SCOMM

33:21

STATE OF ALASKA

THE LEGISLATURE

1980

Source

Legislative Resolve No.

SCS CSHCR 59

33

Relating to workers' compensation.

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

WHEREAS there have been several major revisions of the state workers' compensation law since statehood; and

WHEREAS the many changes that have taken place in the state since statehood are sufficient reasons for the legislature to thoroughly review the provisions of the Alaska Workmen's Compensation Act; and

WHEREAS the cost of workers' compensation can be a burden on employers in the state;

BE IT RESOLVED by the Alaska State Legislature that under AS 24.20.090 and Uniform Rule 48(c) the legislative council is directed to establish a Workers' Compensation Study Commission consisting of the following members:

(1) three employers subject to the workers' compensation law appointed jointly by the speaker of the house of representatives and the president of the senate;

(2) three representatives of labor organizations who are covered by the workers' compensation law appointed jointly by the speaker of the house of representatives and the president of the senate;

(3) one representative of an insurer providing workers' compensation coverage in the state appointed by the president of the senate;

(4) a state senator and a state representative appointed by the chairman of the legislative council who shall be co-chairmen of the study commission; and be it

FURTHER RESOLVED that the Legislative Affairs Agency is directed to make available staff, administrative support, and facilities reasonably required to carry out the functions of the Workers' Compensation Study Commission established by this resolution; and be it

FURTHER RESOLVED that the governor is respectfully requested to direct the Department of Labor to contribute to the work of the Workers' Compensation Study Commission established under this resolution; and be it

FURTHER RESOLVED that the Workers' Compensation Study Commission shall meet at least bimonthly and shall by the 30th day of the First Session of the Twelfth Legislature report to the legislature on its preliminary findings and recommendations concerning changes in the workers' compensation law needed to eliminate antiquated and inadequate provisions, to provide fully for the legitimate rights of injured Alaskan workers, to bring the workers' compensation law into harmony with current needs and conditions, and to minimize the cost of workers' compensation to employers in the state.

8/1 W Comp Study Commission

1

Jan Hansen / Rep Jackie McClintock
(Workers Comp Division)

SAT	Sept	20	Fbks
SAT	Nov	15	Anch
SAT	Dec	13	Jnu
	JAN		JNU

CHANCY CROFT: QUID PRO QUO: Quick comp for loss of rights

5 CONCERNS:

① Statute works well — w/o formal participatin when adjuster/claimant fair.
Poorly when decision-making brought into play.
WC Bd violates law (20-day law) w/ exception of Fbx Bd.

→ ② Rehabilitation. In long run — does most for employee.
Best possible chance.

③ Arb. Arary problems —
$60,000 permanent partial — arrived at by ins. industry
No relationship to anything
scheduled injuries out of date

NEW AREA: 1 Serious physical injury, w/o loss of income
Person can have ~~it~~ w/o comp

④ Premium cost Haven't had real evaluation of cost. Little coord/
272 Div Ins/WC Bd to make sure
761 Premiums realistic

⑤ Technical / cleanup
— 2nd injury fund

Dwayne — need administrative suggestions

MIKE SWALLING:

Every study — WC Act deficient.
Piecemeal amendment. "Shotgun" approach. Formidable task.
Slow pmts
Cumbersome
Duplication
High premium costs

DENNIS MALONEY:

In addition:

① misinterpretations by Sup Ct → extending benefits
② Rehabilitation — look @ interest of party in being rehab prior to award
③ Amount/method of setting reserves — unrealistic
"Present value" approach to reserves
④ Malingering/fraud difficult to handle

DWAYNE CARLSON:

(Swalling: 14 yrs — Goal by 4 most fortunate. May be difficult to do legislation: Progressive extension).
Lack of reliable data. Watch data from WC/DOSH/Insurance.
Need to know where accidents happening ⇒ trying to lower occ hazard
: Outside Actuarial firm (Johnson Higgins)
→ Set up cost factors, Reserves — cut costs w/o benefits

BILL O'KEEFE: 17 yrs INSURANCE
Coord w/ National Council. WCCRA (rating)
Info avail from insurers.
2 REPORTS: Richard Block report.
Many reports 200 recommendations
Decision-making / timeliness.

DAVE RADLEY Dp Engr 13 yrs. Members w/ injuries
- one 'starved out' broken families.
Concerned w/ cost, but 1st intent →
→ Help legit injured worker on timely basis.
Needs overhauling —
Independent State investigative unit —
unbiased org w/ better idea of legit
Skeptical that can do w/i time allotted

FRANK CHAPADOS. Small transport employers. Chmn AK Trk Bd
Good wc law + benefits
Concerned about cost.
Studies (F+B) established basis
Timing → A lot of study to acquaint
[participated in Block study]
Transport/Regulated industry — can't
pass on cost w/o justification
Inequities:
AGC employees contract diff/fm Transport
[Sick leave + W Comp]

Maloney: worker w/ more take-home than where working
other state studies w/ recommendations.
List recommendations
Benefits
Entitlements
Administration
Rehabilitation
Methodically go thru all.
Croft: Prefer Sat meets
Mechanism for accurate statistics
Compile stats ≠ examples
(Research div)
1979 stats from WC Bd
cases
solely medical, temp, etc
Avg amt
Easley: Interpretation of "compensation"

DICK BLOCK (Ely Guess + Rudd): Workers Comp Committee of Ak
WCCA: AGC AFTA Retail Merch Air Carrier etc
History of legislation: Labor vs mgmt
WC Law thru 70 not living up — inadequate
Natl Comm: 84 recommendations
19 "essential" 71-75 and many states adopted
75 → bill brought Ak up to speed
Pipeline impacted all employers, comp
76/77 - reducing benefits SSI offset
cumulative impact 76/77 - nominal rate
reduction 28%
Increased net cost
Concerned: length of committee work [Effect of boom]
CROFT: Special exemption for TAPS
Manual rate: Modified by acc rate.

Block Alyeska experience not included → costs born by other industries
Reg unitary policy shouldn't go to other employer
Chepados – Impact of avg weekly wage
Dwayne – A.W.W. driving cost. w/o that ceiling higher.
Dennis – London doesn't provide state w/ ~~stats~~
Jack – Ratemaking (2 levels). Alyeska stat problem discovered in time.

Block: 1. Look @ total spectrum (calculate indiv wage, arbitrary amts, claims adjustment practice, interim appeal)
2. Statistics, computer processing
3. Insurance alternatives – coord w/other benefits
self-insurance, alternative insuring mechanisms
4. Every recommendation has been reviewed
→ 1971 Natl comm Report
→ Inter Agency Task Force
→ Studies by states – FLORIDA wage loss approach
MINNESOTA – WC analysis. [has own rating bureau]
OREGON – perm partial benefit
CALIF – WC Institute (insurers + employers)
→ Ak – Fineberg + Block report
1976 LAA study of state funds, rating mechanism

Take reports + digest. Categorize. Then basis for debate.
Many fundamental public policy (not statistical)
Need more meetings. Need a bill or bills in January.
Req for data – don't ask for too much.

BLOCK: $1.25 - $1.30 paid to deliver $1 in benefits? A: IN Aggregate. STATE FUND
DWAYNE: 2ND INJURY FUND
CONTROVERTED CLAIMS Need Atty's
RASLEY:

Jnn: N/c FBX:

Dwayne: Div Ins input on computer?
Don: Yes
Dwayne: OSHA / Div Ins correlation
Don: Yes. Communic improved. Not best one. Have been in contact.

JAN HANSEN: (WC Div). Computer - early design stage.
R+A / DoL + WC → Travelled to 3 states. Basis from pgm. RFP submitted + out. Target date 1/1/82.
SYSTEM: (1) New claims entered onto computer
Terminals in field off / pull out data
on spec
Data - nature, wts, zwe, ppd
DOSH - where what kind of injury
Reporting capability

Croft: What info available now?
→ R+A: Injuries by industry. Data spotty
→ Go thru sample of files.
(Actuary, statistician?).

Tom O'K: no ins stats
Croft: Need statistical basis
Frank: Thought we'd find statistics. Suggest engagement of consultant. Go thru info.

Robt McAymour (OVIA)
JAN: (1) 2nd injury fund in critical condition - Bankrupt in Feb. Primary problem.
(2) Alloc risk among carriers. (2) rehabilitation
(2) Admin problems. (penalties for late payments, etc). Div hasn't enforced - lack of personnel
Act gives Bd auth to make rules. Bd hasn't.
(3) Technical problems w/ Act. Concerned w/ "Rush to judgment"

⇒ Robt MacArmour (OVHA). No validity to Block report. What are profits of insurance companies? Monitor ⇒ Lawyers representing
Problems – pressure. detectives chasing.
People cut off benefits. People better off if treated well from beginning
800 men + women in AK part of org
have helped – ~160 people w/ claims
Funded by CETA. RMacA put up most of funding for last 3 years

Gilg (after lunch) (Johnson)

Claimant's compensation attorney 6 DoL 14 WC Atty caseload
225 cases. Handle 800 cases/yr.
Problems: 1) disappointed in overall approval. When need, can't get ⇒ 2nd class citizens. 2/3 PAY. (misleading → there is a maximum.
LOOK AT RESERVING
ON AVERAGE – atty gets case a year later.
CLAIMANT ATTORNEY'S fees are regulated — paid 25% of 1st $1000, 10% over that
LOOK AT: (Smallwood case — needs regulation).
Was taking 13–14 mos. from hearing ⇒ decision.
⇒ Use professional hearing officers
⇒ Need DoL $ to get an order (takes 3 6 mos to get hearing) 60-90 days for decision. Look @ US DoL ⇒ Medical report → advises compensation should start.
⇒ Speed is biggest problem
VOCATIONAL REHABILITATION. Run thru DVR etc.
Excellent job 3 month wait. Eligibility, 3 wk testing.
[Sec 191 – ½ benefits while training]
BD should write rules + regs
42,000 TIME LOSS INJURIES/YR
probably 25,000 open files

Hearing offs not paid enough.

DWAYNE: Instruct DoL to promulgate regs (w/ Dept Law)

GJ: 2200 cases / +2,000 go to court

? Investigative work → Look @ cases to see what people are going thru. Problem - 6 or 7 conflicting medical report. Intermediate appellate might be good.

Dwayne If controverted - stop paying. Carrier doesn't have to prove why controverted.

Maloney: 225 cases open — all controverted - all stop payment — 90-95% end up as claimant win.

Frank: Employee losing pension? Employer taking person back — could aggravate injury. Look at tough time for employer rehire.

GJ → Add protection for employer who rehires.

Dennis — Union retirement fund. Could union trust have a provision for resting when disabled.

Dwayne: Remember non-union worker.

GJ: Interest on judgements is customary. When claim is controverted, worker should get interest on ~~claims not~~ payments not paid during controversion period.

FINEBERG: January report. Since then, haven't been too close. Specific recommendations

(1) Take a group of cases — look at problems. Should be a starting point for task force. A large # of disabled cases, some of which still there. Find out if there are pipeline people who need help. 50-100 people who fell out of system.

RAF A lot of the problem is the conflicting medical decisions.

(2) Suggest: 2330.250 misdemeanor for fraud. Commission should look @ non-enforcement of this provision.

(3) 23.30.155(c) Carrier must notify Board when stop payment. (in resisted cases). Not being enforced.

(4) Div/Insurance not enforcing 23.30.030(7).

(5) Time lag in hearing process. First payments are often delayed; non-reporting of suspensions.

(6) Need Remedial Actions report (p52) REQUEST THIS REPORT

(7) Examine referee system. Look @ Oregon, Wisconsin, Minnesota

(8) Booklet for claimant. (State should do)

(9) Cost-cutting for employer. Systemic problem. Those who pay will try to cut the cost. Not as efficient a mechanism for claimants.

(10) Look @ reserving, investment income. Where does comp $ go.

(11) Look @ time lag betw/ onset of problem (WC 76/77) and solution (81/82). Lack of interface betw/ WC Div & Div/Ins

3889 cases - pmt w/i 14 days - only 1093 pd on time

3 INSTITUTIONS: (1) The lawyers. don't make assumption lawyers represent claimants interest in comp law.

(2) Dwayne + Unions - way ahead on computers. Unions need to spend more time on worker safety

(3) Insurance

(10)

Don Koch ... comp law Non payment / late claims
should be a clearer penalty
O'Keefe re on time payments
5 AMC 3 FAI 1
hearing officers in ... Aug 18-22

DATA

(1) Legis Research 200 cases filed in 1998. At
random, pull out ... ... [go thru]
A. Only issue part of medical
Temp total dis
perm part dis
perm total / death
open / closed
date injury, 1st pmt, last paid
hearing req, actual hearing
Atty involved ?
Cases appealed beyond bd decision
% from uninsured employers
Sec 12(?) Cases set aside

→ ins cos
→ Div ins
Take % of med-only as %
... studies (...) Report available.

(2) Profitability
Reserves — how long held [investment income]

Ask Board, Hearing off - define areas
write indiv Bd members.

Biblio

Restatement of loss ratio

State of Delaware

2ND injury

[illegible] Trial Lawyers — booklet on injured

Copies of Sup Ct opinions

I RECOMMENDATIONS

II DATA NEEDED (investigator)

III CONSULTING

IV BIBLIOGRAPHY

(1) Crisis issues
(2) Comprehensive revision

Ask Board for input

SUBCOMITTEES

A,A,A (1) Stimson, MALONEY, CROFT

F,F,F (2) Rogers, Chapados, Rasley

A,J,A (3) O'Keefe, Carlson, Swalling

See Licia before lunch

AGENDA

LONGSHORE & HARBORWORKERS' ACT SEMINAR
Upper 1 - Anchorage International Airport

June 25, 1980

8:00 - 8:30	Registration
8:30 - 8:40	Welcome & Introductions
8:40 - 9:10	"The Longshore & Harborworkers Act (an overview)" Will Massey, Deputy Commissioner, U.S. Department of Labor
9:10 - 9:40	"The States View of Concurrent Jurisdictions" Paul Troeh, Deputy Director, Alaska Workmen's Compensation Board
9:40 - 10:10	"Industrial Claims Association Analysis of the L&H Act" Barbara Grissom, Vice President, Pacific Marine Insurance Company
10:10 - 10:25	Coffee Break Sponsored by Alaska Airlines
10:25 - 10:55	"U.S.D.L. Rehabilitation Program" Zee Jackson, Vocational Rehabilitation Specialist, U.S.D.L.
10:55 - 11:30	"Differences & Similarities of the State of Alaska and L&H Rehabilitation Programs, Concepts, Procedures, & Philosophies" (Panel Discussion) Zee Jackson, U.S.D.L. Paul House or Kaye Wilkerson, State of Alaska Bernice Barr, R.N., Manager, International Rehabilitation Associates Virginia Collins, R.N., Director, Medical Consulting Services Renee Murray, Manager, Scott Wetzel Services
11:30 - 12:00	Questions/Discussion
12:00 - 1:15	Luncheon
1:15 - 2:45	"The Importance & Problems of Timely First Reports and Payments & The Worker's Compensation System Generally" (Panel Discussion) Will Massey, Deputy Commissioner, U.S.D.L. (federal claims administration) Paul Troeh, Deputy Director, AWCB (state claims administration) Joyce V. Stevenson, Administration Assistant, Sea Alaska Products (employer) Warren Gore, Dist. #6 Representative, Operating Engineers (employee) Renee Murray, Manager, Scott Wetzel Services (insurer)
2:45 - 3:00	Questions/Discussion
3:00 - 3:15	Coffee Break Sponsored by Reeve Aleutian Airlines
3:15 - 3:45	"Recent Litigation Developments, L&H" Michael Barcott, Attorney, Faulkner, Banfield Doogan & Holmes
3:45 - 4:15	"Concurrent Jurisdictions - P&I" John Bradbury, Attorney, Bradbury & Bliss
4:15 - 4:30	Questions/Discussion & Wrap Up

19 NECA Commentaries

The Report of

The National Commission on State Workmen's Compensation Laws

WASHINGTON, D. C.
July 1972

Introduction & Summary

Major Conclusions and Recommendations

INTRODUCTION

Congress, in the Occupational Safety and Health Act of 1970, declared that:

> the vast majority of American workers, and their families, are dependent on workmen's compensation for their basic economic security in the event such workers suffer disabling injury or death in the course of their employment; and that the full protection of American workers from job-related injury or death requires an adequate, prompt, and equitable system of workmen's compensation as well as an effective program of occupational health and safety regulation . . . .

Congress went on to find, however, that:

> in recent years serious questions have been raised concerning the fairness and adequacy of present workmen's compensation laws in the light of the growth of the economy, the changing nature of the labor force, increases in medical knowledge, changes in the hazards associated with various types of employment, new technology creating new risks to health and safety, and increases in the general level of wages and the cost of living.

For these reasons, Congress established the National Commission on State Workmen's Compensation Laws to "undertake a comprehensive study and evaluation of State workmen's compensation laws in order to determine if such laws provide an adequate, prompt, and equitable

system of compensation." The Act required that a final report, containing a "detailed statement of the findings and conclusions of the Commission, together with such recommendations as it deems advisable," be transmitted by the Commission to the President and to the Congress no later than July 31, 1972.

Activities of the Commission

On June 15, 1971, the President appointed 15 Commission members, representing State workmen's compensation agencies, business, labor, insurance carriers, the medical profession, educators, and the general public. In addition, the Act designated three members of the President's cabinet as Commissioners.

The Commission faced a formidable task. We were asked to evaluate 56 diverse jurisdictions and 16 specific topics, many complex. Our effective working period was less than a year. We resolved at our first meeting to meet our deadline despite the advantages that would have flowed from additional time. We made this decision because important and pressing issues dictated prompt action. The Congress had expressed a keen sense of urgency about workmen's compensation in setting the July 31 deadline. The Commission members and staff have responded to this urgent concern with their best effort.

The Commission has had an active and productive year. Since its first meeting, on July 21, 1971, ten additional meetings have been held to develop the plan and review the substance of this Report. In total, these sessions consumed 32 days with, on the average, 17 Commissioners in attendance.

In addition to the meetings, the Commission held nine public hearings for a total of 18 days. These hearings included three in Washington, plus regional hearings in Chicago, Boston, San Francisco, Dallas, Atlanta, and New York. Because the first hearing was scheduled on short notice, only 10 Commissioners were able to attend. For the subsequent eight hearings, never were fewer than 15 Commissioners present. More than 200 witnesses appeared. The edited transcript of the hearings, to be published, is expected to exceed 800 printed pages.

A full-time staff of 30 employees assisted the Commissioners. The professional staff included economists, lawyers, physicians, statisticians, and others specialising in workmen's compensation and rehabilitation. More than 200 documents were provided to the Commission by the staff, including selections from previous publications and original reports based on staff surveys and studies.

The Commission was authorized to enter into contracts with government agencies, private firms, institutions, and individuals for the conduct of research or surveys and the preparation of reports to be published by the Commission. These publications include a *Compendium on Workmen's Compensation*, a comprehensive review of the issues and information concerning workmen's compensation, and a series of *Supplemental Studies* which examine selected issues in detail. As the *Compendium* and *Supplemental Studies* were prepared and edited by independent scholars, the Commission assumes no responsibility for the ideas expressed in these publications. With some of these ideas the Commission disagrees. Nonetheless, the material was valuable to the Commission and is being published in order to encourage further studies and appraisals of workmen's compensation.

We have carefully considered the views presented at our hearings and by our staff and contractors. The issues have been analyzed thoroughly in our formal sessions, correspondence, and conversations. Although we have given serious attention to previous recommendations for workmen's compensation programs, such as the widely approved standards published by the U.S. Department of Labor and the Model Act published by the Council of State Governments, we assumed as our responsibility a complete reexamination of workmen's compensation in light of the historical changes noted by Congress. We have evaluated the effects of these changes on the "fairness and adequacy" of the program launched more than 50 years ago. We have concluded there is a substantial and vital role for workmen's compensation in contemporary America.

The main body of our Report contains three parts which lead to this broad conclusion. The general objectives of a modern workmen's compensation program are discussed in Part One. A detailed evaluation of the present workmen's compensation program and our recommendations follow in Part Two. In Part Three, we discuss the future of workmen's compensation.

These three parts are summa
Many supporting data and analy
tained in the corresponding sect
Report. References for factual inf
the Report are included in the *Comp*

PART I. OBJECTIVES FOR A MO WORKMEN'S COMPENS PROGRAM

There are five major obj
modern workmen's compe
gram: four of them basic and an
tant one that supports the others.

The four basic objectives are

Broad coverage of employees and of work-related injuries and diseases

Protection should be extend
workers as feasible, and all work-re
and diseases should be covered.

Substantial protection against inter of income

A high proportion of a dis
lost earnings should be replaced
compensation benefits.

Provision of sufficient medical cur and rehabilitation services

The injured worker's phy
and earning capacity should be
stored.

Encouragement of safety

Economic incentives in
should reduce the number of w
juries and diseases.

The achievement of these
jectives is dependent on a fifth ob

An effective system for delivery of the benefits and services

The basic objectives shou
prehensively and efficiently.

These three parts are summarized below. Many supporting data and analyses are contained in the corresponding sections of the Report. References for factual information in the Report are included in the [illegible]

[illegible]

There are five major objectives for a modern workmen's compensation program: four of them basic and an equally important one that supports the others.

The four basic objectives are:

Broad coverage of employees and of work-related injuries and diseases

Protection should be extended to as many workers as feasible, and all work-related injuries and diseases should be covered.

Substantial protection against interruption of income

A high proportion of a disabled worker's lost earnings should be replaced by workmen's compensation benefits.

Provision of sufficient medical care and rehabilitation services

The injured worker's physical condition and earning capacity should be promptly restored.

Encouragement of safety

Economic incentives in the program should reduce the number of work-related injuries and diseases.

The achievement of these four basic objectives is dependent on a fifth objective:

An effective system for delivery of the benefits and services

The basic objectives should be met comprehensively and efficiently.

[illegible]

[illegible] below [illegible] with reference to the objectives most pertinent and with a citation of the chapter in the Report which deals most extensively with the respective topics.

In addition to the five objectives, another basis for our evaluation is the Congressional directive to determine if State workmen's compensation laws provide an "adequate, prompt, and equitable" system. We use "adequate" to mean sufficient to meet the needs or objectives of the program; thus, we examine whether the resources being devoted to workmen's compensation income benefits are sufficient. We use "equitable" to mean fair or just; thus, we examine whether workers with similar disabilities resulting from work-related injuries or diseases are treated similarly by different States. (See Glossary for full definitions of these and other terms.)

1. A Modern Workmen's Compensation Program Should Provide Coverage of Employees and Work-Related Injuries and Diseases

Coverage of Employees
(Section 27(d)(1)(C))

Although the percentage of employees covered by workmen's compensation is increasing, State and Federal programs now reach only about 85 percent of all employees. This coverage is inadequate. Inequity results from the wide variations among the States in the proportion of their workers protected by workmen's compensation. Thirteen States that cover more than 85 percent of their workers contain more than half of the nation's labor force, but 15 States cover less than 70 percent. Inequity also results because the employees not covered usually are those most in need of protection: the low-wage

workers, such as farm help, domestics, casual workers, and employees of small firms.

The lack of coverage is due primarily to the statutory exclusion of specific occupations or classes of employers. Another important factor is the persistence in some States of a tradition that coverage be elective.

Our recommendations on coverage are in essence that coverage be extended so as to provide protection to most employees now excluded and that coverage be mandatory.

Elective coverage [Section 27(d)(1)(I)]. Despite progress in recent decades, the laws of more than a third of the States retain the elective feature, installed originally in deference to constitutional interpretations that are largely irrelevant now.

We recommend that workmen's compensation be compulsory rather than elective. (See R2.1)

(In this Introduction and Summary, in the interest of brevity, we have abbreviated and reworded some of our recommendations contained in Chapters 2 through 6. Each recommendation in this summary contains a reference to the full text of the recommendations published in these five chapters. R2.1 is the first recommendation in Chapter 2.)

Numerical exemptions [Section 27(d)(1)(C)]. Barely half the States extend coverage to firms with one or more employees, and among these are States which exempt certain classes of employers, such as charitable organizations.

We recommend that employers not be exempted from workmen's compensation because of the number of their employees. (See R2.2)

Exclusions [Section 27(d)(1)(C)]. Exclusions include such categories as farmworkers, casual and domestic workers, and employees of State or local governments.

Farmworkers. Only about a third of the States cover farmworkers on essentially the same basis as other workers. Because of administrative considerations, we recommend a two-stage approach to coverage for agricultural workers.

As of July 1, 1973, coverage should be extended to agricultural employees whose employer's annual payroll exceeds $1,000. By July 1, 1975, coverage should be extended to farmworkers on the same basis as all other employees. (See R2.4)

Casual and domestic workers. Although several States cover some casual household employees, no State covers them on the same basis as all other workers. The transient or casual character of domestic jobs and the large number of households argue against efforts to provide coverage by conventional means.

We recommend that by July 1, 1975, household workers and all casual workers be covered under workmen's compensation at least to the extent they are covered by Social Security. (See R2.5)

Government employees. The laws of 44 States require coverage of some or all State employees; 36 States require coverage of employees of local governments; the other laws are elective.

We recommend that workmen's compensation coverage be mandatory for all government employees. (See R2.6)

Conflicts among State laws [Section 27(d)(1)(M)]. Employees who are subject to the laws of two or more jurisdictions are often uncertain as to where to file a claim. The claim may be compensable under one State law and invalid under another, or, in the extreme, compensable under neither.

We recommend that the employee be given the choice of filing a claim for workmen's compensation in any State where he was hired, or where his employment was principally localized, or where he was injured. (See R2.11)

Coverage of Injuries and Diseases
Section 27(d)(1)(D)

Substantial litigation results from efforts to determine which injuries or diseases are work-related and compensable. There are both legal and medical questions in each claim. The medical question is whether there was in fact an impairment or death caused by an injury or disease that was work-related. The legal question is whether the worker has suffered disability, i.e., a loss of actual earnings or earning capacity

attributable at least in part to the work-related impairment.

The traditional test for determining whether an injury or disease is compensable, is that the cause must be an "accident," sudden, unexpected, and determinate as to time and place. This interpretation has served to bar compensation for most diseases and for injuries which were considered routine and usual in the place of employment.

We recommend that the "accident" requirement be dropped as a test for compensability. (See R2.12)

The compensability of diseases has been hampered also by the uncertain etiology of many impairments. Efforts to overcome this uncertainty by listing specific compensable diseases results in lack of coverage for some diseases.

We recommend that all States provide full coverage of work-related diseases. (See R2.13)

2. A Modern Workmen's Compensation Program Should Provide Substantial Protection Against Interruption of Income

In general, workmen's compensation programs provide cash benefits which are inadequate. The majority of disabled beneficiaries receives less than two-thirds of the lost wages. In most States, the most a beneficiary may receive, "the maximum weekly benefit," is less than the poverty level of income for a family of four. Moreover, many States limit the duration or the total amount of cash payments.

Payments are inequitable as well as inadequate. Benefits differ widely from State to State. Within States, high-wage workers, if disabled, receive a smaller proportion of their lost earnings than do low-wage earners because they are limited by the ceiling of the maximum weekly benefits. Also, in some States, it appears that benefits paid for minor injuries are relatively more generous than payments for serious injuries.

Many programs appear to pay uncontested claims with reasonable promptness. When claims are contested, the record is less satisfactory.

Cash benefits are based primarily on the worker's actual loss of wages or loss of wage earning capacity. Also, whether or not they suffer a loss of wages or of earning power, workers in many States may receive cash payments because of work-related impairments.

Benefits usually are computed as a percentage of gross pay, rather than spendable earnings. Tax factors and the number of dependents contribute to inequities in this approach, and the inequities would be compounded if higher benefits were paid. The traditional payments are two-thirds of pre-tax wages. Benefits calculated as 80 percent of spendable earnings would better reflect the worker's pecuniary economic circumstances and cost the system little more. The small increase in cost would in any event recognize the value of the supplements or fringe benefits which have been introduced since the two-thirds formula was established, and which are not included in gross pay.

Temporary total disability benefits [Section 27(d)(1)(A)]. A worker who is temporarily and totally disabled experiences a temporary and complete loss of wages. Benefits do not begin unless the disability persists for a specified waiting period. Usually, if the disability continues beyond a specified qualifying period, the worker receives benefits retroactively for the time lost in the waiting period. A worker's benefit is calculated as a prescribed proportion of his previous wages, subject to minimum and maximum weekly benefits.

Waiting period [Section 27(d)(1)(B)]. Recommendations published by the Department of Labor propose a 3 day waiting period and a 14 day retroactive period. In contrast, the Model Act of the Council of State Governments specifies a 7 day waiting period and a 28 day retroactive period. Most States meet the standard of the Model Act, but do not meet the Department of Labor recommendation. Although the Model Act would provide benefits for 83 percent of lost time, the U.S. Department of Labor standard would compensate for 93 percent. The purpose of the waiting and retroactive provisions are to reduce payments for truly minor incidents and to assure benefits for even moderately serious injuries.

We recommend that the waiting period be no more than 3 days and that the retroactive period be no more than 14 days. (See R3.5)

Maximum weekly benefits. Both the Department of Labor and the Model Act recommend that the maximum weekly benefit should be at least two-thirds of the average weekly wage in the State. The majority of States do not meet this standard; most did in 1940, but since then have not kept pace with the rise in wages. In 32 States as of January 1, 1972, the maximum for a family of four was less than 60 percent of the State's average wage. Such levels of payment are clearly inadequate.

A maximum of two-thirds of the State's average wage, coupled with a provision that purports to provide disabled workers at least two-thirds of their individual wages, produces the anomaly that almost half of all disabled workers those who had earned more than the State's average wage would receive less than two-thirds of their lost pay.

We recommend progressive increases in the maximum weekly wage benefit, according to a time schedule stipulated in Chapter 3, so that by 1981 the maximum in each State would be at least 200 percent of the State's average weekly wage. (See R3.8 and R3.9)

Proportion of lost wages to be replaced. The decision fixing the proportion of lost wages to be replaced must balance incentives to employers to improve safety with incentives to the disabled to take full advantage of rehabilitation services and to return to work.

We recommend that cash benefits for temporary total disability be at least two-thirds of the worker's gross weekly wage. The two-thirds formulation should be used only on a transitional basis until the State adopts a provision making payments at least 80 percent of the worker's spendable weekly earnings. (See R3.6 and R3.7)

Each worker's benefit would be subject to the State's maximum weekly benefit.

Permanent total disability benefits [Section 27(d)(1)(A)]. A worker is eligible for permanent total benefits when he experiences a complete loss of wages for a prolonged period. In a few States, a worker may receive permanent total benefits merely because he is unable to return to his previous job.

We recommend that our permanent total benefit proposals be applicable only in those cases which meet the test of permanent total disability used in most States. (See R3.11)

Our position on maximum weekly benefits and the proportion of wages to be replaced is identical with our recommendations for temporary total disability. The main issues for permanent total disability benefits concern the total sum allowed and the duration of payments.

Although there is wide agreement that payments for permanent total disability should be paid for life, we found that 19 States in 1972 failed to comply with that recommended standard. In 15 States, duration of payments was limited to 10 years and in 11 States the gross sum payable was less than $25,000, which is less than the average full-time worker in the United States earns in four years.

We recommend that permanent total benefits be paid for the duration of the worker's disability without limitations as to dollar amount or time. (See R3.17)

Relationship to other programs [Section 27(d)(1)(O)]. The variability of benefits provided to disabled workers from sources other than workmen's compensation aggravates the inequities of the system.

If our recommendations for increases in the maximum weekly benefit for permanent total disability and the removal of limitations of time and duration are accepted, we believe that these permanent total benefits should be coordinated with other programs.

We recommend that the Social Security benefits for permanent and total disability be reduced in the presence of workmen's compensation benefits. (See R3.18)

Permanent partial disability benefits. The issues arising from benefits for permanent partial disability are so critical to the future of workmen's compensation that the subject warrants the highest priority. Unfortunately, the critical need for corrective action is matched by the elusiveness of the proper remedy, and there is a serious danger that premature or insufficiently detailed recommendations might only worsen

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the present problems. These problems include the wide variation from State to State in the ratio of permanent partial benefits to total benefits, and the apparent tendency in some States for the payment of disproportionately large benefits for minor permanent partial disabilities relative to the benefits for major permanent partial and permanent total disabilities. Also, in some States, evaluations of the extent of permanent partial disability often seem to be without consistent guidelines. Although the recently issued American Medical Association's *Guides to the Evaluation of Permanent Impairment* are a welcome contribution, they are designed only for the evaluation of impairment and do not purport to provide guidance for the evaluation of disability, as opposed to impairment.

These apparent inconsistencies and deficiencies warrant a separate study and report. We do not deny the importance of the permanent partial phase of workmen's compensation; we feel our responsibility at this time is to point to the need for the immediate commencement of a thorough examination of permanent partial benefits.

Death benefits. Death benefits consist of payments to the surviving spouse, minor children, or other dependents of a worker who dies as a result of a work-related injury or disease. Such benefits account for less than one percent of all workmen's compensation cases and less than ten percent of the total payments. The limits on the weekly benefits and on the total duration or amount, as found in many States, result in little overall cost saving for the program and are particularly ill founded.

We recommend that death benefits be at least 66 2/3 percent of the worker's gross weekly wage. The two-thirds formulation should be used only on a transitional basis until the State adopts a provision making payments at least 80 percent of the spendable earnings of the worker. (See R3.20 and R3.21)

We recommend that the minimum weekly benefit for death cases be at least 50 percent of the average weekly wage in the State. (See R3.26)

In death cases, we recommend that the State's maximum weekly benefit be increased until, by 1981, the maximum represents 200 percent of the State's average weekly wage. (See R3.23 and R3.24)

We see no justification for arbitrary limitation of the amount or duration of benefits to survivors of a deceased worker.

We recommend that benefits in death cases be paid to a widow or widower for life or until remarriage, and in the event of remarriage we recommend that two years' benefits be paid in a lump sum to the widow or widower. We also recommend that benefits for a dependent child be continued until the child reaches 18, or beyond such age if actually dependent, or at least until age 25 if enrolled as a full-time student in any accredited educational institution. (See R3.25)

Relationship to other programs (Section 27(d)(1)(O)). Adoption of our recommendations will assure that families of those who die from work-related causes will have greater and more continuous protection than they might receive from Social Security.

We recommend that workmen's compensation benefits be reduced by the amount of any payments received from Social Security by the deceased worker's family. (See R3.27)

3. Workmen's Compensation Should Provide Sufficient Medical Care and Rehabilitation Services

Medical care and rehabilitation services contribute both a monetary and a human value to the workmen's compensation system. Medical benefits have a monetary value of one billion dollars a year, about a third of the charges to the system. Four out of five beneficiaries receive medical services only.

In addition to medical services from the time of injury or detection of the disease, the system provides physical restoration services, including surgery and physical therapy, guidance and instruction in restoring earning capabilities, and placement in productive employment.

The record of delivering such services varies. Performance of medical services is reasonably good but, with only a few exceptions, the performance of physical restoration is less successful. Vocational guidance and instruction services are spotty and placement services for rehabilitated workers are generally inadequate.

These services need increased attention and coordination.

Choice of physician [Section 27(d)(1)(B)]. Among the issues that relate to the quality of medical care is the method of selecting a physician for the injured employee. The recommended standard published by the U.S. Department of Labor would permit the employee to select the physician freely or in accord with rules of the workmen's compensation agency. Half the States use this system. It can be argued that such freedom for the employee is illusory or disadvantageous to one with a work-related disease which may be improperly diagnosed by a physician unfamiliar with a specialized working environment. Conversely it may be argued that any limitation on the freedom of choice is an infringement on access to independent medical services.

We recommend that the worker be permitted the initial selection of his physician, either from among all licensed physicians in the State or from a panel of physicians selected or approved by the State's workmen's compensation agency. (See R4.1)

Amount and duration of medical benefit [Section 27(d)(1)(B)]. Limits on the amount or duration of medical care are more prevalent for work-related diseases than for injuries. The trend has been to remove such limits for injuries: 41 States comply with the U.S. Department of Labor standard of full medical benefits for those injured on the job. The trend has been similar with respect to diseases but only 36 States in 1972 provide full benefits. The limitations apply largely to diseases activated by dust.

Where the statutes specify payment of "all reasonable" charges, this language has been interpreted in some States to impose limitations on the types of services used. The wisdom of limiting services according to the merits of an individual situation is not open to challenge, but we oppose arbitrary rules that limit medical or rehabilitation services without regard to their merit. Such limits can be self-defeating if they deny benefits, such as prosthetic devices, which restore a patient to a productive career. For the same reasons we oppose compromise and release agreements which terminate an employee's right to medical benefits. Even when lump sum payments are offered in exchange for such waiver of rights, we believe the agreements should require approval of the administrative agency.

We recommend there be no statutory limits on the length of time or dollar amount for medical care or physical rehabilitation services for any work-related impairment. (See R4.2)

Supervision of quality care at reasonable cost. There are no short cuts to economical delivery of medical care of satisfactory quality. There is no substitute for conscientious supervision by competent professionals in order to insure that a job is done well. Nevertheless, fewer than half the States provide such supervision within the workmen's compensation agency. Supervision can not be effective if limited to a clerical review of case histories. There must be skilled observation and authority to order provision of necessary services, to curb excessive charges, and to recommend or require workmen to seek appropriate consultation.

Fewer than half of the States have a medical-rehabilitation division and only 26 provide such supervision in a manner consistent with recommended standards.

We recommend that each workmen's compensation agency establish a medical rehabilitation division, with authority to effectively supervise medical care and rehabilitation services. (See R4.5)

Vocational rehabilitation [Section 27(d)(1)(E)]. Medical care would be far more effective if well coordinated with vocational rehabilitation services. Such coordination would require employers to report promptly to the medical-rehabilitation division on the condition of claimants who are seriously disabled. Simultaneously, the claimant should be informed of his rights and opportunities to use restorative, guidance, and instruction services. Employees of the medical-rehabilitation division would be held responsible for following the course of such services and for assisting in their delivery.

Although some vocational services are provided by insurance carriers and employers, vocational aspects of rehabilitation are handled in most States mainly by agencies that rarely

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have more than a tangential relationship with workmen's compensation or physical rehabilitation services.

Many disabled workers fail to receive vocational services partly because they are not aware of their rights, partly because they lack motivation because of a fear they will lose compensation benefits if rehabilitated, and partly because they cannot afford the out-of-pocket costs of maintenance during instruction.

We recommend that the medical-rehabilitation division within each State's workmen's compensation agency be given the specific responsibility of assuring that every worker who could benefit from vocational rehabilitation services be offered those services. (See R4.7)

The cost of such services should be assessed against the employers, if only to assure that rehabilitation receives appropriate attention within the workmen's compensation program. Provision of special maintenance benefits during the period of instruction, with the sum and period to be determined by the medical-rehabilitation division, would help to assure cooperation of the worker in the instruction program. A worker who refuses vocational assistance might also be subject to denial of other benefits.

Placement of the disabled and use of second-injury funds [Section 27(d)(1)(F)]. "Hire the Handicapped" campaigns have a much broader base than workmen's compensation. They aim to employ not only those disabled on the job, a small portion of the total number of disabled, but others, notably veterans.

The employer concerned with operating costs, including premiums for workmen's compensation insurance, tends to be dubious about, if not averse to, hiring anyone with a preexisting impairment. If an employee with only one hand loses the other, or if an employee with sight in only one eye becomes totally blind, it is inequitable to burden the employer with the charges for the total disability. For this reason, all but four States have established a subsequent- or second-injury fund which assumes responsibility for paying for the compounding effects of a second injury. By this means, the worker receives in full the benefits which are his right, but the employer is charged only for the contributing effects of the last injury and not for the total. He is charged for one eye only: the fund pays the balance of the award for total blindness.

Unfortunately, many employers appear to have little knowledge of such funds. Also, in many States, the funds are insufficiently financed. Only 20 States have second-injury funds with broad coverage of preexisting impairments. Coverage that is so broad as to cover virtually every employee would defeat the purpose of the fund. The Model Act specifies 26 permanent impairments eligible for coverage by a second injury fund and, in addition, covers any impairment which is equivalent to 50 percent of total impairment.

We recommend that States establish a second-injury fund with a broad coverage of pre-existing impairments. We recommend that the second-injury fund be financed by charges against all carriers, State funds, and self insuring employers in proportion to the benefits paid by each, or by general revenue, or by both sources. We urge State workmen's compensation agencies to interpret eligibility for second-injury funds liberally in order to encourage employment of the physically handicapped and to publicize the programs to employers and employees. (See R4.10, R4.11, and R4.12)

4. Workmen's Compensation Should Encourage Safety

Consistent with its aims to protect maintenance of income and to deliver services of high quality with the maximum economy, workmen's compensation also offers incentives to improve the safety of working conditions.

Although the supporting evidence is limited, we believe that the experience rating of insurance premiums can offer employers an incentive to develop safe designs, practices, and working arrangements. It has been demonstrated in individual industries that preventive health and safety programs dramatically improve productivity and reduce labor costs. The spur to safety from experience rating is restricted because 80 percent of all employers are too small to be eligible under present regulations.

We recommend that, subject to sound actuarial standards, the experience rating principle be

extended to as many employers as practicable. (See R5.3)

In addition to the built-in stimulus to safety provided by experience rating, workmen's compensation also promotes safety by expending substantial resources on accident prevention services. However, in some States there are so many carriers writing workmen's compensation insurance, it is unlikely that all provide effective safety programs. Likewise, some State-operated insurance funds and some self-insuring employers devote insufficient resources to safety programs.

We recommend that insurance carriers be required to provide loss prevention services and that the workmen's compensation agency carefully audit these services. State-operated workmen's compensation funds should provide similar accident prevention services under independent audit procedures where practicable. Self-insurers should likewise be subject to audit with respect to the adequacy of their safety programs. (See R5.2)

5. There Should Be an Effective Delivery System for Workmen's Compensation

The effectiveness of workmen's compensation is to be judged by the program's ability to deliver the benefits and services which fulfill its basic objectives.

Six obligations of administration [Section 27(d)(1)(J)]. In this connection, the primary obligations of the workmen's compensation agency are: (1) to take initiatives in administering the act, (2) to provide for continuing review and seek periodic revision of both the workmen's compensation statute and supporting regulations and procedures, based on research findings, changing needs, and the evidence of experience, (3) to advise employees of their rights and obligations and to assure workers of their benefits under the law, (4) to apprise employers, carriers, and others involved of their rights, obligations, and privileges, (5) to assist voluntary resolutions of disputes, consistent with the law, (6) and to adjudicate disputes which do not yield to voluntary negotiation. Adjudication should be the least burdensome of these six obligations if the others are well executed.

Legal expenses [Section 27(d)(1)(K)]. Originally it was hoped that the compensation program would be self-administering; that employees would protect their interests without need for legal counsel or other outside intervention. The no-fault concept and prescribed benefits, it was assumed, would reduce the need for litigation. The complexities of the law and doubts about the sources and nature of impairments have dashed these expectations, although, given sufficient assistance by administrative agencies, claimants might have relied less on privately retained counsel and the system as a whole might have been spared the concomitant legal expenses.

We recommend that attorneys' fees for all parties be reported for each case, and that the fees be regulated under the rulemaking authority of the workmen's compensation administrator. (See R6.15)

Administrative organization. Disputes on claims in five States are assigned immediately to the general courts. Adjudicators who handle workmen's compensation cases exclusively have the primary duty to resolve disputes in 45 States. Only if they fail are the decisions appealed to the courts.

We recommend that each State utilize a workmen's compensation agency to fulfill the administrative obligations of a modern workmen's compensation program. (See R6.1)

In line with their traditional role of providing a laboratory for experimentation, with variations suited to their own experience, needs, or creativity, the States have devised a variety of structures to administer their workmen's compensation programs. It is difficult to evaluate these structures outside the entire political and economic context of each State. The State agencies vary remarkably in their assignment and exercise of responsibilities. Some agencies do little but adjudicate, with small regard for the effective delivery of workmen's compensation services or for their other administrative obligations, cited above. For this reason, we advocate a strong administrative leadership with authority commensurate to the responsibility, empowered to supervise all employees except the members of the appeals board. One person should be

responsible for the administration of the State workmen's compensation program. This emphasis on personnel as a crucial factor in the excellence of the system extends to the entire staff of the agency.

We recommend that, insofar as practical, all employees of the agency be full-time with no outside employment, with salaries commensurate with this full-time status. (See R6.5)

Processing of claims. A number of positive recommendations on administrative procedure appear in Chapter 6. In this summary, we will mention only two, which are included in the list of subjects assigned to us for evaluation by Congress.

Time limits on filing claims [Section 27(d)(1)(G)]. The problem for an employee in meeting the time limit for filing his claim is particularly acute when his impairment results from a work-related disease. A substantial lag may occur between exposure to the disease-producing substance and the manifestation or diagnosis of the disease. The recommendation published by the Department of Labor favors a flexible time limit, so that workers with long developing disabilities can still receive benefits, and about one-half of the States meet this recommended standard.

We recommend that the time limit for initiating a claim be three years after the date the claimant knows, or by exercise of reasonable diligence should have known, of the existence of the impairment and its possible relationship to his employment, or within three years after the employee first experiences a loss of wages which the employee knows or, by exercise of reasonable diligence, should have known was because of the work-related impairment. If benefits have previously been provided, the claim period should begin on the date benefits were last furnished. (See R6.13)

A uniform system of reporting [Section 27(d)(1)(L)]. An active State agency, such as we have recommended, requires the receipt and analysis of substantial data. Most of these data may be useful only within the particular State, but there are advantages which would result from nationally uniform data on several aspects of workmen's compensation, such as promptness of payments, the number of workers receiving the maximum benefits, and the amount of legal fees. At the present time, most States cannot provide this information on any basis, and almost none of the data can be compared across States.

A salutary consequence of preparation and dissemination of comparable data would be the enhancement of one virtue of the Federal system, namely that States can be laboratories of experiment and learn from one another.

Insurance systems [Section 27(d)(1)(N)]. Most workmen's compensation laws provide that qualified employers may self-insure their obligations. Other employers are required to buy insurance from a private carrier or a State fund. Although private carriers are excluded from some States, they provide 63 percent of all workmen's compensation benefits; State funds, 23 percent; and self-insured employers, 14 percent.

The studies available to us indicate that no type of insurance has a general advantage over another in delivering services.

We recommend that States be free to continue their present insurance arrangements or, if the States wish, to permit private insurance, self-insurance, and State funds where any of these types of insurance now are absent. (See R6.20)

Protection against insolvency. Special means are needed to protect employees in the event the employer fails to comply with the insurance requirements of the workmen's compensation law or if a carrier or employer becomes insolvent. Insolvency is a risk of the free enterprise system, but the penalties should not be assessed upon disabled employees.

We recommend that procedures be established in each State to provide benefits to employees whose benefits are endangered because of an insolvent carrier or employer, or because an employer fails to comply with the law mandating the purchase of workmen's compensation insurance. (See R6.21)

PART III. THE FUTURE OF WORKMEN'S COMPENSATION

Our intensive evaluation of the evidence

compels us to conclude that State workmen's compensation laws are in general neither adequate nor equitable. While several States have good programs, and while medical care and some other aspects of workmen's compensation are commendable, strong points too often are matched by weak.

In recent years, State laws have improved. In 1971, more than 300 bills were enacted, about 100 more than customary in odd-year legislative sessions. This encouraging burst of activity nevertheless failed to satisfy many basic needs. Of 16 recommendations for workmen's compensation published by the Department of Labor, the average State meets only eight. The wide variation among the States also are disturbing. While 9 States meet at least 13 of the recommendations, 10 States meet 4 or fewer.

An appropriate response to the serious deficiencies of workmen's compensation has been the major concern of our Commission. Are we to conclude that workmen's compensation is permanently and totally disabled, or is there a rational basis for continuing the program?

That fundamental question has obliged us to consider the possible alternatives to workmen's compensation. We have discussed the implications of abolishing workmen's compensation and reverting to the negligence suits, a remedy abandoned some 50 years ago. This option is still inferior to workmen's compensation: its deficiencies include uncertainties for both employer and worker and the substantial costs arising from litigation over the degree and source of impairment. Such litigation also has serious adverse effects on efforts at rehabilitation.

An even more radical option is the proposal to disassemble the program and distribute the components elsewhere. We are convinced that the problems associated with partition are insoluble, and that the injured workingman would be adversely affected. Each of the programs to which the components would be assigned has at least one serious deficiency compared to workmen's compensation. For example, the eligibility requirements of the Disability Insurance program under Social Security preclude benefits until the worker has several quarters of covered employment. In workmen's compensation, in contrast, the worker is eligible from the first day he is employed. Also, we do not believe there is likely to be in the near future a source of medical care as satisfactory as workmen's compensation. Under most proposals for national health insurance, there are deductibles and other limitations on benefits not found in most workmen's compensation statutes. The ultimate weakness of partition, however, is that there are no well established locations for the two most important components of workmen's compensation: cash benefits for short-term total disabilities and cash benefits for long-term partial disabilities.

Perhaps in another decade or two, an attractive alternative to workmen's compensation will emerge.

For the foreseeable future we are convinced that, if our recommendations for a modern workmen's compensation program are adopted, the program should be retained.

The issue then becomes the final subject assigned to us by Congress: what are the "methods of implementing the recommendations of the Commission?" As we have reviewed the efforts for improvement by the various States, it has become apparent that the answer to this question is the most elusive of all that have been raised. Our recommendations are not fundamentally different from those of earlier investigations; yet previous recommendations have won no strong support.

Several reasons for the indifferent response to previous reform proposals are evident. The lack of interest in or understanding of workmen's compensation by State legislators and the general public is attributable in part to the complexity of the program. Various interest groups, including employers, unions, attorneys, and insurance carriers, have often allowed their specialized concerns to stand in the way of general reform. And State legislators and officials, even when they have been genuinely interested in reform, have too often been dissuaded by the irrational fear that the resulting increase in costs would induce employers to transfer business to States with less generous benefits and lower costs.

In view of these experiences, we have contemplated various strategies for improving workmen's compensation. Among those suggested at our hearings were a complete Federal takeover; retention of present State programs with only voluntary responses to Federal guidance or recommendations; and various methods of combining the basic State-

tection would be required. The normal enforcement method would be the imposition of fines on non-complying employers. Most claims would be handled by existing State workmen's compensation agencies using their regular procedures, except that the scope of protection afforded by the State must include the essential recommendations.

The Commission was unanimous in concluding that congressional intervention may be necessary to bring about the reforms essential to survival of the State workmen's compensation system. We believe that the threat of or, if necessary, the enactment of Federal mandates will remove from each State the main barrier to effective workmen's compensation reform: the fear that compensation costs may drive employers to move away to markets where protection for disabled workers is inadequate but less expensive. There was disagreement concerning the appropriate time for Congressional action, with a majority concluding that States should be given until 1975 to act before Federal mandates are enacted if States have not adopted our essential recommendations. One reason for the delay is the feeling that an immediate push for congressional legislation would precipitate a confrontation which would delay positive action at the State level pending the outcome. Another reason is that many necessary reforms in the State workmen's compensation programs are not susceptible to Federal mandates. If our mandates immediately were adopted by Congress and made applicable to the States, some States might fail to undertake the thorough review of our recommendations that are not appropriate as Federal mandates.

If the Federal government guarantees the adoption of our essential recommendations, if a new Commission is established to encourage and assist the States, and, most important, if those who control the fate of workmen's compensation at the State level accept responsibility for the program's reform, we believe that soon the protection provided by workmen's compensation to "the vast majority of American workers, and their families . . . in the event such workers suffer disabling injury or death in the course of their employment. . . [will be] adequate, prompt, and equitable."

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WORKERS' COMPENSATION PROBLEMS IN ALASKA

An Assessment Prepared for

The Alaska Legislative Affairs Agency

by

Richard A. Fineberg

Preliminary Draft

January 21, 1980

Summary and Conclusions

Summary

Sharp criticism of the workers' compensation system comes from diverse quarters. From one side, employers feel they pay too much to insure their employees against accidents; from the other side, some claimants feel their insurance carriers have short-changed them and the state has not been responsive to their situation. This report attempts to identify major problem areas and potential courses of action.

Due to a records system a Department of Labor in-house management review reveals to be chaotic and cumbersome, it is not possible to present a precise statistical assessment of claimant complaints. However, the wide range of sources, the wealth of detail and the similar thrust of testimony presented in Chapter 2 makes it difficult to subscribe to the notion, expressed by some defenders of the comp system, that the comp protest comes from a few malcontents who happened to get the wrong end of the stick.

State agency handling of workers' comp is reviewed and found to be lackluster.

With regard to premium rates, this study asks for more precise data on the uses carriers make of the comp premiums they collect. This analysis also suggests there may be ways to cut premium costs without reducing benefits.

Conclusions

Information gathered during interviews and research under this contract strongly supports the Administration's request for capital and operating budget increases to expand and modernize the state's claim monitoring operations.[1] The information presented here equally strongly suggests that additional and immediate legislative attention to workers' comp is needed.

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[1] Due to budget and timing constraints of this contract, this study did not consider other specific proposals before the 1980 Legislature relating to workers' comp.

Conclusions (continued)

The following measures are recommended as necessary short-term steps to improve the workers' comp program:

= Hearings to determine the reasons the Workers' Comp Division and the Division of Insurance have routinely failed to enforce various statutes relating to workers' comp, including statutes requiring: (1) prompt carrier payment of claims; (2) prompt carrier notification to the Workers' Comp Board if carrier stops payment for any reason; and (3) Board decisions to be issued within 20 days of hearing.

= Special review of specific comp complaints to ascertain whether Alaska carriers, the Division and the Board carry out their tasks in a manner consistent with the goals of the comp system. (Workers' comp was established to give the job injury victim the assistance s/he requires to resume a constructive existence; the program was established on the premises that the modern worker faces worksite risks, and that the right to sue for damages after an injury occurs does not provide adequate redress. Interviews and file reviews conducted over the past twelve months — first for newspaper articles and later for this project — convince the writer that the protestors have a case.)

= Legislation to provide specific follow-up information on progress in reducing delays in first payments and hearing decisions.

= Legislation mandating publication of a booklet to explain to the claimant what s/he can and cannot expect from workers' comp, thereby reducing misunderstandings and contested cases before they become part of the backlog in the workers' comp hearing schedule.

Conclusions (continued)

In addition to the preceding immediate measures, this report identifies areas that the Legislature might address once the brushfires are out. Since other states have already experienced major comp crises, it is suggested that the Legislature consider the actions of other states that have overhauled their comp systems. Subjects the Legislature might address include:

-- feasibility of establishing a referee system and an investigating unit within the Workers' Comp Division;

-- the need for meaningful and precise information on how carriers spend comp premium dollars;

-- the need for a complete rewrite of AS 23.30, including a statement of legislative intent;

-- the need for closer interaction among the Workers' Comp Division, the Division of Insurance and the Division of Occupational Safety and Health;

-- programs that might reduce the premium rates of small employers, such as a reinsurance plan and a group insurance plan;

-- the possibility of establishing a competetive state fund.

WORKERS' COMPENSATION PROBLEMS IN ALASKA

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Acknowledgement . . . .

The willingness of the people in the Division of Insurance and the Workers' Compensation Division to explain their operating procedures and to provide information made an otherwise wearisome task a pleasure. If the openness and courtesy I experienced in both state agencies is an indication of desire to find solutions to the workers' comp problems that confront Alaska, then we are on the right track.

The customary disclaimer is of course in force: Responsibility for the contents of this report is my own.

Richard A. Fineberg

January 20, 1980

A Note on Terminology . . . .

Except when quoting a document, the term workers' compensation or workers' comp is used instead of the gender-specific workmen's compensation. Following this guideline (and dispensing with -ensation), the agency whose official title is Workmen's Compensation Division is usually identified as Workers' Comp Division; likewise the Workers' Comp Board.

Chapter 1. Introduction

A. General Background

In the decade between 1968 and 1977 workers' compensation premium and benefit payments in Alaska increased from approximately $38 million to $107 million. Comp insurance made up 10 per cent of the total Alaska insurance business in 1968, compared to 24 per cent a decade later, according to Division of Insurance statistics.[1]

Although the growth of the Alaska workers' comp bill is noteworthy, economic expansion is not the purpose of the comp system. Simply put, workers' comp exists to provide prompt wage replacement and medical benefits to victims of work-related accidents.[2] The legal premise that led all states to establish workers' compensation systems early in this century is a trade-off: the worker gives up his/her common law right to sue his/her employer for damages resulting from a job-related injury in exchange for guaranteed accident benefits.[3]

In addition to prompt wage replacement and medical coverage, the U.S. Chamber of Commerce's Analysis of Workers' Compensation Laws lists five other objectives that underlie workers' comp statutes:

-- To provide a single remedy and reduce court delays, costs and work loads arising out of personal injury litigation;

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[1] Insurance Report, 1977-78 (State of Alaska, Dept. of Commerce and Economic Development, Division of Insurance; 39th/40th Annual Report, no date) and other Division of Insurance reports.

[2] The Alaska Workmen's Compensation Act (AS 23.30) does not provide a precise definition or statement of purpose. The statement of intent from the Washington state comp law and the Oregon comp statute preamble are included in Appendix 1.

[3] Legislative Affairs Agency, Division of Research, Workers' Compensation: The Feasibility of Establishing a State Fund (Juneau, 1977), pp. 1-10. (In recent years rehabilitation has been added to wage replacement and medical payments in many states.)

= to relieve public and private charities of financial drains incident to uncompensated industrial accidents;

= to eliminate payment of fees to lawyers and witnesses as well as time-consuming trials and appeals;

= to encourage maximum employer interest in safety and rehabilitation through appropriate experience-rating mechanisms; and

= to promote frank study of causes of accidents, reducing preventable accidents and human suffering.[1]

Despite the tremendous increase in the dollar-value of the comp program and a similar increase in claims, the administrative structure with which the state oversees the workers' comp program has remained essentially unchanged since statehood. In 1975 the legislature increased benefits, then readjusted those benefits in the following two sessions. In 1979, faced with a backlog of comp hearings acknowledged by the Workers' Comp Division as a crisis, the division added a new hearing officer in Anchorage and two new Board members in Fairbanks in anticipation of adding a new hearing officer in that city. During the past two sessions workers' comp has received scant legislative attention.[2]

The major institutional forces directly concerned with workers' comp in Alaska are: employers, who seek to cut rising costs of this compulsory program; insurance companies that write the policies and pay injured workers on behalf of their employers; the Workers' Comp Division (Dept. of Labor), which administers the program through the quasi-judicial Workmen's Compensation Board; the

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[1] Chamber of Commerce of the United States, Analysis of Workers' Compensation Laws: 1979 Edition (Washington, D.C., 1979), p. 3.

[2] For a discussion of the development of workers' comp in Alaska, see Legislative Affairs Agency, Workers' Compensation (op. cit.), pp. 10-17. For an interpretative analysis of recent developments, see Chapters 2 and 3 below.

Division of Insurance (Dept. of Commerce and Economic Development), which regulates all insurance companies operating in Alaska; physicians and other specialists who treat injured workers (claimants); attorneys who represent carriers or claimants; unions; the legislature, which frames the statutes under which the carriers, the board and the agencies operate; and claimants, some of whom contend all the institutions listed above are failing them.

B. Paperwork Problems and Claimant Problems

The last three goals of the workers' comp system listed by the U.S. Chamber of Commerce (to eliminate legal fees and litigation; to encourage safety and to promote frank study of causes of accidents) appear to have nothing whatsoever to do with the mountains of paperwork that flow through the Alaska comp system. As to the first three goals (income maintenance and medical coverage; prompt, single-remedy delivery of services; relief of public and private charities), the disparity between the purpose and the practice of workers' comp is so great that in 1978 some claimants began demonstrating outside state buildings, writing letters to reporters, editors, legislators and administrators to complain in anguished terms about their plight. The comp protestors claim to represent many more claimants who have been further victimized by the failure of the comp system they thought was supposed to help them.

Although comp protestors have not been able to document their charges in quantifiable terms, this study finds the following indications that the comp system fails to deliver efficiently the services the program was established to provide: (1) the wide range of vehement protestors from various parts of the state and the duplication of protest items; (2) the lack of response from administrative and elected officials; (3) the long-standing failure of state agencies to insure that statutory requirements are met; and (4) the increase in disputed comp cases. (See chapters 2, 3.)

C. Premiums and Benefits: How Do the Two Relate?

Testimony at a Division of Insurance comp rate hearing in Anchorage Nov. 8 indicates employer dissatisfaction with comp rates. It is often said that comp premium rates and comp benefits have a direct correlation, but other factors also play a significant role in comp premiums. For example, the recent rise in comp premium rates is usually blamed on the benefit increases legislated in 1975, but changes in procedures carriers use to calculate rates accounted for approximately 25 per cent of the premium increase.[1]

Other states have found it is possible to reduce premium rates without reducing benefits. For example, comp rates were significantly higher in Minnesota than in neighboring Wisconsin, even though there were no obvious differences between the two states in kinds of industry or accident rates. What accounted for the difference in premium rates, the Minnesota workers' comp task force discovered, was that Wisconsin had far less comp litigation and therefore consumed much less time and money in legal fees than did Minnesota. Legal fees paid by the carrier are fed back into the comp rate as a cost of the policy. According to the Minnesota task force, Wisconsin effected this relative savings because the state of Wisconsin took an activist posture at early stages, contacting workers and publishing a booklet to advise claimants of their rights. These measures, Wisconsin found, reduced contested cases and kept comp premium rates down.[2]

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[1] Legislative Affairs Agency, Workers' Compensation (op. cit.), p. 16.

[2] Steve Keefe, speech to Legis 50 Conference on Workers' Comp, Portland, Ore., June 14, 1979. (See Appendix 2. Minnesota State Senator Keefe served as majority whip of the State House, chair of the Subcommittee on Labor and chair of the Minnesota workers' comp task force.)

The relationship between premiums and benefits in Alaska is not evident in the data insurance carriers are required to file with the Division of Insurance. Although carriers file voluminous reports, the major carriers lump their Alaska comp business figures with those of their comp figures from other states. A second difficulty in acquiring this information is that the carriers are not required to provide a breakdown of comp premiums by income maintenance payments, medical benefits, litigation costs, administrative overhead and profits.

Although the insurance industry frequently asserts comp is not a lucrative line of insurance, here again the data compiled by the state neither proves nor disproves the point. Regarding the profitability of comp, it is interesting to note that Alaska Pacific Assurance Co. (Alpac) writes 56 per cent of the comp business in Alaska and its share of the market has grown faster than the rapidly increasing dollar value of comp insurance.[1] Unfortunately, figures indicating how much money Alpac makes writing workers' comp policies cannot be ascertained from Division of Insurance records.

D. Experience of Other States

A survey of 54 states and territories indicates that Alaska is one of 34 states and territories that handles workers' comp through private insurance and self-insurance; eight use a state fund and self-insurance; the remaining 12 states and territories use all three comp mechanisms -- self-insurance, private carriers and state funds.[2]

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[1] Division of Insurance reports.

[2] Legislative Affairs Agency, Workers' Compensation (op. cit.), p. 5.

Since 1975 workers' comp has become a top-priority political issue in many states. Four states referenced in this study are Florida (which completely revised its workers' comp law in 1979), Oregon (where a task force made preliminary recommendations early in 1979 and was to make its final report by the end of the year), Washington (where the legislature has been investigating and revamping its self-insurance program) and Minnesota (where a task force has studied the issue and the legislature has enacted many of the recommendations).[1]

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[1] Cursory contact with other states indicates their experiences may be of use to the legislature in analyzing and revising the Alaska workers' comp system. As Florida's workers' compensation bureau chief commented after listening to a brief review of the problems facing Alaska's comp program, "It sounds as if we've already been through the crisis in Florida you are about to experience in Alaska." (Telephone conversation, Nov. 26, 1979.)

Chapter 2. Comp Protestors: Clear Signals of Distress

A. Perspectives

1. Anchorage, November 7-8, 1979

"Everybody thinks they're faking. Sure, there are some fakes, but let me tell you something: It's hell to lay home and suffer, and there is nothing like getting up in the morning to go to work. There is nothing like feeling good and working."

The short, white-haired man who spoke at an informal public meeting held by the Division of Insurance in Anchorage November 7[1] did not give his name. He said his comp claim was proceeding smoothly at this point and he did not want to rock the boat. He said he was speaking because he had seen a lot of other claimants in doctors' waiting rooms, hospitals and various insurance offices, and he had spent long painful hours at home; what he had learned from his own experience, and from other comp claimants, convinced him that, "There is something wrong here, mighty wrong."

"This man in front of me and this man here I know," he continued. He described them as upstanding people who had suffered on-the-job injuries, only to be further aggrivated by the medical and workers' comp systems to which they had turned for assistance. He rambled on a while longer, then caught himself, stopped and sat down. "I'm sorry I got so steamed up," he said, "but people's lives are being ruined."

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[1] Author's notes. Since this was an informal meeting, the Division of Insurance did not record it. For an interpretation of the Division of Insurance's response to comp claimants, see Chapter 3C.

A younger man, unacquainted with the white-haired speaker, chimed in: "It's not fair to our families the way they prolong everything." A middle-aged woman who had her own comp problems added an amen: "You can starve to death."

Similar views were aired the following day at a formal hearing on workers' comp rates. At the hearing one claimant told the Division of Insurance:[1]

> . . . . the carrier is ALPAC Insurance, whatever the name of it is there . . . . they have flagrantly from what we can see have been breaking the law. They are not doing what the state law says that they are supposed to be doing . . . . They just flat ignore what the board says . . . . They are not paying my doctor bills . . . . my lawyer told me that they don't go along with chiropractic help. State law says that chiropractic doctors can operate and help people in this state. It says it in the book and I would like to know why that the insurance carriers can say that they just aren't going to pay these doctors. . . . they just keep dragging these things out and dragging them out and the last time I talked to my doctor, I don't know where he gets his information but the impression I got from him is that he has heard something and that he felt and he told me to get rid of my lawyer because he felt that there had been a deal made between my lawyer and the insurance lawyer. Now, I can't prove this. The only thing I know is the statement has been made that they say they are not going to pay my doctor bills. I can't pay them. . . . My doctor is getting a little concerned and if I can't continue to see him, I am going to be in one heck of a fix. . . . it is just such a runaround, it takes a long time to get any help whatsoever and from what I have seen . . . you are going to lose your home, you are going to lose everything you have got before you can even get any help from anybody. And that is not right. Why should a person have to go clear to the bottom of the barrel?

2. Fairbanks: Orientation for Victims of Industrial Accidents (OVIA)

Judy Lambeth of Fairbanks has some workers' comp stories to tell. She has never been a comp claimant, but for four months during 1979 she worked as secretary for the Organization for Victims of Industrial Accidents (OVIA), a Fairbanks group that attempted a community outreach project on CETA funding.

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[1] Condensed from Division of Insurance transcript. For interpretation of the agency's response to grievances expressed at the hearing Nov. 8, see Chapter 3C.

"I've seen people lose their house and car," the OVLA secretary said. "It just makes you feel terrible.

Lambeth and OVLA coordinator Charles MacMillan report that the new Fairbanks organization was hampered by lack of direction from its board, lack of staffing and lack of funding.[1] Nevertheless, they said, OVLA counselled about 30 persons with comp problems before a cutback in CETA funding closed the office Nov. 30. MacMillan and Lambeth say the organization could have been of service to many more comp claimants if OVLA's funding were continued. "We've had many other people tell us they wish we had been there when they were hurt, and some who came in told us of friends who had been hurt and have gone to the Lower 48," Lambeth said. "And we were gathering more people all the time when we closed down."

Asked about malingerers, MacMillan (whose observations are based on 17 years of professional nursing) said he felt one of the persons he counselled was exaggerating and he was dubious about a second claimant because "that fellow was just too active."

"Even if 50 per cent were faking — and I don't believe the figure is anywhere near that high — what about the other 50 per cent?" MacMillan asked. "That's still an awful lot of people who are getting a very bad deal." Lambeth concurred.[2]

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[1] Lack of direction: OVLA founder and comp claimant Robert MacArmour (see Chapter 3A) was in therapy in Anchorage and the remaining board members did not play an active role. Lack of staffing: Due to her own injury and personal problems, the claimant MacArmour had hoped would run the program was not available. The program's first coordinator resigned after three weeks. MacMillan, who moved up from a staff position, was unable to fill the position he vacated when he became coordinator. Lack of funding: Lambeth and MacMillan began working July 26 but did not get paid until Oct. 6. Overhead payments were similarly delayed. To keep the office open, MacMillan worked out an unusual arrangement with the landlord: the staff person-turned coordinator took over building janitorial duties in lieu of rent.

[2] Lambeth's perception is noteworthy because she came into the job without prior knowledge about comp. She qualified for CETA because her husband (a builder) had been unemployed for some time. After she went to work he also found a job, and this enabled her to stick with OVLA for 72 days without a paycheck. She says she stayed because she became convinced the comp system was either unable or unwilling to help many claimants with legitimate problems.

B. Narratives

Five Claimants Who Allege the System Is Failing Them

Preface

The following case narratives are taken from the accounts of five individuals who have contacted public officials and/or reporters to complain about problems they have encountered with the comp system. None of the five were involved in the Anchorage Division of Insurance meeting or hearing, nor were they among the people OVIA counselled; these cases comprise a third and separate bloc of comp claimants who say the system has denied them assistance they believe the law is supposed to guarantee them as victims of on-the-job accidents. Records cited were provided by the individual or obtained from comp files in Juneau, Anchorage or Fairbanks. Author's supplementary comments follow each example.[1]

1. Patrick Jackson

March 1977: Jackson was working as a surveyor in a pipeline camp, where his duties included ". . . bending, kneeling, climbing over objects in sub-zero weather and riding in a crowded vehicle along the pipeline. He could not recall a specific trauma to his leg, but upon going to the camp medic and being flown to Fairbanks, he was found to have a tender, swollen left knee."

May 1977: Released for work in late May and continued to work until laid off June 21, 1977; unemployed until July 11, 1978.

July 1978: "The applicant testified that for a couple of weeks prior to his return to work in July 1978 he had been having slight cramps in his left leg and that the cramps had been getting worse. He said he was able to work six days

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[1] The reader who scans these five cases will get some idea of the difficulty of evaluating comp claims, as well as a range of claimant complaints. Cursory examination of the records available indicates none of the complaints should be discounted without further investigation. Author has met none of the claimants in this group but has had phone contact with one.

before the problem with his leg got so bad that he had to quit work and return to Fairbanks for medical care."

July 17, 1978: Diagnosed as having acute thrombophlebitis; July 26, 1978, operation performed.

August 1978: Jackson's carrier (Alpac) declined to cover his expenses on the grounds that the problem was not related to his pipeline work, but to a problem he had had 14 years prior. Jackson was out of work, out of insurance and his knee was not getting any better. He contacted an attorney.

September 1978: A second operation in Fairbanks was unsuccessful.

December 1978: At the comp hearing in December 1978, Alpac based its case on the expert testimony of an orthopedic surgeon who advised Alpac: "It is my opinion that the condition simply spontaneously developed during the course of the patient's employment and has no causal relationship to his employment. Likewise, I can find no compelling evidence that the patient's work did not affect his problem. . . ."

Another equally credentialled medical expert testified, on the other hand, that reasonable medical probability indicated the thrombophlebitis was a direct result of Jackson's job-related 1977 problem.

At this point Jackson's Fairbanks physicians thought he should go to Seattle for special treatment, but Jackson was broke and his carrier was refusing to cover further medical expenses. According to sources familiar with the case, hospital aides considered taking up a collection to send Jackson to Seattle and his lawyer also considered giving Jackson the money to cover the treatment he required.

January 1979: In an unusually rapid decision, the Workers' Comp Board found Jackson's physician more compelling and ordered Alpac to pay comp for the 20 weeks between July and December 1978. By that time Jackson had somehow scraped together the money to go to Seattle. Alpac decided to go to court to overturn the Board's decision.

June 1979: Superior Court Judge Geral Van Hoomissen upheld the Board. "The sole issue presented by this appeal," Van Hoomissen wrote, "is whether there is any substantial evidence to support the decision of the Board." Van Hoomissen simply cited the testimony of Jackson's physicians.

July 1979: Alpac decided to make one last pitch (still in process) to the Supreme Court.

Comment: Jackson is still in Seattle under outpatient therapy and could not be contacted in time to corroborate some details of this account. Due to the cumbersome and archaic nature of the Workers' Comp Division's records, information to verify some aspects of this narrative was not readily available, either. Nevertheless, the Board and Court decisions clearly indicate that Alpac's action in this case stands in direct contradiction to the company's stated position that when there is any doubt, the company sides with the claimant.[1]

2. Carr R. Ortberg

Ortberg was working for U V Industries (Alaska Gold Co., a self-insured carrier) when he injured his back in 1975. He was advised in Nome to seek treatment elsewhere because the Nome hospital was not equipped to handle his back problem.

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[1] In January 1979 Alpac's director of workers' comp told the author, "I personally would rather pay a claim that was doubtful . . . than to take the chance I had denied benefits to a man unjustly." Similar statements were made on at least two other occasions by the comp director, and by then vice-president Gay Dwyre.

August 1976: For the second time in a month, Ortberg wrote the Workers' Comp Division to say,

> I left Nome to see a surgeon as advised. . . . I payed the expense to come to California, and now that I am here where they do have equipment to fix my back I cannot get anything done, by reason known only by Alaska Gold Co. I am unable to work, my family is on welfare, and I am very disturbed over this whole matter.

December 1976: Ortberg returned to Alaska at his own expense for a Board hearing on the matter. Early in 1977, Ortberg was sentenced to prison in California. According to his account, during the 1976 period in which the company refused to cover him under workers' comp he stole and slaughtered a cow to feed his family.

April 1977: The Board ruled in favor of Ortberg, then in prison. The April 4, 1977 decision said:

> We believe he could have obtained adequate medical treatment in Alaska but went to California where he could be with relatives and expenses were expected to be less. Applicant said he still has his home in Nome and expects to return and resume working there if possible. . . . Applicant should be examined by an orthopedic . . . . The cost is to be paid by the employer. The employer shall also pay temporary total disability for the period May 25, 1976 . . . until applicant is no longer disabled or has reached maximum improvement. . . .

September 1977: Even before the Board's April 1977 decision, a new problem was developing. Sept. 17 Ortberg con tacted Workers' Comp again to report that, "I have received compensation for May to Dec. 1976 but have not received as much as a letter in the past 9 months. My family is in need, and it would be greatly appreciated if some kind of regular income could be arranged." After contacting U-V's attorney, the Workers' Comp Division informed Ortberg that the attorney

> was under the impression that payment was being made regularly and was surprised that it was not. He will contact UV Industries and have it resume payment. It should bring the back payments up to date and continue to make regular payment. . . . This was the order of the Board.

May 1978: Despite the assurances of the company attorney and the Board, Ortberg's family did not receive the promised payments. The company maintained it had stopped payment because Ortberg had refused to submit to x-rays and it AS 23.30.095(e) stipulates that if an employee refuses to submit to an examination, his rights to compensation shall be suspended until the refusal ceases. Ortberg maintains he was willing to see a doctor at all times, but that he would have been in physical danger from other inmates had he submitted to the x-ray in question.

In upholding the company's right to refuse payments, the Division also cited California prison authorities' assertion that Ortberg's "records fail to to show compliance" with exercises recommended for his back. Ortberg replied that he had in fact been exercising, that he didn't know that he had been accused of failure to exercise; he enclosed signatures of five other inmates to attest to his claim that he had been exercising.[1] At this point the Division staunchly upheld the claimant's right to due process by advising him of his right to take his case to the Board once again.

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[1] Ortberg's own assessment of the situation is worth quoting. In a May 28, 1978 letter from prison, Ortberg responded to the Division by writing:

Dear Mr. John Cook:
My wife has brought your letter to me today, it is my regret that this burden keeps falling back on myself. Dec. 8, 1976 I borrowed the money to fly to Fairbanks for the hearing, when I was asked what did I want, I stated I only wanted my back fixed and my family cared for until I was able to do so. The Board said "it will be done." I didn't ask for any other reimbursement or compensation. I don't wish to burden you with all my personal problems, but I think there must be a need to point a few things out to you. I am in prison of my own judgement by getting involved in killing a cow to feed my family; if all had been right as agreed by UV, I would have either been fixed or receiving compensation, as not to be faced with making a wrong discussion. I have spent many years of hard work, study and schooling to learn my trade, I'm yet young with many working years ahead of me. . . .I still have three children to support. . . . As for the allegations (I refused to submit to x-rays and declined to exercise as prescribed). . . I don't feel I should have to go into a bunch of constitutional safeguards for you surely know more about that than I. I didn't know that I was going to be in need to give evidence of following the Williams flexion exercises, but I have asked five of the 120 who live in the same dorm if they would give their signature. . . if more are needed or certification, please let me know. . . . As not submitting to a full exam-

Nov. 28, 1979: Back in Nome again, Ortberg went before the Board again. He had to fly to Fairbanks at his own expense for the proceedings. Although a decision has not been issued, hearing notes indicate that since more medical information is needed to determine the extent of his permanent partial disability, another hearing will have to be set.

Comment: The ironic possibility that a man might have gone to jail for stealing a cow because the comp system failed to provide benefits supposedly guaranteed by law may not lend itself to legislative redress, but another aspect of Ortberg's case may: The apparent failure to enforce AS 23.30.155(c), which requires that "upon suspension of payment for any cause, the employer shall immediately notify the board," figures into Ortberg's case at two different times. Had the company complied with that provision in August 1976, and had the Division responded in a timely manner (either by requiring interim payments or making the decision the Board finally reached eight months later) Ortberg might not have been in the position in which he made what he calls "a wrong decision" to feed his family. When the company violated the same statute a second time, the Division jumped the claimant for his alleged statutory violation but apparently ignored the company's. Again the problem would have been much simpler to resolve had the Division been staffed and equipped to insure that the company complied with 155(c).

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ination. . . . I have seen many doctors. . . . I haven't refused an examination by any doctor . . . . I did sign a refusal for a prison inmate to perform x-rays on me. . . . I have done some shameful things in my lifetime, but none as disgraceful as having to show to you my sorrowful heart and privations, please forgive me. I am to be released July 4th, tell me Mr. Cook, what am I subpost to do?

In a follow-up letter June 12, 1978, Ortberg wrote:
I do not believe Alaska workmen's compensation act at AS 23.30.095(e) [cited by Cook in his letter] to violate my constitutional safeguards, nor do I believe it to have been written that I should have to submit myself to dangers. . . . I do believe the stopping of compensation with out first providing some kind of proceeding and representation, is in violation of my Constitutional rights and in favoritism to the Employer. I wish for this matter to be dealt with as fairly and as soon as possible.

3. Lois Salisbury

Claimant says she has filed a malpractice suit against Alaska doctors based on a comp claim resulting from a 1976 back injury. In a May 1979 letter to a legislator she alleges

> . . . the Alaska Workmen's Compensation Board knows . . . and has documentation in the form of X-rays, bone scan and testimony, that I was treated and released by my Alaskan doctors for psychosomatic back problems and psychomatic malingering when, in fact my back was fractured and I had a ruptured disc in my neck. I now have advancing spinal arthritis, due to both the injury and the very lengthy delay in treatment. Most unfortunately this delay was caused by the interference of the Workmen's Compensation Board and Alaska Pacific refusing to pay treating doctors outside of Alaska and ignoring their diagnoses in favor of the doctors they "knew " in Alaska.

Comment: Medical records in Salisbury's file in Juneau appear to support her allegation of misdiagnosis. The claimant accepted a $4000 compromise and release settlement in June 1978. The author has received no response as of this date to a letter requesting a copy of the malpractice complaint Salisbury says she filed in California.

The manner in which carriers negotiate compromise and release settlements may be of some interest. Because of the complexity of the factors affecting each individual case it was not possible to document a pattern to compromise and release settlements, but some comp critics maintain carriers will remove a claimant from temporary disability payments in order to encourage the claimant to accept carrier terms in a compromise and release settlement.

4. George Coon

George Coon's right leg was crushed in a truck accident on the Sterling Highway. The trucker's narrative follows:[1]

> Here is what I myself have incountered with workmans compensation insurance after a job related accident of June 9. 1976.
>
> In this accident . . . the right tibula — lower section — below my knee was crushed and held only by a piece of skin.
>
> This lower section was reattached during surgery, but after two years of infection and numerouse set backs, my leg was amputated on March 3, 1978.
>
> Here are a few of the runarounds I went through. First off Workmans Compensation Insurance cut me off of disability payments shortly before my amputation. They were reissued after hassling with their adjustor.
>
> Due to the long duration of infection in my blood stream, I started having heart problems which were diagnosed as congestive heart failure. . . . I went to Workman's Compensation Insurance . . .asking them to pay for these now accumulated hospital and Dr. bills, since my leg was the cause of my heart problem.
>
> They're adjustor would not recognize the two being related and refused to pay the bills.
>
> I then contacted an attorney to have him get Workman's Compensation Insurance to pay for these bills, that I was having to pay, cause I knew my leg had caused this. . .
>
> At this time I had letters from three Drs. all which stated my infected leg was definitly the cause of my heart trouble.
>
> All these letters and reports, I personally hand carried to the attorney. After several months and numerouse phone calls to his office, he turned my case over to another attorney in his firm.
>
> We had a few meetings in which I told him to put me before the board to get them to make Workmans Compensation Insurance to not only pick up the . . . Dr. & hospital bills, but I felt I was now intitled to a disability rating on my heart. He stated, he would only be able to get them to pick up the bills.
>
> I have since learned Workmans Comp under rated me on my disability checks, and I am still waiting to go before the board.
>
> I'd like to mention I also belong to not only Teamsters, but 302 (operating engineers) as well. Whom neither dished out a dime on this accident.
>
> It's ashame that people have to lose not only their jobs but nearly everything they've worked for and paid into these Unions to receive so little support when they are laid up.
>
> I never received the benefit money from either Union, due to loss of limb, because the Dr's tried to save it, and I did not lose it at the time of the accident.

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[1] Letter to author; emphasis added. At author's request on short notice Mr. Coon provided documents on current Board proceedings, as well as medical evaluations that appear to corroborate the direct relationship between his accident-caused leg problems and his subsequent heart condition.

> I've since received a letter from 302 stating I have lost all benefits because I have been unable to fill the required hours. Therefore I have lost all that I have paid into retirement. . . .

At a Board hearing last July, the carrier (Alpac) agreed to pay some of Coon's outstanding medical bills. It is not clear why the carrier was resisting the medical payments at that time.

According to Coon, lawyers have been of little help. He says that "the only reason I know what I'm entitled to is I sat down and read that law with a fifth grade education." Despite the fact that Coon has permanent disability ratings from two doctors of 50% and totally disabled, at the hearing last July Coon's present attorney waived Coon's disability claims.

Coon says this action was taken without his consent and he has demanded another hearing on past and future permanent disability issues. He says he would like to fire his attorney because he believes the attorney failed to familiarize himself with the case adequately, or to represent him properly. However, he says, he cannot do so because the hearing is coming up shortly and he does not think he could find another lawyer on short notice.

Comment: Whatever else the documents of this case might reveal on close investigation, the statements and records provided by Mr. Coon indicate a striking discrepancy between Alpac officials' sentiments ("I personally would rather pay a claim that was doubtful . . . than to take the chance I had denied benefits to the man unjustly" is one such typical statement) and the company's actions in some cases.

5. Lyle Heffner

Injured when a truck hit him at a pipeline camp in 1976, Heffner was denied comp benefits by the carrier (Alpac). In 1977 the Board heard his case and ruled against Heffner, finding that:

> Considering the evidence in its entirety, we are unable to find the applicant is disabled. Given the minor trauma involved and no objective medical findings, we do not, quite frankly, believe applicant. . . .

The psychiatrist who examined Heffner for the carrier determined that "this man's secret ambition in life is to retire comfortably, early."

Heffner has taken the decision to court. According to his brief, in reaching its conclusion the Board declined to consider the conflicting testimony of a psychiatric social worker with 25 years of counselling experience. The testimony the Board rejected (by sustaining carrier's objection) explained Heffner's psychological make-up in a manner that would appear to contradict the psychiatrist and to validate Heffner's claim.

Was the Board correct in excluding that testimony? One of the few regulations governing the Board's procedure is 8 AAC 45.120(c), which provides in part:

> The hearing need not be conducted according to technical rules rules relating to evidence and witnesses. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil actions.

Documents on file with the Workers' Comp Division indicate Heffner claims he was not able to afford a psychiatrist to review the carrier-paid psychiatric evaluation. The Board has statutory authority to appoint examiners but declined to do so. Heffner's court brief contends:

> Having argument identifying the alleged psychiatric basis of the claim, some evidence supporting that claim, and knowledge that the appellant was financially unable to secure a psychiatric evaluation, the Board neglected its duty and committed error in failing to order a psychiatric examination and to state the reasons for the denial. . . .

AS 23.30.110(c) says in part: "The board shall make the investigation which it considers necessary in respect of the claim. . . ." AS 23.30.135(h) says in part:

> (h) The board may upon its own initiative at any time . . . and shall in a case where right to compensation is controverted. . . make the investigations, cause the medical examinations to be made, or hold the hearings, and take the further action which it considers will properly protect the rights of all parties.

Early in 1979 Heffner landed a clerical job. At that point he was able to front the money for a psychiatric evaluation. The findings supported the psychologist's testimony the Board had declined to consider. The psychiatrist's report says in part:

> To summarize, my reasons for not believing he is malingering are:
> (1) He did not make an anxiety-free adjustment to his physical injury as most people do who are malingering. . . .
> (2) His being activity oriented, this created a problem of adjustment to the injury. As a matter of fact, it made his adjustment . . . unsatisfactory to him.
> (3) We have a better explanation for his disability than the malingering theory — mainly that it was psychologically determined.
> (4) His history is in no way inconsistent with the formulation. As a matter of fact, he reacted to the injury just as one expected he would . . . .
> (6) He is not sophisticated enough to fabricate the clinical data which reveal the psychological problem.
> (7) Given the material it had, the board made a correct determination. It is not clear why the real story didn't come out. The reason may have been that Mr. Heffner was not psychologically minded enough to help much before his therapy experience and only with learning how to express himself did it become possible to get the story. Another is that he superficially presents himself with a macho pseudomasculine smart-guy attitude which in this situation would make people suspicious.

Heffner has made several attempts to alert officials outside the Workers' Comp Division of the problems he has encountered. In April 1977, for example, he sent the following letter to Gov. Hammond:

> Dear Sir:
>
> I was injured in February of 1976 . . . on the Trans-Alaskn Pipeline for Fluor Inc. at Pump Station #10. I was employed as an Operating Engineer Apprentice.
>
> In February of 1977 Alaskn Pacific Assurance Company, the Insurance Carrier for the State Workmans Compensation sent me to San Francisco to be examined by a doctor there that they were familiar with. In short, his findings have been interpreted by the carrier in such a manner that all benefits have been suspended. Not only the weekly check for my survival but also medical benefits. This interpretation is in direct conflict with those findings of . . . (the doctor who) has been treating me. . . .
>
> Fortunately I have some savings to live on before being given an opportunity to appear before a board in June of this year, unfortunately, I do not have the money to continue medical treatments and buy medication. But, in my 15 years as a resident of this state I could not ever imagine a state agency being as disorganized as to allow this to happen to the residents it is intended to serve. I am informed this practice of sending persons to Doctors outside the state by the insurance Company is a ploy to increase hardships caused by these injuries and help quicken settlements.
>
> Sir, I have invested two years in training, examining and competing to enter into the Operating Engineer Apprentice Program in Alaska and I am not interested in a quick settlement but in recovering from my injury, returning to work and becoming productive once again. I ask you how can this be accomplished if I am denied the medical treatment by the physicians who are trying with me to accomplish this.
>
> I just pray that you were not aware of the workings of the system. I seem to find myself under for if you are I can only condemn you as well as I hope I have condemned those people who have brought this grief upon me.
>
> Sincerely,
>
> Lyle Heffner

Routing slips attached to this letter indicate that it was passed to the Director of Workers' Comp with the request to "Please draft a response for the Commissioner's signature. Thank you!"

Comment: Without attempting to adjudicate this case, several points about the comp system's operation are demonstrated by this narrative:

(1) The Board does not have the staff to conduct investigations contemplated in AS 23.30.110(c) and AS 23.30.155(h) and sometimes declines to appoint an independent medical evaluator to resolve controversies.

(2) Heffner is one of several comp claimants who maintains he has been unfairly treated by carrier-paid physicians in the Lower 48. Although there is some evidence to back up this charge in other cases with other physicians (see Alaska Advocate, Jan. 25, 1979 and Anchorage Daily News, April 30, 1979, included as Appendix 9.), neither the Division nor the Board have attempted to ascertain the extent of t is problem (see Chapter 3A below).

(3) To this point, the comp system as a whole — carrier, Board, Division and various elected officials — do not appear to have responded in a positive manner to this citizen's complaint.

Chapter 3. An Assessment of Agency Responses to Claimant Problems

A. Preface

This chapter focuses on the response to claims problems by the two agencies that administer the workers' compensation program for the state — the Department of Labor's Workers' Compensation Division and the Department of Commerce and Economic Development's Division of Insurance. This current status report is designed to give the reader a sense of (1) the scope of current claimant problems, (2) how those problems developed and (3) the manner in which the responsible agencies have responded.

In the preceding chapter we looked at a number of claimant complaints about the comp system; now we approach the problem from the agency side. Three things strike the casual observer of the workers' comp system: (1) Statistics and surveys are lacking that would delineate the significance of the problems described in Chapter 2 above. To be sure, we will find statistics on some aspects of the problem, but a word of caution is in order: these figures do not touch all the salient aspects of the problems claimants face.[1] (2) The individuals administering the comp program in both agencies appear to be overloaded. "My desk looks like the Bermuda Triangle," one person muttered as he rooted around in an attempt to locate the document he needed to answer a question. And finally (3) there is little interaction between the two agencies that deal with workers' comp.

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[1] From a paper-processing point of view, the Workers' Comp Division has developed indicators of the crisis in comp administration. But paper processing is only one aspect of claimant problems. To take a naive and far-fetched example: the Division could have resolved all five cases covered in the preceding chapter's narratives quite quickly with an arbitrary ruling that each was fraudulent. It would have taken very little time to run them through the hurdles, write quick decisions—and the paperwork problems would go away. But what about the claimants? They would no longer have a 100-day delay to complain about, but they would still face many of the same difficulties coping with their wage loss, injuries, rehabilitation and adjustment.

B. Workers' Compensation Division

(1) Background

In its budget request for FY 81 the Division acknowledges a serious problem in workers' comp administration due to an increasing caseload over the last five years. The Division requests new positions, as well as capital appropriations to modernize its antiquated and cumbersome record-keeping system. The author believes the request, though several years late in coming, is legitimate: the comp caseload has increased dramatically and the recordkeeping system has long been inadequate.[1]

For background purposes, let's take a look at the workload increase the Workers' Comp Division faces. The Division estimates it handles 15,000 to 20,000 individual comp claims per year. Disputed cases probably total 15 to 20 per cent of that figure.[2] The Division's figures on formally disputed cases in Table I. will be followed by a brief explanation of the categories.

TABLE I.

HEARING LOAD OF WORKERS' COMPENSATION BOARD

	FY 75	FY 76	FY 77	FY 78	FY 79	% Net Increase
1. Controverted cases	615	1296	1630	1630	1462	237%
2. C & R's approved by order	150	178	266	635	997	664%
3. Cases set for hearing	504	426	781	930	903	184%
4. Decisions and orders	176	170	251	379	326	185%
Staff person-years	8	8	11.75	12.5	13.5	169%

(Source: Workers' Comp Division)

[1] Some details from the proposal will be covered in this chapter. See 3.B.(2).

[2] Estimates based on discussions with Division personnel.

Controverted cases are those in which the carrier has said, "we won't pay any more," the claimant has objected and nobody wants to back down. The controversion rate is parallelled by a set of cases Division personnel describe as "carrier resisted." In these cases the carrier is doing the same thing without filing a formal notice of controversion.[1] Based on her experience as a claims officer, Workers' Comp Director Jacquelyn McClintock believes there are as many resisted cases as there are controversions. Resisted cases do not appear in Table I. — the Division has no tally on them — but the resisted case, like the controverted one, requires the time of the hearing officers to talk to claimants, make phone calls to carriers, locate the files (often a time-consuming task), write letters or do whatever it takes to get shut of the resisted case in order to get back to other cases that require attention.

The second category, compromise and release (C & R) settlements, includes controverted cases in which the two parties work out an agreement before the Board works one out for them. Since the Board must approve all C & R's, the hearing officer may be involved twice — in the negotiating process, and in reviewing the final agreement before signing it.

Cases set for hearing often get delayed, or the two parties may work out a C & R settlement before the case can go to the Board. These factors — plus the backlog in decisions — account for the difference between the third and fourth categories.

Nobody seems to have a clear handle on precisely which factors account for the workload increase, or to what extent each factor is responsible. Population growth, coupled with the benefit increase of 1975 (which looks

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[1] I am indebted to Workers' Comp Division personnel for graciously taking time to clarify these terms for me; responsibility for errors is my own.

increasingly juicy during the post-pipeline period of high unemployment), may be contributing factors; part of the increase may be caused by decline in the quality of claimant services. For analytical purposes the central points to bear in mind are: (1) that the workload has increased (by 237% between FY 75 and FY 79, if you count controversions, or 185% if you count Board decisions); and (2) the Division does not have a clear handle on the reasons for the increases.

With the increase in caseload in mind, let's take a look at the manner in which the Division budget has increased during the same period.

TABLE II.

COMPARISON OF BUDGET REQUESTS AND LEGISLATIVE APPROPRIATIONS, FY 76-80

State Fiscal Year	Department Request	Administration Request	Legislative Appropriation
FY 76	$297,500	$297,500	$269,300
FY 77	431,000	408,500	397,600
FY 78	448,700	444,400	395,700
FY 79	494,800	485,600	485,600
FY 80	724,500	606,300	582,100[a]

(Sources: FY 76-79 from Dept. of Labor summary, Free Conference Committee Reports; FY 80 from Free Conference Committee Report)

[a] FY 80 figure does not include an $83,000 supplemental appropriation by Governor

In a meeting with comp protestors in Fairbanks Oct. 5, the Commissioner of Labor blamed the problems of the Workers' Comp Division on lack of attention and lack of funding by the Legislature. The Commissioner stated, "The Legislature . . . refused to look at workers' comp . . . . and that's our problem."[1]

[1] Dept. of Labor recording. Other statements by the Commissioner include: "We haven't been able to get the Legislature's attention," and, "And that's been the problem with workmen's comp: the funds haven't kept up with the workload." Meeting was arranged by the Governor's office after protestors who had previously demonstrated at state buildings in Anchorage and Fairbanks requested a meeting with the Governor.

There is a kernel of truth to the Commissioner's contention: the Legislature has not paid sufficient attention to workers' comp in recent years and funding has not kept pace with the workload. But careful review of the budget information presented here does not substantiate the Commissioner's argument that Legislative inattention and budget-cutting are the primary causes of the current problems. The figures in Tables I. and II. indicate that the Department's failure to request adequate funding in a timely manner and the Governor's budget cuts are both more significant factors than Legislative action. Over the five year period between FY 76 and FY 80, the Governor dropped the Commissioner's requests by 6.4 per cent; by comparison, the difference between the Governor's request and legislative appropriation for the same period was 5.2 per cent. For the five years in question the total Legislative cut — $112,000 — would have funded one position at $22,500 per year. In view of the marked increase in the Board's workload, it does not seem likely that the addition of one staff person would have solved the problem. (In fact, to tackle the problem this year the Department's in-house review recommended a 7-person staff increase plus a much-needed and long-overdue capital budget appropriation to computerize the records system.)

The Commissioner notes that the Senate Finance Committee took action on the Department budget last year without requesting the Commissioner's appearance, and that the Legislature has paid little attention to workers' comp since the benefits were raised and adjusted in 1975 and 1976. The Commissioner also cites his Nov. 16, 1977 Workmen's Compensation Budget memorandum to the Governor's Budget Review Committee, in which he said:

> Current staff levels are not and will not be adequate to carry out the Legislative intent of the Workmen's Compensation Program. Repeatedly requests for new positions have been denied. At this time it is critical to provide this program with the necessary staffing; service to the public is continually eroding and cannot be considered 'adequate' at this time. . . . While I am very much aware of the available anticipated revenues for FY 79 and the subsequent budget constraints, the budgetary approval for this position is the department's number one priority.

Although the Commissioner claims repeated requests for new positions were denied, the same memorandum indicates that during the preceding three years the Commissioner requested a total of 4.5 positions and received 2.[1] The Division got the extra person requested in FY 79; in fact, that year the Commissioner got 97.8% of his workers' comp budget request — and the 2.2% cut was not made by the Legislature, but by the Governor. Last year it was the Governor — not the Legislature — that took a major chunk out of the Division's budget request increase; the Legislature's comparatively dainty bite was more than restored by a supplemental appropriation from the Governor.

To summarize, while it is true that the Legislature has not devoted much time to workers' comp since 1976, it is difficult to demonstrate the Legislative cuts in the Administration's budgets are the primary cause of today's problems. To the contrary, a careful comparison between the increasing caseload and Administration budget requests indicates a major cause of current comp problems may be that the Department of Labor failed to anticipate or take timely measures to cope with the situation as it developed. Although the Commissioner acknowledged a critical situation in November 1977, until this year there was little outward indication of concerted Department of Labor efforts to get the comp program back on the track.[2]

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[1] Different Department of Labor recapitulations give slightly different figures for the increase in comp personnel since FY 75. When he referred to repeated requests for new positions, the Commissioner may have been thinking of requests for major increases in comp personnel that were turned down in FY 72 and FY 75; those requests were made by the preceding Commissioners under a different administration.

[2] Possible signs of this effort might include: proposals for sweeping changes; press releases about comp; letters to unions, civic and business groups calling attention to comp problems; requests for meetings with legislators, legislative aides, the Governor and/or executive aides to discuss comp; contact with comp protest organizers, or comp reform groups such as CVIA.

The remainder of this section will focus on the specific problems the Division faces and the manner in which the Division has responded to these problems. The gist of this assessment is that the proposal to add staff and computerize the record-keeping system is commendable and long overdue, but other measures to improve the comp system are also necessary. Because the Workers' Comp Division seems to be too swamped to generate the momentum to make the necessary changes, it is to be hoped that the Legislature will encourage the Department to take an aggressive role in promoting reform of the comp system.

(2) Modernizing the Record-Keeping System

A Dept. of Labor internal review of Workers' Comp Division operations concluded that

> . . . so much time is devoted to finding a case to put the various elements together, no time is left to question injury and first payment reports that may be months late. . . . the staff is so busy manipulating paper, there is no time for enforcement efforts when very late reports are received.[1]

The analysis of paper flow described a system incapable of processing reports in a timely manner. For example, Alaska statutes require the carrier to make first payment within 14 days of notification; the law adds a 20 per cent penalty payment for noncompliance.[2] A Division tally disclosed during 1978 that out of 3,889 first payments to cover wage loss, only 1,093 (28 per cent) were made within the 14-day period required by law. The remaining 72 per cent were almost evenly divided between the 15-to-28-day period and over 28 days.[3]

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[1] Department of Labor, Internal Review Section, Workmen's Compensation Division: Analysis & Recommendations (Nov. 23, 1979), p. 6.

[2] AS 23.30.155(b): "The first installment of compensation becomes due on the 14th day after the employer has knowledge of the injury or death." AS 23.30.155(e): "If any installment of compensation payble without an award is not paid within 14 days after it becomes due, as provided in (b) of this section, there shall be added to the unpaid installment an amount equal to 20 per cent of it. . ."

[3] Dept. of Labor, "Report to the IALABC on Promptness," Exhibit K of Analysis & Recommendations (op. cit.).

In its current budget request document, the Division cites similar figures and says it hopes improvements in the record-keeping system will enable the Division to assess the penalty, thereby providing incentive for compliance with the law. (Keep in mind that the purpose of the payment is to replace wages the worker who is laid up suddenly loses.)

The internal review also reports:

> Anytime compensation is stopped or suspended, carriers and self-insured employers are required by law (AS.23.30.155) to notify the Workmen's Compensation Board within 16 days. Failure to report within that time should result in an assessment of a $100 civil penalty. Penalties are now being assessed whenever the Board is made aware compensation has stopped and no report is made, but only as a result of claimant complaints. Carriers reporting beyond the 16 day deadline are not routinely penalized under the current system.[1]

The failure to enforce compliance of A.S. 23.30.155(c) twice affected the affairs of Cary Ortberg, whose case is described above (Chapter 2.B.2.). Many claimants allege that carriers cut off payments to starve the claimant into accepting a compromise and release settlement. One claimant — a man with an eighth grade education and a 25-30% disability rating due to a back injury — alleges in an affidavit that, "I did not feel that $17,500.00 was enough compensation for my injury . . . but Alpac had stopped paying me any money a couple of weeks previously, and I needed to settle because I needed the money."[2]

At this time an individual may holler and get his temporary benefits reinstated, but the Division has no way of knowing whether this is an isolated incident, or whether the carrier is similarly squeezing other claimants who

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[1] Dept. of Labor, Analysis and Recommendations (op. cit.), p. 9.

[2] Affidavit of Roy L. Kuhl, Dec. 5, 1978. One Fairbanks attorney says he has a file of several similar affidavits alleging the carrier cut temporary benefit payments to increase negotiating leverage on a permanent settlement. At present the Division's record-keeping system is incapable of keeping tabs on this practice. (Affidavit in appendices.)

lack the knowledge or the capability to fight back.

The Division's most widely publicized problem is the delay in issuing hearing decisions. Although required by law to issue a finding within 20 days,[1] the current time lapse between hearing and decisions is 97 days. The Division is proposing to establish a second and entirely separate computer system to help speed the decision process. This system — a smaller system similar to the one that indexes Alaska statutes — would list Board decisions by key words and subject matter, giving hearing officers ready access to precedent decisions. This information storage and retrieval system would save hearing officers time in researching decisions and would also improve the quality and consistency of those decisions, according to the proposal. Moreover, ready access to precedent decisions and the knowledge that the Board would rely on the precedent might dissuade attorneys from bringing some cases to the Board, further reducing the workload.[2]

Both proposals are worthy of legislative attention and support; they will improve the quality of claims service by both the carrier and the state.[3] In fact, the idea is so good that one cannot help wondering why the Division did not make this recommendation long ago.[4]

(3) Hearing Referees, Investigators

The Department's internal review considered "work flow, Division objectives and problems of coordination;" however, the review paid little attention

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[1] AS 23.30.110(c). In 1979 this violation triggered a civil suit against the state.

[2] Dept. of Law has manually indexed recent Board decisions. To get an idea of what an index of Board decisions is all about, the reader might track down that compendium through Assistant Attorney General Kathy Kolkhorst.

[3] To be consistent, if the Legislature authorizes the claims-processing system it must also authorize the Board decision index. See Chapter 5.

[4] AFL-CIO lobbyist Dwayne Carlson has been promoting the idea for years; in the past, he says, he has not had any support from the Department of Labor.

to the operation of the Board. In view of the Board's delays in scheduling and in issuing decisions — apparent violations of AS 23.30.110(b) and (c) — and the Board's inability to investigate — apparent violations of AS 23.30.110(c) and AS 23.30.155(h) — it is surprising that the study did not look more closely at the manner in which the Board effects Division objectives.

In some states the Board retains a professional investigating staff. If the Board had its own capability of determining issues of fact — however minimal — the existence of this fact-finding capability might reduce the tendency to litigate a comp case "just for the hell of it." Another characteristic of other states the review did not consider was the utilization of referees to hear comp cases.[1] Under a referee system, the Board would hear only the cases in which one of the parties protested the hearing officer's decision. The internal review did recommend that the Division alter its organizational structure to isolate the adjudicators (hearing officers) from the personnel who process claims day-to-day. (This reorganization would not require Legislative approval per se; however, the change would not be possible unless the Legislature appropriates the additional positions the Division is requesting.)

Another practice from other states the review did not consider is the possibility of making all Board members full-time employees with responsibility for writing decisions. One factor that contributes to the current backlog is that the appointed labor and management representatives serve on a per-diem basis and do not write decisions.

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[1] Oregon's Division staff includes both referees and investigators. Although the Division is not considering these ideas formally at this time, the Deputy Director did indicate that he would like to see the Division consider revising the hearing process. At this time, however, all hearing officers are working on cases and have their hands full trying to close out the backlog while keeping up with current cases.

(4) Rewriting the Statute

Because the statute governing workers' comp has been amended piecemeal over the years, the Commissioner of Labor told critics of the comp system Oct. 5, "Alaska is in real need of a real rewrite."[1] Despite the Commissioner's belief that a complete rewrite of the law is necessary, this year the Division plans to introduce only a few minor changes the Director describes as "mostly housekeeping," and the Division has no plans to rewrite the statute at this time. It is not clear when the Commissioner concluded a rewrite was necessary, or what action he has taken in this regard. Meantime, the comp claimant who wants to learn the law must wade through a statute that begins with a 13 page index to key terms (which are undefined), followed by 103 pages of densely packed legal phrasing and 9 pages of Board rules. For some suggestions on changes in the law, see Chapter 5.

(5) Explanatory Booklet

OVIA has asked for a booklet explaining the law to the lay person. Several states publish a condensed manual in simple terms because they believe a major cause of much time-consuming and expensive litigation before the Board is friction that arises when the lay person does not understand what the law expects of him/her, the carrier or the state.[2] To date there is no indication the Division has explored this reasonable suggestion that might spare claimants a great deal of anguish and could save the state a great deal of money in the long run.[3]

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[1] Dept. of Labor tape, Oct. 5, 1979

[2] See speech of Minn. comp task force chief Steve Keefe (App. .)

[3] Division of Insurance has been no more responsive to this proposal. See Ch. 3 .

(6) Claimant Complaints

When the Commissioner finally met with comp protestors Oct. 5, he took the position that he could not get involved in the operation of the Board. "They make these decisions and then their decisions are appealable in court. . . . I can't get involved in them or try to influence them on their decisions," the Commissioner stated.[1] In fact, Alaska statute names the Commssioner as chair of the Board (and permits him to designate the task to a subordinate) and gives his Department clear authority to carry out the operations of the Board.[2]

The Commissioner expressed the idea that the Board often leans toward the claimant. Conceding that the panel is bound to miss a few cases in the other direction, he said there is nothing he can do about the situation since he cannot interfere with the Board. But it is not clear that the Commissioner described the situation accurately, and it is clear that there are a number of things he could do. For starters, he could ascertain whether he is correct that only a few cases are at issue, rather than the operating procedures of the carriers, the Division and the Board, as some protestors allege. This could be done by a survey of random cases, or of cases selected because they bear a striking resemblance to each other or fit alleged patterns.

One such pattern the Division has ignored concerns the use by Alaska carriers of certain San Francisco specialists to evaluate individuals with back complaints.[3] At least three claimants of whom this writer has knowledge allege

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[1] Dept. of Labor recording. Apart from the fact that the Commissioner has statutory responsibility for the Board, his statement is surprising because the comp protestors were not asking him to intervene in individual cases; they were asking for review of and changes in the system the Commissioner supervises.

[2] AS 23.30.005(b): "The commissioner shall act as chairman and executive officer of the board. . . ." AS 23.30.005(h): "The Department of Labor may make . . . rules . . . and regulations to carry out the provisions of this chapter. . . ."

[3] See for example 1977 letter from claimant Heffner (Chapter 2.B.5.).

that Alpac sent them to San Francisco for examination by Dr. Willard F. Pennell, M.D.; all three say that after one interview/examination Dr. Pennell determined each to be a malingerer and sent the carrier a long report describing his findings in detail; all three say Dr. Pennell's opinion played a significant part in the carrier's refusal to make payments and the Board's eventual decision against them.[1]

What makes this pattern interesting is that Dr. Pennell's firm is featured in a legal textbook that says the firm consistently provides insurance companies with testimony damaging to plaintiffs seeking insurance payments. The author of the text, Marvin E. Lewis, past president of the American Trial Lawyers Association, says he has been up against insurance companies that have retained Dr. Pennell's firm in at least half a dozen cases. Is there a pattern? "They always say my client is faking it; I always win," snaps the San Francisco attorney.[2]

In the textbook, attorney Lewis shows the student how to do it. In one of the cases involving Dr. Pennell's partner, the lawyer told the jury:[3]

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

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[1] The three claimants are Robert MacArmour, Diane Black and Alice Angel. Early in 1979 Alpac's director of workers' comp told this writer she thought Alpac had sent at least half a dozen claimants to Dr. Pennell; in addition, at least one other Alaska claimant was examined by Dr. Pennell for another Alaska carrier. Dr. Pennell reportedly visited Alaska once and toured the trans-Alaska pipeline on a business trip to meet with Alpac officials.

[2] The attorney-author, Marvin E. Lewis, made this statement in an interview with the writer. The text, by Lewis and Robert L. Sadoff, M.D., is Psychic Injuries (New York: Matthew Bender. Vol. 12, Courtroom Medicine. 1975; updated annually). Dr. Pennell, a licensed psychiatrist and neurologist, is in good standing with the San Francisco Medical Society.

[3] Marvin E. Lewis in Lewis & Sadoff, Psychic Injuries, p. 380.

In view of the reputation of this firm, some claimants are surprised the Board has apparently relied heavily on Dr. Pennell's findings in some cases without exercising its authority to appoint an independent examiner. The Division contends it does not place undue emphasis on Dr. Pennell's testimony, but the Board decision against MacArmour noted the San Francisco specialist had found a "predisposed neurosis" and "conscious exaggeration of symptoms which seemed to change constantly." The Board continued:

> These developed such a pattern that each new doctor he saw was put to the test of trying to sort out an objective symptom to go along with subjective symptoms. Because of the short periods of treatment, no one doctor ever sorted it out until the pattern was explained by Dr. Pennell.[1]

In ruling against Diane Black twice, the Board cited Dr. Pennell both times. The second decision read in part:[2]

> And after considering the medical evidence it (the Board) advised as follows:
>
> > We (the Board) believe, as stated in Dr. Pennell's report, that it is probable that some secondary gain or need for attention is motivating her to perpetuate her symptoms and that she will continue to seek treatment and take medication as long as it is provided. . .
> > Her claim for additional benefits should be denied and dismissed.
>
> The Board considered all of the medical evidence and believed her disability was unrelated to the February, 1976 injury but rather, as stated by Dr. Pennell, to secondary gain and need for attention which was motivating her to perpetuate her symptoms.
>
> We conclude that the Board did not make a mistake in determination of a fact in its November 1, 1977 decision.

Asked how many times the Board has encountered the testimony of Dr. Pennell, then-Director of Workers' Comp John Cook replied that he did not know. When

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[1] For more on MacArmour's case, see articles by this writer in Alaska Advocate, Jan. 25 and Feb. 15, 1979, and Anchorage Daily News, April 30, 1979 (Appendix 9).

[2] In this passage from the Board's second decision against Black (May 24, 1978), the Board is quoting its earlier decision.

he was apprised of the allegations against Dr. Pennell, the Director said he could not assign staff to investigate because the Division was already overburdened. If the Division cannot respond to serious questions on major cases such as the use and influence of specialists such as Dr. Pennell, one wonders how well the Division investigates day-to-day controversies about other carrier practices — disputes in which the carrier repeatedly delays payment to chiropractics, allegations that certain doctors or lawyers are consistently hostile to claimants, charges that carriers stop temporary disability payments to increase leverage in negotiating a permanent settlement, etc.

(7) Summary

Although the Division's current proposal to add personnel and modernize its record-keeping system will reduce some problems, it will not deal with others. The budget request makes no reference to other necessary reforms such as:

= major statutory revision;

= explanatory booklet for claimants;

= study to ascertain whether the Board should consider appointing its own case investigators, or whether a referee system should be adopted;

= study of claimant complaints.

Specific reforms and aspects of the comp system the Legislature might consider overhauling are identified in Chapter 5.

C. Division of Insurance

Claimants who bring complaints about comp to the Division of Insurance are told as a matter of policy that benefit questions are not within that agency's jurisdiction. The only way the Division of Insurance can become involved in the delivery of comp services, explains Chief of Market Surveillance Don Koch, is if the claimants can document an unfair trade practice in accordance with AS 21.36.125. And that statute, as the Division interprets it, won't do the individual comp claimant much good. One hurdle to using the statute, says Koch, is that an unfair claim settlement practice must be treated in terms of resolved cases; you can't bring a trade practice violation charge, he says, until the case is closed. The second hurdle is that there are no guidelines to determine what constitutes an unfair claim settlement practice.[1]

Despite the Division's oft-repeated assertion that it cannot become involved in comp claims, the workers' comp statute appears to give the Division of Insurance clear authority to become involved in comp claims problems. AS 23.30.030(7) reads (emphasis added):

> If the insurer fails or refuses to pay a final award or judgement (except during the pendency of an appeal) made against it, or its insured, or if it fails or refuses to comply with a provision of this chapter, the insurance commissioner shall revoke the approval of the policy form, and may not accept further proofs of insurance from it until it has paid the award or judgement or has complied with the violated provision of this chapter. . .

The Division's perception of unfair claim settlement practices does not prevent the Division from operating an Anchorage field office whose primary task

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[1] For statement of the Division's interpretation of the law as it relates to workers' comp, see the Division's transcript of workers' comp rate hearing, Anchorage, Nov. 8, 1979.* Similar interpretation expressed to this writer in interviews in April and December 1979. Director of Insurance Kenneth Moore referred all substantive questions for this project to the Chief of Market Surveillance.
(* Claimant testimony portion appendixed to this report.)

is to respond to consumer complaints. If an employer is concerned about his workers' comp bill, the Anchorage office will look into the matter. But if an injured employee is concerned about his treatment, the Anchorage office will refer the individual to the Workers' Comp Division.

Last spring, when this writer asked the Anchorage office chief how many comp claimants bring problems to his office, he checked with his staff and reported back that his office routinely forwarded about three complaints a week to the Workers' Comp Division. He seemed somewhat surprised by the frequency of comp complaints and acknowledged that if comp were a field of insurance for which his office had responsibility, that rate of complaints would require attention. However, he explained, claimant comp problems are outside his jurisdiction.[1] In December Division officials said they had not instituted any procedures to keep tabs on the number of complaints shuffled over to the Workers' Comp Division; nor had efforts been made to learn what action, if any, the Workers' Comp Division takes on complaints about the insurance that accounts for almost one-fourth of the total insurance premium bill in Alaska.[2]

A widespread practice that clearly violates the comp statute, identified in the preceding section, is late payment of first benefits. According to the Workers' Compensation Division budget request, only 26 per cent of all comp claimants receive their first payment within 14 days of notifying their employer — illegal by AS 23.30.155(b).are the remaining 74 per cent. Advised of this statistic, the Division of Insurance Chief of Market Surveillance seemed surprised. If true,

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[1] Interview in Anchorage, April 1979. See Anchorage Daily News, April 30, 1979.

[2] Interviews with Division personnel, December 1979.

he said, the practice might not be a trade practice violation. If the practice were that widespread, he explained, that could indicate the law — rather than the practice — ought to be changed.[1] One flaw in this flexible approach to enforcement is that the Workers' Comp Division does not agree (that agency says it wants to enforce the statute in question and hopes increased manpower and improved data-processing techniques will make this possible — see preceding section). Without going into the question of the extent to which an administrator should interpret a statute, this anecdote reinforces the general impression that impetus to resolve claimant problems is not coming from the Division of Insurance.

Although the Division puts out consumer information booklets on other types of insurance — auto and home-owners, for example — the agency has not done so for workers' comp. Again, Division officials say, delivery of services is the responsibility of the Workers' Comp Division.

Although the Division of Insurance is to be commended for listening to comp claimants at an informal meeting in Anchorage Nov. 7 and in the rate hearing Nov. 8, it must be noted that the officials apparently did little more than listen. Officials promised claimants at both meetings they would look into some of the complaints. As of Dec. 21, however, the only action that had been taken was to transcribe a tape-recording of the Nov. 8 hearing for forwarding to the Workers' Comp Division. Chief of Market Surveillance Koch did not attend the informal Nov. 7 meeting, and he says he never received a report on that meeting or a request to look into some of the problems with comp that were raised at that meeting (see chapter 2.A.1.).

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[1] If being widespread makes a practice legitimate, then anything Alpac does would seem to be legitimate since that company writes 56 per cent of the comp premiums in Alaska.

This section can be summarized in one sentence: Although workers' comp is the largest insurance by premium dollar in Alaska and the Division of Insurance has a consumer complaint office and apparent statutory authority to involve itself in comp claim problems, claimants with comp problems get little help from the Division of Insurance. (The Division of Insurance spends much of its time on rate-setting matters for all kinds of insurance, including workers' comp; some aspects of the workers' comp rate-setting mechanism are considered in the next chapter.)

Chapter 4. A Brief Look at the Workers' Comp Rate-Setting Mechanism in Alaska

When legislators speak of comp rates, they usually refer to benefit rates for injured workers, which are set by the legislature; when employers talk about comp rates, they probably refer to the premium rates they pay, which are set by the insurance industry, subject to approval by the Division of Insurance.[1] The relationship between benefit rates and premium rates is not necessarily one-to-one.[2]

The premium an employer pays for workers' comp eventually finds its way into one of five categories:

70% —
- (1) injured worker income maintenance;
- (2) injured worker medical expenses (including rehabilitation);
- (3) litigation costs;

30% —
- (4) insurance company administrative costs;
- (5) insurance company profits.

As a general rule of thumb, the insurance industry puts the break-even point for comp at 70 per cent; in other words, if the carrier pays out 70 per cent of the premium for items (1), (2) and (3), the carrier will break even.

After studying the subject for two years, the chair of the Minnesota Workers' Compensation Task Force offered this observation about comp rates:

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[1] For background information on Alaska premium and benefit rate levels, see the following:

Legislative Affairs Agency, Workers' Compensation Rates in Alaska (A Study by Woodward and Fondiller Actuarial Consultants; Feb. 1977)

Legislative Affairs Agency, Workers' Compensation (The Feasibility of Establishing A State Fund; Feb. 1977)

Division of Insurance, Hearings on Workers' Comp Rates, Ketchikan, Anchorage and Fairbanks, Nov. 1975 (2 vols.; on file with Division of Insurance)

Division of Insurance, Alaska Workman's Compensation Insurance Rate Hearing, Anchorage, Nov. 8, 1979 (on file with Division of Insurance)

Division of Insurance, Order 76-1 (Feb. 17, 1976)

[2] Due to the complexity of the insurance industry and the number of elements that are cranked into the rate base, there is bound to be some slack in the system.

> One of my goals in Minnesota, when we started to study the insurance system was to satisfy myself whether there are excessive profits to insurance companies in the workers' compensation system in Minnesota. I spent a lot of time on that question and I came to three conclusions:
>
> —First, the insurance companies sincerely believe they are losing money on workers' compensation insurance.
>
> —Second, there are others who just as sincerely believe that they are getting rich.
>
> —Third, and maybe most important of all, the Minnesota Commissioner of Insurance, whose responsibility it is to regulate workers' compensation rates in Minnesota does <u>not</u> know. In fact, there is evidence presented to him that points clearly in both directions.
>
> In Minnesota, at least, the regulation of workers' compensation rates is hopelessly inadequate and frankly it's the Legislature's fault. . . . we haven't given him the staff. Workers' compensation rate requests are analyzed by part-timers loaned from other departments, people with experience in other areas of insurance, people whose primary responsibilities are regulation for solvency, not regulation of rates. But even if he had the staff, under the current system, at least in Minnesota, the Insurance Commissioner doesn't have enough information to be able to know whether he is promulgating a fair rate. . . .[1]

A reasonable first step in dealing with Alaska workers' comp benefit and premium rates would be to ask the following questions:

(1) What percentage of the workers' comp premium bill goes to claimant income maintenance?

(2) What percentage goes to medical examinations, treatment and rehabilitation?

(3) What percentage goes to attorneys and other costs associated with disputed cases?

(4) What percentage goes to carriers for administrative costs?

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[1] Remarks of Minnesota State Sen. Steve Keefe (chair, Minnesota workers' comp task force), Legis 50 Conference on Workers' Compensation, Portland, Ore. (June 14, 1979).

(5) What percentage goes to carriers as profit?[1]

In Alaska, as in Minnesota, the information is not available to answer the basic question. The Division of Insurance requires exhaustive annual reports from all carriers and exercises its statutory authority on comp rate filings, but the columns of figures do not tell the lay person what percentage of the premium dollar goes into the five categories identified above.

The annual reports of the major carriers operating in Alaska do not answer the key questions because the figures from Alaska are lumped together with those of the other states in which the carrier operates. Another reason the annual reports leave questions unanswered is that the accounting process for insurance is rather complicated — the discrete elements of premium payments are rather intricately related.

Why so complicated? One reason is that the premium an employer buys on May 1 to cover accidents over the next 12 months will fall within two calendar years. During that period the carrier will be making some injury payments on the policy, but the carrier will also be making payments on injuries incurred on policies previously purchased. Moreover, some payments for injuries covered by the policy we began with will continue into the following policy year, and some injuries to be covered by that policy will not be identified as payable until some future date. The bookkeeping process to handle all this is bound to be tricky.

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[1] Concerning profits on comp, the 1972 Report of National Commission on State Workmen's Compensation Laws made the general observation that ". . . statutory underwriting profits . . . averaged only about 1 per cent of premiums, and the rate of return on net worth for all private carriers is not out of line with the return in other industries." (Report, p. 113.) The profit margin written into Alaska premium costs is 2.5 per cent; it is important to note that this figure does not include investment income and therefore does not reflect the profitability of workers' comp. The significance of investment income will be treated in this chapter.

Keeping tabs on comp profits is not an academic matter; in Alaska comp carriers collect over $100 million annually. Let's look briefly at what the carrier does with the investment income from that money. A 1977 study of Alaska comp rates by an actuarial firm concluded that under the rate-setting procedures used in Alaska "nearly all of the investment income is excluded from the rate making process."[1] According to the report, in 1974 Alaska comp carriers earned $2,257,000 in investments held to guarantee future comp payments. The underwriting operation for that year showed a net loss of $669,000 for all carriers writing comp in Alaska, but the investment income enabled the carriers to pay expenses with $1,588,000 left over ($2,257,000 minus 669,000 = $1,588,000). According to the report, the insurance companies' return on capital — a standard measure of profitability — was a healthy 12.4 per cent.[2] However, because comp investment income was excluded from rate-making calculations, comp underwriting in Alaska for 1974 showed on the books as a net loss; since Alaska rates allow a 2.5% profit, the 1974 "loss" data enabled the carriers to push comp premium rates higher when rates were subsequently readjusted to reflect actual experience. This hidden profit factor is often overlooked by some policymakers who hold rising benefit payments solely responsible for pushing comp premium rates higher. It follows from this analysis that one item the reader might like to keep in mind as he/she considers comp premium rates is investment income.

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[1] Legislative Affairs Agency, Workers' Compensation Rates in Alaska (A Study by Woodward and Fondiller Actuarial Consultants; Feb. 1977), p. VII-6. Other jurisdictions handle investment income differently. In some states carriers have been required to write premiums at a theoretical loss to balance the profit they will earn on investment income before they eventually pay out on claims.

[2] Woodward and Fondiller study, p. VII-20. In light of the quadrupling of comp premiums since 1974, it would be interesting to develop current figures on investment income.

In Alaska comp rates are determined in the following manner: The carriers report data to the National Council on Compensation Insurance (NCCI), a national group formed by the carriers to process comp data and set up rates; the data is verified and analyzed by the NCCI,[1] then rates are sent back to the Alaska Classification and Rate Committee,[2] an Alaska carriers' group that reviews the work of the NCCI. That committee makes the final filing with the Division of Insurance.[3]

As the Division of Insurance sees its task in this complicated situation, the agency is supposed to make sure the rates provide a fair return for the carrier at a fair price; to make sure the rates for comp premiums are properly distributed among some 650 various categories of work that are charged differentially, depending on the hazards of the work; and to make sure the carriers are adequately reserved (i.e., that the carrier will have the money to cover the losses that can be expected to occur).

Late in 1978 the Alaska Division of Insurance commissioned a thorough review of insurance industry reserving practices to cover long-term injury payments in workers' comp.[4] The broad issue of profit from investment income was not the focus of this study. One purpose of the study was to make sure that when an insurance carrier purchased an annuity to cover a long-term payment, the carrier entered the actual purchase price into the rate base — not the amount the annuity actually paid out. The Division was concerned by indications that carriers might have been plugging in the higher pay-out amount into the rate base, even though the actual purchase price on the annuity was discounted; however, the study con-

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1 NCCI does not audit data carriers submit but does try to ascertain accuracy.

2 The "C & R" acronym is used for this committee, as well as for Compromise and Release settlements discussed in Chapters 2 and 3. The fact that the same acronym is used indicates the lack of interaction between those who process the money and those who deliver the services for which that money was collected.

3 See Division of Insurance rate hearing transcript (op. cit.).

4 Milliman & Robertson Consulting Actuaries, Workers' Compensation Ratemaking Procedures (prepared for the State of Alaska Division of Insurance, Oct. 1, 1979). See also NCCI response and Milliman & Robertson reply, attached to report.

cluded that reserving was reported accurately, by and large. Although the study dealt with a portion of investment income from actual losses, much of the carriers' investment income comes from a category the report did not study — investments known as "incurred but not reserved" (IBNR), which are set aside on statistical probability that a loss will occur in the future even though there is no known loss for which that money is set aside at the time.

Early in 1979 the Division returned an industry rate filing to the NCCI for more information before approving it; the filing was eventually resubmitted and was the subject of the Nov. 8 rate hearing in Anchorage. The hearing was not required by law, according to the Division, but it was decided to hold a hearing because none had been held since 1975. In all, approximately 50 people came to the Anchorage hearing. The group appeared to be evenly divided between insurance industry people there to praise the rates and employers there to curse them; a handful of those present -- three of whom eventually testified — were there to express criticism of comp services for injured workers.

Although the Division deserves credit for attempting to involve the public in the rate-making procedure, it should be noted that copies of the rate filing were not available for public analysis prior to the hearing (in fact, there was only one copy of the filing). A spokesman for a Fairbanks company who came to Anchorage for the hearing told the Division he was disappointed that copies of the filing were not distributed so that comp purchasers could comment intelligently on the rates they were being asked to pay. At the time the hearing was held, the Milliman and Robertson report on reserve reporting had not yet been made public. [1]

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[1] The Division was waiting for carrier responses to the Oct. 1 report before releasing both the report and the responses. The carriers waived a special hearing on the report itself in exchange for an extension on the normal response time; the Division acquiesced.

Summary: This brief look at the comp rate-setting mechanism attempts to cut through a complicated area to identify a few key questions policymakers might consider noteworthy. The questions on which this chapter focuses are:

1. Where do comp premiums actually go? How much of the premium dollar goes to claimant income maintenance, medical expenses and rehabilitation? How much to litigation? How much to carrier overhead and profits?

2. A key factor sometimes overlooked in analyzing the profitability of comp is investment income. How is investment income treated in the rate structure and how does this income affect the apparent unprofitability of comp?

Chapter 5. Conclusions

The information gathered in this study suggests that in addition to supporting Administration requests for personnel and equipment to handle the increased caseload in workers' comp,[1] the Legislature should (A.) take immediate measures to abate the crisis in claimant services during the 1980 session while (B.) laying the groundwork for thorough review and possible major overhaul of the Alaska workers' comp system.

A. Recommendations for Immediate Action

Immediate short-term measures that might be taken include:

1. Hearings concerning Workers' Compensation Division and Division of Insurance failure to uphold certain provisions of the workers' comp statute (AS 23.30).

Although cumbersome and in need of revision (see long-term proposals, Part B. of this chapter), the Alaska workers' comp statute contains provisions that would, if enforced, guarantee the claimant more timely and equitable resolution of comp problems such as those described in Chapter 2. However, the agencies charged with carrying out the intent of the workers' comp statute have not enforced or complied with certain provisions; this failure appears to have contributed to a situation in which statutory abuse is widespread, to the detriment of the claimant the statute was enacted to protect. (In reviewing this list of statutory violations the reader should bear in mind that the Administration may be proposing legislation to abate some of these problems; legislative proposals were not available in time for inclusion in this report.)

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[1] For background on the Administration's budget request, see Chapter 3B. Proposal covers personnel and two computer systems for recording (1) routine paperwork and (2) decisions of the Workers' Comp Board on disputed cases. It strikes this writer that it would be inconsistent to approve the routine claims filing system (which would enable the Division to crack down on carriers for failure to comply with AS 23.30) without also approving the Board decision index and the additional hearing officers (enabling the Division to comply with its statutory responsibilities).

a. Workers' Comp Division Failure to Enforce Statutes

(1) AS 23.30.110(c) and AS 23.30.155(h) both contemplate that the Workers' Comp Division shall investigate controverted claims, but the Division has no investigating staff or capability. In many cases the Board's investigation appears to be the hearing, at which the Board merely considers and attempts to adjudicate controverted cases on the basis of conflicting information presented. In some instances the Board's efficiency appears to be impaired by the lack of factual and technical information its own ivestigation (contemplated and/or required by statute) might have provided.

(2) AS 23.30.155(c) requires a carrier who stops payment for any reason to notify the Board of this action. Information on compliance with and enforcement of this statute is not readily available, in part due to the abysmal nature of the Division's present record filing system. Carriers appear to be violating this statute in all resisted cases (cases in which the carrier declines to make payments but does not file a notice of controversion). The Director of Workers' Compensation believes the number of resisted cases equals the number of controverted cases; formal controversions have more than doubled since FY 75. It is not clear to this writer whether this violation: carries no penalty; carries an automatic 20 per cent penalty added to each improperly unpaid installment as per AS 23.30.155(e); or carries a $100 civil penalty, as stated in the Department's internal review.[1] In view of the potential damage to claimants resulting from noncompliance, the Legislature may wish to determine (a) extent of violation, (b) which remedy is in force at this time, (c) how widely the sanction is applied and (d) whether both the sanction and the enforcement effort need to be strengthened.

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[1] See Chapter 3.B.2. above for a description of the Division's operations; for potential impacts on the individual claimant, read case 2.B.2.

(3) AS 23.30.155(b) requires employer to make first payment to cover wage loss within 14 days of notification of the injury; AS 23.30.155(e) imposes a 20 per cent penalty for noncompliance. The Division has documented widespread noncompliance; however, it appears that the Division has condoned this long-standing statutory violation by failure to assess the penalty.

(4) AS 23.30.250 makes it a misdemeanor to wilfully make a false or misleading statement to obtain benefits. Although the Division and carriers say one of their headaches is identifying fraudulent claims and the Board has turned down claimants citing physicians' findings such as "conscious exaggeration," there is no apparent attempt to reduce this problem by apprising claimants of the statutory prohibition, or attempting to enforce that prohibition.

(5) AS 23.30.110(c) requires the Board to issue findings within 20 days after a hearing is held, but for several years the average time lapse has been estimated at approximately 100 days. In view of the length of time it has taken the Administration to propose concerted efforts to resolve this illegal delay, the Legislature might wish to ascertain whether the current proposals to alleviate the problem are appropriate and sufficient.

(b) Division of Insurance Failure to Enforce Statutes

(1) AS 23.30.030(7) says in part, "If the insurer fails . . . to comply with a provision of this chapter, the insurance commissioner shall revoke the approval of the policy form. . ." Despite this clear statement of statutory authority, the Division maintains it does not have authority to deal with comp settlement problems. Instead, the Division of Insurance routinely turns over three complaints a week to the Workers' Comp Division and apparently makes no effort to ascertain how that agency responds. (As well as being a violation of the comp statute, this position seems inconsistent with the Division of Insurance's role as protector of the public interest.)

2. Special Review of Division and Board Actions

Extensive case tracking through file reviews and interviews indicates the quality of claimant services deteriorated as the caseload grew in the wake of the pipeline. The state's paperwork problems dealing with comp may have been compounded by the fact that the carrier that writes more than half the comp premiums in Alaska grew even more rapidly than the comp industry as a whole during the same period; that company's personnel experienced the same kind of paperwork probelms the state has been struggling with, compounding claimant problems. If this situation wrought a pattern of injustice upon a group of claimants, the normal process of judicial review may be an insufficient remedy. First of all, the aggrieved claimants will not receive redress in a timely manner. Second, because of the time and expense of pressing court appeals, it is probable that only a few claimants will make it through the judicial system, irregardless of the merits of their cases — too few to establish a pattern to which the comp system can respond. For these reasons, this writer believes the Workers' Comp Division should be mandated to undertake a special review of comp cases to insure that the Board's practices in fact uphold the intent of the law. If this review finds that problems exist, the Board has statutory authority to reconsider cases at its own initiative. Because the Department has been resistant to the idea of investigating its own conduct, the Legislature might require this review.

3. Short Report to Keep Legislature Posted on Effects of Remedial Actions

In view of the routine but illegal delays in (a) first payments, (b) issuing Board decisions and (c) non-reporting of payment suspensions — practices that have existed for some time with the knowledge of the Workers' Comp Division — it might be appropriate to attach to remedial legislation a requirement that the Division report to the Legislature and others the compliance rate for items the Legislature deems significant.[1]

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[1] For Florida statute mandating a report on problem areas, see Appendices.

4. Explanatory Booklet

Other states have found that a booklet explaining in lay terms what the injured worker can and cannot expect from workers' comp appears to reduce misunderstandings that lead to contested cases. Since disputed cases prove time-consuming and costly to the individual and to the overburdened Workers' Comp Division,— and to the state, which loses the positive contribution to the work force the individual might have made — the expense of the booklet might be one of the best investments the Legislature could make. (Florida's booklet, which cost $89,000 to print, is included in the appendices.)

Since the appropriate agencies do not seem willing to undertake this task on their own initiative, legislation mandating and financing such a publication is recommended.

B. Some Suggestions for Long-Term Consideration

Implementation of some or all of the preceding measures should help abate the immediate crisis in claimant services, but broad public policy questions concerning the workers' comp system remain; these considerations require Legislative attention. Because workers' comp has been a subject of intense public controversy in several other states, it might be useful to consider the accomplishments and failures of other states in reviewing Alaska's workers' comp system.

1. Structure, Staffing and Operating Procedures of the Workers' Comp Board

Although the Legislature's addition of a new hearing officer and Board last year appears to be relieving the case overload somewhat, a new problem may be developing. Although a hearing officer can sit in hearings one day per week and write decisions for four days as a full-time employee, some board members apparently find it inconvenient to hear cases once a week since they are retained by the state on a per diem basis and already devote one week a month to the Board.

Possible long-term solution would be to make all Board members full-time employees. It is recommended that any solution to this problem be considered in conjunction with the possibility of staffing the Board with referees and/or investigators to make the hearing process more efficient. Oregon has full-time Board members who supervise referees and hear cases only if one party objects to the referee's judgement. Observation of other states' comp systems would be useful in evaluating this proposal.

2. Revision of Statute

To serve as an efficient framework for the activities of the Division and Board, the workers' comp statute (AS 23.30) needs a complete overhaul. The statute has been amended, as the Commissioner of Labor points out, in a piecemeal fashion on numerous occasions since its adoption in 1959. In redrafting the law the Legislature might address the following points:

= Some statutes begin with a preamble or statement of legislative intent. The Alaska comp statute opens abruptly by stating, "The Alaska Workmen's Compensation Board shall consist of five members. . . " Although the mechanics of the Board are described, the law never states the reasons for creating the Board. Similarly, Article 2 deals with the duties of the employer but does not spell out the rationale for the institution of comp benefits.

= Perhaps the cumbersome structure of the present law is one reason state agencies have failed to enforce several passages. To figure out the time limit in which the Board must schedule hearings under AS 23.30.110(b) and (c), one has to slither through a verbal pathway whose blockages appear to require a plumbers' friend, or similar tool, to clear. (Translation: The law does not make it clear how quickly a hearing must be held.) Part of this confusion may be caused by the failure to spell out the difference between "hearing" and "investigation." Apparently AS 23.30.110(c) intends the two to be different, but the

phrasing of AS 23.30.155(h) appears to indicate that in some instances hearings and investigations are interchangeable. It would be useful to clear up this ambiguity.

3. Interagency Interaction

In some states the close relationship between on-the-job safety and workers' comp is recognized by the state's organizational set-up. In Oregon, for example, accident prevention (including occupational safety inspections) is a division of the workers' comp department. In Alaska a close working relationship between the Division of Occupational Safety and Health (DOSH) and Workers' Comp is not apparent: DOSH is based in Anchorage; Workers' Comp is headquartered in Juneau; although their tasks are complementary, personnel have little formal interaction. Interplay might be useful with regard to safety programs. Although there is an overlap in the mission of insurance company safety inspections and those of DOSH, the Workers' Comp Division deals primarily with claimant issues after the fact, giving little attention to the inspection programs that might have prevented the accident. It appears that the relative lack of interaction does not maximize the effectiveness of the two agencies. Similarly, as discussed above, legislation establishing closer interaction between the Division of Insurance and the Workers' Comp Division should also be considered.

4. Need for Fiscal Information

In view of the growth and importance of workers' comp, the dominance of one carrier and the breakdown in the service system that handles comp controversies, to effect policy changes constructively the Legislature might take

measures to determine how much of the premium dollar is spent on:

= income maintenance payments;

= medical payments (including rehabilitation);

= litigation;

= insurance company overhead;

= insurance company profits

The question of investment income figures prominently in any such analysis. As noted in Chapter 4, investment income is usually treated apart from the rate base and is thus a form of hidden profit. A corrollary policy question is whether the state should play a role in determining where and how insurance company investments are placed.

5. Proposals to Reduce Premium Rates for Small Employers

Minnesota has tried two programs that might reduce comp premium rates for small employers. One program is a state reinsurance program which takes responsibility for all benefit payments over $300,000, thus reducing the risk to the carrier that the carrier may have to pay a virtually unlimited amount on even a small policy. The other idea, which Minnesota borrowed from Florida, is a mechanism that allows small businesses to band together to purchase comp insurance. This gives the group the potential for purchasing a large joint policy at the lower rates a large company enjoys because it spreads its risk, because it can get the benefit of rating techniques that are not possible for small employers, such as retrospective ratings. The Legislature might wish to examine whether statutory changes would be necessary to effect these changes in comp insurance, and whether these and similar proposals might reduce costs to the employer without reducing benefits.[1]

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[1] See remarks of Minn. State Sen. Steve Keefe, included in appendices.

6. Proposals for a State Fund

A 1977 Legislative Affairs Agency study estimated a competitive state fund could be set up to write workers' comp insurance with a $2 million investment.[1] Even if the infant state carrier failed, the report argued, the state fund could be closed down in five years, leaving the state with new information on aspects of the insurance industry about which the state has too little knowledge, such as claims management and reserving practices.[1] A second 1977 Legislative Affairs Agency report recommended the formation of a competetive state fund.[2] On the plus side, the study said, a state fund: lowers premium costs to employers because state funds operate with significantly less overhead; increases availability of insurance because state funds normally accept any risk; increases retention of capital in-state since premium payments do not flow to an outside parent company; establishes a yardstick by which to assure the reasonableness of commercial rates; creates some new jobs. On the other side of the ledger, state funds seem socialistic; they are sometimes (but not always) poorly managed; private industry is doing the job. Continued business hostility toward rising premium rates and information gathered for this report pointing to a breakdown in the delivery of services are factors that tend to strengthen arguments for consideration of a state fund.

7. Task Force

In states where the comp system has been perceived as a subject of major political controversy (Minnesota, Oregon and Florida, for example) task forces have been organized to promulgate reform of the system. In Alaska the situation is somewhat different in two respects: First, workers' comp is not

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1 Legislative Affairs Agency, Workers' Compensation: The Feasibility of Establishing a State Fund (Feb. 1977).

2 Legislative Affairs Agency, Workers' Compensation Rates in Alaska: A Study by Woodward and Fondiller Actuarial Consultants (Feb. 1977).

widely perceived as a top-priority political issue in Alaska. Consequently, the impetus for a task force is lacking. Second, in Alaska task force members would have to travel great distances, making meetings both expensive and difficult to arrange. For these reasons this writer believes inquiry into workers' comp problems may be more effectively handled through the existing legislative committee system than through creation of another camel. If legislative research is undertaken, care should be taken to insure that all groups concerned with workers' comp are involved in the process.

Appendices

List of Items in Appendices

1. Statements of Legislative Intent (from Washington and Oregon statutes)
2. Remarks of Minnesota State Sen. Steeve Keefe at Legis 50 Conference
3. Alaska Workers' Compensation Insurance Rate Hearing (Nov. 8, 1979 — abridged transcript)
4. Some documents supporting Case Narratives in Chapter 2.
5. Commissioner of Labor's Workers' Comp Budget submission to Budget Review Committee, Nov. 15, 1977
6. Affidavit of Roy L. Kuhl
7. Oregon Workers' Compensation Department Organization
8. Workers' Compensation Brochure Printed by Florida Division of Workers' Compensation
9. Newspaper articles on Alaska workers' compensation

THESE ITEMS ARE ON FILE AT HOUSE LABOR & MANAGEMENT COMMITTEE

WORKER'S COMPENSATION STUDY COMMISSION

ORGANIZATIONAL MEETING

AUGUST 1, 1980

CO-CHAIRMEN

SEN. T. STIMSON
REP. B. ROGERS

A. FUTURE MEETING DATES AND LOCATION.

B. CONCERNS RELATING TO WORKER'S COMPENSATION BY EACH COMMISSION MEMBER.

C. COMMENTS FROM THE GENERAL PUBLIC AND CONCERNED GROUPS.

D. SCOPE AND DIRECTION OF THE COMMISSION.

E. RECOMMENDATIONS/IDENTIFICATION OF RESOURCES AVAILABLE.

F. ADJOURN.

MEMORANDUM

CAPITAL OF ALASKA
155 SOUTH SEWARD ST. JUNEAU, ALASKA 99801

TO: Attorney

DATE: January 16, 1980

FILE NO. State Agencies - Legislature 1980 Proposed Legislation

SUBJECT: Amendment to Alaska Workmen's Compensation Act Revising Requirement for Proof of Insurance by Persons Contracting with the State or Political Subdivisions of the State.

FROM: Laura Davis
Asst. Attorney LD

As it now reads, AS 23.30.045(d) requires the state or any political subdivision of the state to obtain proof of workmen's compensation insurance or self-insurance before contracting with any "person". Failure of the state or political subdivision to obtain such proof of insurance or self-insurance before contracting with any person subjects the state or political subdivision to liability for any workmen's compensation claim made by an injured employee of the contractor if the employee is unable to recover from the contractor because of its lack of financial assets.

The Alaska Workmen's Compensation Act requires every person who is an "employer" under the Act to obtain workmen's compensation insurance or to show proof to the board of its financial ability to pay directly any workmen's compensation claims. AS 23.30.075. The Act specifically provides that officers of corporations, municipal corporations and non-profit corporations are employees under the Act. AS 23.30.240. That section also provides that an executive officer of a corporation may waive coverage under the Act. The Alaska Workmen's Compensation Board will issue an executive officer waiver for particular persons upon request.

A problem arises when we choose to enter into a contract with a party who is not required by the Act to have workmen's compensation insurance. The Act currently requires us to obtain such proof of insurance from every "person," without regard to whether that person is required to have such insurance under the Act. Compliance with this requirement is impossible where the contractor has no employees (e.g., a consultant) and is thus unable to obtain either workmen's compensation insurance or a certificate of self-insurance from the board. The proposed legislation which is attached would amend §23.30.045(d) of the Act to require the state or political subdivisions of the state to obtain proof of insurance or self-insurance only when contracting with a party who is "an employer" under the Act. It would also modify the requirement of proof to include proof of a waiver of coverage under the Act issued by the board.

FORM NO. 210-5

Under the current provisions of the Act, we cannot effectively protect ourselves from liability to the potential employees of persons with whom we contract unless we contract only with persons who are already "employers" under the Act. If we contract with a person who has no employees at the time of contract, but later hires employees, we are exposed to statutory liability for the workmen's compensation claims of those future employees, even though our contract provides that it shall be terminated immediately upon the hiring of employees without providing prior proof of workmen's compensation insurance. A contractual remedy against the contractor cannot be adequate because we are liable only when the contractor is financially unable to pay the workmen's compensation claim.

Under the Act as modified by the attached proposed legislation, we would be exposed to statutory liability only when we failed to obtain proof of insurance or self-insurance from a contractor who is required by the Act to maintain such insurance or self-insurance.

LLD:jg

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to workmen's compensation to employees of an employer contracting with the state or a political subdivision of the state."

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

*Section 1. AS 23.30.045(d) is amended to read:

(d) No contract may be awarded by the state or a home rule or other political subdivision of the state to an employer unless the employer [PERSON] to whom the contract is to be awarded has submitted to the contracting agency one or more of the following: proof, furnished by the insurance carrier, of current coverage by workmen's compensation insurance from an insurance company or association authorized to transact the business of workmen's compensation insurance in this state or proof, furnished by the board, of a current certificate of self-insurance from the board, or proof, furnished by the board, of a waiver of coverage under the Act for certain employees. The employer [PERSON] to whom the contract is awarded shall keep his workmen's compensation insurance policy in effect during the life of the contract with the state or political subdivision. If the state or the political subdivision of the state fails to obtain proof of coverage or self-insurance

or waiver of coverage or to protect itself under (e) of this section, and an employee of the contractor is injured during the term of the contract, the state or political subdivision is liable for workmen's compensation to the employee if the employee is unable to recover from the employer because of the employer's lack of financial assets. The state or political subdivision is not liable, however, to the employee for workmen's compensation if the employee can recover from the employer under (a) and (b) of this section.