ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672
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347

FRAMING THE ISSUES

Workers' compensation laws originated as a modern society's response to the accidents that were a natural outgrowth of the industrial Revolution. Occupational injuries in the early 1900's were a fertile source of litigation, resulting in delays, uncertainty and red tape. An employee injured on the job had to prove the employer was at fault to collect medical expenses and lost wages. The employee's reluctance to jeopardize his job by bringing suit against the employer, in combination with the employer's formidable legal defenses, imposed a near-impossible burden upon the injured worker and his family.

The enactment of workers' compensation laws came after reciprocal concessions by employees and employers. In exchange for prompt, certain benefits, paid automatically regardless of fault, workers relinquished their right to sue in tort. Employers agreed to accept the financial responsibility for all workplace injuries, thereby permitting them to limit and budget their liability for workplace accidents. The legislative compromises were aimed at correcting an economic condition, not to curing a legal wrong.

Today workers' compensation is an integral part of a social insurance package that seeks to assure economic security to workers. Social Security and pension programs, both private and public, assume the task of handling old age retirement and survivorship. The state-federal unemployment compensation system addresses economy-related earnings loss. And workers' compensation affords protection against hardships that result from earnings loss caused by job injury.

The original workers' compensation laws explicitly recognized the income protection principle. All of the pioneering European systems — and 10 of the first 11 U.S. acts, including California's — emphasized earnings loss as the sole basis for indemnity. In the event of a job-related disability, the worker would receive a specified percentage of his pre-injury wage.

The shift away from replacement of actual lost earnings began with the enactment of the 1911 New Jersey law which introduced a "schedule" of benefits for permanently (as opposed to temporarily) disabled workers. Under this schedule approach, the loss, or loss of use, of a bodily member became a proxy for future lost earnings; compensation then is paid for a certain period of weeks (or up to a maximum dollar amount), regardless of actual economic consequences.

The introduction of schedules in compensation acts originated largely as an administrative convenience. The economic aftermath of a residual permanent impairment often extends over an employee's working life, but workers' compensation administrators were unwilling to wait a lifetime to determine and compensate actual earnings loss as it occurred. Early resolution and prompt benefit payments, even for long-term disabilities, required a different approach. This perceived administrative need led to the development of schedules that allowed a specific dollar amount for equally specific residual impairments of an injury. To preserve the income protection theory, however, the drafters rationalized that the scheduled amount was not payment for physical loss but, instead, an estimate of future earnings loss that might result from the physical injury. Today, scheduled benefits are the predominant method for compensating permanent disability in the United States.

In concept, scheduled benefits for permanent disability work some rough justice. In practice, however, the conceptual purpose frequently is unmet. Disability schedules presume a direct link between

physical impairment and future earnings in every instance, an assumption that ignores reality. For example, the adverse economic consequences of some injuries may continue long after the scheduled payments have been paid and spent. On the other hand, scheduled amounts may be paid even when there is no earnings loss, in which case the award resembles installment payment of damages, a concept alien to America's premier no-fault insurance program. Between these extremes are varying examples of over- and under-compensation for job-incurred disability.

As a mechanism for compensating the long-term impact of a job injury, a disability schedule inevitably creates equity problems. A schedule emphasizes certainty of result at the expense of individual differences. The historical California response to this conflict was adoption of a less rigid schedule that, at least in theory, attempts to predict the economic consequences of a physical impairment by permitting variations in the individual case. Some of the variables are objective, taking into account the age and occupation of the injured worker. But modifications also are permitted for purely subjective factors, e.g., pain and estimates of the worker's ability to bend, stoop, lift and perform the other physical requirements of working for a living. Most usually, the determination of these subjective factors are based on the worker's own description.

If the variables are objective, results can be predictable. But recognition of and allowance for subjective factors, which cannot be substantiated much less quantified, introduces uncertainty — and where uncertainty exists, litigation follows. Today in California three of every four permanent disability claims are litigated. The predominant issue in the vast majority of these claims is not the existence but, instead, the *extent* of permanent disability, a determination that encourages the involvement of attorneys and forensic medical testimony so that the "right words" will be used.

Dissatisfaction with the use of a schedule for predicting and compensating the long-term economic effects of job injury has increased in recent years. Moreover, both the adequacy and equity of benefits allowed by the schedule have been criticized repeatedly by employees, employers, administrators and legislators.

While the discontent is real, its roots are based on conjecture since hard data did not exist. Three years ago the California Workers' Compensation Institute authorized a research study to fill the vacuum. This report summarizes the findings and conclusions of that research and provides an objective basis for evaluating the performance of the California workers' compensation system in alleviating the economic hardships of industrial injuries.

JOB INJURY AND EARNINGS LOSS

Despite seven decades of experience, relatively little is known about the economic consequences of job injury, much less how well workers' compensation responds to these consequences. State administrative agencies and the insurance industry are repositories of abundant statistics, although most of the figures — nature and type of injuries, incidence rates, claim costs, etc. — are only pertinent to operational aspects of the program. With few exceptions, little is known about what happens to the injured worker after the claim file is closed.

Three years ago, after nearly a year in development and design, the Institute commissioned a research project to determine the scope of post-injury earnings loss and to test the effectiveness of the California Permanent Disability Schedule in providing income protection after a job injury.

(While measurement of earnings loss attributable to job injury was the primary purpose of the study, there were other complementary objectives. These goals included determining the extent to which other public and private programs duplicate or supplement workers' compensation as an economic remedy, the causes and results of litigation, and the effectiveness of vocational rehabilitation in restoring disabled workers to productive employment — issues which are or will be the subject of other CWCI reports. Because of the multiple objectives, the research project was labeled the "global study.")

The study relied upon two related data bases: (1) Responses to structured, personal interviews with a representative sample of California workers whose job injuries produced residual permanent impairments; and (2) Individual earnings records of the disabled worker sample as reported to the State Employment Development Department.

The latter data alone quantifies the extent and duration of gross earnings loss which occurs after injury. However, some portion of the loss may be due to factors unrelated to the injury — retirement, voluntary withdrawal from the labor market, subsequent nonindustrial injury or illness, economic unemployment — as related by the workers themselves during interviews. Only by melding the two data bases is it possible to respond to the study's two central questions:

- How much of the subsequent earnings loss is attributable to the injury?
- How well does the California system compensate injury-related earnings loss?

The research answers these questions in detail. Additionally, the data provide baseline information about the economic consequences to those who suffer job injury, while defining policy issues that must be addressed if the California workers' compensation law is to achieve the adequacy and equity promised by its enactment 70 years ago.

POST-INJURY EARNINGS

In the four years following injury, a period during which earnings patterns stabilized for those who returned to the workforce, permanently disabled workers sustain an average $17,800 earnings loss. Assuming the same degree of earnings loss continues to age 65, as it will for the severely disabled, then the average earnings loss over a working lifetime increases to $115,000.

Aside from the limitations of averages, these estimates of gross post-injury earnings loss suffer other inadequacies:

- In the first instance, the figures are overstated to an unknown degree because they are derived from wages reported to the State Employment Development Department. Not included are earnings from the so-called "underground economy," i.e., cash payments made to some workers — most frequently in the construction, transportation and service industries — and which may not be reported for payroll and tax purposes.
- On the other hand, the figures are understated because they do not reflect wage increases that might have occurred but for the injury. While it is possible to estimate the potential effect of wage escalation, income benefits of the California law are based on earnings and benefit levels in effect at the time of the injury and, accordingly, no adjustment was made.
- More pertinently, the figures do not take into account the reasons for changes in earnings. The estimates are only measurements of gross post-injury earnings loss, *not* earnings loss attributable to the injury.

'Peeling the Onion': Nearly 60 per cent of the gross post-injury earnings loss is experienced by workers whose permanent disabilities generally are not considered handicaps to employment or wage-earning ability. In some instances the earnings loss is attributable to the job injury, but much of it can be traced to other causes, according to the workers themselves. Thus, the gross post-injury earnings losses were offset by the amount of wage reductions due to non-injury factors, a process the analysts labeled "peeling the onion" — stripping away the outer layers to arrive at estimates of net injury-related earnings loss.

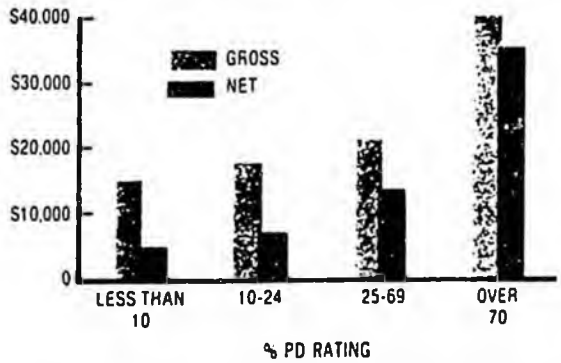
Some of the reductions are based on the employee's own statements during structured interviews (e.g., "reached retirement age," "only wanted part-time work," "quit to be with family" and other examples of voluntary withdrawal from the labor market). Excluded also were earnings losses incurred after normal retirement at age 65; during periods of self-reported major illnesses that were unrelated to the job injury; and while receiving unemployment insurance benefits, when the employee was available and able to work — earnings losses that would have occurred even if the worker had not been injured.

Other reductions, most usually made when the post-injury earnings pattern was inconsistent with the nature of the injury, were arrived at more subjectively. For example, the analysts concluded that an 18-year-old service station attendant's total absence of earnings except during the summer months probably was due to enrollment in college, not the minor injury he suffered four years earlier. Similarly, the earnings loss experienced by a 24-year-old female office worker after returning to work for two years at wages above her preinjury wages was ascribed to marriage or pregnancy.

Two other adjustments were made. Earnings loss that occurred after the employee's treating physician provided an unrestricted medical release to return to regular employment was eliminated as unrelated to the injury. Finally, if the employee returned to work and the earnings equalled or exceeded preinjury wages for three consecutive months, recovery was presumed to be complete and any subsequent earnings loss due to factors other than the injury.

The adjusting criteria assume that, after controlling for non-injury factors, earnings loss is a function of injury severity. In other words, the more severe the resulting disability, the greater the potential for earnings loss. If the criteria were valid, seriously disabled workers would be least affected by the application of the adjustments. For example, the most severely disabled workers would not have retired voluntarily, would not be eligible for unemployment compensation and would not be able medically to return to their former jobs; therefore, the difference between gross and net earnings loss would be least for these workers and greatest for those with minor disabilities. A series of comparisons validated this hypothesis and established the appropriateness of the criteria.

GROSS VS. NET EARNINGS LOSS, BY PDR

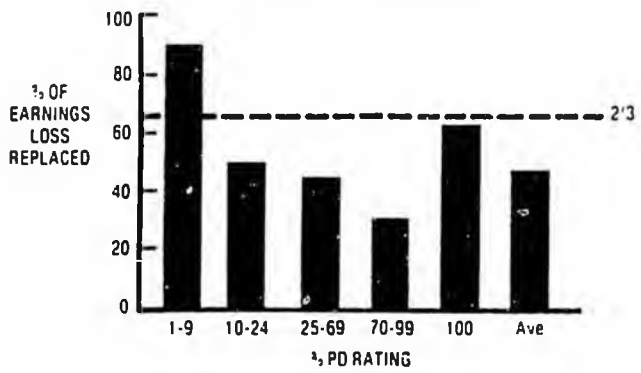


After adjustment for reasons unrelated to the injury, the net earnings loss in the four years after injury is reduced by 55 per cent, to an average of $8080 per worker. The projected earnings loss over the working life of these employees drops even more, 85 per cent, to $17,700. With few exceptions, the gross vs. net differences are because of non-injury related earnings losses of younger workers with minor disabilities.

ADEQUACY & EQUITY

A comparision of net earning loss to disability payments shows the California program is neither adequate nor equitable. On average, workers' compensation income benefits (for both temporary and permanent disability) replace only 49 per cent of the net earnings lost by permanently disabled workers over their working life.

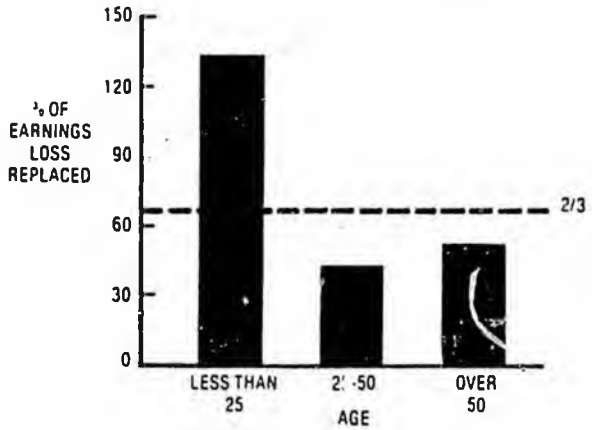
REPLACEMENT RATE, BY PDR



Moreover, replacement rates vary widely according to injury severity and the age of the worker. Workers with very minor disabilities, those rated under 10 per cent on the California schedule, fare best, exceeding the two-thirds wage replacement intended by the workers' compensation law by a wide margin. Other disabled employees are less fortunate, however, and the degree of their economic misfortune progresses with the severity of their injuries. The exception is the permanently and totally disabled worker whose compensation approaches the program's wage replacement goal — but then such workers are compensated, not according to the schedule, but by two-thirds of their average pre-injury wages for life.

Compensation for younger workers exceeds their actual earnings loss due to work injury and, on the average, more than double the intended two-thirds replacement rate. Workers between 25 and 50 years, the majority of disabled workers, fare worse than their younger and older counterparts. With fewer years to retirement, workers in the oldest category suffer less earnings loss than the mid-group, but they recover proportionately more because the California schedule contains an upward adjustment for age.

REPLACEMENT RATE, BY AGE



The limitations of the California permanent disability schedule, and the dimensions of the resulting inadequacy and inequity, are demonstrated in a matrix that combines severity and age in calculating the percentage of earnings loss replaced by income benefits.

REPLACEMENT RATE, BY PDR & AGE

PDR	AGE <25	AGE 25-50	AGE 50>	Average
1-9	176	80	77	88
10-24	208	53	36	51
25-69	111	42	49	46
70-99	53	26	61	32
100	—	47	94	64
Average	135	44	51	49

If two-thirds wage-replacement is the goal, younger workers are over-compensated. Older permanently injured employees, most notably those 25 to 50 years who dominate the workforce, are severely under-compensated. Regardless of age, workers with the least disability are compensated best and, with the exception of permanently and totally disabled workers whose compensation is not predicated on the schedule, the percentage of earnings loss replaced declines with severity — the wrong movement in the wrong direction affecting the wrong population.

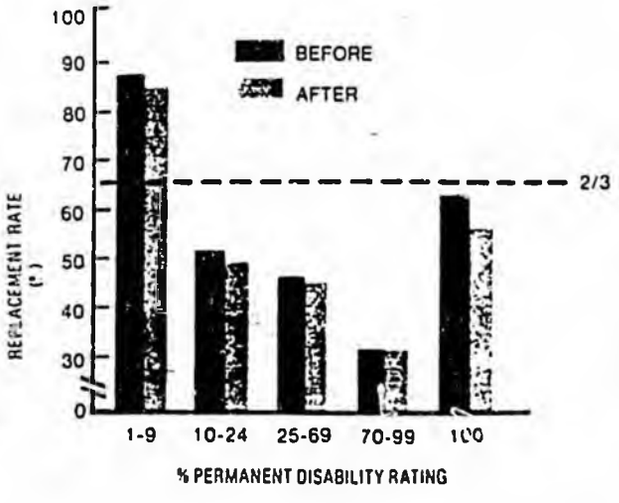
The deficiencies of the California schedule as a mechanism for compensating permanent disability are manifest. The system may have been adequate and equitable when adopted 70 years ago; clearly, it is no longer. Today workers' compensation indemnity benefits in California bear no relationship to economic loss, and replacement of earnings loss due to the injury is not accomplished in any rational manner.

RIGHTING THE BALANCE

Over the past 70 years the California workers' compensation program has earned deservedly high marks for its progressive features: scope and extent of coverage, expeditious delivery of virtually unlimited medical services, and the provision of vocational rehabilitation services. On the other hand, California's position in income protection for injured workers lags badly. For many years benefit levels have ranked well below the national median — and usually at the bottom of a listing of comparable industrial states. Additionally, the Institute's research shows the distribution of income benefits lacks consistency and certainty in alleviating the financial consequences of industrial injury.

Correcting the deficiencies of income benefits could take a number of paths. The first and most obvious choice would be an increase in indemnity benefits. This approach has the virtue of simplicity, but its effectiveness is questionable if past performance is instructive. For example, during 1983-84 the state legislature doubled partial disability indemnity and increased benefit levels for total disability by 28 per cent. Yet, even after the infusion of nearly $1 billion in additional benefits, the overall replacement rate — the proportion of earnings loss replaced by income benefits — dropped to 47 per cent from the previous 49 per cent.

REPLACEMENT RATES
Effect of 1983-84 Benefit Increase



Greater equity could be achieved through reallocation of benefit dollars and balancing over- and under-compensation among the various categories of permanently disabled workers. However, this approach would require reducing benefits for some, primarily the younger, less seriously injured employee, an alternative legislators have found unattractive in the past. Additionally, unless the reallocation were accompanied by another substantial benefit increase, the overall replacement rate would still remain at 47 per cent, well below the two-thirds objective.

Another option, a variation on the reallocation theme, involves changing the California Permanent Disability Schedule. Adjusting the factors used to modify the percentage of disability according to the individual worker's age and occupation could moderate the peaks and valleys present in the current distribution of income benefits, although the effect would be muted by the schedule's continued dependence upon subjective factors.

The answer, then, might be to eliminate all subjective elements from the schedule and rely solely upon objective, measurable impairments as the basis for compensating permanently disabled workers. This approach offers certainty and uniformity — but at the loss of the ability to recognize individual circumstances. Disability is not a constant. Different workers, even those with the same impairment, will suffer differing degrees of disability, a fact the workers' compensation program acknowledges by individualizing income benefits. More to the point, tinkering with the California schedule leaves unanswered the question of whether any schedule, flexible or static, can ever be an accurate and reliable predictor of the economic consequences of job injury.

Selection of the precise remedy to cure the California program's inadequacies and inequities requires addressing a more fundamental policy issue: the *purpose* of income benefits in workers' compensation. Is it indemnity for impairment of the worker's natural capacities? A substitute for common law damages? An approximation, however inexact, of potential loss of earning capacity? Or is it, as the original architects intended, compensation for actual loss of earnings because of job injury?

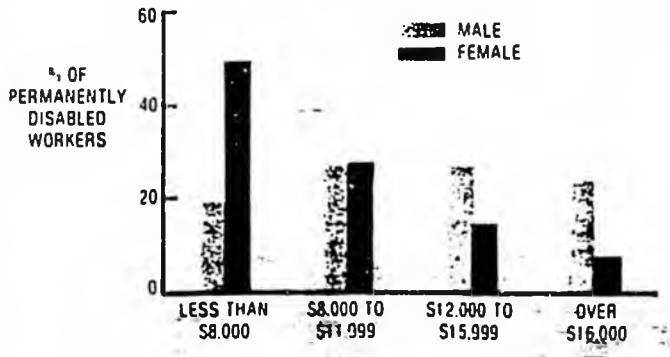
The resolution of this issue is the first step to righting the balance and reconciling the objectives of a modern workers' compensation program with the realities of contemporary California.

THE PERMANENTLY DISABLED WORKER

The prototypical worker whose injury results in permanent disability is a 39-year-old, white male, blue collar union member. At the time he strained his back, he had more than five years experience in his occupation, more than five years tenure with the same employer, and earned $12,300 annually, about 8 per cent more than others in the general workforce because of experience and seniority. He was unable to work for 24 weeks because of his injury but returned full-time at the same or higher wages for the same employer. Compared to non-injured members of the labor force, the permanently disabled worker is older by nearly 10 years and, in part because of the age difference, is more experienced, less educated, and more likely to be married.

Averages, however, obscure the numerous variables within the permanently disabled population. Sex is a significant factor in differentiating earnings. For example, more than one-quarter of the workers are females, a group whose median annual earnings are substantially below males ($8062 vs. $12,333). Only 2 per cent of the male employees were working part-time when the injury occurred, compared to 14 per cent of the women, findings which together with somewhat less job experience for women accounts for some — though not all — of the disparity in earnings.

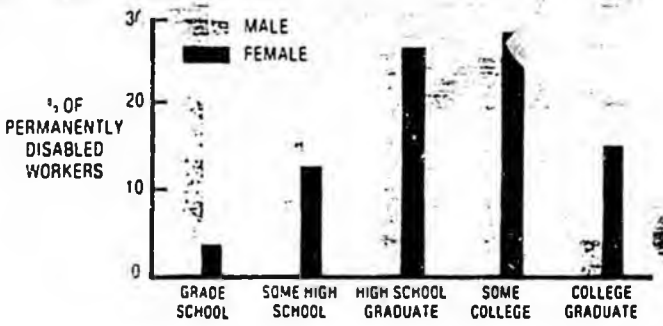
ANNUAL INCOME AT INJURY



Occupation also is a factor in earnings. About half of the women are in white-collar jobs, particularly business services and retail trade. In contrast, nine of 10 males are blue collar workers, for the most part in the manufacturing, construction and transportation industries.

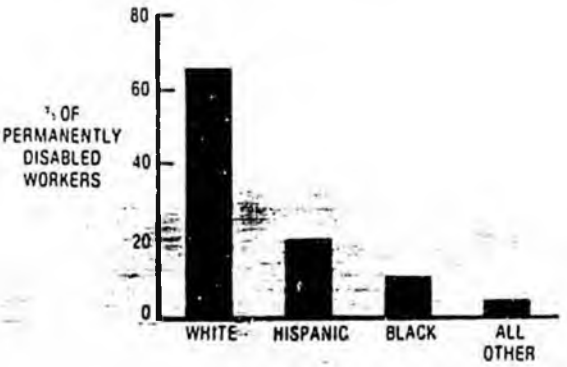
Age patterns are similar for workers of both sexes (although females on average are two years older), but women have higher education levels.

EDUCATION COMPLETED



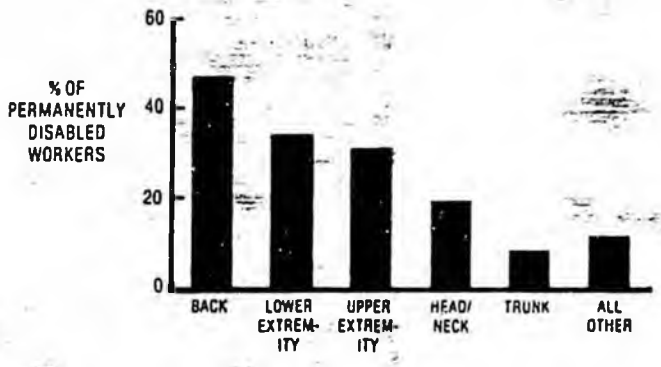
More than one third of the male workers did not complete high school, a finding that appears to conflict with California's mandatory education requirement. However, the fact that one in eight of the male workers do not speak English and the likelihood that they are twice as likely as females to be of Hispanic or Asian origin suggests that immigration may be a contributing factor to the comparatively low educational attainment of permanently disabled men.

ETHNICITY



Nature of Injury: Back injuries, either alone or in combination with other injuries, account for nearly half of all permanent disabilities. Impairments to upper and lower extremities each affect about a third of the disabled population. One in five disabled workers suffered an injury to the head or neck.

NATURE OF INJURY
(multiple responses)



Soft tissue injuries — strains, sprains, and muscle, ligament or tendon tears — are the principal cause of disability in more than half of the cases. Fractures and crushing injuries are next in importance, accounting every third permanent impairment, followed by cuts and lacerations (8 per cent) and amputations (6 per cent). No other injury type accounted for as much as 1 per cent of the total.

Only 1 per cent of the injuries are catastrophic. The vast majority, seven of every 10, are so-called "minor" disabilities, i.e., those rated less than 25 per cent under the California schedule.

DISABILITY SEVERITY

Post-Injury Employment: A substantial majority of permanently disabled workers return to work after their injuries, and most are currently employed. However, 16 per cent of those who are permanently injured — every sixth worker — never returns to employment after the job injury.

SEVERITY OF INJURY AND POST-INJURY WORK STATUS

The severity of the injury — measured either as the percentage of permanent disability or the length of convalescence (i.e., the duration of temporary disability) — is the primary reason for leaving the workforce. However, half of those who never return to work have "minor" disabilities, an indication that factors other than the injury — or, more correctly perhaps, factors in addition to the injury — may have contributed to their withdrawal from the labor market.

Workers who never return to work force after the job injury are, on the average, 12 years older than their working counterparts and are more likely to be female, working part-time, and in white-collar occupations.

Of those workers who return to work after the injury, 85 per cent go back to full-time employment. Another 7 per cent start on a part-time basis but subsequently return to full-time employment. The remaining 8 per cent continue in part-time work, either because of limitations imposed by the injury or by choice.

Most permanently disabled workers who return to work go back to the same job with the same employer, but a significant minority experience some displacement. Nearly three in ten return to work for a different employer, and 19 per cent return to both a different employer and a different type of work. The injury and resulting disability are major factors in many of the job changes, but almost as important are dissatisfaction with the prior job or employer, lack of job openings because of the general economy, and "changing employers is common in my line of work."

Upon returning to full-time work, 86 per cent of the disabled workers earn the same or more than before their injury. For the most part, the adverse impact falls upon workers who change employers, type of work, or both. However, for every worker in these circumstances who earns less, another earns more than before the injury.

Six years after the injury another 18 per cent of the permanently disabled population leave the work force (compared to a 12 per cent withdrawal rate among a matched sample of non-injured workers). Thus, 34 per cent of workers permanently injured in a job accident — 16 per cent who never returned to work after the injury, plus 18 per cent who went back to work for a time but now describe themselves as "unemployed and not looking for work" — are out of the labor market six years after the job injury.

EMPLOYMENT STATUS
(Six Years Post-Injury)

Severity of the disability is not a major factor among those who return to work for a time but later retire or withdraw from the job market. Various measures of severity — permanent disability rating, duration of temporary disability, incidence of hospitalization, and mean amount of indemnity — show no appreciable differences. Instead, the critical variables are age and sex. Workers in this group are significantly older than permanently injured employees who are working (a median age of 54 years versus 40 years). One in three are 60 years or older. In addition, women, regardless of age, are more than half again as likely to stop working at some time in the six years following their injury.

TECHNICAL NOTES

This report summarizes the results of Institute research into the experience of workers who suffered serious on-the-job injuries, which resulted either in permanent disability or, in fewer than 5 per cent of the cases, a period of temporary disability lasting more than 12 weeks.

Sample Design: The study employed a two-stage sampling procedure. In the first stage, the Workers' Compensation Insurance Rating Bureau selected a stratified sample of 8364 cases from a universe of 55,926 serious claims incurred under workers' compensation insurance policies issued in the 12-month period ending June 30, 1976. At the request of the legislature, the State Employment Development Department furnished earnings records for each of the selected workers under confidentiality requirements that protected their identity. Depending upon the date of injury, the individual earnings records ranged from one to nine calendar quarters preceding the disabling injury and 16 to 21 calendar quarters after the quarter of injury.

The original sample also included cases involving employees of self-insured employers, selected from the records of the Office of Self-Insurance Plans within the California Department of Industrial Relations. Approximately 800 claims were identified based on disabling work injuries that occurred in May and June of 1976 and which were still in "open" status at December 31, 1976. Although the proportion of self-insurer claims were under-represented — about 10 per cent, compared to a targeted 14 per cent — the analysts believe the resulting data are representative of the disabled workers population during the study period.

In each case a survey form was sent to the insurer or self-insured employer with a request to provide the employee's last known address and other information from the claim file necessary to the study. A total of 7081 survey forms (77 per cent) were returned with sufficient qualifying information.

Questionnaire Design: The Institute contracted with Field Research Corporation (FRC), a San Francisco-based consulting firm with broad experience in opinion research, to conduct structured personal interviews with workers disabled during the study period. The questionnaire was developed by FRC under guidance of a research task force appointed by the Institute. The development phase spanned several months, during which research objectives were identified and refined, interview protocols established, interviewers trained and a pretest conducted. After approval of the final version of the questionnaire, a translation was produced for use with workers who preferred to be interviewed in Spanish.

A random sample was drawn from the 7081 completed claims data forms and FRC then was provided the names and addresses of 3374 disabled workers. To maximize the efficiency of the field effort, interviewing was restricted to workers living in the 10 Standard Metropolitan Statistical Areas of California, which collectively account for 85 per cent of the state's population. After completion of prescribed tracing procedures to secure current addresses, 1076 interviews were completed, or 32 per cent of the *a priori* sample and well above the 15-20 per cent completion ratio considered acceptable for opinion research.

Total Sample	(3374)	100%
Not Interviewed	432	13
Out of state/country	291	9
Out of statistical area	60	2
Deceased	73	2
Language barrier, deaf	8	*
Not Located	1257	37
Respondent Not Available	257	8
Health reasons	50	1
Other reasons	235	7
Refused	324	10
Interviewed	1076	32

Interviews were conducted in the homes of the workers between December 8, 1981 and March 24, 1982, and averaged approximately one hour in duration. To assure candor, all interviews were "blind", i.e., respondents were unaware the research was being conducted on behalf of the workers' compensation community. Instead, with the cooperation of the State Department of Rehabilitation, workers were informed the interviews were under the aegis of that agency.

Certain characteristics — age, sex, extent of disability, attorney representation, etc. — of the interviewed and non-interviewed workers were compared to test the representative quality of the interviewed sample. Women and workers who received vocational rehabilitation services were slightly more prevalent in the interviewed sample than were represented in the original universe. For all other variables, the distributions are consistently close and, accordingly, the differences do not require any qualification of the sample.

Estimating Earning Loss: An average pre-injury quarterly wage for interviewed workers was calculated from data supplied by the State Employment Development Department (EDD). In each instance the amount was an arithmetic average unless earnings in the calendar quarter immediately preceding the injury quarter was greater, in which case the higher figure was used.

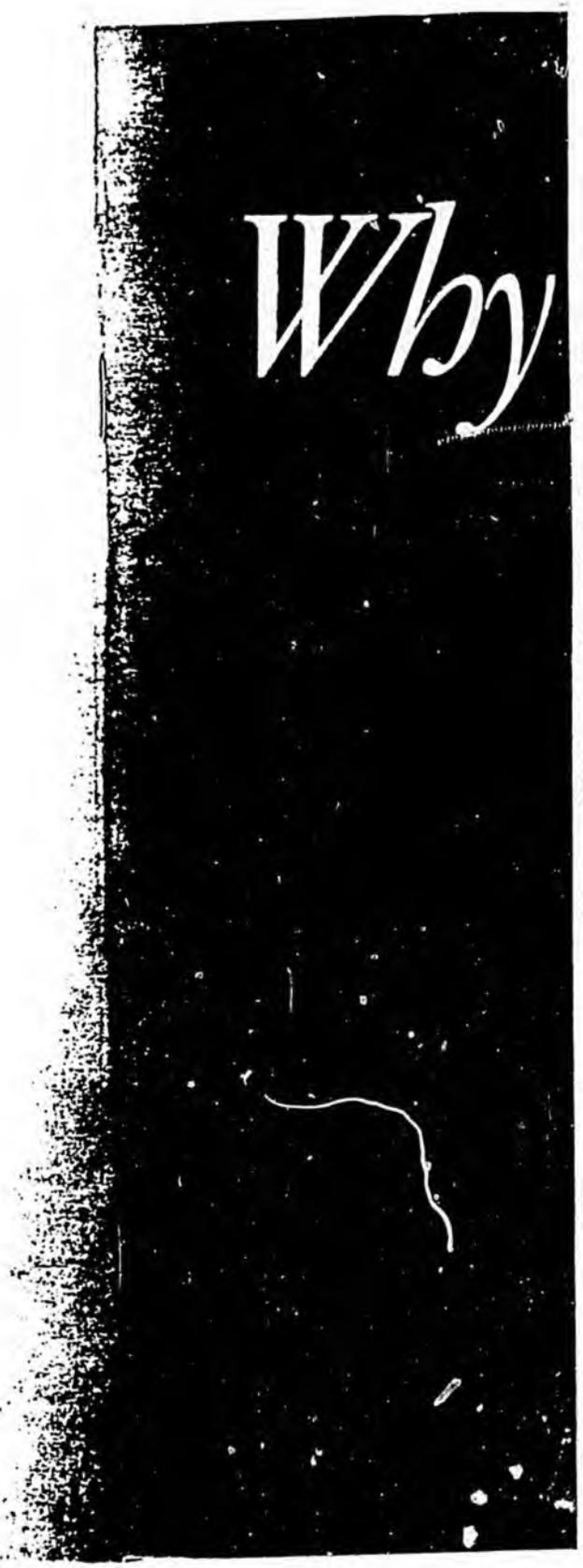
The average was multiplied by 16 to estimate the worker's expected earnings in the four years after injury, a period selected to reflect maximum rehabilitation of earnings potential. Gross post-injury earnings loss was arrived at by reducing the product by the amount of actual earnings reported to EDD. The calculation of gross earnings loss did not take into account wage increases that might have occurred in the four post-injury years, nor take credit for quarterly earnings in excess of the individual worker's pre-injury average — adjustments that are estimated to approach parity.

The gross amount was reduced further by earnings losses caused by reasons other than the injury, according to the worker's own account related during interview or by other factors described in the body of the report (see page 5). Finally, the four-year net amount was projected to age 65 to produce an estimate of injury-related earnings loss occurring over the working lifetime of the permanently disabled employee.

Acknowledgments: The Institute gratefully acknowledges the cooperation of the Department of Industrial Relations, the Department of Rehabilitation and the Employment Development Department of the State of California, and the Workers' Compensation Insurance Rating Bureau of California.

Assistance in the preliminary analysis of the data was provided by Peter Barth, Department of Economics, University of Connecticut, and John F. Burton Jr., New York State School of Industrial & Labor Relations, Cornell University.

Special mention also is due members of the Institute's Research Task Force whose ungrudging cooperation, attention to detail and unwavering patience made the study's completion a reality. They are: Laurence C. Peabody, Liberty Mutual Insurance Co., chairman; Robert J. Benjamin, State Compensation Insurance Fund; George P. Janich, Fremont Indemnity Co.; Will J. Murphey, Industrial Indemnity Co.; James Smith, Fireman's Fund Insurance Cos.; Bert Zahner, Hartford Insurance Group; and James J. Holland, Travelers Insurance Co.



Why DO WORKERS' COMPENSATION RATES KEEP GOING UP?

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

To the average employer, few subjects are more obscure (and probably less interesting) than insurance rate-making. Yet as workers' compensation premiums have increased, employers, state officials and legislators are asking, "Why do workers' compensation rates keep going up...and what's being done about it?"

This pamphlet explores the reasons for the recent escalation in workers' compensation premiums, explains how the insurance industry distributes costs among employers, and offers practical suggestions for reducing the cost of job injuries and illnesses.

WCRI RESEARCH BRIEF

WORKERS COMPENSATION RESEARCH INSTITUTE • 245 First Street • Cambridge, MA 02141 • (617) 494-1250

NOVEMBER 1987 — VOLUME 3, NUMBER 11

MORE ON CONTAINING MEDICAL COSTS

Fee Schedules and Choice of Treating Physician

Strong reader response to the announcement of our new book *Medical Cost Containment in Workers' Compensation: Innovative Approaches* shows the high level of interest in the stubborn problem of controlling escalating health care costs. Our readers often call the Institute to ask what specific states are doing to contain costs or which states are using a specific approach. Wherever possible, we provide this information.

A recent study undertaken by the Medical Committee of the International Association of Industrial Accident Boards and Commissions (IAIABC) is a source of much useful information. The committee kindly agreed to share excerpts of its report with our readers, with the following caveat: The information was gathered by a survey of U.S. jurisdictions and Canadian provinces. The response to the survey was high, but less than 100 percent, thus the information may not be complete. Also the information was verified where possible but not in every case. If you should have additional information, please write the Institute and we will pass it on to the committee.

Here we offer information on the following issues:

- Which states currently use medical fee schedules? What is the basis for the schedules? Are they mandatory?
- Which states have plans to use schedules?
- Who has the first choice of treating physician in the various states?

Current Use of Fee Schedules

There are twenty states that now use fee schedules (Table A). The Canadian Provinces all use some kind of schedule, most negotiated by provincial medical associations.

Considering Adopting a Fee Schedule

There are ten states now considering the use of a fee schedule:

Arkansas	North Dakota
Georgia	Ohio
Kentucky	Oklahoma
Michigan	Texas
Mississippi	West Virginia

WCRI RESEARCH BRIEF is a periodic publication of the Workers Compensation Research Institute. It reports on significant ideas, issues, research studies, and data of interest to those working to better understand and to improve workers' compensation systems.

WCRI RESEARCH BRIEFS augment WCRI's primary publications for reporting the results of its work: RESEARCH REPORTS, SOURCEBOOKS, and WORKING PAPERS. All WCRI research publications are widely distributed to policymakers and others interested in workers' compensation issues.

WCRI is a nonpartisan, not-for-profit public policy research organization funded by employers and insurers. For further information about the Institute, its work, membership, or the material in this WCRI RESEARCH BRIEF, contact Dr. Richard B. Victor, Executive Director.

Table A. Current Use of Fee Schedules

Basis	State	Mandatory
Relative value scale	Arizona	Yes
	California	Yes
	Colorado	Yes
	Maryland	No
	Montana	Yes
	Nebraska	Yes
	Nevada	Yes
	New York	Yes
	North Carolina*	Yes
	Oregon	Yes
	Utah	No
	Washington	Yes
	Wyoming	Yes
Usual and customary/prevailing and reasonable	Florida	Yes
	Hawaii	Yes
	Puerto Rico	No
	North Carolina†	Yes
	South Carolina	Yes
Medicaid schedule	Massachusetts‡	Yes
Medicare schedule	Rhode Island	Yes
Blue Cross/State Department of Human Services	Minnesota	Yes

*Also uses usual and customary.
†Also uses relative value scale.
‡150 percent of Medicaid rates

First Choice of Treating Physician

In twenty-nine U.S. jurisdictions, workers make the first choice of treating physician; employers make the first choice in twenty-two jurisdictions (Table B). In sixteen jurisdictions, these choices are subject to various restrictions or review.

Table B. First Choice of Treating Physician

State	First Choice	Restrictions
Alabama	Employer	None
Alaska	Worker	None
Arizona	Worker	None
Arkansas	Employer	Agency may change
California	Worker	If prior notification to employer
Colorado	Employer	Agency may change

Table B continued

State	First Choice	Restrictions
Connecticut	Worker	From state listing
Delaware	Worker	None
D.C.	Worker	From district listing
Florida	Employer	None
Georgia	Worker	From employer list
Hawaii	Worker	None
Idaho	Employer	None
Illinois	Worker	None
Indiana	Employer	None
Iowa	Employer	None
Kansas	Employer	None
Kentucky	Worker	None
Louisiana	Employer	None
Maine	Worker	None
Maryland	Employer	None
Massachusetts	Worker	None
Michigan	Employer	Initial choice only
Minnesota	Employer	Agency may change
Mississippi	Worker	None
Missouri	Employer	Agency may change
Montana	Employer	None
Nebraska	Worker	None
Nevada	Worker	From state list
New Hampshire	Worker	None
New Jersey	Employer	None
New Mexico	Employer	None
New York	Worker	From state list
North Carolina	Employer	None
North Dakota	Worker	None
Ohio	Worker	None
Oklahoma	Worker	Agency may change
Oregon	Worker	None
Pennsylvania	Employer	None
Rhode Island	Worker	None
South Carolina	Employer	None
South Dakota	Employer	None
Tennessee	Worker	From employer list
Texas	Worker	None
Utah	Employer	Agency may change
Vermont	Employer	Agency may change
Virginia	Worker	From employer list
Washington	Worker	None
West Virginia	Worker	None
Wisconsin	Worker	None
Wyoming	Worker	None

SOURCE: U.S. Chamber of Commerce, *Analysis of Workers' Compensation Laws, 1987.*

BULLETIN

California Workers' Compensation Institute

120 Montgomery Street San Francisco, CA 94104 (415) 981-2107

March 3, 1988

No. 88-2

Impact of insurers' medical cost containment strategies, including the use of preferred provider organizations and automated auditing of physicians' bills, are reflected in the results of the Institute's latest medical fee study.

Payments to treating physicians during 1987 averaged nearly 3 percent under levels authorized by the Official Medical Fee Schedule, the greatest differential in the history of the CWCI series. Moreover, although doctors continued billing above permitted fees, about 9 percent on average, paid amounts were below schedule in four of the five sections. Average conversion factors per unit of service:

Section	Allowed	Billed	Paid
Medicine	$ 6.15	$ 6.64	$ 5.96
Surgery	153.00	179.49	156.67
Radiology	12.50	14.34	12.40
Pathology	1.50	1.93	1.48
Anesthesia	34.50	39.85	34.39
Avg. % from Allowed		+ 9.3	- 2.7

Change was most apparent for procedures in the schedule's Medicine section -- office and hospital visits, physical therapy, etc. -- which accounts for 83 percent of all procedures and 63 percent of payments in the most recent sample. Every third procedure was billed below the schedule level and nearly half were paid less than allowed.

However, physicians may be compensating for the discounting common to most PPOs by billing for a higher level of service, e.g., charging for an "intermediate" rather than a "limited" visit. As a result, the relative frequency of office visits of all types declined 12 percent compared with last year, but their share of the medical fee dollar increased by 10 points.

General practioners continued to be the most frequent provider, accounting for nearly every third procedure and payment dollar. Alternative modalities may explain the shift away from surgery: 40 percent decrease in the frequency of and payments for procedures performed by orthopedic, neuro- and general surgeons. Any savings, however, were offset to a large degree by a 63 percent increase in the proportion of the medical fee dollar paid to physical therapists.

-more-

According to the study, insurers pay physicians' bills 21 days after receipt on average, and 81 percent are paid within 30 days.

Results of the study are based on an analysis of billings for nearly 49,000 medical procedures paid during the two-week period ending October 30, 1987. Twenty-six insurer groups representing 63 percent of statewide premium participated in the study. For further information, please contact Tom Parry, CWCI research director.

* * *

Enclosed is a copy of the most recent Institute publication that explores the reasons for the recent escalation in workers' compensation insurance costs. Additional copies are available upon request; single copies free, quantity orders are $16 per 100 plus tax and shipping charges.

AT/grp
Enclosure

WHY DO WORKERS' COMPENSATION RATES KEEP GOING UP?

The question undoubtedly is the one fielded most often by insurance representatives. The frequency with which it's asked probably matches the frequency of rate increases – six raises aggregating 44 percent in the 1985-87 period alone.

Premium rates essentially are a function of two factors: The cost of claims and the overhead expense of running the insurance company. If the cost of either factor increases, rates go up.

But that's too simplistic an explanation for most employers, one that masks the forces driving claims costs and overhead expense in workers' compensation insurance. These elements include:

BENEFITS

Payment levels set by the state legislature are a significant cost component in workers' compensation insurance. Since 1985 benefits have increased 33 percent, 56 percent in the past ten years. Higher benefits produce higher claims costs and that in turn dictate higher rates to employers.

INFLATION

Most goods and services cost more today – up an average of 14 percent in the past five years, 81 percent in the 19[illegible]-86 period for all items included in the Consumer Price Index.

Admittedly, many of the CPI components have little impact on claims and overhead expense. But others directly affect workers' compensation premiums. For example, the cost of medical treatment increased twice as fast as the general rate of inflation in the past five years. Because medical treatment accounts for 42 cents of every claims dollar, the increase results in higher premium rates.

LITIGATION

Workers compensation was intended to eliminate the costs, delays and uncertainties of the common law system it replaced. The founding architects thought that by getting rid of the idea of fault and prescribing benefits by statute, there would be little controversy, much less a need for litigation. Their hopes proved to be both overly optimistic and short-lived.

Today, in California every ninth workers' compensation claim is litigated. If the injury results in lost time, the litigation rate climbs to 45 percent. And if the injury produces residual permanent disability, three of every four claims are litigated.

Litigation is expensive, even in a no-fault system. In 1986 the direct out-of-pocket costs alone – attorneys' fees, forensic medical testimony and related expenses – reached $985 million in California, according to a recent research study. The total – more than was paid to physicians to *treat* injured workers – is three times higher than ten years ago. More distressingly, these frictional costs are growing four times faster than benefit levels. The bottom line: higher costs for employers.

LOSS DEVELOPMENT

California law requires insurance companies to operate on a "drop dead" basis, i.e., to set aside sufficient funds to pay all outstanding claims in full at any point in time. The process, known as loss reserving, forces the insurer to estimate the cost of a claim and make adjustments, up or down, as conditions change during the life of the claim. "Loss development" measures the change from initial estimate to the final actual cost.

Historically the insurance industry's estimates came close to reality, ±3 percent. Beginning in the mid-1970's, however, original predictions consistently began to fall short by 13-14 percent – and sometimes more. Late reporting of claims, the increasing impact of vocational rehabilitation benefits, medical uncertainties, new court decisions all contributed to the deficit and the need for higher rates.

Finally, workers' compensation premium rates are a percentage of payroll. If wage levels increase faster than claims costs, rates go down. (A $1 rate on $2000 of payroll produces the same premium as a $2 rate on $1000 payroll.) But workers' compensation costs have grown more rapidly than wages, particularly in recent years. When wage inflation began to slow down in 1984 to about half the pace in the previous ten years, higher insurance rates were needed just to stay even. So long as claims costs grow faster than wages, compensation rates will go up.

HOW CAN EMPLOYERS BE SURE THEY'RE NOT PAYING MORE THAN THEIR FAIR SHARE?

In an absolute sense, they can't – since insurance is a mechanism in which the premiums of the many go to pay the losses of the few. The rate-making process, however, allocates claims costs and overhead expense as evenly and equitably as possible.

CLASSIFICATIONS

The first step in pricing is to determine the employer's occupational classification. All businesses and industries in California are grouped into approximately 425 classifications – from Acid Manufacturing to Yarn Dyeing – based on the relative hazards.

The classification structure provides the data for pricing workers' compensation insurance. All elements of the data base – number and amount of losses, premiums, and payroll – are reported by classification. Regulations of the state insurance commissioner require all insurers to adhere to the same reporting ground rules. Moreover, the commissioner's statistical agency, the Workers' Compensation Insurance Rating Bureau, audits insurance companies to be sure the data base is accurate and complete.

MANUAL RATES

The losses and premiums of all employers in each classification are compared and a manual rate calculated. ("Manual" refers to the rating manual, not manual labor.) The manual rate for a given classification represents the average loss cost, plus a uniform percentage to cover insurer expenses (now 35 percent of the manual rate). The rate usually is expressed as dollars and cents for each $100 of payroll.

Manual rates are average rates. Since few employers are statistically average, using manual rates would be unfair to the typically non-average employer. Other features of the pricing system recognize and adjust for the differences between employers.

EXPERIENCE RATING

If the "claims experience" of an individual employer is better (or worse) than the average for all employers in the same classification, the difference will be expressed as a percentage credit (or debit) and applied to the manual rate. For example, an employer with a better than average safety record may earn a 92 percent "experience modification" and gets an 8 percent discount off the manual rate. On the other hand, employers with poor claims experience will pay more than their safer competitors, in some instances substantially more.

The experience rating plan assumes past experience is the best indicator of future performance. So although the percentage modification is based on the employer's past record, it is applied prospectively, at the time the policy goes into effect. All policies above a certain premium (currently $4833) are experience-rated, and they cover an estimated 80 percent of the insured workforce.

DIVIDENDS

To most employers, policyholder dividends are a familiar cost-equalizer. Policies accounting for nearly 90 percent of statewide workers' compensation premiums are written on a "participating" basis that allows an employer to participate in the profits of the insurer.

The average manual rate for any particular class will be more than adequate for some employers – because losses can and do differ among employers within that class. Similarly, the uniform 35 percent loading for overhead expense may be more than adequate for some underwriters and, because fixed costs are a smaller percentage of large premium policies, more than necessary for larger employers. Investment income also varies among insurers. Thus, an insurer may accumulate surplus funds over and above the dollars needed to pay losses and expenses.

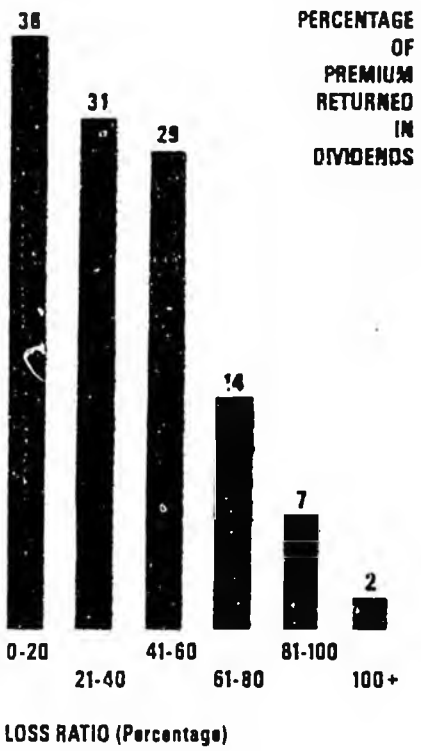
Insurance is different from other products or services in the marketplace. Unlike a suit of clothes or a pound of butter, the production cost isn't known at the time of purchase – and the ultimate cost won't be known (or knowable) until well after the policy expires. The uncertainty over final cost makes precise up-front pricing difficult, particularly for coverage of the long-term liabilities characteristic of workers' compensation. Prices that are too high are unacceptable to the employer. At the other extreme, inadequate rates may threaten solvency and endanger payments to injured workers.

In enacting the laws governing the price of workers' compensation insurance, the California legislature opted for solvency and the certainty that injured workers receive the benefits to which they were entitled. The lawmakers saw that the use of average rates would result in premiums too high for some employers, bargains for others. To avoid these inequities, the legislature authorized the return of any excess premium – after costs are known – by payment of dividends to policyholders.

Dividends serve a twofold purpose: an economic incentive to employers for safe operation and, as the final step in pricing, assurance that the employer pays the "right" cost.

Dividend payments are cost-sensitive, both in the aggregate and for the individual policyholder. When claims costs decrease, dividends increase.

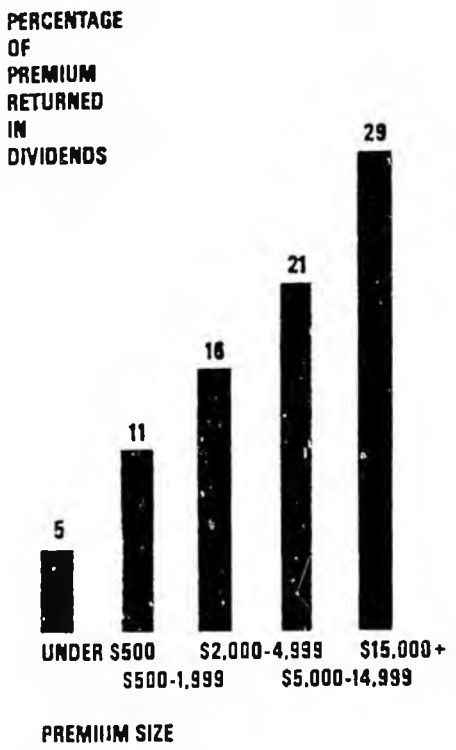
LOSS RATIO AND DIVIDENDS



Some of the costs involved in issuing and servicing an insurance policy are fixed and remain constant regardless of premium size. Consequently, as premium size increases, overhead expense as a percentage of total premium declines. In calculating average manual rates, however, the expense factor is uniform for all employers, regardless of premium size. By taking into account both claims costs and overhead, dividend payments compensate for any expense savings due larger employers. Generally, as the premium increases, so does the dividend percentage.

Over the past 15 years, policyholder dividends have reduced insured employers' net costs by an average of 15 percent, ranging from about 5 percent in 19[illegible] to more than 24 percent in 1982. Aggregate dividend payments exceeded $5.6 billion – a return to employers of 65 percent of the insurance industry's net pre-tax income during the 1972-86 period.

PREMIUM SIZE AND DIVIDENDS



An employer's insurance premium mirrors the underlying loss costs and overhead expense. Some of the reasons for increased claims costs – court decisions and uncertainties of the governing statute, for example – are beyond the control of most individual employers. But an employer can take steps to reduce costs – and premiums.

There's no magic to the first: reduce employee injuries. Workers' compensation insurers have safety professionals on staff to help policyholders provide a safe work environment. The range of services is virtually unlimited – surveys, visual aids, educational programs, inspections, counseling, industrial hygiene analysis, advice on compliance with safety standards.

There's no additional costs since these services are included in the premium. It's the employer's responsibility, however, to get value received by asking for the services, to set up or expand a safety program, and to enforce safety rules rigorously. The combination of professional services and employer commitment means lower losses – both in human and financial terms.

Injury prevention is still the best way, maybe the only real way, to cut workers' compensation costs. Moreover, safe operation makes good economic sense. Eliminating accidents not only reduces premiums but also cuts the indirect costs of job accidents such as damage to equipment, production delays, and lost time of co-workers.

Unfortunately accidents, like death and taxes, are sure things too. Even the safest workplace will be the scene of an accident at some time or another. When it happens, the employer must know how to respond and what to do.

Claims management is the job of the insurance company, but the process begins with the employer. Here are actions an employer can take to help the injured employee, comply with the law, and minimize the cost of injuries.

KEEP THE EMPLOYEE INFORMED

A job injury can be a frightening experience for many employees. Few have any knowledge of workers' compensation. Any misunderstanding about where they stand can slow recovery and lead to numerous complications, most of them expensive.

Employees who are uncertain about their rights and protections frequently turn for reassurance to an "expert," i.e., an attorney. If so, that usually means litigating the claim and additional direct expense – an average of $5100, according to a 1986 study – over and above the cost of medical treatment and indemnity payments.

So, reduce the anxiety by letting the injured employee know, early on, that medical and hospital bills will be paid, the wage replacement payments will be made automatically, that the job is waiting when the employee can return to work. (Most insurers have a variety of materials to help employees understand workers' compensation.) Focus the employee's attention on recovery and reemployment, not disability.

ASSURE PROMPT, QUALITY MEDICAL CARE

Expert medical treatment, including referral to specialists when necessary, is a wise investment. Skilled treatment can minimize time off the job, reduce the chance of permanent handicap, and get the employee thinking in terms of recovery from (rather than recovery for) the injury.

Consider the role of the physician in workers' compensation. Every claim starts with a doctor. Every step – treatment, evaluation, rehabilitation, release for work – directly involves a physician. The quality of medical care and the confidence the employee places in the treating doctor can influence the length and extent of disability and, directly, employer costs.

FILE REPORTS PROMPTLY

The employer's report of injury starts the claims process; without it the insurance company can't act. Delays in reporting can delay the employee's payments – which in turn increases the hardship on the employee, impedes recovery, and can lead to dissatisfaction and disputes. Timely reports permit timely payments. As a general rule, the faster the payment, the sooner the employee returns to work.

BE SYMPATHETIC AND UNDERSTANDING

No injury is "minor" if it happens to you. Research shows many injured workers turn to an attorney because the employer (or foreman or supervisor) was indifferent and not helpful. Understanding the employee's concerns, coupled with continued contact during recovery, can reduce litigation and claims costs.

MINIMIZE RECURRENCE

Investigate and analyze all accidents, no matter how minor. Take steps to correct identified hazards. Maintain complete written records, including statements of witnesses. But emphasize prevention, not fault.

FOR MORE INFORMATION

Your insurance representative can answer questions about rates, coverage, reporting requirements, claims handling, injury prevention programs and other aspects of workers' compensation.

COURT CASES

WORKERS' COMPENSATION

The following court decisions involving workers' compensation are available in the House Judiciary Committee files. They are separated by general topic. If you want to see any of them or get copies, please ask Shari.

EVIDENCE

Burgess Construction Co. v. William S. **Smallwood**

AVERAGE WEEKLY WAGE

Orval L. **Ragland** v. Morrison-Knudson Co.
Jack **Peck** v. Alaska Aeronautical
Gerald R. **Brunke** v. Rogers & Babler
William **Bailey**, Jr. v. Litwin Corporation
State of Alaska v. Harold H. **Gronroos**
Richard F. **Deuser** v. State Of Alaska
Robert E. **Johnson** v. RCA-OMS
State of Alaska v. **Lee Dupree**

COMPENSATION RATE

Alaska Pacific Assurance Co. v. Robert **Brown**

PERMANENT PARTIAL DISABILITY

Sang Suh v. Pingo Corporation
Harold **Standley** v. State of Alaska
Providence Washington Insurance Co. v. Virgil F. **Grant**
Kermit **Cesar** v. Alaska Workmen's Compensation Board
Virgil **Hewing** v. Alaska Workmen's Compensation Board
John **Absher** v. State of Alaska
Jack J. **Sherman** v. Holiday Construction Co.

STRESS

Cruz D. **Bilbao** v. Alascom
Guy E. **Hayes** v. Chevron USA
Rosde K. **Reeder** v. Wendy's Old Fashioned Hamburgers
Susan **Kent** v. State of Alaska
Regina **Wade** v. Anchorage School District
Corazon **Fox** v. Alascom

WCCA

April 4, 1988

Rep. John Sund
House Judiciary Committee
P.O. Box V
Juneau, Alaska 99801

Dear Rep. Sund,

Enclosed are miscellaneous articles, press releases and general information regarding the workers' compensation issue you will be reviewing in your committee this week. The articles enclosed represent a very small percentage of the coverage this issue has generated statewide. Much of this has been provided to prior committees as well and is available from there files. Additionally, WCCA sent all legislators an information packet prior to the 1988 session.

I hope you will make the enclosd information available to committee members. Please feel free to call upon myself or other WCCA members who will be in Juneau to testify before your committee if we can provide further information.

I sincerely hope that your committee will deal with this legislation quickly and positively. Passage of a beneficial workers' comp reform bill is vital to the concerns of both labor and management.

Sincerely,

Steve Haag

Steve Haag
President
WCCA

WCCA

THE WORKERS' COMPENSATION COMMITTEE OF ALASKA, INC.

The Workers' Compensation Committee of Alaska, Inc. is an organization of business persons who are determined to reduce the budget-breaking costs of workers' compensation insurance.

Compensation rates will increase as much as 65 percent in 1988.

Even while business volumes and numbers of employees drop, many businesses are experiencing insurance rate increases. In a shrinking economy, these increased costs can no longer be passed on as part of overhead and are threatening the viability of Alaskan jobs and businesses.

WCCA includes representatives from:

Arco
Standard Alaska
Associated General Contractors, Anchorage Chapter
The Municipality of Anchorage
Klukwan Inc,
Northern Air Cargo
Hickel Investments
Enserch
GCI
Alaska Airlines
Totem Ocean Trailer Express
Anchorage Refuse
North Slope Contractors
Building Industry of Alaska - Anchorage
Alaska Timber Insurance Exchange
Alaska Support Industry Alliance
Carr-Gottstein Enterprises
VECO
Anglo Alaska Petroleum Services
Dimond Alaska Coal
Robinhood, Inc. ....and many others!

WCCA committees are researching the following areas of concern:

* The proportion of funds paid to injured workers, to medical care, vocational rehabilitation and other service providers.

* Rate setting and classification.

* Formulas for compensating loss of wages.

* Pitfalls of state funds.

Workers' Compensation Committee of Alaska, Inc., 11401 Olive, Anchorage, AK 99515
(907) 344-1577

* Effectiveness of vocational rehabilitation.

* Making all injuries "scheduled" instead of some being allowed to run open-ended.

* Usefulness of the Second Injury Fund.

* Payments to injured workers who have left Alaska for other states with lower costs of living.

* Prosecution of fraudulent claims.

TIMETABLE

WCCA is formulating legislative proposals in coordination with labor representatives. Efforts are being made to reach agreements on which areas will be addressed. Specific proposals will be presented to legislators prior to the 1988 legislative session.

WCCA's major goal is to see workers' compensation statutes overhauled during the 1988 legislative session. WCCA will continue to work until the cost of workers' compensation insurance is reduced by at least 33 percent.

BUDGET

WCCA has set a budget of $100,000 to cover activity necessary through the 1988 session. The 1988 budget includes the cost of professional lobbying services.

WCCA

OFFICERS AND EXECUTIVE COMMITTEE

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Vice President	Howard Cutter Risk Manager Alyeska Pipeline Co. Anchorage
Secretary	Elaine Taylor Taylored Construction Building Industry of Alaska Anchorage
Treasurer	Eric Tollefson Personnel Director Carr-Gottstein Enterprises Anchorage
Member-at-large	Renee Murray Vice President Scott Wetzel Services Inc. Anchorage

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Barbara Reierson
Co-owner
RG&B Construction Company
Anchorage

WCCA

WHAT DRIVES THE COST OF WORKERS' COMPENSATION

Alaska has the most costly workers' compensation system in the United States! Alaskan laws have been written and interpreted to allow the most generous application possible. Here are some examples:

* Alaska is one of two states which provide that the benefits paid to an injured worker will be based on 200 percent of the statewide average weekly wage. That means a North Slope worker whose job ends and who then finds a job in another location at lower pay and who then becomes injured may draw as much as $4,500 per month in workers' compensation.

* Benefits are calculated on the basis of the past two years' earnings. A drop in the economy or in the wages of a worker may result in an injured person actually making more from compensation than from wages.

* Vocational rehabilitation is mandatory for workers whose injuries keep them from returning to employment within 90 days. Even when an injury is known to require 6 months to heal, expenditures must be made to meet the letter of the law.

* Alaska's relatively small range of occupations limits the potential for placement of workers who have permanent partial disabilities.

* Unlike many other states, Alaska has no provision for periodic review nor standards for treatment of injured workers by medical or rehabilitation providers, nor any guidelines for fees.

* Unlike many states, injured workers do not pay any portion of their medical costs.

* Unlike many states, few types of injuries are scheduled -- that is, lump sum payments are mandated for very few injuries.

* Unlike many states, pensions are not calculated to offset workers' compensation payments. Only social security payments can be offset.

Workers' Compensation Committee of Alaska, Inc., 11401 Olive, Anchorage, AK 99515
(907) 344-1577

WCCA

WCCA GOALS

The short-term goals of WCCA are to:

A.) Monitor and detect waste and abuse within the Alaska workers' compensation system, irresepective of the source of such waste and abuse, and bring such proven or suspected waste and abuse to the attention of the public and public officials.

B.) Study the structure of Alaska's workers' compensation statutes and administrative regulations and compare them with the laws of other states.

C.) Study the relationship and interaction of system providers (i.e., adjustors, medical and chiropractic communities, rehabilitation counselors, attorneys, insurance companies and others) with the Alaska workers' compensation system and compare it with experience in other states.

D.) Study the structure, organization and mission of the Division of Workers' Compensation and the Workers' Compensation Board.

E.) Study the structure, organization and mission of the Alaska Classification and Rate Committee.

F.) Study the classification and rating system utilized by the National Council on Compensation Insurance and the Alaska Classification and Rating Committee.

G.) Study, jointly with labor, the creation of a competitive state insurance fund for workers' compensation insurance along with other insuring alternatives.

H.) Study the structure, organization and mission of the Second Injury Fund to gauge its effectiveness as an employer incentive to hire the pre-injured and disabled.

I.) Communicate the results of such studies as well as the conclusions and recommendations of WCCA to the public and public officials.

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

WCCA

THE MISSION OF WCCA

The mission of the Workers' Compensation Committee of Alaska, an Alaska corporation, is to:

A) Promote management's continued education and understanding of Alaska's worker's compensation laws and regulations.

B) Act as a platform for communication between management and the service providers whom interact daily with the Alaska workers' compensation system.

C) Act as a liaison between management and various governmental and non-governmental institutions, including, but not limited to:

* The Department of Labor
  Division of Workers' Compensation
  Workers' Compensation Board

* The Department of Commerce
  Division of Insurance

* Alaska Classification and Rate Committee

* National Council on Compensation Insurance

D) Administer and foster greater practical utilization of the Second Injury Fund among Alaskan employers.

E) Play an active role in the rate making and classification process by gaining and retaining admission to the Alaska Classification and Rate Committee.

WCCA

THE 1988 RATE INCREASES

On January 1, workers' compensation rates increased an average 25 per cent. The following is a partial listing of industries and the actual rate increases which relate to them.

Oil or Gas Pipeline Work	68%
Oil/Gas Lease Operators	56%
Millwright	54%
Street or Road Construction	54%
Oil/Gas Lease Work/Contractor	53%
Drilling	53%
Oil and Gas Pipeline Operation	52%
Light/Power Line Construction	49%
Sheet Metal Work Erection	48%
Oil and Gas Logging/Surveying	47%
Contractors/Permanent Yard	47%
Iron or Steel Erection	47%
Logging	45%
Drivers and Chauffeurs	43%
Aircraft Commuter Flying Crew	43%
Lumber Yard Store Employees	43%
Water Works Operation	43%
Gasoline/Oil Dealers	43%
Automobile Salesmen	43%
Hotel Restaurants	43%
Hospitals, Professional	42%
Barber Shops, Beauty Parlors	41%
Street Paving	40%
Electric Light and Power Co.	40%
Insulation Work	39%
Labor Unions	39%
Wallboard Installation	38%
Oil Still Erection or Repair	38%
Restaurants	35%
Bakeries	33%
Newspaper Publishing	32%
Hospitals, Other	32%
Commissary	31%
Concrete Construction	30%
Carpentry	30%
Contractors/ Exec. Supervisors	30%
Attorneys	29%
Plumbing	28%
Printing	28%
Auto Body Repair	25%
Carpentry Shop Only	25%

Workers' Compensation Committee of Alaska, Inc., 11401 Olive, Anchorage, AK 99515
(907) 344-1577

CRCC

GUIDE TO REHABILITATION COUNSELOR CERTIFICATION

COMMISSION ON REHABILITATION COUNSELOR CERTIFICATION
1156 Shure Drive, Arlington Heights, Illinois 60004
A DIVISION OF
BOARD FOR REHABILITATION CERTIFICATION

SECTION 3: CRITERIA FOR ELIGIBILITY

To be eligible to sit for the CRCC examination, an applicant **must meet all requirements in** ONE of the categories of eligibility listed below. **Education and employment experience requirements must be fully satisfied by the application deadline date (January 1 or July 1).** Any application that does not meet the eligibility criteria of one of the following categories at the application deadline date **will be rejected automatically, with no refund of the application processing fee. CRCC WILL CHARGE A $20 HANDLING FEE FOR ANY CHECK RETURNED FOR NON-SUFFICIENT FUNDS.**

CATEGORY A

Degree required:	Master's in rehabilitation counseling.
Granted by:	A rehabilitation counselor education program that was fully accredited by CORE at the time the applicant's degree was granted.[1]
Internship required:[2]	Internship in rehabilitation counseling of 600 hours (semester system) or 480 hours (quarter system) under the supervision of a Certified Rehabilitation Counselor (CRC).
Acceptable employment experience required:	None

CATEGORY B

Degree required:	Master's in rehabilitation counseling.
Granted by:	A rehabilitation counselor education program that was **NOT** fully accredited by CORE at the time the applicant's degree was granted.[1]
Internship required:[2]	Internship in rehabilitation counseling of 600 hours (semester system) or 480 hours (quarter system) supervised by a CRC on-site or by a faculty member who is a CRC.
Acceptable employment experience required:[3]	One year under the supervision of a CRC.[4]

CATEGORY C

Degree required:	Master's in rehabilitation counseling.
Granted by:	A rehabilitation counselor education program that was NOT fully accredited by CORE at the time the applicant's degree was granted.[1]
Internship required:	None
Acceptable employment experience required:[3]	Two years, one of which must have been under the supervision of a CRC.[4]

CATEGORY D

Degree required:	Master's **RELATED** to a Master's in rehabilitation counseling.[5]
Acceptable employment experience required:[3]	Three years, one of which must have been under the supervision of a CRC.[4]

CATEGORY E

Degree required:	Master's **UNRELATED** to a Master's in rehabilitation counseling. **(This category will be phased out at the end of 1992.)**
Acceptable employment experience required:[3]	Five years, one of which must have been under the supervision of a CRC.[4]

CATEGORY F

Degree required:	Bachelor's in any discipline. **This category will be phased out at the end of 1992.**
Acceptable employment experience required:[5]	Seven years, one of which must have been under the supervision of a CRC.[4]

CATEGORY G

Category G is a special eligibility category ONLY for students working towards a Master's degree in rehabilitation counseling. In order to be eligible under Category G, a student must:

a. be enrolled in a Master's degree program in rehabilitation counseling that is fully accredited by CORE[1],

b. have completed 75% of the coursework toward a Master's degree by the application deadline date (January 1 or July 1) for the CRCC examination for which he/she is applying;

c. (by graduation) have completed an internship[2] in rehabilitation counseling of 600 hours (semester system) or 480 hours (quarter system) supervised by a CRC; and

A student who applies before the appropriate deadline and who qualifies under Category G may sit for the CRCC examination on the next scheduled administration date. **However, the individual's examination results, profile, and certificate will be released only when CRCC receives an official transcript reflecting the granting of the Master's degree in rehabilitation counseling.** The "CRC" may not be used by these individuals until they have received their examination profiles indicating they have achieved a passing score in the Certification Examination.

CATEGORY H

CRCC has created this limited category to facilitate the development and advancement of the rehabilitation counseling profession outside the United States. To be eligible an applicant may not hold U. S. citizenship nor reside in the United States. Category H is limited to the first 1000 applicants. Residency may be proved by employment verification, a certified copy of a passport, affidavit, or other legal documents.

Category H is available ONLY to an applicant who meets the required educational and employment criteria in any one category listed. The only exception is that CRCC does not require CRC supervision at internship or employment.

Applicants applying under this category are reminded that the examination is based upon the body of knowledge of laws, public regulations, and the delivery of rehabilitation services in the United States.

All CRCs, regardless of their residence, must comply with CRCC's Certification Maintenance Plan in order to maintain their certification.

CATEGORY I

Degree and Dissertation required:	Doctorate with a specific program and Doctoral Dissertation emphasis in rehabilitation.
Internship required:	600 hours of internship at the doctoral level in a rehabilitation setting, supervised by a CRC.
OR	
Acceptable employment experience required:[5]	One year full-time employment under the supervision of a CRC.[4]

1, 2, 3, 4, 5, see page 26, "Notes to Section 3."

MARJORIE T. LINDER, M.A., C.R.C., C.I.R.S.
Vocational Rehabilitation Counselor

MTL SERVICES
9111 Vanguard Drive
Anchorage, Alaska 99507
(907) 344-3341

MAR 28 1988

March 23, 1988

Representative John Sund
Pouch V
Juneau, Alaska

Dear Representative Sund:

I am a vocational rehabilitation counselor who has worked in Alaska in the workers' compensation system for ten years, which gives me a unique vantage point. I also worked on the WCCA rehab committee. Thus, I believe I understand the intent of the proposed legislation.

Rehabilitation under the current Alaska Workers' Compensation System reminds me of the movie, "Requiem for a Heavy Weight," which deals with a no longer popular but aging boxer. His trainer and manager arrange a phony wrestling match for this once proud athlete and then they bet against him. Like the movie's protagonist, the injured worker, in the course of his claim, must enter an arena he does not want, participate in a contest he does not choose, and purposely throw the fight to support others who bet against him. If he works hard to preserve his income, under the wage loss concept, he receives no money. I have seen many a frustrated claimant utilize rehabilitation not to advance himself but to advance his claim. Likewise, I have seen many an insurance company utilize rehabilitation services to decrease the value of the claim. Both are a waste of time, energy, and money!

I believe that SB322 provides the claimant with an alternative to winning by losing. By scheduling all injuries, the claimant can obtain a settlement based on the degree of medical impairment and help himself without hurting his claim. By requiring the claimant to invest the proceeds from his claim into his own support during his rehabilitation program should the program's length extend past medical stability, the system can attend to more motivated clients and promote early intervention. By reducing the amount of support provided after medical stability, the system will discourage crippling dependency. By making participation voluntary, the system will encourage freedom of choice. The increased length of training programs should make bonafide programs more possible.

While I hope I have your attention, I wish to comment on a recent amendment which came out of the House Labor and Commerce Committee regarding a Board order to change the specialty of the Board selected IME physician from that of the treating physician.

Some people have dubbed this the "chiropractic amendment". I believe the issue is much larger than chiropractor vs. M.D. It has to do with the Board's right to have complete information to make an informed decision without requiring the employer to put on an expensive hearing and the employee to incur delays in swift adjudication of his case. It has to do with quality medical attention. For instance, I can think of cases in which the claimant naively chose the wrong specialist as his treating physician. I remember a claimant who was utilizing a pulmonary specialist to treat her back pain. I remember a claimant who was misdiagnosed by a GP as having a herniated disc when the claimant's real problem was a disc space infection (a life threatening problem, I might add). I remember a chiropractor who alleged that a plantar wart was somehow related to a female claimant's lifting a cow. Yet another claimant's cancer of the spine was missed by his family practioner from whom he sought care after he experienced back pain on the job. Obviously, all of these folks were treating with the wrong specialist for their problem. Had it not been for an IME ordered by the employer, no one would have had appropriate information. In these cases, the IME physicians' opinions radically differed from the claimants' treating physicians. Under the House amendment outlined, the Board would be limited to selecting yet another inappropriate specialist for the claimant's problem. Somehow, this does not make sense in either the name of justice or the quality medical care.

Yet one more amendment to the bill disturbs me. This one has to do with a mandated roll back in insurance rates. I believe the proposed bill, should it not be tampered with, has at least a 6% reduction in costs built into it. My understanding is that a new NCCI report corroborates this belief. However, having a roll back in rates thwarts the free enterprise system. It may well chase carriers from Alaska leaving only one Alaskan based company. Creating a monopoly may foster opportunism. I strongly urge you to reconsider this additive, which I believe will prevent healthy competition and eventually raise the insurance rates.

In short, I support the original Senate Bill negotiated by the Labor Management Task Force and no House substitute. I invite you to call on me to provide information to you or your committee. Please thank Sherry Kockman for being responsive to my comments when I telephoned her last week.

Yours truly,

Marjorie T. Linder, M.A.,CRC, CIRS

MTL SERVICES
9111 Vanguard Drive
Anchorage, Alaska 99507
(907) 344-3341

MARJORIE T. LINDER, M.A., C.R.C., C.I.R.S.
Vocational Rehabilitation Counselor

April 5, 1988

Representative John Sund
State of Alaska
House of Representatives
Juneau, Alaska 99811

Re: SB 322

Dear Representative Sund:

The following represents my feelings in support of scheduling all injuries using the Whole Person theory under the AMA Guides instead of using the wage-loss concept.

As a rehabilitationist, I believe that any system for compensating disability of any sort tends to contribute to the degree of disability by reducing the normal economic incentives for return to work. I believe that scheduled systems seem to offer an advantage over wage loss systems in that they discontinue the dependency relationship between the worker and the insurance company at the earliest possible opportunity. That minimizes the effect of compensation on functional overlay and incentives for return to work.

Scheduled systems also minimize the necessity for insurance companies to maintain relatively large numbers of reserves against the potential of future wage loss, a very expensive proposition in the current insurance rating system. By removing the interest of the claimant and his attorney to build awards based on wage loss, substantial savings in costs should be realized. By discontinuing the relationship with the insurance company at the earliest possible time, the claimant will also discontinue his relationship with his attorney sooner, thus reducing litigation (which I believe will be heavy at first.)

Despite the critics and actuarial reports, I know that while the currently scheduled awards may increase, the unscheduled awards will decrease and be more predictable. Please give every consideration to supporting this bill.

Yours truly,

Marjorie T. Linder, M.A., CRC, CIRS

NORTHERN REHABILITATION SERVICES, INC.

4325 Laurel, Suite 103
Anchorage, Alaska 99508
(907) 561-3162

MAR 30 1988

March 10, 1988

House Judiciary Committee
Mr. John Sund, Chairman
Post Office Box "V"
Juneau, Alaska 99811

Re: Rehabilitation of Injured Workers
Bill #322

Dear Mr. Sund:

Northern Rehabilitation Services (NRS) is a private firm offering a variety of vocational rehabilitation services to industrially injured persons throughout the state of Alaska. Over the past 12 months, many interested parties have asked Northern Rehabilitation Services (NRS) what our position is concerning rehabilitation of the injured worker. This correspondence will act as a position paper, outlining thoughts and beliefs regarding how to establish a more cost effective system. In an effort to remain objective, and due to the sensitivity of this issue, NRS has not previously taken a position; however, as we come closer to legislative endorsement and approval of new rehabilitation proposals, NRS has become increasingly concerned with the proposed changes in rehabilitation of the injured worker.

NRS agrees that changes need to be made in Worker's Compensation, and more specifically, rehabilitation of the injured worker. WCCA has spent time and effort establishing a new system within Worker's Compensation, and those efforts to make changes should be commended. NRS does not intend to criticize WCCA's proposal for changes in rehabilitation; however, after reviewing the most recent proposal, NRS is unable to endorse it. This statement comes primarily from two main issues: eligibility determination for rehabilitation; and voluntary vs mandatory rehabilitation.

WCCA's proposal states eligibility for rehabilitation services as follows: "An employee shall be eligible for rehabilitation benefits upon his written request by having physical capacities predicted to be permanent by a physician which are less than the physical demands of the job as described in the U.S. Department of Labor's `selective characteristics of occupations defined in the Dictionary of Occupational Titles' for:

1. Job at the time of injury.

2. Other jobs the injured worker has held within the past ten years that he/she can physically handle according to specific vocational preparation codes as described by the Classification of Jobs (COJ)."

While the above eligibility definition may appear to be quite structured, its validity is rather weak. It is NRS's experience that the COJ is adequate at best in determining the physical requirements of occupations, and is limited in vocations specific to Alaska. Often the COJ may underestimate the physical

P.O. Box 876813
Wasilla, Alaska 99687
(907) 373-4680

103 E. Holly, Ste. 308
Bellingham, WA 98225
(206) 676-1927

232 Second Street Graehl
Fairbanks, Alaska 99701
(907) 451-0544

requirements of the job; therefore, if this approach is utilized, the accuracy factor may be only fair. At the present time, an on site job analysis is performed of the person's position at the time of injury, and/or transferable skills he/she may have that could be used to return them to suitable gainful employment. It is felt this approach more accurately determines the physical requirements. The rehabilitation counselor can assess the physical capacities of the job at the job site.

The other issue of determining eligibility for rehabilitation is that of using the treating physician's statement of the client's physical capacities. Physicians do not enjoy completing physical capacities evaluation (PCE) forms. If, and when a physician fills out a PCE, they will generally consult with the injured worker, and essentially complete the form in a subjective manner, making it more difficult for the rehabilitation counselor to establish a Vocational Rehabilitation Services Plan (VRSP), following through with the requirements of suitable gainful employment.

It has always been NRS's position that an occupational/physical therapist is more qualified to determine an injured claimant's physical capacities. The Alaska chapter of the American Physical Therapy Association and American Therapy Association have organized a committee which strives to establish standards on how best to evaluate Worker's Compensation claimants to determine their true physical capacities in an objective manner. By utilizing occupational/physical therapists, the system would avoid subjective information and in turn save time and money for insurance companies that have been "chasing their tails" trying to work with physicians on this issue.

The eligibility statement also discusses the issue of returning an injured person to work within 60% or more of the wages he/she was earning at the time of injury, i.e., if an individual was earning $20.00 per hour ($3360.00/month) at the time of injury and a transferable skill is identified that will provide the injured person an hourly rate of $12.00 ($2016.00/month), he/she would not be eligible for rehabilitation services. When looking at that difference, it is NRS's belief that a loss of $8.00 per hour ($1344.00/month) is quite drastic. Based on experience, NRS is of the opinion that most people could not handle such a reduction in salary. Conversely, the seasonal employee or an injured worker obtaining a position whose salary far exceeds their usual earning capacity would greatly benefit. Using an individuals average weekly wage would be more in line with their current life style and financial commitments when assessing transferable skills and/or a new vocational objective.

It has also been noted that the new rehabilitation proposal states the injured person and/or employer may make a request for an eligibility evaluation. The word "may" is interpreted by NRS to mean eligibility evaluations <u>may</u> never happen. How is the injured worker provided the necessary information regarding rehabilitation? If the injured person is not provided with this information, and it is left up to the employer to make that decision, a percentage of cases may go unserved.

Mandatory rehabilitation on the surface may appear to be a costly approach; however, it is NRS's opinion that early referral to rehabilitation will result

in cost savings for the insurance company. While this may be disagreed upon by many people in the insurance industry, a study conducted by NRS substantiates early referral to be the most cost effective method.

If a sound eligibility determination is implemented, injured worker's who do not need rehabilitation services would be eliminated from the system. The injured workers who require the service should be referred immediately to rehabilitation. NRS receives many referrals where the injured person has been off work for more than a year. When that injured worker is finally referred to rehabilitation, they are so bitter and angry that the rehabilitation specialist has difficulty establishing a positive working relationship. Generally, the injured worker who has been off work for more than a year is in financial jeopardy, often depressed, lacks motivation, and will play a passive role in cooperation with rehabilitation.

Based on past experience, the following issues are often present:

1. The claimant has made a decision in his/her mind that they are going to "get even" with the insurance company.

2. The claimant has become comfortable with compensation benefits, and consequently will not make an effort to return to gainful employment, especially if a significant loss of wage earning is identified.

3. The claimant becomes dependent upon the system and, therefore, overreacts to the injury when interacting with the physician regarding physical capabilities.

If the insurance company is given authority to make referrals on a voluntary basis, a portion of the injured workers who would benefit from services may be denied the right to rehabilitation. It will be those cases where the insurance adjuster may influence the claim by conducting "piece work" rehabilitation. The final result is a hostile injured worker with no end in sight for resolving the claim or returning to gainful employment as a productive member of society.

It is because of the above two issues that NRS is unable to specifically endorse WCCA's rehabilitation proposal. It has always been NRS's position that our present rehabilitation law (.041) be preserved with the necessary changes. Resolutions to the present rehabilitation law should be implemented and monitored by a committee of insurance personnel, employers, doctors, attorneys and rehabilitation specialists. These professionals should be appointed for a period of two years and statistics maintained for future recommendations and revisions.

What needs to be absolutely avoided is the "Pendulum Affect." If we eliminate our present law (.041) and establish a totally new law, the pendulum, in essence, will swing from the one extreme to the other. A new law will have problems that will also need to be changed and litigated. It is NRS's position that the industry should work with what is now available and make it more effective.

The professional staff at NRS has many years of experience working in the field of Worker's Compensation. With that experience, and under the .041 guidelines, the following concerns continue to arise:

1. What constitutes a reasonable labor market?

2. How does one deal with a change in the labor market due to economic instability when a Vocational Rehabilitation Services Plan is successfully completed?

3. What constitutes non-cooperation?

4. How much time is needed to train injured persons in appropriate occupations?

5. How does one deal with "doctor shopping", or physicians that refuse to cooperate with the rehabilitation process?

6. What can one do to effectively obtain an appropriate physical capacities evaluation form?

7. What is the definition of suitable gainful employment?

8. Is there a better way of resolving claims when an injured worker establishes a goal that goes beyond the .041 training time requirements (74 weeks)?

9. When an injured worker wants to resolve a claim, is unnecessary litigation required to obtain that result?

10. How can situations be avoided where the insurance company may not support the rehabilitation provider's recommendations; consequently, they hire and fire specialists until one is found to endorse their concept of what they feel is appropriate rehabilitation?

The above issues need to be addressed within our present .041 rehabilitation system. It is strongly felt that the rehabilitation community is aware of the problems and may have recommendations to resolve them. Why has it become apparent that most persons with interests in Worker's Compensation want nothing to do with rehabilitation?

Because costs have increased over the years in Worker's Compensation, it is more important than ever that all parties objectively establish a sound Worker's Compensation Rehabilitation Program.

NRS has gathered statistical data in the past two years to identify the outcome of claims referred to our office for rehabilitation services. After reviewing the data, one may determine that the results were cost effective; however, a percentage of cases were closed through compromise and release. Certain individuals are not willing to accept the time frames rehabilitation has to offer within our present system. There should be a more effective way of resolving a claim that is heading towards an agreed upon conclusion.

There have been positive results in rehabilitation within NRS, as well as other rehabilitation firms in the Anchorage community over the past four years. Due to greatly increased costs in Worker's Compensation over the years, it is important that all parties involved within the system avoid emotional reaction. Granted, there are problems within each profession, but instead of dealing with a negative approach, we should deal with change in a positive manner and work with each other to arrive at resolutions. Objectivity and professionalism, with good common sense, are necessary to establish a sound program that is fair to all parties.

If an individual reading this letter is interested in speaking with a rehabilitation specialist regarding their concerns, please do not hesitate to contact NRS at the above number or contact the Executive Board of the Alaska National Association for Rehabilitation Professionals in the Private Sector.

Respectfully submitted,

Duane G. Mayes, M.S.,C.I.R.S.,C.V.E.
Rehabilitation Counselor/Evaluator

Carol Jacobsen, R.N.,C.R.R.N
Certified Rehabilitation Registered Nurse

DM:gm
2173

Chiropractors' Recommendations for changes to the original WCEA Bill

SECTION A.S. 23.30.095(a):

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

RATIONALE: This passage is objectionable for several reasons:

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

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

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

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

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

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

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

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

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

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

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

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

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

RATIONALE: This passage is ill considered:

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

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

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

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

(e) because the provision imposes maximum limits arbitrarily.

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

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

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

SECTION A.S. 23.30.95(e):

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

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

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

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

SECTION A.S. 23.30.95(f):

DELETE (UNDERLINED) changes.

AMEND LANGUAGE

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

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

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

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

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

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

SECTION A.S. 23.30.95(j):

DELETE changes. AMEND CURRENT LANGUAGE.

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

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

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

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

We suggest the following language REPLACE Section (j):

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

SECTION A.S.23.30.095(k):

(1) AMEND proposed language.

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

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

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

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

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

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

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

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

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

SECTION A.S. 23.30.155(c):

DELETE Added language.

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

SECTION A.S. 23.30.155(m):

DELETE changes.

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

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

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

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

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

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

SECTION A.S. 23.30.265 (34):

AMEND proposed language.

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

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

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

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

SECTION ENTITLED LEGISLATIVE INTENT, SUBSECTION (b):

AMEND proposed language.

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

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

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

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

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

PLD

IRELAND
Clinic of Chiropractic APC
541 WEST 36TH AVENUE, ANCHORAGE, ALASKA 99503-5899, (907) 561-1222

MAR 04 1988

February 28, 1988

Representative John Sund
P.O. Box V
Juneau, AK 99811

RE:PROPOSED WORKERS' COMPENSATION LEGISLATION (H.B.352/S.B.322)

Dear Representative Sund,

Your time is precious and valuable; hence I will keep my remarks as brief as possible. As you attend to the vital task of organizing and running state affairs, and bringing about economic recovery, I feel that you should be aware of the following information.

H.B. 352 and S.B. 322 are NOT likely to benefit the injured worker as they claim to do. The language utilized is cleverly written to protect the interests of MANAGEMENT. It is legislation that is clearly out of balance. The labor participation during the drafting stage ("Task Force") therefore appears to be of "mysterious" significance and value.

The proposed legislation places few controls on insurance carriers but many on the health care providers. This bill is conspicuous in nature, in that insurance carriers are given NO guidance to pay health care providers on a timely basis and NO authority is provided for a FINANCE CHARGE AND/OR PENALTY to be levied on an insurance carrier when a delinquency occurs. The "Board" recommends payment within 15 days, but experience and statistics show that payment is usually made many months later, after an exercise in collection procedures has transpired!

To perpetuate the free enterprise system and therefore encourage competition between the various health care providers (best procedure to decrease costs) it is essential to keep the professions "distinct and unique" unto themselves. (Naturally inter-professional relationships would be encouraged.) In keeping with the American way, it is recommended that EACH PROFESSION DOES ITS OWN INDEPENDENT MEDICAL EXAMINATIONS (I.M.E.).

It should specifically be noted that Chiropractors take care probably of the majority of neuro-musculoskeletal (neck and back) injuries. The proposed legislation, supported by the Alaska Medical Association, is designed to move patient care from the Chiropractic model to the MEDICAL MODEL. Research over many years, utilizing tens of thousands of patient studies, has concluded that CHIROPRACTIC IS COST-EFFECTIVE OVER MEDICINE in treating these

injuries. Is it logical therefore to embrace a more costly approach when trying to save money? Furthermore, extensive documented research reveals that WORK TIME LOSS can be significantly decreased utilizing the CHIROPRACTIC approach!

The history of medicines' activities cannot be ignored . . . even though Chiropractors would like to "move on positively" into the future. In 1972, the Alaska Medical Association supported legislation to ELIMINATE CHIROPRACTIC on the basis that it was "QUACKERY." In 1987, the A.M.A., the American College of Surgeons and American College of Radiology were all found guilty, in the United States District Court, of CONSPIRACY TO DESTROY THE CHIROPRACTIC PROFESSION. It should therefore come as no surprise that Chiropractors are "sensitive" whenever a situation requires medical co-operation . . . such as I.M.E.'s performed on Chiropractic patients by medical doctors!

Please be aware that at the "practical field level" I.M.E.'s are "devices" frequently utilized by insurance carriers to interfere and disrupt Chiropractic care. These I.M.E.'s are almost always done by medical doctors (orthopedic surgeons not educated or trained in Chiropractic Methodology.) In my extensive practice experience I have never seen a patient under medical care receive an I.M.E. by a Chiropractor! It seems only reasonable that a professional trained in a particular specialty should evaluate treatment within that specialty. Does a neurologist suggest a patient should seek a second opinion from a pediatrician? It should also be noted the I.M.E.'s performed by MEDICAL DOCTORS usually take about 15 minutes of the physicians' time (an average time according to patients) and COST about $500. This professional fee also EXCLUDES diagnostic studies like x-rays, CAT-scans etc. The present and proposed I.M.E. procedure simply perpetuates DISCRIMINATION and elevates COSTS!

I am the elected Western Regional Director for the International Chiropractors Association, representing the Chiropractors in Alaska, Washington, Oregon, Idaho, Montana, Wyoming, California, Utah, Arizona, Nevada and Hawaii, and have practiced continuously in Anchorage for 17 years. In the interest of "fairness and economics," you are requested to please research and evaluate the issues raised by the Alaska Chiropractors. The Alaska Chiropractic profession, its legal counsel, and lobbyist Mitch Gravo, Esq. are willing to participate in discussions that will mature into laws that are fair to all parties concerned.

I request that you consider the following criteria and proposed amendments, and that they become, at the least, minimum requirements for an acceptable workers' compensation bill.

* The injured worker receives fair benefits and compensation;

* The insurance industry guarantees a 20% reduction in premiums for at least a two year period (premium increase only upon the objective display of need);

* I.M.E.'s are performed by the same type of licensed health care provider as the treating doctor;

* The health care providers are paid by the insurance carriers within 30 days and a legally enforceable finance charge to prevail thereafter. A penalty clause should be invoked for habitual offenders and for other irresponsible actions;

* That injured workers are regarded as important individuals and treated as such. The obligation for the physician should be to provide only "necessary care" and not categorize individuals under a health care delivery system that demands or forces upon people a pre-determined visit structure; (The Medical and Chiropractic professions already have PEER REVIEW panels in existance to control "utilization.")

* That health care providers charge only "reasonable fees" for services provided; (The fee profile to be documented by a skilled person [statistician] for specific geographic areas in Alaska and updated on a quarterly basis. An independent audit of the fee profiles is also essential for the maintenance of accuracy.)

* That non-licensed health care providers (usually insurance adjusters, etc.) NOT be given the authority to approve or reject "TREATMENT PLANS," on the basis of having insufficient Medical/Chiropractic experience and knowledge;

The ultimate solution, which has not been addressed in the proposed legislation, is to PREVENT the industrial accident from happening in the first place! According to an article in the "Anchorage Times," which appeared on February 22, 1988, the following is true: "...as well as an insurance industry that pays more attention to the premiums than it does lowering accident rates." This same newspaper article claims that a safety program reduced a construction firms' annual premium...and furthermore resulted in a REBATE of $110,000 (that the insurance company reimbursed to the construction company). The CORE ANSWER to the Alaska workers' compensation situation could be found in placing emphasis on SAFETY PROGRAMS which could imply a drastic departure from the present version of H.B. 352 and S.B. 322.

Thank you for taking the time to acquire insight into the "other

side of the story." We, as Chiropractors, are positive that by the implementation of the above stated ideas, we can improve the system for all parties concerned and furthermore help Alaska to get back on its "financial feet" by helping business (employers) to pay reasonable workers' compensation premiums again.

Sincerely,

IRELAND CLINIC OF CHIROPRACTIC, A.P.C.

Trevor V. Ireland

Trevor V. Ireland, D.C., F.I.C.A., F.P.C.W., F.P.A.C.

TVI/dld

attch: Anchorage TIMES article "Firm Funds Safety Cut Workers' Comp. Fee"

P.S. Cost effective research studies, Court decisions, etc. are available upon request.

IRELAND
Clinic of Chiropractic A.P.C.
541 WEST 36TH AVENUE, ANCHORAGE, ALASKA 99503-5899, (907) 561-1222

March 3, 1988

MAR 0 4 1988

Representative John Sund
P.O. Box V
Juneau, AK 99811

Re: Proposed Workers' Compensation Legislation (HB 352/SB 322)

Dear Representative Sund,

As the Western Regional Director for the International Chiropractors Association, I feel obligated to express my opinion pertaining to the proposed workers' compensation legislation.

The proposed legislation, in a subtle manner, moves the Chiropractic model of health care into the MEDICAL model. This "movement" is likely to ELEVATE COSTS because numerous studies have proven Chiropractic care to be cost-effective over medicine.

Medicine has long relied on the "diagnostic and objective" approach in providing health care. This approach typically entails many x-ray studies, CAT-scans, M.R.I.'s etc... all of which are COSTLY.

Chiropractic care, in contrast to medical care, has emphasized a "hands-on" approach with a blending of objective and subjective findings. (Subjective findings are those elements such as the feeling of pain, headache etc.)

Chiropractors understand neck and back problems probably better than anyone else. They also understand that BACK and NECK PAIN CAN EXIST WITHOUT OBJECTIVE DOCUMENTATION.

H.B. 352 and S.B. 322 insists upon "objective" documentation. Should these bills become law it is reasonable to assume that ALL health care providers will be FORCED to perform additional COSTLY tests and procedures to PROVE that the care rendered was necessary.

RECOMMENDATION: Necessary care may be rendered when "subjective" and/or "objective" findings are demonstrated. (Psycho-somatic observations and malingerer tests should be utilized by the physician to eliminate non-compensable type conditions.)

Thank you for taking the time to note our Chiropractic concerns.

Sincerely,

IRELAND CLINIC OF CHIROPRACTIC, A.P.C.

Trevor V. Ireland

Trevor V. Ireland, D.C., F.I.C.A., F.P.C.W., F.P.A.C.

TVI/mli

PLEASE NOTE: Additional information available upon request. Please refer to "Information Package" forwarded to you dated February 28, 1988.

IRELAND
Clinic of Chiropractic APC
541 WEST 36TH AVENUE, ANCHORAGE, ALASKA 99503-5899, (907) 561-1222

March 9, 1988

Representative John Sund
P.O.Box V
Juneau, AK 99811

RE: Proposed Workers' Compensation Legislation (HB352/SB322)

Dear Representative Sund,

I have practiced in Anchorage for almost 17 years. It is apparent that we need workers' compensation reform in Alaska. The proposed legislation unfortunately corrects some problems, but CREATES others.

The most visible problem, at least to Chiropractors, is the subtle language utilized to move the practice of Chiropractic into the MEDICAL MODEL of practice. Study after study has proven Chiropractic to be COST-EFFECTIVE over medicine! (As referenced in "Information Package" forwarded to you February 28, 1988.)

Having medical doctors evaluating Chiropractic patients is like having plumbers evaluating electricians work. Independent Medical Examinations (I.M.E.'s) usually provide the medical doctor with a "classroom setting" to discuss their anti-Chiropractic feelings...and seldom result in the clinical merits of the case being adequately evaluated!

Chiropractors are collectively "upset" when the vast majority of I.M.E.'s, performed by medical doctors claim "The care is unnecessary," "The care is palliative," "The care is hindering your progress," "The care is actually causing you additional injury," etc. These misleading and inaccurate statements are encountered so frequently that many Chiropractors feel that certain medical (I.M.E.) doctors have ONLY these findings programmed into their word processors!

Chiropractors have complained about the situation for many years. On August 27, 1987, the United States District Court in Chicago found the American Medical Association, American College of Surgeons, and the American College of Radiology guilty of conspiring to destroy the nations' Chiropractic practice.

In view of this court decision, it is apparent that there may be more to the I.M.E. situation than meets the eye!

RECOMMENDATION: Require that each licensed health care profession perform its' OWN I.M.E.'s.

Sincerely,

IRELAND CLINIC OF CHIROPRACTIC, A.P.C.

Trevor V. Ireland

Trevor V. Ireland, D.C., F.I.C.A., F.P.C.W., F.P.C.A.

TVI/mli

PLEASE NOTE: Additional information available upon request. Please refer to "Information Package" forwarded to you dated February 28, 1988.

PLACE EMPHASIS ON PREVENTION (SAFETY PROGRAM). H 20% REDUCTION IN PREMIUM IS POSSIBLE! (SEE "REBATE" BELOW.)

Firm finds safety cuts workers' comp fee

By Harry McFarland
Times Business Writer

The owner of a Homer construction firm, a $110,000 rebate check from his insurer in hand, believes safety programs may be a partial answer to lowering the workers' compensation insurance crisis in Alaska.

"It's not uncommon to receive a rebate," Tony Neal, president of Neal & Company, said Saturday. "It is uncommon to receive such a large check."

Neal credits his insurance agent, Doug Vincent of Corroon & Black, and his insurer, Industrial Indemnity, for helping design the safety program that has helped reduce annual premiums.

Workers' comp pays medical, rehabilitation and compensation costs to employees injured on the job. The benefits package is specified by state law but provided by private insurers, whose policies are reviewed by the Alaska Division of Insurance. All employers must carry the coverage.

Neal's annual workers' compensation bill for 250 employees totaled $500,000, he said, but the company, which was established in 1974, had no accidents. Neal started negotiating to lower premiums for his company, which has branch offices in Anchorage and Guam.

Working with Vincent and Industrial Indemnity, Neal's company added a safety engineer to oversee an accident prevention program. And when the Industrial Indemnity representative re-

See Safety, page B-8

Safety: Pays off

Continued from page B-6

commends procedural changes, Neal said the company complies.

With the two years of rebate checks, he ultimately subtracted $170,000 — $110,000 for 1987 and $60,000 for the previous year — from his firm's operating costs.

"A lot of the credit should go to Industrial Indemnity," Neal said. "They pay a lot of attention to safety when a lot of insurance companies don't."

Currently, the legislature is considering a measure aimed at lowering insurance premiums, which have skyrocketed 42 percent the past two years. Experts say the higher premiums can be blamed on high medical expenses, permanent and partial disability payment policies, vocational rehabilitation that ends up in confrontation and litigation and stress at the workplace as well as an insurance industry that pays more attention to the premiums that it does lowering accident rates.

Among the proposals in the legislature are lowered weekly benefits for claimants living outside Alaska and taking steps to stop "doctor shopping" by workers looking for the medical opinion they want to hear. The legislation also proposes lowering the maximum benefit.

> NOTE.

WCCA

For Release October 14, 1987

Contact: Steve Haag
344-1577

ALASKAN BUSINESSES FACE 25 PERCENT INCREASE IN WORKERS' COMPENSATION INSURANCE RATES

Alaskan businesses will be faced with an average 25 percent rate increase in the cost of workers' compensation insurance effective January 1, 1988, according to the director of the state Division of Insurance, John George. George made the announcement at a recent seminar sponsored by the Workers' Compensation Committee of Alaska.

Employers are required by law to carry workers' compensation insurance to pay for the medical costs and lost wages incurred by employees who are injured on the job. Employees do not contribute toward the cost of the insurance.

"Based on the paid loss method of determining what the workers' compensation rate increase will be effective January 1, 1988, the average will be an increase of 25.1 percent. That's not good news," George said.

The 1988 average rate is almost double the 1987 rate increase of 14.3 percent. In 1987 industries such as construction, manufacturing and oil and gas experienced increases of almost 40 percent. George says the continuing increases are founded in losses via claims incurred by insurance companies.

- more -

Workers' Compensation Committee of Alaska, Inc., 11401 Olive, Anchorage, AK 99515
(907) 344-1577

"Payrolls have been going down in Alaska for the last few years. One would expect that the losses incurred by carriers would also be going down," George said. The opposite is true.

George noted that workers' compensation claims totalled $70 million in 1983, $89 million in 1984, $124 million in 1985 and $150 million in 1986 despite a decreasing payroll base.

He said the rate hike this coming year could have been even higher since one method of calculating rates showed Alaska facing a 58 percent increase. "We insisted the national rating company use the method that came up with the lowest increase," George stated.

He added that the Division of Insurance ran its own calculations and predicted a 25-30 percent rate hike was legitimate. "We're fairly confident that the 25.1 percent is a legitimate number. It is an unfortunate number," George said.

Steve Haag, President of the Workers' Compensation Committee of Alaska, said the rate increase is bad news for Alaskan businesses already impacted by slow economic growth. "Without a doubt I can say some of the businesses here today will not be here several months from now and the skyrocketing insurance rates will be a major cause of that," Haag said.

George agreed that the rate hikes will have a negative impact on Alaskan employers and employees. "We recognize the problem it is causing employers and employees. We recognize it makes Alaskan employers non-competitive with employers in other states who come up and do the work with an all-states endorsement on their policy," George stated.

- more -

George encouraged employers and employees to examine the factors that affect rates to determine if the benefits are appropriate and if employers can legitimately afford to pay the cost of those benefits.

"I don't think anyone wants to deprive a truly injured worker of his due benefits," George stated, "Yet we're getting to a point where employers just can't afford to keep paying, insurers can't afford to keep selling insurance if they can't charge an adequate rate and we end up at a place where you can't have a business in Alaska employing people."

WCCA reorganized last winter after the 1987 rate increases were announced. The organization is currently examining all aspects of workers' compensation law in an effort to prepare a reform package for the legislature in 1988.

"I think this group is doing a good job of looking at the things that go into making up the losses to see if there are appropriate adjustments," George said. "I think it's outstanding that we finally have gotten the employers and employees together to do this."

George said the Division of Insurance would hold two public hearings in Anchorage on the rate increases. They will be at the Loussac library from 1-4 p.m. and 7-10 p.m. Friday, October 23.

# # # #

WCCA

For Release
October 23, 1987

Contact: Steve Haag
344-1577

1988 Workers' Compensation Increases Hardest on Oil and Gas Industry

The oil and gas industry can expect workers' compensation insurance premium increases of as much as 68 percent beginning January 1, 1988 according to State Division of Insurance Deputy Director Don Koch. Koch unveiled the official increases during two public presentations Thursday in Anchorage.

The average rate increase for all businesses will be about 25 percent with ranges depending on the specific type of business. Rates are broken into four general classes with the following average and range increases:

	Average	Range
Oil and Gas	43%	18% to 68%
Contracting	29%	4% to 54%
Manufacturing	10.5%	-14% to +36%
All Other	17.6%	-7% to +43%

The rate hikes will mean Alaskan businesses will pay about $38 million more in 1988 for workers' compensation insurance.

"This filing could not have come at a worse time," Koch said while warning there may be more bad news in future years if the system remains unchanged. "I have a suspicion these rates will still be somewhat inadequate. The filing we had last year was absolutely deficient."

Koch referred to the fact that workers' compensation losses have more than doubled in the past four years, from $71 million in 1983 to over $150 million in 1986 despite a drop in overall state payroll to pre-1982 levels.

The rate increase is the result of an analysis conducted by the National Council on Compensation Insurance, an organization responsible for analyzing insurance rates in 32 states. NCCI actuary Mark Mulvanney explained that much of the rate increase came from workers' compensation claim experience in the past few years.

Between 1979 and and 1986 wages in Alaska rose about 30 percent while hospital costs escalated 80 percent and other medical service costs skyrocketed 90 percent. The most recent year analyzed, 1986, showed medical costs inflated by 6.8% while indemnity payments showed an inflation rate of 30.2%. Indemnity costs include payment of wages while recovering from an injury.

"The new experience figures that came in were a lot worse than past years. "We are seeing basically the same numbers and types injuries but paying more for lost time and wages. A lot of that has to do with the change in the economy in 1986," Mulvanney explained.

While not formally adopted by the Division of Insurance, Koch said he recommended that the Director of Insurance accept the rates as adequate and not excessive nor discriminatory.

Koch explained the Division only reviews the rates to determine if they are adequate under the current benefit system which is administered by the Division of Workers' Compensation. The House of Representatives Labor and Commerce Committee has planned a public hearing in Anchorage for November 12 to review the entire workers' compensation system and statutes. # # #

WCCA

For Release
January 11, 1988

Contact: Steve Haag
344-1577

WORKERS' COMP BILL INTRODUCED TO LEGISLATURE

Legislation designed to reform Alaska's costly and inefficient workers' compensation system will be introduced to the 1988 Legislature this week. After more than a year's work, the legislation was finalized by a joint labor-management task force. The legislation will be introduced in both the House and Senate by the Labor and Commerce Committees.

WCCA President Steve Haag calls the bill one of the most important pieces of legislation lawmakers will address this session. "With our current economy, every legitimate step to protect businesses and jobs must be taken. Passage of this bill as it exists, will save hundreds of jobs that will otherwise be lost due to skyrocketing insurance rates," Haag says.

Workers' compensation insurance rates increased by an average 25 percent effective January 1 with some industries seeing rates jump by as much as 68 percent.

The proposed legislation makes substantial changes in statutes regarding vocational rehabilitation services. It also places limits on how often doctors may be consulted by a claimant without an independent medical examination. Limits on charges for medical services would also be imposed.

- more -

The proposed legislation would reduce the maximum weekly compensation benefits while increasing the minimum weekly benefits. Under the new law, benefits could be readjusted if a claimant moved outside the state to an area with a lower cost of living.

Haag says the bill strikes a delicate balance between the needs of employers and employees. "I'm hopeful the legislature will pass this bill with little amendment as it represents a year's worth of negotiation and compromise. Any major change to the bill will affect one side substantially and that could jeopardize cooperative support that has been generated from both sides," Haag says.

Legislative hearings have been scheduled on the bill for January 19 and 21 in Juneau and January 29 and February 12 in Anchorage.

House Labor and Commerce Committee Chairman Dave Donley, D-Anchorage, says the legislation needs to be viewed as a jobs bill. "Employers are having to lay off employees, in part, because of the high compensation rates and claims they have to pay. This is one area where the legislature can make a positive impact on the job situation in Alaska without spending more money," Donley notes.

Senate Labor and Commerce Committee Chairman Tim Kelly says legislative action on the issue could be swift. "There's enough momentum so I think there will be a bill passed early in the session," Kelly says. # # # #

Note: A summary of the proposed legislation is attached FYI.

WCCA

Workers' Comp Reform
Management Perspective

by Steve Rhenberg

Workers' Comp Reform: An Employer's Perspective

For employers in Alaska, workers' compensation reform is not an issue of insurance but an issue of survival. Skyrocketing premiums for workers' compensation insurance have forced many Alaskan businesses to close causing a loss of jobs for Alaskan workers.

Within a two year period, Alaskan employers were subjected to an increase in workers' compensation premiums in excess of 42 percent and the State Division of Insurance indicates those increases were substantially inadequate.

For the past fifteen months, individuals representing Alaskan employers and labor unions met as a combined labor-management task force to study and recommend changes in the workers' compensation statutes. The goal of the task force was to reduce the cost of workers' compensation in Alaska but not at the expense of the injured worker. The result of the task force work is the legislation now being debated.

Workers' Compensation Committee of Alaska, Inc., 11401 Olive, Anchorage, AK 99515
(907) 344-1577

As a management representative to the task force and an Alaskan employer, I believe the proposed legislation will result in at least a 15 percent cost reduction within a short period of time. The reduction will come from control of medical costs, limiting vocational rehabilitation services and reduced litigation. Additional savings will come from limitations placed on stress related claims, reduction in the maximum weekly benefit from 200 percent of the average weekly wage and scheduling awards for all injuries.

In 1983 medical costs represented 25 percent of a $70 million in claims. In 1986 medical costs represented 38 percent of $150 million in claims. Currently there is no limit to what medical providers can charge for services. Our proposal limits medical charges to usual, customary and reasonable fees, similar to controls used in medical insurance plans.

Medical providers would be required to establish a written plan for treatments of a multiple or continuing nature. However, the proposed legislation does not limit treatment when proven to promote recovery.

To reduce "medical opinion shopping", employers would have to agree to a change in medical provider if an injured worker changes more than once. The bill proposes a cost-effective, unbiased method to settle medical disputes which currently result in lengthy and costly litigation.

Both management and labor strongly endorsed a voluntary vocational rehabilitation program that provides effective and efficient services to the worker.

The proposed legislation establishes guidelines for service providers and employer and employee responsibilities. Rehabilitation specialists would be required to prepare written plans establishing reasonable occupational goals that meet the mental and physical capabilities of the injured worker. The plan would need agreement from both employee and employer.

Rehabilitation plans would be limited to 2 years and a maximum cost of $10,000. Plan disputes would be settled by the workers' compensation board.

The bill proposes that compensation benefits be increased for major disabilities but also places a cap on awards for necks and backs, awards which now are litigated to extremes.

Temporary total disability payments would be limited to the sooner of when the injured worker is deemed medically stable or two years. Temporary partial disability benefits would end at the time of medical stability except as provided for in a rehabilitation plan. The goal of management and labor in establishing limits on benefits is to create an incentive for a worker to return to work or to seek alternative training rather than lingering in the system.

An estimated thirty percent of workers' comp recipients reside outside the state but collect benefits based on Alaska's cost of living. The proposed bill would adjust benefits for those recipients based upon differences in the cost of living between Alaska and the "lower 48."

Included within the bill are provisions to bar an employee from collecting benefits under a workers' compensation claim if the employee had, knowingly and willfully, falsely represented his physical condition prior to employment. Other provisions provide that am employee claiming stress as a work related injury must be able to prove that such stress was extraordinary and unusual for the employment situation.

A major consensus of both labor and management is that the courts should not construe workers' comp laws in favor of either party but should be fair and decide cases on their individual merits and within the limits of statutes.

The major asset of any Alaskan business is its employees. When an employee becomes injured through a work related accident, immediate and adequate medical treatment should be provided as well as adequate compensation for lost wages while the employee is unable to work. The legislation now before the State Senate and House will ensure that this continues while, at the same time, making the system affordable and thereby helping employers provide the jobs on which labor depends.

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WCCA

Workers' Comp Reform
Labor Perspective

by Robert Anders

Workers' Comp Reform: An Employee's Perspective

Workers' compensation should be exactly what those two words describe. It is not lawyer, doctor, chiropractor or vocational rehabilitation compensation. The system was designed to compensate an injured worker for lost time and wages and to help return an employee back to productive work. In Alaska, that system is failing.

Realizing that Alaskan employers pay an extremely high rate for workers' comp coverage, labor representatives worked cooperatively with management to search for ways to lower the cost of insurance for employers while improving the system for injured workers. The proposed bill before the legislature accomplishes that goal.

The process followed in preparing the current proposal was one of give and take. Both sides brought their specific goals and issues to the table and negotiations over very sensitive issues became strained at points.

The end result has proven what the real meaning of labor-management cooperation is all about. Working together to solve problems and improve the system for both in the process has truly resulted in a win-win situation for labor and management.

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Workers' Compensation Committee of Alaska, Inc., 11401 Olive, Anchorage, AK 99515
(907) 344-1577

From labor's perspective the bill provides many benefits. The minimum weekly benefit will be raised from $110 to $154 while the maximum will be dropped from $1100 to $700. Labor feels this is necessary to better provide for individuals at the low end of the scale.

Out of 365 permanent partial disability cases in 1985, only 11 were able to claim over $700 per week. The vast majority of cases come at the low end. By raising minimums we will be able to provide assistance for those who most need it. The bill will also authorize vested pension and profit sharing benefits to be included when determining an average weekly wage.

The changes proposed in the permanent partial disability rating structure will significantly increase payments to the more severly injured workers while putting reasonable time limits on the length of time some benefits may be paid.

Employer disputes over who is responsible to pay claims can cost an employee their life savings, home and possessions. The proposed legislation would reduce the effects of those disputes on the worker by requiring the last employer of a worker to pay claims until a dispute is resolved. This will ensure worker's that they are quickly and adequately compensated.

The bill would prohibit discrimination against workers who have filed workers' compensation claims.

Vocational rehabilitation was an area labor and management both felt was necessary to change. The bill would make acceptance of rehabilitation services voluntary rather than mandatory.

First, under the present system it's estimated that many of those who enter a rehabilitation plan return to their prior occupation or an occupation of their choosing as is evidenced by the fact that 90 percent of all compromise and release agreements waive vocational rehabilitation.

Second, when carriers control a mandatory rehabilitation system that's tied to the claims process, as is done now, there are abuses on both sides and a lack of trust which results in program failure.

Labor supports a voluntary program which takes service provider selection away from the carriers and removes it from the claims process. The end result should be more cooperation from the injured worker and those providing rehabilitation services, less litigation and lower costs.

The injured worker will have control over the rehabilitation plan along with a quick method to resolve disputes over how the plan is carried out.

Labor agreed with management that language to prevent an avalanche of stress claims is necessary. This bill would provide adequate guidelines necessary to make these determinations. Without this preventative measure, we're going to see the floodgates to stress claims open causing further rate hikes and lost jobs.

Labor also supports denial of benefits to an employee who knowingly misrepresents his physical condition prior to employment. If an employee withholds information, he could be endangering himself or others since it's not known what duties that employee may be required to perform.

Labor's belief in supporting these and other changes is that a greater portion of worker compensation dollars will be directly allocated to injured workers while providing for a cost effective, equitable program which provides incentive for injured workers to return to work.

As expected, some attorneys and members of the medical profession have criticized our efforts because we focused our concerns on the litigation and disputes that are presently built into the system. I would hope that reasonable minds would put concerns for injured workers ahead of vested financial interests such as those which are held by the critics of our efforts.

In proposing the changes now before legislators, both labor and management realized some major issues are yet to be addressed. Both parties agree the process to reform the current system must continue. The complexity of the issue will require our cooperative, ongoing effort in the years ahead but we are off to a positive beginning.

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WCCA

For Immediate Release
March 2, 1988

Contact: Steve Haag
344-1577

1989 WORKERS' COMP RATE INCREASES PREDICTED

The Alaska Division of Insurance and independent actuaries expect insurance companies to request substantial workers' compensation insurance premium increases again in 1989 unless legislation now before the Alaska House and Senate is passed this session.

Workers' comp rates increased an average 25 percent in 1988 with some industries being hit with increases as high as 68 percent. The 1988 rates followed a 1987 rate hike which averaged over 14 percent.

Division of Insurance Special Deputy Don Koch says the 1988 rate increase, as large as it was, was about 8 percent deficient. Koch says passage of the bill could eliminate the need for a rate increase in 1989.

"If the language in the bill is correct and the intent is followed, the bill could have a substantial effect on rates in the long run and an immediate effect on stabilizing rates," according to Koch.

Without passage of the bill, rates can be expected to rise significantly according to the independent actuarial firm Milliman and Roberston.

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M and R was retained by the State Division of Insurance to assess premium cost impacts of proposed legislation and to recommend changes which would result in additional cost savings for employers.

M & R spokesman Mike McMurray says 1989 rates can be expected to increase unless the current legislation is passed. "An increase of 10 percent or more would not be unexpected," McMurray says.

M & R's recent report on the proposed bill stated, "In general, we believe the proposed revisions to the Alaska workers' compensation law will improve the benefit delivery system. Changes such as the proposed reduction in the average weekly benefit maximum, reduction of benefits for out of state claimants and limits on duration of temporary benefits will almost certainly reduce costs."

Workers' compensation losses have more than doubled in the past four years, from $71 million in 1983 to over $150 million in 1986 despite a drop in overall state payroll to pre-1982 levels. The 1988 rate hike is expected to result in Alaskan businesses paying about $38 million more than paid in 1987 for workers' compensation insurance.

Proposals now being considered by the legislature were drafted by a statewide labor-management task force which conducted 15 months of research into Alaska's workers' compensation system. The legislation, which has garnered broad support from organized labor and employers statewide, has passed the Senate and awaits action in the House.

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WCCA

For Immediate Release
March 8, 1988

Contact: John Lewis
(305) 443-8111

NATIONAL WORKERS' COMPENSATION EXPERT PROMOTES CHANGES IN ALASKA'S SYSTEM

Solutions which have worked in other states to reduce the cost of workers' compensation insurance will also work in Alaska. That's the opinion of John Lewis, a nationally recognized expert in the field of workers' compensation.

Lewis has practiced as a trial lawyer for 15 years. He has devoted the last 8 years exclusively as a workers' compensation law consultant representing both management and labor clients. Lewis assisted a statewide management-labor task force in preparing reform proposals now before the Alaska legislature. He has been involved with Alaska's workers' compensation system for 6 years.

In the past two years Alaskan employers have been burdened by a 42 percent increase in the cost of workers' compensation insurance. An additional major increase is expected in 1989 unless the legislature passes reform measures this session.

Lewis says problems with the system being identified in Alaska are similar to problems experienced in other states.

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"Twenty years ago it was not a terribly important cost item in any state. It also meant that many injured workers were not getting what they needed in terms of benefit support. Now it's expensive in many cases. You couple that cost with what's gone on in the economy and suddenly people are paying attention," Lewis says.

Labor and management working together to solve workers' comp problems in not unique to Alaska. "It's a joint issue in many jurisdictions. Employers obviously perceive workers' comp as a cost but so do employees and labor representatives," Lewis says.

"As an employer, when your paying 20 dollars per hundred in workers' comp costs, that affects wages so that employees pay those costs just as much as employers do. All of a sudden we have labor concerned about wages and jobs and all the things affected by workers' comp premiums."

Lewis is highly critical of Alaska Supreme Court decisions which he says have increased the cost of the system by misinterpreting what the system was designed to provide.

"They have come down with more earth shattering decisions than any other court that I'm aware of. They tear the fabric of the system apart more often than most Supreme Courts," Lewis says.

"The frustrating part is that they are using a statute that's 80 years old and which has been used across the country and they come to totally contrary decisions as compared to states with history."

In contrast, Lewis says efforts of a statewide ad hoc labor-management task force to reform Alaska's system have been productive and have targeted the same issues addressed in other states.

Among those issues are medical costs. Lewis says placing reasonable limits on medical costs is one action many people believe offers a tremendous opportunity for cost savings without negatively impacting on injured workers in terms of benefit duration or the quality of medical care received.

Medical costs represent 30-50 percent of all workers' comp costs according to Lewis.

"In every other area there are lots of medical cost containment activities going on. Workers' comp is viewed as one of the last bastions of fee for service medicine."

"The doctor says how much you're going to pay and how long you're going to pay it. There's very little out there that permits anyone to control what goes on in the delivery of medical benefits," Lewis says.

Proposals before the Alaska legislature would impose a limit of "usual, customary and reasonable" limits on what doctors could charge workers' comp recipients similar to what is allowed under medical insurance plans.

Another major area where Lewis feels Alaska can improve benefit delivery to injured workers while cutting employer costs is in the delivery of vocational rehabilitation services.

Lewis says vocational rehabilitation services are relatively new to the workers' comp systems nationwide. "Until ten years ago there was virtually no significant vocational rehabilitation activity in any jurisdiction."

"When it was put into place in Alaska in 1982, it was not met with open arms. Now you hear people say it is the heart and sole of the system," according to Lewis.

While he says there are less than a dozen states that provide substantial amounts of vocational rehabilitation in their systems, he adds that the states with the most experience are abandoning it or changing it significantly.

"They are finding it's extremely difficult to make rehabilitation work within the context of a workers' comp system, particularly one where things are resolved on the basis of litigation," Lewis says.

Lewis notes there is a great deal of cynicism about vocational rehabilitation in the states that have had major programs. "Many of the parties are willing to simply walk away from it. In most workers' comp systems there is simply no incentive to make vocational rehabilitation work."

Lewis claims there are states that have no rehabilitation programs that appear to have just as good return to work results as states that have very active rehabilitation systems.

As an example Lewis points to California, the first state that made a major attempt to put in a significant vocational rehabilitation system. Initial estimates stated it would cost 3-5 percent of total system cost.

It now consumes 15% of total system cost. Lewis says there is virtually no evidence proving more people are returning to work as a result of that program compared to no program at all.

"What we are seeing in other jurisdictions is that we have to get back to basics and provide a small amount of rehabilitation in serious cases first and then provide it in other cases as we make the small system work first. That is the approach I'm seeing in other states," Lewis says.

The bill before the Alaska legislature significantly changes the philosophy of rehabilitation services making the system voluntary for an injured worker rather than mandatory. The bill places limits on how long and at what cost services may be provided.

"I think under the Alaska proposals there will be major inroads into vocational rehabilitation in terms of getting it to the people who need it and eliminating from the system the people who are just using it as a way to stay out of work longer," Lewis says.

One of the latest developments in workers' comp are stress claims. Legislation being considered in Alaska would place limits on when stress related claims could be filed. Lewis says such limits are being imposed in other states and are necessary to prevent the workers' comp system from self-destructing.