic care per patient in this largely chronic sample was approximately £35.
On fees as at January 1988 the average cost is approximately £120.

d) These results are consistent with those reported in Canada by Kirkaldy-Willis and Cassidy (para 13 above).

Comparison figures from medicine are not available. However, this is evidently cost-effective management of acute and chronic low-back pain.

Workers Compensation Costs

19. WCB studies relate to both acute and chronic low-back pain. There is an injury, but this is often a re-injury or aggravation of an advancing degenerative problem. United States WCB studies have been performed in Florida (1960) Iowa (1969), Oregon (1971), California (1972) and Wisconsin (1978). All favour chiropractic, and suggest a 45-50% saving in health care costs for low-back pain when the treatment is chiropractic rather than medical.

20. Methodology used in the studies has varied. The most thorough study is that in Wisconsin in 1978[24] concerning which:

a) It was performed by an experienced researcher from the University of Wisconsin. The methodology is fully described, and demonstrably thorough.

b) The study deals with all injuries diagnosed as back strain or sprain under the Wisconsin WCB during 1977, and compares those treated by a chiropractor and those by a medical doctor. Thus fractures and other more serious cases treated by medicine which would have biased the study are excluded.

c) The average compensation periods for time off work were 13.2 days for chiropractic cases versus 21.8 days for medical cases – *40% saving in compensation costs.*

d) The average health care costs were $145.64 per chiropractic case, $267.68 per medical case - *a 46% saving.*

e) These results are consistent with the outcomes of the other studies mentioned, including the large California study done by Richard Wolf, MD, a specialist in occupational medicine.[25]

21. Given the staggering cost of low-back pain to WCBs – and thus employers, and thus all of us who buy their services and products - and this evidence, WCBs should be making far greater use of the chiropractic profession.

Failure to do so represents gross inefficiency. Sadly it also represents, as those who deal with WCBs know, the victory of medical politics over patient and employer interests.

C. Neck Pain/Migraine/Headache

22. The following case, an appeal to a Canadian WCB,[26] illustrates well the cost-effectiveness of chiropractic treatment for chronic neck pain:

a) Mr. C. suffered severe strain and sprain type neck injuries in a motor vehicle accident. He received medical care for seven months without improvement. This included consultations with a general practitioner, a specialist in physical medicine and two neurosurgeons, extensive use of medication, four months of intensive physiotherapy treatment, and use of a surgical collar.

His condition worsened throughout. Both neurosurgeons recommended neck surgery.

b) Mr. C. considered chiropractic treatment, but by letter

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**ADMITTED IN WASHINGTON D.C. AND ALASKA

ALL OTHERS ADMITTED IN ALASKA

March 17, 1988

Ms. Mary Pierce, Co-Chair
Joint Labor and Management Task Force
900 Brown Street
Anchorage, Alaska 99501

Mr. Robert Anders, Co-Chair
Joint Labor and Managment Task Force
3310 West 78th Avenue
Anchorage, Alaska 99501

RE: CSSB 322

Dear Ms. Pierce and Mr. Anders:

Thank you for your letter received DHL courier, 3/11/88. On behalf of the American Insurance Association, we appreciate that the Joint Labor and Management Task Force does not support mandatory rate reductions.

As you know the bill emerged from the House Labor and Commerce Committee with numerous amendments, including a mandatory rate decrease. Testimony regarding the amendments was limited to witnesses specifically invited by the committee. The House Labor and Commerce Committee substitute includes a 6% mandatory rate decrease, and a mandatory rate rebate. The acting director of the Division of Insurance testified regarding the disaster that such mandatory language had in the State of Maine, including a withdrawal of many insurers from the state and ultimately the reinstatement of adequate rates. The mandatory rate decrease and mandatory rate rebate is a "red flag" which will discourage new companies, from entering the Alaska market place, and reduce competition. There would likely be an increase in the assigned risk pool.

We agree with the Joint Labor and Management Task Force that the need for change in the workers' compensation system is

immediate. We reaffirm our support of legislation that will not only produce a more efficient system, but also ultimately result in cost savings for management. However, we unequivocally oppose mandatory rate decreases, or rate rebates, neither of which are actuarially supported by the Millman and Robertson report.

American Insurance Association companies writing compensation in Alaska, include Industrial Indemnity of Alaska, Alaska Pacific Assurance Company (ALPAC), Providence Washington of Alaska and Fireman's Fund, accounting for approximately 50% of the direct premiums written in the state. We plan on having representatives from the Alaska Insurance Industry present to testify at the House Judiciary Committee hearings. Representatives from the AIA member companies would be delighted to meet with the Joint Labor and Management Task Force to discuss passage of this much needed workers' compensation legislation.

Sincerely,

Thomas J. Slagle

TJS:kll/8.26
Enclosures
cc: Senator Tim Kelly ✓
Representative Dave Donley
Members of the House and Senate Labor & Commerce Committees
Paul Roller, Acting Director of the Division of Insurance
Jackie McClintock, Director of the Division of Workers' Compensation
Stephen Young - AIA
Gary Purdom - Industrial Indemnity
John Flemma - Providence Washington Ins. Co. of AK., Inc.
Dave Sever - Alaska Pacific Assurance Company

506 W. 6th Avenue #9
Anchorage, Alaska 99501
(907) 272-9312

Entertaining Alaskans since 1967

February 3, 1988

Senator Kelly:

I am enclosing a copy of a workman's comp. summary which I passed out at the legislative hearings on workman's compensation in November. At that time I told the committee that the crippling 36% rate we are now paying--which will be raised to 47% in April--will put my company out of business. One quick glance at my experience modification and loss ratio, which the insurance companies insist their rates are based on magnifies the injustice to my company.

The entire problem rests with the classification 9186, carnival or circus-traveling-all employees and drivers (emphasis added). This is simply unfair. All our employees do not experience the same risk exposure.

On May 6, 1987, after five years of trying to be heard, I was granted twenty minutes before the classification board, Don Koch attending. I asked for different classifications within my business. More specifically, the classifications 9180, which positively identifies ticket sellers and game attendants, and 9016, for my shop maintenance crew. The committee denied any change. We are currently appealing this decision through the Department of Commerce, Insurance Division.

In 1987 $165,640 was payroll relating to ride erection and operation, while $213,630 went to other areas of our operational payroll; yet our insurance premium was based on all payroll and calculated using the highest classification, 9186.

For comparison, may I add that 1987 workman's compensation insurance cost my company 255% more than public liability insurance.

Senator Kelly will you please review the appeal currently in the Department of Commerce, Insurance division on behalf of my company, 200 Alaska jobs, Three Alaska State Fairs, Fur Rendezvous and Chambers of Commerce throughout the state.

Respectfully:

Claire

Claire Morton

506 W. 6th Avenue #9
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Entertaining Alaskans since 1967

GOLDEN WHEEL AMUSEMENT WORKMAN'S COMPENSATION

SUMMARY 1981 TO DATE

FISCAL YEAR	GROSS PAYROLL	PREMIUM	CLAIMS	LOSS RATIO
81/82	$ 80,000.00	$ 19,128.00	$ - 0 -	- 0 -
82/83	100,000.00	22,386.00	- 0 -	- 0 -
83/84	176,893.00	35,251.00	582.82	1.7%
84/85	176,117.00	30,198.00	4,334.00	14.4%
85/86	215,000.00	57,173.00	154.25	0.3%
86/87	252,000.00	70,900.00	4,002.15	5.6%
87 to date	370,107.80	132,868.70	(est) 4,000.00	3.0%
Totals	$1,370,117.80	$367,904.70	$ 13,073.22	3.6%

Current Rate: 35.90

Experience Modification: 0.90

Claire Morton, Owner • Manager

R. CLARK DAVIS, D.C.
CHIROPRACTOR
320 BAWDEN, SUITE 306 KETCHIKAN, ALASKA 99901 - (907) 225-6815

February 19, 1988

Senator Kelly
Capitol Room 101
P.O.Box V
Juneau, Alaska 99811

RE: HB 352/ SB 322

Dear Senator Kelly:

I am writing in regard to the Workman's Compensation bill. In previous correspondence I have pointed out than an arbitrary limit on treatment under proposed Workman's Compensation regulation changes (e.g. 20 visits for the first sixty days and subsequent limits) is not practical for realistic patient care. Admittedly MOST patient treatment schedules fall within the above proposed limits but the most severely injured patients will have their essential treatment being interfered with by setting limits effectively in stone. This will result in patients that are making progress under the chiropractic treatment but faced with an arbitrary cut off of treatment benefits, by third party payors, to be steered toward LESS CONSERVATIVE treatments such as SURGERY and CHEMONUCLEOLYSIS, at times unnecessarily. To prematurely force an injured worker into the above alternatives with their record of HIGH FAILURE RATES an UNACCEPTABLE costs is unreasonable at best, and unpardonable in my estimation.

Recent government inquiries in Australia (1986)[1] and Sweden (1987)[2] have found chiropractic treatment effective and cost-effective, and recommended increased government funding for chiropractic services. This report looks at the evidence of cost-effectiveness, emphasizing acute and chronic back pain including workers' Compensation figures, neck pain/migraine/headache, and prevention.

Compelling evidence of effectiveness and cost-effectiveness comes from Kirklady-Willis, an orthopaedic surgeon, and Cassidy, a doctor of chiropractic, who have been researching chiropractic treatment of chronic low-back pain for the past 10 years. Their striking results have been published in a number of prominent texts [3,4] and journals.[5,6] This included a population of 171 patients examined by consulting chiropractors in a hospital setting and found to have posterior joint syndrome

and/or sacroiliac joint syndrome[5], totally disabled by low back pain, averaging 7.6 years.

In a trial study[7] Silverman, a Florida chiropractor, was sent a consecutive series of 100 patients with persistent low-back or neck pain by AV-MED, a large South Florida health maintenace organization (HMO). Faced with fixed funding per patient, and prohibitive rates and costs of surgery, Dr. Herbert Davis, AV-MED's medical director, agreed to a study wherein the next 100 patients requiring hospital evaluation with a view to surgery would first be sent for chiropractic evaluation and, if appropriate, care.

a) The patients had already been seen by 1.6 MD's on average.

b) 2% had already been hospitalized.

c) 12% had been confirmed medically as requiring surgery.

d) Chiropractic care consisted of spinal adjustment supplemented with physical therapy modalities, remedial exercise programs and advice.

e) Chiropractic treatment was shown to be very cost-effective.

f) There were no referred costs for outside diagnostic investigations, other health care practitioners, or hospitilization.

g) No patient, including the 12 medically diagnosed as needing surgery, required surgery.

In conclusion, chiropractic treatment, unlike medical practice, does NOT increase costs through the medical system through adjunctive and specialist services, hospitalization, and pharmaceutical supplies. "Usually a dollar spent on chiropractor services causes no further costs"[8]. This cost-effectiveness is both in terms of direct costs (treatment) and indirect costs (compensation, lost production, lost opportunity). An injured workers access to chiropractic treatment should not be restricted by an arbitrary treatment limit that does not take into account the most severly injured patients. These most seriously injured patients still often successfully avoid spinal surgery and other similarly invasive and very costly procedures. I recommend ammending HB 352/ SB 322 accordingly. If it is not ammended so, I strongly recommend a negative vote.

If you have any question feel free to call.

Sincerely,

R Clark Davis, D.C.

R. Clark Davis, D.C.

References

1 Second Report (June 1986), Medicare Benefits Review Committee, C.J. Thompson, Commonwealth Government Printer, Canberra, Australia, Chapt. 10.

2 "Legitimization for Vissa Kiropraktorer" (1987). Report of Commission on Alternative Medicine, Social Departementete, Stockholm, English Summary, SOU 1987:12.

3 Kirkaldy-Willis W H (1985), "Managing Low-Back Pain" Churchill Livingston, New York and London.

4 Cassidy J.D., Kirkaldy-Willis W H and McGregor M (1985), "Spinal Manipulation for the Treatment of Low Back and Leg Pain: An Observational Study" Chapt 9 in "Empirical Approaches to the Validation of Spinal Manipulation" ed. by Bucger A A and Greenman P E , Charles C. Thomas, Springfield, Illinois.

5 Kirkaldy-Willis W H and Cassidy J D (1985)"Spinal Manipulation in the Treatment of Low-Back Pain"Can Fam Phys 31:535-540.

6 "Team Effort Between MD and DC Produces Results at Canadian University", an interview (1984), ACA J Chiro 21(7):36-48.

7 Silverman M (1983), "Study of the First 100 Patients Referred to the Silverman Chiropractic Center by AV-MED", unpublished. Personal communication (1987).

8 Chapman-Smith (Aug 1988), "The Chiropractic Report",Vol.2,No.2, Toronto.

DR. R. CLARK DAVIS
CHIROPRACTOR
320 BAWDEN, SUITE 306 KETCHIKAN, ALASKA 99901 - (907) 225-681[illegible]

January 9, 1988

Senator Kelley
Capitol Room 101
P.O.Box V
Juneau, Alaska 99811

Dear Senator Kelly:

This letter is in follow-up to my phone call of 1-8-88. I feel that the Worker's Compensation bills: HB 352 (and SB 322) are not appropiate in their present form to be passed. Unfortunately the ad hoc business and labor force that developed the "Comp Bill" did not include health care providers who must live with the system.

I suggest that several amendments of the bill be made. A copy of the amendments are enclosed. Of prime importance are Sections A.S. 23.30.095(a), A.S. 23.30.095(c), A.S. 23.30.095(f), A.S. 23.30.095(j), A.S. 23.30.095(k), A.S. 23.30.265(34), and Section 1. "Legislative Intent" subsection(b) (p.1).

In reference to "Legislative Intent": subsection (b), I can personally attest to several attempts by insurance adjusters, either by ignorance, malfeasance, or perceived monetary considerations, have tried to intimidate or otherwise convince patients to see a surgeon rather than a chiropractor for neuro-musculo-skeletal injuries that were already favorably progressing with chiropractic treatment. Our enclosed suggestions would remedy this problem for all patients and allow freedom of choice of treatment.

Please read, consider, and actively support these enclosed reasonable suggestions. I recommend that they be implimented. If they are not implemented I strongly recommend a negative vote on HB 352 (and SB 322).

If you have any questions feel free to call.

Sincerely,

R Clark Davis, D.C.

R.Clark Davis, D.C.

enc: HB 352 Amendment recommendations

RCD/kk

WCCA BILL

SECTION A.S. 23.30.095(a):

(1) DELETE underlined passage beginning page 12, line 7 through line 11, starting with "The employee".

RATIONALE: This passage is objectionable for several reasons:

(a) because there is an insufficient definition of "attending physician";

(b) because there is an insufficient definition of "specialist";

(c) because there is no indication of when a physician becomes an "attending" physician as opposed to an examining or consulting physician; and,

(d) because there is no real indication of how a choice of a different specialty is treated. For instance, if employee's attending physician is a GP and he has a broken leg and decides that a orthopedist would be better able to treat him, does that decision count as a change? Or, the employee has a lower back injury, choses to try an osteopath or a chiropractor instead of his GP, does that decision count as a change when he is not merely changing from one doctor to another but is actually seeking a different type of treatment?

If the passage must remain in, here is a suggested change:

The employee may not make more than one change of attending physician within the employee's attending physician's specialty without the written consent of the employer.

(2) Keep language that will be deleted (bracketed langauge on page 12, line 11 through line 13). There does not appear to be any justification for taking away the boards authority to make exceptions to this rule in the appropriate cases.

(3) Amend the language in the next sentence, page 12, line 13, starting "Upon procuring" to read:

Upon procuring the services of an attending physician, etc.

(4) Add sentence to end of present section stating:

With the exception of the above, no party shall attempt to interfere with or restrict by any means the employee's right to select a physician of his or her choice.

SECTION A.S. 23.30.095(c):

(1) DELETE the added language (underlined and appearing on page 13, line 2 through line 13).

RATIONALE: This passage is ill considered:

(a) because there is no definition of what is considered "continuing and multiple treatments" and health care providers must necessarily guess;

(b) because there is no designation of who will approve the plan and what standards will be employed and upon what facts or basis the review will rest;

(c) because the process of review will occur simultaneously with the provision of treatment and, according to the current language, the health care provider must bear the financial risk of disapproval;

(d) because there are no provisions for amendment of the plan should the need arise; and,

(e) because the provision imposes maximum limits arbitrarily.

Generally, it appears to us that these provisions will probably result in an increase in litigation and resulting costs rather that a decrease since so much is left unstated.

If the reason for this amendment is to guard against unreasonable or unnecessary treatment, there are already regulations in place and the employer can, with most health care professions, submit perceived abuses to the appropriate peer review committees.

If the reason for this provision is, as some of our members strongly suspect, an indirect attack on Chiropractic, it is not in fact cost effective and is, to say the least, discriminatory.

SECTION A.S. 23.30.95(e):

(1) Proposed amendment deleting requirement that examining physician be authorized to practice is inappropriate and suspect. Therefore, bracketed section on page 13, line 18 through line 19, should be RETAINED.

How is either the Board or the employee able to rely upon the competence of a report or examination if there is no requirement that the physician doing the examining be appropriately licensed? Does the legislature really intend to require that the employee must submit to an examination by someone who may not be capable of meeting license requirements?

(2) The creation of a presumption of reasonableness of requiring examinations every 30 days appears to be irrational. It seems obvious that the added language could easily be used by the employer to harass an employee in cases where either (1) the condition is stable enough that monthly examinations are unnecessary, and/or the examination technique used is painful and the likelihood of substantial changes in condition would not, in the absence of an adversary relationship, be normally considered justified. In addition, should the employee not be able to work at his/her old job, a requirement for monthly examinations by the former employer's doctor may well interfere with the ability of the employee to secure other employment.

(3) Although there are fairly draconian provisions within this section for employee non-cooperation, there are no provisions for (i) advance (reasonable) notice requirement by the employer; or, (ii) a means by which the employee can contest the necessity and/or reasonableness of the monthly examinations prior to their imposition.

SECTION A.S. 23.30.95(f):

DELETE (UNDERLINED) changes.

RATIONALE: The present section, prior to amendment, limited fees charged for medical treatment and services to charges that generally prevailed in the community. (See bracketed section, page 14, lines 18 through 19). The new section (underlined, page 14, line 20 through line 22) adds to the Board's responsibility the necessity to determine whether or not the charge, which may well be customary in the community, is reasonable (underlined).

That being true, the phrase that the Board may regulate fees and charges contained within this section would become a reality since the Board would have authority under this section to override free market considerations, including local economics and the effects of local competition and declare that charges that were in fact usual and customary but, in the Board's opinion, unreasonable.

The proposed change is actually unnecessary since normal free enterprise processes supply reasonableness of price through market place competition.

95(j)?) SECTION A.S. 23.30.99(j):

DELETE changes. AMEND CURRENT LANGUAGE.

The most offensive of the added language is contained on page 14, lines 25 through 26, which allows for an out-of-state organization to advise the Board on the appropriateness and necessity for and costs of medical treatment of Alaskan workmen by Alaskan physicians. A host of questions arise by this wording. If an out-of-state organization is appointed, how well qualified are they to judge these issues? Could they pass the relevant Alaska boards? Are they in fact licensed physicians/health care providers? Are they anything more than claim adjusters? How is an out-of-state organization going to determine appropriateness of treatment without recourse to examining the patient or taking additional xrays or additional studies? Why is an out-of-state organization needed when there are peer review committees set up within the various disciplines for these purposes now?

Regarding costs, once again, how is an out-of-state organization going to determine appropriate levels of costs? If for instance, the person making the determination on appropriateness of costs lives in and is familiar with medical costs in some small town in Illinois, will that familiarity influence the advice he gives to the Board on treatment rendered in Alaska where the cost of everything is higher?

Based upon the recommendations that are made to the Board, the Board will be determining whether an employer should pay a bill for services that have already been rendered. Because it has the power to approve of the withholding of payment, the employee and the local physician in Alaska rendering treatment to him is at a distinct disadvantage in challenging the advice of an out-of-state organization.

If the advice is unsound, but because of economics, remains unchallenged, the Board's decision will eventually begin to influence the manner in which Alaskan physicians treat injured workmen since their choices will essentially be to either adopt an approved (but unsound) procedure or to refuse to treat the injured workman. Additionally, injured employees may not seek appropriate treatment since they might end up having to pay for it themselves, which will either add to the term of the injury or begin to increase costs of employee medical insurance plans.

We suggest the following language REPLACE Section (j):

> The board may appoint a medical services review board consisting of physicians licensed in the state and employer and employee representatives to assist and advise the Board in matters involving the costs of health care services. The medical services advisory board shall conduct anonymous surveys biannually to determine usual and customary costs of treatment and procedures, and in the case of unusual situations, may conduct special surveys to determine usual and customary costs for treatment of procedures not normally encountered. If the Board shall determine that a physician or health care provider has inappropriately or unnecessarily provided treatment, or has habitually and substantially exceeded the usual and customary charges in the community in which treatment was rendered, the committee shall refer the matter to the peer review committee of the health care provider's discipline and advise the Board to disapprove the charges in question.

SECTION A.S.23.30.095(k):

(1) AMEND proposed language.

RATIONALE: The clear import of this section is to provide the Board with an independent source to turn to when a dispute arises between the party's experts. Unfortunately, the proposed section as it's presently worded does not go far enough to insure the independence of the source. Additionally, it fails to guard against apples and oranges comparisons that so often create or increase litigation before the Board. Finally, the proposed section creates an inappropriate limited standard of review which is inconsistent with current diagnostic techniques.

First, in order to insure the independence of the review, the selection of a physician or health care provider should be from a rotating list so that there can be no question as to impartiality in the selection process.

Second, both parties should have the right to object to one selection within a reasonable time period so that questions of bias may be minimized.

Third, the lists that are resorted to by the Board should be kept by discipline and specialty and the selection made should conform to the discipline or specialty of the health care provider of the employee. Otherwise, there is every likelihood that the Board will become embroiled in jurisdictional disputes between disciplines and specialties that will provide no meaningful comparison.

Fourth, limiting the standard required to overcome the presumption to objective evidence deselects critical subjective findings that often times form the backbone of a valid diagnosis.

We would suggest the following language be substituted for the proposed language:

> In the event of a medical dispute regarding determinations of causation, medical stability, degree of impairment, functional capacity, the amount and efficacy of the continuance of or necessity of treatment, or compensability between the employee's attending physician and the employer's medical evaluation, an independent medical evaluation shall be conducted by a physician or physicians of the same

physicians licensed in the State of Alaska or the state that treatment was rendered from a list established by, with the aid and advice of the medical advisory board, and maintained by the Board. Both the employee and employer shall have the right to challenge one appointment. In the event of a challenge, the next physician on the list will be appointed. The contents of the list and the order of its contents shall be kept confidential by the Board. The report of the independent medical examiner shall be furnished to the Board and both parties within 14 days after the examination is concluded. The opinion of the independent medical examiner shall, in the absence of clear and convincing evidence to the contrary, be presumed to be correct. A person may not seek damages from an independent medical examiner caused by the rendering of an opinion or providing testimony under this subsection, except in the case of fraud, misrepresentation or gross negligence.

SECTION A.S. 23.30.155(c):

DELETE Added language.

RATIONALE: As will be explained more fully when Subsection (m) is discussed, the exception being grafted onto this section is, in essence, gutting the penalty provisions by allowing an employer to escape the penalties by simply performing once a year ministerial acts that have nothing to do with the merits of a particular controversion, or for that matter, to do with a habitual practice of unjustifiably controverting employee claims. As a result, it is our suggestion that the amenditory language be deleted.

SECTION A.S. 23.30.155(m):

DELETE changes.

RATIONALE: This section as it is proposed, essentially vacates the penalty provisions in subsection (c) by allowing an employer to avoid penalties for failure to timely notify the employee and the board of changes it unilaterally makes to the employee's compensation, or whether or not the employer intends to controvert at all. In essence this provision allows, on a sliding scale, an employer to escape substantial penalties if it performs the ministerial acts that, under the present and proposed statute, it must perform.

For the employee who is caught within the exception's parameters, however, there is little relief. If the filing requirements did not incorporate notifications to the employee and were, in fact, only ministerial, there might be some justification for the proposal, although it is not readily apparent even in that situation. However, the reports do require notification to the employee and, in the absence of receiving timely reports, the employee may well make decisions that he might not should he receive a timely notification that the employer was either going to controvert, suspend or terminate his compensation. In essence then, the employer is, according to this section, allowed to escape penalties for failing to comply with the employee notification provisions in Subsection (c).

SECTIONS A.S. 23.30.185, A.S. 23.30.200:

DELETE proposed language unless the term medical stability is changed as noted below.

RATIONALE: Obviously, the employers and their carriers are seeking to place a limit upon TTD and TPD payments. However, they are basing the proposed limit upon an unrealistic and unfair standard, "medical stability". As will be demonstrated below, the definition for the term "medical stability" is suspect.

SECTION A.S. 23.30.265 (34):

p 24

AMEND proposed language.

RATIONALE: According to the proposed language, an employee's medical condition is "stable" after the date that no further objectively measurable improvement is reasonably expected to result from additional medical care or treatment. This definition has several flaws.

First, hinging a definition of medical stability on whether or not the patient will improve disregards situations where continued treatment is necessary to prevent a diminishment of medical status, or to prolong the patient's medical status.

Second, once again the standards for masking the determination are based solely upon objective findings when modern diagnostic techniques used a combination of objective and subjective techniques. As a result, the employee and all of the physicians coming into contact with him are artificially limited to decision making that bears no relationship to how medical decisions are normally made.

SECTION ENTITLED LEGISLATIVE INTENT, SUBSECTION (b):

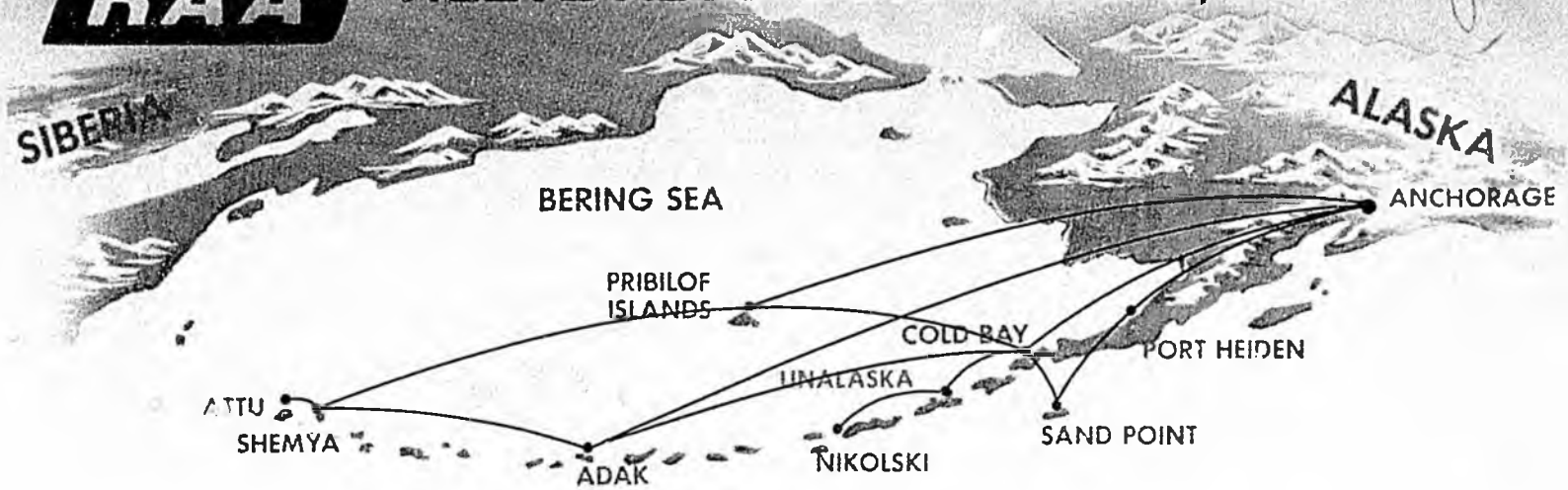
AMEND proposed language.

RATIONALE: In decreeing that the Board has increased powers, there must be some authority for decision making concerning his medical treatment left to the injured employee. Therefore, there should be some provision contained within the statute that it is not the legislature's intent that the employee's right to chose who his health care provider will be will not be restricted unreasonably.

We suggest that the following language be added to subsection (b):

> With the exception of the provisions contained in A.S. 23.30.095(a), nothing contained within this section shall empower either the board or any party to interfer with or infringe upon the employee's right to select the type of health care and the person to provide it for the treatment of his injuries. Any employer or its representative that violates this section is guilty of practicing discrimation against the employee and subject to the provisions of A.S. 23.30.247.

RAA REEVE ALEUTIAN AIRWAYS, INC.



February 5, 1988

The Honorable Tim Kelley
Alaska State Senate
P.O. Box V
Juneau, AK 99811

Dear Senator Kelly:

Senate Bill 322, having to do with reform of the present Workers' Compensation laws, is a very important bill to all Alaskan employers. The premiums paid by Reeve have increased 100% in the past several years. But despite this there has been no increase in the benefits available to employees. SB 322 will help reduce the amount we employers currently pay for compensation coverage, but will not reduce the benefits to injured employees.

I urge you to vote in favor of this legislation.

Sincerely,

David A. Jensen

David A. Jensen
Vice President, Administration

4700 W. INTERNATIONAL AIRPORT RD. • ANCHORAGE, ALASKA 99502-1091

PROPOSED TASK FORCE CHANGES TO THE WORKERS' COMPENSATION PROGRAM

The major proposed changes to the Workers' Compensation program outlined below are to be divided into five categories:

1. Vocational Rehabilitation Services
2. Medical
3. Compensation
4. Benefits
5. Other

Any changes enacted by the legislature in 1988 would not take effect until **July 1, 1988.** Injuries, claims and settlements occurring before July 1, 1988 will not be affected.

Vocational Rehabilitation Services. Major proposed changes include:

- changing rehabilitative services from a mandatory to a voluntary program;
- limit vocational rehabilitation services to workers whose injury prevents them from performing their job;
- limit vocational rehabilitation programs to two years;
- cap rehabilitation plan costs to a maximum of $10,000.

Medical.

- proposed changes would allow an injured worker to change their doctor only once, thus eliminating "doctor shopping";
- limit treatments to no more than 20 visits within 60 days;
- allow for an independent medical examiner (IME) to evaluate workers with extended periods of injury.

Compensation.

- lower the maximum benefit from $1,100 to $700 a week;
- raise the minimum benefit from $110 to $154.

Benefits.

- changes the degree of disability to be based upon the American Medical Association guidelines;
- limit Temporary Total Disability payments to two years;
- limit Temporary Partial Disability payments to such time as the injured worker is deemed to have reached medical stability.

Other.

- changes would require the worker who claims mental injury to prove it resulted from extraordinary and unusual stress;
- prohibit employers from discriminating against employees who have filed a claim or received workers' compensation benefits.

Scheduled Workers' Compensation Hearing and Teleconferences*

Date	City	Time	Place
Jan. 19	Juneau	3:30 pm	Capitol Bldg. Beltz Room
Jan. 20	Juneau	3:30 pm	Capitol Bldg. Beltz Room
Jan. 29	Anchorage	9am-4pm	3111 "C" St. First Floor
Feb. 12	Anchorage	9am-4pm	3111 "C" St. First Floor

*Fairbanks, Mat-Su, Kenai, Southeast and other Teleconference sites.

TO CONTACT YOUR LEGISLATOR:

During Session address all legislator and committee mail to:

Your Legislator
P.O. Box V
Juneau, AK 99811

The Senate Labor and Commerce Committee will kickoff Senate hearings on proposed changes to workers' compensation legislation on Tuesday, January 19 in Juneau. From left, Sen. Bette Fahrenkamp, Sen. Dick Ellason, Sen Tim Kelly, Chair, and Sen. Mike Syzmanski (not pictured: Sen. Rick Uehling)

KLUKWAN FOREST PRODUCTS, INC.

P.O. Box 34659 · Juneau, Alaska 99803-4659 · 907-789-7104 · Fax: 907-789-0675

9

February 12, 1988

The Honorable
Mr. Kelly
Chairman & Senator
Department of Labor & Commerce
Alaska State Legislature
P.O. Box V
Juneau, Alaska 99811

Dear Mr. Kelly

Enclosed is a copy of Klukwan Inc.'s position on SB 322. We at Klukwan Forest Product's (a wholly owned subsidiary of Klukwan, Inc.) do endorse the position taken. We would appreciate your support in passage of SB 322 in its original form.

Sincerely,

William A. Thomas, Jr.
Lobbyist

WAT:skw

CLUB
PARIS

9

February 15, 1988

Dear Senator Kelly:

I wish to add my support to the enactment into law SB222 and HB352 which addresses the problem of increasing rates in the Workman's Compensation program. It is my opinion that this legislation will be a start to curb the abuses that are now present in the current system.

I would like to solicit your support for the passage of this legislation.

Very truly yours,

Charles H. Selman

Charles H. Selman

417 WEST 5TH AVENUE, ANCHORAGE, ALASKA 99501

ANCHORAGE
SCHOOL DISTRICT

4600 DeBarr Avenue
P.O. Box 196614
Anchorage, Alaska 99519-6614
AREA CODE [907] 333-9561

February 1, 1988

The Honorable Tim Kelly
Alaska State Legislature
P. O. Box V (MS 3100)
Juneau, Alaska 99811

Dear Senator Kelly:

The Anchorage School District employs over 5,000 people. Since 1979, we have self-insured our Workers' Compensation claims. While our annual outlay for claims and expenses has steadily increased, in the last three years alone, our outlay has jumped from $880,000 to $1,500,000.

As a self-insurer, we have detailed knowledge of many abuses of and inequities in the Alaska Workers' Compensation system due to ambiguities in the language of the Act and the absence of clear definitions of legislative intent, benefit durations, and compensable conditions.

Upon close scrutiny of the specific reforms proposed in Senate Bill 322 and House Bill 352, we are convinced that prompt enactment of the legislation, as written, will have a very favorable impact on employer costs in the future. In addition, this legislation will go a long way to correct the inequitable treatment of injured workers which arises under the present system by improperly enriching some claimants while under-compensating others.

The proposed legislation is a fair compromise which has been carefully worked out over the past year by a joint task force representing both employers and organized labor. It is responsive to the needs of the two partners in any Workers' Compensation system, the injured worker and the employer.

On behalf of the Anchorage School District and all its employees, I urge you to support this legislation without amendments and assist in its speedy passage.

Sincerely,

William Coats
Superintendent

wd
cc Bill Miles, School District Lobbyist

February 4, 1988

LABOR OF COMMERCE COMMITTEE
Senate
Room 101
P. O. Box "Y"
Juneau, Alaska 99811

Dear Senator Kelly:

The purpose of this letter is to express my unqualified support for the passing of Senate Bill 322/House Bill 352.

It is extremely important with the unpalatable condition of the economy that action be taken to improve our Workmen's Compensation System.

I urge you to proceed without delay on the passing of this essential legislation.

Sincerely,

D. T. Dorsey
6135 Eastwood Court
Anchorage, Alaska 99504

DTD/pml

GENERAL CONTRACTORS 6041 MACKAY ANCHORAGE, ALASKA 99518 (907) 563-3021 (ANCHORAGE)
(907) 262-5558 (SOLDOTNA)

HAP

enterprises inc

DEALERS FOR
VARCO-PRUDEN BUILDINGS
A Unit of AMCA International Corporation

9

JANUARY 26, 1988

STATE SENATE
P.O. BOX V
ROOM 101
JUNEAU, AK 99811

ATTN: TIM KELLY

RE : SENATE BILL #322

Gentlemen:

GLOOM & DOOM is the topic of conversation these days and we can attest to that.

There is an important bill that if left in-tact will be beneficial to all employers in the State. We ask that you support that important piece of Workman's Compensation legislation.

Sincerely,

H A Bing Prichard /rjc

H.A. BING PRICHARD
HAP ENTERPRISES, INC.

HAP/rjc

CC: WCCA
Lynn Phillips
2204 Cleveland Ave.
Anchorage, AK 99517

February 5, 1988

Senator Tim Kelley, Chairman
Senate Labor and Commerce Committee
Alaska State Legislature
P.O. Box V (M.S. 3100)
Juneau, Ak. 99811

Dear Senator Kelley:

Re: S.B. 322

I strongly support the recommendations of the Management/ Labor ADHOC Committee for Workers' Compensation Reform.

I encourage you and your fellow senators to pass S.B. 322.

Sincerely,

Pepper Smith

ALASKA BUSINESS INSURANCE INCORPORATED

January 27, 1988

Senator Tim Kelly
Alaska State Legislature, Room 101
P.O. Box V (MS3100)
Juneau, AK 99811

Re: Senate Bill 322

Dear Senator Kelly:

We have had the opportunity to review Senate Bill 322 and we believe that this bill should be passed as proposed with minimal interference from the Legislature.

We have attended many of the meetings that preceded the writing of this bill and we know that careful consideration was given to the interests of all concerned parties. The bill, as written, is a compromise to labor, management and the insurance industry. The impact of the bill has been researched and discussed for over a year and any attempt by the legislature to rewrite it for special interests will be counterproductive and will jeopardize the compromises that have already been made.

We believe that this bill will reduce insurance costs thereby making Alaska Labor more competitive. This will result in keeping more people in the State employed and slow down the procurement of goods and services from outside.

Sincerely,

Phillip J. Bressen, Pres.

James W. Campbell, V.P.

Wayne A. Burger, V.P.

1400 Benson Blvd., Suite 410 Anchorage, Alaska 99503
Phone: (907) 272-1825
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6041 Mackay Street • Anchorage, Alaska 99518

Phone: (907) 562-2260 • FAX: (907) 563-0644

9

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STATE SENATE
P.O. BOX V
ROOM 101
JUNEAU, AK 99811

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RE : SENATE BILL #322

Gentlemen:

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There is an important bill that if left in-tact will be beneficial to all employers in the State. We ask that you support that important piece of Workman's Compensation legislation.

Sincerely,

Merrill K. Clark/rjc

MERRILL K. CLARK
DALTA DOOR SALES

MKC/rjc

CC: WCCA
Lynn Phillips
2204 Cleveland Ave.
Anchorage, AK 99517

MR. AND MRS. JOHN MARION
3800 STELLER DRIVE
ANCHORAGE, ALASKA 99517

8,

February 9, 1988

Senator Tim Kelley, Chairman
Senate Labor and Commerce Committee
Alaska State Legislature
P.O. Box V (M.S. 3100)
Juneau, Ak. 99811

Dear Senator Kelley:

Re: S.B. 322

Reduced to simplest terms, passage of S.B. 322 would benefit Alaska.

With labor and management in general agreement on the fairness of the suggested legislation, some negative aspects of current legislation would be removed.

One factor that capital/business cranks into its decision making process before entering a new market is the reasonableness of prevailing workers' compensation laws. Some states have been hurt by overly generous legislation. For example, when the decision to invest was close, new business was slow to move into the state and some businesses moved out because of prohibitive penalties. Illinois and Florida are examples of two states that, a few years back, suffered.

Alaska, for several reasons, could use an infusion of new capital. Lets not risk a negative decision when it is within our power to remove one glaring obstacle.

Sincerely,

John Marion

John Marion
Retired

9

HOFFMAN CONSTRUCTION COMPANY
OF ALASKA

February 4, 1988

Alaska Senate Labor and Commerce Committee
Juneau, Alaska 99881

RE: Testimony in Favor of Workers Compensation Reform Legislation

Dear Chairman Kelly and Committee Members:

Hoffman congratulates the Labor/Management Task Force for their tireless effort over the past year in negotiating and writing House Bill #352.

One of the questions on the Senate Committees' Workers' Compensation Reform Survey is "How much have your rates increased since 1985?" Hoffman's experience is that our rates ballooned by 50% during the same period that we set a State record for General Contractors by working 484,000 hours without a Lost Time Accident at the Eklutna Water Project. Also, during this period, Hoffman and Subcontractors worked 113,000 hours at the Chugiak High School project accident free and we earned the 2nd Safety Recognition Award ever given by the Alaska Army Corps of Engineers for working 60,000 hours accident free at our Elmendorf Air Freight Terminal project.

If having the worst ever Workmans' Compensation rates at the same time as record-setting safety performance, is ironic for Hoffman, it is a disaster for Alaska. We remain in the midst of an anemic economy where both Public and Private development and construction dollars must be stretched as far as possible. Since Contractors have no alternative but to pass these costs along to consumers, too many dollars intended for construction projects actually get spent underwriting this bloated Workers' Compensation system.

The Labor/Management Task Force has done a good job of identifying and developing solutions for the most glaring problems such as:

a. streamlining vocational rehabilitation services.
b. reducing the maximum weekly compensation benefit, thereby, promoting a recuperating worker's desire to return to work.
c. indexing weekly benefits to the lower cost of living in other states thereby reducing the dollars Alaska pumps into these states when a claimant convalesces Outside.
d. structuring a medical fee scale.

3201 "C" STREET SUITE 610 ANCHORAGE, ALASKA 99503 907•561•5578

Hoffman Construction encourages this Committee to introduce and expedite passage of this bill as soon as possible to rollback premimus in the latter half of 1988.

Thank you.

Very truly yours,

E. N. Newman
President

ENN:mg
cc: J. D. Hutchison

February 5, 1988

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Alaska State Senate
P.O. Box V
Juneau, AK 99811

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Sincerely,

David A. Jensen
Vice President, Administration

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KLUKWAN FOREST PRODUCTS, INC.

P.O. Box 34659 · Juneau, Alaska 99803-4659 · 907-789-7104 · Fax: 907-789-0675

February 12, 1988

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Alaska State Legislature
P.O. Box V
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Dear Mr. Kelly

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Lobbyist

WAT:skw

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HAP

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DEALERS FOR
VARCO-PRUDEN BUILDINGS
A Unit of AMCA International Corporation

JANUARY 26, 1988

STATE SENATE
P.O. BOX V
ROOM 101
JUNEAU, AK 99811

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DALTA DOOR SALES

MKC/rjc

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Lynn Phillips
2204 Cleveland Ave.
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February 9, 1988

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Alaska State Legislature
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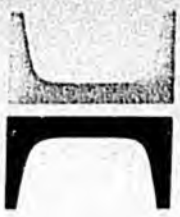
Sincerely,

John Marion

John Marion
Retired

9



HOFFMAN CONSTRUCTION COMPANY
OF ALASKA

February 4, 1988

Alaska Senate Labor and Commerce Committee
Juneau, Alaska 99881

RE: Testimony in Favor of Workers Compensation Reform Legislation

Dear Chairman Kelly and Committee Members:

Hoffman congratulates the Labor/Management Task Force for their tireless effort over the past year in negotiating and writing House Bill #352.

One of the questions on the Senate Committees' Workers' Compensation Reform Survey is "How much have your rates increased since 1985?" Hoffman's experience is that our rates ballooned by 50% during the same period that we set a State record for General Contractors by working 484,000 hours without a Lost Time Accident at the Eklutna Water Project. Also, during this period, Hoffman and Subcontractors worked 113,000 hours at the Chugiak High School project accident free and we earned the 2nd Safety Recognition Award ever given by the Alaska Army Corps of Engineers for working 60,000 hours accident free at our Elmendorf Air Freight Terminal project.

If having the worst ever Workmans' Compensation rates at the same time as record-setting safety performance, is ironic for Hoffman, it is a disaster for Alaska. We remain in the midst of an anemic economy where both Public and Private development and construction dollars must be stretched as far as possible. Since Contractors have no alternative but to pass these costs along to consumers, too many dollars intended for construction projects actually get spent underwriting this bloated Workers' Compensation system.

The Labor/Management Task Force has done a good job of identifying and developing solutions for the most glaring problems such as:

a. streamlining vocational rehabilitation services.
b. reducing the maximum weekly compensation benefit, thereby, promoting a recuperating worker's desire to return to work.
c. indexing weekly benefits to the lower cost of living in other states thereby reducing the dollars Alaska pumps into these states when a claimant convalesces Outside.
d. structuring a medical fee scale.

3201 "C" STREET SUITE 610 ANCHORAGE, ALASKA 99503 907•561•5578

Hoffman Construction encourages this Committee to introduce and expedite passage of this bill as soon as possible to rollback premimus in the latter half of 1988.

Thank you.

Very truly yours,

E. N. Newman
President

ENN:mg
cc: J. D. Hutchison

February 5, 1988

Dear Sen. Kelly:

I would ask for your support of HB 352 on the grounds that it is quite possibly the most progressive workers compensation legislation in the country. It attempts to solve many of the welfare dependency problems created with the current law, it will take better care of the more injured worker, it will require doctors and chiropractors to charge reasonable fees, it will increase minimum benefits for those receiving temporary total disability benefits, it removes the adversarial relationship between rehabilitators and workers by only allowing those who can and want to benefit from rehabilitation to be eligible for it, it takes us out of the syndrome where each side masses their own set of biased doctors on each side of a claim in favor of a streamlined system that affords the board the opportunity to use qualified specialists to settle medical disputes, it discourages doctor shopping, it will provide the community with the information to know who the effective rehabilitators really are, it requires that doctors and chiropractors who provide continuous multiple treatments to show a need for such treatment, it makes it unlawful for employers to discriminate against workers who previously received workers compensation benefits, in cases of disputes between inusrance carriers the injured worker still gets paid his or her entitled benefits, it sets minimum standards for individuals providing rehabilitation services, it sets a reasonable standard for stress claims, it reduces benefits to individuals who move out of state to areas where the cost of living is less, it reduces the amount of litigation in the system and streamlines decision making by the board, and if that is not enough, it saves money.

I have been very disappointed that those in opposition to the bill who are taking injured workers and further victimizing them by distorting the facts of the legislation and convincing them that they will be hurt by the bill. The truth is that this bill takes much better care of those truly in need. The only way we could afford to do this though was to reduce permanent partial benefits to those with minor injuries. In total though, we expect very little overall changes in benefit levels paid by employers. The real savings come in the medical, rehabilitation, and legal costs to the system.

Please support this reform package, it, I am sure, is the only jobs bill the legislature can pass that will in fact save the state money rather than cost it money.

Thank you.

Sincerely,

David Gottstein
2621 Kelsan Circle
Anchorage, Ak 99508

Senator Johne Binkley

Senate Finance Committee
P.O. Box V • Juneau, Alaska 99811 • (907) 465-4985

Finance Committee
Co-Chairman

February 12, 1988

The Honorable Tim Kelly
Chairman, Labor & Commerce Committee
Alaska State Senate
P. O. Box V
Juneau, AK 99811

Dear Tim:

Attached please find a letter I received from Chancey Croft on the worker's compensation bill. I am sure you have received the same letter. I am curious as to the accuracy of his assertions. Can you or your staff shed some light on them for me? Thank you.

Sincerely,

Senator Johne Binkley
Yukon-Kuskokwim and
Interior Rivers

jka

Chancy Croft Law Office
738 H Street -- Suite 200
Anchorage, Alaska 99501

Janice

Chancy Croft
Michael J. Jensen

(907) 272-3508

February 5, 1988

RECEIVED FEB 0 9 1988

Senator Johne Binkley
Alaska State Legislature
P. O. Box V(MS 3100)
Juneau, Alaska 99811

Dear Senator Binkley:

Senate Bill 322 is not going to reduce workers compensation premiums. That is what the NCCI concluded. In fact, it may cause an increase. It's hard to believe. But that is what a national insurance industry funded group just said. Why pass this bill which produces no benefits and reduces no costs? Why not consider the real problems that both injured workers and employers face with the present workers compensation system?

I'm a compensation attorney. Why should you believe me? Because the figures came from the National Council on Compensation Insurance. NCCI is the insurance industry funded group which proposes insurance rates. Its filing of 1987 produced the 25% increase in workers compensation premiums which the State Division of Insurance allowed to go into affect January 1, 1988. The NCCI says the "savings" of the proposed legislation is only 2.3%. This must be a shock to John Lewis, WCCA spokesman, who said in legislative testimony in January that the savings would be 15%-20%. Of course, Lewis conceded he was talking about soft dollars and subjective factors. About Lewis's subjective factors, the NCCI said that this would cause a savings of only four percentage points. Without that, the bill actually provides for an increase.

At the recent statewide hearings on this bill, every injured worker spoke against this legislation. Senate Bill 322 promises the first devisive and bitter fight over workers compensation in more than a decade. Such fights were common years ago. But, for the first time in the memory of legislative observers, a workers compensation bill is being proposed which will offer no benefits to either employers or employees. Stripping away the myth of premium reduction means the only reason for further legislative consideration is the strange notion that it is the legislature's job to ratify, without question or amendment, a "deal" struck by private interest groups.

Very truly yours,

Thank you for your letter of Feb 2. I would appreciate knowing if there is still a great deal of support for SB 322 once people understand that there will be no premium reduction.

CHANCY CROFT

MASON & GRIFFIN
ATTORNEYS AT LAW
550 W. 7th Avenue • Suite 285
Anchorage, Alaska 99501

Robert B. Mason
Admitted in:
Alaska, Texas
Robert L. Griffin
Andrew J. Lambert

(907) 274-5546

February 2, 1988

Senator Tim Kelly
Capitol Building, Room 101
Juneau, AK 99803

RE: Proposed Workers Compensation
Legislation

Dear Senator Kelly:

As you know, I have testified and lobbied that the joint labor management bill will reduce the volume of litigation presented to the Alaska Workers Compensation Board. The purpose of this letter is to point out some specific areas where I believe litigation will be reduced.

This law firm has been in numerous cases over the years where the sole issue was a rate increase from the minimum of $110 to a figure that would fall below the $154 proposed minimum compensation rate. This simple $44 increase in the minimum compensation rate will result in a reduction of litigation, simply because the employees that were claiming wage rate increases from $110 to something less than $154 will no longer have to file a claim, in that they will receive $154.

In regard to medical issues, I think the reliance on the AMA Guidelines to determine employee's permanent impairment, and therefore, his entitlement to permanent partial disability benefits, will reduce the amount of litigation. The AMA Guides provide an objective evaluation format, as opposed to the subjective opinion of a doctor. Even if two doctors have differing opinions, one would have to presume that if the AMA Guides were appropriately applied, they would be very close to each other. A variation of 5 percent could and would be expected, but anything more than that would suggest that one of the doctors misapplied the guidelines, or that the patient performed differently before the doctors. The difference in the demonstration of the patient's physical skills could be because of an actual change in his physical condition for a number of reasons, or because the employee is trying to enhance the value of his claim. There will be litigation over these issues, but it is not going to be as much as it is today. The use of objective standards will

reduce the amount of litigation.

The termination of temporary total disability benefits at the point the employee becomes medically stationary or upon the expiration of two years will also result in fewer cases to be litigated. Under the present system, an employee is still entitled to temporary total disability benefits during the time that the lawyers are arguing about the rehabilitation program. This often takes up to six months or a year to resolve, and it is not uncommon for rehabilitation issues to be litigated over a period far exceeding one year. With the termination of temporary total disability benefits at the end of two years or when the employee is permanent and stable, there will be a renewed emphasis on finding a suitable rehabilitation plan in the shortest period of time possible.

One of the most frequently litigated issues is the disputes over future wage earning capacity. Under the current system, for back injuries or neck injuries, the employee is compensated based on his actual loss of wage earning capacity. The wage earning capacity is established by determining what the employee could have made in the future had he not been injured, as compared to what he will make in the future after his injury. The first of these is very subjective, and the second is often subjective, as opposed to a comparison of actual numbers. When such issues are left so wide open for interpretation, attorneys often get involved. The proposed system would be to pay permanent partial disability benefits based upon the permanent impairment rating in accordance with the AMA Guidelines. This is an objective standard as noted above, and should result in a significant decrease in litigation over permanent partial disability benefits.

The last major areas where the bill will reduce litigation is in the determination of the compensation rate. The changes as proposed will make it a more objective standard, thereby eliminating the need for attorneys. I am not entirely pleased with the language as presented in the portion of the Act dealing with determination of the employee's spendable weekly wage, but it is acceptable.

Thus, it is my opinion that this bill will result in a significant decrease in litigation. I do believe that you will probably see an increase in litigation for a year or two after the bill is passed. This is typical with any major change in a system, in that both sides will want to present their arguments on how the new law is to be interpreted. After a year and a half or two years, the frequency of litigation should begin to decline.

I am not sure why I have worked so hard to make my support for this bill known. It is most definitely going to cost my law firm some business, as the decrease in litigation begins to occur. However, I do think this is the best thing for the system overall.

I do want to present you with one word of caution. The bill takes many of the incentives away for attorneys that represent injured employees. You are directly affecting their livelihood in a significant way. The same is true for vocational rehabilitation counselors and the medical profession in general, and chiropractors in particular. Because of that, I would take any of their testimony with a grain of salt, and determine whether they are testifying from a true belief, or whether they are testifying from a fear that the bill will have a negative effect on their personal income.

I would still like to meet with you in order to discuss the workers' compensation system in more detail. This may not be necessary if the bill will pass largely intact, but if you are encountering opposition, I will be able to provide you with some specific information that you can use to support the bill.

I would appreciate it if you could let my office know when the next hearing in Anchorage is going to be. I will be out of town until February 21, and hopefully, the hearing will not be until after that time. If you have a chance to spend some time with me prior to the next hearing, please let my office know so we can arrange a meeting.

In addition to the above, I have done some work determining exactly what payments would be made under the new system for PPD as opposed to the old system. If you want that information and a further breakdown on how the AMA Guidelines work, I will be glad to provide that to you as well.

Sincerely,

MASON & GRIFFIN

Robert B. Mason

RBM:mrm

MANAGEMENT/LABOR AD HOC COMMITTEE

RESPONSES TO

MEMORANDUM FOR POINTS OF DISCUSSION
DATED FEBRUARY, 5, 1988

We have examined the concerns raised in the above referenced memorandum. For ease of comparison, our replies follow the same sequence as that used in the memorandum.

1. We are also concerned about the "any evidence" standard and have asked that John Lewis provide some direction as to the standard used in other jurisdictions. The concern of both management and labor is with the overly broad interpretation the courts have applied to the "substantial evidence" standard currently in effect. We will hopefully have a recommendation by February 12.

2. Our language was drafted and reviewed by attorneys knowledgeable in the constraints imposed by the courts. It is their opinion that the language will withstand a constitutional challenge.

3. For the system to operate as designed, it must be fair to both the injured worker and the employer. Therefore, providers to the system must provide services free of bias for or against either party. It is our desire that the regulations should allow for a bias free system and providers that exhibit bias will not be allowed to provide IME's or rehabilitation services. Health care providers could still continue to operate in the system if chosen by the employee or employer even if they were not on the list of IME providers.

4. We think that the standard for knowingly making a false statement is sufficiently strict that it will be difficult to abuse by an employer. If an employee withholds information from an employer for any reason, he could be endangering himself or others since he does not know what duties might be called for on a given job. We think that this section is important to the bill.

5. We have recommended to the board that the lists be maintained on a geographical basis to remove a certain amount of the unnecessary expenditures. We are concerned however that if we deal with the concerns expressed, we are losing sight of the needs of the injured worker, and instead place the travel costs of the rehabilitation specialist above the needs of the worker.

6. Under the present system, it is estimated that approximately 90% of those that have been rehabilitated have gone back to their prior occupation. It is our belief that when this occurs, it is not necessary to rehabilitate someone for yet another job should they receive a subsequent injury. They have already received the training necessary to compete in a new occupation and we would encourage them to enter that labor market.

The concerns about the minimum threshold of 60% of pre-injury wages fail to recognize that this is the minimum threshold and it would represent an entry level wage. As skills improve, it would be anticipated that salary levels would increase.

7. Dispute resolution language was omitted by legislative drafting. We have included a rewrite of Section 041 which deals with that and other problems.

8. We have modified the time for the eligibility determination from 60 days to 90 days. The time frames are now consistent with the current statute.

9. We have attempted to remove the rehabilitation section from the litigation process To accomplish this we have put the injured worker in control of his plan, and we have given the administrator the authority to quickly resolve disputes. Since the administrator reports to the board, the board can review his performance on an ongoing basis and accordingly modify the general approach to the job when it does not conform to the guidelines of the board. We believe that this approach is in the best interests of the worker and the system.

10 Employment in this economy is a difficult standard to achieve. Employability is better in that it defines the time when the person is available and prepared to work, and it additionally puts some of the responsibility for the acquisition of a job on the worker.

11. The opposition to the labor market definition is based on misunderstandings. We have established a priority which starts with the area of residence, then the area of last employment, then the State of Alaska, and finally other states. We do not understand the concerns.

12. We have modified this section to include Certified Rehabilitation Counselors. It is the desire of the committee that these specialists be professionals in the area of vocational rehabilitation. That is not the case currently and as a result, both the employee and the employer suffer.

13. See number 6 above.

14. It is the desire of the committee to see that the employee is provided good quality medical care in a timely, efficient manner. Abuses currently exist in the system and we believe that our

language will remedy many of the problems. We think that the suggestion that we allow no more than one change within each speciality does not eliminate the problem. The treating physician can still refer the patient to specialists as necessary.

The concerns regarding the definition of treating physician are inappropriate as the concept is part of the current law and does not cause a problem.

15. See 14 above and 16 below.

16. This section of the bill requires that a treatment plan be submitted if continuing and multiple treatments are prescribed. It seems reasonable that both the employee and employer should know what the physician is intending to do and what he anticipates will happen. The limits on the number of visits was based on the recommendations of experts, but we provided a exception when needed. All the physician would need to do is document the need for additional services. Again we were attempting to deal with abuses to the system.

17. The current statute has no limits at all, therefore we have restricted the frequency of the employer IME. We have modified our recommendation to every 60 days thereafter. It should be acknowledged that the employer is restrained by the costs of such IME's which must be borne by the employer. In should also be remembered that in the case of a dispute, the board's IME will determine the outcome.

18. While no one on the committee was aware of any problems in this area, we have added language which should deal with the concerns expressed. We suggest that when medically appropriate, the IME physician should use already existing diagnostic data to make his determination.

19. Our proposal suggests the adoption of a usual and customary fee schedule. Such schedules are normal in health care plans and under the Social Security System. It does not envision a separate schedule for an employee's physician and an employer's physician.

20. This language merely gives the board the authority to administer the act by hiring experts, be they Alaskans or not.

21. We were concerned about the supreme court giving the presumption to the treating physician in cases where evidence clearly suggests that they were in error. Since the board selected IME will be independent, we believe that giving his opinions greater weight is appropriate.

22. We have added gross incompetence to the language. We do not believe that mispresentation is an appropriate standard and its inclusion will lead to litigation.

23. We do not understand the constitutionality question on this issue. We believe that this standard is legal.

24. See #1.

25. See #2.

26. See #11.

27. It is our belief tha if a person has skills which can be used in the job market, they are not a permanent total disability.

28. We have added language which will clarify our intent. We are suggesting that after two years, a person be tested to determine their degree of impairment and given a lump sum settlement.

29. It is our desire to pay more money for severe injuries and less money for less severe injuries. We have attempted to do so without increasing the overall costs of this section.

30. Medical stability in this section is essential to determine the timing and the degree of permanent impairment Medical benefits are not limited and will continue for the duration of the injury.

31. This secion currently exists as Section 210 of the Statute. We merely moved it to section 200 since it now only applies to that section.

32. We did not receive Attachment 3, so we are unclear as to their concerns.

33. Vested benefits were used to make this section manageable and to recognize that a worker have no legal right to "unvested" benefits. Vesting has nothing to do with union vs nonunion.

34. Workers' compensation was created to deal with work related injuries and should not be seen as the vehicle to address other social goals. The items outlined represent issues that are adequately addressed in other State and Federal statutes.

35. See #30 above.

OTHER ITEMS

1. Our agenda for 1988 includes a review of the Division of Workers Compensation. We are particularly interested in the timely resolution of a workers' compensation claim and will examine both the delays caused by the system and those caused by the employers or employees attorneys.

2. We believe that our proposal will include system modifications which will result in cost savings of at least 15%. We hope the insurance community will concur and ask for a rate reduction effective July 1.

3. Issues regarding the insurance industry were not addressed in this bill because of the complexity of the problem. We will be addressing these issues in 1988.

4. This problem is particularly difficult since the courts have held that the contractors insurance carrier is liable when the sole-proprietor has a work related injury The insurance company takes the position that they need to collect premiums to cover the risk and accordingly charge the contractor

5. Final billing after audit is necessary to make sure that adequate premiums are collected for the actual wage exposure. Quotes given at the initiation of the policy are based on the employers estimates of wages by classification, and if accurate will result in no additional premiums. Unless insurance companies are given the ability to audit payroll records, everyone will underestimate payroll and the system will become even more chaotic.

6. We will examine this when we examine the insurance company, but an "all states rider" does not eliminate the Alaska rates. They will be charged during the audit on the policy. We believe that the problem comes from misrepresenting and misclassifing payroll and the insurance carrier not catching the problem at audit.

7. We would have no problem with such an amendment to the unemployment law.

SUGGESTED CHANGES TO LEGISLATION

Page 2, Line 4 The department shall [may] adopt [identical]

Page 2, line 7 , and shall [may]

Page 13, Line 5 commencement of such ...

Page 13, line 24 board. When medically appropriate, the IME physician should use already existing diagnostic data to make his determination.

Page 14, Line 22 board. In no event shall the injured worker be responsible for any fees in excess of those determined by the board.

Page 15, Line 4 treatment, the ability to enter a re-employment services plan, ...

Page 15, Line 16 fraud, or gross incompentence.

Page 18, Line 29 or death [for a recipient residing in the state]

Page 19, Line 7 wages. If the employer can verify that the employees spendable weekly wage is less than $154, the employer can pay the lesser amount without board order.

Page 19, line 20 cost of living index of the state [locality]

Page 19, line 21 cost of living index of Alaska [the state]

Page 19, Line 25 if the gross [average] weekly earnings [wage]

Page 20, Line 5 for Alaska [the state] and other states [localities] ...

Page 20, line 19 the state of Alaska or the state of residence

Page 21, Line 27 percent. If an injury cannot be rated by use of the American Medical Association Guides, the Manual for Orthopedic Surgeons may be used.

Page 21, Line 28 supplemental recognized schedule.

Page 22, Line 19 stability.[, unless otherwise provided under AS 23.30.041.]

Page 27, line 4 APPLICABILITY Except for sections 5, 18, 20, and 21, this....

BIG NEWS ABOUT THE NEW WORKER'S COMPENSATION BILL RECENTLY INTRODUCED! FOLLOWING ARE A FEW OF THE HIGH POINTS:...

* An insurance rehabilitation specialist will have <u>total control</u> over your rehabilitation. You will have almost no say. Also, you can only be rehabilitated once in your life, regardless of how many injuries you suffer. And it can't cost more than $ 10,000.00.

* You can only receive 20 treatments in 60 days, regardless of how extensively you are injured!

* After 14 days, the insurance company can make you go to their doctor, even if you are happy with your doctor, regardless of your wishes.

* The insurance company can use "lower 48" companies to determine fees, making you responsible for the difference!

* Permanent disability benefits will have a limit, no matter how extensively you are injured.

* Once you have stopped improving, or if your condition is expected to get worse without continued care, you can receive no additional medical care, regardless of how extensively you are injured, unless you prove it to the Board, which could take months, or longer.

* Your doctor has 1 week to submit his treatment schedule to the insurance company, and they have 2 weeks to accept or deny it. Therefore, if they do not like you, your doctor, or his plan of treatment, they can deny the entire claim without penalty.

* You can only change doctors once without written approval from the insurance company.

* If there is a dispute between you and the insurance company, they can stop all benefits to you, regardless of your condition, until you take it to a Board hearing. <u>You are guilty until you prove yourself innocent!</u>

* *Independent Medical Examinations (IME) performed on chiropractic patients can be done by orthopedic surgeons biased against chiropractors. The IME doctor is not held liable for his report.*

For all of this (and more), the insurance companies are not required to report how much they set aside in reserves, how much is spent on injuries, or how much was collected in premiums. Therefore, they can charge whatever they want, regardless of how it may strangle our economy.

We urge you to phone your representatives and strongly oppose this Bill. <u>It is highly discriminatory, and will seriously jeopardize your ability to seek health care as an injured worker.</u> Employers, demand that the insurance companies justify these exorbitant rates which they charge us. This is Alaska. We all live and work here. LET'S MAKE IT SAFE, AND FAIR.

Chiropractors Handout

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John —

Adrian Barber —
Chiropractor — Anch.
562-5566

please call — 9:15 —

BILL SB DELAYED - SIGNED - INPUT FROM OTHER GROUPS.

BILL WON'T SOLVE PROBLEMS

EMPLOYERS & KNOW WHAT'S GO SOMETHING SIMILAR TO PPAC ON INSURANCE COMPANIES

SAMPLES FOR POSTCARDS

1. I have seen House Bill (H.B.) 352 concerning the workers' compensation. I feel it severely compromises the injured worker's rights. Please do not pass this bill in its present form.

2. House Bill (H.B.) 352 benefits only the insurance carrier. I am strongly opposed to the passage of this bill the way it currently is.

3. I have seen House Bill (H.B.) 352. I don't support it. Please don't pass it.

4. I believe the new workers compensation bill is unfair to the injured worker and takes away his freedom of choice. Please don't pass this bill.

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ALASKA STATE SENATE

SENATOR TIM KELLY
ANCHORAGE/EAGLE RIVER
CHAIRMAN

SENATOR DICK ELIASON
SITKA
VICE CHAIRMAN

LABOR AND COMMERCE COMMITTEE

MEMBERS
SENATOR BETTYE FAHRENKAMP
FAIRBANKS

SENATOR RICK UEHLING
ANCHORAGE

SENATOR MIKE SZYMANSKI
ANCHORAGE

January 28, 1988

Scott McVey
7340 Hillside Way
Anchorage, Ak. 99516

Dear Scott,

I appreciate you taking the time to send me a card with your thoughts on the worker's compensation bill before us.

After receiving a number of cards, we have reviewed the flier suggesting the postcards and making comments about the legislation. I am somewhat disappointed to see that a good portion of the information given you about the legislation is inaccurate. To clarify the situation, I want to give you some additional information.

This bill was developed by a task force made up of 5 representatives of organized labor and 5 representatives of management. Both groups realized that a solution to the current problem needed to be found and that an agreement had to be negotiated. After several months of work, this agreement was reached and the same bill was introduced in both the House and the Senate to use as a starting point.

First let me highlight a few points that the bill does for Alaskan workers.

* There is a significant increase in the payment for permanent partial disabilities. This assures that the more substantially injured workers receive greater benefits.

* The minimum weekly benefit is being raised and the maximum weekly benefit is being reduced. Only about 3 percent of the cases will be effected by the reduction and a much larger number of workers will get increased benefits. This section will actually increase in dollar amounts, the overall wage benefits to injured workers.

* The bill requires that pensions and benefits be included in calculating a workers' average weekly wage instead of just wages and salaries.

P.O. BOX V, JUNEAU, AK 99811 (907) 465-3822 • P.O. BOX 210001, ANCHORAGE, AK 99521 (907) 278-3284

* An injured worker will immediately receive benefits if an argument breaks out over which carrier will be responsible. Currently a worker can go for months without benefits.

* Vocational rehabilitation will become voluntary under the bill. The injured worker has a choice of whether or not to enter a vocational rehabilitation program,and will no longer be forced to "play the game" just to continue receiving benefits.

* Discrimination against a worker who has filed a worker's compensation claim will be prohibited under this new law.

There has been some other misunderstandings that need to be clarified.It has been said that the cost of vocational rehabilitation can't exceed $10,000. In truth, only the cost of the plan for rehabilitation can't exceed that amount. There isn't a cap on the cost of the rehabilitation itself.

It is not the insurance company who must approve additional changes of doctors, but the worker's employer. Referrals to other doctors by a primary physician don't count as a change of doctors. Additional changes of doctors can be made if the worker's employer approves.

The area of only allowing 20 visits in 60 days has also been mis-stated. After the 60 day period 4 visits per month are allowed. If more than the 20 are needed, they are allowed if they are justified in the written plan.

Under the current system, less than 40 cents out of every dollar paid in worker's compensation premiums actually goes to the injured worker. The bill being worked on is designed to give more of the money to the injured workers and less money to the people in the middle. The idea behind worker's compensation is to provide a system to ensure that an injured worker gets the appropriate care and compensation. It is my intention to support a bill that is fair to both the injured worker and the employer, after all, that's who the system was designed to protect in the first place.

Hopefully, I have cleared up some of your concerns. Please be assured that I won't support a bill that I feel is unfair to injured workers.

Best Regards

TIM KELLY
State Senator

SAMPLES FOR POSTCARDS

1. I have seen House Bill (H.B.) 352 concerning the workers' compensation. I feel it severely compromises the injured worker's rights. Please do not pass this bill in its present form.

2. House Bill (H.B.) 352 benefits only the insurance carrier. I am strongly opposed to the passage of this bill the way it currently is.

3. I have seen House Bill (H.B.) 352. I don't support it. Please don't pass it.

4. I believe the new workers compensation bill is unfair to the injured worker and takes away his freedom of choice. Please don't pass this bill.

Finally, in this instance, the language should say insurance carrier or employer instead of employer. Again it is a question of avoiding delays in the process.

23.30.041 (h)

After the first sentence (after the word "approved"), add "by employee, rehabilitation specialist, and employer or insurance company."

Maybe

Again, Alaska National makes a good faith effort to comply with the intent, spirit and letter of workers' compensation laws. Our claims adjusters deal with these matters daily and [illegible]. Their input into a reemployment plan is vital and will have an overall positive effect on the program.

23.30.041 (k)

Consideration could be given to [illegible] the [illegible] year benefit period. I assume the language also implies a limit of [illegible] years on the rehabilitation plan. We have found the current 52 week limit (with extension of another 52 weeks [illegible]) to be reasonable. In practice, we have [illegible] voluntarily extended the period [illegible] nature of the case.

23.30.095 (k)

In those cases involving a medical dispute, I believe the decision process would be enhanced if the independent medical [illegible] consisted of a panel of three physicians.

23.30.155 (m)

Alaska National will make every effort to comply with all reporting requirements. In order to allow adequate time to change computer systems and other internal procedures, [illegible] reporting period be for calendar year [illegible] [illegible] instead of March 1.

OK

Considerable effort is expended after each year end to meet current regulatory reporting requirements to the Division of Insurance, National Association of Insurance Commissioners, [illegible] which also have a March 1 deadline.

23.30.175 (b)(1)

It is recognized that the cost of living adjustment, if constitutional, will produce some savings to the system. Unfortunately, it will also cause an extra administrative burden in making annual adjustments to all claimants.

One idea that we had was to pattern the out of state differential similar to the current Alaska State Employees Retirement Plan wherein a 10% bonus is paid to retirees who remain in Alaska.

A similar approach could work here by changing the percentage of the employee's spendable weekly wage from 80% to 70% and then adding a provision which would provide an additional 10% to those employees who remain in Alaska.

23.30.190

I do not care to make any specific recommendation except to point out the fact that the greatest potential for savings is here. The rate impact of a downward adjustment of the $240.00 at a greater degree of impairment to reach a 100% adjustment factor can be readily measured by an actuary and is the most likely area to result in decreased costs.

23.30.265 (15)

To prevent an unearned windfall to attorneys we suggest the following new section after section 15:

"No attorney fees will be due and owing on these benefits unless the insurance carrier fails to calculate and pay the benefits under this statute within 21 days after the wage information is presented to them."

Our current practice is to pay the minimum benefit immediately until we receive wage documentation from the employee. In those cases, we do not believe it is appropriate to pay attorney fees when an attorney unnecessarily submits the wage information to us after we have first notice of same.

As we discussed previously, Alaska National will certainly support a rate reduction which can be attributed to "easy" to file savings as determined by the actuaries. We have a problem, however, with arbitrarily attributing such savings to the essentially "easy" medical items for which no reputable actuary is willing to adjust.

I am well aware that the intent of the drafters of the bill is to produce savings from the subjective provisions. Under an ideal environment along with favorable determinations by the Board and Court system, some of the savings may be realized.

However, I refer you to pages 8, 9 and 10 of the Workman & Robertson report, which details some legitimate concerns four of which you have addressed in the Committee Substitute which could lead to an increase in costs rather than a savings.

During my visit to Juneau last week, I heard some discussion of a mandated rate reduction. Historically, it can be demonstrated that the insurance industry is notorious for bringing on its own price wars when rates become adequate. This situation occurred just a few years ago in Alaska and rates have weakened in several other lines currently. When workers compensation [illegible] to return profitably to Alaska, like night follows day, you can be sure that individual companies will utilize rate credits to get the business.

To artificially reduce rates without justification will not only adversely affect market availability, it will have a negative impact on those companies which continue to maintain a market.

In 1987, the Alaska insurance industry was assessed $[illegible] by the Alaska Insurance Guaranty Association to pay claims of insolvent carriers. This number does not include a potentially much larger assessment if the Pacific Marine Insurance Company can be liquidated. For the workers compensation line alone, we anticipate an assessment equal to the full 2% of written premium in Alaska for 1988 and many years to come.

Contrary to the opinion of some people, the insurance industry does not capriciously view its role as a cost plus concept. We are well aware that workers compensation must [illegible] to a reasonable level so that employers other than [illegible] can survive. At Alaska National we have [illegible] ultimately it must be the legislature who determines what the reasonable level should be.

Finally, these comments represent only the opinions of Alaska National, are presented to you in the belief that they may be helpful in your final evaluation of the bill, and are not [illegible] for discussion to others or to the [illegible].

If I can be of further assistance, please advise.

Yours truly,

James F. Pfeifer
President

STATE OF ALASKA 1988 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date : 2/22/88

REQUEST

Bill/Resolution No. : CSSB 322 (L & C)
Title : An Act relating to worker's compensation and providing for an effective date.
Sponsor : Senate Labor & Commerce
Requestor :
Date of Request :

FISCAL DETAIL

Agency Affected : Labor
BRU : workers' compensation

Components : workers' compensation

EXPENDITURES/REVENUES : (Thousands of Dollars)

OPERATING	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY93
PERSONAL SERVICES			0	0	0	0	0
TRAVEL							
CONTRACTUAL							
SUPPLIES							
EQUIPMENT							
LAND & STRUCTURES							
GRANTS, CLAIMS							
MISCELLANEOUS							
TOTAL OPERATING			0	0	0	0	0
CAPITAL							
REVENUE							

FUNDING : (Thousands of Dollars)

GENERAL FUND							
FEDERAL FUNDS							
OTHER							
TOTAL			0	0	0	0	0

POSITIONS :

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS : Attach a separate page if necessary

Prepared by : John Ringstad
Division : Senate Labor & Commerce Committee
Phone :
Date : 2/22/88

Approved by Commissioner :
Date :
Agency :

Distribution (by Agency preparing fiscal note) :
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

3/16/88

MEMORANDUM State of Alaska

TO: Jacque McClintock, Director
Workers' Compensation Division

DATE: February 22, 1988

FILE NO:

TELEPHONE NO: 465-4500

FROM: Chuck Caldwell, Chief
Research and Analysis

SUBJECT: Runzheimer and
Cost of Living

I have completed a review of the technical material provided by Runzheimer and Company Inc. regarding their methods of determining relative cost of living for states. Furthermore, I contacted the Bureau of Labor Statistics to determine if there were other companies providing this information.

Only two comparative cost of living data series are widely accepted. Runzheimer's and the American Chamber of Commerce Researchers Association (ACCRA) Inter-City Cost of Living Index.

Characteristic	Runzheimer	ACCRA
Coverage	Statewide with weighting by city size. This would simplify the administration of payments.	Separate indices for 264 cities, without any overall data at a statewide level.
Market Basket	No total count of items is available, but 130 are included in the goods and services category alone. The housing category is also extensive.	Sixty items in the market basket total.
State and Local Taxes	Included.	Not included.
Support in future court cases.	Will provide expert testimony in court.	Will not provide expert testimony in court.
Cost	$50,000 for the first year, and $46,000 for subsequent years.	$75 per year.

Attached is a memo which provides detail on the cost savings associated with reducing out of state Workers' Compensation payments by the relative cost of living.

MEMORANDUM State of Alaska

TO: Chuck Caldwell, Chief
Research & Analysis

Sally Saddler, Research Supervisor
Research & Analysis

FROM: Jeff Hadland, Labor Economist
Research & Analysis

DATE: February 22, 1988

FILE NO:

TELEPHONE NO: 465-4500

SUBJECT: Impact of Reducing Out-of-State Worker's Comp Payments for Cost-of-Living

Jackie McClintock requested that we analyze out-of-state worker's compensation claimant information to determine the possible savings that might accrue if out-of-state payments were reduced by a reliable interstate cost-of-living adjustment factor.

Findings

1) As of February 16, 1988 an estimated $12.35 million would have been paid to out-of-state residents that were disabled in 1985, 1986 and 1987 if payments (weekly pay rates) were capped at $700. (Note: claimants with incomplete residence information are excluded from this analysis.)

2) When the worker's compensation payments (weekly pay rates) are adjusted by an interstate cost-of-living index, the estimated total payment amount is reduced by $2.55 million (26 percent reduction for the three year period). This assumes that the weekly pay rate was capped at $700 after the cost-of-living adjustment was made.

3) An additional $137,000 savings over three years might have been achieved if the cost-of-living adjustment was applied to a weekly pay rate that was capped at $700 before applying the cost-of-living adjustment. Table 1 contains the actual estimated figures summarized above.

Procedure

Worker's compensation records used in this analysis had injury dates in 1985, 1986 and 1987, and had accurate state of residence information. A total of 2,259 individual records (payment histories) met these criteria.

The cost-of-living adjustment factors were based upon an unweighted simple arithmetic mean of the Inter-City Cost of Living Index of all cities in a given state. This information is published by the American Chamber of Commerce Researchers Association (ACCRA). The ratio of the state's cost-of-living index to Alaska's index was used to adjust the pay rates. This information is listed in Table 2.

Limitations

These data are the best interstate cost-of-living differential information available without cost at this time. Runzheimer and Company Inc. can provide cost-of-living data that are even more comprehensive, and weighted

for statewide indices. Any significant changes in the indices for Washington, Oregon and/or California will have a large impact on the cost savings estimates since those three states comprise the vast majority of out-of-state claimants.

Table 1
Total Estimated Out-of-State Worker's Compensation Payments
For Injuries in 1985, 1986 and 1987 as of 2/16/88
With and Without Interstate Cost-of-Living Adjustments

Cap Weekly Payment at $700 After
Cost-of-Living Adjustment

Year	Base Case	Cost-of-Living Adjusted	Savings
1985	$7,638,285.16	$6,020,463.00	$1,617,822.16
1986	3,590,696.77	2,837,612.86	753,083.91
1987	1,125,077.02	945,148.58	179,928.44
Total	$12,354,058.95	$9,803,224.44	$2,550,834.51

Cap Weekly Payment at $700 Before
Cost-of-Living Adjustment

Year	Base Case	Cost-of-Living Adjusted	Savings
1985	$7,638,285.16	$5,927,363.47	$1,710,921.69
1986	3,590,696.77	2,796,523.99	794,172.78
1987	1,125,077.02	941,709.12	183,367.90
Total	$12,354,058.95	$9,665,596.58	$2,688,462.37

Table 2
American Chamber of Commerce Researchers Association
Inter-City Cost-of-Living Indices [1]
and Ratio of State Index to Alaska Index

STATE	INDEX	RATIO
AL	94.80	.71
AR	91.30	.69
AZ	106.40	.80
CA	111.70	.84
CN	119.20	.90
CO	94.40	.71
CT	119.20	.90
DC	133.20	1.00
DE	102.70	.77
FL	102.30	.77
GA	98.50	.74
HA	132.60	1.00
HI	132.60	1.00
HW	132.60	1.00
IA	97.10	.73
ID	92.90	.70
IL	103.50	.78
IN	96.30	.73
KS	93.50	.71
KY	95.60	.72
LA	98.40	.74
MA	135.00	1.02
MD	105.70	.80
ME	96.90	.73
MI	102.70	.77
MN	100.90	.76
MO	92.70	.70
MS	92.10	.69
MT	97.60	.74
NB	93.00	.70
NC	99.50	.75
ND	95.80	.72
NE	93.00	.70
NJ	107.00	.81
NM	101.00	.76
NV	105.10	.79
NY	107.00	.81
OH	97.70	.74
OK	97.00	.73
OR	99.80	.75
PA	103.70	.78
SC	95.90	.72
TN	94.30	.71
TX	97.90	.74
UT	92.70	.70
VA	104.10	.79
VT	122.20	.92
WA	97.80	.74
WI	95.50	.72
WV	97.30	.73
WY	92.00	.69

[1] The state index is the unweighted simple arithmatic mean of the inter-city cost-of-living index in a given stste; published by the American Chamber of Commerce Researcher's Association (ACCRA).

ALASKA
COMPUTERIZED BUSINESS SERVICES
840 WEST 36TH AVENUE • SUITE 4 • ANCHORAGE, ALASKA 99503
PHONE (907) 561-1817

February 18, 1988

Sen. Tim Kelly
P.O. Box V
Capitol, Room 101
Juneau, Ak. 99811

Dear Sen. Kelly,

Along with the increase in Workmens Compensation rates, we have experienced a very large increase in the rates the employers' have to pay for the unemployment tax. Much of this increase is due to the unfair way the state computes their rates. At present, the state only uses the declining level of wages method of determining individual employer rates. The level of claims against an individual employer are not even considered.

Please refer to the attached copy of a letter we received as a reply to my appeal to the Division of Employment Security. My justification for the appeal has been quoted in their reply. Also, please note that we had a fifteen (15) day period from the date of their letter in which to initiate a hearing to appeal our case. The letter is dated January 19, 1988 and was received in our office on February 3, 1988. We did not even get a legal chance to appeal the decision.

I would like to add that the rate for our small company of three (3) people is 4.28% on the first $21,100.00 of wages or $903.08 per employee. This total of $2709.24 is very high. In the present economy, some months we have not been able to even pay the two (2) principal partners their salary, which results in additional declining wage rates and again a higher employer rate. These high rates just add to the present problem of staying in business. We have had as many as nine (9) employees, but never laid anyone off, we just simply did not replace them as they left.

The state could help our economy right now by funding the Unemployment Fund and giving the employers some relief in reduced rates. It would help in cutting our high operating costs and hopefully not have to lay off anyone.

Thank you for your time.

David J. Parnow
Vice-President,
Ak. Computerized Business Services, Inc.

STATE OF ALASKA

DEPARTMENT OF LABOR

DIVISION OF EMPLOYMENT SECURITY
AFFILIATED WITH U.S. EMPLOYMENT SERVICE

STEVE COWPER, GOVERNOR

P.O. BOX 3-7000
JUNEAU, ALASKA 99802-0700
PHONE: (907)465-2757
Status Unit

264-2462

January 19, 1988

Mr. David J. Parnow
Alaska Computerized Business Services
640 West Thirty-Sixth, Suite 4
Anchorage, AK 99503

Dear Mr. Parnow:

ACCOUNT #0000358045

Alaska's economy has had a bad jolt this last year. The number of people claiming unemployment benefits was very high, and the unemployment fund level became very low. Hopefully, the rebuilding process has begun and our economy will see better times. The average employer rate in Alaska increased .8 percent, and the employee share increased .1 percent.

We have received your letter dated December 14, 1987, in which you request a redetermination of your Employment Security contribution rate for 1988.

You have set forth the following reasons in support of your request:

> "Our firm only has three (3) employees and in the fourth quarter of 1986, the two (2) main employees did not receiver ANY pay during the last months of the quarter due to the economy and no cash flow.
>
> "This rate is far in excess of other employers who have a much higher turnover rate of employees. I know this for a fact, because we provide payroll services for several employers around the state. Please check your claims against our company and you will find very few. Our declines in the past are not a result of laying off employees but a reduction of salaries and bonuses. I also take leave without pay during the summer months so I can go commercial fishing, this creates another decline in two (2) quarters during the year.

Received 2-3-88

07-G7LH

> "For a small business such as ours, we will have to pay close to $3000.00 in 1988. This is a severe hardship in our present economy and might cause layoffs or contribute to the closing of the business, resulting in more expensive claims made for unemployment."

Alaska Statutes provide a formula for establishing twenty-one contribution rates based on the cost of benefits, the declining level of wages, and the solvency of the Trust Fund.

You have indicated that you understand the determination of individual rates based on experience with quarterly declines.

Neither the turnover rate, reduction of salary, failure to pay employees, nor claims against wages paid by an employer is a factor in determining an employer's assignment to one of the twenty-one rate classes.

We regret to inform you that no basis can be found to grant the relief you have requested. Therefore, your application is hereby denied.

This notice will become final unless, within 15 days from the date of this letter, you initiate a formal request to the Commissioner of Labor to be granted a reasonable opportunity for a fair hearing, stating your reasons for the appeal. The appeal may be filed by mail to the Commissioner's Hearing Officer, Box 1149, Juneau, AK 99802.

Sincerely,

Harry Sturrock

Harry Sturrock, Supervisor
Accounts and Contributions

3-16-88

Tim Kelly
p.o. box v
Juneau Ak. 99811

Dear Tim,

Thank you for your letter of 3-10-88. I guess what I really don't understand is, when a worker is injured why should that worker lose anything? After I was injured I immediatly lost approx. two hundred dollars a week in wages, I also lost all of my benefits. With that kind of a loss my wife and I had to move to Portland as we no longer could afford to live in Alaska. My Dr. had already told me that I couldn't return to my trade. While we here the first winter I almost begged for some kind of retraining but all I got was reams of reports.The follwing April I had a chance to go to work at a cold storage at Douglas Alaska and learn how to be a refrigeration engr. This position would have eventually paid close to what I was making when I got hurt. I asked the ins. co. for financial help to get there but they declined. We went ahead and took our savings to go there. I spent fifteen months trying that job but it was just to much for me phyiscally and I was let go. As that ment taking another cut in pay we again had to come back to Port.. It was a gamble that cost us $3800.00 and the ins. co. nothing! Out of all the dealings I had with nine rehab. people I went on one job interview. I personally don't believe in big pain and suffering awards but, I don't think I should have to lose anything either. It would seem to me that I'm losing a lot of rights here. If you were injured on the job would you lose a dime in wages or your benifits? I doubt it. I stand to lose hundreds of thousands of dollars between now and the time I retire and my s.s. benefits will be affected to. My crime for all of this? Working with a defective crane.

Thank you,

Pete

Pete Weyhrich
3317 S.E. 159th
Port. Or. 97236

Boyko, Davis, Dennis,
Baldwin & Breeze
Attorneys at Law

February 17, 1988

Alaska State Legislature
P.O. Box V (MS 3100)
Juneau, AK 99811

Dear Legislators:

Once again the issue of tort reform is being raised in the Legislature and once again you will have to be making decisions regarding that issue. Therefore I would like to share some of my thoughts on this subject with you.

First it might be helpful if "tort reform" were defined. As you are aware there are many different parts to "tort reform": abolition of punitive damages, limiting attorney's fees, placing a cap on "non-economic" damages, abolition of joint and several liability and miscellaneous other provisions that have been proposed over the years. Each legislative session, "tort reform" takes on a new meaning depending on what has been proposed. This years proposals are found in SB 211.

In 1986 the Legislature accepted the proposition that tort reform should be enacted and changes to the civil justice system were made even though the opponents vigorously argued that the insurance crisis would end when the insurance industry adjusted its investment practices to be more profitable. Time has proved the opponents to "tort reform" correct. At least certain insurance lines have registered price reductions, Allstate and State Farm have reduced auto insurance premiums. In my opinion the price reduction is a result of changes within the insurance industry and the financial world, rather than with tort reform. Thus, we do not need any further "tort reform" now.

Unfortunately because the Legislature has not passed laws regulating the insurance industry and compelling accurate and regular reporting requirements, neither you nor I can state with certainty how much money the insurance industry makes or loses and where it is made or lost. I would urge you to not change the tort system until accurate reporting requirements are in place for the insurance industry, so any additional changes can be based upon facts rather than hysteria promoted by the insurance industry.

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If we study the various aspects of the tort reform legislation that are currently pending in SB 211, we see many of the same issues which were raised in 1986 and addressed by the legislature at that time. The objections to these issues are the same now as then. I believe it is worthwhile for me to address each provision of SB 211 as it is currently proposed.

The first provision of SB 211 is to place a $100,000 cap on non-economic damages. This provision effects only a few individuals out of the total number but they are the most seriously injured.

The cap idea is aimed at the concept that juries regularly lose their mind and award huge sums where there is minimal inconvenience to the injured plaintiff. This is simply not true. Judges have the power of "remittitur" to reduce verdicts which appear to be excessive and they regularly exercise this power when they feel the jury award is too high. If the trial judge fails to do so it is appealed to the Supreme Court as an excessive verdict and the Supreme Court reduces the verdict. Of course, the appeal takes years and the plaintiff receives no money during the appeal period. There is simply no need to place a cap on non-economic damage awards to bridle juries.

Another argument for a "cap" is that no amount of money can replace a person's loss of enjoyment of life or pay them for the physical and emotional distress they have suffered and any award by a jury is very subjective. That is true. So does that mean that seriously injured people are simply to suffer in silence while healthy tort feasors do not pay their bill? If that is an acceptable social balance, then we should simply abolish the tort system altogether and when someone suffers an injury they would automatically be placed on welfare for as long as they are disabled and all of their creditors, including the doctors and hospitals which provided them with health care, should be prevented from attempting to collect their "just debts".

The distinction between economic and non-economic damages could be characterized as damages necessary to pay society's debts versus damages to pay personal debts; society's debt being wages and other payments which are necessary to pay for groceries, medical services, mortgage payments and other consumer goods, and personal damages being to compensate him for physical and emotional pain and suffering, permanent disfigurement and loss of enjoyment of life. Non-economic damages could also be viewed as damages awarded to the individual to pay for the inner-hurt which he will suffer for the rest of his life.

As every single person who has suffered a personal injury can tell you these damages are no less significant damages than economic damages. This was once again pointed out to me when I was recently visiting with a physician friend of mine whose wife suffered a "soft tissue injury" (whiplash) a year ago. This lady who is about 35 years old, is the mother of two very active children. She was in good health at the time of the accident but for the last year and a half she has suffered headaches and back-aches which have limited her physical activity. She has been unable to engage in activities with the family like she had previously and she is generally depressed over the whole situation.

About 4 weeks ago the insurance adjustor called her up and offered her $5,000 to settle her claim. My friend arrived home to find his wife in tears with the frustration, pain and the insult that she felt had been perpetrated upon her. He shared her indignation. When he asked me if offering $5,000 for a case of this nature was typical of an insurance company I assured him that it was. He conceded that this experience has certainly given him a different perspective on what it is really like to be the victim of an accident and the victim of insurance company insensitivity.

All of the damages my friend was complaining about, pain and suffering, inconvenience, loss of enjoyment of life, and frustration in dealing with the insurance company are non-economic damages. But, of course SB 211 will not prevent my friend's wife from collecting her non-economic damages because her damages would not exceed $100,000, though she would probably be willing to pay more than that to have her health back.

An example of a person who would be seriously hurt by the passage of SB 211 is one of my clients. I represent a State of Alaska employee who was severely injured in December of 1983 when an air traffic controller cleared a Japan Airlines 747 tc land on the same runway where he was operating a pickup truck. As a result of the collision my client suffered horrendous injuries, including loss of body parts, severe loss of body function, permanent disability from ever working again, permanent disability from ever performing the physical activities which were so important to him, being in constant pain and having to take pain medication to cope with the pain. His marriage and family life have been stressed beyond belief though both the marriage and family still stick together.

Workers Compensation benefits pay his medical expenses, rehabilitation expenses and a portion of his living expenses. The workers compensation benefits are several hundred dollars less than his pre-accident take home pay. Because of his disabilities his living environment had to change from a cramped mobile home to a more expensive but more livable home. Furthermore at the time of the accident his wife was 8½ months pregnant and they have the added expense of a child who is now 4 years old. Though my clients' expenses increased over the last 4 years due to medical reasons and a change in his family circumstances, his workers compensation benefits which were based upon pre-injury earnings, have not. Fortunately, as a State employee, my client had selected a disability program as one of his optional state benefits. Therefore, the family does receive enough money between workers compensation and the disability program to barely make ends meet. They would be on welfare if the disability insurance program which he paid for as an employee hadn't been selected by him.

The federal government made a settlement offer that was totally inadequate (it wouldn't even cover the economic damages) one week before trial. The trial, before U.S. District Court Judge Holland, which started just about 3 years after the accident, was limited to the issue of damages and lasted approximately ten days. Because this was a claim against the Federal Government under the Federal Tort Claims Act my clients were not entitled to a jury trial. After the December 1986 trial was concluded months of delay followed. Judge Holland finally scheduled a closing argument on August 13, 1987 after doing an indepth review of all of the evidence presented in December 1986. Following the final argument a final judgment was entered by Judge Holland. He made awards as follows:

Mr. C:	
Future Medicals =	$ 606,369.51
Loss of body parts or functions =	824,680.00
Net Economic Damages =	1,066,668.76
Physical and Emotional Pain & Suffering	1,226,000.00
Loss of Enjoyment of Life (past and future)	342,500.00
Total Judgment For Mr. C	$4,066,218.27
Mrs. C:	
Nursing Services	$ 6,242.40
Loss of Consortium (past and future)	402,000.00
Total Judgment For Mrs. C	$ 408,242.40

State Of Alaska:	
Disability Payments in lieu of wages	$ 49,539.24
Permanent Partial Disability	43,320.00
Medical Costs	422,440.92
Total Judgment For State of Alaska	$ 515,300.16

The Government has now filed an appeal to the Ninth Circuit even though Judge Holland's award was less than a case with similarly serious injuries affirmed by the Alaska Supreme Court. That case Exxon v. Alvey, 690 P.2d 733 (Alaska 1984), was tried to a jury in State Court resulting in a $7 million dollar verdict which Judge Souter reduced to $5 million dollars by a remittitur because he believed it was excessive.

I anticipate that the Ninth Circuit Court of appeals in my client's case will affirm Judge Holland's decision and my clients will see the first dollars from the guilty tort feasors (the United States Government) some six years after his injury. It can be borne in mind that neither my client, I nor the state of Alaska have seen one red cent to date.

If the SB 211 cap were applicable to my clients case, Mr. C would receive $606,369.51 for future medical expenses, $1,066,668.76 for future wage loss and $100,000 for all other damages. As you can see non-economic damages for Mr. C total $2.4 million. If SB 211 is enacted placing a $100,000 cap on non-economic damages and if it were applicable to Mr. C, he would receive $100,000 for his loss of enjoyment of life, for his physical and emotional pain and suffering for his permanent disfigurement and his lack of bodily function. He would receive $100,000 for his "personal damages", for the damage to his life.

Mrs. C would receive $6,242.42 for nursing service and $100,000 for loss of consortium. This lady has been through pure hell being 8½ months pregnant at the time her husband was severely injured, not knowing whether she would be a widow or not, and maintaining a vigilance at the hospital for virtually months while Mr. C clung to life. Furthermore, she has stayed with Mr. C and will stay with him the rest of her life. Their life together is very significantly different than it would have been but for the accident. Her damage is certainly worth more than $106,000.

Please bear in mind when a federal judge awards millions of dollars to an injured person you can believe that the award is not based upon passion, prejudice or sympathy; it is based upon solid judgment and the law.

In summary, there simply should be no cap on the damages suffered by the individual whether they are economic or non-economic damages. Caps arbitrarily discriminate against those few individuals who are seriously injured. Such legal discrimination would constitute oppression of the worse kind by the majority of our society against the minority. If we are going to impose caps on certain types of damages it would be more fair to abolish the system totally and implement a new system that across the board takes care of injured individuals which society pays for.

The amendment to the punitive damage provision is simply a red herring and a waste of time. Even before the 1986 statute pertaining to punitive damages, in order for an injured person to recover punitive damages against a wrongdoer he had to prove that the wrongdoer had acted with willful, wanton and reckless disregard for the rights of the plaintiff. Willful, wanton and reckless disregard has also been described as malice, gross negligence or reckless misconduct. What I am saying is that the amendment proposed adds nothing to the law as it exists now and has existed for years.

The amendment which references damages resulting from commission of a crime is another red herring. However, it does have greater significance than amendments regarding punitive damages. I can conceive of a situation where the statute would lead to a grave social injustice. For instance, if a person was driving while intoxicated, (a criminal act) just over the legal limit, and another more intoxicated person ran a stop light and collided with him the first person would recover nothing and an argument would be made that the victim's intoxication prevented him from avoiding the accident. Is this a good social policy? I think the language contained in this section was the subject of a lot of negotiation in 1986 and it should not be changed.

The suggested amendment to AS 09.17.040(d), requiring that a court may at the request of either party order periodic payments of a judgment is simply wrong. Why should a guilty defendant have anything to say about how an innocent plaintiff receives payment of a debt owed? If we are going to enact this type of law for personal injury plaintiffs, we should also enact the same

sort of payment scheme in all lawsuits. When a bank files suit based on a promissory note and successfully obtains a judgment, would it be appropriate to allow the judgment debtor to then ask that future damages be paid by periodic payments rather than as a lump sum? What about a dispute between businesses over a breach of contract? I believe that if the statute is amended to provide that either party may request judgment be paid on a periodic payment that this will make the statute unconstitutional as a violation of the equal protection clause.

Furthermore, what guarantees would there be that the judgment debtor would be able to make the periodic payments in the future. Why should the plaintiff who has fought the battle to prove the debt is owed have to risk the defendant going broke in the future.

Also, the major purpose behind litigation is to resolve disputes once and for all and let the parties go on about their respective lives. If the injured party is continually receiving payments from the party responsible for the injury there is no resolution. Instead the unpleasant experience continues and continues and continues. This is not beneficial to our society.

The amendment to AS 09.17.050(a) providing that members of boards of directors or officers of electrical or telephone cooperatives are immune from suit is not particularly offensive so long as the underlying organization would be liable for any misconduct by the director or officer acting within his official capacity.

The next issue addressed by SB 211 is the collateral source rule. The 1986 statute regarding the collateral source rule was a result of a compromise which to date has not had an opportunity to be tested. The primary difference that I see between the 1986 statute which I thought was outrageous when it was passed, and the amendment which has been proposed was that no consideration whatsoever is given for the costs incurred by the plaintiff in collecting the debt (the attorney's fees). I continually must ask myself why somebody who suffers an injury innocently and then must incur costs and attorney's fees in order to collect the damages should not be fully compensated for the reasonable attorney's fees that they have incurred. At least the 1986 collateral source rule attempted to take the attorney's fees and cost factors into consideration. The 1988 amendment does not.

Instead, it simply allows the wrongdoer to benefit from collateral sources which the victim through his or her own foresight has put into place to protect themselves.

If this amendment were applicable in the case described above, the federal government would have to pay less future wage loss to my client because of the disability benefits that he paid for though his employment before he was injured. Why should the guilty defendant be able to benefit one bit from the thoughtfulness of a responsible person who protects himself from accidental loss of his earnings.

Applying this statute or for that matter even the 1986 statute to my client who was hit by the 747, we would find that the Federal Government would reduce its liability to my client by the amount my client will receive for permanent disability benefits under the State disability program which he paid for. This would be a windfall to the government. Since the government did not pay the premiums nor decide to provide for that coverage they should not be entitled to receive the windfall.

Next is the issue of joint and several liability. SB 211 creates several liability. What this means is that when more than one person is responsible for an accident the jury shall determine the percentage of responsibility and enter a judgment only against the particular defendant for his respective percentage of fault. This sounds fair at first blush but there are some serious problems with it. First, what happens if one of the defendants has no money? The answer is simple. The plaintiff does not get compensated from that defendant. Thus what the change in law will do is shift the risk of injury by a judgment proof defendant from his co-defendants to the innocent victim. This is even less fair than an arrangement where a wrongdoer who is 10% at fault has to bear all the costs because the wrongdoer who was 90% at fault has no money. The 1986 amendment provided some relief to the defendant who was less than 50% at fault, though it still left payment responsibility on the shoulders of that partially responsible defendant. This seems like a reasonable compromise between pure joint and several liability and several liability. It shouldn't be tampered with.

Even if the Legislature in its wisdom decides that on a social policy basis it is better to make the innocent plaintiff suffer the consequences of being hurt by a judgment proof

defendant than to make his fellow wrongdoers suffer the consequences, an even more practical reason exists to not adopt the several liability provision.

Under pure several liability if a person has even one percent of responsibility they will have to be named in the lawsuit. Any time an attorney files a lawsuit without naming everyone who may have responsibility he would be committing malpractice. If a party with some responsibility is omitted and the case goes to trial those who are named in the suit will be pointing a finger at the "empty chair" and doing their best to shift as much responsibility onto the empty chair. This means that every general surgeon, anesthesiologist, nurse, emergency room technician, emergency room doctor, ambulance crew, and hospital will have to be named in a lawsuit arising out of an automobile accident where someone died and it looks like they would have lived if they had received just a little bit better medical care. This will make lots of money for defense attorneys, take significantly longer to try cases, and make simple cases even more complex. I predict under a pure several liability system the civil justice system as we know it today will suffer many, many more problems than we see currently.

Last but not least was the movement in SB 211 to amend Title 9 §60.010 abolishing rule 82 attorney's fees. This effort makes absolutely no sense if we want Alaska's civil justice system to fairly compensate people who are damaged. If I owe the bank a debt and they have to incur substantial costs and attorney's fees to attempt to collect that debt which I have agreed to pay they ought to be paid their reasonable collection costs. That is what Rule 82 does. Not only in personal injury cases but also in breach of contract actions and all other civil disputes.

The existence of Rule 82 deters many plaintiffs from pursuing claims which are weak or non-meritorious. They simply do not want to take a chance that they will lose and then have to pay the other side's costs and attorney's fees. Without Rule 82 they would have no risk and there would be no reason for them not to pursue any lawsuit that has a colorable chance of surviving. By the same token a defendant either an insurance company or an individual is going to be more willing to resolve the case out of court if he knows that he is going to lose in court and if he knows that he will have to pay Rule 82 attorney's fees.

I would point out that in Federal Court attorney's fees are only awarded under certain specific statutes. In the case described above regarding my client who was hit by the 747, the trial Judge denied my request for attorney's fees because Judge Holland does not believe that the law permits him to make such an award. It is my firm conviction that the United States would have made a more reasonable settlement offer and would have avoided trial in that case if they had known that an additional award for attorney's fees would be imposed against them. As it is the government had no threat of attorney's fees being awarded against them hanging over their head and accordingly they have acted with utter disregard for my clients' rights. Also punitive damages may not be awarded against either the Federal government or the State government. Therefore, the attorney's representing governmental entities could act in the most irresponsible manner imaginable.

In summary I would like to reiterate some of the following points. First, there is simply no evidence that making the changes described in SB 211 which will seriously impact the rights of individuals who suffer injuries will provide the rest of us with any relief in insurance rates. If there was reliable evidence of this fact then there might be some justification for the sacrificing of the rights of injured for the good of the rest of us. But there simply is no such evidence and there will not be any such evidence until the laws regulating the insurance industry are changed requiring accurate reporting of losses, earnings, claims and other information. Second, it is appalling that a civilized society would change the law that gives full monetary recovery to people who have suffered horrendous injuries while not making any change to the law which though effecting a greater number of people, effects people who have less significant injuries. That is the legislative equivalent of the robber who steals the purse of the rape victim. The act amending joint and several liability to just several liability will be known as the 1988 attorney's welfare act because it will create more employment for attorney's than any legislation enacted in modern times. Last but not least, the abolition of Rule 82 attorney's fees will result in more litigation, fewer settlements and less money ending up in the pockets of victims with more ending up in the pockets of the defense attorneys. This legislature should leave well enough alone; it should leave the 1986 tort reform act in place without amendments until we can see what effects that has had.

Yours very truly,

Elliott T. Dennis

W/C 8

Rene Bales
4859 Weslyan
Anchorage, Alaska 99508
February 5, 1988

Dear Senator:

We all agree the system is not working. We all agree too much money is spent to keep the present system. But a wrong doesn't make a right! Things that need to be changed should equally be done for the good of all and not the good of some. Injustices have to stop. For by whatever name they are called they do exist and are causing a lot to hurt. I for one would like to see costs down but not at the expense of the worker and family. They are the real victims. The insurance raises premiums, the employer pays, but what does the worker do when he is injured, unable to work or make wages that are not able to put food on the table? It is well and good to say that people are using the system for monetary gain, but lets be sensible, who stands to gain by all of this, surely not the injured worker. If you really check claims you will see that most of the money goes to the doctor, rehabilitation, therapy and defense attorney. Only after people can't afford to have to hold out any longer they submit and accept too soon and settle. I know of many of such cases.

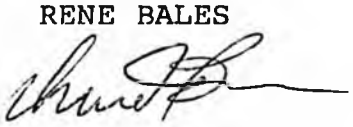
It is a known fact that doctors are being influenced prior to doing an IME requested by defense attorneys. They are told what they want to hear and some doctors very unprofessionally comply even at the point of asking such questions as how much money the injured workers' spouse makes, why are they doing this (meaning going to hearing). Vocational Rehabilitation doesn't help. They go through the motions but they know there is no industry or job that will employ injured workers with limitations. They collect all that is in the kitty and more and after harrassment, lies, etc., they throw you to the wolves. As for the word stress, you can be sure that by the time they get through with you if you were a normal, unstressed person, you aren't after they are finished. Some doctors treat us like criminals and by the time vocational rehabilitation gets through with y ou we are nothing. But that's OK with them. They can blame stress that may have been pre-existing and try to get away from the main issue that you are injured. You are not OK and will never be again. Your life has changed and it is easy for those who are not in your shoes to say forget the continuous harassment. The injured worker has trouble getting an attorney when by law they only get 10% on top of the benefit awarded. Thus very few attorneys who are willing to stay in workers' compensation cases because there is little money in it but the defense attorney have the right to

set fees and they can afford to spend unlimited amounts to find reasons as to why claimants shouldn't receive the money due him or her even after proof of injury. IME's only serve for the purpose of finding a willing doctor to lie or twist the truth and we have quite a few in this town that are doing just that. If this situation exists now it can only worsen by giving insurance carriers power without repercussion when mistakes are made deliberately. It is ironic that insurance companies want to take steps to stop doctor shopping by workers, for the reverse is true. IME's are intended for just that and injured workers are usually being sent to them even after medical proof on disability. In my particular case the doctor's deposition in my favor I ended up paying for $660 for wasn't even introduced.

I go on with life for me it will never be the same. I have lost 6½ years of my life, the years when I should have been the happiest. I feel like an old lady already unable to do the things I like. All they can say is chronic pain - Give me a break! Why would I want to not work? The money I get now isn't even enough to go out to dinner or pay for the help in my house that I need. I was a very happy energetic person before. I enjoyed work and independence. I have nothing to gain from this except misery. I would gladly give you the $35.00 a a week if I could gain my health back.

Sincerely,

RENE BALES



ALASKA
CLEANERS

January 29, 1988

Senator Tim Kelly, Chairman
& Members of the Senate
Labor & Commerce Committee

Representative Dave Donley, Chairman
& Members of the House
Labor & Commerce Committee

As a service industry we are very labor intensive and very sensitive to the cost of maintaining that labor.

During 1985 our Workers Compensation premium costs were $ 548.27/employee; by 1987 this had risen to $ 840.83/employee and now is projected to be $ 1115.43/employee for 1988. This represents an enormous increase of over 103% in just four years and represents a considerable real dollar increase in our expenses when applied to our 165 employee labor force.

In a memorandum, dated October 22, 1987 prepared by Don Koch, a Special Deputy for the Alaskan Division of Insurance, the following statement was made:

"Recently, I had occasion to look at losses isolated from the premium and I had a bit of a shock. In 1983 worker's compensation losses were $70,678,000; in 1984, they were $89,789,000; in 1985 they were $124,447,000; and in 1986 they were $150,294,000. That is more than doubled in a four year period and with a decreasing payroll base to boot."

In analyzing our claims during recent years I am of the belief that somewhere between 30 & 40% of the claims are the result of problems that are not directly caused or occasioned by employment. Bursitis, rheumatoid arthritis, osteoarthritis, hypertension, depression, coronary heart disease and even hemorrhoids are but some of the many pre-existing conditions that can result in a worker's compensation claim.

While it is unfortunate that individuals have to suffer with these and other disabling diseases, aliments and infirmities, it must be recognized that many of these and other ailments and infirmities are related to diseases, ageing, diet and other environmental factors other than those of employment in and of itself.

The original purpose of the worker compensation law was to insure a speedy and humanitarian remedy for injured workers. The key phrase here is "injured workers" not those with diseases, ailments and infirmities that are not directly or substantially caused or occasioned by

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employment and certainly not those that were in existence prior to employment.

Therefore, I would propose that the following addition to AS 23.30.120 (insert between line 4 and 5 on page 16) be made by the Legislature:

"(a)(5) The injury, illness, infirmity or ailment was, wholly or substantially, directly caused as a result of employment. Further, that, the injury, illness, infirmity or ailment was not a pre-existing condition."

It is my belief that this one single action will have a far greater impact on premium reduction than any other single action. It certainly leaves intact the basic purpose of the law which is to insure a speedy and humanitarian remedy for injured workers.

It is imperative that the employers in this State receive some Statutory relief and that Alaskan Jobs be protected, therefore,if the legislature does not agree with the wisdom of my proposed change then I prey that at the very least SB 322 and HB 352, which represent an unusual alliance of both labor and management, will be passed, thereby helping to aid all the citizens of our Great State along the road of economic recovery.

Thank you,

Tim R Crawford,
General Manager
Alaska Cleaners

Alaska State Legislature

Please enter into the record my testimony to the Joint House Senate Labor & Com. committee name

HB 352 — SB 352

committee on Workman's comp bill/subject, dated 2/12/88.

My testimony concerns my own personal treatment by Alaska Timber Insurance Exchange. I work for Wrangell Forest Products - Wrangell and incurred a knee injury 7/5/87 with required a subsequent knee surgery 12/29/87 - this claim has been judged valid by A.T.I.E. however it has been 47 days since my knee surgery and I have not received any weekly compensation or any compensation at all. I feel this is an unreasonable amount of time to delay payment of benefits. I am single, have a child in school and no financial support to fall back on other than my personal savings and I don't see this as speedy response to a just claim and this has created an undeserved hardship on me.

Signed: Joan Orr
Testifier

Self
Representing (Optional)

POBox 952 Wrangell
Address

907 874-3760
Phone No.

P.S. I would like a response to my letter, please.
Thanks Joan Orr

9/86 Legislative Information Office

9

February 22, 1988

To: All Legislators, in the State of Alaska

In responce to Senate Bill No. 332 before the Labor & Commerce and Judiciary Committee:

It seems to be a collective opinion among suppliers, subcontractors, and general contractors that the adoption of this bill would be detrimental to sound business practices and in direct opposition to responsible legislation. Please consider the following:

1) Liens are not placed on a construction project until all other avenues of payment collection has been exhausted and payment promises have not been kept.
   a) we know that if a lien is placed against a project that we may never work for that builder again
   b) it is time-consuming and costly to place a lien on the project in the first place
2) Some of us have had promises of payment within 7-10 days from an aggressive approach in our collection efforts, only to find out that we had given them enough time to transfer from a construction loan to a long-term loan.
   a) a lien on property in long-term financing means nothing until the property sells again, and we know that may take 1 to 20 years until we get our money.
   b) without civil court action, the builder who failed to pay construction costs is removed from responsibility.
   c) the bank is also removed from responsibility, even though they were expected to insure that all monies in the construction loan were spent for that purpose.
   d) the bank should make sure that there is no chance of a lien before long-term financing is considered.

The result of current laws has left the buyer and the subcontractor alone (without court action) to settle any problems resulting from the failure of the bank to verify that all involved in the construction project were paid and they are offering a lien-free building.

Your legislation No. 332 is going in the wrong direction since it supports those who do not pay their bills in a timely manner, and would give them additional time to avoid their responsibility. (SEE #2 ABOVE)

Again, we only lien as a last resort and this irresponsible legislation will force all of us to file an intent to lien before the work actually commences (which we can't do unless the builder also owns the land, which is not always the case).

May I suggest some responsible legislation? I feel that the State of Alaska would be acting responsible if there were legislation requiring all lending institutions to receive a lien clearance from all construction participants upon completion and final payment for their charges on that project, before any long-term financing is completed.

a) this would prevent the person(s) receiving the construction funds from using it for other purposes.

b) this would insure the buyer(s) that the project would not be liened at a later date. (now they, theoreticaloy, can receive a guarenteed title policy -lien free- dated "July 1, 1988" and then receive notice that on "July 2, 1988" a lien was filed since the construction costs for the project had not been paid; leaving no recorse except through legal channels)

c) this would keep the lending institutions, the builder, the subcontractor, the supplier, and the new owner all in a position to settle any differences; rather than, as stated previously, relieving the bank and builder from any responsibility (these two should have had responsible control of the construction funds in the first place)

Again, it would seem like such a simple solution to require the bank to have signed lien releases from all contractors, subcontractors, and suppliers before transfering from a construction loan to a permanent, long-term loan.

I would also recommend that on the lean release form, all contractors and subcontractors be completely identified in order to verify they are duly licensed, bonded, and insured as per State requirements. They way it is now, there is no better way to enforce your own past legislation.

My opinion, which is shared by many others, is that the State is irresponsible in these areas. I would be happy to face any committee with this charge, as it is based upon 13 years as a subcontractor in Alaska.

I will maintain a complete record of all of your personal responses to me about this matter, and, although there are a great number of people involved in the construction trade in Alaska, I will do my best to forward your information and comments to them. This will let us know who we feel is working for us and which of you oppose us.

I would rather feel that my suggested legislation will increase responsibility, confidence, better construction and communication by meeting the needs of all Alaskans.

Please be interested enough to respond and express your opinion, pro or con.

David J. Tilton

P.O. Box 83770
Fairbanks, Alaska 99708

February 23, 1988

Dear Senator:

Will you Please consider sponsoring legislation to address the following:

I feel that the state is inconsistant when they legislate laws that plumbers and electricians be tested and licensed as craftsmen, but do not verify that when Alaska Housing monies are spent that the work is actually being preformed by those fully qualified craftsmen, as the state mandates.

Many times an individual who receives a construction loan and hires out or preforms the work themselves, are doing substandard work (because they just are not qualified, as mandated by the state). They then sell the new house and its construction problems to some poor individual, who thought that since the Alaska Housing had provided the funds, they had a quality built dwelling. Your present legislation doesn't protect the unsuspecting buyer. Your state inspectors will tell you that new buildings have safety violations and maintenance problems built in. Let's close the loop holes.

Legislate laws that would require all lending institutions to insure that at least the electrical and plumbing installations were performed by state mandated licensed plumbers and electricians (espically when using state monies). If you feel that the owner has a right to do all the work himself, then require him to have a craftsman inspect his work and sign their approval in case the property is sold at a future time. Or, you could increase your current number of state electrical and plumbing inspectors and staff and require they inspect before the bank or lending institution closes the construction loan. This makes sure that the buyer gets what he believes he is getting, from relying on the state requirements.

Someone, other than the new buyer, should be held responsible for poor construction. It should not be a buyer-beware purchase, but a transaction with responsibility for all parties concerned. Let's protect everyone.

Your present mandate, that plumbers and electricians be licensed, is really only holding the ones that are fulfilling all state requirements responsible. In the meantime, at least half of the work performed outside of the city limits is performed BY less than qualified craftsmen. You may check with the state plumbing and electrical inspectors to verify this point.

I feel that you should repeal the licensing OR fully enforce it by closing all loop holes. As noted, currently you basically target only licensed craftsmen. This is because you don't have the banks and lending institutions helping you hold responsible the unknowns who are not registered.

I would bet that every legally licensed plumbing company in Alaska has been called into a new home to correct the problems created by unlicensed craftsmen in the past two years. Let's hold those unlicensed people responsible for the problems they create for the new home owner. The only way you would be able to do this is to enforce your own mandate, having that craftsman on record.

Will you please write me whether or not you have decided to create such legislation on this matter. I also would like you to include all your thoughts and comments (pro and con).

Daivd J. Tilton
P.O. Box 83770
Fairbanks, AK. 99708

February 2, 1988

Dear Senators and House Members:

This letter references the proposed new Workman's Compensation Bill (Senate Bill No. 322 and House Bill No. 352). After attending the recent teleconference hearings and testifying before the committee at the public hearing held in Anchorage on January 29, I decided to send each of you a copy of my speech.

I am not a public speaker, nor am I a politician. I am an injured worker who has been through some of the bad faith methods the insurance company practices. This bill made me so mad that I recently registered to vote and have joined a group that will campaign against anyone who votes for the bill as is.

The proposed bill has been tailored to benefit insurance companies and employers, while the employee is often left in the cold. I feel you were elected to serve as the people's voice and to represent the public interest, not the concerns of big money. I am asking for your support in ensuring that worker's needs will be met.

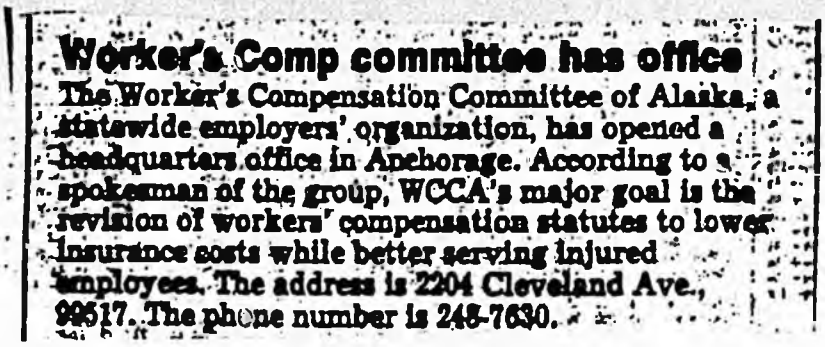
In closing, please feel free to call me if you have any questions or feel I am off base in my statements. If you have already decided to vote against this bill, please disregard this letter. In any case, thank you for your time.

Sincerely,

Rodney J. Fults

Rodney Joe Fults
6311 Debarr Road, #124
Anchorage, Alaska 99504
(907) 333-2576

Hello. My name is Rodney Fults and I am speaking as an injured worker that knows the Workman's Compensation System. I've been through it... The reason I got involved with this bill? I read this in the paper...



Worker's Comp committee has office

The Worker's Compensation Committee of Alaska, a statewide employers' organization, has opened a headquarters office in Anchorage. According to a spokesman of the group, WCCA's major goal is the revision of workers' compensation statutes to lower insurance costs while better serving injured employees. The address is 2204 Cleveland Ave., 99517. The phone number is 248-7630.

Well, I went to the Legislative Affairs Building, got a copy of the bill, and read it when I got back to my truck. After I read it, I got out of the truck and walked back to see if I had dropped part of the bill, because I couldn't find the part that "better served the worker."

FIRST OF ALL, I would like to comment on the part that states "the board poses the greatest possible authority in the exercise of its fact finding responsibilities and that the board's decisions be conclusive if supported by any evidence." This means you can't take it to the courts if you feel you've been wronged. The words "any evidence" could mean "wrong evidence" or "bad evidence." This is a clear violation of the 14th Amendment of our constitutional rights...the right to due process. What's wrong with the WCCA? Don't they have any faith in the Alaska Court System? They trust twelve board members but not twelve honest people and a judge? I feel this gives the Comp Board too much power. We need a check and balance system.

Section #9 page 1 House Bill #352

SECOND...the part of the bill that states changes of benefits according to what state you live in...I believe this will encourage out-of-state hiring, especially for self-insured companies. It would be cheaper if you had a job going and some worker from Mississippi was injured than if an Alaskan worker was injured. Alaskans would be discriminated against more than they are now. Imagine living in Anchorage and having to get a post office box in Seattle so you could get a job in Alaska...

Sec. #21 page 19

THIRD...The Independent Medical Exam...This bill talks about cutting medical cost, yet at the request of the insurance company an injured worker must go to a doctor, hand picked by the insurance company, for an exam. This doctor is paid very well--$500 to $1,000 for 30 to 45 minutes. If the doctor doesn't give the report the insurance company wants, they discontinue future use of this doctor for Independent Medical Examinations. If he gives them the report they want to hear, they've found themselves a "new friend." As a normal doctor visit only averages $50.00, I feel this should be looked at as a bad faith method.

Sec. #10 page 13

FOURTH...Litigation...Litigation is brought on by the insurance company's lawyers to try and get out of the responsibility, not the injured worker trying to get on workers compensation. Defense lawyers are paid two to three times the amount the lawyer for the injured worker receives. Lawyers fees for the injured worker have to be okayed by the Comp Board. If they are not okayed, they will not be paid. The defense lawyers, on

the other hand, do not have to be okayed and they can make up any excuse to litigate a case--literally "starving out" the injured worker in the process. This should be changed to where all lawyers fees need to obtain approval from Board. This needless waste of money should be stopped.

FIFTH...I would like to see a breakdown in cost. What are the litigation costs listed under? Rehabilitation? Medical? Wages? I also feel that before anyone votes on this bill, insurance companies should show their profit margins for last two years as premiums have gone up 40 to 60% in that period. A lot of costs seem to be hidden or not monitored. As one committee member said in the public hearings in Juneau last week..."they have a difficult time getting that information." If only 30 cents of $1.00 goes to the injured worker, I think we should know exactly where the rest goes...

SIXTH...The subject of a Rehabilitation Specialist...They want to cut cost, but yet they speak of hiring more people through the State. This would not only give one person too much power over another person's future, but would also add cost to the State. I feel rehabilitation should be a voluntary program. This certainly needs to be re-examined.

Sec. #6 page 4

SEVENTH...Cooperation...If you don't cooperate with the Rehabilitation Specialist you lose your benefits. That means if you don't agree with what they say about your future, you're screwed. If you don't attend designated programs, your benefits stop. Does this mean if a person gets the flu and misses a week of school, they're out of the program? These things are worded too vaguely. It leaves too many loopholes that are not to the injured worker's advantage.

Sec. #6 page 7

EIGHTH...Requires the most recent employer to make the compensation payments if there is a dispute of liability. This should not even be in this bill. There is already a law that covers the "last injurious exposure". All this would do is discourage anyone from hiring you if you've ever been injured before.

Sec. #19 page 17

NINTH...Section 9 deals with a "written plan for continuing medical treatment" within seven days of treatment from your attending physician. I don't know about you, but I'm not a damn car going to the body shop for an estimate. Doctors don't always know what you're going to need in a week.

Sec. #9 page 13

TENTH...I don't agree with this bill, but I do agree with a maximum of $700.00 per week. I don't know many workers who can't make it on that amount.

Sec #21 page 18

In summary, I've listened to several people in Juneau stand up and beg for the legislature to pass this bill "as is" because the WCCA worked so hard putting it together. Hard work isn't the issue here. Jesse James worked hard, but that doesn't make what he did right. I've also heard Workman's Comp referred to as a runaway train. You don't stop a runaway train by shooting the passengers.

Next time the WCCA decides to write a bill of this nature, I hope they talk to the workers and ask for their input.

BENJAMIN B. TALLEY
Brig. Gen. U. S. Army, Retired
HC 67, Box 600
Anchor Point, AK 99556-9702

Tel: 907 235-7473

31 January 1988

Senator Tim Kelly
P. O. Box V
Juneau, AK 99811

Dear Tim:

Thanks for your letter of January 27th pertaining to committee hearings on the Workers' Compensation Reform questionnaire.

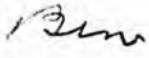
I will try to attend the Committee hearing in Anchorage on February 12th.

The fact that only 30% of funds appropriated for workers' compensation actually reaches the injured workers does not surprise me too much. I believe this can be improved.

May I cite one improvement made in New York City. Originally, relief checks were mailed to recipients at their New York City addresses. The procedure in New York was changed, and recipients were required to call in person for their checks. The number of recipients dropped by more than 12%. Many no longer lived in New York but had moved to Florida, to Hawaii and elsewhere.

If feasible, I would like to discuss this with you or someone on your staff at the Legislative Office in Anchorage in mid-afternoon of 11 February. In anticipation of this, please send me a copy of the Questionnaire.

Sincerely,



BENJAMIN B. TALLEY
BRIG. GEN. U. S. ARMY, RETIRED
STAR ROUTE BOX 600
ANCHOR POINT, AK 99556
(907) 235-7473

10 February 1988

COMMENTS OF B. B. TALLEY, BG, USA (RET)
ON WORKERS' COMPENSATION REFORM
FOR HEARING BY ALASKA LEGISLATURE
SENATE & HOUSE LABOR & COMMERCE COMMITTEE
February 12th, 1988

These comments are based on my own experience during the period I was respnsible for spending $350,000,000 on military construction in Alaska during WWII, and more than $1 billion on military and civil works for the Corps of Engineers while District Engineer at Huntington, West Virginia and at Louisville, Kentucky, as Division Engineer, North Pacific Division, New York, and Mediterranean Division, Nouasseur Air Base, Casa Blanca, Morocco.

It is not too surprising that only thirty cents of each dollar appropriated for Workers' Compensation reaches the injured workmen. I am not familiar with the details of the Workers' Compensation legislation, but I accept the fact it was enacted in good faith and with the best of intentions.

Then, why has it gotten out of hand? There may be many reasons. The more likely will be discussed.

The first is a spirit of laissez-faire; meaning, among other things, non-influence in matters of economics and business, or, more simply, "Don't rock the boat." Over a period of time, these can result in a situation such as the Reform Questionnaire is endeavoring to correct.

Also: there is the question of politics, which I will comment on from what two of us were told in 1946 by then Governor Gates of Indiana. The official from Washington who was with me said to the Governor: "Then, there's the question of politics." The Governor replied, "It is my experience that the best politics is 'Good Government'."

In each organization of which I was in charge, I had a comptroller who was a watchdog over expenditures and the efficiency of operations. My door was always open to him, and I listened to his comments and recommendations.

Here are some of the results.

In Alaska, our "overhead" for operations by civilians was approximately 5%.

In the Mediterranean Division, I refused to accept approximately 124 pickup trucks which had been ordered from "available funds." Also, when the U.S. was given responsibility for heavy construction by their respective governments in Iran and Pakistan, initial cadres of personnel for Corps of Engineer Engineer Districts at Tehran, Iran, and Karachi, Pakistan, came from "available" personnel in Morocco, together with the trucks mentioned above.

In North Atlantic Division, New York, after WWII, when we were demobilizing, we received a quarterly personnel ceiling showing our future authorized quarterly strength. When the first ceiling came, the comptroller told me we were already below that ceiling. We stayed below it in succeeding quarters without a "RIF". We met it by normal attrition and a reshuffling of personnel.

The problems of handling Workers' Compensation are different from those mentioned, but the principle is the same. It is based on the will to do what is required to accomplish the necessary result.

New York City had a similar problem. Relief rolls were exhorbitant. Relief checks were sent through the mail. This was changed by requiring the recipient to call in person for his or her check. Relief payments dropped by about 12%. Many no longer lived in New York, and checks were being forwarded by the Postal Service. Many were sent to Florida, California and Hawaii.

Now, what to do about the workmen who have left Alaska?

It may be possible for the State to examine the Federal income tax returns of recipients of disability compensation, or to ask the individual recipient to furnish a copy of the return. The returns would show whether wages are being received for work done by the recipient of the workers' compensation. The return would also show the address which the recipient used for tax purposes. The legality of obtaining returns from the federal government should be investigated.

The question of continuation of payment of disability compensation at Alaska rates for those who have left the state can, I believe, be handled equitably.

Residents of Alaska who are eligible for the Longevity Bonus must apply for it each month. If they are out of the state for more

than one month, they do not receive the Bonus payment for the period they are absent. If they are out of the state for more than three months, they are disqualified for payments until they are again residents for one year. Also, checks cannot be forwarded from the Alaska address to which they are sent.

An analogous solution can be applied to the payment of workers' compensation, either by eliminating payment to those whose income as shown by data on their income tax return shows they are employed and are no longer dependent on workers' compensation for their livelihood, or it can be reduced to compensation at rates similar to those in the locale where they are living.

January 19, 1988

John J. Breyer
P.O. Box 141845
Anchorage, AK 99514

Senator Tim Kelly
Senate Labor & Commerce Committee
P.O. Box V
Juneau, AK 99811

Dear Senator Kelly:

I have enclosed the Workers' Compensation Reform Survey and am also including some additional comments that I believe you will find helpful.

Not all, but most, unions and employers turn their backs on their injured workers and those workers are left to fend for themselves. I believe the unions and employers should work more in conjunction with the State in retraining the injured worker. If this is not possible, then the injured worker should be trained in a new field.

The amount of workers' compensation benefit should not be reduced. The benefit is based on the injured workers' past wages and, in many cases, is far lower than they were making when they were actively employed. Neither should the injured worker be penalized for moving outside for retraining as this could be the only way he can keep his head above water.

A year should be enough time before the worker is determined to be permanently disabled depending on the injury suffered and the amount of time anything medical has been done.

I believe that one of the main reasons costs are getting out of hand is not the benefit being paid the injured worker but all the people involved in the administration of his case, i.e. rehab counselors, adjusters, IME doctors. The private rehabilitation counselor should be replaced with a State rehabilitation counselor who could perform the same function of the private counselor at a much lesser expense.

Injured workers should not be limited to just one doctor. The claimants should be allowed to be treated by a physician that they have confidence in and feel comfortable with. The insurance adjusters have a group of doctors that they use. These doctors will almost always come up with an IME report that will contradict the claimant's treating physician. I know of one doctor in Anchorage who testified in court that he makes $60 to 80,000 a year, just from the work he performs for the insurance adjusters. How can this opinion not be biased?

To place a limit on the rehabilitation program could be very discriminating. It is much easier to retrain someone who was making $7.00 an hour and is 24 years old versus someone who made $20.00 an hour and had 20 years work experience in one field. The worker who was earning more at the time of injury would need training that would restore him to something close to his former earning capacity. To limit the voc-rehab plan to two years with a cap of $10,000 would be very unfair and in many cases placing a limit on retraining programs would limit those programs to only low paying positions.

If total temporary disability were limited to two years, I believe the adjuster would drag his feet until the two years were almost up and then dump the worker without any retraining being given. Temporary partial disability should not start being paid until the worker has been retrained and back to work, if that is the case.

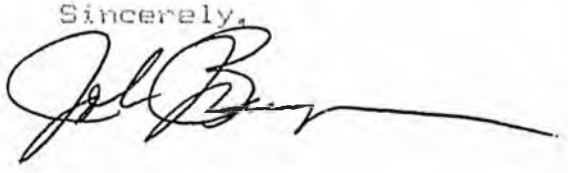
The adjuster should be restricted as far as his reasons for cutting off benefits to an injured worker. When you are on workers' compensation the harshest thing you deal with, aside from your injury, is the uncertainity. Not knowing whether the adjuster has decided that this was the week to cut you off without having any legitimate reason.

I agree that the system needs to be overhauled. The inequities that are present in the system are both unfair to the worker and very costly to the employers. The real problem, as I view it, is all the other persons who make a living off the injured worker's claim, i.e. adjusters, rehab counselors, doctors who give IMEs.

I believe that within the statutes there should be guidelines set down that all parties would have to abide by. (When the worker is able to start retraining, deciding on the voc-rehab plan,etc.)

At the present time, the injured worker is in the weaker position compared to the adjuster who seems to have all the control and, in many cases, uses it unmercifully.

Sincerely,



ROY W. WILLIAMS
P.O. BOX 671011
CHUGIAK, ALASKA
99567

January 20, 1988
Senator Tim Kelly

This letter is in response to your questionaire concerning workers compensation.

My first impression is one of anger in light of the limited structure of this questionaire, and the disregard it shows for professional opinion and comment.

My feeling is that you have not pursued the insurance carriers for the reasons causing these rate increases. Should you do this with dedication I feel you will find gross missmanagement of their funds and a feeling that the easy way to cover their losses is to raise rates and cut services.

I have never filed a claim for injuries with workers comp. but I do work heavy construction and oil field service where the possibility of major injury is always a mis step away. Also you must consider the lesser revenue causes these companies to make cuts in safety practices; even though no one wants to admit to it; neverthe less it is the real situation and will continue to get worse as time goes by.

Before you set out to penalize the working people of ALASKA for trying to earn an honest living , please reflect on the cost of babysitting the criminal element you so readily protect . Also consider the amount of money this state controls but offers no kind of health insurance for the people, or partnership proposal to address this problem.

Also consider that working people already pay for 3 health coverages, Medicare, medicaid,Veterans and then we pay for our own with--out the benefit of tax relief until we spend at least 7% of our income.

In summary I hope you and your committee will reflect on the fact that you represent the people that voted for you to represent them... Companies and Insurance agencies do not vote.

THANK YOU

Roy W. Williams

Dear Senators and House Members:

This letter is in regard to House Bill 352 which proposed changes in the Workers' Compensation law. On page one of this proposal at line 14-15, it states "The legislature declares that the Workers' compensation laws must not be construed by the courts in favor of any party." This part denies the worker to take any dispute to the courts. Has the legislature found our courts wanting or needing.

Page 6, line 5, part E states "an employee is not eligible for re-employment benefits if" (see part 2 line 11) the employer has been previously rehabilitated in a former workman's comp claim and returned to work in the same or similar occupation in terms of physical demands." My question is, if the injury is clearly a new injury, why do you not want to give the injured worker his right to re-employment benefits or have you guys decided to have this as a once-in-a-lifetime benefit. What a sorry commerce kissing plan.

Page 7, line 14-19 - If an employee is in the re-employment part of workmen's compensation, an employee will be considered non-cooperative if he fails to maintain average grades (C) in any schooling they propose, and if you don't maintain an average C grade, you are history. Any one who can see through a ladder can see that this new piece of legislation is definitely not for your average worker. If the average construction hand could hold down average graded (C), or better, he darn sure would not be a blue-collar worker.

Page 9, line 4-6, the cost of the re-employment plan incurred under this section shall be the responsibility of the employer, but may not exceed $10,000. It will take a lot more than $10,000 to re-employ a man physically incapacitated, especially if a limb is missing.

As the law states, a person doesn't even have to have a degree to be a rehabilitation specialist. I believe they should.

Page 9, line 26, your definition of "employability" is an amazing snow-job designed to dump the worker off workmen's comp. You are aware of this and I plan to make the workers and voters in my voting district aware of this in the next election. Rest assured of this fact. I will also organize other voters in other districts come next election.

Page 10, line 6, if you are injured and on workman's compensation and a job in Timbuktu is available, you must take that job - 3,000 miles from home, family, friends, future union benefits, relatives, possessions, or whatever, or you are off workman's compensation. If by now you have discovered I am mad ------ you are right!

Page 12, line 7-9, this next one really blows my mind. The bill states "the employee may not make more than one change in the employee's choice of attending physician without the written consent of the employer." The injured worker has never been the one who is doctor shopping. It has always been the insurance companies who search (doctor shop) for a doctor who will give them a favorable report or diagnosis and the insurance companies pay well, and I mean <u>well</u> if this new found prostitute will examine you and report back with the right words. They are paid $700 to $900 for a 45-minute exam of the injured worker, and if they don't give the insurance company the <u>right</u> report about the injured worker, they are no longer used by the insurance company for independent medical exams. They then are back into honest medicine.

You may not know it, but there are only a few (10 or 12) doctors in town who will prostitute themselves and these are used a lot by insurance companies. Most doctors will give an honest IME, but that is not what the insurance company wants.

<u>Scenario</u>: A man is injured and is sent to town and is usually coerced into seeing the company's doctor or the one recommended by the insurance company. Then he can make only one more change and then must get permission from his past employer (who by now is mad cause this man got hurt) and will not get their permission and <u>must</u> stay with his <u>second</u> choice irregardless of the doctor's field of expertise and specialties.

You are either ignorant or you think the voters are ignorant if you think we will take this piece of legislation as is. Your opinion of the general public must be at a new low if you think we believe this new law is for the injured worker. Don't forget who you are supposed to represent.

Page 13, line 8-9. "The initial treatment plan may not include more than 20 visits in the first 60 days." Why limit the visits to 20 the first 60 days and 4 per month in the next month unless you have completely disregarded the injured worker's needs and rights to fair treatment.

Page 13, line 15-29, more money will be spend by the insurance company on IME than the employees will spend on treatment. And, yet, the insurance company is screaming that too much money is spent on doctors. What a farce!

Page 14, line 1-3, the employee must submit to "[ANY]" examination by the 10 or 12 doctors (prostitutes) or his compensation is suspended. These exams are electro-milogram which is where they stick 2 inch needles into your muscles and they turn the electricity on and see if the muscle moves, which is a hideous thing if a person is afraid of being shocked. And, if needed, the electricity can be turned up to make you do an uncontrolled dance if needed. Usually one visit is all that is needed to get the injured worker to drop workers compensation and find self-help.

Page 14, lines 17-22, here you have limited the injured worker to going to doctors who are average in price for services, but no limit was put on IME doctors. Whose side are you on anyway? All you want is average care for the injured worker.

Page 15, line 1-13. This bill states that if a dispute between the injured worker's doctor and the insurance company's doctor (prostitute) exists, the insurance company's doctor will be presumed to be the correct one. My, my, my, does our prejudice show! You are so narrow-minded and prejudice that a gnat could sit on your nose and kick both of your eyes out.

Same page next lines, same paragraph. You have the audacity to write into this bill these words, "a person may not seek damages from an independent

medical examiner caused by the rendering of an opinion or providing testimony under this subsection, except in the event of fraud." If IME are caught prostituting for the insurance company with a false statement, they will plead ignorance which doesn't constitute fraud.

You have made it an air-tight case for the insurance company. Shame on you! If you had a part in making or drafting this bill, then plead ignorance-----it works for the IME doctor, but don't vote for it.

Page 16, lines 9-11. It reads as follows: "Subject to an employer's or employee's burden of proof, a finding of fact made by the board as a part of a compensation order is conclusive if supported by any evidence." What have you got against the court system in Alaska? Are you afraid of judges and jury's decisions? Our court system may not be perfect at times, but its better than a group of hand-picked workman's comp board members whc are also slanted and prejudiced in favor of big commerce and insurance companies.

Page 20, lines 21-23. "Failure to achieve remunerative employability as defined in AS 23.30.04(n)(7) does not, by itself, constitute permanent total disability." In my mind and to anyone else who has been on workman's compensation, we know what your motives are.

Jerry Brinkley
4106 Northwood
Anchorage, Alaska 99517
Phone: 248-0266

8

February 5, 1988

Senator Tim Kelley, Chairman
Senate Labor and Commerce Committee
Alaska State Legislature
P.O. Box V (M.S. 3100)
Juneau, Ak. 99811

Dear Senator Kelley:

Re: S.B. 322

I strongly support the recommendations of the Management/ Labor ADHOC Committee for Workers' Compensation Reform.

I encourage you and your fellow senators to pass S.B. 322.

Sincerely,

Karen Morris

Karen Morris

Conoco Inc.
3201 C Street
Suite 200
Anchorage, AK 99503
(907) 564-7600

January 26, 1988

Mr. John Ringstad
Senator Tim Kelly's Office
Alaska State Legislature
P. O. Box V (MS 3100)
Juneau, Alaska 99811

Dear John:

As we discussed in Juneau on January 19, I had asked both Conoco and DuPont personnel who are directly involved with Worker's Compensation plans to review the proposed legislative changes. I have attached copies of their comments for your information. Both reviewers have favorable comments on the proposed legislation, the only suggestion was that the provisions for the Review Committee in AS23.30.095 could be better defined.

I hope this information is useful to you. I'm looking forward to seeing you and Ann on my next trip to Juneau.

A. E. Hastings

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File: 801.25

News Paper Ad
Full Page

Date: 2.5.88

Draft

HL: WHAT YOU SHOULD KNOW ABOUT THE PROPOSED WORKERS' COMPENSATION LEGISLATION.

The proposed law now before the legislature came about as a result of a year long effort conducted by a statewide labor-management task force.

If passed, the new law would do the following:

1. Increase disability benefits for seriously injured workers.

2. Increase temporary total disability benefits for workers employed in low paying jobs to match at least minimum wage.

3. Provide for voluntary rehabilitation for workers who want to prepare for future employment.

4. Encourage cooperation between injured workers and rehabilitation counselors.

5. Establish minimum qualification standards for rehabilitation counselors, and offer a referral service to workers and employers.

6. Allow physicians to charge only "reasonable" fees for specific services.

7. Provide for unbiased and cost effective settlements in medical disputes.

8. Encourage patients to seek quality medical care that promotes recovery rather than dependency.

9. Require health care providers to show cause for continuous multiple treatments. It does not, however, limit treatment if it can be proven to promote recovery.

10. Make it unlawful for an employer to discriminate against a job applicant who has previously filed for workers' comp benefits.

11. Protect workers from loss or delay of benefits in the event of a dispute where an insurance carrier is ultimately liable.

12. Allow for the reduction of benefits for workers who relocate to an area with a lower cost of living.

13. Set a standard under which stress claims may be judged valid.

14. Allocate a greater portion of worker compensation dollars directly to injured employees.

15. Provide for a cost effective, equitable program that provides incentives to injured workers to return to work.

We support this legislation because it is fair to injured workers, cost effective for employers and will save jobs in Alaska.

ANCHORAGE SCHOOL DISTRICT
ARCO Alaska, Inc.
STANDARD ALASKA PRODUCTION
SCOTT WETZEL SERVICES
ALASKA AIRLINES
WESTMARK HOTELS
ALASKA TIMBER INSURANCE EXCHANGE
ANGLO ALASKA PETROLEUM
CARR-GOTTSTEIN
CIMARRON HOLDINGS
COMPREHENSIVE REHAB SERVICES
ARCTIC FOUNDATIONS, INC.
NORTHERN ADJUSTORS
ALASKA STATE MEDICAL ASSN.
ALASKA NATIONAL INSURANCE
MARKAIR
HOLLAND AMERICA
NORTHERN AIR CARGO

ALASKA STATE CARGO
ALASCOM
TOTEM OCEAN TRAILER EXPRESS
ANCHORAGE REFUSE
ALASKA CLEANERS
KLUKWAN, INC.
LYNDEN INC.
HICKEL INVESTMENT
REEVE ALEUTIAN
NATIONAL BANK OF ALASKA
GCI
DOYON DRILLING
CENTRAL PLUMBING AND HEATING
SPENARD BUILDING SUPPLY
UNOCAL
ALASKA OIL MARKETERS ASSN.
ALASKA PULP CORPORATION
RAIN PROOF ROOFING
MARATHON OIL
USIBELLI COAL MINE
ALASKA STATE CHAMBER OF COMMERCE
RESOURCE DEVELOPMENT COUNCIL
RG & B CONTRACTORS
MECHANICAL CONTRACTORS OF FAIRBANKS
A& B TOOL
ACME FENCE
PACIFIC MOVERS
SAUPE ENTERPRISES
ALYESKA AIR SERVICES
SMYTH MOVING SERVICES
BAILEY'S RENT ALL
MIDAS MUFFLER

ALASKA STATE AFL-CIO
WESTERN ALASKA BUILDING AND CONSTRUCTION TRADES COUNCIL
FAIRBANKS BUILDING AND CONSTRUCTION TRADES COUNCIL
CARPENTERS LOCAL 2162
CARPENTERS LOCAL 1281
PUBLIC EMPLOYEES UNION LOCAL 71

377-5454

INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS LOCAL 1547
LAUNDRY AND DRYCLEANING LOCAL 333
LABORERS INTERNATIONAL UNION LOCAL 341
LABORERS INTERNATIONAL UNION LOCAL 942
PAINTERS AND ALLIED TRADES LOCAL 1140
PAINTERS AND ALLIED TRADES LOCAL 1555
INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL 302
UNITED TRANSPORTATION UNION LOCAL 1626
UNITED FOOD AND COMMERCIAL WORKERS LOCAL 1496
ROOFERS AND WATERPROOFERS LOCAL 190
TEAMSTERS UNION LOCAL 959
SHEETMETAL WORKERS LOCAL 23
FIREFIGHTERS LOCAL 1264
BRICKLAYERS LOCAL 1

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WORKERS COMP

PEOPLE WANTING TO TESTIFY

SUE ROTH - JUNO 1/21

BERT MASON - JUNO 1/19

TOM SLAEGLE 586 - 3340

DAWSON

[illegible]ON

GRAND

GORDON

KANZ

BILL SNIEDER - AGC RESA

NATIVE CORP

TIM & PAT ALLEN

Comments on the Workers' Compensation Bill HB #352
and what is wrong with the existing laws

Source of Problems: Presently there exists a rehabilitation program, however vague, it does not work well.
The reason for it is that the client becomes lost in the paper work between the Rehab. firm, the employer's lawyer and the Department of Labor's inability to settle disputes quickly.

Several Rehab. outfits are existing in the Juneau area for instance, but I know one that is totally incompetent in handling injured people. I have been a witness to one case over two years and have since done research on this issue. Injured people have special problems, they suffer from depression, are inclined to become alcoholics and suicidal. Without the proper care these people are not able to become contributing members of this society.

The present so-called renab. program does not provide enough training that will reemploy an injured party at a reasonable economic bases. What does a 43 credit diploma get you? Not much unless you win a lottery to supplement your income.

Presently 61 cases are pending for review by the Department of Labor's Administrator. There is only one administrator and it can take as long as 7 months to get a hearing. This is unacceptable.

Employer's attorneys play often god, doctor etc. without recourse to the injured party. Some renab. outfits need not proof any particular training or schooling to ensure quality work, yet we let them lose on injured people, who are often incapable of making proper decisions because of pain and stress. Torts against the injured party are therefore committed again without any recourse to the injured party. A very sad state of affairs at a nigh cost.

What to do about it?

As a witness I can testify to several viable means of operation and will cost less money and will provide better services for these injured parties.

First of all license these rehabilitation outfits. You cannot live without them, or you could appropriate the moneys back to the Department of Education, Voc.. Rehab. Without standards of conduct you have nothing to measure against.

Secondly, I would suggest that you do not use a 2 year term for rehabilitation, some people take longer than that. Restrict the employer's lawyer to use vindictive methods of operations, operating often on the premise of falsehood

and misinformation.

Perhaps establish a trustee status, a qualified individual who would serve with little cost to the client and would help as a good Samaritan to the injured party.

Employ more Administrators to handle the cases quickly. There should not be a waiting period longer than one month.

Attorney's ought to not be allowed to make medical judgements and disallow medical care when reasonably related to the injury.

The injured party must be evaluated in whole, not in part. For rehabilitation purposes, body, sole and injury. You can't rehabilitate an injured party unless you know how to handle the personality etc.

I feel in whole if you implement some of the above items that you will bring the costs down and at the same time have a better rehabilitation program in effect.

If you need further information or wish to talk to me. I will be happy to do so.

Maria Iverson
10742 Horizon Drive
Juneau, Alaska 99801

Phone no. 463-2253

MITCH

WCCA BILL

SECTION A.S. 23.30.095(a):

(1) DELETE underlined passage beginning page 12, line 7 through line 11, starting with "The employee".

RATIONALE: This passage is objectionable for several reasons:

(a) because there is an insufficient definition of "attending physician";

(b) because there is an insufficient definition of "specialist";

(c) because there is no indication of when a physician becomes an "attending" physician as opposed to an examining or consulting physician; and,

(d) because there is no real indication of how a choice of a different specialty is treated. For instance, if employee's attending physician is a GP and he has a broken leg and decides that a orthopedist would be better able to treat him, does that decision count as a change? Or, the employee has a lower back injury, choses to try an osteopath or a chiropractor instead of his GP, does that decision count as a change when he is not merely changing from one doctor to another but is actually seeking a different type of treatment?

If the passage must remain in, here is a suggested change:

The employee may not make more than one change <u>of attending physician within the employee's attending physician's specialty</u> without the written consent of the employer.

(2) Keep language that will be deleted (bracketed langauge on page 12, line 11 through line 13). There does not appear to be any justification for taking away the boards authority to make exceptions to this rule in the appropriate cases.

(3) Amend the language in the next sentence, page 12, line 13, starting "Upon procuring" to read:

Upon procuring the services of an attending physician, etc.

(4) Add sentence to end of present section stating:

With the exception of the above, no party shall attempt to interfere with or restrict by any means the employee's right to select a physician of his or her choice.

SECTION A.S. 23.30.095(c):

(1) DELETE the added language (underlined and appearing on page 13, line 2 through line 13).

RATIONALE: This passage is ill considered:

(a) because there is no definition of what is considered "continuing and multiple treatments" and health care providers must necessarily guess;

(b) because there is no designation of who will approve the plan and what standards will be employed and upon what facts or basis the review will rest;

(c) because the process of review will occur simultaneously with the provision of treatment and, according to the current language, the health care provider must bear the financial risk of disapproval;

(d) because there are no provisions for amendment of the plan should the need arise; and,

(e) because the provision imposes maximum limits arbitrarily.

Generally, it appears to us that these provisions will probably result in an increase in litigation and resulting costs rather that a decrease since so much is left unstated.

If the reason for this amendment is to guard against unreasonable or unnecessary treatment, there are already regulations in place and the employer can, with most health care professions, submit perceived abuses to the appropriate peer review committees.

If the reason for this provision is, as some of our members strongly suspect, an indirect attack on Chiropractic, it is not in fact cost effective and is, to say the least, discriminatory.

SECTION A.S. 23.30.95(e):

(1) Proposed amendment deleting requirement that examining physician be authorized to practice is inappropriate and suspect. Therefore, bracketed section on page 13, line 18 through line 19, should be RETAINED.

How is either the Board or the employee able to rely upon the competence of a report or examination if there is no requirement that the physician doing the examining be appropriately licensed? Does the legislature really intend to require that the employee must submit to an examination by someone who may not be capable of meeting license requirements?

(2) The creation of a presumption of reasonableness of requiring examinations every 30 days appears to be irrational. It seems obvious that the added language could easily be used by the employer to harass an employee in cases where either (1) the condition is stable enough that monthly examinations are unnecessary, and/or the examination technique used is painful and the likelihood of substantial changes in condition would not, in the absence of an adversary relationship, be normally considered justified. In addition, should the employee not be able to work at his/her old job, a requirement for monthly examinations by the former employer's doctor may well interfere with the ability of the employee to secure other employment.

(3) Although there are fairly draconian provisions within this section for employee non-cooperation, there are no provisions for (i) advance (reasonable) notice requirement by the employer; or, (ii) a means by which the employee can contest the necessity and/or reasonableness of the monthly examinations prior to their imposition.

SECTION A.S. 23.30.95(f):

DELETE (UNDERLINED) changes.

RATIONALE: The present section, prior to amendment, limited fees charged for medical treatment and services to charges that generally prevailed in the community. (See bracketed section, page 14, lines 18 through 19). The new section (underlined, page 14, line 20 through line 22) adds to the Board's responsibility the necessity to determine whether or not the charge, which may well be customary in the community, is reasonable (underlined).

That being true, the phrase that the Board may regulate fees and charges contained within this section would become a reality since the Board would have authority under this section to override free market considerations, including local economics and the effects of local competition and declare that charges that were in fact usual and customary but, in the Board's opinion, unreasonable.

The proposed change is actually unnecessary since normal free enterprise processes supply reasonableness of price through market place competition.

SECTION A.S. 23.30.99(j):

DELETE changes. AMEND CURRENT LANGUAGE.

The most offensive of the added language is contained on page 14, lines 25 through 26, which allows for an out-of-state organization to advise the Board on the appropriateness and necessity for and costs of medical treatment of Alaskan workmen by Alaskan physicians. A host of questions arise by this wording. If an out-of-state organization is appointed, how well qualified are they to judge these issues? Could they pass the relevant Alaska boards? Are they in fact licensed physicians/health care providers? Are they anything more than claim adjusters? How is an out-of-state organization going to determine appropriateness of treatment without recourse to examining the patient or taking additional xrays or additional studies? Why is an out-of-state organization needed when there are peer review committees set up within the various disciplines for these purposes now?

Regarding costs, once again, how is an out-of-state organization going to determine appropriate levels of costs? If for instance, the person making the determination on appropriateness of costs lives in and is familiar with medical costs in some small town in Illinois, will that familiarity influence the advice he gives to the Board on treatment rendered in Alaska where the cost of everything is higher?

Based upon the recommendations that are made to the Board, the Board will be determining whether an employer should pay a bill for services that have already been rendered. Because it has the power to approve of the withholding of payment, the employee and the local physician in Alaska rendering treatment to him is at a distinct disadvantage in challenging the advice of an out-of-state organization.

If the advice is unsound, but because of economics, remains unchallenged, the Board's decision will eventually begin to influence the manner in which Alaskan physicians treat injured workmen since their choices will essentially be to either adopt an approved (but unsound) procedure or to refuse to treat the injured workman. Additionally, injured employees may not seek appropriate treatment since they might end up having to pay for it themselves, which will either add to the term of the injury or begin to increase costs of employee medical insurance plans.

We suggest the following language REPLACE Section (j):

> The board may appoint a medical services review board consisting of physicians licensed in the state and employer and employee representatives to assist and advise the Board in matters involving the costs of health care services. The medical services advisory board shall conduct anonymous surveys biannually to determine usual and customary costs of treatment and procedures, and in the case of unusual situations, may conduct special surveys to determine usual and customary costs for treatment of procedures not normally encountered. If the Board shall determine that a physician or health care provider has inappropriately or unnecessarily provided treatment, or has habitually and substantially exceeded the usual and customary charges in the community in which treatment was rendered, the committee shall refer the matter to the peer review committee of the health care provider's discipline and advise the Board to disapprove the charges in question.

SECTION A.S.23.30.095(k):

(1) AMEND proposed language.

RATIONALE: The clear import of this section is to provide the Board with an independent source to turn to when a dispute arises between the party's experts. Unfortunately, the proposed section as it's presently worded does not go far enough to insure the independence of the source. Additionally, it fails to guard against apples and oranges comparisons that so often create or increase litigation before the Board. Finally, the proposed section creates an inappropriate limited standard of review which is inconsistent with current diagnostic techniques.

First, in order to insure the independence of the review, the selection of a physician or health care provider should be from a rotating list so that there can be no question as to impartiality in the selection process.

Second, both parties should have the right to object to one selection within a reasonable time period so that questions of bias may be minimized.

Third, the lists that are resorted to by the Board should be kept by discipline and specialty and the selection made should conform to the discipline or specialty of the health care provider of the employee. Otherwise, there is every likelihood that the Board will become embroiled in jurisdictional disputes between disciplines and specialties that will provide no meaningful comparison.

Fourth, limiting the standard required to overcome the presumption to objective evidence deselects critical subjective findings that often times form the backbone of a valid diagnosis.

We would suggest the following language be substituted for the proposed language:

> In the event of a medical dispute regarding determinations of causation, medical stability, degree of impairment, functional capacity, the amount and efficacy of the continuance of or necessity of treatment, or compensability between the employee's attending physician and the employer's medical evaluation, an independent medical evaluation shall be conducted by a physician or physicians of the same

physicians licensed in the State of Alaska or the state that treatment was rendered from a list established by, with the aid and advice of the medical advisory board, and maintained by the Board. Both the employee and employer shall have the right to challenge one appointment. In the event of a challenge, the next physician on the list will be appointed. The contents of the list and the order of its contents shall be kept confidential by the Board. The report of the independent medical examiner shall be furnished to the Board and both parties within 14 days after the examination is concluded. The opinion of the independent medical examiner shall, in the absence of clear and convincing evidence to the contrary, be presumed to be correct. A person may not seek damages from an independent medical examiner caused by the rendering of an opinion or providing testimony under this subsection, except in the case of fraud, misrepresentation or gross negligence.

SECTION A.S. 23.30.155(c):

DELETE Added language.

RATIONALE: As will be explained more fully when Subsection (m) is discussed, the exception being grafted onto this section is, in essence, gutting the penalty provisions by allowing an employer to escape the penalties by simply performing once a year ministerial acts that have nothing to do with the merits of a particular controversion, or for that matter, to do with a habitual practice of unjustifiably controverting employee claims. As a result, it is our suggestion that the amenditory language be deleted.

SECTION A.S. 23.30.155(m):

DELETE changes.

RATIONALE: This section as it is proposed, essentially vacates the penalty provisions in subsection (c) by allowing an employer to avoid penalties for failure to timely notify the employee and the board of changes it unilaterally makes to the employee's compensation, or whether or not the employer intends to controvert at all. In essence this provision allows, on a sliding scale, an employer to escape substantial penalties if it performs the ministerial acts that, under the present and proposed statute, it must perform.

For the employee who is caught within the exception's parameters, however, there is little relief. If the filing requirements did not incorporate notifications to the employee and were, in fact, only ministerial, there might be some justification for the proposal, although it is not readily apparent even in that situation. However, the reports do require notification to the employee and, in the absence of receiving timely reports, the employee may well make decisions that he might not should he receive a timely notification that the employer was either going to controvert, suspend or terminate his compensation. In essence then, the employer is, according to this section, allowed to escape penalties for failing to comply with the employee notification provisions in Subsection (c).

SECTIONS A.S. 23.30.185, A.S. 23.30.200:

DELETE proposed language unless the term medical stability is changed as noted below.

RATIONALE: Obviously, the employers and their carriers are seeking to place a limit upon TTD and TPD payments. However, they are basing the proposed limit upon an unrealistic and unfair standard, "medical stability". As will be demonstrated below, the definition for the term "medical stability" is suspect.

SECTION A.S. 23.30.265 (34):

AMEND proposed language.

RATIONALE: According to the proposed language, an employee's medical condition is "stable" after the date that no further objectively measurable improvement is reasonably expected to result from additional medical care or treatment. This definition has several flaws.

First, hinging a definition of medical stability on whether or not the patient will improve disregards situations where continued treatment is necessary to prevent a diminishment of medical status, or to prolong the patient's medical status.

Second, once again the standards for masking the determination are based solely upon objective findings when modern diagnostic techniques used a combination of objective and subjective techniques. As a result, the employee and all of the physicians coming into contact with him are artificially limited to decision making that bears no relationship to how medical decisions are normally made.

SECTION ENTITLED LEGISLATIVE INTENT, SUBSECTION (b):

AMEND proposed language.

RATIONALE: In decreeing that the Board has increased powers, there must be some authority for decision making concerning his medical treatment left to the injured employee. Therefore, there should be some provision contained within the statute that it is not the legislature's intent that the employee's right to chose who his health care provider will be will not be restricted unreasonably.

We suggest that the following language be added to subsection (b):

> With the exception of the provisions contained in A.S. 23.30.095(a), nothing contained within this section shall empower either the board or any party to interfer with or infringe upon the employee's right to select the type of health care and the person to provide it for the treatment of his injuries. Any employer or its representative that violates this section is guilty of practicing discrimation against the employee and subject to the provisions of A.S. 23.30.247.

AACD
ALASKA ASSOCIATION FOR COUNSELING AND DEVELOPMENT

ALASKA
— STATE BRANCH —
AMERICAN
ASSOCIATION FOR
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Jim — your support is very much needed! Best wishes, Pat

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1-24-88

TO: SENATOR TIM KELLY

FROM: Pat Reeves, Legislative Chair
Alaska Association for Counseling and Development

In Re: Proposed Addition: p. 10, (6) REHABILITATION SPECIALIST
WORKMEN's COMP BILL - SB322/HB352

The Alaska Association for Counseling and Development strongly supports the inclusion of other nationally certified professionals to be listed in SB322/HB352, p. 10 (6) as rehabilitation specialists.

You have selected only one group to be listed: certified insurance rehabilitation specialists aka CIRS(or CIRSC). We are aware that there are other equal or more qualified certified groups that need to be listed in this bill. Why "determine" criteria at a future date?

The present bill reads (p.10 (6)) as follows:

> "(6) "rehabilitation specialist" means a person who is a certified insurance rehabilitation specialist or a person who has equivalent or better qualifications as determined under regulations adopted by the department."

It could be surmised that the "certified insurance rehabilitation specialists" have been approved to provide reemployment services and other groups have not been sanctioned.

A letter dated 12-10-87 from Eda Holt, Executive Director of the CIRSC (CIRS) - certified insurance rehabilitation specialist - Board states: (copy attached)

> ". . . As you can see by the standards, a person certified as CIRS may not necessarily do vocational counseling "

Further, the application for the "certified insurance rehabilitation specialists (CIRS/CIRSC), page 1, clearly states: (copy attached)

> "The holder of the CIRS credential has demonstrated a minimum acceptable level of knowledge pertaining to

> disability compensation systems as determined by the commission. THE CIRS DESIGNATION, IN AND OF ITSELF, HOWEVER, NEITHER IMPLIES NOR REPRESENTS THAT ITS HOLDER POSSESSES KNOWLEDGE AND SKILLS IN A SPECIFIC DISCIPLINE (e.g. ADMINISTRATION, COUNSELING, NURSING, VOCATIONAL EVALUATION, WORK ADJUSTMENT, JOB PLACEMENT,) THAT MAY BE NECESSARY TO PROVIDE REHABILITATION SERVICES TO ELIGIBLE DISABLED INSURANCE RECIPIENTS.

Why was this certificated group (10-11 in Alaska) set up as the standard to deliver reemployment (rehabilitation) services at the exclusion of equal or more qualified groups? Their own certification (as quoted above) "neither implies nor represents that its holder possesses knowledge and skills . . . that may be necessary to provide rehabilitation services to eligible disabled insurance recipients."

Other professionals in Alaska spend time, effort and money to maintain higher professional credentials (national certification status).

We request that you include the following professionals among the groups qualified to provide reemployment services to Alaska's injured workers:

> NATIONAL CERTIFIED COUNSELORS (NCC), credentialed by the National Board of Certified Counselors. Requirements for Certification: Masters Degree; Annual Fee; Supervised Practicum; Work Experience; References; Written four-hour examination; Annual continuing education units to maintain professional knowledge.
>
> AMERICAN BOARD OF VOCATIONAL EXPERTS (ABVE) - Fellow or Diplomate status. Certificate requires Masters Degree; Rehabilitation experience; Board Annual Review/Approval; Written four-hour examination; Fee; 14 Annual Continuing Education Units.
>
> Vocational Expert (VE) - Certified by U.S. Government Health & Social Services, Social Security Division, Board of Hearings & Appeals. Requirement: Rehabilitation experience/training/approval and annual evaluation. Serves at request of Administrative Law Judge for Social Security Disability Hearings as Vocational Expert.

Your compliance with this request will be greatly appreciated by the professional organization and by those who will be receiving the reemployment services.

Thank you for this consideration.

CRCC
CIRSC
BOARD FOR REHABILITATION CERTIFICATION
1156 Shure Drive, Suite 350, Arlington Heights, Illinois 60004 (312) 394-2104

December 10, 1987

Dear

In response to your letter sent to the NRA. The letter was forwarded to me at CRCC and CIRSC for handling.

Enclosed, please find applications for CRC and CIRSC.

Please read the eligibility standards for each process carefully.

Please send our office a copy of the Workers Compensation Law. As you can see by the standards, a person Certified as CIRS may not necessarily do vocational counseling.

The grandparenting period for CIRS occurred over 18 month period, from October, 1984 through October, 1985-three field test examinations with 3,465 applicants.

The CRC and CIRS Certifications are separate and distinct. No, the CIRS was not designed to replace the CRC.

Should you desire further information, please feel free to contact me.

Sincerely,

Eda Holt

Eda Holt, Executive Director
EH/pc

Comments on the Workers' Compensation Bill HB #352
and what is wrong with the existing laws

Source of Problems: Presently there exists a rehabilitation program, however vague, it does not work well.
The reason for it is that the client becomes lost in the paper work between the Rehab. firm, the employer's lawyer and the Department of Labor's inability to settle disputes quickly.

Several Rehab. outfits are existing in the Juneau area for instance, but I know one that is totally incompetent in handling injured people. I have been a witness to one case over two years and have since done research on this issue. Injured people have special problems, they suffer from depression, are inclined to become alcoholics and suicidal. Without the proper care these people are not able to become contributing members of this society.

The present so-called rehab. program does not provide enough training that will reemploy an injured party at a reasonable economic bases. What does a 43 credit diploma get you? Not much unless you win a lottery to supplement your income.

Presently 61 cases are pending for review by the Department of Labor's Administrator. There is only one administrator and it can take as long as 7 months to get a hearing. This is unacceptable.

Employer's attorneys play often god, doctor etc. without recourse to the injured party. Some rehab. outfits need not proof any particular training or schooling to ensure quality work, yet we let them lose on injured people, who are often incapable of making proper decisions because of pain and stress. Torts against the injured party are therefore committed again without any recourse to the injured party. A very sad state of affairs at a high cost.

What to do about it?

As a witness I can testify to several viable means of operation and will cost less money and will provide better services for these injured parties.

First of all license these rehabilitation outfits, you cannot live without them, or you could appropriate the moneys back to the Department of Education, Voc.. Rehab. Without standards of conduct you have nothing to measure against.

Secondly, I would suggest that you do not use a 2 year term for rehabilitation, some people take longer than that. Restrict the employer's lawyer to use vindictive methods of operations, operating often on the premise of falsehood

and misinformation.

Perhaps establish a trustee status, a qualified individual who would serve with little cost to the client and would help as a good Samaritan to the injured party.

Employ more Administrators to handle the cases quickly. There should not be a waiting period longer than one month.

Attorney's ought to not be allowed to make medical judgements and disallow medical care when reasonably related to the injury.

The injured party must be evaluated in whole, not in part, for rehabilitation purposes, body, sole and injury. You can't rehabilitate an injured party unless you know how to handle the personality etc.

I feel in whole if you implement some of the above items that you will bring the costs down and at the same time have a better rehabilitation program in effect.

If you need further information or wish to talk to me, I will be happy to do so.

Maria Iverson
10742 Horizon Drive
Juneau, Alaska 99801

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TELEPHONE 586-3811
AREA CODE 907

January 11, 1988

The Honorable Tim Kelly
Chairman,
Senate Labor and Commerce Committee
P.O. Box V
Juneau, Alaska 99811

SUBJECT: S.B. 322/H.B. 352--Proposed amendments to Alaska Workers' Compensation Act

Dear Senator Kelly:

As an attorney representing injured workers in workers' compensation cases, I have viewed with interest the recent efforts to reform the Alaska workers' compensation laws. It has long been clear to everyone involved in the system that changes are necessary. Costs are out of control, numerous abuses are occurring on both sides of the system, and too much money is going to individuals other than the most deserving injured workers. It is even more important, however, that the rush to make those changes does not result in a bill that deprives injured workers of basic fairness, and does not achieve the needed savings. I have reviewed the amendments contained in S.B. 322 and H.B. 352, and I am appalled at some of the proposed changes. Cost savings should not be achieved at the expense of fundamental fairness.

It must be remembered that workers' compensation benefits are not handouts. Workers' compensation was devised as a trade-off--workers were allowed benefits, without regard to fault, to compensate them in part for their losses resulting from on-the-job injuries, in exchange for losing their right to sue their employers for negligence. If employers are to continue to be immune from suit, their employees have a right to receive fair and adequate benefits in return.

Clearly, the bill represents a great deal of effort by a large number of people. While much of the proposal is a constructive approach to the problem, I feel that many of the proposed amendments are discriminatory, unfair, or simply unworkable.

The bill's tone is set by its first section, which states that its intent is to assure the "quick, efficient, and predictable" delivery of benefits. While these are worthwhile goals, there is no mention of fairness--not only to the injured worker, but also fairness to the employer.

The major structural changes in the statute are in the areas of rehabilitation and computation of permanent partial disability benefits. I will first discuss my concerns about the rehabilitation provisions.

Although I have other concerns about the rehabilitation section of the bill, I am most concerned about a few items. First, under new section 041(j)(2), the injured worker is ineligible for vocational rehabilitation unless he or she requests a rehabilitation eligibility determination within 60 days after the injury. This will automatically deprive many needy workers of rehabilitation, since 60 days after their injury most employees don't know whether they will be able to return to their old jobs. Most workers that I speak to are almost totally unaware of their right to rehabilitation benefits. The average injured worker does not want rehabilitation after 60 days, since he expects to return to his previous job. It is only after the worker discovers that he will not recover fully that rehabilitation becomes necessary. The 60 day requirement of new section 041(j)(2) sets a trap for the unwary injured worker.

New section 041(i) defines "noncooperation" with rehabilitation, which disqualifies the worker from further rehabilitation benefits. The proposal needs to define noncooperation more carefully. This section could be interpreted to provide that an injured worker forfeits his or her reemployment benefits if he or she misses one meeting with the rehabilitation specialist. The statute should contain the requirement that the noncooperation be unreasonable. It is also not fair to deprive a worker of his or her benefits for failure to maintain average grades. By definition, half of all students are above average, and half are below average. It seems somewhat elitist to suppose that any student who does not maintain average grades is not cooperating.

The rehabilitation section eliminates the provision in present law that an employee's ability to return to work be judged by the availability of work in his or community, or the place of work at the time of injury. Instead, it is judged by the existence, not availability, of work anywhere in the state. Under this rule, a Petersburg resident who is injured would not be eligible for rehabilitation if a job exists anywhere in the state, whether in Petersburg, Anchorage, or Nome, which he is capable of performing--regardless of whether the job is available to him.

The new statute also eliminates any payment of temporary compensation as maintenance during rehabilitation. Employees instead are expected to live on their permanent partial disability award during rehabilitation. Maintenance would be awarded only after the worker has exhausted his or her PPD award. I find it unfair to require an employee to live off his or her permanent partial disability settlement during the period of rehabilitation. Coupled with the changes in permanent partial disability awards, this will leave many workers with no money after they complete their rehabilitation programs. This is inconsistent

with the purpose of permanent partial disability, which is to partially compensate injured workers for their permanent loss of earning capacity.

I am very concerned about the changes in permanent partial disability (PPD) awards. PPD is intended to be compensation for an employee's permanent loss of earning capacity. For the typical worker with a back injury (or any "unscheduled" injury), the existing system attempts to base compensation on actual loss of earnings. The new statute eliminates any attempt to calculate actual loss of earnings. Instead, the award is based on the arbitrary disability ratings established in the AMA Guides to the Evaluation of Permanent Impairment. Most physicians will agree that the AMA Guides are a poor way of evaluating many injuries. They are particularly arbitrary when it comes to evaluating back injuries. The gross unfairness with this system is that the arbitrary award is paid whether or not the injury affects the employee's ability to work. A longshoreman with a 5% impairment of his back may be unable to do his job, but he would receive an award of $250. An attorney with a 40% disability may be fully able to work, but he or she would receive $96,000. While this may meet the stated intent of "quick, efficient and predictable" delivery of benefits, it is far from fair--to either side.

Section 190 contains another curious provision. After the injured worker's impairment is rated, the rating is "adjusted" by multiplying it by an "Adjustment Factor", ranging from zero for impairments of 5% or less, to one for impairments of 31% or greater. This will result in the following payments for permanent disabilities:

Impairment	Payment
5%	$250
10%	$4,800
15%	$14,400
20%	$28,800
25%	$42,000
30%	$57,600
50%	$120,000

While workers with large impairment ratings will receive large sums of money, the new schedule, for some reason, sharply discounts the awards to workers with small disabilities. If a worker with a 5% impairment is onetenth as impaired as one with a 50% impairment, it is not clear why the second worker should receive an award four hundred and eighty times as large. The use of the "Adjustment Factors" to discount small awards is discriminatory.

It is interesting to note that, at the same time that Alaska seems to be moving toward a purely scheduled system, the general trend nationwide is away from such systems. This state would do well to heed the example of other states such as Florida, which abandoned a scheduled disability scheme when it found, according to Professor Arthur Larson, the national authority on workers' compensation, that 79 percent of administrative and legal time

was consumed arguing about disability ratings. I predict that, if this section is adopted, there will be just as many disputes about disability ratings as there are now about earning capacity.

Another provision of the bill which I find unduly harsh is the two year limit on temporary total benefits contained in new section 185. While benefits generally are not paid for more than two years, there are instances in which an injured worker has not fully recovered in two years. Occasionally, an employee's condition is not properly diagnosed right away. If an employee needs major surgery, or complications develop, he or she may well be left destitute, while still under medical treatment.

Under new section 095(k), medical disputes are to be submitted to a physician selected from a list kept by the Board. The determination of this physician is presumed to be correct, in the absence of clear and convincing evidence to the contrary. In many cases, all three doctors may be on the Board's list. There is simply no reason to decide a case solely on the basis of the opinion of one doctor who has seen the worker just once. This is just another way of making the process more arbitrary, and less fair.

Under new section 020, a worker is totally ineligible for benefits if he or she misrepresented the worker's physical condition at the time of hire, and the employer relied thereon. It would appear that, under this section, a worker who denied a previous back injury would go uncompensated if he or she aggravated the previous injury on the new job. The consequences of this section for many workers will be disastrous.

In many industries, such as the logging industry, it is very difficult, if not impossible, for a worker with even a minor back injury to return to work. No logging company, if given a choice, will hire a worker with a back problem. Under this section, a logger with a prior back injury will have to make a choice between mentioning his injury, and probably not getting a job, and not mentioning it, and forfeiting his workers' compensation benefits if he is reinjured. While the new statute does contain a toughened anti-discrimination section, such provisions are very difficult to enforce. It is usually impossible to prove discriminatory intent.

This section illustrates the peril of assuming that labor interests can speak for injured workers. A union worker, dispatched through a hiring hall, would not be harmed by this section. The employer could not discharge the worker if his preemployment health questionnaire reflects an injury. A nonunion worker, such as a logger, does not have this protection.

New section 220 revises the procedure for calculation of compensation rates. Under section 220(1), which is unchanged from existing law, rates are based on wages during the two years preceding the injury. Under existing law, if those wages do not

fairly represent the employee's wages at the time of the injury, the Board may adjust the wages by considering the employee's work and work history. This "escape hatch" has been substantially enlarged in recent years by the Supreme Court. The new section would limit this "escape hatch." The rate could only be adjusted if the employee had no earnings, or was "voluntarily" absent from the labor market for 18 months or more during the two years. I can see no justification for limiting this section to voluntary absences. The main justification for the "escape hatch" of section 220(2) has always been to allow the Board to adjust the compensation rate when the employee was absent from the labor market for a portion of the previous two years due to previous illness, disability, or other circumstances beyond the employee's control. Under the new language, such involuntary absences from the labor market would not qualify an employee for an adjustment. This cannot be justified.

Under new section 265, an employee is presumed to have reached medical stability if he or she goes 45 days without objective medical improvement. Medical stability becomes all the more important under the new rehabilitation provisions, since it marks the point at which an employee's temporary benefits end. While the standard of objective medical improvement has some merit, 45 days is much too short a time to judge stability. Many workers go more than 45 days between follow up visits after major surgery. It is not fair to throw an injured worker back in the labor market simply because his injury is slow to recover.

I would suggest four basic reforms which would substantially cut the costs of the system. First, lower the maximum benefit, as S.B. 322 and H.B. 352 do. Second, restore the adjustment of benefits for out of state claimants, as S.B. 322 and H.B. 352 do. Third, return the calculation of compensation rates in section 220 to what the Legislature originally intended, which is that the rate be based on the employee's historical wages. Finally, and most importantly, rewrite the vocational rehabilitation provisions to require a quick, fair determination of an injured worker's entitlement to rehabilitation. Too many workers draw temporary benefits for many months or even years while waiting for a rehabilitation plan to be completed. I can provide more specific proposals along those lines if necessary.

Clearly, the present system has major flaws. Too much money and time is expended in litigation. Too much money is wasted on meaningless rehabilitation. Too many workers are being financially devastated by injuries while other workers receive excessive benefits. The existing statute is an attempt, although not an entirely successful one, to compensate injured workers for their lost wages, and to return them to work. The proposed bill would abandon that effort, and instead pay settlements based solely on the impairment of the body--without regard to earnings. We must not let the need to cut litigation costs and promote certainty eliminate fairness. Fairness, after all, means only that benefits have some relation to what a worker has lost as a result

of an injury. That is what the system is supposed to do--and can do, if we are willing to make it work. I sincerely hope that this Legislature will not be remembered as the one which stripped injured workers of their right to be fairly compensated for their injuries.

Very truly yours,

Philip M. Pallenberg

cc: Governor Cowper
Members of the Senate Labor and Commerce Committee
Members of the House Labor and Commerce Committee
Senator Duncan
Representative Hudson
Representative Ulmer

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January 11, 1988

Senator Tim Kelly
Capitol Bldg., Room 101
Juneau, Alaska 99803

Dear Senator Kelly:

First of all, I would like to thank you for providing me with a copy of the draft legislation regarding the Alaska Workers' Compensation Act. I have reviewed this legislation in detail, and attached is a memorandum that I have done in regard to the changes. This memorandum was principally designed to identify the changes for myself and my clients. There are some comments as to what I perceive to be problem areas within the legislation.

As I mentioned to you on the phone quite some time ago, I am principally concerned with trying to obtain an amendment to the Act that would require disability benefits to be calculated upon the employee's wages at the time of the injury. To that effect, I have drafted a change to AS 23.30.220, which is attached. The definition of spendable weekly wage remains the same. The change is based on how to calculate the gross weekly earnings of the employee.

If the employee has worked for the employer in excess of forty weeks, his actual wages during the prior forty weeks will be divided by forty to determine his gross weekly earnings. This provision would eliminate many of the disputes that are now encountered in determining the compensation rate. In addition, the computation of disability benefits based upon the employee's wages at the time of injury would seem to more accurately reflect what the employee needs to survive on during the duration of his disability. Computing benefits in this manner would also follow the economic trends in the state of Alaska. During a down swing, benefits would drop, but during upswings, benefits would tend to increase. In addition, insurance carriers compute the premium to be paid based upon the actual wages paid.

Under the present system, it is not uncommon at all to find an employee who is making $10 an hour when he was injured receiving disability benefits that amount to $12 or $14 an hour or more. Under such a system, the employee has no economic incentive to return to work. In addition, the carrier is then faced with paying for a loss that he did not and could not anticipate when

he wrote the insurance policy.

The proposed legislation goes on to provide provisions for employees who have not worked for forty weeks, and have irregular paychecks. For those working overtime hours, the amount of overtime hours will be computed and added into the gross weekly earnings. The same is true for commissions for salesmen or other people that get paid based upon the actual amount of work performed. Monthly salaries are to be divided by 4.3 to determine the weekly wage.

The current provisions regarding minors or trainees is retained. The only difference is that there is a limitation so that the compensation rate of the employee does not exceed his actual spendable weekly wage at the time of his injury.

The current provision regarding ambulance attendants, policemen or firemen is retained.

I have inserted here the language regarding contributions by an employer to pension or profit sharing plans that was added to AS 23.30.265(15).

I do not represent any particular insurance company or adjusting company in regard to this proposed legislation. It is my own idea, and one that I have harbored for quite some time. I do believe that it will result in a more equitable situation for both the employee and the employer. In some cases, it will result in lesser benefits for the employee, but in other cases, it will result in more benefits. The major benefit that will be derived by both the employer and the employee is that there will be little room for dispute as to what the compensation rate shall be.

In order to present this concept to your committee, I would appreciate it if you could schedule me to testify to the committee for at least thirty minutes. In addition, I would appreciate the opportunity to address some other issues that are contained in the proposed amendments to the Act. If I could obtain an additional thirty minutes of time before the committee, I would certainly appreciate that opportunity. I will be available on both January 19 and 20 to testify. I will come by your Senate offices on January 18. Thank you very much for your cooperation, and if I can answer any questions or otherwise be

of help, please do not hesitate to give me a call. My home phone number is 694-9520.

Sincerely,

MASON & GRIFFIN

Robert B. Mason

RBM:mrm
Enclosures

MEMORANDUM

RE: Proposed Amendments to Workers Compensation Act

DATE: 1/11/88

This memo is intended to provide a brief overview of the significant changes in the proposed workers' compensation legislation that will be considered this session. This memo is not intended, nor does it purport to cover all aspects of the proposed changes. The section numbers referred to below refer to the sections of AS 23.30 and not the sections as identified in the Senate bill. There are several groups and committees who have reportedly drafted provisions/amendments that differ significantly from the ones presented here.

Section 1.

-- Workers' compensation cases are to be considered and decided upon the merits and the Act is NOT to be construed in favor of any party. The obvious exception to this is the presumption of compensability contained in Section 120.

-- The Board is to have virtually exclusive fact-finding responsibilities and decisions will be conclusive if supported by "any evidence."

Section 5.

-- The Department of Labor is empowered to adopt lists and procedures for selection, retention and removal of vocational rehabilitation counselors and/or physicians under Sections 41 and 95 of the Act.

Section 20.

-- If an employee makes a false statement regarding his physical condition on an employment application or questionnaire, he is not entitled to any benefits under the Workers' Compensation Act <u>if</u> the employer relied upon the false representation and that reliance was a substantial factor in hiring the employee, <u>and</u> there was a "causal connection" between the false representation and the injury. It is unclear what would constitute a substantial factor in the hiring and what would constitute a causal connection between the false representation and the injury. I would anticipate a substantial amount of litigation on these issues to determine their meaning and the result would be an application of a test to the facts in each and every case. The concept is good, bu language could be

inserted in the Act to clarify the intent.

Section 40.

-- Requires the contribution to Second Injury Fund be made at the time of the report filed with the Department of Labor as required by Section 155(m).

Section 41.

-- There are substantial changes in the rehabilitation provisions within the Act. In addition, there seems to be a change in intent from "rehabilitation" to "reemployment."

-- The reemployment services administrator (RSA) has numerous responsibilities, including an annual report that is aimed at determining the cost of providing rehabilitation services. These reports should be distributed to interested parties.

-- Within 60 days of filing of the notice of injury, the employee may request an evaluation to determine whether he is eligible for reemployment benefits. The RSA will select the counselor to perform this eligibility evaluation from a rotating list which will deprive the carrier from having an input as to who they will hire for rehabilitation services. The counselor performing the eligibility evaluation is not necessarily the counselor that will provide rehabilitation services through the course of the claim.

-- The RSA has the authority to extend the 60-day period if he determines that "unusual and extenuating physical limitations of the employee preclude the employee from making a timely request." Thus, it would seem that the employee must request the rehabilitation counseling within 60 days of his injury; however, the employer can also request that such an evaluation be made. It is unclear whether the employee would waive his right to rehabilitation if he does not make the request within 60 days.

-- The eligibility evaluation is to be performed and apparently the report filed within thirty days following the initial referral. The RSA can grant an additional thirty days.

-- The employee shall be eligible for rehabilitation upon the employee's written request and if a physician determines or predicts that the employee will ultimately have physical capabilities that are less than those required to perform the job as described in the United States Department of Labor's "Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles," for the employee's job at the time of the

injury, and for any other job that the employee has held within ten years before the injury, or employment following the injury that has been sufficient enough to establish the employee's ability to function in that labor market. Thus, the employee has to make a written request for rehabilitation, and a doctor has to determine that he has a physical impairment that will preclude him from his normal occupation or occupations that he has had in the past. This is very significant when coupled with the definition of reemployability. Further, the burden of requesting reemployment benefits lies with the employee.

-- The employee is not eligible for rehabilitation if the employer offers him a job within his physical capabilities at at least 60 percent of his "gross hourly wages at the time of injury," and there is a labor market for those skills.

-- In addition, the employee is not eligible for rehabilitation benefits if he has been previously rehabilitated in a workers' compensation claim and returned to work "in the same or similar occupation in terms of physical demands." This does not require the same occupation, but only an occupation that requires the same physical capabilities.

-- Once eligible, the employee can select his own rehabilitation specialist. If the employer disagrees with the employee's choice, and the disagreement is not resolved, then the RSA shall assign the case to a third rehabilitation specialist. The employer and employee each have one right of refusal of the counselor selected by the RSA.

-- The reemployment plan requirements are essentially the same as they were before.

-- The priority of retraining is the same as it was before.

-- Non-cooperation will result in a termination of benefits as of the date of the non-cooperation. Non-cooperation is defined to mean failure to keep appointments, maintain average grades, attend programs, maintain contact with the counselor, cooperate in developing a plan and participating in activities relating to reemployment, comply with the requirements of the plan, or comply with the request of the RSA.

-- Benefits, which presumably includes disability benefits, will not extend past two years from the date of the acceptance of the plan.

-- The employer and the employee have ten days after it has been determined he is eligible for reemployment benefits to select a rehabilitation specialist. There are no provisions to determine how this will work or what happens if the ten days lapses, or who has to make the first choice. I can see some disputes developing here, although they should not be major ones.

-- The reemployment plan must be formulated and approved by the parties within 90 days of the determination of eligibility. I feel that this 90 day requirement is going to be impossible to meet in many cases, and there are no provisions for an extension of this time. It would seem that if the parties would agree to an extension of time there would be no problem. In addition, I would suspect that the RSA could extend the time within his reasonable discretion. This 90 days would expire within the first 180 days after the injury if the other time requirements are met. In some cases, six months is not long enough for the doctors to determine what the employee's physical capabilities will be, and the Plan cannot be formulated until that is determined.

-- The plan shall be initiated when the physician determines that the employee is physically able to engage in the plan. There should be a provision for extending the 90-day limitation added to this clause.

-- If a plan cannot be agreed upon, either party may submit a plan to the RSA. The RSA shall approve or deny a plan within fourteen days after it is submitted, and within ten days of that decision, either party may seek a review of the decision by hearing pursuant to Section 110. The Board shall uphold the decision of the administrator unless there is an abuse of discretion. This puts a great deal of power in the hands of the administrator. In addition, it opens up the rehabilitation field to employee and employer oriented firms. The natural prejudices of the individual counselors involved will be hidden under the guise of impartiality, but it is quite clear to me that the battle lines will be drawn within six months. This will put too much control in the hands of one person, whose personal beliefs and philosophies can cause a great deal of dispute. The abuse of discretion standard should be changed.

-- The cost of the plan cannot exceed $10,000, which apparently does not include disability benefits.

-- If the employee becomes medically stationary before completion of the plan, the carrier will begin paying PPD as opposed to TTD. However, if PPD benefits are exhausted before the completion or termination of the reemployment plan, the employer must pay up to 60 percent of the employee's spendable weekly wages, not to exceed $525, until the plan is completed. At the end of the plan, any PPD benefits remaining unpaid shall be paid in a lump sum.

-- The fees of rehabilitation counselors are paid by the employer, and this would include the cost of the one hired by the employee, and are not included in the $10,000 limitation of the cost of the plan. Thus, in many cases, there will be three rehabilitation counselors hired to assist the employee, not

counting the eligibility evaluation.

-- There is a limitation placed upon who can perform rehabilitation work, and if he is not a rehabilitation specialist, he must be employed by a firm that is. There should be a distinction drawn between rehabilitation specialists and job developers.

-- Employability means having the ability to engage in employment that is consistent with the employee's physical capabilities, "but not necessarily the opportunity." This would mean that once the person is retrained and has marketable skills, he is employable. This definition applies only to the rehab section. Once the employee becomes employable, rehab benefits would cease, as would temporary total disability benefits.

-- Labor market means the geographical area where the employee resides, the area of last employment, the state, other states. This provision does not limit the labor market that would be used in determining the employability of the injured employee. I can foresee some difficulties and intense litigation in the case where the employee moves to an economically depressed area and says "this is my area of residence." The definition of employability does not include the opportunity, but a labor market survey in the area of residence would indicate that there are very few skills that would provide a job opportunity for the injured employee. I am not sure what was intended by defining the labor market area in this manner, and it would appear to me that this section of the Act will cause a great deal of litigation and clarification is needed.

-- Physical capacity means "objective and measurable physical traits" such as lifting, carrying, etc.

-- Physical demand means the physical requirements of the job.

-- Reemployment benefits that are limited to $10,000 would include the cost of the eligibility determination and the plan development, but would not include provider fees. It does not say this, but it is quite clear that this would also not include PPD or TTD.

-- Rehabilitation specialist is defined to mean somebody who is a "certified insurance rehabilitation specialist" or someone with equal or better qualifications, as determined by the Board.

-- Renumerative employability means having the skills to allow a worker to earn wages equivalent to at least 60 percent of the worker's wages at the time of injury. If the employment is found out of state, it shall be adjusted to reflect the difference between the average weekly wages of the two states.

It is important to note that this is a comparison of the wages after return to work to the wages at the time of injury, and not necessarily the wages used to determine the compensation rate.

Section 55.

-- Deals with the exclusive remedy provisions, which stay essentially the same. The liability of the employer is exclusive even if the employee's claim is barred because of a misrepresentation on his job application.

Section 95.

-- In regard to medical care, the employee is to designate a physician inside the state where he resides, and cannot make more than one change in his choice of attending phyicians without the written consent of the employer. Referral to a specialist is not a change. Notice of changing attending physicians will be given before the change. There is nothing in here that states the penalty or repercussions for multiple changes or failing to provide notice of a change beforehand. It must be assumed that the employee would not be entitled to have his medical benefits paid if he does not comply with the statute. If he provides notice of the change after the fact, I would assume that the employer would be responsible for medical costs after notice of the change is received.

-- Where a course of treatment requires multiple treatments of a similar nature, a claim for the cost of those treatments is not valid unless the treatments are carried out pursuant to a written plan detailed and prescribed before the commencement of such treatment. In addition, the plan must be signed by the physician and mailed to the employer within one week of the beginning of the treatment. Again, there are no provisions as to what happens if this is not complied with. I would assume that the employer would not have to pay for any treatment up until the time the plan is received. If the plan is not developed before the treatment starts, the employer would presumably be only liable for treatments within the plan after the plan is completed.

-- The plan must include the objectives to be reached, the frequency of the treatment, and the method, manner and means of the treatment. The treatment plan cannot include more than twenty visits within the first 60 days, or four visits a month after the first 60 days. If this is not sufficient, the physician must document the need for services in excess of the guidelines contained herein. This sounds good, but it is not going to affect long range treatment plans, particularly by chiropractors. They will simply have a standardized plan drawn up and put inside their computerized typewriters. They will be

punched out with new names and some slight changes. I suspect there will be some litigation over this issue.

-- Specific penalties and repercussions for failure to comply with the above provisions should be delineated. If not, it will require Board interpretation to determine what happens, which will result in extensive litigation.

-- The employer can request an IME no sooner than 14 days after the injury, and every thirty days thereafter. Requests for an IME shall be presumed to be reasonable, and the employee should submit to the examination without dispute. If he refuses, his rights to compensation shall be suspended until the refusal ceases.

-- Fees charged for medical treatments are currently limited to "charges that prevail in the same community." Fees will be subject to the regulation by the Board "and may not exceed usual, customary, and reasonable fees for the treatment or service in the community in which it is rendered, as determined by the Board," pursuant to the change.

-- The Board is authorized to appoint a medical services review committee or to contract with somebody to provide such services as necessary to assist and advise the board in medical issues.

-- If there is a dispute regarding causation, medical stability, degree of impairment, functional capacity, the necessity of treatment, or compensability between the employee's attending physician and an IME doctor, a second IME shall be conducted by a physician selected by the Board. The cost of such IME shall be paid by the employer. The opinion of this doctor shall "in the absence of clear and convincing objective evidence to the contrary" be presumed to be correct. In other words, the IME as directed by the Board will in essence be conclusive. I can foresee a significant battle in identifying and determining which doctor will provide the IME. The battle lines of defense and plaintiff's doctor, which already exist, will be emphasized even more with this provision. Since neither party can object to the appointment of a physician, it would appear that the Board would have a great deal of control over who should perform the IME.

-- This doctor is protected from liability, except in the case of fraud.

Section 120.

-- The presumption of compensability does not apply to mental injuries.

Section 155.

-- When benefits are controverted solely because of the last injurious exposure rule or that another employer/carrier are responsible for whatever reason, the most recent employer or insurer who is a party to the claim and who may be liable is responsible to make the TTD benefit payments until the case is resolved. Upon a final determination, reimbursement is required to the prevailing party of the benefits paid, including interest and costs and fees. This payment shall be made within 14 days of the decision.

-- The statute does not specifically provide for the payment of attorney's fees to a prior employee who is brought in by a subsequent employer. However, it is safe to assume that what is good for the goose is good for the gander, and that costs and fees will become an expense to be awarded to the prevailing employers in a last injurious exposure rule claim.

Section 155(m)

-- Provides for the filing of annual reports and a reduction in the amount of penalties assessed for late filing of reports.

Section 175

-- The maximum compensation rate has been established at $700. The minimum compensation rate, initially, may not be less than $110. However, if it is determined that the employee's spendable weekly wage is less than $110 per week, "or less than $154 per week in the case of an employee who has furnished documentary proof of the employee's wages" the minimum compensation rate will be adjusted to equal the employee's spendable weekly wages. If 80 percent of the spendable weekly wages are less than $154, the employee's compensation rate shall be $154. I am not sure why there is a distinction between wages computed to be $110 a week pursuant to Section 220 and where the employee furnishes proof of $154 a week wage. In any event, the minimum comp rate has been changed to equal the employee's actual spendable weekly wages, or if the spendable weekly wages are greater than $154, and 80 percent of that figure is less than $154, the compensation rate shall be $154.

-- Overpayments will be deducted from unpaid compensation "in the manner the Board determines." This would indicate that in each situation, if the parties cannot agree, then they must go to the Board to determine how to recover the overpayment. The 20 percent deduction, now in effect, would seem to be the appropriate method to accomplish this.

-- For injured employees who reside out of the state of Alaska, their compensation rate shall be determined by multiplying the ratio of the cost of living in that state divided by the cost of living in Alaska. In theory, if the cost of living in the state where the injured employee resides is greater than Alaska, his comp rate could be increased.

-- In any event, the minimum comp rates will apply.

Section 180.

-- The definition of permanent total disability has not changed. However, in making the determination of whether the employee is permanently and totally disabled, the labor market to be considered is the area of residence, area of last employment, and the state. This would appear to mean that the first labor market considered is where the employee is currently residing, be it in Alaska or out of Alaska. The second area to be considered, in that priority, is the area of last employment, and the third is the state of Alaska. There are no provisions to state at what point you can change priorities, and therefore, it must be assumed that it would be based upon the reasonable probabilities of obtaining employment in each separate area.

-- Inherent in this provision is the concept that you can force an employee to move to accept employment or terminate his PTD benefits. It is unclear to me as to what this particular provision in this section and other sections is intending to accomplish. It should be defined in more definite terms. Failure to meet the wage goals as established in the rehabilitation provisions, that the employee have the skills that would allow him to earn wages that equate to at least 60 percent of his wages at the time of the injury (reduced proportionately if he is residing outside the state of Alaska) does not in and of itself constitute permanent total disability.

-- I am concerned that the establishment of the priorities for the labor market in this and other sections will be interpreted by the board and/or the courts to mean that you must rehabilitate the employee so that he has skills that would allow him to return to work in his area of residence. If that cannot be accomplished, and the employee is not willing to return to his area of last employment or to relocate to another portion of Alaska or the state where he currently resides, that he will be found to be unemployable. Again, the provisions listing the labor market throughout this proposed legislation should be explained in more detail.

Section 185.

-- TTD is to be paid based on 80 percent of the employee's spendable weekly wages for a maximum of two years, "regardless of the continuance of the disability." In addition, TTD benefits will not be paid after the employee is determined to be medically stable. At that point, PPD benefits kick in.

Section 190.

-- The concept of permanent partial disability has been completely revised, and it is entirely based upon a schedule with a presumed loss of wage earning capacity. In some cases, this will greatly increase the amount of benefits one person will receive without the need for such benefits, and greatly reduce the amount of benefits that another would receive when he is in dire need of such benefits. A journeyman carpenter and an attorney will receive the exact same amount of money for the loss of an arm, where it would have little impact on the attorney's ability to return to his prior employment, while precluding the carpenter from doing so. I have always favored the idea of permanent partial disability benefits being paid based upon the actual loss of wage earning capacity suffered by the injured employee. The use of a schedule will reduce the amount of dispute and litigation stemming from permanent partial disability, but it will result in some inequity in the system, and in some cases, a severe inequity.

-- PPD is based upon a total payment of $240,000, to be multiplied by the "percentage of net permanent impairment of the whole person." The payment is to be made in a lump sum and will not be discounted for present value.

-- Net permanent impairment is determined by multiplying the actual degree of permanent impairment as determined by the AMA Guide times the adjustment factor listed in the statute. A person with a 5 percent disability of the whole person would receive no permanent partial disability benefits. The factor increases with each 5 percent of impairment by .2. Thus, an employee with a 6 percent impairment rating for the whole man would receive 1.2 percent of $240,000, or $2,880. A person with an impairment of 30 percent would receive $57,600. For any impairment in excess of 30 percent, the employee would receive that percentage times $240,000. Thus, an individual with a 31 percent disability rating would receive $74,400.

-- The AMA Guides will be used to determine the impairment rating and the impairment rating is not to be rounded off to the nearest 5 percent. The board may adopt a supplemental schedule for injuries that cannot be rated by these guidelines.

-- The minimum payment for a permanent impairment is $250.

-- The percentage of impairment as determined under this section will be reduced by the percentage of permanent impairment that existed before this compensable injury. However, this reduction of an impairment rating will not preclude finding the employee to be permanently and totally disabled.

Section 200.

-- For temporary partial disability benefits, payments will be made based upon 80 percent of the difference between the employee's spendable weekly wages before the injury and the wage-earning capacity of the employee after the injury, for a period of not more than five years. This should be changed so that you are comparing the employee's actual weekly wages before the injury to the wage-earning capacity after the injury, as has been done in other sections.

-- TPD benefits are not to be paid after the employee has reached medical stability.

-- There is a contradiction in this statute where the proposed language says that TPD benefits will not be paid for more than two years regardless of the continuance of the disability. This is inconsistent with the five year period stated above.

-- The wage earning capacity is to be determined by the actual spendable wage if that figure fairly and reasonably represents the wage earning capacity of the employee. The board may use other factors if it does not fairly and reasonably represent the wage earning capacity of the employee. This is likely to cause some dispute, and it would seem, as noted above, that the actual wages before the injury should be compared to the actual wages after the injury.

Section 220.

-- The spendable weekly wage at the time of injury is the basis for computing compensation. This would equal the gross weekly earnings minus payroll tax deductions. Gross weekly earnings are computed by dividing the gross earnings in the two prior calendar years by 100.

-- If the employee has no earnings during the two calendar years or was voluntarily absent from the labor market for 18 months or more of the two calendar years, the board shall determine the gross weekly earnings by considering the nature of the employee's work and work history, but the compensation may not exceed the employee's earnings at the time of injury. This does not mean that the gross weekly earnings cannot exceed it, it means that the compensation rate cannot exceed it. Therefore,

in cases of a declining economy, it would not be unusual for an employee to have a compensation rate that equals his actual earnings at the time of injury.

Section 225.

-- If employer contributions to a pension or profit plan have been included in determining the gross earning and the employee is receiving pension or profit sharing payments, benefits are reduced by the amount so paid or payable. The amount of this reduction may not exceed the increase in compensation benefits caused by the inclusion of these contributions.

Section 247.

-- The employer cannot discriminate against a person who has filed a claim for workers' compensation. This is not to be construed as prohibition for an employer to require the completion of a preemployment questionnaire or application regarding the prospective employee's health or disability history, so long as this document is meant to either document written notice for the Second Injury Fund or to determine whether the employee is physically capable of doing the job. This statute should go further and allow employers to require prospective employees to fill out such a form. Many employees are refusing to fill out questionnaires.

Section 265(15).

-- The definition of gross earnings has been revised to include the total amount of contributions made by an employer to a pension or profit sharing plan during the two plan years preceding the injury, multiplied by the percentage of the employee's vested interest in the plan at the time of injury.

Section 265(17).

-- Injury does not include mental stress unless it is established that the work stress was extraordinary and unusual and the work stress was a predominent cause of the mental injury. The amount of work stress shall be measured by the actual events rather than the misperceptions of the employee. Mental injury does not arise out of the course and scope of employment if it results from a disciplinary action, work evaluation, job transfer, lay off, demotion, termination or similar action taken in good faith by the employer.

Section 265(34).

-- Medical stability means that point at which further objectively measurable improvement is not reasonably expected to be achieved from additional medical care or treatment, notwithstanding the possible need for additional care for the possibility of improvement or deterioration resulting from the passage of time. Medical stability shall be presumed in the absence of objectively measurable improvement for a period of 45 days. This presumption can be overcome only by clear and convincing evidence.

1. AS 23.30.220 is repealed and reenacted to read:

Section 23.30.220. Determination of Spendable Weekly Wage. (a) The spendable weekly wage of an injured employee at the time of an injury is the basis for computing compensation. It is the employee's gross weekly earnings minus payroll tax deductions. It is the intent of the legislature that the gross weekly earnings be computed as closely as possible to reflect the actual wages the employee was earning at the time of his injury. The gross weekly earnings shall be calculated as follows:

(1) If the employee has worked for the employer for a period of time in excess of forty weeks, the gross weekly earnings will be computed by dividing the total wages and/or commissions earned and dividing by forty. In the absence of clear and convincing evidence to the contrary, this shall be the employee's gross weekly earnings.

(2) The gross weekly earnings will include wages received for overtime hours. If the employee is working overtime hours on an irregular basis, an average of such overtime hours and the corresponding wages will be used to determine his gross weekly earnings. This average will be computed by determining the number of overtime hours per week worked in the twenty weeks immediately preceding the injury. If the employee has not worked for that employer for twenty weeks, then the number of overtime hours will be determined by first the number of overtime hours worked by the person that the employee replaced, or secondly, the number of overtime hours worked by employees of the same employer in the same job function.

(3) If the employee receives commission based on sales achieved or the amount of work performed, such commissions will be included in the determination of his gross weekly earnings. The average of such commissions will be computed by determining the number of commissions received in the twenty weeks immediately preceding the injury, or if the employee has not worked for that employer for twenty weeks, by determining the reasonable amount of such commissions to be earned by the employee over a twenty week period and dividing by twenty weeks.

(4) If the employee is being paid based upon a monthly salary, regardless of whether payments are made on a weekly, bimonthly or other basis, the gross weekly earnings shall be the monthly salary divided by 4.3.

(5) If an employee when injured is a minor, an apprentice, or a trainee, as determined by the Board, whose wages absent such injury would automatically increase during the period of disability, the projected increase will be included in computing the gross weekly earnings of the employee. This increase will be limited so that the compensation rate of the employee will not exceed his actual spendable weekly wage at the time of the injury.

(6) If the employee is injured while performing duties as a voluntary ambulance attendant, policeman or fireman, the gross weekly earnings for calculating compensation shall be the minimum gross weekly earnings paid a full time ambulance attendant, policeman or fireman employed in the political subdivision where the injury occurred, or if the political subdivision has no full time ambulance attendants, policemen or firemen, at a reasonable figure previously set by the political subdivision to make this determination, but in no case may the gross weekly earnings for calculating compensation be less than the minimum wages computed on the basis of forty hours per week.

(7) Gross weekly earnings will include the amount of contribution made by an employer to a qualified pension or profit sharing plan, to be computed on a weekly basis. The gross weekly earnings will be increased by the amount of such contribution on a weekly basis, multiplied by the percentage of the employee's vested interest in the plan at the time of injury.

(b) The Commissioner shall annually prepare formulas that shall be used to calculate an employee's spendable weekly wage on the basis of gross weekly earnings, number of dependants, marital status, and payroll tax deductions.

2. Section 23.30.225 is amended by adding a new subsection to read:

(c) If employer contributions to a qualified pension or profit sharing plan have been included in the determination of gross earnings and the employee is receiving pension or profit sharing payments, weekly compensation benefits payable under this chapter shall be reduced by the amount paid or payable to the injured worker under the plan for any week or weeks during which compensation benefits are also payable. The amount of the reduction may not in any week exceed the increase in weekly compensation benefits brought

about by the inclusion of employer contributions to a qualified pension or profit sharing plan in the determination of gross earnings.