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GROUP WORKERS' COMPENSATION PLAN

# LETTER NEWSLETTER NEWS

Thomas Hays, Secretary
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1261 Oakmead Parkway, Sunnyvale, California 94068
October 1, 1980

## Household Goods 8293 Rate Deteriorates, Bureau Proposes 10% Increase 1-1-81

Leo Souza, President of the Workers' Compensation Bureau, in filings made with the California Department of Insurance, indicates that on the basis of 1980 benefit levels, the overall California rate level could go down 6.7% next year. Current filings **do not** include adjustments for law cost increases effective in January, but enacted after the Bureau rate filing in August.

**RATE PROPOSAL 1-1-81**

| Classification | | 1-1-80 Rate | 1-1-81 Proposal | % Chang. If Adoptec |
|---|---|---|---|---|
| 2701 | Log Trucks | $ 18.24 | 17.93 | –3.1% |
| 6206 | Vacuum Trucks | 9.66 | 8.79 | –0.9 |
| 7198 | Parcel Delivery | 5.68 | 6.45 | +13.6 |
| 7219 | Truckmen | 11.43 | 11.11 | –2.8 |
| 7222 | Oilfield Equipment | 14.18 | 15.98 | +12.7 |
| 7382 | Bus or Limousine | 7.08 | 6.50 | –8.9 |
| 8215 | Grain Warehouse | 9.54 | 8.66 | –9.2 |
| 8291 | Cold Storage Warehouse | 6.21 | 6.19 | –2.0 |
| 8292 | General Warehouse | 8.60 | 7.29 | –15.2 |
| **8293** | **Household Goods** | **14.15** | **15.57** | **+10.0** |
| 8742 | Sales | .83 | .73 | –12.0 |
| 8810 | Clerical | .43 | .41 | –4.3 |

The impact of recent benefit level increases enacted by the legislature and approved by the Governor are not included in the present rate proposal but are expected to raise the proposed rates by 2.5%. Benefit increases include raising the maximum temporary disability rate from $154 weekly to $175 and the maximum death benefit for two or more dependents from $55,000 to $75,000. HOUSEHOLD GOODS WAREHOUSMEN, 8293, is slated for an increase from the present $14.15 to $15.57 effective 1-1-81 if the Bureau filing is approved. TRUCKMEN, 7219, will get a 2.8% reduction, reducing their rate from $11.43 to $11.11. The table above outlines proposed changes in individual trucking and warehousing classification rates, subject to (1) Insurance Department Approval, and (2) Law Cost increase adjustments over 1980 levels. With the 25% benefit level cost increase the 8293 rate, if approved by the Commissioner, will be $16.38 per $100 payroll.

## Rate Making Objective 65% Loss Ratio - But When Do You Count Results?

The current rate proposals are based upon the loss experience developed during the 1976 and 1977 years adjusted so as to reflect current economic factors and law costs. The dilemma is, that the rates set for next year will only produce all the premium the insurers of the State will get for the business to be transacted during the prospective rate year.

How well does the Bureau really do in producing a statutory loss ratio? If you follow loss developments through the subsequent three years following that for which they are set, the Bureau comes close, generally within a couple of percentage points. But, look at the same experience developed out to ten years, the results really aren't that good.

Here are the currently developed loss ratios for 1969 through 1979 as reviewed in 1980:

**1980 DEVELOPED LOSS RATIO**

| Rate Year | Target Loss Ratio | Developed Loss Ratio |
|---|---|---|
| 1969 | .65 | .70 |
| 1970 | .65 | .66 |
| 1971 | .65 | .70 |
| 1972 | .65 | .76 |
| 1973 | .65 | .77 |
| 1974 | .65 | .80 |
| 1975 | .65 | .76 |
| 1976 | .65 | .67 |
| 1977 | .65 | .59 |
| 1978 | .65 | .58 |
| 1979 | .65 | .60 |

Considering that the maturation of the insurer's experience takes place long after all the premium is collected and long after dividends are disbursed, there is little left to the imagination as to why reserving is such a critical business.

Critics of the system complain that insurer's don't take

[Continued on page 2.]

investments into consideration in the prospective rate making process. Apart from the reason that no one knows what any permitted investments will yield prospectively, what kind of investment income would be required to offset the problem of maturation? Take 1969, for example. The entire earned workers' compensation premium that year for the State amounted to $579,238,656. Deduct the statutory expense allowance of 35% that went to cover running costs and disbursed dividends for that year and you have $308,581,210 allocable to losses that by 1980, cost $407,427,592, a shortfall of 32%! Not only did the loss costs rise, but so did the cost of managing the maturing losses. The short fall is not only substantial, it is alarming. It continues as a characteristic of the workers' compensation business.

During the intervening time the average yield on allowable investments ranged from a top of about 11% down to 3% on an ever declining investment base contributed by the results of a given year.

Insurance is the only business wherein the cost of goods sold cannot be determined for many years after the sale is made. It takes a lot of capital, a lot of luck, and a lot of good planning and organizing to make it.

There is no other system of finance known that can deal as effectively with the risks inherent in workers' compensation. It takes a sound rate making system, a very good data gathering and processing system, and it takes a competitive insurer environment to make it all come together and stay together as a viable resource for industry. The Workers' Compensation Insurance Rate Bureau has the Nation's outstanding record of accomplishing an effective balance between the needs of insurers on the one hand, and the social costs imposed on buyers by laws and rules imposed by the legislature and the courts.

If 1969, a relatively good year, turned out badly for California insurers ten years down the road, what will the results from 1974 or 1975 look like later?

CMSA Group Members should consider the very remarkable fact that despite all pressures on loss costs, their Group is delivering a stable and substantially better economic result for participating CMSA Members. Stability of underwriting results and continued high earnings of Members year after year are assured the Group where individual risk cooperation, Association advocacy, and insurer efficiency are working in harmony.

Our Group isn't playing rate roulette, we're producing better results.

## Rate Levels Yield To A Variety Of Pressures - Social Patterns Make Rate Making More Complicated And Costly

In its report to the Insurance Department, the Bureau makes special note of changing social policies that warrant a three-year average loss development for rate making purposes instead of a current two year loss development.

Pressures include cumulative trauma, inflation of medical costs, vocational rehabilitation, changes in benefit levels and rising medical fees.

Death and permanent disability claims comprise 83% of loss costs. Eighty percent of these claims are now litigated which contributes to a significant added late cost to insurer expense. Cumulative trauma claims now comprise about 6.5% of claims costs, down from 8.9% five years ago. Vocational rehabilitation is involved in 37.8% of claims now, up from 28% five years ago; actual rehabilitation costs have risen 58%, or from 3.4% of loss dollars to 5.0%.

## California Experience Rating Plan A Marvel In Efficiency

It is recognized that any rate level setting is prospective in character and contemplates adjustments in individual buyer rates brought about by the Experience Rating Plan. Careful records are maintained to enable examination of the efficiency of the system. Prospectively, no one can accurately predict individual business activity variations and past experience maturation. Just how well and in what way is the California Bureau coping with the problem of building incentives for excellence into the rate system?

Overall, the cumulative effect of achieved rate results and prospective premium levels show that the off-balance, (the difference between predicted and achieved), is now maintained within a tolerance of ½ of 1% yearly! This is an accomplishment on the order of a rifleman hitting a dime from a moving rowboat situated 300 yards from his target.

## Household Goods Classification Experience And California Insurers All Industry Experience

RATE-YEAR BASIS COMPARISON

| Year | 8293 Loss Ratio | All California Insurers Loss Ratio |
|---|---|---|
| 1970 | 51.9 | 58.1 |
| 1971 | 63.7 | 60.4 |
| 1972 | 57.9 | 63.1 |
| 1973 | 44.9 | 62.8 |
| 1974 | 64.5 | 66.5 |
| 1975 | 68.0 | 67.5 |
| 1976 | 64.0 | 69.5 |
| 1977 | 70.3*(1) | 60.0 |
| 1978 | *(2) | 63.5 |
| 1979 | *(2) | 60.5 |

*(1) Pure Premium Review 1980.
* (2) Data Unavailable

## CMSA Group Experience Continues To Buck Classification Trend

Approaching the Group's second dividend distribution, the CMSA Group Comp Insurance Committee tracks

Group loss results trends during current and past years. The loss development determines current paybacks to Group Members, it also determines whether any residual dividends can be captured for past years.

Here is what is developing:

**CMSA GROUP LOSS RATIO MATURATION**

| Group Year | At 12-1-78 | At 12-1-79 | At 9-1-80 |
|---|---|---|---|
| 77-78 | 31.1% | 47.4%*(1) | 67.6%*(2) |
| 78-79 | | 28.1 | 41.6*(1) |
| 79-80 | | | 26.4 |

*(1) Dividend base.
*(2) Before stop-loss adjustment. Adjusted loss ratio is 62.8%.

## CMSA Rate Development A Product Of Declining Payroll, Rising Loss Costs

| Year | Mover Payroll | Cost Of Mover Work Injuries | Loss Cost As A Percentage Of Payroll |
|---|---|---|---|
| 70 | $ 41,580,700 | $ 1,467,000 | 3.53% |
| 71 | 45,044,300 | 1,901,300 | 2.64 |
| 72 | 49,088,300 | 2,302,200 | 4.55 |
| 73 | 51,401,800 | 2,012,400 | 3.92 |
| 74 | 53,065,400 | 2,879,400 | 5.43 |
| 75 | 54,061,600 | 3,202,800 | 5.92 |
| 76 | 61,053,200 | 4,268,900 | 6.99 |
| 77 | 69,733,900 | 5,935,200 | 8.51 |

*Unadjusted to 1970 levels. 1977 adjusted to 1970 wage levels = $33,577,430 1969 payroll value.

This suggests that the number of claims may be remaining constant, a function of the level of employment. The facts are:

| Year | Number Of Claims | Number Of Employers |
|---|---|---|
| 1970 | 2,020 | 1,132 |
| 1971 | 1,865 | 1,258 |
| 1972 | 2,151 | 1,291 |
| 1973 | 1,976 | 1,171 |
| 1974 | 1,921 | 1,204 |
| 1975 | 1,794 | 1,087 |
| 1976 | 2,041 | 988 |
| 1977 | 2,179 | 1,472 |

The sharp rise in the number of reporting employers between 1976 and 1977 follows the rise in number of very small employers.

Putting the two facts together, we can conclude the attributable wages from which 8293 premium is derived has been dropping in relationship to the number of employed persons. Two things would contribute to this condition: (1) More risk is covered by the owner-operator premium protocol, and/or (2) more uninsured workers claiming.

As the cost of claims rise due to inflationary pressure on medical services and social costs rise through law cost increases, the division of costs by attributable payrolls continues to rise abruptly.

Another proof lies in the average premium per policy for the 8293 classification:

| Year | Average Premium Per Policy |
|---|---|
| 1970 | $ 2,493 |
| 1971 | 2,378 |
| 1972 | 2,898 |
| 1973 | 3,819 |
| 1974 | 3,705 |
| 1975 | 4,334 |
| 1976 | 6,745 |
| 1977 | 5,757 |

The break in the upward trend of average premium to policy is a 15% decline in one year despite the fact that wages generally rose during the same period of time and economic activity remained fairly constant for the household goods industry.

The bottom line is this: The employers who are not engaging owner-operators are cross-subsidizing those who do. They pay higher premiums because the losses are there but the premium base is being eroded by the inordinately smaller cost for owner-operator coverage to those who are paying for the coverage, and because the losses of owner-operators for whom premium is not being paid are laid off against the relatively declining payroll. The trend will continue because the losses will continue and there continues to be employers who try to beat the system.

## How Big Is California's Work Comp Insurance Bill?

| Year | Calender Year Premium |
|---|---|
| 1969 | $ 579,238,656 |
| 1974 | 990,591,763 |
| 1979 | 2,531,156,266 (4.37 times 1969) |

The figures do not include legally uninsured (self-insured) enterprises.

## 8293 Premium Increasing, But Not At The Same Rate As Loss Costs

| | Earned Premium Paid | % Change From Previous Year | Pure Losses Incurred | % Change From Previous Year |
|---|---|---|---|---|
| 1971 | 2,821,772 | | 2,821,772 | |
| 1972 | 2,983,398 | + 5.7 | 2,232,022 | - 20.9 |
| 1973 | 3,850,184 | + 29.1 | 2,012,372 | - 9.8 |
| 1974 | 4,472,749 | + 16.2 | 2,435,304 | + 21.0 |
| 1975 | 4,462,171 | - 5.6 | 3,202,778 | + 31.5 |
| 1976 | 6,664,542 | + 49.4 | 4,268,879 | + 33.3 |
| 1977 | 8,475,660 | + 27.2 | 5,935,275 | + 39.0 |
| Seven Year Change: | | + 136.0% | | + 157.0% |

*For the past 3 years loss cost increases have averaged 34% each year while earned premium has advanced an average of only 23.7%.*

## All California Work Comp Endorsements Now Required To Bear Penalty Warning Concerning Failure To Secure Comp Benefits

The specific language, **"Failure to secure the payment of full compensation benefits for all employees as required by Labor Code Section 3700 is a violation of law and may subject the employer to the imposition of a work stop order, large fines and other substantial penalties."** (Labor Code Section 3710.1, et seq.)

In view of the Appellate Court decision in Mission Insurance Co. vs. Workers' Compensation Appeals Board of the State of California WCAB No. 78 POM 57633, any employer of so-called owner-operators might well reconsider his position on not maintaining insurance on such individuals. It is clearly apparent the RIGHT to control is a governing element and overriding consideration in whether a person furnishing a truck and a driver is, in fact, for purposes of workers' compensation, an employee, especially where the truck is furnished by the driver. The overlying carrier is the logical and economic preference for providing coverage for owner-operators.

## Experience Rating Plan Changes To Be Effective 1-1-81

Experience ratings for growing, better managed risks will improve and the costs of poor loss experience for less successful enterprises will rise as a result of Experience Rating Plan revisions.

As the cost of components of the experience rating plan rise in response to inflation and law-cost changes, so do the weights that establish the proportion of loss experience an individual employer must be responsible for in his own experience rating.

Under the new tables an average death claim is taken to be $40,700, up from the current $37,900. With the maximum death benefit now pegged at $75,000, the probable average death claim will now go up.

A risk becomes self-rating, that is, the full value of all its losses become the basis of rate making for the risk, is now taken to be $871,000 in losses. In other words, full credibility of the individual's risk occurs when his loss experience equals or exceeds ten times the maximum loss value permissible under the plan of $87,000. Currently, the maximum loss value attributable on any claim stands at $82,000.

With the Truckman, 7219 being reduced somewhat in the current rate revision, employers with static payrolls and losses will get smaller experience discounts, or, in the case of debit rated risks, higher debits than under the old Experience Rating tables.

As soon as the Bureau Proposal is approved by the Insurance Commisioner, the CMSA Group Coordinating Agent will reprogram its Experience Rating Test Program to enable insured employers to see what their experience rating outlook is. We are trying to give employers a little advance notice about their cost development wherever possible.

## Dividend Sharing 1980 Readied, Participation Rules Reviewed

**(1)** Dividends are paid to the Group by the insurer, shares are paid to Qualifying Group Members.

**(2)** The basis of dividends, losses and premium, are reviewed three times for each Group year. **First**, at the agreed interval immediately following the end of the Group year (seven months following the end of the Group year). **Second**, one year later, and **third**, on the second anniversary date **after** the first payment. Funds paid to the Group by the insurer are non-retrievable. They may be increased, but never diminished. Credit losses may reduce any payment.

**(3)** Members' shares are determined by the Group Governing Committee. The CMSA Group Workers' Compensation Plan Committee examines the experience of the membership and selects from alternative distribution strategies that program which best apportions available funds, taking into consideration administrative costs, loss costs, and risk size of the individual members. The Committee is empowered to employ any part of a distribution to support loss control and prevention activity for the group or for contingencies which can affect the well being of the Group or its members.

**(4)** The Group Committee sets eligibility rules which in part are derived from laws and administrative regulations imposed by governmental authority, and Association rules having to do with fostering growth and stability of the Group.

Present legal and administrative law require:

1/ Participant must be a bona-fide Member of CMSA at the time of distribution.

2/ Must be a Member of the Group on the last day of the Group year for which a first dividend is being distributed, and, must be a Member of the Group at the time of any subsequent distribution.

Committee and Association rules require:

1/ Members shall have all premium obligations to the insurer paid up – for any past or current Group policy term.

2/ The Members' losses and share of insurance expense shall not exceed the premiums paid and apparent at the time of distribution.

3/ Must be a Member of the California Moving and Storage Association in good standing.

Great care is taken by your Association's Committee to ascertain the true and fair condition of each loss, premium, and status value. The actual share calculations involve, after loss and premium audits, more than 150 separate steps in calculation. If any Member has a question, subsequent to receiving his individual share, he should write his Association c/o Tom Hays, Group Secretary. A detailed and prompt explanation will be provided.

# *A Special Report:*

# CMSA WORK COMP GROUP 1980 DIVIDEND DISTRIBUTION

## 23% Of 1978-79 Earned Premium Of Qualifiers Returned

Tom Hays, Secretary of your CMSA Group Workers' Compensation Plan Committee is pleased to announce that share checks will be mailed on November 1 to qualifiers.

The '78 Group Year closed with an incurred loss ratio of 41.6% of earned premium. The result compares favorably with the 1977 Group Year results which were based on an initial base loss ratio of 40.6% of earned premium and a 24% return to the Group.

As the Group Year closes these comparative statistics are reported by the Truck Insurance Exchange:

| 1978-79 Group Year At Distribution 10-15-80 | | | 1977-78 Group Year At Distribution 10-15-79 | |
|---|---|---|---|---|
| 476 | 100% | Incurred Claims | 348 | 100% |
| 366 | 86% | Closed Claims | 309 | 89% |
| 60 | 14% | Open Claims | 39 | 11% |
| $1,407 | | Average Cost Of Incurred Claims At Closing Date | $1,595 | |
| $5,188 | | 1977-78 Average Cost Of Open Claims | $7,445 | |

## 1977-78 Group Year Underwriting Results Reviewed

At this time it is noteworthy that the matured value of 1977-78 Group Year losses valued as of 1980's closing were:

| 1977-78 Group Year Revaluation | | | Change From 1979 |
|---|---|---|---|
| Incurred Claims: | 415 | 100.0% | + 19% |
| Claims Closed: | 383 | 92.3% | + 16% |
| Claims Open: | 32 | 7.7% | – 3% |
| Average Cost Per Incurred Claim: | | $ 2,175 | + 35% |
| Average Cost Per Open Claim: | | $16,565 | + 55% |

Original reserve values upon which the 1977-78 Group Year dividend sharing was based have now developed to the point that no immediate prospects of a second provisional payment for the year exist. Changing medical histories on the more complicated injuries, together with sharply increased medical services costs cause the shift.

The 1977 Group claims cost can be compared with the results for the entire classification rate year. Using the Group experience taken at present matured values, the Group average cost of claim, $1,595, compares very favorably with the $2,277 average cost of claim experienced by the entire 8293 classification as disclosed in March, 1980 by the Rating Bureau. Although CMSA Group loss cost developments are presently disappointing, the Group is outperforming the rest of the classification. Our average incurred loss is lower by 30% and the percentage of closed claims is higher by 6%. Closed claims can't come back to haunt you.

The average cost of serious claims sustained by the Group during the 1977-78 Group Year, valued as of now, is $16,565. The 8293 classification comparable value is $34,422!

## CMSA Group Is A Major Force In Holding Entire Movers' Classification Down

Your 77-78 Group represented 27% of all the 8293 classification in 1977. The absence of the Group's positive force for risk improvement would have resulted in a much higher rate increase for 1981 renewals.

Cohesion of the Group and individual risk improvement effort is the one vital means by which California Movers can effect cost containment in the months ahead. The growth of the Group and intensive Member loss control activity pays off three important ways:

(1) Better industry dividend sharing.
(2) Improved experience rating.
(3) Lower manual rates.

## Employers' Target Loss Control Problems

GROUP EXPERIENCE–THREE YEARS

| Injury Source | % Of Claims | % Of Cost |
|---|---|---|
| **Moving Vehicles** (Striking Other Vehicles, Striking Fixed Objects, Overturning.) | 8.9 | 15.1 |
| **Exertion Injuries** | | |
| Back | 14.7 | 11.5 |
| Other Than Back | 7.8 | 4.5 |
| **Falls** (Same Level, Different Level, From Vehicles.) | 14.9 | 19.9 |
| | 46.3% | 51.0% |

A 10% reduction in occurrences from these three sources of injury would save the Group $150,000, and

would save the Moving & Storage Industry $600,000 in pure loss costs yearly. Productivity loss costs probably represent an additional 75% of economic waste.

Here's what the average work comp loss cost is by type of injury:

| | |
|---|---|
| **Moving Vehicles** | $ 6,690 |
| **Exertion** | |
| Back | $ 1,814 |
| Other Than Back | $ 1,315 |
| **Falls** | $ 5,669 |

## Loss Ratio Distribution Of 1978 Group Participants

| Loss Ratio | % Of Members |
|---|---|
| 0 – 9.9% | 64% |
| 10 – 19.9 | 11 |
| 20 – 29.9 | 3 |
| 30 – 49.9 | 2 |
| 50 – 59.9 | 5 |
| 60 – Over | 15 |

## How Good Is A 23% Dividend Ratio?

In 1979, California private workers' compensation insurers returned the equivalent of 10.2% of 1979 earned premium. The ten year average dividends returned by all private comp insurers in California was 8.2% of earned premium.

## Who Generated The Claims In 1978?

| 1978 Premium Size Class | % Of Group Class ($ Value) | % Of Members |
|---|---|---|
| $ To 9,999 | 35% | 58% |
| 10,000 – 29,999 | 18% | 22% |
| 30,000 – 49,999 | 28% | 18% |
| 50,000 – Over | 19% | 2% |

**8293 Classification average annual premium $5,757.**
**CMSA Group Member average annual premium $10,599.**

## Who Earned The Distributed Dividends In 1978?

| Premium Class | % Of Dividends |
|---|---|
| 0 – $9,999 | 16% |
| 10,000 – 29,999 | 38% |
| 30,000 – 49,999 | 29% |
| 50,000 – Over | 17% |

## California Bureau Approves 1980 Group Renewal

Ed Goldberg, Policy Examination Department, Workers' Compensation Rating Bureau, has approved your Association's Group renewal filing for the December, 1980 to 1981 Group Year. This constitutes the fourth annual examination and approval of Group plans and operations by the rating organization since December, 1977. Renewal effort will begin at once.

## Permanent Disability Ratings Are Based On Guidelines For Work Capacity–But Age At Time Of Injury Is An Important Factor

Here are nine examples of how age and work capacity limitations affect the cost of permanent disability indemnity:

| Back Injury – Driver – Loading & Unloading | | | |
|---|---|---|---|
| **Age 30** | **(A)** Restricted From Heavy Lifting | 20% | $ 6,510 |
| | **(B)** Restricted From Heavy Work | 30 | 10,522 |
| | **(C)** Restricted From Light Work | 50 | 19,810 |
| **Age 40** | **(A)** | 20 | 7,560 |
| | **(B)** | 30 | 12,022 |
| | **(C)** | 50 | 21,770 |
| **Age 50** | **(A)** | 30 | 8,662 |
| | **(B)** | 42 | 13,702 |
| | **(C)** | 63 | 23,240 |

Indemnity payments are disbursed at the rate of $70 per week after the employee has been declared medically permanent and stationary. Thus, our 50 year old 63% disabled worker will draw 332 weeks of permanent disability indemnity (6.38 years). If the settlement was reached by compromise and release and approved, that is the end of the claim. If the claim is resolved by a findings and award settlement by the Appeals Board, the injury will carry with it additional medical cost liabilities as well as the workers' potential petition for deconsideration if he feels the condition of his injury is worsened.

Permanent disability settlements do not provide for credit from temporary disability payments or for rehabilitation costs.

Permanent disability is the most misunderstood and complex work injury benefit. While the attempt has been made to objectively arrive at permanent disability ratings, the system can be manipulated by persons knowledgeable in the system's ways. It is the knowledge in claims management practices that largely determines the results for the insured.

That is why the Group Agent-of-Record assists the Group Committee in evaluating the quality of claims service on serious losses. During 1980, your Group examined over 250 claims generally, and intensively examined an additional 50 major Group losses. While the effort takes time and is expensive, it also pays off in better results. It applies expertise to the Members' needs and assures a fair result for employer and employee. One good question can prevent a bad result, any Member with a question as to the reason for a claim cost development can write the Group Agent-of-Record for an expanation and update:

August Enterprises
P.O. Box 256
Encino, California 91316

Some medical details may be confidential but general case information is part of the right of the policyholder to know under Group Membership terms.

# VOCATIONAL REHABILITATION - CALIFORNIA

## I. STATUTORY PROVISIONS

A. 139.5. [Added 1965, operative 1/15/66, amended 1972, operative 4/1/72, 1974, 1976] (a) The Administrative Director shall establish within the Division of Industrial Accidents a rehabilitation unit, which shall include appropriate professional staff, and which shall have all of the following duties:

(1) To foster, review, and approve rehabilitation plans developed by a qualified rehabilitation representative of the employer, insurance carrier, state agency, or employee.

(2) To adopt rules and regulations which would expedite and facilitate the identification, notification, and referral of industrially injured employees to rehabilitation services.

(3) To coordinate and enforce the implementation of rehabilitation plans.

(b) The salaries of the personnel of the rehabilitation unit shall be fixed by the State Personnel Board.

(c) When a qualified injured workman chooses to enroll in a rehabilitation program, he shall continue to receive temporary disability indemnity payments, plus additional living expenses necessitated by the rehabilitation program, together with all reasonable and necessary vocational training, at the expense of the employer or the insurance carrier, as the case may be.

(d) No provision of this section nor of any rule, regulation, or rehabilitation plan developed or promulgated under this section nor any benefit provided pursuant to this section shall apply to any injured employee whose injury occurred prior to January 1, 1975. Nothing in this section shall affect any plan, benefit, or program authorized by this section as added by Chapter 1513 of the Statutes of 1965 or as amended by Chapter 83 of the Statutes of 1972.

B. 3207. [3(3), amended 1965, operative 1/15/66] "Compensation" means compensation under Division 4 and includes every benefit or payment conferred by Division 4 upon an injured employee, including vocational rehabilitation, or in the event of his death, upon his dependents, without regard to negligence.

C. 4651.2. [Added 1965, operative 1/15/66] No petitions filed under Section 4651.1 shall be granted while the injured workman is pursuing a rehabilitation plan under Section 139.5 of this code.

D. 5100.6. [Added 1965, operative 1/15/66, amended 1976] Notwithstanding the provisions of Section 5100, the appeals board shall not permit the commutation or settlement of compensation or indemnity payments or other benefits to which the employee is entitled under rehabilitation.

## II. DECISIONAL LAW

### A. Settlement of Rehabilitation Benefits

Vocational rehabilitation benefits may be settled only in those cases where there is a serious and good faith jurisdictional issue (e.g., AOE/COE, employment) genuinely existing which, if resolved against the employee, would defeat his claim for all benefits. The workers' compensation judge must make a specific finding that such an issue exists to justify such a settlement. Thomas vs. Sports Chalet, 42 CCC 625.

### B. Qualified Injured Worker Status

An employee who refuses to quit a fulltime job in order to participate in a rehabilitation program is not a "qualified injured worker." McPheeters vs. Southern California Edison Company, 43 CCC 609.

### C. Public Employees

Public employees are entitled to vocational rehabilitation benefits under the provisions of Labor Code Section 139.5 in the same manner as employees of private employers. State Compensation Insurance Fund vs. WCAB (Slotten), 44 CCC 376.

### D. Costs - Right of Contribution

In a cumulative injury or occupational disease claim, the direct costs of vocational rehabilitation may be apportioned among all insurers in proportion to their respective periods of coverage even though one insurer's coverage entirely preceded the effective date of the mandatory vocational rehabilitation benefit. Denton Engineering vs. WCAB (Roberts), 42 CCC 48. (However, the courts have not yet resolved whether the TD rehabilitation maintenance benefit can be apportioned among insurers in these types of cases.)

### E. PD, TD Payments during Vocational Rehabilitation

An employee undertaking a vocational rehabilitation program is not entitled to permanent disability indemnity payments at the same time he is receiving the TD rehabilitation maintenance payment. Tangye vs. Henry Beck, 43 CCC 3.

Labor Code Section 4661.5, which requires TD indemnity payments made two years or more after the injury to be paid at the then current rate, applies to the TD rehabilitation maintenance payments. Glidewell vs. United Parcel Service, 43 CCC 1140; Diaz vs. Borcher Bros. Inc., 43 CCC 500.

Entitlement to the TD rehabilitation maintenance payment commences with the qualified injured worker's demand for vocational rehabilitation, not the date the employer determined the worker's medical eligibility. Webb v WCAB (DiGiorgio), 3rd Civ. 17714. (Appeal pending)

The time to commence TD rehabilitation maintenance payments is a factual matter to be determined on a case-by-case basis, which will contemplate a continuation of regular TD benefits, actual enrollment in a vocational rehabilitation program, and/or the employee's manifested interest in choosing to enroll in a rehabilitation program. Ponce de Leon vs Glaser, 42 CCC 962.

Entitlement to TD rehabilitation maintenance payments commence when the qualified injured worker accepts a vocational rehabilitation program approved by the Rehabilitation Bureau. San Diego Transit Corp. v WCAB (Renfro), 4 Civ. 18383 (Appeal pending)

California Workers' Compensation Institute
201 Sansome Street, San Francisco, California 94104, (415) 981-2107

Significant Decision 79-7

VOCATIONAL REHABILITATION MAINTENANCE PAYMENTS
San Diego Transit Corp. v WCAB (Renfro)
4 Civ. 18383

SIGNIFICANCE: Entitlement to rehabilitation temporary disability payments (Labor Code Section 139.5) commences when the qualified injured worker accepts the vocational rehabilitation program approved by the Rehabilitation Bureau of the Division of Industrial Accidents.

FACTS: Linda Renfro sustained injuries to her shoulder, back and arm on three separate occasions in 1976 while employed as a bush driver. On July 29, 1976 she wrote to her employer requesting vocational rehabilitation. The employer referred her for vocational evaluation during August and, after counseling, she expressed a desire to be retrained for hotel and restaurant management.

The employer did not deny the employee's right to rehabilitation but did question the vocational goal as inappropriate because of the extent of her permanent disability. A conference was held October 25, 1976 and on December 3 the Rehabilitation Bureau issued its decision approving the program requested by Renfro. The employer appealed but the workers' compensation judge upheld the Bureau and ordered payment of the rehabilitation TD payments retroactive to June 6, 1976 (the day after medical TD benefits ended). On reconsideration the judge's order was modified to require payments retroactive to July 29, 1976, the date Renfro first expressed an interest in vocational rehabilitation, a decision consistent with the earlier Appeals Board en banc decision in Ponce de Leon, 42 CCC 962.

HOLDING: The court rejected the Ponce de Leon rationale on the theory that it could not impose penalties on either the employee or employer. Based on its own interpretation of legislative intent, the Court held the rehabilitation TD benefits should commence when there is a qualified injured worker and the worker announces his willingness to participate in the rehabilitation plan. In annulling the Appeals Board decision, the Court ruled these two factors came together December 3, 1976, the date the Bureau approved the particular vocational rehabilitation program.

COMMENT: Some confusion should be expected because the Court's view of when the employee is "qualified" -- Bureau approval of the specific rehabilitation program -- differs from the definition contained in administrative rules and regulations (both current and amended effective August 27). Thus, under current practice an injured employee who is both medically eligible and vocationally feasible may receive rehabilitation TD payments during the period of rehabilitation plan is being prepared and submitted to the Bureau; under this decision, such payments are not due until the Bureau approves a program and the worker agrees to participate.

The Appeals Board will ask for a rehearing and, if not granted, intends to file an appeal with the Supreme Court. Until such time as this decision is final, the Institute strongly recommends insurers to follow their current practices and conform to the applicable administrative rules.

August 16, 1979

California Workers' Compensation Institute
201 Sansome Street, San Francisco, California 94104, (415) 981-2107

Significant Decision 78-3

VOCATIONAL REHABILITATION
Industrial Indemnity Co. v. WCAB (Duncan)
Liberty Mutual v. WCAB (Brown)
Court of Appeal 2nd Civil 48374

SIGNIFICANCE: The mandatory vocational rehabilitation provisions of Labor Code Section 139.5, effective 1-1-75, apply only to injuries occurring on or after that date.

HOLDING: In reversing a 4-3 WCAB decision which held the mandatory provisions applied retroactively, the Court ruled "something more than a desirable social objective (must exist) . . . to infer a legislative intent of retroactivity. Retroactive operation is not necessary to the rehabilitative purpose."

Specifically, the Court found the amendment in question substantially enlarged employee rights and there was no indication the Legislature intended the amendment to apply retroactively.

COMMENT: The decision is consistent with an amicus curiae brief filed by the Institute on behalf of its members.

###

November 16, 1978

California Workers' Compensation Institute
201 Sansome Street, San Francisco, California 94104, (415) 981-2107

Significant Decision 78-2

## TEMPORARY DISABILITY BENEFITS DURING VOCATIONAL REHABILITATION
## Tangye v. Henry Beck, 43 CCC 3

SIGNIFICANCE: A recent en banc opinion of the Appeals Board clarifies the carrier's obligation to pay benefits during vocational rehabilitation.

HOLDING: The Board held that: (1) An applicant is not entitled to simultaneous payment of temporary and permanent disability indemnity during a rehabilitation program; (2) The disability of a worker involved in a vocational rehabilitation program should not be considered permanent and stationary until after vocational and medical rehabilitation; and (3) Payment of permanent disability benefits should begin three days after the termination of the rehabilitation program.

###

February 7, 1978

California Workers' Compensation Institute
201 Sansome Street, San Francisco, California 94104, (415) 981-2107

Significant Decision 77-6

SETTLEMENT OF REHABILITATION BENEFITS
Douglas Thomas v. Sports Chalet, Inc.
42 CCC 625

Vocational rehabilitation benefits may not be settled absent a valid jurisdicational issue, according to an en banc decision of the Workers' Compensation Appeals Board.

The decision, which supports the position taken by CWCI in an amicus curiae statement, relies upon provisions of Labor Code 5100.6. However, the Appeals Board recognized rehabilitation benefits may be settled "in cases in which there is a good faith issue which, if resolved against the applicant, would defeat all benefits."

The long-expected decision underscores the necessity to assure that such settlements involve bone fide issues which support termination of the right to all compensation benefits. In addition, there should be an explicit finding by the WCAB judge that compensability is questioned as a part of the order approving the C&R.

###

May 12, 1977

Report of the REHABILITATION COMMITTEE
September 26, 1978
Los Angeles

# VOCATIONAL REHABILITATION COST STUDY

**Principal Findings:**

- The development and implementation of vocational rehabilitation plans cost an average of $4218 during 1975-76, the first two years of the mandatory vocational rehabilitation provision in the California law (see Exhibit 1)

- More than half of the expense in so-called "plan" cases was paid to the employee as a maintenance benefit while undergoing rehabilitation. Payments to vendors for testing and evaluation services accounted for 28 per cent of plan expenditures, with the remainder paid for tuition, books, tools, transportation and other retraining expenses (Exhibit 1).

- Vocational rehabilitation plans involving formal school training were the most expensive, an average of $5707 each, during 1975-76 and were the most frequent type of retraining program (42 per cent of all plans) approved by the Rehabilitation Bureau of the Division of Industrial Accidents. Direct placement programs, often a modified job with the same employer, were the least costly ($1495) during the same period (Exhibit 1).

- Formal schooling programs, on-the-job training, or a combination of both, accounted for seven of every ten rehabilitation plans (Exhibit 1).

- Of the 204 rehabilitation plans reviewed, only seven (3 per cent) did not require expenditures for vocational rehabilitation benefits (Exhibit 1).

- Plan cases, including plans terminated after initial implementation, approximated 19 per cent of closed files and accounted for nearly two-thirds of rehabilitation expenditures during the study period (Exhibit 2).

- The remaining third of vocational rehabilitation costs was spent in non-plan cases, in most instances to determine or establish the employee's non-eligibility for vocational rehabilitation benefits (Exhibit 2).

- Non-plan closings were attributable mainly to cases where the employee's medical condition did not warrant vocational retraining (29 per cent of all closed files), where the employee refused services (22 per cent), or where vocational rehabilitation was not feasible (11 per cent). Collectively these three categories accounted for 28 per cent of all vocational expenditures and nearly 80 per cent of all non-plan case costs (Exhibit 2).

- More than half of all files closed by the Rehabilitation Bureau required vocational rehabilitation expenditures, even though only one-third of those cases entailed the provision of services pursuant to a rehabilitation plan. Non-plan expenditures occurred most often in closings for non-feasibility, employee refusal of services and medical ineligibility (Exhibit 3).

- Nearly 80 per cent of the employees in the study sample were represented by an attorney during the pendency of their workers' compensation claim. Although the study did not attempt to measure the extent of attorney involvement in the vocational rehabilitation process, employees were less likely to be represented in plan cases and more likely to be represented where rehabilitation services were refused (Exhibit 5).

- Bureau conferences were held in 6.5 per cent of all cases, most frequently in plan cases which ultimately were terminated (Exhibit 6). Every fourth plan required one or more conferences, and plan cases accounted for 78 per cent of all conferences. Multiple conferences were held in 56 per cent of all conferenced cases.

- Information concerning the Work Status Report (Form RB-1) -- required when vocational rehabilitation is necessary or in every case where temporary disability is 120 days or longer -- was not recorded in 18.6 per cent of the files reviewed (Exhibit 7). On a worst cases basis, i.e., assuming the form was not submitted in all these cases, this finding casts doubt on the accuracy of the Bureau's earlier contention that work status reports are not contained in 32 per cent of its files. Moreover, it appears RB-1 reports were not required in nearly 60 per cent of the non-recorded cases.

Description of the Study: Data was compiled from a sample of closed files of the Rehabilitation Bureau selected during March-April 1978 by staff of the Institute. The sampling prodecure generally required the selection of every ninth file unless the employer involved was self-insured, in which event the next closed file of an insured employer was selected. However, in order to assure a representative number of plan cases (designated C-4 or C-5 by the Bureau), such cases were over-sampled by selecting every fifth case. Consequently, closed files in each of the Bureau's 15 offices were separated into plan and non-plan files before selecting every fifth and ninth case, respectively. This sampling technique produced inter-office variations (see Exhibit 8) due to client mix, employer mix, caseloads and backlogs, but the committee believes the sample is valid and representative.

The initial sample consisted of 1043 cases (14 per cent of all closed files at the time), of which 23 per cent involved the development, implementation and either the completion or termination of a specific rehabilitation plan. After elimination of incomplete files, worksheets on 1017 cases were prepared and forwarded May 25, 1978 to 53 insurers. By the end of June 786 worksheets had been returned, of which 770 were usable (see Exhibit 9 for composition of the returned sample by Bureau closing mode). Thus the results contained in this report are based on 76 per cent of the a priori sample, far in excess of the 15-20 per cent return necessary for statistical reliability.

One of the subordinate purposes of the study was to verify the accuracy of the Bureau's closing codes. Exhibit 10 shows the results of this test. While the differences generally are not extreme, the committee believes the insurer's assessment of the reason for case closure is more accurate -- particularly considering 24 cases "closed" by the Bureau where benefits still are being provided -- and these designations were used in the preparation of other exhibits contained in this report.

Finally, the over-sampling of plan cases described earlier produced a distribution in which such cases were 164 per cent of what otherwise might be expected in a random sample. In an effort to provide the industry with an approximate overview of vocational rehabilitation during 1975-76, the sample was restructured to eliminate this deliberate bias. The results of this exercise are shown in Exhibits 2 and 3 and, while admittedly not correct statistically, these displays may be useful to industry personnel responsible for delivering vocational rehabilitation benefits.

Limitations: The committee appreciates the limitations of the study data and recognizes the hazards inherent in making recommendations based on history, particularly when the history is biased.

In the first instance, the study was limited to closed files of the Rehabilitation Bureau; it seems reasonable to assume the "easiest" cases may close sooner, so the sample may not be representative of today's reality. Secondly, 60 per cent of the sample consisted of cases where the year of injury was 1975, the first year of mandatory vocational rehabilitation, and employees' and insurers' response to a new benefit and a new procedure probably does not parallel current conditions. Thirdly, the committee concedes -- based in viscera more than fact -- that some costs of a new program may not have been allocated correctly, e.g., the rehabilitation maintenance benefit may have been recorded as temporary disability indemnity, so the per-case costs could be understated.

Nevertheless, the study produced the first industrywide hard data available, and the committee recommends the results -- with appropriate caveats -- be distributed to interested parties.

Marilyn Wilson, R.N., Fireman's Fund Insurance Cos., chairman
Bob Dyer, State Compensation Insurance Fund
Andrea Hartman, Employers Insurance of Wausau
Russell Hoyt, Travelers Insurance Company
Lilly Ikegami, Western Employers Insurance Company
William H. McKee, Liberty Mutual Insurance Company
Fred Seyferth, Argonaut Insurance Company
Frank Woodbury, Allstate Insurance Company
Michael Craig, Transport Indemnity Company

AVERAGE COST BY PLAN TYPE
(Including terminated plans)

| Plan Type | Cases # | Cases % | Average Costs Maint. | Vendor | Other | Total |
|---|---|---|---|---|---|---|
| OJT | 43 | 21.1 | $1,648 | $1,221 | $ 618 | $3,486 |
| Schooling | 86 | 42.1 | 3,182 | 1,323 | 1,202 | 5,707 |
| OJT & Schooling | 14 | 6.9 | 1,794 | 1,458 | 1,351 | 4,603 |
| Direct Placement | 32 | 15.7 | 705 | 740 | 50 | 1,495 |
| Self-Employment | 11 | 5.4 | 1,971 | 1,467 | 1,329 | 5,267 |
| Other | 18 | 8.8 | 1,581 | 904 | 269 | 2,754 |
| | 204 | 100.0 | $2,168 | $1,190 | $ 860 | $4,218 |
| | | | 51.4% | 28.2% | 20.4% | |

DISTRIBUTION AND COSTS BY CLOSING MODE
(Reconstructed sample)

| Closing Mode | # | % of Total | $ Cost | % of Total |
|---|---|---|---|---|
| Not medically eligible | 200 | 28.6 | 61,391 | 7.1 |
| Not vocationally feasible | 80 | 11.4 | 84,349 | 9.8 |
| Pre-1975 injury | 53 | 7.6 | 18,964 | 2.2 |
| Other non-QIW | 49 | 7.0 | 4,797 | 0.6 |
| Rehabilitation refused | 152 | 21.7 | 97,385 | 11.3 |
| Completed plan, RTW | 100 | 14.3 | 398,840 | 46.2 |
| Completed plan, no RTW | 9 | 1.3 | 60,980 | 7.1 |
| Plan terminated | 25 | 3.6 | 96,481 | 11.2 |
| Other | 8 | 1.1 | 2,091 | 0.2 |
| Open | 24 | 3.4 | 37,579 | 4.3 |
| | 700 | 100.0 | $863,357 | 100.0 |

AVERAGE COST BY CLOSING MODE
(Reconstructed sample)

| Closing Mode | # Cases w/Costs | # Cases w/o Costs | Average $ per Case (Cost Cases Only) |
|---|---|---|---|
| Not medically eligible | 63 | 137 | $ 975 |
| Not vocationally feasible | 63 | 17 | 1,347 |
| Pre-1975 injury | 3 | 50 | 6,321 |
| Other non-QIW | 4 | 45 | 1,199 |
| Rehabilitation refused | 87 | 65 | 1,119 |
| Completed plan, RTW | 96 | 4 | 4,155 |
| Completed plan, no RTW | 9 | 0 | 6,777 |
| Plan terminated | 24 | 1 | 4,020 |
| Other | 4 | 4 | 523 |
| Open | 18 | 6 | 2,088 |
| | 371 | 331 | $ 2,327 |

Vocational Rehabilitation Cost Study
CWCI REHABILITATION COMMITTEE
August 1978

## % DISTRIBUTION OF COSTS
## (by closing mode)

| Closing Mode | % Total VR costs allocated to | | |
|---|---|---|---|
| | Maint | Vendor | Other |
| Not medically eligible | 29.5 | 67.5 | 3.0 |
| Not vocationally feasible | 36.0 | 61.1 | 2.9 |
| Pre-1975 injury | 62.8 | 37.0 | 0.2 |
| Other non-QIW | 46.4 | 49.9 | 3.7 |
| Rehab refused | 42.9 | 52.8 | 4.3 |
| Completed plan, RTW | 49.3 | 29.7 | 21.0 |
| Completed plan, no RTW | 59.5 | 21.2 | 19.3 |
| Plan terminated | 48.8 | 33.0 | 18.2 |
| Other | 0.0 | 99.5 | 0.5 |
| Open | 45.3 | 52.7 | 2.0 |

## ATTORNEY REPRESENTATION

| | Represented? | |
|---|---|---|
| | % Yes | % No |
| All closings | 78.8 | 21.2 |
| Plan cases only | 73.0 | 27.0 |
| Refusal cases only | 82.2 | 17.8 |

## CONFERENCES

| Closing mode | % Cases requiring conference | Average number conferences per case |
|---|---|---|
| Not medically eligible | 0.5 | 1.0 |
| Not vocationally feasible | 3.75 | 1.7 |
| Pre-1975 injury | -- | -- |
| Other non-QIW | -- | -- |
| Rehab refused | 1.3 | 1.0 |
| Completed plan, RTW | 13.4 | 1.8 |
| Completed plan, no RTW | 53.3 | 1.3 |
| Plan terminated | 68.0 | 1.8 |
| Other | -- | -- |
| Open | 20.8 | 1.3 |
| | 6.5 | 1.6 |

Vocational Rehabilitation Cost Study
CWCI REHABILITATION COMMITTEE
August 1978

## DISPOSITION OF CASES WITHOUT RB-1 INFORMATION

| Closing Mode | # | % |
|---|---|---|
| Not medically eligible | 28 | 19.6 |
| Not vocationally feasible | 7 | 4.9 |
| Pre-1975 injury | 42 | 29.3 |
| Other non-QIW | 12 | 8.4 |
| Rehabilitation refused | 17 | 11.9 |
| Plan completed, RTW | 14 | 9.8 |
| Plan completed, no RTW | 2 | 1.4 |
| Plan terminated | 5 | 3.5 |
| Open | 7 | 4.9 |
| Other | 9 | 6.3 |
| | 143 | 100.0 |

## INITIAL COMPOSITION OF SAMPLE

| Bureau Office | # Closed Files | Sample # | Sample % | Completed Plans in Sample # | Completed Plans in Sample % |
|---|---|---|---|---|---|
| Bell Gardens | 219 | 32 | 14.6 | 9 | 28.1 |
| Fresno | 517 | 74 | 14.3 | 19 | 25.7 |
| Long Beach | 271 | 42 | 15.5 | 14 | 33.3 |
| Los Angeles | 348 | 47 | 13.5 | 16 | 34.0 |
| Oakland | 597 | 72 | 12.1 | 16 | 22.2 |
| Panorama City | 1409 | 194 | 13.8 | 20 | 10.3 |
| Pomona | 683 | 83 | 12.2 | 15 | 18.1 |
| Sacramento | 567 | 74 | 13.1 | 13 | 17.6 |
| San Bernardino | 167 | 28 | 16.8 | 7 | 25.0 |
| San Diego | 148 | 34 | 23.0 | 12 | 35.3 |
| San Francisco | 408 | 75 | 18.4 | 20 | 26.7 |
| San Jose | 700 | 97 | 13.9 | 20 | 20.6 |
| Santa Ana | 583 | 82 | 14.1 | 20 | 24.4 |
| Santa Rosa | 509 | 70 | 13.7 | 15 | 21.4 |
| Ventura | 274 | 39 | 14.2 | 12 | 30.8 |
| | 7300 | 1043 | 14.3 | 244 | 23.4 |

**Vocational Rehabilitation Cost Study**
**CWCI REHABILITATION COMMITTEE**
**August 1978**

## SAMPLE COMPOSITION

| Bureau Closing Code | Original Sample | Returned # | Returned % |
|---|---|---|---|
| C1 - Not medically eligible | 253 | 200 | 79.1 |
| C2 - Not vocationally feasible | 112 | 86 | 76.8 |
| C3 - Rehab refused | 183 | 133 | 72.7 |
| C4 - Plan completed, no RTW | 26 | 23 | 88.5 |
| C5 - Plan completed, RTW | 219 | 161 | 73.9 |
| C6 - Plan terminated | 21 | 15 | 71.4 |
| C7 - Pre-1975 injury | 59 | 44 | 74.6 |
| C8 - Other | 80 | 62 | 77.5 |
| No code shown | 65 | 46 | 70.7 |
| | 1017 | 770 | 75.7 |

Vocational Rehabilitation Cost Study
CWCI REHABILITATION COMMITTEE
August 1978

## COMPARISON OF BUREAU CLOSING CODE TO INSURER'S RESOLUTION MODE

| Reason for case closing | Bureau | Insurer |
|---|---|---|
| Not medically eligible | 200 | 200 |
| Not vocationally feasible | 86 | 80 |
| Pre-1975 injury | 44 | 53 |
| Other non-QIW | 62 | 49 |
| Rehab refused | 133 | 152 |
| Plan completed, RTW | 161 | 164 |
| Plan completed, no RTW | 23 | 15 |
| Plan terminated | 15 | 25 |
| Bureau code not shown | 46 | -- |
| Other closing | -- | 8 |
| Open cases | -- | 24 |
| | 770 | 770 |

Division of Industrial Accidents
REHABILITATION BUREAU
California Department of Industrial Relations
455 Golden Gate Avenue
San Francisco, CA 94102

# REHABILITATION BUREAU NEWSLETTER

JANUARY 1980

A joint legislative committee hearing was held in Monterey early in November. All sectors of the community interested in the injured worker were present. Testimony was given by over twenty people, one of whom was an injured worker.

Generally, the Bureau was praised for its progress. The Bureau's testimony noted the manner in which the Bureau is organized and detailed its role in this program. The rehabilitation process was briefly outlined.

It was pointed out that less than five years ago the Bureau was created knowing its purpose only in the most general terms, and having no models on whose experience they could draw. With the beginning of 1979, the Bureau had conducted studies which led to:

1. Extensive revisions in the Rules and Regulations already effective;

2. Provision of forms and guidelines for all phases of the rehabilitation process (included here);

3. Changes in internal procedures;

4. Changes in the Policy and Procedure Manual.

* * * * *

## RESULTS OF STUDY;
## SAMPLE OF 1978 CASE CLOSURES OF WORKERS
## MEDICALLY ELIGIBLE FOR REHABILITATION BENEFITS

### Areas of Injury

The information gathered in this study indicated 55% of rehabilitation candidates have incurred back injuries, followed by 6% with knee injuries, 4% each to neck, arm, or leg; 3% each to head, foot or allergy; 2% each to shoulder, elbow, hip, wrist or nervous system; and 1% each to ankle or chest.

### Time

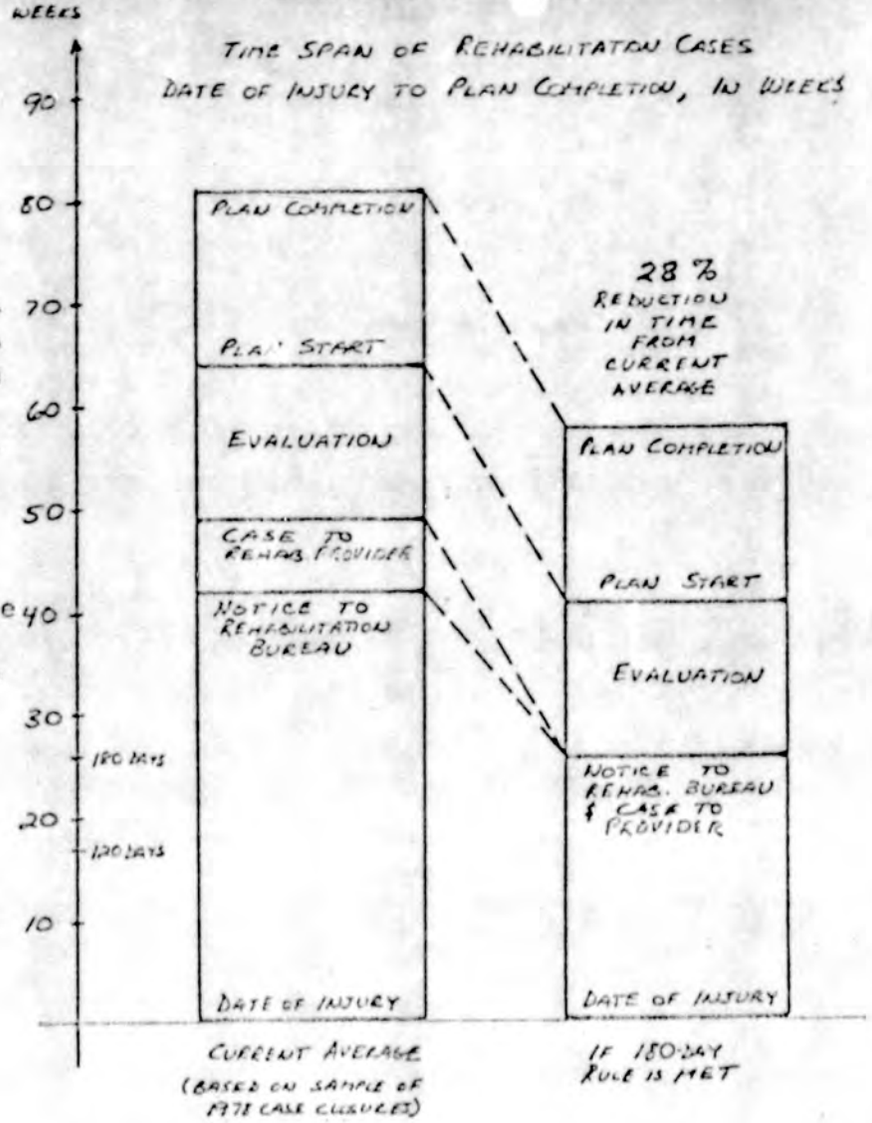
On Page 2 we have illustrated the average length of time it took to get through the rehabilitation process for a plan completed in 1978. The total process took 81 weeks. The average time was 42 weeks from the date of injury to report to the Bureau, 25 weeks later than the 120 days reporting requirements in effect at the time these cases were in process. It took an average 7 more weeks

Time (cont'd)

before a provider of rehabilitation services was assigned, and 15 weeks from that point for an evaluation to occur and plans to be submitted. The plans averaged 17 weeks. The graph also shows that there would be a 28% reduction in total time if the new 180-day reporting requirement is met and a case is referred to a provider of rehabilitation services at the same time.

REHABILITATION BUREAU

TIME SPAN OF REHABILITATON CASES
DATE OF INJURY TO PLAN COMPLETION, IN WEEKS

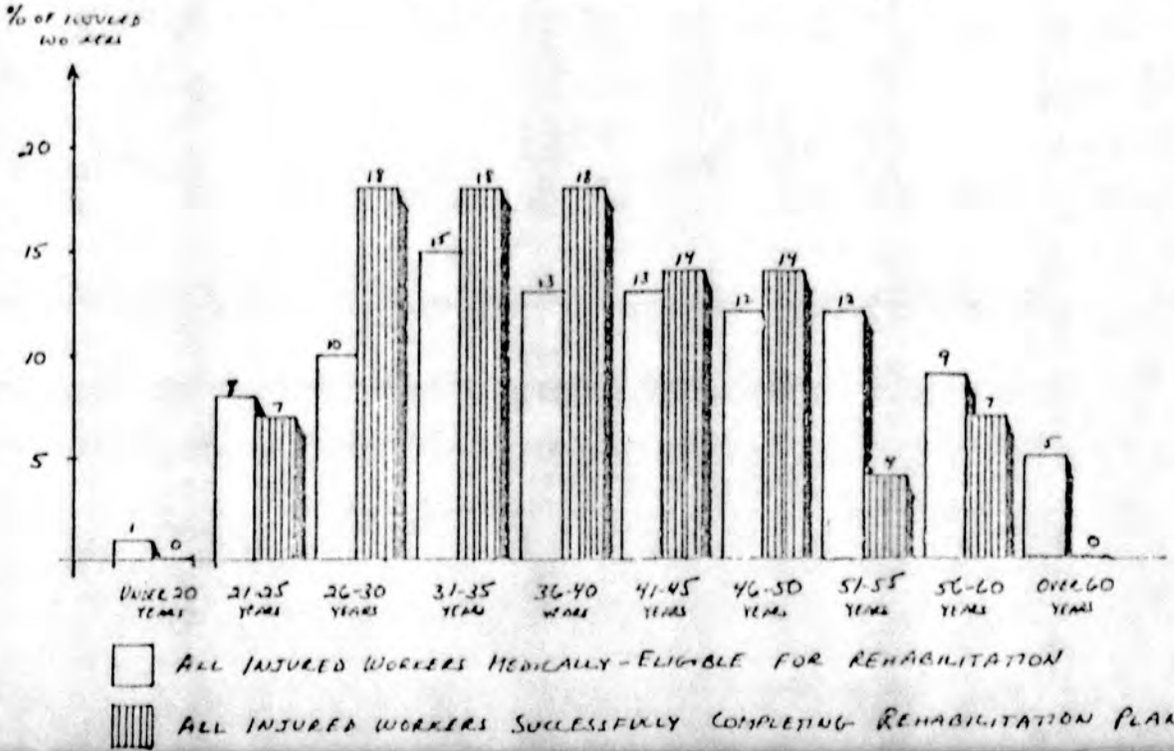



Age

The next illustration gives the percentage of injured workers eligible for rehabilitation that falls into each age category. It also gives the percentage of people in each grouping who successfully completed a rehabilitation program and returned to work. The highest percentage of people (82%) completing plans were in the 26 to 50 year age groups, yet only 63% of the total population entitled to rehabilitation benefits were in this age group.

This shows that more workers who drop out rather than complete the rehabilitation process are

% DISTRIBUTION OF INJURED WORKERS IN REHABILITATION SYSTEM, BY AGE GROUPINGS
(SOURCE: SAMPLE OF 1978 CASE CLOSURES)



either under 26 or over 50. The average age of the successfully rehabilitated worker is 38½ years.

Wages

Fifty-four percent of the injured workers successfully completed a plan to return to the same or increased wages. The median wage was $225.00 weekly, with a $40.00 increase for 38% of all workers and a $36.00 decrease for 45% of the workers. Sixteen percent returned to the same salary as that at the time of injury.

Plan Type

What type of plans are resulting in successful rehabilitation and return to work? According to plans successfully completed in 1978, modified work meets with the highest success of 32%, followed by plans involving formal training at 25%. The next category of plans are those for direct job placement at 16%. A combination of formal training and on-the-job training comprises 11% of the total. On-the-job training alone makes up 9%. Finally, self-employment has the smallest portion of the total with 7%.

* * * * *

## OTHER FACTS AND FIGURES

In 1978 only 47% of all Bureau cases resulted from a report by an employer. In January of 1979, through August, this figure rose to 60%.

The Bureau has processed 93,000 Work Status Reports and developed 54,000 cases; 49% of these have flowed into the Bureau in the last 18 months. Presently, the Bureau has an open caseload of 23,000 cases.

In the third quarter the Bureau consultants reported referring an average of two cases per consultant for independent vocational evaluations. Only one counselor received three referrals and two received two; the rest were spread among a variety of counselors.

Ninety-five appeals were reported during this same time period. Four percent for eligibility; 29% for temporary disability issues; 18% for unknown reasons; and 13% for a variety of reasons including further services, statute of limitations, liens, appropriateness of plans, and cross-examination of Agreed Medical Examiners.

* * * * *

## PANEL DECISIONS: APPEALS ON BUREAU ORDERS

In a panel decision in the case of Manuel W. Perez vs. Eagle Truck; Zenith National Insurance Company, the WCAB stated the manner in which appeals of decisions and orders of the Rehabilitation Bureau were to be made.

1. A petition is to be filed containing (a) the title and number of the case; (b) the specific issue or issues individually stated, e.g., eligibility, feasibility, temporary disability,etc.;

(d) a copy of the petition must be served on the Bureau.

2. A Declaration of Readiness must be filed together with the petition, giving information such as hearing or conference wanted, number of witnesses, time required, etc.

The decision clearly stated that the Bureau consultant may request that the matter be returned for reconsideration by the Bureau.

* * * * * * *

NEW FORMS

Attached are the new forms. There may be some changes after they are reviewed by a form designer. Final copies will be sent out later, in the meantime, please use the attached. We suggest that you wait for the final forms before reproducing in great numbers.

Medical Evaluation Form

This form should be used only when a physician is being asked to comment on the need for rehabilitation. It is especially useful when used together with a job description or job analysis. This form is not required, but should be helpful when there is a possibility of a need for rehabilitation and a physician has not previously commented regarding this.

Employee Job Description
and Employer Job Description Form

These are non-required, but Bureau recommended forms which may be used by claims personnel or rehabilitation coordinators to:

1. Determine if there is an agreement on the physical demands of the job between the employee and employer.

2. Assist the physician and employee in setting realistic return to work goals.

3. Determine whether or not the employee is medically eligible for rehabilitation services.

The forms are designed to be sent during the first month of disability with a cover letter explaining the positive purpose (#2 above).

When there is general agreement on the physical demands of the job between the employee and employer, the employee's form should be forwarded to the treating physician with a cover letter asking the following questions:

1. Will the employee be physically able to do the job described?

2. Is more information on the physical demands needed? If so, an on-site job analysis can be completed.

If there are major discrepancies on the physical demands of the job between the employee and the employer, you should consider the need for an on-site job analysis. These forms cannot be used in lieu of a job analysis requested by the Bureau.

On-Site Job Analysis

This is another not required, but Bureau recommended form. It must be completed by the carrier/employer personnel trained in this technique, or a vocational rehabilitation provider, and signed by the employee with his/her comments as necessary. This type of analysis may be reported in a narrative style but must meet the minimum requirements as indicated on this form.

New internal procedures have been implemented January 1, 1980; therefore, the Conference and Closure Request Forms ARE REQUIRED!

Request for Conference Form

Requests submitted in any other manner will be returned for proper submission. Anyone may request a conference, however, it is preferred that the employer or the employee (or his/her representative) request conferences when necessary, rather than the rehabilitation provider.

Request for Closure Form

This may be sent by anyone, preferably the employer/insurance carrier. This form is needed by the Bureau both to identify potential closures and to purge cases from the computer.

Vocational Rehabilitation Plan,
Work Status Report and Request for Rehabilitation Benefits

These forms are not complete and will not be available until a later date.

* * * * *

SERVICE OF REPORTS ON BUREAU

The Bureau would like to see all reports served by the authorizing party, rather than by the providers of rehabilitation services. For the present, we will not return reports submitted by counselors, but may do so in the future should providers of rehabilitation services continue to serve reports on the Bureau routinely.

Reports should be served on the Bureau at the following times, rather than as each report be comes available:

1. When an injured worker is determined not eligible either for medical or feasibility reasons, and a Bureau decision is necessary;

2. When issues arise and the Bureau must mediate, e.g., a conference is requested;

3. When a plan is submitted;

4. When the Bureau requests information; or

5. When a closure is requested.

The Bureau has no opinion or direction on service of reports to other parties.

# MEDICAL EVALUATION

## FUNCTIONAL LIMITATION/CAPACITY

IDENTIFYING INFORMATION:

NAME: _____

DATE OF BIRTH: ___/___/___ DATE OF INJURY: ___/___/___

NOTE:
The information on this form is obtained from the physician to be used for the sole purpose of determining the medical qualifications of the injured worker for rehabilitation. The information is intended to include functional limitations pre-existing the industrial injury and the functional limitations resulting from the industrial injury for which this evaluation is required. This form is not designed nor intended to be used for permanent disability rating.

### FUNCTIONAL CAPACITIES EVALUATION

NOTE: In terms of an 8 hour workday, "Occasionally" equals 1% to 33%, "Frequently" equals 34% to 66%, and "Continuously" equals 67% to 100%.

I In an 8 hour work day, injured worker can: (Circle full capacity for each activity).

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| A. Sit - Number of Hours: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| B. Stand - Number of Hours: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| C. Walk - Number of Hours: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |

| II Injured worker is able to: | Not At All. | Occasionally. | Frequently. | Continuously. |
|---|---|---|---|---|
| A. Bend/Stoop | ( ) | ( ) | ( ) | ( ) |
| B. Squat | ( ) | ( ) | ( ) | ( ) |
| C. Crawl | ( ) | ( ) | ( ) | ( ) |
| D. Climb | ( ) | ( ) | ( ) | ( ) |
| E. Reach above shoulder level | ( ) | ( ) | ( ) | ( ) |
| F. Crouch | ( ) | ( ) | ( ) | ( ) |
| G. Kneel | ( ) | ( ) | ( ) | ( ) |
| H. Balancing | ( ) | ( ) | ( ) | ( ) |
| I. Pushing/Pulling | ( ) | ( ) | ( ) | ( ) |

| III Injured worker can carry: | Not At All. | Occasionally. | Frequently. | Continuously. |
|---|---|---|---|---|
| A. Up to 10 pounds. | ( ) | ( ) | ( ) | ( ) |
| B. 11 to 24 pounds. | ( ) | ( ) | ( ) | ( ) |
| C. 25 to 34 pounds. | ( ) | ( ) | ( ) | ( ) |
| D. 35 to 50 pounds. | ( ) | ( ) | ( ) | ( ) |
| E. 51 to 74 pounds. | ( ) | ( ) | ( ) | ( ) |
| F. 75 to 100 pounds. | ( ) | ( ) | ( ) | ( ) |

| IV Injured worker can lift: | Not At All. | Occasionally. | Frequently. | Continuously. |
|---|---|---|---|---|
| A. Up to 10 pounds. | ( ) | ( ) | ( ) | ( ) |
| B. 11 to 24 pounds. | ( ) | ( ) | ( ) | ( ) |
| C. 25 to 34 pounds. | ( ) | ( ) | ( ) | ( ) |
| D. 35 to 50 pounds. | ( ) | ( ) | ( ) | ( ) |
| E. 51 to 74 pounds. | ( ) | ( ) | ( ) | ( ) |
| F. 75 to 100 pounds. | ( ) | ( ) | ( ) | ( ) |

V Injured worker can use feet for repetitive movements as in operating foot controls:

Right: ___Yes ___No. Left: ___Yes ___No. Both: ___Yes ___No.

VI Injured worker can use hands for repetitive movements such as:

| | Simple Grasping. | Firm Grasping. | Fine Manipulation. |
|---|---|---|---|
| A. Right: | ( ) Yes ( )No | ( )Yes ( )No | ( )Yes ( )No |
| B. Left: | ( ) Ye ( )No | ( )Yes ( )No | ( )Yes ( )No |

VII Restriction of activities. For example: being around moving machinery; driving automotive equipment; other restrictions required by the physical impairment.

SIGNATURE OF PHYSICIAN: _____ DATE: __/__/__

PLEASE RETURN TO:

# EMPLOYER JOB DESCRIPTION

IDENTIFYING INFORMATION:

EMPLOYEE: _____

ADDRESS : _____

DATE OF INJURY: ____/ ____/ _____ CLAIM #: _____

EMPLOYER: _____

CARRIER/AGENT: _____

NOTE: In terms of an 8 hour workday, "Occasionally" equals 1% to 33%, "Frequently equals 34% to 66%, and "Continuously" equals to 67% to 100%.

I In an 8 hour workday, employee is required to: (Circle full capacity for each activity).

A. Sit - Number of Hours: 1 2 3 4 5 6 7 8
B. Stand - Number of Hours: 1 2 3 4 5 6 7 8
C. Walk - Number of Hours: 1 2 3 4 5 6 7 8

| II On the job employee must: | Not at All. | Occasionally. | Frequently. | Continuously. |
|---|---|---|---|---|
| A. Bend/Stoop | ( ) | ( ) | ( ) | ( ) |
| B. Squat | ( ) | ( ) | ( ) | ( ) |
| C. Crawl | ( ) | ( ) | ( ) | ( ) |
| D. Climb | ( ) | ( ) | ( ) | ( ) |
| E. Reach above shoulder level | ( ) | ( ) | ( ) | ( ) |
| F. Crouch | ( ) | ( ) | ( ) | ( ) |
| G. Kneel | ( ) | ( ) | ( ) | ( ) |
| H. Balancing | ( ) | ( ) | ( ) | ( ) |
| I. Pushing/Pulling | ( ) | ( ) | ( ) | ( ) |

| III On the job employee is: | Not at All. | Occasionally. | Frequently. | Continuously. |
|---|---|---|---|---|
| A. Up to 10 pounds. | ( ) | ( ) | ( ) | ( ) |
| B. 11 to 24 pounds. | ( ) | ( ) | ( ) | ( ) |
| C. 25 to 34 pounds. | ( ) | ( ) | ( ) | ( ) |
| D. 35 to 50 pounds. | ( ) | ( ) | ( ) | ( ) |
| E. 51 to 74 pounds. | ( ) | ( ) | ( ) | ( ) |
| F. 75 to 100 pounds. | ( ) | ( ) | ( ) | ( ) |

| IV On the job employee lifts: | Not at All. | Occasionally. | Frequently. | Continuously. |
|---|---|---|---|---|
| A. Up to 10 pounds. | ( ) | ( ) | ( ) | ( ) |
| B. 11 to 24 pounds. | ( ) | ( ) | ( ) | ( ) |
| C. 25 to 34 pounds. | ( ) | ( ) | ( ) | ( ) |
| D. 35 to 50 pounds. | ( ) | ( ) | ( ) | ( ) |
| E. 51 to 74 pounds. | ( ) | ( ) | ( ) | ( ) |
| F. 75 to 100 pounds. | ( ) | ( ) | ( ) | ( ) |

V On the job employee uses feet for repetitive movements as in operating foot controls:

Right: ____Yes ____No Left: ____Yes ____No Both: ____Yes ____No

VI On the job employee uses hands for repetitive action such as:

| | Simple Grasping | Firm Grasping | Fine Manipulating |
|---|---|---|---|
| A. Right | ( )Yes ( )No | ( )Yes ( )No | ( )Yes ( )No |
| B. Left | ( )Yes ( )No | ( )Yes ( )No | ( )Yes ( )No |

VII Does job require:

A. Working on unprotected heights. ( )Yes ( )No Comment: _____

B. Being around moving machinery. ( )Yes ( )No Comment: _____

C. Exposure to marked changes in temperature and humidity. ( )Yes ( )No Comment: _____

D. Driving automotive equipment. ( )Yes ( )No Comment: _____

E. Exposure to dust, fumes, gases. ( )Yes ( )No Comment: _____

COMMENTS:

SIGNATURE OF EMPLOYER: _____ DATE: __/__/__

TITLE: _____

PLEASE RETURN TO:

# ON-SITE JOB ANALYSIS

EMPLOYER: _____ DATE OF ANALYSIS: __/__/__

EMPLOYEE: _____ CLAIM NUMBER: _____

1. Exact job title: _____ DOT #: _____
2. Date of Hire: __/__/__ Date began present position: __/__/__
3. Training required to perform duties: _____

_____

4. Work hours: From _____ To _____ Number of days per week: _____
   Breaks: First _____ To _____ Overtime hours per week: _____
   Meal _____ To _____ Overtime: How often: _____
   Last _____ To _____
5. Any work restrictions when hired: ( ) Yes ( ) No If yes, specify: _____

_____

_____

_____

6. General description of job: _____

_____

_____

_____

_____

7. Types of machines, tools, office equipment, and other special equipment used in job:

_____

_____

_____

8. Vehicles or moving equipment drive as part of job: _____

_____

9. Amount of each day spent:
   Standing _____% Walking _____% Sitting _____% Total 100%
10. Employee works: Outside _____% Inside _____% Total 100%
11. While performing job was employee required to:

| | | How often and How long. |
|---|---|---|
| Stoop/Bend | ( )Yes ( )No | _____ |
| Squat | ( )Yes ( )No | _____ |
| Kneel | ( )Yes ( )No | _____ |
| Crawl | ( )Yes ( )No | _____ |

(CONTINUED) How Often and How Long.

Climb Ladders ( )Yes ( )No _____

Climb Stairs ( )Yes ( )No _____

Walk on Uneven Ground ( )Yes ( )No _____

Work above Ground on:

_____ ( )Yes ( )No _____

Lift under 10 pounds ( )Yes ( )No _____
Lift 10 to 25 pounds ( )Yes ( )No _____
Lift 25 to 50 pounds ( )Yes ( )No _____
Lift 75 to 100 pounds ( )Yes ( )No _____
Lif over 100 pounds ( )Yes ( )No _____

Carry under 10 pounds ( )Yes ( )No _____
Carry 10 to 25 pounds ( )Yes ( )No _____
Carry 25 to 50 pounds ( )Yes ( )No _____
Carry 50 to 75 pounds ( )Yes ( )No _____
Carry 75 to 100 pounds ( )Yes ( )No _____
Carry over 100 pounds ( )Yes ( )No _____

Reach above shoulder height ( )Yes ( )No _____
Reach at shoulder height ( )Yes ( )No _____
Reach below shoulder height ( )Yes ( )No _____

12. The heaviest weight lifted while either sitting or standing in one place weighs: _____. The object's name is _____ and the estimated times lifted is _____

13. The heaviest weight carried while walking from place to place weighs _____ The object's name is _____ and the extimated items carried is _____

14. Job required: Description of object, weight, how moved, how often.

Pushing ( )Yes ( )No _____

_____

Pulling ( )Yes ( )No _____

_____

15. Job can be modified: Temporarily ( )Yes ( )No Permanently ( )Yes ( )No

If yes, specify: _____

_____

NOTE: The following is to be completed for HAND INJURY ONLY.

| 16. Hand Coordination Activities: | Right | Left | Both | How Often | How Long |
|---|---|---|---|---|---|
| Major Hand | ____ | ____ | ____ | _____ | _____ |
| Fine Manipulation | ____ | ____ | ____ | _____ | _____ |

(CONTINUED) HAND INJURY ONLY

| | Right | Left | Both | How Often | How Long |
|---|---|---|---|---|---|
| Gross Manipulation | ____ | ____ | ____ | _____ | _____ |
| Simple Grasping | ____ | ____ | ____ | _____ | _____ |
| Power Grip | ____ | ____ | ____ | _____ | _____ |
| Hand Twisting | ____ | ____ | ____ | _____ | _____ |

17. COMMENTS:

_____

_____

_____

_____

_____

COMPLETED BY: _____ TITLE: _____
(Signature)

COMPLETED WITH: _____ TITLE: _____
(Signature)

EMPLOYEE COMMENTS/CORRECTIONS:

_____

_____

_____

_____

_____

I have reviewed this job analysis and agree with its content, except for comments/ corrections as noted above.

EMPLOYEE: _____ DATE: __/__/__
(Signature)

FROM

REQUEST FOR CONFERENCE

TO

STATE OF CALIFORNIA * REHABILITATION BUREAU
Division of Industrial Accidents

_____

_____ ZIP _____

REHABILITATION BUREAU USE ONLY.

COMPLETE

EMPLOYEE: _____

ADDRESS: _____

_____

DATE BIRTH: __/__/__ DATE INJURY: __/__/__

BUREAU #: _____

EMPLOYER: _____

CARRIER/
AGENT: _____

CLAIM #: _____

INSTRUCTIONS: Please type or print legibly. Submit form to Rehabilitation Bureau that has the case for which you are requesting conference.

Include Bureau Case Number.

NOTICE

In accordance with Article 12, Rule 10007, the Rehabilitation Bureau, either on its own motion or upon the request of either the employer or the employee, may schedule a conference. A conference is intended to resolve questions such as an employee's entitlement to vocational rehabilitation services, or where a vocational rehabilitation plan is not offered by the employer, or where the vocational rehabilitation plan is not acceptable to the employee. The Bureau will generally require that the parties meet and confer without the Bureau's presence prior to the conference in order to try to resolve their problem. A written summary of what took place at these meetings may be required prior to scheduling a conference.

A. The parties involved are unable to resolve the following problem: _____

_____

_____

B. The following steps were taken in an attempt to resolve the problem:

___ Agreed on Medical Evaluator (AME)
___ Agreed to independent evaluation by party to be selected by Rehabilitation Bureau (IVE)
___ Parties have met and conferred informally
If not, why not: _____
_____
_____

___ Agreed on Vocational Evaluator (AVE)
___ Submitted Work Evaluation
___ Submitted On-Site Job Analysis
___ Arranged for Testing
___ Other: _____
_____
_____
_____

C. An interpreter will be needed. ___Yes ___No. Language: _____
If yes, employer will arrange for services of an interpreter.

COPIED

Copy of this request and all medical and vocational rehabilitation reports have been sent to the following at the time of conference request:

_____

_____

_____

_____

SIGNED: _____ DATE: __/__/__

FROM

REQUEST FOR CASE CLOSURE

TO

STATE OF CALIFORNIA * REHABILITATION BUREAU
Division of Industrial Accidents

_____

_____ ZIP _____

REHABILITATION BUREAU USE ONLY

EMPLOYEE: _____

BUREAU #: _____

EMPLOYER: _____

CARRIER/
AGENT : _____

CLAIM # : _____

INSTRUCTIONS: Please type or print legibly. Submit form to the Rehabilitation Bureau that has the case you are requesting closure on. Include Bureau Case Number.

Temporary Disability is being paid through: ___/___/___ (Date.)

We wish to request that the Rehabilitation Bureau now close this file in the following category: (Check and complete only one.)

( ) 01 Worker is not medically eligible for rehabilitation.

( ) 02 Worker is not vocationally feasible for rehabilitation.

( ) 03 Worker declines (refuses rehabilitation benefits. Attach copy of statement signed by the injured worker, or copy of notice sent to the injured worker.

( ) 04 Rehabilitation plan is completed. Worker is not working.

( ) 5A Rehabilitation plan is completed. Worker is now working in the new occupation for which he/she was rehabilitated. Fill in information below.

NAME OF EMPLOYER: _____

ADDRESS: _____

JOB TITLE: _____

DATE OF HIRE: _____

( ) SALARY (Circle One): $_____ PER W H S M O

WEEK HOUR SEMI-MONTH OTHER: PLEASE DESCRIBE ABOVE.

( ) 5B The rehabilitation plan is completed. Worker is now working in an occupation other than that for which he/she was rehabilitated. Fill in information above.

( ) 06 Rehabilitation services terminated.

( ) 08 Suspension requested. (Attach information verifying need for suspension.)

( ) 09 Issues of injury or lack of jurisdiction.

( ) 19 Other: _____

( ) __ Bureau use only: _____

ATTACH: Copy of employer advice to employee explaining the action taken. (Rules and Regulations 10004) Any pertinent information (medical or vocational) and documentation of the above action and criteria on which the decision was made.

SIGNED: _____ DATE: ___/___/___

RB-20 (1/80)

# Casualty Insurance Marketing — 1979

- *Workers' Compensation*
- *General Liability*
- *Medical Malpractice*

MARKETING TRENDS in 1979 for workers' compensation, general liability and medical malpractice insurance are surveyed in this issue, continuing our series of annual reviews of major lines of property/casualty business. The three classes covered this month produced nearly $23.9 billion in premiums in 1979, representing 26.5% of the total property/casualty insurance volume. In 1978, these classes accounted for 26.1% of the total; in 1977, 24.9%; and in 1976, 23%.

## WORKERS' COMPENSATION

An 18% gain in premiums for workers' compensation in 1979, on top of a 22% gain in 1978, a 27% gain in 1977 and a 23% gain in 1976 brought this line to more than $14.3 billion in premiums. Five years earlier, workers' compensation premiums were $5.6 billion. This line now represents 15.9% of the total property/casualty insurance volume. In 1974 it was 12.9%. Despite the rapid growth in premium volume, workers' compensation still suffers from a combined loss and expense ratio in excess of 100%. However, the pure loss ratio in 1979 improved by 2.7 points to 75.3% from 78% in 1978.

The main problem in workers' compensation continues to be the near impossibility of securing adequate rates to keep up with higher benefits and increasingly liberal interpretations of what is compensable.

The national agency companies increased their workers' compensation premiums at the industry average of 18%, while the regional/specialty companies were ahead 25%, and the direct writers gained 13%. This slip by the direct writers, which have been steadily increasing their market share until now, cost them a full point in the market to 25.7%. The national agency companies gained two-tenths of a point to 57.7% and the regional/specialty companies went to 16.6%. The movement in market share over the last five years looks like this:

| | % Market Share | | | | |
|---|---|---|---|---|---|
| | 1979 | 1978 | 1977 | 1976 | 1975 |
| National Agency Cos. | 57.7 | 57.5 | 58.0 | 59.4 | 59.0 |
| Regional/Specialty Cos. | 16.6 | 15.7 | 15.7 | 15.6 | 15.9 |
| Direct Writers | 25.7 | 26.8 | 26.2 | 24.9 | 24.2 |

The Old Republic Group, the largest regional/specialty writer in this field, showed the greatest percentage gain in premiums among the top 50 writers of workers' compensation as it advanced 85% and moved up seven places in the rankings to 14th. It had far and away the largest increase as the next largest was the 34% gain of CNA Insurance Group. There were no decreases in premiums among the top 50 writers.

Among the 10 leading writers of workers' compensation, the top four were the same as in 1978. The number five spot was taken by the Hartford, which moved up one place on a 16% gain, while Fireman's Fund dropped to sixth on an 8% gain. Home Insurance, on a 28% premium increase, moved to eighth place from ninth, displacing U.S.F.&G., which fell one place to ninth position.

The top 10 writers of workers' compensation insurance in 1979 ac-

(Continued)

### Leading Writers of Workers' Compensation Insurance

| | 1979 Direct Prems.* | % of Market Share 1979 | 1978 | 1977 | 1976 | 1979 Gain Prems.* | % Gain | Loss Ratios 1979 | 1978 | % of Total Prems. |
|---|---|---|---|---|---|---|---|---|---|---|
| Liberty Mutual | 1,300,372 | 9.1 | 9.7 | 8.9 | 8.2 | 123,306 | 10 | 75.0 | 86.5 | 49.3 |
| Aetna L&C | 836,280 | 5.8 | 5.7 | 5.5 | 4.7 | 142,738 | 21 | 70.0 | 80.6 | 22.1 |
| Travelers | 823,423 | 5.7 | 5.6 | 6.2 | 7.8 | 138,807 | 20 | 85.5 | 96.8 | 20.6 |
| CNA | 688,904 | 4.8 | 4.7 | 4.2 | 3.8 | 120,334 | 21 | 84.5 | 89.4 | 26.2 |
| Hartford Group | 536,014 | 3.7 | 3.8 | 3.8 | 4.0 | 74,203 | 16 | 72.5 | 85.8 | 20.3 |
| Fireman's Fund | 531,863 | 3.7 | 4.1 | 4.2 | 4.1 | 39,240 | 8 | 82.0 | 87.6 | 22.3 |
| Wausau Group | 528,106 | 3.7 | 3.6 | 4.3 | 4.6 | 87,963 | 20 | 79.1 | 86.6 | 52.5 |
| Home Group | 442,976 | 3.1 | 2.8 | 2.9 | 2.8 | 97,034 | 28 | 68.2 | 83.3 | 28.8 |
| U.S.F.&G. | 437,593 | 3.1 | 3.2 | 3.1 | 3.0 | 52,074 | 14 | 74.7 | 71.0 | 22.6 |
| Crum and Forster | 398,640 | 2.8 | 2.8 | 3.1 | 3.2 | 64,037 | 19 | 65.1 | 66.7 | 24.4 |
| CNA | 351,608 | 2.7 | 2.4 | 2.4 | 2.3 | 99,068 | 34 | 79.2 | 94.2 | 26.4 |
| Continental | 349,465 | 2.4 | 2.6 | 3.0 | 3.7 | 31,407 | 10 | 74.4 | 72.1 | 14.2 |
| Kemper Group | 346,321 | 2.4 | 2.5 | 2.4 | 2.1 | 45,772 | 15 | 73.7 | 73.4 | 26.3 |
| Old Republic | 286,497 | 2.0 | 1.3 | 1.4 | 2.2 | 131,361 | 85 | 158.9 | 95.5 | 75.2 |
| AIG | 277,764 | 1.9 | 1.8 | 1.3 | 1.0 | 58,167 | 26 | 57.6 | 69.1 | 13.8 |

*In dollars, 000 omitted.

Notes: Loss ratio is losses incurred to premiums earned, not including loss adjustment expense, but adjusted for dividends to policyholders.
% of total premiums is percent of workers' compensation premiums to insurer's total property/casualty premium volume.

counted for 45.5% of the business, five-tenths of a point less than they handled in 1978. Six of the top 10 companies showed increases better than the industry average of 18% and only one – Fireman's Fund – had an increase of less than 10%.

In addition to the more than $14 billion of workers' compensation business written by insurance companies, approximately $3 billion is handled by state insurance funds, some of it on a monopolistic basis. In many states, including California (which is the leading state in workers' compensation premiums for insurance companies), the state funds are the largest single writers of compensation business. Other states where this is true are Arizona, Colorado, Nevada, New York, Ohio, Oregon, and Washington. Nationally, the funds handle about 20% of the more than $17 billion aggregate workers' compensation insurance that is purchased in this country.

Leading states in workers' compensation premiums written by insurance companies are California, Texas, Pennsylvania, New York and Illinois. The volume of workers' compensation is influenced by legislation, the nature of the economy of the state and the presence or absence of state insurance funds (although in three of the top five states, the funds play an important competitive role – in California, the state fund wrote $457 million in premiums; in New York, the fund wrote $463 million; and in Pennsylvania, the fund was the second largest writer with $129 million in direct premium writings). The five leading states account for 44.6% of the workers' compensation business handled by insurance companies.

In California, where more than 15% of the commercial workers' compensation business is conducted, premiums rose 13%, with the national agency companies advancing the aver-

(Continued)

## Workers' Compensation Insurance Premium Distribution and Leading Writers by State

| Rank | State | Total Direct Prems.* | % of U.S. Total | Loss Ratio % | Market Share: National Cos. | Market Share: Regional Cos. | Market Share: Direct Writers | Leading Writer | % of State Market | Second and Third Leaders and Market Share | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 26 | Alabama | 144,113 | 1.0 | 70.3 | 58.9 | 18.7 | 22.4 | Liberty Mutual | 11.2 | U.S.F.&G. | 10.7 | Travelers | 8.0 |
| 37 | Alaska | 77,265 | .5 | 87.4 | 75.2 | 16.2 | 8.6 | INA | 45.6 | Providence Wash. | 14.3 | Crum and Forster | 10.2 |
| 24 | Arizona | 176,130 | 1.2 | 56.9 | 54.9 | 28.7 | 16.4 | Mission Group | 12.4 | Crum and Forster | 8.2 | Fremont General | 8.1 |
| 30 | Arkansas | 105,867 | .7 | 74.9 | 62.6 | 15.6 | 20.8 | Aetna L&C. | 5.9 | Hartford Group | 5.7 | Travelers | 5.7 |
| 1 | California | 2,195,460 | 15.3 | 67.5 | 53.1 | 26.6 | 20.3 | INA | 7.7 | Fremont General | 6.5 | Fireman's Fund | 6.5 |
| 34 | Colorado | 89,807 | .6 | 63.8 | 67.5 | 8.7 | 23.8 | Liberty Mutual | 8.0 | Employers of Wausau | 7.8 | U.S.F.&G. | 6.4 |
| 16 | Connecticut | 251,747 | 1.8 | 77.1 | 71.2 | 4.8 | 24.0 | Aetna L&C. | 15.7 | Liberty Mutual | 15.0 | Travelers | 11.7 |
| 41 | Delaware | 39,096 | .3 | 71.6 | 51.5 | 13.7 | 34.8 | Liberty Mutual | 11.5 | Pa. Manufacturers | 8.2 | Aetna L&C. | 7.8 |
| 28 | D.C. | 120,951 | .8 | 84.7 | 76.5 | 1.4 | 22.1 | Liberty Mutual | 19.1 | Kemper Group | 15.2 | Aetna L&C. | 12.6 |
| 7 | Florida | 669,728 | 4.7 | 53.9 | 58.6 | 19.4 | 21.9 | Liberty Mutual | 9.8 | Travelers | 7.2 | Aetna L&C. | 6.3 |
| 14 | Georgia | 270,134 | 1.9 | 73.6 | 55.3 | 15.3 | 29.3 | Liberty Mutual | 14.9 | Aetna L&C. | 6.2 | Travelers | 5.0 |
| 36 | Hawaii | 79,584 | .6 | 82.8 | 65.2 | 27.9 | 6.8 | Continental | 21.8 | Hawaiian Group | 15.3 | Hartford Group | 11.2 |
| 40 | Idaho | 47,740 | .3 | 78.0 | 54.4 | 23.3 | 22.4 | Teledyne Group | 19.8 | Crum and Forster | 15.3 | Employers of Wausau | 10.4 |
| 5 | Illinois | 901,468 | 6.3 | 80.4 | 61.6 | 15.8 | 22.6 | Liberty Mutual | 8.0 | Travelers | 6.8 | Aetna L&C. | 5.5 |
| 23 | Indiana | 177,255 | 1.2 | 66.4 | 61.3 | 17.6 | 21.1 | Liberty Mutual | 6.6 | U.S.F.&G. | 6.4 | Employers of Wausau | 5.9 |
| 25 | Iowa | 171,847 | 1.2 | 69.6 | 45.5 | 31.4 | 23.1 | Liberty Mutual | 7.2 | Employers Mutual | 7.0 | Aetna L&C. | 5.7 |
| 29 | Kansas | 118,972 | .8 | 74.3 | 69.8 | 11.4 | 18.8 | Travelers | 12.0 | U.S.F.&G. | 7.3 | Hartford Group | 6.5 |
| 12 | Kentucky | 320,818 | 2.2 | 123.8 | 45.1 | 33.5 | 21.4 | Old Republic | 27.7 | Liberty Mutual | 11.0 | Travelers | 6.4 |
| 10 | Louisiana | 383,439 | 2.7 | 88.9 | 59.4 | 24.3 | 16.4 | Aetna L&C. | 8.0 | Highlands Group | 6.9 | Liberty Mutual | 6.0 |
| 33 | Maine | 86,170 | .6 | 112.3 | 64.7 | 3.0 | 32.3 | Liberty Mutual | 19.8 | Aetna L&C. | 10.7 | Commt. Union | 10.6 |
| 15 | Maryland | 252,311 | 1.8 | 86.8 | 69.8 | 8.0 | 22.3 | Travelers | 10.3 | Liberty Mutual | 9.7 | Home Group | 6.2 |
| 11 | Massachusetts | 367,392 | 2.6 | 91.2 | 57.7 | 5.8 | 36.4 | Liberty Mutual | 21.3 | Aetna L&C. | 10.4 | Travelers | 6.9 |
| 6 | Michigan | 860,317 | 6.0 | 61.4 | 68.5 | 9.1 | 22.4 | Mich. Mutual | 8.7 | Liberty Mutual | 8.4 | Travelers | 5.9 |
| 9 | Minnesota | 422,788 | 3.0 | 83.3 | 58.0 | 11.3 | 30.8 | Liberty Mutual | 8.5 | Travelers | 8.1 | Employers of Wausau | 8.1 |
| 32 | Mississippi | 86,340 | .6 | 74.5 | 75.5 | 8.0 | 16.5 | U.S.F.&G. | 23.8 | Travelers | 10.0 | Liberty Mutual | 8.3 |
| 20 | Missouri | 202,759 | 1.4 | 76.8 | 64.0 | 9.6 | 26.5 | Liberty Mutual | 11.6 | Aetna L&C. | 5.6 | Employers of Wausau | 5.3 |
| 42 | Montana | 25,592 | .2 | 85.3 | 61.5 | 19.5 | 18.9 | INA | 13.6 | Capri Group | 9.3 | U.S.F.&G. | 6.3 |
| 39 | Nebraska | 59,653 | .4 | 83.5 | 59.3 | 24.4 | 16.3 | Travelers | 6.3 | Aetna L&C. | 6.2 | U.S.F.&G. | 5.5 |
| 50 | Nevada | 1,116 | .0 | 52.4 | 73.3 | 2.8 | 23.8 | Aetna L&C. | 60.2 | Liberty Mutual | 18.7 | Hartford Group | 5.6 |
| 35 | New Hampshire | 79,820 | .6 | 70.5 | 68.1 | 6.5 | 25.4 | Liberty Mutual | 12.8 | Home Group | 11.6 | Commt. Union | 8.9 |
| 8 | New Jersey | 573,725 | 4.0 | 84.9 | 47.1 | 8.2 | 44.7 | N.J. Manufacturers | 26.6 | Liberty Mutual | 8.6 | Aetna L&C. | 6.5 |
| 31 | New Mexico | 87,168 | .6 | 75.2 | 69.2 | 20.8 | 10.9 | Mountain States | 9.4 | U.S.F.&G. | 9.2 | Travelers | 8.5 |
| 4 | New York | 938,814 | 6.6 | 68.2 | 67.4 | 11.2 | 21.4 | Liberty Mutual | 10.1 | Travelers | 7.0 | Aetna L&C. | 7.0 |
| 22 | North Carolina | 177,482 | 1.2 | 82.5 | 57.1 | 11.1 | 31.8 | Liberty Mutual | 19.0 | Aetna L&C. | 10.8 | Travelers | 5.3 |
| 51 | North Dakota | 342 | .0 | 56.2 | 81.8 | 4.5 | 13.7 | Aetna L&C. | 32.3 | Hartford Group | 17.8 | Home Group | 10.5 |
| 43 | Ohio | 25,574 | .2 | 70.4 | 50.7 | 43.5 | 5.8 | Old Republic | 38.6 | Aetna L&C. | 27.8 | ERC Corp. | 6.3 |
| 21 | Oklahoma | 177,636 | 1.2 | 65.3 | 62.5 | 19.5 | 18.0 | Home Group | 10.4 | Liberty Mutual | 7.9 | U.S.F.&G. | 7.5 |
| 19 | Oregon | 203,883 | 1.4 | 61.4 | 35.4 | 8.9 | 55.6 | Employee Benefits | 32.8 | Crum and Forster | 13.2 | Liberty Mutual | 8.4 |
| 3 | Pennsylvania | 1,114,476 | 7.8 | 75.9 | 45.6 | 24.7 | 29.7 | Pa. Manufacturers | 13.3 | Liberty Mutual | 9.4 | Old Republic | 7.8 |
| 38 | Rhode Island | 63,631 | .4 | 109.1 | 62.3 | 7.1 | 30.7 | Liberty Mutual | 21.0 | Aetna L&C. | 19.4 | Travelers | 8.0 |
| 27 | South Carolina | 121,282 | .9 | 72.2 | 58.7 | 7.7 | 33.6 | Liberty Mutual | 19.8 | U.S.F.&G. | 10.6 | Aetna L&C. | 7.5 |
| 45 | South Dakota | 21,210 | .2 | 61.6 | 65.3 | 15.4 | 19.3 | Western Group | 10.6 | St. Paul Cos. | 6.8 | Employers of Wausau | 6.9 |
| 18 | Tennessee | 207,239 | 1.4 | 64.2 | 69.7 | 9.0 | 21.4 | Liberty Mutual | 13.4 | Aetna L&C. | 9.0 | Travelers | 8.7 |
| 2 | Texas | 1,233,580 | 8.6 | 69.1 | 56.2 | 10.9 | 32.9 | Texas Employers | 18.1 | Liberty Mutual | 6.0 | Travelers | 5.3 |
| 47 | Utah | 18,991 | .1 | 60.8 | 71.1 | 6.4 | 22.5 | Liberty Mutual | 14.6 | INA | 12.9 | Travelers | 7.3 |
| 44 | Vermont | 24,700 | .2 | 64.8 | 70.2 | 6.8 | 23.1 | Aetna L&C. | 9.8 | Liberty Mutual | 8.3 | AIG | 8.1 |
| 13 | Virginia | 294,542 | 2.1 | 86.6 | 59.3 | 18.6 | 22.1 | Liberty Mutual | 12.6 | Old Republic | 11.6 | Travelers | 7.9 |
| 46 | Washington | 19,300 | .1 | 127.4 | 74.9 | 9.1 | 15.9 | INA | 42.3 | Aetna L&C. | 19.6 | Employers of Wausau | 10.9 |
| 49 | West Virginia | 1,325 | .0 | 999.9 | 33.4 | 15.8 | 50.9 | Liberty Mutual | 36.6 | Old Republic | 14.3 | Travelers | 11.8 |
| 17 | Wisconsin | 243,072 | 1.7 | 77.7 | 44.0 | 13.2 | 42.8 | Employers of Wausau | 23.8 | Liberty Mutual | 6.9 | Aetna L&C. | 6.4 |
| 48 | Wyoming | 2,022 | .0 | 101.9 | 48.3 | 40.2 | 11.4 | Aetna L&C. | 46.5 | Old Republic | 36.2 | Amer. Mut. Liab. | 4.1 |
| | Total | 14,329,534 | 100.0 | 75.3 | 57.7 | 16.6 | 25.7 | Liberty Mutual | 9.1 | Aetna L&C. | 5.8 | Travelers | 5.7 |

*In dollars, 000 omitted.

Note: Loss ratio is losses incurred to premiums earned, not including loss adjustment expense, but adjusted for dividends to policyholders.

## ALASKA WORKERS' COMPENSATION

(000 OMITTED)

| | CALENDAR YEAR | 1973* | | 1974 | | 1975 | | 1976 | | 1977 | | 1978 | | 1979 | | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | $ | % | $ | % | $ | % | $ | % | $ | % | $ | % | $ | % | $ | % |
| Line 1- | STANDARD EARNED PREMIUM | 17,335 | | 19,443 | | 32,996 | | 58,806 | | 76,387 | | 68,005 | | 74,039 | | 347,011 | |
| Line 2- | NET EARNED PREMIUM (est.) | 16,122 | 100.0 | 17,670 | 100.0 | 29,159 | 100.0 | 51,585 | 100.0 | 67,490 | 100.0 | 62,423 | 100.0 | 63,835 | 100.0 | 308,284 | 100.0 |
| Line 3- | PROVISION IN RATES FOR: | | | | | | | | | | | | | | | | |
| Line 4- | LOSSES | 10,175 | 63.1 | 11,452 | 64.8 | 19,468 | 66.8 | 34,754 | 67.4 | 45,221 | 67.0 | 40,327 | 64.6 | 44,349 | 69.5 | 205,746 | 66.7 |
| Line 5- | EXPENSES & LOSS ADJUSTMENT | 5,544 | 34.4 | 5,776 | 32.7 | 8,952 | 30.7 | 15,541 | 30.1 | 20,582 | 30.5 | 20,536 | 32.9 | 17,899 | 28.0 | 94,830 | 30.8 |
| Line 6- | PROFIT & CONTINGENCY | 403 | 2.5 | 442 | 2.5 | 729 | 2.5 | 1,290 | 2.5 | 1,687 | 2.5 | 1,561 | 2.5 | 1,596 | 2.5 | 7,708 | 2.5 |
| Line 7- | TOTAL | 16,122 | 100.0 | 17,670 | 100.0 | 29,159 | 100.0 | 51,585 | 100.0 | 67,490 | 100.0 | 62,423 | 100.0 | 43,204 | 100.0 | 308,284 | 100.0 |
| Line 8- | ACTUAL INCURRED LOSSES | 10,435 | 64.7 | 16,309 | 92.3 | 19,731 | 67.7 | 41,216 | 79.9 | 46,611 | 69.1 | 60,465 | 96.9 | 50,573 | 82.2 | 245,340 | 79.6 |
| Line 9- | PROVISION FOR LOSSES MINUS TOTAL | (259) | (1.6) | (4,857) | (27.5) | (263) | (.9) | (6,462) | (12.5) | (1,390) | (2.1) | (20,138) | (32.3) | (6,224) | (9.8) | (39,594) | (12.8) |

SOURCE: NCCI CIRCULARS COMPENSATION EXPERIENCE AS OF DECEMBER 31 FOR 1973-1979, AND NCCI RATE FILINGS.

DETAIL MAY NOT ADD TO TOTALS DUE TO ROUNDING.

*INCLUDES ALEYESKA.

11/11/80
DCG:bh

# Asbestosis victim tries to aid others

by Naomi Kaufman
Associated Press

San Francisco — When Jim Vermeulen was 50 years old, "a time bomb went off" in his chest. Now permanently disabled and perhaps dying from exposure to asbestos, Vermeulen wants to help millions of similar victims.

"Because of what we did then, we were injured and are dying now," said the Soquel, Calif. organizer of a group called Asbestos Victims of America. "We're cast adrift and in limbo."

The 54-year-old Vermeulen is a victim of asbestosis, an incurable progressive lung disease caused by exposure to asbestos fibers. He worked with asbestos at a Stockton factory from 1957 to 1968. His disease was diagnosed in 1976.

His breath comes now in frequent, short gasps, and he carries portable oxygen tanks with him: "It's like taking years to drown."

Vermeulen is not alone. More than 11 million people — shipbuilders, construction workers and others — have been heavily exposed to asbestos since the early 1940s, according to federal experts.

At least half may die of asbestos-related diseases, experts say. Among the diseases is mesothelioma, the type of lung cancer contracted by actor Steve McQueen, which is associated with asbestos exposure. McQueen died last week of a heart attack.

"When that time bomb went off in my chest, I was finished," Vermeulen said. "It's really a frightening thing when you're diagnosed and you're all alone as I was."

He found little information and support available for asbestosis sufferers. So he started AVA in March.

Vermeulen, who has filed for workers' compensation, operates his organization on a shoestring budget, paying expenses out of his Social Security disability income and donations. He has a small office in Capitola, 60 miles south of San Francisco. The group, which claims 1,200 members, charges $5 a year in dues and asks nothing from victims who cannot pay.

Alliance

Pacific Coast Office:
Thomas F. Conneely
Regional Vice President

Alliance of American Insurers
160 Sansome Street, Suite 1411
San Francisco, California 94104
415·362·0870

Rehabilitation - Workers' Compensation Model Approach

One of the primary purposes of the Workers' Compensation Act shall be the restoration of the disabled employee to gainful employment, preferably that for which there has been previous training or experience. While the frequency of work related disability severe enough to warrant physical and/or vocational rehabilitation is relatively low, when the need exists, it must be met promptly and directly by insurers and/or employers.

I. DEFINITION OF REHABILITATIVE SERVICES

A. Rehabilitation services are those services designed to restore the individual to an optimum level of physical and emotional recovery. Vocational rehabilitation services are those training services designed to return the individual to (1) a job related to former employment; or (2) a job in a nonrelated work field which produces an economic status similar to that enjoyed prior to the disability; or (3) a job producing a higher economic status than pre-disability if, as a practical matter, and because of physical limitations this is the only vocation for which the individual can be trained.

II. SUPERVISION OF REHABILITATION SERVICES

A. There shall be established a rehabilitation section. The Commission shall be authorized to employ a qualified Administrator of Rehabilitation and such other assistance, including clerical help, as may be deemed necessary, and to fix the compensation of all persons

so employed. The Administrator shall be responsible to the Director of Workers' Compensation. The compensation paid shall reflect the training, experience and background of the individual and shall be consistent with the compensation paid to those persons employed to do similar work in other state departments.

B. To assist the Administrator of Rehabilitation in assuring that all persons requiring rehabilitation services receive them in timely fashion, there shall be established a Rehabilitation Panel. All matters pertaining to rehabilitation under the Workmen's Compensation Law, shall be the responsibility of the Rehabilitation Panel. This panel shall be composed of the Administrator of Rehabilitation, Medical Director, physicians, and representatives of other medical specialties, all to be qualified by experience and training and appointed by the Director of Workers' Compensation in consultation with an advisory committee. The advisory committee shall be appointed by the Governor, and shall be composed of equal representation from labor, employers, insurers, vocational rehabilitation, and the medical community, and each of whom shall be qualified by experience and training.

C. The supervision of the delivery of all rehabilitation services shall be the responsibility of the Administrator of Rehabilitation. The Panel shall continuously study rehabilitation, both physical and vocational, and shall investigate and maintain a directory of all private and public rehabilitation facilities. The Administrator, in consultation with the Panel, shall approve as qualified such facilities, institutions and physicians as are capable of rendering competent rehabilitation service to injured employees. No facility or institution shall be considered as qualified unless it is specifically equipped and staffed with trained and qualified personnel. Physical rehabilitation must be supervised by a physician qualified to render such service. No physician shall be considered qualified unless he has the experience and training specified by the Director of Worker's Compensation.

D. The Panel shall also be responsible for developing and recommending rehabilitation regulations and activities to the Administrator of Rehabilitation.

E. Reporting Procedures

1. Physician's Responsibility

The physician should report to the state workers' compensation agency (rehabilitation section) with a copy to the employer-insurance carrier within 90 days post accident on all cases where it appears likely that the employee will not return to his regular employment within 30 days thereafter.

2. Employer-Insurance Carrier Responsibility

Within 120 days from the accident, or when the employer-insurance carrier has medical information that an injured employee will be unable to return to his pre-injury occupation or employment for which he has previous training or experience, the employer-insurance carrier must file a completed rehabilitation questionnaire with the workmen's compensation agency, rehabilitation section . Since the employer/ insurer bears the burden of financing the rehabilitation of the employee, they should be entitled to copies of all reports that show the type of rehabilitation services being rendered and the progress achieved.

III. SPECIFIC RESPONSIBILITIES

A. Employers Responsibility - the employer's responsibilities for rehabilitation services must include:

1. Medical care and physical restoration, consistent with the needs of a disability without regard to:
   a. duration of time
   b. total expenditure

2. Assistance in returning the individual to gainful employment.

3. Vocational evaluation, counseling, training and job placement. It is the responsibility of the employer to provide a total vocational rehabilitative training period that will not exceed 26 weeks, subject to extension by special order of the Director when the employee demonstrates satisfactory progress.

4. The employer is responsible for paying for the cost of those rehabilitation services supplied by a state Division of Vocational Rehabilitation only if the employer-insurer initiates them, or the state administrative authority orders them. In the event that an employer-insurance carrier voluntarily develops a rehabilitation program in agreement with the disabled worker the employer-insurance carrier will submit appropriate information to the state agency (medical-rehabilitation panel) including periodic progress reports.

B. Employee's Responsibility - The employee's responsibility for rehabilitation must include:

1. Submission to all reasonable requests for examinations and evaluations as required by the employer-insurance carrier, and/or the state agency (medical-rehabilitation panel) as may be necessary to determining need for, or to develop a plan for rehabilitation.

2. Cooperation in conjunction with a reasonable timetable once a plan has been developed and/or filed with the state agency (medical-rehabilitation panel) following consultation with all involved individuals.

## IV. DEVELOPMENT AND IMPLEMENTATION OF A REHABILITATION PROGRAM

A. Rehabilitation Plans

The employer-insurance carrier must develop and file with the state agency (medical-rehabilitation panel) a rehabilitation plan for the disabled employee on all cases when because of the disability it appears likely that the employee will not return to his regular employment or work for which he has previous training and experience. In developing the plan, consideration must be given to the employee's age, education, previous work history and skills.

B. Change of Plans

Upon application for a hearing by either party to the agreed upon rehabilitation program, the state agency (medical-rehabilitation panel) can suspend, terminate or change an agreed upon rehabilitation program for good and sufficient reasons including but not limited to:

1. A physical impairment that will not allow the worker to follow the vocation being trained for;
2. The workers' performance level indicates he cannot complete the course satisfactorily;
3. The worker fails or refuses to cooperate in the program;
4. The worker requests termination of the program in favor of a different program because he feels he is not suited for the type of work for which training is being provided. A change of program for this reason shall only be allowed once, and only if the request is made by the worker within 90 days after commencement of the training period.

C. Disputes

If rehabilitation services are not voluntarily offered by the employer or if offered and not accepted by the employee, the administrator, on his own motion, or upon application affording the parties an opportunity to be heard, may refer the employee to a qualified physician or facility for evaluation. Such evaluation shall include the practicability of, need for, and type of service, treatment or training necessary and appropriate to render the employee fit for a remunerative occupation. Upon receipt of such evaluation report, and after affording the parties an opportunity to be heard by the Commission, the Director, in consultation with the panel, may order the services and treatment recommended in the report, or such other rehabilitation treatment or services he may deem necessary, be provided at the expense of the employer. If any party refuses to accept rehabilitation pursuant to an order of the state workers' compensation agency, they shall lose disability compensation benefits for each week of the period of such refusal.

D. Lump Sum Settlements

The monetary value of a rehabilitation plan tendered to the employee by the employer/insurer or recommended by the Administrator of Rehabilitation and refused by the employee shall not be subject to consideration as a part of any lump sum settlement.

E. Job Placement Services

The employer-insurance carrier will be obligated to pay the cost of any job placement services as may reasonably be required by the disabled employee at the end of the rehabilitation period. If the employee refuses to accept the position for which he has received training and for which he is physically able to perform, his right to further weekly compensation benefits will be suspended.

V. FINANCIAL RESPONSIBILITY FOR REHABILITATION SERVICES

A. The employer is responsible for all costs of rehabilitation services and supplies necessary for the implementation of the plan voluntarily devised by the employer-insurance carrier in conjunction with the disabled worker, or the plan ordered by the state agency (medical-rehabilitation panel) subject to the limitations set forth in IV (B), (1-4).

B. All fees and other charges for vocational rehabilitation services shall not be higher than the charges that prevail in similar communities for similar services to injured persons of like status and shall be subject to review by the administrator.

C. Where rehabilitation requires residence at or near a facility or institution, away from the employee's customary residence, reasonable costs of his board, lodging or travel shall be paid for by the employer.

D. The administrative costs, salaries and reasonable travel expenses of state agency personnel required to staff the rehabilitation panel shall be a part of the operating cost of the workers' compensation agency and will be funded in like manner to that agency.

E. All members of the rehabilitation panel, with the exception of the Administrator shall be compensated at a reasonable per diem rate consistent with other state agencies plus reasonable expenses as approved by the Administrator of Rehabilitation and consistent with state allowances for other similar travel.

VI. OTHER STATE AGENCIES

The director and rehabilitation panel may cooperate on a reciprocal basis with the vocational rehabilitation section of the (Department of Education) and the employment service of the (Division of Employment Security).

/sj/le

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT

M E M O R A N D U M

October 29, 1980

To: Licia Piceno

From: Bob Williams BW

Re: Miscellaneous

Enclosed is a copy of the Khrest Bill from Oregon, as we discussed. Also, a copy of my phone bill is included. I just got it.

VICTOR ATIYEH
GOVERNOR

# Workers' Compensation Department
ADMINISTRATIVE SERVICES DIVISION
LABOR AND INDUSTRIES BUILDING, SALEM, OREGON 97310 PHONE 378-8093

January 24, 1980

RECEIVED
JAN 28 1980
OFFICE OF THE COMMISSIONER

Judy G. DuBois
Special Assistant to the Commissioner
Department of Labor
State of Alaska
P.O. Box 1149
Juneau, Alaska 99811

Dear Ms. DuBois:

Your letter of January 14 to Chairman M. Keith Wilson of the Workers' Compensation Board, regarding Oregon House Bill 3125, was referred to me.

HB 3125, sponsored by the Committee on Labor at the request of Representative Jim Chrest and known as the Workers' Recovery Act, was re-referred to the House Labor Committee on June 30, 1979. It "died" when the Legislature adjourned on July 4, 1979. The bill, however, is far from dead! It continues to receive study by the House Interim Committee on Labor and the Governor's Task Force on Workers' Compensation. A similar version undoubtedly will be introduced in the 1981 Legislature.

The Interim Labor Committee will hold meetings on February 21-22, 1980, beginning at 9:30 a.m. in Hearing Room F at the Capitol. Dick Goss, the attorney who helped draft the bill, will provide an explanation of HB 3125 A-Engrossed (1979 Legislative Session) at the Committee meeting--which is open to the public.

The Chairman of the Committee is Representative Jim Chrest. Committee staff consist of the Administrator, Diane Kolb, and an Assistant, Vicki Gridley. Their telephone number is (503) 378-8816.

The Governor's Task Force on Workers' Compensation was appointed in January 1979 and is to make its final report no later than December 1, 1980. It is to recommend changes that will provide the maximum benefit to the injured worker at the least possible cost. It made a preliminary report to the Governor in May 1979. The recommendations contained in that preliminary report were conservatively estimated by the Task Force to amount to $39 million.

F.F. "Monte" Montgomery is Chairman of the Governor's Task Force on Workers' Compensation and Jan Perry is its Administrative Assistant. Their office is located in Room S-401 at the Capitol; their telephone number is 378-3632.

A status Report from the Task Force also will be made at the February 21-22 meeting of the House Interim Committee on Labor.

Members of the Task Force and House Interim Committee on Labor are cooperating in the task of seeking to obtain beneficial and cost reducing changes for the Oregon workers' compensation system. You may wish to contact both groups for their guidance regarding HB 3125 and pertinent new bills now under consideration to modify Alaska's workers' compensation laws.

In the meanwhile, you may find the enclosed copies of HB 3125 A-Engrossed and a seven-page summary of it, prepared by Associated Oregon Industries, to be useful.

Sincerely,

Ed Eberhardt
Informational Representative

Enclosures: Two

ELE:dr

DEC 28 1979

WCB/ASD INFORMATION

# SUMMARY OF

## A-Engrossed HOUSE BILL 3125

Section 1. Adds to and makes Sections 2 to 7 and 19 of this Act a part of ORS 656.001 to 656.794 (current Oregon Workers' Compensation Law).

Section 2. Provides that the injured worker shall be reinstated by the employer to the former position of employment, without reduction in wages, if the worker is able to perform the primary duties of the position. This is applicable only when a worker is employed by an employer who employs 10 or more subject workers. If the worker is not able to perform the primary duties of the former position, the worker shall be reinstated to any other position in the employer's operation, the primary duties of which the worker is able to perform. Exempts an employer from this section if the worker's position has been eliminated by a reduction in force or two years after the date of injury or aggravation have lapsed. Provides that this section shall prevail over the terms of any collective bargaining agreement entered into after the effective date of this Act.

Section 3. Provides that when the department determines that the worker will not be able to return to the worker's previous employment, the department, as soon as practicable, shall commence employment search, retraining or vocational rehabilitation for the purpose of reemploying the worker at a wage as close as possible to the worker's wage at the time of injury.

Section 4. Provides that an employer who fails to comply with the reinstatement provisions shall be liable for all wages, fringe benefits and other remuneration which would have been payable had the worker been reinstated, accruing from the date the employer received notice of the worker's desire to return to work until such time as the employer reinstates the worker or the worker obtains other employment. Prohibits the employer from insuring against this liability. Provides that a worker who refuses to accept reinstatement without good cause and despite ability to perform the work shall lose the right to employment reinstatement and shall lose all benefits except for medical services for conditions causally related to the injury.

Section 5. Provides for total wage loss benefits when a compensable injury incapacitates a worker from performing any work for the employer. Defines "total wage loss benefits" as equal to 66 2/3 percent of wages at the time of injury, but not more than 200 percent of the average weekly wage. Provides that "weekly wages at time of injury" shall be determined from the worker's historical earnings over the 365 days immediately preceding the date of injury. Provides that a worker who has a decrease in wages proximately caused by a compensable injury but is not eligible for total wage loss benefits shall receive wage differential benefits. Defines "wage differential benefits" as equal to specific percentages of the difference between wages at the time of injury less wages after injury for the given ratios of wages after injury to wages at time of injury. Provides that no worker shall receive wage differential benefits after the worker's 70th birthday, after the worker has voluntarily left the labor market, after any two-year period during which time wage differential benefits or total wage loss benefits have not been payable during at least three consecutive months, or after 10 years of first receipt of wage differential benefits, except that for those injuries occurring after July 1, 1987, the maximum period shall be 20 years.

Section 6. servitors for the treatment of industrially injured workers and prescribe rules covering the following areas: (a) time of recuperation standards to correspond to usual healing periods for those illnesses and injuries which the director finds necessary; (b) particular treatment regimens for particular illnesses or injuries; and (c) requirement of prior approval of the medical director for certain elective surgical procedures. Requires the State Accident Insurance Fund to set up a billing schedule based on specific statutory standards based on the 85th percentile of the range of all billings for that service category and the historical billing of the provider for that service.

Section 7. Provides for specific lump sum payments for loss by amputation or permanent or complete loss of function equivalent to amputation.

Section 8. Changes the name of the Workers' Compensation Department to the Workers' Recovery Department; Workers' Compensation Board to Workers' Recovery Board; Workers' Compensation Law to Workers' Recovery Law.

Section 9. Provides that ORS 656.001 to 656.794 may be cited as the Workers' Recovery Law.

Section 10. Provides for changes in definitions to conform to Section 8 and 9; eliminates references to "carrier-insured employer", etc.

Section 11. Removes "insurance carrier" from that section of the law pertaining to treatment by certain religious practitioners.

Section 12. This section was deleted by amendment. Subsequent sections were not renumbered.

Section 13. Removes reference to "carrier-insured employer" from that section of the law pertaining to an employer electing to be a contributing employer.

Section 13a. Conforms the Civil Rights Law to the reinstatement rights of the injured worker under this Act.

Section 14. Removes reference to "guaranty contract insurer" from that section of the law pertaining to application for coverage.

Section 15. Conforms that section of the law pertaining to owner-operators of certain equipment to changes in definitions and coverage requirements under this Act.

Section 16. This section was deleted by amendment. Subsequent sections were not renumbered.

Section 17. Provides for death benefits for certain dependents if the injured worker dies while receiving total wage loss benefits and after having received total wage loss benefits continuously for four years, unless the worker is participating in vocational rehabilitation at the time of the death.

Section 18. Provides that with the authorization of the board the amount of any total wage loss benefits payable to an injured worker shall be reduced by the amount of any disability benefits the worker receives from federal social security.

Section 19. Provides that if an injured worker dies while receiving total wage loss benefits or wage differential benefits, the persons who would have been entitled to receive death benefits if the compensable injury had been fatal shall receive that amount which equals 52 times the average weekly wage, but only if no other death benefits are payable under this chapter.

Section 20. This section was deleted by amendment. Subsequent sections were not renumbered.

Section 21. Provides that for every compensable injury, the direct responsibility employer or the State Accident Insurance Fund shall cause to be provided medical services for conditions resulting from the injury. Eliminates the following language from the current law: "for such period as the nature of the injury or the process of the recovery requires, including such medical services as may be required after a determination of permanent disability." Provides that the worker may choose his own attending doctor or physician within the State of Oregon, subject to section 6 of this Act.

Section 22. Removes reference to "carrier" under that section of the law pertaining to certain medical reporting requirements.

Section 23. Removes reference to "the guaranty contract insurers" under that section of the law pertaining to the use of certain medical report forms.

Section 24. Provides that the contributing employer shall pay to the worker directly the total wage loss benefits provided in this chapter which shall be reimbursed by the State Accident Insurance Fund upon receipt of documentation of those payments, except that in the case of an aggravation of a prior compensable injury which occurred while the worker was not employed by the employer at the time of aggravation, the insurer or self-insured employer shall pay the total wage loss benefits Provides for a hearing and certain penalties if a denial or delay in payments was unreasonable.

Section 25. Removes reference to "guaranty contract insurers" and "other insurers" from that section of the law pertaining to certain reporting requirements of the director.

Section 26. Provides that the primary purpose of the Workers' Recovery Law is to restore the injured worker as soon as possible and as near as possible to a condition of self support and maintenance as an able-bodied worker. Claims shall not be closed nor wage loss benefits terminated until one of the following occurs: (a) the attending physician has approved the worker's return to regular employment; (b) the worker refuses to comply with the return to work-rehabilitation plan ordered by the director; (c) the worker commences employment; or (d) the worker is able to perform work at a gainful and suitable occupation. Outlines reporting requirements by the worker, State Accident Insurance Fund or the self-insured employer when the worker is eligible for wage differential benefits.

Section 27. Provides that a claim for aggravation must be filed within five years after the determination fixing the maximum wage differential benefit was made or, if no such determination was made, the claim for aggravation must be filed within five years after last receipt of total wage loss benefits.

sation hearing when there is an issue regarding whether the worker is able to perform work at a gainful and suitable occupation or whether the worker is eligible for vocational rehabilitation.

Section 29. This section was deleted by amendment. Subsequent sections were not renumbered.

Section 30. Provides that a claimant may accept and cash any check given in payment of any award or compensation without affecting his right to a hearing and removes the exception that the right of hearing on any award shall be waived by acceptance of a lump sum award by a claimant where such lump sum award was granted on his own application.

Section 31. Removes reference to "insurer" in that section of the law where there is an issue regarding which of several subject employers is the true employer of a claimant worker; responsibility between two or more employers involving payment of compensation for two or more accidental injuries; or joint employment by two or more employers.

Section 32. This section was deleted by amendment. Subsequent sections were not renumbered.

Section 33. Deletes language which allows the suspension of compensation where the worker refuses to submit himself for medical examination, if requested by the director, State Accident Insurance Fund or a direct responsibility employer. Deletes language stating that a worker who has received an award for unscheduled permanent total or unscheduled partial disability should be encouraged to make a reasonable effort to reduce his disability.

Section 34. Deletes current language pertaining to criteria for determining attorney fees and provides that the self-insured employer or the State Accident Insurance Fund shall pay to the claimant or the claimant's attorney a reasonable attorney fee at any hearing, board or court review in which the claimant prevails. If a contributing employer has caused the fund to be charged such fees, the fund may charge such fees to the employer.

Section 35. Removes from the law the provision that when there has been a dispute over the amount of an attorney fee and the presiding judge of the circuit court in the county in which the claimant resides determines the amount of such fee, the approved claim shall be a lien upon compensation.

Section 36. Removes reference to "insurance obtained by a carrier-insured employer" from section of law pertaining to responsibility for claims administration and payment of compensation.

Section 37. Removes reference to "carrier-insured employer" from section of law pertaining to qualifying as a direct responsibility employer.

Section 38. Removes reference to "guaranty contract insurer" from section of law pertaining to the issuance of guaranty contracts, permitting only the State Accident Insurance Fund to issue such contracts.

Section 39. Removes reference to "insurer" other than the State Accident Insurance Fund from section of the law pertaining to cancellation of coverage.

Section 40. Removes reference to "guaranty contract" in section of law pertaining to termination of surety bond, etc.

Section 41. Removes reference to "guaranty contract" and "carrier-insured employer" in section of law pertaining to default by a direct responsibility employer in payment of compensation or other payments due to the director under the Act.

Section 42. Removes reference to an insurer other than the State Accident Insurance Fund from that section of the law pertaining to providing consultative services designed to promote occupational safety and reduce occupational health hazards.

Section 43. Removes reference to "costs incurred by the Insurance Commissioner" from that section of the law pertaining to assessments for the Administrative Fund.

Section 44. Removes reference to "guarantor" in section of law pertaining to Direct Responsibility Employers Adjustment Reserve.

Section 45. This section was deleted by amendment. Subsequent sections were not renumbered.

Section 46. Provides that the director may offset from the Second Injury Reserve the additional amount paid in compensation with respect to any injury resulting in total wage loss benefits exceeding 26 weeks or resulting in death where the injury is attributable wholly or partially to a preexisting disability of the employe. Defines "preexisting disability" to mean any permanent condition due to previous accident or disease or any congenital condition which is or likely to be a substantial handicap in obtaining or regaining employment. Provides that financing of the Second Injury Reserve shall be from employer assessments of the Administrative Fund, as well as current employe contributions.

Section 47. Removes certain references to "permanent total disability" and "permanent partial disability" from that section of the law pertaining to the Direct Responsibility Employers Awards Reserve. Conforms the section of the law pertaining to Retroactive Reserve to changes made in benefits under this Act.

Section 48. Removes reference to a "bona fide rating organization" in that section of the law pertaining to the records of the State Accident Insurance Fund.

Section 49. Removes reference to "insurance carrier" from that section of the law pertaining to rights of the State Accident Insurance Fund in cases dealing with alleged noncomplying employers.

Section 50. Removes reference to "insurer" in that section of the law pertaining to civil penalties against employers.

Section 51. Removes reference to "insurer" other than the State Accident Insurance Fund from that section of the law pertaining to civil penalties for failing to provide consultative services.

Section 52. Removes reference to "private insurance carrier" in that section of the law pertaining to the purpose and operations of the State Accident Insurance Fund.

Section 53. Removes reference to "other carriers who are qualified to write workers' compensation insurance in Oregon" from that section of the law pertaining to the Industrial Accident Advisory Committee.

Section 53a. Substitutes "fire fighters" for "firemen" under the section of the law pertaining to occupational disease. Removes language pertaining to basis for denying a fire fighter's claim for an occupational disease.

Section 53b. Provides that a fire fighter who is disabled by an occupational disease subsequently starts rehabilitation and suffers a reoccurrence, as determined by physical examination, shall have the reoccurrence treated as an original injury.

Section 54. Exempts the State Accident Insurance Fund from complying with Insurance Code requirements pertaining to membership in a rating organization.

Section 55. Removes from the Insurance Code that section of the law pertaining to a private insurance carrier having to provide safety and health consultative services.

Section 56. Removes from the Insurance Code that section of the law pertaining to reciprocal insurers covering workers' compensation insurance.

Section 57. Removes from the Insurance Code that section of the law pertaining to certain deposits made by workers' compensation insurance carriers.

Section 58. Removes from the Insurance Code that section of the law pertaining to certain deposits made by workers' compensation insurance carriers.

Section 59. Removes from the Insurance Code that section of the law pertaining to certain deposits made by workers' compensation insurance carriers.

Section 60. Removes from the Insurance Code pertaining to the Oregon Insurance Guaranty Association references to covered claims arising out of workers' compensation policies.

Section 61. Removes from the Insurance Code references to certain recovery rights on workers' compensation claims.

Section 62. Removes from the Insurance Code certain references requiring insurers to be members of a workers' compensation rating organization and adher to the rates, rating systems and policy forms of the rating organization.

Section 63. Removes from the Insurance Code relating to the making and use of rates certain references to workers' compensation insurance.

Section 64. Removes from the Insurance Code relating to rate filings certain references to workers' compensation insurance.

Section 65. Removes from the Insurance Code relating to membership in a workers' compensation rating organization the requirement that any insurer must become a member of or a subscriber to any rating organization.

Section 66. Removes from the Insurance Code relating to certain health insurance policies references to workers' compensation insurance policies.

Section 67. Removes from the Insurance Code relating to certain health insurance policies references to workers' compensation.

Section 68. Removes from the Insurance Code relating to certain health insurance policies references to workers' compensation.

Section 69. Provides that sections 70 to 72 of this Act are added to and made a part of the Workers' Recovery Law.

Section 70. Provides that any direct responsibility employer who provided coverage for workers' compensation by contracting with an insurance carrier on or before the operative date of this Act can continue such coverage for the remainder of the term of the contract. Bans such contracts from private insurance carriers after the operative date of this Act.

Section 71. Provides that after the effective date of the Act, an insurance carrier that issued guaranty contracts to direct responsibility employers to provide the coverage required by law shall not provide coverage under such a contract for a period longer than one calendar year.

Section 72. Provides that nothing in the Act relieves any insurance carrier that issued a guaranty contract to a direct responsibility employer to provide the coverage required by law, prior to the operative date of the Act, from any duty to administer and pay claims or any other liability or obligation prescribed by law prior to the operative date of the Act.

Section 73. Repeals various sections of the current Workers' Compensation Law pertaining to the determination and payment of TTD, PTD, TPD and PPD; medical service rates; certain attorney fees; sanctions against private carriers; assigned risk plan; and various sections of the Insurance Code dealing with insurers issuing guaranty contracts.

Section 74. Provides that certain sections of the current workers' compensation law are to be added to and made a part of the Workers' Recovery Act.

Section 75. Provides that the Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and the Act takes effect on its passage. However, sections 1 to 70 and 72 to 74 of the Act first become operative on January 1, 1980.

A Engrossed

# House Bill 3125

Ordered by the House June 29
(Including Amendments by House June 29)

Sponsored by COMMITTEE ON LABOR (at the request of Representative Chrest)

## SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Revises manner of providing compensation for industrial injuries to emphasize loss of wages as the measure of benefits. Establishes program to encourage early reemployment of injured workers. Revises delivery and rate schedule for providing certain medical and rehabilitative services. Changes names of Workers' Compensation Department, Workers' Compensation Board and Workers' Compensation Law to Workers' Recovery Department, Workers' Recovery Board and Workers' Recovery Law. Establishes "two-way" system for providing benefit coverage by eliminating coverage by private insurers. Makes transitional and other technical and administrative changes.

Declares emergency with private insurance carrier restrictions effective on passage and other changes becoming operative January 1, 1980.

## A BILL FOR AN ACT

Relating to workers' compensation; creating new provisions; amending ORS 656.001, 656.005, 656.010, 656.039, 656.121, 656.128, 656.140, 656.208, 656.209, 656.245, 656.252, 656.254, 656.262, 656.264, 656.268, 656.273, 656.287, 656.304, 656.307, 656.325, 656.382, 656.388, 656.403, 656.407, 656.419, 656.423, 656.427, 656.443, 656.451, 656.612, 656.614, 656.622, 656.636, 656.702, 656.740, 656.745, 656.750, 656.752, 656.790, 656.802, 656.807, 731.028, 731.418, 731.566, 731.608, 731.620, 731.640, 734.570, 734.640, 737.265, 737.310, 737.320, 737.560, 743.402, 743.459 and 743.462; repealing ORS 656.206, 656.210, 656.212, 656.214, 656.216, 656.218, 656.222, 656.230, 656.248, 656.386, 656.447, 656.728, 656.730, 731.480, 731.628 and 731.832; and declaring an emergency.

**Be It Enacted by the People of the State of Oregon:**

SECTION 1. Sections 2 to 7 and 19 of this Act are added to and made a part of ORS 656.001 to 656.794.

SECTION 2. (1) When a worker who is employed by an employer who employs 10 or more subject workers incurs a compensable injury:

(a) The worker shall be reinstated by the employer to the former position of employment, without reduction in wage, if the worker is able to perform the primary duties of the position.

(b) If the worker is not able to perform the primary duties of the former position, the worker shall be reinstated to any other position in the employer's operation, the primary duties of which the worker is able to perform.

(c) As used in this chapter, "primary duties" are those activities which comprise the substantial amount of time for, and are essential to, the performance of that position after the employer has made reasonable accommodations for the worker's impairments.

(2) The department may require reasonable modification of the job site of a subject employer's operation if the modification would enable the worker and employer to comply with subsection (1) of this section.

NOTE: Matter in bold face in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted; complete new sections begin with SECTION.

(3) A worker may present a certificate of the worker's attending physician that the worker is able to perform described types of activity which shall be prima facie evidence of such ability.

(4) An employer is relieved of the obligation to reemploy an injured worker:

(a) If the worker's position has been eliminated by a reduction in force, but only so long as the reduction in force lasts; or

(b) Two years after the date of injury or aggravation, but a worker who suffers an aggravation has no reinstatement privileges unless employed by the employer at the time of the original injury.

(5) An employer shall not discriminate against a worker with respect to hire or tenure or any term or condition of employment because the worker has applied for benefits, is receiving wage differential benefits or has invoked or utilized the procedures provided for in this chapter or given testimony pursuant thereto. However, nothing in this subsection prevents an employer from terminating a worker for cause unrelated to the purposes of this chapter.

(6) A worker may enforce the provisions of this section by requesting a hearing as provided in ORS 656.283.

(7) An employer is not excused from complying with this section because a vacancy does not exist or the injured worker lacks seniority to fill a position. However, if a seniority system is in use, an employer need not demote or terminate another worker with greater seniority in order to place the injured worker.

(8) The provisions of this section prevail over the terms of any collective bargaining agreement entered into after the effective date of this 1979 Act.

SECTION 3. When the department determines that the worker will not be able to return to the worker's previous employment, the department, as soon as is practicable, shall commence employment search, retraining or vocational rehabilitation for the purpose of reemploying the worker at a wage as close as possible to the worker's wage at the time of injury.

SECTION 4. (1) An employer who fails to comply with section 2 of this 1979 Act shall be liable for all wages, fringe benefits and other remuneration which would have been payable had the worker been reinstated, accruing from the date the employer received notice of the worker's desire to return to employment until such time as the employer reinstates the worker or the worker obtains other employment, whichever occurs first. An employer is prohibited from insuring against this liability or in any way transferring the responsibility for the payment of damages arising out of this subsection. The State Accident Insurance Fund shall have a lien against any such damages for the sum of wage loss benefits paid pursuant to subsection (2) of this section.

(2) The State Accident Insurance fund or self-insured employer shall pay the worker total wage loss benefits from the date of a request for a hearing for employment reinstatement, or from the date the employer receives notice of the worker's desire to be reinstated, whichever occurs first, notwithstanding that the worker is able to perform work at a gainful and suitable occupation. However, the worker must request a hearing for employment reinstatement within 30 days of the day the employer provides notice in writing to the worker of rejection. Total wage loss benefits shall continue until the employer reinstates the worker, the worker obtains other employment or there is a decision adverse to the worker, whichever occurs first. However, benefits shall be reinstated when a decision adverse to the worker is reversed. If the worker prevails, the employer shall reimburse the State Accident Insurance Fund for all wage-loss benefits paid under this subsection.

(3) An employer may be relieved of the duty to reinstate an injured worker by filing a request for a hearing stating the grounds for relief. If the worker is receiving total wage loss benefits, the worker shall continue to

receive such benefits until a decision adverse to the worker is rendered. However, the employer is not liable for wages, fringe benefits or other remuneration prior to a decision adverse to the employer.

(4) A worker who refuses to accept reinstatement without good cause and despite ability to perform the work shall lose the right to employment reinstatement and shall lose all benefits except for medical services for conditions causally related to the injury. "Good cause" may include any violation of this chapter by the employer. A worker who returns to work but is unable to perform primary duties shall not have benefits terminated.

SECTION 5. (1) (a) When a compensable injury incapacitates a worker from performing any work for the employer and until that time provided in subsection (1) of ORS 656.268, the worker shall receive total wage loss benefits and any medical insurance or benefits which the worker was receiving as remuneration at the time of the injury. "Total wage loss benefits" shall be equal to 66-2/3 percent of wages at time of injury, but not more than 200 percent of the average weekly wage. Notwithstanding the limitation imposed by this subsection, an injured worker who is not eligible to receive an increase in benefits for the fiscal year in which compensation is paid shall have benefits increased each fiscal year by the percentage which the applicable average weekly wage has increased since the previous fiscal year.

(b) "Weekly wages at time of injury" shall be equal to one fifty-second of all wages earned during the 365 days immediately preceding the date of injury, which wages shall include all wages subject to withholding pursuant to the personal income tax laws of this state or of the United States, and any other wages earned while covered by workers' compensation insurance, or its equivalent, in any jurisdiction. If the worker was employed for less than 176 days of the preceding 12 months, the director shall set a reasonable weekly wage to be used as wages at time of injury under this section, but in no instance shall weekly wages be less than 40 times the federal hourly minimum wage.

(c) If the injured worker has been employed by the employer continuously during the 365 days immediately preceding the date of the injury, the employer may compute the total wage loss benefit from the employer's payroll records. However, the worker may present documentation of additional wages from other employment during that period, in which case the benefit shall be based on the total lost wages of the worker. If the injured worker was not employed by the employer continuously during the 365 days immediately preceding injury, the employer shall notify the worker or his representative to produce documentation of any other wages. If the worker or his representative states that there are no other wages, the employer shall compute the benefit from the payroll records. The worker shall have 30 days to produce documentation of other wages during which time the benefit shall be based on the worker's average weekly wage paid by that employer, after which time the employer may presume that there are no other wages until the worker presents documentation to the contrary. In any case where the worker was employed less than 176 days of the preceding 365 days, the employer shall request that the director set a reasonable weekly wage. The employer may make adjustments to benefits or wages at a rate not to exceed 20 percent of the benefits or wages per week if there has been a prior overpayment. In claims for aggravation, "weekly wages at time of injury" shall be equal to one fifty-second of all wages earned during the 365 days immediately preceding the date of filing the claim for aggravation if it results in a greater benefit for the worker.

(d) "Documentation" may include W-2 forms, unemployment insurance determinations, payroll check stubs, income tax reporting forms and letters of prior employers, anyone of which shall be prima facie evidence of wages. The worker may submit as documentation an affidavit, in a form provided by the department, if

other documentation is unavailable. With the worker's consent the employer may request a verification by the department of any wages alleged to be earned in Oregon and the Employment Division of the Department of Human Resources shall provide such information to the Workers' Recovery Department.

(2) (a) A worker who has a decrease in wages proximately caused by a compensable injury but is not eligible for total wage loss benefits shall receive wage differential benefits.

(b) "Wage differential benefits" shall be equal to the following percentages of the difference between wages at time of injury less wages after injury for the given ratios of wages after injury to wages at time of injury:

| Percentage of difference | Ratio |
|---|---|
| 95% | Greater than 74% but less than 91% |
| 80% | Greater than 49% but less than 75% |
| 50% | Greater than 25% but less than 50% |
| 33-1/3% | Less than 25% |

However, a worker who has been employed subsequent to the injury shall continue to receive during any period of unemployment, when the worker is otherwise eligible for benefits, that amount which the worker received as wage differential benefits the month preceding the month the worker became unemployed.

(c) No worker shall receive wage differential benefits after the worker's 70th birthday, after the worker has voluntarily left the labor market, after any two-year period during which time wage differential benefits or total wage loss benefits have not been payable during at least three consecutive months, or after 10 years of first receipt of wage differential benefits, except that for those injuries occurring after July 1, 1987, this maximum period shall be 20 years.

(d) Beginning with the 25th month after the date of first payment of wage differential benefits, for purposes of computing wage differential benefits, wages after injury shall be discounted by the percentage by which the average weekly wage on that date has increased since the date of the injury. Wage differential benefits shall be so indexed at the end of each two-year period thereafter. A worker who is ineligible for wage differential benefits because wages after injury exceed 90 percent of wages at time of injury shall not have wages after injury discounted unless wages after injury subsequently decreases to less than 90 percent of wages at time of injury.

(3) No total wage loss benefit is recoverable for the first three calendar days after the worker leaves work as a result of a compensable injury unless eligibility for total wage loss benefits continues for a period of 14 days or the worker is an inpatient in a hospital. If the worker leaves work the day of the injury, that day shall be considered the first day of the three-day period.

(4) A worker who suffers a subsequent compensable injury during the period in which the worker is eligible for wage differential benefits from a prior injury shall receive as total wage loss benefits the amount which represents the greatest benefit for which the worker is eligible. No worker shall receive more than one wage differential benefit nor shall the worker receive total wage loss benefits and wage differential benefits simultaneously. For purposes of determining "wages at time of injury" in paragraph (b) of subsection (1) of this section, wage differential benefits and total wage loss benefits shall be included as wages.

**SECTION 6. (1) The medical director, in consultation with the advisory committee on medical care, shall compile a roster of consultants of physicians, psychologists or other medical personnel who treat industrially injured or ill patients. The roster need not include every practitioner but may be limited to those recognized by their peers as excelling in their respective specialties.**

**(2) The Director of the Workers' Recovery Department, in consultation with the medical director, the advisory committee on medical care and with other medical practitioners who treat industrially ill or injured workers, shall promulgate rules:**

**(a) Prescribing time of recuperation standards to correspond to usual healing periods for those illnesses and injuries which the director finds necessary, taking into consideration the early return to work standard of this 1979 Act;**

**(b) Prohibiting particular treatment regimens for particular illnesses or injuries; and**

**(c) Requiring prior approval of the medical director for certain elective surgical procedures.**

**(3) The medical director may order the worker to appear for examination by one or more consultants from the roster of consultants if the worker does not report for work within the applicable time of recuperation standard. The department, after consultation with the consultants, the worker, the treating physician and the employer, shall order a return to work-rehabilitation plan. If the worker refuses to comply with such order, the director may order cessation of any or all benefits until compliance or until such order is reversed on appeal.**

**(4) A physician shall obtain the approval of the medical director prior to those elective surgical procedures that have been specified by rule. The medical director shall not deny approval unless the worker has been examined by a physician from the roster of consultants who advises that the proposed surgery is not indicated.**

(5) The medical director may order the worker to change treating physicians or to change a treatment regimen after the worker has been examined by a physician from the roster of consultants who advises that the treatment regimen is not indicated.

(6) If the medical director orders a worker to be examined, the worker may choose from the roster of consultants any consultant within those specialties the medical director determines has applicability to the worker's injury or illness. The worker may choose to be examined by a second consultant from the roster in that specialty if the worker disagrees with the diagnosis of the first consultant.

(7) The director may prohibit payment for future medical services for treatment of an injured worker by a physician who is found, after notice and hearing, to have violated any section of this chapter or of any rule promulgated thereunder. The period of prohibition of payment for medical services under this subsection shall be no less than six months nor more than five years. Exceptions to this subsection may be allowed for emergency medical services which were not otherwise available, after review and approval by the medical director. The medical director may consult with the advisory committee prior to approving or disapproving payment for emergency medical care.

(8) A "return to work-rehabilitation plan" may include:

(a) Physical rehabilitation and other treatment regimens or therapies;

(b) Admission to medical and rehabilitation facilities;

(c) Prohibitions against insanitary or injurious practices or treatment regimens;

(d) Gradual, intermittent or immediate return to employment;

(e) Light, sedentary or structured duties of employment;

(f) Physical, psychological, intelligence and skill examinations;

(g) Vocational or on the job training;

(h) Hygienic instruction;

(i) A schedule of one or more of such activities or the requirement for regularly reporting to one or more of such activities; or

(j) Any combination of such activities, except admission to a state mental hospital.

(9) The worker shall report to the employer at the earliest date when light or sedentary duty at intervals of one-half day does not interfere with healing.

(10) A referee may select from the roster of consultants one or more physicians to give expert testimony in those cases in which the issue of medical causation of the injury or illness is disputed. No physician who has had previous experience with the case shall be eligible for such selection. The insurer or self-insured employer shall pay for the fees of the consultants.

(11) The State Accident Insurance Fund shall collect and record each fee for medical services billed to the fund and categorize them according to nature of service and according to the provider. The fund shall construct a profile of each provider by recording the billing history for each service category for that provider. The fund shall also construct a composite profile for each service category by all providers.

(12) The State Accident Insurance Fund shall not pay any more of a billing than the sum which equals the 85th percentile of the range of all billings for that service category nor shall the fund pay any more of a billing which exceeds that sum the provider has historically billed for that service. In no instance shall the fund pay the provider more than the usual fee charged by that provider for similar services. The provider shall not charge or have a cause of action against a patient for the difference between the billing and the amount determined payable under this section.

(13) The fund may use any source of the data required by this section or may purchase the services required by this section. The fund shall make such data available, upon request and payment therefor, to self-insured employers.

(14) Self-insured employers are not required to make payment for medical services that exceed the amounts prescribed by this section.

SECTION 7. (1) As used in this section "loss" means amputation or permanent or complete loss of function equivalent to amputation. Determination of benefits under this section shall be made by the Evaluation Division pursuant to ORS 656.268.

(2) A worker who sustains a compensable injury and suffers the following losses as a result of such injury shall receive in a lump sum, in addition to any other benefits the worker is entitled to under this chapter, an amount equal to the average weekly wage at time of injury multiplied by the factor stated for each loss as follows:

(a) For the loss of two hands, two feet, or one hand and one foot, 120.

(b) For the loss of both hands and both feet, 240.

(c) For the loss of one arm at or above the elbow joint, 64.

(d) For the loss of one forearm at or above the wrist joint, or the loss of one hand, 50.

(e) For the loss of one leg, at or above the knee joint, 50.

(f) For the loss of one foot, 45.

(g) For the loss of a great toe, 6; of any other toe, 2.

(h) For the loss of a thumb, 16.

(i) For the loss of a first finger, 8; of a second finger, 7; of a third finger, 4; of a fourth finger, 2.

(j) For complete loss of hearing in one ear, 20.

(k) For complete loss of hearing in both ears, 64.

(L) For complete loss of vision of one eye, 33.

(m) For complete loss of vision of both eyes, 120.

**SECTION 8.** (1) The name of the Workers' Compensation Department is changed to the Workers' Recovery Department. Any reference in the statute sections published in Oregon Revised Statutes to the Workers' Compensation Department shall be considered a reference to the Workers' Recovery Department.

(2) The name of the Workers' Compensation Board is changed to the Workers' Recovery Board. Any reference in the statute sections published in Oregon Revised Statutes to the Workers' Compensation Board shall be considered a reference to the Workers' Recovery Board.

(3) The name of the Workers' Compensation Law is changed to the Workers' Recovery Law. Any reference in the statute sections published in Oregon Revised Statutes to the Workers' Compensation Law shall be considered a reference to the Workers' Recovery Law.

(4) For the purpose of harmonizing and clarifying statute sections published in Oregon Revised Statutes, the Legislative Counsel may substitute, for words designating:

(a) The Workers' Compensation Department, wherever such words occur in Oregon Revised Statutes, words designating the Workers' Recovery Department.

(b) The Workers' Compensation Board, wherever such words occur in Oregon Revised Statutes, words designating the Workers' Recovery Board.

(c) The Workers' Compensation Law, wherever such words occur in Oregon Revised Statutes, words designating the Workers' Recovery Law.

Section 9. ORS 656.001 is amended to read:

656.001. ORS 656.001 to 656.794 may be cited as the Workers' [*Compensation*] Recovery Law.

Section 10. ORS 656.005 is amended to read:

656.005. (1) "Administrative Fund" means the fund created by ORS 656.612.

(2) "Average weekly wage" means the Oregon average weekly wage in covered employment, as determined by the Employment Division of the Department of Human Resources, for the last quarter of the calendar year preceding the fiscal year in which the injury occurred.

(3) "Beneficiary" means an injured worker, and the husband, wife, child or dependent of a worker, who is entitled to receive payments under this chapter. However, a spouse of an injured worker living in a state of abandonment for more than one year at the time of the injury or subsequently is not a beneficiary. A spouse who has lived separate and apart from the worker for a period of two years and who has not during that time, received or attempted by process of law to collect funds for support or maintenance, is considered living in a state of abandonment.

(4) "Board" means the Workers' [*Compensation*] Recovery Board.

[*(5) "Carrier-insured employer" means an employer who provides workers' compensation coverage with a guaranty contract insurer.*]

[*(6)*] (5) "Child" includes a posthumous child, a child legally adopted prior to the injury, a child toward whom the worker stands in loco parentis, an illegitimate child and a stepchild, if such stepchild was, at the time of the injury, a member of the worker's family and substantially dependent upon the worker for support. An

invalid dependent child is a child, for purposes of benefits, regardless of age, so long as the child was an invalid at the time of the accident and thereafter remains an invalid substantially dependent on the worker for support. For purposes of this chapter, an invalid dependent child is considered to be a child under 18 years of age.

[*(7)*] (6) "Claim" means a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge.

[*(8)*] (7) (a) A "compensable injury" is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means.

(b) A "disabling compensable injury" is an injury which entitles the worker to compensation for disability or death.

(c) A "nondisabling compensable injury" is any injury which requires medical services only.

[*(9)*] (8) "Compensation" includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by a direct responsibility employer or the State Accident Insurance Fund pursuant to this chapter.

[*(10)*] (9) "Contributing employer" means an employer who provides workers' compensation coverage with the State Accident Insurance Fund.

[*(11)*] (10) "Department" means the Workers' [*Compensation*] Recovery Department.

[*(12)*] (11) "Dependent" means any of the following-named relatives of a worker whose death results from any injury and who leaves surviving no widow, widower or child under the age of 18 years: Father, mother, grandfather, grandmother, stepfather, stepmother, grandson, granddaughter, brother, sister, half sister, half brother, niece or nephew, who at the time of the accident, are dependent in whole or in part for their support upon the earnings of the worker. Unless otherwise provided by treaty, aliens not residing within the United States at the time of the accident other than father, mother, husband, wife or children are not included within the term "dependent."

[*(13)*] (12) "Direct responsibility employer" means a self-insured employer or a carrier-insured employer.

[*(14)*] (13) "Director" means the Director of the Workers' [*Compensation*] Recovery Department.

[*(15)*] (14) "Doctor" or "physician" means a person duly licensed to practice one or more of the healing arts in this state within the limits of the license of the licentiate.

[*(16)*] (15) "Employer" means any person, including receiver, administrator, executor or trustee, and the state, state agencies, counties, municipal corporations, school districts and other public corporations or political subdivisions, who contracts to pay a remuneration for and secures the right to direct and control the services of any person.

[*(17) "Guaranty contract insurer" means an insurer that is authorized under ORS chapter 731 to transact insurance in this state and to sell workers' compensation insurance.*]

[*(18)*] (16) "Insurer" means the State Accident Insurance Fund or a guaranty contract insurer.

[*(19)*] (17) "Insured employer" means a contributing employer or a carrier-insured employer.

[*(20)*] (18) "Invalid" means one who is physically or mentally incapacitated from earning a livelihood.

[*(21)*] (19) "Noncomplying employer" means a subject employer who has failed to comply with ORS 656.017 or who is in default under ORS 656.560 in the payment of contributions required by ORS 656.504.

[*(22)*] (20) "Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer.

[*(23)*] (21) "Payroll" means a record of wages payable to workers for their services and includes vacation pay, bonus pay, commissions, value of exchange labor, amounts payable under profit sharing agreements and the reasonable value of board, rent, housing, lodging or similar advantage received from the employer.

[*(24)*] (22) "Person" includes partnership, joint venture, association and corporation.

[*(25)*] (23) "Self-insured employer" means an employer who has been certified under ORS 656.430 that he meets the qualifications of a self-insured employer set out by ORS 656.407.

[*(26)*] (24) "State Accident Insurance Fund" and "fund" mean the State Accident Insurance Fund created under ORS 656.752.

[*(27)*] (25) "Subject employer" means an employer who is subject to this chapter as provided by ORS 656.023.

[*(28)*] (26) "Subject worker" means a worker who is subject to this chapter as provided by ORS 656.027.

[*(29)*] (27) "Wages" means the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, including reasonable value of board, rent, housing, lodging or similar advantage received from the employer. The State Accident Insurance Fund may establish assumed minimum and maximum wages, in conformity with recognized insurance principles, at which any worker shall be carried upon the payroll of the employer for the purpose of determining the contribution of the employer.

[*(30)*] (28) "Worker" means any person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer and includes salaried, elected and appointed officials of the state, state agencies, counties, cities, school districts and other public corporations, but does not include any person whose services are performed as an inmate or ward of a state institution.

Section 11. ORS 656.010 is amended to read:

656.010. Nothing in this chapter shall be construed to require a worker who in good faith relies on or is treated by prayer or spiritual means by a duly accredited practitioner of a well-recognized church to undergo any medical or surgical treatment nor shall such worker or his dependents be deprived of any compensation payments to which he would have been entitled if medical or surgical treatment were employed, and the employer or [*insurance carrier*] State Accident Insurance Fund may pay for treatment by prayer or spiritual means.

NOTE: Section 12 was deleted by amendment. Subsequent sections were not renumbered.

Section 13. ORS 656.039 is amended to read:

656.039. (1) An employer of one or more persons defined as nonsubject workers or not defined as subject workers may elect to make them subject workers. If the employer is or becomes a contributing employer, the election shall be made by filing written notice thereof with the State Accident Insurance Fund with a copy to the director. The election becomes effective when the written notice is received by an authorized representative of the fund. [*If the employer is or becomes a carrier-insured employer, the election shall be made by filing written notice thereof with the insurer with a copy to the director.*] The effective date of coverage is governed by subsection (4) of ORS 656.419. If the employer is or becomes a self-insured employer, the election shall be made by filing written notice thereof with the director, the effective date of coverage to be the date specified in the notice.

(2) Any election under subsection (1) of this section may be canceled by written notice thereof to the insurer or, in the case of a self-insured employer, by notice thereof to the director. The cancellation is effective at 12 midnight ending the day the notice is received by the insurer or the director, unless a later date is specified in the notice. The insurer shall, within 10 days after receipt of a notice of cancellation under this section, send a copy of the notice to the director.

(3) When necessary the insurer or the director shall fix assumed minimum or maximum wages for persons made subject workers under this section.

Section 13a. ORS 656.121 is amended to read:

659.121. (1) Any person claiming to be aggrieved by an unlawful employment practice prohibited by ORS 659.024, 659.026, 659.030, 659.410[, *659.415*] or subsection (1) of 659.425 may file a civil suit in circuit court for injunctive relief and the court may order such other equitable relief as may be appropriate, including but not limited to reinstatement or the hiring of employes with or without back pay. Back pay liability shall not accrue from a date more than two years prior to the filing of a complaint with the Labor Commissioner, pursuant to ORS 659.040, or if no such complaint has first been filed, then, more than two years prior to the filing of the civil suit provided for in ORS 659.040, 659.045, 659.095 and this section. In any suit brought under this subsection, the court may allow the prevailing party costs and reasonable attorney fees.

(2) Any person claiming to be aggrieved by alleged violations of subsection (1) or (2) of ORS 659.033, subsection (2) of 659.425 or ORS 659.430 may file a civil action in circuit court to recover compensatory damages or $200, whichever is greater, and punitive damages not to exceed $2,500. The court may provide such equitable relief as it deems appropriate. In any action brought under this subsection, the court may allow the prevailing party costs and reasonable attorney fees.

(3) Where no complaint has been filed pursuant to subsection (1) of ORS 659.040 or subsection (1) of 659.045 and except as otherwise provided herein, the civil suit or action shall be commenced within one year of the occurrence of the alleged unlawful employment practice. Where a complaint has been filed pursuant to subsection (1) of ORS 659.040 or subsection (1) of 659.045 the civil suit or action provided for herein shall be commenced only in accordance with the time limitations provided for in ORS 659.095. The filing of a complaint with the commissioner under subsection (1) of ORS 659.040 or subsection (1) of 659.045 shall not be a condition precedent to the filing of civil suit or action under this section.

(4) This section shall not be construed to limit or alter in any way the authority or power of the commissioner or to limit or alter in any way any of the rights of an individual complainant until and unless the complainant commences civil suit or action. The filing of a civil suit or action shall constitute both an election of remedies as to the rights of that individual with respect to those matters alleged in the complaint filed with the commissioner, and a waiver with respect to the right to file a complaint with the commissioner pursuant to subsection (1) of ORS 659.040 or subsection (1) of 659.045.

Section 14. ORS 656.128 is amended to read:

656.128. (1) Any person who is a sole proprietor, or a member of a partnership, may make written application to the State Accident Insurance Fund or a guaranty contract insurer to become entitled as a subject worker to compensation benefits. Thereupon, the fund shall[, *or the guaranty contract insurer may,*] accept such application and fix a classification and an assumed monthly wage at which such person shall be carried on

**the payroll as a worker for purposes of computations under this chapter. If the person making application to the fund under this section is an employer of subject workers, his application shall not be accepted unless he is a contributing employer.**

**(2) When the application is accepted, such person thereupon is subject to the provisions and entitled to the benefits of this chapter. He shall promptly notify the insurer whenever his status as an employer of subject workers changes. Any subject worker employed by such a person after the effective date of his election shall, upon being employed, be considered covered automatically by the same guaranty contract that covers such person.**

**(3) No claim shall be allowed or paid under this section, except upon corroborative evidence in addition to the evidence of the claimant.**

**(4) Any person subject to this chapter as a worker as provided in this section may cancel such election by giving written notice to the insurer. The cancellation shall become effective at 12 midnight ending the day of filing the notice with the insurer.**

Section 15. ORS 656.140 is amended to read:

656.140. (1) Any person, or persons operating as partners, who have an ownership or leasehold interest in equipment and are engaged in the business of operating such equipment for hire, may elect to cover themselves under the Workers' [*Compensation*] **Recovery Law** by qualifying as a contributing employer [*or a direct responsibility employer*] pursuant to this chapter and by filing with the State Accident Insurance Fund [*or another insurer*] a written application to become entitled as subject workers to the benefits of the Workers' [*Compensation*] **Recovery Law**.

(2) As used in this section "equipment" means:

(a) A motor vehicle used in the transportation of logs, poles or pilings.

(b) A motor vehicle used in the transportation of rocks, gravel, sand or dirt.

(c) A backhoe or other similar equipment used for digging and filling ditches or trenches.

(d) A tractor.

(e) Any other motor vehicle or heavy equipment of a kind commonly operated for hire.

(3) The fund shall[*, or the other insurer may,*] accept such application and fix a classification and an assumed monthly wage at which such person, or persons operating as partners, shall be carried on the payroll as workers for purposes of computations under this chapter.

(4) When the application is accepted, such person, or persons operating as partners, become subject workers. Thereupon, such person, or persons operating as partners, shall be subject to this chapter as a subject employer notwithstanding ORS 656.023 and shall be entitled to benefits as subject workers.

(5) No claim shall be allowed or paid under this section, except upon corroborative evidence in addition to the evidence of the claimant.

(6) Any person, or persons operating as partners, electing coverage under this section, have the same duties and responsibilities of any other subject employer in the event they hire one or more subject workers.

(7) The rights given to a person, or persons operating as partners, and their beneficiaries pursuant to this section for injuries compensable under this chapter are in lieu of any remedies they might otherwise have for

**such injuries against the person for whom services are being performed.**

**NOTE: Section 16 was deleted by amendment. Subsequent sections were not renumbered.**

Section 17. ORS 656.208 is amended to read:

656.208. (1) If the injured worker dies [*during the period of permanent total disability*] **while receiving total wage loss benefits and after having received total wage loss benefits continuously for four years, unless the worker is participating in vocational rehabilitation at the time of the death,** whatever the cause of death, leaving:

(a) A spouse who was the husband or wife of the worker either at the time of the injury causing the disability or within two years thereafter; or

(b) Any dependents listed in ORS 656.204, payment shall be made in the same manner and in the same amounts as provided in ORS 656.204.

(2) If any surviving spouse to whom the provisions of this section apply remarries, the payments on account of a child or children shall continue to be made to the child or children the same as before the remarriage.

Section 18. ORS 656.209 is amended to read:

656.209. (1) With the authorization of the board, the amount of any [*permanent total disability*] total wage loss benefits payable to an injured worker shall be reduced by the amount of any disability benefits the worker receives from federal social security.

(a) If the benefit amount to which the worker is entitled pursuant to ORS 656.001 to 656.794 exceeds the worker's federal disability benefit limitation determined pursuant to 42 USC 424(a), the reduction in worker's compensation benefits authorized by this subsection shall not be administered in such manner as to lower the amount the worker would have received pursuant to ORS 656.001 to 656.794 had such reduction not been made.

(b) If the benefit amount to which the worker is entitled pursuant to ORS 656.001 to 656.794 is less than the worker's federal disability benefit limitation determined pursuant to 42 USC 424(a), the reduction in worker's compensation benefits authorized by this subsection shall not be administered in such manner as to lower the amount of combined benefits the worker receives below the federal benefit limitation.

(2) No reduction of [*permanent total disability*] total wage loss benefits shall be made pursuant to this section unless authorized by the board.

(3) No reduction of benefits shall be authorized pursuant to this section except upon actual receipt of federal social security disability benefits by the injured worker.

**SECTION 19. If an injured worker dies while receiving total wage loss benefits or wage differential benefits, the persons who would have been entitled to receive death benefits if the compensable injury had been fatal shall receive that amount which equal 52 times the average weekly wage, but only if no other death benefits are payable under this chapter.**

NOTE: Section 20 was deleted by amendment. Subsequent sections were not renumbered.

Section 21. ORS 656.245 is amended to read:

656.245. (1) For every compensable injury, the direct responsibility employer or the State Accident Insurance Fund shall cause to be provided medical services for conditions resulting from the injury. [*for such period as the nature of the injury or the process of the recovery requires, including such medical services as may be required after a determination of permanent disability.*] Such medical services shall include medical, surgical,

hospital, nursing, ambulances and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services.

(2) Subject to section 6 of this 1979 Act, the worker may choose his own attending doctor or physician within the State of Oregon.

Section 22. ORS 656.252 is amended to read:

656.252. (1) In order to insure the prompt reporting and payment of compensation in compensable injuries the director shall make rules and regulations governing reports of attending and examining physicians. Such rules and regulations shall include, but not necessarily be limited to:

(a) Requiring attending physicians to make the State Accident Insurance Fund [*or carrier*] a first report of injury within a specified time after the first service rendered.

(b) Requiring attending physicians to submit follow-up reports within specified time limits or upon the request of an interested party.

(c) Requiring examining physicians to submit their reports, and to whom, within a specified time.

(d) Such other reporting requirements as the director may deem necessary to insure that payments of compensation be prompt and that all interested parties be given information necessary to the prompt determination of claims.

(2) In promulgating the rules and regulations regarding medical reporting the director may consult and confer with physicians and members of medical associations and societies.

Section 23. ORS 656.254 is amended to read:

656.254. (1) The director shall establish medical report forms, in duplicate snap-outs where applicable, to be used by the State Accident Insurance Fund, [*the guaranty contract insurers,*] the self-insured employers and the physicians, including in such forms information necessary to establish facts required in the determination of the claim.

(2) The director shall establish sanctions for the enforcement of medical reporting requirements.

Section 24. ORS 656.262 is amended to read:

656.262. (1) Processing of claims and providing compensation for a worker in the employ of a contributing employer shall be the responsibility of the State Accident Insurance Fund, and when the worker is injured while in the employ of a direct responsibility employer, such employer shall be responsible. However, the contributing employer shall pay to the worker directly the total wage loss benefits provided in this chapter which shall be reimbursed by the State Accident Insurance Fund upon receipt of documentation of those payments, except that in the case of an aggravation of a prior compensable injury which occurred while the worker was not employed by the employer at the time of aggravation, the insurer or self-insured employer shall pay the total wage loss benefits. However, all employers shall assist the fund [*or their insurers*] in processing claims as required in this chapter.

(2) The compensation due under this chapter from the fund or direct responsibility employer shall be paid periodically, promptly and directly to the person entitled thereto upon the employer's receiving notice or knowledge of a claim, except where the right to compensation is denied by the direct responsibility employer or fund.

(3) Contributing employers [*and carrier-insured employers*] shall, immediately and not later than five days after notice or knowledge of any claims or accidents which may result in a compensable injury claim, report the same to the fund [*or other insurer*]. The report shall include:

**(a) The date, time, cause and nature of the accident and injuries.**

**(b) Whether the accident arose out of and in the course of employment.**

(c) Whether the employer recommends or opposes acceptance of the claim, and his reasons.

(d) Any other details the fund or other insurer may require.

**Failure to so report subjects the offending employer to a charge for reimbursing the fund for any penalty the fund is required to pay under subsection (8) of this section because of such failure.**

[*(4) The first instalment of compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim. Thereafter, compensation shall be paid at least once each two weeks, except where the director determines that payment in instalments should be made at some other interval. The director may by regulation convert monthly benefit schedules to weekly or other periodic schedules.*]

**(4) The first instalment of wage loss benefits shall be paid by the employer on the next regular payday of the injured worker and on each regular payday thereafter until such time that either the employer or the worker declares that the worker will not return to that employment, which declaration the employer shall report to the department.**

(5) Written notice of acceptance or denial of the claim shall be furnished to the claimant by the fund or direct responsibility employer within 60 days after the employer has notice or knowledge of the claim. The fund shall also furnish the contributing employer a copy of the notice of acceptance. **The notice of acceptance shall[:] inform the claimant of the rights to reemployment, wage differential and hearing, the early return to work standard and aggravation rights.**

[*(a) Advise the claimant whether the claim is considered disabling or nondisabling.*]

[*(b) Inform the claimant of hearing and aggravation rights concerning nondisabling injuries including the right to object to a decision that his injury is nondisabling by requesting a determination thereon pursuant to ORS 656.268.*]

(6) If the State Accident Insurance Fund, the direct responsibility employer itself [*or its guaranty contract insurer*] or any other duly authorized agent of such employer for such purpose on record with the Director of the Workers' [*Compensation*] **Recovery** Department denies a claim for compensation, written notice of such denial, stating the reason for the denial, and informing the worker of hearing rights under ORS 656.283, shall be given to the claimant. A copy of the notice of denial shall be mailed to the director and to the contributing employer by the fund. The worker may request a hearing on the denial at any time within 60 days after the mailing of the notice of denial.

(7) Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof.

(8) If the fund or direct responsibility employer [*or its insurer*] unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the fund or direct responsibility employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382.

(9) The fund may authorize contributing employers to pay compensation to injured workers and shall reimburse employers for compensation so paid.

(10) The fund and all direct responsibility employers shall report every claim for disabling injury to the director within 21 days after the date the employer has notice or knowledge of such injury. If within one year

**after the injury, a worker claims a nondisabling injury has become disabling, the fund or direct responsibility employer shall report the claim to the director immediately after receiving notice or knowledge of such claim. A claim that a nondisabling injury has become disabling, if made more than one year after the date of injury, shall be made pursuant to ORS 656.273 as for a claim for aggravation.**

**(11) If it appears to the director that a subject worker has sustained a compensable injury and the contributing employer fails to pay wage loss benefits as required by subsection (1) of this section, the director shall order the State Accident Insurance Fund to commence paying the worker wage loss benefits immediately and schedule a hearing. If the denial or delay was unreasonable, the contributing employer shall be liable for an additional sum equal to one month's wage loss plus any attorney fees which may be assessed under ORS 656.382.**

Section 25. ORS 656.264 is amended to read:

656.264. (1) The State Accident Insurance Fund[*, guaranty contract insurers*] and self-insured employers shall report to the director compensable injuries, claims disposition and payments made by them under this chapter.

(2) The director may require the fund[*, other insurers*] and such employers to report other information as required to carry out this chapter.

(3) The director may prescribe the interval and the form of such reports and establish sanctions for the enforcement of reporting requirements.

Section 26. ORS 656.268 is amended to read:

656.268. (1) [*One*] **The primary** purpose of this chapter is to restore the injured worker as soon as possible and as near as possible to a condition of self support and maintenance as an able-bodied worker. Claims shall not be closed nor [*temporary disability compensation terminated if the worker's condition has not become medically stationary or if the worker is enrolled and actively engaged in an authorized program of vocational rehabilitation that has been provided according to rules adopted pursuant to ORS 656.728, provided however, that temporary disability compensation shall be proportionately reduced by any sums earned during the vocational rehabilitation period.*] **wage loss benefits terminated until one of the following occurs:**

**(a) The attending physician has approved the worker's return to regular employment;**

**(b) The worker refuses to comply with the return to work-rehabilitation plan ordered by the director;**

**(c) The worker commences employment; or**

**(d) The worker is able to perform work at a gainful and suitable occupation. As used in this paragraph, a suitable occupation is one which the worker has the ability and the training and experience to perform, or an occupation which the worker is able to perform after rehabilitation.**

[*(2) When the injured worker's condition resulting from a disabling injury has become medically stationary, unless he is enrolled and actively engaged in an authorized program of vocational rehabilitation, the State Accident Insurance Fund or direct responsibility employer shall so notify the Evaluation Division, the worker, and contributing employer, if any, and request the claim be examined and further compensation, if any, be determined. A copy of all medical reports and reports of vocational rehabilitation agencies or counselors necessary to make such determination also shall be furnished to the Evaluation Division and to the worker and to the contributing employer, if requested by such worker or employer. If the attending physician has not approved the worker's return to his regular employment, the fund or direct responsibility employer must continue to make temporary total disability payments until termination of such payments is authorized following examination of the medical reports submitted to the Evaluation Division under this section.*]

**(2) When the worker commences employment or the attending physician has approved the worker's return to regular employment and the regular employment is available, the wage loss benefits may be terminated by the fund or self-insured employer without approval of the director. In all other instances wage loss benefits may not be terminated without approval of the director. At the termination of any wage loss benefits the State Accident Insurance Fund or self-insured employer shall issue a notice to the worker stating the cause for the termination, the right of the worker to present evidence to the director that such cause does not exist, and inform the worker of hearing and aggravation rights and of such other information as the director may require. Within one year of the date of the notice of such a termination, a determination order subsequently may be issued on the claim at the request of the worker or by the director upon review of the claim if the director finds the claim was terminated improperly.**

**[***(3) Within 30 days after the Evaluation Division receives the medical and vocational reports relating to a disabling injury, the claim shall be examined and further compensation, including permanent disability award, if any, determined under the director's supervision. If necessary the Evaluation Division may require additional medical or other information with respect to the claim, and may postpone the determination for not more than 60 additional days. Any determination under this subsection may include necessary adjustments in compensation paid or payable prior to the determination, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against permanent disability awards and payment of temporary disability payments which were payable but not paid. The Evaluation Division shall reconsider determinations made pursuant to this subsection whenever one of the parties makes request therefor and presents medical information regarding the claim that was not available at the time the original determination was made. However, any such request for reconsideration must be made prior to the time a request for hearing is made pursuant to ORS 656.283. The time from request for reconsideration until decision on reconsideration shall not be counted in any limitation on the time allowed for requesting a hearing pursuant to ORS 656.283.***]

**(3) The worker who is eligible for wage differential benefits shall be provided with necessary forms on which to report earnings monthly to the State Accident Insurance Fund or the self-insured employer who shall remit the appropriate wage differential benefit within 14 days after receipt of the report. The insurer or self-insured employer shall perform wage differential computations each month, making adjustments for increases and decreases. The director by rule may require that insurers and self-insured employers report such computations to the department. If the worker voluntarily limits income or fails to accept employment commensurate with the worker's ability, the wages after injury shall be considered to be the amount which would have been earned if the worker had not limited income or accepted appropriate employment. The director may make such a determination only after the worker has been notified of the request for such a determination and of the reasons advanced therefor and has been notified to respond thereto. A worker who is disqualified from unemployment compensation benefits under subsection (2) of ORS 657.176 is also disqualified from wage differential benefits until such time as the worker commences employment.**

**[***(4) If, after the determination made pursuant to subsection (3) of this section, the director authorizes a program of vocational rehabilitation for an injured worker, any permanent disability payments due under the determination shall be suspended, and the worker shall receive temporary disability compensation while he is enrolled in the authorized vocational rehabilitation program. When the worker ceases to be enrolled and actively engaged in an authorized vocational rehabilitation program, the Evaluation Division shall redetermine the claim pursuant to subsection (3) of this section unless the worker's condition is not medically stationary.***]**

**(4) The director may prescribe rules for the reporting of income by a worker receiving wage loss or wage differential only as is necessary to prevent overpayments.**

(5) The Evaluation Division shall mail a copy of the determination to all interested parties. Any such party may request a hearing under ORS 656.283 on the determination made under subsection (3) of this section within one year after copies of the determination are mailed.

(6) If the claim resulted from an injury to a worker while in the employ of a contributing employer, the fund shall set aside in the Contributing Employers Awards Reserve an amount of money sufficient to pay the award or benefits. If the claim resulted from an injury to a worker while in the employ of a direct responsibility employer, the director may, in the event of:

(a) The insolvency or threatened insolvency of such employer or his surety or guarantor, and

(b) The inadequacy of cash, bond or securities otherwise on deposit by any of them to secure such payment,

require the employer to deposit cash, securities or other assets in such amount as it deems necessary to assure ultimate payment of the award.

(7) Upon receipt of a request made pursuant to subsection (5) of ORS 656.262, the Evaluation Division shall determine whether the claim is disabling or nondisabling. A copy of such determination shall be mailed to all interested parties in accordance with subsection (5) of this section.

Section 27. ORS 656.273 is amended to read:

656.273. (1) After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury.

(2) To obtain additional medical services or disability compensation, the injured worker must file a claim for aggravation with the State Accident Insurance Fund or the direct responsibility employer. In the event the direct responsibility employer cannot be located, is unknown, or has ceased to exist, the claim shall be filed with the director.

(3) A physician's report indicating a need for further medical services or additional compensation is a claim for aggravation.

(4) (a) Except as provided in paragraphs (b) and (c) of this subsection, the claim for aggravation must be filed within five years after the [*first*] determination fixing **the maximum wage differential benefit was** made [*under subsection (3) of ORS 656.268*].

(b) If no such determination was made, the claim for aggravation must be filed within five years after the [*date of injury*] **last receipt of total wage loss benefits**.

(c) If a nondisabling injury did not become disabling within at least one year from the termination of medical services, the claim for aggravation must be filed within five years from the date of injury rather than the date of any determination issued in the claim.

(5) The director may, in his discretion, order the claimant, the State Accident Insurance Fund or the direct responsibility employer to pay for such medical opinion.

(6) A claim submitted in accordance with this section shall be processed by the direct responsibility employer or the State Accident Insurance Fund in accordance with the provisions of ORS 656.262[*, except that the first instalment of compensation due under subsection (4) of ORS 656.262 shall be paid no later than the 14th day after the subject employer has notice or knowledge of medically verified inability to work resulting from the worsened condition*].

**(4) The director may prescribe rules for the reporting of income by a worker receiving wage loss or wage differential only as is necessary to prevent overpayments.**

(5) The Evaluation Division shall mail a copy of the determination to all interested parties. Any such party may request a hearing under ORS 656.283 on the determination made under subsection (3) of this section within one year after copies of the determination are mailed.

(6) If the claim resulted from an injury to a worker while in the employ of a contributing employer, the fund shall set aside in the Contributing Employers Awards Reserve an amount of money sufficient to pay the award or benefits. If the claim resulted from an injury to a worker while in the employ of a direct responsibility employer, the director may, in the event of:

(a) The insolvency or threatened insolvency of such employer or his surety or guarantor, and

(b) The inadequacy of cash, bond or securities otherwise on deposit by any of them to secure such payment,

require the employer to deposit cash, securities or other assets in such amount as it deems necessary to assure ultimate payment of the award.

(7) Upon receipt of a request made pursuant to subsection (5) of ORS 656.262, the Evaluation Division shall determine whether the claim is disabling or nondisabling. A copy of such determination shall be mailed to all interested parties in accordance with subsection (5) of this section.

Section 27. ORS 656.273 is amended to read:

656.273. (1) After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury.

(2) To obtain additional medical services or disability compensation, the injured worker must file a claim for aggravation with the State Accident Insurance Fund or the direct responsibility employer. In the event the direct responsibility employer cannot be located, is unknown, or has ceased to exist, the claim shall be filed with the director.

(3) A physician's report indicating a need for further medical services or additional compensation is a claim for aggravation.

(4) (a) Except as provided in paragraphs (b) and (c) of this subsection, the claim for aggravation must be filed within five years after the [*first*] determination **fixing the maximum wage differential benefit was** made [*under subsection (3) of ORS 656.268*].

(b) If no such determination was made, the claim for aggravation must be filed within five years after the [*date of injury*] **last receipt of total wage loss benefits**.

(c) If a nondisabling injury did not become disabling within at least one year from the termination of medical services, the claim for aggravation must be filed within five years from the date of injury rather than the date of any determination issued in the claim.

(5) The director may, in his discretion, order the claimant, the State Accident Insurance Fund or the direct responsibility employer to pay for such medical opinion.

(6) A claim submitted in accordance with this section shall be processed by the direct responsibility employer or the State Accident Insurance Fund in accordance with the provisions of ORS 656.262[*, except that the first instalment of compensation due under subsection (4) of ORS 656.262 shall be paid no later than the 14th day after the subject employer has notice or knowledge of medically verified inability to work resulting from the worsened condition*].

(7) A request for hearing on any issue involving a claim for aggravation must be made to the [*department*] Hearings Division in accordance with ORS 656.283. Adequacy of the physician's report is not jurisdictional. If the evidence as a whole shows a worsening of the claimant's condition the claim shall be allowed.

Section 28. ORS 656.287 is amended to read:

656.287. (1) Where there is an issue regarding [*loss of earning capacity*] whether the worker is able to perform work at a gainful and suitable occupation or whether the worker is eligible for vocational rehabilitation, reports from vocational consultants in governmental agencies or private vocational consultants regarding job opportunities, the fitness of claimant to perform certain jobs, wage levels, or other information relating to claimant's employability shall be admitted into evidence at compensation hearings, provided such information is submitted to claimant [*10 days prior to hearing*] within such time as the board by rule may require and that upon demand from the adverse party the person preparing such report shall be made available for testimony and cross-examination.

(2) The board shall establish rules and regulations to govern the admissibility of reports from vocational experts, including guidelines to establish the competency of vocational experts.

NOTE: Section 29 was deleted by amendment. Subsequent sections were not renumbered.

Section 30. ORS 656.304 is amended to read:

656.304. A claimant may accept and cash any check given in payment of any award or compensation without affecting his right to a hearing[, *except that the right of hearing on any award shall be waived by acceptance of a lump sum award by a claimant where such lump sum award was granted on his own application under ORS 656.230*]. This section shall not be construed as a waiver of the necessity of complying with ORS 656.283 to 656.301.

Section 31. ORS 656.307 is amended to read:

656.307. (1) Where there is an issue regarding:

(a) Which of several subject employers is the true employer of a claimant worker;

[*(b) Which of more than one insurer of a certain employer is responsible for payment of compensation to a worker;*]

[*(c)*] (b) Responsibility between two or more employers [*or their insurers*] involving payment of compensation for two or more accidental injuries; or

[*(d)*] (c) Joint employment by two or more employers,

the director shall, by order, designate who shall pay the claim, if the claim is otherwise compensable. Payments shall begin in any event as provided in subsection (4) of ORS 656.262. When a determination of the responsible paying party has been made, the director shall direct any necessary monetary adjustment between the parties involved. Any failure to obtain reimbursement from a direct responsibility employer or its insurer shall be recovered from the Direct Responsibility Employers Adjustment Reserve.

(2) No employer [*or its insurer*] shall be joined in any proceeding under this section regarding its responsibility for any claim subject to ORS 656.273 unless the issue is entitled to hearing on application of the worker.

**(3) The claimant shall be joined in any proceedings under this section as a necessary party, but may elect to be treated as a nominal party.**

**NOTE: Section 32 was deleted by amendment. Subsequent sections were not renumbered.**

Section 33. ORS 656.325 is amended to read:

656.325. [*(1) Any worker entitled to receive compensation under ORS 656.001 to 656.794 is required, if requested by the director, State Accident Insurance Fund or a direct responsibility employer, to submit himself for medical examination at a time and from time to time at a place reasonably convenient for the worker and as may be provided by the rules of the director. If the worker refuses to submit to any such examination, or obstructs the same, his rights to compensation shall be suspended with the consent of the director until the examination has taken place, and no compensation shall be payable during or for account of such period.*]

[*(2)*] (1) For any period of time during which any worker commits insanitary or injurious practices which tend to either imperil or retard his recovery, or refuses to submit to such medical or surgical treatment as is reasonably essential to promote his recovery, his right to compensation shall be suspended with the consent of the director and no payment shall be made for such period. The period during which such worker would otherwise be entitled to compensation may be reduced with the consent of the director to such an extent as his disability has been increased by such refusal.

[*(3) A worker who has received an award for unscheduled permanent total or unscheduled partial disability should be encouraged to make a reasonable effort to reduce his disability; and his award shall be subject to periodic examination and adjustment in conformity with ORS 656.268.*]

[*(4)*] (2) When the employer of an injured worker, or the employer's insurer determines that the injured worker has failed to follow medical advice from his treating physician or has failed to participate in or complete physical restoration or vocational rehabilitation programs prescribed for the worker pursuant to ORS 656.001 to 656.794, the employer or insurer may petition the director for reduction of any benefits awarded the worker. Notwithstanding any other provision of ORS 656.001 to 656.794, if the director finds that the worker has failed to accept treatment as provided in this subsection, the director may reduce any benefits awarded the worker by such amount as the director considers appropriate.

[*(5)*] (3) Any party may request a hearing on any dispute under this section pursuant to ORS 656.283.

Section 34. ORS 656.382 is amended to read:

656.382. [*(1) If a direct responsibility employer or the State Accident Insurance Fund refuses to pay compensation due under an order of a referee, board or court, or otherwise unreasonably resists the payment of compensation, the employer or fund shall pay to the claimant or his attorney a reasonable attorney's fee as provided in subsection (2) of this section. To the extent a contributing employer has caused the fund to be charged such fees, such employer may be charged with those fees.*]

[*(2) If a request for hearing, request for review or court appeal is initiated by an employer or the fund, and the referee, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or fund shall be required to pay to the claimant or his attorney a reasonable attorney's fee in an amount set by the referee, board or the court for legal representation by an attorney for the claimant at the hearing, review or appeal.*]

[*(3) If upon reaching a decision on a request for hearing initiated by an employer it is found by the referee that the employer initiated the hearing for the purpose of delay or other vexatious reason or without reasonable ground, the referee may order the employer to pay to the claimant such penalty not exceeding $750 and not less*

*than $100 as may be reasonable in the circumstances.*] **The self-insured employer or the State Accident Insurance Fund shall pay to the claimant or the claimant's attorney a reasonable attorney fee at any hearing, board or court review in which the claimant prevails. If a contributing employer has caused the fund to be charged such fees, the fund may charge such fees to the employer.**

Section 35. ORS 656.388 is amended to read:

656.388. (1) No claim for legal services or for any other services rendered before a referee or the board, as the case may be, in respect to any claim or award for compensation, to or on account of any person, shall be valid unless approved by the referee or board, or if proceedings on appeal from the order of the board in respect to such claim or award are had before any court, unless approved by such court.

(2) If an attorney and the referee or board cannot agree upon the amount of the fee, each forthwith shall submit a written statement of the services rendered to the presiding judge of the circuit court in the county in which the claimant resides. The judge shall, in a summary manner, without the payment of filing, trial or court fees, determine the amount of such fee. This controversy shall be given precedence over other proceedings.

[*(3) Any claim so approved shall, in the manner and to extent fixed by the hearing officer, board or such court, be a lien upon such compensation.*]

[*(4)*] (3) The board shall, after consultation with the Board of Governors of the Oregon State Bar, establish a suggested schedule of fees for attorneys representing a worker under ORS 656.001 to 656.794.

Section 36. ORS 656.403 is amended to read:

656.403. (1) A subject employer who is qualified as a direct responsibility employer directly assumes the responsibility for providing compensation due his subject workers and their beneficiaries under this chapter.

(2) The claims of subject workers and their beneficiaries resulting from injuries while employed by a direct responsibility employer shall be handled in the manner provided by this chapter. A direct responsibility employer is subject to the rules of the director with respect to such claims.

(3) [*Insurance obtained by a carrier-insured employer and*] Security deposited by a self-insured employer shall not relieve any such employer from full and primary responsibility for claims administration and payment of compensation under this chapter. [*This subsection applies to a self-insured employer even though he insures or reinsures all or any portion of his risks under this chapter with an insurance company authorized to do business in this state or with any other insurer with whom insurance can be placed or secured pursuant to ORS 744.305 to 744.405.*]

Section 37. ORS 656.407 is amended to read:

656.407. (1) To qualify as a direct responsibility employer, an employer must have sufficient financial ability and qualified staff to be able to make certain the prompt payment of all compensation and all other payments that may become due from such employer under this chapter. An employer shall establish proof with the director that he is so qualified [*either:*]

[*(a) As a carrier-insured employer by causing a contract issued by a guaranty contract insurer to be filed with the director; or*]

[*(b)*] as a self-insured employer by establishing proof that he has an adequate staff qualified to process claims promptly and that he has the financial ability to make certain the prompt payment of all compensation and other payments that may become due to the board under this chapter.

(2) A self-insured employer shall establish proof of financial ability by depositing in a depository, designated by the director, money, government securities or a surety bond written by a surety insurer

authorized to transact insurance in this state. The money, securities or bond shall be in an amount reasonably sufficient to insure payment of compensation and other payments that may become due to the director but not less than the employer's normal expected annual claim liabilities and in no event less than $100,000. In arriving at the amount of money, securities or bond required under this subsection, the director may take into consideration the financial ability of the employer to pay compensation and other payments and his probable continuity of operation. The money, securities or bond so deposited shall be held by the director to secure the payment of compensation for injuries to subject workers of the employer and to secure other payments that may become due from the employer to the director under this chapter. The amount of security may be increased or decreased from time to time by the director.

Section 38. ORS 656.419 is amended to read:

656.419. (1) A guaranty contract issued by the State Accident Insurance Fund [*or a guaranty contract insurer*] shall provide that the insurer agrees to assume, without monetary limit, the liability of the employer, arising during the period the guaranty contract is in effect, for prompt payment of:

(a) All compensation for compensable injuries that may become due under this chapter to subject workers and their beneficiaries; and

(b) All assessments, contributions and other obligations imposed on the insured employer and his subject workers under this chapter that may become due from such employer to the director, except the obligation to pay a penalty assessed against the employer under ORS 656.745.

(2) A guaranty contract issued by the State Accident Insurance Fund [*or a guaranty contract insurer*] shall be filed with the director by the insurer within 30 days after workers' compensation coverage of the employer is effective. A guaranty contract shall contain:

(a) The name and address of the employer;

(b) A description of the occupation in which the employer is engaged or proposes to engage;

(c) The effective date of the workers' compensation coverage;

(d) A specific statement that a named sole proprietor, partner or corporate officer is covered by the contract by reason of an election to be covered, if such is the case, and, if coverage extends to any other person by reason of an election of his employer, a statement of that fact; and

(e) Such other information as the director may from time to time require.

(3) Workers' compensation coverage is effective when the application of the subject employer for coverage together with any required fees or premium are[:]

[*(a)*] received by an authorized representative of the State Accident Insurance Fund[*; or*].

[*(b) Accepted by an authorized representative of a guaranty contract insurer.*]

(4) If the name or address of an insured employer is changed, the insurer shall, within 30 days after the date the change is received by the insurer, file a change-of-name or change-of-address notice with the director setting forth the correct name and address of the employer.

(5) Coverage of an employer under a guaranty contract continues until canceled or terminated as provided by ORS 656.423 or 656.427.

Section 39. ORS 656.423 is amended to read:

656.423. (1) An insured employer may cancel his coverage with the State Accident Insurance Fund or other insurer by giving the insurer at least 30 days' written notice, unless a shorter period is permitted by subsection (3) of this section.

**(2) Cancellation of coverage is effective at 12 midnight 30 days after the date the cancellation notice is received by an authorized representative of the insurer, unless a later date is specified.**

(3) An employer may cancel his coverage effective less than 30 days after written notice is received by an agent of the insurer [*by providing other coverage or*] by becoming a self-insured employer. A cancellation under this subsection is effective immediately upon the effective date of the other coverage or the effective date of certification as a self-insured employer.

(4) The State Accident Insurance Fund [*or other insurer*] shall, within 10 days after receipt of a notice of cancellation under this section, send a copy of the notice to the director.

Section 40. ORS 656.427 is amended to read:

656.427. (1) An insurer other than the State Accident Insurance Fund that issues [*a guaranty contract or*] a surety bond to an employer under this chapter may terminate liability on its [*contract or*] bond[*, as the case may be,*] by giving the employer written notice of termination. If a contributing employer fails to pay any required contribution, fees, premiums or deposits on or before the due date, the fund shall terminate coverage of the employer by giving the employer written notice of termination. [*When an employer ceases to be a member of a group that is insured by one guaranty contract, the insurer shall terminate liability for such employer under its guaranty contract by giving the employer written notice of termination. A notice of termination shall state the effective date and hour of termination.*]

(2) A termination under this section is effective at 12 midnight not less than 30 days after the date the notice is mailed. However, termination of the coverage of a contributing employer does not take effect if, prior to the effective date, the employer pays the contributions, fees, premiums and deposits due together with any penalty imposed under ORS 656.560.

(3) Notice under this section shall be given by mail, addressed to the employer at his last-known address. If the employer is a partnership, notice may be given to any of the partners. If the employer is a corporation, notice may be given to any agent or officer of the corporation under whom legal process may be served. When notice is given under this section, a copy shall at the same time be sent to the director. The fund shall also notify the director if a contributing employer, after notice is given, pays the sums due and termination does not take effect.

(4) Termination shall in no way limit liability that was incurred under the [*guaranty contract or*] surety bond prior to the effective date of the termination.

Section 41. ORS 656.443 is amended to read:

656.443. (1) If a direct responsibility employer defaults in payment of compensation or other payments due to the director under this chapter, the director may, on notice to the employer and any insurer providing a [*guaranty contract or*] surety bond to such employer, use money or interest and dividends on securities, sell securities or institute legal proceedings on any surety bond [*or guaranty contract*] deposited or filed with the director to the extent necessary to make such payments.

(2) Prior to any default by the employer, the employer is entitled to all interest and dividends on securities on deposit and to exercise all voting rights, stock options and other similar incidents of ownership of the securities.

(3) If for any reason the certification of a self-insured employer is canceled or terminated[*, or the coverage of a carrier-insured employer is canceled or terminated,*] the security deposited [*or the guaranty contract filed*] with the director shall remain on deposit [*or in effect, as the case may be,*] for a period of at least 62 months

after the employer ceases to be a self-insured [*or a carrier-insured*] employer. The security [*or contract*] shall be maintained in such amount as is necessary to secure the outstanding and contingent liability arising from the accidental injuries secured by such security [*or contract,*] and to assure the payment of claims for aggravation and claims under ORS 656.278 based on such accidental injuries. At the expiration of the 62 months' period, or such other period as the director may consider proper, the director may accept in lieu of any such security [*or contract*] a policy of paid-up insurance in a form approved by the Insurance Commissioner and the director.

Section 42. ORS 656.451 is amended to read:

656.451. (1) The State Accident Insurance Fund [*and any insurer that issues guaranty contracts to subject employers pursuant to this chapter*] shall, in accordance with a program approved by the director, furnish occupational safety and health consultative services to its insured employers. Such consultative services shall be designed to promote occupational safety and reduce occupational health hazards.

[*(2) A guaranty contract insurer may furnish any of the services required by subsection (1) of this section through an independent contractor that is approved by the director.*]

[*(3)*] (2) The program of [*an insurer, including*] the State Accident Insurance Fund, for furnishing consultative services as required by this section shall be adequate to meet the minimum standards prescribed by the director by rule from time to time. An application for approval of a program, or a proposed change in an approved program, shall be filed with the director. Upon approval of an application, the director shall notify the applicant [*and, upon approval of the application of a guaranty contract insurer, send a copy of such notice to the Insurance Commissioner*].

Section 43. ORS 656.612 is amended to read:

656.612. (1) The Administrative Fund is created to provide for the payment of all expenses of the department in carrying out its duties under this chapter and ORS chapter 654. [*and for the costs incurred by the Insurance Commissioner under subsection (4) of ORS 737.320;*] The moneys in the fund are continuously appropriated to the department for such purposes. The director shall administer the fund subject to the instructions of the board with respect to its expenses. The State Treasurer is the custodian of the fund. Except as otherwise provided by statute, all money and securities in the fund shall be held in trust and invested by the treasurer, and shall not be the money or property of this state.

(2) The director shall impose and collect assessments from all subject employers in an amount sufficient to pay the expenses described in subsection (1) of this section. The assessments shall be paid in such manner and at such intervals as the director may direct and when collected shall be deposited in the Administrative Fund.

(3) The assessments shall be apportioned among subject employers in direct proportion to the individual contributions of contributing employers and the contributions direct responsibility employers would have paid had they been contributing employers under such systems and procedures as the board, in its discretion determines will reasonably and substantially accomplish such objective at the least possible administrative cost to everyone. The director may use actual claim costs of employers, plus fair and reasonable overhead expenses as a base for computing assessments under this section.

(4) Notwithstanding the provisions of this section, the director may establish a minimum assessment applicable to all subject employers and shall establish the time, manner and method of imposing and collecting

assessments subject to applicable budgeting and fiscal laws.

**Section 44. ORS 656.614 is amended to read:**

656.614. (1) The Direct Responsibility Employers Adjustment Reserve shall be established within the Administrative Fund. It shall be used to pay the claims of workers of direct responsibility employers when the director finds that the worker cannot obtain payment from the employer responsible for payment of the claim because of insolvency of such employer [*and*] or any surety [*or guarantor*] of the employer, and exhaustion of security deposited to secure such payment and to meet deficits in the Direct Responsibility Employers Awards Reserve.

(2) If at any time the director finds that the amount of moneys in the Direct Responsibility Employers Adjustment Reserve is not sufficient to carry out the purposes stated in subsection (1) of this section, he may impose and collect from all the direct responsibility employers as a class an assessment computed as in ORS 656.612 sufficient to raise the amount of moneys in the reserve to the point where it can carry out such purposes. If at any time the director finds that there is a surplus in the Direct Responsibility Employers Adjustment Reserve beyond an amount that can reasonably be anticipated as sufficient to carry out the purposes stated in subsection (1) of this section, he may transfer the surplus to the Administrative Fund and reduce the total amount of direct responsibility employer assessment by the amount so transferred.

(3) Assessments imposed under this section shall be paid to the director in the manner and at such times as the director may direct.

NOTE: Section 45 was deleted by amendment. Subsequent sections were not renumbered.

Section 46. ORS 656.622 is amended to read:

656.622. (1) The director shall establish a Second Injury Reserve within the Administrative Fund for the benefit of employers and their workers and for the purpose of:

(a) Giving employers and their workers the benefits provided in subsection (2) of this section.

(b) Assisting sheltered workshops as provided in ORS 656.530.

(c) Establishing or constructing a physical rehabilitation facility within the limit of the available funds including those transferred as provided in ORS 656.638. Prior to the construction of any buildings or other facilities pursuant to ORS 656.506, 656.530, 656.622, 656.636 and 656.638 the Director of the Workers' [*Compensation*] Recovery Department shall submit plans for such construction for review and approval to the Emergency Board or the Joint Ways and Means Committee if the legislature is then in session.

(2) In order to encourage the employment of individuals who have incurred compensable injuries that result in permanent disability which may be a substantial obstacle to employment, the director may provide, to employers who employ such individuals, assistance from the Second Injury Reserve in such manner and amount as the director considers appropriate. Notwithstanding any other provision of law, determinations by the director regarding assistance pursuant to this subsection are not subject to review by any court or other administrative body. The director may offset, to the extent reasonably justified by the facts, within such rules as are promulgated by the director, the additional amount paid in compensation with respect to any injury resulting in total wage loss benefits exceeding 26 weeks or resulting in death where the injury is attributable wholly or partially to a preexisting disability of the employe or another employe of the same employer or where the resultant disability or death is due wholly or partially to a preexisting disability. As used in this subsection, "preexisting disability" means any permanent condition due to previous accident or disease or any congenital condition which is

or is likely to be a substantial handicap in obtaining or regaining employment. The amount of the payment shall be paid to the employer from the Second Injury Reserve.

[*(3) The Second Injury Reserve shall be made up of and operated with moneys collected as provided in ORS 656.506. The director may also transfer from any surplus in the Administrative Fund to the Second Injury Reserve in any fiscal year an amount not exceeding the receipts of the reserve in that year from ORS 656.506.*]

**(3) The Second Injury Reserve shall be made up of and operated with moneys from assessments as provided in ORS 656.612 together with moneys collected as provided in ORS 656.506.**

[*(4) Any assistance from the Second Injury Reserve shall be to the extent of the moneys available in the reserve for the purpose of the reserve.*]

[*(5)*] (4) The director may make such rules as may be required to establish, regulate, manage and disburse the reserve created in accordance with the intent of this section, including the nature and extent of injuries which qualify for assistance.

[*(6)*] (5) The director may set aside such other reserves within the Administrative Fund as are deemed necessary.

Section 47. ORS 656.636 is amended to read:

656.636. (1) For every case where the State Accident Insurance Fund must pay an award or benefits for death or permanent total disability or permanent partial disability, the State Accident Insurance Fund forthwith shall set aside in the Industrial Accident Fund in a reserve account to be known as the Contributing Employers Awards Reserve the amount required to equal, together with the anticipated interest increment, the present worth of the instalments payable on account of that injury. The number of instalments shall be computed [*in case of permanent total disability or death*] according to the ages of the beneficiaries, and according to the actuarial practices in the insurance field as recommended by the Insurance Commissioner [*and, in the case of permanent partial disability, according to the schedule in ORS 656.214 and 656.216*]. When the claim was for an injury to a worker while in the employ of a direct responsibility employer and the director has determined under ORS 656.268 it is necessary for the employer to deposit cash to assure payment of the award, the director forthwith shall set aside in the Administrative Fund in a reserve account to be known as the Direct Responsibility Employers Awards Reserve the amount so specified by the director and received from the employer.

(2) The respective Awards Reserve shall be charged with the payment of the instalments on claims for which moneys have been set aside in the reserve accounts pursuant to subsection (1) of this section.

(3) Any deficiency in the Direct Responsibility Employers Awards Reserve shall be made good out of the Direct Responsibility Employers Adjustment Reserve and any overplus shall revert to the Direct Responsibility Employers Adjustment Reserve.

(4) (a) Three-fourths of all receipts under ORS 656.506 shall be set aside in the Administrative Fund in a special reserve account to be known as the Retroactive Reserve. The existing funds in the special reserve Retroactive Reserve of the Industrial Accident Fund are transferred to the Administrative Fund in the Retroactive Reserve. The cost of administering the Retroactive Reserve shall be charged to it.

(b) The purpose of the Retroactive Reserve is to provide increased benefits to claimants or beneficiaries eligible to receive compensation [*under the benefit schedules of ORS 656.204, 656.206, 656.208 and 656.210 which are*] lower than currently being paid for like injuries. However, benefits payable under ORS 656.210 shall not be increased by the Retroactive Reserve for claimants whose injury occurred on or after April 1, 1974.

Notwithstanding the formulas for computing benefits provided in [*ORS 656.204, 656.206, 656.208 and 656.210*] this chapter, the increased benefits payable under this subsection shall be in such amount as the director considers appropriate. The director shall annually compute the amount which may be available during the succeeding year for payment of such increased benefits and determine the level of benefits to be paid during such year. If, during such year, it is determined that there are insufficient funds to increase benefits to the level fixed by the director, the director may reduce the level of benefits payable under this paragraph. The increase in benefits to workers shall be payable in the first instance by the State Accident Insurance Fund or direct responsibility employer subject to reimbursement from the Retroactive Reserve by the director.

Section 48. ORS 656.702 is amended to read:

656.702. The records of the State Accident Insurance Fund, excepting employer account records and dividend schedules and formulas, shall be open to public inspection. [*The accident experience records of the fund shall be available to a bona fide rating organization to assist in making workers' compensation rates but any costs involved in making the records available shall be borne by the rating organization. Accident experience records of carrier-insured employers shall also be available on the same terms to assist in making such rates.*]

Section 49. ORS 656.740 is amended to read:

656.740. (1) A person may contest a proposed order of the director declaring that person to be a noncomplying employer, or a proposed assessment of civil penalty, by filing with the department, within 20 days of receipt of notice thereof, a written request for a hearing. Such a request need not be in any particular form, but shall specify the grounds upon which the person contests the proposed order or assessment.

(2) Where [*any insurance carrier, including*] the State Accident Insurance Fund, is alleged by an employer to have contracted to provide him with workers' compensation coverage for the period in question, the board shall join [*such insurance carrier*] the fund as a necessary party to any hearing relating to such employer's alleged noncompliance and shall serve the [*carrier*] fund, at least 30 days prior to such hearing, with notice thereof. If the [*carrier*] fund does not file with the board, within 20 days of receipt of such notice, a written denial of such coverage, the [*carrier*] fund shall be conclusively presumed to have so insured the employer.

(3) A hearing relating to a proposed order declaring a person to be a noncomplying employer, or to a proposed assessment of civil penalty under ORS 656.735, shall be held by a referee of the board's Hearings Division; but a hearing shall not be granted unless a request for hearing is filed within the period specified in subsection (1) of this section, and if a request for hearing is not so filed, the order or penalty, or both, as proposed shall be a final order of the department and shall not be subject to review by any agency or court.

(4) Notwithstanding subsection (1) of ORS 183.315, the issuance of orders assessing civil penalties pursuant to this chapter, the conduct of hearings and the judicial review thereof shall be as provided in ORS 183.310 to 183.500, except that:

(a) The order of a referee in a contested case shall be deemed to be a final order of the board.

(b) The director shall have the same right to judicial review of the order of a referee as any person who is adversely affected or aggrieved by such final order.

Section 50. ORS 656.745 is amended to read:

656.745. (1) The director may assess a civil penalty against an employer [*or insurer*] who:

(a) Intentionally or repeatedly induces claimants for compensation to fail to report accidental injuries, causes employes to collect accidental injury claims as off-the-job injury claims, persuades claimants to accept less than the compensation due or makes it necessary for claimants to resort to proceedings against the

employer to secure compensation due;

(b) Fails to pay assessments or other payments due to the director under this chapter and is in default; or

(c) Habitually fails to comply with rules and orders of the director regarding reports or other requirements necessary to carry out the purposes of this chapter.

(2) A civil penalty shall be not more than $2,000 for each violation or $10,000 in the aggregate for all violations within any three-month period. Each violation, or each day a violation continues, shall be considered a separate violation.

(3) Subsections (5) to (7) of ORS 656.735 and ORS 656.740 also apply to orders and penalties assessed under this section against the corporation.

Section 51. ORS 656.750 is amended to read:

656.750. (1) The director may assess against the State Accident Insurance Fund [*or any other insurer who*], if the fund fails to comply with ORS 656.451, or against an employer who fails to comply with ORS 656.455, a civil penalty of not more than $250 a day for each day such failure continues.

(2) When an order assessing a civil penalty becomes final by operation of law or on appeal, unless the amount of penalty is paid within 10 days after the order becomes final, it constitutes a judgment and may be filed with the county clerk in any county of this state. The clerk shall thereupon record the name of the fund, the insurer or employer incurring the penalty and the amount of the penalty in the judgment docket. The penalty provided in the order so docketed shall become a lien upon the title to any interest in property owned by the fund, insurer or employer named, and execution may be issued upon the order in the same manner as execution upon the judgment of a court of record.

(3) All money collected under this section shall be paid into the Administrative Fund.

Section 52. ORS 656.752 is amended to read:

656.752. (1) The State Accident Insurance Fund is created for the purpose of transacting workers' compensation insurance business formerly transacted by the State Industrial Accident Commission. The State Accident Insurance Fund also may insure a contributing employer against any liability such employer may have on account of bodily injury to his worker arising out of and in the course of employment[, *as fully as any private insurance carrier*].

(2) The functions of the State Accident Insurance Fund shall be:

(a) To confer with and solicit employers and to determine, handle, audit and enforce collection of contributions, premiums, assessments and fees of contributing employers;

(b) To receive and handle and process the claims of workers and beneficiaries of workers injured in the employ of contributing employers; and

(c) To perform all other functions which the laws of this state specifically authorize or which are necessary or appropriate to carry out the functions expressly authorized.

(3) The State Accident Insurance Fund in its name may sue and be sued.

(4) The State Accident Insurance Fund may authorize direct responsibility employers to use any physical rehabilitation center operated by the State Accident Insurance Fund on such terms as the State Accident Insurance Fund deems reasonable.

(5) The State Accident Insurance Fund in its own name, for the purpose of providing adequate housing and space for its offices and operational facilities, the cost of which shall be paid out of the Industrial Accident Fund may:

**(a) Acquire, lease, rent, own and manage real property;**

**(b) Construct, equip, and furnish such buildings or other structures as may be deemed necessary to** accommodate its immediate and reasonably anticipated future needs;

(c) Subject to the provisions of ORS 276.004, lease or rent space not needed for its immediate requirements;

(d) Rent space in any such buildings in order of priority, first to other public agencies, then to private citizens provided the building may in the first instance contain space for private concessions;

(e) Sell or otherwise dispose of any property acquired pursuant to this subsection after consultation with the Joint Committee on Ways and Means and the Emergency Board; and

**(f) Moneys received by the State Accident Insurance Fund in accordance with the provisions of paragraphs** (c), (d) and (e) of this subsection shall be deposited in the Industrial Accident Fund.

**(6) Any real property acquired and owned by the State Accident Insurance Fund under this section shall be** subject to ad valorem taxation.

**(7) The State Accident Insurance Fund may furnish advice, services and excess workers' compensation** and employer liability insurance to any political subdivision qualified as a self-insured employer under the provisions of ORS 656.017, on such terms and conditions as the State Accident Insurance Fund deems reasonable.

Section 53. ORS 656.790 is amended to read:

656.790. (1) The director may appoint an Industrial Accident Advisory Committee composed of nine members: Three representing subject workers, three representing subject employers, and three ex officio members, without a vote, representing [*each of the following:*] the State Accident Insurance Fund[*, other carriers who are qualified to write workers' compensation insurance in Oregon,*] and self-insured employers.

(2) The director may recommend areas of the law which he desires to have studied or the committee may study such aspects of the law as the committee shall determine require their consideration. The committee shall report its findings to the director for such action as the director deems appropriate.

(3) The members of the committee shall be appointed for a term of two years and shall serve without compensation, but shall be entitled to travel expenses. The committee may hire, subject to approval of the director, such experts as it may require to discharge its duties. All expenses of the committee shall be paid out of the Administrative Fund.

Section 53a. ORS 656.802 is amended to read:

656.802. (1) As used in ORS 656.802 to 656.824, "occupational disease" means:

(a) Any disease or infection which arises out of and in the scope of the employment, and to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein.

(b) Death, disability or impairment of health of [*firemen*] **fire fighters** of any political division who have completed five or more years of employment as [*firemen*] **fire fighters**, caused by any disease of the lungs or respiratory tract, hypertension or cardiovascular-renal disease, and resulting from their employment as [*firemen*] **fire fighters**.

(2) Any condition or impairment of health arising under paragraph (b) of subsection (1) of this section shall be conclusively presumed to result from a [*fireman's*] **fire fighter's** employment. However, any such [*fireman*] **fire fighter** must have taken a physical examination upon becoming a [*fireman*] **fire fighter**, or subsequently thereto, which failed to reveal any evidence of such condition or impairment of health which preexisted his

*employment. [Denial of a claim for any condition or impairment of health arising under paragraph (b) of subsection (1) of this section must be on the basis of medical or other evidence that the cause of the condition or impairment is unrelated to the fireman's employment.]*

Section 53b. ORS 656.807 is amended to read:

656.807. (1) Except as otherwise limited for silicosis, all occupational disease claims shall be void unless a claim is filed with the State Accident Insurance Fund or direct responsibility employer within five years after the last exposure in employment subject to the Workers' Compensation Law and within 180 days from the date the claimant becomes disabled or is informed by a physician that he is suffering from an occupational disease whichever is later.

(2) If the occupational disease results in death, a claim may be filed within 180 days after the date of the death; and the provisions of subsection (1) of this section do not limit the filing of a claim in fatal cases to less than 180 days from the date of death.

(3) The limitation of five years shall be extended to 10 years in claims for radiation injury.

(4) The procedure for processing occupational disease claims shall be the same as provided for accidental injuries under ORS 656.001 to 656.794.

**(5) A fire fighter who is disabled under ORS 656.802, who subsequently starts rehabilitation as per the Workers' Recovery Law, ORS 656.001 to 656.794, and suffers a reoccurrence, as determined by physical examination, shall for the purpose of the 1979 Act, have said reoccurrence treated as an original injury.**

Section 54. ORS 731.028 is amended to read:

731.028. The State Accident Insurance Fund is subject as a domestic insurer to ORS 731.256, 731.260, 731.296, 731.300 to 731.316, 731.574, 733.010 to 733.060, 733.140 to 733.170, 733.210, 737.205 to 737.340, [*737.560,*] 746.075, 746.110 and 746.145 to 746.155 to the extent that such provisions are not inconsistent with the express provisions of ORS chapter 656. However:

(1) ORS 731.300 and 731.574 first apply to the State Accident Insurance Fund after December 31, 1972.

(2) The requirements of the Insurance Commissioner under ORS 733.010 to 733.060, 733.140 to 733.170 and 733.210 govern in the case of a conflict between those requirements and the requirements of any accounting system prescribed by the Executive Department.

(3) The filing requirements of ORS 737.205 to 737.340 [*and 737.560*] are in lieu of any similar filing requirements prescribed by any other law of this state.

Section 55. ORS 731.418 is amended to read:

731.418. (1) The commissioner may refuse to continue or may suspend or revoke an insurer's certificate of authority if he finds after a hearing that the insurer:

(a) Has violated or failed to comply with any lawful order of the commissioner, or any provision of the Insurance Code other than those for which suspension or revocation is mandatory.

(b) Is in unsound condition, or in such condition or using such methods and practices in the conduct of its business, as to render its further transaction of insurance in this state hazardous or injurious to its policyholders or to the public.

(c) Has failed, after written request by the commissioner, to remove or discharge an officer or director who has been convicted in any jurisdiction of an offense which, if committed in this state, constitutes a misdemeanor involving moral turpitude or a felony, or is punishable by death or imprisonment under the laws of the United States, in any of which cases the record of his conviction shall be conclusive evidence.

**(d) Is affiliated with and under the same general management, interlocking directorate or ownership as another insurer that transacts direct insurance in this state without having a certificate of authority therefor, except as permitted under the Insurance Code.**

**(e) Refuses to be examined; or its directors, officers, employes or representatives refuse to submit to examination relative to its affairs, or to produce its accounts, records, and files for examination by the commissioner when required, or refuse to perform any legal obligation relative to the examination.**

**(f) Has failed to pay any final judgment rendered against it in this state upon any policy, bond, recognizance or undertaking issued or guaranteed by it, within 30 days after the judgment became final, or within 30 days after time for taking an appeal has expired, or within 30 days after dismissal of an appeal before final determination, whichever date is the later.**

**(g) Fails to comply with subsection (1) of ORS 743.925.**

**[*(h) Has failed to comply with subsection (1) of ORS 656.451.*]**

**(2) Without advance notice or a hearing thereon, the commissioner may suspend immediately the certificate of authority of any insurer as to which proceedings for receivership, conservatorship, rehabilitation, or other delinquency proceedings, have been commenced in any state by the public insurance supervisory official of such state.**

**Section 56.** ORS 731.566 is amended to read:

731.566. (1) To qualify for authority to transact insurance in this state, a reciprocal insurer shall possess and thereafter maintain a surplus of not less than $500,000[*, and any reciprocal insurer which exchanges policies of insurance covering workers' compensation insurance shall possess and thereafter maintain a surplus of not less than $1,500,000*].

[*(2) A reciprocal insurer holding a valid certificate of authority to transact insurance other than workers' compensation insurance in this state immediately prior to January 1, 1975, shall maintain a surplus of not less than $50,000 until January 1, 1978, after which date it shall comply with subsection (1) of this section.*]

[*(3)*] (2) Notwithstanding [*subsections (1) and (2)*] subsection (1) of this section, a domestic reciprocal insurer which exchanges policies of insurance covering only wet marine hull insurance for individuals whose earned income is at least 50 percent derived from taking and selling food resources living in an ocean, bay or river shall possess and thereafter maintain a surplus of not less than $5,000.

**Section 57.** ORS 731.608 is amended to read:

731.608. (1) Except as provided in subsection (2) of this section, deposits made in this state under ORS 731.624 shall be held for the faithful performance by the insurer of all insurance obligations, including claims for unearned premiums, with respect to domestic risks pertaining to the particular class of insurance for which the deposit was made. However, there shall be excluded from each such obligation the same amount as is excluded in determining the obligation of the Oregon Insurance Guaranty Association under ORS 734.510 to 734.710.

(2) If at any time a deposit made under ORS 731.624 by a particular insurer is insufficient to perform the insurance obligations upon the faithful performance of which the deposit was conditioned, then any other deposit made under ORS 731.624 by that insurer shall be so used to the extent that such other deposit is not used to perform the insurance obligations upon the faithful performance of which such other deposit was conditioned.

*[(3) Deposits made in this state under ORS 731.628 shall be held for the payment of compensation benefits to workers employed by direct responsibility employers to whom the insurer has issued a guaranty contract under ORS 656.001 to 656.794.]*

*[(4)]* (3) A deposit made in this state by a domestic insurer transacting insurance in another jurisdiction, and as required by the laws of such jurisdiction, shall be held for the purpose or purposes required by such laws.

*[(5)]* (4) Deposits of foreign and alien insurers required pursuant to ORS 731.854 shall be held for such purposes as are required by such law, and as specified by the commissioner's order by which the deposit is required.

*[(6)]* (5) Deposits of domestic reciprocal insurers required pursuant to ORS 731.632 shall be held for the benefit of subscribers wherever located.

Section 58. ORS 731.620 is amended to read:

731.620. (1) *[Except for deposits made in accordance with ORS 731.628,]* The insurer shall assign in trust to the commissioner and his successors in office all securities being deposited through him under the Insurance Code that are not negotiable by delivery; or, in lieu of such assignment, the insurer may give the commissioner an irrevocable power of attorney authorizing him to transfer the securities or any part thereof for any purpose within the scope of the Insurance Code.

(2) Upon release to the insurer, or other person entitled thereto, of any such security the commissioner shall reassign the security to such insurer or person; or, in the case of power of attorney given pursuant to subsection (1) of this section, the commissioner shall deliver the power of attorney, together with the securities covered thereby, to the insurer or person entitled thereto.

Section 59. ORS 731.640 is amended to read:

731.640. (1) Deposits which are required or permitted under the Insurance Code shall consist only of the following:

(a) Cash;

(b) Amply secured obligations of the United States, a state or a political subdivision thereof[.] ;

(c) Certificates of deposit or other investments described in subsection (4) of ORS 733.650 to the extent such investments are insured by the Federal Deposit Insurance Corporation or the Federal Savings and Loan Insurance Corporation[.] ; or

(d) A surety bond, approved by the commissioner, executed by an authorized surety insurer that is not under common ownership, management or control with the person making the deposit. This paragraph does not apply to deposits made by surety insurers *[or to workmen's compensation deposits made under ORS 731.628]*.

(2) Deposits of domestic insurers made pursuant to the laws of other jurisdictions shall consist of cash or securities as required or permitted by the laws of such jurisdictions.

Section 60. ORS 734.570 is amended to read:

734.570. The association shall:

(1) Be obligated to pay covered claims existing at the time of determination of insolvency of an insurer or arising within 30 days after the determination of insolvency. *[Except for covered claims arising out of workers' compensation policies,]* Such obligation shall include only that amount of each covered claim that is less than $300,000. *[The association shall pay the full amount of any covered claim arising out of a workers' compensation policy.]* In no event shall the association be obligated in an amount in excess of the obligation of

the insolvent insurer under the policy from which the claim arises, or for claims arising from any policy expiration, policy replacement by the insured or policy cancellation caused by the insured.

(2) Be the insurer to the extent of the association's obligation on the covered claims and to such extent have all the rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent.

(3) Assess member insurers the amounts necessary to pay the expenses incurred by the association in meeting its obligations and exercising its duties and powers under ORS 734.510 to 734.710. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year bears to the net direct written premiums of all member insurers for the preceding calendar year, but shall in no event exceed in any one year two percent of the member insurer's net direct written premiums for the preceding calendar year. Each member insurer shall be notified of an assessment not later than the 30th day before the day it is due. If the funds of the association do not provide in any one year an amount sufficient to pay the obligations and expenses of the association, the funds available shall be prorated among the obligations and expenses, and the unpaid portions shall be paid as soon thereafter as funds become available. If an assessment would cause a member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance, the association may exempt from or defer payment of the assessment, in whole or in part, by the member insurer. However, if the member insurer is a controlled insurer, the association, in making determinations regarding the exemption or deferral of assessments, shall treat all dividends paid during the three calendar years immediately preceding the year in which the assessment is made as assets of the insurer just as if such dividends had not been paid. Each member insurer designated as a servicing facility may set off against any assessment authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer in its capacity as a servicing facility.

(4) Investigate claims brought against the association and adjust, compromise, settle and pay covered claims to the extent of the association's obligation, and review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which such settlements, releases and judgments may be properly contested.

(5) Reimburse servicing facilities and employes of the association for obligations and expenses incurred and paid in the handling of claims on behalf of the association, and pay all other expenses the association incurs in carrying out ORS 734.510 to 734.710.

Section 61. ORS 734.640 is amended to read:

734.640. (1) Any person who has a claim under an insurance policy against an insurer other than an insolvent insurer which would also be a covered claim against an insolvent insurer must first exhaust his remedies under such policy.

(2) Any person who has a claim that may also be recovered from one or more insurance guaranty agencies that perform functions similar to that of the association shall first seek recovery from whichever organization serves the place of residence of the insured, except that[:]

[*(a)*] recovery on first party claims for damage to property with a permanent location shall first be sought from whichever organization serves the location of the property.[*; and*]

[*(b) Recovery on workers' compensation claims shall first be sought from whichever organization serves the residence of the claimant.*]

(3) Any recovery under ORS 734.510 to 734.710 from the association shall be reduced by the amount of any

recovery pursuant to subsections (1) and (2) of this section.

Section 62. ORS 737.265 is amended to read:

737.265. [*(1)*] Members and subscribers of rating or advisory organizations may use the rates, rating systems, underwriting rules or policy or bond forms of such organizations, either consistently or intermittently, but, except as provided in ORS 737.275, 737.312, 737.365, 737.390[,] and 737.526 [*and subsection (2) of this section,*] shall not agree with each other or rating organizations or others to adhere thereto. The fact that two or more authorized insurers, whether or not members or subscribers of a rating or advisory organization, use, either consistently or intermittently, the rates or rating systems made or adopted by a rating organization, or the underwriting rules or policy or bond forms prepared by a rating or advisory organization, shall not be sufficient in itself to support a finding that an agreement to so adhere exists, and may be used only for the purpose of supplementing or explaining any competent evidence of the existence of any such agreement.

[*(2) All insurers required by subsection (2) of ORS 737.560 to be members of a workers' compensation rating organization shall adhere to the rates, rating systems and policy forms of the rating organization, except that such an insurer may file with the commissioner a percentage decrease or increase to be applied to any classification rate filed by the rating organization. Any such deviation shall be subject to the requirements of ORS 737.320 and shall be effective for a maximum of one year. Such a deviation may be terminated earlier with the approval of the commissioner, but not before the deviation has been in effect for six months.*]

Section 63. ORS 737.310 is amended to read:

737.310. The following standards shall apply to the making and use of rates:

(1) Rates shall not be excessive, inadequate or unfairly discriminatory.

(2) As to all classes of insurance, other than [*workmen's compensation and*] title insurance:

(a) No rate shall be held to be excessive unless:

(A) Such rate is unreasonably high for the insurance provided; and

(B) A reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable.

(b) No rate shall be held inadequate unless:

(A) Such rate is unreasonably low for the insurance provided; and

(B) Continued use of such rate endangers the solvency of the insurer; or unless

(C) Such rate is unreasonably low for the insurance provided and the use of such rate by the insurer has, or if continued will have, the effect of destroying competition or creating a monopoly.

(3) Due consideration shall be given to past and prospective loss experience within and outside this state, to the hazards of conflagration and catastrophe, to a reasonable margin for underwriting profit and to contingencies, to dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, to past and prospective expenses both countrywide and those specially applicable to this state, and to all other relevant factors including judgment factors, deemed relevant, within and outside this state.

(4) In the case of fire insurance rates, consideration may be given to the experience of the fire insurance business during the most recent five-year period for which such experience is available.

(5) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or group of insurers to reflect the requirements of the operating methods of

any such insurer or group of insurers with respect to any class of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination separate expenses are applicable.

(6) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates for casualty, surety or inland marine risks may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions or both. Such standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses.

Section 64. ORS 737.320 is amended to read:

737.320. (1) The commissioner shall review [*workmen's compensation and*] title insurance filings as soon as reasonably possible after they have been made in order to determine whether they meet the requirements of this chapter.

(2) The effective date of each [*workmen's compensation and*] title insurance filing shall be the date specified therein but not earlier than the 15th day after the date the filing is received by the commissioner or from the date of his receipt of the information furnished in support of a filing if such supporting information is required by him. The waiting period may be extended by the commissioner for an additional period not to exceed 15 days if he gives written notice within such waiting period to the insurer or rating organization which made the filing that he needs such additional time for the consideration of such filing. Upon written application by such insurer or rating organization, the commissioner may authorize a filing, which he has reviewed, to become effective before the expiration of the waiting period. A filing shall be deemed to meet the requirements of this chapter unless disapproved by the commissioner within the waiting period or any extension thereof.

(3) Notwithstanding the provisions of subsection (1) of ORS 737.205, the commissioner may require any person to comply with the requirements of subsection (2) of this section if he has good cause to believe that a reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable.

[*(4) The commissioner shall investigate and evaluate all workmen's compensation rate filings made by a licensed rating organization to determine whether or not such rates are excessive, inadequate or unfairly discriminatory. The commissioner shall employ such experts and other personnel as may be reasonably necessary to make such investigation and evaluation, the cost of which shall be paid out of the Administrative Fund created under ORS 656.612.*]

Section 65. ORS 737.560 is amended to read:

737.560. [*(1) Except as provided in subsection (2) of this section,*] Nothing contained in this chapter shall be construed as requiring any insurer to become a member of or a subscriber to any rating organization.

[*(2) All insurers qualified to issue guaranty contracts to direct responsibility employers under ORS 656.001 to 656.794 shall be, and the State Accident Insurance Fund may be, a member of a workmen's compensation rating organization. If the State Accident Insurance Fund becomes a member of such an organization, it is entitled without election to membership on any committee thereof established in connection with the operation of the rating organization in this state.*]

Section 66. ORS 743.402 is amended to read:

743.402. Nothing in ORS 743.405 to 743.498 shall apply to or affect:

(1) Any [*workers' compensation insurance policy or any*] liability insurance policy with or without supplementary expense coverage therein;

(2) Any policy of reinsurance;

(3) Any blanket or group policy of insurance; or

(4) Any life insurance policy, or policy supplemental thereto which contains only such provisions relating to health insurance as:

(a) Provide additional benefits in case of death or dismemberment or loss of sight by accident; or

(b) Operate to safeguard such policy against lapse, or to give a special surrender value or special benefit or an annuity in the event the insured shall become totally and permanently disabled, as defined by the policy or supplemental policy.

Section 67. ORS 743.459 is amended to read:

743.459. (1) A health insurance policy may contain a provision as follows: "INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount' of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage."

(2) If the policy provision set forth in subsection (1) of this section is included in a policy which also contains the policy provision set forth in ORS 743.462, there shall be added to the caption of the provision set forth in subsection (1) of this section the phrase "EXPENSE INCURRED BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employe benefit organizations. For the purpose of applying the policy provision set forth in this section with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any [*workmen's compensation or*] employer's liability statute), whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the policy provision set forth in this section no third party liability coverage shall be included as "other valid coverage."

Section 68 ORS 743.462 is amended to read:

743.462. (1) A health insurance policy may contain a provision as follows: "INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such

proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined."

(2) If the policy provision set forth in subsection (1) of this section is included in a policy which also contains the policy provision set forth in ORS 743.459, there shall be added to the caption of the provision set forth in subsection (1) of this section the phrase "OTHER BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employe benefit organizations. For the purpose of applying the policy provision set forth in this section with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any [*workmen's compensation or*] employer's liability statute), whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the policy provision set forth in this section no third party liability coverage shall be included as "other valid coverage."

**SECTION 69.** Sections 70 to 72 of this Act are added to and made a part of ORS 656.001 to 656.794.

**SECTION 70.** Nothing in this 1979 Act affects the right of any direct responsibility employer who provided the coverage required by ORS 656.001 to 656.794 by contracting with an insurance carrier issuing guaranty contracts on or before the operative date of this 1979 Act to continue such coverage for the remainder of the term of any contract for such coverage, entered into before the operative date of this 1979 Act, between such direct responsibility employer and an insurance carrier. However, after the operative date of this 1979 Act, no insurance carrier shall accept or approve any new applications for coverage by direct responsibility employers, nor shall any insurance carrier renew or extend any such previously existing coverage for any such employer.

**SECTION 71.** After the effective date of this 1979 Act, an insurance carrier that issues guaranty contracts to direct responsibility employers to provide the coverage required by ORS 656.001 to 656.794 shall not provide coverage under such a contract for a period longer than one calendar year.

**SECTION 72.** Nothing in this 1979 Act relieves any insurance carrier that issued a guaranty contract to a direct responsibility employer to provide the coverage required by ORS 656.001 to 656.794, prior to the operative date of this 1979 Act, from any duty to administer and pay claims or any other liability or obligation prescribed by law prior to the operative date of this 1979 Act.

**SECTION 73.** ORS 656.206, 656.210, 656.212, 656.214, 656.216, 656.218, 656.222, 656.230, 656.248, 656.386, 656.447, 656.728, 656.730, 731.480, 731.628 and 731.832 are repealed.

**SECTION 74.** ORS 656.264, 656.285, 656.287, 656.407, 656.411, 656.415, 656.419, 656.423, 656.427, 656.430, 656.434, 656.440, 656.443, 656.451, 656.455, 656.745 and 656.750 are added to and made a part of ORS 656.001 to 656.794.

**SECTION 75.** This Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this Act takes effect on its passage. However, sections 1 to 70 and 72 to 74 of this Act first become operative on January 1, 1980.

PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

# STATE OF IDAHO

## INDUSTRIAL COMMISSION

**REHABILITATION DIVISION**

November 4, 1980


J. Paul House, Administrator
Second Injury Fund
Department of Labor
Division of Workmen's Compensation
P. O. Box 1149
Juneau, AK 99811

Dear Mr. House:

I am writing in response to your telephone request for information regarding the Idaho Industrial Commission's Rehabilitation Division.

Although the state of Idaho has established a Rehabilitation Division in order to assist injured workers in returning to employment, the primary responsibility of assisting the individual remains with the employer and the insurance carrier. The Rehabilitation Division was established in order to assist in reducing the period of temporary disability resulting from an industrial injury and to aid in restoring the injured employee to gainful employment with the least possible physical impairment. It was the intent of the Legislature that this program concern itself with both the physical and vocational rehabilitation with a special emphasis in job placement.

The goal of the Rehabilitation Division is to provide for the earliest possible return of the injured worker to meaningful, safe work. The Division consists of one Administrator and ten Field Consultants each having a secretary to assist in the clerical portions of their work. The Division's role is to coordinate and implement rehabilitation, medical care, and vocational placement programs for the disabled worker. The Rehabilitation Division does not provide medical treatment or maintain treatment facilities, nor does it in any way compete with the insurance companies claims personnel.

The Field Consultant is a representative of an independent third party which has been called in because of its expertise in the area of rehabilitation. The Field Consultant is involved in virtually every aspect of the rehabilitation pro-

cess providing assistance in coordination and evaluating the claimant's needs and progress, identifying potential problems before they become serious and proposing practical and effective solutions. This process has proven to be very cost effective for the industry of the state of Idaho.

In an effort to avoid duplicating services available from other sources, the Rehabilitation Division has chosen not to purchase services or provide services other than those provided by the Field Consultant in the form of coordination of services. The Rehabilitation Division contacts the surety and other agencies available such as the Division of Vocational Rehabilitation and the Department of Employment in obtaining the needed services.

I hope this letter as well as the attached information is of some assistance to you and would urge if you have further questions that you contact me.

Sincerely yours,

GARY W. STIVERS, Administrator
Rehabilitation Division

GWS:pm

Enc.

cc: I.C. File

# Rehab Review

PUBLISHED BY IDAHO INDUSTRIAL COMMISSION — REHABILITATION DIVISION

Vol. 1 No. 1 September 1978

## 1978 Legislature Establishes Rehabilitation Division

The 1978 Legislature amended Section 72.501A of Idaho Workmen's Compensation Law to provide for the establishment of a Rehabilitation Division of the Industrial Commission.

The Rehabilitation Division was established in order to assist in reducing the period of temporary disability resulting from an industrial injury and to aid in restoring the injured employee to gainful employment with the least possible physican impairment. It is the intent of the Legislature that this program concern itself with both physical and vocational rehabilitation with a special emphasis in the area of job placement.

The goal of the Rehabilitation Division will be to provide for the earliest possible return of the injured worker to meaningful safe work. For most cases, this return will be quick and easy; a return to the same job and the same employer. For those individuals unable to return to the same job, selective placement in a job using known skills and compatible with the remaining abilities may be needed. It is our hope that early contact and placement will prevent the development of chronic long term disability that may be a prelude to later unsuccessful vocational training. If an appropriate assessment of remaining abilities and work experience identify a placement opportunity, this route is preferable to the uncertainties of a retraining program.

Field consultants have been hired and offices located in Coeur d'Alene, Lewiston, Caldwell, Boise, Twin Falls, and Pocatello. Offices will be located in additional areas of the State as the need is indicated to the Rehabilitation Division. If you are, or know of, an individual who has a job related injury or disease for which rehabilitation services would be indicated, we would encourage you to contact the field consultant located in your area.

## Division Administrator Named

Gary Stivers has been named by the Industrial Commission as Administrator of it's newly established Rehabilitation Division.

Prior to coming to the Industrial Commission, Gary served with the Idaho Division of Vocational Rehabilitation for seven years acting as Rehabilitation counselor, special liaison to rehabilitation facilities and school district work-study programs. Gary joined the State office of I.D.V.R. in 1976 as co-ordinator of the Idaho Renal Disease Program and later was named supervisor of special programs, a position overseeing the Social Security programs in addition to the Renal Disease Program.

Gary is a native of Idaho receiving his Bachelor's Degree in Education from Boise State University followed by a Master's Degree in Guidance and Counseling from the College of Idaho. Gary will be housed in the Industrial Commission's offices in Boise located at 317 Main, Boise, Idaho 83720, or can be reached by calling 384-2461.

# Consultants Receive Orientation on Rehabilitation Process

The newly formed Rehabilitation Division of the Idaho Industrial Commission held an orientation for its field consultants in Boise August 1st through 4th. This orientation was designed to give the Field Consultants an overview of the Rehabilitation Process.

David Robinson, Ph.D., discusses the psychological aspects of disability.

The orientation was conducted by the administrative staff of the Industrial Commission in an effort to acquaint the new field consultants with the policies and operations of the Industrial Commission along with providing training in the area of rehabilitation of the industrially disabled. Included in this training were six Field Consultants of the Rehabilitation Division who will be officed throughout the State of Idaho.

Topics covered in this orientation included the Purpose and Function of the Industrial Commission, the Role of the Field Consultant, Adjustment to Severe Disability, and an introduction to the Philosophies and Procedures of the Newly Formed Rehabilitation Division.

The field consultants were also introduced to the medical and psychological aspects of rehabilitation. This portion of the orientation included a discussion by Dr. James Coughlin, an orthopedic consultant from Boise who discussed the medical aspects of the Rehabilitation Process, and a discussion by David Robinson, Ph.D., on the psychological aspects of disability. In addition to these fine professionals, a tour of the Elk's Rehabilitation Hospital was made with a discussion of services offered by the Rehabilitation Hospital and specific orientation to the Low Back Clinic. The medical portion of this orientation was capped off by a demonstration and discussion of orthotics and prosthetics by Bill Brownfield of Brownfield's, Inc. of Boise.

Additional training programs during the first year of the Rehabilitation Division will be conducted to give the field consultants a well-rounded background in the area of rehabilitation of the injured worker.

All field consultants are now in their assigned areas serving the disabled workers of the State of Idaho. If you are, or know of, a disabled worker who is in need of rehabilitation services, referrals can be made directly to the field consultant in your area.


## Rehab Review

Published Quarterly by the Rehabilitation Division
Idaho Industrial Commission
317 Main Street, Boise, Idaho 83720




## Boise Area

### Dennis Wheeler

Dennis Wheeler will be working from the Boise office of the Industrial Commission's Rehabilitation Division serving injured workers in that area.

Dennis has his Bachelor's Degree from Boise State University and his Master's Degree from Portland State University in Guidance and Counseling. Dennis comes to the Industrial Commission from Portland Community College where he was employed as a career counselor.

The Boise office is located at 317 Main, Boise, Idaho 83720, or Dennis can be contacted by calling 384-2461.

## Caldwell Area

### Charlene McCormick

Charlene McCormick will serve as Field Consultant for the Caldwell office.

Charlene, a graduate of the Registered Nursing Program at Boise State University, comes to the Industrial Commission after her nursing career with the Veteran's Hospital in Boise was terminated due to a back injury.

Charlene will be serving injured workers from the Caldwell area office at 109 N. Kimball, Caldwell, Idaho 83605, or she can be contacted by phoning 459-0016.

## Coeur d'Alene Area

### Robert 'Jim' Faraca

Jim Faraca, a long time resident of North Idaho has been appointed by the Industrial Commission as Field Consultant in the Coeur d'Alene office.

Jim attended the University of Idaho and has worked in the logging and mining industries of Northern Idaho. Prior to coming to the Industrial Commission Jim was on leave of absence from the Bunker Hill Co. in Kellogg working as financial secretary for the United Steel Workers Local Union #7854.

Jim's office will be located at 416 Coeur d'Alene Avenue, Coeur d'Alene, Idaho 83814, or he can be contacted by calling 667-9714.

## Lewiston Area

### Deborah Rash

Debbie Rash, Moscow, has been selected by the Industrial Commission to serve as Field Consultant in the Lewiston area.

Debbie received her Bachelor's Degree in Sociology from Washington State University, and her Master's of Public Administration from the University of Idaho. Debbie comes to the Industrial Commission from the Department of Health & Welfare where she was employed for two years in Kellogg, Idaho.

Debbie's office will be located at 1708 "G" Street, Lewiston, Idaho 83501, or she can be contacted by phoning 746-3935.

## Pocatello Area

### Eddie Loya

The Pocatello office of the Industrial Commission's Rehabilitation Division will be served by Eddie Loya, Pocatello.

Eddie is a graduate of Vocational School at Santa Monica City College in the area of auto mechanics and attended Boise State University studying in the field of social work. Eddie's employment prior to coming to the Industrial Commission consisted of five years with the Department of Employment and two years with the Department of Corrections specializing in the area of job placement.

The Pocatello office is located at 432 N. 5th, Pocatello, Idaho 83201, or Eddie can be contacted by calling 234-2810.

## Twin Falls Area

### James Spooner

Jim Spooner, Twin Falls, has been appointed by the Industrial Commission as Field Consultant in the Twin Falls area.

Jim, a San Francisco State College graduate, comes to the Rehabilitation Division from the Division of Vocational Rehabilitation where he has served four years as a rehabilitation counselor. At the time Jim left D.V.R. to join the Industrial Commission, he was leading all other rehabilitation counselors in the State in the number of individuals rehabilitated this fiscal year.

Jim's office will be located at 1043 Blue Lakes Blvd., Twin Falls, Idaho or he can be contacted by calling 734-8300.

Idaho Industrial Commission
Rehabilitation Division
Statehouse Mail
Boise, Idaho 83720

# Rehab Review

PUBLISHED BY IDAHO INDUSTRIAL COMMISSION — REHABILITATION DIVISION

Vol. 1 No. 2 March 1979

## Cooperative Agreement Provides Better Service To Disabled Workers

The Industrial Commission and the Idaho Division of Vocational Rehabilitation (IDVR) have entered into an agreement to provide an expanded program to better meet the needs of the industrially injured worker in the State of Idaho. This agreement has greatly facilitated the provision of prompt services to injured workers. Sections of this agreement which would be of interest to those involved in the rehabilitation process are as follows:

1. **Free Exchange of Information:** This Agreement provides for free exchange of information between IDVR counselors and the Industrial Commission's field consultants.
2. **Confidentiality:** All information received from IDVR under this Agreement will be used only for the provision of rehabilitation services to the disabled worker.
3. **Development of a referral system between the two agencies:** This Agreement provides for a clear understanding of the process to be taken in the exchange of referrals between these two service agencies.

In summary, we feel this Agreement should add greatly to the communication between the two agencies. Effective rehabilitation can only occur when all parties involved are unified in the common goal of providing services to the disabled worker.

## Commissioner Geddes Named Chairman

Gerald A. Geddes was recently elected to serve as chairman of the Industrial Commission for the final two years of his present term. Mr. Geddes has had more than 27 years' experience in the electrical industry at various locations throughout the United States. Prior to being appointed by Governor Samuelson as a member of the Industrial Commission in 1969, and reappointed in 1975 by Governor Andrus, Mr. Geddes was the Business Manager of the Electricians Local Union in Pocatello, Idaho. Mr. Geddes is an active member of the International Brotherhood of Electrical Workers. Mr. Geddes serves jointly with commissioners Lawrence G. Sirhall and Will S. Defenbach.

Lawrence G. Sirhall was appointed as a member of the Commission by Governor Andrus in 1971 and reappointed in 1977, after more than twenty-four years in the insurance business, most of which were spent supervising workmen's compensation claims in California, Washington, Oregon, Montana, Idaho and Utah.

Will S. Defenbach, the third member of the Commission, has been reappointed by Governor Evans to serve a third term as a member of the Industrial Commission. Mr. Defenbach originally came to the Commission as Referee, after having served in the Idaho Legislature in 1967 and was appointed to the Commission by Governor Samuelson in 1968. Mr. Defenbach is a member of the Idaho State Bar and is presently serving as President of the Western Region of the International Association of Industrial Accident Boards and Commissions, for which Idaho will host a convention in Sun Valley during July, 1979.

## AN IMPORTANT DATE TO REMEMBER

The Western Region Meeting of
The International Association of Industrial Accident Boards and Commissions (IAIABC)
Tuesday, July 24, 1979 in Sun Valley, Idaho

## Anne Balog Named Caldwell Consultant

The Industrial Commission has announced that Anne Balog has been named as the new field consultant in the Rehabilitation Division's Caldwell Office.

Anne is a 1975 graduate of Boise State University in the area of Secondary Education and Sociology. In addition to this degree, Anne has also studied at the University of Idaho and Idaho State University in the area of Vocational Special Needs. Anne presently holds a certificate in Vocational Special Needs, enabling her to work with handicapped and disadvantaged students.

The Caldwell office of the Industrial Commission serves disabled workers in Canyon, Payette, Gem, Washington, Valley, Adams and parts of Idaho and Owyhee Counties. Anne's office is located at 109 N. Kimball, Caldwell, Idaho 83605, or she can be contacted by calling 459-0016.


### Rehab Review

Published Quarterly by the Rehabilitation Division, Idaho Industrial Commission, 317 Main St., Boise, Idaho 83720

Will Defenbach, Commissioner
Gerald Geddes, Commissioner
Lawrence Sirhall, Commissioner
Lawrence Sppute, Administrator 384-3250
Gary Stivers, Administrator Rehabilitation Division 384-2461

**Area Offices**

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Caldwell, 109 N. Kimball, Phone 459-0016
Couer d'Alene, 416 Couer d Alene Avenue Phone 667-9714
Lewiston, 1708 "G" Street, Phone 746-3935
Pocatello, Center 151 Bldg. Suite 105 Phone 234-2810
Twin Falls, 630 Blue Lakes Blvd. Phone 734-8300


# Rehabilitation Division Reviews First Five Months' Activities

The beginning of the new year provides an excellent opportunity to review the progress of the newly formed Rehabilitation Division. The Division was established by the 1978 Legislature in an effort to assist in reducing the period of temporary disability resulting from an industrial injury and to aid in restoring the injured employee to gainful employment with the least possible physical impairment. It was the legislatures' intent that the program concern itself with both physical and vocational rehabilitation, with a special emphasis in the area of job placement.

Six field consultants were hired in August and located in Coeur d'Alene, Lewiston, Caldwell, Boise, Twin Falls and Pocatello. During the first five month period, the Rehabilitation Division has received 560 referrals averaging 90 new referrals per month.

In the early stages of our program, almost 100% of the referrals received were through the accident reports filed with the Commission. As the services provided by the Division have gained acceptance by the insurance industry and employers, the nature of our referrals has changed. During the month of December, 59% of the referrals received by the Division were from employers, 13% from insurance companies, and only 17% were received by a screening of accident reports.

This change in the source of referrals has resulted in improved identification of injured workers needing rehabilitation services. Early in the program, approximately 60% of the individuals referred by screening accident reports were closed as not needing services. With the change in the referral source, we are finding that a much larger percentage of those referred are actually determined eligible for the services provided by the Rehabilitation Division. To date 282 of the 560 referrals to the Division have been determined in need of rehabilitation services. The Rehabilitation Division reports that 20 of 282 workers found in need of services have been successfully returned to employment as a result of a significant service provided by the Division. An additional 25 workers have been placed in training programs.

We are very encouraged with the statistics generated through the first five months of operation. If you are, or know of, and individual who has a job related injury or disease for which rehabilitation services would be indicated, we would encourage you to contact the field consultant located in your area.

## Advisory Committee

In an effort to provide for meaningful services to disabled workers of the State of Idaho, an advisory committee has been established. This committee includes many leaders in the areas of rehabilitation, workmen's compensation, labor and industry. It is the hope of the Rehabilitation Division that information provided by the advisory committee will improve services to the injured worker.

Members of this advisory committee are as follows:

Jim Fields, General Counsel, Idaho Association of Commerce and Industry, Boise.

Robert W. MacFarlane, President, Idaho State AFL-CIO, Boise.

James J. Coughlin, M.D., Orthopedic Association, member of the Board of Directors of Elk's Rehabilitation Hospital, Boise.

Sam Kaufman, Jr., Attorney at Law, Boise.

George Greenfield, Attorney at Law, Boise.

Marion L. Peterson, Chief Claims Manager, Argonaut Insurance Co., Boise.

Ray W. Turner, Administrator, Idaho Division of Vocational Rehabilitation, Boise.

Gerald Turnbow, Vice President, Employee and Public Relations, Bunker Hill Company, Kellogg.

We encourage individuals with suggestions or concerns regarding the Rehabilitation Division to contact Gary Stivers, Administrator of the Rehabilitation Division, or one of the advisory committee members listed above. Only through open communication can a successful program be developed. The first meeting of the advisory committee was held November 27 at which time the present status of the Rehabilitation Division along with future goals and objectives were discussed.

# Idaho Employers Honored for Efforts In Hiring Handicapped Workers

The Idaho Governor's Committee on Employment of the Handicapped has honored employers of the handicapped during the fall awards luncheon held in Boise. The event was part of a statewide observance for National Employ the Handicapped Week, October 1-7.

In welcoming Governor's Committee members, Mayor's Committees, and guests to the awards luncheon, Lieutenant Governor Murphy, representing Governor Evans, acknowledged those being honored and challenged all Idahoans to join the growing movement towards securing for handicapped citizens their rightful place in today's social-economic system with assurance of free choice in occupational goals.

## Outstanding Employer of Handicapped Award

The Governor's Committee selection for this year's outstanding Employer of the Handicapped Award was E. G. & G. Idaho, Inc., an Energy Research, Development and Testing Firm of Idaho Falls. This employer exercises outreach for contacting potential handicapped workers and has 15 handicapped persons on the payroll representing eight disability categories ranging from paraplegics to organic heart disease conditions.

Employer of the Year Award presented to Ronald Keen, General Manager of EG&G Idaho, Inc., Idaho Falls, Idaho by Lt. Governor William Murphy assisted by Larry Laughridge, Administrator Division of Veterans Services.

## Handicapped Citation Award

The 1978 American Legion National Handicap Citation Award went to the FMC Corporation of Pocatello. The Pocatello firm was cited for having 52 handicapped persons on a payroll of 600 employees. FMC has a record of retraining employees disabled either on or off the job and retraining them in new occupations at the plant.

American Legion Citation Award presented to A. Cameron McKay, Employee Relations Mgr. of F.M.C. Corporation, Pocatello, Idaho by Milt Sasser, Dept Commander American Legion, assisted by Lt. Governor Murphy.

## Federal Service Award

Region IV of the U.S. Forest Service received the Federal Service Employer Award for leadership fostering the agency's policy of hiring the severely handicapped. Numerous handicapped individuals have been placed by the Forest Service in the Southern Idaho area.

The Commission would like to join all involved in efforts to return disabled Idahoans to employment in congratulating these fine employers for their efforts in this most worthy undertaking.

Federal Service Award presented to Claude R. Elton, Deputy Regional Forester U.S. Forest Service Region IV by William R. Erickson, Boise Area Manager, U.S. Civil Service Commission, assisted by Lt. Governor Murphy.

# Rehabilitation Division Establishes Reporting System

In an effort to provide expanded communication between insurance companies, self insureds or adjustment bureaus and the Industrial Commission's Rehabilitation Division, a system of reporting has been established. It is the intent of this system to report the progress of the injured workers' rehabilitation program. These reports will involve communication from the Rehabilitation Division to the insurance carrier at the following points in the rehabilitation process:

1. **At time of referral.** The insurance carrier will be notified by telephone at the time an injured worker is referred to the Rehabilitation Division. This contact will be made prior to any contact with the injured individual and therefore should not be interpreted as an acceptance of the worker for services of the Division. Information will be exchanged at this point regarding the status of the claim.
2. **Acceptance for rehabilitation services.** After an evaluation of the injured worker's status is completed and the field consultant determines his acceptance for services by the Division, a report will be made in writing to the insurance company regarding the social and work history of the individual along with a summary identifying the need for rehabilitation services.
3. **Summary of planned services.** As a plan for rehabilitation services has been developed, a summary of these services along with the ultimate goal of the rehabilitation process will be submitted.
4. **Change in planned services.** At any time planned services or the vocational goal are changed during the process, a summary of this change along with an identification of the rehabilitation goal will be submitted.
5. **At time of closure.** On all cases closed, either successfully or unsuccessfully, by the Rehabilitation Division, a summary of services provided and the outcome of the rehabilitation process will be submitted to the insurance company.

It is our hope that with these routine reports, along with additional communication by telephone, a cooperative effort can be maintained in the provision of needed services.

# Industrial Commission Adopts Regulations

The Idaho Industrial Commission, in order to improve services to the injured worker, has adopted several new regulations. In an effort to keep you informed of the activities of the Commission, we are providing a brief summary of each. Questions regarding these regulations and their implications should be directed to the Industrial Commission.

Regulation 72.401A (3) assures that information obtained by the Rehabilitation Division will be used for rehabilitation purposes only and not in any way that may prove harmful — medically, psychologically, or otherwise — to the claimant, cause unfavorable reaction to a provider of information, or violtate the confidentiality regulations of any agency providing information as part of an interagency agreement.

Regulation 72.432-7 requires physicians or other practitioners to submit a written report to the Industrial Commission within 7 days following any evaluation, and/or treatment of any person claiming to have suffered a job related injury. The regulation further specifies the information required to be contained in the report.

Regulation 72.806 requires that written notice be mailed to a worker within 10 days of any change of status or condition effecting workmen's compensation benefits to which he is presently or might ultimately be entitled. Regulation 72.806 determines who will provide the written notice, when the notice is to be mailed, the form in which such notice shall be given, and the address to which the notice shall be mailed.

Copies of the regulations are on file at the Industrial Commission, in each county law library, and at the State Law Library.

Idaho Industrial Commission
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# Rehab Review

PUBLISHED BY IDAHO INDUSTRIAL COMMISSION — REHABILITATION DIVISION

Vol. 2 No. 1 October 1979

## The Rehabilitation Division Completes First Year

The Industrial Commission's Rehabilitation Division completed its first year on July 1. We at the Industrial Commission are very proud of the progress made during this year and feel you will find some of the statistical information gathered of interest.

The Rehabilitation Division was established by the 1978 Legislature in an effort to reduce the period of temporary disability resulting from industrial injury or disease and to aid in restoring the disabled employee to gainful employment with the least possible physical impairment. Six Field Consultants were hired in August of 1978 and located in Coeur d'Alene, Lewiston, Caldwell, Boise, Twin Falls, and Pocatello. A great deal of time during this initial year was spent in the training of Field Consultants. During fiscal year 1979, the Industrial Commission received in excess of 44,000 accident reports. Upon receipt of these reports, they were screened to identify those cases needing rehabilitation services. In addition, the Division Administrator and Field Consultants contacted physicians, attorneys, employers, insurance companies, local agencies and organizations in an effort to develop an effective referral process. Of accepted referrals, 47 percent came from screening accident reports, 22 percent from employers, and 21.6 percent were received from insurance companies. A total of 1,061 referrals were received during FY 79. Research in the area of rehabilitation has identified as key factors early intervention and timely service delivery. It is our hope that by expanding our source of referrals, we will be able to identify much earlier those individuals needing services.

A goal of the Rehabilitation Division is early contact and determination of eligibility for our services. During our first year, the average length of time between referral and a determination of eligibility was 27.7 days. We feel it is important that the referral source, as well as the claimant, know in as short a time as possible the services, for which the claimant is eligible. Of these individuals determined to be in need of our services, 46 percent of those eventually closed were closed as rehabilitated as a result of significant services provided by the Field Consultant. Those rehabilitated were broken down as follows: 26 percent returned to the same job with the same employer, 26 percent returned to a new job with the same employer, and 48 percent were placed in a new job with a new employer.

Although we at the Industrial Commission are quite pleased with these first year statistics, we are also quite excited about the potential we see for the second year of operation. As we begin the second year, we have hired two additional Field Consultants and established a new field office in Idaho Falls. This additional staff, along with the experience we have gained, will help provide an even more dramatic statistical picture a year from now.

***Rehabilitation centers on the positive of returned self-sufficiency rather than the negative of the adversary process.***

## 72% Of Benefits Paid Go To 5% Of The Injured Workers

The Industrial Commission recently completed a study of the 11,193 injured workers with back problems whose cases were closed during 1977 and 1978. This study revealed that of back cases closed during this period, 72.9 percent of the benefits paid went to 5 percent of these injured workers. Translated in terms of dollars, 594 injured workers received 9.8 million dollars in benefits.

This study further indicated 26 percent of the benefits paid, or 3.5 million dollars, was spent on less than 1 percent of the individuals closed. This amounts to an average of $36,000 per case. These figures dramatically point out the group of individuals upon whom the Rehabilitation Division hopes to have an impact. If through our services an average of $1,000 per case could be saved on the 594 individuals, the savings would more than offset the $281,000 first-year budget of the Rehabilitation Division. We ask your assistance in identifying as early as possible those individuals whose case histories indicate a long period of temporary disability, and cases of individuals unable to return to previous employment for medical reasons. Your help is needed to reduce the costs identified in this report as well as allow us to provide services that enable the injured worker to once again become self-sufficient.

# Temporary Benefits May Be Extended For Retraining Purposes

In an effort to meet the rehabilitation needs of injured workers, the 1978 Legislature amended the Workmen's Compensation Law to provide an extension of benefits when retraining is necessary.

Upon motion of the employer, employee, or by the Commission it may be determined that the employee requires retraining. In such cases, the employer will continue to pay the employee temporary total, or temporary partial disability benefits for no more than 52 weeks. However, following the expiration of the first 52 week period, the Commission may extend the retraining period for a maximum of another 52 weeks. See Idaho Code Section 72-450.

The goal of the Rehabilitation Division is to provide the earliest possible return of the injured worker to meaningful, safe work. Generally, this return will be to the same job and the same employer. For those individuals unable to return to the same job, selective placement in a job using known skills and compatible with remaining disabilities will be provided. Hopefully, early contact and placement will prevent the development of chronic long-term disability which may be a prelude to later unsuccessful vocational training.

If assessment of remaining abilities and work experience indicate that placement for the individual would not be feasible considering these limitations, the Rehabilitation Division investigates retraining possibilities. Here again, the goal of the Division is early return to employment. Our first approach is development of on-the-job training, the second approach, vocational school, and four-year academic training used only as a last resort. Recommendations for the extension of benefits for retraining purposes would be made when it has been clearly established that without retraining the injured worker would be unable to return to competitive employment. The Field Consultant would further evaluate whether the proposed training was the most efficient and timely way to gain the skills necessary for a return to work. If on-the-job training can be substituted for a two-year vocational program, such on-the-job training will be sought. In all cases, when a plan has been developed, sufficient information will be provided the surety or employer to make an appropriate decision as to whether to become involved in the extension of benefits. We in the Rehabilitation Division have been very happy with the support received from the insurance industry during our first year. During this time, only one case has gone to a hearing for extension of benefits for retraining purposes. In all other cases, negotiation between the Rehabilitation Division, the claimant, and the surety have produced compromises that have met the needs of all parties involved in the worker's return to employment.

Additional questions regarding these extensions of benefits should be addressed to the Industrial Commission.

Rita Arthur has been named as field consultant in the newly established Idaho Falls office.

## Rehabilitation Division Establishes Idaho Falls Office

The Industrial Commission is proud to announce the opening of a new field office in Idaho Falls. The need for this newly established regional office is a result of an ever increasing number of referrals in the Eastern Idaho area. Establishment of this office, along with the placing of a Field Consultant in the Idaho Falls area, will greatly increase the quality of services available to injured workers.

Rita Arthur, an Idaho Falls resident, will be working from this office. Rita received her Bachelor of Arts degree from Colorado State University in Public Administration and Criminal Justice. Since the completion of this degree, Rita has worked for the Idaho Division of Probation and Parole as an Employee Development Coordinator. In this capacity, Rita was responsible for the development of placement opportunities for unemployed and under-employed adult offenders.

The new field office is located at 101 Park Avenue, P.O. Box 803, Idaho Falls, Idaho 83401, or Rita can be reached by calling 523-4011.

If you know of an individual living in the Idaho Falls area who has a job-related injury or disease needing rehabilitation services, we would encourage you to contact Rita for assistance.


### Rehab Review

Published Quarterly by the Rehabilitation Division, Idaho Industrial Commission, 317 Main St., Boise, Idaho 83720

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Lewiston, 1118 "F" Street, Phone 746-3935
Pocatello, Center 151 Bldg., Suite 105 Phone 234-2810
Twin Falls, 630 Blue Lakes Blvd. N. Phone 734-8300
Idaho Falls, 101 Park Ave., P.O. Box 803 Phone 523-4011

# IAIABC Holds Regional Meeting In Sun Valley

The International Association of Industrial Accident Boards and Commissions held its Western Region meeting July 24, 1979 in Sun Valley, Idaho. Representatives of Industrial Commissions, insurance companies, labor, industry, and other interested parties, including physicians and attorneys from twenty-one states were in attendance.

Mr. Will S. Defenbach, President of the Western Region Chapter of the I.A.I.A.B.C., was Chairman of the meeting which had as its theme "The Bottom Line." As is indicated by the theme, the conference dealt primarily with the ever rising costs experienced in administering Workmen's Compensation programs.

After a welcome from Robert Saxvic, Chief of Staff, Office of Governor John V. Evans, and a run down of activities of the international organization by Phillip T. Bork, Executive Director of the I.A.I.A.B.C., the program moved into its regular topic areas. Topics included the soaring costs of Workmen's Compensation benefits as affected by emotional problems such as conversion reactions and overlays, cost savings through rehabilitation, and, costs as affected by lump sum (full and final release) settlements and the pros and cons of such settlements.

Will Defenbach, member of the Idaho Industrial Commission, presides over the recent IAIABC Regional Meeting.

The main concern expressed was the continuing rise in the cost of Workmen's Compensation. The responsibility for the cost effectiveness is being laid squarely on the handlers of the Worker's Compensation Insurance, the insurance industry, and the employer. If cost savings are to be made, those involved with this program must become more aware of the needs of the injured worker, become actively involved in the "whole person," and must become involved in the rehabilitation process of these workers.

In summary, the participants of this meeting found it to be very informative. The information provided will be of assistance in providing cost effective as well as complete services to the injured workers.

Pauline Neilsen has been appointed to the Boise office of the Rehabilitation Division.

# Pauline Neilsen Named Field Consultant In The Boise Area

Pauline Neilsen, a long time resident of the Boise area has been appointed by the Industrial Commission as Field Consultant in the Boise office.

Pauline comes to the Industrial Commission after a career in a variety of fields related to the work she will be doing with the Rehabilitation Division. Pauline has worked as a lab technician while a member of the Teamster's Union, has had experience in public relations and as an area coordinator for sales representatives. Most recently, Pauline has been a part owner of an employment agency in Nampa, Idaho, where she served as manager and counselor. Pauline's background will add a great deal of strength to the Rehabilitation Division in the area of job development and community relations.

Pauline's office will be located at 317 Main Street, Boise, Idaho 83720, or she can be contacted by calling 384-2461.

# Coeur d'Alene Office Changes Location

Jim Faraca, Coeur d'Alene Field Consultant, has recently announced the acquisition of a new office in the Coeur d'Alene area. Jim is now located at 401 Front Street, Suite 210, Coeur d'Alene, Idaho 83814. Jim and his secretary, Karen, are very happy with the new location and invite all their friends and associates in the Coeur d'Alene area to visit them at the new office. Jim's phone number will continue to be 667-3056/9714.

## Defenbach Named To IAIAIBC Executive Committee

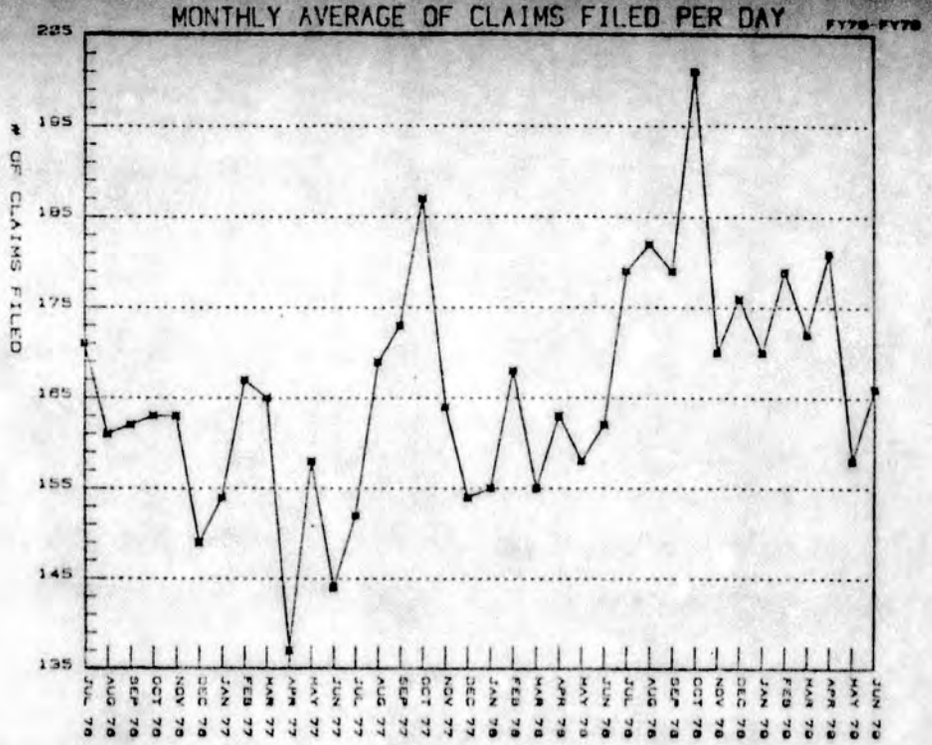
Will S. Defenbach, member of the Idaho Industrial Commission since 1968, has been elected to the five-member Executive Committee of the International Association of Industrial Accident Boards and Commissions.

The Association's more than one thousand members come from New Zealand, South Africa, Australia and the Province of Canada, as well as the United States and its territories.

Not since former Industrial Accident Board member Leo Houtz was elected in 1949 has the State of Idaho been so honored.

## Industrial Commission Adopts Regulation

The Industrial Commission recently adopted Regulation 72.419 (4) (a), which establishes guidelines for determining what remuneration is to be included in computing the employee's average weekly wage, pursuant to Idaho Code, Section 72.419 (4) (a), and what remuneration is to be excluded from that computation as premium pay. Copies of the regulation are on file at all county law libraries, the State Law Library, and at the Industrial Commission, 317 Main, Boise, Idaho.




## NEAR RECORD NUMBER OF CLAIMS FILED IN SEPTEMBER

The Claims Department of the Idaho Industrial Commission reports a near record of 191 claims filed per day during the month of September. This 191 claims was second only to October of 1978 when 201 claims per day were filed.

The months of September and October traditionally bring an increase in the number of claims filed as indicated in the graph shown above.

Data indicates the percentage of workers injured is on the down swing even though the number of reported injuries increase every year. This down swing is a result of the number of workers covered by the Workmen's Compensation Law increasing much faster than the number of accidents reported.

Although many more individuals are injured than we would like, those involved with the safety of the worker should be congratulated on accomplishments made to date. It is our hope that through additional efforts an even greater number of workers can be spared the physical as well as financial stress which results from industrial injuries.

Idaho Industrial Commission
Rehabilitation Division
Statehouse Mail
Boise, Idaho 83720

Administrative Rules
Division of Industrial Accidents

ARTICLE 12. REHABILITATION
(effective August 27, 1979)

10001. Authority. The rules and regulations contained in Article 12 are adopted pursuant to the authority contained in sections 133, 139.5 and 5307.3 of the California Labor Code.

COMMENT: No change from original regulations adopted 1-1-75.

10002. Operative Date. The provisions of this article apply to industrial injuries or diseases occurring on or after January 1, 1975.

COMMENT: No change.

10003. Definitions. As used in this article:

(a) "Bureau" means the rehabilitation unit established within the Division of Industrial Accidents pursuant to Labor Code Section 139.5.

(b) "Employer" includes the insurer providing the security for the compensation required by Division 4 and 4.5 of the California Labor Code.

(c) "Qualified injured worker" means an employee: (1) The effects of whose injury, whether or not combined with the effects of a prior injury or disability, if any, permanently preclude, or are likely to preclude the employee from engaging in his or her usual and customary occupation or the position in which he or she was engaged at the time of injury; and (2) Who can reasonably be expected to return to suitable gainful employment through the provision of vocational rehabilitation services.

COMMENT: Clarifies the two-part test for entitlement to vocational rehabilitation benefits -- and the order in which it should be addressed. The first part requires a medical determination by a physician (not a vocational counselor), who has knowledge of the physical demands of the employee's job. This may require providing the physician with a detailed job description or analysis which has been reviewed by the injured employee.

The second part of the test, vocational feasibility, should be determined after medical eligibility has been established. The evaluation

of the injured employee's ability to compete in the labor market is made by a qualified rehabilitation representative as defined in the next subdivision.

(d) "Qualified rehabilitation representative" means a person capable of developing and implementing the plan submitted pursuant to Section 10006. Such person may be either a vocational rehabilitation consultant employed by a state, public, or private agency, or an agent of the employer or employee whose experience and regular duties involve the evaluation, counseling or placement of disabled persons.

(e) "Independent vocational evaluator" means a person meeting the minimum standards set forth in Section 10011.

(f) "Vocational rehabilitation service" means those services required to determine an employee's eligibility as a qualified injured worker, and those services reasonably necessary to restore a qualified injured worker to suitable gainful employment. Such services may include, but are not limited to vocational evaluation, counseling, retraining including on-the-job training or training for alternative employment with the same employer, and job placement assistance.

COMMENT: Broadened to encompass those services necessary to establish the injured employee's eligibility (or non-eligibility) for vocational rehabilitation benefits, as well as services provided pursuant to a particular rehabilitation plan after the employee has been determined to be a "qualified injured worker." Amended definition also recognizes "training for alternative employment with the same employer" for the first time.

(g) "Vocational rehabilitation plan" means the written description of the manner and means by which it is proposed a qualified injured worker may be returned to suitable gainful employment. The plan may contemplate modification of the employee's occupation at the time of injury, provision for alternative work with the same employer, direct job placement assistance, on-the-job training, retraining, or job placement assistance, and the plan shall define the responsibilities of the employee, employer and other parties in implementing the plan.

COMMENT: Where subdivision (f) defined the "what" of the vocational rehabilitation process, subdivision (g) deals with the "how", the written document describing the particular services to be furnished to restore a particular qualified injured worker to employability. Note the permitted components track the types of return-to-work plans in priority of effectiveness, and the requirement that every written plan "define the responsibilities" of the parties.

(h) "Suitable gainful employment" means that employment or self-employment which is reasonably attainable and which offers an opportunity to restore the employee as soon as practicable and as near as possible to maximum self-support, due consideration being given to the employee's qualifications, interests and incentives, pre-injury earnings and future earning capacity, and the present and future labor market.

COMMENT: Continues the multiple factors the Rehabilitation Bureau must consider in evaluating the appropriateness of a particular rehabilitation plan, i.e., an occupational goal that is (1) reasonably attainable; (2) capable of achieving maximum self-support for the injured employee; considering (3) the employee's qualifications, interests and incentives; (4) the employee's pre-injury earnings and future earning capacity; and (5) the present and future labor market. These criteria reinforce the rank order of plan types enunciated in subdivision (g).

(i) "Rehabilitation temporary disability indemnity" means those payments required by Labor Code Section 139.5 to be made as a maintenance benefit, at the same rate as the employee's temporary total disability rate, while the employee is receiving vocational rehabilitation services subsequent to the date the employee's medical condition is permanent and stationary, or the employee would no longer be entitled to receive temporary total disability indemnity.

COMMENT: Defines the maintenance allowance due while the employee is receiving "vocational rehabilitation services." Note the definition attempts to distinguish between "medical" TD -- paid before the employee's condition is permanent and stationary -- and "rehab" TD due after that date. Note also the rule requires payment of the maintenance benefit during evaluation, i.e., before the employee's status as a "qualified injured worker" has been established in some instances.

This provision is contrary to the holding in the recent Renfro decision, but that case is on appeal; pending a final decision, the Institute recommends insurers conform to the amended administrative regulations.

10004. Reporting Requirements. (a) The employer shall report disability status to the Bureau, on forms prescribed for that purpose: (1) Immediately upon knowledge that the employee is unlikely to be able to return to his or her usual and customary occupation, or to his or her occupation at the time of injury, on a permanent basis; or (2) Immediately following 180 days after the date of injury when the employee is still unable to return to work for cases not previously reported under (1) above.

Reports submitted under this subsection shall specify the services being provided to determine the employee's eligibility as a qualified injured worker and the date when the Bureau will be notified of such determination. If the employee's condition does not then permit determination of qualified injured worker status, the employer shall so advise the Bureau and indicate the date when such determination will be made, reported and documented.

If the employer believes the employee is not a qualified injured worker, the report shall include documentation of medical or vocational ineligibility supporting the employer's determination. In these instances the reports also shall include a copy of the employer's advice to the employee that, in the opinion of the employer, the provision of vocational rehabilitation services is not necessary, the reasons therefor, and the following mandatory language:

"If you are not satisfied with this explanation, please contact the Information & Assistance Officer at the (city) office of the State Division of Industrial Accidents located at (street address). His (Her) name is , the telephone number is , and there is no charge for this service.

If the employee's disability status changes at any time subsequent to submission of the initial report, the employer shall file a supplemental report to the Bureau.

COMMENT: Extends deadline for reporting injured employee's work status (Form RB-1) to 180 days post-injury, rather than 120 days of temporary total disability, a requirement applying both to pending and new claims in the opinion of the administrative director of the Division of Industrial Accidents. The change to a time certain post-injury will simplify insurers' diary systems, but may require some further explanation on the reporting form in some isolated instances, e.g., the employee who has no lost time until five months after the injury, in which case the first date of disability should be indicated on the RB-1.

Even though the reporting period has been extended, the employer/insurer still has the responsibility to report work status before the 180-day deadline if the employee is not likely to return to his usual occupation or time-of-injury occupation. Without active claims management, the 180-day reporting rule can be counter to the goal of early identification of potential candidates for vocational rehabilitation so claims supervisors should be wary.

If the employee's eligibility for vocational rehabilitation services is undetermined at the time the RB-1 is submitted, the report must advise what action is being taken and when a follow-up will be made (e.g., "Dr. Smith will examine Mr. Jones on September 15 to determine return-to-work status, and the Bureau will be notified of the doctor's opinion by September 25.") Similarly, if medical eligibility has been established, then specify what is being done to determine vocational feasibility and when a follow-up will be filed.

Under the old 120-day rule upwards of 70 per cent of RB-1's submitted required no further action -- because the employee was able to return to his job sometime after the reporting deadline. The shift to 180 days will reduce the percentage of non-functional reports, but our determination that the employee is not eligible for vocational rehabilitation benefits imposes two additional requirements:

1. Substantiation for your decision; for example, attach to the RB-1 a copy of the doctor's report that the employee will be able to return to his usual job; and
2. Attach a copy of your explanatory letter to the employee (CWCI Rehabilitation Committee is preparing draft language for insurers' consideration). To avoid future problems, it's recommended the employee get an explanation -- by phone or in-person -- before he receives the letter.

(b) Termination or suspension of rehabilitation services and the reasons therefor shall be reported to the Bureau by the employer immediately following such terminatio or suspension on forms prescribed for that purpose. The report shall include a copy of the employer's advice to the employee explaining the action taken, the reasons therefor, and referral to an Information & Assistance Officer if further information is desired.

COMMENT: The employer/insurer may terminate or suspend vocational rehabilitation services without prior approval of the Bureau, although a report must be made. The Bureau is developing a form for this purpose and the Institute's Rehabilitation Committee will recommend draft language that may be used to advise the employee as required by the regulations. Again, however, a personal explanation to the employee prior to sending the required letter should be considered whenever possible.

(c) The employer shall report to the Bureau immediately upon the employee's completion of a rehabilitation plan, indicating the results thereof and such other pertinent information as may reasonably be prescribed by the Bureau. The report shall include a copy of the employer's advice to the employee explaining the action taken, the reasons therefor, and referral to an Information & Assistance Officer if further information is desired.

COMMENT: A standardized form to report plan completions is being developed by the Bureau.

10005. Initiation of Vocational Rehabilitation Services. The employer shall have the primary responsibility to provide timely vocational rehabilitation services through a qualified rehabilitation representative designated by the employer in consultation with the employee. If the employer fails to meet this responsibility, the employee may request the Bureau to order the provision of vocational rehabilitation services at the expense of the employer. The Bureau shall advise the employer of the receipt of such request.

Within 20 days after receipt of the Bureau's advice, the employer shall either; (1) Agree to provide vocational rehabilitation services; or (2) Establish through medical or vocational reports that the employee is not a qualified injured worker. If the employer fails to respond within such period, the Bureau may order the provision of vocational rehabilitation services through a qualified rehabilitation representative of the employee's choice or, at the employee's request, through a qualified rehabilitation representative designated by the Bureau.

Nothing in this section shall preclude the employee and employer from agreeing to the change of a qualified rehabilitation representative. If agreement cannot be reached, the employee may request the Bureau to order a change in qualified rehabilitation representative or a consultation with a qualified rehabilitation representative of the employee's choice, and the Bureau shall order such change or consultation if it finds such to be in the best interests of the parties.

COMMENT: Extensive changes in this section are intended to eliminate the multiple vendor problem and vest responsibility in the employer/insurer to provide vocational rehabilitation services automatically, promptly and effectively. The employee (or an attorney or vendor on his behalf) still may request rehabilitation services -- just as the employee always has the right toclaim any other specie of compensation benefits. But the employer/insurer can retain management of the case by responding timely, either by providing the services or by documenting the employee's ineligibility for the vocational rehabilitation benefit. Absent a timely response, services will be provided by a vendor selected by the employee, his representative or the Bureau.

The revised rules continue the requirement that the qualified rehabilitation representative be designated by the employer but "in consultation with the employee." For represented employees, this requirement can best be met by making advance arrangements with applicants' attorneys in your area that their clients will be referred to one of the vendors on a mutually acceptable list; if this isn't possible, then contact should be made on a case-by-case basis. Both unrepresented and represented employees should have an understanding of why a particular vendor was selected, what services will be provided, the results expected, and that the vendor may be changed if communication or other problems arise. If a change in vendor is indicated, involve the employee and secure his cooperation; without agreement the employee may request the Bureau to order a change.

10006. Plan Submission. (a) Unless the employee refuses the provision of vocational rehabilitation services, the employer shall submit a proposed vocational rehabilitation plan, together with all related medical and vocational reports, to the Bureau on forms prescribed for that purpose. The employer also shall send a copy of the plan to the qualified injured worker and/or his/her representative and secure his/her concurrence to the plan.

COMMENT: Bureau currently is preparing a revision of the prescribed form (RB-2), which is expected to clarify requirements and specify necessary documentation.

(b) Within 30 days of submission to the Bureau district office responsible for that particular plan, the plan will be approved or disapproved. In reaching its decision the Bureau may request additional information, confer with the parties, recommend reasonable modifications to the plan, and otherwise seek agreement concerning terms and conditions of the plan.

If Bureau approval or disapproval is not made 30 days after submission, a properly documented plan shall be deemed approved; provided, however, the Bureau may extend the review period for an additional 30 days if additional information or conferences are required.

COMMENT: Rehabilitation plans will be deemed approved unless the Bureau disapproves within 30 days of submission or extends the review period for up to an additional 30 days -- assuming, of course, the qualified injured worker is satisfied and the details and rationale of the plan are documented appropriately. The automatic approval provision, long sought by the industry as one means to help the Bureau cope with its backlog, creates added incentives to develop and submit effective rehabilitation plans, however. If a plan is inappropriate, the Bureau still has the authority to modify it (see subsection (c) of 10007) subsequent to its deemed approval.

(c) Implementation of the plan shall begin as soon as the qualified injured worker is capable of participating in the program and medical opinion indicates his or her recovery will not be impeded by participation. Implementation may begin upon Bureau approval or the date specified in the plan, whichever date first occurs. Commencement of a plan shall not be deemed approval.

COMMENT: Note plans now may be implemented before Bureau approval -- although to do so is at the risk of the employer/insurer as the Bureau still can disapprove or require modification during the review period, or modify it any time after implementation. Appropriate and effective plans still are the best means to avoid expensive problems and delays.

10007. Authority and Responsibility of the Bureau. All matters regarding vocational rehabilitation services shall be submitted initially to the Bureau except those arising in cases before a judge of the Appeals Board. Where injury is an issue, or where the question of the need for vocational rehabilitation services first arises in a proceeding of the Appeals Board, the question shall be referred by the judge to the Bureau. The Bureau shall exercise its authority and meet its responsibilities in the following manner.

(a) Where there are questions concerning an employee's entitlement to vocational rehabilitation services, or where a vocational rehabilitation plan is not offered by the employer, or where the vocational rehabilitation plan is not acceptable to the employee, the Bureau, either on its own motion or upon the request of either the employer or employee, may schedule a conference to determine the practicability of, need for and kind of vocational rehabilitation services, if any, necessary to restore the employee to suitable gainful employment. The Bureau may require the parties to meet and confer informally prior to granting a request for a conference. The Bureau may order necessary and reasonable medical examinations and vocational evaluations to be conducted at the expense of the employer. After allowing the parties an opportunity to be heard and to present information supporting their respective positions, the Bureau shall issue its findings and serve copies on the parties.

COMMENT: "Request for Conference" form being developed by the Bureau will require the requesting party to explain what steps have been taken as a condition precedent to Bureau involvement. Bureau believes (and the Institute agrees) too much conference time is expended on issues which could have been resolved had the parties made a good faith effort. This is not to say Bureau involvement isn't necessary in some instances, but every effort should be made to resolve any differences informally between the parties before seeking Bureau conciliation.

(b) If the disability status report required by subsection (a) of section 10004 is incomplete or filed untimely, the Bureau may order the provision of vocational rehabilitation services at the expense of the employer.

COMMENT: Late or incomplete RB-1's may result in Bureau requiring employer to provide "vocational rehabilitation services" -- not a plan necessarily, but evaluation and other services to establish the injured employee's eligibility (or non-eligibility) for the vocational rehabilitation benefit.

(c) Upon the request of either the employee or employer, or upon its own authority, the Bureau may modify, suspend or terminate a vocational rehabilitation plan.

10008. Appeals. (a) Any party aggrieved by a finding, decision or order of the Bureau may initiate proceedings before the Appeals Board.

(b) Any finding, decision or order of the Bureau shall be final unless an appeal is filed within 20 days after service upon the parties.

COMMENT: Restates and simplifies appeal procedure and finality of Bureau orders.

10009. Rehabilitation Voluntary. Nothing in these rules shall require an employee to participate in a rehabilitation plan if the employee does not choose to do so.

COMMENT: Restates existing statutory and regulatory provisions. In those instances where the employee refuses rehabilitation, the employer/insurer should document by requesting the Bureau to issue an order terminating its liability (with a copy of the request to the employee). A signed waiver has no legal standing. Vocational rehabilitation benefits cannot be commuted or settled (Labor Code Section 5100.6) unless there is genuine jurisdictional issue, Thomas v. Sports Chalet, Inc., 42 CCC 625.

10010. Agreements Permitted. The Bureau may utilize the services of the State Department of Rehabilitation, State Employment Development Department, and any public or private vocational rehabilitation or employment service or facility.

COMMENT: No change.

10011. Standards for Independent Vocational Evaluator. When a vocational rehabilitation evaluation or plan is submitted to the Bureau pursuant to Section 10006 and in the judgment of the Bureau it is in the best interests of all parties that the employee be vocationally evaluated, a plan be prepared or a proposed or existing plan be reviewed, the Bureau may order such service be provided by an independent vocational evaluator holding one of the following credentials:

(a) A Doctorate or Master's degree in vocational rehabilitation counseling or its equivalent, and have one or more years experience in vocational counselling of the industrially injured worker;

(b) A Doctor of Medicine degree and have one or more years experience in psychiatric or psychological evaluation of disabled adults in relation to rehabilitation counseling;

(c) A Doctorate or Master's degree in counseling or psychology or its equivalent, and have one or more years fulltime employment using rehabilitation counseling technique and conducting vocational evaluations or psychological assessments of disabled adults under the direct supervision of a qualified rehabilitation representative meeting the requirements of this section; or

(d) A Bachelor's degree and, in addition, have two or more years fulltime employment using rehabilitation counseling techniques and conducting vocational evaluations or psychological assessments of disabled adults under the direct supervision of a qualified rehabilitation representative meeting the requirements of this section.

COMMENT: Establishes standards for independent evaluators, not for the qualified rehabilitation representative defined in subsection (d) of 10003. While many QRR's have these qualifications, the standards apply only to a representative designated by the Bureau to assist in resolving a dispute.

10012. Representation. When an employee or employer chooses to be represented by a third party in matters before the Bureau, the Bureau shall be notified in writing of the name, address and telephone number of said representative at the earliest possible date. Notice of representation to the Appeals Board shall not be considered notice to the Bureau.

COMMENT: No substantive change.

10013. Service of Reports. The party authorizing vocational rehabilitation services shall provide the Bureau with copies of all pertinent medical and all vocational reports as required by the Bureau. If the authorizing party fails to provide the required reports within 10 days of the Bureau's request, the Bureau may request information from any of the parties.

Vocational reports and medical reports filed with the Bureau shall be served upon the parties. However, the filing of such reports with the Appeals Board shall not constitute filing with the Bureau.

COMMENT: Vests responsibility for serving medical, vocational and other pertinent reports upon the party authorizing services, i.e., generally, the employer/insurer. In most instances reports need not be submitted as received (e.g., the treating physician's progress reports, or the vendor's interim reports on efforts to determine feasibility or plan development). Instead, unless requested otherwise by the Bureau, batch and submit pertinent reports when:

- Submitting a rehabilitation plan (RB-2)
- Terminating or suspending vocational rehab benefits
- Requesting a conference
- Reporting non-qualified injured worker status.

Copies of filed reports must be served on the other parties. Failure to respond to a Bureau request permits the Bureau to request the information directly from any party, but section as amended repeals Bureau's original authority to require qualified rehabilitation representatives to file written reports containing "such pertinent information as is required by the Bureau."

10014. Requests for Reimbursement. When the Department of Rehabilitation or any qualified rehabilitation representative has provided vocational rehabilitation services at the request of an injured worker, a request for reimbursement may be filed with the Bureau, and the Bureau shall determine the extent to which such services shall be paid by the employer.

COMMENT: Extends Bureau's authority to determine reimbursement value of "vocational rehabilitation services", authority previously limited to cases in which a rehabilitation plan was in fact developed.

10015. Enforcement of Reporting Requirements. The chief of the Bureau shall gather data and make recommendations to insurers, self-insured employers or adjusting agents who appear to have an established pattern of delay in reporting disability status, as required by Section 10004, or in the timely development of vocational rehabilitation plans for qualified injured workers. In the event the recommendations for corrective action are not followed, the chief of the Bureau shall request intervention by the Chief of Ancillary Services, who may ask the Insurance Commissioner or Director of Industrial Relations, as the case may be, to audit and enforce the reporting requirements pursuant to the authority contained in Section 129 of the Labor Code.

COMMENT: Formerly Section 10016; no substantive change.

10016. Rehabilitation Temporary Disability Indemnity Payment. (a) An injured employee's entitlement to rehabilitation temporary disability indemnity payments shall commence on the day the employer knew, or with reasonable diligence should have known, of the employee's inability or likely inability to return to his or her usual and customary occupation or to the position he or she was engaged in at the time of injury. Such payments shall continue during the pendency of vocational rehabilitation services unless the Rehabilitation Bureau otherwise orders.

(b) In determining the period for which employee is entitled to receive the rehabilitation temporary disability indemnity payment, the Bureau may consider the following factors:

(1) The date on which the employer first obtained knowledge of the possible need for rehabilitation services.

(2) Whether the employer has complied with Article 8.5 of the rules of the administrative director requiring the employer to advise the employee about entitlement to benefits.

(3) Whether the employer has complied with the reporting requirements of Section 10004.

(4) Whether the employee has requested vocational rehabilitation services.

(5) Whether the employee has been cooperative, or available for vocational rehabilitation services.

(6) Whether the employee is likely to benefit from the provision of vocational rehabilitation services.

COMMENT: Attempts to codify existing practice and decisional law at the time the regulations were promulgated, i.e, the maintenance allowance (rehab TD) is payable from the date the employer had actual or constructive knowledge that the employee's medical condition made unlikely his return to his usual and customary occupation. Also, maintenance payments due during evaluation, testing and plan development -- even if the employee subsequently is determined to be not qualified -- if such services are provided after the employee's condition is permanent and stationary (see subsection (i) of 10003).

Regulation conflicts with Court of Appeal decision in San Diego Transit Corp. vs WCAB (Renfro), 4 Civ. 18383. That decision is under appeal to the Supreme Court, however, and in the interim the Institute recommends insurers conform to the new regulation.

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114 0020

INTER-OFFICE MAIL
BILL CAMPBELL
LARSON

Bill Gunter
STATE TREASURER
INSURANCE COMMISSIONER
FIRE MARSHAL

Insurance Commissioner
STATE OF FLORIDA
TALLAHASSEE 32301

August 8, 1980

DIVISION OF INSURANCE RATING

INFORMATIONAL BULLETIN 80-224

TO: ALL INSURER GROUPS AUTHORIZED TO WRITE WORKERS' COMPENSATION INSURANCE IN FLORIDA

FROM: BILL GUNTER, INSURANCE COMMISSIONER AND TREASURER

SUBJECT: CHAPTER 80-236, LAWS OF FLORIDA
(HB 1677)
EXCESS PROFITS TEST
FLORIDA RATES IN THE SUNSHINE LAW

The above captioned legislation became effective July 1, 1980.

Subsection (6) of Section 627.091, Florida Statutes, has been amended to clarify that a committee of a rating organization need meet in Florida only when the committee will be discussing matters related to Florida rates.

Subsection (2)(a) of Section 627.215, Florida Statutes, changes the definition of excessive profits for workers' compensation insurance. When submitting this information, you should use Form F which has been submitted previously and was attached to Informational Bulletin 79-12.

It is necessary that you review these changes, copy of which is attached, and be guided accordingly.

Please direct all submissions and inquiries to:

Bureau of Workers' Compensation
Florida Department of Insurance
Larson Building
Tallahassee, Florida 32301

BG:Vs

(11) The .ivision shall furnish to any employer or carrier, upon quest, its individual experience. The division shall furnish to the partment of Insurance, upon request, the Florida experience as veloped under accident policy year or calendar year.

Section 20. Subsection (6) of section 627.091, Florida Statutes, is ended to read:

627.091 Rate filings; workers' compensation and employer's liability surances.--

(6) Whenever the committee of a recognized rating organization with sponsibility for workers' compensation and employer's liability surance rates in Florida meets to discuss the necessity for, or a quest for, Florida rate increases or decreases, the determination of rida rates, the rates to be requested, and any other matters taining specifically and directly to such Florida rates, such meetings all be held in Florida and shall be subject to s. 286.011, the Florida vernment in the Sunshine Law. The committee of such a rating anization shall provide 6 weeks' notice to the department. The partment shall provide at least 3 weeks' notice to the public of such etings.

Section 21. Subsections (2), (6), (7), (8) and (9) of section .215, Florida Statutes, are amended to read:

627.215 Excessive profits for workers' compensation and employer's bility insurance prohibited.--

(2)(a) Excessive profit has been realized if underwriting gain plus ~~investment income generated by loss reserves~~ is greater than the icipated underwriting profit plus 5 percent of earned premiums for the ost recent calendar years.

(b) As used in this section with respect to any 3-year period, icipated underwriting profit" means the sum of the dollar amounts tained by multiplying, for each rate filing of the insurer group in fect during such period, the earned premiums applicable to such rate ing during such period by the percentage factor included in such rate ing for profit and contingencies, such percentage factor having been termined with due recognition to investment income from funds generated Florida business. Separate calculations need not be made for secutive rate filings containing the same percentage factor for fits and contingencies.

(6) If the insurer group has realized an excessive profit, the partment shall may order a return of the excessive amounts to ~~policyholders~~ after affording the insurer group an opportunity for ring and otherwise complying with the requirements of Chapter 120, rida Statutes. Such excessive amounts shall be refunded in all ances unless the insurer group affirmatively demonstrates to the isfaction that said refund of the excessive amounts will render a member the insurer group insolvent under the provisions of the Florida surance Code.

~~(7)--In--determining--what--action--should--be--taken--if--excessive--profits--are--realized,--the--department--shall--consider--the--following,--as--they--relate--to--Florida--workers'--compensation--and--employer's--liability--insurance:~~

~~(a)--The--underwriting--profit--or--loss--of--the--insurer--group--in--prior--years.~~

~~(b)--The--financial--strength--and--stability--of--the--insurer--group.~~

~~(8)--The--department--may--excuse--an--insurer--from--complying--with--the--reporting--requirements--if--the--volume--of--business--written--by--the--insurer--would--not--justify--the--expense--of--the--reporting--requirement.~~

(7)(9) Any excess profit of an insurance company offering workers compensation or employer's liability insurance shall be returned t policyholders in the form of a cash refund or ~~rather than~~ a credit towar the future purchase of insurance. The excessive amount shall be refunde on a pro rata basis in relation to the final compilation year earne premiums to the workers' compensation policyholders of record of th insurer group on December 31 of the final compilation year.

(8)(a) Cash refunds to policyholders may be rounded to the neares dollar.

(b) Data in required reports to the department may be rounded to the nearest dollar.

(c) Rounding, if elected by the insurer, shall be applie consistently.

(9) Refunds shall be completed in one of the following ways:

(a) If the insurer group elects to make a cash refund, said refun shall be completed within 60 days of a final order indicating excessiv profits have been realized.

(b) If the insurer group elects to make refunds in the form of credit to renewal policies such credits shall be applied to polic renewal premium notices which are forwarded to insureds more than calendar days after a final order indicating excessive profits have be realized. If an insurer group has made this election but an insur thereafter cancels or otherwise allows his policy to terminate, th insurer group shall make a cash refund not later than 60 days afte termination of such coverage.

(c) Upon completion of the renewal credits or refund payments, the insurer group shall immediately certify to the department that th refunds have been made.

(10) Any refund or renewal credit made pursuant to this section shal be treated as a policyholder dividend applicable to the year in which i is incurred for purposes of reporting under this section for subsequen years.

Section 22. If chapter 627, Florida Statutes, is repealed i accordance with the intent expressed in the Regulatory Reform Act o 1976, as amended by chapter 77-457, Laws of Florida, or as subsequentl amended, it is the intent of the Legislature that sections 20 and 21 o this act shall also be repealed on the same date as therein provided.

Section 23. Section 629.401, Florida Statutes, is amended to read:

629.401 Florida insurance exchange.--

(1) There may shall be created one or more insurance exchanges, wit one or more offices each, a Florida insurance exchange, subject to su rules as may be promulgated by the commissioner. For the purposes this section, the term "exchange" shall apply to any such insurance exchange proposed or created under this section. The purposes of t exchange are:

(a) To provide a facility for the underwriting of:





CODING: Words in ~~struck-through~~ type are deletions from existing law; words in underscored type are additions.

Bill Gunter
STATE TREASURER
INSURANCE COMMISSIONER
FIRE MARSHAL

114 0310 00
INTER-OFFICE MAIL
CHARLES GRAY
LARSON BUILDING



Insurance Commissioner
STATE OF FLORIDA
TALLAHASSEE 32304

August 17, 1979

*F & C INFORMATIONAL BULLETIN 79-12*

*TO:* *All Insurer Groups Authorized to Write Workers' Compensation Insurance in Florida*

*FROM:* *Bill Gunter, Insurance Commissioner and Treasurer*

*SUBJECT:* *Chapter 79-40, Laws of Florida (CS/SB 188) Excess Profits Test*

*The subject legislation, effective August 1, 1979, requires insurer groups to submit certain information to the Department of Insurance each year.*

*Such information is detailed on the attached reporting form and its accompanying set of instructions.*

*Please direct all submissions and inquiries to:*

*Actuarial*
*Florida Insurance Department*
*Larson Building*
*Tallahassee, Florida 32301*

*MT/ps*
*Attachments*

*FLORIDA DEPARTMENT OF INSURANCE*

*INSTRUCTION SHEET FOR REPORTING FORM F*
*ACCOMPANYING F & C INFORMATIONAL BULLETIN 79-12*

1. *Data is on an insurer group basis and entered in whole dollars. Negative amounts are to be placed in parentheses.*

2. *Data is direct with respect to reinsurance.*

3. *Data is for Florida experience only.*

4. *Administrative and Selling Expense refers to commission, brokerage, other acquisition, field supervision, collection and general expenses, as well as taxes, licenses and fees.*

5. *Loss development factors are to be based on Florida historical data.*

6. *The submission of July 1, 1979, requires completion of Items (1) through (4) inclusive for calendar/ accident year 1978. The submission of July 1, 1980, requires completion of the entire Form F for the First Report of accident year 1979. The July 1, 1981 submission requires completion of the entire Form F for First Report of accident year 1980 as well as completion of the entire Form F for Second*

*Report of accident year 1979. The July 1, 1982 submission requires First Report of 1981, Second Report of 1980 and Third Report of 1979. This sequence of annual submissions will continue so that each accident year, beginning with 1979, will be reported at three stages of development and developed appropriately as detailed in the form.*

Form F

FLORIDA DEPARTMENT OF INSURANCE

WORKERS' COMPENSATION EXCESS PROFITS TEST REPORTING FORM

SUBMISSION OF JULY 1, 19 [ ][ ]

COMPANY/GROUP CODE [ ][ ][ ][ ][ ] (Leading Company Fla. Certificate of Authority Number)

CALENDAR/ACCIDENT YEAR 19 [ ][ ] AS OF 12/31/ [ ][ ]

FCC [W][C][4] IAC [3]

COMPANY OR GROUP NAME _____

ADDRESS _____ ZIP _____

FORM SUBMITTED BY (Name, Title) _____

_____ PHONE _____

1. Calendar Year Earned Premium.....$_____

2. Calendar Year Policyholder Dividends Incurred.....$_____

3. Calendar Year Administrative and Selling Expenses Incurred.....$_____

4. Accident Year Loss and Loss Adjustment Expense Incurred.....$_____

5* Loss and Loss Adjustment Expense Development Factor (1st to Ultimate [ ], 2nd to Ultimate [ ], 3rd to Ultimate [ ]).....

6. Control Total (Sum of items 1, 2, 3 and 4) (Do Not Include Item 5 in Control Total).....

*EXAMPLE: 1.200 or .950

Bill Gunter
STATE TREASURER
INSURANCE COMMISSIONER
FIRE MARSHAL

Office of Treasurer
Insurance Commissioner
STATE OF FLORIDA
TALLAHASSEE 32304

August 17, 1979

F & C INFORMATIONAL BULLETIN 79-11

TO: All Insurers Authorized to Write Workers' Compensation Insurance in Florida

FROM: Bill Gunter, Insurance Commissioner and Treasurer

SUBJECT: Chapter 79-40, Laws of Florida (CS/SB 188 and SB 669) Revised Reporting Form

The subject legislation, effective August 1, 1979, requires insurers authorized to write workers' compensation insurance in Florida to transmit certain information to the Department of Insurance each year with the Annual Report of such insurer.

Such information is detailed on the attached reporting form and its accompanying set of instructions.

The requirements of Chapter 79-40, Laws of Florida, reflected in this bulletin replace F & C Informational Bulletin 78-10 and render it obsolete.

Please direct all submissions and inquiries to:

Actuarial
Florida Department of Insurance
Larson Building
Tallahassee, Florida 32301

MT/ps
Attachments

*FLORIDA DEPARTMENT OF INSURANCE*

*INSTRUCTION SHEET FOR REPORTING FORM D*

*ACCOMPANYING F & C INFORMATIONAL BULLETIN 79-11*

1. *Data is to be separate by company and entered in whole dollars. All coding boxes are to be filled in. Negative amounts are to be placed in parentheses.*

2. *Data is direct (with respect to reinsurance) for Florida experience and net (with respect to reinsurance) for countrywide experience.*

3. *The first report is due on or before August 1, 1979, and is for calendar/accident year 1978 as of 12/31/78.*

4. *On or before April 1, 1980, a second report for calendar/accident year 1978 as of 12/31/79 will be due in addition to a first report for calendar/accident year 1979 as of 12/31/79.*

5. *Subsequent reports (due April 1, of subsequent years) will be required so that each year will be reported eight times at eight stages of development.*

This public document was promulgated at a total cost of $120 or 18¢ per copy to inform companies of the changes in the law.

FORM D

FLORIDA CERTIFICATE OF AUTHORITY NUMBER -- COMPANY CODE [ ][ ][ ][ ][ ]

CALENDAR/ACCIDENT YEAR [ ][ ] VALUED AS OF 12/31/ [ ][ ]

FORM CONTROL CODE [W][C][1] INPUT ACTION CODE [3]

COMPANY NAME _____

ADDRESS _____ ZIP _____

FORM SUBMITTED BY (Name, Title) _____

_____ PHONE _____

| | | Florida (Direct) | Countrywide (Net) |
|---|---|---|---|
| (1) | Premium Written | $_____ | $_____ |
| (2) | Premium Earned | $_____ | $_____ |
| (3) | Dividends Paid or Credited to Policyholders | $_____ | $_____ |
| (4) | Losses Paid | $_____ | $_____ |
| (5) | Allocated Loss Adjustment Expense Paid | $_____ | $_____ |
| (6) | Unallocated Loss Adjustment Expense Paid | $_____ | $_____ |
| (7) | Number of Claims Outstanding as of 12/31 | _____ | _____ |
| (8) | Losses Unpaid as of 12/31 | $_____ | $_____ |
| (9) | Allocated and Unallocated Loss Adjustment Expense Unpaid as of 12/31 | $_____ | $_____ |
| (10) | Control Totals (Sum of Items (1) through (9)) | _____ | _____ |

by Albert J. Millus * President
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We are witnessing history being made in the recent trends toward substituting market place competition for state regulation of rates for Workers' Compensation premium. The movement is really much broader in that its supporters advocate open competitive rates for all personal and commercial property and casualty insurance coverage, and the arguments advanced for and against it exemplify the historic differences in approach by certain elements in the industry to a problem that has gone full circle over the past century.

A Bit of History

As long ago as 1869, the United States Supreme Court in the case of Paul v. Virginia(1) held that insurance was not commerce under the commerce clause of the Constitution. As a result of that decision, states were left free to regulate insurance and if states did not do so, the insurance industry was free to set up its own mechanisms to control the business. Fire insurance was an important line of coverage and the competition for this business became very widespread. At the same time the agency system for procuring business was developing rapidly and before long insurance carriers began to devote more time and energy to building up a strong agency system than to direct competition for the fire insurance business. Soon rate wars began to threaten the solvency of some of the insurance companies. As a means of protecting their interests the companies began to "fix" rates by agreement among themselves. Many insurers refused to adhere to such practices and some states began to enact anti-trust laws. States realized that insurance required regulation and their laws began to recognize the need for rating bureaus where the insurers could collectively submit their loss experience and where an objective base could be found for fair rates. By the early 1940's most states had authorized rate bureaus and in effect the business of rate fixing was largely in the control of the insurance industry.

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(1) 8 Wall. 168, 19L.6Ed. 357.

although "regulated" by the Insurance Commissioners in the several states. The situation that brought about the McCarran-Ferguson Act - Public Law 15 - developed when one of the groups of fire rating organizations - the Southeastern Underwriters Association - promulgated rates for fire coverage and the United States brought suit against the Association and its members. The United States Supreme Court (1944)(2) held such activity subject to federal anti-trust laws. Congress thereafter passed Public Law 15, which, in substance, declared that historically states had the right to regulate insurance and that the federal law would be applied only if the states failed to do so. However, agreements to boycott, coerce or intimidate would continue to be subject to the federal law. This law gave the states the incentive to pass regulatory laws and most did so, using a model law proposed by the National Association of Insurance Commissioners (NAIC). Each state varied its laws to some extent from the model law to suit its own situations but most provided for rate organizations to collect loss data by classification and promulgate rates for the approval of the State Industrial Commissioner. Practically all state laws required that rates so calculated may not be excessive, inadequate or unfairly discriminatory. With the development of multiperil policies the historic gap between fire insurance companies and other personal lines began to narrow. Now there is hardly any distinction and as many of the independent, non-bureau insurance companies grew into national operations the tendency toward reliance on open market competition to regulate rates became more widespread. State laws were changed to make bureaus advisory only and various forms of file & use and other forms of non prior approval changes became prevalent. Thus we see a full circle from the position of the insurance industry demanding the right to fix rates by agreement to one where many are advocating complete open competition with the market place determining the rate. This latter position is most strongly advocated by the large, national

(2) 322 U.S. 533

direct writers, although the old line bureau companies are reluctantly joining the demand even though they may have some serious reservations about the ultimate effect on themselves and the public.

Workers' Compensation

While this trend to open competitive rates is directed at all property and casualty lines, large segments of the industry do not agree that it should apply to Workers' Compensation. The author claims no expertise in the area of rate making in property and casualty insurance generally and so will limit this article to the area of Workers' Compensation rate making, where he does claim knowledge and understanding of the subject.

NAIC - Report of the Advisory Committee on Competitive Rating

The National Association of Insurance Commissioners appointed a subcommittee to consider competitive rating as the primary means of regulating rates in the personal and commercial property and casualty markets. In August, 1979, the subcommittee appointed a widely based Advisory Committee to assist the subcommittee. This Advisory Committee submitted its Report at the 109th Annual Meeting of the NAIC held in June, 1980. The report is comprehensive, clear and reasonably concise. However, the divergence of opinions as expressed by particular members of the Advisory Committee shows that there is little basic agreement in what should be done or how it should be done. In the area of Workers' Compensation the report of the Advisory Committee made three recommendations:

1. "that workers' compensation be included in the competitive rating law and not be separately regulated in a law which requires mandatory rating organization membership and/or permits members or subscribers to depart from bureau rates only by a 'deviation';

2." workers' compensation insurance rates be subject to a prior filing pro-

cedure before they become effective, but not subject to specific prior approval; and

3." statistical data for workers' compensation insurance be collected on a uniform basis."(3)

The report alleges that workers' compensation does not now qualify for open competitive pricing and precisely because of the laws which now regulate rates in the several states, plus the requirement that insurers must belong to and adhere to bureau rates. The report further points out that workers' compensation is not currently regulated by a competitive rating law in any state;(4) that six states have exclusive State Funds, and that fifteen other states have special laws regulating workers' compensation exclusive of other more general laws regulating property and casualty rates. The other states subject workers' compensation to some form of prior approval or to a waiting period of some kind.

The report states "[t]he present system works well in terms of availability, affordability and the quality of services."(5)

While the Advisory Committee was composed of the heads of the largest nationwide insurance companies as well as representatives of agents, bureaus, consumers and academia, their varied special interests were such that several felt the need to file their own "minority" reports. They were not, of course, called that, but that is what they are. Several of them are worthy of noting both as an indication of the difficulty of obtaining agreement on this subject and as an example of the wide range of thought that leaders in the industry hold on this basic problem of regulation. Let us take a closer look at a few of them.

"Minority" Reports

John S. Trees, Group Vice President Personal Lines, represented Mr. Archie R. Boe, Chairman of the Board of Allstate Insurance Company, who was appointed as a Committee member. In its separate comments(6) Allstate pointed out:

(3) Report of the Advisory Committee on Competitive Rating (NAIC) page 44-45

(4) This statement is questionable in view of the rating laws of Illinois and California (discussed below).

(5) Id. page 43

(6) Id. page 124 et seq.

"While the Advisory Committee seems clearly to endorse the goal of enhanced competition in insurance markets - a goal we ardently share - it is our view that implementation of certain specific recommendations of the report could, in practical application, tend to frustrate rather than further that goal. It is for this reason that we felt it necessary to submit these separate views.

"Initially, we regret that the Committee chose to adopt a regulatory approach more restrictive even than that which has existed for more than 20 years in the State of California - a state frequently cited as a model for competitive improvements. In this connection, we note that we have also reviewed the views of the State Farm Insurance Companies, and, while we cannot endorse at this time any of the technical details of the State Farm proposal, we believe such is in concept more faithful to the goal of advancing competition than is the Advisory Committee report."

A group of Advisory Committee members filed a separate paper specifically directed to Workers' Compensation(7). The group consisted of:

Melvin B. Bradshaw, President, Liberty Mutual Insurance Company

Samuel Fortunato, President, Metropolitan Property and Liability Insurance Company

John W. Joanis, Chairman, Sentry Insurance, A Mutual Company

Robb B. Kelley, President, Employers Mutual Casualty Company

Paul S. Wise, President, Alliance of American Insurers

In their comments they say:(8) "The system of Administered Pricing for workers' compensation has a proven track record of success and service to the public.... The public policy considerations appropriate to workers' compensation insurance differ substantially from those applicable to other property/casualty lines, and warrant broader study and consideration....

"In order to maintain the integrity of the data base, the administered pricing system encourages the use of rating bureau services by insurers, subject in most states to statutory right of deviation. Without the volume of quality statistical

(7) Id. page 128 et seq.
(8) Id. page 129 et seq.

detail now required by rating bureaus and obtained from all insurers, sound actuarial analysis of benefit changes and the determination of creditable rate levels would not be possible. Without uniform input of statistical data to the bureaus, the data base would be diluted and eroded. As the quality of the data deteriorates, there will be a declining incentive for larger insurers with their own sophisticated data processing equipment to submit data. This, in turn, will accelerate the detriment to smaller insurance carriers, which are absolutely dependant on broadly based statistical support. Thus, we believe that in addition to the steps recommended by the committee, it is also necessary to preserve manual rules, rating plans and the classification system, in application; this will require some degree of adherence, now rejected in the committee report.

"Further, we take issue with the committee's decision to eliminate rate service organization adherence requirements. We do not think this is appropriate for workers' compensation. We believe a workers' compensation rate service organization should be able to require adherence to manual rules, classifications, and rating plans."

Perhaps the most incisive "minority" viewpoint was filed by State Farm Insurance Companies, represented on the Advisory Committee by Edward R. Rust, President, State Farm Mutual Automobile Insurance Company. State Farm's comments were thoughtful, extensive, of deep probative value and marked with an objectivity born of conviction in the merit of the viewpoint expressed. While the author does not necessarily agree with the concept that open competitive pricing is desirable for workers' compensation rate making, he recognizes a worthy adversary in State Farm's presentation of the case for market place rate making. State Farm places maximum reliance on competitive forces and presents convincing arguments for that viewpoint. State Farm went so far as to draft a model competitive rating law embodying their concepts of what such a law should contain. Their model

law excludes workers' compensation with the note: "Workers' Compensation insurance is excluded.... primarily because it may be regulated in a separate Article. It is possible that many of the provisions of this Article would be appropriately applied to Workers' Compensation insurance."(9) Since this article is primarily concerned with Workers' Compensation no further comment will be made on State Farm's presentation but the author earnestly recommends a thorough perusal of it by anyone interested in open competitive pricing as a general approach to property and casualty insurance rate regulation.

Several other Advisory Committee members filed papers expressing their views. The consumer advocates, Robert Sable, Executive Director, National Consumer Law Center, Inc., and Sandra L. Willett, Executive Vice President, National Consumers League, generally felt the report did not go far enough in favor of the consumer; Berry L. Griffin, Jr., President, Risk and Insurance Management Society, representing some 3300 corporate members, disagreed with the Advisory Committee's conclusions on Workers' Compensation and argues for even broader open competitive activity in all lines including Workers' Compensation' and Arthur C. Mertz, President, National Association of Independent Insurers also argued that the Advisory Committee's position on Workers' Compensation was too restrictive and that Workers' Compensation should be subject to the same rules as all other insurance lines.

Comments on Advisory Committee Report

As one can see from the above summary of the many viewpoints expressed in the report and in the comments by several Committee members, there is a wide divergence of opinion on the role for market pricing especially as it applies to Workers' Compensation. Historically the large independent carriers are in favor of free and open competition and the old line bureau members generally want to hold onto what they are accustomed to and feel comfortable with. It will not be easy for these two powerful and divergent groups to find a common ground on

(9) Id. Page 176.

which they can agree. The present trend in federal circles to repeal McCarran-Ferguson and substitute a mandatory open competitive law makes a resolution of these basic conflicts not only desirable but as a practical matter, almost imperative if the insurance industry is to present a united front on what to many appears to be a life and death matter. This necessity focuses on the solutions reached in at least two states - California and Illinois. Allstate referred to the California system in its comments on the Advisory Committee report, and State Farm mentioned the Illinois statute as a rebuttal to the Advisory Committee's position that there is no experience available in Workers' Compensation outside the rating bureau experience. What then can we learn from the experience in these two states.

California Workers' Compensation Law

Over 20 years ago California adopted what can be described as a minimum rate law for Workers' Compensation. Under that law, as amended to date, "[t]he Commissioner shall approve or issue, as adequate for all workers' compensation insurers, a classification of risks and premium rates relating to California workers' compensation insurance. He may also approve or issue a system of merit rating,"(10) which must be adhered to by all California workers' compensation insurance carriers, including the State Fund. Merit rating is restricted to California experience and may not be combined with the risks experience in any other state. Any expense provisions included in the classification of risks and premium rates approved by the Commissioner shall be uniform as to all insurers and insured affected thereby. "An insurer shall not issue, renew or continue in force any workers' compensation insurance.... at premium rates which are less than the rates approved or issued by the Commissioner"(11)

The law recognizes and approves rating organizations to collect data helpful in making adequate minimum rates for workers' compensation and employer's liability

(10) Workers' Compensation Law of the State of California, Sec. 11732
(11) Id. Sec. 11736.

coverage and to submit such rates to the Commissioner for issuance or approval. The law authorizes the existence and cooperation of qualified rating organizations and requires every insurer to belong to one such rating organization. Under the law, a [r]ating organization means any organization which has as its primary object or purpose, the collecting of rating information, the making of rates, rating plans and rating systems for workers' compensation insurance and employer's liability insurance incidental thereto and written in connection therewith and presenting them to the Commissioner for issuance or approval."(12)

Rating organizations are given authority to inspect risks to determine proper classification, to make test audits of employer's payrolls and generally to do all the things rating organizations have historically been permitted to do.

In view of the foregoing it is difficult to understand how Allstate would seem to be saying that the California system is closer to an open competitive pricing plan than that proposed by the Advisory Committee. In any event, the California plan has been working for over twenty years so it is at least a workable plan and appears to enjoy the reputation of being, as Allstate says: "a model for competitive improvements."(13)

Illinois Workers' Compensation Law

Illinois has an Article in its law covering Workers' Compensation and Employers' Liability Rates, separate from its rules and regulations applying to Property and Casualty Rates other than Workers' Compensation. A comprehensive policy statement as to Workers' Compensation rates is found in the law under the title - "Purpose of Article":(14)

"The purpose of this Article is to promote the public welfare by regulating workers' compensation and employer's liability insurance rates to the end that they shall not be excessive, inadequate or unfairly discriminatory, and to authorize and regulate co-operative action among companies in rate making and in other

(12) Id. Sec. 11750. 1b
(13) Advisory Committee Report (NAIC) page 124
(14) Illinois Workers' Compensation Law - Sec. 1065.1

matters within the scope of this Article. Nothing in this Article is intended (1) to prohibit or discourage reasonable competition, or (2) to prohibit, or encourage except to the extent necessary to accomplish the aforementioned purpose, uniformity in insurance rates, rating systems, rating plans or practices. This Article shall be liberally interpreted to carry into effect the provisions of this Section."

The law spells out the factors that shall be used in making rates and provides that:

"(1) Every company shall file with the Director every manual of classifications, every manual of rules and rates, every rating plan and every modification of any of the foregoing which it proposes to use."(15)

"(2) A company may satisfy its obligation to make such filings either by making an individual filing or by becoming a member of, or a subscriber to, a licensed rating organization which makes such filings, and by authorizing the Director to accept such filings on its behalf; provided, that nothing contained in this Article shall be construed as requiring any company to become a member of or a subscriber to any rating organization."(16)

"(6) Upon the written application of the insured, stating his reasons therefor, filed with and approved by the Director, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

"(7) No company shall make or issue a contract or policy except in accordance with filings which are in effect for said company as provided in this Article or in accordance with Subsection (6) of this Section."(17)

"Deviations. Every member of or subscriber to a rating organization shall adhere to the filings made on its behalf by such organization except that any such company may make written application to the Director for permission to file a

(15) Id. Sec. 1065.4
(16) Id. Sec. 1065.4
(17) Id. Sec. 1064.4

deviation from the class rates, schedules, rating plans or rules thereof."(18)

Thus the Illinois law breaks with the past at least by recognizing competition as a means of rate regulation and by its provision for filing by individual companies of their rates and by providing specifically that premium rates need not be uniform. This was a substantial variance from any other State law enacted at the time(19) and the reasons for the development of the law along these lines offers an interesting bit of history. For many years the concerted action on rates sanctioned by the approval of mandatory membership in a rating organization by the insurance companies bothered regulators and some members of the insurance industry as being tainted with anti-trust implications. Efforts to make rating organizations advisory only had not really removed the stigma. Further, under open competitive rate laws the insurance industry agrees that certain anti-competitive actions of rating bureaus, especially the right to make rates and file them with regulatory authorities for approval, could not be reconciled with the concept of free and open competition. The NAIC Advisory Committee recognized this conflict but apparently was unable to solve the dilemma. This brings us to the Illinois situation in 1971 and 1972. When the Illinois law that was in effect in 1970 expired, the insurance industry were operating without any rate regulation and were thereby open to anti-trust action under the Illinois equivalent of the Sherman Act. Fearful of the situation it faced the industry prevailed upon the Insurance Commissioner to issue regulations permitting concerted action by the industry. Before doing so, the discussions focused on what essential concerted action was essential and what other areas of concerted action, which had been permitted to authorized rating bureaus, were not essential. Thereupon the Commissioner issued regulations which were later reinforced by the statute passed in 1972 and the reissue of regulations under that statute.

(18) Id. Sec. 1065.7
(19) 1972

As a result of several years' experience under the Illinois "open competitive" rating system, those industry members who advocate this approach claim there is ample proof of benefits to the public without a need for concerted action by the industry regarding rate filing data. Others do not feel there is a sufficiently broad base from the experience of one state to claim success over a long period of time. Those not convinced by the Illinois situation point out that insurance companies have the experience of other large industrial states to use in formulating rates for Illinois and that regardless, the smaller insurance carriers could not operate successfully without the benefit of reliable statistical data that is only available under the present rating organization system of concerted action.

There is no apparent or obvious solution to this fundamental difference in approach and none is likely to be found unless and until some extraneous situation developes, as it did in Illinois, to force an agreement with which neither group would be entirely satisfied. Such an extraneous situation could well be the repeal of McCarran-Ferguson with a distinct possibility of a law requiring open competition. Because of all these uncertainties the efforts of the NAIC to reach some sort of accomodation among insurers is both understandable and praiseworthy. It is this author's private opinion that short of the happening of some compelling event, the liklihood of agreement among the industry giants is quite remote.

Typical of the relevancy of this topic in the minds of the insurance industry leaders, were the remarks of John A. Schoneman, President, Wausau Insurance Companies, at the 4th Annual National symposium on Workers' Compensation held in July 1980 at the University of Maine. He discussed the problem generally and made several points regarding the specific problems involving Workers' Compensation coverage which sum up the position of those who advocate a continuance of the present rating bureau system as far as Workers' Compensation is concerned. Mr. Schoneman pointed

out that as far as competition is concerned that the good and desirable large risks (over $100,000. annual premium) are very competitive, pricewise, and will continue to be so under any rate system.(20) However, this cannot be said for the smaller risks which comprise by far the larger number of risks (perhaps as much as 75% of all risks in number) but account together for only a small percentage of total premium, (perhaps only 10% of total premium). He pointed out further that there are many competitive factors built into the present rate structure such as premium discount, dividends, retrospective rating, loss limit and excess loss factors and others. It was also Mr. Schoneman's opinion that the basis for the continued success of the present system over such a long period of time was the sound statistical base used to project losses and expenses. This has resulted in a stability not found in other lines of insurance and this stability encourages new insurance companies to enter the market and thus makes coverage more accessable. Since workers' compensation is a government mandated social program with definite goals, great care must be exercised to make certain any changes made will not adversely affect those goals. Mr. Schoneman does not believe we can say that open competitive pricing will do as good a job as the tried and proven system we presently have. Again since we are dealing with long term loss payments involving human beings we dare not experiment with the rights of injured workers or their dependents without assurance that what we change will result in a better situation - legislators will demand assurances on this point as well as upon the cost effectiveness of any proposed changes. Mr. Schoneman repeats the argument so often made that any dilution of the data base will adversely affect smaller carriers and once lost the reliability of the data base cannot be reestablished. The discussion by Mr. Schoneman was equally as effective in favor of the present system of administered rate making or pricing as was State Farm's "minority" views as expressed in the Advisory Committee (NAIC) Report, in favor of open competitive pricing.

(20) Risks subject to the Longshoremen's and Harbor Workers' Compensation Act are excluded. Generally such risks are not "competitive" except as to how much the charge will be over and above standard rates through various insurance plans.

New York and New Jersey

Amid all the discussion that is going on throughout the country on the question of open competitive rating for Workers' Compensation, it is interesting to note that New York and New Jersey, which are both heavy industrial and manufacturing States, have thus far elected to stay with regulated rating bureau rates for this important line of insurance.

A bill was introduced in the New York legislature (1980 session) (S.4240-A.6210) to amend Section 184 of the Insurance Law which would eliminate the need for approval of the Superintendant of Insurance prior to making effective rates filed by a rating organization or an insurer and which provided that insurers could establish rating schedules which would allow for a reduction of not to exceed fifty percent or a surcharge not to exceed one hundred percent of the rates recommended by the workers' compensation rating board. While neither bill passed this year, their introduction indicates the trend toward unregulated rates that is gaining ground all over the country. However, the idea of a discount and differential limit, while still using rating bureau rates, would be novel were it not for the fact that it is the way the New York State Insurance Fund has operated for over sixty years.

In New York the law established the State Insurance Fund as a competitive carrier to which employers could turn to insure their liability under the law. Since the private insurance industry demanded and retained their right to refuse to insure any risk it did not want, the legislation provided for a State Fund rather than an assigned risk pool or some such other technique. So that the State Fund would not need to be subsidized, the law permitted the fund to establish its own rates which were not under the supervision of the Superintendant of Insurance. It is interesting to note that during the first few years of its existence the State Insurance Fund (New York) did establish its own rates which were different

from those used by the private insurance companies. However, the Fund's representatives soon discovered that the employers were too confused by the different rates being quoted to be able to decide where their coverage could be had at the lowest cost. The Fund then joined the rating board and used the identical rates the private carriers were using but established a fixed advance discount from these rates which averaged 20% and were thus able to quote on identical rates with a definite discount over the private industry. The 20% was arrived at by taking the agents' commission (at that time 15%) and adding the profit allowance built into the rate - 2½% (since by law the Fund had to operate without profit) and 2½% less than the expense allowance in the rates, since the fund was operating in one State with one line of insurance. On the other side of the coin, the Fund established a range of "differentials" or higher rates which it applied to risks with bad experience, generally on a retrospective basis, so that by close attention to accident prevention thereby establishing an average or better experience, the specific risk could "earn" back the extra charge the differential rate created. This system of advance discounts and differentials has been maintained for the sixty odd years the Fund has operated in New York State. In retrospect you might say that the New York State Fund has operated on an open competitive basis for all these years.

The experience of the author as Executive Director of The State Insurance Fund (New York) for over six years (1972-1978) convinces him that regardless of what form regulation of rates takes, as far as the large risks are concerned (21) whether in manufacturing, retailing, construction or whatever, the competition to write these risks is always intense, innovative/and often times self-destructive in its intensity. The State Fund over the years was involved in this competition and witnessed first hand the lengths to which one or more of the large carriers would go to cover some of these risks. Typical examples were the several water tunnel

e.g. paid loss retros

(21) Risks subject to the Longshoremen's and Harbor Workers' Act excepted

jobs carrying water from upstate New York to New York City, the Brooklyn-Battery tunnel, the World Trade Center buildings, the subway tunnel jobs to name but a few. Without a doubt this type of work could not be more competitive no matter what sort of law the carriers operate under.

But of course these jobs represent only a drop in the bucket as far as the number of businesses which need coverage is concerned. At the other end of the scale there are literally thousands of risks whose annual premium is less than $750. These risks designated as small risks are the type the large carriers do not want. The State Fund has over 70,000 such small risks and because it has such a volume of them it was able to computerize this segment of its business so as to minimize the expense factor in handling them and control the loss factor as far as that was possible. While the Fund wrote most of these risks at Board rates, or the rates the private industry used, as their experience justified it they were extended the discount offered to larger risks.

These examples are mentioned to demonstrate that there is a great deal more competition in fact even under regulated bureau rates, or administrated pricing, as some proponents of the present system describe it, than a casual reading of the rules would indicate. True there is concerted action among carriers in membership in and adherence to rating bureau calculated rates, but offsetting this, to a degree not generally admitted by regulators, is the review, delay and often the arbitrary reduction in the request for rate increases that the Superintendants' office makes in the proposals of the rating bureaus.

New Jersey does not have a State Fund but it does have a really independant rate bureau.

Most states use the National Council on Compensation Insurance to collect loss and expense data and file rates for approval by the State Insurance Department. Not so in New Jersey. Its rating bureau under the direction of a Deputy Insurance

Commissioner collects its own data and compiles its own statistics using them to establish rates for use within the State. Among all the discussion about rating bureaus and the need to have reliable statistics little reference is ever made to the detailed and complicated system followed by the bureaus, and which individual companies would have to follow for each company to establish rates independently of rating bureaus. It is not the purpose of this article to get into the details of how workers' compensation rates are established.(22) Suffice it to say it is a technical and special business requiring not only acturial expertise but also sophisticated equipment, a knowledge of underwriting principles and the ability to make judgmental decisions - skills not possessed by the average man on the street, and surely not generally available to small insurance carriers. Businesses in both New York and New Jersey are fortunate to have workers' compensation available from a number of large and small insurance carriers with flexible plans of insurance, suited to a variety of situations and conditions, whose presence is encouraged by an alert, forward looking administration of the State Workers' Compensation laws in these two States. The administration of the law is as good or better than that found in many States and the regulation of rates has produced a stable, steady, strong and growing insurance industry that is fully capable of discharging its responsibilities to its policyholders, their injured employees and their dependents.

Conclusions

The report of the NAIC Advisory Committee has been filed and the Subcommittee expects to make its recommendations on the draft model open competitive rating bill before the end of 1980. The industry is faced with a decision that will give direction to the development of workers' compensation coverage over the next several

(22) The author published an article "How Workers' Compensation Rates are Formulated," which appeared in Risk Management, January 1979, and which outlines the various elements involved in this very specialized work.

years. There is a substantial segment of the insurance industry as well as others outside the industry that want a change toward more free and open competition. This uneasiness with the present system is evident even in a monopolistic State Fund State like Ohio. There a Committee has been formed to amend the Ohio law to permit the private insurance companies to compete with the State Fund and also to permit self-insurance. This will require an amendment to the Constitution of Ohio but the Committee feels it has a good chance of success. Since New York State started over 60 years ago with justwhat the Ohio Committee now seeks, their approach seems mild in the light of other demands for open competition.

Whichever way the NAIC's decision goes, whether to take the moderate way included in the Advisory Committee's model law, or go all the way to open, unregulated rates for workers' compensation as State Farm and Illinois Insurance Director Philip R. O'Connor, Chairman of the Subcommittee charged with drafting the model law, prefer, it is the author's opinion that regardless of the type of rating laws that are enacted the good, large and desirable risks will be intensely competed for and the small, less desirable risks will be avoided as far as possible. The medium size risk will be sought after or avoided depending on how near average or better its experience is. In the last analysis the insurer's underwriting judgment, whether it can make a profit on the risk or not, will determine how competitive its bid will be. One thing is fairly certain - the lack of reliable loss statistics will drive business to the large carriers and to the State Fund in New York and will have a tendency to push rates for the undesirable risk with less than average experience to a point that may well adversely affect such a risk's ability to stay in business. This same effect will probably result in other jurisdictions since the same competitive factors exist in all states. Such a result would be a repetition of the experience which followed the general adoption of the multiperil policy. The better business was packaged and the whole bundle was priced as competitively as possible. But the poorer business continued in single

policy coverage and rates increased because the experience of the better business multiperil policies did not get into the data on which the rates for the single line policies were based. Without reliable, complete and extensive data to produce quality statistics, a similar deterioration can be expected in the area of Workers' Compensation rates with a similar result to the less than average and poor risks, especially smaller risks.

For certain, it will take many years to see the full effect of any major change in regulation of rates - just as it will probably take many years for any kind of a model law to be acted upon by a majority of the States. The proposals for changes in rating techniques has started something that will be around for a long time - for the simple but unassailable reason that the topic has no single or correct answer.

Edited Version approved in 11/80 Best's Review

# WORKING TO RESTORE INDEPENDENCE

## Preamble

While insurance losses and benefits are usually stated in monetary terms, the full consequences of human disability cannot be measured by money alone. Earnings lost due to accident or sickness can be replaced and medical expenses can be reimbursed, but there is no meaningful way to financially translate the value of an arm or leg, or the personal dignity of being able to contribute to society as a useful member rather than merely existing disabled and dependent.

If insurance is to protect against these human losses, it must do more than provide financial compensation alone. It must also strive to restore such losses. Insurance should provide the means for disabled workers to return to gainful employment whenever possible, and to regain as much functional independence as they can, even if they cannot return to work. Compensation cannot accomplish these goals without rehabilitation.

The members of the Insurance Rehabilitation Study Group, recognizing this basic purpose of insurance, offer the following statement of principles and model legislative language to assist in drafting workers compensation, no-fault automobile, or other insurance laws, to expedite the rehabilitation process.

## Statement of Principles

1. The primary purpose of insurance for accidents or sickness, whether purchased voluntarily or required by law, is to provide the financial means to restore disabled people to their maximum functional capacity. Where society collectively mandates this coverage such as under workers compensation or no-fault automobile laws, insurers and self-insured employers not only have a legal obligation to pay contractual benefits equitably, but also an obligation to society to administer those benefits to most effectively and economically achieve the basic rehabilitation purpose for which these laws were intended.

2. Vocational rehabilitation services are just as important to the total restoration of some disabled persons as medical services, and should be provided for when they are needed. Benefits covering both physical and vocational rehabilitation services should be sufficient in duration, scope, and amount to complete necessary rehabilitation programs.

3. Indemnity for loss of earnings should be structured to support rather than discourage rehabilitation and return to gainful employment. Loss of income benefits paid during periods of vocational retraining should be geared to earnings, so that total income from both sources during such retraining does not exceed the income earned prior to the disability. Income replacement benefits from a number of collateral sources such as workers compensation, no-fault automobile benefits, social security and private disability coverage, which may combine to exceed pre-disability earnings can create a serious motivational barrier to re-employment. Rules should be promulgated to integrate such benefits in order to avoid over-compensation which deters rehabilitation and wastes tax and benefit dollars.

4. Vocational rehabilitation plans and objectives should be consistent with both the reasonable needs and potential of disabled individuals, and with their prior occupational status. Insurance or compensation should not be expected to finance unnecessary, ill-advised, or overly ambitious retraining programs, nor should disabled claimants be required to participate in inappropriate programs as a condition for continuing benefits.

   Insurers or employers should be able to use qualified private services and agencies to plan and implement individual rehabilitation programs as well as those tax supported rehabilitation services for which the disabled person qualifies.

   Rehabilitation programs which are agreed upon by both the claimant and insurer (or self-insured employer) should be allowed to proceed without delay. Disagreements on rehabilitation programs between these parties should be adjudicated by appropriate bodies such as the state workers compensation board or insurance department and should not be empowered to any other state agency which does not otherwise serve a judicial or insurance regulatory function.

5. Procedures should be developed for the state to monitor performance by insurers and self-insured employers in promptly identifying and acting upon the need for rehabilitation services as part of the claim function. These monitoring procedures should be direct and simple enough to accomplish their purpose without adding any more than necessary to claim administration costs.

6. Licensing or certification programs for rehabilitation counselors or similar specialists, based on reasonable standards of training and competency, can help to protect the public. Such programs should properly apply however to professionals offering services to the public for remuneration. Licensing programs should not restrict insurance company employees or consultants from managing or coordinating the provision of rehabilitation services to claimants and policyholders. Disabled individuals sometimes require services from a broad spectrum of different professional disciplines. Coordinating these services effectively within an insurance program requires not only an understanding of rehabilitation techniques, but also an expert knowledge of insurance provisions and claim procedures which frequently is best gained through practical insurance experience.

vitally important that insurers be allowed to provide appropriate services without going to private or public sector in all cases).

# MODEL REHABILITATION PROVISIONS

## WORKERS' COMPENSATION

### 1. Objective

A primary purpose of workers' compensation is to restore the injured worker to gainful employment or where this goal is impractical, provide for the injured worker to live as independently as possible.

To guarantee that the injured worker will be afforded the means to achieve these goals, there should be established within the workers' compensation system a rehabilitation unit, with a rehabilitation director, who shall have authority to monitor rehabilitation programs, resolve rehabilitation disputes and order rehabilitation services when indicated.

### 2. Definitions

(A) Medical Rehabilitation

Prompt and appropriate medical treatment required to relieve the effects of injury including medical, surgical, nursing, hospitalization, prosthetics and physical rehabilitation services.

(B) Vocational Rehabilitation

Those vocational services, including training which will enable the injured worker to perform in a gainful occupation as nearly compatible to the previous occupation as possible. Training in non-related work should occur only where there appears to be no other physical/medical alternative.

(C) Eligible Vocational Rehabilitation Candidate

An injured worker who: (1) because of the effects of injury or disease, whether or not combined with the effects of prior injury or disability is permanently precluded or is likely to be precluded from engaging in either his/her usual and customary occupation or the position in which he/she was engaged at the time of injury, and; (2) can be reasonably expected to benefit from a vocational rehabilitation program.

(D) Vocational Rehabilitation Plan

A vocational plan which has been voluntarily offered, accepted and approved by the rehabilitation unit.

(E) Gainful Employment

Return to his/her former occupation and/or alternatively, employment which is reasonably attainable and which offers an opportunity to restore the injured worker to self support consistent with the injured workers' qualifications.

add - "as soon as practicable".

3. Responsibilities

(A) Self Insured/Insuror

1. To promptly recognize the need for vocational assistance and initiate necessary action to restore the injured worker to gainful employment and/or to a position of independent living.

2. Vocational rehabilitation training or services shall be provided for a period of no more than 6 months, except by agreement of the parties; or, in unusual cases, when by order of the director of rehabilitation, an extension for an additional reasonable period may be given.

3. Where vocational rehabilitation requires residence at or near a facility or institution, the reasonable cost of board, lodging or travel shall be paid for by the self insured/insuror.

4. Where vocational rehabilitation requires purchase of books, supplies, tools, uniforms or other equipment necessary to complete training, these costs shall be paid in addition to the basic cost of the rehabilitation program by the self insured/insuror.

5. Provide continuing disability benefits during the period of the vocational rehabilitation program.

(B) Eligible Vocational Rehabilitation Candidate

1. Where vocational services are required, the injured worker will cooperate in the development of a suitable vocational plan.

2. When medical opinion indicates recovery will not be impeded by participation, prompt and responsive participation in the agreed plan will be the responsibility of the injured worker.

4. Organization

(A) Rehabilitation Unit

Establish within the workers' compensation system, a rehabilitation unit, responsible to the agency director for administration of workers' compensation.

(B) Authority

The rehabilitation unit, under the direction of a rehabilitation director and necessary supportive staff, will have responsibility to:

1. Adopt rules and regulations consistent with authority and provisions of the workers' compensation act, including administrative guidelines, to expedite and facilitate the identification, notification and referral of industrially injured workers to rehabilitation services.

2. Review and approve rehabilitation plans.

3. Monitor prompt implementation and progress of vocational plans.

4. Resolve vocational training plan disputes.

(C) Rehabilitation Director Authority

The rehabilitation director will have administrative authority for the rehabilitation unit as follows:

1. Selection of a qualified staff.

2. Establish within the rehabilitation unit an organizational alignment which will be responsive to delegated areas of responsibility and accountability (refer to authority).

3. Monitor self insured/insuror performance and provide appropriate direction as indicated.

4. Ongoing review and evaluation of rehabilitation programs, both physical and vocational.

5. Identification and approval of qualified facilities, institutions and physicians capable of rendering competent rehabilitation services to the injured worker.

not necessary

6. Ensure if vocational services are not voluntarily offered and accepted, the director on his/her motion, or upon application of the injured worker or self insured/insuror, after affording the parties an opportunity to be heard, may refer the injured worker to a qualified physician/vocational counselor or facility for evaluation of the practicability of, need for and kind of service, treatment or training necessary and appropriate to render the injured worker fit for gainful employment and/or independent living. Upon receipt of the report, and after affording the parties an opportunity to be heard, may order that the services and treatment recommended or other rehabilitation treatment he/she deems necessary, be provided at the expense of the self insured/insuror.

7. Reviewing on request any existing or suggested rehabilitation plan to determine its adequacy or need.

8. Reviewing on request any existing or suggested rehabilitation plan to determine its adequacy or need.

5. Operating Procedures

(A) Initiation of Rehabilitation

1. Responsibility for initiation of a rehabilitation plan shall be that of the self insured/insuror utilizing professional resources in those situations requiring testing, evaluation and/or other areas where professional vocational skills might be required. The complete plan including medical reports must be submitted to the rehabilitation unit for approval.

2. Nothing in this section shall preclude development of a rehabilitation plan by a qualified professional person designated by the injured worker. However, notification of such interest must be made to the self insured/insuror and rehabilitation unit. The plan must be submitted to the rehabilitation unit in the prescribed format.

delete it should be a competent person

(B) Reporting Requirements

The employer shall report the injured workers' disability status to the rehabilitation unit in writing:

1. Immediately upon knowledge that the injured worker is unlikely to be able to return to either his/her usual and customary occupation, or his/her occupation at the time of injury, on a permanent basis.

2. Immediately following 120 days of temporary total disability for injuries not previously reported. Such a report need not be filed if a rehabilitation plan has been previously submitted to the rehabilitation unit.

3. Upon termination of a rehabilitation program.

(C) Submission, Acceptance or Rejection of the Plan

1. The self insured/insuror, upon acceptance of the rehabilitation plan by the injured worker, shall prepare a written description of the plan for submission to the rehabilitation unit and shall send a copy thereof to the injured worker. The description shall include:

(a) The date, nature, extent of injury, age, occupation and average weekly earnings of the injured worker at the time of injury.

(b) The suitable gainful employment objective of the rehabilitation plan and estimate of earnings expected upon successful completion.

(c) The nature, extent and duration of services to be provided during the period of rehabilitation.

(d) The amount of temporary disability indemnity payments and additional living expenses, if any, and the time and manner such payments will be made to the injured worker during rehabilitation.

(e) The injured worker's written acceptance of the plan, and any comments he/she wishes to add.

2. In submitting the plan to the rehabilitation unit, the self insured/insuror shall include copies of all medical, psychological, and vocational evaluation reports related to the case under consideration.

3. Where the proposed plan indicates areas of disagreement between the self insured/insuror and injured worker, the rehabilitation unit will attempt to resolve the differences, and upon obtaining agreement order the plan approved.

4. Upon receipt of a proposed plan acceptable to both parties, the rehabilitation unit, after review will promptly order the plan be: (1) Approved; (2) disapproved, or: (3) modified.

mandated appeal from rehab unit within 30 days as in Calif.

If the plan is either modified or disapproved, the rehabilitation unit must submit a written report to the self insured/insuror and injured worker explaining the reasons for such and provide an opportunity for parties to request further proceedings or to present additional information.

5. Implementation of the plan shall begin as soon as the injured worker is capable of participating in the program and medical opinion indicates that the injured worker's recovery will not be impeded by participation in the program. In no event shall implementation take place later than the termination of temporary total disability. (The program shall be commenced upon rehabilitation unit approval or the date specified in the plan whichever occurs last.)

(D) Rehabilitation Unit Procedure first sec Calif rules

1. All matters regarding rehabilitation plans and programs shall be initially submitted to the rehabilitation unit except those arising in cases before a *workers' compensation judge where injury is in issue, or where the question of need for rehabilitation first arises during the course of a proceeding on other issues.

2. The injured worker shall be entitled to continuing temporary disability benefits during the period of his/her rehabilitation program.

3. Where the question of need for rehabilitation first arises in a litigated proceeding before a *workers' compensation judge, this question shall be referred to the rehabilitation unit for its recommendations. In resolving disputes, the rehabilitation unit shall utilize conciliation and mediation insofar as possible and may order necessary and reasonable medical examinations as well as vocational evaluation at the expense of the self insured/insuror.

4. Where a rehabilitation plan is not offered by the self insured/insuror, or where an self insured/insuror offered plan is not accepted by the injured worker, the rehabilitation unit, either on its own motion or upon the request of either the self insured/insuror or the injured worker, shall make a determination of the practicability, need for, and kind of services necessary to restore the injured worker to suitable gainful employment.

5. After allowing the parties opportunity to present supporting information, a written determination shall be promptly prepared by the rehabilitation unit and served on the parties.

6. Unreasonable refusal to accept or complete vocational rehabilitation pursuant to an order of the rehabilitation director shall result in loss of temporary disability benefits for each week of such refusal.

7. An injured worker's right to vocational rehabilitation shall not be converted into cash or other benefits.

8. The determination of the extent of the injured worker's permanent disability shall be deferred until after termination of the vocational rehabilitation program.

9. No petition for permanent disability filed shall be granted while the injured worker is pursuing a rehabilitation plan under this code.

Appeals

(A) When the parties are unable to agree upon a plan, both self insured/insuror and injured worker shall fully utilize the conciliation and mediation services of the rehabilitation unit prior to initiation of any proceedings before a workers' compensation judge.

(B) An self insured/insuror or injured worker who objects to a final determination of the rehabilitation unit may initiate proceedings before a workers' compensation judge on all questions regarding rehabilitation.

(C) Where the rehabilitation unit is unable to achieve a rehabilitation plan through mediation and conciliation, it may initiate proceedings before a workers' compensation judge.

7. Modification, Suspension or Termination of Rehabilitation Plans

(A) Matters regarding modification, suspension or termination of a rehabilitation plan, whether approved by the rehabilitation unit or ordered by a workers' compensation judge shall be reviewed by the rehabilitation unit upon its own motion or the request of either the self insured/insuror or injured worker.

(B) The rehabilitation unit may issue an order modifying, suspending or terminating the rehabilitation plan if it finds that:

1. Satisfactory progress is not being made in the approved plan.

2. The plan is not likely to prepare the injured worker for suitable gainful employment due to unexpected contingencies.

3. The employee refuses to complete a rehabilitation plan approved by the rehabilitation unit.

(C) Where the rehabilitation unit has ordered modification, suspension or termination of a rehabilitation plan which the parties originally agreed upon, the injured worker shall have (10) days from service of the order to indicate his/her acceptance. If the injured worker accepts the order of the rehabilitation unit, the self insured/insuror shall have (10) days from receipt of written notice thereof in which to notify the rehabilitation unit in writing of its acceptance or rejection. Should the self insured/insuror reject the order, the rehabilitation unit may initiate a proceeding before a workers' compensation judge.

(D) Where the injured worker objects to the rehabilitation unit's modification, suspension or termination of a rehabilitation plan, he/she may initiate a proceeding before a workers' compensation judge.

(E) Where the rehabilitation unit recommends modification, suspension or termination of a rehabilitation plan ordered by a workers' compensation judge, it shall submit its recommendation to the workers' compensation judge who issued the original order. If such workers' compensation judge is not available, the recommendations shall be submitted to the appropriate person in charge of the workers' compensation legal process.

Note: *That person with judicial responsibility under the workers' compensation system, e.g., workers' compensation judge, hearing officer, referee.

# RESTATEMENT OF THE CONSIDERATION OF INVESTMENT INCOME IN WORKERS' COMPENSATION INSURANCE RATEMAKING

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## I. Introduction:

The purpose of this restatement of the treatment of investment income on reserves in workers' compensation insurance ratemaking is to appraise the expected total return on the workers' compensation insurance transaction, inclusive of investment income, and to describe the consideration given to investment income in the ratemaking process.

With rising claim costs and, therefore, rising rates marking its recent history, workers' compensation insurance has been the object of close examination in the search for relief from rising insurance costs.

The expense provision in workers' compensation insurance includes a percentage allowance to the underwriters for profit. Since profit would result only to the extent that unforeseen contingencies do not arise, this percentage is called a "profit and contingency" allowance.

The workers' compensation pricing program is legally bound to provide for the full and immediate funding of employee benefits even though claims may be paid over substantial periods of time. This means that after receipt of premium and prior to final disposition of incurred liabilties, insurance carriers have an interest earning opportunity to the extent such liabilities do not exceed levels contemplated by premiums received. For example, to the extent premium is paid in advance and incurred expenses are not immediately paid, there is a comparable interest earning opportunity related to the unearned premium reserve.

The underwriting profit and contingency allowance together with the interest earning opportunity constitute the carriers' expected return on the premiums that policyholders are asked to pay.[1] For purposes of this restatement, real estate earnings and other "other income" items are included in the term "investment income". Also, the analysis applies to aggregate results and expectations, not those for individual policies.

The restatement consists of five sections in addition to this Introduction. Section II presents the principles for measuring investment income in a ratemaking context. Section III analyzes the theoretical functions and interaction of investment income and the profit and contingency allowance in light of actual data. Section IV provides further background on investment income both as to insurance and other industries. Section V applies the results of the preceding sections to ratemaking. Section VI summarizes the conclusions of the other sections. Finally, there are appendices consisting of various statistical exhibits referenced in the restatement.

## II. Principles of Investment Income Measurement:

The fundamental concern in ratemaking is that rates be neither excessive, inadequate, nor unfairly discriminatory. These standards must be applied on a prospective basis in reviewing rate filings and, therefore, where investment income is considered, the present value of the investment income that insurers can anticipate

[1] The insurers' total return, as stated in Section IV-A would, of course, include investment income on their own net worth

from expected loss reserves and unearned premium reserves is the relevant consideration. Accordingly, the National Council on Compensation Insurance approaches the estimation of expected investment income as a three-part process — (1) determination of an appropriate investment yield, (2) application of this investment yield to unearned premium reserves in order to estimate investment income attributable to unearned premium reserves, and (3) application of the investment yield to the expected loss reserves in order to estimate investment income attributable to loss reserves.

II-A. **Measuring the Investment Yield:** Five-year average investment yields have been used to estimate the amount of investment income produced. Such a base is a reasonable reflection of the need for stability in considering that payment amounts are subject to substantial fluctuation and extend over long and fluctuating durations (claims on the average are consistently underestimated as to amount by insurance companies and are payable over longer durations than estimated). The policy contract affords the insurer only one year of premium to cover lifetime obligations; the income and return of principal from the investment part of the premium can change radically depending on events beyond the insurer's control and there is little or no chance to correct a bad estimate of the yield, or to correct an investment that goes sour either as to maturity, rate or principal amount. Thus, the use of a five-year[2] average investment return provides some stability which reflects the long, varying, and not entirely predictable duration of claims and reduces the effects of unpredictable fluctuations in interest rates.

Computation of the applicable five year investment rates is based upon stock company totals reported in Best's Aggregates and Averages for Property-Casualty Insurers for the years 1972-1976. The investment income less investment expense is compared with assets available for investment and a rate determined. This is shown in Appendix A. The rate therein determined is applied to unearned premium reserve data and loss reserves as described in sections II-B and II-C.

II-B. **Investment Income on Unearned Premium Reserves:** Investment income on unearned premium reserves for the latest two calendar years is estimated using data obtained from Best's Aggregate and Averages. These estimates reflect the average unearned premium reserves subject to investment (adjustments being made for such items as delayed remission of premiums), the five-year average investment rate and Federal Income Tax.

Appendix B provides the calculations of investment income as a percentage of standard earned premium for calendar years 1975 and 1976. These values are respectively .68% and .69% before Federal Income Tax and .59% for both years after Federal Tax.

II-C. **Investment Income on Loss Reserves:** Investment income on loss reserves is

[2] Some studies recognize the difficulty inherent in predicting the exact timing of claim payments and/or the level of interest rates by using averages of up to ten years or more (including or excluding unrealized capital gains) and variations thereof for some aspects of investment income. See, for example, "Statement of Dr. Irving H. Plotkin, Sr. Economist, Director of Regulation and Economics, A.D. Little, Inc., on Investment Income and Ratemaking for Property Insurance before the Texas State Board of Insurance, Austin, Texas, Feb. 16, 1977." Workshop 1

calculated based on the average investment rate and the average duration during which the carrier has an interest earning opportunity. For workers' compensation insurance, claims information is compiled under the Unit Statistical Plan according to the following categories:

Death
Permanent Total
Major Permanent Partial
Minor Permanent Partial
Temporary Total
Non-compensable and Contract Medical

The latest available two policy years of data were used to determine the relative dollars incurred in each category, how much was paid as a lump sum, how much was paid periodically and how long such payments are paid on the average for each type of case. The five year average investment yield as shown in Appendix A was used to calculate the amount of investment income generated by the reserves prior to payment. This investment income is expressed as a percent of the standard earned premium required by the claim amounts.

The details of these calculations, which result in an estimate of 3.94% of standard earned premium[1] for the latest available two policy years before Federal Taxes and 3.37% after Federal Taxes, are shown in Appendix C.

II-D. **Comparison to Values Reported in the Insurance Expense Exhibit:** It should be noted that, for the past decade, actual aggregates and averages of losses and expenses have usually exceeded the premium provisions for expected losses and expenses and have absorbed some or all of the contingency elements of premium and investment income. The real world has required that funds provided through investment income be available as a means for mitigating the actual riskiness of insurance operations. For example, reported investment income for the year 1976 is extraordinarily large as is the level of adverse loss experience. The loss reserves in excess of the expected losses (less payments) are actually being reserved out of policyholders' surplus; nevertheless, NAIC instructions recommend that investment income be distributed to line of insurance in proportion to reserves.[2] Thus, not only are insurers required to reduce their surplus in order to fund claims in excess of expected, but the investment income being earned is being attributed to policyholder supplied funds despite the fact that the investment income was generated by the insurer's surplus which had to be transferred to loss reserves because of inadequate premiums paid by policyholders. This is something that must be adjusted for in comparing investment income as quantified in this restatement with that reported in the Insurance Expense Exhibits of the companies. There are other such adjustments (e.g. five year

[1] or approximately 4.38% of net earned premium based upon a 10% average premium discount.

[2] It should be noted that for calendar years prior to 1975, the instructions to the Insurance Expense Exhibit require that " . . . a full description of the method used to allocate investment income by line of business . . . (be) submitted to the supervisory official of . . . (the) jurisdiction." For calendar year 1975 and 1976 these instructions require allocation of investment income by line based upon total reserves (unearned premium and loss reserves) while providing that modifications to this procedure are allowed subject to explanation.

average rate of return; standard and net premiums; present value; Federal Income Tax).

Because of differences between policy years, calendar years, development of claims, NAIC requirements and recommendations in reporting calendar year investment income, etc., comparisons of investment income using Unit Statistical Plan data with those in the Insurance Expense Exhibit will show some differences.

NAIC rules for allocating investment income to line of insurance are predicated on the apparently logical notion that such income should be distributed in proportion to reserves. While this may be satisfactory when rate levels are adequate, to the extent that the source of reserves has been net worth (i.e. premiums have been inadequate to cover losses and expenses), it would be erroneous to attribute the investment income to policyholder supplied funds. The extent of "overestimating" such investment income for these companies during these years may be crudely approximated by comparing expected losses (approximated at 60% of standard earned premium) with actual losses and applying the resulting ratio to reported investment income. The adjustment ratios are shown below:

**CALCULATION OF RATIOS TO ADJUST REPORTED INVESTMENT INCOME**
**(000 Omitted)**

| (1) Year | (2) Standard Earned Premium | (3) 60% of Standard Earned Premium | (4) Total Incurred Losses | (5) Ratio (3) ÷ (4) |
|---|---|---|---|---|
| 1972 | 2,110,914 | 1,266,548 | 1,398,716 | .91 |
| 1973 | 2,498,112 | 1,498,867 | 1,632,695 | .92 |
| 1974 | 2,893,812 | 1,736,287 | 1,956,503 | .89 |
| 1975 | 3,121,432 | 1,872,859 | 2,171,644 | .86 |
| 1976 | 3,587,603 | 2,152,562 | 2,655,369 | .81 |
| 1972-76 | 14,211,873 | 8,527,123 | 9,814,927 | .87 |

Investment income reported by these insurers for this line of business during these years and the correction to adjust for overreporting is as follows (000 omitted):

**ESTIMATED INVESTMENT INCOME FROM PREMIUMS**

| (1) Year | (2) Reported Investment Income | (3) Ratio to Adjust Reported Amount | (4) Estimated Investment Income From Premiums (2)x(3) |
|---|---|---|---|
| 1972 | 95,569 | .91 | 86,968 |
| 1973 | 117,709 | .92 | 108,292 |
| 1974 | 155,123 | .89 | 138,059 |
| 1975 | 215,494 | .86 | 185,325 |
| 1976 | 255,748 | .81 | 207,156 |
| 1972-1976 | 839,643 | xx | 725,800 |

Since the investment income was earned throughout the year, conservatively we may assume that this provided an interest earning period of approximately .5 years which at 5.25% interest would bring the present value of the 725,800 to 707,467 which is 4.98% of standard earned premium of $14,211,873,[5] before Federal Income Tax or 4.26% (4.98% x .856) after Federal Income Tax.

II-E. **Rates of Taxation and Return After Tax:** As stated earlier, the income from investment of unearned premium reserves and loss reserves should be combined with the anticipated underwriting return to determine the reasonableness of the overall return from both operations. Appendices B and C show our estimate of the amount of investment income based on the reserves during the most recent available periods. Note that the total yield from both reserves for the latest available periods (Before Federal Income Taxes) is 4.63% (3.94% + .69%). This, combined with the anticipated 2.5% return from underwriting, produces an anticipated total return from both underwriting and investments of policyholder supplied funds (before Federal Income Taxes) of 7.13% (4.63% + 2.5%), or an estimated total net return (after Federal Income Taxes) of 5.26% (3.96% + 1.3%).

## III. Theory and Interaction of Investment Income and the Profit and Contingency Factor:

III-A. **Background:** Income from a profit and contingency factor, together with the use of premium prior to payout for expenses and losses has been the basis of the workers' compensation insurance industry's pricing structure for a great many years.

The current provision for underwriting profit and contingency in the workers' compensation rate is 2.5% of premiums. This has been the allowance for many years during which time interest income from unearned premium and loss reserves has varied with the cost of money.[6] It has generally been considered a minimal allowance even in periods when workers' compensation underwriting results were more predictable than today's conditions permit.

The necessity for an underwriting profit and contingency allowance rests on sound grounds. First, since rates are set at levels calculated to meet expected claim costs and expenses and no more, it is an essential element of the rate structure to provide part of the wherewithal to assume the risks of the business.

Second, to place the profit and contingency mechanism entirely out of the price structure, either by formal removal or, backhandedly, by unqualified subtraction of investment income, moves in the direction of undermining basic goals and virtues of the workers' compensation insurance system, namely:

(a) The incentive to provide insurance is impaired; sooner or later this must mean the drying up of the market.

---

[5] or 5.36% of net earned premium of $13,192,112.

[6] The cost of money, commonly associated with rates of interest, is one of the determining factors reflected in the expected profitability of an enterprise. An increase in the cost of money almost invariably will be reflected in an increase in the appropriate profit expectation of most businesses, as a potential reward for risk bearing. Traditionally, exclusion of investment income from explicit consideration in ratemaking has served to recognize this flywheel effect, thereby reducing the need for changing the underwriting profit and contingency factor.

(b) The desideratum of maintaining a prudent and conservative instrumentality for dispersing and accommodating the risks of the employer, *and no less importantly for assuring benefits to his employees,* is eroded in favor of additional reliance on the speculations and vagaries of the investment market.

The degree to which the goals and virtues of the system are diminished will, of course, depend on the actual methodology applied, but deterioration cannot be avoided.

Third, as it will be demonstrated later, today's emerging conditions make it difficult to keep rates for the business overall at an adequate level, although it is hoped that up-to-date ratemaking methods will keep them respectably close to target. The risk of loss to individual insurers is, of course, much greater than that for the industry as a whole.

Despite its obvious necessity, the profit and contingency factor in ratemaking has sometimes been misconceived to be solely a profit factor. On occasion, this has been further compounded by a presumption that large amounts of investment income derived from policyholder supplied funds are piled on top of otherwise adequate profit margins.

Contingency and profit are complementary to each other in the following sense. There is a contingency that the sum of actual losses and expenses will not be exactly equal to the amounts provided for that sum in the premium. The premium structure contains an element for such a contingency. If in fact there turns out to be no difference between the actual and theoretical costs, then the contingency has not arisen and the difference between actual costs and the premium becomes a profit, albeit modest. If actual costs are less than the amounts provided, then the profit is increased. If the reverse is true, the profit will be decreased and may become a loss. In all situations the elements are usually expressed in percentage terms with the premium being described as 100%.

The modest profit and contingency provision contained in workers' compensation rates reflects the parallel fact that use of premium before pay out is counted upon by the insurer. But the focus of this restatement will be on the entire profit and contingency story as it is reflected in the historical record of actual results (which shows, in fact, underwriting losses) as well as the dispersions of results by company. It will demonstrate the riskiness of the insurance business and develop a basis for quantifying the contingency element. In this way, it will treat investment income as it interacts with the profit and contingency factor in the rates.

But first, it is worthwhile to review, very briefly, the intrinsic significance and value of the subject of the business venture, viz. insurance.

III-B. **Insurance as a Source of Funds for Security and Growth:** Insurance is a source of funds for financing business. By assuming the risks of others it permits individuals to go about their business of manufacturing, processing, distributing, etc., secure in the knowledge that the effects of any untoward event will be mitigated by insurance coverage. With specific reference to workers' compensation costs, insurance enables the employer to level out that part of his labor cost relating to the

potentially high expenditures resulting from lifetime indemnity payments and unlimited medical benefits payable to his injured employees.

Were it not for insurance, the average employer would have to divert substantial amounts from direct use in his business. He would need to maintain such amounts in liquid form in order to be able to pay one or more workers' compensation claims which, with today's benefits, could amount to hundreds of thousands of dollars. Thus insurance contributes significantly to security, growth, and assurance that the Gross National Product will continue to grow.

Survival of the insurance industry as a whole is vital for the well-being of individual businesses. Insurers must be able to endure adversity and still continue to accept the risks transferred to them by employers; otherwise employers would need to seriously curtail their own activities in order to comply with the workers' compensation laws.

III-C. **Fluctuation, Averages and the Public Interest:** The fluctuation of insurance company results is evidence of a real risk and cannot be ignored. It must be viewed together with the consideration that insurance is charged with the public interest. It is tragic when insurers become insolvent; the immediate effect of such insolvency falls on claimants who have a right to the benefits as specified by law. Also, when due regard is not given to solvency considerations, it becomes necessary for insurers to restrict their writings[1] and, consequently, policyholders have difficulty finding insurers to whom they can transfer their risks.

It is not enough to dismiss this problem on the bland assumption that a security fund will handle the matter, certainly not when we are talking in terms of as much as 30% or more of the business.[2] On the other hand, this does not mean that rates should be so high that more than 97% of the business can operate so profitably that its growth would be guaranteed. It does mean that a balance must be struck such that the individual insurer which operates at higher than average cost is permitted to function and pay its obligations to claimants and to policyholders, but not to grow without improving its efficiency. Such a balance provides the framework and the boundary line between regulation in the public interest and competition in the public interest. Additionally, it is desirable that insurers who are operating at modestly higher than average cost be able to continue in business and to provide insurance to policyholders in the interest of maintaining and improving the economy, thereby increasing the Gross National Product. The present modest allowance of 2.5% for underwriting profit and contingencies plus actual investment income affords this reasonable balance. Other ways of looking at this problem are set forth below.

III-D. **Contingency as a Ratemaking Element:** The calendar year 1972-1976 standard premium loss ratio experience can be used to determine reasonable contingency parameters which will permit companies somewhat more costly than the average to operate at a reasonable level. The relationship between the average loss ratio, $\bar{r}$, and

[1] Thus maintaining a prudent amount of surplus to back up any adverse fluctuation in reserve liabilities or decrease in asset values.

[2] See page 10.

the standard deviation of the loss ratio, $s_r$, for stock companies for the years 1972-1976 follows:

| Calendar Year | Loss Ratio $\bar{r}$ | Std. Dev. $s_r$ | $s_r + \bar{r}$ |
|---|---|---|---|
| 1976 (All) | .7522 | .1072 | .143 |
| 1975 (Non-Par.) | .6977 | .0816 | .117 |
| 1974 (Non-Par.) | .6761 | .0750 | .111 |
| 1973 (Non-Par.) | .6538 | .0621 | .095 |
| 1972 (Non-Par.) | .6606 | .0630 | .095 |
| Average | xxx | xxx | .112 |

From the foregoing we see that the standard deviation from the expected loss ratio for the five years was approximately 11.2% of the average loss ratio; for 1976 it was 14.3%. Analysis of 1976 experience for all stock companies shows the standard deviation of the loss ratio to be 10.7% of the standard premium. Also, analysis of the 1976 experience for both stock and mutual companies shows the standard deviation of the loss ratio to be 10.7% of the standard premium. The 1976 distribution of loss ratios at or above given ratios to the average loss ratio is as follows (a complete table appears in Appendix C):

| (1) Loss Ratio As Ratio to Average | (2) % of Business Higher Than (1) |
|---|---|
| 1.00 | 42.3% |
| 1.05 | 30.2 |
| 1.10 | 22.7 |
| 1.15 | 19.0 |
| 1.20 | 8.5 |
| 1.25 | 5.8 |

It will be seen that 22.7% of the business have loss ratios worse than 1.10 times the average. Ten percent (1.10-1.00) above the average is taken at .69 standard deviations (.10 x .7360 ÷ .1071 = .69) above the mean loss ratio (see end of Appendix G).

It does not serve public policy to perfect a system wherein investment income is completely removed as a source of income leaving a significant percentage of the business to operate at a net income loss, i.e. those insurers with loss ratio as little as 4.2% above the average (current profit and contingency factor of 2.5% divided by an approximate standard permissible loss ratio of 60.0%). Interpolation at 1.042 yields 32% of the business which would more than exceed the 2.5% contained in the

rates for profit and contingency, assuming the average loss ratio were in fact the expected loss ratio.

The foregoing discussion can be translated into a manual rate structure[9] which would be as follows:

| | |
|---|---|
| Production, General, Taxes | 28.2%[10] |
| Losses, Loss Adj., Profit and Contingency | 71.8% = 100% - 28.2% |
| Manual Premium | 100.0% |

Now, let us suppose that the selected profit and contingency allowance reflects the 1976 stock companies' standard deviation in the prior table. Taking the figure at .14 of loss and loss adjustment (71.8%), then losses plus loss adjustment are 63.0% and profit and contingency is 8.8% and, taking loss adjustment to be 11.5% of losses, losses comprise 56.5% and loss adjustment 6.5% of manual premium. The final premium structure would be as follows:

| | |
|---|---|
| Production, General, Taxes | 28.2%[10] |
| Losses | 56.5% |
| Loss Adj. | 6.5 |
| Profit and Contingency | 8.8 |
| Manual Premium | 100.0% |

It is possible to show the correspondence between the selected percentage of the business whose experience will fall outside of the profit and contingency loading, the amount of such loading, and the corresponding permissible loss ratio. Entering Appendix G, we can show the necessary distribution of the standard premium dollar which will provide profit and contingency margins for selected percentages of the

[9] On a net premium basis, this structure would contemplate 19.0% for production, general expenses and taxes and 81.0% for losses, loss adjustment and profit and contingency (this breakdown of the net premium dollar is derived from a typical distribution of policies by premium size).

[10] For illustrative purposes the 28.2% value assumes 17.5% for production, 8.0% for expenses and 2.7% for taxes.

business that can be expected to operate unprofitably. In doing so, it is assumed that actual average loss ratios would equal expected. A table follows:

**Table of Profit and Contingency Relationships and Permissible Loss Ratios Based on Selected Percentages of Business Operating Unprofitably**

| | | | | | | | | Explanation |
|---|---|---|---|---|---|---|---|---|
| (1) Selected Percentage Operating Unprofitably | 5.8% | 8.5% | 19.0% | 22.7% | 30.2% | 33.6% | 42.3% | Selected from Appendix G |
| (2) Loss Ratio Corresponding to (1) Expressed as Ratio to Average | 1.25 | 1.20 | 1.15 | 1.10 | 1.05 | 1.036 | 1.00 | |
| (3) Premium Less Expenses | 71.8 | 71.8 | 71.8 | 71.8 | 71.8 | 71.8 | 71.8 | |
| (4) Loss & Loss Adj. | 57.4 | 59.8 | 62.4 | 65.3 | 68.4 | 69.3 | 71.8 | (3) ÷ (2) |
| (5) Loss | 51.5 | 53.6 | 56.0 | 58.6 | 61.3 | 62.2 | 64.4 | (4) ÷ 1.115 |
| (6) Loss Adj. | 5.9 | 6.2 | 6.4 | 6.7 | 7.1 | 7.1 | 7.4 | (4)-(5) |
| (7) Profit and Contingency | 14.4 | 12.0 | 9.4 | 6.5 | 3.4 | 2.5 | 0.0 | (3)-(4) |

Even if averages worked out as expected, the above demonstrates that over 33%of the business will operate unprofitably with the current profit and contingency provision of 2.5%. Fortunately, these 33% have available investment income approximately equal to 6.7% of standard premium (the 1976 result).[11] Even so, there still remain somewhere between 19.0% and 22.7% of the business that will operate at a net income loss. Following the relationships in the above table indicates that this percentage is 20.3%.

Stated in terms as observed in the real world, it is apparent that the largest element of variance in insurers' results is to be found in the loss ratio. With an underwriting profit and contingency loading of 2.5%, the standard premium permissible loss ratio is approximately at 62.2%; as stated in Section III-E, the 1972-1976 average operating ratio in excess of 97.5% of net premium was 10.86% for stock companies and 8.84% for mutual companies. Adjusted for the 1976 relationship between net and standard premium, these figures become 10.1% and 8.4% respectively and average to 9.7%.[12] Thus, it will be seen that the present system as a whole has resulted in missing the target by approximately 9.7% of standard premium, that the 9.7% is not entirely absorbed by the 2.5% + 5.6% (1972-1976 average stock company investment income) available in the total workers' compensation insurance system, and that the temporal risk (observation of 9.7% larger cost than the expected average) combined with the spatial risk (observation that 42.3% of the business will incur costs higher than the achieved average) point up that workers' compensation insurance is indeed a "risky" business. The present provision for profit and contingency plus investment income is modest and required for both the temporal and the spatial risk. That it is required to do "double duty" for both risks demonstrates the bare necessity afforded by the present program.

III-E. **Investment Income as an Offset to Contingencies and Fluctuations:** The role of investment income has been largely misunderstood in insurance ratemaking. It is

[11] See page 15.

[12] 9.7% = (10.1% x 5,317,986,963 Stock Standard Premium + 8.4% x 1,797,649,021 Mutual Standard Premium) ÷ 7,115,635,984 Total Standard Premium.

wrong to assume that the insurance industry consists of a single monolithic insurer and that ratemaking never misses its target. Further, it cannot be assumed that if ratemakers have missed their target in the past, nevertheless no such difference between theory and practice will occur in the future.

In the real world, the insurance industry is not monolithic. Net operating ratios, i.e. the sum of incurred losses and incurred expenses related to net earned premium, vary greatly and are substantially beyond the control of individual insurers. It is proper that insurers be compensated for the risks involved in undertaking to provide insurance, the results of which will show wide fluctuation.[13]

In addition, it has not been possible on a practical level to achieve the target of 2.5% of premium for underwriting profit and contingency largely because there is an increasing non-diversifiable (systematic) element of risk in writing workers' compensation insurance. For example, in societal terms, the past experience cannot be precisely adjusted to reflect the ever growing awareness on the part of employees and society in general of the complex interrelationships between work, injury, disease, disability and financial well-being (this has sometimes been called "social inflation"). While science has progressed toward making work environments safer, it has also produced, implied or inferred statistical relationships between work and disability which are being urged upon workers' compensation administrators at ever increasing rates. Thus, damage to various parts of the body or the psyche are inferred to be the resultant of cumulative injuries to the organism arising from the work environment rather than to be the result of the normal life process. Seldom is this inference clearly delineated as either one or the other — rather it is that the data simply reflect a gradually increasing success on the part of individuals in legally connecting the disability with the work environment. Those persons who find themselves with a disability are apt to be attracted to the premise that it is work induced because, aside from the psychological benefit of attributing the disability to an external force beyond the individual's control, there is the very real economic benefit of providing a continuing income to the individual and his dependents. Additionally, the uncertain effect of changes in economic conditions, retiree benefits and other such elements in today's socio-economic order make the insurance operation a volatile one.

The inherent upward bias, generated by the increasing level of this awareness, is not fully compensated for, even with the use of trend factors. This bias significantly augments the need for an adequate profit and contingency element in ratemaking. Such biases have always been an implied part of both the underwriting profit and contingency and the investment elements; if the latter becomes a specific consideration to be credited toward reduced rates then the counterpart contingency which cannot be diversified must also become much more of a specific consideration to be incorporated in rates as well.

Failure to realize average expectations is documented in Appendices D and E at-

[13] "(Re:) The risk inherent in the line of insurance itself (:) some lines will have greater unpredictability and fluctuation of losses than others and an investor in a company which wrote such lines would demand a greater expected return than he would in a company in which the return was more certain." — Attorney General vs. Commissioner of Insurance (and four companion cases) Mass. Adv. Sh. (1976)2068

tached. Despite the use of a relatively sophisticated ratemaking system wherein the insurance industry has endeavored to realize 2.5% for underwriting profit, or an operating ratio of 97.5% of premium, the results have fallen short in the years 1972-1976.

Since workers' compensation insurance is a kind of insurance subject to audit at policy expiration with long reserve and claim payment durations, the expenses recorded in part will relate to premiums of older policy years. Accordingly, an argument could be made that actual expenses may in fact emerge in larger amounts when the more current policies have run their course. Nevertheless, no adjustments for this have been reflected in the operating ratios. Based on the attached Appendices D and E, actual operating ratios (losses, expenses and policyholder dividends related to net earned premiums)[14] exceeded 97.5% of net premium by the following amounts:

**Operating Ratio In Excess Of 97.5% Of Net Premium**

| Calendar Year | Stock | Mutual |
|---|---|---|
| 1976 | 14.83% | 7.20% |
| 1975 | 11.46 | 7.80 |
| 1974 | 11.88 | 10.25 |
| 1973 | 7.39 | 8.55 |
| 1972 | 8.76 | 10.42 |
| Average | 10.86% | 8.84% |

Such figures are undoubtedly explained in large part by non-diversifiable or systematic risk associated with increasing social awareness. Conservatively, these five year shortages of 10.86% for stock companies and 8.84% for mutual companies will be seen to exceed the 2.5% provision for profit and contingencies and wipe out the investment income. Although this is not recommended, it could therefore not be unreasonable to incorporate a profit and contingency provision of as much as 12.5% in order to hope to achieve an underwriting profit of 2.5%.

That fluctuation and variation from expectation is a reality for the workers' compensation insurance industry is readily evident from the operating results of stock and mutual insurance companies in each of the five years 1972-1976 as shown in Appendices D and E. Whether one considers the results on a net premium or standard basis, it is obvious that the target underwriting result of 2.5% was not realized by the industry as a whole in any of the five years and also not by very many individual insurers. The stock company bottom line results presented in Appendix D bring out the role of investment income in leveling out fluctuation of insurance company results without penalizing policyholders for the consequences of possible poor

[14] Wherever operating ratios are used, these are defined in terms of losses and expenses (including dividends paid to policyholders) related to premiums. When premiums exclude premium discount from the base, corresponding adjustments are reflected in the numerator and vice-versa.

investment policies of insurance company managers. This can be seen by comparing standard deviations for operating ratios with standard deviations for income (inclusive of investment income) to premium ratios and also by comparing standard deviations over time of each statistic. In virtually every case the inclusion of investment income reduces the standard deviation from the average. More simply put, the income to premium ratios, as bad as they are, would have been much worse without the availability of investment income.

Operating results are shown below:

**Stock Company Operating Results Per $100 Of Net Earned Premium**

| | Average |
|---|---|
| 1976 | -$12.33 |
| 1975 | -8.96 |
| 1974 | -9.38 |
| 1973 | -4.89 |
| 1972 | -6.26 |

*Notes:*

1. Operating results per $100 of net earned premium comprise 100 times incurred losses plus incurred expenses plus policyholder dividends divided by net earned premiums.
2. Data are from the Insurance Expense Exhibit. For 1976 they are for all stock companies. Data for the years prior to 1976 are large samples (88 to 91 nonparticipating stock companies and groups).

To illustrate the substantial fluctuation in these averages, it should be noted that in 1975 the lowest and highest operating results per $100 of Net Earned Premium for companies with net earned premiums exceeding $1,000,000 were −$61.63 and +$34.12; for 1974 the corresponding results were −$41.80 and +$30.28.

Investment income operates as an offset to adverse net operating ratios. For example, the $8.96 industry loss in 1975, was offset in some degree by $6.95 average investment income (as developed from Appendix D — see footnote 22)[1] per $100 of earned premium for the industry. Individual companies writing more than $1,000,000 of net earned premium realized as much as $13.53 or as little as $.02 per $100 of net earned premium (see Appendix F1). In these circumstances, it should be apparent that operating an insurance company in the workers' compensation insurance field is a "risky" business. In 1975, the industry needed to use up all of the investment income attributed (erroneously, in part) to policyholder supplied funds and still lost money. It was even more so in 1976. This should be contrasted with the

[1] As mentioned earlier investment income as presented in Insurance Expense Exhibits is computed in accordance with N.A.I.C. instructions allocating total investment income, excluding earnings on stocks, on the basis of line-by-line reserves. Consequently, for lines for which losses exceed ratemaking expectations, investment income can be considered overstated to the extent that funds are borrowed from surplus to create reserves. Adjustment of data to recognize this phenomenon would indicate greater riskiness and need for greater contingency elements than presented in this paper.

theoretical ratemaking premise that the industry as a whole is expected (assuming no contingencies arise) to realize $2.50 out of each $100 of earned premium, plus actual investment income.

Subsequent discussions refer to stock insurance company figures, although a review of mutual insurance company statistics in Appendix E will show that similar results follow.

The fluctuations in the individual results are explained on the basis that insurance is not like most other businesses. The claims, i.e. reserves for losses, are the most significant part of an insurance company's inventory. Whereas most businesses can know the value of their inventory with little or no error, the insurer's inventory is subject to radical fluctuation because of future events such as error of estimation of the value of known claims or in subsequent identification of claims not known at the date of inventory closing.[14] These fluctuations in number and amount carry through into aggregate loss estimations. The mean industry averages of net operating ratios are inadequate estimates of future needs of the individual company. The mean averages by company are distributed about the industry average and are relatively widely dispersed. Statistically, such dispersion can be measured by the standard deviation. In the year 1976, the standard deviation of the net operating ratio was $11.80 per $100 of earned premium. In 1975, it was $8.86. In 1974, it was $8.87. In 1973, it was $5.55. In 1972, it was $6.78. For the five years the standard deviation was approximately equal to or slightly larger than the average industry loss.

Net operating ratios are not as useful for ratemaking as are loss ratios based upon standard premiums. The latter are more directly related to manual rates and permit an evaluation of such manual rates independent of the effects of expense economies (premium discounts) which are actually afforded on the basis of risk size. Further, it permits analysis of experience for insurers with a variety of operating philosophies. Consequently, we should look at the relationship between investment income and the fluctuation in loss ratio expressed as a percentage of earned standard premium.

In 1976, investment income averaged 6.74% of earned standard premium before tax and this amount was available to partially offset the variation in loss ratio to an extent somewhat less than one standard deviation in loss ratio which amounted to 10.72% of earned standard premium. In 1975, 6.46% of earned standard premium was available through investment income to offset almost one standard deviation in loss ratio which amounted to 8.16%. In 1974, the comparable figures were 5.37% and 7.50%. In 1973, the comparable figures were 4.73% and 6.21%. In 1972, the comparable figures were 4.66% and 6.30%.

The five year average relationship of investment income to the standard deviation of loss ratios is as follows:

[14] Claims thought to be non-compensable medical become compensable, those believed temporary become permanent, etc., leading to the need for large reserves subject to substantial errors of estimation.

**Percent of Standard Premium**

| (1) Year | (2) Investment Income | (3) Std. Deviation of Loss Ratio | (4) Ratio (2) ÷ (3) |
|---|---|---|---|
| 1976 | 6.74% | 10.72% | .63 |
| 1975 | 6.46 | 8.16 | .79 |
| 1974 | 5.37 | 7.50 | .72 |
| 1973 | 4.73 | 6.21 | .76 |
| 1972 | 4.66 | 6.30 | .74 |
| Average | 5.59% | xx | .73 |

Current provisions of 2.5% for profit and contingencies and 1976 investment income of 6.74% together represent only 86% of 10.72%, one standard deviation in loss ratio for 1976. *If ratemaking actually achieved the 2.5% for underwriting profit, this would mean that 20% of the business (intermediate between 19.0% and 22.7% as shown in Section III-D) would suffer a net income loss.* (This contrasts with actual 1976 results prior to adjustments to average wherein 54.6% of the business suffered a net income loss.)[17] Such a program definitely is not based on an excessive premium base.

## IV. Further Considerations:

IV-A. **Investment Income and Rates of Return.** Some persons, in arguing for rates of return based on net worth, have stated that one way of enhancing such rates of return would be for the corporation to incur long term debt, i.e., issue bonds, so-called "senior securities", as is done in the public utilities industry and some other regulated businesses. The issuance of bonds commonly is not a practical consideration with respect to the insurance business because insurance laws and the general purposes of insurance require maximum protection for the policyholder and the claimant. The policy holder and the claimant generally will have first call on the assets of the insurance company. Therefore, issuance of debentures which would be subordinated to the claims of policyholders and claimants are generally unattractive to investors. Consequently, growth in the insurance business is actually financed through internal means.[18]

In attempting to assess appropriate rates of return in regulated businesses, Plotkin[19] has drawn comparisons between insurance and other businesses subject to

[17] 54.6% = $3,649,252,709 (Net Premium for Insurers with Net Income Loss) ÷ $6,682,337,100 (Total Net Premium for Stock and Mutual Insurers)

[18] "Because of the first claim of debt to income, the risk ... is greater than the risk of an investment in a firm without debt ... insurers seldom issue debt-an obligation to repay borrowed funds would conflict with the role of capital as a guaranty fund in an insurance company ..." supra-Mass. Adv. Sh. (1976)2068 (footnote 32)

[19] "Statement of Dr. Irving Plotkin, Senior Economist, Director of Regulation and Economics, Arthur D. Little Inc., on Investment Income and Rate-Making for Property Insurance, before the Texas State Board of Insurance, Austin, Texas, February 16, 1977."

regulation. He has made the point that loss reserves and unearned premium reserves in insurance serve a function similar to long-term debt in other regulated businesses. In insurance, the assets underlying loss reserves and unearned premium reserves are at risk just as, for example, telephone equipment, railroad cars, aeroplane equipment, etc. are part of the business operation. In insurance, the situation is somewhat more complex in that not only are the assets underlying these reserves at risk but the actual settlement values of losses are subject to variation and, in the light of history, tend to exceed initial reserves.

Thus in Plotkin's comparison of insurance with other regulated industries, he points out that for the non-insurance industry, rate of return includes net income plus the corporation's cost of servicing the long term debt related to basically, usefully employed plant and equipment, or, approximately, net assets. In insurance, the appropriate measure is the underwriting net income plus the investment income generated by loss reserves and unearned premium reserves stemming from policyholder supplied funds plus the investment income generated by net worth. This sum is measured against net worth plus the loss reserves and unearned premium reserves or, approximately, net assets.

Plotkin's comparison can be developed further. The use of investment income generated by the reserves in lieu of a substantial profit and contingency factor is seen to be the companies' consideration afforded to the policyholder for the use of policyholder supplied funds. It is entirely comparable to the monetary consideration afforded to bond holders for borrowing by regulated business. This furnishes additional perspective on the interrelationship between investment income and the underwriting profit and contingency margin. The two taken together represent the total consideration and should be measured against the combined sum of net worth and reserves. Rates of return measured in this way reflect a consideration of the total riskiness of the enterprise. Such riskiness necessarily is found to be at a level higher than that of a regulated monopoly such as a public utility. The rationale for this conclusion should be obvious in that insurance is a competitive business with substantial market dispersion of the product and ease of entrance and egress by insurers of various types in competition with each other. In terms of hierarchy, it is reasonable to conclude that rates of return measured in the manner described above should be larger than that afforded, e.g., to competing airline carriers in that the latter industry is not as competitive as insurance. Ease of entry and egress is considerably less for airlines than for the insurance industry and, as a capital intensive industry, airlines are able to generate substantially more leverage between capital and long term debt than insurers can develop between net worth and loss reserves and unearned premium reserves.

Actual 1972-1976 net investment yield on assets available for investment is shown in Appendix A. This, together with the non-participating stock company workers' compensation insurance operating ratios shown in Section V-B provide a reasonable basis for appraising the total return from writing workers compensation insurance. (In the following, the operating ratios expressed as a percentage of premiums have been adjusted by a factor of 50% to reflect the fact that premiums for

all lines constitute approximately 50% of assets.) The results are shown below:

**Workers' Compensation Insurance Estimated Return on Assets Available for Investment**
(Before Federal Income Taxes)

| Year | Investment Income[20] | Operating Ratios | Total Return[19] |
|---|---|---|---|
| 1972 | 4.4% | -3.2% | 1.2% |
| 1973 | 4.8 | -2.4 | 2.4 |
| 1974 | 5.6 | -4.7 | 0.9 |
| 1975 | 5.8 | -4.6 | 1.2 |
| 1976 | 5.6 | -6.0 | -.4 |
| 5 Year Total | 5.3% | -4.4% | 0.9% |

The foregoing can be modified to show what the projected returns would have been if the 2.5% profit and contingency factor were actually achieved.

**Workers' Compensation Insurance Projected Return on Assets Available for Investment**
(Before Federal Income Taxes)

| Year | Investment Income[20] | Operating Ratios | Total Return[19] |
|---|---|---|---|
| 1972 | 4.4% | 1.3% | 5.7% |
| 1973 | 4.8 | 1.3 | 6.1 |
| 1974 | 5.6 | 1.3 | 6.9 |
| 1975 | 5.8 | 1.3 | 7.1 |
| 1976 | 5.6 | 1.3 | 6.9 |
| 5 Year Total | 5.3% | 1.3% | 6.6% |

The difference between the 0.9% figure and the 6.6% estimate before Federal Income Taxes points up the riskiness of the insurance business both from an underwriting and total income viewpoint. On an after tax basis the 5 year total projected return on assets would be approximately 5.2%, which is indeed a modest return. For comparative purposes we show the annual after-tax rates of return on total capital developed from data reported to the Federal Trade Commission and the Securities and Exchange Commission.[21]

[19] Does not include capital gains or losses. Standard and Poor's combined index (500 stocks) showed an approximate increase of 6% for the total five year period. Changes in the value of bonds are not included.

[21] As reported in Table 2, p.23 [sic], in Plotkin, I.H., On the Theory and Practice of Rate Review and Profit Measurement in Title Insurance, A.D. Little Inc., 1978.

**TABLE 2**

**ANNUAL AFTER—TAX RATES OF RETURN**

**ON TOTAL CAPITAL**

**FTC/SEC COMPANIES**

**1960-1967**

| Year | Rate of Return* |
|---|---|
| 1966 | 11.52% |
| 1967 | 10.06 |
| 1968 | 10.22 |
| 1969 | 9.75 |
| 1970 | 8.65 |
| 1971 | 8.86 |
| 1972 | 9.48 |
| 1973 | 11.10 |
| 1974 | 12.60 |
| 1975 | 10.08 |
| 1976 | 11.95 |
| 1973-1976 | 11.43 |
| 1966-1976 | 10.38 |

*Rate of return on total capital defined as net income after tax plus interest, divided by net worth plus debt. Interest calculated assuming embedded debt costs of 5% for 1966-1969 and 7% for 1970-1976.

Source: Developed from Federal Trade Commission/Securities and Exchange Commission, Quarterly Financial Reports.

IV-B. **An Economic Model for Capitalization of a Workers' Compensation Insurer:** The question sometimes arises as to how much net worth is necessary in order to write workers' compensation insurance. Since there are hardly any insurers who write *only* workers' compensation, we can answer this question only by constructing a model. In our model we begin with a net worth equal to 50% of the earned premium. In its over-simplified form we first assume that the underwriting target of 2.5% will invariably be

reached in every year, investment income will amount to 5% of earned premium, federal income taxes will be payable at 48% on underwriting and at 15% on investment income; premiums will increase at 20% per year; after federal income tax investment earnings on net worth will be paid out as dividends to owners.

IV-B-1. **The 2 to 1 Ratio of Premium to Net Worth:** If we begin with a net worth of 1,000 units and a premium of 2,000 units, by the end of the first year net worth will have increased to 1,111 units (underwriting income after federal income taxes equals 2.5% × 2,000 units × 52% after tax retention rate or 26 units, and investment income after federal income taxes equals 5% × 2,000 units × 85% after tax retention rate or 85 units, for a total increase of 111 units), and this will be the underlying capital related to the second year's premium of 2,400 units. The figures for each of the years are displayed in the following table:

| Year | Premium | Beginning Net Worth | Ratio |
|---|---|---|---|
| 1 | 2,000 | 1,000 | 2.00 |
| 2 | 2,400 | 1,111 | 2.16 |
| 3 | 2,880 | 1,244 | 2.32 |
| 4 | 3,456 | 1,403 | 2.46 |
| 5 | 4,147 | 1,595 | 2.60 |
| 6 | 4,976 | 1,825 | 2.73 |

It will be seen that the ratio of premium to net worth increases at a decreasing rate. However, the foregoing description does not describe the real world because it allows neither for failure to achieve expectations nor for the possibility that expectations are exceeded. In order to more closely reflect reality we need to modify the description to reflect real world facts such as the following which occurred during the years 1972-1976:

**RETURN[11] AS RATIO TO EARNED PREMIUM FROM**

| Year | Underwriting | Investment |
|---|---|---|
| 1972 | −.063 | +.050 |
| 1973 | −.049 | +.051 |
| 1974 | −.094 | +.059 |
| 1975 | −.090 | +.070 |
| 1976 | −.123 | +.072 |

When these actual conditions are recognized, the results change enormously. Because each of the years produces underwriting losses, the following computation

[11] See Appendix D. The figure for underwriting is one minus the operating ratio which includes dividends paid to policyholders. The figure for investment is the difference between the Income/Premium ratio and the underwriting figure.

assumes that there will be no federal income tax payable on investments. The relationship between premium and net worth as modified is shown below:

| Year | Premium | Beginning Net Worth | Ratio |
|---|---|---|---|
| 1 | 2,000 | 1,000 | 2.00 |
| 2 | 2,400 | 974 | 2.46 |
| 3 | 2,880 | 979 | 2.94 |
| 4 | 3,456 | 878 | 3.94 |
| 5 | 4,147 | 809 | 5.13 |
| 6 | 4,976 | 598 | 8.32 |

It will be seen that by the beginning of the sixth year, the industry is operating at a premium to net worth ratio of 8.32, an increase of more than 30% per year. Such a condition is quite risky—risky to claimants, risky to policyholders, risky to stockholders, and risky to the economic security of society in general.[23] However, even this does not tell the entire story. A study presented to the Casualty Actuarial Society Workshop in November, 1977 indicates that as of the end of 1976 (the 5th year in our example) companies on the average were underreserved for IBNR losses to the extent of 8% of earned premium (see Appendix H). In our example, this amounts to 8% of 4,147 units or 332 units which would need to be deducted from the 598 units of net worth at the beginning of the 6th year and leave 266 units, this would then produce a premium to net worth ratio of 18.71.

One of the reasons that the ratios have not actually become as large as the model indicates is that net worth during the last five years has been augmented by an increase in unrealized appreciation of stocks. However were the stock market to decline by as much as 25% during the fifth year, in our model net worth would have declined an additional 202 units assuming that the fifth year's net worth were all invested in stocks[24]; net worth would then constitute 64 units. Such a bleak scenario would place the industry on the brink of insolvency at a premium to net worth ratio of 77.75. It is a situation which might happen. It probably would be prevented from happening by drastic action by insurance regulators. But it demonstrates the implications of unwarranted cut-backs in the pricing program, including the use of investment income reserves, as we know it today.

IV-B-2. **The 1 to 1 Ratio of Premium to Net Worth—A Realistic View:** Prudent evaluation of the real world situation requires that premium to net worth ratios be more nearly 1.00, so as to make it rare that the ratio in any given year would reach the

[23] It should be noted that investments in bonds, being recorded at amortized values, do not exhibit the volatility of investments in stocks (which are generally carried at market values) thus permitting higher premium to net worth ratios for a given degree of solvency for companies whose major investment is in bonds.

[24] This is consistent with legal requirements that reserve liabilities for unearned premiums and claims be invested in bonds; these are recorded at unrealistic amortized values during periods of declining bond prices.

warning level of 3.00 for the industry as a whole.[25] We can take the previous model which reflects real underwriting and investment results and modify it to begin at a ratio of 1.00 and also reflect that net worth at the end of each year will include the changes in the stock market (based upon the movements of the Standard and Poor Index[26] from December of the prior year to December of the current year). The percentage change is applied to the net worth at the beginning of the year. The results of this real world situation are shown below:

| 1. Year | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| 2. Premium (20% Annual Growth) | 2,000 | 2,400 | 2,880 | 3,456 | 4,147 | 4,976 |
| 3. Net Worth Beginning of year (Line 7 of prior year) | 2,000 | 2,344 | 1,897 | 1,242 | 1,573 | 1,645 |
| 4. Net Operating Income During Year after Federal Income Tax | -26 | +5 | -101 | -69 | -211 | |
| 5. Net Worth End of Year w/o Unrealized Capital Gains [(3) + (4)] | 1,974 | 2,349 | 1,796 | 1,173 | 1,362 | |
| 6. S&P Change Index During Year | | | | | | |
| (a) Per Cent | +18.5% | -19.3% | -29.2% | +32.2% | +18.0% | |
| (b) Amount [(3)4 × (6a)] | +370 | -452 | -554 | +400 | +283 | |
| 7. Net Worth End of Year with Unrealized Capital Gains: [(5) + (6b)] | 2,344 | 1,897 | 1,242 | 1,573 | 1,645 | |
| 8. Premium to Net Worth Ratio: [(2) ÷ (3)] | 1.00 | 1.02 | 1.52 | 2.78 | 2.64 | 3.02 |

Notes:
(a) Line 4 assumes after tax investment income from net worth is distributed as dividends to owners.
(b) S&P change index is measured from previous to current December index.
(c) Years 1-5 correspond to 1972-1976. Underwriting and investment percentages for those years were applied to the corresponding earned premiums. Since underwriting losses offset investment incomes no federal income tax was assumed.

Now, by reducing the 5th year's end net worth by 332 units for the 8% deficiency due to inadequate loss reserves (see Appendix H), there would be left 1,313 units which would then make the 6th year's premium to net worth ratio 3.79. If we further assume a drop in the stock market of 25% instead of the 18.0% increase during the 5th year, this would cause a reduction of 393 units instead of the 283 unit increase shown in the table; the final number of units would be 637 (637 = 1313 − 283 − 393) for a premium to net worth ratio of 7.81, a dangerous situation (a combined net income and stock market loss equal to 13% (13% = 1 ÷ 7.81) of premium would wipe out the entire industry) but not nearly as volatile as the 77.75 ratio we encounter, where we began with a 2 to 1 ratio. There a combined net income and stock market loss equal to only 1.3% of premium would wipe out the entire industry.

[25] Currently, the National Association of Insurance Commissioners employs a ratio of 3 to 1 in its test of solvency.

[26] Standard & Poor's combined Index (500 Stocks) — Survey of Current Business (U.S. Dept. of Commerce/Bureau of Economic Analysis) and the 1975 Biennial Supplement.

The recent history of underwriting, investment income, and stock market performance demonstrates that workers' compensation insurance is indeed a "risky" business. The risk assumed by insurers in writing workers' compensation consists of both diversifiable and non-diversifiable (systematic) elements as described elsewhere in this restatement. For example, insurance provides the mechanism whereby "social inflation" is diversifiable for the insured but not for the insurance industry.[27] Accordingly, a fair expected total return for insurers must reflect both sources of risk. In light of recent experience, the insurance industry can attract only limited outside venture capital due to its record of low returns and high total risk. The role played by investment is to generate such capital internally and to smooth out adverse underwriting results. Finally, it should be observed that net worth is stated at current market values of stocks (surely, such massive volumes could not readily be sold without depressing the stock market) as a way of providing the capital necessary to fund premium growth. It is erroneous to believe that 2.5% of premium alone is adequate for profit and contingencies.

## V. Review of Ratemaking Considerations.

V-A. **General Considerations:** The structure and function of investment income and the contingency factor have been reviewed. It is now appropriate to address the question of whether investment income should be incorporated in ratemaking and subjected to periodic review in the same manner as underwriting experience.

Underwriting and investments are two separate and distinct operations of casualty insurance companies, and two separate and distinct opportunities for profit. Underwriting profits represent the residue, if any, remaining after losses and expenses incurred during a given period are subtracted from premiums earned during that same period. Investment profit, however, is derived from the intelligent investment of funds in the possession of the carriers, to the extent that it is prudent for the carriers to make such funds available for investment. In practice these two functions are handled as completely separate operations of the insurance company. Their distinctness is well recognized in the NAIC Annual Statement blank. In the Statement of Income portion of the Underwriting and Investment exhibit, the carrier is required to make a separate accounting of underwriting income and investment income.

In spite of the traditional and well recognized separability of these two operations, the view is sometimes advanced that underwriting data and investment income should somehow be intermingled in the ratemaking procedure. Investment income aggregates are not ratemaking experience data and should not be treated as such; neither should investment income be used as an automatic reduction from the margin for underwriting profit and contingencies or any other element of workers' compensation rates with no consideration given to the reasonableness of the pricing program *in its entirety*, including the provision for underwriting profit and contingencies. That the statutory scheme does not call for any such conclusion, absent clear instruc-

[27] The investment policy of an insurer is to some extent determined by its position vis a vis premium, net worth and riskiness of the fluctuation inherent in the line of insurance; the greater the fluctuation and the larger the premium to net worth ratio, then the greater will be the investment of net worth in bonds which are carried at amortized values (i.e., insulated from the vagaries of the stock market).

tion to the contrary, would seem to allow for little argument. Why such a conclusion should in no event be arrived at merits the following discussion.

A second reason why there should be no attempt to bring investment dollars into the mechanics of ratemaking is the likely effect upon the investment policy of individual companies. The investment policy a particular company should adopt depends on many factors including the relative size of its capital and surplus account. If a high level of surplus is available, higher yield from more volatile investments may safely be sought. Introducing an investment income element into the rate formula would tend to induce some companies to shift from more conservative investments, to the detriment of the public interest in maintaining high standards of solvency. A company which feels it needs to keep an appreciable portion of its reserves for workers' compensation insurance either in the form of cash or comparatively low-yield investments, should not be discouraged from so doing by the ratemaking procedure.

A third reason is that a drop in the investment dollars because of fluctuating economic conditions must of necessity be made up by increased rates under this theory. Coupled with the incentive toward more speculative investing alluded to above, there may very well be an aversion to a "two-way" operation on the inclusion of investment income; and yet, to conduct the program on any other basis would tend to produce a pricing bias against the carriers.

A fourth reason is that if investment income earned by insurance companies were taken into account in the mechanics of workers'compensation insurance ratemaking, the present provision of 2.5% of premium for profit and contingencies would be completely inadequate. The 2.5% profit and contingencies factor produces, at best, marginal rates today. Obviously, if the modest 2.5% profit and contingencies factor were reduced or eliminated it would make it increasingly more difficult to attract capital to this business.

Finally, consideration would have to be given in the ratemaking procedure to the particular type of investments properly attributable to reserve accounts. Since these accounts generally represent liabilities that must be met promptly, the assets represented by them would generally be invested in highly liquid low-yield securities, or held as cash or its equivalent. Very probably the reserve funds are invested differently for the several lines of insurance depending on the particular company's relative volume by line and the degree of liquidity necessary.

The companies writing workers' compensation insurance are not monopolistic utilities. There are a sizable number competing for the business in every state. In addition to competing in final premium charged, they are competing strenuously with each other in the service and attention which they render to policyholders. Therefore, they are entitled, even though regulated, to that profit on sales which prudent management feels is necessary for the long-run good of the business.

With this background, it is evident that the underwriting profit and contingencies allowance (if earned), plus the investment income on reserves adds up to a most modest income for workers' compensation insurance carriers. Otherwise expressed, the rates meet all of the standards set forth in the rating law, and due consideration

has been given to investment income from unearned premium reserves and loss reserves, as well as all other factors deemed relevant.

V-B. **Specific Considerations:** The investment income with the addition of any underwriting profit (loss) make up a company's earnings from this line of insurance.

In considering the propriety of the potential earnings to be derived by writing a line of insurance, it is appropriate and necessary to review the earnings history of that line of insurance. Such review will provide a benchmark for analysis of the risks involved in writing the line of insurance and will indicate whether the potential earnings are adequate to cover such risks.

The actual countrywide experience of company groups which were predominantly non-participating, in each of the past five years has produced costs in excess of the premiums charged for workers' compensation insurance coverage as is shown in the following table (000 omitted).

| | 1972 | 1973 | 1974 | 1975 | 1976 | 1972-76 |
|---|---|---|---|---|---|---|
| 1. Net Premiums Earned | 1,972,294 | 2,330,990 | 2,653,355 | 2,888,816 | 3,346,657 | 13,192,112 |
| 2. Total Incurred Losses | 1,398,716 | 1,632,695 | 1,956,503 | 2,171,644 | 2,655,369 | 9,814,927 |
| 3. Total Incurred Expenses(a) | 698,081 | 811,347 | 944,468 | 982,262 | 1,092,475 | 4,528,633 |
| 4. Operating Results (1) – (2) – (3) | 124,503 | – 113,052 | – 247,616 | – 265,090 | – 401,187 | – 1,151,448 |
| 5. Operating Ratio (4) ÷ (1) | – 6.3% | – 4.8% | – 9.3% | – 9.2% | – 12.0% | – 8.7% |

(a) Excludes Federal Income and Excess Profits Taxes and includes dividends paid to policyholders.

The adverse results achieved in the country as a whole during the last five years demonstrate that the historical profit and contingency margin of 2.5% of premium was not sufficient to cover the contingencies which existed.

While contingency margins cannot be set high enough to offset truly disastrous results such as those of 1974, 1975 and 1976, the recent history of Workers' Compensation insurance in the United States clearly indicates the potential and realized magnitude of the risk assumed by the insurance companies. It is prudent, therefore, to retain the historical profit and contingency provision which has proven to be necessary.

With respect to policyholder supplied funds, the investment income from premium combined with the operating results comprise the total earnings (before Federal Income Taxes) achieved by the non-participating stock insurance industry nationally on the workers' compensation line as follows (000 omitted):

**COUNTRYWIDE TOTAL EARNINGS FROM WORKERS' COMPENSATION INSURANCE PREMIUMS (BEFORE FEDERAL INCOME TAXES) (000 OMITTED)**

| (1) | (2) | (3) | (4) | (5) | (6) |
|---|---|---|---|---|---|
| | | | | TOTAL EARNINGS | |
| Year | Net Premiums Earned | Operating Results | Investment Income From Premiums | Amount (3) + (4) | Per Cent (5) ÷ (2) |
| 1972 | 1,972,294 | −124,503 | 86,968 | −37,535 | −1.9% |
| 1973 | 2,330,990 | −113,052 | 108,292 | −4,760 | −0.2 |
| 1974 | 2,653,355 | −247,616 | 138,059 | −109,557 | −4.1 |
| 1975 | 2,888,816 | −265,090 | 185,325 | −79,765 | −2.8 |
| 1976 | 3,346,657 | −401,187 | 207,156 | −194,031 | −5.8 |
| 1972-76 | 13,192,112 | −1,151,448 | 725,800 | −425,648 | −3.2% |

We can evaluate the potential earnings from policyholder supplied funds in standard premium ratemaking terms. The components are the potential profit and contingency element of 2.5% of standard premium, the five year historical investment earnings of 4.98% of standard premium reflecting an adequate premium base (see Section II-D) and the Federal Income Tax structure. These indicate a potential earnings of 5.6% of standard earned premium after tax as shown below:

| | Per Cent of Standard Earned Premium |
|---|---|
| Underwriting Profit and Contingency Margin | 2.5% |
| Federal Income Tax @ 48% on Underwriting Profit and Contingency Margin | 1.2 |
| Underwriting Result after Federal Income Tax | 1.3 |
| Estimated Investment Income after Federal Income Tax | 4.3[25] |
| Potential Total Earnings as a % of Premiums | 5.6 |

Despite potential earnings of 5.6% of standard earned premium, actual before tax earnings with investment income from premiums on a present value basis averaged −3.1% per year as a per cent of standard earned premium. While the achieved earnings are plainly unsatisfactory, even the potential earnings are not at a very high level when one considers that retained earnings are the chief vehicle for funding premium volume growth. Over the last five years, total workers' compensation premium volume, i.e., demand for workers' compensation insurance, has increased at an average rate exceeding 14% per year. This increase was caused by a variety of factors. Among these factors were the general inflation, particularly medical cost in-

[25] As per Section II-D

flation, inflation in wages resulting in higher benefit levels, increases in legislated benefit levels and increases in the number of covered workers.

The riskiness of the insurance business has long been recognized by the establishment of conservative accounting practices and by setting bench mark premium to surplus ratios at a low level. One of the current NAIC Regulatory Tests states that a premium to surplus ratio exceeding 3 to 1 is a potential danger signal of insolvency. Earlier it was shown that a 1 to 1 ratio for workers' compensation insurance is more prudent. Looking ahead to be able to meet a premium volume growth of 20% per year, the after tax workers' compensation insurance earnings should be at least 20% of premium so as to promote a 1 to 1 premium to surplus ratio. The Kenney rule, which is considered prudent for most casualty lines riskier than fire lines, suggests that a premium to surplus ratio of 2 to 1 is more appropriate. In order to maintain this less prudent premium to surplus ratio, the after tax earnings should be at least 10% of premium.

Considering the future growth in demand for workers' compensation insurance in the United States, it is possible that the total potential earnings achievable under the current pricing program may not be sufficient to fully fund the growth in demand. As shown previously, the potential after tax earnings of 5.6% of premiums available to fund the growth of premium volume are based on retaining a profit and contingency margin of 2.5% of premium plus investment income. Certainly, should the potential earnings be reduced by lowering the profit and contingency margin, it must be expected that significant deterioration in the average insurer's financial strength will occur. Such deterioration will of necessity adversely impact the availability of workers' compensation insurance generally.

## VI. Summary and Conclusions.

To summarize, net investment income operates as an offset to two contingencies; namely, (1) the contingency that the insurance industry as a whole does not meet the target results contemplated and (2) the contingency that even if the industry as a whole were to meet the target, then many individual companies would still require investment income to stay in business and to offset the contingency that its results would in some degree be more adverse than the average. Thus, the combined elements of 2.5% expected return for underwriting profit and contingency plus the realized investment income represent a very modest expectation for undertaking the risk inherent in the insurance business. At the same time, the ratemaking system, based on an underwriting profit and contingency allowance, insulates the policyholder from the investment risk which a particular insurance management may undertake, i.e., investing in riskier securities or writing insurance at large premium to surplus ratios; these latter risks remain with the insurer and are not "retroceded" to policyholders through ratemaking.

Realistically, the insurance industry as a whole has not achieved the underwriting target set by ratemakers. Even if conditions worked out "on the average" as expected, 33.6%[19] of the workers' compensation insurance business would fail to realize as much as 2.5% in underwriting profits, i.e., actual contingencies will ex-

[19] See Section III

ceed the contingency factor for more than 33% of the business. Modifications of ratemaking have been undertaken to recognize that the statistical data base for ratemaking of necessity reflects conditions of the past and that it requires adjustment to anticipate conditions during the period when new policies will be in force. Nevertheless, even if ratemaking were perfect, there still would be a need to deal with the likelihood that more individual companies would face insolvency than is warranted by the public interest.

The history of underwriting losses indicated that contingencies have not been adequately reflected. New contingencies are constantly coming to the fore. An expanding "state of the art" and increased awareness of occupational disease and cumulative injury resulting from continuous activity such as repetitive motion, etc., are current examples. It is quite possible that escalation (i.e., adjustment of future benefits to claimants for claims on old cases) will be another. Such elements might render the fluctuation in investment income and individual insurer's underwriting results minor considerations compared to the non-diversifiable or systematic risk in a changing society. Indeed, these considerations could indicate the need for an additional contingency element. This is confirmed by the steady upward movement of the 1972-1976 standard premium loss ratio which actually went from .6606 to .7522. The five year average loss ratio[10] was .6881 with a standard deviation of .0396.

In the National Council's view, the proven riskiness of the insurance business requires that the present underwriting provision for profit and contingencies of 2.5% be considered as a minimum. As it stands, it can be expected that, even if the industry achieves this, it will result in exhaustion of both contingencies and investment income by 19% to 23% of the business. Any changes which might be made should be in the direction of increasing the 2.5% profit and contingency factor to recognize the risks inherent in the business.

[10] See Section III

# APPENDICES

## APPENDIX A
## STOCK COMPANIES
## INVESTMENT INCOME AS A % OF ASSETS†

| | | 1972 | 1973 | 1974 | 1975 | 1976 | 5 yr. Total |
|---|---|---|---|---|---|---|---|
| (1) | Total Mean Admitted Assets* | 53,897,085 | 60,337,185 | 61,253,821 | 65,004,745 | 76,644,141 | 317,136,977 |
| (2) | Mean Premium Balances* | 4,179,107 | 4,944,194 | 5,426,389 | 5,854,717 | 6,515,393 | 26,919,800 |
| (3) | Mean Other Assets* | 2,648,135 | 3,422,304 | 4,105,166 | 4,437,142 | 4,957,028 | 19,569,775 |
| (4) | Mean Assets Available for Investment* | 47,069,843 | 51,970,687 | 51,722,266 | 54,712,886 | 65,171,720 | 270,647,402 |
| (5) | Investment Income* | 2,232,408 | 2,655,294 | 3,084,128 | 3,347,168 | 3,856,958 | 15,175,956 |
| (6) | Investment Income Yield Rate % | 4.74% | 5.11% | 5.96% | 6.12% | 5.92% | 5.61% |
| (7) | Investment Expenses Incurred* | 164,156 | 174,077 | 193,547 | 204,306 | 228,044 | 964,130 |
| (8) | Investment Expense % | .35% | .33% | .37% | .37% | .35% | .36% |
| (9) | Net Rate Investment Yield as % | 4.39% | 4.78% | 5.59% | 5.75% | 5.57% | 5.25% |

* In thousands

† Data from Best's Aggregates and Averages — Property and Casualty

## APPENDIX B

### Investment Income on Unearned Premium Reserves

The attached exhibits present estimates of investment income from unearned premium reserves for stock carriers based on countrywide data covering Calendar Years 1975 and 1976.

An explanation of certain of the items in the exhibits follows. The items are assigned the same number as the lines on the exhibit.

1,2 — These figures were obtained from Best's Fire and Casualty Aggregates and Averages. (Hereinafter referred to as Best's).

4(a) — It is estimated that workmen's compensation premiums are remitted on the average approximately 105 days after effective dates of policies. This is 7/24 of a year, and, thus, a .292 reduction factor is applied to the mean unearned premium reserves.

The average delay in remission of premiums for *all fire and casualty lines combined* is approximately 60 days. This is derived from the ratio of premium balances to net premiums written for stock companies, as shown in Best's, together with a small increment for the non-admitted premium balances over 90 days due. In workmen's compensation insurance premiums are actually collected by the carriers at a much slower rate than that for most other lines. This is due to the fact that virtually all workmen's compensation policies are written on a payroll audit basis, with either a single audit made after the termination of the policy or interim audits made during the policy term. Of necessity, there is usually about a two month delay in making audits, and on balance the results of audits show a substantial excess of additional premium due over premium returns.

It is estimated, therefore, that there is an additional 45 day delay in remitting workmen's compensation premiums over the average 60 day delay applicable to all lines combined.

4(b) — Deduction is taken here of certain items of expense which must be prepaid by the carrier out of its own resources since at inception 100% of the premium is allocated to the unearned premium reserves. The amount of the deduction has been reduced to recognize the delayed remission of premium referred to in 4(a) above. The figures cited below (except the Allowance for Profit and Contingencies) were obtained from the Insurance Expense Exhibit compilation prepared by the National Council and distributed to all Insurance Departments:

| Item | 1975 | 1976 |
|---|---|---|
| Commission | 9.3% | 9.1% |
| Other Acquisition | 2.4 | 2.2 |
| 50% of General Expense | 3.4 | 3.1 |
| Taxes | 4.1 | 4.1 |
| Allowance for Profit and Contingencies | 2.5 | 2.5 |
| | 21.7% | 21.0% |

These deductions for the Accounting Method are, in our opinion, conservative for the following reasons:

a. The rates of Commission and Other Acquisition expenses actually incurred and employed in the calculation reflect such expenses from all sized risks, including a substantial volume of business derived from the larger insureds. With respect to the larger risks, the rates of commission are lower and the greater proportion of the premium is developed on interim audits. These audits are made usually monthly or quarterly and when billed represent earned premium in full. Unearned premium reserves are developed only from deposit premiums and additional premiums charged by endorsement during the policy term. Since the smaller risks are not the ones normally using the interim audit arrangement, it can be assumed that a great proportion of the premiums going into the unearned premium reserve is derived from the smaller risks with their relatively higher rate of commission. Thus, it is a fair assumption that the many thousands of risks with premium under $1,000 require expenditure of 17.5% for commissions and other acquisition at inception (this is the allowance for Acquisition applicable to the 1st $1,000 of premium) and the deposit premium from these same risks must be allocated to the unearned premium reserve without deduction for this expense.

b. Concerning interim audits, this method of operation is the equivalent of a negative investment income. First, the premium is not developed until the exposure to loss has gone by and, second, there is a 60 day delay in remitting the premium through the agent. What this means is that as respects any one risk, the payment of any loss is coming from company surplus and any recovery to surplus will not take place until several months later when the interim audited premiums are remitted.

c. Only 50% of the General Expense item has been assumed as applicable at inception of the policy. This is to recognize that payroll audit and the preparation of unit cards represent expenses incurred after expiration of the policy. It could be reasoned, however, that these are offset somewhat by the expenditure of the allowance for inspection for this expense starts when business is written. It is

quite probable that more than 50% of the General Expense is absorbed at or near the inception of the policy.

8 — The average net rate of return is the five-year average ratio of investment income to all assets available for investment and was based on data for stock companies from Best's. The figure was reduced for investment expense which is the five-year average ratio of investment expenses incurred to all assets available for investment and also was based on figures from Best's.

10 — This is derived from net earned premium aggregates for stock companies as reported in Best's, converted to a standard premium basis by application of the ratio of standard to net premium from National Council calendar year experience.

12 — The Federal Income Tax used here was calculated by applying the Federal Tax rates to the distribution of assets for stock companies appearing in Best's.

## STOCK COMPANIES — WORKERS' COMPENSATION

## INVESTMENT INCOME ON UNEARNED PREMIUM RESERVES

(1975 Countrywide Data, Last Three 000 Omitted)

| | | |
|---|---|---|
| 1. | Unearned Premium Reserve — 12-31-74 | 1,133,391 |
| 2. | Unearned Premium Reserve — 12-31-75 | 1,300,137 |
| 3. | Mean Unearned Premium Reserve in 1975 | 1,216,764 |
| 4. | Deductions | |
| | *(a) Delayed Remission of Premiums .292 x (3) | 355,295 |
| | **(b) Accounting Methods | 216,428 |
| 5. | Net Subject to Investment (3) – (4a) – (4b) | 645,041 |
| 6. | Average Rate of Return | 5.40% |
| 7. | Investment Expense | .36% |
| 8. | Average Net Rate of Return | 5.04% |
| 9. | Investment Earnings on Net Subject to Investment (5)x(8) | 32,510 |
| 10. | Standard Earned Premium for 1975 | 4,780,790 |
| 11. | Average Rate of Return as Percent of Earned Premium (Prior to Federal Income Tax) (9) ÷ (10) | .68% |
| 12. | Average Rate of Return after Federal Income Tax [86.9% x (11)]† | .59% |

*To reflect delay in remitting premium to companies.

**Adjusted for the fact that commission and taxes are incurred upon receipt of premium [.217(3) – (4a) (.134)]

† 100.0% – 13.1% = 86.9%.

## STOCK COMPANIES — WORKERS' COMPENSATION

### INVESTMENT INCOME ON UNEARNED PREMIUM RESERVES

(1976 Countrywide Data, Last Three 000 Omitted)

| | | |
|---|---|---|
| 1. | Unearned Premium Reserve — 12-31-75 | 1,300,137 |
| 2. | Unearned Premium Reserve — 12-31-76 | 1,510,391 |
| 3. | Mean Unearned Premium Reserve in 1976 | 1,405,264 |
| 4. | Deductions | |
| | *(a) Delayed Remission of Premiums .292 x (3) | 410,337 |
| | **(b) Accounting Methods | 240,941 |
| 5. | Net Subject to Investment (3) – (4a) – (4b) | 753,986 |
| 6. | Average Rate of Return | 5.61% |
| 7. | Investment Expense | .36% |
| 8. | Average Net Rate of Return | 5.25% |
| 9. | Investment Earnings on Net Subject to Investment (5)x(8) | 39,584 |
| 10. | Standard Earned Premium for 1976 | 5,741,190 |
| 11. | Average Rate of Return as Percent of Earned Premium (Prior to Federal Income Tax) (9) ÷ (10) | .69% |
| 12. | Average Rate of Return after Federal Income Tax [85.6% x (11)]† | .59% |

*To reflect delay in remitting premium to companies.

**Adjusted for the fact that commission and taxes are incurred upon receipt of premium. [.210 (3) – (4a) (.132)]

†100.0% – 14.4% = 85.6%.

# APPENDIX C

## Investment Income on Loss Reserves — Countrywide

The attached exhibit presents an estimate of investment income from loss reserves based on a method of tracing payments of losses during the time premium from transactions giving rise to such losses is in the possession of the carriers. It is a method which is based on the use of actual statistical data showing the distribution of losses by type of injury and the average duration of cases by type of injury. For convenience, the calculations are expressed in terms of the amount of investment income per $10,000 of losses.

An explanation of certain of the columns on the exhibit follows:

Column (2) represents countrywide distribution of incurred losses by type of injury obtained from unit report summary data.

Column (4) represents the percentage of losses by type of injury which are estimated to be paid in installments and not paid in a lump sum. It is the best estimate of insurance company actuaries that all permanent partial non-schedule amounts and 50% of the schedule amounts are paid on an installment basis. The figures in column (4) for permanent partial cases are derived according to the relative weight of non-schedule and schedule losses in each type of injury category. With respect to the medical portion of permanent total and major permanent partial cases, see notes (a) and (b) at the bottom of the exhibit.

Column (6) has been obtained by dividing total incurred average annual benefit by type of injury for this period. The average duration of medical losses in major permanent partial cases is estimated to be 75% of the duration of major permanent partial indemnity losses. The average duration of medical losses in minor permanent partial cases is estimated to be 50% of the duration of minor permanent partial indemnity cases.

Column (7) is the investment income at 5.25% per annum from the amounts in Column (5) for the duration indicated in Column (6). The Column (5) amounts will decrease each year as a result of payouts to injured workmen. Note, however, that under the National Council's Unit Statistical Plan death and permanent total cases involving life pensions must be reported on a present value basis at 3½% interest. As respects these cases the investment income figures in Column (7) are *overstated*.

Line 11. The Federal Income Tax used here was calculated by applying the Federal Tax rates to be distribution of assets and capital gains for stock companies appearing in Best's.

## INVESTMENT INCOME BASED ON $10,000 OF EXPECTED LOSSES—COUNTRYWIDE

| (1) Type of Injury | (2) % of Countrywide Losses | (3) Col. (2) Expressed In Dollars | (4) % of Col. (3) Not Paid In Lump Sum | (5) Amount Not Paid In Lump Sum (3) × (4) | (6) Average Duration Of Case (Years) | (7) Investment Income (Based on 5.25% Rate of Return) |
|---|---|---|---|---|---|---|
| Death (Ind. Only) | 6.15 | 615.00 | 93.50 | 577.05 | 10.2259 | 130.99 |
| Permanent Total (Ind.) | 5.25 | 525.00 | 100.00 | 525.00 | 13.5017 | 147.77 |
| Permanent Total (Med.) | 2.60 | 260.00 | (a) | 260.00 | 13.5017 | 33.81 |
| Major P.P. (Ind.) | 27.15 | 2,715.00 | 72.00 | 1,954.80 | 4.4537 | 230.08 |
| Major P.P. (Med.) | 9.67 | 967.00 | (b) | 967.00 | 3.3403(c) | 45.80 |
| Minor P.P. (Ind.) | 15.29 | 1,529.00 | 74.00 | 1,131.46 | 0.8028 | 38.61 |
| Minor P.P. (Med.) | 6.37 | 637.00 | 100.00 | 637.00 | 0.4014(d) | 13.21 |
| Temporary Total (Ind.) | 13.16 | 1,316.00 | 100.00 | 1,316.00 | 0.1385 | 18.66 |
| Medical (Death, T.T., non-comp., and contract | 14.36 | 1,436.00 | –0– | –0– | –0– | –0– |
| TOTAL | 100.00 | 10,000.00 | xx | xx | xx | 658.93 |

| | | |
|---|---|---|
| 8. | Permissible Loss Ratio (Excl. Loss Adj.) | .598 |
| 9. | Standard Premium $10,000/(8) | 16,722 |
| 10. | Investment Income from Loss Reserves as a Percent of Premium Prior to Federal Income Tax: Sum (7)/(9) | 3.94% |
| 11. | Average Federal Income Tax Rate | 14.4% |
| 12. | Investment Income from Loss Reserves as a Percent of Premium after Federal Income Tax: (10) × [100% – (11)] | 3.37% |

(a) 50% of Permanent Total Medical Losses are paid in first year, 20% in second year, and 30% over remaining duration.
(b) 90% of Major Permanent Partial Medical Losses are paid in first year, and 10% over remaining duration.
(c) Major Permanent Partial Medical duration is 75% of Major Permanent Partial Indemnity Duration.
(d) Minor Permanent Partial Medical duration is 50% of Minor Permanent Partial Indemnity Duration.

# APPENDIX D

## OPERATING RESULTS—STOCK COMPANIES*

| Calendar Year | Net Premium | | Standard Premium | |
|---|---|---|---|---|
| | Mean | Standard Deviation | Mean | Standard Deviation |
| 1972: | | | | |
| Loss Ratio | 0.7078 | 0.0668 | 0.6606 | 0.0630 |
| Operating Ratio | 1.0626 | 0.0678 | 1.0585 | 0.0639 |
| Income#/Premium | −0.0127 | 0.0636 | −0.0119 | 0.0599 |
| 1973: | | | | |
| Loss Ratio | 0.7010 | 0.0590 | 0.6538 | 0.0621 |
| Operating Ratio | 1.0489 | 0.0555 | 1.0456 | 0.0526 |
| Income#/Premium | 0.0019 | 0.0558 | 0.0017 | 0.0528 |
| 1974: | | | | |
| Loss Ratio | 0.7379 | 0.0841 | 0.6761 | 0.0750 |
| Operating Ratio | 1.0938 | 0.0887 | 1.0859 | 0.0814 |
| Income#/Premium | −0.0351 | 0.0858 | −0.0322 | 0.0790 |
| 1975: | | | | |
| Loss Ratio | 0.7506 | 0.0900 | 0.6977 | 0.0816 |
| Operating Ratio | 1.0896 | 0.0886 | 1.0833 | 0.0820 |
| Income#/Premium | −0.0201 | 0.0873 | −0.0187 | 0.0813 |
| 1976: | | | | |
| Loss Ratio | 0.8053 | 0.1103 | 0.7522 | 0.1072 |
| Operating Ratio | 1.12[illegible]3 | 0.1180 | 1.1151 | 0.1097 |
| Income#/Premium | −0.0516 | 0.1099 | −0.0477 | 0.1012 |

* Based on 91 companies or groups for 1972, 90 companies or groups for 1973, 91 companies or groups for 1974, 88 companies or groups for 1975 and all stock companies or groups for 1976.

# Includes investment income.

Data from Insurance Expense Exhibits.

# APPENDIX E

## OPERATING RESULTS—MUTUAL COMPANIES*

| Calendar Year | Net Premium | | Standard Premium | | Net Premium After Dividends | |
|---|---|---|---|---|---|---|
| | Mean | Standard Deviation | Mean | Standard Deviation | Mean | Standard Deviation |
| 1972: | | | | | | |
| Loss Ratio | 0.6789 | 0.1397 | 0.6419 | 0.1373 | 0.7843 | 0.1631 |
| Operating Ratio | 1.0792 | 0.1727 | 1.0749 | 0.1676 | 1.0916 | 0.1880 |
| Income#/Premium | -0.0148 | 0.1106 | -0.0140 | 0.1068 | -0.0171 | 0.1214 |
| 1973: | | | | | | |
| Loss Ratio | 0.6709 | 0.0918 | 0.6246 | 0.0844 | 0.7778 | 0.1070 |
| Operating Ratio | 1.0605 | 0.0820 | 1.0563 | 0.0775 | 1.0701 | 0.0912 |
| Income#/Premium | 0.0012 | 0.0697 | 0.0011 | 0.0654 | 0.0013 | 0.0800 |
| 1974: | | | | | | |
| Loss Ratio | 0.6858 | 0.1057 | 0.6310 | 0.1003 | 0.7959 | 0.1199 |
| Operating Ratio | 1.0775 | 0.1076 | 1.0713 | 0.1018 | 1.0899 | 0.1189 |
| Income#/Premium | -0.0163 | 0.0900 | -0.0150 | 0.0845 | -0.0190 | 0.1017 |
| 1975: | | | | | | |
| Loss Ratio | 0.6896 | 0.0798 | 0.6437 | 0.0722 | 0.7812 | 0.1046 |
| Operating Ratio | 1.0530 | 0.0903 | 1.0495 | 0.0848 | 1.0601 | 0.1055 |
| Income#/Premium | 0.0133 | 0.0913 | 0.0124 | 0.0860 | 0.0150 | 0.1054 |
| 1976: | | | | | | |
| Loss Ratio | 0.7206 | 0.0947 | 0.6874 | 0.0967 | 0.8028 | 0.0983 |
| Operating Ratio | 1.0470 | 0.0963 | 1.0449 | 0.0920 | 1.0524 | 0.1037 |
| Income#/Premium | 0.0155 | 0.0838 | 0.0147 | 0.0800 | 0.0172 | 0.0915 |

* Based on 71 companies or groups for 1972, 72 companies or groups for 1973, 68 companies or groups for 1974, 67 companies or groups for 1975 and all companies or groups for 1976.

# Includes investment income.

Data from Insurance Expense Exhibits.

## APPENDIX F1

# OPERATING RESULTS FOR CALENDAR YEAR 1975 USING NET PREMIUMS

| Carrier | Net Earned Premium | Incurred Losses | Losses + Expenses* | Net Income | Loss Ratio | Operating Ratio | Ratio of Net Income to Premium# |
|---|---|---|---|---|---|---|---|
| Aetna Cas. & Sur. Grp. | $ 263,151,800 | $ 195,197,110 | $ 281,921,762 | $ 4,266,088 | 0.7418 | 1.0713 | 0.0162 |
| Aetna Ins. Grp. | $ 62,227,427 | $ 39,596,873 | $ 61,913,572 | $ 4,785,024 | 0.6363 | 0.9950 | 0.0769 |
| Agway Ins. Grp. | $ 89,717 | $ 37,042 | 101,055 | $ -7,346 | 0.4129 | 1.1264 | -0.0819 |
| All Star Ins. Co. | $ 9,069 | $ 27,956 | $ 32,006 | $ -21,553 | 3.0826 | 3.5292 | -2.3766 |
| All City Ins. Co. | $ 1,916,504 | $ 1,035,308 | $ 2,254,278 | $ -170,194 | 0.5402 | 1.1762 | -0.0888 |
| Alliance Assur. Co. Ltd. | $ 1,812,830 | $ 1,502,371 | $ 2,161,476 | $ -214,690 | 0.8287 | 1.1923 | -0.1184 |
| American General Group | $ 78,563,259 | $ 63,973,127 | $ 89,961,268 | $ -8,732,488 | 0.8143 | 1.1451 | -0.1112 |
| Amer.Home&Natl.UnionGrps. | $ 26,705,607 | $ 18,249,354 | $ 28,324,422 | $ -24,780 | 0.6834 | 1.0606 | -0.0009 |
| American States Ins. Cos. | $ 16,598,079 | $ 10,412,682 | $ 16,312,867 | $ 1,354,604 | 0.6273 | 0.9828 | 0.0816 |
| Amer. Universal Ins. Co. | $ 877,524 | $ 669,025 | $ 923,261 | $ 22,016 | 0.7624 | 1.0521 | 0.0251 |
| Bituminous Cas. Corp. | $ 47,379,170 | $ 33,759,774 | $ 52,470,038 | $ -1,572,506 | 0.7125 | 1.1074 | -0.0332 |
| Casualty Ins. Co. | $ 5,380,136 | $ 3,925,642 | $ 5,731,374 | $ -143,524 | 0.7297 | 1.0653 | -0.0267 |
| Centennial Ins. Co. | $ 4,748,818 | $ 2,877,883 | $ 4,954,818 | $ 159,657 | 0.6060 | 1.0434 | 0.0336 |
| Chicago Ins. Co. | $ 17,797 | $ 120,986 | $ 141,607 | $ -123,810 | 6.7981 | 7.9568 | -6.9568 |
| Commerc. Union Assur. Cos. | $ 140,665,401 | $ 114,434,432 | $ 164,633,989 | $ -11,943,342 | 0.8135 | 1.1704 | -0.0849 |
| Companion Ins. Co. | $ 13,991 | $ 3,690 | $ 10,620 | $ 3,820 | 0.2637 | 0.7591 | 0.2730 |
| Continental Ins. Cos. | $ 243,527,992 | $ 213,417,769 | $ 292,933,760 | $ -32,081,487 | 0.8764 | 1.2029 | -0.1317 |
| CNA Grp. | $ 131,979,949 | $ 107,701,298 | $ 157,670,679 | $ -10,604,413 | 0.8160 | 1.1947 | -0.0803 |
| Covenant Ins. Co. | $ 563,595 | $ 144,216 | $ 336,700 | $ 274,139 | 0.2559 | 0.5974 | 0.4864 |
| Crum & Forster Grp. | $ 209,312,850 | $ 156,521,825 | $ 228,521,618 | $ -19,168,537 | 0.7478 | 1.0918 | -0.0916 |
| Eagle Star Ins. Co. Ltd. | $ 787,985 | $ 517,663 | $ 868,641 | $ -17,726 | 0.6569 | 1.1024 | -0.0225 |
| Employers Cas. Co. | $ 16,413,209 | $ 10,525,374 | $ 16,097,428 | $ 1,064,957 | 0.6413 | 0.9808 | 0.0649 |
| Excelsior Ins. Co. of NY | $ 430,036 | $ 229,781 | $ 438,521 | $ 7,366 | 0.5343 | 1.0197 | 0.0171 |
| Farmers & Merchants Ins. Co. | $ 717,841 | $ 459,577 | $ 741,825 | $ -14,916 | 0.6402 | 1.0334 | -0.0208 |
| Federal Ins. Co. | $ 34,325,856 | $ 27,044,504 | $ 39,817,943 | $ -3,312,331 | 0.7879 | 1.1600 | -0.0965 |

* Includes Dividends

Data from Insurance Expense Exhibits

\# Net Earned Premium Less
Losses, expenses, dividends and investment income related to net earned premium.

## APPENDIX F1

# OPERATING RESULTS FOR CALENDAR YEAR 1975 USING NET PREMIUMS

| Carrier | Net Earned Premium | Incurred Losses | Losses + Expenses* | Net Income | Loss Ratio | Operating Ratio | Ratio of Net Income to Premium# |
|---|---|---|---|---|---|---|---|
| Fireman's Fund/American | $ 237,464,228 | $ 158,188,388 | $ 239,877,621 | $ 11,519,771 | 0.6662 | 1.0102 | 0.0485 |
| First Ins. Co. of Hawaii | $ 6,261,548 | $ 5,101,970 | $ 6,771,427 | $ −63,510 | 0.8148 | 1.0814 | −0.0101 |
| Forum Ins. Co. | $ 570,749 | $ 513,339 | $ 685,838 | $ −103,024 | 0.8994 | 1.2016 | −0.1805 |
| General Accident Grp. | $ 32,512,974 | $ 23,805,850 | $ 37,107,606 | $ −2,053,724 | 0.7322 | 1.1413 | −0.0632 |
| Gen Cas. Co of Wisc. | $ 3,563,962 | $ 1,891,392 | $ 2,942,697 | $ 864,590 | 0.5307 | 0.8257 | 0.2426 |
| Gen Fire & Cas. Co. | $ 2,311,425 | $ 1,484,038 | $ 2,082,664 | $ 367,108 | 0.6420 | 0.9010 | 0.1588 |
| Gen Ins. of Trieste & Venice | $ 19,317 | $ −13,879 | $ −8,090 | $ 32,545 | −0.7185 | −0.4188 | 1.6848 |
| Great Amer Ins. Cos. | $ 78,946,706 | $ 57,908,932 | $ 84,117,457 | $ 1,402,565 | 0.7335 | 1.0655 | 0.0178 |
| Great Northern Ins. Co. | $ 2,384,742 | $ 1,944,701 | $ 2,863,112 | $ −345,203 | 0.8155 | 1.2006 | −0.1448 |
| Gulf Ins. Grp. | $ 17,900,244 | $ 18,699,798 | $ 25,572,466 | $ −6,656,070 | 1.0447 | 1.4286 | −0.3718 |
| Hanover Ins. Grp. | $ 15,951,113 | $ 12,471,505 | $ 19,248,684 | $ −1,900,366 | 0.7819 | 1.2067 | −0.1191 |
| Harbor Ins. Grp. | $ 675,396 | $ 1,172,658 | $ 1,369,783 | $ −571,422 | 1.7363 | 2.0281 | −0.8461 |
| Hartford Ins. Grp. | $ 271,501,858 | $ 210,450,701 | $ 312,987,838 | $ −21,408,185 | 0.7751 | 1.1528 | −0.0789 |
| Hawaiian Ins. & Guar Co. Ltd. | $ 4,663,703 | $ 2,158,986 | $ 3,854,636 | $ 1,090,834 | 0.4629 | 0.8265 | 0.2339 |
| Highlands Ins. Grp. | $ 45,388,775 | $ 36,851,554 | $ 46,165,604 | $ 1,859,125 | 0.8119 | 1.0171 | 0.0410 |
| Home Grp. | $ 159,757,680 | $ 102,731,870 | $ 150,677,969 | $ 18,409,073 | 0.6430 | 0.9432 | 0.1152 |
| Illinois Ins. Co. | $ 172,184 | $ 102,498 | $ 197,935 | $ −19,833 | 0.5953 | 1.1496 | −0.1152 |
| Ins. Co. of Greater NY | $ 1,442,130 | $ 722,986 | $ 1,410,928 | $ 84,830 | 0.5013 | 0.9784 | 0.0588 |
| Ins. Co. of North America | $ 101,577,327 | $ 76,139,144 | $ 109,089,393 | $ 4,319,541 | 0.7496 | 1.0740 | 0.0425 |
| Interstate Fire & Cas. Co. | $ 53,392 | $ 362,959 | $ 424,823 | $ −371,431 | 6.7980 | 7.9567 | −6.9567 |
| Island Ins. Co. Ltd. | $ 1,020,268 | $ 522,405 | $ 1,027,718 | $ 94,639 | 0.5120 | 1.0073 | 0.0928 |
| London Assurance Co. | $ 2,818,136 | $ 2,314,726 | $ 3,370,941 | $ −366,945 | 0.8214 | 1.1962 | −0.1302 |
| Mid-Continent Cas. Co. | $ 5,114,717 | $ 4,438,580 | $ 5,730,444 | $ −467,865 | 0.8678 | 1.1204 | −0.0915 |
| Midland Ins. Co. | $ 7,717,144 | $ 8,041,530 | $ 9,849,772 | $ −1,406,608 | 1.0420 | 1.2763 | −0.1823 |
| Mission Ins. Co.* | $ 40,515,046 | $ 28,414,295 | $ 40,942,654 | $ 679,386 | 0.7013 | 1.0106 | 0.0168 |

Data from Insurance Expense Exhibits

* Includes Dividends

\# Net Earned Premium Less
Losses, expenses, dividends and investment income related to net earned premium.

## APPENDIX F1

# OPERATING RESULTS FOR CALENDAR YEAR 1975 USING NET PREMIUMS

| Carrier | Net Earned Premium | Incurred Losses | Losses + Expenses* | Net Income | Loss Ratio | Operating Ratio | Ratio of Net Income to Premium# |
|---|---|---|---|---|---|---|---|
| Monarch Ins. Co. of Ohio | $ 291,293 | $ 124,622 | $ 319,381 | $ -10,381 | 0.4278 | 1.0964 | -0.0356 |
| Motor Vehicle Cas. Co. | $ 547,120 | $ 288,366 | $ 510,287 | $ 97,692 | 0.5271 | 0.9327 | 0.1786 |
| National Indem. Cos. | $ 5,065,452 | $ 3,663,127 | $ 5,410,369 | $ -26,520 | 0.7232 | 1.0681 | -0.0052 |
| Netherlands Ins. Co. | $ 645,407 | $ 375,822 | $ 647,373 | $ 42,668 | 0.5823 | 1.0030 | 0.0661 |
| New Hampshire Ins. Cos. | $ 32,547,404 | $ 21,492,628 | $ 32,459,872 | $ 1,578,595 | 0.6603 | 0.9973 | 0.0485 |
| Ohio Cas. Ins. Co. | $ 13,792,922 | $ 8,718,615 | $ 13,879,834 | $ 614,492 | 0.6321 | 1.0063 | 0.0446 |
| Patriot Gen Ins. Co. | $ 185,825 | $ 45,511 | $ 179,362 | $ 53,035 | 0.2449 | 0.9652 | 0.2854 |
| Pekin Ins. Co. | $ 265,582 | $ 119,425 | $ 207,023 | $ 71,183 | 0.4497 | 0.7795 | 0.2680 |
| Phoenix of London Grp. | $ 15,519,265 | $ 13,624,782 | $ 18,766,611 | $ -2,248,816 | 0.8779 | 1.2092 | -0.1449 |
| Protective Fire & Cas. Co. | $ -897 | $ -172 | $ 46,506 | $ -46,525 | 0.1918 | -51.8462 | 51.8673 |
| Protective Ins. Co. | $ 1,783,547 | $ 2,276,368 | $ 2,882,784 | $ -962,749 | 1.2763 | 1.6163 | -0.5398 |
| Providence Wash. Ins. Co. | $ 11,797,671 | $ 7,381,551 | $ 11,343,900 | $ 807,144 | 0.6257 | 0.9615 | 0.0684 |
| Ranger/Pan Amer. Ins. Cos. | $ 7,283,961 | $ 5,073,055 | $ 7,352,222 | $ 725,289 | 0.6965 | 1.0094 | 0.0996 |
| Reliance Ins. Cos. | $ 66,624,148 | $ 51,723,455 | $ 78,196,351 | $ -6,577,241 | 0.7763 | 1.1737 | -0.0987 |
| Republic-Vanguard Grp. | $ 9,352 | $ 7,483 | $ 13,274 | $ -3,687 | 0.8001 | 1.4194 | -0.3942 |
| Reserve Ins. Co. | $ 2,820,131 | $ 1,772,977 | $ 1,858,010 | $ 1,039,505 | 0.6287 | 0.6588 | 0.3686 |
| Royal-Globe Ins. Cos. | $ 114,199,099 | $ 87,451,391 | $ 123,361,076 | $ 2,026,831 | 0.7658 | 1.0802 | 0.0177 |
| St. Paul Ins. Cos. | $ 77,849,431 | $ 55,394,462 | $ 81,372,146 | $ 2,418,801 | 0.7116 | 1.0453 | 0.0311 |
| Sea Ins. Co. Ltd. | $ 1,953,881 | $ 1,612,942 | $ 2,354,347 | $ -290,258 | 0.8255 | 1.2050 | -0.1486 |
| Security Ins. Grp. | $ 17,931,536 | $ 13,756,264 | $ 20,459,251 | $ -1,032,155 | 0.7672 | 1.1410 | -0.0576 |
| South Carolina Ins. Co. | $ 3,052,755 | $ 1,933,967 | $ 3,106,781 | $ 9,577 | 0.6335 | 1.0177 | 0.0031 |
| Southern Home Ins. Co. | $ 81,199 | $ 7,854 | $ 17,898 | $ 63,334 | 0.0967 | 0.2204 | 0.7800 |
| State Farm Fire & Cas. Co. | $ 15,612,796 | $ 9,104,177 | $ 14,545,556 | $ 1,984,452 | 0.5831 | 0.9316 | 0.1271 |
| Sun Ins. Office Ltd. | $ 3,236,567 | $ 2,671,030 | $ 3,972,406 | $ -528,375 | 0.8253 | 1.2274 | -0.1633 |
| Tower Ins. Co. | $ 816,112 | $ 268,698 | $ 647,219 | $ 221,673 | 0.3292 | 0.7931 | 0.2716 |

Data from Insurance Expense Exhibits

* Includes Dividends

\# Net Earned Premium Less
Losses, expenses, dividends and investment income related to net earned premium.

## APPENDIX F1

# OPERATING RESULTS FOR CALENDAR YEAR 1975 USING NET PREMIUMS

| Carrier | Net Earned Premium | Incurred Losses | Losses + Expenses* | Net Income | Loss Ratio | Operating Ratio | Ratio of Net Income to Premium# |
|---|---|---|---|---|---|---|---|
| Transamerica Group | $ 28,359,628 | $ 20,701,515 | $ 32,830,203 | $ -3,146,555 | 0.7300 | 1.1576 | -0.1110 |
| Travelers Indem. of Ill. | $ 4,057,746 | $ 3,246,248 | $ 3,965,516 | $ 287,574 | 0.8000 | 0.9773 | 0.0709 |
| Travelers Ins. Co. | $ 44,457,831 | $ 45,210,882 | $ 48,660,670 | $ 1,813,889 | 1.0169 | 1.0945 | 0.0408 |
| Trinity Universal Ins. Co. | $ 5,739,031 | $ 3,188,950 | $ 5,122,897 | $ 989,642 | 0.5557 | 0.8926 | 0.1724 |
| Tri-State Ins. Co. | $ 3,589,203 | $ 2,297,886 | $ 3,772,015 | $ -110,015 | 0.6402 | 1.0509 | -0.0307 |
| Unigard Ins. Co. | $ 274,754 | $ 339,028 | $ 479,881 | $ -186,163 | 1.2339 | 1.7466 | -0.6776 |
| United Fire & Cas. Co. | $ 1,015,638 | $ 419,553 | $ 784,284 | $ 291,656 | 0.4131 | 0.7722 | 0.2872 |
| U. S. Fidelity & Guar. Co. | $ 175,760,412 | $ 120,982,604 | $ 176,704,361 | $ 10,744,985 | 0.6883 | 1.0054 | 0.0611 |
| Vernon Fire & Cas. Co. | $ 191,549 | $ 79,862 | $ 146,143 | $ 51,478 | 0.4169 | 0.7630 | 0.2687 |
| Vigilant Ins. Co. | $ 6,212,341 | $ 5,051,700 | $ 7,563,408 | $ -994,111 | 0.8132 | 1.2175 | -0.1600 |
| Western Cas. & Sur. | $ 21,829,482 | $ 14,161,473 | $ 21,820,267 | $ 733,245 | 0.6487 | 0.9996 | 0.0336 |
| Westfield Cos. | $ 2,228,004 | $ 1,088,443 | $ 2,290,182 | $ -39,287 | 0.4885 | 1.0279 | -0.0176 |
| Zurich-American Ins. Cos. | $ 49,291,388 | $ 36,569,688 | $ 54,322,808 | $ -930,523 | 0.7419 | 1.1021 | -0.0189 |
| Totals | $ 3,065,439,772 | $ 2,301,032,420 | $ 3,340,009,922 | $ -61,692,772 | | | |
| Means | x x x | x x x | x x x | x x x | 0.7506 | 1.0896 | -0.0201 |
| Standard Deviations | x x x | x x x | x x x | x x x | 0.0900 | 0.0886 | 0.0873 |

W:PJW-7/19/76

Data from Insurance Expense Exhibits

* Includes Dividends

\# Net Earned Premium Less
Losses, expenses, dividends and investment income related to net earned premium.

## APPENDIX F2

# OPERATING RESULTS FOR CALENDAR YEAR 1974 USING NET PREMIUMS

| Carrier | Net Earned Premium | Incurred Losses | Losses + Expenses* | Net Income | Loss Ratio | Operating Ratio | Ratio of Net Income to Premium# |
|---|---|---|---|---|---|---|---|
| Aetna Cas. & Sur. Grp. | $ 222,798,590 | $ 171,421,442 | $ 252,329,461 | $ -9,233,030 | 0.7694 | 1.1325 | -0.0414 |
| Aetna Ins. Grp. | $ 51,436,272 | $ 37,039,261 | $ 56,078,387 | $ -2,003,881 | 0.7201 | 1.0902 | -0.0390 |
| Agway Ins. Grp. | $ 68,057 | $ 7,419 | $ 48,567 | $ 22,636 | 0.1090 | 0.7136 | 0.3326 |
| All Star Ins. Co. | $ 16,464 | $ 10,260 | $ 13,775 | $ 4,080 | 0.6232 | 0.8367 | 0.2478 |
| All City Ins. Co. | $ 1,184,502 | $ 553,904 | $ 1,327,830 | $ -32,972 | 0.4676 | 1.1210 | -0.0278 |
| Alliance Ins. Co. Ltd. | $ 1,758,942 | $ 1,376,046 | $ 2,003,347 | $ -163,405 | 0.7823 | 1.1390 | -0.0929 |
| Amer.Home&Natl.UnionGrps. | $ 7,269,833 | $ 5,432,232 | $ 9,694,397 | $ -1,900,736 | 0.7472 | 1.3335 | -0.2615 |
| Amer. States Ins. Co. | $ 14,432,794 | $ 11,839,886 | $ 17,497,835 | $ -2,446,778 | 0.8203 | 1.2124 | -0.1695 |
| Amer. Universal Ins. Co. | $ 1,473,929 | $ 1,076,405 | $ 1,717,596 | $ -163,289 | 0.7303 | 1.1653 | -0.1108 |
| Bituminous Cas. Corp. | $ 45,177,338 | $ 33,709,720 | $ 50,962,549 | $ -2,879,594 | 0.7462 | 1.1281 | -0.0637 |
| Casualty Ins. Co. | $ 3,880,821 | $ 2,570,372 | $ 4,081,495 | $ -57,487 | 0.6623 | 1.0517 | -0.0148 |
| Centennial Ins. Co. | $ 4,450,736 | $ 3,195,488 | $ 5,244,784 | $ -558,243 | 0.7180 | 1.1784 | -0.1254 |
| Chicago Ins. Co. | $ 221,896 | $ 225,226 | $ 309,818 | $ -87,289 | 1.0150 | 1.3962 | -0.3934 |
| Commerc. Union Assn. Cos. | $ 122,713,023 | $ 82,262,712 | $ 126,388,946 | $ 3,805,277 | 0.6704 | 1.0300 | 0.0310 |
| Companion Ins. Co. | $ 8,926 | $ 6,516 | $ 12,114 | $ -2,731 | 0.7300 | 1.3572 | -0.3060 |
| Continental Ins. Co. | $ 181,368,443 | $ 161,548,047 | $ 224,066,239 | $ -37,570,984 | 0.8907 | 1.2354 | -0.2072 |
| CNA Grp. | $ 173,297,060 | $ 143,601,352 | $ 200,148,755 | $ -14,137,965 | 0.8286 | 1.1549 | -0.0816 |
| Covenant Ins. Co. | $ 433,000 | $ 271,042 | $ 423,053 | $ -5,187 | 0.6260 | 0.9770 | -0.0120 |
| Crum & Forster Grp. | $ 61,892,852 | $ 40,311,228 | $ 62,247,053 | $ -354,201 | 0.6513 | 1.0057 | -0.0057 |
| Eagel Star Ins. Co. Ltd. | $ 527,673 | $ 349,054 | $ 601,347 | $ -30,618 | 0.6615 | 1.1396 | -0.0580 |
| Employers Cas. Co. | $ 12,240,852 | $ 8,028,499 | $ 12,543,737 | $ 25,554 | 0.6559 | 1.0247 | 0.0021 |
| Excelsior Ins. Co. Of NY | $ 314,539 | $ 158,401 | $ 286,280 | $ 45,581 | 0.5036 | 0.9102 | 0.1449 |
| Farmers & Merchants Ins. Co. | $ 650,278 | $ 409,349 | $ 684,566 | $ -27,666 | 0.6295 | 1.0527 | -0.0425 |
| Federal Ins. Co. | $ 33,884,473 | $ 26,988,292 | $ 40,612,934 | $ -5,342,461 | 0.7965 | 1.1986 | -0.1577 |
| Fireman's Fund/American | $ 182,092,145 | $ 119,110,898 | $ 194,707,210 | $ 318,142 | 0.6541 | 1.0693 | 0.0017 |

Data from Insurance Expense Exhibits

* Includes Dividends

\# Net Earned Premium Less
Losses, expenses, dividends and investment income related to net earned premium

## APPENDIX F2

# OPERATING RESULTS FOR CALENDAR YEAR 1974 USING NET PREMIUMS

| Carrier | Net Earned Premium | Incurred Losses | Losses + Expenses* | Net Income | Loss Ratio | Operating Ratio | Ratio of Net Income to Premium# |
|---|---|---|---|---|---|---|---|
| First Ins. Co. of Hawaii | $ 4,745,589 | $ 3,588,632 | $ 4,966,525 | $ 187,191 | 0.7562 | 1.0466 | 0.0394 |
| Forum Ins. Co. | $ 409,761 | $ 194,625 | $ 355,90[illegible] | $ 66,665 | 0.4750 | 0.8686 | 0.1627 |
| General Accident Grp. | $ 30,036,309 | $ 19,215,774 | $ 31,308,805 | $ 664,319 | 0.6398 | 1.0424 | 0.0221 |
| Gen. Cas. Co. of Wisc. | $ 2,939,132 | $ 1,501,601 | $ 2,435,951 | $ 640,954 | 0.5109 | 0.8288 | 0.2181 |
| Gen Fire & Cas. Co. | $ 2,371,513 | $ 1,090,241 | $ 1,653,421 | $ 915,601 | 0.4597 | 0.6972 | 0.3861 |
| Gen Ins. Co. of Trieste & Venice | $ 47,274 | $ -1,005 | $ 20,626 | $ 30,532 | -0.0213 | 0.4363 | 0.6459 |
| Great Amer. Ins. Grp. | $ 57,265,041 | $ 36,224,188 | $ 54,336,013 | $ 7,397,770 | 0.6326 | 0.9489 | 0.1292 |
| Great Northern Ins. Co. | $ 2,063,620 | $ 1,599,850 | $ 2,436,687 | $ -302,067 | 0.7753 | 1.1808 | -0.1464 |
| Gulf Ins. Grp. | $ 18,178,817 | $ 14,577,975 | $ 20,708,759 | $ -1,675,467 | 0.8019 | 1.1392 | -0.0922 |
| Hanover Ins. Grp. | $ 13,209,351 | $ 7,981,669 | $ 13,113,317 | $ 96,625 | 0.6042 | 0.9927 | 0.0073 |
| Harbor Ins. Grp. | $ 979,162 | $ 394,836 | $ 543,820 | $ 511,234 | 0.4032 | 0.5554 | 0.5221 |
| Hartford Ins. Grp. | $ 299,638,575 | $ 213,241,594 | $ 320,298,851 | $ -1,269,853 | 0.7117 | 1.0690 | -0.0042 |
| Hawaiian Ins. & Guar.Co.Ltd. | $ 2,516,917 | $ 2,401,007 | $ 3,527,805 | $ -837,498 | 0.9539 | 1.4016 | -0.3327 |
| Highlands Ins. Co. | $ 49,037,510 | $ 38,418,698 | $ 51,389,524 | $ 99,090 | 0.7835 | 1.0480 | 0.0020 |
| Home Grp. | $ 122,719,386 | $ 84,674,310 | $ 125,386,260 | $ 1,406,333 | 0.6900 | 1.0217 | 0.0115 |
| Illinois Ins. Grp. | $ 130,716 | $ 103,973 | $ 188,647 | $ -52,930 | 0.7954 | 1.4432 | -0.4049 |
| Ins. Co. of Greater NY | $ 1,417,712 | $ 577,811 | $ 1,209,805 | $ 307,492 | 0.4076 | 0.8534 | 0.2169 |
| Ins. Co. of North America | $ 83,184,507 | $ 71,367,606 | $ 104,356,727 | $ -12,195,096 | 0.8579 | 1.2545 | -0.1466 |
| Interstate Fire & Cas. Co. | $ 665,689 | $ 675,684 | $ 929,459 | $ -261,870 | 1.0150 | 1.3962 | -0.3934 |
| Interstate Ins. Co. | $ 2,803 | $ 815 | $ 2,586 | $ 217 | 0.2908 | 0.9226 | 0.0774 |
| Island Ins. Co. Ltd. | $ 890,281 | $ 886,677 | $ 1,205,070 | $ -273,092 | 0.9960 | 1.3536 | -0.3067 |
| London Assurance Co. | $ 2,613,359 | $ 2,037,437 | $ 3,032,327 | $ -314,968 | 0.7796 | 1.1603 | -0.1205 |
| Maryland Amer. Gen. Ins. Co. | $ 63,731,860 | $ 45,052,705 | $ 67,152,454 | $ -526,754 | 0.7069 | 1.0537 | -0.0083 |
| Mid-Continent Cas. Co. | $ 4,284,548 | $ 3,282,676 | $ 4,311,140 | $ 85,826 | 0.7662 | 1.0062 | 0.0200 |
| Midland Ins. Co. | $ 9,941,016 | $ 6,944,417 | $ 8,299,267 | $ 2,111,462 | 0.6986 | 0.8349 | 0.2124 |

Data from Insurance Expense Exhibits

* Includes Dividends

\# Net Earned Premium Less
Losses, expenses, dividends and investment income related to net earned premium

## APPENDIX F2

# OPERATING RESULTS FOR CALENDAR YEAR 1974 USING NET PREMIUMS

| Carrier | Net Earned Premium | Incurred Losses | Losses + Expenses* | Net Income | Loss Ratio | Operating Ratio | Ratio of Net Income to Premium# |
|---|---|---|---|---|---|---|---|
| [illegible]ns. Co. | $ 28,950,324 | $ 17,985,574 | $ 25,766,721 | $ 4,221,418 | 0.6213 | 0.8900 | 0.1458 |
| Mot[illegible] Ins. Co. of Ohio | $ 122,284 | $ 126,228 | $ 173,668 | $ -21,718 | 1.0323 | 1.4202 | -0.1776 |
| Mot[illegible]ehicle Cas. Co. | $ 551,905 | $ 309,086 | $ 509,807 | $ 100,282 | 0.5600 | 0.9237 | 0.1817 |
| National Indem. Cos. | $ 4,723,027 | $ 3,292,656 | $ 4,830,904 | $ 93,058 | 0.6971 | 1.0228 | 0.0197 |
| Netherlands Ins. Co. | $ 517,174 | $ 262,492 | $ 489,877 | $ 53,550 | 0.5076 | 0.9472 | 0.1035 |
| New Hampshire Ins. Co. | $ 21,734,695 | $ 13,868,774 | $ 21,680,258 | $ 635,683 | 0.6381 | 0.9975 | 0.0292 |
| Ohio Cas. Ins. Co. | $ 13,358,749 | $ 6,498,705 | $ 11,065,886 | $ 2,678,556 | 0.4865 | 0.8284 | 0.2005 |
| Patroit Gen Ins. Co. | $ 378,515 | $ 383,571 | $ 508,906 | $ -142,793 | 1.0134 | 1.3445 | -0.3772 |
| Pekin Ins. Co. | $ 204,434 | $ 150,315 | $ 229,061 | $ -13,755 | 0.7353 | 1.1205 | -0.0673 |
| Phoenix of London Grp. | $ 11,625,761 | $ 10,354,854 | $ 14,427,453 | $ -2,231,392 | 0.8907 | 1.2410 | -0.1919 |
| Protective Fire & Cas. Co. | $ 7,526 | $ -3,417 | $ 49,308 | $ -41,188 | -0.4540 | 6.5517 | -5.4728 |
| Protective Ins. Co. | $ 1,027,634 | $ 878,461 | $ 1,192,820 | $ -84,357 | 0.8548 | 1.1607 | -0.0821 |
| Providence Wash. Ins. Co. | $ 7,211,581 | $ 4,789,875 | $ 7,457,390 | $ 45,736 | 0.6642 | 1.0341 | 0.0063 |
| Prudential Prop. & Cas. Co. | $ 1,497 | $ 17,570 | $ 20,413 | $ -13,471 | 11.7368 | 13.6359 | -8.9987 |
| Ranger-Pan American Grp. | $ 8,667,458 | $ 8,924,310 | $ 12,290,554 | $ -3,124,984 | 1.0296 | 1.4180 | -0.3605 |
| Reliance Ins. Cos. | $ 59,685,313 | $ 39,207,648 | $ 63,437,215 | $ -3,031,312 | 0.6569 | 1.0629 | -0.0508 |
| Republic-Vanguard Grp. | $ 6,939 | $ 9,442 | $ 12,392 | $ -5,237 | 1.3607 | 1.7858 | -0.7547 |
| Reserve Ins. Grp. | $ 1,449,756 | $ 1,334,566 | $ 1,663,657 | $ -228,720 | 0.9205 | 1.1475 | -0.1578 |
| Royal-Globe Ins. Co. | $ 113,375,763 | $ 92,229,023 | $ 126,907,198 | $ -5,048,185 | 0.8135 | 1.1194 | -0.0445 |
| St. Paul Ins. Co. | $ 68,175,982 | $ 48,282,901 | $ 72,686,438 | $ -587,902 | 0.7082 | 1.0662 | -0.0086 |
| Sea Ins. Co. Ltd. | $ 1,723,619 | $ 1,348,049 | $ 1,977,697 | $ -180,078 | 0.7821 | 1.1474 | -0.1045 |
| Security Ins. Grp. | $ 15,420,490 | $ 11,184,073 | $ 17,240,279 | $ -1,416,097 | 0.7253 | 1.1180 | -0.0918 |
| South Carolina Ins. Co. | $ 2,573,086 | $ 1,573,276 | $ 2,526,758 | $ 146,716 | 0.6114 | 0.9820 | 0.0570 |
| Southern Home Ins. Co. | $ 81,943 | $ 43,024 | $ 78,550 | $ 5,207 | 0.5250 | 0.9586 | 0.0635 |
| State Farm Fire & Cas. | $ 11,986,359 | $ 8,103,308 | $ 12,427,623 | $ 148,496 | 0.6760 | 1.0368 | 0.0124 |

Data from Insurance Expense Exhibit

* Includes Dividends

\# Net Earned Premium Less
Losses, expenses, dividends and investment income related to net earned premium.

## APPENDIX F2

# OPERATING RESULTS FOR CALENDAR YEAR 1974 USING NET PREMIUMS

| Carrier | Net Earned Premium | Incurred Losses | Losses + Expenses* | Net Income | Loss Ratio | Operating Ratio | Ratio of Net Income to Premium# |
|---|---|---|---|---|---|---|---|
| Sun Ins. Office Ltd. | $ 2,501,404 | $ 1,958,771 | $ 2,980,745 | $ -347,341 | 0.7831 | 1.1916 | -0.1389 |
| Tower Ins. Co. | $ 427,903 | $ 315,343 | $ 452,286 | $ 2,003 | 0.7369 | 1.0570 | 0.0047 |
| Trans. America Ins. Co. | $ 20,122,319 | $ 12,614,675 | $ 22,048,961 | $ -977,010 | 0.6269 | 1.0957 | -0.0486 |
| Travelers Indem. of Ill. | $ 3,005,981 | $ 2,495,048 | $ 3,239,123 | $ -90,392 | 0.8300 | 1.0776 | -0.0301 |
| Travelers Ins. Co. | $ 78,393,930 | $ 57,456,853 | $ 85,358,838 | $ 1,772,570 | 0.7329 | 1.0888 | 0.0226 |
| Trinity Universal Ins. Co. | $ 4,894,985 | $ 3,556,761 | $ 5,051,843 | $ 95,374 | 0.7266 | 1.0320 | 0.0195 |
| Tri-State Ins. Co. | $ 3,251,393 | $ 2,046,746 | $ 3,420,592 | $ -85,976 | 0.6295 | 1.0520 | -0.0264 |
| Unigard Ins. Co. | $ 183,573 | $ 139,618 | $ 231,383 | $ -43,021 | 0.7606 | 1.2604 | -0.2344 |
| United Fire & Cas. | $ 813,144 | $ 332,273 | $ 607,380 | $ 251,082 | 0.4086 | 0.7470 | 0.3088 |
| U. S. Fidelity & Guar. Co. | $ 146,453,317 | $ 104,770,275 | $ 152,114,650 | $ 967,178 | 0.7154 | 1.0387 | 0.0066 |
| Vernon Fire & Cas. Co. | $ 192,151 | $ 137,765 | $ 214,848 | $ -9,826 | 0.7170 | 1.1181 | -0.0511 |
| Vigilant Ins. Co. | $ 4,936,121 | $ 3,917,792 | $ 5,883,974 | $ -765,853 | 0.7937 | 1.1920 | -0.1552 |
| Western Cas. & Sur. Co. | $ 18,241,889 | $ 11,612,284 | $ 17,943,488 | $ 535,574 | 0.6366 | 0.9836 | 0.0294 |
| Westfield Cos. | $ 1,843,476 | $ 783,774 | $ 1,716,891 | $ 35,998 | 0.4252 | 0.9313 | 0.0195 |
| Wolverine Ins. Co. | $ 2,486,510 | $ 1,513,159 | $ 2,386,349 | $ 211,494 | 0.6085 | 0.9597 | 0.0851 |
| Zurich-American Ins. Co. | $ 36,968,484 | $ 32,384,635 | $ 47,706,463 | $ -7,972,189 | 0.8760 | 1.2905 | -0.2156 |
| Totals | $ 2,594,892,280 | $ 1,914,726,983 | $ 2,838,210,469 | $ -91,064,637 | | | |
| Means | xxx | xxx | xxx | xxx | 0.7379 | 1.0938 | -0.0351 |
| Standard Deviations | xxx | xxx | xxx | xxx | 0.0841 | 0.0887 | 0.0858 |

W:GAC-3/23/78

Data from Insurance Expense Exhibits

* Includes Dividends

\# Net Earned Premium Less
Losses, expenses, dividends and investment income related to net earned premium.

# LOSS RATIO DISTRIBUTION
# BASED ON CALENDAR YEAR 1976 USING STANDARD PREMIUM
# STOCK AND MUTUAL COMPANIES

| (1) Ratio To Average | (2) Loss Ratio | (3) No. of Cos. at Loss Ratio Interval | (4) % of Cos. at Loss Ratio Interval | (5) % of Cos. at or Above Interval | (6) Premium at Loss Ratio Interval | (7) % of Premium at Loss Ratio Interval | (8) % of Premium at or Above Interval |
|---|---|---|---|---|---|---|---|
| 0.00 | 0.000 | 2 | 0.7905 | 100.0000 | 9,941 | 0.0001 | 100.0000 |
| 0.05 | 0.037 | 1 | 0.3953 | 99.2095 | 3,064 | 0.0000 | 99.9999 |
| 0.10 | 0.074 | 2 | 0.7905 | 98.8142 | 212,354 | 0.0030 | 99.9998 |
| 0.15 | 0.110 | 1 | 0.3953 | 98.0237 | 614,104 | 0.0086 | 99.9968 |
| 0.20 | 0.147 | 0 | 0.0000 | 97.6285 | 0 | 0.0000 | 99.9882 |
| 0.25 | 0.184 | 0 | 0.0000 | 97.6285 | 0 | 0.0000 | 99.9882 |
| 0.30 | 0.221 | 1 | 0.3953 | 97.6285 | 974,847 | 0.0137 | 99.9882 |
| 0.35 | 0.258 | 1 | 0.3953 | 97.2332 | 1,310,645 | 0.0184 | 99.9745 |
| 0.40 | 0.294 | 2 | 0.7905 | 96.8379 | 710,294 | 0.0100 | 99.9561 |
| 0.45 | 0.331 | 0 | 0.0000 | 96.0474 | 0 | 0.0000 | 99.9461 |
| 0.50 | 0.368 | 3 | 1.1858 | 96.0474 | 2,735,736 | 0.0384 | 99.9461 |
| 0.55 | 0.405 | 7 | 2.7668 | 94.8617 | 19,749,661 | 0.2776 | 99.9077 |
| 0.60 | 0.442 | 10 | 3.9526 | 92.0949 | 22,187,159 | 0.3118 | 99.6301 |
| 0.65 | 0.478 | 7 | 2.7668 | 88.1423 | 91,768,588 | 1.2897 | 99.3183 |
| 0.70 | 0.515 | 15 | 5.9289 | 85.3755 | 176,018,432 | 2.4738 | 98.0285 |
| 0.75 | 0.552 | 20 | 7.9051 | 79.4466 | 106,511,480 | 1.4969 | 95.5548 |
| 0.80 | 0.589 | 17 | 6.7194 | 71.5415 | 208,918,858 | 2.9362 | 94.0578 |
| 0.85 | 0.626 | 34 | 13.4387 | 64.8221 | 618,276,596 | 8.6893 | 91.1217 |
| 0.90 | 0.662 | 24 | 9.4862 | 51.3834 | 1,926,558,254 | 27.0761 | 82.4323 |
| 0.95 | 0.699 | 25 | 9.8814 | 41.8972 | 928,035,400 | 13.0427 | 55.3562 |
| 1.00 | 0.736 | 19 | 7.5099 | 32.0158 | 865,413,821 | 12.1626 | 42.3135 |
| 1.05 | 0.773 | 17 | 6.7194 | 24.5059 | 532,678,292 | 7.4863 | 30.1509 |
| 1.10 | 0.810 | 7 | 2.7668 | 17.7866 | 257,899,353 | 3.6245 | 22.6645 |
| 1.15 | 0.846 | 9 | 3.5573 | 15.0198 | 750,568,731 | 10.5486 | 19.0400 |
| 1.20 | 0.883 | 5 | 1.9763 | 11.4625 | 192,898,775 | 2.7110 | 8.4914 |
| 1.25 | 0.920 | 5 | 1.9763 | 9.4862 | 318,837,160 | 4.4810 | 5.7804 |
| 1.30 | 0.957 | 2 | 0.7905 | 7.5099 | 68,697,457 | 0.9655 | 1.2994 |
| 1.35 | 0.994 | 0 | 0.0000 | 6.7194 | 0 | 0.0000 | 0.3339 |
| 1.40 | 1.030 | 0 | 0.0000 | 6.7194 | 0 | 0.0000 | 0.3339 |
| 1.45 | 1.067 | 2 | 0.7905 | 6.7194 | 4,281,768 | 0.0602 | 0.3339 |
| 1.50 | 1.104 | 1 | 0.3953 | 5.9289 | 3,356,649 | 0.0472 | 0.2737 |
| 1.55 | 1.141 | 4 | 1.5810 | 5.5336 | 7,292,578 | 0.1025 | 0.2266 |
| 1.60 | 1.178 | 0 | 0.0000 | 3.9526 | 0 | 0.0000 | 0.1241 |
| 1.65 | 1.214 | 0 | 0.0000 | 3.9526 | 0 | 0.0000 | 0.1241 |
| 1.70 | 1.251 | 0 | 0.0000 | 3.9526 | 0 | 0.0000 | 0.1241 |

# LOSS RATIO DISTRIBUTION
# BASED ON CALENDAR YEAR 1976 USING STANDARD PREMIUM
# STOCK AND MUTUAL COMPANIES

| (1) Ratio To Average | (2) Loss Ratio | (3) No. of Cos. at Loss Ratio Interval | (4) % of Cos. at Loss Ratio Interval | (5) % of Cos. at or Above Interval | (6) Premium at Loss Ratio Interval | (7) % of Premium at Loss Ratio Interval | (8) % of Premium at or Above Interval |
|---|---|---|---|---|---|---|---|
| 1.75 | 1.288 | - | 0.7905 | 3.9526 | 430,195 | 0.0060 | 0.1241 |
| 1.80 | 1.325 | 0 | 0.0000 | 3.1621 | 0 | 0.0000 | 0.1180 |
| 1.85 | 1.362 | 1 | 0.3953 | 3.1621 | 7,104,315 | 0.0998 | 0.1180 |
| 1.90 | 1.398 | 0 | 0.0000 | 2.7668 | 0 | 0.0000 | 0.0182 |
| 1.95 | 1.435 | 1 | 0.3953 | 2.7668 | 835,576 | 0.0117 | 0.0182 |
| 2.00 | 1.472 | 2 | 0.7905 | 2.3715 | 15,850 | 0.0002 | 0.0064 |
| 2.05 | 1.509 | 0 | 0.0000 | 1.5810 | 0 | 0.0000 | 0.0062 |
| 2.10 | 1.545 | 0 | 0.0000 | 1.5810 | 0 | 0.0000 | 0.0062 |
| 2.15 | 1.582 | 0 | 0.0000 | 1.5810 | 0 | 0.0000 | 0.0062 |
| 2.20 | 1.619 | 0 | 0.0000 | 1.5810 | 0 | 0.0000 | 0.0062 |
| 2.25 | 1.656 | 0 | 0.0000 | 1.5810 | 0 | 0.0000 | 0.0062 |
| 2.30 | 1.693 | 0 | 0.0000 | 1.5810 | 0 | 0.0000 | 0.0062 |
| 2.35 | 1.729 | 0 | 0.0000 | 1.5810 | 0 | 0.0000 | 0.0062 |
| 2.40 | 1.766 | 0 | 0.0000 | 1.5810 | 0 | 0.0000 | 0.0062 |
| 2.45 | 1.803 | 0 | 0.0000 | 1.5810 | 0 | 0.0000 | 0.0062 |
| 2.50 | 1.840 | 0 | 0.0000 | 1.5810 | 0 | 0.0000 | 0.0062 |
| 2.55 | 1.877 | 0 | 0.0000 | 1.5810 | 0 | 0.0000 | 0.0062 |
| 2.60 | 1.913 | 0 | 0.0000 | 1.5810 | 0 | 0.0000 | 0.0062 |
| 2.65 | 1.950 | 0 | 0.0000 | 1.5810 | 0 | 0.0000 | 0.0062 |
| 2.70 | 1.987 | 0 | 0.0000 | 1.5810 | 0 | 0.0000 | 0.0062 |
| 2.75 | 2.024 | 0 | 0.0000 | 1.5810 | 0 | 0.0000 | 0.0062 |
| 2.80 | 2.061 | 0 | 0.0000 | 1.5810 | 0 | 0.0000 | 0.0062 |
| 2.85 | 2.097 | 0 | 0.0000 | 1.5810 | 0 | 0.0000 | 0.0062 |
| 2.90 | 2.134 | 0 | 0.0000 | 1.5810 | 0 | 0.0000 | 0.0062 |
| 2.95 | 2.171 | 0 | 0.0000 | 1.5810 | 0 | 0.0000 | 0.0062 |
| 3.00 | 2.208 | 0 | 0.0000 | 1.5810 | 0 | 0.0000 | 0.0062 |
| 3.05 | 2.245 | 1 | 0.3953 | 1.5810 | 50,082 | 0.0007 | 0.0062 |
| 3.10 | 2.281 | 0 | 0.0000 | 1.1858 | 0 | 0.0000 | 0.0055 |
| 3.15 | 2.318 | 0 | 0.0000 | 1.1858 | 0 | 0.0000 | 0.0055 |
| 3.20 | 2.355 | 0 | 0.0000 | 1.1858 | 0 | 0.0000 | 0.0055 |
| 3.25 | 2.392 | 0 | 0.0000 | 1.1858 | 0 | 0.0000 | 0.0055 |
| 3.30 | 2.429 | 1 | 0.3953 | 1.1858 | 159,583 | 0.0022 | 0.0055 |
| 3.35 | 2.465 | 0 | 0.0000 | 0.7905 | 0 | 0.0000 | 0.0033 |
| 3.40 | 2.502 | 0 | 0.0000 | 0.7905 | 0 | 0.0000 | 0.0033 |
| 3.45 | 2.539 | 0 | 0.0000 | 0.7905 | 0 | 0.0000 | 0.0033 |

# LOSS RATIO DISTRIBUTION
# BASED ON CALENDAR YEAR 1976 USING STANDARD PREMIUM
# STOCK AND MUTUAL COMPANIES

| (1) Ratio To Average | (2) Loss Ratio | (3) No. of Cos. at Loss Ratio Interval | (4) % of Cos. at Loss Ratio Interval | (5) % of Cos. at or Above Interval | (6) Premium at Loss Ratio Interval | (7) % of Premium at Loss Ratio Interval | (8) % of Premium at or Above Interval |
|---|---|---|---|---|---|---|---|
| 3.50 | 2.576 | 0 | 0.0000 | 0.7905 | 0 | 0.0000 | 0.0033 |
| 3.55 | 2.613 | 0 | 0.0000 | 0.7905 | 0 | 0.0000 | 0.0033 |
| 3.60 | 2.649 | 0 | 0.0000 | 0.7905 | 0 | 0.0000 | 0.0033 |
| 3.65 | 2.686 | 0 | 0.0000 | 0.7905 | 0 | 0.0000 | 0.0033 |
| 3.70 | 2.723 | 0 | 0.0000 | 0.7905 | 0 | 0.0000 | 0.0033 |
| 3.75 | 2.760 | 0 | 0.0000 | 0.7905 | 0 | 0.0000 | 0.0033 |
| 3.80 | 2.797 | 0 | 0.0000 | 0.7905 | 0 | 0.0000 | 0.0033 |
| 3.85 | 2.833 | 0 | 0.0000 | 0.7905 | 0 | 0.0000 | 0.0033 |
| 3.90 | 2.870 | 0 | 0.0000 | 0.7905 | 0 | 0.0000 | 0.0033 |
| 3.95 | 2.907 | 0 | 0.0000 | 0.7905 | 0 | 0.0000 | 0.0033 |
| 4.00 | 2.944 | 0 | 0.0000 | 0.7905 | 0 | 0.0000 | 0.0033 |
| 4.05 | 2.981 | 0 | 0.0000 | 0.7905 | 0 | 0.0000 | 0.0033 |
| 4.10 | 3.017 | 0 | 0.0000 | 0.7905 | 0 | 0.0000 | 0.0033 |
| 4.15 | 3.054 | 0 | 0.0000 | 0.7905 | 0 | 0.0000 | 0.0033 |
| 4.20 | 3.091 | 1 | 0.3953 | 0.7905 | 24,854 | 0.0003 | 0.0033 |
| 4.25 | 3.128 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 4.30 | 3.165 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 4.35 | 3.201 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 4.40 | 3.238 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 4.45 | 3.275 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 4.50 | 3.312 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 4.55 | 3.349 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 4.60 | 3.385 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 4.65 | 3.422 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 4.70 | 3.459 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 4.75 | 3.496 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 4.80 | 3.533 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 4.85 | 3.569 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 4.90 | 3.606 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 4.95 | 3.643 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 5.00 | 3.680 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 5.05 | 3.717 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 5.10 | 3.753 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 5.15 | 3.790 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 5.20 | 3.827 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |

# LOSS RATIO DISTRIBUTION
# BASED ON CALENDAR YEAR 1976 USING STANDARD PREMIUM
# STOCK AND MUTUAL COMPANIES

| (1) Ratio To Average | (2) Loss Ratio | (3) No. of Cos. at Loss Ratio Interval | (4) % of Cos. at Loss Ratio Interval | (5) % of Cos. at or Above Interval | (6) Premium at Loss Ratio Interval | (7) % of Premium at Loss Ratio Interval | (8) % of Premium at or Above Interval |
|---|---|---|---|---|---|---|---|
| 5.25 | 3.864 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 5.30 | 3.901 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 5.35 | 3.937 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 5.40 | 3.974 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 5.45 | 4.011 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 5.50 | 4.048 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 5.55 | 4.085 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 5.60 | 4.121 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 5.65 | 4.158 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 5.70 | 4.195 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 5.75 | 4.232 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 5.80 | 4.269 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 5.85 | 4.305 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 5.90 | 4.342 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 5.95 | 4.379 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 6.00 | 4.416 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 6.05 | 4.453 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 6.10 | 4.489 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 6.15 | 4.526 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 6.20 | 4.563 | 0 | 0.0000 | 0.3953 | 0 | 0.0000 | 0.0029 |
| 6.25 | 4.600 | 1 | 0.3953 | 0.3953 | 208,013 | 0.0029 | 0.0029 |

MEAN: 0.7360
STANDARD DEVIATION: 0.1071
W: MC-3/15/78

# APPENDIX H

## ANALYSIS OF WORKERS' COMPENSATION IBNR RESERVES

Incurred but not reported loss reserves are shown in Schedule P on a country-wide basis. Such reserves are not available on a statewide basis.

For purposes of evaluating the movement of IBNR reserves and the amounts reserved for such cases, a study of 86 companies (25 largest groups according to Best's Executive Data Service) representing approximately two-thirds of all stock and mutual insurance company experience was summarized and reviewed. The basic data are shown in Exhibit I and contain calendar year earned premiums, accident year incurred but not reported (IBNR) losses unpaid at December 31, 1976 and amount of IBNR developed during 1976 by accident year. The premiums in column (B) were taken from Schedule P, part 1D — workers' compensation. The IBNR amounts in columns (C) and (D) were taken from Schedule P, columns (5) and (10) of part 1F. The information was obtained from Best's Reproductions of Convention Statements.

Columns (E) through (I) formulate the data into an analysis of the emergence of IBNR losses and compare the results with the companies' estimated IBNR loss reserve amounts at December 31, 1976. The underlying basis for the analysis is that the amount of IBNR losses is a function of the maturity of the particular accident year. Also, the best available measure of exposure to loss is the earned premium for the particular year. Accordingly, each year's reported development of IBNR losses has been measured against premiums earned. For example, during 1976, $3,773,288 of reported IBNR losses developed on accident year 1969; this represented .001736 of 1969 earned premium. Similar computations were made for later accident years and are shown in column (E). With respect to accident years prior to 1969, it was felt appropriate to use 1969 premiums earned as the measure of exposure to loss.

On accident years prior to 1969, the companies' actual estimates of unpaid IBNR losses at December 31, 1976 were used to ascertain the appropriate ratio to earned premiums to measure future IBNR loss liabilities. The ratio which represents the emergence of IBNR losses during the year were accumulated to provide an estimate of IBNR loss reserves needed on or after December 31, 1976 for the accident year. For example, for line 2 of column (G), there would be needed $15,354,427; this is equal to .004320 plus .002745 or .007065 in column (F) applied to $2,173,308,898 in column (B) to cover future IBNR claims on accident year 1969. For accident year 1970, .007065 + .001736 or .008801 of $2,354,426,741 would be needed for future IBNR claims.

Column (H) compares the estimates derived as described above with the estimates made by the companies in column (C). The comparison shows a deficiency ratio of .079908 (column (I), line 10) of one year's premium. In other words, the companies appear to still be under-reserved to the extent of almost 8% of premium. Therefore, the argument that calendar year experience represents the result of substantial strengthening of reserves or possible over-reserving is not a proper one. Additionally, it should be observed that one might reasonably except further adverse developments to emerge and, therefore, observed loss developments for the years 1976 and prior probably represent a conservative estimate of future developments.

Frank Harwayne, FCAS, MAAA

For release November 20, 1977.
at CAS Workshop

# EXHIBIT – I
## SCHEDULE P – WORKERS' COMPENSATION
## ANALYSIS OF IBNR RESERVES
## 1976

| (A) Years in Which Losses Were Incurred | (B) Premiums Earned | (C) IBNR Losses Unpaid | (D) 1 Year Development Of IBNR Losses | (E) Ratio (D) ÷ (B) | (F) E Cumulated Down | (G) Estimated IBNR Reserves (F) x (B) | (H) Indicated IBNR Deficiency (G) – (C) | (I) Deficiency Ratio (H) ÷ (B) |
|---|---|---|---|---|---|---|---|---|
| 1. Prior to 1969 | 2,173,308,898* | 5,965,053 | 9,388,714 | .004320 | .002745† | 5,965,733 | 680 | 0.000000 |
| 2. 1969 | 2,173,308,898 | 2,993,972 | 3,773,288 | .001736 | .007065 | 15,354,427 | 12,360,455 | 0.005687 |
| 3. 1970 | 2,354,426,741 | 5,586,866 | 8,259,595 | .003508 | .008801 | 20,721,310 | 15,134,444 | 0.006428 |
| 4. 1971 | 2,446,466,512 | 9,810,116 | 16,450,744 | .006724 | .012309 | 30,113,556 | 20,303,440 | 0.008299 |
| 5. 1972 | 2,686,196,476 | 14,425,192 | 16,473,367 | .006133 | .019033 | 51,126,378 | 36,701,186 | 0.013663 |
| 6. 1973 | 3,119,875,831 | 21,362,549 | 31,794,532 | .010191 | .025166 | 78,514,795 | 57,152,246 | 0.018319 |
| 7. 1974 | 3,510,187,420 | 61,998,635 | 66,576,895 | .018967 | .035357 | 124,109,697 | 62,111,062 | 0.017695 |
| 8. 1975 | 3,968,458,779 | 123,019,284 | 402,022,899 | .101305 | .054324 | 215,582,555 | 92,563,271 | 0.023325 |
| 9. 1976 | 4,876,756,744 | 665,597,598 | – | – | .155629 | 758,964,775 | 93,367,177 | 0.019145 |
| 10. Totals | 4,876,756,744** | 910,759,265 | 554,740,034 | xx | xx | 1,300,453,226 | 389,693,961 | 0.079908 |

* Annual estimate based on 1969

** Annualized estimate based on 1976

† (C) ÷ (B)

Column (B) from Schedules P part 1D

Columns (C) and (D) from Schedules P part 1F

Presented at 11/20/77 CAS Workshop