SCOMM

33:13

Worker's Compensation Committee of Alaska (WCCA)
P.O. Box 1647
Anchorage, Alaska 99501

Mr. Brian D. Rogers
Box K
College, Alaska 99708

Dear Representative Rogers:

The Worker's Compensation Committee of Alaska (WCCA) is a political action committee. The committee was formed by a group of Alaskan employers concerned about the economic impact on business of the workers' compensation system in Alaska.

The committee does not want to deprive workers of legitimate benefits. Our objectives are to establish a mechanism for the handling of disputed claims, to encourage a well structured rehabilitation program, and to establish an awareness of the fact the workers' compensation costs are passed on directly to the consumer.

To these ends, we have been actively working with and communicating with employers and employer groups all over the State. We have encouraged these employers and groups to appear at hearings on Workers' Compensation offering input based on a wide range of experiences, and showing the broad base of employer concerns with the problems in the current system.

At this time, we are enclosing an information booklet on the status of the present Workers' Compensation law and our Position Paper outlining our recommendations for legislative and administrative changes in the Workers' Compensation system in the State of Alaska. If you desire any further clarification of our position, WCCA will be happy to provide you with additional information.

Very truly yours,

Richard Cattanach

Board of Directors
Worker's Compensation Committee of Alaska

Howard Addison, Tesoro Alaska Petroleum Co.
Richard Cattanach, Unit Company, Alaska Chapter, AGC
Ann Cox, DHL Worldwide Express
Howard Cutter, Alyeska Pipeline Service Co.
Ken Kleker, J.B. Gottstein and Co.
Bud Obermeyer, INA/Alpac
Don Scott, NANA Regional Corp.
Jan Sloan, Clary Insurance Agency
Tom Tierney, Corroon & Black/ Dawson & Co.
Jack Thompson, Air Van Lines
Ike Waldrop, Alaska Chapter, NECA
David Wilkes, American Federation of Business

Workers' Compensation in the State of Alaska:

An Introduction

December 13, 1980

Prepared by

The Workers' Compensation Committee of Alaska (WCCA)

TABLE OF CONTENTS

INTRODUCTION AND PURPOSE OF REPORT

In 1978, the cost of Workers' Compensation insurance in the State of Alaska had increased a total of 132% over the rates in effect in 1968. This dramatic leap in premiums and fees paid by Alaska Employers (as required by law) for the financial protection of their employees for on-the-job injuries resulted in the formation of the Alaska Conference of Employers. This non-profit corporation is helping to determine strategy to reduce Worker's Compensation costs borne directly by all Alaskan employers.

To determine ways which might be effective in containing or reducing costs, the Alaska Conference of Employers contracted with Richard L. Block and Associates to conduct a study. Its purpose was to identify and evaluate strategies which would result in a long term reduction in payroll related costs for the broadest base of Alaskan employers to a level commensurate with employers in the remaining forty-nine (49) states while concentrating on preserving the legitimate entitlement of injured Alaskan workers.

The Workers' Compensation Committee of Alaska is a political action organization dedicated to the task of reforming the current Workers' Compensation Statutes. The Committee was specifically formed for this purpose as well as to 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. It is our intention that we present an unbiased as well as informative look into the system and the statutes.

WORKERS' COMPENSATION HISTORY

Workers'Compensation is a means for providing financial reimbursement to an injured worker for wages lost and medical bills incurred due to an on-the-job injury. The program was designed to replace employers' liability statutes and common law remedies and to apply the economic and legal principle of liability without fault.

In the late 19th century, the high industrial injury rate coupled with the difficulty of recovery under existing common law brought about limited statutory relief. Employers' liability statutes as adopted removed or weakened the three (following) defenses available to employers;

1. Contributory negligence-an employee could not recover if his own negligence had been even partly responsible for the injury,
2. The "fellow servant" doctrine-there could be no recovery if a fellow worker's negligence was a contributing cause of injury,
3. Assumption of the risk-no award was allowed if the injury resulted from an inherent hazard of that employment of which the worker was, or should have been, aware.

The objectives of the new compensation laws were;

1. To eliminate wasteful litigation and legal fees
2. To provide predetermined, adequate and prompt benefits through the use of fixed scales.
3. To increase the certainty of payment despite the financial condition of the employing business

However, despite the changes made in the law in general which were less than satisfactory, each state labored with its own problems of its' employers.

HISTORY OF WORKERS' COMPENSATION IN ALASKA

1915 - First Workers' Compensation Law passed covering mining industry only
Permissive law-allowing employer and employee to choose or refject coverage

1923 - Broadening of the statute

1947 - National Council on Compensation Insurance supported the insurance industry by making available advisory rates on behalf of almost all carriers for approval or disapproval by the Alaska Commissioner (new Director) of Insurance

1956 - Inauguration of an effective insurance regulatory agency

1915 - 1967 Underwriters at Lloyds (London) are (near) sole underwriters in Alaska

1968 - 1978 Workers' Compensation rates increased 132% between 1968 and 1978

1974 - Impact of the Trans-Alaska Pipeline reflects rapid escalation in rates coupled with more workers making additional claims in the high income brackets

1976 - In May, Senate Bill 146 made the following changes;

1. A worker became entitled to a benefit equal to two-thirds of his wages at the time of the injury and continuing for the period of disability,
2. Permanent total benefits were payable for the life of the injured worker,
3. Death benefits were payable for the life of the surviving spouse with exceptions.
4. Permanent partial scheduled benefit maximums were doubled,
5. The limit of unscheduled permanent partial benefits were removed,
6. The maximum indemnity benefit was fixed at 100% of the State's average weekly wage with the maximum to increase from 1979 and 1980 rate of 166.7% to 200% for 1981.

STATUS OF PRESENT LAW

Workers' Compensation in Alaska consists of several hundred provisions inclusive in Alaska Statute 23.30. Probably the most serious problem existent in these provisions is the ambiguity and lack of clarity to those for whom the law should benefit... the injured worker. Because of the complexity of workers' compensation law, employers and legal personnel administering it have equal difficulty with its meaning.

One of the goals incorporated in this writing (and indeed of the Workers' Compensation Committee of Alaska) is to provide a better understanding for all the above mentioned in the hope that this law itself might become a better tool.

It is, in the opinion of many, a critical time for change in Alaska's Workers' Compensation System. As the reader is aware, every employer (with one or more employees) must have viable workers' compensation insurance coverage. Under the present law/system, even the smallest employer must carry adequate coverage to protect his employees and sometimes the very existence of his business.

We in Alaska are presently expecting and awaiting another surge in our economy with the construction of the Alas-Can Gas Pipeline. So that equity can prevail for both injured workers and their employers, several provisions relating to disability-both temporary and permanent, partial and total, and finally death, need complete revision.

Before we elaborate on our position on possible changes to the current law and administrative handling of the system, we should compare Alaska Workers' Compensation Law with that of other states;

1. Alaska premiums are the highest of any of the remaining forty-nine (49) states.

2. Alaska benefit levels are also the highest of any state's, even adjusting for the higher cost of living.

3. Alaska has a higher ratio of hazardous occupations covered under Workers' Compensation.

PROPOSED COURSE OF ACTION

It is the intent that each member of WCCA be individually informed to aid others in the community and State-wide as well, to understand needed and recommended reform in the current Alaska Statues. We shall attempt to explain guidelines included in those recommendations listed as well as the general reasons for their inclusion or omission.

As time permits, we as interested, concerned citizens will actively participate and lobby toward those ends to improve the quality of the law for other Alaskans who will become victims of misfortune and for those who must pay to insure the benefits paid those injured.

WCCA will participate in community involvement programs and hopes to be asked to interface with interested personnel from all businesses.

In order to amend, change or add to any of the recommended Alaska Statutes, we shall need a more informed public and a more informed legislative body. To change the administrative systems and other areas of Workers' Compensation will require the dedication of many. It is our hope that many persons from all kinds of Alaska businesses will become involved as they see a need for change.

It is of course understandable that many of those with whom we as members of WCCA come into contact, will not agree with our position. Some, but perhaps not many, will feel that the law as it stands is adequate. We recognize the very fact that perhaps those not in total agreement shall have to have become

more informed to have arrived at that position. This document has been prepared as an overview of a very complex and critical portion of Alaska Law and Procedure, and those for whom the law is to protect have been carefully considered so as to be protected fully. The injured worker is everyone's concern, directly or indirectly. But fairness and equity must exist.

The effect on all business owners, particularly small business owners, should be one for the good. Present high costs to them can be reduced with careful planning. It is necessary to consider the effect of the law as applied to those whose margin of profit is dwindling as costs to operate soar.

IN CONCLUSION

Workers' Compensation costs in Alaska continue to spiral upward at a rate far in excess of other health related programs. This has a direct effect on the prices consumers pay for products and services.

It is the WCCA position that the costs of the Workers' Compensation Program can be contained by legislation encompassing the proposed changes. WCCA feels the injured worker will still derive full benefits under the law if the proposed changes are made to the Workers' Compensation Program of the State of Alaska. We solicit your support on the proposed changes.

Workers Comp°

WCCA → lower benefits for persons earning over $600/wk pre-injury (by up to 30%)
→ limit to 36 mos. permanent partial injury benefits
→ average weekly wage calculation to preceding 52-weeks
→ cease unemployment benefits to WC claimants
→ limit employee selection of doctors
→ reduce WC benefits by amt pd in retirement benefits
→ repeal 23.30.180 automatic presumption total disability
→ encourage utilization of pain clinics
→ segregate premiums + losses for extraordinary construction

→ dir WC publish "average or customary" fees for physicians
→ compromise + release on medical w/ Bd approved
$ → hire additional hearing officers
$ → workers benefit brochure
$ → employers w comp brochure
→ monitor + regulate self-insured organization
→ allow cash flow program / premiums receivable
→ allow health care insurers/health & disability/ to write combined comp
→ accumulate accident year data
→ lower assigned risk pool expense loading

→ use general fund to subsidize 2nd injury fund
→ pay 2nd injury medical from 2nd injury fund
→ allow use of 2nd injury funds whenever knowledge that it is 2nd injury.
→ allow lump-sum 2nd injury payments

STATE OF ALASKA

DEPARTMENT OF REVENUE
TREASURY DIVISION
Pouch SB
Juneau, Alaska 99811
(907) 465-2351

GENERAL AND SEGREGATED STATE PROGRAM FUNDS

MONTHLY INVESTMENT REPORT

NOVEMBER 30, 1980

CONTENTS

STATE OF ALASKA

DEPARTMENT OF REVENUE

TREASURY DIVISION

BILL S. HAMMOND, GOVERNOR

ELEVENTH FLOOR
STATE OFFICE BUILDING
POUCH SB
JUNEAU, ALASKA 99811
PHONE:

To the Reader:

We present herein the investment report of the General and Segregated State Program Funds for November 30, 1980, with year-to-date figures for the Fiscal Year 1981. Accounting procedures used in preparation include:

1. All transactions are recorded on the cash basis, i.e., when cash is received or disbursed.

2. Accrued interest purchased with marketable securities is recorded as an asset that is subsequently charged to income on the first coupon date. Accrued interest purchased with other holdings has not been material and is charged against income at the time of acquisition.

3. Other holdings will be held until repayment at or prior to maturity.

4. The cost of investments represents the amount paid for securities and other holdings.

5. Safekeeping charges are billed to the State and not deducted from operating income. Transaction charges are deducted from operating income at the time securities mature or are sold.

Amounts identified as net contributions from or to the Retirement Funds represent the excess of Retirement Fund payments over contributions or contributions over payments, respectively, during the month as adjusted for investment activity in loans and mortgages. Cash revenues of the State and warrants redeemed are indicated by State contributions from taxes and other receipts and State expenditures, respectively.

For purposes of source and use of funds analysis, we have defined the term "funds" to include demand deposits, clearing cash, savings deposits, purchased interest receivable and repurchase agreements. Funds provided by the loan and mortgage programs, separately invested funds and Alaska deposits are assumed to increase the operating account prior to investment unless specifically identified otherwise. Funds used for loan and mortgage programs, separately invested funds and Alaska deposits are assumed to be withdrawn from the operating account unless specifically identified otherwise.

Sincerely,

Anselm C. Staack

Anselm C. Staack
Treasury Comptroller

04-D12LH

STATE OF ALASKA

GENERAL AND SEGREGATED STATE PROGRAM FUNDS

INVESTMENT ACTIVITY

NOVEMBER 30, 1980

At the end of November 30, 1980, the General and Segregated State Program Funds totaled $1,645,404,699.82, down from $1,683,089,615.28 at the close of the previous month. The operating and marketable securities accounts were increased by $19,025,067.04 during November. In this period $135,760,812.31 was received from taxes and other State revenues, while $180,630,339.09 was used for the payment of State expenditures. Cash and repurchase agreements, including purchased interest receivable, were increased by $1,897,731.52.

Holdings of short term issues (securities of less than one year maturity) increased by $12,271,057.21 during November, while holding of intermediate/long term issues (securities of one year or more maturities) remained the same after netting purchases, sales and maturities. Activity included the marketable securities account and separately invested funds.

During November, $6,334,829.77 was deposited with Alaska financial institutions in thirty (30) day to two hundred ten (210) day certificates of deposit which yield 15.25% to 16.00%. The commitment to loan and mortgage programs amounted to $420,374,529.74 at month end, of which State loan programs accounted for $307,365,691.84. The commitment to loan and mortgage programs decreased $57,377,877.59 during November.

STATE OF ALASKA

GENERAL AND SEGREGATED STATE PROGRAM FUNDS

STATEMENT OF PORTFOLIO ASSETS

NOVEMBER 30, 1980

	Current Month	
	%	Cost
Cash	1 %	$ 23,170,350.52
Purchased Interest Receivable		223,600.46
Marketable Securities, at Cost:		
Repurchase Agreements	4	59,700,000.00
Short Term Issues	45	741,683,848.66
Intermediate and Long Term Issues	14	229,248,540.67
Total Marketable Securities	63	1,030,632,389.33
Other Holdings, at Cost:		
Commercial Fishing & Agriculture Bank	2	32,000,000.00
Certificates of Deposit	6	93,824,829.77
Debt Certificates	3	45,179,000.00
Bank Loans and Mortgages	3	50,988,890.11
Rural Mortgage Program Bonds		5,600,000.00
Obligations of State Corporations	3	47,506,947.79
State of Alaska Loan Programs	19	307,365,691.84
Loans to Alaska Municipalities		8,913,000.00
Total Other Holdings	36	591,378,359.51
Total Assets	100%	$ 1,645,404,699.82

STATEMENT OF OPERATIONS/CHANGE IN TOTAL ASSETS

	Current Month	Year-to-Date
Portfolio Operations:		
Interest Income	$ 12,462,071.09	$ 71,993,283.71
Net Gain (Loss) on Sale/Maturity of Securities	(25.00)	959,080.12
Total Operating Income	12,462,046.09	72,952,363.83
Beginning of Month Cash and Invested Funds	1,683,089,615.28	2,148,250,283.36
State Contributions from Taxes and Other Receipts	135,760,812.31	700,871,481.27
Net Contribution from Retirement Funds	-0-	-0-
Net Contribution from Permanent Fund	-0-	9,234,109.73
State Expenditures	(180,630,339.09)	(1,251,186,011.46)
Net Contribution to Retirement Funds	(5,277,434.77)	(34,717,526.91)
End of Month Cash and Invested Funds	$ 1,645,404,699.82	$1,645,404,699.82

STATE OF ALASKA

GENERAL AND SEGREGATED STATE PROGRAM FUNDS

STATEMENT OF CHANGES IN PORTFOLIO CONDITION

NOVEMBER 30, 1980

	Current Month	Year-to-Date
During the Month Funds were Provided by:		
Portfolio Operations:		
Interest Income	$ 12,462,071.09	$ 71,993,283.71
Net Gain (Loss) on Sale/Maturity of Securities	(25.00)	959,080.12
Total Provided by Operations	12,462,046.09	72,952,363.83
Sale/Maturity of Marketable Securities:		
Short Term Issues	265,754,842.72	1,345,456,045.99
Intermediate/Long Term Issues	-0-	2,892,575.00
Total Provided by Sales/Maturities	265,754,842.72	1,348,348,620.99
Collections of Loans and Mortgages:		
State Loan Programs	4,091,842.86	147,611,782.36
Other Loans and Mortgages	648,550.25	206,017,232.21
Total Provided by Collections	4,740,393.11	353,629,014.57
Redemption of Deposit/Savings Certificates	10,810,656.37	67,810,656.37
Taxes and Other State Receipts	135,760,812.31	700,871,481.27
Permanent Fund Income	-0-	9,234,109.73
TOTAL Funds Provided During the Month	429,528,750.60	2,552,846,246.76
During the Month Funds were Used for:		
Purchase of Marketable Securities:		
Short term Issues	283,025,899.93	1,068,243,452.89
Intermediate/Long Term Issues	-0-	34,186,182.50
Total Marketable Securities Purchased	283,025,899.93	1,102,429,635.39
Purchase of Loans and Mortgages:		
State Loan Programs	(49,754,859.51)	(47,802,252.78)
Other Loans & Mortgages	2,117,375.03	58,372,978.84
Total Loans & Mortgages Purchased	(47,637,484.48)	10,570,726.06
Purchase of Deposit/Savings Certificates	6,334,829.77	63,545,486.14
Purchase of Debt Certificates	-0-	-0-
Purchase of Stock - CFAB	-0-	30,000,000.00
State Operating Expenditures	180,630,339.09	1,251,186,011.46
Net Contribution to Retirement Funds	5,277,434.77	34,717,526.91
TOTAL Funds Used During the Month	427,631,019.08	2,492,449,385.96
NET CHANGE IN FUNDS	$ 1,897,731.52	$ 60,396,860.80
Summary of Changes:		
Increase (Decrease) in Clearing Accounts	$ (78,346.22)	$ (3,056,950.09)
Increase (Decrease) in Demand Deposits	25.00	25.00
Increase (Decrease) in Savings Deposits	19,874,185.19	19,792,896.75
Increase (Decrease) in Compensating Balances	500,000.00	-0-
Increase (Decrease) in Repurchase Agreements	(18,400,000.00)	44,800,000.00
Increase (Decrease) in Purchased Interest Receivable	1,867.55	(1,139,110.86)
NET CHANGE IN FUNDS	$ 1,897,731.52	$ 60,396,860.80

STATE OF ALASKA

GENERAL AND SEGREGATED STATE PROGRAM FUNDS

COMPOSITION OF INVESTMENT HOLDINGS

NOVEMBER 30, 1980

Asset Type	Current Month % of Total Cost Value	Cost	Yield
OPERATING ACCOUNT			
Clearing Accounts	38.8 %	$ 1,244,494.29	N/A
Compensating Balances	61.2	1,965,000.00	N/A
TOTAL	100.0%	3,209,494.29	
MARKETABLE SECURITIES ACCOUNT			
Cash Deposits			
Savings	2.0 %	$ 19,960,748.61	5.13
Purchased Interest Receivable		217,896.90	N/A
Repurchase Agreements	5.9	59,700,000.00	15.90
Short Term Issues			
Commercial Paper	4.2	42,831,690.00	16.49
U. S. Treasury Bills	6.9	69,821,906.66	12.19
Bankers Acceptances	21.4	216,611,331.40	12.32
Certificates of Deposit	32.7	330,799,792.12	12.05
U. S. Treasury Notes & Bonds	4.9	49,124,232.25	6.71
Federal Agency Securities	2.0	20,000,015.00	8.95
Corporate Bonds		725,015.00	7.08
Total Short Term Issues	72.1	729,913,982.43	11.96
Intermediate/Long Term Issues			
U. S. Treasury Notes & Bonds:			
1 - 2 Years	17.8	179,693,148.75	10.41
Federal Agency Securities:			
1 - 2 Years	1.0	10,000,085.00	6.65
Over 5 Years	.8	8,077,500.00	7.16
Sub-Total	1.8	18,077,585.00	6.88
Corporate Bonds:			
Over 5 Years	.4	4,060,105.00	10.29
Total Intermediate/ Long Term	20.0	201,830,838.75	10.10
TOTAL	100.0%	$ 1,011,623,466.69	11.69
LOAN AND MORTGAGE PROGRAMS			
State of Alaska Loan Programs			
Business Loans	.6	$ 2,438,000.00	N/A
Agriculture	.3	1,339,410.54	5.44
Commercial Fishing	17.0	71,578,006.24	7.59
Fisheries Enhancement	1.6	6,886,338.00	7.96
Small Business	22.4	94,101,648.66	8.22
Tourism	1.6	6,883,914.98	8.05
Veterans	29.5	123,902,908.43	6.96
Childcare Facilities		65,550.63	6.03
Historical District	.1	169,914.36	6.56
Total Loans	73.1 %	$ 307,365,691.84	7.48

Schedule continued on following page

COMPOSITION OF INVESTMENT HOLDINGS - Continued

Asset Type	Current Month: % of Total Cost Value	Current Month: Cost	Current Month: Yield
LOAN AND MORTGAGE PROGRAMS - Continued			
Bank Loan Incentive Program	.8 %	$ 3,387,856.72	8.64
Mortgage Option Program			
Mortgages	4.3	17,884,305.53	9.16
Business Loans	3.3	13,901,827.85	9.25
Mobile Home Loans	1.3	5,548,355.03	9.50
Total Mortgage Op. Programs	8.9	37,334,488.41	9.25
Obligations of State Corporations			
ASHA Mortgages	.3	1,230,186.08	7.50
AHFC Notes	5.8	24,412,385.58	6.87
ARRC Mortgages		110,530.52	10.00
ASHA Notes	3.6	15,257,845.61	7.00
ASDC Bonds	.2	550,000.00	4.75
MICA Notes	.7	3,000,000.00	7.00
U of A Notes	.7	2,946,000.00	5.00
Total Obligations	11.3	47,506,947.79	6.81
Obligations Pledged to AHFC			
FHA/VA Mortgages	2.5	10,266,544.98	7.09
Rural Mortgage Program Bonds	1.3	5,600,000.00	7.50
Total Pledged	3.8	15,866,544.98	7.24
Loans to Alaska Municipalities	2.1	8,913,000.00	6.00
TOTAL	100.0%	$ 420,374,529.74	7.54
SEPARATELY INVESTED FUNDS			
AHFC Mortgage Insurance Fund			
Savings Deposits	%	$ 82.62	N/A
Demand Deposits		25.00	N/A
Purchased Interest Receivable		5,703.56	N/A
Repurchase Agreements		-0-	
Banker's Acceptances		-0-	
Federal Agency Securities	17.6	6,898,265.64	9.08
U. S. Treasury Bills	8.1	3,169,966.23	11.22
U. S. Treasury Money Market	.5	199,900.00	N/A
U. S. Treasury Notes	13.5	5,275,687.50	9.73
Total	39.7	15,549,630.55	9.62
Public School Permanent Fund			
Certificates of Deposit	16.1	6,300,000.00	10.50
U. S. Treasury Notes & Bonds	10.3	4,045,391.41	9.57
Federal Agency Securities	20.4	8,014,118.75	8.04
Total	46.8	18,359,510.16	9.22
U of A Permanent Fund			
Certificates of Deposit	5.4	2,100,000.00	14.80
U. S. Treasury Notes & Bonds	2.6	1,006,863.62	8.49
Federal Agency Securities	5.5	2,177,375.00	7.69
Total	13.5	5,284,238.62	10.67
TOTAL	100.0%	$ 39,193,379.33	9.57
DEBT CERTIFICATES	100.0%	$ 45,179,000.00	8.66
CERTIFICATES OF DEPOSITS	100.0%	$ 93,824,829.77	8.94
COMMERCIAL FISHING & AGRICULTURE BANK	100.0%	$ 32,000,000.00	N/A
SUMMARY OF COMPOSITION			
Operating Account	.2 %	$ 3,209,494.29	N/A
Marketable Securities Account	61.5	1,011,623,466.69	11.69
Loan and Mortgage Programs	25.5	420,374,529.74	7.54
Separately Invested Funds	2.4	39,193,379.33	9.35
Certificates of Deposits	5.7	93,824,829.77	8.94
Debt Certificates	2.7	45,179,000.00	8.66
Commercial Fishing & Agriculture Bank	2.0	32,000,000.00	N/A
TOTAL INVESTMENT HOLDINGS	100.0%	$ 1,645,404,699.82	10.09

STATE OF ALASKA

GENERAL AND SEGREGATED STATE PROGRAM FUNDS

SUMMARY OF ALASKA DEPOSITS

NOVEMBER 30, 1980

Institution	Total	General Fund	Bond Construction	International Airport
Commercial Banks				
Alaska Bank of Commerce	$ 3,470,000	$ 3,470,000	$ -0-	$ -0-
Alaska National Bank	5,465,000	2,965,000	2,500,000	-0-
Alaska Pacific Bank	500,000	500,000	-0-	-0-
Alaska Statebank	3,650,000	3,650,000	-0-	-0-
B. M. Behrends Bank	2,500,000	2,500,000	-0-	-0-
First National Bank - Anchorage	6,980,000	6,980,000	-0-	-0-
First National Bank - Fairbanks	1,000,000	1,000,000	-0-	-0-
First National Bank - Ketchikan	695,000	695,000	-0-	-0-
National Bank of Alaska	8,350,000	8,350,000	-0-	-0-
Peoples Bank & Trust	200,000	200,000	-0-	-0-
Security National Bank	1,000,000	1,000,000	-0-	-0-
United Bank Alaska	6,950,000	3,950,000	3,000,000	-0-
Total	41,760,000	36,260,000	5,500,000	-0-
Mutual Savings Banks				
Alaska Mutual Savings Bank	18,680,000	2,680,000	13,500,000	2,500,000
Mt. McKinley Mutual Savings Bank	-0-	-0-	-0-	-0-
Total	18,680,000	2,680,000	13,500,000	2,500,000
Savings & Loan Institutions				
Fred Meyer S & L - Anchorage	100,000	100,000	-0-	-0-
Peninsula S & L - Soldotna	100,000	100,000	-0-	-0-
Alaska Federal S & L	-0-	-0-	-0-	-0-
Arctic First Federal S & L	1,000,000	1,000,000	-0-	-0-
First Federal S & L	5,000,000	-0-	2,000,000	3,000,000
Home Federal S & L	600,000	350,000	-0-	250,000
Total	6,800,000	1,550,000	2,000,000	3,250,000
TOTAL ALASKA DEPOSITS	$67,240,000	$40,490,000	$21,000,000	$ 5,750,000
Trust Deposit	$ 1,334,830	$ -0-	$ -0-	$ -0-
Other Deposits	$25,250,000	$ -0-	$ -0-	$25,250,000
Total Certificates of Deposit	$93,824,830	$40,490,000	$21,000,000	$31,000,000

SUMMARY OF OPERATING ACCOUNT

Institution	Location	Clearing Accounts	Compensating Balances
Alaska National Bank	Fairbanks	$1,244,494.29	$1,500,000.00
Alaska Pacific Bank	Anchorage	-0-	60,000.00
American Security & Trust Co.	Washington, D. C.	-0-	25,000.00
B. M. Behrends Bank	Juneau	-0-	350,000.00
Pacific National Bank	Seattle	-0-	30,000.00
TOTAL		$1,244,494.29	$1,965,000.00

STATE OF ALASKA

GENERAL AND SEGREGATED STATE PROGRAM FUNDS

DEBT CERTIFICATES - CREDIT UNIONS

NOVEMBER 30, 1980

Description	Balance	Yield
Alaska Coast Guard Credit Union	$ 860,000.00	
Alaska District Engineers FCU	960,000.00	
Alaska Feminist FCU	124,000.00	
A. L. P. FCU	975,000.00	
Alaska Municipal Employees FCU	1,840,000.00	
Alaska Railroad FCU	1,290,000.00	
Alaska School Employees FCU	3,530,000.00	
Alaska State Employees FCU	975,000.00	
Alaska Teamsters FCU	2,090,000.00	
Alaska U. S. A. FCU	19,000,000.00	
Bering Straits FCU	45,000.0	
Eielson Employees FCU	1,515,000.00	
Fed Alaska FCU	3,600,000.00	
Fort Wainwright FCU	1,165,000.00	
KPC Employees FCU	681,000.00	
Matanuska Valley FCU	1,230,000.00	
North Country FCU	313,000.00	
Northern School FCU	930,000.00	
R. A. A. FCU	694,000.00	
Skagway FCU	44,000.00	
Starliner FCU	293,000.00	
Tlingit & Haida FCU	478,000.00	
Tongas FCU	671,000.00	
Union Collier FCU	406,000.00	
Western Alaska Trades FCU	770,000.00	
Wein Employees FCU	700,000.00	
TOTAL	$ 45,179,000.00	8.66

CHANGE IN PORTFOLIO COMPOSITION

OPERATING ACCOUNT	Current Month	Year-to-Date
Net Contribution (to) From:		
Taxes and Other Receipts	$ (7,582,930.53)	$(149,304,872.35)
Loan and Mortgage Programs	60,414,726.74	357,179,300.19
Separately Invested Funds	130,593.75	(5,700,789.49)
Certificates of Deposit/Debt	767,037.68	4,472,949.93
State Operating Expenditures	(48,030,339.09)	(144,986,011.46)
Retirement Funds	(5,277,434.77)	(34,717,526.91)
Commercial Fishing & Agriculture Bank	-0-	(30,000,000.00)
NET CHANGE IN FUNDS	$ 421,653.78	$ (3,056,950.09)

CHANGE IN PORTFOLIO COMPOSITION - Continued

	Current Month	Year-to-Date
MARKETABLE SECURITIES ACCOUNT		
During the Month Funds were Provided by;		
Portfolio Operations:		
Interest Income	$ 7,859,695.42	$ 55,822,998.89
Net Gain (Loss) on Sale/Maturity of Securities	(25.00)	959,080.12
Total Provided by Operations	7,859,670.42	56,782,079.01
Sale of Marketable Securities	4,770,034.72	76,269,732.09
Maturity of Marketable Securities	260,984,808.00	1,266,833,140.29
Taxes and Other Receipts	143,343,742.84	850,176,353.62
Other Interest Earnings	-0-	304,192.05
Permanent Fund Income	-0-	9,234,109.73
TOTAL Funds Provided During the Month	416,958,255.98	2,259,599,606.79
During the Month Funds were Used for:		
Purchase of Marketable Securities	282,876,099.93	1,089,919,903.53
State Operating Expenditures	132,600,000.00	1,106,200,000.00
TOTAL Funds Used During the Month	415,476,099.93	2,196,119,903.53
NET CHANGE IN FUNDS	$ 1,482,156.05	$ 63,479,703.26
LOAN AND MORTGAGE PROGRAMS		
During the Month Funds were Provided by:		
Interest Income	$ 3,036,849.15	$ 9,121,011.68
Principal Repayments	4,740,393.11	353,629,014.57
Redemption of Certificates of Deposit	5,000,000.00	5,000,000.00
Net Contribution from Operating Account	-0-	935,277.85
TOTAL Funds Provided During the Month	12,777,242.26	368,685,304.10
During the Month Funds were Used for:		
Purchase of:		
Loans and Mortgages	(47,637,484.48)	10,570,726.06
Certificates of Deposit	-0-	-0-
Total Purchases	(47,637,484.48)	10,570,726.06
Net Contribution to Operating Account	60,414,726.74	358,114,578.04
TOTAL Funds Used During the Month	12,777,242.26	368,685,304.10
NET CHANGE IN FUNDS	-0-	-0-

CHANGE IN PORTFOLIO COMPOSITION - Continued

	Current Month	Year-to-Date
SEPARATELY INVESTED FUNDS		
During the Month Funds were Provided by:		
Portfolio Operations:		
Interest Income	274,315.44	1,537,301.39
Net Gain (Loss) on Sale of Securities	-0-	-0-
Total Provided by Operations	274,315.44	1,537,301.39
Sale/Maturity of Marketable Securities	-0-	5,245,748.61
Net Contribution from Operating Account	-0-	5,831,383.24
TOTAL Funds Provided During the Month	274,315.44	12,614,433.24
During the Month Funds were Used for:		
Purchase of Marketable Securities	149,800.00	12,509,731.86
Net Contribution to Operating Account	130,593.75	130,593.75
TOTAL Funds Used During the Month	280,393.75	12,640,325.61
NET CHANGE IN FUNDS	$ (6,078.31)	$ (25,892.37)
CERTIFICATES OF DEPOSIT/DEBT CERTIFICATES		
During the Month Funds were Provided by:		
Interest Income	$ 1,291,211.08	$ 5,207,779.70
Redemption of Deposit/Savings Certificates	5,810,656.37	62,810,656.37
Net Contribution from Operating Account	-0-	161,582.79
TOTAL Funds Provided During the Month	7,101,867.45	68,180,018.86
During the Month Funds were Used for:		
Purchase of Deposit/Savings Certificates	6,334,829.77	63,545,486.14
Purchase of Debt Certificates	-0-	-0-
Net Contribution to Operating Account	767,037.68	4,634,532.72
TOTAL Funds Used During the Month	7,101,867.45	68,180,018.86
NET CHANGE IN FUNDS	$ -0-	$ -0-
COMMERCIAL FISHING & AGRICULTURE BANK		
Purchase	$ -0-	$30,000,000.00
SUMMARY OF CHANGES		
Operating Account	$ 421,653.78	$(3,056,950.09)
Marketable Securities Account	1,482,156.05	63,479,703.26
Loan and Mortgage Programs	-0-	-0-
Separately Invested Funds	(6,078.31)	(25,892.37)
Certificates of Deposit/Debt	-0-	-0-
NET CHANGE IN FUNDS	$ 1,897,731.52	$60,396,860.80

WORKERS COMPENSATION COMMITTEE OF ALASKA

Workers' Compensation Committee of Alaska (WCCA) is a political action committee. The committee was formed by a group of Alaskan employers concerned about the economic impact on businesses of the workers' compensation system. A partial listing of those employers and other interested groups considered as members is attached. The list represents those who have demonstrated their interest through various means, either active participation, financial contributions, political or technical support, and supportive endoresement.

BOARD OF DIRECTORS

The following is a current list of the Board of Directors for WCCA.

Howard Addison - Tesoro Alaska Petroleum Company
Richard Cattanach - Unit Company - Associated General Contractors, Alaska Chapter
Ann Cox - DHL Worldwide Express
Howard Cutter - Alyeska Pipeline Service Co.
Ken Kleker - J.B. Gottstein and Companies
Bud Obermeyer - ALPAC - INA
Don Scott - Nana Regional Corporation
Jan Sloan - Clarey Agency
Tom Tierney - Carroon, Black & Dawson
Jack Thompson - Air Van Lines
Ike Waldrop - National Electrical Contractors Assoc., Alaska Chapter
David Wilkes - American Federation of Business

Corporate Objectives

The Board of Directors adopted the corporate charge; (1) to objectively evaluate the findings and recommendations, concerning changes in the workers' compensation law, from various published reports, and study groups; (2) to evaluate employer reported problems and their recommended solutions; (3) to formulate these recommendations into proposed legislative changes of the current workers' compensation statutes.

Structure

To accomplish the objectives the Board was strutured into subcommittees each with specific funtions.

Executive Committee

Members

Howard Addison
Richard Cattanach
Ken Kleker
Bud Obermeyer
Jan Sloan
Jack Thompson

Functions

- Corporate policy decisions.
- Corporate structure changes.
- Board membership
- Strategic planning
- Direct and control the operating committees
- Authorize actions by any committee which will obligate the corporation.

Financial Resource Subcommittee

Members

Howard Addison
Jan Sloan
Tom Tierney
David Wilkes

Functions

- Plan the financial budget
- Plan the financial contribution effort
- Control financial obligations and disbursements
- Submit regular financial reports to the Executive Committee.

Education and Information Subcommittee

Members

Bud Obermeyer
Jan Sloan
Howard Cutter
Jack Thompson
Ann Cox

Functions

- Monitor the direction of legislative study commission on workers' compensation.
- Evaluate recommendations from all input sources.
- Establish a position for WCCA on recommendations.
- Direct educational information effort through Alaska Conference of Employers
- Publish WCCA positional and informational literature.
- Submit regular status reports to the executive committee.

Legislative Affairs Subcommittee

Members

Richard Cattanach
Bud Obermeyer
Ike Waldrop
Howard Cutter
Ann Cox

Functions

- Plan lobbying strategy
- Monitor all legislative action directed at workers' compensation.
- Direct all phases of the lobbying effort.
- Prepare a legislative bill to submit early in the 1981 session.
- Coordinate efforts with each resource committees.
- Delegate bill preparation and lobbying effort to a registered agent and monitor.
- Submit periodic status reports to the executive committee.

Political Resource Subcommittee

Members

Richard Cattanach
Ken Kleker
Don Scott
Jack Thompson
Ike Waldrop
David Wilkes

Functions

- Direct pre-election campaign contributions
- Direct post-election campaign contributions
- Meet with legislators as deemed necessary
- Coordinate constituent support on critical points
- Coordinate with Resource and Affairs Committees
- Submit periodic reports to the Executive Committee

The person whose name appears first on each sub-committee list will act as sub-committee chairman. The chairman has the responsibility of planning and directing the functions of his sub-committee.

Strategy

WCCA will to the best of its ability utilize the committed resources of employer groups and members to direct a concentrated effort in the interest of those employer groups and members. This will be accomplished through the co-ordinated direction of the sub-committees.

FINANCIAL REQUIREMENTS

Estimated

Educational Information	$ 15,000
Political Contributions	17,000
Lobbying Effort	43,000
Miscellaneous	10,000
TOTAL	$ 85,000

To Date

Contributions	$ 37,000
Committed (Additional)	18,000
Required	30,000
	$ 85,000

WCCA
CONTRIBUTOR MEMBER LIST
DECEMBER 10, 1980

CLARY INSURANCE AGENCY
J. B. GOTTSTEIN & CO.
INDUSTRIAL INDEMNITY
NABORS ALASKA DRILLING
AIR VAN LINES
NORTHERN ADJUSTERS
SOHIO PETROLEUM
RELIABLE TRANSFER
FRONTIER EQUIPMENT
ARCO
ALYESKA PIPELINE SERVICE CO.
SOURDOUGH TRANSPORT
WORLDWIDE MOVERS
WIEN AIR ALASKA
AAA DELIVERY
DENALI TRANSPORTATION
ALEXANDER & ALEXANDER
SCOTT WETZEL SERVICES
EVERGREEN HELICOPTER
AVIS RENT-A-CAR
ALASKA INTERNATIONAL INDUSTRIES
ALASKA TRUCKERS ASSOC. TRUST
ALASKA CHAPTER, AGC
CHEVRON, USA
FRONTIER CO. OF ALASKA
INSURANCE COMPANY OF NORTH AMERICA
LYNDEN TRANSPORT, INC.
ROLLINS BURDICK HUNTER
TESORO ALASKA PETROLEUM

STATE OF ALASKA

DEPARTMENT OF REVENUE
TREASURY DIVISION
Pouch SB
Juneau, Alaska 99811
(907) 465-2350

TEACHERS' RETIREMENT SYSTEM

MONTHLY INVESTMENT REPORT

NOVEMBER 30, 1980

CONTENTS

STATE OF ALASKA

DEPARTMENT OF REVENUE

TREASURY DIVISION

WM S. HAMMOND, GOVERNOR

ELEVENTH FLOOR
STATE OFFICE BUILDING
POUCH SB
JUNEAU, ALASKA 99811
PHONE:

To the Reader:

We present herein the investment report of the Teachers' Retirement System for November 30, 1980, with year-to-date figures for the Fiscal Year 1981. Accounting procedures used in preparation include:

1. All transactions are recorded on the cash basis, i.e., when cash is received or disbursed.

2. Accrued interest purchased is charged against income at the time of acquisition.

3. Other holdings will be held until repayment at or prior to maturity.

4. The cost of investments represents the amount paid for securities and other holdings.

5. Safekeeping and transaction charges are billed to the Teachers' Retirement System and not deducted from operating income.

Amounts identified as net contributions from or to the General Fund represent the excess of Retirement Fund contributions over payment or payments over receipts respectively during the month, as adjusted for investment activity in loans and mortgages. For purposes of source and use of funds analysis we have defined the term "funds" to include demand deposits, savings deposits and repurchase agreements.

Surplus funds are invested in the marketable securities account each day unless needed by the other portfolios within the Retirement Fund. Funds provided by each of the portfolios are returned to cash with the Treasury for subsequent reinvestment unless specifically identified otherwise.

Sincerely,

Anselm C. Staack
Treasury Comptroller

04-012LH

STATE OF ALASKA

TEACHERS' RETIREMENT SYSTEM

INVESTMENT ACTIVITY

NOVEMBER 30, 1980

At the end of November 30, 1980, cash and investments of the Teachers' Retirement Fund totaled $344,027,350.51, up from $339,310,111.78 at the close of the previous month. Holdings of intermediate/long term issues decreased by $578,260.64 while common stock holdings increased by $3,452,101.04. The Teachers' Retirement Fund expanded its position in short term issues by $4,709,261.12. The Gold Account increased by $1,794,010.30 and the Real Estate Equity Fund remained the same. Purchases of loans and mortgages exceeded repayments by $272,786.15. Cash and repurchase agreements including purchased interest receivable were reduced by $4,932,659.24.

STATE OF ALASKA

TEACHERS' RETIREMENT SYSTEM

STATEMENT OF PORTFOLIO ASSETS

NOVEMBER 30, 1980

	Current Month	
	%	Cost
Cash		$ (83,581.05)
Purchase Interest Receivable		10,465.36
Marketable Securities, at Cost:		
Repurchase Agreements	1 %	2,635,000.00
Short Term Issues	6	19,197,214.59
Intermediate and Long Term Issues	40	137,254,362.23
Common Stock	11	39,403,093.92
Gold Account	4	13,429,565.35
Real Estate Equity Fund	2	7,250,000.00
Total Marketable Securities	64	219,169,236.09
Other Holdings, at Cost:		
Loans and Mortgages	36	124,931,230.11
Total Assets	100%	$ 344,027,350.51

STATEMENT OF OPERATIONS/CHANGES IN TOTAL ASSETS

	Current Month	Year-to-Date
Portfolio Operations:		
Interest and Dividend Income	$ 1,945,927.68	$ 11,884,987.47
Net Gain (Loss) on Sale of Common Stock	193,025.03	3,590,071.95
Net Gain (Loss) on Sale of Securities	97,483 79	107,243.16
Total Gain Loss	290,508.82	3,697,315.11
Total Operating Income	2,236,436.50	15,582,302.58
Beginning Cash and Invested Funds	339,310,111.78	318,390,567.20
Net Contribution from (to) General Fund	2,480,802.23	10,054,480.73
Ending Cash and Invested Funds	$344,027,350.51	$344,027,350.51

STATE OF ALASKA

TEACHERS' RETIREMENT SYSTEM

STATEMENT OF CHANGES IN PORTFOLIO CONDITION

NOVEMBER 30, 1980

	Current Month	Year-to-Date
During the Month Funds were Provided by:		
Portfolio Operations:		
Interest and Dividend Income	$ 1,945,927.68	$ 11,884,987.47
Net Gain (Loss) on Sale of Securities	290,508.82	3,697,315.11
Total Provided by Operations	2,236,436.50	15,582,302.58
Sale/Maturity of Marketable Securities:		
Short term Issues	25,275,074.02	140,560,171.85
Intermediate/Long Term Issues	578,260.64	2,075,719.00
Common Stock	2,085,100.61	20,404,450.54
Total Provided by Sales/Maturities	27,938,435.27	163,040,341.39
Collections on Loans and Mortgages	807,471.31	3,947,902.47
Redemption of Alaska Savings Certificates	-0-	200,000.00
Net Contribution from General Fund	2,480,802.23	10,286,652.62
TOTAL Funds Provided During the Month	33,463,145.31	193,057,199.06
During the Month Funds were Used for:		
Purchase of Marketable Securities:		
Short Term Issues	29,984,335.14	127,256,882.89
Intermediate/Long Term Issues	-0-	18,665,937.50
Gold	1,794,010.30	13,429,565.35
Real Estate Equity Fund	-0-	7,250,000.00
Common Stock	5,537,201.65	26,809,833.04
Total Securities Purchased	37,315,547.09	193,412,218.78
Purchase of Loans and Mortgages	1,080,257.46	5,827,543.51
Net Contribution to General Fund	-0-	232,171.89
TOTAL Funds Used During the Month	38,395,804.55	199,471,934.18
NET CHANGE IN FUNDS	$ (4,932,659.24)	$ (6,414,735.12)
Summary of Changes:		
Increase (Decrease) in Demand Deposits	$ (374,775.92)	$ (142,871.86)
Increase (Decrease) in Savings Deposits	(13,348.68)	(7,328.62)
Increase (Decrease) in Repurchase Agreements	(4,555,000.00)	(6,275,000.00)
Increase (Decrease) in Prepaid Interest	10,465.36	10,465.36
NET CHANGE IN FUNDS	$ (4,932,659.24)	$ (6,414,735.12)

STATE OF ALASKA

TEACHERS' RETIREMENT SYSTEM

COMPOSITION OF INVESTMENT HOLDINGS

NOVEMBER 30, 1980

	Current Month		
	% of Total Cost Value	Cost	Yield
MARKETABLE SECURITIES ACCOUNT			
Cash Deposits			
Savings	%	$ 42,732.73	5.13
Prepaid Interest		10,465.36	
Repurchase Agreements	.8	1,200,000.00	16.75
Short Term Issues			
Commercial Paper		-0-	
Bankers Acceptances	8.6	12,732,933.34	14.23
U.S.T. Notes & Bonds	.3	518,281.25	6.59
Certificates of Deposit		-0-	
Total Issues	8.9	13,251,214.59	13.93
Intermediate/Long Term Issues			
U. S. Treasury Notes & Bonds:			
1 - 2 Years	1.7	2,492,700.00	7.20
2 - 5 Years	31.5	46,744,431.26	9.41
Over 5 Years	23.1	34,239,459.37	8.54
Sub-Total	56.3	83,476,590.63	8.99
Federal Agency Securities:			
2 - 5 Years	.6	1,000,000.00	7.55
Over 5 Years	1.4	2,019,795.32	10.11
Sub-Total	2.0	3,019,795.32	9.3
Goverment National Mortgage Assn.	14.0	20,693,958.78	8.19
Corporate Notes & Bonds:			
1 - 2 Years	1.0	1,492,500.00	7.50
2 - 5 Years	.8	1,243,750.00	9.58
Over 5 Years	16.2	23,912,655.00	8.30
Sub-Total	18.0	26,648,905.00	8.31
Private Placements		-0-	
Total Issues	90.3	133,839,249.73	8.74
TOTAL	100.0%	$148,343,662.41	9.26

Schedule continued on following page

COMPOSITION OF INVESTMENT HOLDINGS - Continued

	Current Month		
	% of Total Cost Value	Cost	Yield
COMMON STOCK ACCOUNT			
Cash Deposits			
Demand	(.3)%	$ (133,933.18)	
Savings		7,619.40	5.25
Total Deposits	(.3)	(126,313.78)	
Repurchase Agreements	2.9	1,435,000.00	15.5
Short Term Debt Issues			
Commercial Paper	11.9	5,946,000.00	16.05
Intermediate/Long Term Issues			
U.S. Treasury Notes		-0-	
Corporate Bonds	6.8	3,415,112.50	8.07
Total Issues	6.8	3,415,112.50	8.07
Common Stock	78.7	39,403,093.92	3.06
TOTAL	100.0%	$ 50,072,892.64	5.30
GOLD ACCOUNT - Cum. Fine Troy Ounces 20573.367	100.0%	$ 13,429,565.35	
REAL ESTATE EQUITY FUND	100.0%	$ 7,250,000.00	
LOAN AND MORTGAGE PROGRAMS			
Federal Insured Loans and Mortgages	6.8	8,434,039.02	7.74
Conventional			
Insured	55.8	69,767,123.35	
Bank Participation	37.4	46,730,067.74	
TOTAL Conventional Loans	93.2	116,497,191.09	10.65
TOTAL	100.0%	$ 124,931,230.11	10.45
SUMMARY OF COMPOSITION			
Marketable Securities Account	43.1 %	$ 148,343,662.41	9.26
Common Stock Account	14.5	50,072,892.64	5.30
Gold Account	3.9	13,429,565.35	N/A
Real Estate Equity Fund	2.1	7,250,000.00	N/A
Loan and Mortgage Programs	36.4	124,931,230.11	10.45
TOTAL INVESTMENT HOLDINGS	100.0%	$ 344,027,350.51	8.56

STATE OF ALASKA

TEACHERS' RETIREMENT SYSTEM

CHANGE IN PORTFOLIO COMPOSITION

NOVEMBER 30, 1980

	Current Month	Year-to-Date
MARKETABLE SECURITIES ACCOUNT		
During the Month Funds were Provided by:		
Portfolio Operations:		
Interest Income	$ 904,262.88	$ 6,263,951.30
Net Gain (Loss) of Sale of Securities	-0-	9,759.37
TOTAL Provided by Operations	904,262.88	6,273,710.67
Sale of Marketable Securities	-0-	60,278,141.56
Maturity of Marketable Securities	7,949,834.66	8,360,761.77
Net Contribution from General Fund	2,480,802.23	10,286,652.62
Net Contribution from Loan & Mortgage Programs	624,197.77	3,854,242.71
TOTAL Funds Provided During the Month	11,959,097.54	89,053,509.33
During the Month Funds were Used for:		
Purchase of Marketable Securities	10,771,335.14	66,432,864.12
Net Contribution to;		
Gold Account	1,794,010.30	13,429,565.35
Real Estate Equity Fund	-0-	7,250,000.00
General Fund	-0-	232,171.89
Loan & Mortgage Program	-0-	798,723.44
TOTAL Contributions	1,794,010.30	21,710,460.68
TOTAL Funds Used During the Month	12,565,345.44	88,143,324.80
NET CHANGE IN FUNDS	$ (606,247.90)	$ 910,184.53
COMMON STOCK ACCOUNT		
During the Month Funds were Provided by:		
Portfolio Operations:		
Interest and Dividend Income	$ 144,680.88	$ 885,875.86
Net Gain (Loss) on Sale of Securities	290,508.82	3,687,555.74
Total Provided by Operations	435,189.70	4,573,431.60
Sale of Marketable Securities	19,988,600.61	79,978,438.06
Maturity of Marketable Securities	-0-	14,423,000.00
TOTAL Funds Provided During the Month	20,423,790.31	98,974,869.66
During the Month Funds were Used for:		
Purchase of Marketable Securities	$ 24,750,201.65	$ 106,299,789.31
TOTAL Funds Used During the Month	24,750,201.65	106,299,789.31
NET CHANGE IN FUNDS	$ (4,326,411.34)	$ (7,324,919.65)

Schedule continued on following page

CHANGE IN PORTFOLIO COMPOSITION - Continued

	Current Month	Year-to-Date
GOLD ACCOUNT		
During the Month Funds were Provided by:		
Net Contribution from Marketable Securities Account	$ 1,794,010.30	$ 13,429,565.35
During the Month Funds were Used for:		
Purchase of gold - 3,000.017 Fine Troy Ounces	1,794,010.30	13,429,565.35
NET CHANGE IN FUNDS	$ -0-	$ -0-
REAL ESTATE EQUITY FUND		
During the Month Funds were Provided by:		
Net Contribution from Marketable Securities	$ -0-	$ 7,250,000.00
During the Month Funds were Used for:		
Purchase of Real Estate Equity	-0-	7,250,000.00
NET CHANGE IN FUNDS	$ -0-	$ -0-
LOAN AND MORTGAGE PROGRAMS		
During the Month Funds were Provided by:		
Interest Income	$ 896,983.92	$ 4,720,324.23
Principal Repayments	807,471.31	3,947,902.47
Net Contribution from:		
Marketable Securities Account	-0-	798,723.44
Alaska Deposits	-0-	214,836.08
TOTAL Provided by Contributions	-0-	1,013,559.52
TOTAL Funds Provided During the Month	1,704,455.23	9,681,786.22
During the Month Funds were Used for:		
Purchase of Loans and Mortgages	1,080,257.46	5,827,543.51
Net Contribution to Marketable Securities	624,197.77	3,854,242.71
TOTAL Funds Used During the Month	1,704,455.23	9,681,786.22
NET CHANGE IN FUNDS	$ -0-	$ -0-
SUMMARY OF CHANGES		
ketable Securities Account	$ (606,247.90)	$ 910,184.53
mon Stock Account	(4,326,411.34)	(7,324,919.65)
Gold Account	-0-	-0-
Real Estate Equity Fund	-0-	-0-
Loan and Mortgage Programs	-0-	-0-
NET CHANGE IN FUNDS	$ (4,932,659.24)	$ (6,414,735.12)

STATE OF ALASKA

DEPARTMENT OF REVENUE
TREASURY DIVISION
Pouch SB
Juneau, Alaska 99811
(907) 465-2350

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

MONTHLY INVESTMENT REPORT

NOVEMBER 30, 1980

CONTENTS

STATE OF ALASKA

DEPARTMENT OF REVENUE

TREASURY DIVISION

JAY S. [redacted], GOVERNOR

ELEVENTH FLOOR
STATE OFFICE BUILDING
POUCH SB
JUNEAU, ALASKA 99811
PHONE:

To the Reader:

We present herein the investment report of the Public Employees' Retirement System for November 30, 1980, with year-to-date figures for the Fiscal Year 1981. Accounting procedures used in preparation include:

1. All transactions are recorded on the cash basis, i.e., when cash is received or disbursed.

2. Accrued interest purchased is charged against income at the time of acquisition.

3. Other holdings will be held until repayment at or prior to maturity.

4. The cost of investments represents the amount paid for securities and other holdings.

5. Safekeeping and transaction charges are billed to the Public Employees' Retirement System and not deducted from operating income.

Amounts identified as net contributions from or to the General Fund represent the excess of Retirement Fund contributions over payment or payments over receipts respectively during the month, as adjusted for investment activity in loans and mortgages. For purposes of source and use of funds analysis we have defined the term "funds" to include demand deposits, savings deposits and repurchase agreements.

Surplus funds are invested in the marketable securities account each day unless needed by the other portfolios within the Retirement Fund. Funds provided by each of the portfolios are returned to cash with the Treasury for subsequent reinvestment unless specifically identified otherwise.

Sincerely,

Anselm C. Staack
Treasury Comptroller

04-D12LH

STATE OF ALASKA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

INVESTMENT ACTIVITY

NOVEMBER 30, 1980

At the end of November 30, 1980, cash and investments of the Public Employees' Retirement Fund totaled $444,595,584.83, up from $438,231,556.14 at the close of the previous month. Holdings of intermediate/long term issues decreased by $523,364.17 while common stock holdings increased by $3,948,890.04. The Public Employees' Retirement Fund expanded its position in short term issues by $6,584,111.13. The Gold Account increased by $2,153,364.07 and the Real Estate Equity Fund remained the same. Purchases of loans and mortgages exceeded repayments by $276,764.59. Cash and repurchase agreements including purchased interest receivable were reduced by $6,075,736.97.

STATE OF ALASKA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

STATEMENT OF PORTFOLIO ASSETS

NOVEMBER 30, 1980

	Current Month	
	%	Cost
Cash	%	$ 9,239.26
Prepaid Interest		20,930.70
Marketable Securities, at Cost:		
Repurchase Agreements	1	3,440,000.00
Short Term Issues	11	50,626,190.98
Intermediate and Long Term Issues	42	186,832,539.50
Common Stock	8	36,067,048.57
Gold Account	4	16,095,385.93
Real Estate Equity Fund	2	7,250,000.00
Total Marketable Securities	68	300,311,164.98
Other Holdings, at Cost:		
Loans and Mortgages	32	144,254,249.89
Total Assets	100%	$444,595,584.83

STATEMENT OF OPERATIONS/CHANGES IN TOTAL ASSETS

	Current Month	Year-to-Date
Portfolio Operations:		
Interest and Dividend Income	$ 3,325,263.73	$ 16,715,407.30
Net Gain (Loss) on Sale of Common Stock	227,788.67	3,026,035.57
Net Gain (Loss) on Sale of Securities	14,343.75	26,855.75
Total Gain (Loss)	242,132.42	3,052,891.32
Total Operating Income	3,567,396.15	19,768,298.62
Beginning Cash and Invested Funds	438,231,556.14	400,164,240.03
Net Contribution from (to) General Fund	796,632.54	24,663,046.18
Ending Cash and Invested Funds	$444,595,584.83	$444,595,584.83

STATE OF ALASKA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

STATEMENT OF CHANGES IN PORTFOLIO CONDITION

NOVEMBER 30, 1980

	Current Month	Year-to-Date
During the Month Funds were Provided by:		
Portfolio Operations:		
Interest and Dividend Income	$ 3,325,263.73	$ 16,715,407.30
Net Gain (Loss) on Sale of Securities	242,132.42	3,052,891.32
Total Provided by Operations	3,567,396.15	19,768,298.62
Sale/Maturity of Marketable Securities:		
Short term Issues	37,790,883.05	213,482,823.39
Intermeditate/Long Term Issues	523,364.17	1,629,323.47
Common Stock	1,655,212.21	25,607,770.77
Total Provided by Sales/Maturities	39,969,459.43	240,719,917.63
Collections on Loans and Mortgages	1,092,185.41	4,516,184.37
Net Contribution from General Fund	2,796,632.54	24,663,046.18
TOTAL Funds Provided During the Month	47,425,673.53	289,667,446.80
During the Month Funds were Used for:		
Purchase of Marketable Securities:		
Short Term Issues	44,374,994.18	191,819,601.77
Intermediate/Long Term Issues	-0-	48,117,139.50
Common Stock	5,604,102.25	24,191,639.78
Gold Account	2,153,364.07	16,095,385.93
Real Estate Equity Fund	-0-	7,250,000.00
Total Marketable Securities Purchased	52,132,460.50	287,473,766.98
Purchase of Loans and Mortgages	1,368,950.00	8,750,300.96
TOTAL Funds Used During the Month	53,501,410.50	296,224,067.94
NET CHANGE IN FUNDS	$ (6,075,736.97)	$ (6,556,621.14)
Summary of Changes:		
Increase (Decrease) in Demand Deposits	$ (396,097.23)	$ (65,820.81)
Increase (Decrease) in Savings Deposits	1,429.56	10,268.97
Increase (Decrease) in Repurchase Agreements	(5,702,000.00)	(6,522,000.00)
Increase (Decrease) in Prepaid Interest	20,930.70	20,930.70
NET CHANGE IN FUNDS	$ (6,075,736.97)	$ (6,556,621.14)

STATE OF ALASKA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

COMPOSITION OF INVESTMENT HOLDINGS

NOVEMBER 30, 1980

	Current Month		
	% of Total Cost Value	Cost	Yield
MARKETABLE SECURITIES ACCOUNT			
Cash Deposits			
Savings	%	$ 65,862.66	5.13
Repurchase Agreements	1.3	3,000,000.00	16.75
Prepaid Interest		20,930.70	
Short Term Issues			
Commercial Paper		-0-	
Bankers Acceptances	18.0	41,675,034.73	13.10
Certificates of Deposit		-0-	
U. S. Notes & Bonds	1.3	3,080,156.25	6.65
Total Issues	19.3	44,755,190.98	12.66
Intermediate/Long Term Issues			
U. S. Treasury Notes & Bonds:			
1 - 2 Years	9.2	21,372,969.75	10.78
2 - 5 Years	27.0	62,560,931.26	9.50
Over 5 Years	17.2	39,965,017.98	8.62
Sub-Total	53.4	123,898,918.99	9.44
Federal Agency Securities:			
2 - 5 Years	1.6	3,784,252.23	8.66
Over 5 Years	.8	1,842,670.32	10.46
Sub-Total	2.4	5,626,922.55	9.25
Goverment National Mortgage Assn.	9.3	21,201,002.96	8.21
Corporate Notes & Bonds:			
1 - 2 Years	1.1	2,486,562.50	7.48
2 - 5 Years	.5	1,243,750.00	9.58
Over 5 Years	12.7	29,535,745.00	8.57
Sub-Total	14.3	33,266,057.50	8.52
Total Issues	79.4	183,992,902.00	
TOTAL	100.0%	$231,834,886.34	9.93

COMPOSITION OF INVESTMENT HOLDINGS - Continued

	Current Month		
	% of Total Cost Value	Cost	Yield
COMMON STOCK ACCOUNT			
Cash Deposits			
Demand		$ (56,623.40)	N/A
Savings		-0-	
Total Deposits		(56,623.40)	
Repurchase Agreements		440,000.00	14.50
Short Term Debt Issues			
Commercial Paper	13.0	5,871,000.00	16.05
Intermediate/Long Term Issues			
Convertible Issues	7.0	2,839,637.50	7.98
Common Stock	80.0	36,067,048.57	3.10
TOTAL	100.0%	$ 45,161,062.67	5.21
GOLD ACCOUNT - Cum. Fine troy ounces 24676.289	100.0%	$ 16,095,385.93	N/A
REAL ESTATE EQUITY FUND	100.0%	$ 7,250,000.00	N/A
LOAN AND MORTGAGE PROGRAMS			
Federal Insured Loans and Mortgages	10.0	14,476,920.03	8.55
Conventional			
Insured	58.7	84,603,635.12	
Bank Participation	31.3	45,173,694.74	
TOTAL Conventional Loans	90.0	129,777,329.86	10.61
TOTAL	100.0%	$ 144,254,249.89	10.41
SUMMARY OF COMPOSITION			
Marketable Securities Account	52.2%	$ 231,834,886.34	9.93
Common Stock Account	10.1	45,161,062.67	5.21
Loan and Mortgage Programs	32.5	144,254,249.89	10.41
Gold Account	3.6	16,095,385.93	N/A
Real Estate Equity Fund	1.6	7,250,000.00	N/A
TOTAL INVESTMENT HOLDINGS	100.0%	$ 44,595,584.83	9.09

STATE OF ALASKA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

CHANGE IN PORTFOLIO COMPOSITION

NOVEMBER 30, 1980

	Current Month	Year-to-Date
MARKETABLE SECURITIES ACCOUNT		
During the Month Funds were Provided by:		
Portfolio Operations:		
Interest Income	$ 1,824,971.29	$ 10,495,175.10
Net Gain (Loss) of Sale of Securities	-0-	12,512.00
TOTAL Provided by Operations	1,824,971.29	10,507,687.10
Sale of Marketable Securities	7,136,994.44	133,056,534.78
Maturity of Marketable Securities	14,577,752.78	14,820,805.83
Net Contribution from General Fund	2,796,632.54	24,663,046.18
Net Contribution from Loan & Mortgage Programs	1,093,367.46	2,811,367.93
TOTAL Funds Provided During the Month	27,429,718.51	185,859,441.82
During the Month Funds were Used for:		
Purchase of Marketable Securities	25,453,994.18	159,623,385.00
Net Contribution to:		
Gold Account	2,153,364.07	16,095,385.93
Real Estate Equity Fund	-0-	7,250,000.00
General Fund	-0-	-0-
Loan & Mortgage Program	-0-	1,659,414.11
TOTAL Contributions	2,153,364.07	25,004,800.04
TOTAL Funds Used During the Month	27,607,358.25	184,628,185.04
NET CHANGE IN FUNDS	$ (177,639.74)	$ 1,231,256.78
COMMON STOCK ACCOUNT		
During the Month Funds were Provided by:		
Portfolio Operations:		
Interest and Dividend Income	$ 130,160.39	$ 834,161.79
Net Gain (Loss) on Sale of Securities	242,132.42	3,040,379.32
Total Provided by Operations	372,292.81	3,874,541.11
Sale of Marketable Securities	13,414,712.21	76,813,177.02
Maturity of Marketable Securities	4,840,000.00	16,029,400.00
TOTAL Funds Provided During the Month	18,627,005.02	96,717,118.13

Schedule continued on following page.

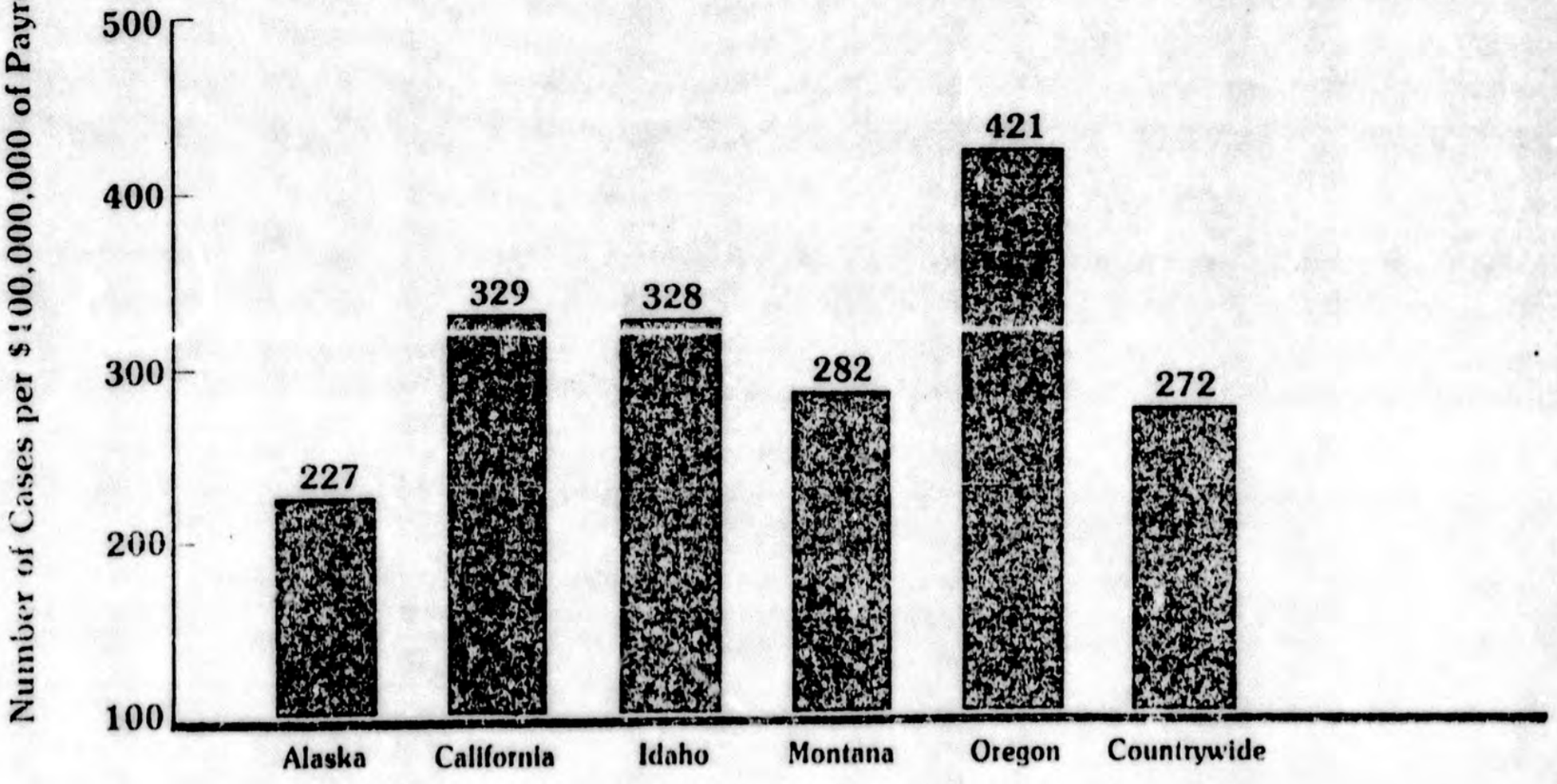
CHANGE IN PORTFOLIO COMPOSITION - Continued

COMMON STOCK ACCOUNT - continued	Current Month	Year-to-Date
During the Month Funds were Used for:		
Purchase of Marketable Securities	$ 24,525,102.25	$ 104,504,996.05
TOTAL Funds Used During the Month	24,525,102.25	104,504,996.05
NET CHANGE IN FUNDS	$ (5,898,097.23)	$ (7,787,877.92)
GOLD ACCOUNT		
During the Month Funds were Provided By:		
Net Contribution from Marketable Securities Account	$ 2,153,364.07	$ 16,095,407.61
During the Month Funds Were Used for:		
Purchase of Gold; 3600.973 Fine troy ounces	2,153,364.07	16,095,407.61
NET CHANGE IN FUNDS	$ -0-	$ -0-
REAL ESTATE EQUITY FUND		
During the Month Funds were Provided by:		
Net Contribution from Marketable Securities Account	$ -0-	$ 7,250,000.00
During the Month Funds were Used for:		
Purchase of Real Estate Equity	-0-	7,250,000.00
NET CHANGE IN FUNDS	$ -0-	$ -0-
LOAN AND MORTGAGE PROGRAMS		
During the Month Funds were Provided by:		
Interest Income	$ 1,370,132.05	$ 5,386,070.41
Principal Repayments	1,092,185.41	4,516,184.37
Net Contribution from: Marketable Securities Account	-0-	1,659,414.11
TOTAL Funds Provided During the Month	2,462,317.46	11,561,668.89
During the Month Funds were Used for:		
Purchase of Loans and Mortgages	1,368,950.00	8,750,300.96
Net Contribution to Marketable Securities	1,093,367.46	2,811,367.93
TOTAL Funds Used During the Month	2,462,317.46	11,561,668.89
NET CHANGE IN FUNDS	$ -0-	$ -0-
SUMMARY OF CHANGES		
Marketable Securities Account	$ (177,639.74)	$ 1,231,256.78
Common Stock Account	(5,898,097.23)	(7,787,877.92)
Loan and Mortgage Programs	-0-	-0-
Gold Account	-0-	-0-
Real Estate Equity Fund	-0-	-0-
NET CHANGE IN FUNDS	$ (6,075,736.97)	$ (6,556,621.14)

	79 w/c	Red Rat	80 w/c	80 RR	[illegible]	80 U.I. wage	U.I. Red Rat		Ra
NY	198.00	0.50	213.00	0.55	1.08	273.76	0.67	1.33	1.2[illegible]
CA	198.00	0.50	213.00	0.55	1.08	265.11	0.65	1.28	1.18
IN	198.00	0.50	213.00	0.55	1.08	257.22	0.63	1.25	1.15
TX	198.00	0.50	213.00	0.55	1.08	248.70	0.61	1.20	1.11
HI	200.00	0.51	200.00	0.51	1.01	228.96	0.56	1.10	1.09
ID	193.00	0.49	193.00	0.49	1.01	220.46	0.54	1.09	1.09
MO	198.00	0.50	213.00	0.55	1.08	238.85	0.58	1.16	1.07
VA	187.00	0.48	199.00	0.51	1.07	222.33	0.54	1.14	1.06
AZ	198.00	0.50	213.00	0.55	1.08	236.64	0.58	1.15	1.06
WV	224.00	0.57	237.00	0.61	1.07	263.00	0.64	1.13	1.06
MT	188.00	0.48	198.00	0.51	1.06	219.12	0.53	1.12	1.05
NM	186.00	0.47	201.00	0.52	1.09	221.51	0.54	1.14	1.05
OK	198.00	0.50	212.00	0.54	1.08	233.01	0.57	1.13	1.05
MI	255.00	0.65	275.00	0.71	1.09	302.20	0.74	1.14	1.05
KS	194.00	0.49	206.00	0.53	1.07	226.22	0.55	1.12	1.04
WA	234.00	0.60	249.00	0.64	1.07	272.88	0.67	1.12	1.04
UT	210.00	0.53	210.00	0.54	1.01	230.02	0.56	1.05	1.04
NH	180.00	0.46	195.00	0.50	1.09	213.40	0.52	1.14	1.04
LA	211.00	0.54	224.00	0.57	1.07	244.88	0.60	1.11	1.04
IA	199.00	0.51	211.00	0.54	1.07	230.12	0.56	1.11	1.04
ND	180.00	0.46	195.00	0.50	1.09	212.38	0.52	1.13	1.04
AL	192.00	0.49	204.00	0.52	1.07	222.08	0.54	1.11	1.04
SD	164.00	0.42	175.00	0.45	1.08	190.50	0.46	1.11	1.04
RE	199.00	0.51	199.00	0.51	1.01	216.49	0.53	1.04	1.03
VT	191.00	0.49	191.00	0.49	1.01	207.37	0.51	1.04	1.03
ME	174.00	0.44	184.00	0.47	1.07	199.30	0.49	1.10	1.03
NJ	234.00	0.60	246.00	0.63	1.06	265.35	0.65	1.09	1.03
NC	178.00	0.45	194.00	0.50	1.10	209.00	0.51	1.13	1.0[illegible]
MN	209.00	0.53	226.00	0.58	1.09	243.19	0.59	1.12	1.02
KY	201.00	0.51	218.00	0.56	1.09	233.26	0.57	1.11	1.02
DE	232.00	0.59	247.00	0.63	1.07	263.00	0.64	1.09	1.01
NV	212.00	0.54	229.00	0.59	1.09	243.32	0.59	1.10	1.01
MA	198.00	0.50	227.00	0.58	1.16	241.04	0.59	1.17	1.01
WY	233.00	0.59	251.00	0.64	1.09	264.88	0.65	1.09	1.00
AK	393.00	1.00	390.00 780	1.00	1.00	410.02 920	1.00	1.00	1.00
IL	247.00	0.63	257.00	0.66	1.05	269.21	0.66	1.04	1.00
SC	278.00	0.71	197.00	0.51	0.71	206.00	0.50	0.71	0.99
GA	198.00	0.50	213.00	0.55	1.08	221.65	0.54	1.07	0.99
OR	224.00	0.57	242.00	0.62	1.09	251.33	0.61	1.08	0.99
PA	213.00	0.54	242.00	0.62	1.14	251.22	0.61	1.13	0.99
FL	217.00	0.55	211.00	0.54	0.98	218.05	0.53	0.96	0.98
OH	216.00	0.55	258.00	0.66	1.20	266.54	0.65	1.18	0.9[illegible]
TN	198.00	0.50	213.00	0.55	1.08	216.75	0.53	1.05	0.97
NB	198.00	0.50	213.00	0.55	1.08	215.59	0.53	1.04	0.96
CT	240.00	0.61	261.00	0.67	1.10	259.83	0.63	1.04	0.95
MD	219.00	0.56	241.00	0.62	1.11	234.23	0.57	1.03	0.9[illegible]
AR	198.00	0.50	213.00	0.55	1.08	202.57	0.49	0.98	0.90
MS	198.00	0.50	213.00	0.55	1.08	196.06	0.48	0.95	0.88
CO	217.00	0.55	278.00	0.71	1.29	244.18	0.60	1.08	0.84
WI	327.00	0.83	350.00	0.90	1.08	242.37	0.59	0.71	0.6[illegible]

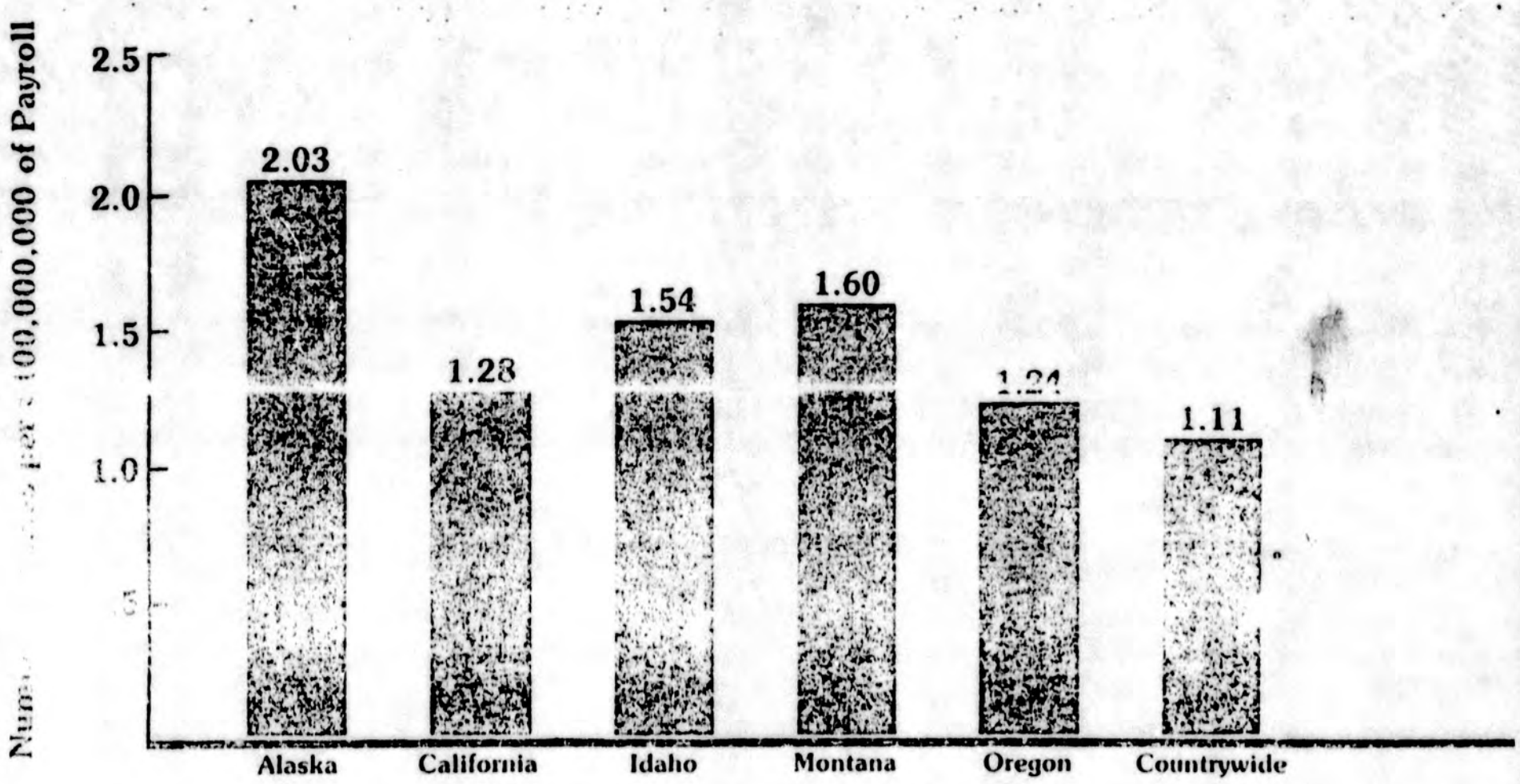
OCCI

Frequency of Lost Time Benefit Cases



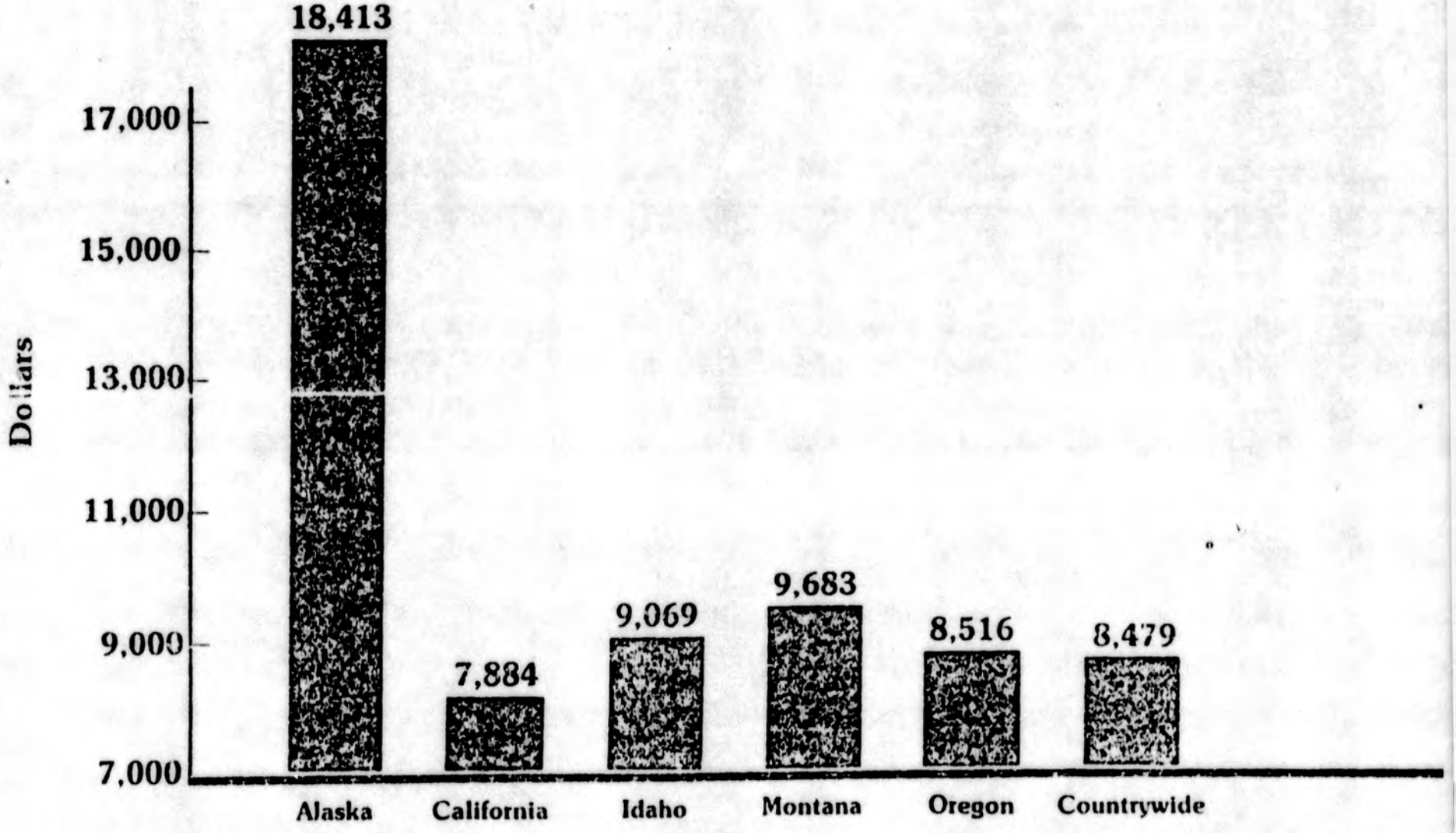
SECTION VIII
EXHIBIT 27

Frequency of Death Cases



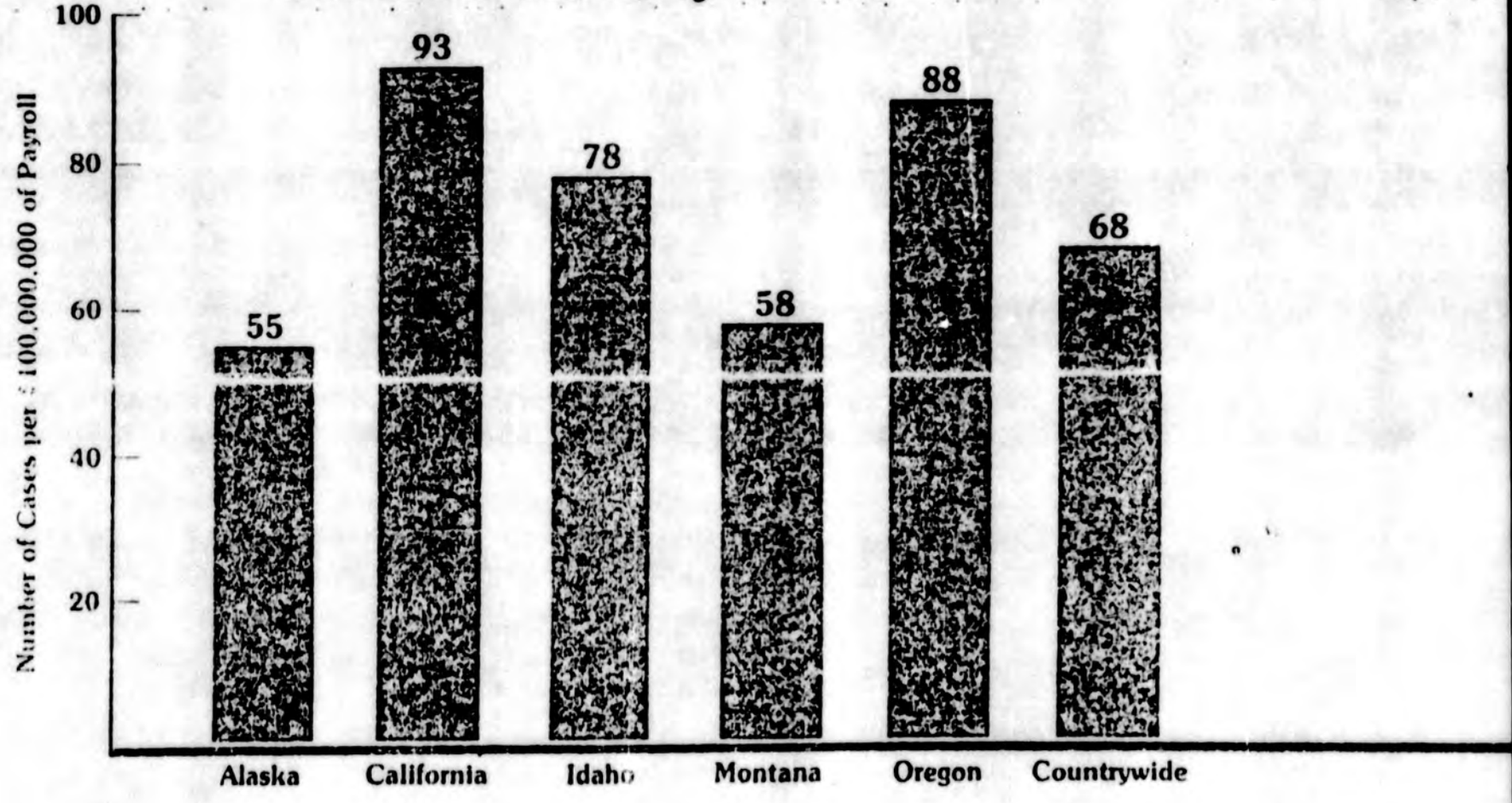
SECTION VIII
EXHIBIT 16

Comparison of Average Cost per Case for Permanent Partial Disability



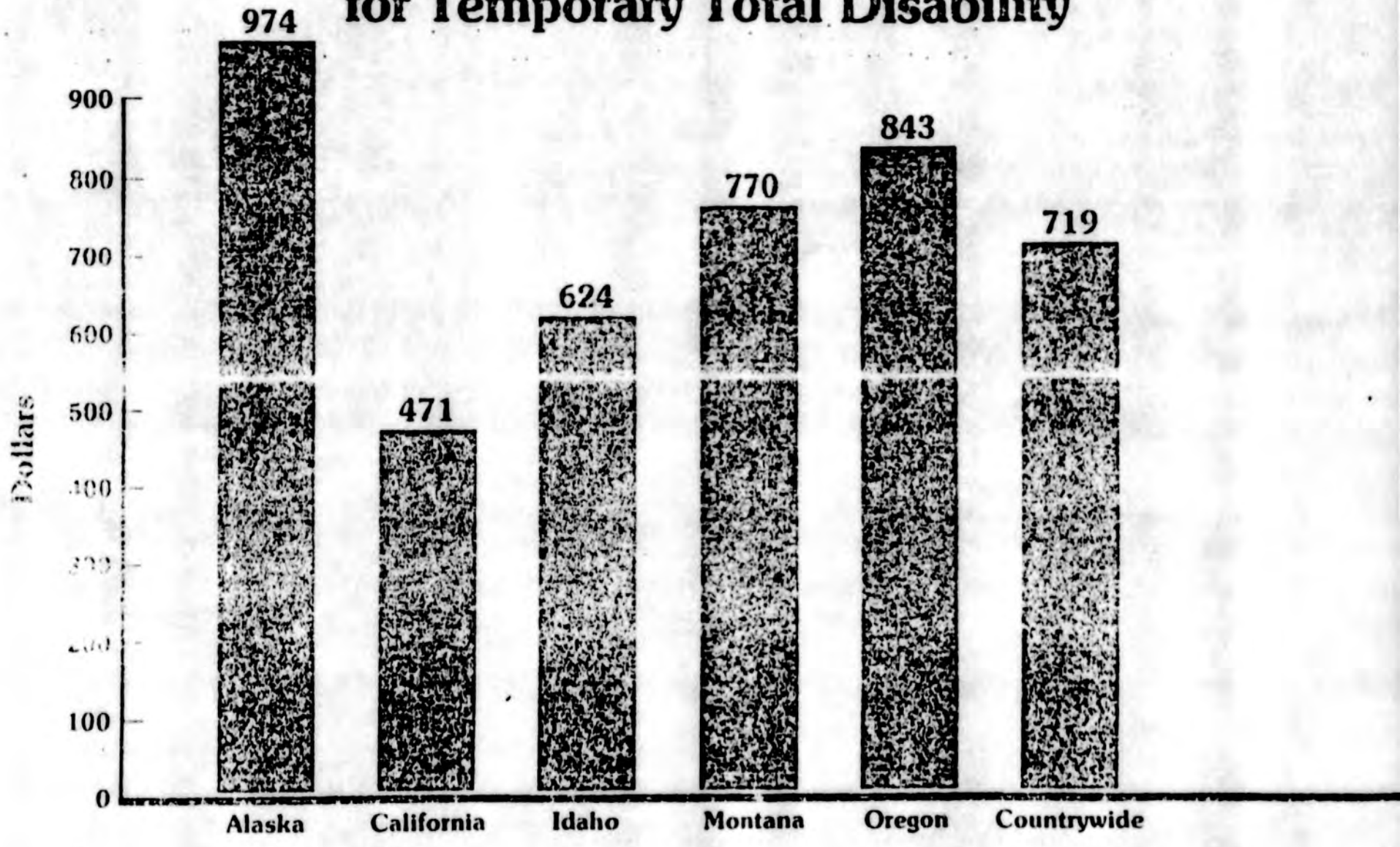
SECTION VIII
EXHIBIT 11

Frequency of Permanent Partial Disability Cases



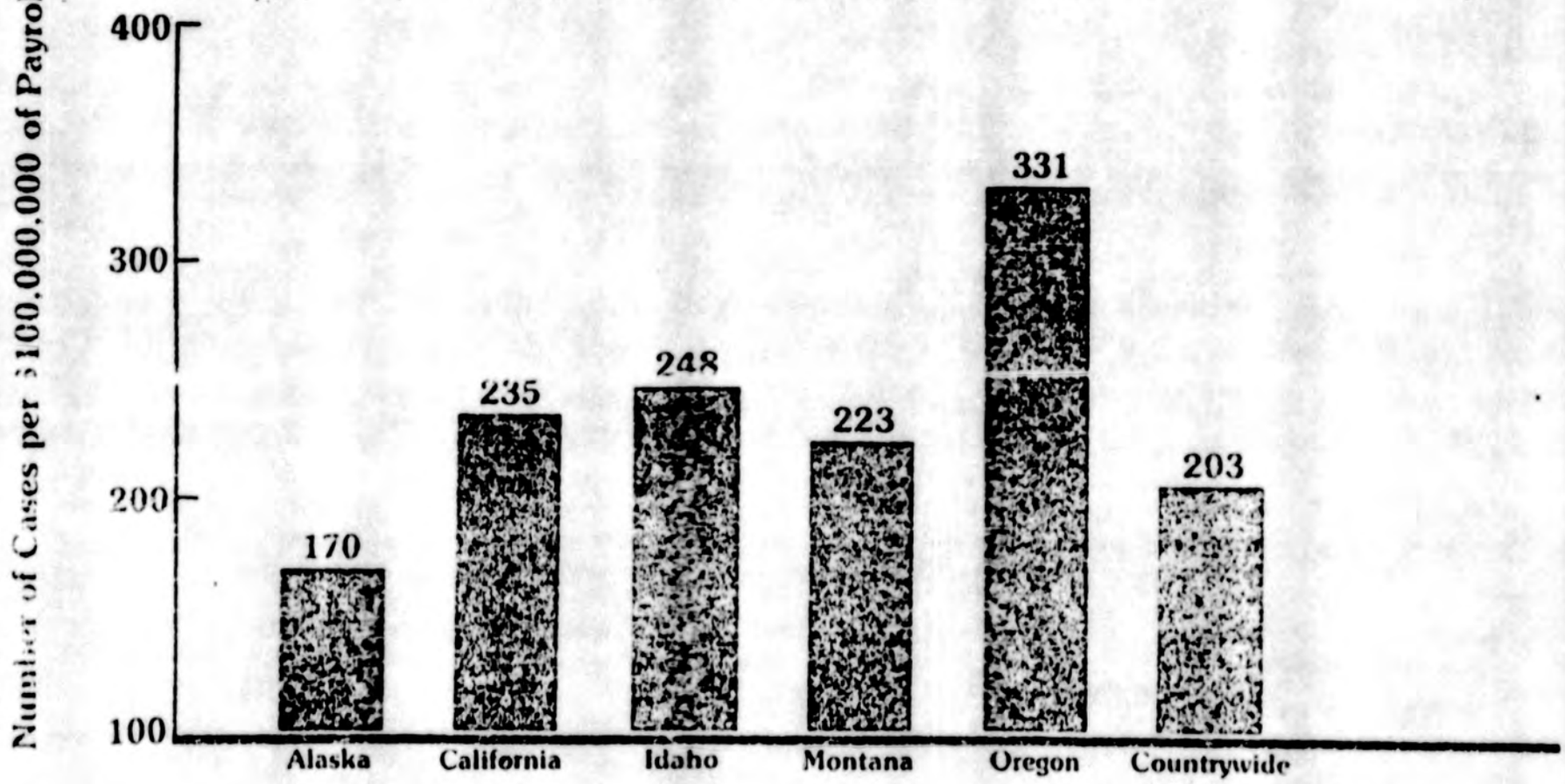
SECTION VIII
EXHIBIT 12

Comparison of Average Cost Per Case for Temporary Total Disability



SECTION VIII
EXHIBIT 13

Frequency of Temporary Total Disability Cases



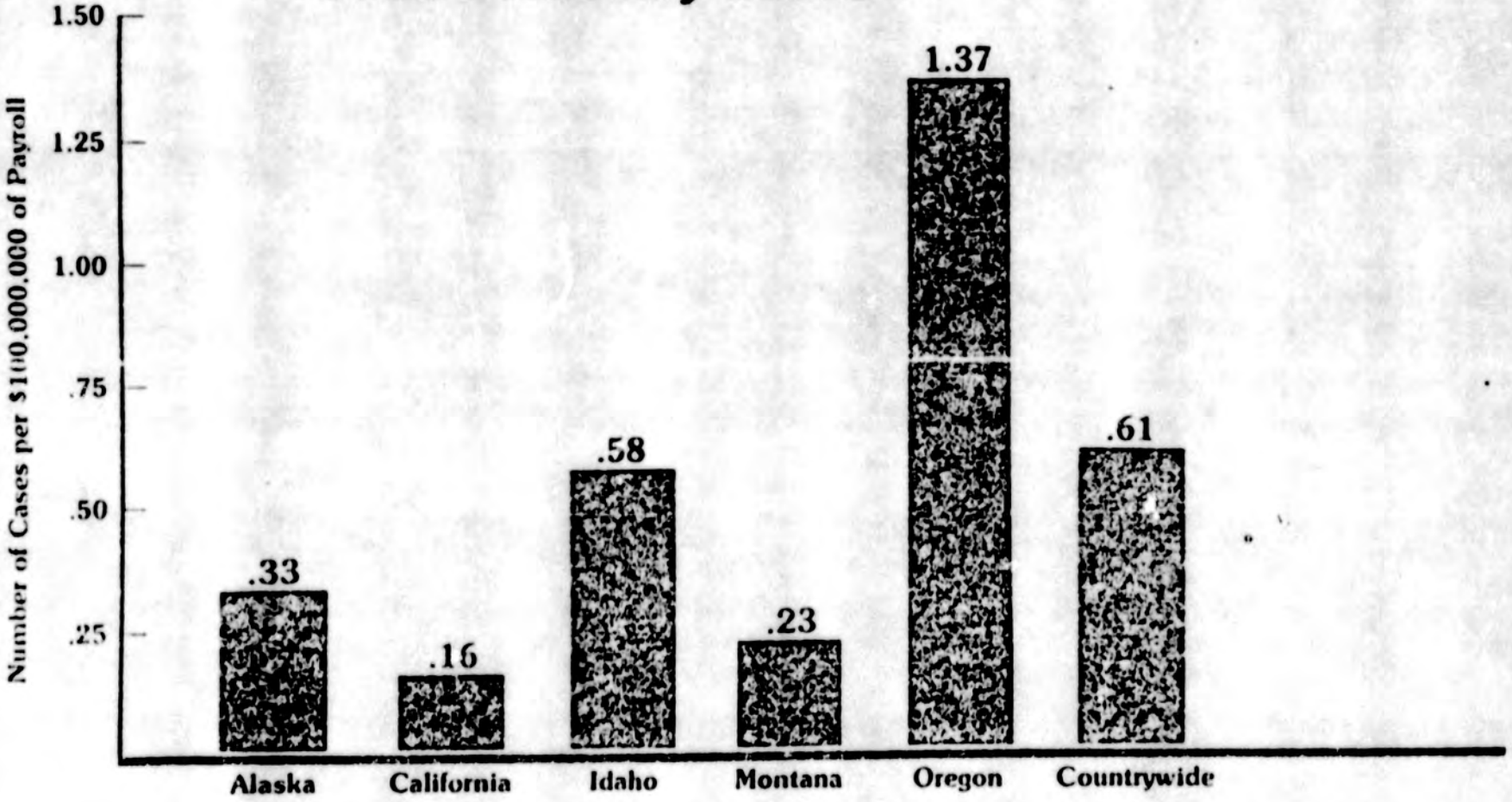
SECTION VIII
EXHIBIT 14

OCCI

Distribution of Lost Time Cases
(Fifth Report Basis)
Per 10,000 Lost Time Cases

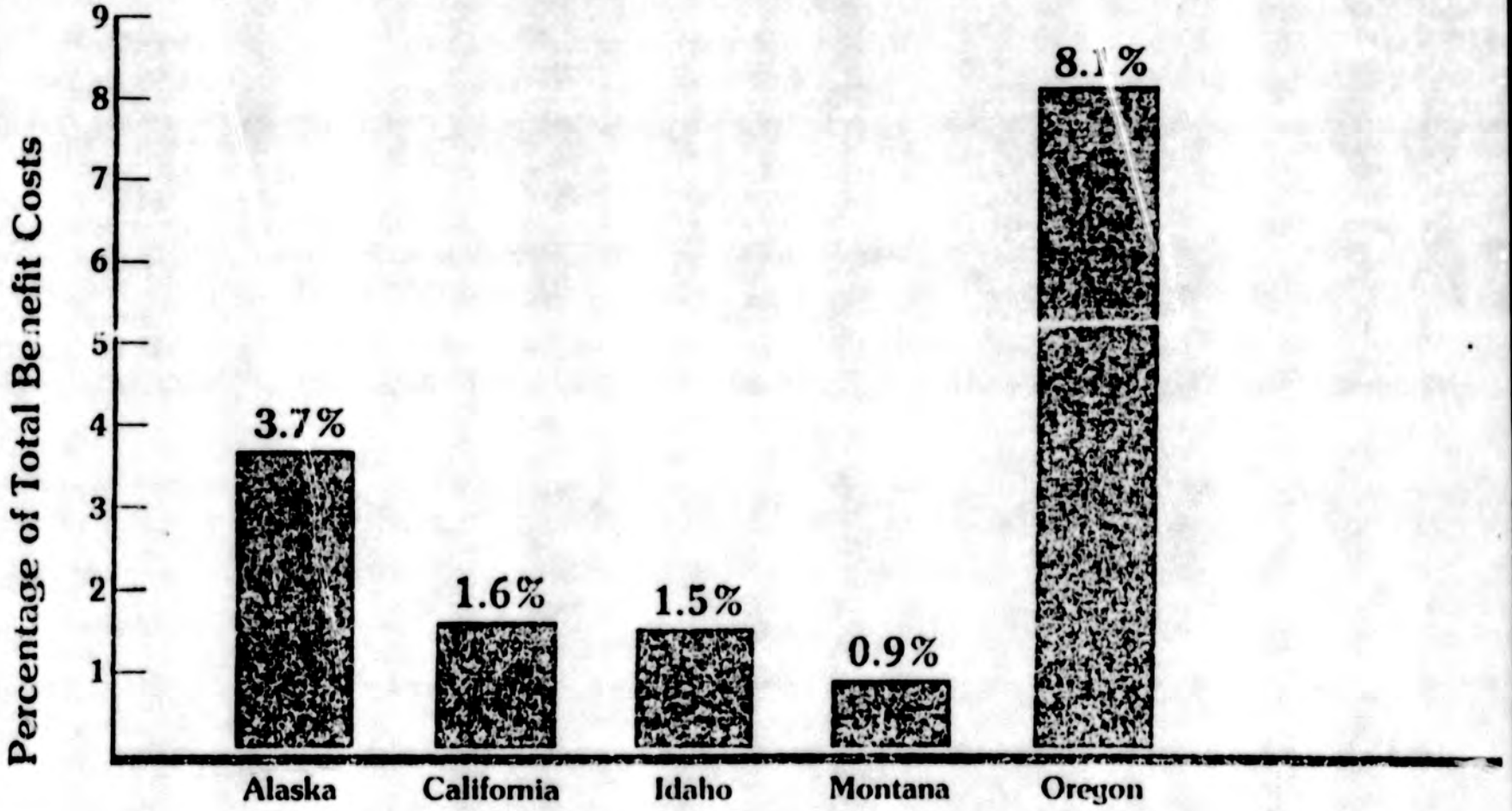
State	Permanent Total	All Other	Sum
Alaska	14	9,986	10,000
California	5	9,995	10,000
Idaho	18	9,982	10,000
Montana	8	9,992	10,000
Oregon	33	9,967	10,000
Countrywide	22	9,978	10,000

Frequency of Permanent Total Disability Cases



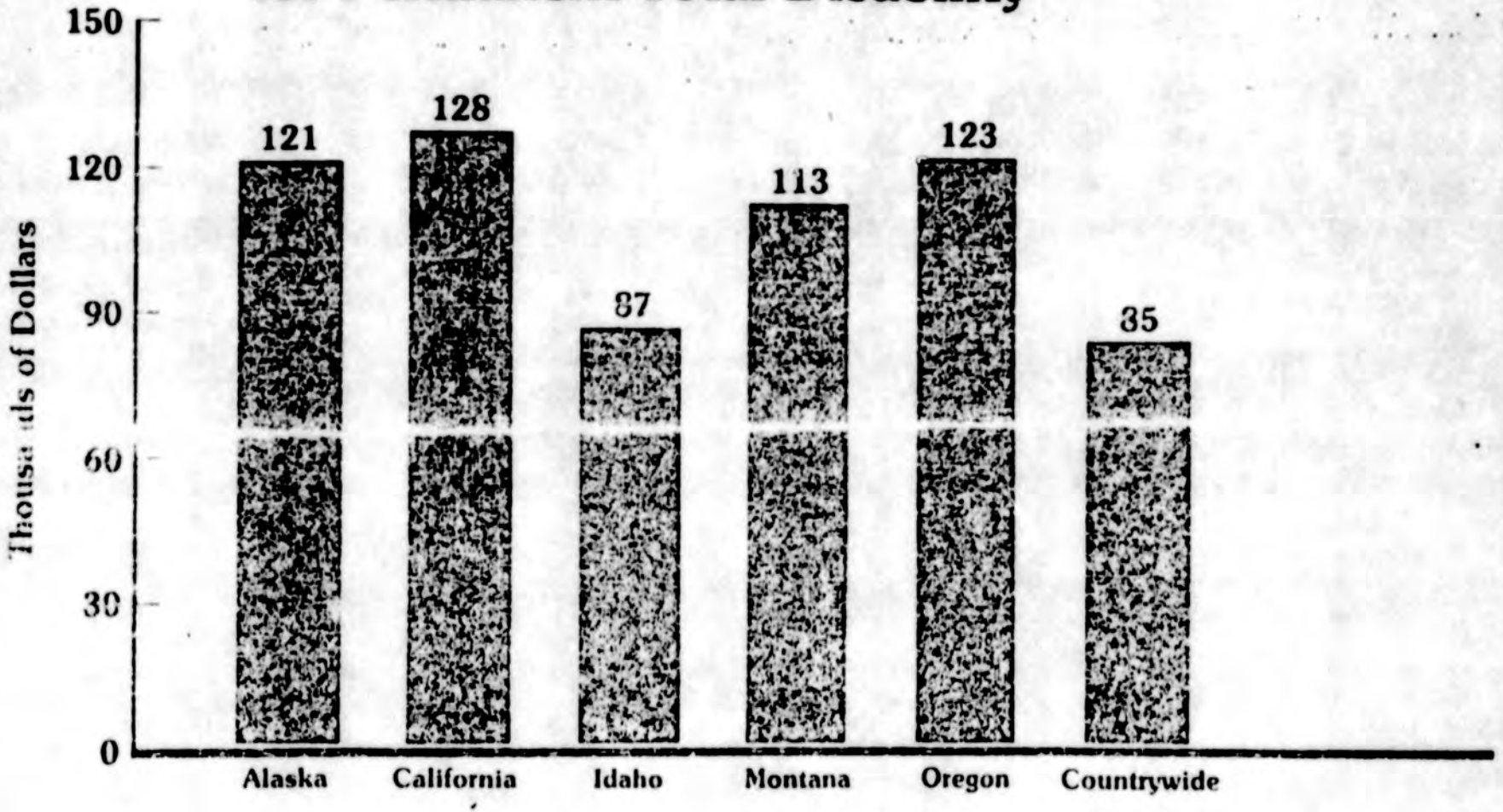
SECTION VIII
EXHIBIT 18

Permanent Total Benefit Costs as a Percentage of Total Benefit Costs
(Fifth Report Basis)



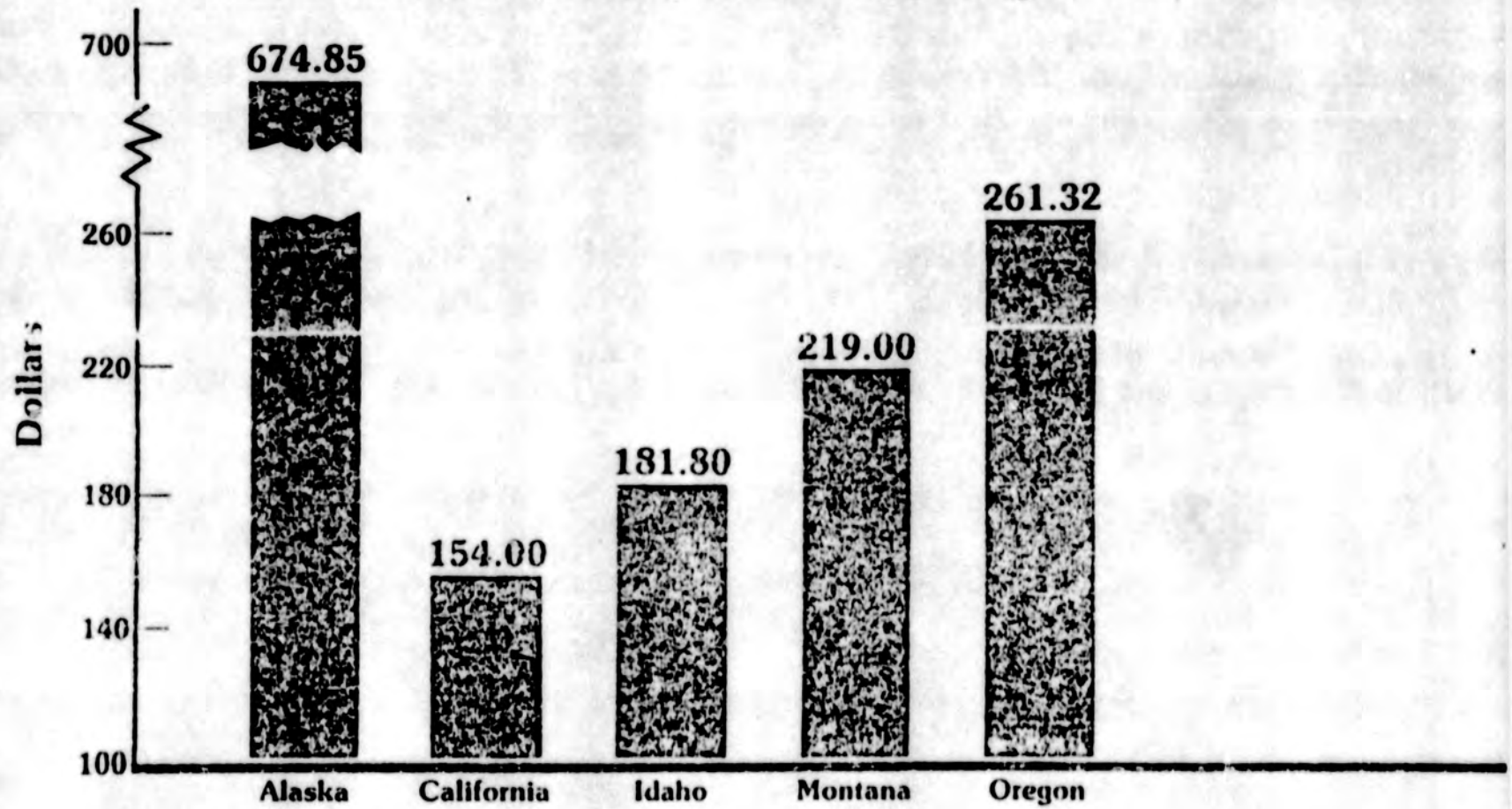
SECTION VIII
EXHIBIT 19

Comparison of Average Cost Per Case for Permanent Total Disability



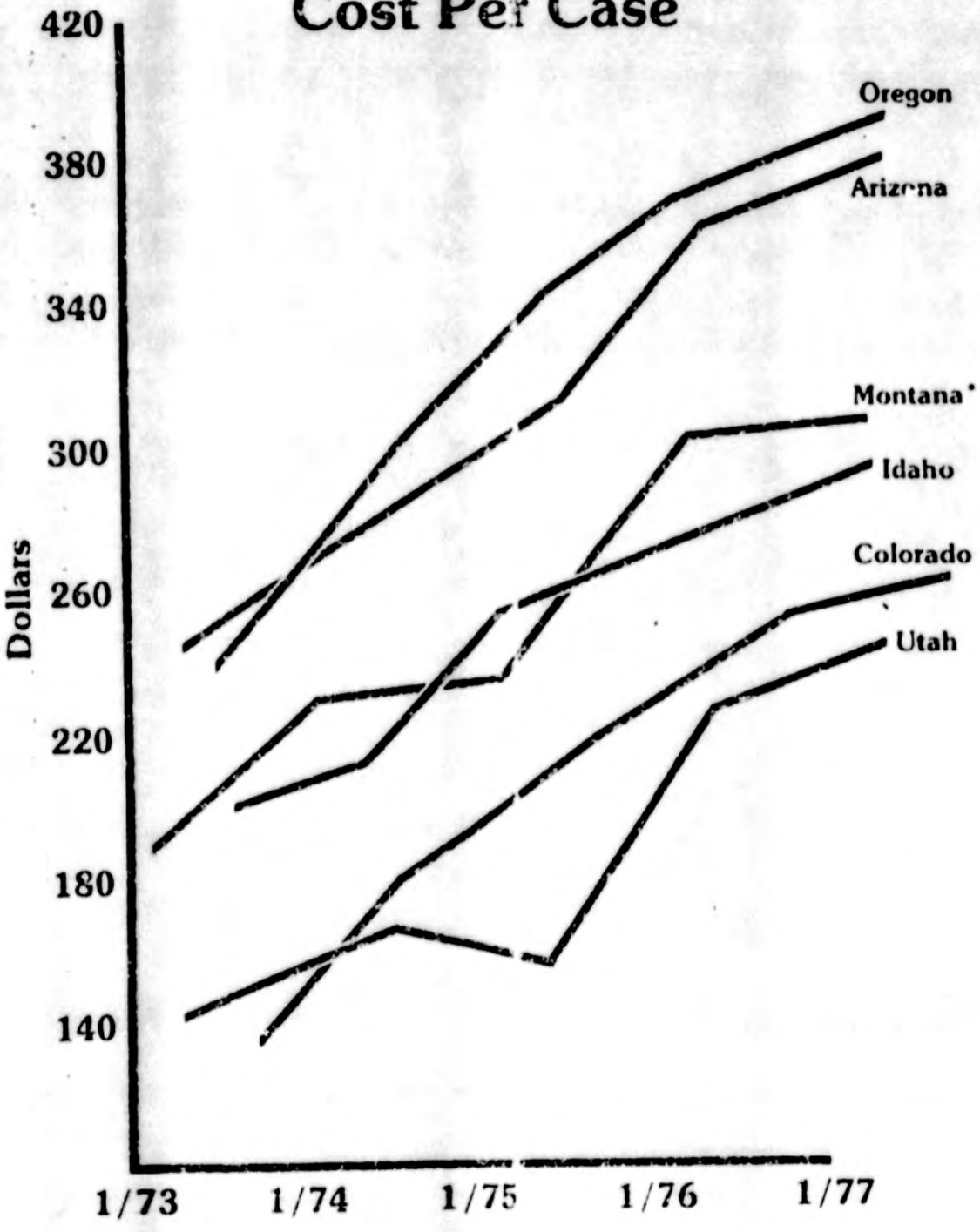
SECTION VIII
EXHIBIT 20

Comparison of Maximum Weekly Benefits for Permanent Total Disability



SECTION VIII
EXHIBIT 21

Average Medical Cost Per Case



*Private carrier only

NOTICE OF PROPOSED CHANGES IN THE REGULATIONS
OF THE DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT
BOARD OF PHARMACY

Notice is hereby given that the Department of Commerce and Economic Development, Board of Pharmacy, under authority vested by AS 08.80.030, .040 and .045 proposes to adopt regulations in Title 12 of the Alaska Administrative Code, dealing with issuing a list of dangerous medicinal drugs, security of dangerous drugs, and emergency regulation of the sale and distribution of patent or nonprescription drugs to implement AS 08.80.030(8), .040(6) and .045(b) as follows:

12 AAC 52 is amended by adding new provisions as follows:

1. Listing of potentially dangerous medicinal ingredients or preparations that may be sold only under the direct supervision of a licensed pharmacist;

2. ensuring adequate security for all dangerous drugs, including methods of storage and labeling; and

3. regulating the sale and distribution of patent or nonprescription drugs under AS 44.62.250 when required by an emergency to protect the public health and safety.

Notice is also given that any person interested may present written statements or arguments relevant to the action proposed by mailing them so they are received by 4:30 p.m., February 18, 1981 to:

Department of Commerce & Economic Development
Division of Occupational Licensing
Board of Pharmacy - Regulations
Pouch D
Juneau, Alaska 99811

This action is not expected to require an increased appropriation.

Copies of the proposed regulation changes may be obtained by requesting them from the above address. The Department of Commerce & Economic Development, Board of Pharmacy, upon its own motion or at the instance of any interested person, may thereafter adopt the proposals substantially as described above without further notice or may decide to take no action on them.

Charles R. Webber, Commissioner

January 13, 1981
Date

STATE OF ALASKA

STATE OF ALASKA
NOTICE OF PROPOSED CHANGES IN THE REGULATIONS OF
THE DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
BOARD OF MARINE PILOTS

Notice is hereby given that the Department of Commerce and Economic Development, Board of Marine Pilots, under authority vested by AS 08.62.040(a)(4), proposes to adopt and amend regulations in Title 12 of the Alaska Administrative Code, dealing with pilotage rates for Southwest Alaska, to implement AS 08.64.040(a)(4) as follows:

The Alaska Board of Marine Pilots adopted pilotage tariffs for Southwest Alaskan ports, effective October 1, 1980. A proposal to amend these tariffs has recently been submitted by the Southwest Alaska Pilots Association and accepted by the Board of Marine Pilots for consideration and public hearing to reclassify and identify that portion of the adopted pilotage tariffs as "cost of pilot boat fees," as follows:

"To reclassify part of the $260,000 shown as appropriate expense for pilot boat fees to other appropriate expense classifications approved by the board, while leaving the existing tariff in force."

Notice is also given that any person interested may present oral or written statements or arguments relevant to the action proposed at a hearing to be held at the third floor conference room, Sealaska Plaza Building, Juneau, Alaska, at 9:00 a.m., on February 17, 1981.

It is estimated that this action will not require an increased appropriation.

Copies of the proposed tariff amendments may be obtained by writing to:

Department of Commerce & Economic Development
Board of Marine Pilots - Regulations
Pouch D
Juneau, Alaska 99811

Copies of the proposed tariff increase regulations may be obtained by writing to the above address.

The Department of Commerce & Economic Development, Board of Marine Pilots, upon its own motion or at the instance of any interested person, may thereafter finally adopt the proposals substantially as described above without further notice.

Charles R. Webber

Charles R. Webber, Commissioner

January 12, 1981
Date

PRESTON, THORGRIMSON, ELLIS & HOLMAN
420 L STREET - SUITE 404
ANCHORAGE, ALASKA 99501
(907) 276-1969

PACE

MEMORANDUM

To: Arlon Tussing

From: John R. Messenger

Date: March 26, 1980

Re: Legal Issues relating to the establishment of the Alaska Citizens Wealth Ownership Program

In the course of drafting legislation for the Alaska Citizens Wealth Ownership Program, it has been necessary to consider numerous legal issues which are not immediately apparent from a reading of the proposed legislation. The purpose of this memorandum is to identify those issues, indicate how they have been dealt with in the proposed legislation and indicate what issues remain unresolved at this time. This final point is particularly important because in the time available, it has not been possible to undertake a complete analysis of all the legal issues.

Perhaps because of the novel and ambitious nature of the project, the legal questions are numerous and wide ranging. For example, it has been necessary to address several federal and state constitutional issues, including: a) whether the program serves a public purpose as required by Art. IX, §6 of the Alaska Constitution, b) whether the conveyance to a trust of the state's oil and gas royalty interests results in a dedication of revenues in violation of Art. IX, §7 of the Alaska Constitution, c) whether the restrictions on eligibility for ownership and/or the restrictions on alienation of the ownership interests runs afoul either of federal and state equal protection clauses, the due process clauses or the federal privileges and immunities clause of the United States Constitution, and d) whether enactment of the proposed legislation is sufficiently similar to the AGSOC initiative certified by the Lt. Governor so as to void the initiative petition as provided for in Art. XI §4 of the Alaska Constitution. In addition to these constitutional matters, we have had to consider federal statutory and regulatory questions in the area of federal securities law, federal income

tax, and federal restrictions on the alienation of the state's minerals. The discussion which follows is intended only to provide a brief, general review of these issues.

EQUAL PROTECTION, DUE PROCESS, AND PRIVILEGES AND IMMUNITY CLAUSES OF THE FEDERAL AND STATE CONSTITUTIONS

Restricting the benefits of the wealth ownership program to residents, creating a closed class of eligible participants, prohibiting the transfer of beneficial rights to nonresidents, each raise serious questions under the federal and state equal protection clauses, due process clauses, and under the federal privileges and immunities clause of the U. S. Constitution and State of Alaska Constitution.

Without reviewing in detail the specific standards state and federal courts might use in reviewing this legislation, we can say that a court will look to the purposes of legislation and the nature of the governmental interests involved, the nature of the interests affected, and how carefully the legislation is tailored to meet the purposes of the legislation.

Because the court will carefully scrutinize the public purposes addressed by the legislation, substantial care must be exercised in stating these purposes and structuring the classifications and restrictions in legislation as closely as possible to accomplish these purposes and not any improper purposes. Each restriction must be examined to determine if it is necessary and whether it is the best, or perhaps only, way to accomplish the desired objective.

There are several legitimate state purposes which can be advanced for an Alaska Citizens Wealth Ownership program and which are set out in the proposed legislation. To the extent possible, the restrictions appear to have been drawn to meet these objectives.

Notwithstanding the care in the legislative drafting, serious constitional questions remain. At this point, it is difficult to predict how a court will resolve these issues I believe additional analysis should be done before any plan is implemented.

PUBLIC PURPOSE

An investment of state funds in business enterprises or the transfer of public property at less than its full value, raises the question whether those investments or

transfers have a public purpose as required by Art. IX, §6 of the Alaska Constitution. In order to satisfy this provision of the State Constitution, a court must be able to conclude that the state funds expended under the Alaska Citizens Wealth Program are being used for a public purpose.

Many older court cases hold that state and local governments may only tax sufficiently to pay for the basic functions of government such as education, police protection, and maintaining public works and may not use public funds for investing in or aiding private individuals or business. In fact, some of those early cases struck down aid given to, and subscription of stock in, private business. Modern case law has given states much more latitude to venture into the private economy to relieve economic stress and unemployment, to encourage industrial development, and to promote local industry. These purposes have been achieved and sustained through the use of loans, loan guarantees, revenue bonds, and tax credits.

Because the courts will not set aside a legislative finding of public purpose unless it appears that the finding is arbitrary and without any reasonable basis in fact; the proposed legislation has been structured to state the legitimate public purposes that would be served by the program. I believe these findings, buttressed by a record of public hearings and debate should allow the legislation to withstand a public purpose challenge.

DEDICATION OF REVENUES

The transfer of the state's royalties, especially if made at less than full value, might be interpreted as a dedication of revenues in violation of Art. IX, §7 of the Alaska Consitution. Although a plain reading of section 7 would seem to say that only the dedication of taxes and license fees is prohibited, the Attorney General has ruled that the constitutional prohibition applies to all revenues including royalties from minerals produced from State-owned lands.

If we accept the Attorney General's conclusion that the dedication of royalties is proscribed, there is a significant possibility that the transfer of royalties to the trust is in violation of section 7 of Article IX. This possibility is increased to the extent, that the royalty interest is sold for less than its full market value and/or is stripped of many of its property ownership attributes.

The legislation has attempted to deal with this problem by structuring the transfer as a sale of the royalty at its fair market value. We believe a fair market sale, where the proceeds from the sale go to the general fund, may overcome the dedication of revenue problems. We also note that, notwithstanding the ruling of the Attorney General, there is a possibility that royalty revenues are not subject to the constitutional prohibition against dedication.

SUBSTANTIALLY SIMILAR LEGISLATION

It is difficult to say whether or not the proposed legislation is sufficient to void the initiative petition creating a general stock ownership corporation.

The Alaska Supreme Court has held that the legislature has wide discretion when enacting legislation and has, therefore, found legislation to be substantially similar, if in general the legislative act achieves the same general purpose as a proposed initiative by comparable means. The court, however, was closely divided over the question. A minority of the court concluded that the legislature has considerably less discretion and that the legislature must almost duplicate the initiative in order to remove it from the ballot.

With respect to the proposed legislation, there are reasons for concluding that the Alaska Citizens Wealth Ownership Program achieves the same general purposes as the initiative. However, there are also reasons for concluding that not all the purposes of the GSOC approach are met by the proposed legislation. If we assume the Supreme Court will adhere to the test established earlier, the outcome is uncertain. On the other hand, if the court should move closer to the minority position, then it is likely that this legislation does not void the GSOC initiative since the means used to reach the public purposes are different.

RESTRICTIONS ON THE ALIENATION OF THE STATE'S MINERALS

Under section 6(i) of the Alaska Statehood Act, the state is required to retain all minerals in mineral lands conveyed to the state by the federal government pursuant to section 6(a) and (b) of the Statehood Act. If the State attempts to convey the mineral estate, the Attorney General of the United States may bring an action for the forfeiture of the lands affected by the purported conveyance.

Although there is room for debate on the matter, I believe a conveyance of only the royalty interest to the trust would not be a violation of section 6(i). The proposed

legislation attempts to assure this outcome by requiring the Commissioner expressly to retain the mineral estate. I must note, however, that the oil and gas law of other states treats the royalty interest in many different ways, and in the absence of Alaskan case law on the subject, it is not possible to predict how an Alaskan state or federal court might treat the conveyance of a royalty interest.

It is possible to avoid the 6(i) prohibition by conveying to the trust only those leases or portions of leases on lands received by the state by operation of the Submerged Lands Act of 1953. Since there is no restriction on the alienation of the state's mineral interest in lands received under the Submerged Lands Act, the state can convey the royalty interest from such lands without fear of the 6(i) forfeiture.

A cautious approach would dictate that only submerged lands be conveyed to the trust.

FEDERAL TAX QUESTIONS

There are several tax questions which must be analyzed further before any of the ownership plans are implemented. Indeed, since the federal tax consequences to both the state and individual citizens are of great importance, I suggest the state request a ruling from the Internal Revenue Service prior to final implementation.*

Some of these questions are:

(1) Must the state pay federal taxes on the income received from the earnings on and sale of assets purchased by the state under each of the plans; (2) Must citizens who receive (or purchase) ownership rights pay federal taxes on the rights received (or purchased); (3) Must the trust or other entity pay federal taxes on the earnings of the assets held by them.

---

* The IRS has refused to issue a ruling on the tax status of two recently created royalty trusts of the type included in the proposed legislation.

Although a state is not generally taxed on the income received from its investment of surplus funds, the issue is not free from doubt when the state owns and operates a business enterprise. To avoid this problem, the legislation is structured so that the state's role is limited to that of making short term investments and subsequent sale of those investments.

Any sale or distribution of ownership rights at less than full value might be the basis for an IRS contention that the individual Alaskan has realized income from the transfer.

On the other hand, purchase of an asset which will produce income in the future does not necessarily result in taxable income to the purchaser in the year of purchase simply because the asset is valuable. The draft legislation contains provisions which require assigning a value to the ownership rights and further requires that the participants pay that value. To the extent, however, that this value is below full market value, it is possible, and perhaps even probable that the IRS will treat the difference between the purchase price and the true value as taxable income to the participant at the time he receives his ownership rights.

Whether the entities to be created under the program will be subject to federal taxation will depend upon the nature of the entity created. Some of the entities contemplated under the program are vehicles which, if properly implemented, should avoid taxation at the corporate or trust level.

In the case of the Energy Resource Trust, the legislation has been drafted to avoid the trust being taxable and to provide that the income and allowable deductions flow through to the individual certificate holders. It should be noted, however, that there are only a few trusts of this type and a dearth of precedent on their taxable status. Whether the trust established under the proposed legislation would be nontaxable is not absolutely free from doubt. If the state decides to implement the trust, it should press the IRS for a ruling.

SECURITIES LAW

The distribution of ownership rights to Alaskans, raise several securities law questions.

For example, the proposed distribution of trust participation certificates under the Energy Resource Trust involves certain federal and state securities law issues. The key issue is

whether the distribution of trust participation certificates will be exempt from the registration requirements of the Securities Act of 1933 ("the 1933 Act") and the Alaska Securities Act of 1959 ("the 1959 Act"). In this regard, the Trust may be deemed to be a "public instrumentality" of the state, exempt from registration under Section 3(a)(2) of the 1933 Act and Section 45.55.140(1) of the 1959 Act may be available. In addition, it is possible that the distribution of trust participation certificates could be exempt from registration under the 1933 Act if the distribution complies with the requirements of Section 3(a)(11) of the 1933 Act regarding securities offered and sold to residents of a single state. The state, in any event, should obtain a "no action" letter from the Securities Exchange Commission before proceeding with the offering. As part of the distribution, the state must comply with the disclosure requirements of the 1933 Act, the 1959 Act and the Securities and Exchange Act of 1934, through the preparation and distribution of a prospectus containing detailed information about the trust and the trust participation units.

If the state elects to sell the trust participation units on an installment basis, it should seek a determination by the Federal Reserve Board that the margin requirements do not apply to such sales. While it appears that the margin regulations do not apply, clearance from the Federal Reserve Board should be sought before any distribution of the trust participation certificates. Similarly, in regard to the other plans being reviewed by the Commissioner, the extension of credit by the state in connection with sales of stock or other participation units raises the issue of compliance with the Federal Reserve margin regulations. Each plan may present differing problems and require separate analysis. A possible planning method would be the issuance of serial warrants to purchase the stock or participation units which could then be excercised by the citizen recipients over a period of time.

NABORS ALASKA DRILLING, INC.
OIL WELL DRILLING CONTRACTORS
HEAD OFFICE
4706 BUSINESS PARK BLVD., SUITE 1
ANCHORAGE, ALASKA 99503

Rec 1/15/81

WORKMEN'S COMPENSATION STATE OF ALASKA

GOVERNOR'S COMMISSION ON WORKMEN'S COMPENSATION

SENATOR TERRY STIMSON, CHAIRMAN

JANUARY 1981

"TESTIMONY"

Prepared by Des Ashley
Safety Director
Nabors Alaska Drilling, Inc.

President: Jim Taylor

I. INTRODUCTION:

A. The chief purpose of the Workmen's Compensation Law was to do away with the old disputed questions of negligence, assumption of risk, etc. It was to establish amounts for damages recoverable for specific loss of wages caused by occupational illness, injury, or death.

This purpose has been circumvented because of the general climate surrounding the attitude of worker, employer, insurance companies, claims representatives, the medical profession, and compounded by legal complexities involved in administering the act. The Alaska Workmen's Compensation Act has deviated far afield from the original intent. It is arbitrary and oppressive now in scope.

B. The philosophy behind compensation as originally intended reflects to the contrary. It certainly fails to be efficient and in some cases is even very undignified.

C. This law has become burdensome. The language and content complex, - so complex the Superior Court of Alaska must define legal intentions of the Act prior to a ruling, or settlement being made by the Workmen's Compensation Board in some cases. Arguments rendered during hearings are usually points of law that cannot be answered by the panel.

II. AREAS OF CONCERN:

Many questions should be raised by the citizenry of the state, as they eventually will pay the bills for this insurance. As an employer of approximately 400 persons, we wish to raise just a few of our concerns to this commission.

Will this commission appointed by the Governor of Alaska address:

A. The need to rewrite the legal aspect of the Workmen's Compensation Act into non-legalese language that can be understood by all, with little chance of misinterpretation of the intent of the law. This would reduce arguments over points of law, and serve as an educational tool for the employee/employer. This would provide the definitions and directions for the Workmen's Compensation Board members.

B. The need to provide substantial relief to employers by use of the Second Injury Fund.

C. The need to adjust compensation rates according to the State of Alaska Department of Labor average weekly wage reported ... When considering the Boom Era employee, use the appropriate percentage of earnings for the previous 2,000 hours at that specific skill.... without considering some method to adjust, let's say, the North Slope worker's earnings now. This insurance that continues to rise will eventually break many private businesses.

D. The need to provide professional crisis intervention to the totally or partially incapacitated worker, quickly. This "intervention" can be initiated by the attending physician, the employer who realizes that in reality, the worker is unable again to perform the job function. Rather than the worker feeling sorry about his loss, professional rehabilitation services could prepare and in most cases start rehabilitation efforts to again make this person a wage earner, upon being released by his attending physician to work.

E. The need to provide better policing of the Act to reduce by at least 25 percent the abusers and malingerers.

F. The need to the State of Alaska to randomly audit annually a percentage of workers drawing Workmen's Compensation. The annual review of the record of professional care rendered, service fees paid, justification for retraining, and monies paid for time loss and physical impairments would provide a good overview to the Alaskan Legislature.

G. AS 23.30.010 - entitled Coverage in the case Wilson v. Erickson, Superior Court (File No. 1277) 1970. ruled, "that Aggravation of a pre-existing condition would in fact be compensable." Let's look at this ruling from an employer's view. To the employer who screens his employees prior to hire -- finds the following impairments.

The employee:

(1) Has a significant high frequency hearing loss (chronic-not reversible).

(2) Has significant disc space narrowing at L-4,5, consistent with degenerative disc disease (chronic-not reversible).

His work history is stable, and skills are needed in the industry.

The employer must weigh his liability that he will assume if in fact he decides to hire. Under this section of Workmen's Compensation, both hearing loss and degenerative disc disease is compensable. The hearing loss was Binaural and under the AMA guide for computing disability, let's assume the loss equals 22 percent. As this represents total loss in both ears, he could theoretically receive 200 weeks of compensation, not to exceed $28,000. So immediately the employer is faced with a liability of approximately $6,160, should in fact he be hired on, and within a short time, the worker becomes disatisfied with his employment. He files a nuisance claim. He could be awarded X amount in settlement. This is, in our opinion, unreasonable. The second chronic medical condition is an abnormal finding to the back, again an example of a compensable disease if aggravated by his condition of work. To further illustrate the importance of this section of law, Nabors Alaska Drilling, Inc. of

Anchorage, from August, 1980 through December 31, 1980, accomplished 100 pre-employment physicals for new hires. Hearing losses were moderate to severe in over 65 percent of those being considered for employment. Acute to chronic back ailments existed in 35 percent. Certainly we must agree that these figures are burdensome when we consider the amount of liability assumed by the employer. Remember, these are new hires. People out of work or wanting to improve their incomes. Now let's look at it from another viewpoint. The employer fails to accept these physical abnormalities out of business necessity, safety of the employee, and others. The next thing you know, a grievance by the worker has been filed with the Office of Equal Opportunity, Department of Labor, Human Rights Commission or whomever - disputing hiring practices, etc. Again the employer has difficulty dealing with more laws. This in turn increases the price of the product. This also sets a poor climate in the work place by giving the employers no recourse but to refuse to hire.

The Second Injury Fund is not the answer as presently written. The State of Alaska, as any other state, has also a responsibility to maintain productivity among its citizenry.

Employers would, in my opinion, be less concerned about hiring the physically impaired employee, if

in fact, the Second Injury Fund would assume some of this burden by favoring the employer's positive attitude in maintaining productive wage earners, rather than increasing unemployment rates or other liberal benefit programs.

H. Sec. 23.30.120: Presumptions: This section of the law was originally very simple. The injured employee was entitled to coverage, unless he caused the act because of his intoxicated state. No, I'm sorry, he was playing basketball, slipped on the waxed floor, fell out of bed, hurt his back when putting on his boots. Most employers have Group Medical Plans to cover such acts, but because it is impossible to prove when the act supposedly took place, it is presumed to have happened while at work. (This section is the catch-all requiring even the involvement of the Supreme Court to define the law.) This aspect of the law is argumentative, and burdensome, and an attorney's dream for dispute.

I. RATES of compensation should be re-addressed to be consistent with the intent of the law. When rates are too high, we create in some workers the attitude of, "Why work? -- Just sit back and collect compensation."

J. PROGRAMS are designed without providing adequate checks and balances to protect itself from the abusers. Our industry alone had many abusers until we started policing the activities of the program participants. The bad part about casting suspicion

on a few is -- that it can lower the dignity of deserving workers.

K. POLICE POWERS must be received at each level of the providers from the Insurance Company, Claim Adjustors, Self-Insured,Medical, Legal, Rehabilitation Services, and Employers.

III. CONCLUSION:

One of the chief kinds of insurance that the law requires an employer to carry is workmen's compensation insurance. Every state requires that the disability for which the workman claims compensation must have occurred in the course of his employment. Injuries that are self-inflicted or that are the result of intoxication of willful misconduct are generally excluded from coverage. A few states have passed laws requiring that employers insure their workers against illness or injury that is not connected with their jobs. This insurance in most cases is paid jointly by the worker and employer. Employers must also contribute toward old age survivors and disability insurance, more popularly known as social security. Employers must pay also toward unemployment insurance. Anyone engaged in a business will find it to his advantage to carry a number of additional kinds of insurance that will protect him against loss or injury caused by his employees or suffered by them.

Where does it end?

Respectfully submitted,

Des Ashley

Jim Taylor
President

Des Ashley
Safety Director

ALASCOM, INC.'s PAPER

IN SUPPORT OF THE POSITION OF

WORKER's COMPENSATION COMMITTEE OF ALASKA

Alascom management has had an opportunity to review the position paper, dated December 13, 1980, of the Worker's Compensation Committee of Alaska (WCCA). Alascom supports the position taken by the WCCA.

Perhaps, for the record, it should be explained that Alascom is Public Utility. Its chief source of revenue is long distance telephone calls. In its ten years of existence, its number of employees has tripled to approximately 1400 and the number of calls it handles increased almost six-fold to over 32,000,000 calls a year.

At Alascom, the Safety Administrator is directly involved in the administration of all worker's compensation claims. So, as Safety Administrator, I've been asked to bring to your attention four (4) different Alascom cases that illustrate excesses permitted by the current statutes and are relevant to WCCA's position. The four cases are representative. They do not constitute the total experience of Alascom. A brief description of those four cases follows:

1. Too Liberal Bunk House Rules Interpretation

   An Alascom employee, assigned to a remote site, drove off the road and was injured after "bartending" at a friend's party. The employee claimed he had had only three beers and fell asleep while driving.

   The Workmen's Compensation Board awarded full benefits. Their decision was based on several comparable cases and decisions. We feel the interpretation was liberal to the point of removing employee incentive to remain healthy.

In our opinion, when an employee disregards his own safety, and defies the laws of self-preservation, the employer should not be held responsible for actions committed outside his regular work assignment.

2. A Search for a Physician to Support Claim

An Alascom employee reported a hip injury, claiming his foot slipped from a step ladder. Medical examination indicated he had had hip surgery as a fourteen year old and additional surgery was again indicated because of the natural growth of the bones (and body). At the request of the employee, a second medical opinion confirmed the original diagnosis and again indicated that there was no connection between the alleged slip from the ladder and the distress the employee was suffering.

Unsatisfied with these medical opinions, the employee started his search for a doctor who would support his claim. We do not know how many doctors the employee talked to before he found one willing to support his claim, but he did find one in Southern California and brought suit against Alascom.

Alascom prevailed and the Workmen's Compensation Board made no award to the employee. Time and expenses incurred by Alascom, however, were not recoverable.

3. Unqualified Medical Opinion and Treatment

Alascom's relationship with the medical profession has been very good. It is the rare exception in which we are in disagreement with any of their decisions or recommendations for any of our employees.

Within the last year however, we had an employee who selected a chiropractor to treat a disease that was, in the opinion of qualified medical people, not related to the chiropractor's speciality. Despite qualified medical opinion to the contrary, both the employee and the chiropractor claimed the disease was the result of an industrial accident. Alascom feels that expenses incurred in incidents of this type are wasteful.

4. Double or Greater Payments

Alascom has had an employee who was collecting allowable absence (sick) pay while working at a job with similar physical requirements outside the Company. He filed for workmen's compensation payments covering the same period of time. Despite the outcome, Alascom once again suffers costs that are wasteful.

Finally, Alascom's position is virtually identical to that of the WCCA. We wish to see the legitimate entitlement of the injured Alaskan worker preserved. We do, however, question the wisdom of any act that makes it financially attractive to be injured, or levies wasteful burdens upon the employer. All of Alascom's worker's compensation expenses are passed along to the consumer. As a public utility we feel a strong obligation to the consumer to control, reasonably, all costs.

In conclusion, we ask that you review those provisions of the Worker's Compensation Act that permit injured employees to abuse a worthwhile benefit. We hope your consideration will lead to an equitable fine tuning of the law.

John Morain
1-16-81

MACI
MINNESOTA ASSOCIATION OF COMMERCE AND INDUSTRY

Joe S. Note Minn. Business Opposition to Insurance Co 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

State Invests in Reliable Workers' Compensation

Ralph J. Marlatt

by Ralph J. Marlatt, President
Insurance Federation of Minnesota

The first responsibility of the insurance industry is to guarantee that Minnesota's workers' compensation system is able to pay the medical expenses and lost wages to persons injured in the course of employment or to their survivors in the case of their death.

No matter if the injuries are the fault of the employer, the employee, or are merely incidental to industry, compensation is made and charged to the cost of production through workers' compensation insurance. Meeting these costs fairly, through responsible laws and administration, is a fundamental requirement for protecting our work force.

The insurance industry is sensitive to mounting criticism over the integrity of our workers' compensation system. A system that has never failed to fund the cost of benefits to injured Minnesota workers in the past 66 years, must be doing something right.

For a clear understanding of the problems that exist in our system today, it is important to know that the last proposal for a revision of rates was filed by the insurance industry on August 29, 1977 (based on 1976 statistics), and the last insurance commissioner's order revising rates was in April of 1978.

The pending proposal for an increase in rates was first filed April 30, 1979. Because of intervening legislative action, enacted by the 1979 special session, that proposal was refiled September 13, 1979. Hearing on this proposal began February 21, 1980. The hearings, while still in progress, are scheduled to be concluded within the near future.

It is fundamental to understand that workers' compensation rates are determined by the actual loss experience incurred in Minnesota by all insurance companies operating in the state. The rate level has increased by 53.7 percent since 1975. This is a yearly average increase of less than 9 percent. Of that 53.7 percent, a shocking 47.3 percent was necessary to pay benefit increases mandated by the legislature, and 4.3 percent was due to actual experience. In other words, over 90 percent of the rate increases over the past five years are directly tied to legislative changes in benefits.

The significant cost impact on the current workers' compensation system is found in three areas: (1) death and permanent total benefits, (2) the annual escalation of benefits, and (3) permanent partial disability benefits.

The primary excesses in the system, however, occur in the permanent partial area. These excesses are caused by the subjective standard for judging disability and inappropriate timing within which such benefits are paid.

Businesspersons in Minnesota are on an unequal footing with businesspersons in Wisconsin because Minnesotans pay up to $226 per week (times the number of scheduled weeks for the injury) compared with Wisconsin's maximum permanent partial disability payment of $72 per week.

If the Minnesota benefit structure for permanent partial disability alone were placed on top of the Wisconsin law, Wisconsin would have to increase its workers' compensation rates by 40 percent. The primary target area for cost control in the system is a restructuring of the Minnesota permanent partial disability benefits.

Permanent partial benefits were originally intended to provide compensation for permanent bodily injuries, which were assumed to affect earning capacity. Today, these benefits in Minnesota are payable for "functional loss of use or impairment of function, permanent in nature," and represent general damages (pain and suffering) rather than payment for loss in earning capacity.

Unfortunately, the concern by many knowledgeable people over the obligation of workers' compensation insurance to fund future costs via the reserving mechanism is often misdirected. The system is not "pay as you go," by law, this liability to pay must be fully funded when the accident or incident happens. This is the risk factor assumed by the insurance carrier or the self-insured company.

For example, many employers point to a workers' compensation benefit payout to an employee for medical and lost wages of, say, $6,000 in one year, while the insurance carrier reserved the total cost of $50,000 -- the $50,000 being the potential cost of future payments necessary to meet statutory requirements in the years ahead. These "reserves," by the way, are monitored for actual payout in the statutory reporting process for ratemaking.

The natural question is, what does the insurance carrier or self-insured company do with this committed money?

They use it. They may invest it -- in good times or bad. Sometimes they make money on the combination of rates, losses paid and income from investments, and sometimes they don't. The real advantage is that this guaranteed payment system has never failed to provide the money for benefits to injured Minnesota workers - a record of stability with 66 years actual experience.

For calendar year, 1978, statistics show that for every dollar a Minnesota workers' compensation insurer had to work with, $1.23 was expended. Even under the most liberal earnings assumptions, one cannot conclude that carriers made rip-off profits on policyholders' dollars after tax.

In addition, the 1979 law prevents insurance carriers from maintaining reserves in excess of $300,000 for claims occurring after October 1, 1979. Claims in excess of $100,000

(Continued on page 14)

or $300,000 (depending on the retention limit selected) are taken over by the Workers' Compensation Reinsurance Association. When the magnitude of a claim is in excess of $100,000 or $300,000 the Reinsurance Association conducts an independent analysis of the claim itself and maintains necessary reserves up to $500,000.

By legislative action, a philosophical break has been made in funding workers' compensation losses. Beyond $500,000 we are in a "pay as you go" concept, pushing these costs into the future. An insurance company no longer receives investment income or reserves in excess of $100,000 or $300,000.

The disincentives in the current workers' compensation system can be balanced if we all work toward improving the process. We are committed to a healthy, responsible insurance industry, combined with a sound economic climate, where all business can grow and prosper.

–Minneapolis Star
May 23, 1980

Workers' Comp
Assigned Risk Applications

Each year the Rating Association returns many Assigned Risk Applications to agents for a wide variety of reasons. This, of course, creates additional work for the agents and the association staff. Essentially there are seven general reasons for which the association may return an application for assigned risk coverage. They are:

1. Inadequate Premium Deposit (generally wrong rates, modifications or codes used)
2. Lack of Authorized Employer's Signature (no signature or non-owner/officer)
3. Wrong Check Format (insured's check must be certified)
4. Premium Owing to Past Carrier (billed and delinquent only)
5. Name Insured (unclear or incomplete)
6. Inadequate Payroll Information (unable to calculate deposit premium)
7. Inadequate Job Description (too general or vague)

A recent survey of returned applications conducted by the association pointed out one particular problem which seems to be on the increase. This is the failure to properly complete Item No. 7 of the Assigned Risk Application. This is the portion of the application which requires the listing of a voluntary market source which has rejected a request for coverage for the applicant. Part of the eligibility rules of the Pool require that a licensed insuror must decline to provide voluntary coverage.

The application requires the name of the declining carrier, the name of the underwriter contacted, and the date of contact must be provided. Care in the completion of this part of the application may avoid the return of the application.

Another problem that has recently been brought to the association has to do with the issuance of Certificates of Insurance. Under the plan rules only the association or the servicing carrier have the authority to issue such certificates.

The servicing carriers are required to respond promptly to requests for certificates. However, when an out-state servicing carrier is involved, and there is an immediate need for the certificate it is suggested that you consider contacting the association offices for the issuance of a temporary Certificate of Insurance. This certificate is valid evidence of coverage and allows the employee to begin work while the servicing carrier processes the certificate.

–Marie Johnson
Workers' Compensation
Insurers Rating Assn.
of Minnesota

1. Mr. Marlatt says that "for a clear understanding" of workers' compensation problems it is important to know that it has been 29 months since the last insurance rate revision. That statement conveys no information at all, except the implicit suggestion that something, presumably inflation, has made the 29-month-old rates inadequate. One's understanding of workers' compensation problems becomes clearer yet when one recalls that insurance rates are based on total payroll dollars; in other words, one pays a premium of X dollars per hundred dollars of payroll. This means that as payrolls rise with inflation, so do insurance premiums, without any need for a rate increase. There is a built-in inflation adjustment.

2. Mr. Marlatt says the "rate level has increased 53.7 percent since 1975"; or less than nine percent per year. Actual dollar figures from the State Insurance Commissioner's Office show that in 1975 total premiums were $162,615,905, and by 1978 had risen to $351,454,462, an increase of about 116 percent in three years.

3 & 4. Mr. Marlatt says that "for calendar year 1978, statistics show that for every dollar a Minnesota workers' compensation insurer had to work with, $1.23 was expended." This sounds like an alarming situation. Fortunately it is not, because the statement is inaccurate. Actually, in 1978 Total Net Earned Premiums were $351,454,462, and Paid Losses (i.e. dollars actually expended) came to $146, 270,601. It would be more accurate to say that for every dollar a Minnesota workers' compensation insurer took in during 1978, a little over 41¢ poured out in payments, or one-third of Mr. Marlatt's figure.

Another 50¢ of each of those 1978 dollars was set aside by the insurance companies to cover long-term costs of injuries occuring that year. The companies do this by estimating the total cost of a claim over the years, allowing for inflation, and then they "reserve" that total amount of needed dollars up front. Mr. Marlatt said that the companies "may invest it"; you bet your boots they do. But they steadfastly resist having investment profits taken into account in setting the rates that employers must pay for their insurance. This means that the proposed rate is really a fiction. Let's look at a simplified example of how this works. Suppose an obligation exists to pay $10,000 per year for 30 years (we'll leave out the inflation factor - it doesn't change the principle). The insurance company would insist on getting the total amount of $300,000, in today's dollars, up front. Also, it needs money for administration expenses and profit, so by their bookkeeping techniques, it would say that it needs about $400,000 of the employers' dollars right now, or it is "losing money." Of course, if you took just half of that amount and invested it at a conservative five percent rate, you could meet your $10,000 per year obligation, pocket the other $200,000, and when 30 years are up, the original invested $200,000 would still be there for you. And in the real world this is exactly what happens.

Employers ought to get some of the benefit of the invested income working for them to help in holding down insurance rates. This is not a particularly radical idea; there is a close parallel in the banking industry, hardly a bastion of wild-eyed speculators. Suppose that you needed $10,000 in the year 1990. If you took slightly over $6,000 down to your friendly neighborhood band and invested it at five percent, you would have your $10,000 in 1990, and the bank would probably still be solvent. But if the insurance industry's bookkeeping principles are applied to this situation, the bank would have "lost" a terrific amount of money; to pay you $10,000 in 1990, they would require a deposit of over $13,000 in 1980, to cover the $10,000 they are obligated to pay plus expenses and a small allowance for profit. If they received less than the $13,000 in 1980, they would

say that they are "losing money" on the transaction. There are a number of conclusions that can be drawn from the above example: either the nation's banks are embarked on a headlong dash to financial disaster, or bankers are a lot smarter investors than insurers, or someone is making more money than they care to admit. You can take your pick.

5. A review of the inpact of taxation on insurance costs is long overdue.

6. Mr. Marlatt said that "a system that has never failed to fund the cost of benefits to injured Minnesota workers in the past 66 years must be doing something right." He has missed the point entirely. The criticism of the insurance industry is not that it is insolvent, but rather that it may well be <u>too</u> solvent, at the expense of the employers of this state.

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...LASKA ...DVOCATE

Anchorage says good-bye to Mr. Whitekeys

Is this man crippled crazy, or a fraud?

The tortured tale of Workmen's Compensation in Alaska.

by Richard A. Fineberg

Workmen's comp under fire

Delay, frustration and charges of fraud plague the plan to benefit injured workers

by Richard A. Fineberg

Fairbanks

Diane Black, Cecil Kossick and Robert MacArmour have something in common: All three find themselves on the short end of a stick wielded by the workmen's compensation system they thought was supposed to assist them.

Marked differences in style and biography underscore their common complaint. Black, 35, a pipeline bullcook, is a wandering, mystical graduate of the youth movements of the '60's; MacArmour, 40, a compressor operator, is a fundamentalist Christian and family man; Kossick, 50, an insurance agent, is a hunky, soft-spoken man whose avocation is trophy hunting.

Despite these outward differences, there are striking similarities in their cases and their conclusions. All three:

- suffered back injuries on the pipeline;
- claim they were unfairly denied disability payment and medical care by Alaska Pacific Assurance Co. (Alpac), the company that handled workmen's comp for Alyeska Pipeline Service Co.;
- say state officials who oversee the workmen's comp program have ignored their pleas;
- want to see the system reformed.

Alpac—the largest workmen's comp insurer (carrier) in the state—denies the charge that injured workers (claimants) are treated unfairly. "I personally would rather pay a claim that was doubtful...than to take the chance I had denied benefits to a man unjustly," Barbara Grissom, Alpac director of worker's compensation, told the *Advocate*.

From the records Alpac has presented, it appears that the insurance company believes Black, Kossick and MacArmour are exagerating their maladies—and that Black and MacArmour's complaints may be caused by pre-existing psychological problems.

If you're injured on the job, workmen's comp is supposed to cover lost income and medical expenses—even rehabilitation, should it be necessary. That's the law, and that's the way the system works—for many people. But there's another side to this coin: If you run afoul of the workmen's comp system, the torturous path to recovery can become a nightmare maze of cumbersome administrative procedures, arcane medical opinions and expensive, time-consuming legal actions.

Black, who has formed a group called Action for Victims of Industrial Accidents (AVIA) says she knows of about 50 workers who, like herself, feel they have received a raw deal from the workmen's comp system. According to Black, although she has about 20 signed statements from workers detailing their complaints, she has received little response and no action from public officials.

John Cook, director of the state Workmen's Compensation Division, acknowledges that his office is understaffed and overworked. "We're understaffed down here (in Juneau)...," he says, "because of the pipeline load."

The state agency, a part of the Department of Labor, provides administrative support for the three-person Workmen's Compensation Board. The Board hears and issues orders resolving problems that develop between injured workers (claimants) and the comp carrier.

The division does not review the Board's work, Cook said. A claimant who feels wronged by a Board decision may file a court case against the comp carrier and the Board.

Comp carriers in Alaska handle 15,000 to 20,000 cases per year, according to Cook. Most injured workers, division personnel maintain, get prompt and complete coverage. There are foul-ups, a state compensation officer told the *Advocate*, but most of the time the problem is simply a matter of paperwork that can be cleared up quickly by a phone call to the insurance carrier.

Although a relatively small percentage of comp claims go to the Board, the case files are voluminous, the procedures and precedents complex. Consequently, the Board is swamped. In 1978 the board issued 394 written orders after hearings in Fairbanks, Anchorage, Juneau and Ketchikan. The Board also considered and approved more than 400 settlements of other disputed

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claims.

According to Cook, although the Board is required by statute to issue its findings within 20 days, the case backlog is so heavy that the average time between hearing and decision, when last calculated, was 96 days. (For a glimpse into the life of a claimant at loggerheads with the comp system, see accompanying story.)

Black, who walks with the aid of a cane and still requires treatment and painkillers for a back injury she says she suffered at a pipeline camp in 1976, said Alpac cut off workmen's comp payment and treatment in 1977 after a California specialist, Dr. Willard F. Pennell, M.D., examined her and advised Alpac:

"It seems apparent there is no need for further treatment of her back and under no circumstances should she be allowed to receive continuing medical care since she will simply utilize this to manipulate everyone with whom she has contact...Termination of her claim in some manner will most probably allow the current complaint to resolve."

Black has testimony from other medical experts contradicting Dr. Pennell. These reports indicate her 1976 pipeline injury has left her with a painfully disabling malady that requires continued treatment.

The Workmen's Comp Board, relying heavily on Dr. Pennell's judgement, has twice ruled against Black's petition that Alpac be required to resume benefit payments and medical care. She says she plans to take the case to court.

Although Dr. Pennell has impeccable professional medical credentials, two knowledgeable attorneys told the *Advocate* Dr. Pennell and his partner are well known for their penchant for siding with insurance companies. San Francisco attorney Marvin Lewis, author of a legal text, *The Psychic Injury*, and past president of the American Trial Lawyers' Association, said he has faced Dr. Pennell's partner in "seven or eight major cases." Commented Lewis:

"They always say my client is faking it; I always win."

Alpac comp director Grissom said Alpac has used Dr. Pennell in five or six Alaska cases she can think of. According to Grissom, Dr. Pennell is "a very competent man" who does not always render a finding that results in denial of benefits to the claimant.

Alpac vice president Gay Dwyre says Pennell is "an independent consultant." Under comp law, Dwyre points out, both the insurance carrier and the claimant have the right to call in one independent consultant.

Pennell's expert opinion plays an important part in the case of Robert MacArmour, who was thrown from a truck in a haul road wreck in May 1977. MacArmour says the back injury he suffered is so painful that he spends most of his time confined to his Fairbanks apartment.

As in Black's case, Dr. Pennell examined the Alpac-sponsored client for an afternoon, then prepared a report for Alpac. In this case the independent consultant said that in his expert opinion MacArmour was faking it and should be denied further benefits. Like Black, MacArmour has medical evaluations from other specialists challenging Dr. Pennell's conclusions. MacArmour's appeal to the Workmen's Comp Board was heard last October 2; he is still waiting for a verdict.

State Workmen's Compensation Director Cook sat on the Board during Black's hearing. On a subsequent trip to Fairbanks, he said, he was here picketing outside the state building.

However, Cook said, he had not been approached directly by AVIA, and he was not aware of the group's specific complaints. The state official said he was unaware of complaints about Dr. Pennell.

The Board's task—sorting our conflicting evidence and deciding who deserves comp benefits and who doesn't—is not an enviable one, Cook said. Frequently the Board is confronted with contradictory medical opinions. According to Cook, "That's one of the Board's problems—deciding which doctor they're going to believe."

Insurance industry sources say that just as some doctors are known for their tendency to side with the carrier, other doctors are known for their leniency to favor the patient by carrying him on workmen's comp for longer than may be necessary.

The problem is particularly acute in the case of soft-tissue injuries in which there is liable to be no clear-cut proof of injury, such as an x-ray showing a fracture. Many back injuries fall into this category.

To some workers facing unemployment, workmen's comp benefits (Alaska's are the highest in the nation) may be worth faking for.

For the comp carrier, as for other insurance policy writers, the problem of sorting out legitimate claims from frauds is a constant one.

One Alpac employee, who said the company tries to handle all cases fairly, said that during the pipeline years "we could always tell a lay-off coming because we'd get a bunch of back injury claims, all at once."

The claims would be filed by several employees of a contractor; a few days later, the contractor would complete an operation and lay off all its workers. This happened several times with several different contractors, she said.

What about the legitimate claimant who finds himself branded a fake? Faced with an overwhelming bureaucracy, complicated medical opinions and a cumbersome, baffling, 110-page, single-spaced booklet that tells him the law, the claimant may need an attorney.

But legal help may be hard to come by for many lawyers shun workmen's comp. "It's very unprofitable," one lawyer told the *Advocate*.

Another lawyer explained that workmen's comp was set up to provide automatic, speedy payment for on-the-job injuries, obviating the need the lawsuits. Nevertheless, workmen's comp has developed into a highly specialized legal field. Although the worker with a comp problem may need a lawyer for the complicated proceedings, the lawyer's fee—which will be set by the Board—is usually minimal.

There are about 75 attorneys in the Fairbanks phone book, but records of workmen's comp proceedings here indicate only a handful regularly represent injured workers before the Board.

(Alpac's Dwyre noted that workers who had comp grievances had access to attorneys through their unions; other sources said union legal staffs were swamped with diverse responsibilities and generally had little time for individual comp cases.

The claimant may have a hard time finding an attorney, but the insurance carrier on the other side seldom lacks for legal talent. One attorney who worked for a large law firm that defended insurance carriers in comp claims said he dealt with only paper, never people. "It's very dehumanizing...I never saw a human being," the attorney said.

The defendant attorney's task in this paper game is to save his client, the insurance

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carrier, money. That means the worker with a comp claim automatically becomes the adversary. "After a while," this attorney said, "you lose perspective; you figure everybody's a fraud."

Alpac writes more comp coverage than all other carriers combined, Alpac's Dwyre says. The company also writes more general liability, she said, than any other carrier in the state.

Unlike most of the insurance carriers in the state, Alpac has its roots in Alaska. The company began in 1967 insuring loggers in Southeast Alaska.

However, Alpac was purchased outright by the Philadelphia-based Insurance Company of North America (INA) in 1971 after the company bagged the contract for the trans-Alaska pipeline project.

According to Alpac's Dwyre, during pipeline construction Alyeska Pipeline Service Co. accounted for about 25 percent of Alpac's business. Additionally, Dwyre said, the pipeline boom greatly increased the business Alpac did with various other Alaska firms on Alpac's roster. (That list includes trucking companies, banks, the Fairbanks Medical Clinic and R&M Engineering, to name a few.)

To handle its pipeline business business Alpac opened offices in Valdez and Fairbanks. The company is also moving Outside.

Alpac offices have sprouted up in Boise and Coeur D'Alene, Ida., Portland, Ore., and Seattle, Wash. Additionally, the company recently moved into California. With the Pacific Coast covered, the Atlantic is next for Alpac: an office is planned for Atlanta, Ga.

In pain and poverty, she is unable to convince officials her plight is a direct result of a back injury... She talks of near suicidal depression.

(photo by Richard Finneberg)

Diana Black

The fuel for Alpac's growth, most observers agree, was the contract with Alyeska. Like many aspects of the pipeline, Alyeska's insurance arrangements were a bit unusual.

Normally, a company purchases workmen's comp insurance for its employees by paying an insurance carrier a premium. In exchange for that premium, the carrier agrees to handle and pay all comp claims out of its own pocket.

That's not the way the Alpac-Alyeska contract worked. Instead, Alyeska paid its own claims, using Alpac to handle the paperwork and adjust the claims. This process, known as self-insurance, has become increasingly widespread in recent years.

It is widely believed Alpac adjusted the claims, took Alyeska's money and gave it to the claimand, then received 13 cents for every dollar paid out as a service charge. In fact, says Alpac controller Don Roark, the contract was quite a bit more complicated.

According to Roark, the Alyeska-Alpac contract divided Alyeska's payment to Alpac into the following major components:

- premium (Alyeska-to-Alpac);
- losses incurred (Alyeska-to-Alpac-to claimant);
- "loss-conversion factor" or service charge (Alyeska-to-Alpac), based on a sliding scale that began at 13 cents per dollar and went down as payments increased;
- state tax (Alyeska-to-Alpac-to-state).

In other words, Alyeska paid Alpac an insurance premium. Then, the pipeline company turned around and paid off the claims, plus a service charge and incidental taxes.

This arrangement reportedly had other pluses for Alpac. For example, Alyeska is said to have deposited a large sum—one source said $500,000—with Alpac at the outset to guarantee there was money to pay comp claims. Alpac garnered the interest from that nest-egg.

In addition, when a worker filed a claim, Alyeska had to deposit the amount the adjustor (Alpac) thought the case might require. Alpac thus had another chunk of interest-bearing cash to add to its account.

It was a rather sizeable chunk: According to Roark, Alpac (Alyeska) paid more than 16,000 workmen's comp claims related to pipeline construction, ranging from incidental medical expenses in some cases to ongoing medical expenses plus thousands of dollars for permanent disabilities.

Considering that Alpac's pipeline money was garnered with no capital investment, no risk, some tax and all ex-

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rotest, challenge over comp

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ses paid, most sources agree Alpac's contract was a fat . Alpac's Roark said he did like that description.

Asked to characterize the ac-Alyeska contract, Roark d, "It was a profitable... cement to Alpac."

Just another bustling bus- s caught up in the commotion the pipeline, Alpac drew e attention. The company tly adjusted claims, pushed ers, made payments and keted profits.

But Alpac was having wing pains. Office managers, stors and clerical staff came went with the fast turn- r rate that plagued most inesses caught in the cur- s of the pipeline. "Swamped" he way Alpac's Dwyre des- ed Alpac's problems with erwork.

Duringthe height of the pipe- , one Alpac employee told *Advocate*, "You could look a (case) file in 16 places; the time you got to the rteenth it had been moved k to the third."

Superimposed on the chaotic estry of this booming little ness were huge chunks of ney floating among Alyeska, nc and the banks, eventually ing parcelled out in slivers jured workers. Alpac's Dwyre firmed reports that $1 million good ball-park estimate

he amount of money that t from Alyeska to Alpac ing a typical month.

According to Roark, the monthly payments took a sudden jump near the end of 1977. "Yes, there was an increase in our losses after the pipeline was completed," the Alpac controller said.

Roark cited three factors for the jump: First, he said, "a lot of supposedly injured workers started developing back and neck problems" as workers faced the end of pipeline wages. Second, the state boosted Alaska's work comp payments. (According to a nationwide survey, Alaska's benefit ceiling is higher than that of any other state in the nation.)

Finally, a number of court cases went against Alyeska, resulting in large court awards.

Late in 1977, while Alpac was requiring more money per month from Alyeska than the company had needed during the peak of pipeline construction, Alyeska's owner companies were exhorting Alyeska to cut costs wherever possible.

The result of this situation, said one knowledgeable source, is that Alpac had to tighten down on comp claims. The seeds of the problem, the source added, were sown during Alpac's rapid growth while the pipeline was being built and came to fruition after the project was completed.

Knife-wielding is a tricky business, and it is easy to see how Alpac, under pressure to bring costs back down, may have cut some people with legitimate problems, as well as the grifters. In any event, many of the problems AVIA members experienced date from those last days of the pipeline.

During the reportedly tense trimming period, Alpac's cutting knife took an ironic twist and chopped off one member of Alyeska's own insurance staff. Cecil Kossick, a heavy equipment damage appraiser for Alyeska, hurt his back early in 1976 when he slipped on the ice boarding a helicopter after inspecting some trailers at Franklin Bluffs.

Alpac dumped Kossick off the workmen's comp roll in April 1977—three months before his doctor released him for light work. Under comp law, if you're injured on the job and cannot work, for two years after the accident you are entitled to wage compensation. If there is permanent damage, the carrier must make a permanent settlement with the claimant.

Unlike the case of Black and MacArmour, in this case Alpac didn't even have its own physicians' report to counter Kossick's; the insurance company just decided Kossick had had enough compensation.

There are several complicating factors in Kossick's case. The comp record shows, for example, that in Kossick's case the Fairbanks Clinic apparently double-billed insurance carriers in some instances, and incorrectly over-billed Alpac in others. But that's not Kossick's fault. The salient fact is that Alpac dropped Kossick without any medical examination or direct testimony.

Stranger still, the Board upheld Alpac. Kossick has gone to court, suing Alpac and the Board.

As Kossick's lawyer argued before the Board: "A Claimant in Mr. Kossick's position is indeed put to difficult decisions. His treating physician tells him... he should not seek work. On the other hand, a claims adjuster for his workmen's compensation carrier tells him that he is able to work and terminates his compensation."

"If he follows his doctor's advice and continues to refrain from work for medical reasons, he suffers economic hardship. If he follows the claims adjuster's advice, he runs the risk of reinjuring himself."

Kossick has rented a small office in Fairbanks and he works part-time as an independent insurance adjustor. He said he still finds climbing difficult and he has to hire somebody to do much of his legwork.

Kossick declines to discuss his comp case and his court appeal of the Board's decision; he is still in the insurance business, he said, and he doesn't want to make waves, noting that the Board case and his appeal are matters of public record, his one comment is, "don't just read the Board's decision (branding him an exaggerator); look at the entire record."

Unlike Kossick, Diana Black will talk to anyone who will listen. In pain and in poverty, unable to convince officials that her plight is a direct result of the back injury she suffered on the pipeline, Black talks of near-suicidal depression. But she is quick to assert that her mental anguish is due to stress created by a system that seems to her cruelly indifferent at best, conspiratorial at worst.

Francisco specialist Dr. Pennell and the Workmen's Compensation Board, Black insists medical reports identify her back problem as "myofascial syndrome," a malady that requires treatment, therapy and rehabilitation. Black holds that under workmen's comp laws she is entitled to coverage by Alpac.

How can Alpac and the Board deny the evidence and diagnoses of doctors familiar with her case and rely instead on the report of a specialist they had to go all the way to San Francisco to get? Black wants to know.

The reason Alpac went to San Francisco, Dwyre said, is that the insurance firm has difficulty finding independent consultants closer to home. Some physicians, fearing malpractice suits or conflicts with their colleagues, don't like to evaluate patients in controversial cases, the Alpac vice president said. For this reason, she explained, Alpac often has to send claimants to Seattle, Portland, San Francisco and Los Angeles for independent consultation.

A Fairbanks attorney who does some insurance work but avoids workmen's comp thinks there may be another answer to Black's question. When a party in an insurance case wants an expert witness, the lawyer told the *Advocate*, "obviously they're going to hire the doctor who gives them what they want."

In the jargon of the insurance world, another attorney familiar with Alpac's comp operations said, Dr. Pennell and his partner are known as "defendant doctors"—physicians who routinely see clients on behalf of an insurance carrier. According to lawyers familiar with insurance practices, some

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defendant doctors file reports with the carrier downgrading the client's complaints with astonishing consistency.

Alpac's Dwyre told the Advocate, "Diana was covered under workmen's comp for as long as...[Alpac felt necessary] to put her back to preinjury status.

"If we cannot put her back to preinjury status or if they end up with permanent impairment," the Alpac executive continued, "...then we have got to sit down and say we can really go no further, And that was the point we finally reached."

Although comp law says that if there is permanent damage the carrier must make a permanent settlement with the claimant, in this case Alpac never did so.

Alpac held that more than $15,000 in direct payments and $6,000 in medical expenses during the temporary disability period was sufficient compensation for Black's injury. The Workmen's Compensation Board agreed.

110 days later, still no answer

The workmen's comp waiting game...

Fairbanks

Blond, wiry, slightly balding at 30, Robert MacArmour limps over to his chair, eases himself down and removes the walking cane from his right wrist. He begins his story slowly, almost haltingly, as if he does not know how to describe for strangers the blank, troubled world he entered unexpectedly in May, 1977 when the truck in which he was riding overturned on the North Slope haul road.

MacArmour, a compressor operator, was on his way down the pipeline to a new work site when the truck careened off a curve on the steep Atigun Pass south descent, plunged over an embankment and rolled. The pipeline worker was bounced around, thrown out of the cab and knocked unconscious.

Since that time MacArmour says he has had back problems, but he has received little solace from the workmen't compensation system, whose stated purpose is to cover lost income, medical expenses and rehabilitation for injured workers.

MacArmour was removed from the workmen's comp rolls by the insurance carrier, Alaska Pacific Assurance Co. (Alpac) during the summer of 1977 after three doctors cleared him to return to work.

MacArmour, who says he is in frequent pain and constant debt, appealed his case to the state-run Workmen's Compensation Board. His case was heard last Oct. 2.

State law required the three-person comp board to issue its findings within 20 days after a claimant's case is heard, but the board is swamped with a backlog of pipeline cases. As of this writing—nearly four months after the hearing—MacArmour is still waiting for his decision.

"They keep saying the decision is coming; is it coming by donkey?" Luz Arrango, MacArmour's girlfriend, asks from the kitchen of their sparse, low-income apartment. Luz is anxious to know for two reasons.

First, they both feel he needs an operation they cannot afford. "He's getting worse," she says.

Second, they are in a tough financial position. Luz works at a jewelry store to support herself, MacArmour and two young children. The bills—including over $4,000 in medical expenses Alpac won't pay—keep piling up.

The strain of waiting compounds the problems. Even if the decision is in MacArmour's favor, says Luz, "There's no way that's going to pay for what we've gone through."

MacArmour's mental health has been questioned by several physicians who have seen him. "I was neurotic at one point," he admits, "but my views have changed...I'm calmer now."

MacArmour says he wants "all the facts out in the open." To explain accurately how the case developed, he asks Luz to get "the box."

She disappears down the apartment hallway and returns a few minutes later, dragging a large cardboard box. The box is filled with records, loosely indexed in chronological order and interspersed with MacArmour's handwritten, narrative additions.

The records show that MacArmour spent eight days in the hospital after the accident and came out with tissue damage but no apparent fractures. He says he was worried about his back, but he wanted to go back to work as soon as he knew there was nothing wrong.

Doctors warned he might experience intermittent pain, but they cleared him to return to work.

"I've always shunned people who complain of back problems," he says. "I told the doctors I was always ready to take anything on...I was playing it tough."

[continued on page 7]

Alaska Advocate
Jan. 25, 1979 (sidebar)

photo by Richard Fineberg

Robert MacArmour, who claims disabilities from an accident covered by Workmen's Compensation, is supported in his allegations by Luz Arrango, pictured here with children.

Changes coming for workmen's comp

No decision yet in the case of Robert MacArmour, the Fairbanks man who is waiting to hear whether the Workmen's Compensation Board will require his employer's workmen's comp carriers to pay medical expenses and benefits for back problems MacArmour claims stems from a wreck on the pipeline haul road in 1977.

The three-person, state-administered Workmen's Compensation Board, which oversees the privately funded and operated comp system, heard MacArmour's appeal last Oct. 2. Although state law requires the board to issue a decision in 20 days, the board is overloaded (Advocate, Jan. 25.)

While MacArmour's waiting period stretched toward four months, all three branches of state government were considering other aspects of the workmen's comp program. This action on diverse fronts underscored the complexity of the insurance program designed to guarantee injured workers prompt coverage for losses incurred due to on-the-job accidents and included the following:

- the State Supreme Court was deliberating arguments some observers believe could reduce greatly an injured worker's right to sue a negligent party;
- Sen. Bill Ray (D-Juneau) introduced a bill that would extend comp coverage to volunteer police officers;
- state administrators were prying money out of state-administered insurance industry account to cover payments for a program known as the Second Injury Fund.

The Supreme Court's problem, posed in three cases involving Alyeska Pipeline Service Co. and heard earlier this month, is to decide whether the fact that Alyeska paid workmen's comp for its contractors on the pipeline project entitles Alyeska to immunity against liability suits by workers injured on the project. Some observers say the high court's decision will have implications far beyond the pipeline.

Generally, if you're injured due to somebody elses negligence, you have the right to sue the negligent party. But if you're a worker injured on the job, you can't sue your fellow workers or your employer.

Instead, you get workmen's comp, which entitles you to salary compensation, medical expenses and rehabilitation (if you need it). If the system works properly, you are covered promptly—no legal hassles, no delays—by your employer's comp carrier.

In exchange for this guarantee, you give up the potentially lucrative payoff a suit for negligence might yield. A successful negligence suit can result in a cash judgement for pain and suffering; under workmen's comp there is no provision for pain and suffering.

What if you are employed by a subcontractor who is working in turn for another contractor? If you—the subcontractor's employee—are injured due to the negligence of the contractor, is workmen's comp your only remedy, or can you sue the contractor? Ths is the essence of the question the Court is considering.

Since pipeline workers' checks and supervision came from contractors—not from Alyeska directly—lawyers for several injured pipeline workers have argued that Alyeska, as the party that set up the job, should be liable for negligence. Alyeska counters that when the pipeline consortium picked up the tab for workmen's comp, Alyeska also picked up the employer's immunity to liability suits.

Alyeska also argues that the pipeline consortium did not have any responsibility for day-to-day safety and therefore should not be held negligent for pipeline accidents.

Legal logic and legal precedents exist to support the positions both Alyeska and the challenging workers have taken. Alaska's workmen's comp statute does not provide a clear answer, and different district court judges in the state have come up with different decisions.

One of the cases was brought by Kelly Everette, who lost a leg when a piece of pipe slid down a hill, crushing the pipeline worker between two sections of pipe. The other case was brought by Howard Vicini, who was injured when food on a freezer room shelf in a pipeline camp fell on him.

Both men have been covered by workmen's compensation obtained by Alyeska on behalf of its contractors but feel they are also entitled to sue Alyeska for negligent damages.

The Supreme Court's ruling—expected later this spring—will set a precedent for contractor liability in similar situations.

Sen. Ray's bill—introduced at the start of the legislative session—would entitle volunteer policement on local police forces to workmen's comp benefits. At the present time volunteer firemen are covered by workmen's comp, but their police counterparts are not.

The Governor's staff is reviewing a request for a $275,000 supplemental appropriation for the Second Injury Fund, according to Paul House, who manages that fund for the state. The Second Injury Fund is funded by comp carriers to pay for rehabilitation, as well as long-term comp benefits for injuries caused by a prior disability.

House said that the supplement to last year's $722,000 Second Injury Fund appropriation will come from an account set up with the state but funded by the comp carriers. "The greater portion" of the supplement, he said, will go to Alaska Pacific Assurance Co. (Alpac.)

Alpac's portion of the supplement has already been paid to claimants, according to Alpac worker's compensation director Barbara Grissom.

Asked why Alpac has a large portion coming, House explained: One requirement for tapping the Second Injury Fund is a written record of the previous injury. Alpac insured the pipeline project, and Alyeska conducted pre-hire physical examinations. This practice, House said, gave Alyeska and Alpac a better written record of previous disabilities than many employers. Consequently, Alpac has a larger-than-average share of comp payments covered by the Second Injury Fund.

—Richard A. Fineberg

Waiting...

[continued from page 4]

Cleared by physicians to go back to work—he says at his own request and urging—Alpac dropped MacArmour from the workmen's comp rolls during the summer of 1977. He did try to work in September, 1977—and quickly wound up back in the hospital.

Since that time, MacArmour has been enmeshed in a bureaucratic struggle to get his bills paid—and to get the medical attention he feels he needs to end his pain and get back on his feet.

MacArmour thinks he made things tougher for himself by trying to go back to work. An attorney familiar with workmen's comp procedures agrees.

Once doctors said MacArmour could go back to work, the lawyer says, it is understandable that a carrier would challenge all subsequent claims before paying them.

What is not so easy to understand is the time it has taken the board to consider the case and let MacArmour know what he can expect.

The case is complicated by conflicting medical testimony. Dr. Willard F. Pennell, M.D. (the same San Francisco specialist who advised Alpac to cut off Diana Black's workmen's comp—see accompanying story) examined MacArmour a year ago and felt MacArmour was faking his symptoms.

"The patient," Dr. Pennell advised Alpac, "overreacts to areas that are said to be painful and attempts to voluntarily inhibit muscle action but then goes through with it. He alleges bizarre sensory abnormalities which make no anatomical sense. I felt these were clearly conscious misrepresentations on his part.

Dr. Pennell concluded: "In my experience patients who perform in the manner that his man did during the neurological examination do so for purposes of litigation and it would not surprise me that such is the case with Mr. MacArthur (sic.) I do not believe that he is in need of any psychiatric treatment and I can find nothing to indicate that he is any way disabled from performing his pre-accident occupation if motivated to do so."

A prior and equally lengthy medical report from a Los Angeles specialist, Dr. Michael Roback, M.S., expresses a different opinion. According to Dr. Roback "The patient's condition with reference to the neck, low back and left arm are the result of a single accident suffered on 5/10/77...the patient has not received the full benefit of medical care and requires further evaluation and treatment."

After Dr. Pennell's report to Alpac, MacArmour—at his attorney's advice and at his own expense—returned to Dr. Roback for another examination.

This time the Los Angeles orthopedic specialist was more emphatic: "Because of the injuries from the work accident," Dr. Roback wrote, "the patient is totally and permanently disabled for all employment and incapable of competing in the open labor market for employment."

Is MacArmour faking it? Luz does not think so. A Fairbanks psychiatrist, she recalls, once told her that MacArmour's problems were psychological.

Luz speaks simply and softly: "I said I believe Robert, because I've been close to him and I've seen his pain."

Epilogue:

I.

In an interview last week, before she left for a San Diego meeting with executives from other subsidiaries of Alpac's parent company, Insurance Company of North America, Alpac vice president Gay Dwyre described some of the problems faced by the injured family man:

"When a man...is severely injured...(sometimes) he becomes dependent upon the family for taking care of him when they never have before...it is one of the most terrible things that can happen to a human being...all of a sudden they are by themselves, not able to leave the house, and it does things...to their mind, and to their family...It can destroy not only him, but the entire family."

Dwyre said she was speaking in general terms and was not familiar with MacArmour's case.

II.

Friday morning, 9 a.m. A solitary figure emerges in the gray Fairbanks dawn. He leans on a cane—not bent forward with age, for he is 39, but to one side. He walks with a stiff, short-stepped gait.

At a drop of three or four inches in the snowpacked walk, he pauses quickly in the cold to give full weight to the cane. Reaching his car, he eases himself in, starts it, then returns to the apartment, head down.

A short time later, a 4-year-old in a red snowsuit comes out, followed by a woman carrying a baby. The man with the cane comes last, his free hand holding the sundries bag for the babysitter and the woman's purse.

After Robert MacArmour drops Luz and the kids, he heads downtown to the adult education center, where he recently began taking a basic math class three mornings a week. The pain, he says, is a problem, but the class is something he has always wanted to do.

His math has always been poor, he says, and if he can improve enough he would like to study economics.

Shortly after noon, the man with the cane returns to the apartment. He checks the mailbox: No word from the Workmen's Compensation Board.

It is the 110th day since his hearing.

He waited 120 days to hear

Workmen's Comp says 'no' to Fbks. claimant

by Richard A. Fineberg

Fairbanks

The Alaska Workmen's Compensation Board has denied Robert MacArmour's appeal for workmen's compensation benefits.

MacArmour says he wants an operation to correct a painful back condition stemming from a wreck on the pipeline haul road in May 1977. While deep in debt for medical expenses incurred since the accident, MacArmour and his family waited 120 days for the overworked board's unfavorable decision (*Advocate*, Jan. 25, 1979).

The board ruling, issued Jan. 30, says MacArmour is a put-on and rejects his claim that Alaska Pacific Assurance Co. (Alpac) should cover his expenses. MacArmour, who says he's fighting mad, plans to appeal the decision to court.

The four-page decision by the board contains several apparent errors of fact and relies heavily on the medical opinion of a San Francisco specialist whose practices—along with those of his partner—have been questioned by other Alaska workers and attorneys in California.

MacArmour is one of an unknown number of pipeline workers injured on the job who subsequently had problems with Alpac. A loosely organized group calling itself Action for Victims of Industrial Accidents (AVIA) claims 50 members, many of whom allege similar problems with Alpac, the insurance firm that bustled its way to the top of the Alaska insurance world during the oil pipeline boom.

Robert MacArmour

MacArmour, who was thrown from a truck and knocked unconscious when the brakes failed on a steep grade, spent eight days in the hospital and received worker's compensation for two months, at which point physicians released him to return to work. He complained of back pains, but tried to work again that fall; medical records indicate he quickly landed back in a hospital bed.

Since then MacArmour has spent much of his time bouncing from doctor to doctor and fighting bureaucracies from his Fairbanks apartment. He appealed his case to the Workmen's Compensation Board, which heard the matter Oct. 2. Although state law requires the board to issue decisions within 20 days, it was 120 days before the board announced a verdict.

"The Board does not question...that the applicant was initially injured and that he had pain," says the board decision. "However, the pain he has today is not real, at least to the extent he testifies. The question essentially is whether the alleged pain is a psychological overlay caused by the accident or is a put-on in order to gain compensation."

Citing findings by San Francisco specialist Willard F. Pennell, M.D., the board concludes, "Any psychological overlay preexisted the May 10, 1977 incident. Applicant's complaints are based on a conscious attempt to get additional workmen's compensation benefits."

Pennell, a San Francisco neurologist and psychiatrist who examined MacArmour during an afternoon told Alpac MacArmour was bizarre and st "conscious misrepres

"In my experi physician noted, "p perform in the mann man did during the examination do so f of litigation and it wo prise me that such is Mr. MacArthur (sic)."

In the final tw his evaluation, Penn MacArmour incorrec cludes, "Thank you f to evaluate Mr. Ma you." The doctor's 12- spaced letter to Alp Jan. 20, 1978—the s examined MacArmo

In the board's Pennell found a "n neurosis" and "cons geration of symptoms to change constantly."

According to

"These developed su that each new doc was put to the test sort out an objective go along with subje toms. Because of periods of treatme doctor ever sorted the pattern was exp Pennell."

Reconstructing medical history to decision, however, t looked or misstated Among them:

- MacArmou return to work is the board as follo tember 6, 1977, appl to work only to qu a few days." Pip records show Ma sent back to Fair

modic at Five-Mile Camp on Sept. 19, 1977. Hospital and clinic records—as well as unpaid bills—show MacArmour was in the hospital for the next two weeks.

• "Dr. Lindig's report of March 17, 1970, released him for work and stated: 'Emotionally unstable for weeks,' " the board wrote. On the form cited, the physician did check a box releasing MacArmour for work, but the physician's handwritten interview note read, "Emotionally unsuitable for work"—not "emotionally unstable for weeks," as the board said in its decision.

• The decision also says, "Dr. Perry Mead on September 12, 1978 reported: 'I doubt that his injury caused his psychiatric disorder.' " In fact, the statement was made by Fairbanks psychiatrist Dr. Irving Rothrock—not Mead.

• "The reports of Dr. Pennell were compared to those of Dr. (Michael) Roback," the board said, noting that Dr. Pennell is a neurologist and psychiatrist while Dr. Roback is an orthopedic surgeon. The board does not indicate that Pennell saw MacArmour once, and the orthopedic surgeon saw him twice — before and after the Pennell interview. Neither of Roback's post-interview conclusions is mentioned by the board.

After their first appointment, Roback said, "The patient has not received the full benefit of medical care and requires further evaluation and treatment." After a second examination, Roback said, "The patient is totally and permanently disabled for all employment and in-

[continued on next page]

Workman

[continued from preceding page]
capable of competing in the open labor market for employment."

To pick and choose among conflicting medical opinions is a part of the task of the Workmen's Compensation Board. In view of Pennell's reported penchant for siding with insurance carriers against claimants, MacArmour and other claimants find it surprising that the board—supposedly the claimant's friend—relies so heavily on Pennell.

Diane Black of Fairbanks, one of the founders of AVIA, says she was shipped off to Pennell, similarly branded an exaggerator with pre-existing psychological disorders, and cut off from worker compensation by Alpac and the board. An Anchorage claimant not connected with AVIA wrote the Advocate to relate a similar experience with Pennell and Alpac. (The claimant asked not to be identified.)

In an interview with the Advocate, San Francisco attorney Marvin E. Lewis, past president of the American Trial Lawyers' Association and author of a legal text on courtroom medicine, said he has faced Pennell's partner in "seven or eight major cases...They always say my client is faking it; I always win."

But attorneys like Lewis are hard to come by. At this point MacArmour's legal case looks like a long shot at best. One Fairbanks lawyer said the case probably will have to go to the Supreme Court, and that takes a lot of money.

Money is something of which MacArmour has little. His girl friend, Luz Arrango, currently supports him and two children. They worry that the family does not have enough money to make it through the month.

Their car is about to be repossessed; there are several thousand dollars in back medical bills hanging over their heads, they say.

Luz Arrango's dark eyes flash as she contemplates the bleak future, and the fact that the board, relying on the questioned expertise of a specialist hired by the insurance industry, kept them waiting four months before proclaiming that MacArmour is a put-on who is not entitled to the help that could put him back on his feet.

Anchorage Daily News

1 68 PAGES ANCHORAGE, ALASKA, SATURDAY, APRIL 28, 1979

(Page 1)

Workmen's comp: high cost of pain

By R.A. FINEBERG
(First of a series)

When you think of insurance, you probably think of the skyrocketing cost of automobile coverage, or that life insurance policy with its provisions you and the insurance agent barely understand. But Alaskans pay more workmen's compensation than any other kind of insurance.

Alaska's compensation program, in fact, pays the highest benefits in the nation to injured workers. But the program is troubled. The ailments afflicting the comp system are many:

• High comp premiums which Alaska employers are required by law to pay may be forcing some businessmen to close their shops because they are eating up profits.

• The state bureaucracy designed to deal with comp problems is virtually paralyzed by its workload. While law requires the Workmen's Compensation Board to settle disputes between an injured worker and the insurance company within 20 days, the decision of a typical case now takes more than three months.

• Many injured workers claim they have been unable to get fair compensation for their injuries, or a fair hearing from the overloaded bureaucracy.

• Other workers reportedly fake injuries to collect lucrative benefits they don't deserve. By doing so, they bilk the insurance company and drive skyrocketing comp premiums still higher.

• Arcane rate-setting procedures and cumbersome bookkeeping practices make it difficult to determine what kind of profits insurance companies reap from workmen's comp. In this clouded situation, many industry observers assert comp is very unprofitable, but the insurance company that handles more compensation insurance in Alaska than all other companies combined appears to be prospering from its rapidly growing business.

The focal point of these diverse problems is a system that was established in the early 20th Century to provide workers injured on the job with insurance to provide income during recovery pay for medical expenses and rehabilitation. Employers are required by law to purchase workmens' comp insurance for all employees' the worker in turn gives up his right to sue an employer or fellow employee for negligence.

In 1968 compensation premiums in Alaska totaled about $8.5 million, about 11 percent of all insurance premiums written in the state. By 1977, the bill for workmen's compensation had jumped to more than $107 million, nearly 24 percent of the state's total insurance premium.

Before comp rates began rising, workers' comp premiums typically cost an employer about 40 cents per $100 of payroll. With increasing benefits and medical costs, today the same employer may be paying $5 to $10 in comp for every $100 of payroll.

Benefit boosts mandated by the state legislature in 1975 were a major source of the jump in comp costs. The legislative action, reflecting the findings of a nationwide presidential study on workers' comp, coincided with the pipeline

See Back Page, COMPENSATION

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...imant who has a dispute ...s insuror may take his ...e to the state Dept. of Workmen's Compensation . A state-run, three-person ...rules on cases in which ...t and carrier cannot agree. ...board's task is an unenvia... Insurance companies and ...ts both go doctor shopping ...ne to the hearing with the ...rsuasive experts money can ...o make its decision, the ...must cut its way through ...lak, medical jargon and ...ins of paperwork. ...board also is swamped with ...og of cases stemming from ...is-Alaska pipeline boom. Al... the Board is required by ... to issue a decision within 20 ... claimants typically wait ...o four months for the over... board to hand down its ...n.

...bers tell the story of the overload. Six hundred and comp cases were contested ... three years later the num... ...l risen to 1630 — an increase ...ercent.

...nal decisions issued by the after hearings increased ...76 in fiscal 1975 to 430 in ...978. During the same period, ...mber of compromise settle... (agreed to by claimant and and approved by the board)

Workmen's Compensation Division director John Cook acknowledges that his agency is swamped. A proposal to add personnel to the comp board to handle the increased work load has been bandied about in Juneau with no legislative action to date.

Alaska benefits — presently at a maximum of $654.30 per week, the level set by the legislature — are higher than any other state in the nation. One federal program, the Federal Employees Compensation Act, sets a higher level ($678.25), according to a trade publication, "Analysis of Workmen's Compensation laws."

Last year, when Alaska paid $607 per week, Iowa was paying injured workers a maximum salary substitute of $247.48 to rank second. Only a few other states paid over $200.

Industry sources frequently comment that Alaska's high comp benefits may be worth faking injuries for — at least until the next pipeline comes along. The extent of the fraud in the state has not been ascertained.

"There is no doubt whatsoever that a huge change in costs — both insurance and average weekly payments — has been noticed," says Richard Jones of Sohio Petroleum Company's employee relations. And, Jones says, "we've noticed that the percentage of applicatns having their claims accepted has gone up. I can't even remember when one was declined."

Ron Krueger, personnel officer for the Alaska Railroad, cites similar discontent with the federal law, estimating that compensation costs have tripled since 1974. The railroad now pays about $1 million in doctor bills and compensation, he says.

"I'm sure that the accident rate has not tripled," he says. "Costs are rising out of proportion to

The other side of the coin is worker unjustly denied benefits. Former state insurance chief Richard Block says he finds it difficult to believe a system that is paying claimants $70 million a year in benefits is treating many workers unfairly.

Not so, says Diane Black of Fairbanks. Injured on a pipeline job in 1976 (she was a cook at Toolik Camp and hurt her back while moving furniture), Black says she and other workers who feel they have been unfairly treated have formed an organization — Action for Victims of Industrials Accidents (AVIA) — to reform the comp system. To date, however, their organization has failed to convince either the government or the insurance industry that there is a widespread or serious problem.

Claimants who are denied benefits often find themselves in pain and in poverty, says AVIA organizer Black. "We have a hard time making ends meet, let alone launching a protest," she states.

Black says she has 15 signed statements and knows of at least 30 more injured workers who feel they got short shrift from the comp system. Many of the cases involve one carrier, Alaska Pacific Assurance Co. (Alpac).

Possibly, Black says, that's because Alpac is the largest comp carrier in the state. Sparked by a contract with Alyeska Pipeline Service Co. that comprised 44 percent of Alpac's business in 1976, according to data on file with the Division of Insurance, Alpac's growth has outpaced all other carriers in the state.

In 1977 Alpac wrote $60,675,000 worth of comp premiums — six times more than any other carrier operating in Alaska and 56 percent of the state total. By comparison, in 1975 Alpac's $17.4 million was nearly three times that of its main competitor and 40 percent of the state's total.

In contrast to AVIA's gloomy view of Alpac, a Division of Insur-

and January [illegible] "got the general impression that the treatment of...claimants...was exemplary." The examiner also characterized the company's rehabilitation program as "excellent." A market conduct exam, which would have directed more attention to the manner in which Alpac handles individual claims, was scheduled by the division but was never conducted.

The Division of Insurance has a consumer complaint section to handle problems individuals encounter with insurance companies. But his agency usually sends comp claimant problems to the overloaded Workmen's Compensation Division in the Labor Department. According to Insurance Division investigator Bob Blakeney of Anchorage, his office refers about three calls a week to the Workmens' Compensation Division.

If it is difficult to get a handle on claimant problems, it is even harder to get a clear picture of the economics of comp insurance. "Very unprofitable," says an industry source, pulling out a recent compilation in an insurance news letter. The unaudited, nationwide data indicates the comp premium-to-payout ratio is one of the worst in the industry and just about at the break-even point.

The purported unprofitability of comp doesn't seem to bother Alpac. Largely on the strength of its Alaska comp writings, this insurance company has grown from five employees in 1968 to 296 today. In recent years the company has opened offices in Fairbanks and Valdez, built a handsome new headquarters in Anchorage and branched out to Montana, Idaho, Washington, Oregon and California.

Records filed in Juneau with that Division do not provide a clear answer to the question, is comp a lemon or a money-maker for insurance companies? Part of the problem is that the state's leading carriers — Alpac, Industrial In-

[illegible] impossible to develop a true picture of the profitability of writing comp insurance in Alaska.

Division of Insurance personnel who readily admit they would like to have more information about the way Alaska's comp carriers figure their rates out and are trying to get that information.

Financial studies are being conducted, and the division has scheduled a public hearing in Anchorage May 15 to discuss workers' comp rate-making issues.

Next: who pays the bill for workmen's comp? (The Fund for Investigative Journalism provided some of the funding for the research for this series).

Anchorage Daily News
April 29, 1979
(cont.)

Former Insurance Division director stumps for study of workers' comp

By R.A. FINEBERG
Daily News correspondent

Since stepping down as director of the state's Insurance Division last December, Richard L. Block has been dividing his time between revamping the Alyeska Pipeline Service Co.'s insurance department and drumming up support from businessmen for a thorough investigation of the worker's compensation system.

Noting that the Director of Insurance is the public's protector and advocate on insurance matters, some observers question the porpriety of the worker's comp reform campaign Block proposed shortly after leaving public office.

The question the critics ask: If reforms in the cumbersome workers' comp system are needed (few deny this proposition) could Block have done more about this problem while he was the state's top insurance official?

Block maintains his present consultant activities are "not a conflict at all" with his past duties. "The work I'm doing as a risk management consultant," he says, "is advising buyers of insurance on how to more effectively utilize the insurance mechanism." Essentially, he continues, that is "the same thing I did as Director."

Although the state's conflict of interest statute seeks "to discourage public officials from acting upon a private business interest in the performance of a public duty," the statute applies only to conduct while in office. No law prohibits a public official from going through the so-called "revolving door" between public and private office.

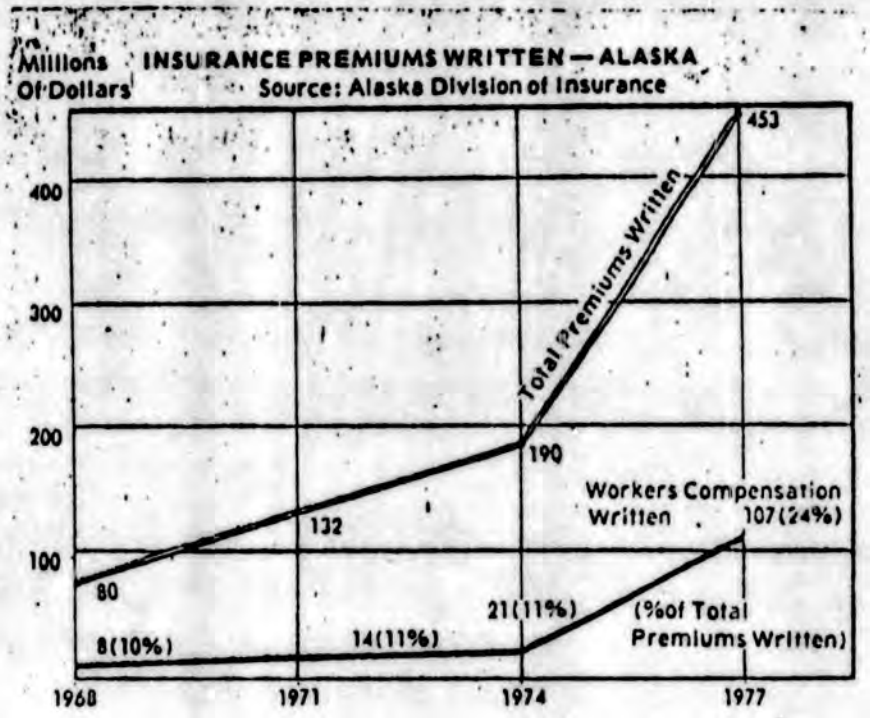
Block's abrupt transition from public servant to would-be business advocate is no more precipitous than his entry into public service. When Block became the state's Director of Insurance Oct. 1, 1975, he resigned from the Board of Directors of Alaska Pacific Assurance Co. (Alpac), the company that dominates the workers' comp field in Alaska.

Generally regarded as one of the most knowledgeable persons about insurance in the state, Block wins high marks from his former subordinates at the Division of Insurance — and from many others — for fairness and intelligence.

But some critics say Block reflected the insurance industry position — rather than the consumer's — on many matters. "I don't necessarily fault that the guy that runs it (the Insurance Division) is out of the industry — he has to have some knowledge, says AFL-CIO spokesman Dwayne Carlson in Juneau. "But it just never turns out right...I don't know of any time an industry request has been rejected," Carlson says.

Deputy director John George, who served under Block, thinks the criticism is unfounded. Anybody who serves as long as Block did in a controversial position, George maintains, is bound to draw somebody's criticism from time to time.

Asked to evaluate his tour as Director of Insurance, Block replies, "We had to make some tough decisions...buy they were decisions that were long overdue...What I really did was motivate people there to understand what a regulatory agency was supposed to do and show them how to do it. Now they're out there doing it."



Graph traces the growth of the Alaska insurance business since 1968 (top line) and the growth of worker's comp costs. In 1968, worker's comp premiums made up approximately 10 per cent of the total insurance market in Alaska; by 1977 comp premiums accounted for 24 percent of all insurance premiums written and weighed in as the largest insurance line in the state by dollar value.

Block's successor at the Division of Insurance, Kenneth Moore, says he found a "clean desk" when he took over Feb. 28. The former director, Moore says, left no specific recommendations no lists of immediate or potential problem areas.

Before Moore arrived from New Mexico to start his new job, however, Block had circulated a proposal to Alaska businessmen calling for a thorough review of workers' compensation. The study Block is proposing points toward major legislative reform, as well as changes for both the state Labor Department's Division of Workmens' Compensation and the Commerce Department agency Block headed for over three years.

(continued)

Anchorage Daily News

Anchorage Daily News
April 29, 1979
(sidebar)

CONT.

Richard Block

Kenneth Moore

Block's "Proposal to the Alaska Coalition of Employers for the Identification and elimination of the causes of High Cost of Workmens' Compensation Insurance to Alaskan Employers" is dated Jan. 18, 1979; his last day as Director of Insurance was Dec. 22, 1978.

Even before the proposal was circulated, Alyeska Pipeline Service Co. had hired Block on a consulting basis to manage temporarily and overhaul the pipeline company's insurance program.

Two oil companies owing a major share of the Alyeska pipeline, Exxon and Sohio, are among the companies sponsoring Block's research proposal, which describes the following probably goals:

- "A legislative package whichmust be carried to Juneau and advocated;"
- "Change in administrative procedures at the Division of Workmens' Compensations;"
- Change of direction by thecourts;
- "Change in the (workers' comp premium) rating structure whichmust be developed and implemented through the Division of Insurance;"
- "Changes in the health care delivery system."

Block's seven-page research proposal traces the recent history of workers' compensation in Alaska, pointing out that the state legislature boosted comp benefits in 1975 to reflect the high wages of the pipeline boom. (This action was taken five months before Block left private industry to become Director of Insurance in October, 1975.)

Increased premiums necessary to pay for the benefit hike resulted in criticism from employers, who must pay for worker's comp insurance fo their employees. In public office Block sought to cut back benefit increases, thereby reducing premium rates.

Before coming to Alaska, Block served as general counsel for Pacific Employers Insurance Co. Like Alpac, Pacific Employers is a wholly-owned subsidiary of the nationwide conglomerate Insurance Co. of North America (INA).

When INA purchased Alpac in 1971, Block helped the parent company with legal technicalities. Block later served a brief stint as Alpac's assistant secretary and spent three years on the Alpac Board of Directors, a position he resigned to become Alaska's Director of Insurance in 1975.

Although he maintains there is no conflict between his present consulting activities and his recently-held public position, Block does agree that he is "more valuable to the people I'm working for...I certainly know a lot more for having worked in the division."

A bill proposed by the state ombudsman last year would prohibit former public officials from being paid to represent any person or business on matters the former official handled in public office for 12 months after leaving office. The bill has yet to receive legislative committee action, however, and the revolving door through which Block entered and left public office is entirely legal.

chorage Daily News
-il 30, 1979
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Some doctors rough on comp claims

By R.A. FINEBERG
(Second of a series)

When Robert MacArmour, a Fairbanks pipeline worker injured in a truck accident in the Brooks Range in May 1977, pressed his claim for workers' compensation benefits, Alaska Pacific Assurance Co. (Alpac) sent him to a San Francisco specialist for examination.

The physician, Dr. Willard F. Pennell, spent three hours with MacArmour, then wrote a 12-page, single-spaced report to Alpac.

The neurologist-psychiatrist told the insurance company, MacArmour most likely was faking his back problems.

Alpac denied MacArmour further benefits. Citing Dr. Pennell's opinion, the state Workmen's Compensation Board upheld the insurance company, concluding MacArmour's complaints were "based on a conscious attempt to get additional workmen's compensation benefits."

Today MacArmour is still seeking medical treatment while he looks for a lawyer to help him tackle Alpac and the compensation board.

MacArmour says he knew early in his interview with Dr. Pennell that the physician was going to side with the insurance company.

Diane Black, another Fairbanks worker who says she too has a back problem, tells an almost identical story about Dr. Pennell and Alpac.

An Anchorage woman, who asked that her name be withheld, claims Alpac sent her to Dr. Pennell and that the San Francisco specialist stripped her of "almost everything but my driver's license."

None of the three Alaska worker's comp claimants knew each other when Alpac sent them to San Francisco. Until recently they had never heard of a lawyer named Marvin E. Lewis.

Lewis says he could have warned them about Dr. Pennell. A San Francisco attorney and past president of the American Trial Lawyers Association, Lewis has been in court with Dr. Pennell and his partner, Dr. Knox Finley, for more than two decades.

"They always say my client is faking it; I always win," the lawyer snaps, noting that he has won at least half a dozen major injury suits for clients against whom Dr. Finley has testified.

Lewis is the author of a legal text, "The Psychic Injury." In that volume he describes in detail several of the cases in which he has faced Dr. Pennell's partner. Those comments, he says, are equally applicable to the work of Dr. Pennell.

In one case quoted in the textbook, Lewis pointed out that Dr. Finley had appeared in nearly 100 cases in San Francisco as an expert witness, then asked the doctor to name a single case in which the physician had testified that there is a link between the accident in question and the psychological damage for which the plaintiff seeks damages.

The physician was unable to name a case in which he sided with the plaintiff.

Lewis concluded one successful prosecution with this statement to the jury:

"Dr. Knox Finely comes from a defense mill. That's what his office is...nearly a hundred times he has testified on the stand like this in...injury cases and always for the City and always for...insurance companies...Then his two partners were doing the same thing. Then they were not only having these cases, but there were other plaintiffs who were injured that never got to Court...they were doing all this...as a business, a business of testifying for insurance companies..."

Dr. Pennell declines to discuss lawyer Lewis' criticisms of himself and his partners. What about the complaints of MacArmour, Black and other Alaskans? Professional ethics, Dr. Pennell replies, prohibit him from discussing individual cases.

See Back Page, WORKMEN'S

Continued

Why does Alpac use Dr. Pennell? According to Alpac comp director Barbara Grissom, Dr. Pennell is one of the few West Coast physicians licensed in both psychiatry and neurology. Grissom describes Dr. Pennell as "a very competent man" who does not always render a finding that results in denial of benefits to the claimant.

Under comp law, Alpac vice president Gay Dwyre points out, both the insurance carrier and the claimant have the right to call in

Grissom says Alpac has used Dr. Pennell in five or six cases she can think of. Other Alaska comp carriers have also used Dr. Pennell on occasion.

How many Alaska comp claimants have been sent to Dr. Pennell? How often has the Workmens' Compensation Board decided controversial cases on the basis of this physician's testimony?

Director of Workmens' Compensation John Cook says he cannot answer the question. To gather this kind of data would require going through mountains of paperwork associated with thousands of comp

Cook says his staff is already overworked and he cannot assign anybody to this task. Despite the fact that Dr. Pennell's opinion was cited at length as the basis for the board's rejection of both Black and MacArmour's appeals for continued compensation, Cook denies that the board is unduly influenced by any one physician in a given case.

Dwayne Carlson, AFL-CIO lobbyist in Juneau, says he has been proposing that the workers' comp and other State Labor Department files should be computerized so that safety and medical trends can be pinpointed and dealt with promptly.

statistics manually to present testimony for workers' comp hearings in 1975. He would have to do the same today, he adds.

Injured Fairbanks workers who have banded together to call attention to their problems want the same information. The group, Action For Victims of Industrial Accidents (AVIA), has gathered names of several dozen allegedly injured workers who claim the comp system has failed them. However, AVIA lacks comprehensive statistics that might underpin the complaints.

Anchorage Daily News
April 30, 1979
(continued)

Workmen's comp doctors criticized

AVIA's prime mover is Diane Black, 34, who injured her back working at a pipeline camp in 1976. She walks with the aid of a cane and requires pills and treatments for pain she says resulted from the accident, which occured when she was moving furniture at Toslik camp.

After paying $24,000 in compensation and $8,000 in medical expenses, Alpac cut Black off in 1977. The Workmens' Compensation Board twice upheld the insurance company. Said the board: "We believe, as stated in Dr. Pennell's report, that it is probable that some secondary gain or need for attention is motivating her to perpetuate her symptoms and that she will continue to seek treatment and take medication as long as it is provided."

The board quoted Dr. Pennell, who advised the insurance company that "Mrs. Black may have sustained a mild low back sprain at the time she lifted the bed at work (in 1976) but certainly that injury could not have produced symptoms of any great duration, and I firmly believe that she recovered from those symptoms."

Black, who is writing her own court brief challenging Alpac and the state board, contends Dr. Pennell and the board ignored and misstated key facts about her case. She feels she needs back surgery to correct the problem stemming from her injury.

Insurance industry sources say back injuries are among the most difficult for physicians — and the workmen's compensation board — to evaluate.

A back injury is also at issue in the case of pipeline compressor operator MacArmour. He was thrown from the passenger seat of a truck when it careened out of control and plunged off a steep bank at the Atigun Pass haul road [illegible] truck rolled several times, flattening the "pigs" that were used to clean the inside of the pipeline to the next job site on May 9, 1977.

The accident knocked him senseless, injuring his back. He was airlifted to Fairbanks for medical treatment.

According to the medical records, MacArmour was released from the Fairbanks hospital after eight days, then spent several months going from doctor to doctor. In September of 1977, he tried to go back to work as a compressor operator, but quickly landed back in the hospital, complaining of intense back pain.

Cut off from compensation benefits in July, 1977, MacArmour brought his case to the Workmen's Compensation Board for a hearing on Oct. 2, 1978.

In its Jan. 30, 1979 decision, the board sided with Alpac and Dr. Pennell. In doing so, the board rejected the finding of California orthopedist Michael Roback, who examined MacArmour twice and concluded MacArmour had not received "the full benefit of medical care" and was "totally and permanently disable" as a result of the haul road accident.

Although the law requires the board to issue an opinion in 20 days, MacArmour had to wait four months for a decision. The delay in MacArmour's case was typical.

The question the board pondered for four months was whether MacArmour's alleged back pain was caused by a genuine physical problem, by a psychological problem, or whether the symptoms were faked. The board, quoting at length from Dr. Pennell's critical evaluation, dismissed MacArmour's case with the judgment: "Applicant's complaints are based on a conscious attempt to get additional workmen's compensation benefits."

MacArmour says he plans to appeal the board's decision in court, but first he has to find a lawyer. Most lawyers said they are reluctant to take MacArmour's case because it promises to be time-consuming and expensive to research and prosecute.

While MacArmour casts about for an attorney, he must also decide what to do about resolving his pain — and several thousand dollars in medical bills that have accumulated since the 1977 accident.

Although Black, MacArmour and other comp claimants with alleged grievances have demonstrated in front of the state building in Fairbanks, besieged the Ombudsman and the Governor's office with complaints and contacted the Workmen's Compensation Division's Fairbanks representative on numerous occasions, they have received a less than heartwarming response from state officials.

Workmens' Comp Director Cook says he hasn't investigated the group's complaints because they haven't addressed specific inquiries to him. Disputed cases requiring the board's attention have jumped from 615 in fiscal 1975 to 1630 in two years later, and Cook acknowledges that the division is hard pressed to handle all the paperwork.

The State Commerce Department's Division of Insurance has a consumer complaint section, but that agency has been of little use to comp claimants like MacArmour. Bob Blakeney, complaint investigator, says his office usually forwards comp claimants to the Workmen's Compensation Board because that institution is set up to deal with claimant-carrier problems.

How do the comp claimants fare with the board? "We don't know," Blakeney replies. His agency and the Workmen's Compensation Board are within different departments, and bureaucrats are normally reluctant to step on toes by [illegible] departmental lines.

Asked how many comp complaints his office directs to the Workmen's Compensation Division, Blakeney checks with two staff members and comes back with an answer: about three a week. He seems somewhat surprised. "I think three a week is a lot of calls," Blakeney says, "and if we had three a week on a standard line (of insurance) we would really feel like we had a tremendous problem."

Former Director of Insurance Richard L. Block, who is serving as a consultant to private business and who plans to conduct a research program aimed at lowering workers' comp rates, says he finds it difficult to believe that a system that is shelling out $70 million a year in comp benefits is treating many workers unfairly.

"Even assuming the company wanted to put the squeeze on workers," Block says, "you've got the Board watching out." The insurance carrier is penalized if it is wrong in denying benefits, Block adds, and the carrier also has to pay the claimant's attorney fees.

Block's view is very much at odds with the impressions of seven comp claimants who met one evening last month at an Anchorage restaurant to discuss their comp problems. Truck drivers, ironworkers and laborers, they all told similar stories. None were associated with the Fairbanks-based AVIA.

Some were cut off without notice; others had to fight for months to win benefits the comp system purports to deliver promptly to injured workers.

One claimant, who felt he had received a raw deal from doctors and insurance companies alike, commented, "I had a brother who was a surgeon and I believe in doctors, but when you find people

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orage Daily News
30, 1979
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like this you can't trust, it turns you around."

The workers compared problems, exchanged bits of information and leafed through the 110-page reprint of the law governing worker's comp, searching for passages that pertained to their individual cases. "The insurance company never informed me at all that there was a book," one said.

Most agreed a concise and clearly written guide to key portions of the comp law would be a great help to the injured worker, who sometimes knows little about the intricacies of law. Although one of the duties of the Director of Insurance is to "inform the public of matters concerning the...coverage, benefits and rights of insurance," former Insurance Director Block thinks that that if such a booklet were necessary, the Division of Workmen's Compensation ought to put it out.

Hovering over claimants at odds with the system is a stigma; they are regarded by many as fakers or malingerers. Nobody knows just how many comp frauds there are, but the problem is a serious one.

Several claims adjustors recall that during the heyday of pipeline construction they could tell when a contractor was about to finish a portion of work and lay people off; a few days before the job finished, a rush of workers employed by that contractor would show up at the worker's comp office with alleged back injuries. The situation today, most observers agree, is even worse.

The fact that some workers find Alaska's lucrative comp benefits worth faking for (the comp system payed $70 million in benefits to Alaska claimants in 1977) is of little comfort to Luz Arrango. The Fairbanks woman, who lives with Robert MacArmour, has been supporting herself, MacArmour and two children since MacArmour was injured in 1977.

Luz does not believe the doctors who have labeled MacArmour a fake. "I have seen his pain," she says.

There have been nights, she recalls, when MacArmour has moaned in anguish in his sleep, twisting and grimacing in obvious pain. Yet she would ask the next morning how he fared during the night, and he'd reply, "not badly."

"Why should Robert and the children pay for other people's frauds?" Luz wants to know.

When Alpac sent MacArmour to Dr. Pennell, the company issued a plane ticket and $60 in expense money. MacArmour received the Alpac check and ticket less than 48 hours before he was scheduled to depart. The expense money was inadequate. He spent part of the day before he left trying to secure enough money to cover taxis to and from the San Francisco airport, a hotel room, meals and miscellaneous expenses. By calling the Workmens' Compensation Division and Alpac he finally got an additional $40.

His expense records show he needed it all.

(Tomorrow: The high cost of workers' compensation — how the rates are set and reviewed. The Fund for Investigative Journalism provided some of the funding for the research for this series).

Anchorage Daily News
May 2, 1979
(Page 1; part 3 of series)

Compensation rates may artificially boost costs

By R. A. FINEBERG
Daily News correspondent

(Last of a series)

Variations in the way Alaska insurance companies report data to the national workmens' compensation rate-making organization may be artificially boosting the price Alaska employers pay for workers' comp insurance, The Daily News has learned.

This possibility has led the state Division of Insurance to hire accounting specialists to examine the complicated comp rate-setting procedure. The report, by the California-based firm of Milliman and Robertson, is due by June 30, according to state insurance director Kenneth Myers.

Informed sources say the investigation was triggered when the Division of Insurance learned Alaska Pacific Assurance Co. (Alpac), the state's largest workers' comp insurance carrier, may not list its reserves — the amount the company sets aside for anticipated payments — in the same way other major carriers operating in Alaska list theirs.

But an Alpac official said Monday the company does not list its reserves in a different manner.

Don Koch, the state's insurance market surveillance chief, said one area of confusion is the manner in which Alpac reports annuity payments to the National Council on Compensation Insurance, the industry's rate-setting organization.

Alpac buys annuities (simply guarantees to make regular payments) to cover long-term payments to disabled comp claimants or to survivors of persons killed in job-related accidents.

Alpac, or any other insurance company, may — for example — buy an annuity that pays $1.5 million over a 30-year period for less than $500,000.

Insurance division officials are concerned that a company may record the money set aside for anticipated pay-outs — the $1.5 million figure — with the National Council for rate-making purposes, even though the company later pays the lower figure.

And it may be that the lower

See Back Page, RATES

Rates Continued

May 2, 1979
(part 3; continued)

figure is the appropriate one to use in calculating the costs that go into the rates a carrier charges for workmens' compensation, Koch said. If some carriers report the $1.5 million pay-out price rather than the $500,000 purchase price, the practice would tend to raise comp rates, Koch said.

But Alpac says the purchase price is what it reports to the National Council.

"What we paid for the annuity is what we report," Alpac vice president Gay Dwyre said Monday.

Koch said, "We're under the impression it's the other way around. However, we have not confirmed that as yet...it is one of the things Milliman and Robertson will look at."

At this time, Koch said, other major carriers are advising the National Council of the actual amount they pay for long-term securities, while Alpac appears to be listing the amount the security, once purchased, ultimately pays out.

Koch emphasized that the division is not prepared at this time to fault any carrier. There is legitimate confusion, he said, about which figure to use.

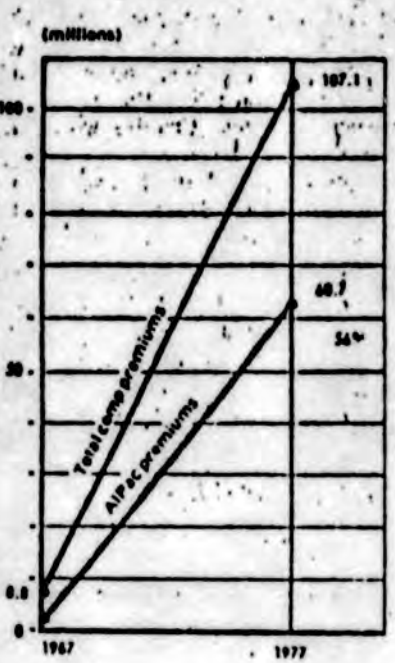
Whether the higher figure or the lower one is used, he said, all companies should use the same system.

"Somebody is not doing it the way it should be done," he said. "We're going to...get it fixed."

The extent to which different reporting methods may inflate Alaska comp rates cannot be determined from records filed with the Division of Insurance in Juneau.

That is one of the reasons the Division of Insurance hired Milliman and Robertson to examine the data submitted to the National Council. The data submitted to the National Council by carriers, Koch said, is generally accepted by the Council without auditing.

Workers' comp premiums written in Alaska



Only a small percentage of comp cases require large, long-term payments according to Richard L. Block, former state Director of Insurance now in charge of Alyeska Pipeline Service Co.'s risk management program. The pipeline carrier had "15,000 to 20,000" comp cases during construction of which less than 800 are still open. But those 800 cases Block says, "represent more in dollars than all we've ever paid out."

Koch said the Milliman and Robertson exam is looking at a wide range of rate-setting practices. However, he said, it was the Division's concern that some of Alpac's figures "may not reflect actual experience" that prompted the study.

The possible discrepancy in reporting methods was uncovered in 1977 when the Divison of Insurance met with Alpac employees to lay the groundwork for a routine financial examination of Alpac. That audit of Alpac, completed in January 1978, criticized the company for sloppy record-keeping and questioned the firm's reserving practices.

Alpac did not contest the audit.

Among the 1978 state audit's findings:

• The accounting firm of Peat, Marwick, Mitchell & Co., which conducted part of the examination for the state, found several weaknesses in Alpac's system of internal accounting. "Because of the overall importance of data processing to the company's system of internal control," the auditing firm advised the state, "we recommend that continued improvements...be given high priority." Alpac instituted the changes recommended.

• The audit revealed a backlog of approximately $619,000 in rejected claimchecks — checks branch offices requested for claimants that were cancelled by Alpac's central office for various reasons. Some, several months old, had yet to be returned to the originating office.

• Alpac's year-end report for 1976 showed an overall reserve deficiency of $2,095,419. However, a study of closed claims made by the state auditors showed that for the next nine months Alpac had a surplus on closed claims of $1,468,922. State financial examiner Don DeMuth finds the contrast in these figures "hard to believe."

Ordinarily, DeMuth said, he would expect a correlation between the two studies. In this case, however, one set of figures appeared to indicate significant under-reserving, while the other set indicated over-reserving.

Nothing that may be a legitimate and logical explanation for this contrast, DeMuth said he would like to know more about Alpac's reserve reporting techniques.

← Noting that there may be a log
(correction appeared 5/3/79)

Anchorage Daily News
May 2, 1979
(Part 3; continued)

"Normally an insurance regulatory body would not be concerned if a company was over-reserved," the 1978 audit stated, "...but since Alaska Pacific Assurance Co. writes approximately one-half the workmens' compensation business in the state, the Division of Insurance...is concerned with the potential effect that conservative loss reserving has on rate-making statistics. The division expects to make a market conduct examination of Alaska Pacific Assurance Co. in the near future which will include a review of the rate-making process and rate-making data base."

The market conduct study was never made market surveillance chief Koch said, because there were too many other projects that required the division's attention. Consequently, Koch advised then-director Richard L. Block, Koch would not be able to conduct the market study. Block, Koch recalls, was not happy about it.

Questions raised in the process of laying the ground work for the routine Alpac audit, however, tipped the state examiners to the possibility that discrepancies existed between the company's actual losses and the losses reported to the National Council. It was that information, division personnel said, that prompted the present study by Milliman and Robertson.

While questioning Alpac's paperwork procedures, the 1978 state audit praised the company's handling of claimants. "While the financial examiner did not make a specific review...(of claim settlement practices)," the report said, inspection of claim files for reserves gave "the general impression that treatment of...claimants was exemplary." Alpac's rehabilitation program was characterized as "excellent."

Alpac's claim handling has been criticized by some claimants who feel the company has unjustly denied them injury benefits. In Fairbanks a disgruntled group of injured workers has formed a group known as Action for Victims of Industrial Accidents. Group spokesman Diane Black has signed statements from at least 15 workers in the Fairbanks area, many of whom felt they got a raw deal from Alpac.

Industry-wide figures show that workers' comp carriers pay about as much for losses and expenses as they collect in premiums, leaving little apparent margin for profit. But these figures do not take into account the income the insurance company generates by investing large sums of money that will not have to be paid out in losses until a future date.

That an insurance company can make money while writing policies at an apparent loss is shown by figures on file with the Division of Insurance for Alpac. From 1973 thru 1976 Alpac recorded an underwriting loss of nearly one million dollars. During the same period, however, the company showed an after-tax profit of $2,328,120.

According to state figures in [illegible] ary of the national giant Insurance Co. of North America, wrote $88,675,000 of workers' comp premiums in Alaska. That's more than all other comp carriers in the state combined.

Alpac is headquartered in Anchorage with about 120 employees here. In Fairbanks, Juneau and Ketchikan offices, the company has another 22 employees, and about another 100 employees in five other western states.

Workers' comp benefits have been a subject of controversy in Alaska since 1975, when the legislature, in keeping with the findings of a Presidential commission, increased the benefit payments for on-the-job injuries. As benefits were increased to reflect pipeline wages, insurance carriers increased premiums to offset benefit payouts.

Criticism from businessmen, who must purchase the mandatory insurance from private carriers, resulted in a slight reduction in benefits — and premiums — in subsequent years, but Alaska's benefits are still the highest in the nation.

During the past decade the state has witnessed a dramatic jump in total comp premium payments, from approximately $8 million in 1968 to $107 million in 1977. During the same period Alpac's has emerged as the dominant comp carrier and the largest insurance company in the state.

The Division Insurance has not yet completed annual report for 1978, but informed sources told The Daily News they expect the total pay-out in comp premiums to drop slightly, while Alpac will retain its dominant position, recording more comp premiums than all other carriers in the state combined.

(The Fund for Investigative Journalism helped pay for some of the research for this series.)

Anchorage Daily News

Winner, 1976 Pulitzer Prize Gold Medal for Public Service

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for workers' comp

A wide-ranging examination of Workmen's Compensation in Alaska carried in The Daily News this week suggests a number of subjects that need close attention to ensure that the program really benefits those it is designed to help. The list of unanswered questions raised about the system demands a careful study be initiated to determine the facts and figures upon which policy makers may judge the program.

Without question, claimants have sometimes been caught in a classic bureaucratic squeeze; overlapping and sometimes conflicting jurisdictions of the Department of Labor's Workmen's Compensation Division and the Insurance Division in the Department of Revenue serve to undermine the comprehensive handling these important claims should receive. Upon checking, an official in the Revenue division office acknowledged a sizeable number of complaints involving workers' comp, but also told us the complaint office hadn't identified the subject as an area needing attention.

It is also troubling to note that a number of claimants — nobody knows just how many — have apparently been denied claims on the strength of medical testimony from a California physician well known for his consistent findings in favor of insurance companies. In cases examined in our reports, those claimants couldn't convince any applicable state agency to investigate the circumstances.

Have legitimate claimants been denied help from the system designed to aid them? The state has a responsibility to find out, and, if the answer is yes, changes ought to be made now.

The Division of Insurance also ought to examine the method by which rates are established for workers' compensation policies. Those rates are now filed by the Northwestern Compensation Rating Bureau, an affiliate of the National Council on Compensation Insurance — an insurance industry organization. Those rates, fixed on the basis of unaudited data, have tremendous impact on Alaska employers who foot the bill, and the state should have greater certainty about their validity.

It is certain that a number of Alaska wokers believe they have been wronged by the current system. It is not enough to answer, as did former Insurance Director Richard Block, that since lots of claims have been paid,

Daily News
Wednesday, July 4, 1979

Anchorage Daily News/Rob Stapleton

Diane Black injured in 1976 while working on the trans-Alaska pipeline, took part in a protest Tuesday at the MacKay Building in Anchorage.

Anchorage Daily News
July 4, 1979
(Page C-1)

Injured workers protest workmen's comp policies

By BRIAN A. HUNTLEY
Daily News reporter

A group of injured workers picketed the MacKay building in Anchorage Tuesday, protesting what they called unfair treatment by state workmen's compensation officials.

The protest led to an afternoon meeting with Lt. Gov. Terry Miller. Miller said the talks with the protesters "were productive" and pledged to inform Gov. Hammond of the group's grievances and schedule a meeting with Labor Commissioner Ed Orbeck.

But not all the picketers were satisfied with the afternoon session.

Diane Black, injured in 1976 while working on the oil pipeline, said "We have heard the promises before, and I guess we'll have to wait and see what happens. But if we don't get action, we will continue the (picket) lines and hunger strikes."

Black said many injured workers were afraid to come forward to protest poor treatment by the Workmen's Compensation Board and insurance companies.

"I guess when we get desperate enough, we have to come forward — we can't get help from Social Security, welfare, or the state vocational rehab (rehabilitation) — it's just a disgrace."

She added workers often cannot afford to fight long legal battles with insurance companies, and after financially draining litigation, the injured worker may be forced to accept a small settlement.

"If you're destitute, you just can't fight any more — you just desperately take whatever you can get, but it may not be fair," Black said.

Robert D. Mill, a Palmer resident injured while working on the pipeline, said he objected to the state's reliance on testimony by insurance company doctors. "Some of the doctors just haven't accurately reviewed our cases. We may have been treated by our own doctors for months, but the insurance doctor may only look at us for 15 minutes — and that will determine our payments for the rest of our lives," Mill added.

Complaints, case backlogs surround workmen's comp rate hearing

By RICHARD A. FINEBERG
Daily News correspondent

Rates which employers must pay to insure workers against on-the-job injuries will be the primary focus of a hearing Thursday in Anchorage, but other aspects of the workmen's compensation program may be considered, according to Kenneth Moore, director of the state's Division of Insurance, who will chair the session.

An issue that could come up at Thursday's hearing is the way the insurance industry and state authorities handle workmen's comp cases. Some workers seeking benefits say they have been disabled by on-the-job accidents but have been denied benefits by insurance companies who run the complicated workmen's comp program under supervision by two state agencies and a review board.

One of the agencies is Moore's Division of Insurance, a branch of the Department of Commerce and Economic Development that licenses and insures all insurance companies operating in Alaska. The other is the Department of Labor's Workmen's Compensation Division, which provides staff and administrative support for the Workmen's Compensation Board, a three-person panel that handles disputes between injured workers and insurance carriers.

The proposed comp rate change on the docket Thursday would result in a relatively small increase in overall comp rates — perhaps [illegible], according to

sources familiar with the filing by the insurance industry's National Council on Compensation Insurance (NCCI). While premium rates for some categories of workers, such as contract construction employees, would jump considerably under the NCCI proposal, other categories would drop.

The NCCI first submitted proposed changes in the comp premium structure earlier this year, but the Division of Insurance sent the proposal back to the NCCI for more supporting information, according to Division of Insurance sources. Comp rates reflect accident and benefit payment data submitted to the NCII by carriers operating in Alaska without audit.

Last spring, concern about the NCCI's unaudited rate-setting procedures prompted the Division of Insurance to commission a special review of the NCCI data by a California specialist. The division has received that report, but the contents will not be made public until the industry has had a chance to review the findings, according to a Division of Insurance source.

The source described the findings as "very, very favorable to the companies ... it found substantially less (problems) than we thought it was going to find." The report will not be part of Thursday's hearing, the source said, but the study might be released later in the month if the companies do not challenge the findings.

While Moore takes testimony in Anchorage on comp rates — and other issues, as time permits — a [illegible] ment's Workmen's Compensation Division moves to Juneau. Jacquelyn McClintock, former comp hearing officer in Fairbanks, steps into the director's slot that Labor Commissioner Ed Orbeck says gave retiring director John Cook ulcers. After 16 years with the state Cook left the job last month for medical reasons, according to Orbeck.

Orbeck and McClintock faced a court challenge Oct. 5 in Fairbanks from seven comp claimants who sued the state after waiting several months for decisions on their cases by the overworked Workmen's Compensation Board. The state officials also met with a second group of disgruntled comp claimants.

Under state law, the board is supposed to rule on comp disputes within 20 days after a hearing, but the average case takes 96 days, according to Labor Department statistics.

"There is no way we can comply with the law as it is written," Orbeck said after the court session. There are just too many disputed cases and too few board members and staff aides to handle the increase in disputes between claimants and carriers in the wake of the pipeline boom, the commissioner said.

The Workmen's Compensation Board consists of three persons, two community members appointed by the governor and one representative of the Commissioner of Labor. In the past, Workmen's Compensation Division hearing officers based in Fairbanks and Anchorage have worked with one gov- hearings in both cities. A second Workmen's Compensation Board, working with another hearing officer, handled the Southeast Alaska panhandle.

This spring, in response to the growing backlog of comp cases, the legislature added a new board for Fairbanks and Anchorage and created positions for a new hearing officer for each city. The beefed-up Anchorage board is hearing more cases and producing faster decisions, according to Chancy Croft, an Anchorage attorney and former legislator who frequently handles comp cases.

The Fairbanks slot has yet to be filled. New director McClintock, who inherited a backlog of cases when she became a hearing officer in Fairbanks last November, says she frequently worked nights and week-ends but still faced a stack of long-delayed decisions when Orbeck promoted her last month.

Two former pipeline workers who claim they represent hundreds of others who have been short-changed by the cumbersome comp system met with McClintock and Orbeck in Fairbanks last month to discuss reform of the program. The workers, Robert Mill and Robert MacArmour, were not parties to the court challenge, but both said their personal lives had been disrupted by long delays in the board hearing process.

MacArmour said that for a broke and injured worker whose carrier denies him benefits, the months of waiting for a decision from the state can be "devastating." MacArmour asked Orbeck to

romise to try to secure additional nds to speed the decision process. rbeck did not make any promises, . did say he wanted to help ..., claimants get quicker deci- ions.

Mill asked Orbeck to set up a pecial committee to review the ork of the Workmen's Compensa- on Board on long-term, disabling njuries. Orbeck said he could not nterfere with the board's opera- on.

MacArmour also asked the state put out a manual that would help ne injured worker understand the omplicated state law that governs orkmen's comp. Orbeck said a omplete rewrite of the law was eeded.

Orbeck seemed surprised when lill said he felt insurance carriers ere abusing the law and that the ate was not respon ling to the roblem. Several times during the eeting Orbeck told the angry rotesters that prior to this meet- g they had never requested a eeting with the commissioner.

"I carried a banner," MacAr- our responded, referring to 1978 nd 1979 demonstrations at state ffices in Anchorage and Fairbanks.

Mill said he picketed, too. Mill so travelled to Juneau to discuss s problems with the Workmen's mpensation Division staff.

Both MacArmour and Mill were jured in truck accidents during peline construction. They both ceive treatment from an Anchor- e chiropractor.

It is not known whether critics the comp system such as Mill d MacArmour will bring their evances to the Division of Insur- ce Thursday, but Moore has left door open. Although the hearing about the rate change, the ad- nce notice says, "as time per- ts, the Division will also hear timony concerning other work- n's compensation insurance is- ."

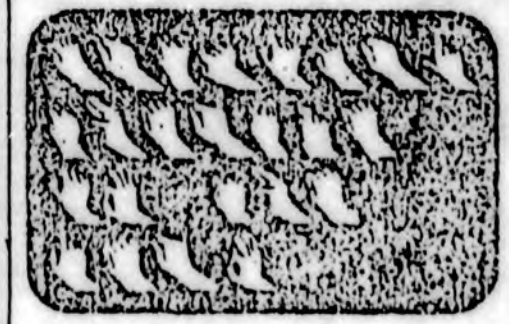
In the past the Division of Insurance has confined its interest in workmen's comp to rate-setting matters, leaving the problem of delivery of services to its sister agency in the Labor Department.

Thursday's hearing will be held from 9 a.m. to 4:30 p.m. at the Municipal Assembly Room, 3500 E. Tudor Road. In addition, Moore and other staff members will host an informal meeting Wednesday night to talk with the public about any insurance-related problems. That meeting will be held at 7 p.m. Wednesday at the Pioneer School, at Third Avenue and Eagle Street.

Anchorage Daily News
Nov. 7, 1979
(continued)

Hurt workers hit delays

Page C-1



orage Daily News

ANCHORAGE, ALASKA, FRIDAY, NOVEMBER 9, 1979

Anchorage Daily News/Marc Olson

...Mill, who says his insurance company won't pay his ...ior bills, despite an order by the Workmen's Compensa... Board, listens to testimony by another angry claimant ...ing hearings Thursday.

Anchorage Daily News/Marc Olson

Robert D. Mill, a former truck driver, told state Insurance Division officials who held hearings on workmen's compensation that insurance carriers stall payments on permanent disabling injuries.

...lurt workers hit compensation delays

Hurt workers hit compensation delays

By RICHARD FINEBERG
Daily News correspondent

Henrietta Nugen left Thursday's workmen's compensation rate hearing smiling. Everybody else who came to learn about the intricate and mysterious process by which the insurance industry sets the rates which employers must pay for their comp premiums left looking unhappy, and a small group of people who claim the comp system gives them a run-around looked like they had just left a wake.

Nugen, who works for the Studio Club rehabilitation center, said she did not want to see higher workmen's comp premium rates. State Division of Insurance Market Surveillance Chief Don Koch thumbed through his new listing of comp rates and told her that institutions such as the rehabilitation center can expect a 19 percent decrease if the division approves the new rates, which are expected to go into effect Jan. 1.

The total comp bill Alaska employers shell out — $102 million last year — will increase by 1.8 percent under the new rates, according to Hank Edmiston, Denver-based vice president of the National Council on Compensation Insurance (NCCI).

Although the overall increase is slight, some comp rates will go up considerably and others, like Studio Club's, will go down. Across the board, contractor will see a 10.7 percent increase, manufacturing will go up 0.6 percent and all other categories will average a 4.2 percent drop, according to the filing proposed by the Alaska Classification and Rate Committee, an insurance company group that retains the NCCI.

About 20 people — employers concerned about their comp rates and individuals concerned about whether that insurance covers them when they are hurt on the job — attended the hearing at the Anchorage Assembly building.

The industry group also presented testimony on a proposed change in rates for small policies. Under this proposal, the current $15 charge for handling small comp policies will go to $35 in 1980 and $60 in 1981. Edmiston said the increase in premiums for the small policy holder would be offset by across-the-board decrease in comp rates, leaving the industry with no additional revenues.

"It's just a redistribution of the total comp bill," one insurance industry official explained.

An audit of the information submitted by Alaska comp carriers to the NCCI by a California specialist "gives us some confidence (in the NCCI)...that we didn't have a year ago," according to state Market Surveillance Chief Koch. However, the report, which the Insurance Division received Oct. 1, will not be released until Dec. 4, Koch said.

The Alaska business people with gripes included veterinarians, who say they have shelled out $182,000 in comp premiums over the past five years to insure employees who have run up a total of less than $4,000 in comp claims. The problem, Koch said, is that the vets are lumped in with animal control personnel, who deal with stray and wild animals and have a higher accident rate.

"It took us five years to find that out, and we didn't get much help from your division or our insurance agents," commented veterinarian Pam Tuomi.

Bill Martin, controller with Sourdough Express in Fairbanks, said he was disappointed copies of the bulky and complicated rate filing were not available in advance, or at the hearing, so that people could comment intelligently.

A different kind of comp problem was described by Robert Mill, Don McGuffin and Nile Hill, workers who claim they were injured on the job and unjustly denied benefits by the comp system. "It's just been a run-around, backwards and forward," said McGuffin, whose comp case has been bouncing between the state Workmen's Compensation Board and the courts for two years.

"If in fact the insurance carriers under Alaska statutes are not upholding their end of the bargain," Mill asked, "who do we appeal to?" Last month Mill and other comp claimants went to Fairbanks to meet with Labor Commissioner Ed Orbeck.

State Director of Insurance Kenneth Moore, who presided over the hearing and an informal meeting at Pioneer School Wednesday night, said his office would look into the specific problems presented by comp claimants at both meetings. Additionally, he said, his division will make a transcript to the Labor Department, which administers the day-to-day operation of the Workmen's Compensation Board.

Anchorage Daily News

Friday, November 9, 1979 C-1

ALASKA WORKMEN'S COMPENSATION BOARD

P. O. Box 1149

Juneau, Alaska
99801

BILL C. ANDERSON

Applicant

vs.

BLANAS INSULATION

Defendant

and

NATIONAL AUTO & CASUALTY

Carrier

DECISION AND ORDER

Case No. 73-12-0371

This matter originally came before the Alaska Workmen's Compensation Board for hearing on October 9, 1974. At that time the applicant had been diagnosed as having lung cancer. The principal question before the Board was whether it was related to his occupation as an insulator; an occupation which involves the use of asbestos and other insulating materials. In a decision dated December 16, 1974, the Board found that, although Mr. Anderson did have lung cancer, a diagnosis of asbestosis or silicosis had not been made. It therefore denied his claim.

In a December 26, 1974 letter to the Board applicant's counsel made application for review pursuant to the provisions of AS 23.30.125(b). The matter again came before the Board for hearing on April 9, 1975. At both hearings the applicant, who is now deceased, was represented by Attorney Albert Maffei. The defendant and its insurance carrier were represented by Attorney Richard J. Willoughby.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. The principal contention is that the Board erred when it found that no diagnosis of asbestosis or silicosis had been made by doctors who had examined and/or treated Mr. Anderson.

This contention is set forth in Attorney Maffei's December 26, 1974 letter to which was attached the June 17, 1974 operative report of Dr. Dietz. In it the doctor stated:

> . . . the right thorax revealed multiple evidence of pleural disease, it seemed like old calcific pleuritis, with a studding hard white plaque throughout the thorax and the parietal pleura and diaphragm and mediastinum. . . .

Our understanding of "plueral disease" is that it was related to pleurisy and not to asbestosis. Nor were we able to interpret Dr. Dietz's October 15, 1974 report as a diagnosis of asbestosis. It was not until we received a subsequent report from the doctor dated December 24, 1974 in which he said, ". . . it was what you would call a classic text book finding for asbestosis. . . ." that we were convinced we had erred.

This error was confirmed by the autopsy report which was presented at the April 9, 1975 hearing. The report states in part:

> Lungs: There is a poorly differentiated malignant enoplasm involving the apical portion of both right and left upper lobes, more predominant on the left side. This is associated with the presence of numerous asbestos bodies. . . . (emphasis ours)

We therefore reverse our previous conclusion that applicant's illness was not asbestosis and find that, although he may have contracted the disease as a result of exposure to asbestos over a period of years, it was the "last injurious exposure" during his employment for the defendant that aggravated and accelerated the disease.

2. As stated in our previous decision, at the time of applicant's illness he was living in the home of Mr. Jack M. Endsley, who is the business agent for the Insulation Workers Union and who had, unknown to Anderson, arranged for the two of them to go to two clinics for examination and/or treatment. One is in Berkeley, California; the other in Tijuana, Mexico. When claim was made for travel expense and living expense connected with the trip, the carrier refused to pay it, although it did not, as we understood at the time of the original hearing, refuse to pay the costs of medical treatment at the clinics.

Bills totalling $14,377.53 covering the costs of medical treatment, hospitalization, and funeral expenses are presented for payment. Some expense was incurred in California, some in Mexico and some in Alaska.

Sec. 23.03.095 contains provisions which require the employer to furnish medical, surgical, and other necessary treatment which may be necessary. One provision is that:

> . . . 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 judgement of the board, care or treatment or both can best be administered by the selection of another physician. . . .

It is well known that in some areas of Alaska adequate facilities are not available for treatment. In those cases the attending physician will often refer a patient to some place, usually Seattle, Washington, where facilities are available. In such a case, the Board has consistently required the insurance carrier to pay transportation costs as well as the costs of treatment. In cases in which the attending physician has not referred the patient to an outside facility, the practice has been for the patient to pay the cost of transportation; however, the carrier pays for the treatment.

In the present case, Mr. Anderson was terminally ill and was living in Anchorage where the medical facilities and the number of doctors available are greater than in any other part of Alaska. If adequate facilities exist anyplace in Alaska, it must be Anchorage.

In this case Mr. Anderson wasn't referred outside Alaska by his physician nor was it his idea to leave Anchorage. Out of concern for his friend and a desire to seek out any source of available help, Mr. Endsley, unknown to Mr. Anderson, made the arrangement and accompanied him to California and Mexico. We therefore conclude that the costs of transportation to the outside facilities and the treatment rendered there should not be assessed against the employer or its insurance carrier. The costs of treatment in Alaska shall be paid by the carrier. As provided by AS 23.30.215, funeral expenses, not to exceed $1,000, shall be paid by the carrier.

3. From the time the carrier ceased payment on this claim, Mr. Anderson, had he lived, would have been entitled to compensation for temporary total disability. He left no surviving dependents. The question naturally arises as to whether or not this sum is heritable. Based upon the following quotations from Larson, we find they are not:

The recipient of installment payments does not ordinarily "own" the unpaid balance of the award so as to entitle his heirs as such to any interest in it.

Not only is the award trimmed on all sides--as to kind of injury, elements of damage, and maximum dollar amount--to ensure that it can never exceed the amount necessary to prevent want during disability; the award itself is completely cut off in most jurisdictions when, through the death of the worker without dependents, for example, there is no further need to worry about anyone's becoming destitute. Thus, if a claimant has been awarded $20 a week for 300 weeks, and dies without dependents after 100 weeks, his heirs usually have no claim upon the unpaid $4000. So the making of an award for disability, far from being an adversary recovery of damages by an injured plaintiff from a defendant guilty of some kind of constructive responsibility for the accident, is rather the signal for the setting in motion of a scheme of social protection which goes no further in nature, amount, or duration than the necessities of that protection require. (See Larson Vol. 1 § 2.60.)

In the opening portion of the book, it was pointed out that one of the features distinguishing a compensation award from a tort recovery is the absence of any property right in an award which can survive in favor of heirs. The problem most frequently arises in connection with schedule or other permanent partial awards, when an employee who has been awarded, say 312 weeks' benefits for loss of an arm dies at the end of 12 weeks. The question is whether his heirs have a claim upon the unaccrued 300 weeks' payments.

Accrued but unpaid installments are, of course, an asset of the estate, like any other debt. This is equally true of the widow's death benefits, accrued but unpaid installments of which go on her death to her heirs. When the award takes the form of a lump sum, the amount due as accrued payments is the entire amount of the lump sum.

When, however, the award, although for a fixed number of weeks, is paid weekly or periodically, most jurisdictions in the absence of a special statute to the contrary have held that the heirs have no claim upon the unaccrued payments, since the award is a personal one, based upon the employee's need for a substitute for his lost wages and earning capacity. There is, however, some contra authority.

This rule has been modified by statute in some states, but it is significant that the modification often takes the form, not of giving the unaccrued balance to heirs indiscriminately, but of giving it in fixed proportions to dependent heirs. Accordingly, if there are no dependents in the statutory sense, the award abates. (See Larson, Vol. 2, p. 10-244 through 10-252.)

4. We find the carrier has resisted payment of applicant's claim and that he employed an attorney who furnished valuable and bona fide legal services reasonably worth $500 and that said amount should be paid by the carrier to applicant's attorney.

ORDER

1. The costs of medical treatment and hospitalization incurred in Alaska, as well as funeral expenses not to exceed $1,000, shall be paid by the employer's insurance carrier.

2. Sums which Mr. Anderson would have been entitled to receive as compensation, had he lived, shall abate.

3. The carrier shall pay $500 to applicant's attorney as attorney's fees.

Dated at Juneau, Alaska, this 15th day of December, 1975.

ALASKA WORKMEN'S COMPENSATION BOARD

s/ Earl J. Turner

Earl J. Turner, Chairman

Chipper L. Parr, Member

s/ Thomas Chandler

Thomas Chandler, Member

Compensation payments, if required to be paid in this decision, are payable within 14 days of its date unless a stay of payment is obtained from Superior Court.

APPEAL PROCEDURES

A compensation order may be appealed through proceedings in the Superior Court brought by a party in interest against the Board and all other parties to the proceedings before the Board, as provided in the Rules of Appellant Procedure of the State of Alaska.

A compensation order becomes effective when filed in the office of the Board, and unless proceedings to appeal it are instituted, it becomes final on the 31st day after it has been mailed or delivered to the party seeking to appeal it.

CERTIFICATION

I hereby certify that the foregoing is a full, true and correct copy of the Decision and Order in the matter of Bill C. Anderson, applicant, vs. Blanas Insulation, defendant, and National Auto & Casualty, Insurance carrier, Case No. 73-12-0371, dated and filed in the office of the Alaska Workmen's Compensation Board at Juneau, Alaska, this 15th day of December, 1975.

Elaine Langpaer

Secretary

Jackie McClintock
Worker's Compensation Officer
Fairbanks

September 4, 1979

John Cook, Director
Workmen's Compensation Division
Juneau

Payment of Temporary Total Disability or Sec. .191 Maintenance Compensation

Your July 19, 1979 memorandum requested guidelines to assist in resolving questions as to when an injured employee undergoing rehabilitation is entitled to temporary disability and when is the employee entitled to maintenance compensation.

In the case of employees enrolled in rehabilitation programs who have unscheduled injuries and whose permanent loss of wage earning capacity cannot be determined, the Board has ordered that temporary disability compensation be paid and not the reduced compensation for maintenance provided under AS 23.30.191. In these cases the employee would not usually be enrolled in rehabilitation if his loss of ability to earn wages was permanent and the loss could not be reduced through retraining in job skills. The Board is urged to continue this policy.

Although the Board has not, to my knowledge, agreed with me on this matter, I believe temporary disability compensation should also be paid in cases of scheduled injury while undergoing rehabilitation rather than reduced compensation under Section .191 after the doctor finds the medical condition has stabilized. I urge the Board to consider ordering continuing temporary disability compensation while undergoing rehabilitation in cases of scheduled injury cases.

It is my opinion that the Board should consider the following:

1. When an employee has applied for rehabilitation with an agency or in a manner accepted by the Board, he should be paid temporary total disability compensation, provided the employee is unable to work and is cooperating in the retraining process. Compensation should not be withheld until a program has been developed and the employee actually starts to school.

2. When an employee is cooperating in rehabilitation efforts, and is able to continue in a job situation at a lesser wage than the wage being earned at the time of injury, the employee should be paid temporary partial disability compensation. (Two-thirds of the difference between the employees average weekly wage and the weekly wage after injury).

3. When an employee has received temporary partial disability compensation for five years (the maximum period allowed for TP) and the employee continues in a lessor paying job but is also participating in rehabilitation efforts to learn skills to upgrade earnings, the employee would be entitled to maintenance compensation under AS 23.30.191 which provides for payment of such compensation when the employee is no longer entitled to temporary total or temporary partial compensation.

4. When the employee has waived rights to further temporary disability compensation by compromise and release, and the employee is eligible for and is actively pursuing vocational rehabilitation under provisions of AS 23.30.040. Compensation necessary for maintenance would be payable under provisions of Sec. 191.

5. When it can be shown that the employee is purposely delaying the rehabilitation process, the Board should find the employee is not doing all possible to mitigate loss, and depending on the seriousness of the employee's failure to cooperate, either order forfeiture of the compensation that would have accrued during the delay or the Board should make a determination of the loss had the delay not occurred and, in the interests of justice, discharge the employers liability by payment of a lump sum.

Present practice of the insurance adjusters is to stop compensation when the doctor indicates the employee's medical condition has stabilized. The practice is wrong. The period of disability is determined by whether or not the employee is able to earn the wages that he was receiving at the time of injury, and if not, whether his inability to earn wages is a temporary or permanent condition. If there is a loss and the condition is temporary, the employee should be paid temporary disability whether or not he is undergoing rehabilitation. If the loss is permanent, then the employee should be paid permanent disability during the period of loss.

AS 23.30.185 provides "In case of disability total in character but temporary in quality, 66-2/3 percent of the injured employee's average weekly wages shall be paid to the employee during the continuance of the disability. (emphasis mine)

AS 23.30.200 provides "In case of temporary partial disability resulting in decrease of earning capacity the compensation shall be 66-2/3 percent of the difference between the injured employee's average weekly wages before the injury and his wage earning capacity after the injury in the same or another employment, to be paid during the continuance of the disability, but not to be paid for more than five years."

AS 23.30.265(10) defines "disability" to mean "incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment."

There is nothing in Sec. 185, Sec. 200 or Sec. 265(10) that states "disability" ends when the injured reaches maximum medical improvement, the treatment has ended or the employee can be rated for physical impairment. The facts that determine whether compensation is due are those that relate to the employee's disability. (Is the employee incapacitated because of injury to earn the wages which the employee was receiving at the time of injury?)

Upon reaching maximum medical improvment the employee may be able to:

1. Return to work and earn the same wage or a higher wage that was being received at the time of injury. In such cases, no compensation is payable.

2. Return to a lesser paying job and engage in a rehabilitation program with prospects of earning the same or higher wage than at time of injury. Temporary partial disability compensation would be due for a period not exceeding five years. After five years, additional compensation could be paid as needed under provisions of Sec. 191.

3. Return to a lesser paying job with no prospects of earning the same or a higher wage an of rehabilitation. Permanent partial disability compensation would be due.

4. Not return to any gainful employment but with prospects of return to work after completion of a rehabilitation program. Temporary total disability compensation would be due.

5. Not return to any gainful employment with no prospect for future employment. Permanent total disability compensation would be due.

6. Return to work or learn work that could be performed dispite impairment from injury but refuses to seek work or rehabiliatation. The Board should find the employee responsible for not mitigating losses and relieve the employer from that period of disability which is not attributable to injury.

In making a finding that the employee failed to mitigate damages, the Board should be first satisfied that the employee's failure to seek work or rehabilitation is not due to post traumatic neurosis. If the latter and the neurosis was set off by the injury, then the employee should not be held responsible for actions brought on by the mental problem.

Apparently, Sec. 191 causes confusion, but it must be noted that it was enacted in 1963 when there was a limit on payment of temporary total and temporary partial of $20,000. In the cases of unscheduled injuries, the limit was $17,000. The limits applied to compensation paid for both temporary and permanent partial in the aggregate and it was often the case that an injured worker would be paid the maximum but needed rehabilitation. To encourage rehabilitation of those who were no longer entitled to temporary disability compensation, Sec. 191 was enacted.

For injuries after 1975 there is no maximum limit for payment of temporary disability and such compensation should be continued while undergoing rehabilitation if the employee is temporarily incapacited from earning the wages as before injury, even though medically, the employee has attained maximum healing. Likewise, payment for temporary partial disability should be continued, when only the employee's medical condition has stabilized but his ability to earn wages has not.

In those cases where injury prior to May 22, 1975 precludes payment of temporary disability beyond a maximum amount, where the employees have waived rights to further temporary disability compensation by compromise settlement, and where an employee's eligiblity for temporary partial has terminated due to the five year limitation in Sec. 200, payment of compensation for maintenance under provisions of Sec. 191 would be appropriate while the employee is undergoing vocational rehabilitation.

Professor Larson states that temporary total disability is payable during the period of healing and complete wage loss. Our statute defines "disability" as the incapacity because of injury to earn the wages which the employee was receiving at the time of injury. When such a condition is temporary, Sec. 185 requires the payment of temporary total disability compensation during the continuance of the disability. I interpret this to mean that, even in cases of scheduled permanent disability cases, temporary compensation is payable when a temporary incapacity to earn wages exists even though at some time during that period the employee is considered medically stationary.

It is easy to find statutory authority for continuing temporary disability while undergoing rehabilitation in unscheduled injury cases because permanent partial disability is awarded based on the employee's permanent loss of wage earning capacity and such a determination cannot be made until the training is completed and the employees loss of wage earning capacity is known.

It is more difficult in the scheduled injury cases because AS 23.30.190(1) through (21) except (20) provides for a specific number of weeks of compensation to be paid depending on the degree of "loss of or loss of use". Sec. 190 provides that such compensation shall be paid in addition to temporary total or temporary partial disability compensation. Temporary disability is payable while the employee is temporarily "unable to earn the wages which the employee was receiving at the time of injury".

For an example, when an employee loses an arm or the use of an arm, the employee may continue to be temporarily disabled from earning pre-injury wages even though the doctor rules that the employee's condition is medically stable and the degree of permanent loss of use can be determined.

In such a case, I believe the employee should be considered to be temporarily disabled and paid temporary disability compensation even though the employee was medically healed, unless at the time of maximum healing and rating for loss of use it can also be said that the employee is able to return to work, does not need rehabilitation and his earning capacity has also reached maximum improvement.

There is one other area of concern relative to the scheduled injury. There will be persons who cannot return to work or can only return to work at a lesser paying job but cannot be rehabilitated to something better. In other words, both their medical condition ability to earn wages are permanent.

In the first instance, if the person is totally disabled from return to work, cannot be rehabilitated and the condition is permanent, the employee could not be paid compensation for disability under Sec. 190 because Sec. 190 provides for a disability "partial in character" but permanent in quality. This case would be total in character and permanent in quality and paid under provisions of AS 23.30.180 for permanent total disability.

In the second circumstance when the condition is permanent at lower paying work, and the employee cannot be rehabilitated to a higher level of earnings, the employee should be paid the number of weeks compensation allowed for permanent loss of or loss of use under Sec. 190(1) through (21) except (20) and no further temporary or partial disability compensation is due. The Board should ascertain, however, that the earnings after injury are not so minimal or sporadic in nature as to fall in the "odd lot doctrine" and if so the earnings should be considered inconsequential and a permanent total award made.

U.S. Department of Labor

October 17, 1980

Employment Standards Administration
Office of Workers' Compensation Programs
4010 Federal Office Building
909 First Avenue
Seattle, WA 98174

File Number:

Licia Piceno
Administrative Assistant to
Senator Stimson
Pouch V
Juneau, AK 99811

Ms. Piceno:

Here is the copy of the National Average Weekly Wage Memo which you requested.

Sincerely,

Collis Overton
Assistant Deputy Commissioner

Enclosure

U.S. Department of Labor

October 8, 1980

Employment Standards Administration
Office of Workers' Compensation Programs
4010 Federal Office Building
909 First Avenue
Seattle, WA 98174

File Number:

MEMORANDUM FOR: All Claims Examiners and Claims Clerks

FROM: Collis Overton, Assistant Deputy Commissioner

SUBJECT: NATIONAL AVERAGE WEEKLY WAGE FOR PERIOD COMMENCING OCTOBER 1, 1980

Per our telephone conversation with Mike Jump in National Office, the following figures are for the period October 1, 1980 to September 30, 1981:

National Average Weekly Wage - $228.12
Maximum Compensation Rate - $456.24
Minimum Compensation Rate - $114.06

Percentage Increase - 7.03 percent

Collis Overton
Assistant Deputy Commissioner

OWCP: C. Overton: vw 10/8/80
Room S-4081 FOB: Ext. 2-4471

October 15, 1980

Dear Brian,

Enclosed is the "Low Credibility Classifications Report" from the Division of Insurance for the October 16th meeting.

Sincerely,

Licia

Licia

LOW CREDIBILITY CLASSIFICATIONS

LOW CREDIBILITY CLASSIFICATIONS

INDEX

BACKGROUND

The Director of Insurance for Alaska has expressed concern as to the accuracy of Workmen's Compensation rates by classification. This concern is primarily with the rate relativity among classifications within the State of Alaska.

To study this problem, a special subcommittee of the Alaska Classification and Rating Committee was appointed. The subcommittee drew upon both actuarial expertise and Alaska underwriting experience to arrive at their conclusions.

The subcommittee directed its attention to "low credibility" classifications since this is the group where the relativities would be most suspect. The current ratemaking procedure for low credibility classes (known as the National Relativity Program) was examined to determine whether the resulting rates are "not excessive, inadequate or unfairly discriminatory". Alternative methods of ratemaking were also considered.

The analysis of low credibility classes led to an additional review of certain classes whose rates had been questioned by underwriters in earlier studies.

CONCLUSIONS

1. The present system of ratemaking is working correctly to bring about accurate relativities between classes.
2. Fair and equitable rates are being produced for the low credibility classifications using the National Relativity Program. This conclusion is sustained both by consideration of the logic of the Program and by objective tests.

Conclusions (continued)

3. This Program is also proving to be effective in an earlier study in refining the "suspect" classes as designated by underwriters. These "suspect classes" included low credibility classes as well as larger classes.

4. In selected instances, an informed judgmental modification of the rate produced by the standard program is appropriate as it applies to a particular classification. A uniqueness of the Alaska situation or a change in some facet affecting premium development should be given special attention by the Alaska Classification and Rating Committee.

5. This report examines only ratemaking procedures. Consistently accurate application of classifications and the rules of the Manual and Statistical Plan are also important to maintain the integrity of the rating system. As more correct information goes into the ratemaking process and more years of classification relativity are brought into the ratemaking process, the greater will be the accuracy of all rates.

RECOMMENDATIONS

1. Retain the procedures currently being used as the standard ratemaking method.

2. The Classification and Rating Committee should periodically identify those individual classifications, if any, which appear to be out of line. Adjustments then should be made on the basis of informed judgment giving due consideration to:

Recommendations (continued)

- Comparison to other higher credibility Alaska classifications.
- Known changes in exposures or premiums not reflected in the statistical data base.
- Relative differences in exposure between Alaska risks and National risks.

SUMMARY OF REVIEW

I. STATISTICAL TESTS

The Actuary from the National Council on Compensation Insurance, Roy Kallop, gave the Committee an overview of the ratemaking procedure and classification relativity in spreading the premium by classification. He also provided background information relative to the introduction of the National Relativity Program which has been introduced in Alaska as a ratemaking tool.

The Actuary from Industrial Indemnity, Lester Dropkin, presented a study of the 638 classifications in the Compensation Manual as filed with the Alaska Division of Insurance. Following is a table of how the classifications are distributed by degree of credibility:

Category	Description	No. of Classif's.	Ratio to Total	Proportion of Payroll in Category
A	Zero Cred. - No Exposure	300	.47	-
B	Zero Cred. - Some Exposure	65	.10	.002
C	Cred. Less Than 10% in All Parts	151	.24	.055
D	Cred. Less Than 10% in 1 or 2 Parts	29	.05	.045
E	Cred. More Than 10% in All Parts Up to 35% in All Parts	51	.08	.201
F	Cred. More Than 75% in All Parts	6	.01	.106
G	All Other*	36	.05	.592
Total		638	1.00	1.000

Note: "Parts" refers to the Serious, Non-Serious and Medical portions.

*Generally speaking, this category can be viewed as being comprised of classifications having between 35% and 75% in the three parts.

An in-depth study of Category E was made. This Category was chosen as a representative of the low credibility classes but with a significant portion of the total Alaska payroll. The use of national relativity modifies the pure premium in all but one classification, but the average difference is only a plus 2.2%. This indicates that in the aggregate, the National Relativity Program has not caused a serious difference in the amount of premium paid by this group of classifications. In addition, a curve of these variances develops a well-disciplined bell-shaped curve. This demonstrates that the current Program causes no serious aberrations in Manual rates for the Category E classifications and, therefore, by implication the Program is working well with respect to all Alaska classifications. The comparison of current and prior procedures on Category E classifications is shown in the following table:

Ratio: Total PP - Current Procedure / Total PP - Prior Procedure	Number of Classifications
.700 - .749	1
.750 - .799	1
.800 - .849	3
.850 - .899	4
.900 - .949	3
.950 - .999	9
1.000	1
1.001 - 1.050	9
1.051 - 1.100	9
1.101 - 1.150	3
1.151 - 1.200	4
1.201 - 1.250	2
1.251 - 1.300	0
1.301 - 1.350	2
Average 1.022	51

A similar review of Category G classifications was made with an average ratio nearing unity at .988 with a well-behaved distribution, as shown on the following table:

Ratio (Total PP - Current Procedure / Total PP - Prior Procedure)	Number of Classifications
.800 - .849	2
.850 - .899	3
.900 - .949	4
.950 - .999	8
1.000	1
1.001 - 1.050	13
1.051 - 1.100	2
1.101 - 1.150	2
1.151 - 1.200	1
Average .988	36

Combining E and G considers almost 80% of Alaska payroll with an average ratio of 1.008. It appears the National Relativity Program is working well. It should be kept in mind that total premium is not affected by the distribution among classifications.

II. SPECIAL CLASSIFICATIONS REVIEW

A few years ago, Alaska Pacific Assurance Company and Industrial Indemnity Company identified 45 classifications that appeared "suspect" as to rate: ten being indicated as overrated and 35 underrated. Four classes, 2702, 2711, 5403 and 6235, are of such high credibility that national relativity has practically no effect.

The same analyses were applied to the remaining 41 classifications that were used on the low credibility classifications. Of the eight remaining "overrated" group, six show a movement to the downward side. Of the 33 "underrated" classes, 27 moved upward. To

restate this, 33 of 41 classes are moving in the direction that underwriting judgment indicated. Five of the variant codes deviate only slightly and current procedures are probably accurate. Code 5606 and two aircraft codes, 7431 and 7422, appear to need administrative consideration.

Code 8831 - Veterinary has specifically been questioned. Low credibility factors, 5%, 12% and 9%, cause the National Relativity Program to have considerable impact. The current ratemaking approach indicates a pure premium of $4.28; the pure premium under the prior procedure is $6.98. It is clear the Program is working well to assist the Veterinary class. As a matter of interest, this Class did have losses in the 1973 - 1975 policy years that developed a pure premium for that period of $5.34.

Attached is a table of the original 45 "suspect" classifications.

III. SUMMARY

From the point of view of both internal logic and objective test, both the Special Committee and the Classification and Rating Committee believe that this study clearly demonstrates that the present methods used to adjust rates on low credibility classifications (and, in fact, on all classifications) are producing fair and equitable rates and are moving rapidly to a more precise distribution of rates.

ALASKA WORKMEN'S COMPENSATION

	Class	Code	Class %	Formula P.P. Current	Formula P.P. Prior	Ratio
Overrated	Logging	2702	100,100,100	33.37	33.37	1.000
	Canneries	2111	87,100,100	7.09	7.14	.993
	Veterinarians	8831	5, 12, 9	4.28	6.98	.613
	Rigging	9530	1, 2, 1	18.03	25.15	.717
	Pile Driving	6003	30, 21, 19	14.28	14.75	.968
	Contractors - Exec. Super.	5606	25, 27, 24	3.29	2.82	1.167
	Sawmills	2710	36, 56, 47	10.35	10.41	.994
	Plumbing	5183	47, 49, 45	3.90	3.87	1.008
	Excavation	6217	66, 54, 48	4.55	4.67	.974
	Clerical	8810	40, 57, 69	.27	.29	.931
Underrated	Carpentry N.O.C.	5403	100,100, 99	5.11	5.11	1.000
	Oil Well Drilling	6235	100, 99, 87	7.01	7.01	1.000
	Rock Excavation	1605	5, 4, 5	5.35	4.82	1.110
	Welding	3365	16, 26, 26	5.74	4.96	1.157
	Concrete Const. N.O.C.	5213	58, 59, 66	5.23	5.12	1.021
	Roofing	5551	29, 30, 33	11.27	11.14	1.012
	Carpentry - New Res.	5645	28, 47, 39	4.49	4.00	1.123
	Sewer Const.	6306	36, 41, 37	6.04	5.90	1.024
	Contractors Yard.	8227	34, 45, 41	3.13	3.24	.966
	Concrete Bridge Const.	5222	17, 16, 16	6.45	6.16	1.047
	Plastering	5480	4, 7, 5	4.52	4.04	1.119
	Road Const. - Rock	5508	11, 11, 11	4.74	4.78	.992
	Sheet Metal Work	5538	20, 25, 28	3.53	3.05	1.157
	Oil Well - Perf. or Casing	6214	4, 4, 5	4.59	4.81	.954
	Paving	5506	64, 72, 65	5.89	5.79	1.017
	Fence Const.	6400	7, 11, 8	4.35	4.28	1.016
	Non-Sched. Airline	7431	61, 75, 61	11.96	14.79	.809
	Lumber Yards	8232	29, 46, 39	4.04	3.70	1.092
	Aircraft N.O.C.	7422	78, 32, 34	9.85	11.62	.848
	Gasoline Oil Dlrs. - Wholesale	8350	15, 16, 17	3.08	2.35	1.311
	Wholesale Meat or Fish	8021	4, 13, 9	3.94	3.93	1.003
	Bottling N.O.C.	2157	3, 6, 6	3.18	2.90	1.097
	Laundries	2585	5, 9, 8	2.42	2.13	1.136
	Carpentry Shop	2802	7, 14, 10	4.18	3.84	1.089
	Printing	4299	3, 9, 8	1.38	1.19	1.160
	Newspapers	4304	4, 7, 6	1.63	1.21	1.347
	Wholesale Stores	8018	10, 22, 19	2.06	1.67	1.234
	Department Stores	8039	12, 25, 28	.88	.75	1.173
	Nursing Homes	8829	8, 20, 15	2.19	2.12	1.033
	Hospital Professionals	8833	16, 27, 30	.78	.75	1.040
	Hospitals - All Others	9040	10, 20, 21	2.05	1.93	1.062
	Household Appl. Inst.	9519	6, 8, 8	1.98	1.64	1.207
	Buildings N.O.C.	9015	13, 22, 21	2.74	2.46	1.114

CONTENTS

IN DEPTH STUDY

INTRODUCTION

A particular Manual Rate for a given classification is the end result of the manual ratemaking system. The ratemaking system itself may be conveniently viewed as having three principal components or steps:

(1) The determination of an overall rate level change indicated by aggregate experience.

(2) The determination of the proportion of the overall rate level change that each classification should bear, i.e., a distribution or allocation of the overall change to individual classifications; and

(3) The inclusion of a provision for expenses.

While the first and third of the aforementioned steps are, of course, of great importance, a concern has recently been expressed with respect to the second component. More particularly, the question has been raised as to whether or not, or to what degree, current approaches and procedures as applied to a certain segment - often referred to as "low credibility" classifications - are producing rates for these classifications which are fair and equitable.

Accordingly, a Special Committee representing both underwriting and actuarial knowledge and expertise was formed to study, analyze and report on the question of the low-credibility classifications.

Specifically, the Special Committee was charged with:

(1) Determining whether the present methods used to adjust rates on low credibility classifications are producing fair and equitable rates, and

(2) Recommending any appropriate changes in methodology or approach which would make rates for low credibility classifications more fair and equitable.

Discussion

That portion of the manual ratemaking system which has been identified above as the second principal component is often referred to as the "relativity" portion of the rate revision. This is a very revealing term, for it emphasizes the fact that the only purpose of this part of the process is to determine the relationship in which one classification stands to another. Whatever methods or procedures may be used will in no way affect the required aggregate amount determined by the overall rate level calculations.

In the relativity portion of the rate revision an examination is made of the actual incurred experience of each classification in terms of "pure premium" rates; that is, the loss rate per unit of exposure, the unit of exposure for virtually all classifications being payroll in hundreds of dollars. Because the individual classifications vary considerably with respect to the volume of experience which is developed, consideration must be given to the credibility which attaches to a given volume of experience.(1) The greater the volume, the greater the credibility.(2)

Although an actual rate revision proceeds by considering the Serious, Non-Serious and Medical portions of the experience separately (including the separate assignments of Serious, Non-Serious and Medical credibilities), it is convenient for the purposes of this discussion not to make specific reference to this fact, since the ideas and concepts used are common to all three parts.

If all classifications were sufficiently large, it is clear that the distribution of an overall change to the individual classifications could proceed quite simply by reference to the individual classification's experience pure premiums.(3)

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(1) "Volume of experience" is measured by the amount of expected losses.

(2) Credibility is assigned as a factor on a scale from 0 to 100 percent; a credibility factor of 100 represents a volume of experience which is fully credible.

(3) There are, of course, a number of actuarial adjustments that must be made to the raw experience as reported under the Statistical Plan. However, these adjustments are outside the present focus of interest and do not affect the concepts under discussion.

The fact that this situation does not exist (in all jurisdictions, as well as in Alaska), i.e., that there is a whole spectrum of credibilities which apply to the various classifications, forces both the ratemaker and the rate regulator to give consideration to additional sources of information.

The mechanism by which the informational content of other sources is brought into the ratemaking process is to compute a formula pure premium which is a credibility weighted average. The classification experience pure premium is weighted by the appropriate classification credibility factor. The complement of the credibility factor (100% minus the class credibility factor) is then available as a weight for the informational content of the other sources. As a formula:

Formula Pure Prem. = Z(Class. Exp. Pure Prem.) + (1-Z) (Info. in Other Sources)

where Z stands for the class credibility factor.

Since the first term on the right is expressed in terms of pure premiums, the information in other sources must also be expressed in terms of pure premiums.

Until recently, a single other source was used to receive the weight of the complement of the class credibility, viz. the present on rate level underlying pure premium. Recognizing, however, that there is an additional source of information that was not being made use of - the relationships among classifications exhibited by the experience in other states - the procedure has been changed to incorporate this additional informational content.

This modification within the relativity portion of the manual ratemaking process, which has been introduced in Alaska (and other states), is referred to as the National Relativity Program. An actuarial description, in the form of a paper appearing in the Proceedings of the Casualty Actuarial Society, is contained in Appendix B. Reviews of the paper, also appearing in the Proceedings of the CAS, are contained in Appendix C.

The essence of the program consists of:

(1) Determining what may be called "indexed" national pure premiums. These indexed pure premiums preserve the relationships or relativities indicated by experience in states other than Alaska, while expressing them in terms of levels appropriate to Alaska; and

(2) Splitting the available credibility, i.e., the complement of the class credibility, into two parts. The first part, the credibility which attaches to the classification experience of the other states - and which in its application to a given Alaska classification is never permitted to exceed one-half of the complement of the complement of the (Alaska) class credibility - becomes the weight given to the indexed pure premium. The residual credibility, i.e., (100% - Alaska Class Credibility - Indexed Class Credibility), is applied to the present on rate level pure premium.

In brief, the situation is as follows:

	Prior Procedure	Modified Procedure
Formula Pure Premium Equals	Z x (Class. Exp. PP) + (1-Z)x(Pres. on Rate Level PP)	Z x (Class. Exp. PP) + Z_n x (Indexed Nat'l. PP) + $(1-Z-Z_n)$x(Pres. on Rate Level PP)

Where Z is the classification credibility and Z_n is the applicable national classification credibility.

Because of the manner in which the program is applied, it is immediately clear that:

(1) As before, there is no impact on overall rate levels, i.e., the total premium collected will be the same under both procedures. (See Appendices B and C, together with the material contained in Exhibit II of 11/11/77 memo in re: Review of Premium Level and Classification Experience Exhibits.)

(2) There can only be a small effect on classifications with moderate to high volumes of experience, since the class credibility, Z, is significant and Z_n is at most one-half of (1-Z).

(3) Potentially, the greatest impact can only be on those classifications with low class credibilities. The actual impact on any given classification depends on the class credibility, the applicable national class credibility and the spread among the class experience pure premiums, the indexed national pure premium and the on-level underlying pure premium.

(4) A modification in the ratemaking procedure which incorporates information which has not previously been utilized about the relationships among classifications elsewhere represents a desirable modification.

There is, of course, a proviso that accompanies the last statement. It depends upon the acceptance of the general proposition that there exists an inherent relativity of hazard among classifications. In this connection, it is most important to recall that in using the national relativities in Alaska, any differences that may exist between Alaska and any other state with regard to wage levels, benefit levels, the administrative and judicial climate, etc., have been factored out. The only information being used is that having to do with intrinsic relativities.

It is also important to distinguish between a program, as an overall program, consistently and uniformly applied to all classifications, and the results of the application of the program to some relatively few classifications wherein, as with any statistical or actuarial program, it is possible that the results produced may justify an override based on informed actuarial or underwriting judgment.

The discussion to this point has been in more or less broad terms. Reference has been made to the national relativity program in general, to classifications in general, and to credibilities in general. This has been necessary in order to:

(1) Provide an appropriate referential structure of concepts, and

(2) Emphasize that the actuarial procedures applicable to the low credibility classifications are continuous with those applicable to classifications with higher credibilities.

Alaska currently has some 638 classifications.[4] Although any categorization of the classifications by amount of credibility obviously involves some degree of arbitrariness, the Special Committee agreed that the segmentation shown below in Table 1 was reasonable and would provide for a meaningful categorization of the classifications. Table 1 shows the number of classifications in each category, the ratio of this number to the total, and the proportion of payroll represented by the given category.[5]

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[4] Excluding the 24 classifications in the 48xx series - the Chemical Plan classes.

[5] The quantitative material in this Report is based on Exhibit II-A (the Pure Premium Exhibits) of the 11/11/77 memorandum in re: Review of Premium Level and Classification Experience Exhibits.

TABLE 1

DISTRIBUTION OF ALASKA CLASSIFICATIONS
BY DEGREE OF CREDIBILITY

Category	Description	No. of Classif's.	Ratio to Total	Proportion of Payroll in Category
A	Zero Cred. - No Exposure	300	.47	-
B	Zero Cred. - Some Exposure	65	.10	.002
C	Cred. Less Than 10% in All Parts	151	.24	.055
D	Cred. Less Than 10% in One or Two Parts	29	.05	.045
E	Cred. Above 10% in All Parts Up to 35% in All Parts	51	.08	.201
F	Cred. More Than 75% in All Parts	6	.01	.106
G	All Other*	36	.05	.592
Total		638	1.00	1.000

Note: "Parts" refers to the Serious, Non-Serious and Medical portions.

*Generally speaking, this category can be viewed as being comprised of classifications having between 35% and 75% in the three parts.

The classifications in categories A and B represent a majority of the classifications by number (57%) but only a miniscule portion of the total Alaska exposure (0.2%). Consequently, these categories are of no concern from the point of view of evaluating the impact of using national relativity experience.

At the other end of the scale, the six classifications in category F, representing 1% of the classifications and 10.6% of the exposure, have high credibilities and - again from the point of view of evaluating the current use of the national program - are also of no concern.

The remaining 42% of the classifications represent the area in which use of the modified approach has the greatest potential impact - and which therefore were subjected to further review and analysis.

Category E, containing 51 classifications with credibilities above 10% in all parts up to 35% in all parts, was selected for further review. This category was chosen for several reasons:

(1) These classifications epitomize the low credibility classifications.

(2) They represent a significant portion of the total Alaska exposure - 20.1%.

(3) Each of the classifications develops a small volume of experience in each of its parts.

(4) A meaningful comparison can be made of the results which would have been obtained under the prior procedure with that which actually results under the current procedure. This will tell us how the overall relativity under the new procedure compares to that under the old procedure and whether the new procedure develops any serious aberrations.

(5) If the review and analysis of this category were to demonstrate that the national relativity program was working well, it would indicate no need for concern with respect to the other categories, especially categories C and D.

Accordingly, for each of the 51 classifications comprising Category E, the total pure premium determined using current procedures (i.e., reflecting the incorporation of the national relativities) was compared to the total pure premium determined using prior procedures (i.e., not using the national relativities) by taking the ratio of the first to the second.

It should be noted here that along with the introduction of the national relativity program, two other modifications were made. These were: (1) the

assignment of classification credibilities on the basis of one percentage point increments in lieu of the 10 percentage point increments previously used; (2) using three policy years of experience for the classification experience base in lieu of the two years previously used. These modifications are not major ones. Nevertheless, to the extent that they have substantive impact on the formula pure premiums, they operate in the direction of making them more reflective of actual Alaska experience. Moreover, since both the prior procedure and current procedure total formula pure premiums entering into the test ratio incorporate these two modifications, it insures that the test ratio is measuring only the impact of the national relativity program and nothing else.

Table 2 below sets forth a summary of the results obtained. A list of the classifications in Category E and the comparison of their total pure premiums under the two procedures is contained in Appendix D.

TABLE 2

COMPARISON OF CURRENT AND PRIOR PROCEDURES
CATEGORY E CLASSIFICATIONS

Ratio: $\frac{\text{Total PP - Current Procedure}}{\text{Total PP - Prior Procedure}}$	No. of Classifications
.700 - .749	1
.750 - .799	1
.800 - .849	3
.850 - .899	4
.900 - .949	3
.950 - .999	9
1.000	1
1.001 - 1.050	9
1.051 - 1.100	9
1.101 - 1.150	3
1.151 - 1.200	4
1.201 - 1.250	2
1.251 - 1.300	0
1.301 - 1.350	2
Average 1.022	51

A review of the information contained in Table 2 will reveal two very important facts. The first is that the average ratio is 1.022. In other words, the incorporation of the national relativity experience into the ratemaking process as respects this group of classifications has not affected, on the average, their rate level to any significant degree. In other words, the relative amount of premium paid by these classifications remains approximately the same.

Now, while the very manner by which the national pure premiums are calculated and used as part of the relativity portion of the rate revision insures that their use with respect to the aggregate of all the 638 classifications will be unbiased, the fact that their use with respect to a significant segment is also unbiased is clearly a very material result.

Moreover - the second important fact - the distribution of the ratios "mounds up" about the mid value. It is at least imaginable that there could have been a distribution which had an average close to unity, but in which most of the classifications had ratios which were either very large or very small. The fact that this did not occur, that on the contrary, the distribution is bell-shaped and well-behaved, is clearly, also a very material result. This indicates there are no serious aberrations in relativity as a result of using national relativity.

Taken together, these two facts demonstrate that the current program is working extremely well as respects the Category E classifications, and therefore by implication with respect to all Alaska classifications.

The Special Committee, however, felt that since the 36 classifications comprising Category G did represent 59.2% of the total Alaska exposure, it would be valuable to perform the same analysis for this category. Table 3 sets forth the summary; Appendix E contains the details.

TABLE 3

COMPARISON OF CURRENT AND PRIOR PROCEDURES
CATEGORY G CLASSIFICATIONS

Ratio: Total PP - Current Procedure / Total PP - Prior Procedure	No. of Classifications
.800 - .849	2
.850 - .899	3
.900 - .949	4
.950 - .999	8
1.000	1
1.001 - 1.050	13
1.051 - 1.100	2
1.101 - 1.150	2
1.151 - 1.200	1
Average .988	36

A review of Table 3 immediately shows that the average ratio of .988 is again very close to unity, and that, here too, the distribution is bell-shaped. In combination, Categories E and G sweep in just under 80% of the total Alaska exposure; the average ratio is 1.008.

Recently, the current manual rate for the Veterinary classification - Code 8831 has been questioned. This classification has credibility factors of 5% Serious, 12% Non-Serious and 9% Medical thus placing it in a category, Category D, which has not been specifically reviewed. The current ratemaking program indicates a pure premium of $4.28; the pure premium under the prior procedure is $6.98. As a result of the application of national relativity, the accuracy of the rate for 8831 has been remarkedly improved.

There is another important inference that can be drawn from the demonstration that the current program is working well. For those classifications which today have, either literally or virtually, no exposure, the introduction of the national relativity program means that the ratemaking system is developing rates which will provide a reasonable starting point should exposure subsequently develop.

From the point of view of both internal logic and objective test, both the Special Committee and the C & R believe that there has now been a clear demonstration that the present methods used to adjust rates on low credibility classifications (and indeed on all classifications) are producing fair and equitable rates.

The foregoing conclusion that the present Program, as a program, should continue to be part of the ratemaking process does not, however, eliminate the fact that in its application to some relatively few classifications informed actuarial and underwriting judgment may indicate that the pure premium derived by formula should be modified. Such a circumstance may arise, for example, if the spectrum of employments, operations or businesses within the given classification is radically different in Alaska as compared to the scope of the same classification in other states.

In such instances it was concluded that it would be appropriate if one of the following techniques were utilized:

(1) Establish the pure premium for the given classification on the basis of a factor relationship to the pure premium developed under the standard program of another classification, or

(2) Establish the pure premium for the given classification as a weighted average of the pure premiums developed under the standard program of other selected classifications, or

(3) Combine, for ratemaking purposes, the experience of the given classification with the experience of one or more other selected classifications, and use the resulting pure premium for all the classifications in the combination, or

(4) Combine experience as in (3), but then distribute the resulting pure premium according to a pre-determined relationship, or

(5) Modify the pure premium for the given classification on a one-time judgmental basis based on reasonable assessments of relative differences between Alaska and other states in wage levels, operations, exposure and employment conditions.

This list is not necessarily intended to be exhaustive, but rather illustrative of approaches. It should be noted that if the pure premium developed by the standard program for a given classification is adjusted, subsequent rate revisions would automatically be geared to the newly-adjusted starting pure premium rate.

CONCLUSIONS AND RECOMMENDATIONS

Conclusions:

(1) Fair and equitable rates are being produced for the low credibility classifications by using present procedures. This conclusion is sustained both by consideration of the inner logic and rationality of the National Relativity Program and by objective tests.

(2) In selected instances, an informed judgemental modification of the rate produced by the standard program is applied to a particular classification is appropriate.

Recommendations:

(1) Retain as the standard ratemaking method, the procedures currently being used.

(2a.) The Classification and Rating Committee should identify those individual classifications, if any, which on the basis of the totality of information available might appear to be out of line, and

(2b.) As appropriate, adjust these classifications; due consideration being given to the several techniques suggested in this Report.

Appendix A

1978 Alaska Classification and Rating Committee,
National Council on Compensation Insurance

Alaska Pacific Assurance Company
C. L. Anderson, Vice President

Alaska Insurance Company
Jerome Stubb, Secretary

Fireman's Fund
W. M. Ray, Resident Vice President

Industrial Indemnity Company
H. S. Fisher, Resident Vice President

Providence Washington Insurance Company
E. L. Wallace, Jr., Vice President
C. A. Szopa, Casualty Manager

Employers Insurance of Wausau
E. E. Anderson, Regional Vice President

Special Committee on Low Credibility Classifications

Electric Mutual Liability Insurance Co.
P. K. Race

Actuarial Representatives:

Alaska Pacific Assurance Company
Robert Migeolis, Insurance Co. of North America

Employers Insurance of Wausau
J. A. Scheibl, Vice President

Industrial Indemnity Company
L. B. Dropkin, Vice President

Underwriting Representatives:

Alaska Pacific Assurance Company
C. L. Anderson, Vice President
D. L. Blakemore, Home Office Director of Underwriting

Industrial Indemnity Company of Alaska
H. S. Fisher, President

Providence Washington Insurance Company
G. A. Szopa, Casualty Manager

Ex-Officio Members:

National Council on Compensation Insurance
R. Kallop
H. Edmiston
L. Jones

APPENDIX B

USE OF NATIONAL EXPERIENCE INDICATIONS IN WORKERS' COMPENSATION CLASSIFICATION RATEMAKING

by

Frank Harwayne

Presented at the May, 1977 meeting of the Casualty Actuarial Society at Washington, D. C.

USE OF NATIONAL EXPERIENCE INDICATIONS IN WORKERS' COMPENSATION INSURANCE CLASSIFICATION RATEMAKING

The use of national experience indications in workers' compensation insurance classification ratemaking is more familiarly known as small credibility ratemaking. It is a response to a current need and one which is closely akin to processes used during the early days of workers' compensation insurance classification ratemaking.

Historically, classification ratemaking depended to a large extent upon national pure premiums[1], that is, pure premiums were derived from observations of the countrywide classification experience. Differences in pure premium from state to state depended upon measured differences in benefit levels provided by workers' compensation law in each state. Subsequently this approximation to costs under individual state laws was abandoned as being too crude.

The general movement of state regulation has been in the direction of recognition of each state's own experience. The rates produced as a result of this movement are valid to the extent that the experience within a state is credible. To the extent that the classification experience is not credible, the post World War II techniques used have been those of changing the rates for the non-credible classifications (that is, the non-reviewed classes) only to the extent of general changes in rate level, industry level or law benefit level. The difficulty with this approach is that the limited experience of the non-reviewed classifications is virtually disregarded as being non-credible. Their rates do not reflect changes in actual costs which take place in non-reviewed classifications. Moreover, this approach tends to produce or perpetuate anomalies with respect to competing manufacturers, processors or distributors who operate in different states within the same industry.

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1 See Hobbs, C. W., "The National Council on Compensation Insurance", pp.6,100.

Small credibility ratemaking is a way of continuing to use state experience wherever feasible and to meld the national experience to the extent of its credibility. It is more refined than the prior national pure premium system. This refinement was achieved by adjusting the experience for the differences between state and average national benefit levels. In its initial stages during the late 1950's and early 1960's, the tentative small credibility ratemaking approach established 50 classifications which have a substantial payroll base and which normally exist in most states. The partial (serious, non-serious and medical) claim frequencies and partial claim costs for these 50 classifications on a countrywide basis were ascertained. A system was devised for obtaining the partial claim frequencies and partial claim costs from the national data base exclusive of the state which would be considered for rate revision. Factors to adjust to state conditions were determined for application to the partial claim costs and partial claim frequencies for all classifications. The program also required that these national partial claim cost and partial claim frequency indications be introduced to a limited degree in the following way: what normally had been the complement of credibility was subdivided into the credible part of the countrywide information (but it could never exceed 50% of the usual complement of the credibility factor) and the balance of the 100% weight was assigned to the state underlying average claim cost or claim frequency of the classification.

Although the process of the tentative approach could work, it appeared to have a number of gaps. Only 50 of the 700 odd classifications were included as the basis for establishing credibilities for all classifications and these were not necessarily large volume classifications. The particular

fo[illegible]hich was mathematically correct appeared to require a more sophisticated knowledge than one might reasonably expect of at least some state regulators; explanations of its derivation and operation could not readily be described to the premium paying public and others who are concerned with workers' compensation insurance costs.

A fresh approach to the problem was undertaken. Instead of the tentative approach of using partial claim frequencies and partial claim costs separately, a partial pure premium was utilized and the 50 classifications were replaced by all classes. The experience of other states was modified to permit its inclusion with the state being revised. Separately, the modified national experience[3] serious, non-serious and medical pure premium for each classification was multiplied by the payrolls for that classification code number in the state undergoing revision. The sum of the products for all classifications represents what the dollars of loss would have been if modified national experience was distributed according to the payrolls

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2 The procedure relied upon fifty key codes or manual classifications to adjust experience in different states to a common level. Countrywide weights based on expected losses for the key codes were used to determine key code average frequencies F_i, and key code average severities S_i, for each state i. For the state k, for which rates were to be revised, actual A-sheet experience was employed to calculate F_k and S_k; for the remaining states data base records were utilized. Separate averages were calculated for serious, non-serious, and medical losses. The national serious pure premium for classification j, when revising state k, was to be computed as:

$$\text{serious pure premium} = [S_k \sum_{i \neq k} (iL_j \div Si)] \; [F_k \div \sum_{i \neq k} (iP_j \times F_i)]$$

where:

S_k = key code average serious severity (cost per case) for state k
iL_j = serious losses (from data base) for classification j in state i
S_i = key code average serious severity (cost per case) for state i
F_k = key code average serious frequency (cases per $100 payroll) for state k
iP_j = payroll in hundreds for classification j in state i
F_i = key code average serious frequency (cases per $100 payroll) for state i

National non-serious and medical pure premiums were similarly derived. The credibility weights assigned to state, national and underlying pure premiums were identical to those finally adopted and described later in the text.

3 The term "modified national experience" used in this paper means the experience of all states except the particular state undergoing a rate revision.

generated in the state being revised. The difference between these aggregate ...es and the actual losses in the state being revised was used to generate a factor to adjust each state's partial pure premium so that it would balance to the average partial pure premium in the state undergoing revision.

With the modified national experience on the level of the state's partial pure premium, the credibility weighting process proceeds. As in the earlier tentative program, the state's own experience is afforded credibility in accordance with customary standards except that credibility intervals of .01 are used in lieu of .10 of the older system. The modified national classification experience is afforded credibility based on number of claims, but is subject to a maximum not to exceed one-half of the complement of the state's credibility for the classification[4]. The remainder of 100% is assigned to pure premium underlying the present rate for the classification[5]. The process is performed separately for the serious, non-serious and medical pure premiums.

The Appendix contains technical description, formulae, credibility tables underlying the process described above and an illustrative example.

From an analytical point of view, the new small credibility program looks upon workers' compensation experience at two levels. Primarily, the first level affords recognition to experience within the state to the extent of the classification credibility. Where the state classification partial pure premium experience is not credible, reliance is placed upon the corresponding partial pure premium for the classification outside the state, with the proviso that the underlying partial pure premium must always be afforded at least half of the complement of the state classification's partial pure premium credibility. In this way, the rate for a manufac-

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4 For example, fully non-serious claims indicates a national credibility of .30; however, if the state non-serious credibility were .60, then the national credibility is limited to one-half the complement of .60, i.e. .20 in lieu of .30.

5 Also described as present on rate level pure premium.

APPENDIX

Small Credibility Ratemaking Procedures

The National Council has developed a small credibility ratemaking procedure which is expected to result in refined ratemaking.[6] The procedure involves the use of a data base consisting of individual classification experience on an individual state basis for three policy years. The experience consists of the following records:

1. payroll
2. number of serious cases
3. amount of serious losses
4. number of non-serious cases
5. amount of non-serious losses
6. amount of medical losses
7. policy periods & law level

Proposed partial pure premiums are the sum of (1) the product of the state indicated partial pure premium and state credibility in 1% intervals, (2) the modified national partial pure premium and national credibility in 1% intervals, and (3) the present rate level partial pure premium and the residual credibility. State credibility is based upon the same 100% standards and the same formula [criterion for credibility value of Z is equal to Z 3/2 x full credibility standard] as at present except that the formula is evaluated at 1%, in lieu of 10%, intervals. National credibility utilizes the same formula but, for simplicity, is premised on number of cases rather than expected losses and is limited to 50% of the complement of the state credibility. The national serious full credibility standard is 25 serious cases, the national non-serious standard 300 non-serious cases, and the national medical standard 300 indemnity (serious and non-serious) cases.[7]

The small credibility procedure is premised upon the principles of uniform relative hazard among states. This principle refers to the hazard for any classification in any state having the same relationship (except for chance variation), after suitable adjustment by indices, to the hazard of any second classification chosen.

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6. See Ballou, Roy H., "A Current Look At Workers' Compensation Ratemaking", P.C.A.S., LXII (1975)

7. See table of "Credibility Criteria For National Experience" appended

turing industry will reflect experience within the state; to the limited extent that no such experience can be relied upon for that industry, reliance is placed upon other states' experience for that manufacturing industry (with appropriate factor adjustments to reflect general state conditions) in combination with the historical record for the class (underlying fire premium) within the state.

This new process is viewed as an improvement in the effort to achieve fair, reasonable, and equitable rates wherein actual experience within and outside the state is expanded substantially.

The formula recognizes uniform relative hazard by means of state-wide average pure premiums derived from actual experience in each state i and the distribution of payroll among classifications in state k, for which rates are to be revised. For any state i, the state average serious pure premium PP_i is computed as:

$$PP_i = \sum_j ({}_iL_j \div {}_iP_j)\,{}_kP_j \div \sum_j {}_kP_j$$

Values of ${}_kL_j$ and ${}_kP_j$ are taken from A-sheet data[8]; for the remaining states, values of ${}_iL_j$ and ${}_iP_j$ are from the data base. The modified national serious pure premium for classification j when revising state k is:

$$\text{serious pure premium} = \sum_{i \neq k} {}_iL_j \,(PP_k \div PP_i) \div \sum_{i \neq k} {}_iP_j$$

where ${}_iL_j$ = serious losses (from data base records) for classification j in state i, and

${}_iP_j$ = payroll in hundreds for classification j in state i

Modified national non-serious and medical pure premiums are similarly derived.

[In the case of classifications that would involve division by zero in the formula definitions of modified national pure premiums, modified national pure premiums are defined to be zero and have no credibility.]

The small credibility procedure does not attempt to improve classification ratemaking by the introduction of new credibility standards and/or formulas. Rather, it expands the volume of classification experience by recognizing modified national indications. The result is greater equity among classification rates and no change in overall rate level.

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8 See Kallop, Roy H., "A Current Look At Workers' Compensation Ratemaking" Exhibit II, P.C.A.S., LXII (1975)

...mple calculation of the process is shown below. For simplicity, it is assumed that states a, b and k comprise the countrywide data base. Within each state codes 1 and 2 represent all classes. The proposed serious pure premiums for State k follow:

State k
Computation of Proposed Serious Pure Premiums for All Classes (Code 1 and Code 2)

	State k		State a		State b	
	Code 1	Code 2	Code 1	Code 2	Code 1	Code 2
1. exposure	10,846,000	8,304,000	7,250,000	110,000,000	3,250,000	210,000,000
2. number of serious cases	15	2	10	10	5	20
3. amount of serious losses	305,100	20,760	220,000	110,000	220,000	440,000
4. state k serious cred.	54%	9%	xx	xx	xx	xx
5. state k present on rate level serious pure premium	2.750	.326	xx	xx	xx	xx

$P_k = 100\ [305,100 + 20,760] \div [10,846,000 + 8,304,000] = 1.702$

$P_a = 100\ [(220,000 + 7,250,000)(10,846,000) + (110,000 + 110,000,000)(8,304,000)] + [10,846,000 + 8,304,000] = 1.762$

$P_b = 100\ [(220,000 + 3,250,000)(10,846,000) + (440,000 + 210,000,000)(8,304,000)] + [10,846,000 + 8,304,000] = 3.925$

$N_1 = 100\ (1.702)\ [(220,000 + 1.762) + (220,000 + 3.925)] + [7,250,000 + 3,250,000] = 2.932$

$N_2 = 100\ (1.702)\ [(110,000 + 1.762) + (440,000 + 3.925)] + [110,000,000 + 210,000,000] = .093$

credibility for N_1 = minimum $((1-.54)+2; ((10+5)+25)^{2/3})$
= minimum (.23; .71)
= .23

credibility for N_2 = minimum $((1-.09)+2; 1.00)$
= minimum (.45; 1.00)
= .45

State k indicated serious pure premium for code 1 = 100 (305,100+10,846,000) = 2.813

State k indicated serious pure premium for code 2 = 100 (20, 760+8,304,000) = .250

proposed serious pure premium for code 1 = (2.813)(.54)+(2.932)(.23) + (2.750)(1-.54-.23) = 2.896

proposed serious pure premium for code 2 = (.250)(.09) + (.093)(.45) + (.326)(1-.09-.45) = .214

CREDIBILITY CRITERIA FOR NATIONAL EXPERIENCE

TIONAL CREDIBILITY	SERIOUS CRITERION (SERIOUS CASES)	NONSERIOUS CRITERION (NONSERIOUS CASES)	MEDICAL CRITERION (SERIOUS & NONSERIOUS CASES)
1.00	25	300	300
0.99	xx	296	296
0.98	xx	292	292
0.97	24	287	287
0.96	xx	283	283
0.95	xx	278	278
0.94	23	274	274
0.93	xx	270	270
0.92	xx	265	265
0.91	22	261	261
0.90	xx	257	257
0.89	21	252	252
0.88	xx	248	248
0.87	xx	244	244
0.86	20	240	240
0.85	xx	236	236
0.84	xx	231	231
0.83	19	227	227
0.82	xx	223	223
0.81	xx	219	219
0.80	18	215	215
0.79	xx	211	211
0.78	xx	207	207
0.77	17	203	203
0.76	xx	199	199
0.75	xx	195	195
0.74	16	191	191
0.73	xx	188	188
0.72	xx	184	184
0.71	15	180	180
0.70	xx	176	176
0.69	xx	172	172
0.68	xx	169	169
0.67	14	165	165
0.66	xx	161	161
0.65	xx	158	158
0.64	13	154	154
0.63	xx	151	151
0.62	xx	147	147
0.61	12	143	143

APPENDIX (Continued)

CREDIBILITY CRITERIA FOR NATIONAL EXPERIENCE

NATIONAL CREDIBILITY	SERIOUS CRITERION (SERIOUS CASES)	NONSERIOUS CRITERION (NONSERIOUS CASES)	MEDICAL CRITERION (SERIOUS & NONSERIOUS CASES)
0.60	xx	140	140
0.59	xx	136	136
0.58	xx	133	133
0.57	11	130	130
0.56	xx	126	126
0.55	xx	123	123
0.54	10	120	120
0.53	xx	116	116
0.52	xx	113	113
0.51	xx	110	110
0.50	9	107	107
0.49	xx	103	103
0.48	xx	100	100
0.47	xx	97	97
0.46	8	94	94
0.45	xx	91	91
0.44	xx	88	88
0.43	xx	85	85
0.42	7	82	82
0.41	xx	79	79
0.40	xx	76	76
0.39	xx	74	74
0.38	6	71	71
0.37	xx	68	68
0.36	xx	65	65
0.35	xx	63	63
0.34	5	60	60
0.33	xx	57	57
0.32	xx	55	55
0.31	xx	52	52
0.30	xx	50	50
0.29	4	47	47
0.28	xx	45	45
0.27	xx	43	43
0.26	xx	40	40
0.25	xx	39	38
0.24	3	36	36
0.23	xx	34	34
0.22	xx	31	31
0.21	xx	29	29

APPENDIX (Continued)

CREDIBILITY CRITERIA FOR NATIONAL EXPERIENCE

NATIONAL CREDIBILITY	SERIOUS CRITERION (SERIOUS CASES)	NONSERIOUS CRITERION (NONSERIOUS CASES)	MEDICAL CRITERION (SERIOUS & NONSERIOUS CASES)
0.20	xx	27	27
0.19	xx	25	25
0.18	2	23	23
0.17	xx	22	22
0.16	xx	20	20
0.15	xx	18	18
0.14	xx	16	16
0.13	xx	15	15
0.12	xx	13	13
0.11	1	11	11
0.10	xx	10	10
0.09	xx	9	9
0.08	xx	7	7
0.07	xx	6	6
0.06	xx	5	5
0.05	xx	4	4
0.04	xx	3	3
0.03	xx	2	2
0.02	xx	1	1
0.01	xx	xxx	xxx

APPENDIX B

USE OF NATIONAL EXPERIENCE INDICATIONS IN WORKERS' COMPENSATION CLASSIFICATION RATEMAKING

Discussion by
Lester B. Dropkin

Frank Harwayne's paper, which describes the methodology adopted by the National Council on Compensation Insurance with respect to the use of national experience indications, quite properly presupposes a fairly close familiarity with the structure of the Workers' Compensation ratemaking process. For those who have such a familiarity - whether by virtue of having carefully read Roy Kallop's recent paper[1], or by service on one or more of the committees of the National Council, or by other means - the present Harwayne paper will fall naturally into place.

A very valuable and necessary insight into the decisions and methods of the Council has been provided, and undoubtedly will continue to be provided, for both the membership of the C.A.S. and that wider public readership of the Proceedings by the series of papers devoted to explaining and recording the ideas and concepts that constitute the standard Workers' Compensation ratemaking procedure.

It is, of course, well known that the Workers' Compensation ratemaking procedure has two quite distinct components. The first, concerned with developing the indicated overall rate level change, is today based on aggregate premium and loss experience, i.e. on financial data. The second, which may be referred to as the relativity portion of the rate revision, is concerned with the equitable and reasonable distribution of the otherwise determined overall rate level change to the individual classifications. While the process proceeds in terms of pure premiums - and thus suggests that we are dealing with absolute levels - in fact the process is one of determining the proper <u>relative</u> level among the classifications.

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(1) Kallop, Roy H., "A Current Look at Workers' Compensation Ratemaking," P.C.A.S., LXII (1975).

Although an actual rate revision proceeds by considering the Serious, Non-Serious and Medical components separately, Mr. Harwayne has found it convenient, for illustrative purposes to refer to one component only - the Serious, since the concepts and procedures applying to the Serious component apply to the other components also. This review will also utilize the convenience of referring to only the Serious component.

For those classifications with a sufficiently large volume of (Serious) expected losses to receive full (Serious) credibility, the experience or "indicated" pure premium becomes the formula pure premium in accordance with what is meant by full credibility.

It is with respect to those classifications which do not develop the necessary volume of (Serious) expected losses for full (Serious) credibility that the present procedure, utilizing national relativities, differs from the former procedure.

Previously, for those classifications with such lesser amounts of (Serious) expected losses the formula pure premium was determined as the credibility weighted average of the indicated pure premium and the underlying or "present" on (rate) level pure premium. However, since there were many classifications in many National Council jurisdictions which were developing either zero or very modest credibilities, the application of the procedure meant that a large number of classifications were simply taking the overall rate level change or something very close to it. In looking at the classifications in a given state, the state was being viewed as though no other state existed, with a consequent loss of valuable information.

Introduction of the national relativity procedure means that the informational input of the relationships exhibited by the modified national experience will now be utilized as part of the process that determines proper classification relativities.

Looking back, we can see in the adoption of the present procedure an almost classic example of Hegelian dialectic with its stages of thesis, antithesis and synthesis:

Thesis	- Original, historical use of national experience.
Antithesis	- Post Public Law 15 use of state experience.
Synthesis	- Present, blended use of both state and national experience.

The new procedure posits the existence of an intrinsic, inherent relativity of hazard among classifications - which, of course, means among employments, operations and businesses - that is independent of state boundaries. To what extent are we willing to accept this premise? This reviewer, for one, has had no difficulty, although the question could be answered more readily perhaps, if we did not have the hundreds of classifications that, in fact, we do have in Workers' Compensation.

Incidentally, it would be interesting to know whether, and if so, how, the Council adapts the procedure to the case of state special classifications and classifications whose definitions may vary somewhat from one jurisdiction to another.

I have no doubt that the paper should be, and will be, required reading for anyone with an interest in the Workers' Compensation ratemaking process. While the paper sets forth the formulae in a concise mathematical way, it may be useful to present part of the illustrative example in an alternative format which explicitly sets out the logical steps of the process, since the paper will surely also be read and referred to by persons less mathematically oriented than actuaries.

The basic information available to us is restated in Exhibit 1; the underlying logic of the steps used to determine the National Pure Premiums is given in Exhibit 2.

Since the relationships among the various classifications will be expressed, in part, by means of ratios to statewide, overall, all classifications combined pure premiums the first part of the process adjusts the Total Statewide Pure Premiums

of states a and b to reflect the distribution by class of state k. [Exhibit 2, Col. (6)]. The variation of these Total Statewide Pure Premiums from that of state k [Exhibit 2, Col. (7)] provides factors to be applied to the indicated, classification pure premiums of states a and b to produce what may be called Indexed National Pure Premiums. [Exhibit 2 Col (10)]. It is these Indexed National Pure Premiums which may be said to constitute the real heart of the process, in the sense that they have preserved the original relativities indicated by experience in states other than state k, yet have been expressed in terms of levels appropriate to state k. This may be seen from the following table:

	Classif. 1	Classif. 2	Ratio
Indicated Pure Premium - State a	3.034	.100	30.34
Indicated Pure Premium - State b	6.769	.210	32.23
Indexed National P. P. - State a	2.9305	.0966	30.34
Indexed National P. P. - State b	2.9350	.0911	32.23

While the illustrative example of the paper of course includes a comparison of the Formula Pure Premiums developed under the two procedures, again it may be useful to exhibit the results in a way which emphasizes the basic concern of this part of a rate revision, viz. the relativities:

	Classif. 1	Classif. 2	Ratio
P.P. Underlying Pres. Rates - State k	2.750	.326	8.44
Indicated Pure Premium - State k	2.813	.250	11.25
National Pure Premium	2.932	.093	31.53
Formula Pure Premium - Prior Procedure	2.782	.326	8.53
- New Procedure	2.826	.214	13.21

Thus we see that while the prior procedure would have changed the present relativity but slightly, the new procedure has allowed a much larger shift, in accordance with the very desirable objective of incorporating the greater body of information provided by the classification experience of other states.

LBD:klm
10/10/77

NATIONAL PURE PREMIUM CALCULATION

(1) State	(2) Classif.	(3) Payroll (State k)	(4) Indicated P.P.	(5) Incurred Losses (3)x(4)	(6) Adjusted Tot.SW PP (5)÷(3)	(7) Ratio: 1.702 Adj.Tot.SW PP
	1	$10,846,000	3.034	$329,068		
a	2	8,304,000	.100	8,304		
	Total SW	19,150,000		337,372	1.762	.9659
	1	10,846,000	6.769	734,166		
b	2	8,304,000	.210	17,438		
	Total SW	$19,150,000		$751,604	3.925	.4336

(1) Classif.	(9) State	(10) Indexed Nat'l. PP (4)x(7)	(11) Payroll	(12) Incurred Losses (10)x(11)	(13) National PP (12)÷(11)
	a	2.9305	$ 7,250,000	$212,498	
1	b	2.9350	3,250,000	95,388	
	Total		10,500,000	307,886	2.932
	a	.0966	110,000,000	106,700	
2	b	.0911	210,000,000	191,100	
	Total		$320,000,000	$297,800	.093

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APPENDIX D

CLASSIFICATIONS IN CATEGORY E

(Credibility Above 10% in All Parts Up to 35% in All Parts)

(1) Class Code	Total Pure Prem. (2) Prior Proc.	(3) Curr. Proc.	(4) (3)÷(2)
3632	4.48	4.13	.922
4034	6.02	6.85	1.138
4207	3.30	3.16	.958
3365	4.96	5.74	1.157
5022	6.47	5.88	.909
5040	20.51	20.52	1.003
5057	13.21	12.48	.995
5059	18.02	17.99	.998
5184	6.75	5.43	.804
5221	3.68	3.76	1.022
5222	6.16	6.45	1.047
5462	4.97	4.93	.992
5474	4.45	4.64	1.043
5479	4.40	4.54	1.032
5508	4.78	4.74	.992
5538	3.05	3.53	1.157
5551	11.14	11.27	1.012
5606	2.82	3.29	1.167
5651	4.87	5.12	1.051
6003	14.75	14.28	.968
6204	11.35	10.67	.940
6206	5.36	5.46	1.019
6233	6.16	6.32	1.026
6319	6.11	6.59	1.079
1005	3.09	4.03	1.304
1165	6.98	5.19	.744
1320	4.30	4.23	.984
4000	4.82	5.19	1.077
5192	2.84	2.51	.884
7222	7.98	8.65	1.084
7360	6.13	5.39	.871
7380	2.36	2.90	1.229
7382	3.66	3.64	.995
7421	10.24	8.53	.833
7502	3.40	2.56	.753
7539	2.18	2.38	1.092
7610	.68	.59	.868
7704	2.82	3.06	1.085
8018	1.67	2.06	1.234
8031	5.05	4.29	.850
8039	.75	.88	1.173
8292	3.76	3.96	1.053
8350	2.35	3.08	1.311
8607	4.38	3.65	.833
8742	.48	.51	1.063
8833	.75	.78	1.040
8901	.43	.49	1.140
9014	2.04	2.12	1.039
9015	2.46	2.74	1.114
9040	1.93	2.05	1.062
9403	6.00	5.92	.987
		TOTAL =	52.133

$$\text{Avg.} = \frac{\text{Total Col. (3)}}{51} = \frac{52.133}{51} = 1.022$$

APPENDIX E

CLASSIFICATIONS IN CATEGORY G

(All Other)

(1) Class Code	Total Pure Prem. (2) Prior Proc.	(3) Curr. Proc.	(4) (3)÷(2)
2710	10.41	10.35	.994
3724	4.22	4.18	.991
5183	3.87	3.90	1.008
5190	3.34	3.44	1.030
5213	5.12	5.23	1.021
5506	5.79	5.89	1.017
5507	6.20	6.21	1.002
5645	4.00	4.49	1.123
6216	5.84	6.37	1.091
6217	4.68	4.55	.972
6306	5.90	6.04	1.024
7538	15.82	15.03	.950
8227	3.24	3.13	.966
7403	3.60	3.13	.869
7422	11.62	9.85	.848
7423	3.55	3.38	.952
7425	10.77	9.98	.927
7431	14.79	11.96	.809
7540	2.37	2.79	1.177
7600	1.59	1.45	.912
7720	3.00	3.13	1.043
8017	1.08	1.03	.954
8033	1.24	1.27	1.024
8107	2.72	3.00	1.103
8232	3.70	4.04	1.092
8293	6.42	6.47	1.008
8387	3.18	3.21	1.009
8391	2.58	2.58	1.000
8601	1.29	1.20	.930
8606	8.63	7.46	.864
8810	.29	.27	.931
8868	.37	.33	.892
9052	1.68	1.71	1.018
9078	3.33	3.24	.973
9101	2.15	2.17	1.009
9410	1.91	1.83	1.022
		TOTAL =	35.555

$$\text{Avg.} = \frac{\text{Total Col. (3)}}{36} = \frac{35.555}{36} = .988$$

APPENDIX-P

USE OF NATIONAL EXPERIENCE INDICATIONS IN WORKERS' COMPENSATION CLASSIFICATION RATEMAKING

By Frank Harwayne

Discussion by James F. Colz

Frank Harwayne's paper, "Use of National Experience Indications in Workers' Compensation Classification Ratemaking," shows the application of some practical actuarial science to the solution of a lingering problem. The problem: because of low credibility, the rates for some classifications in certain states did not seem to be at, or likely to reach, a reasonable level. The solution: adjust experience from other available states to the exposure distribution and average pure premium level of the state in question, and merge it into the classification ratemaking procedure.

A few comments on terminology may be in order. Although the procedure is referred to as "national," it might more properly be termed "multi-state" since the data base currently encompasses only those jurisdictions for which the National Council on Compensation Insurance makes rates. Thus, data from about a dozen states (independent bureaus and exclusive funds) is not available. Likewise, although the method is often called a "small credibility" procedure, its use may have some effect on the rate for any classification which does not possess full credibility for all of its partial pure premiums. Indeed, since three years of classification experience are used (as compared to two under the old procedure in most cases) even fully credible classes can end up with a different pure premium from what formerly would have been calculated.

Another item of interest is the subtle change adopted in the calculation of credibility. Credibilities for state experience have been and continue to be based on expected loss dollars. However, credibilities for the national experience are derived from actual claim counts. This slight change signifies, one presumes, no shift in the philosophy underlying credibility, but is merely an adaptation to the data available.

In order to avoid misinterpretations, the National Council has frequently warned against comparing unadjusted classification rates among states. A staff write-up notes that among the factors which cause rates to vary between states are differences in the industries in the state, the definition of exposure (payroll limitation), the benefit level, the administration of the law, the wage levels, the medical facilities, the quality of the labor force, the safety programs in effect, and the degree of attorney involvement. Since the new procedure affects rates by weighting pure premiums (of which rates are a function) between states, it is instructive to observe how these problems are avoided. Any differences in industries are formally adjusted for when the national pure premiums are computed using the exposure distribution in the state under revision. The other factors are not handled individually. Rather, since they all affect costs, they are reflected in the adjustment of each outside state's experience to the subject state's average pure premium level.

One might argue that the benefit level differences could be separately computed by state and the remaining factors then adjusted for in bulk. The technique adopted not only saves this work, but is consistent with a similar treatment employed in the National Council loss ratio trending technique.

There, the trending of on-level loss ratios automatically includes all factors which affect costs and avoids the problem of separate identification and measurement of adjustments for items such as wage level changes, medical cost changes, and the host of other items which could be involved.

The procedure described by Mr. Harwayne seems to be based on reasonable actuarial judgment. Although the algebra may momentarily appear complex, the technique is conceptually straightforward. One potential area of concern remains the vast volume of data involved. The October, 1977, Scientific American contains an article on the solution of the classic four color problem of mathematics, this solution was accomplished by a computer exhaustion of enumerated possible five-color maps. The authors note the reluctance of some to accept their computer proof since it differs so radically from traditional mathematical terseness and verifiability. Similarly here, success in implementing the new technique may depend as much on the ability to demonstrate that accurate data is available and properly adjusted as on any actuarial theory involved.

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF EDUCATION

DIVISION OF VOCATIONAL REHABILITATION

Michael C. Morgan, Director

October 6, 1980

Honorable Terry Stimson
Alaska State Legislature
1024 West 6th Avenue
Anchorage, Alaska 99501

Dear Senator Stimson:

Please find enclosed information that you requested from the Divison of Vocational Rehabilitation pertaining to Workman's Compensation Rehabilitation. We have compiled statistics which you requested at the hearing in Fairbanks held September 19th and 20th.

The figures include rehabilitations of the last three years and the current listings of where clients are in respective statuses. To better understand those statuses, I have attached what we call a vocational rehabilitation overview that shows the statuses from 00 through 32, and an explanation of those statuses from our statistical reporting system taken from the Rehabilitation Services Manual. Additionally, I've taken the liberty to enclose (for your information) the history of the rehabilitation program and the rehabilitation process. Also included is the Social Security Disability VR program information regarding trial work period and also the special selection criteria established by the Social Security Administration to those individuals that are applying for social security disability and also for vocational rehabilitation services.

If you have any questions and/or concerns regarding this material, please do not hesitate to contact me.

Sincerely,

F. Pat Young

F. Pat Young, Deputy Director

Enclosures

05-511LH

WORKERS COMPENSATION

FISCAL YEAR '79

- 19 Second Injury Fund clients rehabilitated at an average cost of $2,499.

- 44 Second Injury Fund clients were closed prior to the planning process or were not successfully rehabilitated. The average expenditure for these clients was $509.

FISCAL YEAR '78

- 24 Second Injury Fund clients rehabilitated at an average cost of $2,941.

- 38 Second Injury Fund clients were closed prior to the planning process or were not successfully rehabilitated. The average expenditure for these clients was $394.

FISCAL YEAR '77

- 26 Second Injury Fund clients rehabilitated at an average cost of $2,143.

- 46 Second Injury Fund clients were closed prior to the planning process or were not successfully rehabilitated. The average expenditure for these clients was $391.

* Case expenditure averages represent total case expenditures including general funds as well as 2nd Injury monies.

** Client totals for each fiscal year represent only those cases that completed the rehabilitation process during that particular year.

2

History of the rehabilitation program

OVERVIEW AND OBJECTIVES

This chapter offers the reader a general overview of the history and development of the rehabilitation program in the United States. It is divided into three major sections: (1) significant legislation since 1916, (2) development of the public program in the United States, and (3) development of significant private rehabilitation resources, including national rehabilitation programs, rehabilitation centers, and professional organizations with rehabilitation objectives.

Objectives of this chapter are to familiarize the reader with the major components of significant rehabilitation-related legislation in the United States between 1916 and 1978, to furnish an overview of public federal and state rehabilitation-related program developments beginning with Worker's Compensation provisions in 1908 through the establishment of a separate federal rehabilitation agency by Congress in 1975, and to describe some private rehabilitation resources with a history in the rehabilitation movement.

REHABILITATION LEGISLATION

National Defense Act, 1916

The National Defense Act of 1916 placed importance on the provision of vocational training for soldiers while in active military service. The Act provided an opportunity for soldiers to receive instruction and study to increase their military efficiency and enable them to return to civilian life better equipped for competitive occupations. In many ways this Act was the beginning of a congressional attitude toward rehabilitation which would result in the large national program of today.

Smith-Hughes Act, 1917

The 64th Congress passed Public Law 347 on February 23, 1917. Known as the Smith-Hughes Act, it established a federal-state program in vocational education. It also created a Federal Board for Vocational Education which had the authority and responsibility for the vocational rehabilitation of veterans. In addition, it provided federal assistance grants in support of vocational education to the states on a matching basis.

The Smith-Hughes legislation and the Federal Board of Vocational Education provided a basis for a system of vocational rehabilitation. Funds were provided for vocational education services to the states which met certain requirements. To receive these funds, each state had to pass "enabling" legislation and was required to establish a state board. Money was then provided to the states according to a federal plan (Obermann, 1965; McGowan & Porter, 1967; Dean, 1972; Lassiter, 1972).

Soldier Rehabilitation Act, 1918

Public Law 178, the Soldier Rehabilitation Act, was passed on June 27, 1918, by the 65th Congress. Under this act the role of the Federal Board for Vocational Education was expanded to include authorization to provide programs of vocational rehabilitation for disabled veterans. To be eligible, the disabled veteran had to be unable to engage successfully in a gainful occupation. The legislation became known as the Smith-Sears Veterans Rehabilitation Act and, later, was to provide a basis for the vocational rehabilitation of civilians (Obermann, 1965; Lassiter, 1972).

Vocational Rehabilitation Act, 1920

June 2, 1920, was to mark the beginning of the public rehabilitation program in the United States. On this date the Smith-Fess Act was passed to become Public Law 236 of the 66th Congress.

The Smith-Fess Act not only established the federal-state program in rehabilitation but also provided for an equal expenditure of funds by state and federal governments. It required (1) development of a state plan to be submitted and approved by the federal agency, (2) an annual report to the Federal Board for Vocational Education, (3) establishment of the state program under the state's Vocational Education Board, and (4) prohibition of fund expenditures for buildings or equipment (Lassiter, 1972).

The Vocational Rehabilitation Act of 1920, as interpreted by the Federal Board of Vocational Education, provided funds only for vocational guidance, training, occupational adjustment, prostheses, and placement services. Rehabilitation services were to be for the physically disabled and were to be vocational in nature. They could not include physical restoration or socially oriented rehabilitation (Obermann, 1965). The new Act did not specify a minimum age, but the Federal Board considered the minimum age of legal employability within the state to be the service eligibility policy. Homemaking was considered to be a legitimate occupation.

Within 18 months of the passage of the 1920 Vocational Rehabilitation Act, 34 states passed enabling legislation to organize a program of services that could accept the federal funds available to them on a 50-50 matching basis (Lassiter, 1972).

A 1921 bulletin issued by the Federal Board for Vocational Education identi-

fied specific case procedures and techniques to be used by rehabilitation agents (counselors) in managing the rehabilitation service process. A determination of client eligibility had to be made by the agent in terms of the applicant's age, physical disability, and feasibility for rehabilitation success. A job objective was then identified based on an intensive study of the case. After study a tentative rehabilitation plan had to be formulated in accordance with the client's job objective. Follow-up by the rehabilitation agent was to be provided during training and after job placement until the disabled person was producing at his maximum efficiency (Lassiter, 1972). The Federal Board for Vocational Education emphasized that its role was only in promoting vocational rehabilitation of persons. It clearly stated that the primary responsibility for vocational rehabilitation programming was with the state (Obermann, 1965).

The new rehabilitation program encountered a fiscal crisis in 1924. The 1920 Act was due to expire in June. Unfortunately Congress adjourned without providing appropriations for the program. An appeal by the Federal Board for Vocational Education to President Coolidge, however, resulted in permission to spend the administrative funds necessary to maintain the federal program under a deficit arrangement. This funding was only for federal administration and did not include funding grants to states. Nevertheless, all but one of the 39 states cooperating in the federal-state rehabilitation program at the time were able to keep their activities going by utilizing their own resources. Congress then gave authority to continue the program for an additional six years, to 1930. The necessary appropriations were to follow.

In 1930 the Vocational Rehabilitation Act was again renewed for an additional three years. By this time 44 states were participating in the federal-state program, and in 1932 a further extension of four years was granted to the program by Congress.

Social Security Act, 1935

Prior to 1935 the rehabilitation program was the result of a series of short-term congressional extensions. The Social Security Act of 1935 was the first permanent base for the federal vocational rehabilitation program. It provided for continuous authorization, increased grants, and increased support for the federal administration. It also allowed partial reimbursement by the federal government to the states for assistance given to the needy blind. Thus the vocational rehabilitation program was both continued and strengthened by the 1935 Social Security Act.

Randolph-Sheppard Act, 1936

The Randolph-Sheppard Act of 1936 authorized states to license qualified blind persons to operate vending stands in federal buildings. It also set a precedent for many states to make similar arrangements in state-owned buildings with assistance and supervision from a public agency.

Vocational Rehabilitation Act Amendments, 1943

These Amendments, enacted on June 6, 1943, as Public Law 113, 78th Congress, made changes in the federal-state program of rehabilitation. For example:

1. Vocational rehabilitation was defined to include any services necessary for a disabled person to become employed (Obermann, 1965). This meant that physical restoration services were to be made available to the disabled. The range of available rehabilitation services included corrective surgery, therapeutic treatment, hospitalization, transportation, occupational licenses, occupational tools and equipment, maintenance during training, placement in employment, prosthesis training, medical examinations, and guidance.

2. Vocational rehabilitation was extended for the first time to the mentally handicapped and the mentally ill.

3. Federal administration of grants was transferred from the Commissioner of Education to the Federal Security Administrator, who established an Office of Vocational Rehabilitation on September 8, 1943.

4. Each state was required to submit a state plan for vocational rehabilitation to be approved by the Federal Security Administrator. States were also required to designate the State Board of Vocational Education as the sole agency for the administration of the state rehabilitation plan. An exception was programs for the blind, which could continue under their own administration and still be eligible for federal rehabilitation funds. Thus separate state agencies for the blind were included in the federal-state program.

5. State agency administration, guidance, and placement costs (including staff salaries) would be paid by the federal government. In addition, the 1943 Amendments provided authorization for the federal agency to pay the entire expense of rehabilitating disabled veterans and half the expense for other disabled persons. The federal government also paid the entire cost of administering state programs. Previously program costs were shared equally between the states and the federal government.

Thus the Vocational Rehabilitation Act Amendments of 1943 broadened the program's financial provisions, offered a comprehensive definition for vocational rehabilitation, expanded service provisions to include physical restoration, required state plans for approval by the federal agency, expanded service provision to include the mentally handicapped and mentally ill, and fostered separate agencies for general rehabilitation and rehabilitation of the blind to be monitored by one federal agency (Kratz, 1960; Obermann, 1965; Dean, 1972; Lassiter, 1972).

Vocational Rehabilitation Act Amendments, 1954

Public Law 565 of the 83rd Congress, signed by President Eisenhower on August 3, 1954, was a milestone in the development of the rehabilitation program. It reshaped the role of the federal government in the rehabilitation program

and established the basis for a working relationship between public and private rehabilitation organizations.

The 1954 Amendments provided more funds and additional program options for state agencies. They established a federally funded research program and provided training for staff of both public and private programs. They also authorized grants to expand or improve facilities (Dean, 1972). Significant features of the 1954 Amendments were as follows:

1. A new and variable funding formula meant that the most any state would be required to contribute to public program financing was 40% of the total spent in the general rehabilitation program. The federal share varied from state to state, with greater financial support going to states with large populations and small per capita income.

2. For the first time state agencies were permitted to use funds to expand or remodel buildings to make the buildings suitable for rehabilitation of the disabled (Lassiter, 1972).

3. Special grants were authorized to permit states to develop new aspects of their program or extend services to needy disability groups or geographic areas (McGowan & Porter, 1967).

4. Research and demonstration project grants were authorized to support studies for improving rehabilitation services and demonstrations of new knowledge application. Though the required matching funds of grantees was determined on an individual project basis, congressional appropriations limited the federal share to no more than two thirds of project costs (Obermann, 1965).

5. Training for physicians, nurses, rehabilitation counselors, physical therapists, occupational therapists, social workers, psychologists, and other specialists was authorized to meet the needs of a rapidly expanding rehabilitation program. Grants were given to colleges and universities to develop or expand curricula and to provide financial assistance and incentives in the form of traineeships to graduate students. The Act also provided authority for short-term training grants for seminars and workshops, for in-service training programs in state vocational rehabilitation agencies, and for rehabilitation research fellowships to individuals (Obermann, 1965; McGowan & Porter, 1967; Lassiter, 1972).

Vocational Rehabilitation Act Amendments, 1965

Public Law 333 of the 89th Congress provided for increased federal spending. The Vocational Rehabilitation Act Amendments of 1965 enlarged the federal cost share of rehabilitation to 75%. It provided innovative project grant monies to states for the development of new methods of providing services and for serving the severely disabled. Federal funds were authorized to cover 90% of the project cost in three-year projects and 75% of the cost for the remaining two years in five-year grants (McGowan & Porter, 1967). A program of construction assistance was also authorized for building rehabilitation centers and workshops, expanding

present ones, and helping with the initial staffing costs of new or expanded centers and workshops (Dean, 1972).

The 1965 Amendments created a broader base of services to handicapped persons, including persons with socially handicapping conditions. Economic need was eliminated as a requisite for rehabilitation service. The states were permitted, however, to use an economic need test for services other than diagnostic related services, counseling, and placement.

The 1965 Amendments also allowed extended client evaluation to determine whether there was reasonable expectation that rehabilitation services would help the handicapped person to become employable. This extended evaluation feature permitted services to be provided up to a maximum of 6 months, and 18 months for the severely disabled, in determining employability. The Amendments also authorized special grants for statewide planning of vocational rehabilitation. The purpose of these special grants was to develop a comprehensive vocational rehabilitation plan and program within each state to make services available to all eligible handicapped persons by July 1, 1975 (Lamborn, 1970).

Besides enabling expansion of rehabilitation facilities, the 1965 Amendments created a National Policy and Performance Council to guide the HEW Secretary in the development of policies for improving and expanding rehabilitation facilities. A National Commission on Architectural Barriers was also authorized for the development of proposals for making buildings accessible to the handicapped.

Educational benefits were extended to a maximum of four years under the legislation, as opposed to two years provided under previous law for professional training in the field of vocational rehabilitation. A national data system was established, and intramural research within the vocational rehabilitation agency authorized (Obermann, 1965; McGowan & Porter, 1967; Dean, 1972).

The Vocational Rehabilitation Act was again amended in 1967 to separately provide (1) rehabilitation services for migratory workers, (2) elimination of state residency requirements for serving the disabled in need of rehabilitation services, and (3) construction and operation of a National Center for Deaf-Blind Youths and Adults (Dean, 1972).

Vocational Rehabilitation Act Amendments, 1968

The Amendments to the Vocational Rehabilitation Act of 1968 included (1) a change in the federal-state matching ratio for appropriations from 75-25 to 80-20, (2) approval to expend funds for new construction of rehabilitation facilities, (3) approval to provide follow-up services for maintaining an individual in employment and to provide services for family members of handicapped individuals, (4) permission to amend state plans so one state agency could share funding and administration responsibility with another in carrying out a joint project, and (5) authorization to provide vocational evaluation and work adjustment services

to disadvantaged persons by reason of age, educational attainment, or ethnic or other factors (Lassiter, 1972).

Rehabilitation Act, 1973

Public Law 112 of the 93rd Congress was signed by President Nixon on September 26, 1973. This Act replaced the Vocational Rehabilitation Act as amended in 1968 but did retain the major provisions of the 1968 Amendments. There were, however, some important changes.

1. The Act established, by statute, the Rehabilitation Services Administration.

2. The Act emphasized priority service for persons with the most severe handicaps and mandated state agencies to establish an order of selection that would place the most severely handicapped person first for service as part of the state plan.

3. States were required by the Act to conduct continuing statewide studies relative to the needs of handicapped persons and how these needs might be effectively met. The intent of this requirement was to explore the expansion of services for the most severely handicapped. In addition, states were required to conduct periodic reviews of persons in sheltered workshops to determine their suitability for employment or employment-related training.

4. Under the 1973 legislation every client accepted for services had to be provided an Individualized Written Rehabilitation Program (IWRP). It also required joint counselor-client consultation and development of the IWRP and outlined the program in terms of a vocational goal, intermediate objectives, identification of anticipated dates of initiation and completion of services, and evaluation procedures and schedules. It further indicated that the opportunity for the client to achieve a vocational goal must remain available to the client at least until such time as the counselor could, beyond a reasonable doubt, support a change in the goal.

5. The 1973 Rehabilitation Act also required that several special studies be conducted to (a) determine methods of providing comprehensive services to persons for whom a vocational goal might not be feasible and to determine how services could help these individuals live more independently, (b) identify the role of the sheltered workshop in the rehabilitation process and explore the wage payment structure in sheltered workshops, and (c) determine how the basic state grant allocation formula could be improved.

In addition, the 1973 Act provided several other changes from earlier Acts (LaVor & Duncan, 1974):

A new federal mortgage insurance program to assist in the construction of rehabilitation facilities

An Architectural and Transportation Barriers Compliance Board to enforce federal statutory requirements concerning access to public buildings and transportation for the handicapped

The requirement that state rehabilitation agencies would have to seek funds from other existing federal assistance programs before using rehabilitation funds for higher education case service
An annual report on the national program to be submitted to the President and Congress
A clearing house to be established for information concerning programs for handicapped individuals
A federal interagency committee to facilitate employment and advancement of the handicapped in federal government jobs
Prohibition against discrimination solely by reason of a handicap in any program receiving federal financial assistance
Client assistance demonstration projects to inform clients of available benefits under the Act

As indicated in the Preface to this text, there is a trend toward a greater emphasis on independent living services for the disabled. The term "vocational rehabilitation" is gradually being replaced by "rehabilitation" in legislation, in agency names, and in the literature. Some of this change began with the reorganization of the Department of Health, Education, and Welfare in 1967 which created the Social and Rehabilitation Service. However, most of this change in emphasis started with the Rehabilitation Act of 1973—when considerable discussion occurred in Congress regarding the provision of comprehensive services to individuals for whom a vocational goal might not be feasible.

Rehabilitation Act Amendments, 1974

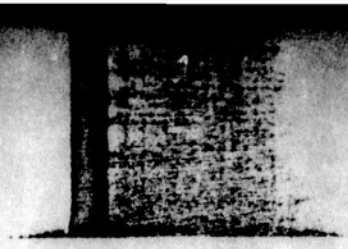
Public Law 516 of the 93rd Congress amended the Rehabilitation Act of 1973 by (1) extending the authorization of appropriations for one year, to June 30, 1976, (2) transferring the Rehabilitation Services Administration to the HEW Secretary (from the Social and Rehabilitation Service) and requiring that the RSA Commissioner be appointed by the President with the consent of the Senate, (3) strengthening the programs for the blind authorized by the Randolph-Sheppard Act of 1936, and (4) providing for a White House Conference on Handicapped Individuals within two years to develop recommendations for solutions to problems facing handicapped persons.

The Rehabilitation Act of 1973 was again extended in 1975 from June 30, 1976, to September 30, 1978.

Rehabilitation Act Amendments, 1978

The Rehabilitation Act of 1973 was again amended on November 6, 1978 (Public Law 602, 95th Congress). Major features are (1) authorization of an annual increase in appropriations for the basic state grant program based on increases in the cost of living, (2) an increase in the minimum state allotment of funds to $3 million, (3) authorization of a comprehensive program of independent living services for severely handicapped persons, (4) authorization of community service employment programs for handicapped individuals, (5) authorization of a National Institute of Handicapped Research, and (6) a change in the definition

for developmental disabilities from a categorical one to a functional one for any disability occurring before age 22. These Amendments are also referred to as "the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978."



3

Rehabilitation process

OVERVIEW AND OBJECTIVES

This chapter provides the reader with an overview of the rehabilitation process that is utilized in the implementation of the public-private rehabilitation program in the United States. It is divided into two major sections (1) the sequence of rehabilitation services and (2) rehabilitation client programming.

Objectives of this chapter are to acquaint the reader with the public program status codes used to identify client progress through the rehabilitation process, to describe the services utilized during the rehabilitation process and the bases for client selection and program priorities, outcome, and service goals, and to detail the Individualized Written Rehabilitation Program for clients.

SEQUENCE OF REHABILITATION SERVICES

As indicated in Chapter 1, the rehabilitation process is a goal-oriented individualized sequence of services designed to assist handicapped persons in achieving vocational adjustment. The delivery of services is based on the development of a rehabilitation program, or plan, for the individual client. This program is the culmination of preliminary and thorough diagnostic studies.

A strength of the rehabilitation program in the United States is that it is goal oriented. Successful delivery of rehabilitation services will enable the disabled person to engage in employment or other gainful activity.

Status codes

To facilitate the implementation of the public program, the rehabilitation process is categorized in terms of status codes. These codes are intended to reflect the service delivery status and progress of clients through the rehabilitation process. There are sixteen two-digit and even-numbered status codes which range from 00 to 32. There is no status 04. Prior to the Rehabilitation Act of 1973, status 04 reflected a 6-month extended evaluation of applicant rehabilitation potential for those with disabilities which were not severe. However, all applicants may now receive up to 18 months of extended evaluation (status 06) for determination of service eligibility. Status codes can be divided into four major types—including

referral processing (statuses 00 to 08), preservice (statuses 10 to 12), in-service (statuses 14 to 24; 32), and closure of active cases (statuses 26 to 30).

A flow diagram of the rehabilitation process as represented by the status codes is presented in Fig. 3-1.

Status 00 represents *referral* to the rehabilitation program. The referral may be from another agency or individual or a self-referral to the state rehabilitation agency. Whether by personal contact, telephone, or letter, the referral information should include: name and address of the disabled individual, the nature of the disability, age and sex of the individual, the date of referral, and the source of referral.

Status 02 represents *application* for rehabilitation services. This application can be made on an agency form or merely be a letter signed by the individual. While the individual is in this status, information is acquired by the rehabilitation counselor to make a determination of eligibility or ineligibility for rehabilitation services. The rehabilitation counselor may decide to provide an extended evaluation period to make such a determination (status 06).

Status 06 represents an *extended evaluation* period. In the event the rehabilitation counselor is unable to determine whether a client will vocationally benefit if provided rehabilitation services, he may authorize an extended period, not to exceed 18 months, in which to evaluate the person's rehabilitation potential and to determine eligibility or ineligibility for services.

Status 08 is an *ineligible closure* status for all persons processed through referral application and/or extended evaluation and not accepted into the active caseload for rehabilitation services.

Status 10 designates a person as eligible for rehabilitation services and permits *Individualized Written Rehabilitation Program development*. At this point the client becomes an active case. During this stage of the rehabilitation process, the counselor utilizes information from the thorough diagnostic study and, with the client's involvement, prepares an Individualized Written Rehabilitation Program of rehabilitation services for the client.

Status 12 is an administrative code representing *completion of the written program* of service for the client. The client remains in this status until the necessary arrangements are made with service delivery agencies for implementing the Individualized Written Rehabilitation Program.

Status 14 is intended as an in-service classification for cases which require *counseling and guidance only*, and possibly placement services, for preparing the client for employment. It should be noted, however, that counseling and guidance occur throughout the rehabilitation process and support other services. If other services are unnecessary for achieving the rehabilitation objectives and goal, status 14 is an appropriate categorization.

Status 16 represents *physical and mental restoration* services, including medical, surgical, psychiatric or therapeutic treatment, and/or the fitting of a prosthetic appliance.

Status 18 represents *training*. This status may be used to reflect almost any sort of learning situation, including school training, on-the-job training, tutoring, and training by correspondence. Many times physical or mental restoration services are also needed. In such cases the client is generally identified with the status which will represent the longest period of time.

Status 20, like status 12, is an administrative code indicating that the individual

is *ready for employment*. The client has completed the preparation stages for employment and is either ready to accept a job or has been placed and has not yet begun employment.

Status 22 signifies that the client is *in employment*. Federal legislation requires that the client remain in this status a minimum of 60 days before being closed as successfully rehabilitated (status 26).

Status 24 is also an administrative classification which indicates *service interruption* in the rehabilitation process (statuses 14 to 22). The client remains in this status until he returns to one of the in-service statuses or his case is closed.

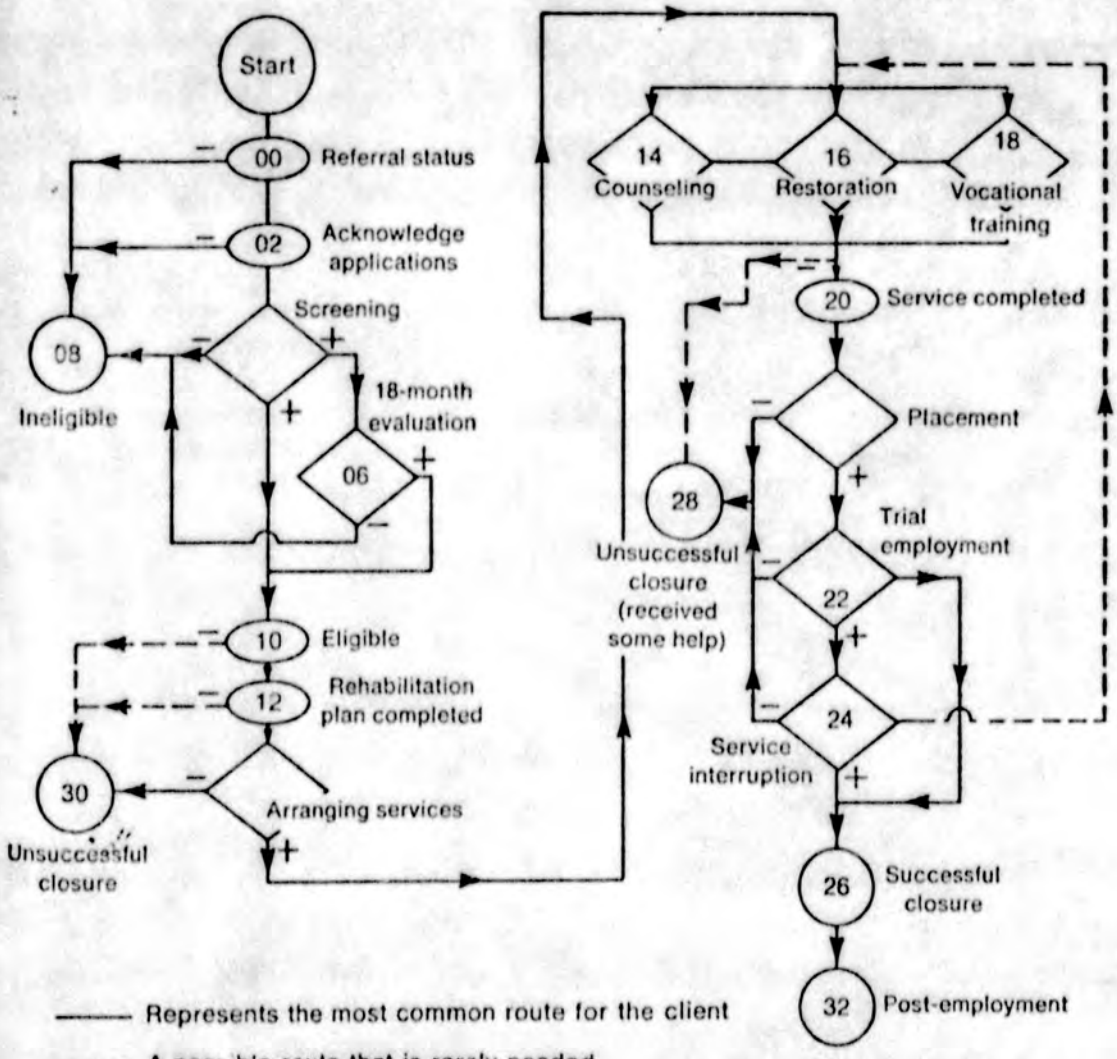


FIG. 3-1

Flow diagram of the rehabilitation process. (Modified from Leary, P.A., & Tseng, M. S. The vocational rehabilitation process—explained. *Journal of Rehabilitation*, 1974, 40[1], 9, 34.)

Status 26 represents *closed, rehabilitated*. This status is the end result of the successful rehabilitation process. To be closed as successfully rehabilitated, the client must have been declared eligible for rehabilitation services, must have received appropriate diagnostic and related services, must have had an Individualized Written Rehabilitation Program, must have completed the program of services, and finally must have been determined to be suitably employed for a minimum of 60 days.

Status 28 indicates that the client's case is *closed for other reasons after the Individualized Written Rehabilitation Program* was initiated. Cases closed in this status have met the eligibility criteria for services and have been provided at least one of the services of the rehabilitation program but the client has not become successfully employed.

Status 30 represents cases *closed for other reasons before the Individualized Written Rehabilitation Program* was initiated. Such clients have been accepted for rehabilitation services but have not progressed to the point where any services were actually implemented under the Individualized Written Rehabilitation Program.

Status 32 is a *postemployment service* phase for assisting rehabilitated clients in maintaining employment. Any rehabilitation service that relates to the client's original goal and does not entail a new comprehensive effort may be provided.

Preliminary diagnostic study

A preliminary diagnostic study is conducted in the public program during the application stage of the rehabilitation process in order to determine whether the individual is eligible for rehabilitation services. This preliminary diagnostic study is for the purpose of determining whether the individual has a physical or mental disability which constitutes a substantial handicap to employment and whether services may be expected to help him achieve employment.

If the benefits of service cannot be anticipated on the bases of the preliminary diagnostic study, an extended evaluation of rehabilitation potential can be conducted to make such a determination. In all cases this preliminary diagnostic study includes a general health examination. If the client has a mental or emotional disorder, an examination must be provided by a psychiatrist or a licensed psychologist (Department of Health, Education, and Welfare, 1974).

Thorough diagnostic study

For each client in the public rehabilitation program, a thorough diagnostic study must be conducted to determine which services are needed. This comprehensive evaluation can include medical, psychological, vocational, educational, and other considerations that might relate to the person's handicap to employment. The findings of the study are then included in considering the Individualized Written Rehabilitation Program with the client.

Medical evaluation. The medical evaluation is one of the most important aspects of the evaluation process. In addition to identifying major and secondary disabilities, the medical evaluation helps identify any functional limitations or

disabilities, particularly as they apply to occupations. The medical evaluation, it is hoped, will contribute to the decision to alleviate or remove the disabling condition; to appraise the capacity and limitations of the client in terms of rehabilitation potential and goals, and for determining how services might best be provided (McGowan & Porter, 1967).

Fundamental to the medical evaluation is obtaining a medical history of the patient/client. The medical history can provide valuable information as to diagnoses and rehabilitation procedures as well as insight to social and vocational problems. As a minimum, the medical history should include identifying information about the patient/client, his chief complaint, a history of present and past illnesses, a family history, the person's habits, a vocational history, a psychosocial history, and a systemic review.

The physical examination of a disabled patient/client includes conventional anatomic and pathologic data and information regarding the person's functional capacities. Basically the physical examination considers the disabled individual's general appearance, the head and the neck, the cardiovascular, respiratory, gastrointestinal, genitourinary, and the neuromuscular and locomotor systems. In cases of physical disability, the examining physician should include tests of muscle strength and range of motion of joints and an evaluation of the person's ability to perform daily living activities (Rusk, 1977).

The determination of rehabilitation program eligibility and subsequent services is the responsibility of the rehabilitation counselor in the federal-state program. Thus the state rehabilitation agencies employ medical consultants (M.D.s) to assist counselors. Consistent and regular medical consultation is needed during the rehabilitation process for clarification of terminology in reports, assessing medical feasibility and treatment results, and obtaining advice concerning medical management problems and the need for specialist exams.

Psychological evaluation. The primary purposes of psychological evaluations are to determine the nonphysical abilities and limitations of the disabled person and to identify attitudes, interests, motivations, and personality variables which will affect the formulation of an Individualized Written Rehabilitation Program and subsequent rehabilitation services. Psychological measures should be administered for specific purposes since not all abilities or all facets of personality are necessarily important for the rehabilitation of an individual (Rusk, 1977).

When psychological measures are used for determining rehabilitation potential and direction, it is important to remember that test information serves only as an aid in decision making. Thus the user of psychological information should attempt to cross validate information and seek patterns in the assessment data. It is generally useful to place test information for a client into perspective by including previous experiences and behavior. Many rehabilitation clients are also handicapped by emotional problems related directly or indirectly to their disability. The user of psychological information should then seek information regard-

ing the client's reaction to the disability, feelings toward adjustment to the disability, and the effect of this disability upon his social adjustment in the community (McGowan & Porter, 1967).

Thus psychological evaluation involves assessing many variables which may help identify behavioral patterns and integrating this information into an Individualized Written Rehabilitation Program of services that can lead to successful adjustment and gainful activity by the client.

Sociocultural evaluation. Social and cultural information about a rehabilitation client is an integral part of planning in the rehabilitation process. A complete understanding of the client's disability necessitates learning the extent of disability and the nature of his reactions to this and other life experiences (McGowan & Porter, 1967).

A social and cultural evaluation generally involves obtaining a social history. This social history includes identifying information about the client, referral information, information about the client's present and previous medical history, a personal and family history (including information about the general climate of the home), an educational history, a work history, and information regarding the client's personality and habits and economic situation (McGowan & Porter, 1967).

When the total picture of the disabled person is being developed, it is also important to place all evaluation information into a cultural and environmental context. Individuals are a part of the constellation of factors inherent in their physical, social, and cultural surroundings and are influenced by the interaction between genetic endowments and the environment. Thus an understanding of a client's background and environment can help to more clearly discern the rehabilitation needs. Sociocultural information is usually obtained through an interview with the client. However, it can also be obtained, in part, by review of social service reports and anecdotal records that might be available. Additional sources are significant others in the disabled client's life: family, friends, teachers, and employers. The client's own social insights, skills, attitudes, and motivations are significant to an understanding of his self-perceptions and relationships to family members as well as to the community.

Vocational evaluation. In its broadest meaning, vocational evaluation includes all medical, psychological, social, cultural, vocational, and educational information which helps to define the rehabilitation client's problems and development of his vocational potential. As used here, however, it will pertain more narrowly to information and techniques for specifically assessing vocational aptitudes, potentials, and prognosis.

The best predictor of future performance is still past performance. Thus, for clients with a work history, information about previous jobs—including work habits, interests, attitudes, areas and degrees of responsibility, and relationships with other employees and with supervisors—represents very important pieces of vocational evaluation information.

For clients without a previous work history, the rehabilitation counselor must rely on assessments of the client's aptitudes and expressions of job interest and aspirations in predicting vocational potential. There are many paper-and-pencil measures and inventories to assess aptitudes and interests. In addition, there are work evaluation procedures which are helpful. The use of work samples, i.e., isolated work tasks that can be compared with standards for employed workers, is a common practice in rehabilitation. Situational assessment is another. The latter involves placing the rehabilitation client in a simulated or real work environment and assessing performance and behavioral adjustment. Another approach to vocational evaluation is to begin with an analysis of the job involving the identification of job requirements and the necessary worker traits for performance of the job and then relating the qualifications of the client to these requirements.

Perhaps the most useful approach to vocational evaluation is job-site rotation. When clients are placed in actual job situations for short evaluation periods, the advantages inherent in a previous work history are attained. Job-site evaluations offer the opportunity to test a client's interests, aptitudes, relationships to supervisors and other employees, and adjustments to varying work environments.

Educational evaluation. The educational evaluation process represents an attempt to identify the learning experiences of the disabled individual so his attitudes, knowledge, skills, and motivations can be understood. The primary purpose of an educational evaluation, of course, is to relate the disabled individual's repertoire of skills to vocational potential and goals. The educational evaluation for a client should include a determination of the attained level of education, including special areas of interest and achievement, an indication of learning capacity, information regarding study habits, an assessment of psychological reactions to educational situations, and information regarding extracurricular activities as they relate to learning.

In most cases, obtaining evidence of previous learning experiences will necessitate a visit to schools to examine school records and perhaps have conferences with school counselors and teachers. It may also necessitate administering educational tests to obtain a correct assessment of the individual's knowledge and capacities. Consideration of the individual's educational achievements in other than academic areas is also essential for evaluation of the client's potential for vocational adjustment and a fuller life after rehabilitation.

Extended evaluation

In the event that a determination of rehabilitation potential cannot be immediately made for an applicant but a physical or mental disability which is a handicap to employment has been established, the public program provides for an extended evaluation period. This extended evaluation cannot, however, exceed 18 months. By the end of 18 months, a decision must be made regarding an applicant's eligibility or ineligibility for rehabilitation services in the public pro-

gram. Only one extended evaluation period can be permitted for each client unless a handicapped individual's needs have been determined to have significantly changed. In decisions of ineligibility, so the rights of individuals to service by the public program will be protected, it must be determined beyond any reasonable doubt that an applicant cannot be expected to benefit in terms of employability (Department of Health, Education, and Welfare, 1974).

Individualized Written Rehabilitation Program

The Individualized Written Rehabilitation Program (IWRP) is a plan jointly developed by the rehabilitation counselor and the handicapped person or, if the person is incapable of independent judgment, the parent, guardian, or appropriate representative. It is a continuously developed plan for each eligible applicant for rehabilitation services or individual in extended evaluation.

The primary emphasis in developing an IWRP is on the determination and achievement of a vocational goal. As a minimum, the IWRP includes (1) the basis for determination of eligibility or extended evaluation, (2) a long-range employment goal, (3) intermediate rehabilitation objectives related to the attainment of the employment goal, (4) identification of specific vocational rehabilitation services necessary to achieve the employment goal, (5) the expected date for initiation of each service and the anticipated duration of these services, and (6) a procedure and schedule for evaluation of progress toward the rehabilitation objectives and the employment goal. In addition, the client or an appropriate representative must be involved in the development of the plan and be informed of his rights and appeal procedures if dissatisfied (Department of Health, Education, and Welfare, 1974).

Counseling and guidance

Though counseling and guidance are integral parts of the provision of most services in rehabilitation, they may also be a distinct and separate service. As has been mentioned, when counseling is the only service needed by the client in addition to job placement the client is considered to be in status 14.

Counseling is the synthesizing function of the rehabilitation process (Malikin & Rusalem, 1969). It is the function which addresses the holistic nature of humans. It is also the counseling function that integrates separate disciplinary practice into a comprehensive approach for serving the individual. Though there are many counseling theories and techniques advocated, there are many more similarities than differences among these. The ultimate goal of counseling is a helping relationship between the counselor and the counselee culminating in improved client function.

Physical and mental restoration

Physical and mental restoration refers to health-related services that are important to correct physical or mental conditions which interfere with optimal

functioning of the rehabilitation client. Examples might be medical, physical, and therapeutic treatment, and/or prosthetic appliances. It can include the many services of physical medicine, physical therapy, occupational therapy, communication therapy, rehabilitation nursing, orthotics and prosthetics, and psychiatry (Department of Health, Education, and Welfare, 1974; Rusk, 1977).

Training

In rehabilitation, training refers to the broad range of learning opportunities and experiences which will help the client progress to the employment goal of the Individualized Written Rehabilitation Program. Jarrell (1972) classifies rehabilitation training into four broad areas: (1) personal adjustment training, (2) prevocational training, (3) compensatory skill training, and (4) vocational training.

Personal adjustment training refers to the development of habits and attitudes which are related to adjustment in the world of work. Examples are dependability, responsibility to others, tolerance, consistency, and capacity for time considerations (Bitter, 1968). *Prevocational training* refers to the background knowledge needed to select and become ready for occupational skill development. It is a preparatory stage for vocational skill training. Program examples are familiarity with occupations through field tours, job-site rotation, and reading. It also includes learning to complete employment applications, using public transportation, and managing an income. Many work adjustment programs combine personal adjustment training and prevocational training. *Compensatory skill training* refers to the development of personal skills that compensate for disability and that may be important for employability. Examples are speech reading, gait training, and mobility training for the blind. *Vocational training* involves the development of specific job skills. These skills may be obtained in numerous ways—through trade and vocational schools, colleges and universities, apprenticeship programs, rehabilitation facilities, sheltered workshops, and on-the-job training.

Job placement

In a vocationally oriented program, job placement represents the culmination of the entire rehabilitation process. Job placement is important in the restoration of an individual to the highest level of functioning of which he is capable. To have been a successful process, the employment situation must be commensurate with the abilities, interests, and potential of the rehabilitated client. Job placement is very complex and often underrated, involving matching the individual to the appropriate job. The process necessitates recognizing relationships between client variables and work environment variables. The former include both personal factors and job skill factors; the latter are all the considerations inherent in the job.

No two work environments are exactly alike (Bitter, 1968). Thus effective job placement requires that the rehabilitation counselor or placement specialist have a thorough knowledge of the community and its resources. In addition, the professional worker must be skilled in job analysis to be able to understand the requirements of the job. Job engineering may also be involved, entailing minor job modifications to help the employer and client fully benefit from the client's skills. It should be noted, however, that job placement is a mutual responsibility of the rehabilitation counselor and client which is considered early in the rehabilitation process. The counselor and the client must work together if they are to effect a vocational outcome that will truly reflect the restoration of the client to his fullest level of vocational functioning.

Postemployment services

Postemployment services are provided in the rehabilitation process after clients are vocationally rehabilitated to assist them in maintaining employment. Postemployment service might be any rehabilitation service(s); but activities should be related to the client's original Individualized Written Rehabilitation Program.

At a minimum, continued counseling may be essential; however, postemployment service may also include any rehabilitation service that does not entail a complex or comprehensive new rehabilitation effort. Such postemployment services may be either a one-time performance or a combination extended over a period of time. There is no limit on the duration of postemployment services in the public rehabilitation program. Some examples of postemployment services are supplementary training resulting from a change in job requirements, health services, arrangements with other agencies for home help, wheelchair repair, and transportation subsidy if needed (Department of Health, Education, and Welfare, 1974; West Virginia Research and Training Center, 1975).

Other services

Maintenance support, through financial payments, may be made available to clients to cover their basic living expenses—including food, shelter, clothing, and any other subsistence that may be important for achieving the rehabilitation goal of the handicapped person.

Transportation support may also be provided to rehabilitation clients to make possible the provision of services. Relocation and moving expenses are also available if related to the achievement of rehabilitation goals.

Services to *family* members of a handicapped individual are oftentimes important for the adjustment of clients to their rehabilitation goals. This and any other *support* service may be provided in the public rehabilitation program if important to the individualized rehabilitation process. Examples of support services are supervision and management for small business enterprises (consulta-

tion, accounting, inspection, etc.), occupational licenses (needed to enter an occupation or a small business), tools, equipment, and supplies, interpreters for the deaf, readers and mobility service for the blind, technological aids and devices, and any assistance which might benefit the handicapped individual in achieving employability.

REHABILITATION PROGRAMMING

Client selection and priorities

The Rehabilitation Act of 1973 required that state rehabilitation agencies establish priorities for serving the handicapped. This, of course, is necessary only if the agency is unable to provide services to all who apply and are eligible or who are in need of an extended evaluation of rehabilitation potential to determine their eligibility. First priority must, according to legislation, be given to the most severely disabled. The 1973 legislation intended that this group should not be denied services or be delayed or deferred because of the complexity of the case, the cost, or the time it takes to successfully rehabilitate a severely disabled person. State agencies may, however, assign subsequent priorities to other disabling conditions, depending on local areas of concern.

Outcome and service goals

After the identification of client selection priorities, state rehabilitation agencies are required to establish outcome and service goals for each priority group. Thus, at a minimum, a state agency must establish such outcomes and service goals for the severely disabled. These must be stated in terms that are measurable. For example, if an agency goal is to expand rehabilitation services to spinal cord injured clients, then a measurable objective might be to serve 15% more severely disabled spinal cord injured clients during the next 12 months. To be useful, agency goals should generally be expressed in terms which can provide for service expansion or program improvement. An example might be to develop new service delivery resources or improve referral procedures or methods to expedite service delivery. Thus the establishment of outcomes and service goals becomes a policy and planning function of rehabilitation agencies (West Virginia Research and Training Center, 1974; Rehabilitation Services Administration, 1975a).

Individualized Written Rehabilitation Program

The Individualized Written Rehabilitation Program (IWRP) was mentioned earlier in this chapter under the "Sequence of Rehabilitation Services." The IWRP is a case planning and management tool. It identifies the basis for determination of eligibility or need for extended evaluation. It also identifies the terms and conditions of the program, for example, client financial participation, availability of rehabilitation funds, availability of class openings in training programs,

any potential possibilities for delay in implementing the program and client responsibilities. If there is dissatisfaction with the provision of services, the rights of the client for an administrative review and a fair hearing are also noted. The IWRP is signed by the rehabilitation counselor or other representative of the agency and the client receives a copy. The IWRP may be amended with any appropriate change anytime during the rehabilitation process; again with client involvement.

The Individualized Written Rehabilitation Program represents a plan of action and a statement of mutual understanding. Though the client is not compelled to sign the IWRP or its amendments, the program should be developed with the client's full participation, understanding, and acceptance. In addition to specifying the basis for applicant eligibility for service, the IWRP contains five primary service-related content areas—including a long-range employment goal, intermediate rehabilitation objectives, specific rehabilitation services, duration of services, and evaluation of progress.

The *long-range employment goal* represents the aim of the rehabilitation process. It is the ultimate realistic vocational achievement of the client and should be based on his interests, abilities, and physical and mental potential. Formulation of a long-range employment goal offers the potential of a goal-directed activity which gives continuous consideration to job placement rather than serves merely as one step at the end of the rehabilitation process.

Intermediate rehabilitation objectives represent the series of steps designed to help the client achieve the long-range employment goal. Examples of objectives might be physical restoration, personal adjustment, and the development of vocational skills.

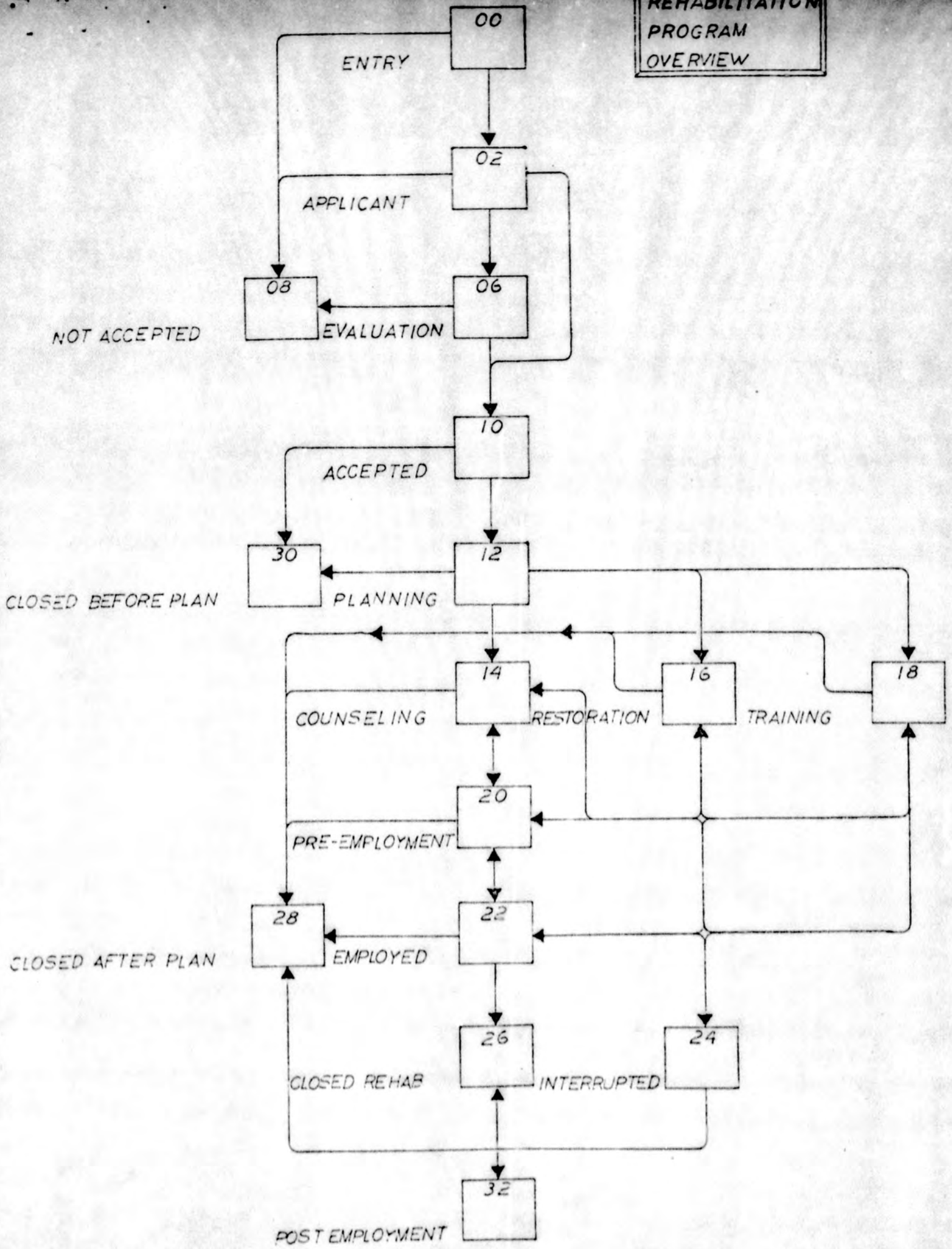
The IWRP also identifies *specific rehabilitation services* directly related to achievement of the intermediate rehabilitation objectives and the vocational goal. Examples might be physical therapy, adjustment counseling, vocational training, purchase of a wheelchair, or development of skills for independent living. However, where possible, the statement of rehabilitation services to be provided to the client should be specific.

The *duration of services* is also specified in the IWRP for each of the planned services. The anticipated date for initiation of each service should be identified and scheduled in a manner which will maximize the benefits of an orderly, sequential rehabilitation process.

The last content area of the IWRP is *evaluation of progress* toward attainment of the long-range employment goal. To be useful, the IWRP ought to outline the criteria for evaluating client progress. Factors that can be used to assess progress include counselor assessments, self-reports of the client, training progress reports, grades, and medical reports. A formal review of the IWRP is required by public program regulations at least annually. However, a review of progress should be a continuous process and formal sessions may be conducted

at any time and may be initiated by either the counselor or the client. The results of such reviews should be recorded and the IWRP redeveloped or amended as appropriate. A number of alternatives are available in the event the client is not making satisfactory progress toward attainment of intermediate objectives and the long-range goal. The levels of achievement may be reconsidered, the appropriateness of the objectives may be reevaluated, the dates for achievement of objectives may be reset, or if necessary services may be terminated (Rehabilitation Services Administration, 1975b).

REHABILITATION PROGRAM OVERVIEW



3005.01 Purpose and Legal Authority

Statistical reporting under the State-Federal Program of Vocational Rehabilitation is sponsored by the Rehabilitation Services Administration (RSA) and conducted under the auspices of the National Center for Social Statistics (NCSS) acting as the collecting and processing agency for RSA-sponsored reports. This section contains copies of the required statistical reports and instructions for preparing them.

Section 101(a)(10) of the Rehabilitation Act of 1973 and Section 401.20 of the Interim Regulations dated January 3, 1974 which implement the Act, relate to the submittal of reports.

3005.02 Caseload Statuses

There are 15 status classifications under the caseload status coding structure coded in even numbers beginning with 00 and ending with 30 (excluded is code 04). Reporting on all statistical forms is based on one or more of the caseload statuses.

Status 00. REFERRAL. This status represents entrance into the vocational rehabilitation process. A referral is defined as any individual who has applied to or been referred to the vocational rehabilitation agency by letter, by telephone, by direct contact, or by any other means; and for whom the following minimum information has been furnished: (1) name and address, (2) disability, (3) age and sex, (4) date of referral, and (5) source of referral.

It should be noted that it is not intended to include in the definition of "referrals" those individuals included in long lists of persons who are "screened out" by criteria established in a cooperative agreement between the vocational rehabilitation agency and another agency. However, all those cases not screened out by the established criteria should be recorded and reported, not just the cases which appear to have good vocational rehabilitation potential after counselor investigation.

All cases must be recorded and reported as referrals for Form SRS-RSA-101 and Form SRS-RSA-300 purposes as soon as the above basic, minimum information is available. Recognition of this basic principle by all

counselors and all State vocational rehabilitation agencies is essential. Referrals should be recorded on these forms even though the counselor may close out the referral almost immediately as not being eligible for services.

Status 02. APPLICANT. As soon as the referred individual (Status 00) signs a document requesting vocational rehabilitation services, he is placed into Status 02 and is designated as an applicant. Generally, the document will be an agency application form, but a letter signed by an individual who provides the minimum basic referral information and requests service should also be considered as a basis for placing the individual in Status 02. This is important, since the applicant must be notified in writing if his request for VR services has been denied, and the only certain basis for determining that the individual has knowledge of having been referred is by the existence of a document signed by the individual.

While the individual is in Status 02, sufficient information is developed to make a determination of eligibility (Status 10) or ineligibility (Status 08) for vocational rehabilitation services, or a decision is made to put the individual into extended evaluation (Status 06) prior to making such a determination.

Status 06. EXTENDED EVALUATION. An applicant should be placed in this status when the counselor has certified the applicant for extended evaluation. Individuals placed in this status may not remain in the status longer than eighteen consecutive months from the date of certification but may be moved from this status to either Status 10 or 08 at any time prior to the expiration of the 18-month period if it is determined that, either (a) there is a reasonable expectation that the individual can benefit in terms of employability (Status 10), or (b) there is no reasonable likelihood that he can benefit in terms of employability (Status 08). No time allowances can be made for interruptions during this period regardless of the nature of, or reason for, the interruptions.

Prior to or simultaneously with acceptance of an individual for services for purposes of determination of rehabilitation potential (extended evaluation), there will be a certification of: (1) the presence of a physical or mental disability, (2) the existence of a substantial handicap to employment, and (3) the inability to make a determination that vocational rehabilitation services may benefit the individual in terms of employability. An individualized written rehabilitation program is required concurrently with or reasonably soon after execution of the certificate of eligibility for extended evaluation services.

Status 08. CLOSED FROM REFERRAL, APPLICANT, OR EXTENDED EVALUATION STATUSES. This status has been provided to furnish a means for identifying all persons not accepted for vocational rehabilitation services, whether closed from referral status (00), applicant status (02), or extended evaluation (06). All persons processed through referral, applicant, and/or extended evaluation, and not accepted into the active caseload for vocational rehabilitation services, will be closed in this status. A certificate of ineligibility is required for a closure in Status 08, except when the client becomes unavailable for services. A copy of the Form SRS-RSA-300, properly completed, dated, and signed is sufficient certification of ineligibility for these cases, provided case documentation includes specific detailed reasons for the closure action. See page 75 for additional instructions concerning closure of cases.

ACTIVE CASELOAD STATUSES

An individual who has been certified as meeting the three basic eligibility requirements is accepted for vocational rehabilitation services, designated as an active case, and placed in Status 10. Eligibility for vocational rehabilitation services is based upon: (1) the presence of a physical or mental disability; (2) the existence of a substantial handicap to employment; and (3) a reasonable expectation that vocational rehabilitation services may benefit the individual in terms of employability.

After an individual has been accepted and his case placed in the active caseload, the case study is completed, an individualized written rehabilitation program is developed,

and the appropriate services are provided, including follow-up prior to case closure to insure the suitability of employment.

The following statuses are designed to provide counselors, district supervisors, and State agency management personnel with a uniform method for recording individual case progress and caseload management information. It may be noted that there are no national reporting requirements for applying these statuses to cases in extended evaluation. However, any large-volume agency desiring to establish case progress identification for their evaluation cases can easily do so by prefixing the following statuses with a "6" to signify status changes during extended evaluation.

Status 10. INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM DEVELOPMENT. While a client is in this status, the case study and diagnosis is completed to provide a basis for the formulation of the individualized written rehabilitation program. A comprehensive case study is basic to determining the nature and scope of services to be provided in order to accomplish the vocational rehabilitation objective of the individual. The counselor and client formulate and plan the rehabilitation services necessary to the solution of the client's problems, and those services are clearly outlined to him. The individual remains in this status until his rehabilitation program is written and approved.

Status 12. INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM COMPLETED. A case is placed in this status when the individualized program has been written and approved. The case remains in this status until at least one arrangement has been made to supply a necessary service and the service has been actually initiated. In those instances where the program as written and approved provides for counseling, guidance, and placement only, the client may be moved immediately after program approval into Status 14 since counseling is a continuing process.

THE IN-SERVICE STATUSES (Statuses 14, 16, and 18). These service statuses are provided for case progress designations to indicate the kind or kinds of services given to the client to prepare him for employment.

In those instances where a client receives restoration and training services simultaneously, the client should be identified by the service which is running for the longer period of time. In those instances where both services run concurrently for the same time period, the counselor must use his professional judgment in assigning the case to the status which is most important to that particular case.

Status 14. COUNSELING AND GUIDANCE ONLY. It is intended that this status be used only for those cases having an approved program which outlines counseling, guidance, and placement as the only services required to prepare the client for employment. It is not to be used to reflect the counseling and guidance which take place during the course of program development or provided by the counselor during the progress of training, or physical or mental restoration. However, within the context of the meaning and intent above, in those instances where there has been a breakdown in the case progress after other services have been provided, and it has been determined by the counselor that substantial counseling and guidance is essential to the successful placement and rehabilitation of the individual, the client may be entered in this status, provided that a program amendment has been written and approved after consultation with the client and that this is the only additional service required to prepare the client for employment.

Status 16. PHYSICAL AND MENTAL RESTORATION. A client is placed in this status if he is receiving any physical or mental restoration services such as medical, surgical, psychiatric or therapeutic treatment, or is being fitted with an appliance. A case remains in this status until physical and mental restoration services are completed or terminated.

Status 18. TRAINING. A client is placed in this status if he is actually receiving academic, business, vocational or personal and vocational adjustment training from any source such as a public or private school, a commercial or industrial establishment, a rehabilitation or other facility, by an individual

teacher or instructor, or by correspondence. Clients remain in this status until the training is either completed or terminated.

Status 20. READY FOR EMPLOYMENT. A client is placed in this status when he has completed preparation for employment (counseling, guidance, treatment, fitting of an appliance, training, etc.) and is ready to accept a job but has not yet been placed, or has been placed but has not yet begun employment. For example, "June graduates" with teaching contracts, who will not begin employment until September, should be placed in this status for Federal reporting purposes.

Status 22. IN EMPLOYMENT. A client is placed in this status when he has been prepared for, been placed in, and begun employment. He must be observed in this employment for a minimum of 30 days prior to being closed rehabilitated (Status 26) to insure adequacy of employment in accordance with the needs and limitations of the individual. Homemakers and unpaid family workers should be included in this status while they meet the observation criteria.

Status 24. SERVICE INTERRUPTED. A client is recorded in this status if services are interrupted while he is in one of the Statuses 14, 16, 18, 20, or 22. Such cases are then held in this status until the client returns to one of the aforementioned statuses or until the case is closed.

ACTIVE CASELOAD CLOSURE STATUSES

A client remains in the active caseload until he has completed his individualized written rehabilitation program or until it has been terminated. Cases closed from the active caseload are classified in one of the three following categories.

Status 26. CLOSED REHABILITATED. Cases closed as rehabilitated must as a minimum (1) have been declared eligible, (2) have received appropriate diagnostic and related services, (3) have had a program for vocational rehabilitation services formulated, (4) have completed the program insofar as possible, (5) have been provided counseling as an essential rehabilitation service, and

(6) have been determined to be suitably employed for a minimum of 30 days. See page 75 for additional instructions concerning closure of cases.

Status 28. CLOSED OTHER REASONS AFTER INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM INITIATED. Cases closed in this category must have met the criteria (1), (2), and (3) above, and at least one of the services provided for by the program must have been initiated, but for some reason one or more of criteria (4), (5), and (6) above were not met (closures from Statuses 14 through 24). Included here are cases which are transferred to another State rehabilitation agency, either within the State, or in some other State. Also included here are those cases for which a rehabilitation program for counseling and guidance only was written, approved, and initiated. See page 75 for additional instructions concerning closure of cases.

Status 30. CLOSED OTHER REASONS BEFORE INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM INITIATED. Cases closed in this category are those cases which, although accepted for rehabilitation services, did not progress to the point that rehabilitation services were actually initiated under a rehabilitation plan (closures from Status 10 or 12). Included here are cases which are transferred to another State rehabilitation agency, either within the State, or in some other State. See page 75 for additional instructions concerning closure of cases.

counseled as to how these provisions will operate to his advantage, in order to strengthen his motivation for undertaking rehabilitation. The VR counselor should also assure that the client-beneficiary understands there is a suspension of benefits for any month in which rehabilitation services are refused without good cause.

3508.02 Trial Work Period

Whether he enters into rehabilitation through his own efforts or with the help of the State vocational rehabilitation agencies (or other agencies), when the disabled worker or childhood disability beneficiary who has not recovered attempts to work, he may continue to receive benefits for himself and his family for nine months while testing out his earning capacity and ability to sustain work. (See 3508.025, when medical recovery is involved.) Not until after a beneficiary has performed "services" in each of nine months (which may or may not be consecutive) will a decision be made as to whether the beneficiary has shown that he has regained his ability to work. If, after nine months of services, it is decided that the beneficiary is able to engage in substantial work and, therefore, is no longer disabled within the meaning of the law, he will still be paid benefits for an additional three months, making twelve months of trial work and adjustment in all. (Note: The trial work period provisions do not apply to disabled widows, widowers, or surviving divorced wives.) It is not possible to predetermine if a beneficiary may be entitled to a trial work period. Caution should be used in counseling the client about the trial work provisions.

A month in which a beneficiary works will count as a month of services in the computation of the trial work period if:

a) The beneficiary's earnings derived from employment are more than $50 in such month, or

b) The beneficiary's earnings from self-employment activities are more than $50 in such month, or he spends more than 15 hours in such month in self-employment activities.

After expiration of the trial period, an evaluation is made of the disabled person's work effort. The decision to terminate or to continue benefits after the trial work period will depend upon the finding of ability or inability of the person to engage in substantial gainful activity.

3508.021 Substantial Gainful Activity

For the purpose of establishing eligibility for disability benefits under the Disability Insurance Program, "Substantial Gainful Activity" means, "...the performance of significant duties over a reasonable period of time in work for remuneration or profit or in work of a type generally performed for remuneration or profit..."

Regardless of the severity of the impairment, disability insurance benefits are not payable to a person who engages in substantial gainful activity. The following earnings guidelines apply for determining substantial gainful activity:

A. Earnings averaging more than $200 a month are deemed to demonstrate ability to engage in substantial gainful activity, in the absence of evidence to the contrary. If the earnings include a subsidy reducing the true earnings to less than $200 a month, substantial gainful activity would not be found. SSA will investigate for the possibility of a subsidy existing in reported wages for the following:

a) Sheltered employment, or

b) Childhood disability or mental impairment, or

c) Marked discrepancy between wages and apparent value of services, or

d) Allegations that pay is not wholly earned.

DESK AIDE

Application of the Special Selection Criteria (SSC) for the SSDI/SSI-Funded VR Programs (Refer to RS Manual)

SSC 1 DISABILITY RAPIDLY PROGRESSIVE AND SUSTAINED SGA UNLIKELY [2]

YES → DO NOT CERTIFY FOR SSDI/SSI-VR FUNDING, CONSIDER SECTION 110 FUNDS

NO → MEETS SSC #1 CONTINUE ON TO SSC #2

SSC 2 MEDICAL IMPROVEMENT LIKELY WITHOUT REHABILITATION SERVICES [3]

YES → DO NOT CERTIFY FOR SSDI/SSI-VR FUNDING, CONSIDER SECTION 110 FUNDS

NO → MEETS SSC #1 AND #2 CONTINUE ON TO SSC #3

[1] DEFINITION OF SGA FOR VR PURPOSES DURING 1978 (CHANGE SGA AMOUNT YEARLY AS PER RSA INSTRUCTION)

$230 Per month of unsubsidized remuneration from employment or self-employment,

$333 Per month for those allowed SSDI benefits because of legal blindness.

[2] EXAMPLES OF SITUATIONS REQUIRING CAREFUL CONSIDERATION OF SSC NO. 1

Do not certify any condition which is likely to cause rapid (within 2 years) deterioration of the ability to sustain SGA. The following are examples of conditions which should not be certified without medical consultation.

Medical Consultation

A. Cancer that is: inoperable; recurrent after radical surgery; not controlled by prescribed therapy; or marked by distant metastasis.
B. Chronic Cor Pulmonale; chronic severe congestive heart failure.
C. For advanced Cirrhosis of the liver.
D. Marked irreversible ventilatory loss resulting in bed or chair confinement.
E. Multiple Sclerosis with severe neurological signs.
F. Rheumatoid Arthritis with severe overall anatomical deformity.
G. Arteriosclerosis Obliterans or advanced ASHD.
H. Uncontrolled Diabetes Mellitus with organ involvement; amputation; blindness; frequent acidosis; or, severe neuropathy.

[3] EXAMPLES OF SITUATIONS NOT MEETING SSC NO. 2 OR REQUIRING CAREFUL CONSIDERATION ARE BELOW

Do Not Certify

A. Beneficiary has reached or will reach a level of improvement (e.g. fracture healed, recovered from mental condition, tuberculosis controlled) leading to termination without VR services.
B. Beneficiary already receiving restorative services when referred to VR (e.g., surgery). These services likely to result in termination.
C. Beneficiary already in SGA level employment when referred to VR and no evidence beneficiary requires VR services to continue in SGA.

Careful Consideration

A. Re-examination diary (MRD) established must have medical evidence to rebut: (consultation or recent (within last 6 months) medical evidence in file.)
B. MRD not established or diary status unknown but medical recovery expected, must have medical evidence to rebut: (consultation or recent (within last 6 months) medical evidence in file.)

SSC 3 SGA PROBABLE [4]

NO → DO NOT CERTIFY FOR SSDI/SSI-VR FUNDING, CONSIDER SECTION 110 FUNDS

YES → MEETS SSC #1 2 AND 3 CONTINUE ON TO SSC #4

SSC 4 PREDICTABLE SAVINGS [5] WILL OFFSET COST OF REHABILITATION SERVICES [6]

NO → DO NOT CERTIFY FOR SSDI/SSI-VR FUNDING, CONSIDER SECTION 110 FUNDS

YES → MEETS ALL FOUR SSC ◆ ★ CERTIFY FOR SPECIAL FUNDS

[4] EXAMPLES OF SITUATIONS NOT MEETING SSC NO. 3 OR REQUIRING CAREFUL CONSIDERATION ARE BELOW

Do Not Certify

A. Impairment so severe as to make SGA unlikely (e.g., severe mental retardation as evidenced by psychological, vocational, or psychiatric evaluation of functional ability).
B. Vocational objective not SGA (e.g., homemaker, unpaid family worker).

Careful Consideration

A. Self-employment (rarely results in SGA).
B. Sheltered work (rarely results in SGA).
C. Occupations such as baby-sitting, artwork, gardening, woodworking, etc. (rarely result in SGA).

NOTE: CRITERION NO. 3 CANNOT BE MET BASED ON A BROAD VOCATIONAL GOAL (e.g., UNSKILLED LABOR, COLLEGE EDUCATION, OFFICE WORK) – MUST BE A SPECIFIC VOCATIONAL OBJECTIVE (e.g., CARPENTER) OR SEVERAL OPTIONS UNDER A SPECIFIC OBJECTIVE (e.g., CLERICAL – SECRETARY, TYPIST)

[5] DEFINITION OF SAVINGS

Disability benefits that won't be paid to the client because client was rehabilitated to SGA and removed from the disability rolls.

[6] METHOD FOR COMPUTING OFFSET

Beginning with the month the client is expected to be removed from the disability rolls (usually 12th month of work activity), client is likely to continue in SGA for (a) ——— months before retirement at age 65.* The discontinuance of monthly benefits of (b) $——— would result in a savings of (a) x (b) $——— to the trust funds or SSI funds offsetting the rehabilitation case service costs of (c) $———. If (c) exceeds (a) x (b), do not certify.

*IF THE CLIENT IS SUFFERING FROM A MEDICAL CONDITION WHICH IS LIKELY TO RESULT IN WITHDRAWAL FROM SGA PRIOR TO AGE 65, MAKE A REASONABLE PROJECTION BASED ON MEDICAL CONSULTATION.

,7 RECORDS PRINTED

FY80 (CLOSED + ACTIVE)

	2nd Injury	No 2nd Injury	TOTAL	REHABS	TRAINING
WC REFERRED	30	51	81	4	17
NON WC REFERRED	166	—	166	33	38
TOTAL	196	51	247	37	55

REHABS

FY 79

	26	28	30	02
WC REF	5	4	6	10
2ND INT	19 44.2	17 58.2	10 80	17 94
WC/2ND	3	2	2	1
TOTAL				
WC REF $	12,432	3,356	736	2,128
TOTAL $	47,487	19,473	1,528	1,405
WC/2ND $	7,975	2,616	497	692
		AVERAGE	COST	
WC REF	2,846	839	123	213
2nd INT	2,499	1,145	153	83
WC / 2nd INT	2,658	1,308	249	692

$509

ALL

AVE COST PER REFERRAL = 2,446

WC referrals $400 higher on average.

425 rehabs

FY 78

	26	28	30	08
WC REF	6	2	2	1
2nd INJ	24	16	4	13
WC/2ND	4	1	1	1
TOTAL				
WC Reg.	13,467	264	66	516
2nd Inj.	10,777.	13,853	234	1,096
	12,749	227	46	113
	2,295	132	33	57 394
	2,941	866	26	84
	3,187	227	46	113.

AVG COST PER CLAIM = 2,104
377 reliable

Case expenditure averages
~~tabulated~~ ~~are~~ ~~figures~~ from
~~all classes~~ represent total
Case expenditure
including general
funds as well as
2nd injury monies

FY77

	26	28	30	08
WC REF	9	2	3	15
2nd INJ	26	17	8	21
WC/2nd	7	1	3	6
TOTAL				

WC REF $	15,624	29	224	608
2nd $	55,726	16,282	368	1357
WC/2nd $	15,091	29	224	267

AVERAGE COST

WC REF $	1,736	15	75	41
2nd $	2,143	958	46	65
WC/2nd $	2,156	15	75	45

391

Ave cost per rehab FY 77 = 1,892
477 rehabs.

M E M O R A N D U M

TO: Licia Piceno

FROM: Bob Williams

DATE: October 26, 1980

RE: Vocational Rehabilitation

Enclosed in Chapter 4 of (The Report of the National Commission on State Workmen's Compensation Laws, July, 1972) which oulines the Commission's position on Vocational Rehabilitaion. Also enclosed is a memorandum from the Division of Worker's Comp, State of Alaska, Dept. of Labor. Page 2 of that memorandum gives a brief outline of the voc rehab program in Idaho.

B. Eligibility
   1. Pre-existing permanent impairment
   2. Subsequent work injury
   3. PTD results from combination of pre-existing and subsequent disability

C. Payment by Subsequent Employer
   Only for disability caused by subsequent injury including scheduled and unscheduled PPD

D. Payment by Fund
   a. Remainder of disability
   b. No funds are expended for rehabilitation

E. Computerization
   Because of the PTD requirement, fund cases are very limited and the Commission feels no need for computerization

IV. REHABILITATION (RETRAINING)

A. Eligibility
   1. Permanent disability
   2. Commission determines in a hearing or an informal conference
      a. The claimant is "receptive" to retraining
      b. The claimant needs retraining to restore his earning capacity.

B. Benefits
   1. The carrier must pay TTD or TPD (if claimant has some earnings) during retraining period
   2. No funds are provided by Commission for books, fee, tuition, etc.
   3. Retraining costs are generally funded through DVR, VA or whatever can be found
   4. Retraining may not exceed 52 weeks unless the Commission at hearing extends the period; extension may not exceed an additional 52 weeks.

C. Rehabilitation Division of Industrial Commission
   1. Funding - Premium tax
   2. Goal - To reduce TTD by aiding in physical and vocational rehabilitation and restoring claimant to employemnt
   3. Method
      a. Division screens first reports and contacts severely injured claimants
      b. Division takes referrals from claimants, doctors, employers, carriers.
      c. Consultant is assigned and works with claimant to conclusion
      d. Consultant contacts employer, doctor, and whoever necessary to place claimant
         1) Back in his job
         2) Or back into a modified job for the same employer
         3) Or into a job for another employer which claimant can perform
         4) Or into an on-the-job training program
         5) Or into appropriate retraining

         in that order of preference.

over -

e. The consultatnt reports the claimant's progress monthly to the carrier.

f. If the consultant finds appropriate employment and claimant refuses to take it, the consultant gives this information to the carrier who may then request permission to terminate compensation; the case is usually set for hearing.

4. Personnel - 13 3mployees in Boise and 5 field offices.

5. Results

a. The present organization has existed since late 1978.

b. The commission and the Rehabilitation Division are excited about the results of their efforts so far.

FY79 - 1061 referrals
58 returned to work
FY80TD - 1258 referrals
185 returned to work.

V. SELF-INSURANCE

A. Basic Requirements

1. Maintain an annual Idaho payroll of $2,000,000 for preceding 3 years
2. Maintain a deposit with the Idaho Treasurer in cash, bonds of $50,000 plus 5% of annual average payroll in Idaho for preceding 3 years not to exceed $5,000,000; deposit additional security in amount equal to all unpaid and outstanding awards of compensation.
3. Maintain claims adjuster resident in Idaho.

B. Application

1. Complete application form
2. Submit last annual statement
3. Deposit appropriate security

C. Approval - by an employee of the Industrial Commission.

D. Continuation

1. Must submit monthly reports of outstanding awards and keep up appropriate deposits
2. Must submit semi-annual reports of payroll and deductions from which Commission computes premium tax.
   a. There is a significant late reporting penalty
   b. Commission computes premium tax and bills employer through date processing.

Chapter 4

The Medical Care and Rehabilitation Objective

An objective of workmen's compensation as important as income maintenance is delivery of medical care and rehabilitation services for work-related injuries or diseases. The system provides more than $1 billion of medical and rehabilitation benefits a year, composing about a third of all workmen's compensation benefits. Most employees with work-related impairments need only medical benefits: of the annual total of 5 million compensable claimants, 4 million are not disabled long enough to be eligible for cash benefits.

A proper medical care and rehabilitation program has three components. First, definitive medical care must be provided to restore the patient's abilities or functions. Medical care requires attention not only to immediate needs, such as hospitalization, but also to the longer-term requirements of workers who would benefit from physical rehabilitation. These workers may require surgery and a wide variety of treatment and supplies furnished by health professionals, including fitting, instruction and exercises associated with prosthetic appliances. Second, vocational counseling and job retraining may become necessary if the worker suffers a loss of endurance or skills needed to perform his previous duties. The third component is the worker's actual return to productive employment.

The three components are closely related. For example, emergency surgery should be performed in a manner to prepare for eventual use of prosthetic devices, if necessary. Also early neglect of immobilized patients may lead to muscular atrophy which can hinder rehabilitation. It is perhaps even more important to begin promptly to prepare patients psychologically for recovery of their capabilities and morale, before apathy or despair become deep-rooted.

The performance record of the present workmen's compensation program varies considerably for these three components of medical care and rehabilitation. In general, the program provides satisfactory medical care during the acute and healing stages of the worker's impairment. Physical rehabilitation, however, is badly neglected in many States, although some carriers and State funds perform well. Second, the record on vocational rehabilitation is spotty: in some States workmen's compensation channels many workers into vocational rehabilitation, but in most States the needed liaison with available agencies is poorly developed or the number of suitable agencies is limited. Finally, as to the job placement of rehabilitated employees, most workmen's compensation programs contribute in some degree to placement through the use of a second- or subsequent-injury fund, but placement services are not adequate in most States.

The considerable variation in the performance of the States may be explained in part by the lack of appreciation that all three functions of medical and rehabilitation are important. A substantial effort is needed to recognize these three functions and provide a coordinated program of aid to the worker as soon as a serious work-related impairment occurs.

A. MEDICAL CARE AND PHYSICAL REHABILITATION

The goal for medical care and physical rehabilitation services is to provide benefits of high quality at reasonable cost. This goal has been pursued by a variety of techniques, including limitations on the employee's choice of physician and sometimes on the amount, duration, or type of medical services.

Choice of Physician

There are three approaches to the initial choice of physician in workmen's compensation. Some States permit a worker the free choice of physician. Others allow the employer or insurance carrier to select the physician. An intermediate approach allows the employee to select his physician from a panel. In three States, the panel is chosen by the employer. In New York, the workmen's compensation board selects the panel, which includes a high proportion of the State's physicians. Connecticut also permits the employee to choose his physician from a list prepared by the agency.

The standard published by the Department of Labor recommends that the initial physician should be selected by the worker in accord with the rules and regulations adopted by the administrative agency. This recommendation has been interpreted to mean that a State which permits an employee to select his physician from a panel complies with the standard (Table 4.1). In 1972, one half of the States were in compliance.

TABLE 4.1. Jurisdictions allowing injured worker initial free choice of a physician or choice from a panel, 1966-72

Year	States (50)	Other "States" (6)	Federal (2)
1966	21	2	1
1972	25	2	1

See Table 2.3 for explanatory notes.

The issues involved in choice of physician are divided between choice of the initial physician and selection of such consultant physicians as may be needed for special diagnostic or treatment problems in difficult cases. All parties desire competent medical service from as many physicians as necessary to provide whatever care the worker's injury or disease requires. The particular emphasis of workmen's compensation on prompt and thorough restoration of the worker places special importance on medical services provided by consultant specialists.

The initial choice of physician is therefore significant in difficult cases as the means of entry into a team of medical consultants. The employee is of course desirous of using a family physician in whom he has confidence through previous experience. The employer or carrier's motive is to assure prompt and expert care directed toward rehabilitation and reemployment. The workmen's compensation agency wants to use physicians familiar with accurate reporting and evaluation of impairments. Few physicians combine in one person all these qualities. Nonetheless, any arguments that physicians treating work-related injuries and diseases should be selected under special limitations are not so weighty as to invalidate completely the normal method of physician selection.

R4.1

We recommend that the worker be permitted the initial selection of his physician, either from among all licensed physicians in the State or from a panel of physicians selected or approved by the workmen's compensation agency.

The union and management of a particular plant may select a physician panel, which could then be approved by the agency. The selection or approval by the agency should be made after consultation with medical authorities and the lists should include those physicians who have demonstrated by practice a special interest and competence in occupational health.

After the initial selection of a physician by the employee, circumstances may arise where a change in physician is necessary in order to provide the most appropriate medical care. As described later in this section, the workmen's compensation agency should have the authority and responsibility to suggest or even require such a change.

Limits on Medical Care by Statute or Regulation

The goal of medical care of high quality at reasonable cost has been pursued in some States by statutory or regulatory limitations on medical care as to duration, total expenditure, or type of service. These limitations sometimes are applied to workers with occupational diseases even when in the same State there are no such limits on benefits for work-related injuries. Table 4.2 shows the extent of compliance with the standard published by the Department of Labor which recommends full medical benefits for workers injured on the job. The number of States meeting this standard has increased substantially in the past 25 years. For no other standard published by the Department of Labor are the 50 States so near full compliance. Table 4.3 indicates the number of States in compliance with the standard recommending full medical benefits for workers who contract an occupational disease. Again, the record of improvement by the States is encouraging, although as of January 1, 1972, 14 States had not met the standard.

As to restrictions on the types of medical services under workmen's compensation, most

TABLE 4.2. Jurisdictions providing, without arbitrary limits on duration or amount, full medical benefits for injuries, 1946-72

Year	States (50)	Other "States" (6)	Federal (2)
1946	26	2	2
1956	31	3	2
1966	39	3	2
1972	41	4	2

See Table 2.3 for explanatory notes.

TABLE 4.3. Jurisdictions providing, without limitation on duration or amount, full medical benefits for occupational diseases, 1946-72

Year	States (50)	Other "States" (6)	Federal (2)
1946	18	2	2
1956	23	3	2
1966	28	3	2
1972	36	4	2

See Table 2.3 for explanatory notes.

State statutes authorize payments for "all reasonable and necessary medical, surgical, and hospital care." Some agencies by regulation interpret this language to deny payments for certain types of medical practitioners or types of health care institutions. For example, some States will not pay workmen's compensation benefits for rehabilitation centers, home health programs, occupational therapists, osteopaths, registered nurses, or psychologists. Puerto Rico and 17 States now have restrictions on at least some kinds of practitioners or health institutions. (See *Compendium*, Chapter 10)

Another limitation on medical services is the rule used in some States that a patient cannot receive further medical benefits if no such benefits were paid during a stipulated period, such as two years. These limitations mean that if the effects of a work-related injury or disease return long after treatment was discontinued, the patient will be ineligible for further medical care.

We do not quarrel with the right of a State to limit medical care benefits based on the

merits of a particular case. We do quarrel with rules which arbitrarily preclude medical care regardless of the merit of the claim or the restorative value of the medical benefits. Indeed, these arbitrary rules, while they may be intended to achieve the worthy objective of high quality care at a reasonable cost, are almost invariably inappropriate to that end. In essence, these limits can be self-defeating because they may force a disabled worker to be unproductive indefinitely because his medical rehabilitation is incomplete.

R4.2

We recommend there be no statutory limits of time or dollar amount for medical care or physical rehabilitation services for any work-related impairment.

R4.3

We recommend that the workmen's compensation agency have discretion to determine the appropriate medical and rehabilitation services in each case. There should be no arbitrary limits by regulation or statute on the types of medical service or licensed health care facilities which can be authorized by the agency.

R4.4

We recommend that the right to medical and physical rehabilitation benefits not terminate by the mere passage of time.

This last recommendation means that once a worker receives medical benefits, a claim for further medical care can be filed at any time. The possible exception would be if the worker has signed a compromise and release agreement. However, we believe such agreements should be rare. (See Chapter 6)

The Appropriate Solution to Quality Care at Reasonable Cost

There are no short cuts to quality medical care and rehabilitation at reasonable cost. This goal for a workmen's compensation program can not be reached by use of arbitrary limits on amount, duration, or type of medical and rehabilitation services, nor can quality at reasonable cost be achieved by permitting the widespread use of private arrangements (compromise and release agreements) to limit potential liability. Ultimately, the only assurance of quality and reasonable cost is effective supervision of medical care and rehabilitation services by the State workmen's compensation agency.

The Department of Labor has published a standard recommending that a rehabilitation division be established within each workmen's compensation agency. Fewer than half the States comply with this recommendation. (Table 4.4)

TABLE 4.4. Jurisdictions with a rehabilitation division in the workmen's compensation agency, 1966-72

Year	States (50)	Other "States" (6)	Federal (2)
1966	17	2	2
1972	22	2	2

See Table 2.3 for explanatory notes.

With or without a rehabilitation division, not all workmen's compensation agencies supervise the delivery of medical care. The Department of Labor also has published a recommendation that agencies supervise medical care in order to achieve the maximum restoration of the worker with a minimum of delay. In only 26 States (Table 4.5) is this function performed in a manner consistent with this standard.

TABLE 4.5. Jurisdictions authorizing workmen's compensation agency to supervise medical care, 1966-72

Year	States (50)	Other "States" (6)	Federal (2)
1966	23	2	1
1972	26	3	1

See Table 2.3 for explanatory notes.

R4.5

We recommend that each workmen's compensation agency establish a medical-rehabilitation division, with authority to effectively supervise medical care and rehabilitation services.

The role of the agency in supervising medical care and rehabilitation services warrants serious, professional attention. The duty can not be performed by a clerical review of records. To exercise its authority well, the division must be staffed or supervised by physicians and other health specialists, with an advisory committee to receive appeals from treating physicians. The supervisory division should be able to order carriers or employers to provide necessary medical care, to limit payments for medical and rehabilitation services to usual and customary levels, and when appropriate, to require patients to seek consultation or change the form and source of treatment.

R4.6

We recommend that every employer or carrier acting as employer's agent be required to cooperate with the medical-rehabilitation division in every instance when an employee may need rehabilitation services.

We believe the key to our preceding recommendations is the recognition that a modern workmen's compensation program cannot meet its medical care and rehabilitation objective if attention is directed exclusively to the provision of medical care in the period immediately following awareness of the injury or disease. Achievement of the objective also entails prompt initiation of physical rehabilitation, as well as the subsequent restoration of vocational skills and the return of the worker to a productive employment. These several components can be achieved only with conscientious supervision by a workmen's compensation agency which has the authority, responsibility, and professional competence for coordinating the many activities of medical care and rehabilitation.

Coordination with Other Programs

There is some coordination between the medical care benefits of workmen's compensation and those presently available through the Medicare program of Social Security, the Veterans Administration programs, the public assistance system, and private health insurance plans. Almost universally, such programs do not pay for medical care if protection is available from workmen's compensation. Some do attempt to overcome present deficiencies in workmen's compensation protection. If a worker over 65 meets the eligibility requirements, Medicare will help pay medical benefits which workmen's compensation does not pay because of statutory limitations or because of compromise and release agreements. If the jurisdiction of workmen's compensation is in doubt, a disabled worker who is a veteran may be treated by the Veterans Administration, subject to recoupment of costs if the worker is subsequently held to be entitled to workmen's compensation benefits. For the most part, however, workmen's compensation now bears first responsibility for medical care of work-related impairments.

The various proposals for national health insurance usually are designed to cover the entire population, but either explicitly or by interpretation exclude medical care provided by workmen's compensation. To the extent that medical care is not provided by workmen's compensation for work-related injuries or diseases because of the program's lack of coverage or limitations on the duration or amount of medical benefits, these proposed national health insurance programs would assume part of the costs associated with work-related impairments. This assumption of costs would be inconsistent with a central tenet of workmen's compensation—that the costs of work-related injuries and diseases should be allocated to the responsible source—and will be unnecessary if our recommendations for medical care under workmen's compensation are adopted.

B. VOCATIONAL REHABILITATION

In general workmen's compensation is not doing an effective job of assuring that workers with work-related disabilities are helped to recover lost abilities and to return to their previous jobs, or, where this is impossible, to learn substitute skills. The major source of such assistance in most States is a department of vocational rehabilitation. These departments largely are funded by Federal money and often are associated with education programs or other activities of the State government with little formal connection with the workmen's compensation agency or even, in some States, with the agency responsible for physical restoration of disabled workers.

Such vocational services as are provided by the workmen's compensation program generally result from efforts of employers and insurance carriers. Carriers and employers have a strong inducement to provide vocational services for disabled workers whose prospects indicate they may return to work and give up their claims to weekly benefits.

Despite the activities by the State departments of vocational rehabilitation and the carriers and employers, it appears that many workers who could benefit from vocational rehabilitation do not receive these services. Workmen's compensation should take a more active role in assuring vocational rehabilitation.

R4.7

We recommend that the medical-rehabilitation division be given the specific responsibility of assuring that every worker who could benefit from vocational rehabilitation services be offered those services.

This responsibility may be substantial because there are many private and public agencies which provide vocational rehabilitation assistance, and the medical-rehabilitation division will have the obligation to channel the impaired worker to the appropriate set of services.

R4.8

We also recommend that the employer pay all costs of vocational rehabilitation necessary to return a worker to suitable employment and authorized by the workmen's compensation agency.

At the present time, much of the cost of vocational rehabilitation for those with work-related impairments is paid from sources outside the workmen's compensation program, such as the Federal grants to the departments of vocational rehabilitation. For two reasons, we recommend that employers finance the cost of vocational services authorized by the workmen's compensation agency. One is that an objective of workmen's compensation is to allocate to the responsible source all the costs of work-related injuries and diseases. Charging the cost of vocational rehabilitation for work-related cases to other sources of revenue violates this objective. The second reason is that State departments of vocational rehabilitation have been less than consistent in attending to the occupationally disabled. They have changed their priorities from time to time. We believe the needs of the occupationally disabled worker will be met best by assuring a reliable source of financial support for vocational rehabilitation within the workmen's compensation program.

Vocational rehabilitation also can be encouraged by providing special incentives for workers. During the period of rehabilitation, many workers need financial assistance to pay for the additional expenses associated with their instruction. This is especially true when the worker must attend training sessions away from home. The recommendation published by the Department of Labor is that special maintenance benefits be paid during the learning period. There are 27 States which offer such payments. (Table 4.6)

TABLE 4.6. Jurisdictions providing special maintenance benefits during period of rehabilitation, 1946-72

Year	States (50)	Other "States" (6)	Federal (2)
1946	7	1	1
1956	15	2	2
1966	19	2	2
1972	27	4	2

See Table 2.3 for explanatory notes.

R4.9

We recommend that the workmen's compensation agency be authorized to provide special maintenance benefits for a worker during the period of his rehabilitation. The maintenance benefits would be in addition to the worker's other benefits.

The nature, amount, and duration of these benefits would be within the discretion of the medical-rehabilitation division.

Still other incentives may be appropriate to encourage workers to seek vocational rehabilitation. There is concern that some workers may

hesitate to restore their capabilities because they fear their cash benefits will be reduced as their earning capacity or actual earnings improve. These are rare instances but can be anticipated. One control would be to pay cash benefits on the basis of the worker's actual disability and impairment, or, if the worker refuses rehabilitation services, on the basis of the extent of impairment or disability which the disability evaluation unit of the agency decides would have prevailed if the worker had utilized the proffered services. An even stronger control would be to make a worker entirely ineligible for cash benefits unless he accepts the restoration services offered by the medical-rehabilitation division. Such encouragement to cooperation appears in several workmen's compensation statutes now, and experience indicates that the procedure sometimes is an effective stimulus to rehabilitation.

C. RETURNING THE REHABILITATED WORKER TO A JOB

A workmen's compensation program which provides definitive medical care, effective physical rehabilitation, and appropriate vocational rehabilitation services is not satisfactory unless it also can return the successfully rehabilitated worker to a job. Placement of the formerly or partially disabled worker is a task made more formidable by the reluctance of some employers to hire the handicapped, whether because of the fear of unusual costs associated with handicapped workers or for other reasons. Basically the reluctance of employers to hire the handicapped must be overcome outside of workmen's compensation because cost of the program is but one of several concerns of employers. But workmen's compensation can at least counteract the fear of employers that employment of a worker with an impairment may result in exceptional workmen's compensation costs if that worker subsequently experiences a work-related injury or disease.

Second-Injury Funds

A second-injury or subsequent-injury fund within the workmen's compensation program insures that a handicapped worker who then subsequently suffers a work-related injury or disease will receive full compensation to cover the resulting impairment. At the same time, the employer will be charged only for the benefits that are associated with the second injury. This is an effort to deal equitably with a situation where the second injury would not have occurred but for the prior impairment or where the degree of impairment that results from the combination of the prior and second injuries is more serious than the total effect of the two injuries considered separately. For example, the loss of one eye is considered a 24 percent impairment relative to the whole man by the American Medical Association's *Guides to Evaluation of Permanent Impairment*. Taken separately, the loss of two eyes would add up to 48 percent, but the loss of both eyes is considered 85 percent impairment of the whole man. The second-injury fund charges the employer only for the impairment caused by the second injury when considered by itself, and the fund pays the worker the difference between the amount charged to the employer and the total benefits warranted.

All but four States have some form of second- or subsequent-injury fund. Some of these laws, however, are applicable only when the prior disability is one of a limited number specified in the act. The standard published by the Department of Labor proposes that the subsequent-injury fund be broad enough to protect workers with all types of prior impairments, including arthritis, heart disease, and epilepsy. Table 4.7 indicates the number of States complying with the standard.

TABLE 4.7. Jurisdictions providing broad coverage of previous impairments by subsequent-injury funds, 1946-72

Year	States (50)	Other "States" (6)	Federal (2)
1946	5	1	1
1956	11	3	1
1966	16	3	1
1972	20	5	1

See Table 2.3 for explanatory notes.

R4.10

We recommend that each State establish a second-injury fund with broad coverage of pre-existing impairments.

Section 20 of the Model Act provides an example of a statute with broad coverage: 26 specific permanent impairments are listed and, in addition under a general clause, any permanent impairment which is equivalent to 50 percent of total impairment is also eligible to be covered by the fund. In general terms, the Model Act approach is consistent with our recommendation.

As implied by the standard published by the Department of Labor and our recommendation, the coverage offered by a second-injury fund may be too narrow to benefit many handicapped workers. It is possible also to make the list of prior impairments covered so broad that virtually every employee can be found, by intensive medical examination, to have a physical limitation which would be compensable by the fund. Since the second-injury funds are usually financed by general assessments against all employers, such broad coverage subverts the policy of allocating the cost of injuries and diseases to the firms primarily responsible.

Only a few States appear to have a second-injury fund with coverage which may be too broad. Usually, the coverage of prior impairments is too narrow, partly because the financial support for second-injury funds in some States is inadequate. Some States finance their second-injury fund by assessing employers a charge for work-related deaths when the victim leaves no surviving dependent. The amount of these assessments per case and the number of deaths in some States do not support a second-injury fund with a sufficiently broad coverage of prior impairments. The most successful method of financing second-injury funds appears to be assessments against employers or their insurers in proportion to the benefits they pay. However, because employment of the handicapped is a concern which transcends the workmen's compensation program, a more general source of financial support for the funds may be desirable.

R4.11

We recommend that the second-injury fund be financed by charges against all carriers, State funds, and self-insuring employers in proportion to the benefits paid by each, or by appropriations from general revenue, or by both sources.

If the fund is financed from charges in proportion to benefits paid, the total amount of the assessments should vary from year to year in accordance with the needs of the second-injury fund. This method is similar to Section 55 of the Model Act.

Another striking factor brought to our attention during our hearings is the general lack of awareness and utilization of second-injury funds. Clearly, a second-injury fund cannot help a handicapped worker get a job if employers are not aware of its nature or not encouraged to use the fund.

R4.12

We recommend that workmen's compensation agencies publicize second-injury funds to employees and employers and interpret eligibility requirements for the funds liberally in order to encourage employment of the physically handicapped.

A related issue is: Should an employer be eligible to use a second-injury fund if he was not aware of the employee's handicap when he was hired. Presumably under these circumstances the employee's handicap did not hinder his employment. Therefore, it can be argued, since he did not need the assistance of a second-injury fund to get his job, the employer should not be eligible to use the fund if the worker is again disabled.

On the other hand, it can be argued that even if the employer was not specifically aware of a worker's impairment at the time he was hired, the employer might be reluctant to hire him if he was one of a class of workers likely to have health problems, such as older workers. If the employer were eligible to use the second-injury fund as long as he could demonstrate the worker had an impairment prior to the time he was injured, then the fund indirectly aids employment of the handicapped by reducing the employer's concern over hiring certain classes of workers.

Another argument for allowing employers to use the second-injury fund for workers whose

impairment was unknown at the time of hiring has little to do with employment of the handicapped. The argument is that it would be unfair to charge an employer for the total cost of a workmen's compensation claim when part of the reason for the extent of impairment was not work-related. The employer should bear the portion of the award due to the work-related injury or disease, but no more.

The underlying issue here appears to be: What is the basic purpose of the fund? If the main intent is to encourage employment of the handicapped, then prior knowledge of the impairment perhaps should be a factor in determining eligibility for coverage by the second-injury fund. If on the other hand the main intent is to spread the risks associated with pre-existing impairments among employers equitably, then prior knowledge of the handicap would seem irrelevant to eligibility for coverage by the fund. In actuality, second-injury funds are presumed to serve both purposes: it would appear to be up to the States to determine for themselves which purpose should dominate.

Those States concerned primarily with employment of the handicapped could require employers to notify the second-injury fund of the nature of a new employee's impairment at the time of hiring. This procedure would assure employers of some protection from the fund, encourage employment of the handicapped, and also encourage employers to provide pre-employment physical examinations.

REFERENCES FOR CHAPTER 4

Section A, See *Compendium*, Chapters 3, 4, 10, 19, and 20
Section B, See *Compendium*, Chapters 3, 4, 11, 19, and 20
Section C, See *Compendium*, Chapters 3, 4, 11, 19, and 20

The *Compendium on Workmen's Compensation* was prepared for the National Commission on State Workmen's Compensation Laws. References for data cited in this *Report* are included in the *Compendium*, but the Commission does not endorse all ideas expressed in the *Compendium*.

WORKERS' COMPENSATION STUDY

COMMISSION

MEETING NOV. 15, 1980

AGENDA

1. REVIEW OF DRAFT LEGISLATION

2. SUB-COMMITTEE REPORTS

3. REVIEW OF PROPOSED LEGISLATION OF THE WORKERS'S COMPENSATION DIVISION.

4. DISCUSSION OF ASBESTOSIS

5. PUBLIC INPUT

6. DISCUSSION OF JANUARY MEETING DATE

RULES OF PROCEDURE
FOR THE HEARING ON
PROPOSED CHANGES IN THE REGULATIONS
OF THE DIVISION OF INSURANCE

1. These hearings shall be conducted in accordance with Alaska Statutes.

2.

Date	Time	Location of Hearing
Dec. 10, 1980	9:00 a.m.	5th Floor Conference Room, Alaska State Office Bldg. Juneau, Alaska

3. The purpose of this hearing will be to set minimum standards for the coverage of attorney fees under the supplementary payments feature of insurance contracts and the disapproval of all forms currently approved that do not meet at least the minimum standards proposed in the regulations.

4. All testimony must be limited to the matters noted in 3 above.

5. Persons wishing to testify or present evidence are urged, though not required, to advise the Director prior to the date of the hearing so that witnesses can be scheduled to accommodate the division's desire to acquire as much information as practical and to accommodate the travel considerations for witnesses from out-of-state. Such advice should include a topical description of the main point of the proposed testimony.

6. If a witness has prepared remarks, five copies of the prepared statement should be given to the Director prior to testifying.

7. The use of charts, tables, or other exhibits is encouraged, however, copies thereof must be given to the Director prior to testifying.

8. All witnesses will be subject to examination by the Director and any member of the Director's staff. No other person will be permitted to question a witness.

9. Should it be necessary in the interest of time, the Director may request any witness to abbreviate his testimony or to defer a portion of the testimony.

10. The hearing will be recorded and unless otherwise specifically requested, all written and oral testimony and all tables, charts, and exhibits shall become part of the official record.

11. Upon request of any witness, the record of the witness's testimony may remain open for a period of up to ten days following the hearing to receive written evidence supplementing, clarifying, or verifying the witness's principal testimony.

12. Persons wishing to present testimony, but unable to attend the hearing may submit their testimony in writing, designating it as testimony to be included as part of the record.

13. A register of persons attending the hearing will be maintained. All persons entering the hearing room will be asked to register, giving their name, address, and company or trade association affiliation, if any.

14. No smoking is permitted in the hearing room.

STATE OF ALASKA

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE

JAY S. HAMMOND, GOVERNOR

POUCH D
JUNEAU, ALASKA 99811
PHONE: 465-2515

NOTICE OF PROPOSED CHANGES IN THE REGULATIONS OF THE DIVISION OF INSURANCE

Notice is hereby given that the Alaska Division of Insurance, under authority vested by AS 21.06.090, proposes to adopt regulations in Title 3 of the Alaska Administrative Code to interpret AS 21.39.040(a) and AS 21.42.120(2) as follows:

> Set minimum standards for coverage of attorney fees under the supplementary payments feature of insurance contracts.

Notice is also given that the division intends to disapprove all forms currently approved that do not meet at least the minimum standards proposed in the above regulation.

Notice is also given that any person interested may present oral or written statements or arguments relevant to the action proposed at a hearing to be held in the 5th Floor Conference Room of the Alaska State Office Building, Juneau, Alaska, at 9:00 a.m., on December 10, 1980.

Copies of the proposed regulations may be obtained by writing to the Director, Division of Insurance, Pouch D, Juneau, Alaska 99811 or by calling 465-2515 during office hours.

The Division of Insurance, upon its own motion or at the instance of any interested person, may at the hearing or after it, adopt the proposals substantially as described above without further notice or may decide to take no action on them.

Date: November 13, 1980

Kenneth C. Moore

Kenneth C. Moore, Director

AS 21 IS AMENDED BY ADDING A NEW CHAPTER TO READ:

CHAPTER 62. WORKER'S COMPENSATION SELF-INSURANCE

PURPOSE: To Provide Protection for employees

SEC. 21.62.010. SELF-INSURANCE. AN EMPLOYER, TWO OR MORE EMPLOYERS HAVING COMMON MANAGEMENT OR TWO OR MORE EMPLOYERS HAVING COMMON INTEREST MAY ELECT TO PAY DIRECTLY THE COMPENSATION REQUIRED IN AS 23.30 AFTER PROVIDING SATISFACTORY PROOF OF ITS FINANCIAL ABILITY TO MAKE DIRECT PAYMENTS AND HAS BEEN ISSUED A SELF INSURANCE CERTIFICATE BY THE DIRECTOR

SEC 21.62.020 SELF-INSURANCE FUND. (a) A WORKER'S COMPENSATION SELF-INSURANCE GROUP FORMED BY TWO OR MORE EMPLOYERS HAVING COMMON INTEREST SHALL ESTABLISH AND KEEP A SELF-INSURANCE FUND WITH AN MINIMUM BALANCE TO BE DETERMINED BY THE DIRECTOR, BUT NOT LESS THAN $250,000.

$1M net worth working capital

(b) THE SELF-INSURANCE FUND SHALL BE ADMINISTERED BY A BOARD OF TRUSTEES SELECTED BY MEMBERS OF THE SELF-INSURANCE GROUP.

(c) THE GROUP SHALL ADOPT BY-LAWS GOVERNING THE OPERATION OF THE FUND

SEC. 21.62.030. APPLICATION. (a) AN EMPLOYER DESIRING TO BECOME AN INDIVIDUAL SELF-INSURER OR TWO OR MORE EMPLOYERS HAVING COMMON MANAGEMENT DESIRING TO BECOME A GROUP SELF-INSURER SHALL MAKE APPLICATION FOR THE PRIVILEGE

ON A FORM PRESCRIBED BY THE DIRECTOR.

(b) THE TRUSTEES OF A GROUP OF TWO OR MORE EMPLOYERS HAVING COMMON INTEREST DESIRING TO BECOME A GROUP SELF-INSURER SHALL MAKE APPLICATION FOR THE PRIVILEGE ON A FORM PRESCRIBED BY THE DIRECTOR.

(c) AN APPLICANT FOR SELF INSURANCE SHALL ANSWER ALL QUESTIONS ON THE APPLICATION. THE ANSWERS SHALL BE SWORN TO AND NOTARIZED. THE APPLICATION SHALL BE SUBMITTED AT LEAST 90 DAYS BEFORE THE PROPOSED EFFECTIVE DATE OR RENEWAL DATE OF THE SELF-INSURANCE CERTIFICATE.

SEC. 21.62.040. DOCUMENTS REQUIRED OF INDIVIDUAL SELF-INSURER. EACH APPLICATION BY AN EMPLOYER FOR INDIVIDUAL SELFINSURANCE SHALL BE ACCOMPANIED BY: The documents req'd under 070 and

(1) A FINANCIAL STATEMENT NOT MORE THAN THREE MONTHS OLD AT THE TIME OF APPLICATION SHOWING A NET WORTH OF NOT LESS THAN $500,000 ~~WITH ASSETS EXCEEDING LIABILITIES~~ TO MEET OBLIGATIONS

(2) AN AGREEMENT TO FULLY DISCHARGE BY CASH PAYMENT ALL AMOUNTS REQUIRED TO BE PAID UNDER AS 23.30.

SEC. 21.62.050. DOCUMENTS REQUIRED OF GROUP SELF-INSURER HAVING COMMON MANAGEMENT. EACH APPLICATION BY A GROUP OF TWO OR MORE EMPLOYERS HAVING COMMON MANAGEMENT FOR GROUP SELF-INSURANCE SHALL BE ACCOMPANIED BY:

(1) A FINANCIAL STATEMENT NOT MORE THAN THREE

MONTHS OLD AT THE TIME OF APPLICATION FOR EACH MEMBER OF THE GROUP SHOWING A COMBINED NET WORTH OF ALL MEMBERS OF THE GROUP TO BE NOT LESS THAN $500,000, ~~WITH CURRENT ASSETS TO EXCEED CURRENT LIABILITIES~~.

(2) AN INDEMNITY AGREEMENT JOINTLY AND SEVERALLY BINDING EACH MEMBER OF THE GROUP TO FULLY DISCHARGE BY CASH PAYMENT ALL AMOUNTS REQUIRED TO BE PAID UNDER AS 23.30.

SEC. 21.62.060. DOCUMENTS REQUIRED OF GROUP SELF-INSURERS HAVING COMMON INTEREST. EACH APPLICATION BY THE TRUSTEES OF A GROUP OF TWO OR MORE EMPLOYERS HAVING COMMON INTEREST FOR GROUP SELF-INSURANCE SHALL BE ACCOMPANIED BY:

(1) FINANCIAL STATEMENTS NOT MORE THAN THREE MONTHS OLD AT THE TIME OF THE APPLICATION FOR EACH MEMBER APPLYING FOR COVERAGE ON THE INCEPTION DATE OF THE SELF-INSURANCE FUND SHOWING A COMBINED NET WORTH OF ALL MEMBERS OF THE GROUP TO BE NOT LESS THAN $1,000,000, ~~WITH CURRENT ASSETS EXCEEDING CURRENT LIABILITIES~~.

(2) AN INDEMNITY AGREEMENT JOINTLY AND SEVERALLY BINDING THE SELF-INSURANCE FUND AND EACH MEMBER OF THE GROUP TO FULLY DISCHARGE BY CASH PAYMENT ALL AMOUNTS REQUIRED TO BE PAID UNDER AS 23.30.

(3) AN INDIVIDUAL APPLICATION FOR EACH MEMBER OF THE GROUP APPLYING FOR COVERAGE ON THE INCEPTION DATE OF THE SELF INSURANCE FUND.

(4) A SET OF BY-LAWS OR TRUST AGREEMENT WHICH SHALL GOVERN THE OPERATION OF THE SELF-INSURANCE FUND.

(5) PROOF OF THE EXISTENCE OF AN INITIAL BALANCE IN THE SELF-INSURANCE FUND AS REQUIRED BY SECTION 020(a) OF THIS CHAPTER.

(6) A ~~PROJECTION~~ for period of cost OF ALL ADMINISTRATIVE EXPENSES OF THE SELF-INSURANCE FUND.

(Ref 020)

SEC. 21.62.070. ADDITIONAL REQUIREMENTS. IN ADDITION TO THE REQUIREMENTS OF SECTIONS 030-070 OF THIS CHAPTER, AN APPLICANT FOR SELF-INSURANCE SHALL SUBMIT THE FOLLOWING DATA WITH THE APPLICATION FOR SELF-INSURANCE:

(1) EVIDENCE OF A WORKING CAPITAL OF AN AMOUNT ESTABLISHING FINANCIAL STRENGTH AND LIQUIDITY TO PAY [redacted] COMPENSATION CLAIMS PROMPTLY.

(2) THE PROPOSED AMOUNT OF RETENTION PER LOSS AND RETENTION IN THE AGGREGATE.

(3) THE PROPOSED PROGRAM OF EXCESS INSURANCE COVERAGE.

(4) PROOF THAT THE APPLICANT HAS AMPLE FACILITIES AND COMPETENT PERSONNEL TO SERVICE THE SELF-INSURANCE PLAN OR A COPY OF A SIGNED SERVICE AGREEMENT WITH AN APPROVED SERVICE COMPANY TO PROVIDE THOSE SERVICES.

(5) THE LOCATION WITHIN THIS STATE WHERE ALL RECORDS OF SELF-INSURED LOSS WILL BE MAINTAINED.

(6) A DESCRIPTION OF ANY LOSS CONTROL OR SAFETY PROGRAMS TO BE UTILIZED BY THE APPLICANT.

Ab. considers safety engineering

(7) ANY FURTHER EVIDENCE WHICH THE DIRECTOR MAY REQUIRE TO ESTABLISH THE ABILITY OF THE APPLICANT TO MEET ITS OBLIGATIONS UNDER AS 23.30.

SEC. 21.62.080 DIRECTORS REVIEW. (a) UPON RECEIPT OF AN APPLICATION AND DOCUMENTS REQUIRED UNDER SECTIONS 030-070 OF THIS CHAPTER, THE DIRECTOR SHALL DETERMINE TO HIS SATISFACTION, whether IF THE APPLICANT HAS THE FINANCIAL ABILITY TO MEET ITS OBLIGATIONS UNDER AS 23.30.

(b) THE DIRECTOR SHALL ~~MAY~~ DETERMINE THE AMOUNT OF EXCESS INSURANCE COVERAGE NECESSARY FOR THE PROTECTION OF THE APPLICANT, # DISCHARGE OF DUTIES UNDER AS 23.30 ~~AND THE EMPLOYEES~~

(c) THE DIRECTOR MAY REQUIRE A SURETY BOND AS A CONDITION TO ISSUANCE OF A SELF-INSURANCE CERTIFICATE. in accordance w/ 21.62.090 (c)

~~(d) THE DIRECTOR MAY WAIVE THE REQUIREMENT THAT ASSETS EXCEED LIABILITIES IN THE CASE OF A PUBLIC UTILITY OR A MUNICIPALITY, IF THE REQUIREMENT IS SHOWN TO BE UNREASONABLE.~~

(d) THE DIRECTOR SHALL INFORM THE APPLICANT IN WRITING NOT LATER THAN 30 DAYS BEFORE THE PROPOSED EFFECTIVE DATE OF HIS DECISION TO APPROVE OR DISAPPROVE AN APPLICATION FOR SELF INSURANCE. HE SHALL, IN THE CASE OF AN APPROVAL, LIST ANY CONDITIONS WHICH MUST BE MET BEFORE THE CERTIFICATE OF SELF-INSURANCE CAN BE ISSUED. HE SHALL, IN THE CASE OF DISAPPROVAL, LIST REASONS.

Appeal

SEC. 21.62.090. CERTIFICATE OF SELF INSURANCE (a)

THE DIRECTOR SHALL, UPON APPROVAL OF AN APPLICATION AND RECEIPT OF PROOF OF ANY CONDITIONS ESTABLISHED UNDER SECTION 080(a) OF THIS CHAPTER, ISSUE A CERTIFICATE OF SELF-INSURANCE.

(b) THE CERTIFICATE OF SELF INSURANCE SHALL BE ON A FORM PRESCRIBED BY THE DIRECTOR AND SHALL BE ISSUED FOR A PERIOD OF ONE YEAR. ~~[illegible]~~ With each ap or re-application

SEC. 21.62.100. BOND. (a) THE DIRECTOR MAY REQUIRE A ~~[illegible]~~ SURETY BOND TO SECURE THE PAYMENT OF ~~[illegible]~~ Obligations UNDER AS 23.30 AS THEY ARE INCURRED. Add New Bond Amount every year

(b) THE BOND SHALL BE ON A FORM PRESCRIBED BY THE DIRECTOR.

(c) THE AMOUNT OF THE BOND FOR each year SHALL BE EQUAL TO OR GREATER THAN THE AGGREGATE RETENTION OF THE SELF-INSURER ~~[PLUS OUTSTANDING WORKERS COMPENSATION LIABILITIES LESS RECOVERIES FROM THIRD PARTIES]~~ BUT may NOT be LESS THAN $25,000.

~~(d) THE DIRECTOR MAY REQUIRE AN INCREASE IN THE BOND AMOUNT IF HE DETERMINES THAT THE SELF-INSURER HAS EXPERIENCED A DETERIORATION IN FINANCIAL CONDITION.~~

(e) THE BOND SHALL BE ISSUED BY A ~~[illegible]~~ SURETY ~~[illegible]~~ AUTHORIZED UNDER AS 21.09. TO DO BOSINESS IN THIS STATE.

(f) A BOND UNDER THIS SECTION MAY BE CANCELLED, EXCHANGED OR REPLACED PROVIDED NOT LESS THAN 60 DAYS WRITTEN NOTICE IS GIVEN TO THE DIRECTOR AND TO THE SELF-INSURER.

SEC. 21.62.110. CONTRACTS FOR EXCESS INSURANCE (a) THE DIRECTOR SHALL MAY DETERMINE THE AMOUNT AND KIND OF EXCESS INSURANCE REQUIRED OF AN APPLICANT FOR SELF INSURANCE BASED ON THE SIZE OF THE APPLICANT, FINANCIAL STRENGTH, PAST HISTORY OF LOSS, DEGREE OF HAZARD IN THE APPLICANTS OPERATIONS AND ANY OTHER FACTORS THE DIRECTOR DEEMS APPROPRIATE.

(b) EXCESS INSURANCE COVERAGE SHALL BE WRITTEN BY A CASUALTY INSURER AUTHORIZED UNDER AS 21.09. TO DO BUSINESS IN THIS STATE, EXCEPT AS PROVIDED IN (h) OF THIS SECTION.

(c) AN EXCESS INSURANCE POLICY ISSUED UNDER THIS CHAPTER MAY NOT BE CANCELLED ~~OR BE NEW OR REFUSED RENEWAL~~ UNLESS THE INSURER GIVES 60 DAYS WRITTEN NOTICE BY CERTIFIED MAIL TO THE DIRECTOR AND TO THE SELF INSURER.

(d) IF AN EXCESS INSURANCE POLICY ISSUED UNDER THIS CHAPTER CONTAINS ANY TYPE OF COMMUTATION CLAUSE IT MUST PROVIDE

(1) THAT ANY COMMUTATION EFFECTED UNDER THE POLICY SHALL NOT RELIEVE THE UNDERWRITER OR UNDERWRITERS OF FURTHER LIABILITY WITH RESPECT TO CLAIMS AND EXPENSES UNKNOWN AT THE TIME OF THE COMMUTATION OR IN REGARD TO CLAIMS APPARENTLY CLOSED BUT WHICH MAY BE SUBSEQUENTLY REVIVED BY OR THROUGH A COMPETENT AUTHORITY, AND

(2) THAT IF THE UNDERWRITER OR UNDERWRITERS PROPOSE TO REDEEM ANY FUTURE PAYMENTS PAYABLE AS COMPENSATION FOR LOSSES OCCURRING DURING THE TERM OF THE POLICY BY THE PAYMENT OF A LUMP SUM TO BE FIXED AS PROVIDED IN THE COMMUTATION CLAUSE OF THE POLICY, THE DIRECTOR SHALL BE GIVEN NOT LESS

NO Commentary

THAN 30 DAYS WRITTEN NOTICE OF THE COMMUTATION. EFF DATE OF

(e) IF A COMMUTATION OF AN EXCESS INSURANCE POLICY UNDER THIS CHAPTER IS EFFECTED, THE DIRECTOR MAY DIRECT THAT THE ~~SUM~~ PROCEEDS EITHER

(1) BE PLACED IN TRUST FOR THE BENEFIT OF THE INSURED EMPLOYEE OR EMPLOYEES ENTITLED TO FUTURE PAYMENTS OF COMPENSATION COVERED BY THE POLICY, OR,

(2) BE INVESTED IN APPROVED SECURITIES AND DEPOSITED WITH THE DIRECTOR TO ASSURE THE FUTURE PAYMENTS OF COMPENSATION TO THE EMPLOYEE OR EMPLOYEES ENTITLED TO BENEFITS COVERED BY THE POLICY.

HOLD until TOMORROW

(f) THE EXCESS INSURANCE POLICY SHALL CONTAIN A PROVISION THAT THE DIRECTOR MAY ORDER THE PAYMENT OF OBLIGATIONS DUE UNDER THE TERMS OF THE POLICY TO BE MADE TO A PARTY OTHER THAN THE EMPLOYER, WHERE SUCH ACTION IS NECESSARY TO ASSURE THE PROMPT PAYMENT OF BENEFITS TO INJURED EMPLOYEES.

(g) ~~THE NAMED INSURED ACTUALLY~~ AN EXCESS INSURANCE POLICY UNDER THIS CHAPTER SHALL COVER ~~ONLY~~ THE ENTITY NAMED IN THE APPLICATION FOR SELF INSURANCE UNDER SECTION 030 OF THIS CHAPTER.

(SEE NOTE ON PAGE 16)

SEC. 21.62.120. SERVICING FOR SELF INSURERS (a) IT SHALL BE THE SOLE RESPONSIBILITY OF EACH SELF-INSURER TO PROVIDE FOR COMPETENT PERSONS TO SERVICE ITS PROGRAMS IN THE AREAS OF CLAIMS ADJUSTING, UNDERWRITING AND LOSS CONTROL. ~~IF THE SELF INSURER IS UNABLE OR UNWILLING TO PROVIDE ANY ONE OF THESE SERVICES, THE DIRECTOR MAY~~ USE

THE self insurer may

~~OF ITS OWN EMPLOYEES, THEN IT SHALL CONTRACT WITH ONE OR MORE~~ Approved SVC Companies. one or more of
~~OUTSIDE AGENCIES WITH ESTABLISHED COMPETENCIES~~ TO PROVIDE THESE
SERVICES ON A FULL-TIME BASIS.

(b) IF A SELF-INSURER ELECTS TO CONTRACT WITH ONE OR MORE APPROVED SERVICE COMPANIES, THE DIRECTOR MAY CHOOSE TO USE ANY OR ALL OF THE SERVICE COMPANIES AS AN INTERMEDIARY IN ITS DEALINGS WITH THE SELF-INSURER. ~~THIS COURSE OF ACTION~~ IS AVAILABLE TO THE DIRECTOR UPON HIS ~~DETERMINATION THAT~~ IT WILL RESULT IN A MORE ~~RAPID AND MORE ACCURATE~~ FLOW OF INFORMATION ~~FROM THE SELF-INSURER~~ AND IF IT WILL ASSIST THE ~~SELF-INSURER'S COMPLIANCE WITH THIS SECTION.~~

(c) reqs to approve servicing companies

SEC. 21-62.130. QUALIFICATIONS FOR SERVICING COMPANIES (a) A BUSINESS DESIRING TO ~~BECOME~~ provide
~~QUALIFIED AS A SERVICE COMPANY FOR SELF-INSURERS IN THIS~~ services
~~STATE FOR ANY OR ALL OF THE SERVICE CATEGORIES NOTED IN~~ under
SECTION 120(a) OF THIS CHAPTER SHALL MAKE APPLICATION TO the Director
THE DIRECTOR ON FORMS PRESCRIBED BY HIM. THE APPLICATION
MUST BE APPROVED BY THE DIRECTOR BEFORE ANY CONTRACT FOR
SERVICE UNDER SECTION 120 OF THIS CHAPTER CAN BECOME
~~RECOGNIZED.~~ EFFECTIVE.

(b) A BUSINESS MAKING APPLICATION AS A SERVICE COMPANY IN ANY OR ALL OF THE SERVICE CATEGORIES NOTED IN 120(a) OF THIS CHAPTER, SHALL FURNISH PROOF THAT IT HAS A SUFFICIENT NUMBER OF EXPERIENCED AND QUALIFIED PERSONS EMPLOYED ON A FULL-TIME BASIS FOR EACH SERVICE CATEGORY TO MEET THE NEEDS OF ALL

IS CONTRACTED.
SELF-INSURERS WITH WHICH IT INTENDS TO CONTRACT. THE LOSS
CONTROL SERVICE CATEGORY SHALL INCLUDE EXPERTISE IN SAFETY
ENGINEERING. THE CLAIMS SERVICE CATEGORY SHALL INCLUDE
EXPERTISE IN WORKER'S COMPENSATION CLAIMS. THE UNDERWRITING
SERVICE CATEGORY INCLUDES EXPERTISE IN THE OVERALL PLANNING
AND COORDINATING OF A SELF-INSURANCE PROGRAM, THE ABILITY
TO PROCURE BONDS AND EXCESS INSURANCE, THE ABILITY TO PROVIDE
SUMMARY DATA REGARDING THE SELF-INSURER'S COST OF ACCIDENTS
INCLUDING THE FREQUENCY AND DISTRIBUTION BY TYPE AND CAUSE,
AND THE SKILL TO MAKE RECOMMENDATIONS TO THE SELF-INSURER
REGARDING THE CORRECTION OF ANY DEFICIENCIES THAT ARISE IN
THE SELF INSURANCE PROGRAM.

(c) A BUSINESS MAKING APPLICATION TO QUALIFY AS A SERVICE
COMPANY SHALL FURNISH PROOF THAT IT MEETS THE FOLLOWING
CONDITIONS BEFORE APPROVAL CAN BE GRANTED:

(1) THAT ALL RECORDS CONCERNING SELF-INSURERS IN THIS
STATE BE MAINTAINED AT A LOCATION WITHIN THIS STATE.

(2) THAT AN OFFICE BE MAINTAINED AT ONE OR MORE
LOCATIONS IN THIS STATE WITH A RESIDENT ADMINISTRATOR
AUTHORIZED TO ACT IN ALL MATTERS CONCERNING THE SERVICE
COMPANY.

(d) UPON COMPLIANCE TO THE SATISFACTION OF THE DIRECTOR
WITH (a) - (c) OF THIS SECTION, HE SHALL ISSUE A CERTIFICATE
OF APPROVAL AS A RECOGNIZED AND AUTHORIZED SERVICE
ORGANIZATION. FAILURE TO COMPLY WITH THE QUALIFICATION
CONDITIONS OR ANY RULES THE DIRECTOR MAY ADOPT SHALL BE

entity - has to provide SVCS as SVC co.

CONSIDERED GOOD CAUSE FOR WITHDRAWAL OF THE CERTIFICATE OF APPROVAL.

SEC 21.62.140 REQUIREMENTS FOR SERVICING COMPANIES. (a) EACH SERVICE COMPANY SHALL FILE WITH THE DIRECTOR, WITHIN 30 DAYS OF ENTERING INTO A CONTRACT FOR SERVICING, A COPY OF ITS SERVICING CONTRACT AND A CERTIFICATION THAT IT HAS PROVIDED SUFFICIENT PERSONNEL TO FULFILL THE TERMS OF ITS CONTRACT.

(b) EACH CLAIMS SERVICE CATEGORY CONTRACT ENTERED INTO BY A SERVICE COMPANY SHALL PROVIDE THAT ALL CLAIMS INCURRED DURING THE CONTRACT PERIOD SHALL BE HANDLED UNTIL THEIR CONCLUSION.

(c) EACH SERVICE COMPANY SHALL FILE A CURRENT ANNUAL FINANCIAL STATEMENT AND A FORM PRESCRIBED BY THE DIRECTOR CERTIFYING THAT THE SERVICE COMPANY IS COMPLYING WITH THE CONDITIONS OF SEC. 130 OF THIS CHAPTER ON A CONTINUING BASIS. THE FINANCIAL STATEMENT AND CERTIFICATION SHALL BE FILED ANNUALLY NO LATER THAN JUNE 30 EACH YEAR. AFTER AN ANNUAL REVIEW FOR COMPLIANCE WITH THIS RULE, THE DIRECTOR SHALL ISSUE A RENEWAL CERTIFICATION TO EACH SERVICE COMPANY FOUND TO BE IN COMPLIANCE. A SERVICE COMPANY WHICH FAILS TO DEMONSTRATE ANNUALLY THAT IT IS IN COMPLIANCE WITH THIS SUBSECTION SHALL HAVE ITS AUTHORIZATION WITHDRAWN.

(d) FINDINGS BY THE DIRECTOR THAT A SERVICE COMPANY IS ENGAGED IN QUESTIONABLE CLAIMS HANDLING TECHNIQUES,

needs work need Section for ① Claims adjustment ② Safety, loss, under writing etc

QUESTIONABLE PATTERNS OF CLAIMS, QUESTIONABLE PATTERNS OF UNREASONABLY CONTROVERTED CLAIMS, POOR PAYMENT PRACTICE, OR VIOLATIONS OF AS 21.36.125 AS CONSTITUTE A GENERAL BUSINESS PRACTICE OF A SERVICE COMPANY SHALL BE CONSIDERED GOOD CAUSE FOR THE WITHDRAWAL OF THE AUTHORIZATION OF THE SERVICE COMPANY.

(e) EACH SERVICE COMPANY SHALL BE SUBJECT TO AUDIT BY THE DIRECTOR OR HIS DESIGNEE AT HIS DISCRETION BUT NOT LESS FREQUENTLY THAN EVERY THREE YEARS. PRIOR NOTICE OF THE AUDIT IS NOT REQUIRED. THE AUDIT MAY CONCERN CLAIMS, FINANCIAL MATTERS OR ANY ISSUE REASONABLY RELATED TO THE QUALIFICATIONS OR DUTIES OF A SERVICE COMPANY UNDER THIS CHAPTER.

(f) THE DIRECTOR MAY ESTABLISH GUIDELINES FOR THE RETENTION OF SELF-INSURER DOCUMENTS MAINTAINED BY A SERVICE COMPANY.

(g) IF THE DIRECTOR HAS CAUSE TO WITHDRAW AN AUTHORIZATION FOR A SERVICE COMPANY, HE SHALL GIVE PRIOR WRITTEN NOTICE OF THE WITHDRAWAL. THE SERVICE COMPANY MAY REQUEST A HEARING WITHIN 20 DAYS OF THE NOTICE BY THE DIRECTOR. FAILURE TO REQUEST A HEARING WITHIN THE TIME PRESCRIBED SHALL RESULT IN THE WITHDRAWAL BECOMING EFFECTIVE 30 DAYS FROM THE MAILING DATE OF THE WITHDRAWAL NOTICE. THE NOTICE SHALL BE GIVEN TO THE SERVICE COMPANY AND ALL INTERESTED PERSONS. THE HEARING SHALL BE HELD UPON 10 DAYS WRITTEN NOTICE TO THE SERVICE COMPANY AND ALL INTERESTED PERSONS. HEARING SHALL BE CONDUCTED PURSUANT TO AS 21.06.180-.240. A RULING BY THE

DIRECTOR SHALL BE MADE EFFECTIVE NOT LESS THAN 15 DAYS FOLLOWING HIS ORDER.

SEC 21.62.150. RECORDS. (a) A SELF-INSURER OR A SERVICING COMPANY ON BEHALF OF A SELF-INSURER SHALL MAINTAIN ALL CLAIMS RECORDS AT A LOCATION WITHIN THIS STATE.

(b) SELF-INSURER RECORDS MAINTAINED BY A SELF-INSURER SHALL BE SUBJECT TO GUIDELINES ESTABLISHED BY THE DIRECTOR CONCERNING THEIR RETENTION AND REVIEW BY THE DIRECTOR.

(c) ALL CLAIMS FILES OF A SELF INSURER ARE SUBJECT TO REVIEW BY THE DIRECTOR DURING NORMAL BUSINESS HOURS AT A LOCATION IN THIS STATE AS STATED IN THE APPLICATION FOR SELF INSURANCE.

SEC. 21.62.160. REPORTS. THE DIRECTOR MAY BY REGULATION REQUIRE REPORTS CONCERNING PAYROLL, LOSSES, RESERVES, FINANCIAL CONDITION AND OTHER MATTERS REASONABLY INTENDED TO AID IN THE EFFECTUATION OF THIS CHAPTER. FAILURE TO COMPLY WITH SUCH REQUIREMENTS IS SUFFICIENT CAUSE FOR REVOCATION OF THE SELF-INSURANCE CERTIFICATE.

SEC. 21.62.170. INDEMNITY AGREEMENT. THE DIRECTOR MAY BY REGULATION ESTABLISH THE FORM OF THE INDEMNITY AGREEMENT REQUIRED IN SECTION 060(2) OF THIS CHAPTER. AN INDEMNITY AGREEMENT MAY ALSO CONTAIN OTHER PROVISIONS NOT

INCONSISTENT WITH THE PROVISIONS ADOPTED UNDER A REGULATION.

SEC. 21.62.180. SOLVENCY OF FUND. THE DIRECTOR MAY BY REGULATION ADOPT RULES DESIGNED TO MAINTAIN ~~REASONABLE~~ THE SOLVENCY OF THE SELF-INSURANCE FUND UNDER SECTION 020 OF THIS CHAPTER.

SEC 21.62.190 REVOCATION OR TERMINATION OF THE SELF INSURANCE CERTIFICATE (a) FAILURE TO COMPLY WITH THE PROVISIONS OF THIS CHAPTER SHALL BE CONSIDERED GOOD CAUSE FOR REVOCATION OR TERMINATION OF THE CERTIFICATE OF SELF-INSURANCE NONCOMPLIANCE WITH AS 23.30 SHALL BE CONSIDERED GOOD CAUSE FOR REVOCATION OR TERMINATION OF THE CERTIFICATE OF SELF-INSURANCE.

(b) THE DIRECTOR SHALL GIVE 15 DAYS WRITTEN NOTICE OF A REVOCATION OR TERMINATION OF THE CERTIFICATE OF SELF-INSURANCE. THE SELF INSURER MAY REQUEST A HEARING WITHIN THAT TIME. FAILURE TO REQUEST HEARING WITHIN THE TIME PRESCRIBED SHALL RESULT IN THE REVOCATION OR TERMINATION BECOMING EFFECTIVE 30 DAYS FROM THE DATE OF MAILING THE ORIGINAL NOTICE. THE NOTICE SHALL BE SENT TO ALL INTERESTED PARTIES.

(c) THE CERTIFICATE OF SELF INSURANCE SHALL AUTOMATICALLY TERMINATE UPON THE DATE WHEN THE SELF INSURER IS QUALIFIED UNDER SECTIONS 040 OR 050 EXPERIENCES A CHANGE IN MAJORITY OWNERSHIP.

(d) A PERSON AFFECTED BY AN ORDER UNDER THIS SECTION MAY APPEAL THE ORDER AS PROVIDED IN AS 21.06.230.

SEC. 21.62.200. INDEXING. THE DIRECTOR MAY ADOPT REGULATIONS TO PROVIDE FOR REVISION OF THE DOLLAR AMOUNTS IN SECTIONS 020(a), 040(1), 050(1), 060(1), 100(a), AND, 110(b) OF THIS CHAPTER TO REFLECT DEVALUATION OF THOSE AMOUNTS DUE TO INFLATION. THE AMOUNTS STATED SHALL HAVE A BASELINE DATE OF JULY 1, 1981.

Nice lang.

~~SEC. 21.62.210. REGULATIONS. THE DIRECTOR MAY ADOPT REGULATIONS TO IMPLEMENT THIS CHAPTER.~~

?

SEC. 21.62.900. DEFINITIONS. AS USED IN THIS CHAPTER

(1) "COMMON INTEREST" MEANS, A GROUP OF EMPLOYERS BELONGING TO THE SAME OR SIMILAR TYPE OF BUSINESS PROVIDED THAT UNRELATED BUSINESSES WHICH ARE OWNED OR CONTROLLED BY THE SAME INTERESTS SHALL BE ELIGIBLE FOR MEMBERSHIP IN A SELF-INSURERS FUND IF ANY ONE OF THEM IS ELIGIBLE.

(2) "COMMON MANAGEMENT" MEANS, A GROUP OF EMPLOYERS ~~THE SAME OR UNRELATED BUSINESSES~~ WHICH ARE OWNED OR CONTROLLED BY THE SAME INTERESTS ~~AND ARE MANAGED BY THE SAME EXECUTIVE OFFICERS.~~

(3) "FUND" MEANS, SELF-INSURANCE FUND.

(4) "TRUSTEE" MEANS A ~~GROUP OF MEMBERS~~ LENDER ELECTED BY A SELF-INSURER'S FUND GROUP FOR A STATED TERM OF OFFICE, TO DIRECT THE ADMINISTRATION OF THE SELF-INSURERS FUND, [AND WHOSE DUTIES INCLUDE RESPONSIBILITY FOR APPROVING APPLICATIONS FOR NEW MEMBERS OF THE FUND ~~AND OTHER MATTERS~~] THE MAJORITY OF

020(b)

020(d)

OF TRUSTEES MUST BE MEMBERS OF THE SELF-INSURERS GROUP F.000. #

~~TRUSTEE MAY NOT BE AN OWNER, OFFICER OR EMPLOYEE OF THAT~~ GROUP'S

~~SERVICE AGENT~~ COMPANY

off date 1/1/82.

NOTE:

ADD ADDITIONAL SUBSECTION TO SEC 21.62.110 ON P.8, L.21

(h) NOTWITHSTANDING (b) OF THIS SECTION, THE DIRECTOR MAY APPROVE AN EXCESS INSURANCE COVERAGE LAYER STARTING AT $1,000,000 IN AN INSURER WRITING BUSINESS IN THIS STATE PURSUANT TO AS 21.33.

F.N. 3 people $145K

Grandfather rights?

Past Record

	Yr	Payroll	Prem	Avg Rate	Losses	Loss Ratio
ALASCOM, INC.	78	41,499,466	413,161	1.25	177,000	37%
	77	45,498,537	611,034	2.09	134,000	22%
	76	35,087,775	581,400	2.42	127,385	22%
ALASKA AIRLINES	78/79	9,519,000	403,279	4.0	278,819	65.9
	77/78	9,996,000	360,069	3.6	290,844	80.9
	76/77	9,508,000	318,818	3.3	302,575	94.9
AK. INTERNATL INDUSTRIES	75	10,739,933	243,598	2.27	430,236	1,77%
	74	5,540,387	100,070	1.81	99,064	99%
	73	2,641,479	57,214	1.94	4,654	9%
AK. RURAL ELECTRIC COOP	79	22,013,000	726,060	3.3	218,680	30.1
	78	19,220,000	628,974	3.27	248,693	38.6
	77	17,163,000	489,080	2.85	34,313	7.0
	76	14,471,000	359,542	2.48	76,974	21.4
ALYESKA PIPELINE SERVICE CO.	75	23,798,822	30,475	.46	9,848	32.4
	74	4,399,185	5,891	.36	54,541	925.8
	73	1,374,200	2,866	.21	9,820	3,42
AMFAC CORP.	75/76	16,540,641	n/a		62,858	
	74/75	21,015,963			76,310	
	73/74	26,131,341			80,112	
	72	61,178			-0-	
	71	57,258			-0-	
	70	53,088			-0-	

	Yr	Payroll	Prem	Avg Rate	Losses	Loss Ratio
AMOCO PROD.	71	1,325,846	28,936	.02	4,608	16%
	70	1,315,242	24,551	.02	211	.8%
	69	1,263,183	25,830	.02	438	1.7%
ANCHORAGE, MUN. OF	74	25,650,000	241,758	.94	227,346	94
	73	21,770,000	164,843	.76	134,290	81
	72	17,250,000	219,665	1.14	158,724	72
ANCH SCHOOL DISTRICT	77/78	61,100,000	653,521	3.0	Pd 111,773 / Rs 368,294	.83
	76/77	88,522,808	489,889	1.4	Pd/ 161,269 Rs 90,050	.51
	75/76	58,726,168	390,523	1.2	A/ 151,298 Rs 95,110	.63
BETHLEHEM STEEL	63	14,533	-	-	-76-	-
	62	-	-	-	-0-	-
	61	9,115	-	-	-40-	-
BUMBLE-BEE SEAFOODS	78	758,206	69,647	9.1	7700	11%
	77	685,508	38,773	8.0	8748	23%
	76	604,442	14,840	4.1	3635	25%
	-	-	-	-	-	-

	Yr	Payroll	Prem	Avg Rate	Losses	Loss Ratio
	-	-	-	-	-	-
	-	-	-	-	-	-
CONSOLIDATED FREIGHTWAYS	69	396,645	-	-	3193	-
	68	363,472	-	-	892	-
	67	462,183	-	-	741	-
DILLINGHAM CORP.	71	1,977,385	398,346	10.6	38,124	76%
	70	2,417,188	389,188	6.4	150,038	38%
	69	3,398,016	378,551	10.6	287,942	10%
DUTCH HARBOR SEAFOODS	78/79	800,000	84,160	10.52	10,000	11.9
	77/78	600,849	48,805	8.12	4,358	8.9
	76/77	223,306	-	-	144	-0-
FAIRBANKS, CITY OF	75/76	-	310,000	-	69,131	-
	74/75	-	172,999	-	54,801	-
	73/74	-	138,348	-	100,204	-
						Claim
FOSS ALASKA LINES	73	-	-	-	250	1
	72	-	-	-	475	3
	71	-	-	-	-	1
	70	-	-	-	-	0

	Yr	Payroll	Prem	Avg Rate	Losses	Loss Ratio
FRED MEYER, INC	77/78	1,687,997	25,892	1.65	6,775	.234
	76/77	1,303,728	13,283	1.64	3,440	.258
	75/76	1,010,421	16,404	1.64	7,816	.476
	71	500,000	-	-	-	-
	70	-	-	-	-	-
	69	-	-	-	-	-
	-	-	-	-	-	-
	-	-	-	-	-	-
HYDRO CONDUIT CORP.	Est 70	186,000	3,999	2.15	2,000	.5 est
	69	171,388	3,806	3.8	575	.151
	68	-	-	-	-	-
INTERNAT'L HARVESTER CO.	72	108,356	400	-	-	-
	71	116,840	432	-	-	-
	70	101,206	374	-	-	-
JUNEAU, CITY & BOROUGH OF	75	12,456,700	175,000	1.40	88,431	.505
	74	9,600,420	111,992	1.17	55,996	.50
	73	8,160,000	89,940	1.10	33,900	.378
					-	

	Yr	Payroll	Prem	Avg Rate	Losses	Loss Ratio
KETCHIKAN PULP CO.	63	6,338,000	169,130	2.67	81,955	48%
	62	9,100,000	303,959	3.34	222,180	73%
	61	5,341,000	177,769	3.33	169,260	95%
	-	-	-	-	-	-
LITTON SYSTEMS, INC.	79 est	45,682	-	-	-	-
	78	71,884	-	-	-	-
	77	39,648	-	-	-	-
LOOMIS CORP.	72/73	801,844	18,017	2.25	500	.028
	71/72	822,988	11,947	1.45	2,547	.213
	70/71	1,033,066	11,077	1.07	1,066	.096
LOUISANA-PACIFIC	75 as of 5/74	752,010	117,842	15.67	15,620	13%
	74	731,686	64,780	8.85	23,470	36%
	73	347,957	26,095	7.5	1,956	7%
MOBILE OIL	68/69	818,721	22,447	-	2,600	11%
	67/68	719,822	16,379	-	249	2%
	-	-	-	-	-	-

	Yr	Payroll	Prem	Avg Rate	Losses	Loss Ratio
NANA REGIONAL	75/74	4,100,000	336,751	8.21	47,925	7%
	73/72	3,174,618	308,242	9.71	58,619	5.3%
	76/77	5,810,000	238,494	4.10	49,345	4.8%
PAN-ALASKA FISHERIES	78	4,834,563	443,872	9.18	234,054	52.7%
	77	4,103,000	264,582	6.45	135,078	51.1%
	76	3,062,282	168,726	5.51	47,104	28%
PAY & SAVE, CORP.	71/72	1,116,232	6,595	.59	484	7.3 ~~52~~
	70/71	777,277	4,235	.54	205	4.8%
	69/70	371,704	1,790	.48	98	5.5%
PHILLIPS PETROLEUM	78	2,202,759	9,595	2.29	2,584	27
	77	1,947,092	16,209	1.20	32	-
	76	1,882,680	28,047	.67	824	3
SAFEWAY STORES	75	6,481,486	55,740	.82	35,235	63
	74	5,579,515	81,789	1.46	52,989	70
	73	3,844,994	53,677	1.37	31,510	60
SEA-LAND SERVICE	76	13,893,208	1,129,863	8.14	346,417	31
	75	12,005,119	815,303	6.79	424,417	52
	74	7,941,384	388,590	4.89	291,242	75
	-	-	-	-	-	-

	Yr	Payroll	Prem	Avg Rate	Losses	Loss Ratio
	–	–	–	–	–	–
	–	–	–	–	–	–
	–	–	–	–	–	–
UNION OIL	67	1,116,249	10,009	.90	3,557	–
	66	749,232	11,617	1.55	246	–
	65	635,376	4,835	.76	388	16%
	–	–	–	–		–
				–		–
WESTERN GEOPHYSICAL	73	189,749	67,161	–	34,851	52%
	72	587,066	35,854		46,269	179%
	71	450,822	22,617	–	1767	8%

	Yr	Payroll	Prem	Avg Rate	Losses	Loss Ratio
VEZO, INC.	79	7,298,025	502,712	7.1	104.420	18.6
	78	7,068,030	577,594	8.2	145,521	25.2
	77	6,803,745	564,841	8.3	63,934	11.3

C. CALCULATION METHOD 2 (THIS IS THE NEW LAW)

1. Enter total wages for 3d quarter 1979 _____
2. Enter total wages for 4th quarter 1979 _____
3. Enter total wages for 1st quarter 1980 _____
4. Enter total wages for 2nd quarter 1980 _____
5. Add lines 1 - 4 _____
6. Enter the highest number from lines 1 - 4 _____
7. Subtract line 6 from line 5 _____
8. ~~Divide line 7 by line 5 (line7/line5=)~~ Multiply amount on line 7 times 10 _____
9. a~~If line 8 is more than .10, enter number from line 5~~

~~b If line 8 is less than .10, multiply line 7 times 10~~ Enter amount from line 8 or line 5 whichever is less. _____

This is your wage basis for computation

10. aDivide line 5 by line 6 (line5/line6=) _____

This should result in a number between 1 and 4, and determines the number of weeks you can collect:

line 10 results	weeks basic	weeks extended	total weeks
1.0 - 1.5	16	8	24
1.5 - 2.0	18	9	27
2.0 - 2.5	20	10	30
2.5 - 3.0	22	11	33
3.0 - 3.5	24	12	36
3.5 - 4.0	26	13	39

b enter total weeks _____

11. Find your basic weekly benefit amount from the following table:

line 9 results	no dependents	1 dependent	2 dependents	3 or more dependents
------	----	----	---	----
------	insert table here		--	---

enter weekly benefit amount _____

12. Multiply total weeks (line 10b) times weekly amount (line 11). _____
This is your total benefit entitlement.

NOW FILL IN THE FOLLOWING BOXES

	METHOD 1	METHOD 2
WEEKLY BENEFIT AMOUNT	method 1, line 10	method 2, line 11
TOTAL WEEKS ELIGIBLE	39 weeks	method 2, line 10b
TOTAL ELIGIBLE BENEFITS	method 1, line 11	method 2, line 12

Now comes your decision. If your total eligible benefits under method 2 is more than under method 1, WAIT UNTIL OCTOBER FIRST TO FILE. If your weekly benefit amount and total eligible benefits under method 1 are both larger than under method 2, FILE NOW. If the weekly benefit amount under method 2 is larger than method 1, but the total eligible benefits is larger under method 1 than method 2, you've got a problem. Basically your choice is to get less money faster or more money slower. You've got to use your judgement on this one -- I think the best way is to guess at the number of weeks you'll collect, multiply by the weekly benefit amount under each method, and go from there.

The next thing you can do is to register to vote, and on November 4th, vote for representatives who'll clean up this mess. Vote for representatives who will represent Alaskan workers.

NEWS RELEASE

ALASKA DEPARTMENT of LABOR

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

SEP 10 1980

Employment Security Division

EXECUTIVE DIRECTOR

ALASKA UNEMPLOYMENT INSURANCE CHANGES EFFECTIVE OCTOBER 1

Juneau--Major revisions to the Alaska Employment Security Act become effective October 1, 1980. The announcement was made by Art Zillig, Director, Employment Security Division of the Alaska Department of Labor.

The maximum weekly benefit for those claimants filing an initial determination after October 1 will be increased to $150 for claimants earning more than $15,500. The allowance for dependents will increase to $24 per dependent up to a maximum of three dependents. Dependents allowance may be increased if a dependent is born or adopted during the claimant's benefit year. The maximum weekly benefit amount for a claimant with three dependents will be $222.

Claimants will now be able to earn up to $50 per week without reducing their UI benefit check. For each dollar of earnings above $50 the UI check will be reduced by 75 cents. By federal law all pensions based on previous work must be recorded and will reduce UI benefits.

Major changes in benefit duration and eligibility will also occur beginning October 1. The duration of benefits will now be linked to the length of time a worker has been employed. The duration of benefits will range from 16 to 26 weeks (24 to 39 with Extended Benefits) depending on a claimant's wage history during the base period.

A new tax rate schedule will take effect January 1, 1981.

-0-0-0-0-

Date of Release: September 8, 1980

FILE PR112-2			
TO:	ACTION	INFO	INITIALS
DIR.		X	
DEP. DIR.		X	
ES		X	
UI		X	
MSU			

REMARKS:

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

Many of the changes in HB 177 are housekeeping in nature. They include language changes with no change in meaning; the changing of "last known address" to "last address of record"; deletion of the date "June 30, 1969"; deletion of statutory citations that were incorrect or are no longer in the law, etc.

Some of the changes are required to stay in conformity with federal law:

AS 23.20.110

Release of information

This new provision allows the department to provide wage information to AFDC agencies to aid in establishing the eligibility or amount of aid for an individual from AFDC.

AS 23.20.277(i)

Reimbursible employers are responsible for 1/2 the costs of Extended Benefits.

State and local governments are responsible for the full costs of Extended Benefits.

None

AS 23.20.362

This provision will reduce UI benefits dollar for dollar for any retirement benefits received. ~~This section will be repealed if the corresponding federal provision is repealed or amended.~~

AS 23.20.525(a)(16)(C)(ii)

Citation change.

Changes recommended by the federal government:

AS 23.20.115

Unauthorized disclosure of information by an employee of the department.

The penalty is extended to agents of the department.

AS 23.20.145

Allowed the legislature to appropriate money from the Reed Act.

Extends the time in which the legislature is able to appropriate money from the Reed Act.

The changes to the TAX provisions are as follows:

AS 23.20.165	
Allows refunds to individuals who have earned more than $10,000 by working for two or more employers.	Will allow a refund only if one employer pays contributions beyond the tax base.
AS 23.20.170	
Uses the one-digit Standard Industrial Classification Code to assign new employers to a tax rate.	Uses the two-digit code.
AS 23.20.175	
Tax base of $10,000	Tax base will be 60% of the average annual wage for CY 81 & 82 and will be 75% of the average annual wage for further years.
AS 23.20.190	
Requires quarterly contribution reports from all employers.	Would allow for monthly reports from employers who are consistently delinquent.
AS 23.20.220	
Filing of an appeal of a tax assessment	Will require a posting of a bond with the appeal if the employer cannot prove the business is solvent.
AS 23.20.240	
RE: collection of delinquent contributions	Extends the definition of employer to include officers of a corporation.
AS 23.20.295	
- Method of experience rating - payroll decline	- Same.
- Number of tax rate classes - 10	- 20

- Calculation of tax rates - Based on fund solvency and tax table	- Tax Rate = (82% x ave. benefit cost rate) x (experience factor) + solvency tax. The experience factor is based on payroll decline.
- Employee tax averages 16% of the total tax contribution.	- Employee tax will be 18% of total contributions.

The changes to the BENEFIT provisions are as follows:

AS 23.20.350

- Requires minimum wages of $750 with $100 earned outside the high quarter.	- Requires $1000 with wages paid in two quarters.
- Benefits determined based on wages earned in base period (BP).	- Benefits determined based on wages paid in the base period; however, base period (BP) wages will be determined as follows: 1) if individual earns 90% or more of BP wages in one quarter, BP wages used for determining benefits equal 10 times the wages paid in the BP outside the high quarter. 2) if individual earns less than 90% in his high quarter, BP wages are total wages paid in the BP.
- Minimum WBA = $18 $36 with dependents	- Minimum WBA = $34 $106 with 3 dependents
- Maximum WBA = $90 $120 with dependents	- Maximum WBA = $150 $222 with 3 dependents

DEPENDENTS' ALLOWANCE (DA):

$10 per dependent; maximum of $30 Dependents allowance is established as of the date claim is filed.	$24 per dependent; maximum of $72. DA will be redetermined if acquire an additional dependent by birth or adoption. Requires proof of dependent; department will verify that no one else is claiming the same dependents.
DURATION:	
18-28 weeks depending on base period wages	16-26 weeks based on the ratio of total base period wages to high quarter wages.
EARNINGS:	
Allow earnings of $10 or 1/2 WBA without a reduction in WBA. Reduce WBA dollar-for-for additional earnings.	Allow earnings of $50 and will reduce WBA for additional earnings by 75¢ for each $1.

Changes in the APPEALS process include: 1) extending the number of days to file an appeal from 10 days to 15; and 2) will grant a waiver for filing a timely appeal for circumstances beyond the claimant's control rather than for good cuase.

The following changes have been made in the DISQUALIFICATION area:

AS 23.20.378

- Waives an individual's availability for work if ill/disabled, subsistence hunting or fishing while in compensable status and while no work is offered.	- Limits waiver for illness, etc. to six weeks. - Waives availability for work if travelling for medical services or serving as a juror. - Disqualifies an individual who is attending 10 or more credit hours of academic instruction.

AS 23.20.379

VOLUNTARY QUIT; MISCONDUCT

Disqualification for 6 weeks from date of occurrence.	- Same - Includes reduction of benefits of 3 x WBA - 6 week disqualification lifted if return to work and earn 8 x WBA

AS 23.20.381

Disqualification of professional school employees between terms.	SAME. ~~Extends disqualification to non-professional school employees.~~ SB 23 reversed This.

AS 23.20.387

Disqualification for misrepresentation is 26 weeks	Disqualification varies from 6 - 52 weeks.

UI LAW CHANGE
FACT SHEET

Please read this sheet carefully. It outlines all the changes of the new law that will affect you and your claim for benefits.

ALLOWANCE FOR DEPENDENTS
The allowance for dependents has been increased to $24 per dependent per week. However, the department may now require you to verify the existence and your support of the dependents that you claim. On the plus side, you may now increase your allowance for dependents, but not to exceed $72 per week, if you obtain an additional dependent during your benefit year by either birth of adoption. Legal wards may now be claimed as dependents.

EARNINGS WHILE DRAWING UI
You will now be able to earn $50 without reducing your UI benefit check. For each dollar of earnings above $50 your UI check will be reduced by $.75.

PENSIONS WHILE DRAWING UI
By federal law all pensions based on your previous work must be reported and will reduce your UI benefits. A monthly pension will be prorated for a week and will reduce your UI benefits $1.00 for each $1.00 of your pension.

BENEFITS WHILE ILL OR DISABLED
You may still receive benefits while you are ill or disabled but under the new law only for six weeks. You must have filed a compensable claim the week before you became ill or disabled and you cannot refuse an offer of suitable work.

JURY DUTY
You will not be denied benefits while you are serving as a prospective or impaneled juror. You must, however, report any wages you receive.

ATTENDING ACADEMIC SCHOOLING:
If you are attending academic courses of 10 or more credit hours, you will be disqualified from benefits.

VOLUNTARY QUIT; DISCHARGE FOR MISCONDUCT; REFUSAL OF SUITABLE WORK:
If you quit your job without good cause, are fired for misconduct, or refuse an offer of suitable work, in addition to being disqualified for benefits for six weeks, your maximum potential benefits will be reduced by three times your weekly benefit amount (excluding any allowance for dependents). The six week disqualification may be terminated by returning to work and earning eight times your weekly benefit amount. However, once a reduction in your maximum potential benefits has been made it will NOT be reinstated by returning to work.

EMPLOYEE REFUND:
You are entitled to a refund only if one employer deducts contributions in excess of the tax base. You will no longer receive a refund if you work for two or more employers and thereby exceed the tax base.

TAX BASE:

The tax base for 1981 will be 60% of the average annual wage; it is estimated to be $13,000. The tax base will increase to 75% of the average annual wage in 1983.

APPEAL PERIODS:
You now have 15 days in which to appeal any decision made by the department; this period may be extended if your failure to file is due to circumstances beyond your control.

CHANGE OF ADDRESS:
You must formally notify the department of any change of address. A new return address is not a notice of change of address. A letter or notification on your claim card will change your address.

CALCULATING WEEKLY BENEFIT AMOUNT AND DURATION

If you file a claim for unemployment insurance after October 1, 1980, use the following method to calculate weekly benefit amount and duration.
Effective October 1, 1980

CALCULATING YOUR WEEKLY BENEFIT AMOUNT

First: Identify your BASE PERIOD: the BASE PERIOD is the first four of the last five completed calendar quarters prior to filing your claim for unemployment insurance.

What is the amount of wages paid to you in each quarter of your base period? Enter amount in boxes below:

					X
Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 5	file your new claim

BASE PERIOD

Second: Calculate your weekly benefit amount:

1. What are your total base period wages? (add amounts in boxes marked quarters 1, 2, 3 & 4) _____
2. What is the amount of wages in the quarter with the highest wages? _____
3. Determine the percent (%) of wages in your highest quarter:

   (Line 2 _____ ÷ Line 1 _____) X 100 = _____ %

   A. If Line 3 is less than 90% go directly to the Benefit Table to determine your weekly benefit amount based on the wages on Line 1.

   B. If Line 3 is 90% or greater, compute the wages to be used in determining your weekly benefit amount by subtracting Line 2 from Line 1, and multipling this amount by 10.

   (Line 1 _____ - Line 2 _____) X 10 = _____

   Use this amount of wages to determine your weekly benefit amount from the Benefits Table.

BENEFITS TABLE

Base Period Wages	Weekly Benefit Amount	Base Period Wages	Weekly Benefit Amount	Base Period Wages	Weekly Benefit Amount
$ - 999.99	$ 0	5,750 - 5,999.99	72	10,750 - 10,999.99	112
1,000 - 1,249.99	34	6,000 - 6,249.99	74	11,000 - 11,249.99	114
1,250 - 1,499.99	36	6,250 - 6,499.99	76	11,250 - 11,499.99	116
1,500 - 1,749.99	38	6,500 - 6,749.99	78	11,500 - 11,749.99	118
1,750 - 1,999.99	40	6,750 - 6,999.99	80	11,750 - 11,999.99	120
2,000 - 2,249.99	42	7,000 - 7,249.99	82	12,000 - 12,249.99	122
2,250 - 2,499.99	44	7,250 - 7,499.99	84	12,250 - 12,499.99	124
2,500 - 2,749.99	46	7,500 - 7,749.99	86	12,500 - 12,749.99	126
2,750 - 2,999.99	48	7,750 - 7,999.99	88	12,750 - 12,999.99	128
3,000 - 3,249.99	50	8,000 - 8,249.99	90	13,000 - 13,249.99	130
3,250 - 3,499.99	52	8,250 - 8,499.99	92	13,250 - 13,499.99	132
3,500 - 3,749.99	54	8,500 - 8,749.99	94	13,500 - 13,749.99	134
3,750 - 3,999.99	56	8,750 - 8,999.99	96	13,750 - 13,999.99	136
4,000 - 4,249.99	58	9,000 - 9,249.99	98	14,000 - 14,249.99	138
4,250 - 4,499.99	60	9,250 - 9,499.99	100	14,250 - 14,499.99	140
4,500 - 4,749.99	62	9,500 - 9,749.99	102	14,500 - 14,749.99	142
4,750 - 4,999.99	64	9,750 - 9,999.99	104	14,750 - 14,999.99	144
5,000 - 5,249.99	66	10,000 - 10,249.99	106	15,000 - 15,249.99	146
5,250 - 5,499.99	68	10,250 - 10,499.99	108	15,250 - 15,499.99	148
5,500 - 5,749.99	70	10,500 - 10,749.99	110	15,500 and more	150

Third: If you are eligible for an allowance for dependents add $24 for each dependent (up to a maximum of $72/week) to your weekly benefit amount.

Fourth: Determine the DURATION of your benefits: You will need to calculate your EARNINGS RATIO. The earnings ratio is total base period wages divided by high quarter wages:

(Line 1) _____ ÷ (Line 2) _____ = _____

Use this number to determine the number of weeks for which you are eligible for benefits.

DURATION TABLE

Earnings Ratio	Duration (# of weeks)
Less than 1.49	16
1.50 - 1.99	18
2.00 - 2.49	20
2.50 - 2.99	22

EXPLANATION
of
U.I. Law and Regulations

AS 23.20.379(a) - An insured worker is disqualified for waiting week credit or benefits for the week of the discharge for misconduct or voluntary quit without good cause and the next 5 consecutive weeks and the department shall reduce the maximum potential benefits of the person by 3 times the weekly benefit amount, excluding dependents allowance, or the amount of unpaid benefits to which the person is entitled, whichever is ~~le~~ less. The 6 weeks disqualification may be removed during the week the person earns 8 times the weekly benefit amount.
8 AAC 85.095 - If a person had excess earnings during the week he quit suitable work without good cause or was discharged for misconduct, the disqualification would begin with the following week and the next 5 consecutive weeks.

AS 23.20.279(b) - An insured worker is disqualified for waiting week credit or benefits for a week and the next 5 consecutive weeks following that week if he fails, without good cause, to apply for available suitable work to which he was referred by the employment office, or he failed to accept suitable work when offered him. The department shall also reduce the maximum potential benefits by 3 times the person's weekly benefit amount, excluding dependents allowance, or the amount of unpaid benefits to which the person is entitled, whichever is less.
8 AAC 85.095(b) - A disqualification for refusal of suitable work remains in effect for a period of 6 weeks or until terminated by earning 8 times the weekly benefit amount. The termination of the disqualification will not restore the reduction of potential benefits.
8 AAC 85.420 - A person will be disqualified under AS 23.20.379(b) when he refuses suitable work without good cause or fails to apply for suitable work when it is offered, if the offer was properly made.

AS 23.20.378 - A person is entitled to receive waiting week credit or benefits for a week if he is able to work and available for suitable work. A person is not considered available for work if he is attending school and taking 10 or more hours per week of academic instruction or the equivalent. The term "school" includes primary and secondary schools and institutions of higher learning.
Unavailability of up to 6 weeks may be allowed if a person is ill or disabled; traveling to obtain medical services not available in his community, for himself, his spouse or dependents; lives within the state and goes noncommerical hunting or fishing for the survival of himself or his dependents; or is an impaneled or prospective juror.
8 AAC 85.350 - A person will be found "able to work" if he is physically and mentally capable of performing work under the usual conditions of employment in his principal occupation or other occupation for which he is reasonably fitted by training or experience. A person will be found available for work if he registers for work when required to do so; he seeks work when directed to do so; he meets the registration requirements while traveling; he remains ready and able to immediately accept any offer of suitable work which he does not have good cause to refuse.

AS 23.20.375(a) - A person is entitled to receive waiting week credit or benefits for a week of unemployment for which he has not been disqualified under AS 23.20.377 - AS 23.20.387 if he has met the filing requirements of the department by filing an initial claim for benefits and for that week certified for waiting week credit or made a claim for benefits.
8 AAC 85.110 - Each interstate claimant shall register for work through an employment office in the agent state, however, a union member may register with the local in the area to meet this requirement. Claims for benefits or waiting week credit shall be filed by interstate claimants on interstate claim forms and in accordance with procedured prescribed.

8 AAC 85.100 - No waiting week credit may be allowed, nor benefits paid prior to any week in which a new claim, additional claim, or reopened claim is filed. No waiting week credit will be allowed, nor benefits paid for any week for which a continued claim has not been filed or for which an untimely claim has been filed without good cause. No continued claim may be filed until after the end of the week claimed and must be filed withing 7 days of the week ending date of the week claimed unless good cause can be established for the late filing. A person shall provide the division with sufficient information to determine his eligibility with respect to any claim. No benefits may be paid, or waiting week credit allowed, for any week for which a person refuses to provide the division with information requested.

AS 23.20.381 - Benefits are not payable to persons participating in, or training for, professional athletic events for any week which commences during the period between two successive seasons or similar period. However, benefits may be paid based on other wage credits earned outside of the professional athletic events.
Benefits are not payable to an alien unless the alien has been lawfully admited for permanent residence or otherwise is permanently residing in the United States.
Benefits based on service in an instructional, research, or principal administrative capacity for an educational institution may not be paid during the period between two successive academic years, or during a similar period between two successive terms, or during a period of paid sabatical leave. However, benefits may be paid based on services other than in an instructional, research or principal administrative capacity.

AS 23.20.382 - Benefits or waiting week credit shall not be denied an individual while attending a training course approved by the division.
8 AAC 85.200 - A person may make written application to the director for approval of attendence in a training or retraining course. Training of under 6 months may be ap- approved if employment opportunities are limited or it is a union requirement. Training of 6 months or more may be approved if employment opportunities do not exist or it is no longer possible to pursue his normal occupation. A person cannot be receiving any allowance of any kind, either directly or indirectly.

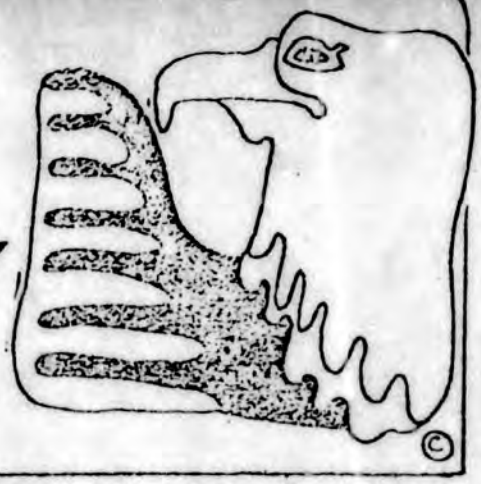
AS 23.20.362 - Pensions, annuities, or similar periodic payments, dismissal pay, or vacation pay are reduced from benefits by the amount received.
8 AAC 85.140 - If dismissal or vacation pay is made in a lump sum payment, it will be apportioned to the weeks or parts of weeks following the termination of employment.

AS 23.20.505 - A person is considered "unemployed" in a week during which no services are performed and for which no remuneration is payable.

AS 23.20.505 - Remuneration includes all compensation, including commissions, earnings from selfemployment, bonuses and guaranteed wage payments, reasonable cash value of payments in mediums other than cash and compensation received as a juror.
8 AAC 85.390 - The cash value of a comodity, product, or other payment in kind will be agreed upon by the individual and his employer. In the absence of any agreement, the cash value will be the fair market value.

ISSUES and COMMENTARY

UI NEWSLETTER



ALASKA DEPARTMENT OF LABOR, RESEARCH AND ANALYSIS SECTION • MARCH 1980

Governor Signs Unemployment Insurance Legislation
by Scott T. Hannigan

Unemployment insurance legislation has been passed by the Alaska Legislature and was signed into law by the Governor on March13, 1980. Extensive revisions to the Employment Security Act encompass benefits, taxes, eligibility, duration, disqualifications, and fraud. Some minor administrative measures were also effected. This paper will present an overview of the legislation and discuss the background, reasoning and expected impact of the major changes.

Benefits

The maximum weekly benefit amount (WBA) has been raised from the current $90 to $150. Allowances for dependents were established at $24 per dependent with a maximum of $72; up from the current $10 per dependent, maximum of $30. A new provision in the dependents section extends eligibility for the allowance to dependents newly born or adopted during claimants' benefit years. Proof of principal support may be required to be eligible for the dependents allowance.

New benefits will be paid to those claimants filing for an initial determination after September 30, 1980. Minimum qualifying wages are $1,000 with at least $100 outside the quarter of highest earnings. Benefits for claimants earning more than 90% of base period wages in a single quarter will be based on earnings equal to ten times the wages paid outside the high quarter.

Allowable earnings before reduction in the weekly benefit amount have been changed from $10 or one-half the WBA (whichever is greater) to $50 plus a reduction of additional earnings by $.75 for each $1 over $50.

UI Benefits are subject to a dollar for dollar reduction for any retirement benefits received. This section brings the Alaska UI law into conformity with federal law. The issue of retirement benefits is still being discussed at the national level so this section will be repealed if the corresponding federal provision is amended or repealed.

The WBA has not been increased since 1973. Rampant inflation with the resultant escalating salaries and the high cost of living in Alaska have seriously eroded the wage replacement value of the WBA. The old maximum benefit of $90 replaced approximately 23 percent of the state's average weekly wage, the lowest percentage wage replacement in the nation. The new benefit schedule will replace at least 50% of claimants' average weeky earnings for the 70 percent of claimants with annual earnings below $15,500.

Changes in the minimum and maximum weekly benefit amounts are shown in the following table:

MINIMUM & MAXIMUM
BENEFIT PAYMENTS

	Old Law	New Law
Minimum Weeks	14	16
Minimum WBA	$ 18	$34
Minimum Payment	$252	$544
Minimum Required Earnings	$750	$1,000
Maximum Weeks	28	26
*Maximum WBA	$120	$222
*Maximum Payment	$3,360	$5,772
Earnings Required for Maximum WBA	$8,500	$15,500

*Includes maximum allowance for dependents:
Old Law - $10 per dependent for 3 dependents
New Law - $24 per dependent for 3 dependents

Duration

The legislation incorporates a duration schedule which links the duration of benefits to a claimant's previous attachment to the labor force. Duration will range from 16 to 26 weeks (24 to 39 weeks with Extended Benefits) depending on the claimant's work history. A ratio of annual earnings to high quarter earnings will be determined for each claimant on a scale of one to four. Those with a ratio less than 1.5 will have a potential duration of 16 weeks and those with a ratio of 3.5 or over will have potential duration of 26 weeks. Others will fall somewhere between the two.

Previous duration ranged from 14 to 28 weeks (21 to 39 with Extended Benefits) with an average of 20 weeks per claimant. Duration was based solely on a claimant's base period earnings. Modification of the duration schedule allows an earlier shift into the Extended Benefits program. This results in little or no loss of benefits to the average claimant and has the advantage of savings to Alaska's trust fund because one half of Extended Benefits are reimbursed by the federal government. This variable duration plan allows higher weekly payments at a lower cost to employers than would be otherwise possible.

Taxes

A new tax rate schedule will become effective January 1, 1981. The new schedule more equitably assigns rates to employers based on their experience with unemployment. Employers' payrolls will continue to be ranked in average decline quotient order. (The average decline quotient measures quarterly payroll variation.) Taxable payroll will be divided into 20 rate classes instead of the current ten. Each rate class will be assigned a tax rate based on the average benefit cost rate and the solvency of the UI trust fund. The benefit cost rate is defined as the cost of benefits over a three year period expressed as a percentage of total payroll over 3 years. Trust fund solvency is the ability of the fund to pay benefits. Fund solvency will be measured against total payroll and will be considered adequate at 3.2 percent of total payroll. A solvency tax will be added to the regular tax if the fund falls below the 3.2 percent level. The solvency tax will be applied uniformly to all employers at a rate of 0.1 percent to 1.1 percent depending on the condition of the fund. The combined regular and solvency tax may not exceed 6.5 percent or be less than 1 percent. The new schedule will be phased in over three years and no employer's rate will exceed 5.1 percent in

Tax Rate= [.82 X (average benefit cost rate) X (experience factor)] + solvency tax.

The experience factor is based on the decline quotient and ranges from .4 to 1.6. Eighty-two percent of the average benefit cost rate is borne by employers with the other 18 percent to be assigned to employees. The employee rate will range from 0.5% to 1.0%, depending on the average benefit cost rate. In any given year, all employees will pay the same rate.

The taxable wage base will be raised from the current $10,000 to a percentage of the state's average annual wage. The tax base will equal 60 percent of the average annual wage beginning January 1, 1981 (the tax base is projected to be approximately $12,000 in 1981). The percentage will be increased to 75 percent January 1, 1983.

The $10,000 base has been fixed by law for several years. Rapidly rising wages in conjunction with a fixed base caused a smaller and smaller proportion to be subject to tax (approximately 54 percent of total wages are currently subject to taxation). A tax base linked to the average annual wage will automatically rise or fall with wages.

Employers' costs will be more closely related to experience. While some employers will have an increase in costs, others will see a decline. Employees will pay 18 percent of total program costs (up from approximately 17 percent). See table below for expected tax impact.

EMPLOYER TAX IMPACT

Tax Base should increase to $12,000 in 1981
$12,500 in 1982
$16,300 in 1983

Projections For:	Old Law		New Law	
	1981	1983	1981	1983
Minimum Rate	2.6%	2.3%	1.81%	1.32%
Maximum Rate	5.1%	4.8%	5.10%	5.00%
Average Rate	4.0%	3.7%	3.90%	3.16%
Tax Base	$10,000	$10,000	$12,000	$16,300
Minimum Payment*	$260	$230	$217	$215
Maximum Payment*	$510	$480	$612	$815
Average Payment*	$400	$370	$468	$515

*At full base of $10,000 in old law; at full base of (60% and 75%) projected average annual wage in new law.

EMPLOYEE TAX IMPACT

	Old Law		New Law	
	1981	1983	1981	1983
TAX BASE	$10,000	$10,000	$12,000	$16,300
RATE	0.8%	0.7%	0.8%	0.7%
MAXIMUM PAYMENT	$80	$80	$96	$114

Disqualifications and Fraud

A claimant who quits work, is fired for misconduct, or refuses suitable work will be subject to a benefit reduction equal to three times the WBA (less dependents allowance) in addition to the current six week period of ineligibility. Present law disqualifies a claimant 26 weeks for misrepresentation. The new law will allow a variable disqualification period from 6-52 weeks depending on the circumstances. Fines and/or prison terms for false statements to secure benefits by claimants and prohibited acts by employers have been increased.

The able and available for work section of the law has been redefined to limit a claimant's waiver from availability if ill or disabled to six consecutive weeks. Availability for work is waived if the claimant is travelling for medical reasons or serving as a juror. An individual who is attending 10 or more hours of academic instruction is disqualified. Non-professional school employees are disqualified between terms.

Miscellaneous and Administrative

- -A provision required by federal law provides for release of wage information by the department to AFDC (welfare) agencies to aid in establishing the eligibility or amount of aid for individuals applying for AFDC.
- -State and local governments that elect reimbursable coverage are responsible for the full cost of extended benefits. Currently, all reimbursable employers are liable for one-half of extended benefits, which is Alaska's share of the cost.
- -Penalties for the unauthorized disclosure of information by an employee of the department are extended to include agents of the department.
- -Employee refunds are now allowed only if one employer pays contributions in excess of the tax base.
- -Several provisions allow for improved methods of collecting delinquent contributions. The interest rate charged on unpaid contributions is increased to 12% from 8%. The department may require monthly reports from consistently delinquent employers. The definition of employer is extended to include the officers of a corporation. This indentifies responsibility of those liable for delinquent contributions. Proof of solvency or the posting of a bond will be required by employers filing an appeal of tax assessment.
- -Changes in the apeals process include extending the number of days to file an appeal from 10 to 15 days. A waiver for filing a timely appeal may be granted for circumstances beyond the claimant's control.

The 1980 legislature passed a new unemployment insurance law which raises benefits for most workers. It may be worth your while to wait until after October 1st to file for unemployment benefits. For some workers, it may be better to file now.

The new law is complicated. It was the result of hard negotiations between anti-worker State Senators (led by Senate President Clem Tillion) and pro-worker State Representatives (led by Reps. Joe McKinnon of Anchorage and Brian Rogers of Fairbanks). THE LAW NEEDS TO BE CHANGED AGAIN NEXT YEAR, but in the meantime, Alaskan workers need to know how the new law affects you. This calculation sheet will show your benefits under the new and old laws; use it to figure out when to file.

A. Have you filed for unemployment benefits within the past 12 months? If so, when does your current benefit year end? If it ends on or after October 1, 1980, you must use calculation method 2. If your benefit year ends before Oct. 1, if you have not established a benefit year, or if you have not filed within the past 12 months, you should calculate your benefits under both methods 1 and 2, then decide whether to file now or to wait until October 1st.

B. CALCULATION METHOD 1. (This is the old law).

1. Enter your total wages for 2nd quarter 1979 (Apr, May, June).....
2. Enter your total wages for 3rd quarter 1979 (July, Aug, Sept).....
3. Enter your total wages for 4th quarter 1979 (Oct, Nov, Dec).....
4. Enter your total wages for 1st quarter 1980 (Jan, Feb, Mar).....
5. Add lines 1 through 4 (line 1 + 2 + 3 + 4).....
6. Enter the highest number from lines 1 through 4.....
7. Subtract amount on line 6 from amount on line 5 (line 5 - line 6).....

A

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3. Enter your total wages for 4th quarter 1979 (Oct, Nov, Dec).....
4. Enter your total wages for 1st quarter 1980 (Jan, Feb, Mar).....
5. Add lines 1 through 4 (line 1 + 2 + 3 + 4).....
6. Enter the highest number from lines 1 through 4.....
7. Subtract amount on line 6 from amount on line 5 (line 5 - line 6).....
   (If line 7 is less than $100, you do not qualify. Try method 2)
8. Determine your basic weekly benefit amount from the following table:

9. Do you have dependents? If YES, enter:
   1 dependent = $10.00; 2 dependents = $20.00; 3 dependents = $30.00.....
10. Add amounts on lines 8 and 9. This is your total weekly benefit amount.....
11. Multiply amount on line 10 times 26. This is your basic entitlement.....
12. Multiply amount on line 10 times 13. This is your extended entitlement.....
13. Add amounts on line 11 and line 12. This is your total entitlement.....

IF YOU FILE FOR UNEMPLOYMENT BENEFITS BEFORE OCT. 1, 1980, your weekly unemployment check will be for the amount on line 10. You are eligible to collect for 26 weeks (amount on line 11) plus 13 weeks of extended benefits (amount on line 12) for a total entitlement of the amount on line 13. Now try the new method.

C. CALCULATION METHOD 2. (This is the new law):

1. Enter your total wages for 3d quarter 1979 (July, Aug, Sept).....
2. Enter your total wages for 4th quarter 1979 (Oct, Nov, Dec).....
3. Enter your total wages for 1st quarter 1980 (Jan, Feb, Mar).....
4. Enter your total wages for 2nd quarter 1980 (Apr, May, June).....
5. Add amounts on lines 1 through 4 (line 1 + 2 + 3 + 4).....
6. Enter the highest number from lines 1 through 4.....
7. Subtract the amount on line 6 from amount on line 5 (line 5 - line 6).....
8. Multiply amount on line 7 times 10.....
9. Enter amount from line 8 or amount from line 5, WHICHEVER IS LESS.....
10. Divide amount on line 5 by amount on line 6. (line 5/line 6).....

line 10 results	weeks basic	weeks extended	total weeks
1.0 - 1.5	16	8	24
1.5 - 2.0	18	9	27
2.0 - 2.5	20	10	30
2.5 - 3.0	22	11	33
3.0 - 3.5	24	12	36
3.5 - 4.0	26	13	39

Use the number on line 10 to determine the number of weeks

you

you can collec
you can collect from the above table.
Enter total weeks.....
11. Find your basic weekly benefit amount from the following table:

12. Multiply total weeks (line 10) times weekly benefit amount (line 11).....

IF YOU FILE FOR UNEMPLOYMENT BENEFITS AFTER OCTOBER 1, 1980, your weekly unemployment check will be for the amount on line 11. You are eligible to collect for the number of weeks on line 10, for the total amount on line 12.

NOW FILL IN THE FOLLOWING BOXES:

NOW FILL IN THE FOLLOWING BOXES:	METHOD 1	METHOD 2
WEEKLY BENEFIT AMOUNT.....	(line 10, m. 1)	(line 11, m. 2)
TOTAL WEEKS ELIGIBLE TOTAL WEEKS ELIGIBLE.....	39	(line 10, m.2)
TOTAL ENTITLEMENT.....	(line 11, m. 1)	(line 12, m.2)

Now comes your decision. If your total eligible benefits under method 2 is more than under method 1, WAIT UNTIL OCTOBER 1 TO FILE. If your weekly benefit amount AND total entitlement under method 1 are both larger then under method 2, FILE NOW. If the weekly benefit amount under method 2 is larger than method 1, but the total entitlement is greater under method 2, you have a problem. Your choice is to get less money faster or more money slower. You have to use your judgement --- I think the best way is to guess at the number of weeks you'll be unemployed, multiply by the weekly benefit amount under each method, and go with the higher method.

It's no secret that the new law is a mess. The best thing you can do is to REGISTER TO VOTE and VOTE!!! in the November 4 general election for legislators who pledge to help clean up this mess. I'm already working on changes which I hope will simplify this law, but I'll need help from pro-labor representatives. In the meantime, if you need help in figuring out your rights and benefits under the unemployment law, give me a call (479-3083 at my office; I'm there every Wednesday all day and other days on occasion). I'd appreciate your support November 4th.

Paid for by Friends of Brian Rogers, Sherry Modrow, treasurer, Box K, College, Alaska 99708

LAWS OF ALASKA

1980

Source

FCCSHB 177

Chapter No.

9

AN ACT

Relating to unemployment insurance; and providing for an effective date.

for info Dennis Hay
452-8195

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

THE ACT FOLLOWS ON PAGE 1, LINE 9

UNDERLINED MATERIAL INDICATES TEXT THAT IS BEING ADDED TO THE LAW AND BRACKETED MATERIAL IN CAPITAL LETTERS INDICATES DELETIONS FROM THE LAW; COMPLETELY NEW TEXT OR MATERIAL REPEALED AND RE-ENACTED IS IDENTIFIED IN THE INTRODUCTORY LINE OF EACH BILL SECTION.

Approved by the Governor: March 13, 1980
Actual Effective Date: Section 2-4, 7-12, 18, 20, 22, 23, 25, 26, 28-30, 39, 40, 42, 45-53, 57, 62, 64, 69, 75 and 81-83 effective March 14, 1980. Sections 76 and 79 effective March 14, 1980, retroactive to January 1, 1978; Sections 1, 5, 6, 32, 54, 55, 56, 58-61, 63, 65-68, 70-74, 78 and 80 effective October 1, 1980; Sections 13-17, 19, 21, 24, 27, 31, 33-38, 41, 43, 44 and 77 effective January 1, 1981.