WCCA NEWSLETTER

HELPING ALL ALASKANS THRU A BETTER WORKERS COMPENSATION LAW

February 1982

WCCA has been involved with a joint effort of management and labor to correct some of the problems in HB159 now under consideration by the House Labor and Commerce Committee. Labor representatives include the AFL-CIO, District Council of Laborers, the Ironworkers, and the Teamsters. Management representatives of WCCA are from WIEN, Unit Construction, and Air Van Lines on the smaller joint labor-management subcommittee which meets nearly daily following the larger WCCA meeting which set direction on February 5, 1982.

While the area of workers' compensation is large and complex, the following five topics have been selected for detailed examination and hopefully consensus and legislative response in this session:

- Bunkhouse rule, which covers a worker at a remote site.
- No compensation payable to a worker injured while under the influence of intoxicating beverage or drugs not taken according to prescription direction.
- Determination of the wage base for setting compensation in an equitable manner for employee and employer (the average weekly wage setting process).
- Use of a spendable income approach in setting compensation to reduce disincentive to return to work due to higher compensation payments than net take-home pay. Iowa has addressed this issue.
- Establish a Vocational Rehabilitation monitoring capability within the Division of Workers' Compensation to obtain a quick response of all parties in a case involving rehabilitation. Guidelines for vocational rehabilitation services would be developed to assure a high quality of service.

2725

Both labor and management representatives would like to have an expanded membership participation on the working committee and be able to address other aspects of workers' compensation in the future. These could include the use of modified work including union members and an examination of a wage loss system.

Due to the imminent legislative committee action, please contact one of the following board members with your ideas or concerns:

Richard Cattanach 349-4568 Jack Thompson 272-0536

" OUR SUPPORT DEPENDS ON YOUR SUPPORT "

CORRESPONDENCE/MEMORANDUM — STATE OF WISCONSIN

Date: July 21, 1980 File Ref:

To: Insurance Carriers and Self Insurers

From: John R. Byrnes, Administrator, Worker's Compensation Division
State of Wisconsin Department of Industry, Labor and Human Relations

Subject: Promptness of First Indemnity Payments in 1979 Under Worker's Compensation Act of Wisconsin

The 1979 percent of prompt first indemnity payments is at the highest level since 1975. The promptness record for the five year period 1975 -1979 is:

	1979	1978	1977	1976	1975
All Cases	82.7%	78.1%	78.8%	80.6%	80.0%
Insurance Carriers	82.8	77.2	78.2	79.9	79.8
Self Insurers	81.8	84.0	82.9	85.8	80.8
Private	78.6	81.9	80.9	83.0	80.1
Public*	94.9	91.0	87.9	91.8	84.1

My congratulations to the insurance carriers and self insurers who maintained or significantly improved their 1979 rating.

Insurance carriers scoring 90.1 and above by size group (excluding the companies with only 1-3 cases tabulated) are:

Carriers with 50 or more cases

West Bend Mutual Insurance Company	98.9%
Mid Century Insurance Company	94.5
American Guarantee and Liability Insurance Co.	92.9
Regent Insurance Company	92.6
Employers Insurance of Wausau	92.1
General Accident, Fire & Life Assurance Corporation, Ltd.	91.3
Twin City Fire Insurance Company	91.1
General Casualty Company of Wisconsin	90.9
Hartford Accident & Indemnity Company	90.4
Reliance Insurance Company	90.2

Carriers with 25 to 49 cases

Employers Reinsurance Corporation	92.9%
Master Plumbers' Limited Mutual Liability Co.	91.1

* Excluding State of Wisconsin

Carriers with 4 to 24 cases

Assurance Company of America	100.0%
Foremost Insurance Company	100.0
Highlands Insurance Company	100.0
North American Company for Property and Casualty Insurance	100.0
Security National Insurance Company	100.0
The Travelers Indemnity Company of Rhode Island	100.0
Transport Indemnity Company	95.2
American Employers' Insurance Company	94.4
Security Insurance Company of Hartford	90.5

Please refer to attached tables for additional information.

Private self-insured employers scoring 90.1 and above by size groups (excluding the employers with only 1-3 cases tabulated) are:

Employers with 50 or more cases

K-Mart Corporation	100.0%
Wisconsin Gas Company	100.0
Oscar Mayer & Company	95.0
Mirro Aluminum Company	94.1
Milwaukee Transport Services, Inc.	93.8
Evans Products Company	93.3
Pabst Brewing Company	93.2
J. I. Case Company	92.0
Cutler-Hammer, Inc.	91.0
Beatrice Foods Company	90.8
Allis-Chalmers Corporation	90.6
General Motors Corporation	90.4

Employers with 25 to 49 cases

Caterpillar Tractor Company	96.4%
Colt Industries Operating Corp.	91.7

Employers with 4 to 24 cases

Amoco Foam Products Company	100.0
Eaton Corporation	100.0
Envirex, Inc.	100.0
Foremost McKesson, Inc.	100.0
International Harvester Company	100.0
Madison Gas & Electric Company	100.0
Northern States Power Company	100.0
Ryder Truck Lines, Inc.	100.0
Scott Paper Company	100.0
Seven-Up Bottling Company of Oshkosh, Inc.	100.0
Western Electric Company, Inc.	100.0
Aunt Nellie's Foods, Inc.	95.2
Chrysler Outboard Corporation	92.5
Dresser Industries, Inc.	90.5

Public exempt employers scoring 90.1% and above are:

Employers with 50 or more cases

City of Madison	100.0%
Milwaukee Public Schools	100.0
City of Milwaukee	99.7
Milwaukee County	93.7

Employers with 25 to 49 cases

Dane County	100.0%

Employers with 4 to 24 cases

Chippewa County	100.0%
Waupaca County	100.0

Insurance carriers which had a poor promptness record in 1979 will receive a claims handling checklist with this memo to help them assess their claims handling procedures. I would like these companies to comment on the questions asked and to let me know what problems they encountered and how they plan to alleviate them. My address is P. O. Box 7901, Madison, Wi 53707.

I have sent the claims handling checklist to the self insurers which experienced poor promptness records in 1979 in previous correspondence.

A prompt first payment is one in which the time lag between the last day on which the injured or ill employee worked and the date on which the insurance carrier or the self-insured employer sent or delivered the first indemnity payment to the injured or ill employee was 14 days or less. Cases in which salary was continued are also considered prompt. Some of the larger public self insurers continue salary payments during temporary disability. This practice brings up the promptness ratio. because salary payments are considered prompt first payments.
A self-insured employer is a subject employer exempt from insuring all or part of his liability as provided by the Worker's Compensation Act of Wisconsin. Injury cases protected by excess insurance are classified with self-insured employers.

The attachments to this memo are:

Tables 1A and 1B which rank insurance carriers and self-insurers by promptness record by size of company in terms of number of cases tabulated.

The Index is an alphabetic list of the insurance carriers and self insurers and their percent of promptness for 1979.

Promptness checklist for insurance companies which had more than three cases tabulated and had less than 80.0% prompt first payments.

In 1977, the former administrator of the Worker's Compensation Division asked 66 insurance conpanies and 13 self-insurers which had pay lag rates of between 3.0% and 77.3% to report on their claims handling procedures and to find ways to improve their performance. The acceptable level of performance is 80.0%.

Sixteen of the 66 insurers and ten of the 13 self-insurers raised their performance levels in 1979 into the 80.0% to 96.4% range. All of these carriers and employers are to be commended on their improved payment delivery systems. They are:

Insurance Carriers	1979	1977
American Employers Insurance Company	94.4%	65.8%
Master Plumbers' Limited Mutual Liability Co.	91.1	62.9
Twin City Fire Insurance Company	91.1	69.4
Security Insurance Company of Hartford	90.9	51.7
Liberty Mutual Insurance Company	86.2	77.3
Vigiland Insurance Company	85.7	72.4
The Ohio Casualty Insurance Company	84.6	59.7
Continental Insurance Company	84.0	74.2
Tower Insurance Company. Inc.	83.7	70.6
Threshermen's Mutual Insurance Company	83.5	70.3
Maryland Casualty Company	82.3	71.9
Atlantic Mutual Insurance Company	81.5	69.9
American Universal Insurance Company	80.9	76.6
St Paul Fire & Marine Insurance Company	80.3	65.1
Transport Insurance Company	80.2	76.3
The North River Insurance Company	80.0	72.6

Self Insured Employers		
Caterpillar Tractor Company	96.4%	77.1%
J. I. Case Company	92.0	72.0
Colt Industries Operating Corp.	91.7	69.1
General Motors Corporation	90.4	50.3
A. O. Smith Corporation	87.2	70.4
Sears, Roebuck & Company	84.4	76.3
Borden, Inc.	84.4	76.3
Armour & Company	82.5	67.1
American Hospital Supply Corp.	81.7	71.8
Consolidated Freightways Corp. of Delaware	80.0	76.6

The following insurance carriers have improved their performance measurement significantly in the last half of 1979 and are expected to continue the upward trend in 1980.

	Last Half 1979	1977
Bituminous Fire and Marine Insurance Company	90.4%	69.6%
Aetna Insurance Company	83.7	69.4
Shelby Mutual Insurance Company of Shelby, Ohio	82.1	78.6
United States Fidelity & Guaranty Company	83.8	70.8
Fireman's Fund Insurance Company	80.0	74.0
Lumbermen's Underwriters Alliance	85.0	40.8
Universal Underwriters Insurance Company	88.9	54.3
Milwaukee Mutual Insurance Company	80.1	54.2
Transcontinental Insurance Company	83.3	71.8
West American Insurance Company	84.2	75.0
National Surety Corp.	81.3	65.6

The remaining 40 insurance carriers did not achieve a noteworthy improvement. However, several of these insurers have been making efforts to improve their systems of payment deliveries. Their efforts should become more apparent in 1980.

The department's monitoring program for carriers and exempt employers will be continued on a quarterly basis. However, individual reports to companies will be discontinued. Companies which continue to have poor records will be contacted. Performance rates will be available on request. If profiles of your injury claims could help isolate problems that are hampering your efforts to improve your benefit delivery systems, they are available under certain circumstances. Please direct specific data requests to Ruth Wilson, P. O. Box 7946, Madison, Wi 53707. Telephone No. 608-266-0317.

Attach.

PERSPECTIVE

Insurers fail to meet promises to provide effective loss control

By Daniel S. Otremba

THE OCCUPATIONAL SAFETY & Health Act (OSHA) of 1970 established the National Commission on State Workmen's Compensation Laws to make "a comprehensive study and evaluation of state workers compensation laws in order to determine if such laws provide an adequate, prompt and equitable system of compensation."

The commission offered that "the encouragement of safety" should be one of the objectives "for a modern workmen's compensation program." It recommended that "insurance carriers be required to provide loss prevention services and that the workers compensation agency carefully audit the services. The agency should insure that all carriers doing business in the state furnish effective loss prevention services to all employers, and, in particular, should determine that reasonable efforts are devoted to safety programs for smaller firms."

Daniel S. Otremba is a senior loss control consultant with Employe Benefits Insurance Co. in Santa Rosa, Calif., and an instructor of safety management at Golden Gate University.

Most workers compensation insurers claim to provide loss prevention services. But are they effective? Industry testimony before the commission indicates that carriers believe the services provided are professional and effective.

John L. Pickens of the Hartford Insurance Group represented the American Insurance Assn. (AIA) and its 230 member insurance companies before the commission. The AIA testimony is significant since it is variously estimated that member companies employ between 33% and 70% of our nation's loss prevention specialists. Moreover, the AIA publicly embraced the professional standards of the American Society of Safety Engineers (ASSE) as its own.

The standards outline the job of the loss control representative as identifying loss producing conditions, developing improved loss control methods, communicating this information to top management, assisting employers in implementing programs and engaging in a continuing evaluation of loss control efforts.

The AIA testimony suggests that member insurance company loss control representatives are expected to do these things if they are to be judged effective professionals in

What's up in the industry

M&M loses a supporter

FOR THE FIRST TIME in four years, stock analyst Leonard Wilson of Drexel Burnham Lambert has withdrawn his "buy" signal on the stock of Marsh & McLennan Cos. Inc. Mr. Wilson, one of the few analysts that follows insurance brokers, retains his buy signal on the other large national brokers—Alexander & Alexander, Frank B. Hall, Fred S. James, Corroon & Black, Rollins Burdick Hunter.

Revenues at M&M increased 16% for the first six months, while revenues at A&A were up 21%, 22% at Hall, 28% for James and 44% at Corroon & Black, which felt overlooked in a previous column and brought their impressive results directly to *BI*'s attention.

In the research report supporting the switch to a "neutral" rating, Mr. Wilson suggests that new business must be slowing. In addition, he believes Mercer is not generating the business expected by M&M. "Mercer does not enjoy the prominence with large corporations equivalent to that of Marsh & McLennan Inc. in insurance brokerage," he says.

Mr. Wilson told *Business Insurance* that the change in rating has been dictated as much by M&M stock's price, 14 times earnings, as by the slowing revenue growth. The other major brokers with the exception of A&A carry lower multiples, he noted.

"I think the other brokers' growth will slow in time," he adds, "but whether it slows down as much for the others remains to be seen."

Greg David

Loss control representatives discriminate against smaller employers in favor of larger firms.

their field.

Using the AIA/ASSE standards as a measure, the author conducted a survey of U.S. workers compensation carriers and their customers to determine if the insurers "furnish effective loss prevention services to all employers." Questions were posed to home office loss control managers who set the standards of performance, to the loss control representatives who provide services, and to the customers who receive the services.

Before the commission, the AIA insisted that loss control departments have two basic functions: "First, assisting the insured employer in preventing losses and, second, providing the company with underwriting information." Yet, 74% of the responding managers and 48% of the loss control representatives (0% of the customers) selected the insurance function as primary. How then can insurance loss control representatives be regarded as safety professionals, if "the encouragement of safety" is not the primary objective?

In the survey, twenty-two of the basic functions of the professional safety position were reviewed and in every instance home office expectations of services rendered and loss control representatives claims of services provided far exceeded customer reports of actual services received. Further, the survey showed that home office managers and loss control reps discriminate against small employers in favor of larger ones; the representatives tend to discriminate more significantly against smaller employers than their managers.

A majority of customers (77%) reported that loss control representatives seldom or never provide consultative services, but limit themselves to ineffective physical inspections of work areas. Only rarely do loss control representatives interpret the total dollar losses (so important to management) that result from accidents and pass that information on to management. Fifty-six percent of the customers asserted that loss control representatives never study the insureds' systems to define likely modes of failure; 22% indicated they seldom do so.

studying the customers' work environment or assisting with job analyses to help the insureds with selection and placement. Only rarely does the representative assist in the development of safety policies. He is lax in compiling, analyzing, interpreting and communicating accident statistical data which can be vital to the improvement of the loss record.

The responses show that the loss control specialists are not committed to the development of methods to evaluate costs in terms of effectiveness. Finally, they are very weak in communicating information to their clients.

Such are the functions of the professional safety representative. But when responses to the survey are compared to the AIA standards, loss specialists seem to limit themselves to one function only, the "identification of loss producing conditions and practices and evaluation of the significance and the severity of these factors." This seems to be in keeping with the view that insurance loss control personnel are in the field only to provide adequate data for underwriting a risk.

This is not in keeping with the professional standards promulgated by the AIA and ASSE. Insurance loss control representatives appear to be weak in the other functions attributed to the safety professional: development of methods and programs, communication of information to top management and evaluation, especially through statistical facilities.

The insurance industry committed itself to a professional standard of excellence as far as loss control is concerned. This survey, conducted in 1976, suggests that its loss control personnel are not living up to those standards.

As the National Commission on State Workmen's Compensation Laws pointed out: "Industry spokesmen . . . have committed themselves and their companies to what must be considered a new era in workmen's compensation, one of cooperation and affirmative action." Perhaps it is time to re-examine the performance of loss control departments, decide whether they are living

Insurance Bills May Rise for Many Firms As Poor Profits Force Insurers to Lift Rates

By Cynthia Saltzman
Staff Reporter of The Wall Street Journal

From the trenches of the insurance industry, Donald E. Bell looks out on fighting of an intensity he has never seen before.

An insurance broker in the Melville, N.Y., office of Alexander & Alexander Services Inc., Mr. Bell watches property-and-casualty companies battling for commercial insurance business by slashing premiums as much as 70%. Recently, he looked around for quotes on renewing insurance on a fleet of trucks—a policy that last year cost $150,000—and found a company offering the insurance for as little as $180,000.

"That's insane," Mr. Bell says. "The losses were higher than that."

Insane or not, there isn't any question that the largely unregulated commercial insurance market is in turmoil. And the cutthroat competition, some observers say, is setting the stage for a backlash in the industry—a backlash that may lead to higher premiums for businesses and thus higher prices of products and services for consumers.

Boom-and-bust cycles have whipped the property-and-casualty insurers around for decades. But observers say the current turmoil differs from seemingly similar periods in the past. For one thing, there are more players — among them foreign insurance companies that are based in countries with strong currencies and are stepping up their U.S. operations.

Too Much Capacity

"There's too much capacity chasing too few premiums," says John H. Bretherick, executive vice president of Continental Corp., an insurance holding company based in New York.

But perhaps the most important force aggravating the competition is the huge income being reaped by property-and-casualty companies from their investments. Traditionally, insurers have split their business into, on the one hand, the operation of taking in premiums and paying out claims and, on the other, investing premium dollars in stocks, bonds and real estate.

In recent times, high returns on investments seem to have made many insurers willing to write money-losing policies just to get more cash to invest. Last year, for example, stockholder-owned insurers lost $1.4 billion on underwriting but posted net income exceeding $5 billion—thanks to the $6.7 billion earned by investing capital, surpluses and reserves set aside to cover insured losses by policyholders.

This "cash-flow game" is played primarily for the high stakes involved in insuring corporate giants whose six- and seven-figure premiums, cut-rate or not, are eagerly sought as investment fodder. By contrast, the relatively small premiums paid by individuals for property-and-liability insurance have remained immune to rate-cutting; indeed, they have been rising.

Auto-Policy Problems

But not enough to satisfy the insurers. Auto coverage, which makes up 25% of the business of stockholder-owned insurers, and homeowners' insurance are state-regulated, and premiums for both haven't kept up with inflation's effect on claims. For example, the cost of automobile claims—in line with the surging cost of health care, auto parts, legal fees and labor—has climbed 16% this year, while auto-policy rates have risen less than 10%.

Because of that disparity and the fierce competition for commercial insurance business, the industry's earnings are beginning to suffer. In this year's second quarter, overall profits of stockholder-owned companies were flat, and operating income fell 9% at Aetna Life & Casualty Co., 11% at Safeco Corp. and 20% at Ohio Casualty Corp. Profits are expected to deteriorate further.

Cushman, insurance-stock analyst at Morgan Stanley & Co.

For 1981, some analysts are predicting at least a 10% drop in insurance-company earnings. Robert Brian of Conning & Co., a Hartford, Conn., firm specializing in insurance-stock analysis, sees the industry's "combined ratio"—the bench-mark statistic measuring claims losses and operating expenses against premiums—climbing to 104% of premiums by year-end and to about 109% in 1981.

Some Optimists

However, many insurance executives and securities analysts expect a turnaround in 1982. One such optimist is B.P. Russell, chairman of Crum & Forster, an insurance holding company based in New York. "We'll really see action to harden prices next spring after insurance-company boards review the 1980 underwriting results," he says.

Mr. Russell adds: "Once you lower underwriting standards, you can't accurately predict where loss ratios will top out. If you don't keep the pressure on to have profitable underwriting, you wish to hell you had." At Crum & Forster, such pressure is applied by means of cash bonuses paid to individual underwriters on the basis of the company's underwriting results alone, apart from its investment income.

But others expect the rate-cutting to extend into 1982—with an increasingly devastating effect. Inflation, the pessimists argue, will keep pushing up claims costs while competition and a lag in rate increases will slow the growth of premiums; and the smaller cash inflow, combined with interest rates considerably below those last spring, will retard gains in investment income. For example, Donald Franz, a securities analyst at Smith Barney, Harris Upham & Co., predicts that the insurance industry's after-tax investment income will grow only 13.6% this year, down from the 1979 record of 26%.

Danger Ahead?

Conning's Mr. Brian says inflation and some large catastrophes next year could throw some small insurers into financial trouble. Companies may continue to lose money on underwriting, he says, until they see return on equity falling to "an unacceptable level" such as 10%.

In fact, Mr. Brian observes, the industry may be accepting underwriting losses as normal. "The big question is whether cycles will be the same in the future," he says. "Will the industry return to making money on insurance or breaking even, or will it accept a whole new level of underwriting loss?"

That question can't be answered readily by looking at history. In past cycles, investment income was much smaller in absolute dollars and less of a cushion for underwriting losses. "This time," says James J. Meenaghan, executive vice president of American Express Co.'s Fireman's Fund Cos. in San Francisco, "investment income may be clouding some people's view."

What worries Mr. Meenaghan and others is the persistence of intense competition. Indeed, without an outside shock such as a stock-market collapse, says Barbara D. Stewart, a Chubb Corp. economist, the current downturn "will be like a bad toothache. It will stretch out for a long time—longer than the last downturn," which went on for three years.

Trouble in 1975

That underwriting plunge, which reached bottom five years ago, is remembered with a shudder by insurance executives as the worst period in the industry's history. In 1975, the stockholder-owned firms posted a $3.2 billion loss on underwriting, and earnings fell to $100 million. The combined ratio hit 108%, the highest since 1906, the year of the San Francisco earthquake.

Ms. Stewart says, "It wasn't simply

plains: "Inflation soared, the stock market went down the tubes, and the surpluses were disappearing. Geico (a large insurance company) almost went bust, and insurers saw exotic liabilities losing money. A number of companies said, 'Stop the music!' "

The result: Many insurers became more selective in writing policies and in some cases bailed out of unprofitable lines. Moreover, rates for certain types of insurance, such as medical malpractice and some product-liability lines, jumped as much as 200% to 300%.

In reaction, many corporations, unable to get coverage, began to set up their own insurance operations to self-insure plants, employes and products—a move that has continued. (Such captive insurers, by later seeking outside business, have intensified the current competition among commercial insurers.)

A Boom Begins

Nevertheless, the insurance industry's tougher policies set the stage for the boom that began in 1977. Because of increased premium rates and the growing demand for coverage, revenues from premiums soared 21% in 1976 and 19% in 1977. Once again, the industry was making money on insurance; at the same time, it was raking in sharply higher investment income.

But it was the desire to fuel that investment income, of course, that led to today's frenzied rate-cutting. The lure of sizable amounts of money to invest, along with an increasing number of people seeking insurance to protect themselves against a surge in lawsuits involving allegedly faulty products and professional negligence, has also contributed to the industry's gradual switch away from property coverage toward more liability insurance. With such "long tail" insurance, companies can hold liability premiums for many years and thereby maximize investment income; a product-liability claim may take five or six years to settle, while a claim for, say, a damaged fence is paid relatively promptly.

By taking on more liability insurance, some observers say, companies are accepting a higher level of risk. And Ernest G. Jacob, an analyst at Alex. Brown & Sons, a Baltimore-based securities firm, says it is difficult to estimate the cost of claims five or six years into the future even without trying to guess the rate of inflation. Consequently, he says, "Loss-reserve adequacy is more critical than it was in the past." He adds that today insurers on the average maintain loss reserves amounting to 99% of earned premiums, a big jump from 65% in 1969.

More Reinsurance

And to reduce their risks in certain lines, insurers are turning more and more frequently to the reinsurance market. Today, for example, with reinsurance cheap and easily available, a small insurer can take on a $1 million policy and "lay off" as much as $900,000 of it on reinsurers—and thus spread far more of the risk among other companies than it could in the past. By, in effect, splitting up insurance policies in this way, insurers can take on risks that they ordinarily would have avoided. The current oversupply of reinsurance contributes to the competitiveness of the primary-insurance market because it enables insurers to write larger policies.

Given the insurance industry's cyclical nature, the currently soft insurance market undoubtedly will harden eventually, despite the increased reliance on investment income.

"I think these cycles are healthy for the business and the economy and certainly for the consumer," says Crum & Forster's Mr. Russell, whose views may be colored by the fact that his company's profits recently have been among the best in the industry. "A well-managed firm can manage in down

MACT
MINNESOTA ASSOCIATION OF COMMERCE AND INDUSTRY

Memo...

TO: John, Brian, Win

FROM: Mark S. Anderson

DATE: November 7, 1980

RE: Insurance Company Taxation

At the state level, insurance company taxation is governed by Minnesota Statutes 60A.15 and Minnesota Statutes Chapter 290.

At the local level, insurance company real property is classified within the commercial-industrial class, paying at the 43% classification rate. Their personal property is, of course, exempt. No comparative analysis at the state level is possible because ABSTRACT OF TAX LISTS and ABSTRACT OF ASSESSMENTS LISTS do not break out insurance company property within the commercial-industrial class.

Insurance Premiums Taxes

Domestic and foreign companies, other than town and farmers' mutuals, and domestic mutuals, other than life, are required to pay a tax equal to 2% of the gross premiums, less return premiums, on all business received in Minnesota. The tax is paid in quarterly installments based on either the tax paid during the previous calendar year, or quarterly installments equal to one-fourth of 80% of the actual tax for the current calendar year. On or before March 1, an annual return must be filed for the preceding calendar year. Any remaining liability must also be paid by March 1, and any overpayment may be credited against the April 15 installment.

Mutual

Domestic mutual insurance companies, including town and farmers' mutual insurance companies, are required to pay a tax equal to 2% of the gross direct fire, lightning and sprinkler leakage premiums, except auto and ocean marine fire premiums, less return premiums, on all direct business on property located in Minnesota. This tax is also paid in quarterly installments.

Ocean Marine

Domestic and foreign companies are required to pay a tax equal to 5% of their three year average taxable underwriting profit from ocean marine insurance written within the state. The tax must be paid on or before June 1 annually.

Foreign

A 2% gross premiums tax (3% beginning August 1, 1978), less any returns, is paid by surplus line agents for obtaining insurance from unlicensed foreign insurers. The tax is collected from the insured by the agent.

Fire

In addition to the preceding taxes, all insurance companies, except mutual fire insurance and town mutual fire insurance companies, are required to pay annually by March 1 a tax of one-half of one percent of their gross fire premiums and assessments, less return premiums.

A surcharge of 2% of the fire, lightning and sprinkler leakage gross premiums, less return premiums, is imposed on all direct business received by any foreign or domestic fire insurance company on property located in the cities of the first class. This surcharge is due and payable in semiannual installments within thirty days following June 30 and December 31.

The Minnesota Insurance Premiums Tax paid is allowed as a credit against the Minnesota Corporation Excise Tax, and for many companies, this credit reduces the amount of income tax they pay to the minimum tax.

The Department of Revenue and the Tax Study Commission have compiled some insurance company INCOME TAX data which may be of interest to you.

YEAR	1977	1978	1979
No. of filers	435	441	460
No. paying minimum of $100	351	340	348
No. paying more than minimum	84	101	112
Total payments	$ 1,307,302	$ 1,469,125	$ 2,248,817
Payments at minimum	35,100	34,000	34,800
Payments above minimum	1,272,202	1,435,125	2,214,017
Average payment	3,005	3,331	4,889

A quick review of the numbers shows that the average payment went up over 60% in two years!

MSA:dmb

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The Minnesota Insurance Premiums Tax paid is allowed as a credit against the Minnesota Corporation Excise Tax, and for many companies, this credit reduces the amount of income tax they pay to the minimum tax.

The Department of Revenue and the Tax Study Commission have compiled some insurance company INCOME TAX data which may be of interest to you.

YEAR	1977	1978	1979
No. of filers	435	441	460
No. paying minimum of $100	351	340	348
No. paying more than minimum	84	101	112
Total payments	$ 1,307,302	$ 1,469,125	$ 2,248,817
Payments at minimum	35,100	34,000	34,800
Payments above minimum	1,272,202	1,435,125	2,214,017
Average payment	3,005	3,331	4,889

A quick review of the numbers shows that the average payment went up over 60% in two years!

MSA:dmb

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Staff Reporter of The Wall Street Journal

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A Boom Begins

Nevertheless, the insurance industry's tougher policies set the stage for the boom that began in 1977. Because of increased premium rates and the growing demand for coverage, revenues from premiums soared 21% in 1976 and 19% in 1977. Once again, the industry was making money on insurance; at the same time, it was raking in sharply higher investment income.

But it was the desire to fuel that investment income, of course, that led to today's frenzied rate-cutting. The lure of sizable amounts of money to invest, along with an increasing number of people seeking insurance to protect themselves against a surge in lawsuits involving allegedly faulty products and professional negligence, has also contributed to the industry's gradual switch away from property coverage toward more liability insurance. With such "long tail" insurance, companies can hold liability premiums for many years and thereby maximize investment income; a product-liability claim may take five or six years to settle, while a claim for, say, a damaged fence is paid relatively promptly.

By taking on more liability insurance, some observers say, companies are accepting a higher level of risk. And Ernest G. Jacob, an analyst at Alex. Brown & Sons, a Baltimore-based securities firm, says it is difficult to estimate the cost of claims five or six years into the future even without trying to guess the rate of inflation. Consequently, he says, "Loss-reserve adequacy is more critical than it was in the past." He adds that today insurers on the average maintain loss reserves amounting to 99% of earned premiums, a big jump from 65% in 1969.

More Reinsurance

And to reduce their risks in certain lines, insurers are turning more and more frequently to the reinsurance market. Today, for example, with reinsurance cheap and easily available, a small insurer can take on a $1 million policy and "lay off" as much as $900,000 of it on reinsurers—and thus spread far more of the risk among other companies than it could in the past. By, in effect, splitting up insurance policies in this way, insurers can take on risks that they ordinarily would have avoided. The current oversupply of reinsurance contributes to the competitiveness of the primary-insurance market because it enables insurers to write larger policies.

Given the insurance industry's cyclical nature, the currently soft insurance market undoubtedly will harden eventually, despite the increased reliance on investment income.

"I think these cycles are healthy for the business and the economy and certainly for the consumer," says Crum & Forster's Mr. Russell, whose views may be colored by the fact that his company's profits recently have been among the best in the industry. "A well-managed firm can manage in down cycles," he adds. "If it can't, it ought to get

Blue Cross
of Washington and Alaska

15700 Dayton Avenue North/P.O. Box 327
Seattle, Washington 98111
206/361-3000

December 30, 1980

Representative Brian Rogers, Co-Chairman
Workers' Compensation Committee of Alaska
Pouch V
State Capitol
Juneau, Alaska 99811

Dear Brian:

The basic data gathering which I did pursuant to Bob William's request seems to indicate that, with a change in the statute, Blue Cross of Washington and Alaska could provide the coverage for the medical services of Workers' Compensation. We see no real problems in integrating that line of business into our overall operations.

We do note that while the costs for processing claims should be comparable to the claims processing costs of our usual business, the administrative costs will be higher. There will be the need to make administrative decisions to determine whether the claim is work related. And that process seems to be quite complicated and subject to certain proofs.

It is, of course, expected that there will be a far higher frequency of claims paid. Our usual business does not pay claims until the deductible has been satisfied, and we pay only a set percentage of the usual charges. Workers' compensation claims are all paid at 100% of all costs, as far as I can discern.

To do any further study of this subject, we would need to know the percentage breakout of premium paid for medical expense versus death benefits and wage loss portions.

I hope this is helpful. See you in Juneau soon.

Sincerely,

Joan

Joan H. Gaumer, Director
Government Relations

JHG:bc
2A/11

cc: Bob Williams

DATE: January 1, 1981 Ph: (907) 465-2790

TO: Insurance Carriers, Adjusters, Self-Insured Employers, & Interested Parties

FROM: Director, Workers' Compensation Division

The following are average weekly wages for states and other U.S. jurisdictions, to be used in calculating rates to be paid benefit recipients as provided by amendment to AS 23.30.175 of the Alaska Workers' Compensation Act, effective September 22, 1976. The ratios are decimal figures (e.g., .517). The applicant's weekly rate is multiplied by the ratio. [See § .175(e).]

Where no average weekly wage is computed and published by a state agency responsible for administering the workers' compensation law of a particular state, the figure used is that published for purposes of the Longshoremen's and Harbor Workers' Compensation Act as revised October 1, 1980, $228.00. (Florida's is coincidently the same.) All figures are rounded to the nearest even dollar.

The effective date of this information is January 1, 1981. The Alaska average weekly wage to be used effective January 1, 1981 is $429.

		Ratio			Ratio
Alabama	$ 222	.517	Nebraska	$ 228	.531
Arizona	228	.531	Nevada	245	.571
Arkansas	228	.531	New Hampshire	213	.496
California	228	.531	New Jersey	265	.617
Colorado	306	.713	New Mexico	222	.517
Connecticut	285	.664	New York	228	.531
Delaware	263	.613	North Carolina	210	.489
District of Columbia	228	.531	North Dakota	212	.494
Florida	228	.531	Ohio	275	.641
Georgia	228	.531	Oklahoma	212	.494
Guam	228	.531	Oregon	261	.608
Hawaii	235	.547	Pennsylvania	262	.610
Idaho	220	.512	Puerto Rico	228	.531
Illinois	269	.627	Rhode Island	217	.505
Indiana	210	.489	South Carolina	216	.503
Iowa	230	.536	South Dakota	191	.445
Kansas	226	.526	Tennessee	228	.531
Kentucky	223	.519	Texas	266	.620
Louisiana	244	.568	Utah	230	.536
Maine	199	.463	Vermont	207	.482
Maryland	248	.578	Virgin Islands	178	.414
Massachusetts	245	.571	Virginia	213	.496
Michigan	313	.729	Washington	273	.636
Minnesota	243	.566	West Virginia	262	.610
Mississippi	228	.531	Wisconsin	373	.869
Missouri	228	.531	Wyoming	326	.759
Montana	219	.510			

JLM:PRT:lb

M E M O R A N D U M

TO: Licia Piceno
FROM: Bob Williams BW
RE: December 18, 1980 Bill Draft Request
DATE: December 19, 1980

Licia, please have Senator Terry Stimson and or Rep. Brian Rogers review the enclosed written bill request to insure that it is substantively what they wish to see on the final Bill Draft Amendments. Thank you.

MEMORANDUM

TO: Tom Sofo
FROM: Bob Williams
RE: Bill Draft Request
DATE: December 18, 1980

This memorandum is to clarify my verbal request to you concerning amendments to the insurance legislation for the Worker's Comp Study Commission.

For amendment #2, please re-incorporate the conditions that any group, "(1) Has a constitution and bylaws" and "(2) Incorporates a safety program", in the final draft.

For amendment #3, please consider if Title 21 is not a more appropriate place for this law change. (See, Koch's Memorandum, Report on Testimony Given to Worker's Compensation Study Commission, November 21, 1980)

To amendment #4, AS 21.39.045(a), please add after the word "profit" on line 18 the words, "except as is necessary to facilitate full rate development for a pool created and subject to AS 21.39.155."

Also add a new sub-section, AS 21.39.045(c), which gives the Director of Insurance the power to invoke AS 21.39.040(d), if he determines that rates for worker's compensation are "excessive, inadequate, or unfairly discriminatory." This section should be drafted broadly enough to allow the Director the discretion to invoke AS 21.39.040(d), for all or any part of any insurer's filing under sub-section (b).

Finally, Amendment #6 should be split into two bills lableled Amendment #6a and Amendment #6b. Amendment #6a should exempt the Alaska Guaranty Association created under AS 21.80.040 from liability in the case that any insurer, subject to the provisions of AS 21.39.045, becomes insolvent. Further, the State General Fund is wholly responsible for payment of all outstanding worker's comp claims of the insolvent insurer.

Amendment #6b should exempt the Alaska Guaranty Association from 50% of the liability for outstanding worker's comp claims, arising from the insolvency of an insurer subject to AS 21.39.045. The other 50% of the liability for payment of outstanding comp claims should be paid from the general fund.

If you have any questions please feel free to give me a call.

STATE OF ALASKA

DEPARTMENT OF EDUCATION

DIVISION OF VOCATIONAL REHABILITATION

Michael C. Morgan, Director

4100 Spenard Road
Anchorage, Alaska 99503

(907) 243-5600

January 12, 1981

Ms. Elaine McManus
% ALPAC/IRA
Pouch 6620
Anchorage, AK 99502

Dear Ms. McManus:

Enclosed you will find a copy of the Authorization for Release of Personal Information which has been signed by our mutual client, Mr. Billy R. Jones.

Based upon our telephone conversation of December 16, 1980, I am providing the following summary to you: Billy is a 42 year old divorced male who experienced an on the job injury to his back in May, 1976. He has experienced persistent back pain and in September, 1977, under went a laminectomy at the L-5 level. As a result of this injury, he has been diagnosed as having a primary disability of lumbo sacral disc disease with continued low back pain. The extent of functional impairment indicates he cannot work at heavy lifting, needs to avoid stooping and bending. Prognosis indicates that he will continue to experience problems especially with heavy exertion. He was declared eligible for DVR services in December of 1979. An academic training program was developed for him in January of 1980 to attend ACC electronic technology program. His academic performance was satisfactory until November of 1980. Because he was "overburdened . . . (had to take) classes one after another . . . unable to take breaks between classes . . . had difficulty sitting for prolonged periods of time" he was referred by his DVR counselor to ACC Handicapped Coordinator, Mike Turner. Following consultation with Mike Turner, he withdrew from fall ACC courses. He will resume ACC courses in January, 1981.

You are well familiar with the difficulties Bob has been experiencing with ALPAC regarding: (1) His efforts to receive medical reimbursement for medical services provided by Swedish Hospital in Seattle which amount to about $10,000 and (2) What Mr. Jones feels is a case of IRA employees mistaking him with another gentleman by the name of "Billy R. Jones."

Enclosed you will find xeroxed copies of the following information:

(1) 1/21/80 training plan written by his previous DVR counselor, Mike Birdsall.
(2) 1/25/80 physical rehabilitation evaluation which gives Billy's functional limitations. Based upon that information, he cannot return to his previous occupation of electrician. Training program was therefore justified. Billy will be returning to Seattle in January, 1981 to see Dr. Chaplain. I will be requesting current functional assessment report.

(3) An ACC college transcript.

Should you have additional quesitons, please feel free to contact me at 243-5608.

Sincerely,

Ruth L. Owens
Vocational Rehabilitation
Counselor

jb

cc: Billy E. Jones

750 West 2nd Avenue, Suite 110
Anchorage, Alaska 99501

Telephone
(907) 276-3037
(907) 276-6200

Dennis Patrick James
Attorney at Law

March 7, 1980

State of Alaska
Department of Labor
PO Box 1149
Juneau, AK 99811

Attention: Jacquelyn L. McClintock, Director
Workman's Compensation Division

RE: House Bill No. 705

Dear Ms. McClintock:

I have had an opportunity to review House Bill No. 705 and would submit the following comments to that bill for your information.

A.S. 23.30.215. The ceiling for monthly and total payments should be raised higher than the currently proposed Two Hundred Dollars per month, with a Ten Thousand Dollar total expenditure. The reasoning for this is that it is highly unrealistic that a claimant in vocational rehabilitaion would be able to survive by paying him Two Hundred Dollars a month plus his 191 funds, while he is in vocational rehabilitation.

A.S. 23.30.095(a) The removal of the two year barrier as far as continuing medical treatment is logical and just. The deletion of the right of the employee to change physicians is going to cause additional litigation. The insurance carriers resist payment for chiropractic care at this time, even though A.S. 23.30.095 (a), allows a change of physicians, (See A.S. 23.30.265). The deletion of this clause will provide the carriers with the right to litigate an employee's right to seek chiropractic help, after having been seen by a doctor of medicine.

A.S. 23.30.095(c) The requirement of submitting an ADL 210, or equivalent form will fall directly on the claimant by the insertion of "each visit for" and deletion of "the first" visit. Currently some adjustors are stopping compensation benefits to the employee when they don't receive the treating physician's reports. This is true whether the treating physician is a doctor of medicine, or a chiropractor. While it might be agreed that the responsibility ultimately rests with the employee to insure medical reports are timely submitted, the act should not provide a vehicle, allowing carriers to harrass employees by playing games with the employees compensation, under the guise of "the treating physician has failed to timely submit his/her medical report". Overcoming psychological trauma, relating to a work-related injury, is an important part of recovery. Allowing the carrier this psychological tool will act to the detriment of the injured employee.

A.S. 23.30.095(e) The independent medical examination by the employer/carrier is not an effort to ascertain whether an employee has been injured, but is used, hopefully to decrease the permanent-partial disability rating or to discredit chiropractic treatment. The right of the injured employee to have his physician present, should not be deleted, thus allowing the injured employee to be at the mercy of the carrier. It should be remembered that most claimants have not had prior exposure to the compensation system, nor do they seek legal counsel until problems between the claimant and carrier develop. The adjustor is intimately familiar with the workings of the system. Thus, I believe the right of the claimant to have his or her physician present, paid for by the employer, acts as a balancing force in behalf of the employee. The employer must address this fact when it wants to convince the employee that a free trip outside to visit an "impartial" doctor, would be a nice vacation.

A.S. 23.30.110(c) The increased time requirement for notice of a hearing appears to work to the benefit of the carrier. As a rule, the claimant requests a hearing because the carrier has controverted the employee's claim or stopped the claimant's compensation payments. The proposed change allows the carrier to use the technical defense of lack of twenty day notice to avoid a hearing.

Increasing the time allowed the Board to render a decision is equally unfair to the claimant. Some cases have been pending written decisions for months after the hearing. The carrier is not required to pay interest, much less principle, on an award until due. It is not due until a written decision has been rendered by the Board. The claimant suffers economic hardship during this period, in some cases, having to seek help from Welfare. If the Board denies a claim, then quick notice of that denial, is equally important. The issue is put to rest, or appealed, while the facts are still fresh.

The twenty day requirement theoretically forces the Board to take some action, once the hearing is requested. Deletion of this requirement will require court action on the part of the moving party, to force the Board to act. This seems to be an unreasonable requirement on the moving party, who is generally the claimant.

Consequently, I would suggest that the current ten day hearing notice and twenty day decision requirements remain intact.

A.S.23.30.145(a) The removal of the minimum fee schedule will create a pandoria's box situation. It allows the Board to set any standard as to what the attorney can recover as attorney fees. Claimant's counsel do not recover on every case. Consequently, the attorney must recover sufficient fees on successful cases to offset the unsuccessful cases. Contingent fees should also be allowed, since some claimants prefer this arrangement. To allow the Board to reject this type of fee arrangement, will create uncertainty within the claimant bar. This will work to the advantage of the carrier,

since, if the claimant cannot secure qualified legal counsel, the claimant will be left to the mercy of the carrier.

It should be pointed out that the carriers are in direct violation of this section, since they do not submit attorneys fees for approval by the Board. Equally relevant is the fact that the carriers attorneys get paid, whether or not they prevail on a particular case.

A.S.23.30.145(b) The proposed changes, coupled with the proposed A.S.23.30.145(a) will allow the carrier to litigate what is "reasonable" with out a minimum fee base. Be assured the carriers will litigate this issue since they are going to have to pay the fees.

The deletion of the minimum fee schedule appears to be in direct response to Alaska Interstate v Houston, 586p.2d 618, (Alaska, 1978). It would have been preferrable that the Supreme Court have granted Mr. Houston Civil Rule 82 attorney fees. It must be remembered that not every claimant is successful. The nonsuccessful claimant is generally destitute, so the claimant's attorney receives nothing for his time and efforts. The attorney must rely upon the successful cases to finance the unsuccessful cases. Very few attorneys represent claimants in workman compensation cases. Recovery of adequate fees may well be the reason for this lack of interest. Further reduction of fees and/or having to litigate "reasonable attorney fees" on every successful case may cause attorneys presently practicing in this field to withdraw from this specialized area of the law. I would suggest that the Board be required to honor contractual arrangements between claimants and counsel. Further that the carriers counsel be required to submit legal fees for Board approval pursuant to A.S.23.30.145(a). Additonally, in controverted cases, that Civil Rule 82 attorney fees plus costs, be applicable.

A.S.23.30.175(b) I fail to see what is wrong with the method currently being utilized to calculate the rate of compensation.

A.S.23.30.175(c) The reasoning behind this section does not seem to be valid anymore. The "snowbird" worker must address similar cost of living through-out the United States. I would suggest repeal of this section, without substitution.

A.S.23.30.191 The cost of living, during vocational rehabilitation, does not decrease, consequently, a claimant's compensation rate should not decrease.

Final comments: A reading of the proposed legislation leaves me with the impression that it was written by a

representative of the insurance industry. There is very little increased protection to the claimant. Almost all proposed changes to the act will be of benefit to the employer/carrier. I would suggest that the entire Act be repealed and allow claimants to sue under a tort theory. This would preclude some claimant's recovery, but would benefit the vast majority of claimants. Alternatively, the entire Act should be redone to bring it current to 1980, thus paying claimants realiztic sums for work injuries. The current ceilings on scheduled and nonscheduled injuries, as well as unreasonably limiting the class of individuals. covered by death benefits is unjust.

Thank you for giving me the opportunity to express my concerns regarding this proposed legislation.

Sincerely yours,

Dennis P. James

DPJ:CJ
cc: Govenor Hammond
President of the Senate
Chairman of the Committee of Labor/House and Senate
Speaker of the House
Members of the Labor Committee

PARRISH LAW OFFICE
ATTORNEYS AT LAW
536 FOURTH AVENUE
FAIRBANKS, ALASKA 99701

TELEPHONE
(907) 456-4070

O. NELSON PARRISH
JAMES A. PARRISH
LANCE C. PARRISH

ROBERT A. PARRISH
OF COUNSEL

March 5, 1980

Mr. Fred Brown
600 3rd St., Suite 2, Graehl
Fairbanks, Alaska 99701

Dear Mr. Brown,

I am enclosing a copy of House Bill Number 705 which I recently received a copy of. I would appreciate it if you would take a look at the proposed amendments to section 145 concerning attorney's fees and see if you agree with the proposed changes.

I practice workmen's compensation solely from the claimant's side. I do not believe that the amendments would be conducive to finding adequate representation for claimants. The way I read the amendments contingent fee contract would be virtually out the window. If you have some comments I would appreciate knowing them, and, if you oppose the change, I would appreciate your efforts in contacting members of the legislature and the Governor's staff and expressing them. Please do not hesitate to contact me on this.

Sincerely,

Lance C. Parrish

LCP:mak

Judge Gerald J. Van Hoomissen
Post Office Box 2059
Fairbanks, Alaska 99707
February 5, 1980

The Honorable Brian Rogers
House of Representatives
P.O. Box K
College, Alaska 99708

Sir:

I am taking this opportunity as a private citizen (as well as a concerned member of the judiciary) to communicate with you recognizing a very serious need which apparently only the legislature of our state can correct.

I had the unfortunate responsibility to sit as the presiding superior court judge in a contempt proceeding involving various members of the Workmen's Compensation Board of this state in a case entitled Gordon, et al. vs. Alaska Workmen's Compensation Board, Superior Court No. 4FA-79-1741. I am no longer involved with the foregoing case as the order to show cause was issued by another judge, and I was handling the matter only in his absence. As you may know, it is encumbent upon the person against whom a citation for contempt is issued, to show cause why that person should not be held in contempt. To meet that burden the chairman of the Fairbanks division of the Workmen's Compensation Board and the labor and management members of the Board were all called to testify and presented a logical and compelling reason why the members of the Board should not be held in contempt. Basically, their testimony demonstrated why they were completely unable to comply with Alaska Statute 23.30.110(b)(c) which in effect requires the Board to make an award within twenty days of a hearing. The gist of their testimony was that the average decision took in excess of ninety-eight

days from the time of hearing to the decision. Many cases took up to one hundred eighty days. All the parties agreed that that was an unreasonably excessive period of time between hearing and decision, and subverted the reasons and purposes for the Workmen's Compensation Act to the detriment of claimants. Such a delay puts the claimant in the position of having to compromise his claim for substantially less than he is entitled to under the law. I have had claimants complain to me personally that they have been put in the position of having to compromise their claim for as little as $.20 on the dollar pending issuance of the decision, sometimes pending appeal. The Supreme Court of Alaska sometime ago recognized that some of the delay preventing ultimate decision in Workmen's Compensation cases rested in the superior court's appellate procedure. Consequently, we, as the judges reviewing the decisions of the Workmen's Compensation Board, are absolutely required to render decision within forty-five days from the date the record is filed in superior court. We have the wherewithal to do that. I am convinced from hearing the testimony of the Board members that substantial hearing officers should be added to the Workmen's Compensation Commission in order to timely and properly process the claims that come before the Board. I have no doubt whatever that the hearing officer, at least in the Fairbanks district, is conscientious and extremely diligent in performing her duties. The testimony is clear that she works many times between fifty and sixty hours a week in order to try and get out these decisions, at the same time performing counseling and other required functions during regular working hours for other claimants.

In addition to the shortage of help in the form of insufficient hearing officers to actually take part in the adjudicative process and write the decisions, it appears from the testimony of one of the Board members that the internal procedures of the Board are extremely antiquated and have not been updated since statehood. Again, it appears that funding is the major problem.

I certainly do not presume nor hold myself up to be any kind of expert in government funding or the management of government agencies. I am aware, however, that Commissioner Orbeck has requested through the Governor's office, Division of Budget and Management, the necessary personnel and funding to properly allow the Workmen's Compensation Commission to fulfill its legislative mandate. I can only sincerely encourage that you consider the Commissioner's request and adequately fund this very important part of government so that it can fulfill its legislative mandate. I am convinced from the testimony I have heard and from my experience in the handling of Workmen's Compensation cases over the past ten years that the people involved in the administration of the Workmen's Compensation program have performed remarkably well in the face of the inadequate personnel and funding. I am equally assured that, in spite of their efforts, a lot of legitimate claimants, residents of the State of Alaska, are suffering needlessly. Since a class action suit against the Workmen's Compensation Board has been instituted by the attorneys for the plaintiffs in Gordon vs. Workmen's Compensation Board, supra, a transcript of the hearing on the order to show cause was prepared. If you would like a copy of the transcript, please do not hesitate to call on me, and I will furnish it to you on your request.

Thanking you in advance for your consideration of this matter, I am

Very truly yours,

Gerald J. Van Hoomissen

Gerald J. Van Hoomissen

FEB 27 RECD

February 25, 1980

WILTON ADJUSTMENT SERVICE TOM WILTON
EXPERIENCED/PROFESSIONAL INSURANCE ADJUSTING

Brian Rogers
Alaska State Legislature
Pouch V
Juneau, Alaska 98111

RE: House Bill #705

Dear Mr. Rogers:

I have recently received a copy of House Bill #705 which was introduced February 11, 1980. I wish to stress my strong opposition to this house bill in its present form.

Of particular concern is section 230.040, paragraph 1, regarding the second injury fund. This paragraph states "if an employee suffers a compensible injury, each employer or insurance carrier shall pay to the fund 8% of the total compensation to which an employee is entitled for permanent partial, permanent total, temporary partial, and temporary total disability".

This 8% surcharge does far more than increase the cost of each claim by 8% and is directly and historically adverse to the spirit of second injury fund in worker's compensation. Second injury fund is intended to encourage employers to hire handicapped people and allows them some protection when they do. The apparent intent of House Bill #705 is to establish a tremendous rehabilitation force in Alaska. Rehabilitation does not require this type of funding to protect employers who, within the spirit of the second injury fund,need protection.

In light of the above, it is all the more apparent that Alaska needs to evaluate it worker's compensation programs. My recommendations of February 20, 1980, regarding the establishment of a task force to study worker's compensation problems is more strongly evident.

House Bill #705 also has very adverse affects on premium rates for small employers far above the 8% it implies.

P.O. BOX 244 FAIRBANKS, ALASKA 99707 ● PHONE (907) 456-4342 BUSINESS ● 452-7583 RESIDENCE

There are numerous other problems in House Bill #705 and prior to the legislature taking such strong action it is recommended that the task force be created and a comprehensive study be made so the legislature will have full understanding of these problems with some positive recommendations for solving them.

Thank you for your attention to this matter.

Sincerely yours,

WILTON ADJUSTMENT SERVICE

Tom Wilton

TW:rmg

Introduced: 2/11/80
Referred: Labor & Management

BY THE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

IN THE HOUSE

HOUSE BILL NO. 705

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

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

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

* Section 1. AS 23.30.040 is repealed and re-enacted to read:

Sec. 23.30.040. SECOND INJURY FUND. (a) There is created a second injury fund, administered by the commissioner of labor in accordance with the orders and awards of the board. The sums required to be paid into the fund must be paid for the sole benefit of those entitled to participate in it under the provisions of this chapter. Disbursements must be made by the commissioner of labor in accordance with the orders and awards of the board.

(b) Each employer or insurance carrier shall make payments to the fund in the following circumstances:

(1) if an employee suffers a compensable injury, each employer or insurance carrier shall pay to the fund eight percent of the total compensation to which an employee is entitled for permanent partial, permanent total, temporary partial, and temporary total disability;

(2) if an employee suffers a compensable injury which results in death and the employee is not survived by a widow, widower, child, or dependant relative eligible to receive death benefits under AS 23.30.215.

(c) The board is authorized to refund a payment made into the fund if the employer or insurance carrier can show that it made the

payment by mistake or inadvertence, or that there existed at the time of the payment a beneficiary entitled to benefits under AS 23.30.215.

(d) The percentage of compensation to be paid into the fund by each employer or insurance carrier under (b) of this section must be redetermined annually by the commissioner.

(1) The percentage must be set at a rate reasonably calculated to maintain the fund at 175 percent of disbursements from the fund for the most recent fiscal year.

(2) The fund's balance at the end of each fiscal year must be subtracted from the disbursements total in making the calculations in this section.

(3) From the effective date of this Act through December 31, 1980, the percentage rate is eight percent.

(4) The commissioner of labor shall redetermine, calculate, and publish the rate on November 1, 1980, and on each succeeding November 1.

(5) The rate published November 1, 1980 is the effective rate for January 1, 1981 -- December 31, 1981. The rate published each succeeding November 1 is effective each succeeding January 1 -- December 31.

(6) The board may adopt regulations necessary to implement this section.

(e) The board may direct and provide the vocational retraining and rehabilitation of a permanently disabled person whose condition is a result of an injury compensable under this chapter by making cooperative arrangements with insurance carriers, private organizations and institutions, or state or federal agencies. The person being retrained or rehabilitated is entitled to receive compensation from the second injury fund for maintenance, in the sum which the board considers

necessary, during the period of retraining and rehabilitation, not exceeding $200 a month. The total expenditures for maintenance, training, rehabilitation, and necessary transportation may not exceed $10,000 for one person.

(f) All amounts collected as civil penalties under this chapter must be paid into the second injury fund.

(g) The attorney general may investigate claims and hire witnesses necessary to a proper defense of the money in the fund and, subject to appropriation made by law, may be reimbursed from the fund for the expenses of that defense.

(h) Subject to appropriation made by law, all administration expenses of the state under this section and AS 23.30.205 must be paid from the fund.

* Sec. 2. AS 23.30.045(c) is amended to read:

(c) For a person eligible for vocational rehabilitation service under AS 23.15.080 and who is placed with an employer for service [WITHOUT WAGES] at the request of the office of vocational rehabilitation to give him on the job training, work readiness or work therapy experience, or work sampling, the liability set out in (a) of this section applies to the state rather than to the employer.

* Sec. 3. 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 HIS DISABILITY AND ITS RELATIONSHIP TO HIS 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 to render the care except in cases where, in the judgment of the board, care or treatment or both can best be administered by the selection of another <u>licensed</u> physician. Upon procuring the services of a physician, the injured employee shall give proper notification of his selection to the employer within a reasonable time after first being treated. [IF FOR ANY REASON DURING THE PERIOD WHEN MEDICAL CARE IS REQUIRED THE EMPLOYEE WISHES TO CHANGE TO ANOTHER PHYSICIAN, HE MAY DO SO IN ACCORDANCE WITH RULES PRESCRIBED BY THE BOARD.]

* Sec. 4. AS 23.30.095(c) is amended to read:

(c) No claim for medical or surgical treatment is valid and enforceable as against the employer unless, within <u>20</u> [TWENTY] days following <u>each visit for</u> [THE FIRST] 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 may, however, excuse the failure to furnish notice within 20 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.

* Sec. 5. AS 23.30.095(e) is amended to read:

(e) The employee shall, after an injury, at reasonable times during the continuance of his disability if requested by his employer or, when ordered by the board, submit himself to an examination by a

physician or surgeon authorized to practice medicine under the laws of the state in which the employee may be found, furnished and paid for by the employer. [THE EMPLOYEE HAS THE RIGHT TO HAVE A PHYSICIAN, PAID FOR BY THE EMPLOYER, PRESENT AT THE EXAMINATION OR EXAMINATIONS.] No fact 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 is 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 himself to any examination provided for herein, his rights to compensation shall be suspended until the obstruction or refusal ceases, and his 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 hereunder, be forfeited. The board in any case of death may require an autopsy at the expense of the party requesting the autopsy. No autopsy may 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 no adequate notice is 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. 6. AS 23.30.110(c) is amended to read:

(c) The board shall make the investigation which it considers necessary in respect of the claim, and upon application of an interested party shall order a hearing on it. If a hearing on a claim is ordered the board shall give the claimant and other interested parties

at least 20 [10] days' notice of the hearing, served personally upon the claimant and other interested parties or sent by registered mail, and shall, within 30 [20] days after the hearing is had, by order, reject the claim or make an award in respect to it. [IF NO HEARING IS ORDERED WITHIN 20 DAYS AFTER NOTICE IS GIVEN AS PROVIDED IN (b) OF THIS SECTION, THE BOARD SHALL BY ORDER REJECT THE CLAIM OR MAKE AN AWARD IN RESPECT TO IT.]

* Sec. 7. AS 23.30.145(a) is amended to read:

(a) Fees for legal services rendered in respect to a claim are not valid unless approved by the board. [, AND THE FEES MAY NOT BE LESS THAN 25 PER CENT ON THE FIRST $1,000 OF COMPENSATION OR PART OF THE FIRST $1,000 OF COMPENSATION, AND 10 PER CENT OF ALL SUMS IN EXCESS OF $1,000 OF COMPENSATION. WHEN THE BOARD ADVISES THAT A CLAIM HAS BEEN CONTROVERTED, IN WHOLE OR IN PART, THE BOARD MAY DIRECT THAT THE FEES FOR LEGAL SERVICES BE PAID BY THE EMPLOYER OR CARRIER IN ADDITION TO COMPENSATION AWARDED; THE FEES MAY BE ALLOWED ONLY ON THE AMOUNT OF COMPENSATION CONTROVERTED AND AWARDED. WHEN THE BOARD ADVISES THAT A CLAIM HAS NOT BEEN CONTROVERTED, BUT FURTHER ADVISES THAT BONA FIDE LEGAL SERVICES HAVE BEEN RENDERED IN RESPECT TO THE CLAIM, THEN THE BOARD SHALL DIRECT THE PAYMENT OF THE FEES OUT OF THE COMPENSATION AWARDED. IN DETERMINING THE AMOUNT OF FEES THE BOARD SHALL TAKE INTO CONSIDERATION THE NATURE, LENGTH AND COMPLEXITY OF THE SERVICES PERFORMED, TRANSPORTATION CHARGES, AND THE BENEFITS RESULTING FROM THE SERVICES TO THE COMPENSATION BENEFICIARIES.]

* Sec. 8. AS 23.30.145(b) is amended to read:

(b) If an employer fails to [FILE TIMELY NOTICE OF CONTROVERSY OR FAILS TO] pay compensation or medical and related benefits within 15 days after it becomes due or otherwise resists the payment of compensation or medical and related benefits and if the claimant has

employed an attorney in the successful prosecution of his claim, the board shall make an award to reimburse the claimant for his costs in the proceedings, including a reasonable attorney fee. The award is in addition to the compensation or medical and related benefits ordered and must be paid by the employer or carrier. In determining the amount of fees the board shall take into consideration the nature, length, and complexity of the services performed, transportation charges, and the benefits resulting from the services to the compensation beneficiaries.

* Sec. 9. AS 23.30.155(c) is amended to read:

(c) Upon making the first payment, and upon suspension of payment for any cause, the employer or carrier shall [IMMEDIATELY] notify the board within 10 days, in accordance with a form prescribed by the board, that payment of compensation has begun or has been suspended, as the case may be. If the employer or carrier fails to so notify the board within 10 days, the board shall assess against the employer or carrier a civil penalty in the amount of $100 plus $25 for each day in excess of the 10 days that the employer or carrier fails to give the notice. Total penalties under this section may not exceed $2,500.

* Sec. 10. AS 23.30.155(h) is amended to read:

(h) The board may upon its own initiative at any time in a case in which payments are being made without an award, and shall in a case where right to compensation is controverted, or where payments of compensation have been reduced, stopped or suspended, upon receipt of notice from a person entitled to compensation, or from the employer, that the right to compensation is controverted, or that payments of compensation have been reduced, stopped or suspended, make the investigations, cause the medical examinations to be made, or hold the hearings, and take the further action which it considers will properly

protect the rights of all parties.

* Sec. 11. AS 23.30.175(b) is repealed and re-enacted to read:

(b) After June 30 and before December 1 of each year, the commissioner shall adopt and publish the average weekly wage, as computed by the United States Secretary of Labor for the purposes of unemployment insurance, for the preceding calendar year for all jurisdictions, including Alaska. These figures are the applicable average weekly wages for the following calendar year. The average weekly wage is the amount determined by dividing (1) the total wages paid by all employers covered for the purpose of computing unemployment insurance by (2) the average monthly employment reported by those employers for the same period and dividing the result by 52.

* Sec. 12. AS 23.30.175(c) is repealed and re-enacted to read:

(c) The following rules apply to out-of-state recipients:

(1) For a recipient who resides in a jurisdiction other than Alaska, the weekly rate of compensation must be calculated using the recipient's average weekly wage times the ratio of the average weekly wage of the jurisdiction in which the recipient resides to the average weekly wage of Alaska.

(2) For the purposes of this chapter, absence from Alaska for a continuous period of more than 90 days creates a rebuttable presumption of non-residential status; however, this presumption does not arise if the absence from Alaska is for medical or rehabilitation services that are not reasonably available in Alaska.

(3) The calculation and reduction required by this subsection does not apply when the recipient's average weekly wage and resulting compensation rate have been determined under the provisions of AS 23.30.220 by use of wages earned wholly in employment in jurisdictions other than Alaska.

(4) Application of this subsection may not result in reduction of the weekly compensation rate to less than the minimum weekly grant of the workmen's compensation system of the jurisdiction in which the recipient is residing, or in any event to less than $65 per week.

(5) Application of this subsection from the effective date of this Act to January 1, 1981 may not result in a weekly rate of compensation which is greater than 166.6 percent of the average weekly wage of the jurisdiction in which the recipient is residing. After January 1, 1981, application of this subsection may not result in a weekly rate of compensation which is greater than 200 percent of the average weekly wage of the jurisdiction in which the recipient is residing.

* Sec. 13. AS 23.30.191 is amended to read:

Sec. 23.30.191. EXPENSES FOR REHABILITATING INJURED EMPLOYEES. An employee, who, as a result of injury, is or may be expected to be totally or partially incapacitated for his normal occupation and who, under the direction of the Department of Labor, is being rehabilitated to engage in a remunerative occupation and who is not entitled to further temporary total disability or temporary partial disability compensation, in addition to the amount allowed under AS 23.30.040 for maintenance, may receive additional compensation necessary for his rehabilitation, not more than one-half of the compensation allowed under AS 23.30.185. <u>The resulting reduction to one-half of the compensation may not reduce the weekly grant to a sum less than $65.</u>

* Sec. 14. AS 23.30.215(h) is amended to read:

(h) In the event a deceased worker is survived by <u>a child or</u> children of a former marriage not living with the surviving widow or widower, then <u>the child or</u> [THOSE] children shall receive the amount being paid under a decree of child support <u>but in no event may the</u>

child or children be entitled to receive benefits in excess of benefits to which the child or children would have been entitled had there not been a decree of child support, unless there are no other beneficiaries or beneficiary entitled to benefits; the difference between the amount payable under a decree of child support [THIS AMOUNT] and the maximum benefit payable under this section shall be distributed pro rata to the remainder of those entitled.

* Sec. 15. AS 23.30.095(g), 23.30.125(b), 23.30.175(d), (e), and (f) are repealed.

* Sec. 16. This Act takes effect immediately in accordance with AS 01.-10.070(c).

WORKMEN'S COMPENSATION

ORIENTATION

DEPARTMENT OF LABOR

Overview	John Cook Director
Administration of Workmen's Compensation	Paul Troeh Deputy Director
Administration of Second Injury	Paul House Workmen's Compensation Officer
Fund Status	Al Gordon Management Analyst
Administration of Fishermen's Fund	Grace Wilson Fishermen's Fund Officer

WORKMEN'S COMPENSATION LAW

I. INTRODUCTION

A. History

The Alaska Industrial Board* was created about 1946. Coverage was made mandatory at that time. Previously coverage had been elective from 1923 to 1946. The first reported judicial decision interpreting Alaska Workmen's Compensation Law was issued in 1917, and an increasing stream of judicial decisions has been steadily published ever since. The district court handled claims from at least 1935 to 1946. Alaska's system has its roots in and is quite parallel to the Federal Longshoremen's and Harbor Workers' Compensation Act.

B. Philosophy

Alaska's system is typical of the "American system." It is neither a branch of tort law (negligence) nor social insurance. It is basically a system of "liability without fault" or "strict liability" unilaterally applied to employers. Neither the state nor the worker contributes to the system. Benefits are based largely on the theory of providing support and preventing injured workers from becoming destitute. It is not a system for assessing blame.

Most errors in the system can be traced to either an assumption that workmen's compensation is like insurance or like the law of personal injury. It is neither and is unique.

The philosophy of the Alaska A[illegible]nters on these main features:

1. The basic operative principle is that an employee is automatically entitled to certain benefits whenever he suffers a "personal injury by accident arising out of and in the course of employment."

2. Negligence and fault are largely immaterial, both in the sense that the worker's contributory negligence does not lessen his rights and in the sense that the employer's complete freedom from fault does not lessen his liability.

3. Coverage is limited to persons having the status of employee, as distinguished from independent contractor.

4. Benefits to the worker include cash-wage benefits (time loss), usually two-thirds of the average weekly wage, and hospital and medical expenses; in death cases benefits for dependents are provided. Arbitrary maximum and minimum limits are imposed.

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*Territorial Insurance Commissioner, Attorney General, and Commissioner of Labor as chairman.

5. The workers and his dependents, in exchange for these assured benefits, give up their common-law right to sue the employer for damages for any injury covered by the Act. The remedy of workmen's compensation is exclusive.

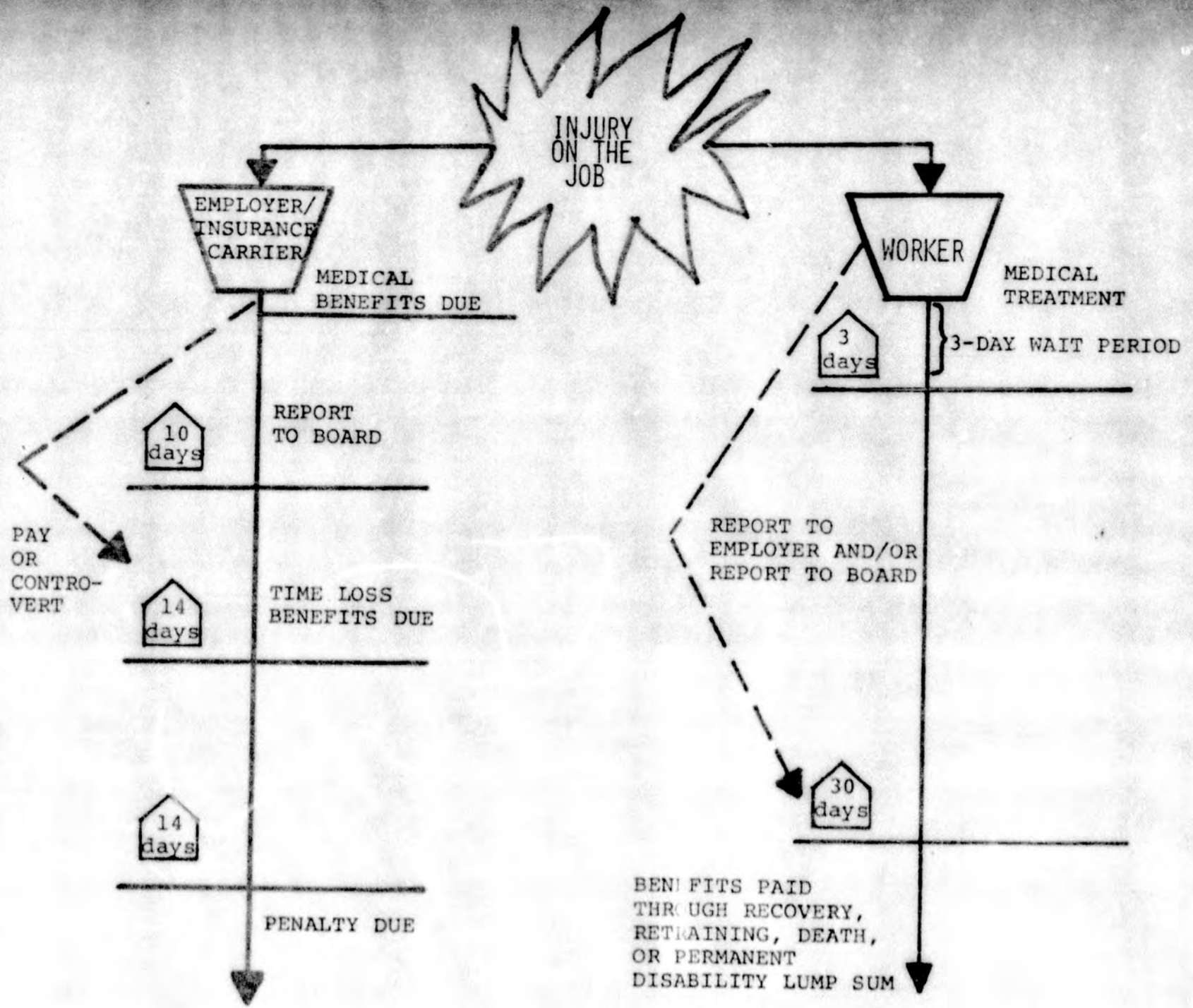
6. The right to sue third persons whose negligence caused the injury remains, however, with the proceeds usually being applied first to reimbursement of the employer for the compensation paid out.

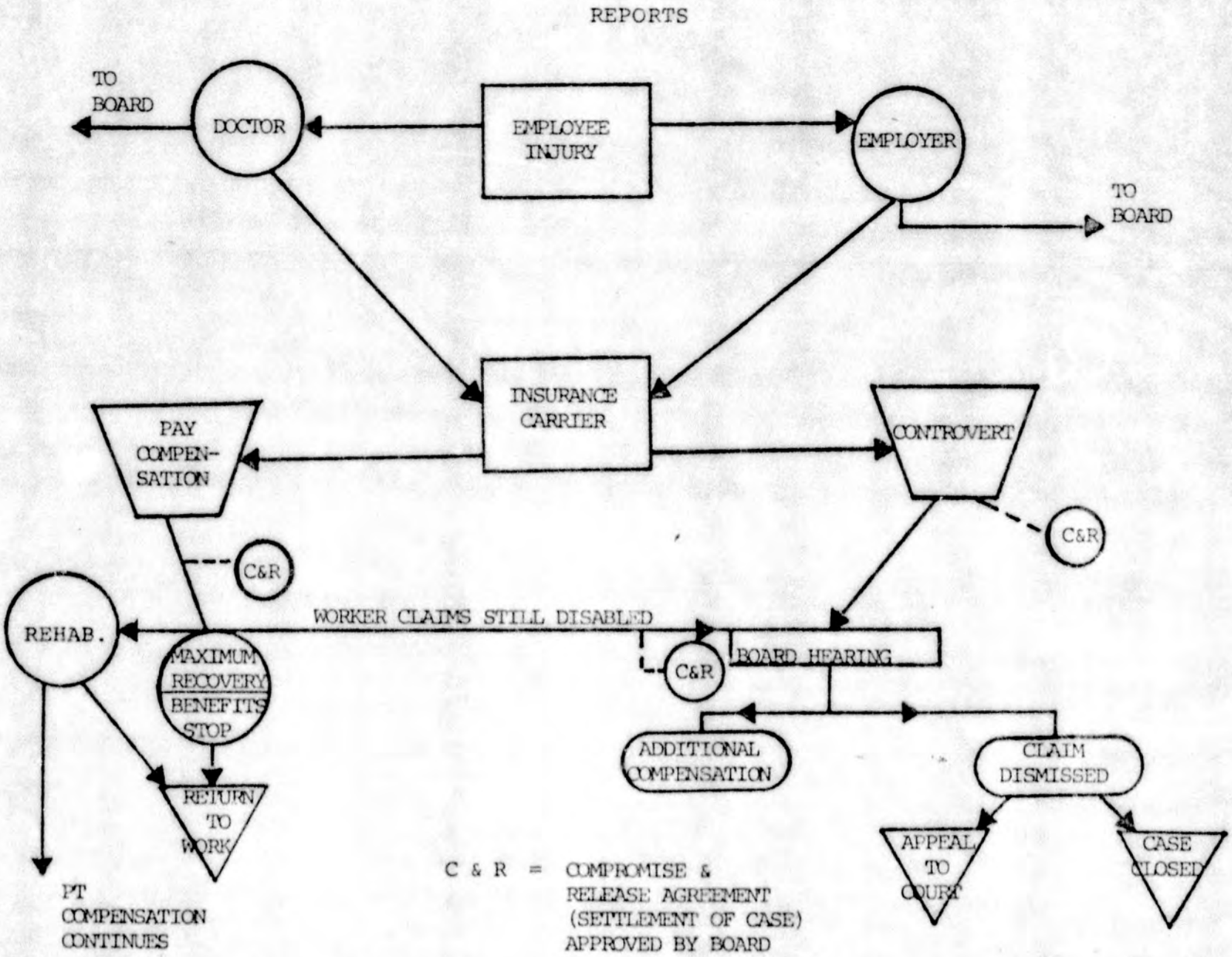
7. Employers are required to insure or to qualify in advance for self-insurance. Civil and criminal penalties apply to uninsured employers.

Without a workmen's compensation statute, injured workers would have to sue their employer in court. The defenses of contributory or comparative negligence, fellow-servant rule, and assumption of risk would defeat the majority of worker injury suits. In exchange for loss of these defenses, the employer obtains a statutory limit as to potential liability.

Six states and the provinces of Canada use an exclusive "state fund," in effect, a "state" insurance company, and the state pays benefits and collects premiums. Twelve states have a competitive fund where the state competes with private insurance carriers for the employers' workmen's compensation premiums. Thirty-two states, including Alaska, are private insurance only states. State funds have been no more or less successful in dealing with workmen's compensation benefits than systems using private insurance carriers.

The State of Alaska, under provisions of AS 23.30.172, pays supplemental compensation in some injury claims that occurred prior to May 4, 1974. These presently are costing the general fund $578,500. We have requested $613,200 for this purpose in FY 80. Sec. 172 was repealed in August 1977, and this cost will drop in future years as the claims prior to 1974 terminate.


INJURY ON THE JOB
EMPLOYER/ INSURANCE CARRIER
MEDICAL BENEFITS DUE
10 days
REPORT TO BOARD
PAY OR CONTRO-VERT
14 days
TIME LOSS BENEFITS DUE
14 days
PENALTY DUE
WORKER
MEDICAL TREATMENT
3 days
3-DAY WAIT PERIOD
REPORT TO EMPLOYER AND/OR REPORT TO BOARD
30 days
BENEFITS PAID THROUGH RECOVERY, RETRAINING, DEATH, OR PERMANENT DISABILITY LUMP SUM


REPORTS
TO BOARD
DOCTOR
EMPLOYEE INJURY
EMPLOYER
TO BOARD
INSURANCE CARRIER
PAY COMPEN-SATION
CONTROVERT
C&R
C&R
REHAB.
WORKER CLAIMS STILL DISABLED
MAXIMUM RECOVERY BENEFITS STOP
C&R
BOARD HEARING
ADDITIONAL COMPENSATION
CLAIM DISMISSED
RETURN TO WORK
APPEAL TO COURT
CASE CLOSED
PT COMPENSATION CONTINUES
C & R = COMPROMISE & RELEASE AGREEMENT (SETTLEMENT OF CASE) APPROVED BY BOARD

BASIC BENEFIT COMPUTATION

AVERAGE WEEKLY WAGE

(HIGHEST YEAR'S EARNINGS OF LAST THREE CALENDAR YEARS DIVIDED BY 52) = X

<NOT TO EXCEED $654.30>

COMPENSATION RATE

TTD, PTD, & DEATH

2/3 (OR .667) of X = RATE

EXAMPLE

AVERAGE WEEKLY WAGE

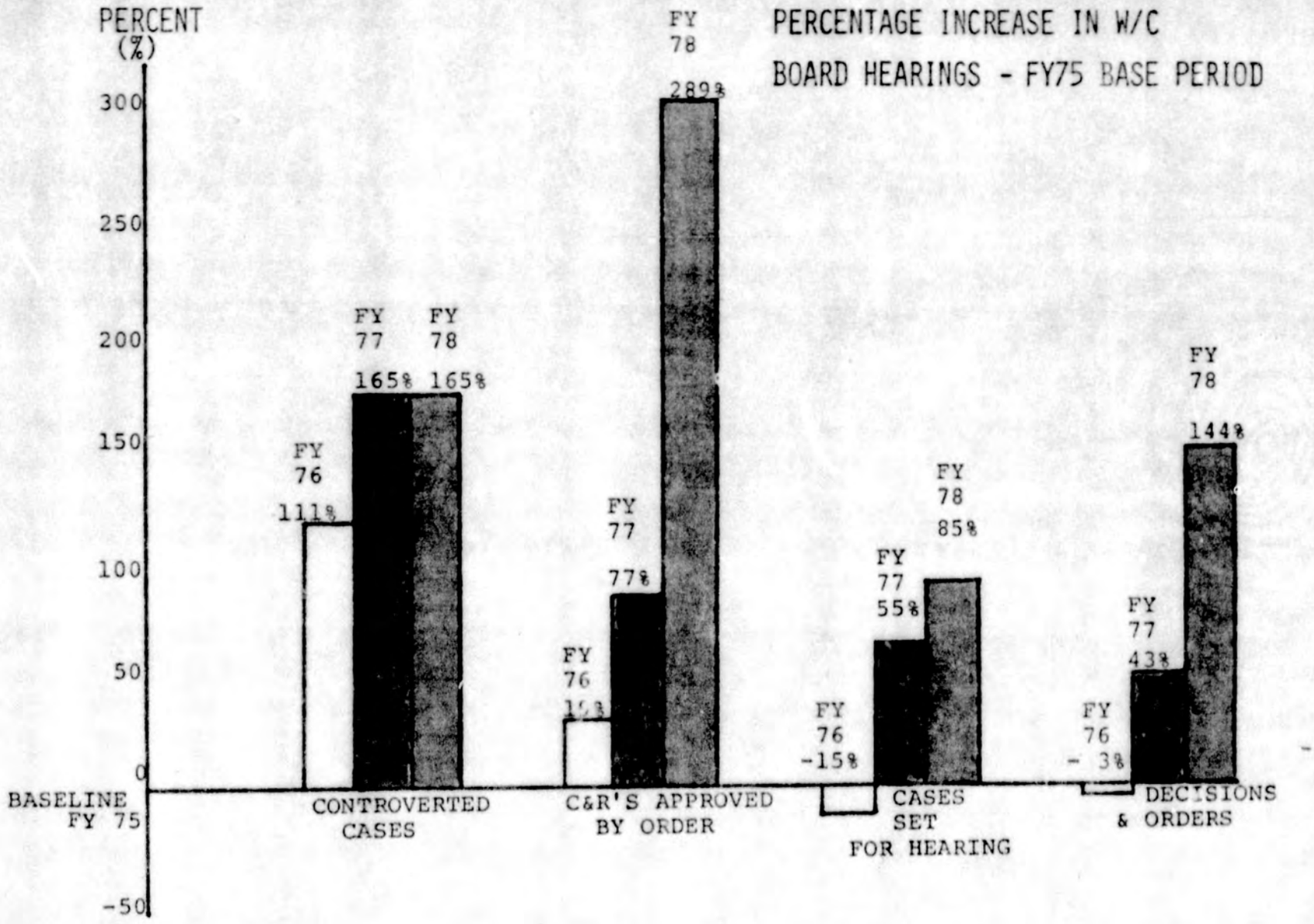
DATE OF INJURY 2-1-79

HIGHEST EARNINGS OF 1978, 1977, 1976

1978 = $22,000 ÷ 52 = $423.08

COMPENSATION RATE

$423.08 X .667 = $282.05 PER WEEK


PERCENT
(%)
PERCENTAGE INCREASE IN W/C
BOARD HEARINGS - FY75 BASE PERIOD
300
250
200
150
100
50
0
-50
BASELINE
FY 75
FY
76
111%
FY
77
165%
FY
78
165%
CONTROVERTED
CASES
FY
76
1%
FY
77
77%
FY
78
289%
C&R'S APPROVED
BY ORDER
FY
76
-15%
FY
77
55%
FY
78
85%
CASES
SET
FOR HEARING
FY
76
- 3%
FY
77
43%
FY
78
144%
DECISIONS
& ORDERS

WORKMEN'S COMPENSATION BOARD

HEARINGS WORKLOAD

	FY 75	FY 76	FY 77	FY 78
CONTROVERTED CASES	615	1296	1630	1630
C&R'S APPROVED BY ORDER	150	178	266	584
CASES SET FOR HEARINGS	504	426	781	930
DECISIONS & ORDERS	176	170	251	430

Patrick H. Jackson
613 N. 107th
Seattle, Washington 98103

October 24, 1979
Brian Rogers
P.O. Box K, College Branch
Fairbanks, Alaska 99708

Dear Mr. Rogers,

I believe Mr. Randall J. Weddle, attorney for AlPac Insurance Co., is acting unethically in delaying payment of a Superior Court judgement in my favor, and I ask your immediate action in reprimanding Mr. Weddle.

Both the Workmen's Compensation Board, on Jan. 13, 1979, and Superior Ct. Judge Gerald VanHoomissen, on June 15, 1979, have ruled in favor of my petition for damages. I enclose copies of those decisions. My attorney, Richard D. Burke of Fairbanks, wrote to me that Weddle had called him and suggested that I sue my doctors for malpractice so that AlPac could recover from the doctors' insurance companies. I believe this suggestion to be comtemptible and a violation of 1) Alaska's Insurance Regulations 2) the Bar Association's code of ethics.

My claim arose as a result of blood clots in my left leg suffered in March, 1977, while I was employed by the Michael Baker Jr. Co. in Happy Valley, Alaska. I now live in Seattle, where I am an outpatient at the University of Washington Hospital, under treatment for this same condition.

Please inform me soon regarding action you are taking in my behalf.

Sincerely,
Patrick H Jackson
Patrick H. Jackson

encl.: 3
lk

Workers Comp

ALASKA STATE LEGISLATURE HOUSE OF REPRESENTATIVES

REPRESENTATIVE SALLY SMITH • 321 CHURCH STREET • FAIRBANKS, ALASKA 99701 • IN JUNEAU: POUCH V • JUNEAU, ALASKA 99811

January 28, 1980

Mr. Dan Schock
S.R. 50529
Fairbanks, Alaska 99701

Dear Mr. Schock:

Senator Mike Gravel's office has sent us copies of letters concerning your problems with Workman's Compensation. We've contacted the Division of Labor in Juneau and found that the decision in your case should be written by the end of next month.

According to what we were told, your case was heard in September. The delay in writing the decision is a result of a backlog of cases causing a delay in processing the heavy paperwork.

I realize this information is not encouraging. Frankly, I'm upset about a six-month delay in writing a decision which, by law, ought to be made within twenty days. I've taken the liberty of forwarding your name to Representative Brian Rogers, also from Fairbanks, and vice-chair of the House Labor and Management Committee. Through Representative Rogers Richard Feinberg has been hired to conduct an investigation into the handling of Workman's Compensation claims. Mr. Feinberg may be contacting you to obtain the details of your case for his study.

If you have any information that may help the Legislature in this matter, I would suggest you contact Representative Rogers as the Labor and Management Committee is in the best position to help you.

Sincerely,

Sally Smith
Alaska State Representative

cc: Rose Anderson
Rep. Brian Rogers

Judge Gerald J. Van Hoomissen
Post Office Box 2059
Fairbanks, Alaska 99707
February 5, 1980

The Honorable Brian Rogers
House of Representatives
P.O. Box K
College, Alaska 99708

Sir:

I am taking this opportunity as a private citizen (as well as a concerned member of the judiciary) to communicate with you recognizing a very serious need which apparently only the legislature of our state can correct.

I had the unfortunate responsibility to sit as the presiding superior court judge in a contempt proceeding involving various members of the Workmen's Compensation Board of this state in a case entitled Gordon, et al. vs. Alaska Workmen's Compensation Board, Superior Court No. 4FA-79-1741. I am no longer involved with the foregoing case as the order to show cause was issued by another judge, and I was handling the matter only in his absence. As you may know, it is encumbent upon the person against whom a citation for contempt is issued, to show cause why that person should not be held in contempt. To meet that burden the chairman of the Fairbanks division of the Workmen's Compensation Board and the labor and management members of the Board were all called to testify and presented a logical and compelling reason why the members of the Board should not be held in contempt. Basically, their testimony demonstrated why they were completely unable to comply with Alaska Statute 23.30.110(b)(c) which in effect requires the Board to make an award within twenty days of a hearing. The gist of their testimony was that the average decision took in excess of ninety-eight

days from the time of hearing to the decision. Many cases took up to one hundred eighty days. All the parties agreed that that was an unreasonably excessive period of time between hearing and decision, and subverted the reasons and purposes for the Workmen's Compensation Act to the detriment of claimants. Such a delay puts the claimant in the position of having to compromise his claim for substantially less than he is entitled to under the law. I have had claimants complain to me personally that they have been put in the position of having to compromise their claim for as little as $.20 on the dollar pending issuance of the decision, sometimes pending appeal. The Supreme Court of Alaska sometime ago recognized that some of the delay preventing ultimate decision in Workmen's Compensation cases rested in the superior court's appellate procedure. Consequently, we, as the judges reviewing the decisions of the Workmen's Compensation Board, are absolutely required to render decision within forty-five days from the date the record is filed in superior court. We have the wherewithal to do that. I am convinced from hearing the testimony of the Board members that substantial hearing officers should be added to the Workmen's Compensation Commission in order to timely and properly process the claims that come before the Board. I have no doubt whatever that the hearing officer, at least in the Fairbanks district, is conscientious and extremely diligent in performing her duties. The testimony is clear that she works many times between fifty and sixty hours a week in order to try and get out these decisions, at the same time performing counseling and other required functions during regular working hours for other claimants.

In addition to the shortage of help in the form of insufficient hearing officers to actually take part in the adjudicative process and write the decisions, it appears from the testimony of one of the Board members that the internal procedures of the Board are extremely antiquated and have not been updated since statehood. Again, it appears that funding is the major problem.

I certainly do not presume nor hold myself up to be any kind of expert in government funding or the management of government agencies. I am aware, however, that Commissioner Orbeck has requested through the Governor's office, Division of Budget and Management, the necessary personnel and funding to properly allow the Workmen's Compensation Commission to fulfill its legislative mandate. I can only sincerely encourage that you consider the Commissioner's request and adequately fund this very important part of government so that it can fulfill its legislative mandate. I am convinced from the testimony I have heard and from my experience in the handling of Workmen's Compensation cases over the past ten years that the people involved in the administration of the Workmen's Compensation program have performed remarkably well in the face of the inadequate personnel and funding. I am equally assured that, in spite of their efforts, a lot of legitimate claimants, residents of the State of Alaska, are suffering needlessly. Since a class action suit against the Workmen's Compensation Board has been instituted by the attorneys for the plaintiffs in Gordon vs. Workmen's Compensation Board, supra, a transcript of the hearing on the order to show cause was prepared. If you would like a copy of the transcript, please do not hesitate to call on me, and I will furnish it to you on your request.

Thanking you in advance for your consideration of this matter, I am

Very truly yours,

Gerald J. Van Hoomissen

Gerald J. Van Hoomissen

FEB 5 RECD

February 2, 1980

WILTON ADJUSTMENT SERVICE TOM WILTON
EXPERIENCED/PROFESSIONAL INSURANCE ADJUSTING

Brian Rogers
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Mr. Rogers:

Thank you for your January 22, 1980 letter and the copy of the preliminary draft on Workers' Compensation Problems in Alaska, by Richard A. Fineberg.

I have reviewed Mr. Fineberg's draft and have had opportunity to discuss it with some claims managers representing various insurance carriers operating here in Alaska. I have made copies available for them as they were very interested in the comments and general proposals. In brief I will comment on the proposals and the paper prepared by Mr. Fineberg but there is a great deal more details which unfortuneately one outside of the insurance industry and in particular the claims aspects of workmen's compensation wouldn't know from his brief investigation and review of these problems.

Gnerally Mr. Fineberg raises some very good points and it's apparent that he prepared his paper based upon his earlier writings in the Alaska Advocate on his workmen's compensation problems relating to the pipeline activities. It appears he did a hurry up job of preparing this report based upon his experiences as he was attempting to get this report in to the legislature to review it and give consideration to solving some of the problems in this current session. Time and budgetary problems obviously kept him from getting into further details in this report. An example would be he has not contacted the insurance carriers in this investigation other than what contacts he had made in the preparation of his article for the Alaska Advocate and there it was only a contact with one particular insurance carrier whom he was leveling the heaviest criticisms.

I would first of all recommend that if there is any serious consideration to be given to making changes and improving procedures and alleviating alot of the problems we experience in handling workmen's compensation claims in Alaska then a much more detailed and objective study be made by those of us in the industry as well as persons outside of it such as Mr. Fineberg in order that we may clearly identify the problem, make reasonable explanations of how they come about and how they are resolved by the various insurance carriers. About five years ago the State Legislature financed a citizen's committee to make recommendations on improving the efficiency of state government in Alaska

P.O. BOX 244 FAIRBANKS, ALASKA 99707 ● PHONE (907) 456-4342 BUSINESS ● 452-7583 RESIDENCE

and their proposal was an indepth investigation and resulted in recommendations which eventually assisted in streamlining and saving millions of dollars in Alaska government. Worker's compensation deserves the same study and analysis by those of us who are in it and have the suggestions for improving the structure and by taking input from other areas such as the medical field and the safety field in order to come with a better product.

I'd like to make it perfectly clear that as an insurance adjuster I don't wish to propound the views which some may think only represent the best interest of the insurance carrier and the greatest profitability for that carrier. I have a long extensive background in worker's compensation having been trained extensively in it and realize the social intent of worker's compensation and the moral responsibility of society. I recoginize that inequities often arise in any system and we must make any efforts to minimize those inequities and hardships which they pose on people. Worker's compensation by law and tradition is a no fault, socially responsible method of giving assistance to the person injured on the job. Insurance carriers and their adjusters realize this and for the most part carry out thier duties in a very responsible and competent manner. The workmen's compensation act designates the law in Alaska as it pertains to the handling of workmen's compensation claims. The Legislature makes the law which goes into that act and has a responsibility to understand them, change them and improve them to better clarity and for better benefit structure when required. The Legislature needs the information presented to them in a precise objective analysis and not an impassioned plea by a number of claimants who may feel they have been wronged by one particular insurance carrier.

Mr. Fineberg raises numerous issues in his report and it would take me as long to review those issues as it did for him to write them and their simply isn't time. I would agree with the conclusion that additional funding is desperately necessary for the Alaska Workmen's Compensation Board to improve their procedures to speed up the ability to make decisions and rulings. I do not agree with his conclusion to computerize precedent decisions in order that they may simply refer to those decisions without any new thinking.

Obviously the Workmen's Compensation Board has become backlogged in their annual 20,000 claims in controlling the paperwork. I'm not so sure that a computerized system is the answer to that because again there are so many things that go into each individual claim such as the report of claim, report of first payment, the medical report, and any communication or letters from carriers or claimants as well as any disputes which may arise in the course of the claim and to put this all on the computer may not be as simple as it sounds.

There's definitely need to revise the statute and consider ways to improve the problems of first pay, allow the Workmen's Compensation Board methods of settling minor disputes short of the formal hearings which they now conduct and allow for greater monitoring of the carrier's in the normal course of handling a claim.

In conclusion I could review in detail many more problems with the current workmen's compensation structure that Mr. Fineberg has raised since I am much

closer to the industry then he. These could come out in the course of a normal indepth investigation by a task force designed to review the entire process and make recommendation to the Legislature to correct the many inequities for both the claimants and the carriers and set up guidelines for future changes in the act. Such an indepth study and investigation could cost the Legislature $100,000.00 but I believe it's firmly necessary to analyze the situation once and for all and bring about reforms so that our system of handling workmen's compensation can become more sophiscated and responsive.

I'd be happy to testify before the committee regarding the problems of worker's compensation in Alaska. I do have a good overview of many of the carriers operating in Alaska such as Providence Washington Insurance Company, Industrial Indemnity Company of Alaska, The Home Insurance Company, Fireman's Fund, Employer's Insurance of Wassau and others. As an ex-claims manager of Alaska Pacific Assurance Company I've also have some familarity with their operations even though I've been out of their employ for over three years.

Thank you for your interest and attention to these worker's compensation problems and I'd like to see the Legislature give serious attention to bring about a much needed change in numerous areas of workmen's compensation in Alaska.

Sincerely Yours,

Tom Wilton

ALASKA STATE LEGISLATURE HOUSE OF REPRESENTATIVES

REPRESENTATIVE SALLY SMITH • 321 CHURCH STREET • FAIRBANKS, ALASKA 99701 • IN JUNEAU: POUCH V • JUNEAU, ALASKA 99811

February 18, 1980

FEB 19 RECD

The Honorable Gerald J. VanHoomisen
P.O. Box 2059
Fairbanks, Alaska 99707

Dear Judge VanHoomisen:

Your letter concerning Workmen's Compensation in the State of Alaska was well taken. We are becoming increasingly aware of the Workman's Compensation Board's inability to settle claims within the time limit mandated by law.

The Legislature currently has before it a bill (HB670) which would immediately appropriate $54,000 to the Workman's Compensation Board to provide hearing officers to speed up the resolution of claims. That bill was heard in the House Labor and Management Committee on February 13th and has been referred to the House Finance Committee. I am hopeful that we can move that bill with some speed to the Senate and to the Governor's desk in order to provide the neccessary money for the Board to effectively do its job.

I realize that this is only a stop-gap measure and that when the operating budget for Fiscal Year 1981 comes up, we will need to look more carefully at the funding of hearing officers for workmen's compensation claims. I am frankly upset that it is taking so long for the claims to be written up once the hearing has taken place.

Judge VanHoomisen, I appreciate your taking the time to write me concerning this matter. I realize you have a special responsibility as a judge and know that it is difficult for you to speak on matters that come before you. I will keep your remarks in mind as the legislation concerning Workmen's Compensation is brought before the Finance Committee.

Sincerely,

Sally

Sally Smith
Alaska State Representative

cc: Rep. Hurlbert, Chair
Rep. Rogers✓
Rep. McKinnon
Rep. Bettisworth
Rep. Branson
Rep. Hayes

BRIAN:

SPENT SEVERAL HOURS TODAY REVIEWING COMP FILES. MEMO TO YOU FOLLOWS.

ALL TASK FORCE MATERIALS HARTLE AND I LOCATED ARE IN THE THIRD DRAWER OF THE FILING CABINET, AT THE FRONT OF THE BACKGROUND COMP MATERIALS FROM JUNEAU.

MIGHT MENTION THAT CHRISTINE JOHNSON'S SUMMARIES LOOKED VERY TIDY TO ME. (DID NOT WANT TO PUT THIS IN MY MEMO FOR FEAR OF MAKING SIMONSON AND WILLIAMS LOOK BAD BY COMPARISON.)

GAVE YOU A WRITTEN MEMO BECAUSE I'VE ALREADY TOUCHED BASE WITH CHANCY AND TERRY STIMSON AND I WANT YOU TO KNOW WHAT THEY KNOW. MEANWHILE, BACK AT THE RANCH, GIL D'INNOCENT STRODE IN LIKE THE LONE RANGER AND PLANTED A GIL D'INNOCENTE POSTER ON THE DOOR HERE. AMAZING....

CHEERS,

TO: BRIAN ROGERS

FROM: RICHARD A. FINEBERG
BOX 81835 - COLLEGE STA.
FAIRBANKS, AK 99708

tel 479-5363

RE: COMP TASK FORCE CONSULTING

DATE: OCTOBER 6, 1980

September meeting minutes are not yet on file and some of the matters I refer to here may have been taken care of during verbal meetings, but I thought it advisable to apprise you of certain holes in the written record at this time.

1. Bob Williams' Sept. 16 memorandum to Senator Stimson needs additions, in my estimation, if it is to be considered a comprehensive study outline.

a. With regard to rates, he suggests an excellent theoretical model for approaching investment income B UT he does not tackle explicitly the central question (again, in my estimation) raised by Woodward and Fondiller in 1977 (see my report, p. 45): investment income is not factored into the rate base by Alaska comp carriers, if I read W&F corectly. Although investment income is of course money the carriers pocket, it is not treated as profit for rate-making purposes. In considering comp rates, let me remind you of the simple-minded questions I posed in my report, p. 42: How much of the comp dollar goes to (1) claimant, (2) doc, (3) lawyer, (4) carrier operating expense, (5) carrier profit.

b. With regard to Legal Procedures and Law Changes, several of the problem areas I identify and outline in my report at pages 49-51 might be added to the Williams list.

2. Diane Simonson's report, in my estimation, needs to be taken a few steps further to yield the kinds of data the Task Force needs to make meaningful recommendations. For example, Simonson states "The division estimates that as many cases are informally disputed, or resisted, as are controverted" (p. 12), and "It appears that at times the carrier quits paying." The critical question is: How many of the 250 cases she reviewed were informally resisted without formal controversion? Since she could not find meaningful payment data in division files, she did not gather that information. Hence we're not too much further along the road than we were when we began. Possible solution: Have Simonson interview the 250 to get this kind of information. I note also that of the 250 cases, 74 were Alpac. Since Alpac has 50-60% of the comp business in Alaska, I'd have expected 125-150 Alpac cases.

For your information, I have relayed most of these concerns to Chancy Croft and Terry Stimson, both of whom will be attending the insurance subcommittee meeting in Anchorage tomorrow, preliminary to the Task Force meeting Oct. 16.

Additionally, Senator Stimson gave me verbal approval to attend the Oct. 16 meeting in Anchorage. Authorization includes TR to be arranged via Legislative Affairs, one day consulting ($150) plus standard per diem. After the meeting Thursday I will meet with Williams and Stimson at Stimson's discretion.

National Council on Compensation Insurance
1 Penn Plaza
New York, New York 10119
Tel. (212) 560-1000
Anthony J. Grippa
Senior Actuary

Title Slide

THE DATA COLLECTION PROCESS

Before addressing how the NCCI goes about the process of obtaining data and performs its extensive validation and editing procedures to insure the quality of information, it is worth reviewing:

WHO needs workers' compensation data?

WHY they need data?

What KIND of data is needed?, and

HOW the data is obtained?

The answers to who needs workers' compensation data fall into five categories: insurance companies, regulatory authorities, legislators, consumers and finally, the National Council on Compensation Insurance.

Insurance companies need workers' compensation data for several reasons. Top management needs it to be able to make business decisions.

Others within the insurance company ranks also need data. Actuaries must have it available if they are to be able to determine reasonable prices for the coverage to be provided. Underwriters must have data available if they are to be able to determine whether the exposure to loss from a particular risk is commensurate with the premium to be paid. Loss prevention specialists, called safety engineers, require data to determine what areas most need their services, and afterwards to measure the success of their efforts.

(4) Regulatory authorities serve a great many functions in the public interest. Two of the most important functions are to watch over the reasonableness of prices being charged, and to watch over the solvency of the companies to be certain that the benefits owed to the injured workers will in fact be paid. Both of these functions are dependent upon the regulator being able to obtain accurate and current data.

(5) Legislators must have workers' compensation data for several reasons. They must be able to assess the quality of their benefits program as compared to generally accepted social standards, and as compared to

neighboring states. They also need information on the cost of the program both in absolute terms, and as compared to states with whom they must compete in the struggle to provide a favorable economic climate. Legislators are also frequently interested in the price equity among various employers within their own state.

Consumers are greatly interested in the availability of workers' compensation data. By consumers we mean not only the employers who directly foot the bill, but also labor which receives the benefits, and which ultimately pays the workers' compensation bill through the price of purchased goods and services. Consumers want data on the benefits, the price level, and the efficiency of the workers' compensation system.

(6)

(7)

The National Council needs data to carry out its assignments in areas such as: establishing proper price levels overall and by classification; cost evaluating changes in benefit programs; tailoring the prices of individual employers to match their costs through rating plans such as experience rating and retrospective rating; and conducting research not only on pricing techniques, but also on providing the information which will enable policy makers such as legislators to make their decisions

(8)

The kinds of workers' compensation data needed are almost without limit. However, there is one common denominator which must exist for every type of data. It must be accurate and current. Data can first be divided into two broad categories: one, that which is useful for pricing; and two, that which is helpful for better understanding how the system is working. The ways in which data can be useful for pricing can in turn be divided into several categories: one, that which is useful for determining an overall price level; two, that which is useful in determining proper price relativities among industry groups or classifications three, data which is useful in tailoring a classification rate to better fit the benefit costs of an individual employer; and four, data which is useful in the costing of changes in the benefits programs.

Any price, be it for insurance, or automobiles, or "widgets", comes in two parts. The cost of the basic product, plus the mark-up for overhead or expenses. Expense data is reported to the NCCI in two ways. First, and most importantly, it is reported countrywide by line of business, such as homeowners and workers' compensation, and by type of expense, such as commissions to agents or claim adjustment expense, on the Insurance Expense Exhibit. The Insurance Expense Exhibit is a report which each

(14) carrier must submit annually to the regulatory authority in each and every state in which it is licensed to do business. In addition the carriers provide a copy of their Insurance Expense Exhibits to the National Council. The Insurance Expense Exhibit is an official supplement to the Annual Statement which must be sworn to for completeness and accuracy by the very top officials of each company. The National Council each year compiles the workers' compensation data on the individual company Insurance Expense Exhibits and publishes a summary booklet which is sent to all regulators, as well as to each company writing workers' compensation insurance. In addition a number of copies are distributed free to all types of interested parties requesting such information.

(15) The NCCI in preparing this booklet, not only carefully validates the entering of the data on EDP medium such as magnetic tape, and the compilation on the data, via a lengthy series of zero balance checks and verifications, but also subjects the data itself to a series of reasonableness checks. When a company's report fails one of these checks, the NCCI goes back to the company to investigate the matter. On many occasions there are satisfactory explanations as to why a data element looks unusual. But, on other occasions, the NCCI will have

uncovered an error which is corrected not only for the National Council, but also for each of the various regulators.

The Insurance Expense Exhibit reports by the companies are not only important for the expense data they provide, but also because they provide a positive reconciliation between the premium and benefit cost data companies report the regulators, and the data they report to the NCCI for determining overall price levels.

The second way in which expense data is reported is by an annual request, or call, for expense data by state, issued by the National Council. We recognize that the proper allocation of some types of workers' compensation expense dollars by state is very difficult if not impossible. However, over the years enough regulators have asked the NCCI to have the companies at least make their best estimates as to the expenses by state, that the NCCI for three years now, has been issuing such a call. As with every other data vehicle used by the National Council, data reported under this call is validated and reviewed to insure not only the National Council's accuracy in capturing the data, but also the accuracy and reasonableness of the reports themselves.

In determining overall price levels, the National Council relies

(17) importantly today upon two types of financial, or aggregate data. When we speak of financial or aggregate data, we are speaking of data which has two major characteristics. First, it can be precisely reconciled back to the carriers financial statement. Second, because it is so current, does not carry a detailed breakdown by policy, nor by classification, nor by injury type.

(18) The two types of financial data, which receive equal weights in determining overall price levels, are called calendar year data and policy year data. Calendar year income, or premium, is simply the premium earned during the calendar period. If you were a building contractor, by analogy, it would be the revenue earned during the year, regardless of when you signed the contracts or received payment. Calendar year benefit costs are the costs incurred during the same period.

(19) Calendar year direct earned premiums and total direct incurred benefits costs are reported on Part 4 of the Insurance Expense Exhibit. In addition the NCCI requests calendar year experience with certain exclusions, be reported to the National Council. Because the NCCI is going to use this data in establishing overall price levels, it requires exclusion of what it considers to be experience inappropriate

(19) CONT

for a state's price level. That is why the National Council's call requires the exclusion of U. S. Longshoremens Act experience, underground coal mine, or Black Lung, data, excess insurance data, and National Defense Project Rating Plan data. However, a part of the National Council's validation process is a reconciliation by carrier by state to insure that the calendar year data report to the NCCI when combined with these other data elements reconciles with Part 4 of the Insurance Expense Exhibit. Once again, besides having stringent checks to see that the data reported has been accurately captured, the NCCI subjects the data to a series of reasonableness checks on quality. These checks include items such as how much does the benefit cost to premium ratio vary from the expected or average, how does a carriers volume compare to previous years' reports, and other such checks. Calendar year data is reported semi-annually, as of June 30 and as of December 31.

The second type of financial data used for overall price level determination is called policy year experience. This is data where all of the premium earned over time for only those policies issued in the particular year is compared to only the benefit costs incurred which

are from claims which were covered by that same specific group of policies. Thus, all policies issued on any day from January 1, 1980 through December 31, 1980 would be included as part of policy year 1980 data. Of course, the premium for a policy issued on December 31, 1980 would not be fully earned until December 31, 1981. But, all of that premium would be assigned to policy year 1980 because the policy became effective during 1980.

Similarly, many of the claims covered by policies issued in 1980 will occur in 1981, but they will be assigned to policy year 1980. Some claims may in fact not be reported until several years later, but if the basis of coverage for the claim was a policy issued in 1980, the claim is still assigned to policy year 1980.

In summary, the final totals of all premiums earned and benefit costs incurred attributable to a particular policy year will not be known until the last payroll audit is completed, and the last benefit claim has been settled.

(20)

This makes it necessary to gather data for a particular policy year not just at one point in time, but rather, annually for many years. The NCCI's annual call to the companies for policy year experience by state requires the company to report as of December 31, the premiums earned and benefit costs incurred not only for the latest year's policies,

but for the sum of each and every workers' compensation policy that has carrier has ever written starting with the first policy ever issued. The eight most recent policy years are listed seperately, plus grand totals for all earlier policy years.

Obviously, the same premium dollars and benefit cost dollars (21) reported in the calendar year data must also appear in the policy year reports. The NCCI uses this accounting fact to reconcile by state for each carrier, its policy year report to its calendar year report. And since the calendar year report has been reconciled to the annual statement this means the policy year reports are also reconciled to the annual statement.

However, we don's stop our validation of data once it has been reconciled. Rather we continue on with a series of checks, both from an accounting stand-point, and from an actuarial reasonableness point of view. By state by carrier we check things such as: the relationship of the new year's volume of premium and loss to older years; the movement of benefit cost newly emerging in older policy years. Many of the checks are the type that are best made by personnel which have an expertise in how benefit cost patterns would normally be expected to emerge in workers' compensation. The NCCI maintains just such a staff of

actuarial personnel.

When the NCCI turns up a data report which app usual, contact is first made with the company statistician who had signed it If this contact can provide a knowledgeable explanation the matter may end there. However, the NCCI will not simply accept a response by the carrier that the questionable data is ok. It must have a rationale explanation of the anomoly. If such an explanation is not obtained from the company

(22)

statistician, the NCCI approaches higher level officers within the company. We work our way up the company's executive ladder until we find an explanation of the data which we are confident will satisfy not only the NCCI, but also any regulator or consumer who may care to inquire.

Once the data needed to determine an overall price level is in place, and after the actuaries have done their calculations, the next step is to find a way to distribute this overall price equitability among the many different kinds and sizes of employers in the state.

(23)

The distribution of the overall price level follows a path: first to three broad industry groups called Manufacturing, Contracting, and All Other; then to approximately 600 price classifications; then to the rating of individual employers comparing their actual experience to the average for their classification; and also to optional "cost plus" pricing of individual employers, called Retrospective Rating

Each of these refinements in the pricing system are based upon data from what we call the Unit Statistical Plan. The Unit Statistical Plan is a method of data collection which is filed with, and approved by, each state insurance regulating authority. It requires that for each and every policy issued, the carrier must submit a seperate report as of 6 months after the policy expires. This report provides, by price classification: covered payroll, premium, and a claim by claim listing of benefit costs incurred broken down by type

(24) of injury, and seperated between indemnity and medical. Not only is this information required as of 6 months after policy expiration, it is also required that the experience of that policy be re-analyzed for a second report as of 18 months after expiration if there were any open

(25) claims on the first report. Furthermore, third, fourth and fifth reports are also required, as of 30, 42, and 54 months after policy expiration if any of the claims remain open. To summarize, each policy is seperately reported on, 6 months after expiration, and reports on that policy are continued for four more years if any claim remains open.

This data is continuously being reported to the National Council. While a great many of the companies still report this data on paper, several larger companies have converted to magnetic tape submissions.

Regardless of whether the data must be key punched by the NCCI, or is already on tape, it is immediately subjected to a checking procedure

(26) which the NCCI calls "daily validation". This procedure, by computer, checks the carrier reports for accounting type errors as well as implementing a series of what we call actuarial reasonableness checks. Typical accounting type checks are that: the sum of the individual data entries match the totals shown on the report; that benefit costs do not appear in classifications that do not have exposure reported; that the cost of any claim reported for a particualr type of injury does not exceed the maximum provided by state law; and that the application of the classification rate to the exposure reported does equal the premium reported.

Reasonableness checks include items such as does the reported cost of each claim fall into the typical expected range of claim costs by type of injury.

When the computer identifies an entry which falls outside of the established edit parameters, a printed message is sent to our data quality department, identifying the question, and the unit card which contains the questionable item. The data quality person will then contact the carrier to pursue the question, and if a correction

while the NCCI will not allow a questionable item to remain in its data base, the NCCI also will not change a carrier's report without written documentation from the carrier.

We mentioned that in addition to classification ratemaking, the Unit Plan data is also used to determine individual employer price modifications through Experience Rating and the optional Retrospective Rating. In fact, more than 90% of the workers' compensation premium is subject to Experience Rating. Experience Rating compares the actual benefit costs of each employer to the expected benefit costs of the employer. As each of these individual employer ratings are computed by the NCCI (or local rating bureau) the detailed listing of experience and calculations producing the rating are sent to the carrier issuing the policy. Therefore, for more than 90% of the business, the employer or his agent, has not only the opportunity but also a monetary interest, in checking the accuracy of the Unit Statistical Reports. If the employer or his agent can detect an improperly listed claim, or omitted payroll report, this would require an immediate recomputation of his premium. In summary, the National Council is checking the quality of each report submitted, and in addition, the employers are looking

over our shoulder to insure the accuracy because it is to their direct and immediate economic advantage to do so.

Thus far we have discussed data which is used day in and day out in the pricing of workers' compensation insurance. But the NCCI also gathers a great amount of data for other purposes.

For example, whenever a person has need for the estimated cost impact of making a change in the benefits program, the person can obtain this information by contacting the National Council. The NCCI produces the required cost estimate by applying accepted actuarial techniques to a data base which has been specifically designed for costing changes in a benefit program. This data base includes the Revised Injury Table which provides: information on the frequency of various injuries by category; information on age of claimants; and the ages of their dependents. This data base also includes the semi-annual call for wages of injured workers by state, and the Wage Distribution Table which tells us the distribution of wages and workers about the average.

As various states, through legislation or administratively, expanded their benefits programs in the 1970's, workers' compensation costs and prices were significantly pushed upward. Insurance prices

went up, employer interest increased, not only in intensity, but also in scope. The desire was expressed to know not only "are the prices justified by the costs?", but also "how come the costs are so high". In short, the emphasis of requests for information changed from HOW MUCH to WHY. But, most of the data that the NCCI had been receiving was designed for pricing purposes rather than answering the "why" or "how come" type of questions. However, the employers directly, and through their state insurance departments and legislators, were demanding that something be done to answer their questions.

The NCCI responded in 1978 by calling together a top echelon group of workers' compensation experts to design a data collection system which could be counted on to respond to these newly emerging questions. In early 1979 this special data collection program, named the Call for Detail Claim Information was set in motion in 12 states. On a scientifically designed sampling basis it requires very extensive reporting of information for claims arising in April 1979 and thereafter. It requires a reporting of each claim valued six months after it was reported to the carrier, and annualy thereafter until the claim is closed. Thus, first claim evaluations were [illegible] October 1979, and started coming into the NCCI [illegible]

is subjected to a lengthy and stringent edit program which will detect virtually any possible error or omission which might have occurred when the claim report was being filled out or key punched. In addition there is a claims inventory which assures that all claims that were designated to be in the scientifically designed sample, have in fact been reported.

(28) The areas of information in the report include attorney involvement, doctor and hospital treatments, types of injury, whether occupational disease or cumulative injury was involved, amounts paid and reserved, when the claim was first reported and if it was reopened, and the NCCI job classification. It also includes several items of personal information about the claimant such as age, sex, weekly wage, marital status, and employment status both before and after the injury.

While the validation and editing process for these reports is an arduous task for both the NCCI and the carriers, we do expect that this data will start becoming available by the end of 1985.

Another major undertaking by the NCCI to help answer how come costs are what they are is the Life Pension Call. This is a study designed to further quantify how many dollars are going for life time benefits.

There are still a substantial number of other data collection programs in place at the National Council which we have not covered. Some are addressed to specific problems in pricing, and some are also designed to provide more information on the question of "how come costs are what they are". While we have only touched upon the major programs, we would be pleased to respond to any specific interests.

However, before closing please keep in mind that data of any type is never just accepted at the National Council. It is always first reviewed for quality. It must meet not only accounting type standards for consistency, but must also meet actuarial type standards for reasonableness. To help support our standards for quality we have put in place a program called PEP. P-E-P stands for Performance Evaluation Program. It is a program whereby carrier-by-carrier we review both the timeliness and quality of data reported. We then, semi-annually, send a PEP report directly to the president of each company advising him of how his company is doing in the area of reporting to the NCCI.

(29)

We would now be pleased to answer any questions on the data compilation process.

FROM THE DESK
OF
SENATOR STIMSON

October 21, 1980

Dear Brian,

For your information, enclosed is the rest of the material from the October 16th sub-committee meeting on Insurance.

Sincerely,

Licia

Licia

National Council on Compensation Insurance

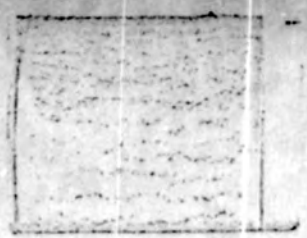
The Effects of Workers Compensation Insurance Reforms

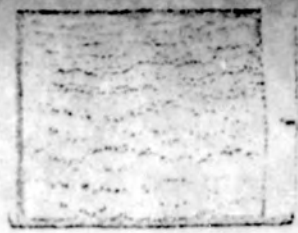
p-Dating of Prices
tarts With:

1. The Cost of Goods & Services.

Compared to

2. Revenue from Existing Prices.





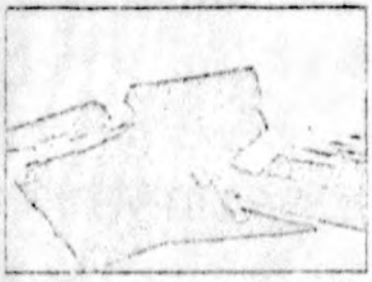
ypes of New Data

1. **Statewide Financial Data**—to determine what state average price level change is needed.

2. **"Unit Plan" or Policy-by-Policy Data**—to determine how the average price change should be distributed.

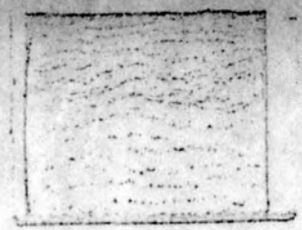
Kinds of Financial Data

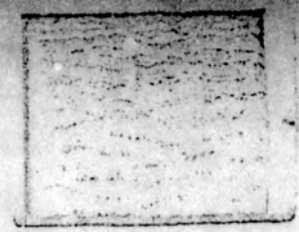
1. Calendar Year For both new entries and changes in premium earned and losses incurred during twelve calendar months.



2. Policy Year Premium earned and losses incurred on all policies issued in a twelve month period.

3. Accident Year Losses with date of occurrence in a twelve month period related to calendar earned premium for that period.



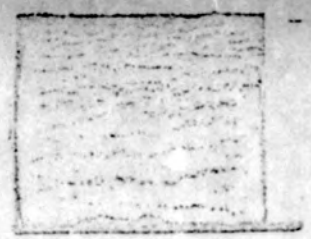


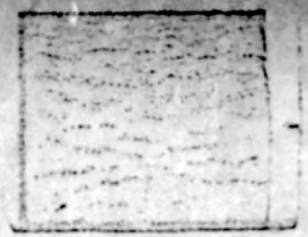
Up-Dating of Prices

(Called Ratemaking)

To Reflect Changes in Conditions:

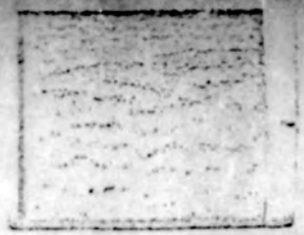
1. New Data.
2. Statutory Benefit Changes.





Business = Expense
Overhead = Allowance

1. Acquisition
2. General
3. Premium Taxes
4. Claims Adjustment
5. Contingency or Profit



Adjustments to Data

Premium:

1. Effect of Recent Price Changes.
2. Additional Premium Development (eg. from late audits).

Benefit Costs:

1. Recent Statutory Benefit Changes.
2. Additional Benefit Cost Development.

Product = Benefit
Cost = Dollars Paid

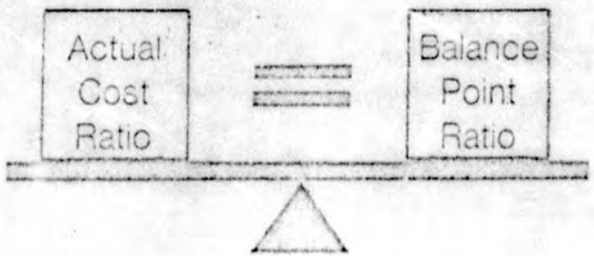
TO INJURED WORKER

MEDICAL SERVICES

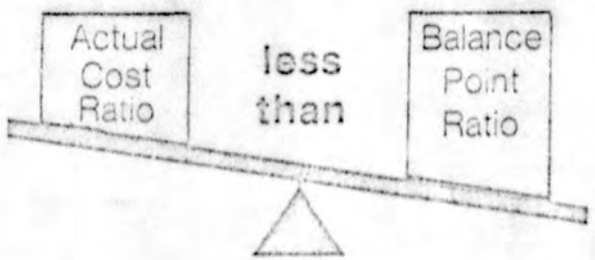
DOCTORS

HOSPITALS

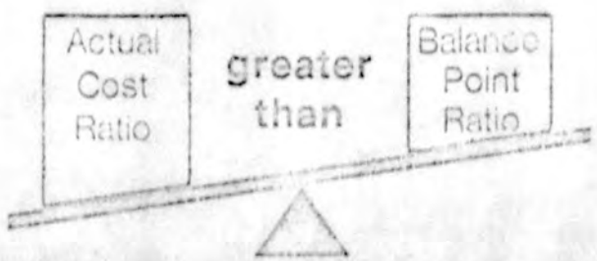
Change in Price Level



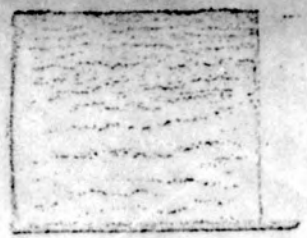
No Change

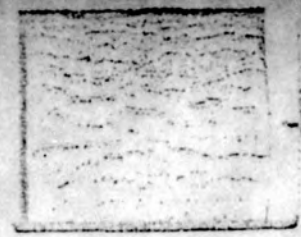


Decrease



Increase





Incurred = 

+ Still Owed

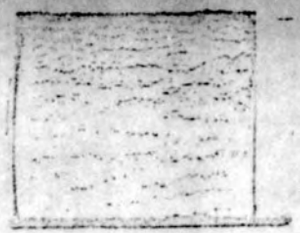
Incurred = 

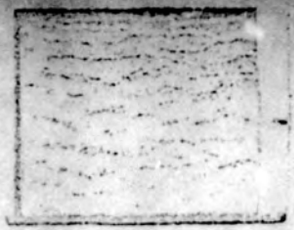
+ Outstanding

Incurred = 

+ Reserved

Thus:
Reserves = Accounts Payable





Policy Year Cost Ratio		Calendar Year Cost Ratio	÷2	=	Average Cost Ratio
+					

Average Cost Ratio	÷	Balance Point Ratio	=	Change in Price Level Based on Past Experience

THIS

ROW

INTENTIONALLY

LEFT

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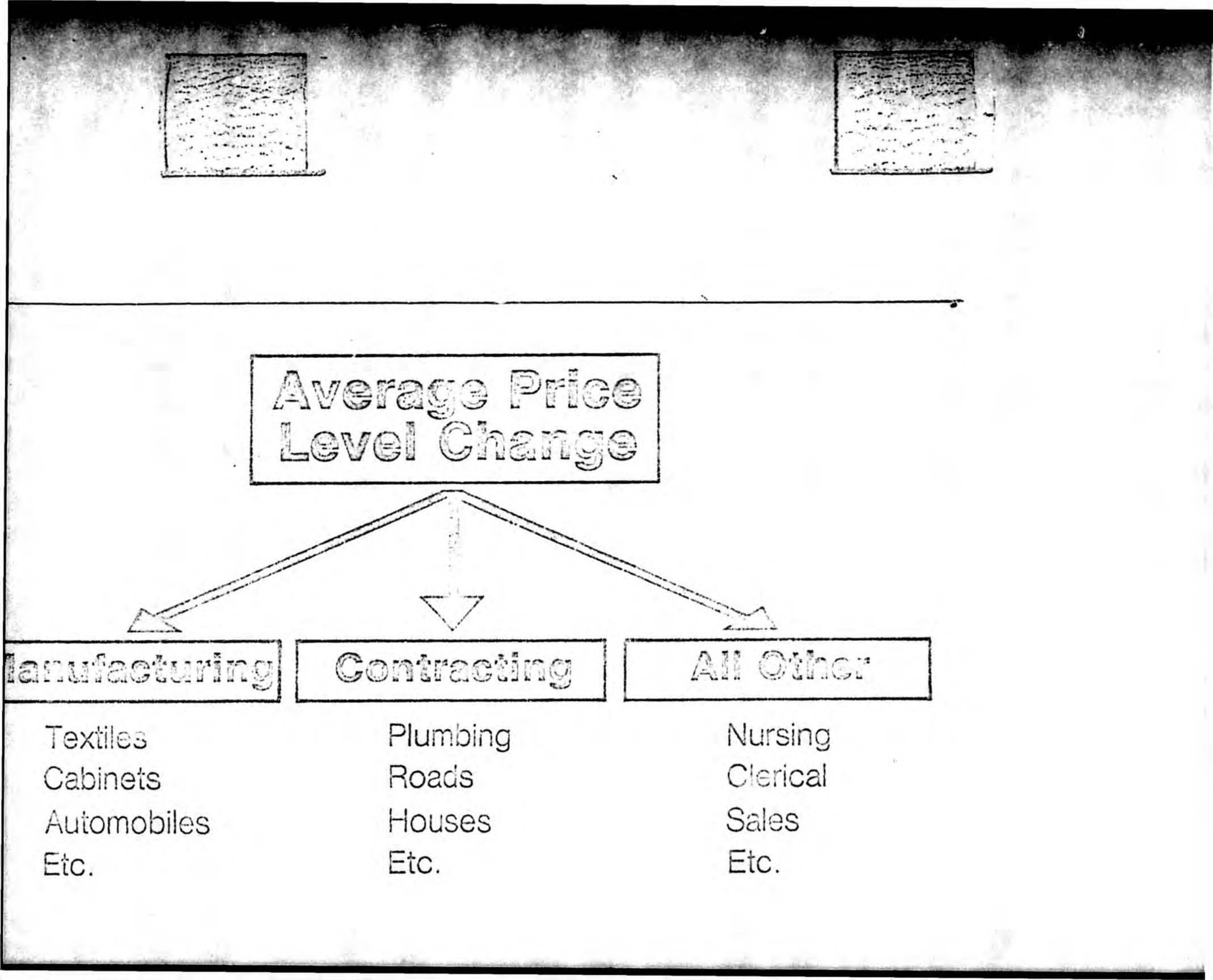
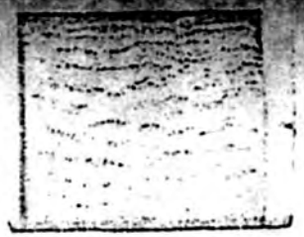
valuate Law Change
y Type of Injury

1. Fatal.
2. Permanent Total Disability.
3. Permanent Partial Disability.
4. Temporary Disability.
5. Medical.


Average Price Level Change
Manufacturing
Contracting
All Other
Textiles
Cabinets
Automobiles
Etc.
Plumbing
Roads
Houses
Etc.
Nursing
Clerical
Sales
Etc.



"Pure Premium"

=

Benefit Cost per
$100 of Payroll

Classification Pure Premium
s Based on:

1. Current Experience

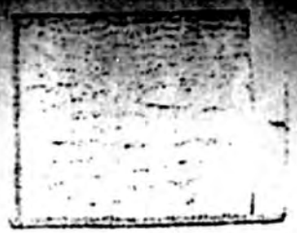
   Plus, if Needed

2. Present Pure Premium.
3. National Relativity.

Present on Level
Pure Premium
=
Pure Premium Underlying
Present Rate
×
Industry Group Average
Price Level Change

Pure Premium Indicated by National Relativity

1. Has no effect on the total amount of premium for the state.
2. Has a weight limited to half of the weight NOT assigned to current experience.



New Rate = Total Pure Premium + Expense Allowance

Class Rate Changes are Limited by:

1. Limiting the dollar amount of large claims that may be used for ratemaking.

2. Applying percentage swing limits as compared to the present rate.

Manual Rate is Starting Point for Determining Cost of Workers' Compensation Insurance.

Additional Factors:

1. Prospective Experience Rating.
2. Premium Discounts.
3. Optional Retrospective Rating.
4. Dividends to Policyholders.

Experience Rating

1. Only Applicable to Insureds Over Eligibility Point.
2. Adjusts Manual Rate by Comparison of Employer's Actual Past Experience to Average or "Expected" Experience.
3. Impact is Proportional to the Size of the Insured.

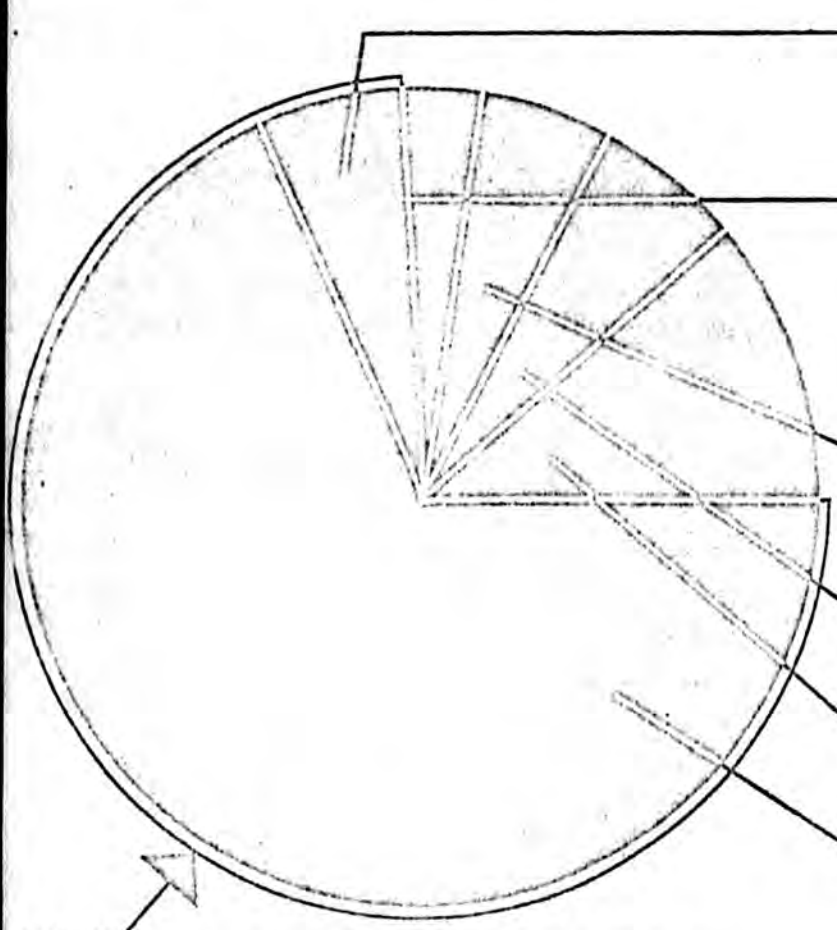
Premium Discounts

1. Give Insureds Credit for Economies of Scale in the Area of Overhead (Expenses).
2. Application of Premium Discount Program is Mandatory.

Retrospective Rating

1. Completely Optional.
2. "Cost Plus."
3. Employer Pays Own Benefit Costs Plus a Basic Charge for Services.
4. Cost to Employer Has Pre-Selected Minimum and Maximum Premium.
5. Actuarial Propriety of Each Agreement Checked by Rating Bureau.

Breakdown of Net Earned Premium Dollar



8% Adjusting and Paying Claims, Representing Employer at Hearings, etc.

2.5% Contingencies and Profit. Available for Profit only when expenses and payments stay within allowances shown in remainder of chart

3.5% Taxes, Licenses and Fees other than Federal Income Taxes.

5% Insurance Company Operating Expense and Bureau Expense

11% Acquisition and Field Supervision

70% Benefits (Compensation plus Medical) to Injured Workers.

78% is for the Direct Benefit of the Employer and his Employees as Shown by the Outer Ring.

National Council on Compensation Insurance

The Data Collection Process

Data

1. Who Needs it?
2. Why?
3. What Kind?
4. How is it Obtained?

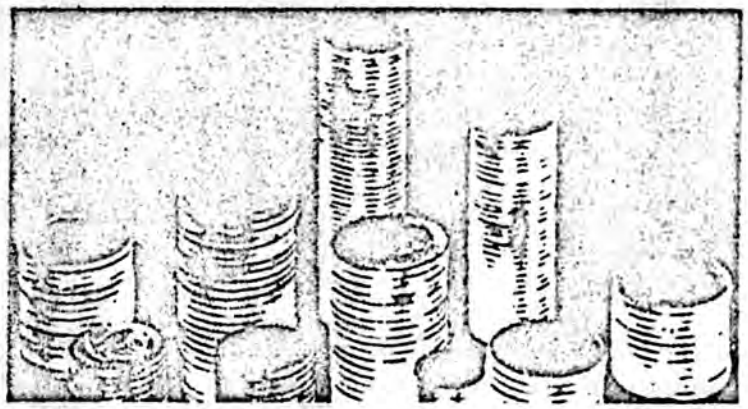
Who?

1. Insurance Companies.
2. Regulatory Authorities.
3. Legislators.
4. Consumers.
5. NCCI.

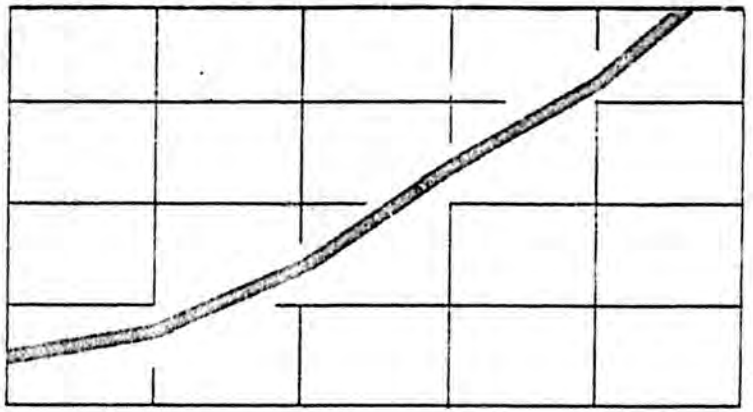
Companies

1. Management.
2. Actuaries.
3. Underwriters.

Regulators



1. Prices.

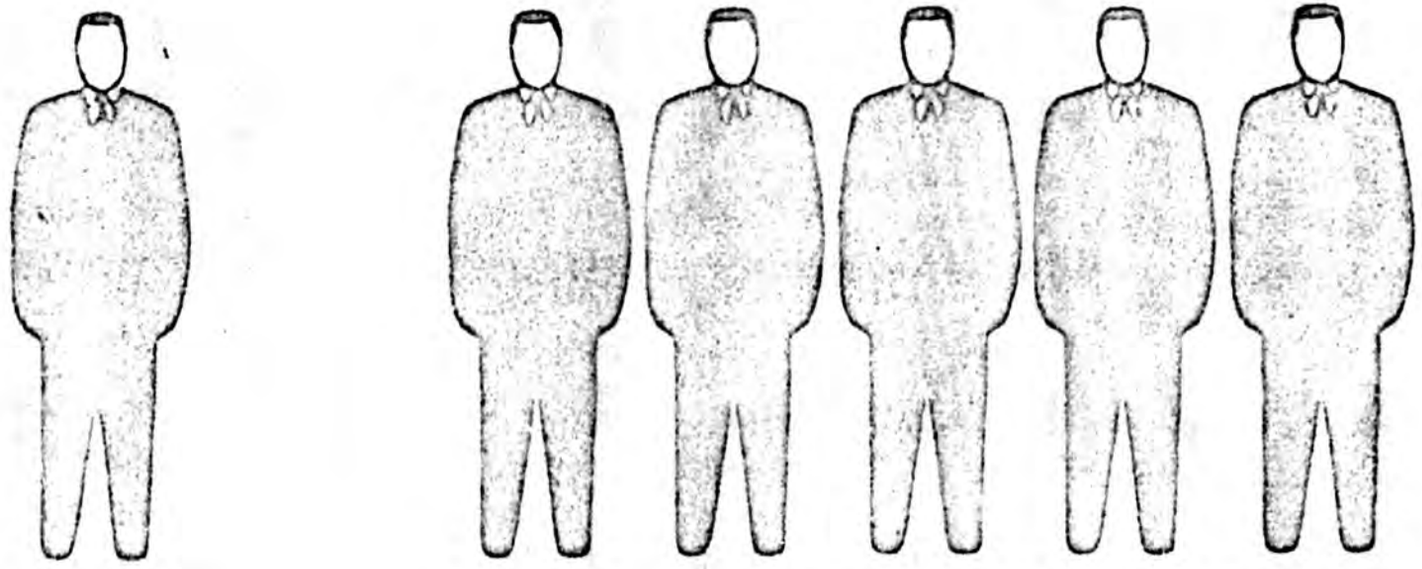


2. Solvency.

Legislators

1. Benefits Program.
   - Society's Standards.
   - Comparison to Neighbors.
2. Cost of Program.
3. Price Equity.

Consumer



Employers

Workers

Consumers

Need Data Re:

1. Benefits.
2. Price.
3. Efficiency.

NCCI / Assignments

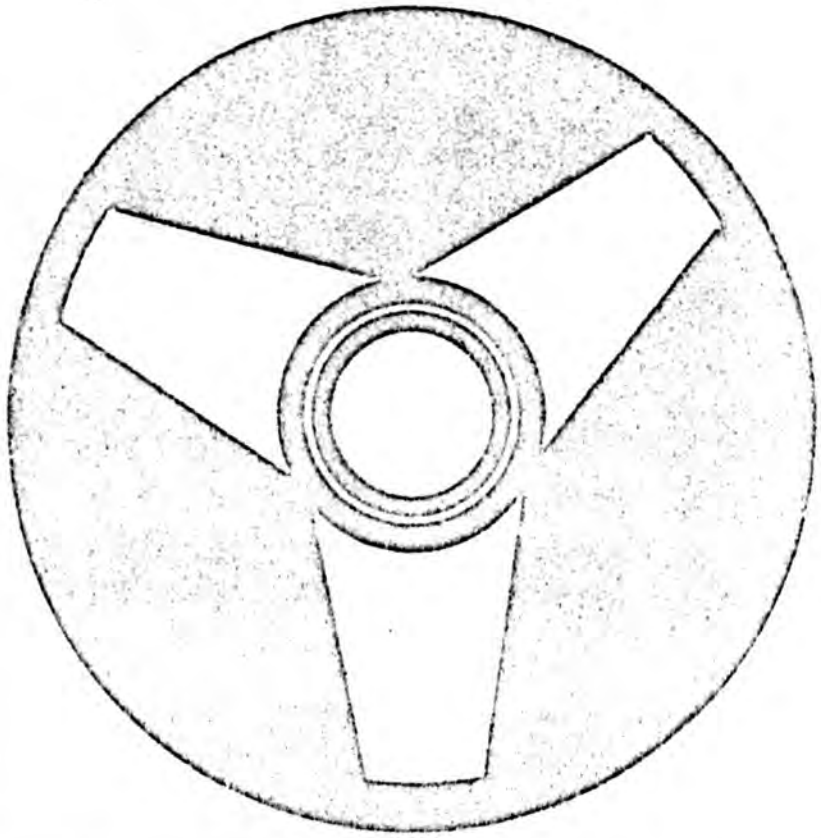
1. Pricing.
2. Benefit Changes.
3. Research.
4. General Information.

Data Must Be:

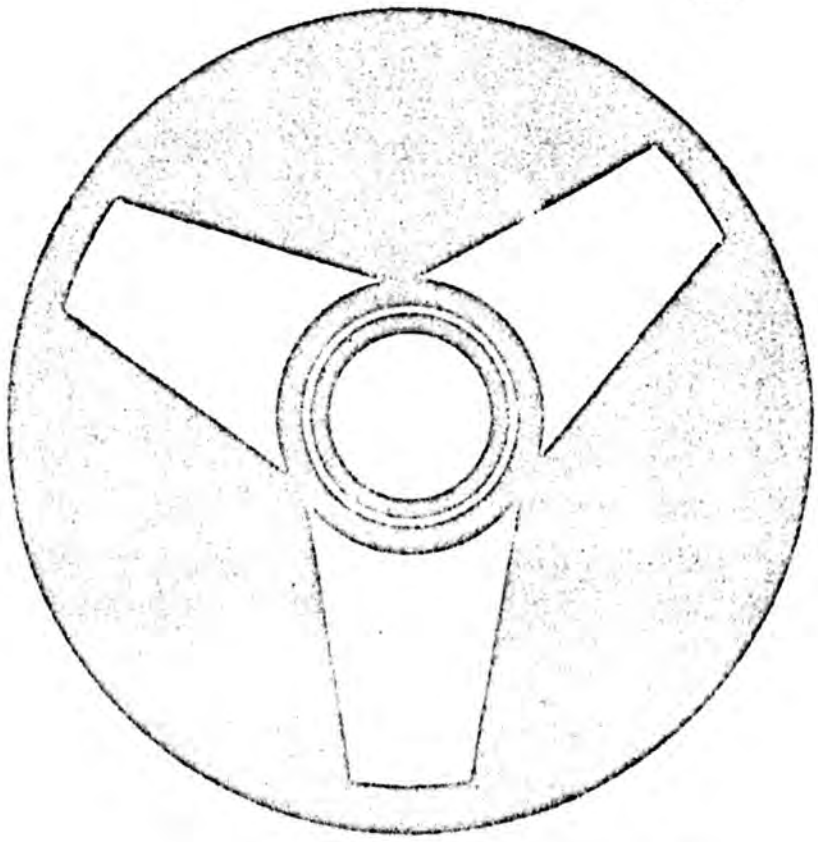
Current
+
Accurate

Data

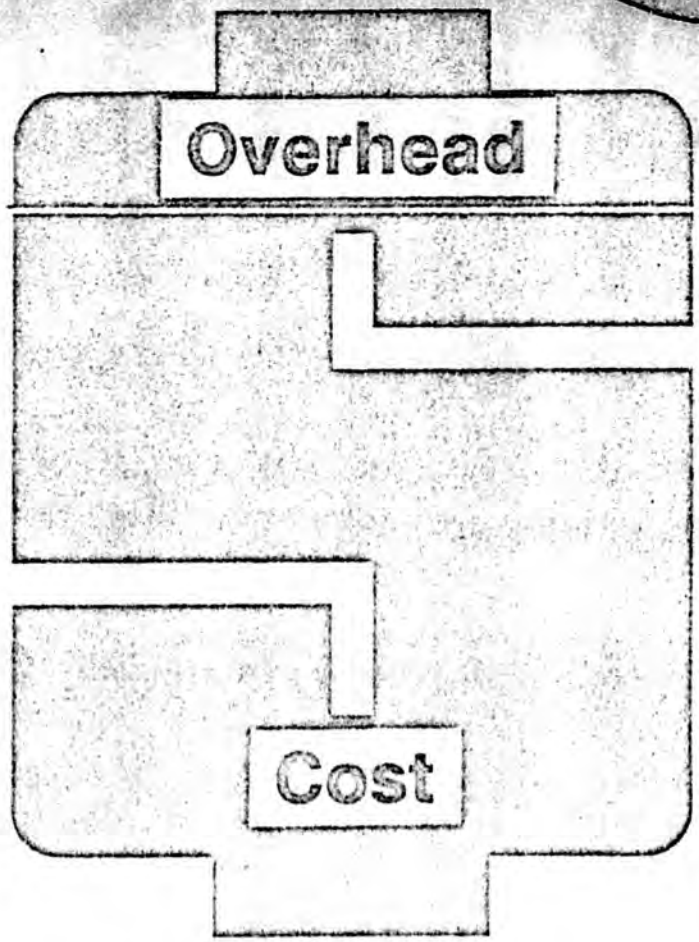
Pricing



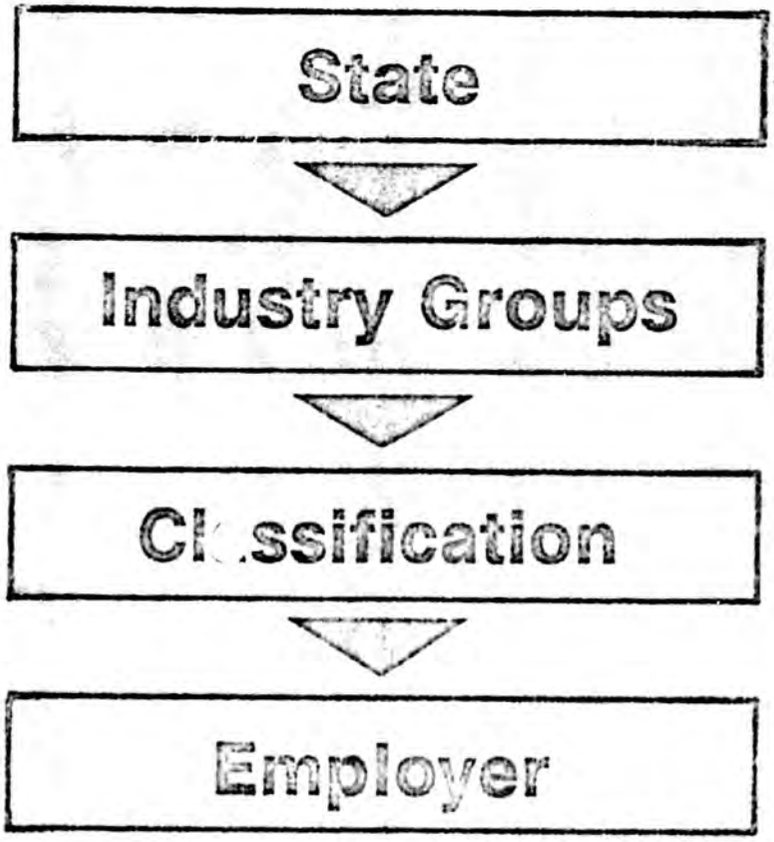
Understanding



Price =



Pricing



Expense Dollar

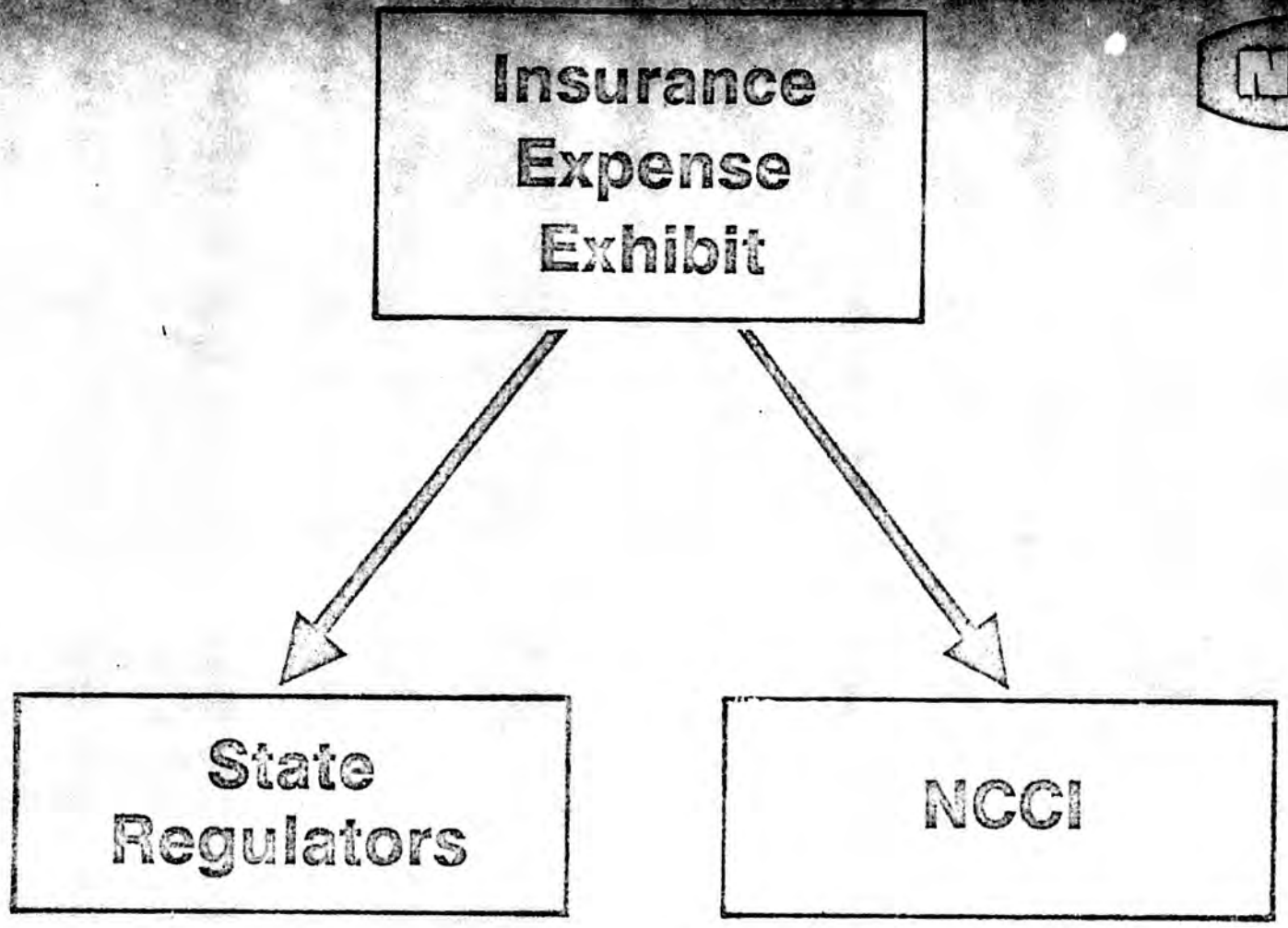
Auto

Fire

W.C.

Etc.

Sales | Tax | Mail | Heat


Insurance
Expense
Exhibit
State
Regulators
NCCI

Insurance Expense Exhibit

NCCI:

1. Checks
2. Summarizes
3. Distributes Summary

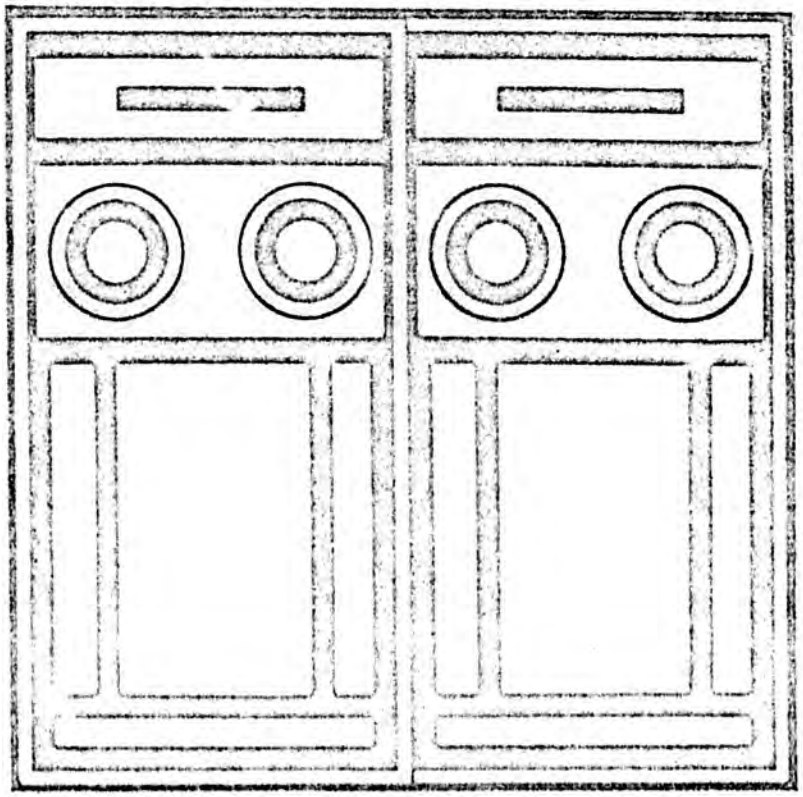
Insurance Expense Exhibit

Provides:

1. Expense Data
2. Reconciliation Between Regulator and NCCI of Income and Benefit Costs

Financial Data

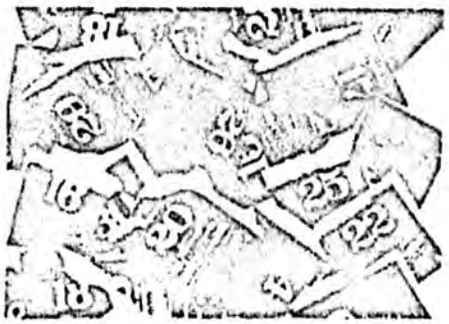
1. Reconcilable.
2. Current.



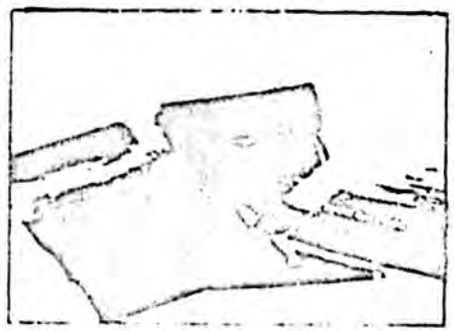
Financial Data

NCCI

Calendar Year Basis



Policy Year Basis



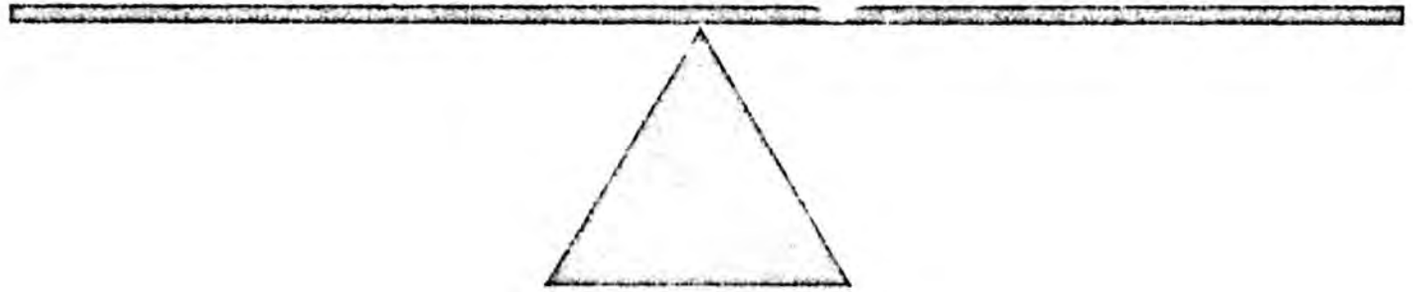
Report to NCCI

+

Data NOT Germane to State Price Level

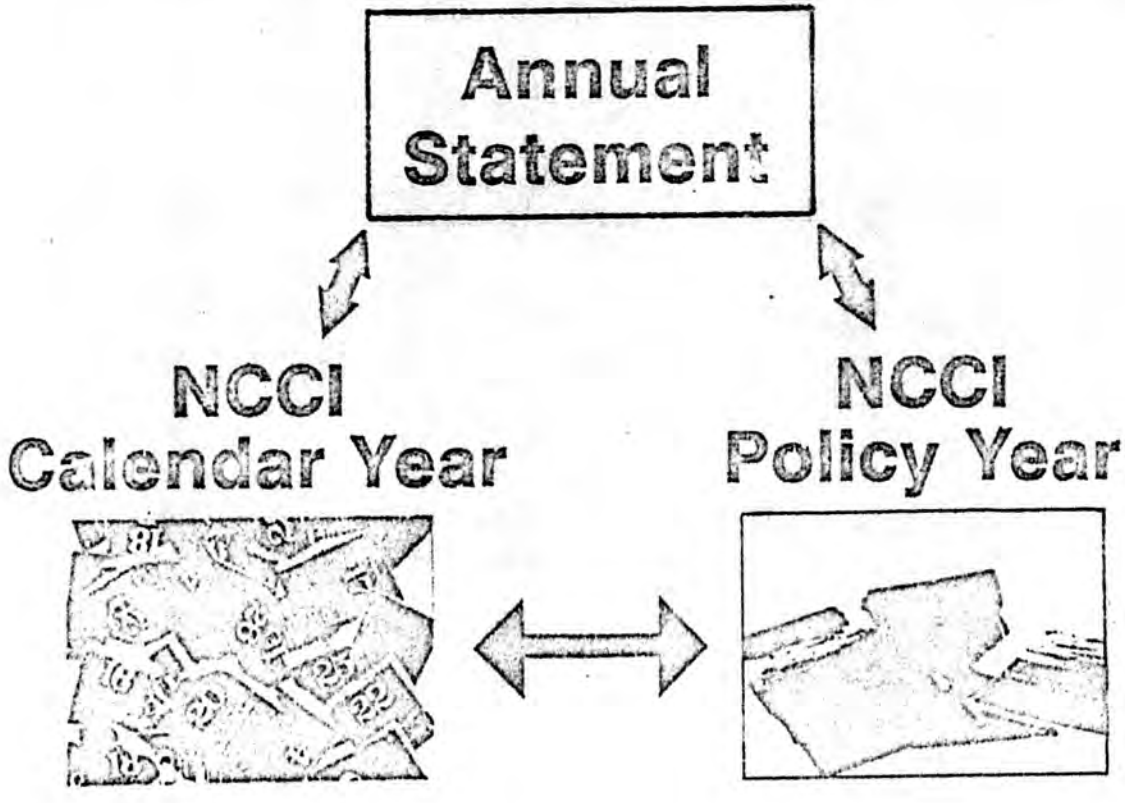
=

Report in Annual Statement

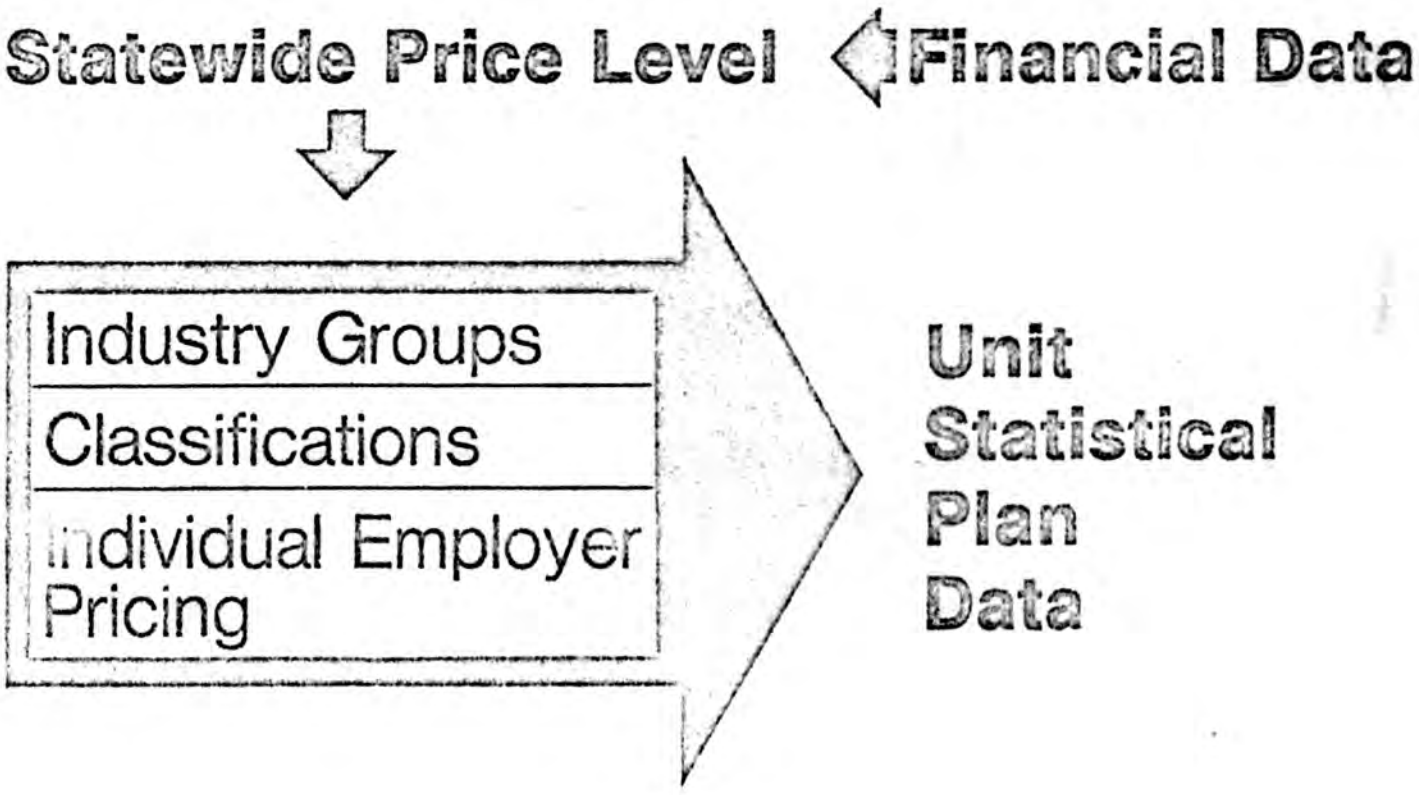


Policy Year Experience

Policy Year Being Valued	Accumulated Earned Premium	Accumulated Total Incurred Losses
A. Prior to 1970		
B. 1970		
C. 1971		
D. 1972		
E. 1973		
F. 1974		
G. 1975		
H. 1976		
I. 1977		
J. 1978		


Annual Statement
NCCI Calendar Year
NCCI Policy Year

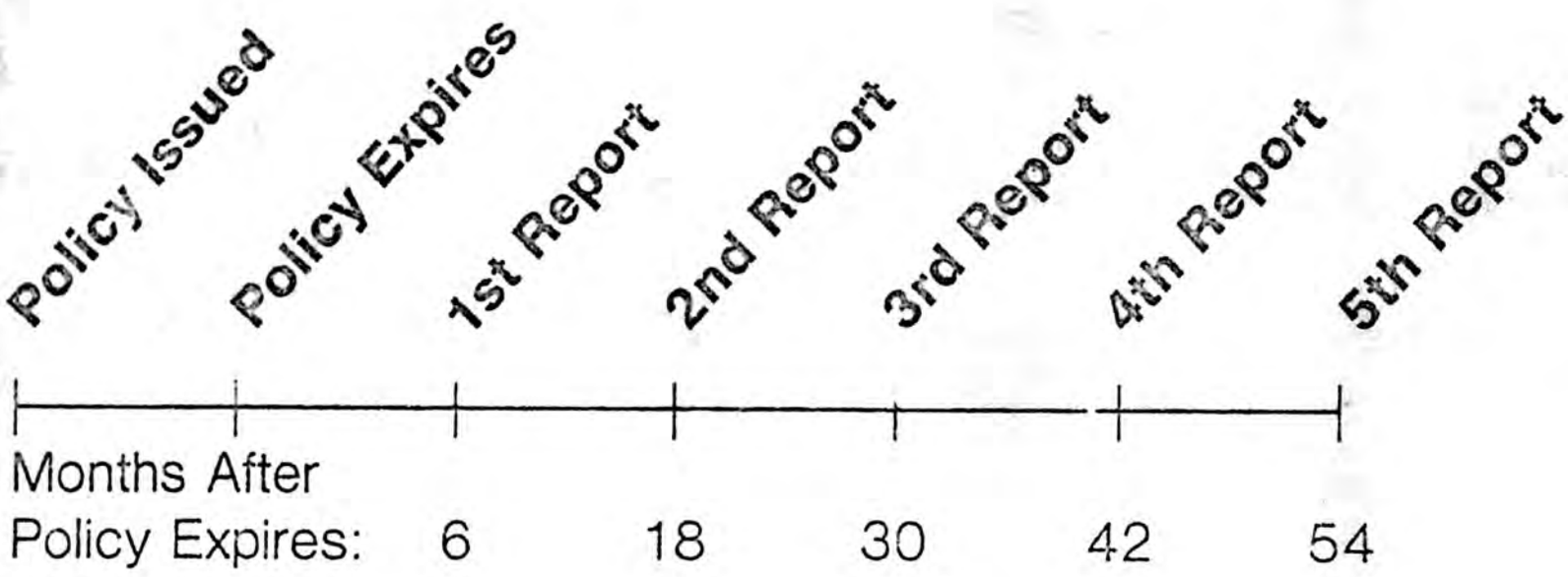
Pricing

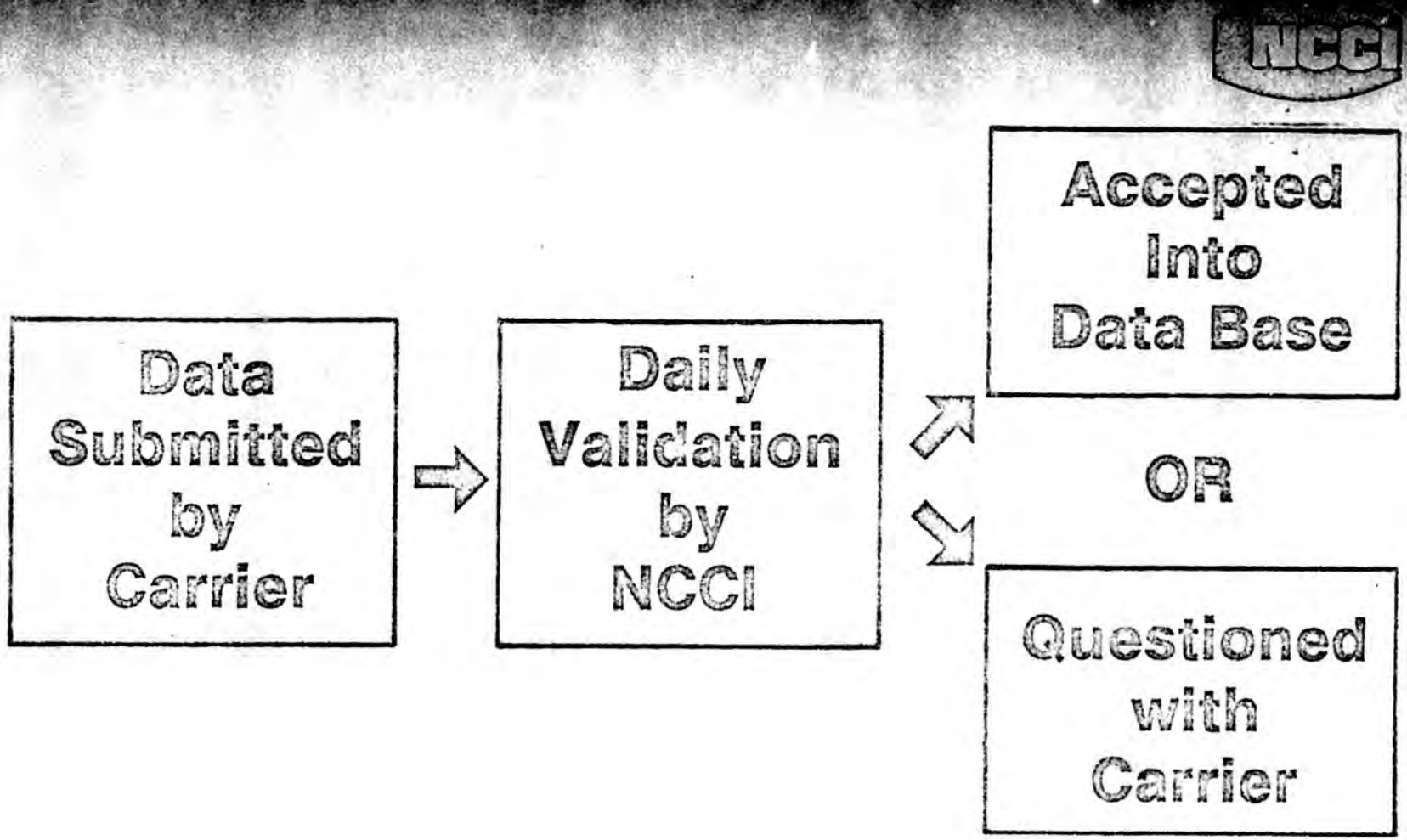

Statewide Price Level
Financial Data
Industry Groups
Classifications
Individual Employer Pricing
Unit Statistical Plan Data

For Each Policy by Classification:

1. Covered Payroll.
2. Premium.
3. Each Claim (Injury Type and Indemnity and Medical Cost Separate).

For Each Policy:




Data Submitted by Carrier
Daily Validation by NCCI
Accepted Into Data Base
OR
Questioned with Carrier

Data for Costing Proposed Law Changes

1. Injury Table.
2. State Wage Data.
3. Wage Distribution Table.

Detail Claim Information

General Areas:

1. Description of Claimant
2. Benefits
3. Claim Administration

Performance Evaluation Program

This Report Covers the Period / / **to** / /

Carrier Name _____

	Carrier	Total Industry
Number of Records Late / Number of Records Submitted	Timeliness	
	_____ %	_____ %
Number of Non-Admitted Records / Number of Records Submitted	Quality	
	_____ %	_____ %

Note: Supplementary exhibits specifically identify areas in which the particular carrier is having quality problems.

NATIONAL COUNCIL ON COMPENSATION INSURANCE

TITLE SLIDE

THE PRICING OF WORKERS' COMPENSATION INSURANCE (RATEMAKING)

IN MOST INSTANCES USING THE WORD "RATEMAKING" IN CONNECTION WITH THE PRICING OF WORKERS' COMPENSATION INSURANCE IS A MISNOMER. IT MORE ACCURATELY SHOULD BE CALLED RATE-UPDATING. EXISTING PRICES, CALLED RATES, ARE UPDATED TO REFLECT THE EFFECT OF CHANGES IN CONDITIONS WHICH HAVE OCCURRED SUBSEQUENT TO THE LAST TIMES RATES WERE CHANGED.

(1) THE CHANGES IN CONDITIONS TO WHICH I REFER CAN BE BROADLY CLASSIFIED UNDER TWO CATEGORIES: 1) NEW DATA ON BENEFITS PAID OUT AND PREMIUM INCOME EARNED BY INSURERS IN A STATE; AND 2) STATUTORY CHANGES IN A STATE'S BENEFIT PROGRAM.

(2) THE NEW DATA TO WHICH I REFER CAN ALSO BE SUB-DIVIDED INTO TWO BROAD CATEGORIES: 1) STATE-WIDE FINANCIAL DATA; AND 2) DETAILED DATA REPORTED ON A POLICY BY POLICY BASIS. THE FINANCIAL DATA IS USED TO DETERMINE THE REQUIRED STATE-WIDE AVERAGE CHANGE IN PRICE LEVEL, WHILE THE POLICY DETAIL IS USED TO DETERMINE HOW THE AVERAGE PRICE CHANGE SHOULD BE DISTRIBUTED AMONG THE VARIOUS INSUREDS, WHO ARE GROUPED IN CLASSIFICATIONS OF BUSINESS WITHIN THE STATE.

(3) STATE-WIDE FINANCIAL OR AGGREGATE DATA CAN BE SEPARATED INTO THREE BROAD CATEGORIES: 1) CALENDAR YEAR EXPERIENCE; 2) POLICY YEAR EXPERIENCE; AND 3) ACCIDENT YEAR EXPERIENCE.

CALENDAR YEAR EXPERIENCE COMES CLOSEST TO THE DATA ONE IS MOST ACCUSTOMED TO SEEING IN THE FINANCIAL REPORTS OF ALL TYPES OF BUSINESS, WHETHER OR NOT THEY ARE RELATED TO INSURANCE. THE PREMIUM EARNED DURING TWELVE CALENDAR MONTHS IS DIRECTLY SYNONYMOUS WITH THE REVENUED ACCURED. THE BENEFIT COSTS INCURRED (CALLED LOSSES WITHIN THE INSURANCE INDUSTRY) ARE DIRECTLY SYNONYMOUS WITH ACCURED COSTS OF RAW MATERIALS. FINANCIAL ANALYSTS ARE INTERESTED IN A COMPANY'S CALENDAR YEAR RESULTS BECAUSE IT PROVIDES A MEANINGFUL REPORT ON THE COMPANY'S ECONOMIC GAINS OR LOSSES FOR THE PERIOD. THE INTERNAL REVENUE SERVICE IS INTERESTED BECAUSE IT PROVIDES THE BASIS FOR TAXATION. ACTUARIES ARE INTERESTED BECAUSE IT IS A MEANINGFUL INDICATOR FOR HOW PRICES SHOULD BE ADJUSTED. PREMIUN AND LOSS DATA WILL STEM FROM BOTH NEW ENTRIES DURING THE CALENDAR YEAR, AND FROM CHANGES IN ESTIMATES ORIGINALLY MADE IN PRIOR PERIODS.

POLICY YEAR EXPERIENCE, IS SIMPLY ALL OF THE PREMIUM AND LOSS DATA FROM POLICIES ISSUED DURING A PARTICULAR PERIOD. TRANSACTIONS FROM POLICIES WHICH BECAME EFFECTIVE AT SOME TIME OTHER THAN DURING THE POLICY YEAR UNDER CONSIDERATION ARE EXCLUDED, AND ARE INSTEAD ASSIGNED TO THE POLICY YEAR FROM WHENCE THEY CAME. THUS, WITH POLICY YEAR EXPERIENCE WE HAVE A DIRECT MATCH BETWEEN THE INCOME EARNED FROM A SPECIFIC GROUP OF POLICIES, AND THE BENEFIT COSTS INCURRED UNDER THAT SPECIFIC GROUP OF POLICIES.

ACCIDENT YEAR EXPERIENCE ACCUMULATES LOSS DATA ON ALL ACCIDENTS WITH DATE OF OCCURRENCE FALLING WITHIN A GIVEN CALENDAR YEAR, RELATING SUCH INCURRED LOSSES TO THE PREMIUM EARNED DURING THE SAME YEAR. THIS PREMIUM FIGURE IS THE SAME AS THAT USED IN CALENDAR YEAR EXPERIENCE.

(4) ANY UPDATING OF PRICES, BE IT IN THE INSURANCE BUSINESS OR ANY OTHER BUSINESS STARTS WITH A COMPARISON OF THE COSTS OF PROVIDING THE GOODS AND SERVICES OF THE BUSINESS AS COMPARED TO THE REVENUE GENERATED BY EXISTING PRICES. THIS IS DONE IN TWO STEPS IN PRICING OF INSURANCE. FIRST, THE COSTS OF DOING BUSINESS, OR THE TOTAL OVERHEAD, IS ESTABLISHED AS A PERCENTAGE OF REVENUE. IN INSURANCE PRICING, THIS IS CALLED

(5) THE EXPENSE ALLOWANCE. THE EXPENSE ALLOWANCE COVERS THE COSTS TO THE INSURANCE COMPANY OF ACQUISITION AND FIELD SUPERVISION, GENERAL EXPENSE, PREMIUM TAXES, CLAIM ADJUSTMENT EXPENSE, AND INCLUDES AN ALLOWANCE FOR CONTINGENCY OR UNDERWRITING PROFIT.

(6) ACQUISITION AND FIELD SUPERVISION INCLUDES COMMISSION TO AGENTS OR BROKERS, AND COMPANY BRANCH OFFICE EXPENSES. THE ALLOWANCE FOR ALL ACQUISITION COSTS AVERAGE 11% OF THE NET PREMIUM DOLLAR.

GENERAL EXPENSE ITEMS INCLUDE HOME OFFICE EXPENSES, SAFETY INSPECTION AND ENGINEERING, AND THE COST OF PAYROLL AUDITS. IT ALSO INCLUDES THE COSTS OF BOARDS AND BUREAUS SUCH AS THE NCCI. AS A PERCENT OF NET PREMIUM, THE ALLOWANCE FOR GENERAL EXPENSE AVERAGE 5%.

COUNTRYWIDE, PREMIUM TAXES AVERAGE 3½%. OF COURSE, TAXES VARY FROM STATE TO STATE.

- CLAIMS ADJUSTMENT EXPENSE, WHICH INCLUDES ITEMS SUCH AS REPRESENTING THE EMPLOYER AT LEGAL PROCEEDING, INVESTIGATION OF CLAIMS, AND ISSUANCE OF BENEFIT PAYMENTS, CARRIERS AN ALLOWANCE OF 8% OF THE PREMIUM DOLLAR.

THE ALLOWANCE FOR CONTINGENCIES AND, UNDERWRITING PROFITS IS 2½%. THE WORD CONTINGENCY REFERS TO THE FACT THAT ACTUAL BENEFIT COSTS MAY EXCEED EXPECTED COSTS. WHEN THIS CONTINGENCY OCCURS, THE PROFIT ALLOWANCE IS WIPED OUT. WHEN ACTUAL EXCESS COSTS AMOUNT TO MORE THAN 2½% OF THE PREMIUM, AN UNDERWRITING LOSS OCCURS.

THUS, THE TYPICAL ALLOWANCE FOR ALL COSTS OF OPERATING THE SYSTEM INCLUDING THE CONTINGENCY ALLOWANCE OF 2½%, AMOUNTS TO A TOTAL OF 30%.

THE SECOND STEP IN THE PROCESS OF COMPARING EXISTING PRICES TO THE COST OF PROVIDING GOODS AND SERVICES, IS TO DETERMINE THE COST OF THE BASIC PRODUCT DELIVERED. FOR THE
(7) INSURANCE BUSINESS, THE PRODUCT DELIVERED IS DOLLARS. IT IS DOLLARS IN THE FORM OF WEEKLY BENEFITS PAID DIRECTLY TO THE INJURED WORKER, AND IT IS DOLLARS IN THE FORM OF PAYMENTS TO DOCTORS, HOSPITALS AND OTHERS TO PAY FOR MEDICAL AND REHABILITATIVE SERVICES PROVIDED TO THE INJURED WORKER. THESE DOLLARS ARE EXPENDED AS BENEFITS TO THE WORKER, AND ARE THE PRODUCT COSTS OF THE INSURANCE CARRIER.

THE BENEFIT COSTS CAN BE DIVIDED NOT ONLY BETWEEN INDEMNITY AND MEDICAL, BUT ALSO BETWEEN PAID AND OUTSTANDING, THAT IS, THE AMOUNT TO BE PAID IN THE FUTURE. IT IS THE TOTAL INCURRED BENEFIT COSTS WHICH MUST BE COMPARED TO THE REVENUE EARNED, WHEN ONE IS DETERMINING WHETHER THERE SHOULD BE A CHANGE MADE TO EXISTING PRICES. IT IS THE RATIO OF BENEFITS PAID OUT TO PREMIUMS COLLECTED WHICH INDICATES WHETHER THE PRICE LEVEL SHOULD BE INCREASED OR DECREASED. THIS IS ACCOMPLISHED BY COMPARING THIS RATIO TO A "BALANCE POINT", OR "AVERAGE RATIO". ACTUARIES CALL THIS A "PERMISSIBLE LOSS RATIO".

THE BALANCE POINT IS OBTAINED BY SIMPLY SUBTRACTING THE TOTAL OVERHEAD OF EXPENSE ALLOWANCE FROM 100%. FOR EXAMPLE, IF THE TOTAL ALLOWANCE IS 30%, THEN THE BALANCE POINT IS 70%.

(8) THEN, IF THE RATIO IS HIGHER THAN 70%, A PRICE INCREASE IS INDICATED. IF THE RATIO IS LOWER, A RATE DECREASE IS INDICATED.

THE APPROACH TO PRICING USED IN MOST STATES STARTS WITH JUST SUCH A COMPARISON OF BENEFITS PAID OUT TO PREMIUM COLLECTED BASED UPON POLICY YEAR EXPERIENCE. POLICY YEAR DATA IS USED BECAUSE IT IS A DIRECT MATCH BETWEEN THE PREMIUMS EARNED FROM A GROUP OF POLICIES, AND THE BENEFIT COSTS FROM THOSE SAME POLICIES.

HOWEVER, BEFORE THE RATIO OF BENEFIT COSTS TO PREMIUM IS OBTAINED, CERTAIN BASIC ADJUSTMENTS MUST BE MADE TO THE

(9) DATA. THE PREMIUM MUST BE ADJUSTED FOR TWO CONDITIONS. FIRST, IT MUST BE ADJUSTED FOR THE EFFECT OF ANY PRICE CHANGES WHICH

HAVE TAKEN EFFECT ON OR AFTER THE EFFECTIVE DATE OF THE FIRST POLICY INCLUDED IN THE POLICY YEAR. THE PURPOSE OF THIS ADJUSTMENT IS TO DETERMINE WHAT THE ACTUAL PREMIUMS WOULD HAVE BEEN IF ALL OF THE PREMIUMS HAD BEEN EARNED UNDER THE LATEST APPROVED PRICES WHICH ARE THE ONES UNDER ANALYSIS. ACTUARIES CALL THIS ADJUSTING PREMIUM TO CURRENT RATE LEVEL. FAILURE TO MAKE THIS ADJUSTMENT COULD RESULT IN AN INSURED BEING CHARGED TWICE FOR THE SAME ADVERSE EXPERIENCE.

THE SECOND ADJUSTMENT IS MADE TO REFLECT WHAT IS CALLED PREMIUM DEVELOPMENT. THE FIRST STEP IN DETERMINING HOW MUCH PREMIUM AN EMPLOYER IS TO PAY, IS TO MULTIPLY THE RATE, OR PRICE, TIMES THE PAYROLL IN UNITS OF $100. OF COURSE, THE FINAL PAYROLL UNDER THE POLICY OFTEN MAY NOT BE KNOWN UNTIL SEVERAL MONTHS AFTER THE POLICY EXPIRES. THE DIFFERENCE BETWEEN THE ESTIMATED PREMIUM AND THE PREMIUM BASED UPON FINAL AUDIT IS THE MAJOR CONTRIBUTOR TO PREMIUM DEVELOPMENT. BY TRACKING THE PREMIUM MOVEMENT IN A STATE FOR EARLIER POLICY YEARS, AN ESTIMATE CAN BE MADE OF HOW MUCH THE PRELIMINARY REPORT OF THE MOST RECENT POLICY YEAR'S PREMIUM WILL CHANGE WHEN THE FINAL AUDIT IS COMPLETED.

POLICY YEAR BENEFIT COSTS MUST BE ADJUSTED, ALSO. THEY MUST BE ADJUSTED TO REFLECT THE COST IMPACT OF STATUTORY BENEFIT CHANGES WHICH HAVE BECOME LAW SUBSEQUENT TO THE START OF THE POLICY YEAR. THIS IS CALLED ADJUSTING BENEFITS

TO CURRENT LAW LEVEL. BENEFIT COSTS, LIKE PREMIUMS, MUST ALSO BE ADJUSTED BY A DEVELOPMENT FACTOR.

POLICY YEAR BENEFIT COSTS ARE THE SUM OF WHAT HAS BEEN PAID TO DATE UNDER THE GROUP OF POLICIES, PLUS WHAT THE INSURERS' STILL OWE, OR STILL HAVE TO PAY UNDER THOSE POLICIES. THAT IS, INCURRED IS DEFINED AS:

(10)

INCURRED = PAID + STILL OWED, OR

INCURRED = PAID + OUTSTANDING, OR

INCURRED = PAID + RESERVED.

THUS, RESERVES ARE TO THE INSURANCE BUSINESS WHAT ACCOUNTS PAYABLE ARE TO OTHER BUSINESS. OF COURSE, WHEN THE RESERVE IS TO PAY FOR LIFETIME WEEKLY BEENFITS, OR FOR FUTURE MEDICAL EXPENSES, IT IS OBVIOUS THERE MUST BE SOME UNCERTAINLY AS TO PRECISELY HOW MUCH MONEY WILL BE PAID ON ANY PARTICULAR CLAIM. EACH COMPANY, USING DEVICES SUCH AS MORTALITY TABLES, MAKES THEIR BEST ESTIMATE AS TO HOW MUCH SHOULD BE RESERVED FOR EACH CASE WHICH HAS NOT YET BEEN CLOSED. OF COURSE, ONCE EVERY CLAIM HAS BEEN CLOSED, ALL OF THE INCURRED BENEFIT COSTS HAVE BEEN PAID AND THE OUTSTANDING COSTS, OR RESERVES, FOR THE POLICY YEAR BECOME ZERO. BY TRACKING THE DIFFERENCE BETWEEN THE FIRST ESTIMATES OF INCURRED BENEFIT COSTS AND FINAL BENEFIT COSTS FOR OLDER POLICY YEARS IN A STATE, A DEVELOPMENT FACTOR WHICH APPLIES TO THE LATEST POLICY YEAR'S INCURRED COSTS CAN BE DETERMINED. THIS DEVELOPMENT FACTOR ADJUSTS COSTS FROM A FIRST REPORT BASIS TO AN ULTIMATE REPORT BASIS.

(11) HAVING COMPLETED THESE ADJUSTMENTS TO THE REPORTED INCURRED BENEFIT COSTS AND EARNED PREMIUMS, IT IS APPROPRIATE

TO DIVIDE THE COSTS BY PREMIUM. THIS RATIO IS THEN DIVIDED BY THE BALANCE POINT OR PERMISSIBLE LOSS RATIO TO DETERMINE THE PERCENTAGE CHANGE IN PRICE LEVEL INDICATED BY THE LATEST POLICY YEAR EXPERIENCE. FOR EXAMPLE, IF THE BENEFIT COSTS TO PREMIUM RATIO IS 77%, AND THE BALANCE POINT IS 70%, A 10% INCREASE IS INDICATED.

AFTER COMPLETING THE EARLIER DESCRIBED CALCULATIONS FOR THE LATEST POLICY YEAR EXPERIENCE, THE SAME PROCESS IS REPEATED BASED ON THE LATEST CALENDAR YEAR EXPERIENCE. WHILE THE CALENDAR YEAR EXPERIENCE DOES NOT ENJOY THE PERCISE MATCH OF PARTICULAR CLAIM COSTS TO PARTICULAR POLICIES, IT DOES ENJOY THE ADVANTAGE OF BEING MORE CURRENT. FOR EXAMPLE, FOR A JULY 1, 1980 RATE REVISION, A FULL POLICY YEAR OF EXPERIENCE IS AVAILABLE FOR POLICY YEAR 1978, BUT THE LATEST AVAILABLE CALENDAR YEAR WILL BE 1979.

THIS RATEMAKING PROGRAM GIVES EQUAL WEIGHT TO THE POLICY YEAR INDICATION AND TO THE CALENDAR YEAR INDICATION. THE AVERAGE INDICATED CHANGE IN PRICE LEVEL IS CALLED THE INDICATED CHANGE DUE TO EXPERIENCE. OF COURSE, SINCE IT IS BASED UPON PAST EXPERIENCE, WHAT IT TELLS IS WHAT THE PROPER PRICE LEVEL SHOULD HAVE BEEN IN THE PAST. BUT, WE HAVE TO MAKE A FAIR PRICE LEVEL FOR THE FUTURE. WHICH MEANS WE MUST HAVE A WAY TO ESTIMATE HOW MUCH DIFFERENT THE PRICE LEVEL (12) IN THE FUTURE SHOULD BE FROM THE PRICE LEVEL INDICATED BY THE LATEST ACTUAL PAST DATA. THIS ADJUSTMENT IS ACCOMPLISHED THROUGH USE OF WHAT WE CALL A TREND FACTOR.

THE TREND FACTOR IS BASED UPON A COMPARISON OF THE MOVEMENT IN BENEFIT COSTS VERSUS PAYROLLS COVERED, OVER THE PAST FIVE YEARS IN A STATE. BENEFIT COSTS ARE FIRST ADJUSTED TO THE CURRENT STATUTORY BENEFIT LEVEL. THIS REMOVES COSTS DUE TO LAW CHANGES FROM THE CALCULATION. THUS, WE ARE COMPARING THE CHANGE IN BENEFIT COSTS EXCLUDING STATUTORY CHANGES, TO CHANGES IN THE LEVEL OF COVERED PAYROLLS. IF BENEFIT COSTS REMAINED CONSTANT WHILE PAYROLLS INCREASED, A (13) DOWNWARD TREND FACTOR WOULD BE CALLED FOR. THIS IS BECAUSE IN WORKERS' COMPENSATION, PREMIUM IS DETERMINED BY MULTIPLYING THE RATE (OR UNIT PRICE) TIMES PAYROLL IN $100 UNITS. THUS, AN INCREASE IN PAYROLL WILL PRODUCE MORE PREMIUM. IF THIS INCREASE IS NOT MATCHED BY INCREASED BENEFIT COSTS, RATES OR UNIT PRICES CAN BE DECREASED. IF BENEFIT COSTS HAVE BEEN RISING AT THE SAME RATE AS PAYROLLS, A ZERO TREND FACTOR IS REQUIRED. BUT, IF BENEFIT COSTS ARE RISING FASTER THAN PAYROLLS, A POSITIVE TREND FACTOR IS NEEDED.

THE NEED FOR A TREND FACTOR IS BASED UPON THE FACT THAT WITHOUT IT, INDICATED PRICES WOULD BE CORRECT FOR A POINT IN THE PAST, BUT BECAUSE OF CHANGING CONDITIONS WOULD BE INCORRECT FOR WHEN THEY ARE TO BE USED IN THE FUTURE. THE CONCLUSION AS TO WHETHER THE SUPPLEMENT TO THE PRICE LEVEL DUE TO TREND IS POSITIVE OR NEGATIVE, DEPENDS UPON WHICH HAS BEEN GROWING FASTER, PAYROLLS OR BENEFIT COSTS.

ACCIDENT YEAR DATA IS USED FOR RATEMAKING PURPOSES IN CALIFORNIA, WHILE NEW JERSEY USES CALENDAR YEAR ONLY AND

PENNSYLVANIA USES POLICY YEAR EXPERIENCE ONLY.

AT THE START OF THIS PRESENTATION WE NOTED THAT THE CHANGES IN CONDITIONS REQUIRING A CHANGE IN PRICE LEVEL COULD BE BROADLY CLASSIFIED UNDER TWO CATEGORIES: NEW INCOME AND COST INFORMATION, OR STATUTORY BENEFIT CHANGES. THUS FAR, WE HAVE MENTIONED HOW NEW DATA AFFECTS PRICE LEVELS. NEXT WE MUST ADDRESS STATUTORY BENEFIT CHANGES.

THE MOST COMMON TYPE OF STATUTORY BENEFIT CHANGE IS TO INCREASE MAXIMUM WEEKLY BENEFITS. IN SOME STATES THIS IS ONLY DONE BY A SPECIFIC CHANGE IN STATUTE. IN OTHER STATES THE LEGISLATURE HAS PASSED A LAW WHEREBY BENEFITS ARE ADJUSTED ANNUALLY DEPENDING UPON THE AMOUNT OF INCREASE, SUCH AS THE STATE-WIDE AVERAGE WAGE OR THE CONSUMER PRICE INDEX. BY USING THIS LATTER APPROACH, THE LEGISLATURE HAS RELIEVED ITSELF OF THE NEED TO ENACT A SEPARATE BENEFITS LAW EACH YEAR. BUT, THE RESULT IS EXACTLY THE SAME AS IF THE LEGISLATURE DID PASS AN AMENDMENT EACH YEAR.

A STATUTORY BENEFIT CHANGE COST EVALUTATION STARTS OUT AS A SYNOPSIS OF THE BENEFIT PROGRAM UNDER BOTH THE OLD LAW AND THE NEW LAW, FOR EACH TYPE OF INJURY. BY TYPE OF
(14) INJURY WE MEAN: DEATH, PERMANENT TOTAL DISABILITY, PERMANENT PARTIAL DISABILITY, TEMPORARY DISABILITY, AND MEDICAL. A COST EVALUATION IS FIRST DONE SEPARATELY FOR EACH TYPE OF INJURY. THE FACTORS WHICH PLAY A PART IN THIS ARE: THE OLD AND NEW STATUTES IN THE STATE; THE AVERAGE WAGE OF WORKERS' INJURED

IN THE STATE; AND A STANDARD DISTRIBUTION OF CLAIMS. BY DETERMINING THE DOLLAR COSTS OF THIS SET OF CLAIMS UNDER BOTH THE OLD AND NEW LAWS, THE COSTS IMPACT OF THE STATUTORY BENEFIT CHANGE IS ISOLATED.

HAVING DETERMINED THE COST IMPACT BY TYPE OF INJURY, WE THEN WEIGH THESE EFFECTS BY THE LATEST DISTRIBUTION OF BENEFIT COSTS BY TYPE OF INJURY IN A STATE TO OBTAIN THE AVERAGE, OR OVERALL COST IMPACT OF THE BENEFIT CHANGE.

NOW LETS TURN TO CLASSIFICATION RELATIVITY.

ONCE ALL OF THE ITEMS WHICH EFFECT OVERALL PRICE

(15) LEVEL IN THE STATE HAVE BEEN DETERMINED, THE NEXT STEP IS TO DISTRIBUTE TO AVERAGE CHANGE FAIRLY, TO THE THREE BROAD INDUSTRY GROUPS CALLED: MANUFACTURING, CONTRACTING, AND ALL OTHER. THE FINAL STEP IS TO FURTHER DISTRIBUTE THE CHANGES TO THE INDIVIDUAL CLASSIFICATIONS WITHIN A GROUP, SUCH AS PLUMBERS, CARPENTERS, MASONS, ETCETERA. THE RESULT OF THIS PROCESS IS CLASSIFICATION PRICES WHICH EQUITABLY TRACT THE ACTUAL EXPERIENCE OF THE INDIVIDUAL CLASSES AND PRODUCE THE PROPER TOTAL PREMIUM FOR THE STATE. IT IS COMMON TO HAVE THE OVERALL PRICE LEVEL FOR THE STATE TO BE GOING UP AND YET HAVE MANY INDIVIDUAL CLASSIFICATION RATES, BECAUSE OF BETTER EXPERIENCE, GOING DOWN.

HOW USEFUL THE LATEST EXPERIENCE IN A PARTICULAR CLASSIFICATION CAN BE FOR DETERMINING THE RATE IN THAT CLASS, IS DEPENDENT UPON THE VOLUME OF EXPERIENCE WHICH HAS

OCCURRED IN THE CLASS. IF, FOR SOME PARTICULAR CLASS, THE TOTAL PREMIUM IN THE LAST THREE YEARS HAS BEEN $3,000, AND A CLAIM HAS OCCURRED COSTING $30,000, IT IS NOT PROPER TO ARGUE THAT THE PRICE FOR THAT CLASS SHOULD BE INCREASED 1000% BASED SOLELY ON THAT EXPERIENCE. THIS IS BECAUSE, THE SMALL AMOUNT OF DATA AVAILABLE IS NOT STATISTICALLY SIGNIFICANT. HOWEVER, THE GREATER THE VOLUME OF DATA THAT DOES EXIST, THE GREATER IS THE STATISTICAL SIGNIFICANCE OF THE DATA. ACTUARIES CALL THIS "STATISTICAL SIGNIFICANCE" OR "CREDIBILITY". THEY SAY THAT IF THERE IS A VERY LARGE AMOUNT OF DATA FOR THE CLASS, THEN THE CLASS DATA IS 100% CREDIBLE. IF THERE IS VERY LITTLE DATA, THEY SAY SUCH DATA HAS ZERO CREDIBILITY. FOR IN BETWEEN VOLUMES OF DATA, THEY ASSIGN INTERMEDIATE CREDIBILITY VALUES.

IF THE LATEST THREE YEARS OF DATA FOR A CLASS GENERATES 100% CREDIBILITY, NO ALTERNATIVE INPUT IS NECESSARY FOR DETERMINING THAT CLASSIFICATIONS RATE. BUT, WHEN ONLY A LESSER VOLUME IS AVAILABLE, SOME OTHER INPUT IS ALSO NECESSARY TO DETERMINE THE PROPER RATE FOR THAT CLASS.

THERE ARE IN FACT TWO ADDITIONAL SOURCES THE RATE MAKER CAN DRAW UPON WHEN NEEDED. ONE IS CALLED THE PRESENT ON LEVEL PURE PREMIUM. THE OTHER IS CALLED THE PURE PREMIUM INDICATED BY NATIONAL RELATIVITY.

(16) A PURE PREMIUM IS SIMPLY THE BENEFIT COST PER $100 OF
(17) PAYROLL. AN UNDERLYING PURE PREMIUM IS THE BENEFIT COST PORTION ONLY, OF THE EXISTING PRICE, OR RATE, FOR THE CLASSIFICATION. A PRESENT ON LEVEL PURE PREMIUM IS THE EXISTING, OR

(18) UNDERLYING, PURE PREMIUM ADJUSTED BY THE AVERAGE CHANGE IN PRICE LEVEL FOR THE INDUSTRY GROUP OF WHICH THE CLASSIFICATION IS A MEMBER.

(19) THE PURE PREMIUM INDICATED BY NATIONAL RELATIVITY IS A PURE PREMIUM WHICH IS BASED UPON COUNTRYWIDE DATA, BUT WHICH HAS BEEN ADJUSTED TO THE COST LEVELS IN A STATE. IT PROVIDES A RANKING OF PURE PREMIUMS BY CLASSIFICATION BASED ON NATIONAL DATA, BUT ONLY WHERE THE COST INDICATION OF ALL NATIONALLY INDICATED PURE PREMIUMS, WHEN SUMMED, EQUALS EXACTLY THE STATE-WIDE COST LEVEL CALLED FOR BY ONLY ONE STATE'S DATA FOR ALL CLASSES. IN OTHER WORDS, IT PROVIDES AN ALTERNATIVE INDICATOR AS TO HOW ONE CLASSIFICATION'S PRICE SHOULD RELATE TO THE PRICES OF OTHER CLASSIFICATIONS, BUT HAS ABSOLUTELY NO EFFECT UPON THE TOTAL AMOUNT OF PREMIUM TO BE CHARGED IN YOUR STATE. IT IS SOLELY AN AID IN REACHING AN EQUITABLE ALLOCATION OF THE STATE'S TOTAL PRICE LEVEL AMONG THE VARIOUS CLASSIFICATION.

WHEN CURRENT EXPERIENCE OF A CLASS WITHIN THE STATE DOES NOT HAVE SUFFICIENT VOLUME TO BE DEEMED 100% CREDIBLE FOR RATEMAKING, WE NEXT LOOK TO THE NATIONAL RELATIVITY INDICATION. HOWEVER, THE WEIGHT, OR CREDIBILITY IN ACTUARIAL TERMS, ASSIGNED TO THIS INDICTION IS LIMITED TO ONE-HALF OF THE WEIGHT NOT ASSIGNED TO THE CURRENT STATE EXPERIENCE. THE REMAINING WEIGHT, TO TOTAL 100%, IS ASSIGNED TO THE PRESENT ON LEVEL PURE PREMIUM.

FOR EXAMPLE, IF THE CURRENT STATE EXPERIENCE IN A CLASSIFICATION WERE ONLY OF SUFFICIENT VOLUME TO BE ASSIGNED 40% CREDIBILITY, THIS WOULD LEAVE A WEIGHT OF 60% TO BE ASSIGNED TO OUR TWO ALTERNATIVE INDICATORS. NO MORE THAN HALF OF THIS REMAINING WEIGHT, OR UP TO 30%, COULD BE ASSIGNED TO THE NATIONAL RELATIVITY ADJUSTED TO YOUR STATE'S LEVEL. THE REMAINING 30% WEIGHT WOULD BE ASSIGNED TO THE STATE'S PRESENT ON LEVEL PURE PREMIUM.

(20) ONCE TOTAL PURE PREMIUMS ARE ESTABLISHED FOR EACH CLASS, THE NEXT STEP IS TO BUILD A TOTAL RATE, OR PRICE. THIS SIMPLY REQUIRES ADDING THE EXPENSE ALLOWANCE OR COST OF ADMINISTERING THE BENEFITS PROGRAM, AS DESCRIBED EARLIER.

INCIDENTALLY, IT IS WORTH NOTING THAT BEFORE WE RELEASE THE PROPOSED SCHEDULE OF PRICES BY CLASSIFICATION, A DETAILED TEST IS MADE TO INSURE THAT THE AVERAGE PRICE LEVEL CHANGE BY INDUSTRY GROUP IS EXACTLY WHAT WAS INDICATED BY THE STATE'S EXPERIENCE ALONE.

IN PROPOSING A SCHEDULE OF PRICES BY CLASSIFICATION, WE BELIEVE IT IS IN EVERYONE'S BEST INTEREST TO AVOID EXTREME FLUCTUATIONS, UP OR DOWN, IN PRICES FROM YEAR TO YEAR. THIS IS ACCOMPLISHED BY TWO FEATURES IN THE RATEMAKING PROCESS:

(21) FIRST, INDIVIDUAL HIGH COST CASES HAVE A DOLLAR VALUE LIMIT PUT UPON THE AMOUNT THAT CAN BE USED IN DETERMINING THE PROCE FOR A PARTICULAR CLASS. THE DOLLARS OF COST THAT WERE

EXCLUDED FROM A CLASS, ARE INSTEAD SPREAD OVER ALL CLASSES IN THE INDUSTRY GROUP. SECOND, THE AMOUNT, UP OR DOWN, THAT A NEW CLASS PRICE MAY VARY FROM THE EXISTING PRICE FOR THAT CLASS IS CONSTRAINED BY WHAT WE CALL "RATE SWING LIMITATIONS". THE FORMULA WHICH DETERMINES THESE LIMITS, IS BASED UPON THE AVERAGE PRICE LEVEL CHANGE FOR THE INDUSTRY GROUP.

THUS FAR WE HAVE ONLY TALKED ABOUT HOW MANUAL RATES, OR THE BASE PRICES PER $100 OF PAYROLL, ARE DETERMINED. BUT, FOR THE MAJOR SHARE OF THE PREMIUM INCOME EARNED IN YOUR STATE, THE MANUAL RATE IS ONLY THE STARTING POINT FOR DETERMINING WHAT AN EMPLOYER WILL PAY FOR HIS WORKERS' COMPENSATION COVERAGE. THE VINAL COST TO AN EMPLOYER CAN ALSO BE AFFECTED BY:

(22)

1. PROSPECTIVE EXPERIENCE RATING
2. PREMIUM DISCOUNTS
3. OPTIONAL RETROSPECTIVE RATING
4. DIVIDENDS TO POLICYHOLDERS.

MANUAL RATES ARE THE LIST PRICE PER $100 OF PAYROLL, AND ARE THE FINAL COST ONLY WHEN OTHER FACTORS ARE NOT APPLICABLE. THESE OTHER FACTORS INCLUDE ITEMS SUCH AS: DOES RECENT EXPERIENCE OF THIS EMPLOYER INDICATE HE IS BETTER OR WORSE THAN AVERAGE? IS THE EMPLOYER OF SUFFICIENT SIZE TO GENERATE ECONOMIES OF SCALE FOR THE INSURER WHICH MANDATE A PREMIUM DISCOUNT? HAVE THE EMPLOYER AND INSURER AGREED TO A "COST PLUS" OR RETROSPECTIVE RATING AGREEMENT? DOES THE INSURER HAVE A PROGRAM OF RETURNING UNUSED PREMIUM TO

THE EMPLOYER AFTER THE POLICY HAS EXPIRED VIA A DIVIDEND?

(23) EXPERIENCE RATING IS A MANDATORY PROGRAM APPLIED ONLY TO INSUREDS OF A SIZE LARGE ENOUGH FOR THE INSURED'S PAST EXPERIENCE TO BE AN INDICATOR OF HOW MUCH BENEFIT COST WILL BE PAID TO THIS INSURED IN THE FUTURE. FOR THE SMALLEST SIZE EMPLOYERS, NO STATISTICAL SIGNIFICANCE CAN BE ASSIGNED TO THEIR PAST HISTORY, THUS THEY ARE CHARGED THE MANUAL RATE.

AN INSURED WITH PERHAPS ONE-HALF MILLION DOLLARS PER YEAR IS OF SUCH SIZE THAT THE COSTS HE HAS GENERATED IN THE PAST ARE A GOOD INDICATOR OF COST HE CAN BE EXPECTED TO GENERATE IN THE FUTURE. FOR EMPLOYERS OF A SIZE IN BETWEEN, THEIR EXPERIENCE IS A GOOD PARTIAL INDICATOR, AND THUS IS ONLY ASSIGNED A PARTIAL WEIGHT.

EXPERIENCE RATING IS A COMPARISON OF THE EMPLOYERS' PAST ACTUAL EXPERIENCE TO THE EXPECTED OR AVERAGE EXPERIENCE.

THE BOTTOM LINE IS THAT IF AN EMPLOYER'S PAST EXPERIENCE IS BETTER OR WORSE THAN AVERAGE, HIS PRICE OR RATE IS ADJUSTED DOWNWARD OR UPWARD, RESPECTIVELY. HOW FAR DOWNWARD OR UPWARD DEPENDS UPON TWO THINGS: ONE, HOW MUCH BETTER OR WORSE THAN AVERAGE HIS EXPERIENCE WAS; AND TWO, HOW LARGE THE INSURED IS, THUS, HOW MUCH WEIGHT CAN BE FAIRLY ASSIGNED TO HIS PAST EXPERIENCE WHEN DETERMINING THE PREMIUM HE MUST PAY FOR THE NEXT YEAR.

THE KEY THINGS FOR AN EMPLOYER TO REMEMBER ABOUT EXPERIENCE RATING ARE:

1. THE PROGRAM MUST BE APPLIED IF YOUR ANNUAL PREMIUM IS OVER ELEGIBILITY POINT.
2. IT ADJUSTS THE MANUAL RATES APPLIED TO THE POLICY UP-WARD OR DOWNWARD DEPENDING UPON HOW ACTUAL PAST BENEFIT COSTS HAVE COMPARED TO THE AVERAGE.

AFTER THE EXPERIENCE RATING HAS BEEN COMPLETED, THE NEXT STEP IN DETERMINING THE COST OF THE POLICY IS TO APPLY THE MANDATORY PREMIUM DISCOUNTS. PREMIUM DISCOUNTS ARE NEEDED BECAUSE MANUAL RATES ARE EQUIVALENT TO A MANUFACTURER'S LIST PRICE APPLICABLE TO GOODS BEING SOLD IN SMALL QUANTITIES. JUST AS THE MANUFACTURER REDUCES HIS UNIT PRICE
(24) WHEN LARGER QUANTITIES OF THE PRODUCE ARE PURCHASED, SO TOO DOES THE INSURANCE COMPANY WHEN THE EMPLOYER HAS A LARGE BASE PREMIUM. THE PREMIUM DISCOUNT PROGRAM IS MANDATORY, AND REQUIRES THAT A DISCOUNT MUST BE APPLIED TO ANY ANNUAL PREMIUM IN EXCESS OF $5000. THERE ARE TWO SETS OF PREMIUM DISCOUNT PLANS AN INSURER MAY CHOOSE FROM. HOWEVER, ONCE AN INSURER SELECTS A PLAN IT MUST: 1) APPLY IT TO EVERY EMPLOYER IT INSURERS; AND 2) NOT CHANGE THE PROGRAM IT HAS SELECTED FOR AT LEAST ONE FULL YEAR.

RETROSPECTIVE RATING IS AN OPTIONAL PROGRAM WHICH ONLY APPLIES WHEN THE EMPLOYER SELECTS IT, AND THE INSURER AGREES TO IT. IT IS A PROGRAM WHERE IN ESSENCE THE EMPLOYER
(25) AGREES, PRIOR TO THE START OF THE POLICY, TO PAY FOR HIS OWN BENEFIT COSTS PLUS A BASIC CHARGE WHICH LARGELY IS TO COVER THE COSTS OF THE INSURER PROVIDED SERIVCES. HOWEVER, IT IS A "COST PLUS" WITH LIMITS: THERE IS A MAXIMUM PREMIUM CHARGEABLE REGARDLESS OF HOW HIGH THE BENEFIT COSTS TURN OUT TO BE, AND A MINIMUM PREMIUM CHARGEABLE REGARDLESS OF HOW LOW THE BENEFIT COSTS TURN OUT TO BE. THE SPECIFIC MINIMUM AND MAXIMUM FOR A PARTICULAR EMPLOYER ARE AGREED TO PRIOR TO THE START OF THE POLICY. THE RATING BUREAUS, ON INSTRUCTION FROM THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, CHECK THAT EACH INDIVIDUAL RETROSPECTIVE RATING AGREEMENT IS WITHIN THE ESTABLISHMENT BOUNDS FOR ACTUARIAL FAIRNESS AND PROPRIETY.

THE COMBINATION OF THE MANUAL RATES, EXPERIENCE RATING, AND PREMIUM DISCOUNTS REPRESENTS A GUARANTEED COST TO THE EMPLOYER. IF THE EMPLOYER BELIEVES IT TO BE TO HIS BENEFIT, HE MAY SEEK A RETROSPECTIVE RATING AGREEMENT WHICH CAN ALTER HIS GUARANTEED COST. EACH OF THESE ITEMS IS PART OF THE TOTAL PRICING PROGRAM TO BE DETERMINED BEFORE COVERAGE IS INITIATED. SOME INSURANCE COMPANIES AS A MATTER OF CORPORATE POLICY MAKE REDUCTIONS TO THE NET COST AFTER THE POLICY HAS EXPIRED. THEY DO THIS THROUGH WHAT IS CALLED

DIVIDEND TO POLICYHOLDERS. WHILE A DIVIDEND CAN NOT BE GUARANTEED, EMPLOYERS OFTEN LOOK TO THE PAST DIVIDEND PAYING PRACTICES OF PARTICULAR INSURERS TO DETERMINE WHAT TYPES OF DIVIDENDS MAY BE PAYABLE IN THE FUTURE. EACH COMPANY MAY HAVE ITS OWN FORMULA FOR DETERMINING DIVIDENDS TO BE PAID. SOME FORMULAS DEPEND UPON SAVINGS IN EXPENSE COSTS, SOME ON PREMIUM SIZE, AND SOME ON BENEFIT COSTS INCURRED. SOME DIVIDEND PROGRAMS DEPEND UPON VARIOUS COMBINATIONS OF ITEMS TO BE CONSIDERED.

DIVIDENDS TO POLICYHOLDERS ARE NOT A PART OF THE BUREAU PRICING PROGRAM, BUT CAN BE A REDUCTION IN THE FINAL COST TO EMPLOYERS.

WORKERS' COMPENSATION COMMITTEE

OF ALASKA (WCCA)

P. O. Box 1647
Anchorage, AK 99501

The Honorable Brian D. Rogers
State Representative
Box K
College, AK 99708

Dear Sir:

The Workers' Compensation Committee of Alaska (WCCA) is an organization of concerned Alaskans dedicated to the task of reforming the current Workers' Compensation statute. Our purpose is not to deprive workers of legitimate benefits. We do, however, want to establish a mechanism to handle disputed claims, encourage a program of rehabilitation and, establish an awareness that all Workers Compensation costs are passed on, in one form or another, to the Alaskan consumer.

The Committee is specifically organized as a political action group so that we might contribute to campaigns of individuals sympathetic to our cause. Once the election is over, we intend to initiate lobbying efforts which hopefully will lead to a statute more responsive to the needs of Alaskan businesses and consumers.

While Workers' Compensation is a complex and pervasive topic, the following selected items are of particular concern to the committee, but are not all inclusive of our position:

1. Alaskan employers are paying for excessively high benefit levels. The maximum weekly benefit payment in Alaska is significantly higher than the maximum payments in Washington, Oregon, Montana, and California. The differences range from 2.7 times the maximum benefit of Oregon to 4.3 times the maximum benefits of California.

   WCCA POSITION Workers' Compensation benefits for Alaskan workers should be tied to the average benefits of California, Oregon, and Washington in the same proportion that the average wages of those states relate to the average wage in Alaska.

2. The current method of calculating average weekly earnings discriminates in favor of pipeline era earnings and may in fact contribute to unemployment in Alaska. The current law permits injured workers to base their benefits on the highest wage earned during the preceding three years. Consequently, an employee may be receiving considerably more after an injury than before that injury. The last employer, of course, pays for those higher benefits.

   WCCA POSITION The method of calculating average weekly earnings should be changed to reflect only the position held at the time of the injury. Where appropriate, the calculation should be structured to reflect the seasonality of a position.

3. The existing compensation system offers little incentive for injured employees to return to work. Under the current system, many Alaskan workers can receive more money under Workers' Compensation than they took home when they were working.

   WCCA POSITION The compensation system should be changed so that after a certain time the employee has a financial incentive to return to work. In cases when the injury prohibits the employee from returning to his or her former position, a system of vocational rehabilitation should be undertaken.

4. There is little incentive for injured workers or physicians to contain medical costs or limit use of medical benefits in any way. The current law permits doctor shopping which,

   while not inherently questionable, may result in the practice of searching for a doctor in the hopes of obtaining the best possible diagnosis. At best, the end result is duplicate treatment and, at worst, may lead to potentially fraudulent claims.

   WCCA POSITION For the benefit of both employees and employers, a system must be developed whereby usual and customary medical fees are published. In addition, if the employer or insurance carrier is not satisfied with the progress of a recommended treatment, they should have the right to seek an additional medical opinion from a list of physicians acceptable to all parties.

5. The State's Division of Workers' Compensation does not have enough staff or sufficient funding to administer the compensation program.

   WCCA POSITION The State should attempt to reorganize its entire Workers' Compensation system with the goal of streamlining document flow and minimizing procedural delays, while at the same time providing timely, professional service.

Based on conversations with you or your staff and members of the WCCA Board of Directors, we believe you are sympathetic with our positions relative to changes in the Workers' Compensation statute. The Board has authorized the enclosed contribution to your campaign.

Best wishes in the coming election.

Sincerely,

WORKERS' COMPENSATION COMMITTEE OF ALASKA

Jack Thompson

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF LABOR

OFFICE OF THE COMMISSIONER

BOX 1149 – JUNEAU 99811

October 27, 1980

The Honorable Brian Rogers
P.O. Box "K"
College Branch
Fairbanks, AK 99708

Dear Brian:

You requested that I send you a copy of the reports on our success in the installation of a completely new Unemployment Insurance Benefit Payment System that we put in operation a few hours before the deadline of October 1, 1980.

You will recall efforts had been going on for three years to consolidate our operation under the Department of Administration. With passage of the Employment Security package during the last session, it became apparent that they could not meet the deadlines set in the new law. It was agreed then to allow the Department of Labor to operate our own section for a three year period.

With the greatest cooperation of the feds, who located new equipment and flew it up to us, we were operational by Oct. 1. The costs were undertaken by the feds and my people put in long (unpaid) hours.

It is a real achievement and we understand that our system will be used as a demonstration of what can be done in data processing at the annual National Data Processing Managers convention in December.

I am very proud of my employees. They accomplished a task no one believed possible in a five month period.

We will be happy to demonstrate the system to you when you are back in Juneau.

Sincerely,

Edmund N. Orbeck
Commissioner

Program Resources, Inc.

12000 Old Georgetown Road • Suite N 1009 • Rockville, Maryland 20852 • (301) 770-4414

October 17, 1980

Comm. ✓
Dp. Com. [illegible]
Sp. Ast.
Inf. Ct.
Adm. Ct.

cc [illegible]
cc
cc

Mr. Edward N. Orbeck
Commissioner of Labor
P.O. Box 1149
Juneau, Alaska 99802

Dear Commissioner Orbeck:

As you know, the Alaska Employment Security Division (ESD), the Martin Marietta Corporation, and Program Resources, Inc. jointly have developed and installed a new Unemployment Insurance Benefit Payment System for the State of Alaska. The system development project began in May 1980 and the new system became operational on a statewide basis on October 1, 1980.

The success of the project on October 1 exceeded the expectations of everyone involved. In many respects, the project team achieved what appeared to be impossible given the five-month time period available for system design and installation. Other states have taken from 18 to 24 months to achieve the same objective with system development costs ranging from $2 to $5 million.

In retrospect, our firm attributes the success of the project to the following major factors:

- Intense involvement and support of Department of Labor (DOL) management in all aspects of the project. Specifically DOL management took a singleminded attitude that the October 1 deadline would be met regardless of the inherent problems caused by a five-month schedule. Nonbureacratic and frequently unpopular decisions were made quickly whenever problems were uncovered. In short, the management environment was the best that our firm has ever encountered during a system development project.

- Hiring of an experienced unemployment insurance specialist to serve as Project Coordinator.

- Assignment of a dedicated, experienced team of ESD personnel to work fulltime on the project. The morale and motivation of the ESD staff were unusually high throughout the project.

- Retention of outside computer services quickly when it became apparent that other computer processing alternatives were not feasible.

- Availability of a flexible, responsive UI benefit software package that had been tested in other states.

In summary, the project was the most successful system development effort in our seven-year corporate history. The results of the project were stated succintly by Mr. David Taysom, the Project Coordinator, in his final report to Art Zillig. He stated:

> "In retrospect, this project stands out as a unique example of what can be done when government is staffed by competent management, freed from the shackles of bureaucratic red tape, and allowed to work together with private industry to do a job. They get it done!"

The ESD staff should be commended for an exceptional effort.

Very truly yours,

Richard J. White
President

Program Resources, Inc.

Erica

Patterns in controversies

problem area. Carter claims -

[redacted]

Bob

2nd injury Fund. Subcommittee - insurance

On verge of bankruptcy.

1) Provide $ for vocational retraining

2) Pay carriers $ for excess liability.

$ may be gone by January

Outstanding debt almost $1 million

Dept Revenue loan (some liability to DoL)

- can't make unless specifically provided for

May wish legislation.

PRIVATE REHAB

479 4261 SUNSHINE

456 4584

Joe Thomas

DONNA

Ruth Barnett

Michael Carey

Brian Rogers

John Coghill

(4) No change

(3) State Fund.

(2) Regulate investment income

(1) Open rating (Div would support)

Pooling w/o safety svcs

8% surcharge on assigned risk pool

Self-insurance

Deductibles

In other states - surcharge not prevalent concern aircraft.

Boucher

Erickson

Greene

Parker

Dapcevich

Mendes

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF LABOR

OFFICE OF THE COMMISSIONER

P. O. BOX 1149
JUNEAU, ALASKA 99811

October 23, 1980

Honorable Brian Rogers
P.O. Box "K", College Branch
Fairbanks, Alaska 99708

Dear Brian:

You will recall that in the last session of the legislature, an amendment to the federal unemployment insurance law was adopted in Chapter 145, SLA 1980. This amendment, which became effective July 5, 1980, required Alaska's Unemployment Insurance Program to reduce the amount of weekly U.I. checks by the money received from a pension.

In effect, the person who received a pension and worked on a job, as well as his employer, had to continue to pay into the U.I. fund but the individual could not receive unemployment insurance benefits in excess of his pension.

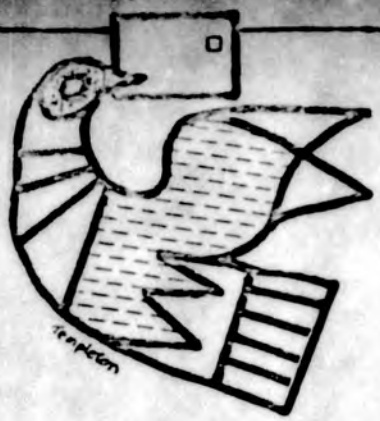
As a result of a great lobby effort by veterans organizations and others, this federal law has recently been changed. In Chapter 9, SLA 1980, a provision was included which automatically repealed the section on pension reduction if the federal law were changed. Effective the week of November 8, 1980 unemployment insurance benefits will no longer be reduced by any amount of pension received by the applicant. See the attached news release the department issued today.

We expect to introduce a bill during the next session of the legislature which will reflect the changes made in Congress and insure conformity for Alaska's Unemployment Insurance Program.

Sincerely,

Edmund N. Orbeck
Commissioner

07-G9LH



NEWS RELEASE

ALASKA DEPARTMENT of LABOR

P.O. Box 1149 Juneau, Alaska 99811 (907)465-2700

FEDERAL SOCIAL SECURITY LAW CHANGES AFFECT ALASKANS

Unemployment Insurance Benefits not reduced by Pensions

Unemployment Insurance Benefits will no longer be reduced by the amount of pensions received effective the week ending November 8, 1980. This will reverse the action taken July 1st of this year when Alaska law was changed to conform with federal law. Anyone who has ceased filing their claims because benefits were reduced should reopen their claims during the week of November 2-8, 1980.

Congress recently amended the social security act which had an affect on Alaska's Unemployment Insurance law. The portion of the Alaska law pertaining to pensions was automatically repealed due to the federal action. The Alaska law tied it to any changes made by the Congress.

The Alaska Employment Security Division will still be gathering pension information from claimants. This information is necessary should a modified pension provision be enacted by the next legislature.

For additional information, contact the Job Service Office servicing the area where you reside.

Date of Release: October 22, 1980

Jay S. Hammond • *Governor*
Edmund N. Orbeck • *Commissioner*
J. Allan MacKinnon • *Information Officer*

INSURANCE ~~Stiles~~ Rogers O'Keefe Swalling Croft Williams

REHABILITATION ~~Rogers~~ Stimson Chapados Rasley O'Keefe Picano

PROCEDURES ~~Stimson~~ Maloney Carlson Croft Swalling Soto ~~Picano~~

BENEFITS Rogers Rasley Carlson Maloney Chapados Williams

7 members 4 committees

3 Labor
3 Management
1 Insurance
2 Legis Interns

	L-M-I	Legis	Div INS	(Div w/Comp)
	LL-M-M	Legis	Div VR	all ins
	LL-M-M	Legis	Div WC	COSHA
	L-M-I	Legis	Div WC	

FOR BRIEF COMMUNICATIONS
MAY BE HANDWRITTEN

Comp

MEMORANDUM

State of Alaska

DEPT.
DIV.
SEC.

TO: Representative Brian Rogers

DATE October 20, 1980

FROM: Senator Terry Stimson

SUBJECT: Draft (Bill)

Terry, has requested that I mail you a copy of the attached Draft Bill "An Act relating to the adoption of regulations by the Alaska Teachers' Retirement Board/"

Please review. Terry also, would like to know if you could introduce it on the House side this coming session?

Should you have any questions please contact me at 272-7555 or 277-8039 - home.

Thank you.

Licia

Rec'd Route 11/13

Call Licia — Ask her what this bill means, ~~what~~ Why it needs to be done

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

* Section 1. AS 14.25.020(a)(1) is repealed and re-enacted to read:

(1) recommend to the Alaska Teachers' Retirement Board regulations to govern the operation of the system;

* Sec. 2. AS 14.25.022 is amended to read:

Sec. 14.25.022. REGULATIONS. Regulations adopted by the Alaska Teachers' Retirement Board [PROMULGATED BY THE ADMINISTRATOR] under AS 14.25.010 - 14.25.220 relate to the internal management of a state agency and their adoption is not subject to the Administrative Procedure Act (AS 44.62).

* Sec. 3. AS 14.25.035 is amended by adding a new subsection to read:

(i) The Alaska Teachers' Retirement Board shall consider and may adopt, amend, or repeal regulations to govern the operation of the system.

Rec'd. 10/13/80

Comm.	
Exp. Com.	
Sp. Ass.	
Int. Of.	
Adm Of.	
cc	
cc	
cc	

ALASKA BENEFITS SYSTEM REDESIGN
PROJECT REPORT

October 10, 1980

Dave Taysom
Consultant

In retrospect, this project stands out as a unique example of what can be done when government is staffed by competent management, freed from the shackles of bureaucratic red tape, and allowed to work together with private industry to do a job. They get it done!

Dave Taysom

BACKGROUND

The 1980 Alaska Legislature enacted major changes to the Alaska Employment Security Act. As soon as the bills were signed into law, the Employment Security Division staff met to evaluate the impact of the law changes and to formulate a plan to meet the legislative mandate.

The most significant and immediate effect was found to be on the Benefits Payment System to be effective October 1, 1980. From a Data Processing standpoint, these changes affected 80 programs, 125 reports, and 160 files and record layouts. Because of the effect on Data Processing programs and the poor quality of existing software with respect to program structure and documentation, the DP personnel consensus of opinion was that a complete rewrite of the UI system, particularly the Benefits Payment portion, was the most efficient use of available resources. They concluded that this approach, with contractual assistance, was the only way the Division could possibly meet the October 1 deadline.

ESD conducted an intensive study of the Benefits System requirements in 1976. That study included visits to several other states and input from claims processing staff who prepared an extensive documentation of system requirements. On the basis of that study and a review of available contractual assistance, it was decided to contract with Program Resources, Inc. to provide the Benefits Payment programs. This system had been successfully implemented in Nebraska and West Virginia. ESD staff concluded it contained most of the requirements for an Alaska system as identified in the 1976 study -- and could accommodate the 1980 law changes.

Because of the enormity and complexity of the project and the need to continue day-to-day operations concurrent with new system efforts, ESD Director A. G. Zillig decided to bring in an outside contractor to coordinate the project. He arranged for the services of Dave Taysom, formerly with the Idaho Department of Employment, as Project Coordinator.

It was also concluded that existing computer facilities would be inadequate to handle the new system. Plans were made to utilize state data processing facilities in the Department of Administration, Division of Data Processing.

PLANNING

The Project Coordinator came on board and began work April 21, 1980. After two days of getting familiar with the Department and basic project requirements, an initial work team was established. This group evaluated conceptual decisions and user requirement definitions. From these early meetings, a general project direction was set and a Design Team was appointed. This team consisted of:

Steven Schlaffman
Virginia Reed
Jane Waid
Randy Guy
Linda Hansen

Jim Coate was assigned to act as backup to the Project Coordinator. The Team

PLANNING (cont'd)

represented broad UI experience including local office claims processing. ESD staff were notified of the project by Harry Sturrock, Assistant Director, UI, on April 30, 1980.

The main Design Team began work on May 3, 1980, by reviewing the provisions of the "West Virginia" system and the detailed requirements of the Alaska Unemployment Insurance Program, including law changes. Priorities were established; and on May 8, a proposal was presented to ESD management for consideration. Management approved the proposal on that date, and the Team began development of a detailed project schedule. This was completed on May 12.

DESIGN

In mid-May, the Team began the systems development work. A detailed flowchart of system procedures was completed by May 23; "West Virginia" option screens were reviewed and general modifications identified by May 19; Alaska data element requirements were completed on schedule; forms design were finished for early purchase requisitions.

Page after page could be written on design effort. Briefly stated, however, all aspects of the project went well and according to plan except in areas dependent upon Data Processing services. That program (covered in a later section) caused most of the design effort to lag from this point on. As a consequence, the project effort failed to meet the training, testing, and documentation goals as thoroughly as we would have liked. Lack of central processing facilities also delayed program development by Program Resources staff. That, in turn, further diluted our testing and training efforts. Delays in installing and fine tuning a field network impaired Team progress. As a result, we went into implementation not as fully trained, with less than adequate testing, and lack of documentation. Individual Team members' effort, management support, and ESD personnel motivation enabled us to succeed in spite of these obstacles.

DATA PROCESSING

Almost from the very beginning, lack of computer services impeded progress for this project. It very nearly caused the effort to fail. Soon after the project began, ESD had to abandon plans to use the Department of Administration's computer facilities for benefit production. It was expected, however, that these services would be available for development, testing, and training, but even this was not provided. It is now apparent that early withdrawal of DDP computer services support was fortunate since there is little doubt that a successful implementation would not have occurred on their equipment.

ETA slowness in responding to the state's acquisition proposals further jeopardized the project. The project did appear to be doomed until, on June 12, 1980, Martin Marietta Data Services performed a successful demonstration of their ability to provide CPU facilities. At that time, we ascertained that they could provide facilities for urgently needed development, testing, and

training. The ultimate decision to use these services and to finally start production on their equipment saved the project from failure. Their prompt assistance in setting up the service, testing the network, and final development of a very satisfactory response time helped make the project succeed.

WAGE RECORDS

The "West Virginia" package did not include wage record programs. Since this subsystem is a requirement for Alaska, a separate contract was negotiated with Program Resources, Inc. to write programs for that subsystem. Final operational coding was completed on September 30, 1980. Minor refinements and some enhancements remain to be accomplished.

EMPLOYER FILES

A new Employer File was required to round out the Benefits System production requirements. Since ESD is in the process of a complete Employer Accounts redesign in association with the Louisiana Redesign Center (an ETA sponsored facility), the Design Team concentrated on early completion of an Employer Accounts File segment. It was made available to the new Benefits System. The file is providing the basic employer data as required.

IMPLEMENTATION

As we neared the October 1 deadline, an implementation date of September 29 was agreed upon. The plan was to "turn off" the old system on September 24, 1980, load the files to a tape, and hand carry that tape to Orlando, Florida (via Ric Dawson) plus ship a separate copy on a later flight. Except for a half-day delay due to fog, this occurred as planned. The actual conversion of files took until late Sunday, and it was not until 5:00 a.m. Monday, September 29, that all systems were set for production. Actual system inquiry and input began at 7:00 a.m. Monday, September 29, with Sitka and Ketchikan. Input the first day was to be a limited controlled volume to allow output review before mailing checks and monetary determinations.

Field operation plans included a Team member or a specially trained person on board in each production office and unit to prepare offices, continue training, clear backlog, etc. Careful screening and rechecking input was necessary because there had been no opportunity for final testing. Except for minor problems, all went well the first day; on September 30, we allowed full production effort in all offices. One hundred and eighteen (118) checks were written the first day; 1,891 the second day. Offices relaxed their review effort, concentrating on production; and on October 2, 1980, Kodiak, Sitka, and Interstate detected new and continued claims supposedly entered into the system were missing. This was first concluded to be "operator error" and heavy screening of input was re-established. More evidence of missing units showed up on October 6, and the problem was found to be a CICS failure. On October 3, 1980, project responsibility was handed over to Jim Coate for continued efforts.

SUMMARY

This project was an almost impossible task from the very beginning. In other states, installation of the new Benefits System has run from two to four years. The five months allowed for this job was very short. Loss of computer services in the first stages further complicated the effort. As a result, we were faced with the following tasks:

1) A new automated Benefits System

2) A new Central Processing Unit

3) A new communications network

4) A new set of claims procedures

5) A new Wage File system

6) A new Employer File

7) Retraining of all claims processing staff

Meeting the deadline (with two days' grace) occurred only because of the unusually high morale and motivation of Alaska Employment Security Division staff (especially the five Design Team members whose attitudes permeated the entire field organization) and the total commitment and support of ESD management. Mr. Zillig, Lee Dalby, and Harry Sturrock gave unhesitating support wherever and whenever needed. The time crunch imposed on this project required management to act swifty and with sound judgement. All three of these men met that challenge extremely well. They received full backing from both the Department of Labor's Commissioner Ed Orbeck and Deputy Commissioner Glenn Lundell.

Program Resources, Inc. President Dick White gave this project his personal attention. He made several trips to Alaska and was available whenever needed. His staff, under guidance from Tom Blair, worked many long, hard hours, day and night, to overcome the delay caused by lack of computer facilities. Providing a CRT to Dick Cotsmire in West Virginia was a major contribution to the success of the project.

RECOMMENDATIONS

1) Retain the Design Team -- not full time, but intact to screen proposed modifications, review problems, recommend solutions, and generally continue the design effort toward a more highly "Alaska" responsive system.

2) Assign a Design Team member as implementation monitor (for nine months to one year) to keep in constant contact with local offices and the Benefits Section, track and analyze problems and errors, make recommendations to the Design Team.

3) Be very cautious in adding to the system as it becomes a temptation to want the computer to do everything. Many functions do not lend

themselves well to automation. It can be done, but this only burdens the system and can eventually bury the basic functions. Any additions should be screened by the Design Team and be forced to prove automation need.

4) Program Resources, Inc. has provided a total system with highly accounting type routines designed to tightly control the payment process. If it is to be a long-term value system, people in the agency must be thoroughly familiar with the programs, they must learn the system before PRI staff leave, and should start now by full-time assignment of one or two people.

5) Develop a good security program as soon as possible. Security involves three major efforts:

   a) Facilities

      - Vandalism
      - Elements

   b) Information

   c) Fund

The latter two go hand-in-hand and are currently most critical. A "paperless" system is a heavy temptation. Much work has been done by other states and ETA. The Fraud & Overpayment Unit of the Employment & Training Administration has considerable fraud prevention information which the Alaska Department should initially review.

1) Complete separation of the Benefit Payment and Wage System Control - Benefit processing staff should not have input capability to the Wage File and vice versa.

2) Tight control over CICS - Bring it up only during specific hours and limit the ability to bring it up to a few DP staff who do not know the Benefits system. Allow no Benefit people to bring up CICS.

3) Better control and degree of confidentiality to CRT "ID" numbers - Stress this need to field users.

4) Maintain (maybe even reduce) the number of weeks paid and the size of checks which can be written in one day.

5) Consider some output report, such as a check register, which would highlight unusual activity.

Attachments: Copies of memos and reports which provide some additional detail of project progress.

DT/jh

Original sponsor: Labor and Management Committee

Offered: 4/28/80
Referred: Finance

IN THE HOUSE

BY THE LABOR AND MANAGEMENT COMMITTEE

CS FOR HOUSE BILL NO. 1011

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the second injury fund established under the Alaska Workers' Compensation Act; and providing for an effective date."

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

* Section 1. AS 23.30.040 is repealed and re-enacted to read:

Sec. 23.30.040. SECOND INJURY FUND. (a) There is created a second injury fund, administered by the commissioner of labor. Money in the second injury fund may only be paid for the benefit of those persons entitled to payment of benefits from the second injury fund under this chapter. Payments from the second injury fund must be made by the commissioner of labor in accordance with the orders and awards of the board.

(b) If an employee suffers a compensable injury after December 31, 1980, which results in temporary total disability, temporary partial disability, permanent partial disability, or permanent total disability, the employer or insurance carrier shall pay into the second injury fund a sum equal to six percent of the compensation to which the employee is entitled for temporary total disability, temporary partial disability, permanent partial disability, permanent total disability, or for rehabilitation under AS 23.30.191.

(c) If an employee suffers a compensable injury which results in death and the employee is not survived by a widow, widower, child, or dependent relative eligible to receive death benefits under AS 23.30.-215, the employer or insurance carrier shall pay $10,000 to the second

injury fund.

(d) The board may refund a payment made into the second injury fund if the employer or insurance carrier shows that it made the payment by mistake or inadvertence, or if it shows there existed at the time of the payment a beneficiary entitled to benefits under AS 23.30.215.

(e) The board may direct and provide the vocational retraining and rehabilitation of a permanently disabled person whose condition is a result of an injury compensable under this chapter by making cooperative arrangements with insurance carriers, private organizations and institutions, or state or federal agencies. The person being retrained or rehabilitated is entitled to receive compensation from the second injury fund for maintenance during the period of retraining and rehabilitation in the sum which the board considers necessary, not to exceed $200 a month. The total expenditures for maintenance, retraining, rehabilitation, and necessary transportation may not exceed $10,000 for one person.

current $100

current $5000

(f) All amounts collected as civil penalties under this chapter must be paid into the second injury fund.

(g) The attorney general may investigate claims and hire expert witnesses necessary to prevent fraudulent or excessive claims for money in the second injury fund and, subject to an appropriation for this purpose, may be reimbursed from the second injury fund for the cost of investigating claims and defending against those claims.

(h) Administration expenses of the state under this section and AS 23.30.205 must be pa' from an appropriation from the secona injury fund.

(i) If there is not enough money in the second injury fund to provide a reasonable reserve for the payment of compensation to persons entitled to payment of benefits from the second injury fund, the commissioner of revenue may loan surplus money in the general fund to the

second injury fund. The loan may be made only from an appropriation for that purpose. The commissioner of revenue and the commissioner of labor shall determine the conditions for repayment of the loan to the general fund.

* Sec. 2. AS 23.30.045(c) is amended to read:

(c) For a person eligible for vocational rehabilitation service under AS 23.15.080 and who is placed with an employer for service [WITHOUT WAGES] at the request of the office of vocational rehabilitation to give him on the job training, work readiness or work therapy experience, or work sampling, the liability set out in (a) of this section applies to the state rather than to the employer.

* Sec. 3. AS 23.30.040(b) enacted in sec. 1 of this Act does not apply to an employer or insurance carrier required to make payments to the second injury fund for an injury to an employee which occurred before January 1, 1981. For those employers or insurance carriers the amount of a payment to the second injury fund and the conditions under which a payment is required must be in accordance with the version of AS 23.30.040(b) in effect on the day that the injury to the employee occurred.

* Sec. 4. This Act takes effect January 1, 1981.