ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672
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very important in view of the not statistically significant finding that those who returned to work took an average $123.53 per week cut in pay. The resulting $28,180 annual wage is only 2% less than the average for all workers in Alaska. Therefore, even if this decrease in income should be proven true when larger numbers of injured workers are sampled, after return to work they are still doing as well as the average worker in Alaska.

Back injuries are normally the single largest type of on the job injury; however, Alaskan workers may have a greater proportion (58%) than the U.S. as a whole. According to the National Safety Council (Hoskin, et al., 1984), nation-wide back injuries account for less than 29% of job related injuries. However, these are all injuries, not just the serious ones. On the other hand, in our study of individual long term disability (LTD) claimants, we found that back injuries accounted for 20% of all worker disabilities (Hester & Decelles, 1985). These disabilities include acute and progressive illness as well as all injuries. Further analysis of the data in our LTD study revealed that back injuries accounted for 56% of all injuries, whether on or off the job. Therefore, it is likely that while back injuries represent about one-fourth of all on-the-job injuries, they are one-half of the

serious injuries, in which case the Alaska experience is no different from the rest of the country.

In view of the high percentage of back injuries among the WC clients served, there was a surprising lack of job modification and back care training being provided. Obviously, job modification is only possible when agreed to by the employer. However, the rehabilitation specialists may not be bringing this possibility to the employers attention as often as could be done. In an unpublished survey of National Safety Council members, we found that only about one-fourth (26%) of the employers consider this a means of returning a disabled employee to work. However, in a study of PWI programs we found that when placement specialists suggested the possibility to employers they generally agreed to try it and were delighted with the results (Hester & Stone, 1984).

The 58% success rate for return to work seems commendable, however, we do not have any real comparative data. In a study of individual LTD claimants who were provided rehabilitation services, we found a 69% rate of return (Hester, Decelles, & Gaddis, 1986). There is no significant difference between these two results (X^2 = 1.33, 1 df.).

Due to the large number of cases where the carrier requested closure, we took a closer look at the reasons for that request. In over one-half (53%) of the cases, the carrier had requested provision of a specific service, such as, job analysis or labor market survey. Upon completion of that service, the case was closed.

It was distressing to find that carriers in Alaska are generally waiting until the person is considered medically stable before making the rehabilitation referral. This undoubtedly contributes to the fact that the average time from ~~referral~~ injury to closure in Alaska is 2.4 years, which is almost identical to the 2.3 yrs. found in a study of California WC cases (California Workers' Compensation Institute, 1985). However, were referrals to be made earlier, it is reasonable to assume that success would be improved and the amount of time from injury to closure would be shortened.

E. REFERENCES

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Hoskin, A., et al. (1984). Accident facts: 1984 edition, Chicago: National Safety Council.

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APPENDIX

Wage after return to work: If the client is receiving a monthly salary divide by 4.3 to convert it to weekly. For an hourly wage, multiply by the number of hours per week or see the attached hourly wage table. If you don't know the number of hours per week, use 40 hours for full-time and 20 hours for part-time and write "? hrs" after the word "week." If the client receives other type of remuneration in addition to the regular wage, put "+ (name of benefit)" after the word week, e.g., "+ tips" or "+ meals." In the case of tips or commissions if you were told what they should average per month, enter that after the words "tips" or "commissions." In the event that the client is working only for commission, put in the average commission per week the client should earn and then after the word "week" write "commission only."

Was there a limit on the amount of time this payment would be made: For Workers' Compensation use the statutory limit less the time the client had received WC payments. For LTD, use the policy limit less the time the client received benefits. For those LTD policies which pay until the claimant reaches a specified age, such as 65, please calculate the number of years based on the client's age at time of placement.

Estimated cost of services provided by others: Include only those services which you recommended or you felt were important to the rehabilitation of the client even though they were provided before the case was referred to you. Do not include hospitalization or strictly medical costs.

Comments: Use the back of Page 3 for any comments you have on the case. If you need to include more information on any question than the space provided allows, asterisk the question and put your explanation on the back of Page 3. If you just have general comments on the case, be sure to put "over" on the bottom of Page 3.

Occupation: The person's last job title.

Spouse employed: At the time of referral, if your records do not contain this information put in a "?."

Employer type: For the purpose of this study a "Major Corp" is one that employs hundreds of employees at the site where the client worked or in the same area. "Self"" means self-employed. If the client was employed by a governmental or quasi-government agency or service, check "Public." This includes school systems, Post Office, etc.

II. SERVICES INFORMATION

Date rehab plan submitted (if required): In addition to submission of a formal rehab plan also consider the submission of a report or letter to the referral source to be a rehab plan if it outlined a recommended summary course of action on the case.

Date rehab plan approved (if required): If a rehab plan was submitted but there was no need for an approval in order to proceed with services then write "N/A" after the space for the date. If the plan was not approved, write "Rejected" after the space for the date. If multiple approvals were needed in a specific case, use the date for the one which allowed you to proceed with services.

Services Provided For This Client: Put an X on the line next to those services provided by you or your company. The second line is for those services provided by another company or organization. If the service was provided by another organiation prior to your involvement, put a "P" on the center line rather than an "X."

III CLOSURE INFORMATION

Date case closed: This date must fall within the time period from which we requested closed cases for this survey.

Closure Status (check only one): Most are self-explanatory but for the following five statuses follow these instructions to insure uniformity in data collection.

Client Uncooperative or Refused Services: Use this status only when benefits continue in spite of the lack of cooperation. If the refusal was used as a basis for stopping benefits, then close as "Employable/Without Job."

Vocationally Non-Feasible: Use this status only on those cases where it was obvious that from a "skill" point of view the client was not employable given the functional limitations, and benefits continued.

Referral Source Requested Closure: Use this status only when the request for closure does not fit into any stated closure status, e.g. "Case Settled." Whenever this status is used, please indicate the reason given for the closure. If no reason was given to you, indicate that fact with a "?" on the line.

Employable/Without Job: Use this status when placement efforts up to the time of closure had not been successful or when the client was declared to be employable and benefits were stopped. Whenever this status is used, indicate if the disability benefits continued after closure.

Case Settled: Use this status only when the case was settled resulting in Vocational Rehabilitation services being terminated prematurely.

If the client is working, is it: ____Full-Time, ____Part-time: If the client was working part-time at the time the case was closed but expected eventually to work into a full-time position, put an "X" in part-time and put "to F-T" after the word "Part-Time."

NARPPS/Menninger Rehabilitation Study Data Collection Instructions

The Menninger Foundation, Attention: Edward J. Hester, Ph.D.,
Return To Work Center, 700 Jackson, 9th Floor, Topeka, Kansas 66603
913/233-2051

Please read these instructions carefully before beginning to fill out the case data collection form. We have only provided explanations for those items which we feel might be confusing or those requiring standardized definitions. Below we have provided information on those items in the order in which they appear on the data collection form. After reading the instructions if you have additional questions or concerns, please call Edward J. Hester, Ph.D. 913/233-2051.

I. CLIENT INFORMATION

Provider ID#: The identification number given to you by The Menninger Foundation for this study. All cases which you submit from one office should have the same Provider ID#.

Client ID#: Assign each case submitted a two-digit identification number. BEGIN WITH 01. Please keep a list of the numbers and names on the attached study summary sheet so that if we need to check back with you on a case you will know which case it is.

Type of referral source: Who referred the case to you.

Employment: If the client worked in a major city, there is no need to record the county.

Types of support: Check all the types of disability support that you are aware the client received during the time you provided services.

Total amount of disability support: The total amount of money per week the client received from all of the above sources. (If payment was in the form of a monthly check, divide the amount by 4.3 to get the weekly equivalent), or see the attached hourly wage table.

Education: The actual number of years but for high school grad and higher use the following:

High School Grad or GED	12 years
Associate or Trade School	14 years
Bachelors	16 years
Masters	18 years
Ph.D., M.D., Ed.D., etc.	21 years

Reading G.L., if known: If the client was given a reading test please record the grade level.

English speaking: "Marginal" means that the client can understand simple verbal instructions.

Date of inability to work: Date that the client left his or her job because of a disabling condition. Record month, date, and year in that sequence.

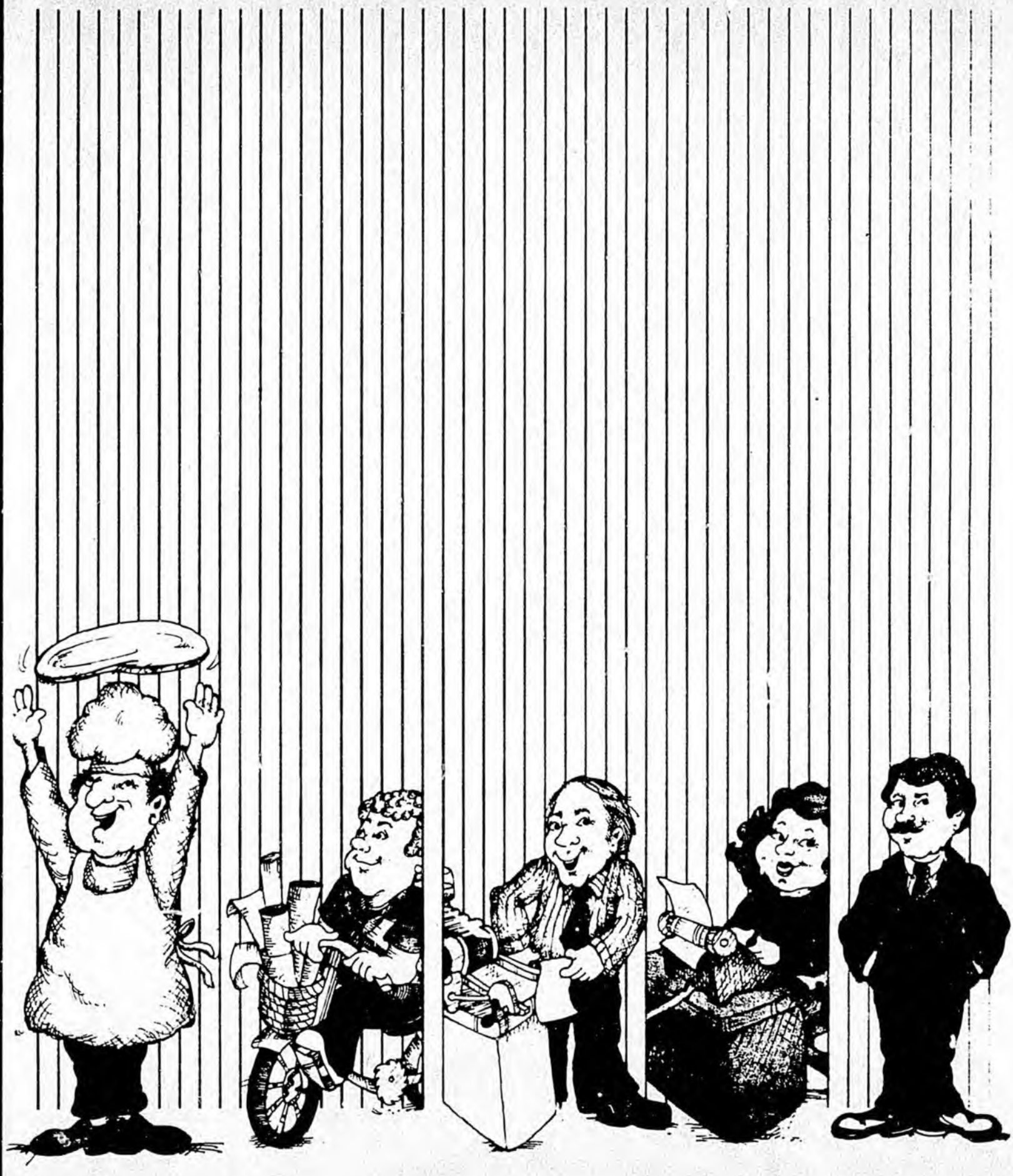
Date medically stable: Date that the client reached maximum medical input (MMI) or was released for at least light work. If during the time you worked with the client, his or her disability did not stabilize nor was he or she medically released for light work, write "NO" after the place for the date. If you do not know the date put in a "?."

Primary disability: This is the "official" primary disability.

Onset: Date of injury or when illness was first observed.

National Council on Compensation Insurance

Classification is Fundamental to Workers' Compensation Pricing



National Council on Compensation Insurance

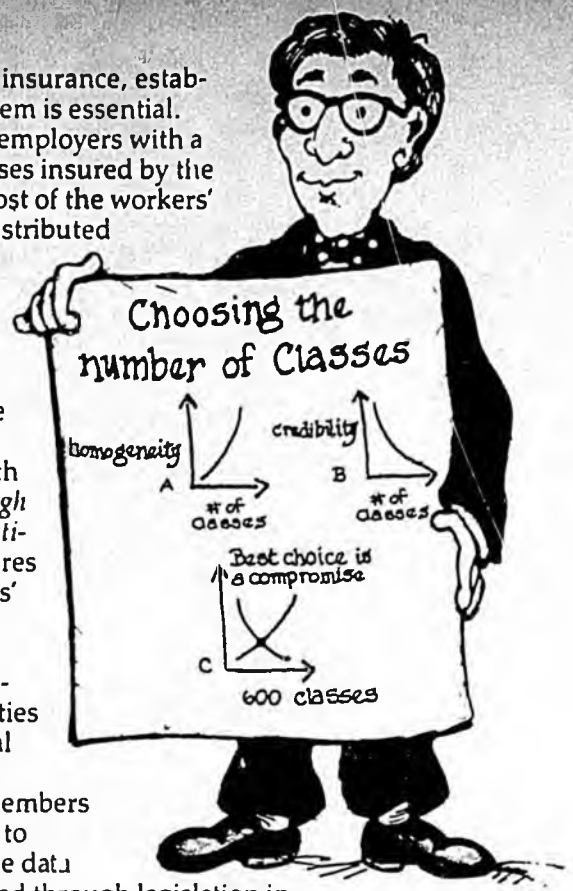
Classification is Fundamental to Workers' Compensation Pricing

Contents

Introduction

In workers' compensation insurance, establishing a classification system is essential. Each classification groups employers with a similar exposure to the losses insured by the policy so that the overall cost of the workers' compensation system is distributed fairly among the employers. Each classification is assigned a rate which is commensurate with its potential for loss.

To ensure an equitable distribution of costs, each classification should be both *homogeneous* and *large enough to provide a meaningful statistical base*. This, in turn, ensures the integrity of the workers' compensation data base, essential for the pricing, experience rating, law evaluation, and research activities undertaken by the National Council on Compensation Insurance (NCCI) for its members and subscribers. The need to preserve the integrity of the data base has been acknowledged through legislation in those states which have adopted competitive rating laws.



"...some industries are inherently more dangerous than others."

The need for classifications can be understood best by imagining a situation without them. With no classifications, a single average price would prevail, distributing the premium required to pay benefits equally among all insureds. This obviously would be inequitable because some industries are inherently more dangerous than others. Without classifications, the premium charge for high hazard industries would be insufficient, while premiums for low hazard industries would be excessive. In effect, the low hazard businesses would be subsidizing the high hazard ones. A classification system serves to distribute premium among employers in an equitable manner, consistent with statistically supportable differences in loss expectation among different kinds of businesses.

Once it has been determined that some form of classification system is necessary, the next step is deciding upon the proper number of classifications. Because all businesses are distinct, there is always some variation among them and, theoretically, all employers in a state could be arrayed in a continuous spectrum from the least to the most hazardous. Thus, the maximum possible number of classifications would be equal to the number of employers in the state, with one classification for each employer. However, few of these "classifications" would produce statistically reliable experience.

At the other extreme, as mentioned above, would be the single statewide classification producing one manual rate. Although the single rate would be a statistically reliable indicator of expected losses, it would produce an extremely inequitable distribution of premium.

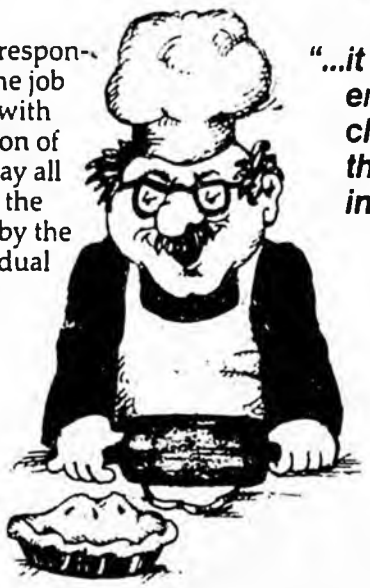
As opposed to these two impractical extremes, workers' compensation insurance uses approximately 600 industrial classifications. This system groups employers involved in the same kind of business. Generally, similar businesses have similar exposures to occupational injury and disease, even though no two businesses are identical.

The experience for each classification is tabulated and serves as the basis for the "manual rate" for that classification. The manual rate is the average price for all employers in the classification. In practice, it tends to produce the premium charge for smaller employers—typically, no more than 15 workers—while for larger employers, the manual premium (i.e., the premium produced by the application of the manual rates to total payroll of the insured) is subject to experience modification based upon the employer's own history of losses. The application of the experience modification can produce a premium higher or lower than the manual premium, depending upon the insured's experience. Other NCCI publications are available upon request explaining the theory and application of experience rating.

The object of the workers' compensation classification system is to group similar employers so that each classification reflects exposures common to them. Subject to certain exceptions to be discussed below, it is the business of the employer (the insured) within a state that is classified, and not the separate employments, occupations, or operations of individual employees within the business. Several reasons for this are:

1. A workers' compensation insurance policy agrees to pay "all compensation and other benefits required of the insured by the workmen's compensation law." Although the injured worker is the beneficiary of the policy, it is the business which is actually insured.

2. Workers' compensation laws hold the employer responsible for compensation benefits to workers injured on the job without any regard to fault. The law places the liability with the employer and the insurance contract, in consideration of payment of premium, obliges the insurance carrier to pay all compensation-related costs established by law. Because the employer's liability is covered, employers are classified by the business undertaken rather than by the duties of individual workers.



"...it is the business of the employer...that is classified, and not the...operations of individual employees..."

3. In addition to being consistent with the principles of workers' compensation insurance, this procedure promotes safety and loss prevention and reduces the expenses of administering the insurance program. By grouping employers in accordance with the nature of the business, each industry has the opportunity to control its own workers' compensation costs through industry-wide safety and loss prevention programs, such as those sponsored by industry trade associations. If such programs produce a lower frequency of accidents, that improved experience will tend to lower manual rates.

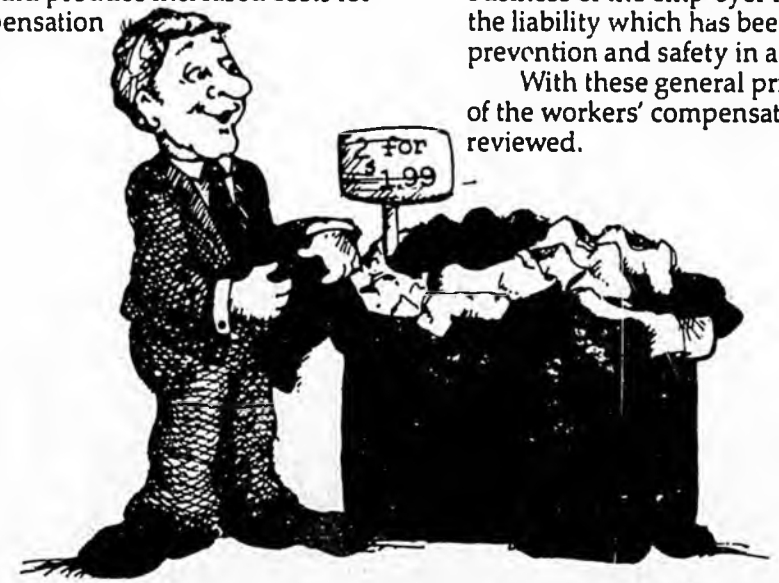
If, on the other hand, a classification system were based upon the individual duties of each employee, each classification would cut across industry lines, and a single industry's safety program, even if successful, would have little impact on its premium costs because it would affect only a small proportion of the total number of workers in the various categories and not alter rates significantly. Thus, classification by industry serves to promote loss prevention and on-the-job safety better than classification by individual occupation.

4. Under a system of classification by individual occupation, total losses would not be affected substantially, although there would be a redistribution of premium, with some employers paying more and others paying less. Such a classification system would almost certainly cause the costs of administering the insurance program to rise. Insurance carriers would be required to audit payroll more closely and to verify proper claim assignment. To enable the carriers to perform these more time consuming and costly audits, employers would be required to keep more extensive records. Not only would the additional record keeping be a source of valid complaint from employers, but a classification procedure based on individual employee duties could result in unfair discrimination between those employers maintaining proper records and those unwilling or unable to maintain them. Reviewing and resolving such complaints at all levels, as well as the increased audit, verification, and record keeping expenses for all parties, would produce increased costs for providing workers' compensation insurance protection.

"...similar businesses have similar exposures to occupational injury and disease, even though no two businesses are identical."

In summary, a classification system based upon the business of the employer has the dual advantage of reflecting the liability which has been insured, while encouraging loss prevention and safety in a cost effective manner.

With these general principles in mind, the evolution of the workers' compensation classification system will be reviewed.



Explanation of Classifications

All the classifications, with the exception of the Standard Exception classifications to be explained below, are called basic classifications. Each basic classification is assigned a four-digit code number. Basic classifications describe the business of the employer, such as:

Business	Classification	Code Number
Manufacture of a Product	Furniture Mfg.—Wood NOC*	2883
A Process	Engraving	4352
Construction or Erection	Carpentry NOC	5403
A General Type or Character of Business	Hardware Store	8010
A Service	Beauty Parlor	9586

*Not Otherwise Classified.

Classifications are listed alphabetically in the *Basic Manual for Workers' Compensation and Employers' Liability Insurance*. In some instances, explanatory footnotes follow the classification listing and these notes are considered part of that classification. There is also a *Classification Code Book* which lists all classifications in numerical order and arranges all classifications into 32 main industry divisions called schedules, which are subdivided into 133 smaller groups of classifications having similar characteristics. As will be explained below, the Code Book can be very helpful in determining a classification assignment because it groups industries with similar operational characteristics. In the numerical listing, all active classifications will be found, including classifications which apply in each state using the Basic Manual, "state specials" (classifications applicable in only one or a few states), and discontinued classifications, incorporating, in many instances, an indication of the classification to which the experience of the discontinued classification was assigned.

Standard Exceptions

Three occupations are common to so many businesses that special classifications have been established for them. These *Standard Exception* classifications cover clerical office and drafting employees; drivers, chauffeurs, and their helpers; and outside salespersons, collectors, and messengers. Employees covered by a standard exception classification are not included in a basic classification unless the basic classification language specifically includes them.

While the Basic Manual provides specific instruction for the use of the standard exception classifications, generally, clerical office or drafting employees are confined exclusively to office work in areas physically separated from other operations. Drivers, chauffeurs, and their helpers are engaged in duties in connection with a vehicle, including garage employees and those using bicycles. Outside salespersons, collectors, and messengers have their primary duties away from the employer's premises, but do not deliver merchandise.

General Inclusions

All of the basic classifications include certain operations which would be classified separately were they to be run as independent businesses. Such operations are called *General Inclusions* and include employee cafeteria operations, the manufacture of packing containers, medical facilities for employees, printing departments, and maintenance work. They are included in the scope of each classification because they are a routine part of most business operations.

General Exclusions

Just as some operations are general inclusions, other operations so exceptional that they are exclude the scope of the basic classifications. These *General E* include aircraft operation, new construction by the i employees, stevedoring, and saw mill operations.

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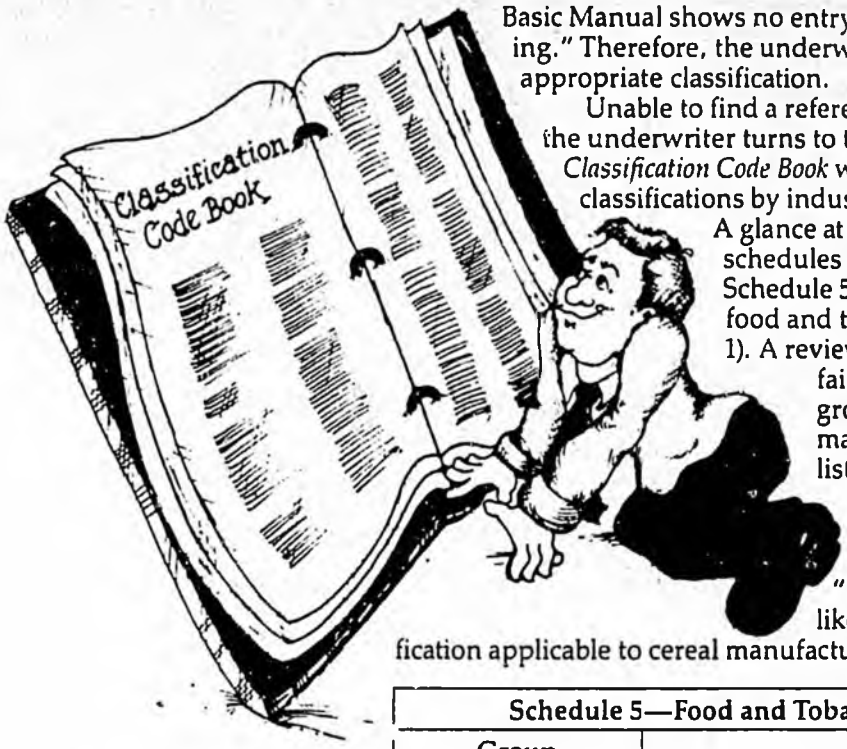
To summarize, insureds are assigned to classifications according to the principle of using the one classification that best describes the routine business of the employer, with the general inclusions, but excluding standard exception employees and general exclusion operations.

Classification Assignment

Having discussed the general theory of classification and the application of classifications, the approach followed by an underwriter or classifier in assigning a classification to an unfamiliar business will be described. Assume, for these purposes, that the insured is a small employer manufacturing corn flakes. A review of the classification pages of the Basic Manual shows no entry for "cereal manufacturing." Therefore, the underwriter must find the appropriate classification.



Unable to find a reference in the Basic Manual, the underwriter turns to the yellow pages in the *Classification Code Book* which lists the manual classifications by industry schedule and group. A glance at the index of industrial schedules narrows the search to Schedule 5, which applies to the food and tobacco industries (Step 1). A review of the 32 schedules fails to indicate any other group under which cereal manufacturing might be listed.

By reviewing the groups comprising Schedule 5, Group 050, "Baking" seems the most likely to include a classification applicable to cereal manufacturing (Step 2).

Schedule 5—Food and Tobacco Industries

Group Numbers	Industries
050	Baking
051	Grain, Sugar and Starch Products
052	Confections and Food Sundries
053	Dairy Products
054	Livestock Handling and Meat Products
055	Preserving and Canning
056	Brewing and Bottling
057	Tobacco

Group 051, which includes grain products, also would be considered, but the classifications in the group include beet sugar manufacturing, corn products, dextrine or starch manufacturing, grain milling and feed manufacturing, and sugar refining. These grain products are not similar to breakfast cereals so the possibilities have been narrowed to the baking group. This process of elimination is quickly accomplished, even for a person not familiar with the classifications, because it is easy to determine at a glance which schedules and groups are inappropriate.

The search has been narrowed to Group 050, which includes four classifications (Step 3).

Group 050—Baking	
Bakery & salespersons, route supervisors, drivers	2003
Breakfast Food Mfg	2016
Cracker Mfg	2001
Macaroni Mfg	2002

The proper classification is Code 2016, entitled "Breakfast Food Manufacturing." Thus, by the process of progressively narrowing the search, the proper classification for corn flake manufacturing has been found. Essentially, this is the procedure undertaken by the classifier or underwriter when determining the appropriate classification assignment for each employer at the time the policy is issued.

While the object of the workers' compensation classification procedure is to assign the one basic classification which best describes the business of an employer within a state, a single classification may not be sufficient. In such cases, procedures have been established to provide for the use of more than one classification as required. For example, different basic classifications may be assigned to separate legal entities insured under a single policy.

If more than one legal entity may be combined in a single policy because of common ownership, in most jurisdictions each enterprise would carry its own basic classification code. Multiple basic classifications also may be assigned in two other circumstances. In the first, a basic classification may require that certain operations or employees be rated separately. For example, Code 4299—"Playing Cards Mfg."—contains the footnote, "paper or cardboard mfg. to be separately rated as 4239." In the second instance, multiple basic classifications may be assigned to an employer who operates a secondary business within the state requiring the assignment of an additional basic classification.

For the assignment of additional basic classifications, all of the following conditions must exist. The secondary business either must be conducted as a separate enterprise or, in accordance with the classification phraseology of the principal classification, it must be treated as a separate enterprise. Separate payroll records must be maintained and each business must be separated physically. Finally, the assignment of a separate classification must not be prohibited by any classification otherwise assigned to the policy.

While the general classification principle is to group similar businesses to produce a fair and equitable manual rate, this approach is not practical in the building trades where contractors undertake different projects using several construction trades for varying periods of time until completion of the project.

In the construction and erection industry it is not possible to define employers having similar average work forces, so each distinct kind of construction or erection operation at the job site is assigned to the classification specifically describing the trade, provided that separate records of payroll are maintained. For small specialty contractors, such as plumbers or electricians, this procedure produces the same result as is the case in non-contracting businesses—a single classification for the entire business. For larger general contractors using different trades during different phases of the project, the classification procedure produces multiple classifications on the policy and develops a manual premium weighted by the distribution of employee work in the several trades.

Because loss prevention and safety programs are developed generally for specific trades and skills, this classification approach for construction and erection incorporates the same safety incentive as the classification by industry for other kinds of businesses.

Classification Dynamics

The theory of classification has been reviewed and workers' compensation classification applications have been explained briefly. While insurance and classification theory require the grouping of like or similar employers with common expectations of losses, it would be a mistake to assume that the classification structure is a rigid, unchanging system in which square pegs are forever being forced into round holes.

There are two important ways in which the classifications used for workers' compensation are continuously changing and evolving. Each classification combines the payroll and losses of similar employers to develop a price for the protection. Through invention, discovery, and innovation, industries are continually refining and upgrading their operating procedures. More efficient manufacturing machines are developed, automation is introduced, raw materials sometimes change, and better assembly methods are devised. Such changes, however, do not occur overnight. Some employers are quick to innovate, while others hesitate to change tried and true methods. Gradually, however, new processes replace old, and the means and materials of business operations change while the basic product remains the same.

When annual rate revisions are made, total state premium needs are distributed to individual classifications, based on the three latest years of payroll and losses. A new year of experience is added annually and the oldest year is discarded. As industry conditions evolve, reflecting modernization and better conditions, so the experience upon which the rate is based continually changes. While the classification describing an industry may not change, the experience for that industry is continually changing and tracking conditions within the industry, with the manual rates revised accordingly. One of the more common comments to the NCCI is that the classification language has not kept pace with the changes in industry nomenclature. The proverbial garbageman becomes a "sanitation engineer" and later a "solid waste manager," while the classification language still refers to garbage, ashes, or refuse collection. While classification language may not change as rapidly as fashion, the experience does change and reflects the use of newer equipment and operating techniques.

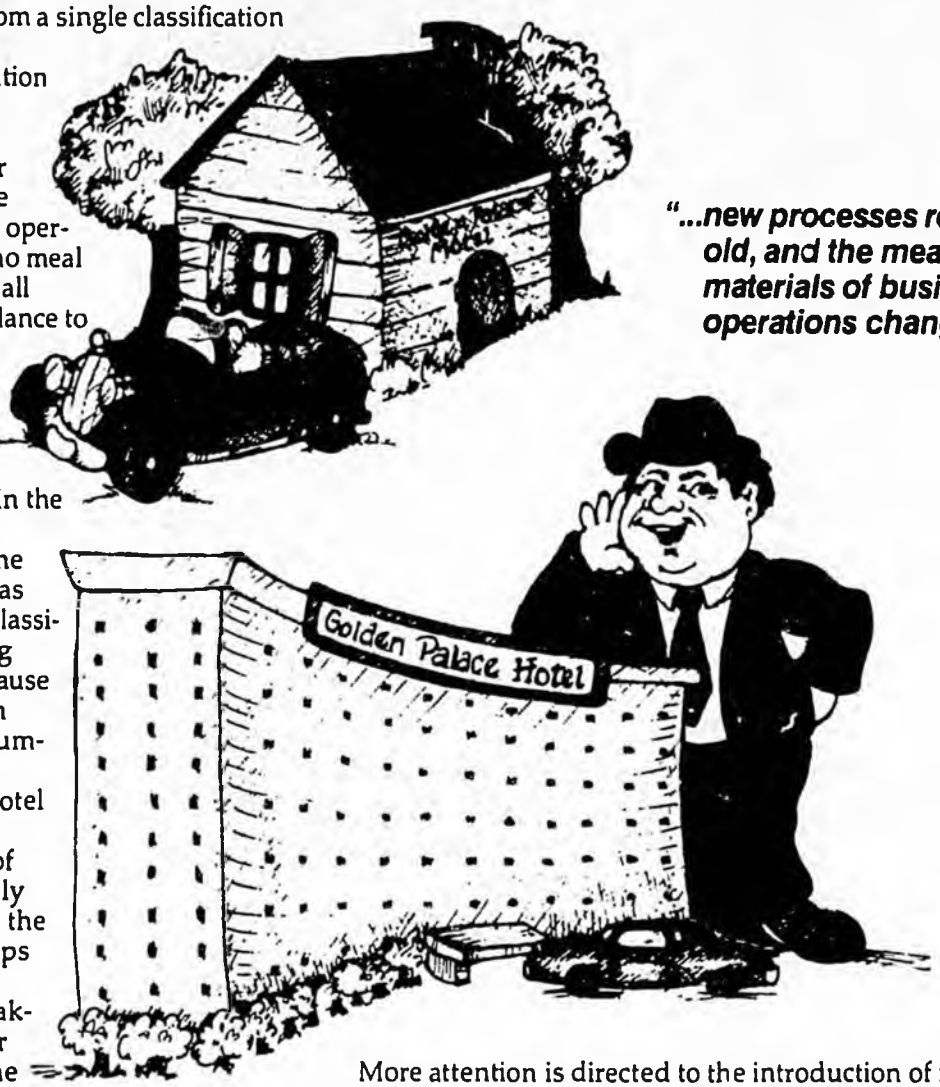
The second, and more important, way in which the classification system changes is through the continual monitoring by the NCCI and its member companies. Classification questions are reported to regional offices by local field offices and, in turn, by the regional offices to the NCCI headquarters in New York. Classifications generating frequent complaints are reviewed to determine whether revisions are needed.

When the workers' compensation system came into existence countrywide after 1911, approximately 1,400 classifications were inherited from workmen's collective and employers' liability coverage which had existed prior to the adoption of the workers' compensation laws. Between 1911 and 1919, the formative years of the workers' compensation system, the classifications were gradually reduced to approximately 800 in the early 1920's and then to approximately 600 in the early 1930's. From 1934 through the mid-1970's, there was no broad restructuring of the classification system. However, the introduction of new classifications over the years produced a net increase to approximately 700 classifications. In the mid-1970's, a major review was undertaken to eliminate and reassign approximately 100 classifications developing little or no payroll in most states. Thus, many of the 600 classifications now used describe industries and businesses that did not exist several years ago.

These changes in classifications have been the result of

requests from various groups of employers for separate classification treatment or the recognition by the insurance industry of the need for a single classification where two or more classes had applied. The typical request from outside the insurance industry for a new classification seeks a subdivision of an existing classification into the two or more components involved in the emergence of new methods of operation. For example, in 1977, a new classification was introduced for self-service gasoline stations, as distinct from a single classification for all gasoline stations.

Perhaps the best example of evolution in the classification system itself is the motel industry. Until the mid-1940's, "motels" were usually tourist cabins or tourist courts and were classified in the manner as camps, i.e., under building operation. These early "motels" provided no meal service and were usually a series of small roadside cabins, bearing scant resemblance to the hotels found in urban areas. Travel increased after the Second World War, creating the need for better lodging facilities. This change was recognized by the introduction of a separate classification code for motels in the early 1950's.



"...new processes replace old, and the means and materials of business operations change..."

By 1960, it became apparent that the loss emergence of hotels and motels was converging and, at that time, the two classifications were combined for ratemaking (producing the same rate for each) because of the similarity of exposure. Finally, in 1974, the separate classification code number for motels was discontinued in recognition of the fact that hotel and motel operations were virtually the same.

As part of the general upgrading of services over the years, motels gradually began to offer food service. Sometimes the motel would be next to a diner—perhaps operated by the same owners—or else would have a small area providing breakfast and basic meal service. Again, over the years conditions have evolved to the point where most motels provide food and entertainment services. Recognition of the distinction between motel operations and food service operations led to the creation of a separate classification for restaurants operated by motels. Thus, the history of this industry illustrates the response of the workers' compensation classification system to changes in business conditions.

The introduction and elimination of classifications is based on studies conducted by the NCCI and insurance carriers interested in a particular industry or classification problem. In general, the introduction of a separate classification requires a group of employers with similar methods of operation or producing a common product which can be distinguished from other businesses.

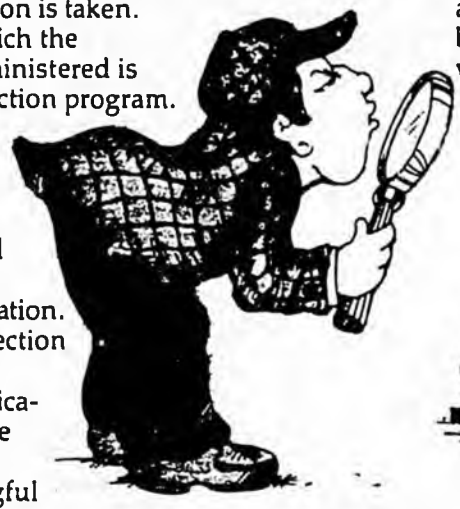
The group of employers also must be sufficiently large to produce payroll and losses which will be meaningful for ratemaking purposes.

More attention is directed to the introduction of new classifications than to the elimination of classifications for industries or operations which have become obsolete. This is because the fading or diminishing of a classification does not call attention to itself. New industries, on the other hand, command attention because of the extra effort needed to determine the proper classification assignment by analogy or because of requests for recognition from the industry or its representatives.

Classification Administration

At the beginning of this booklet, it was explained that classifications are necessary for the development of a fair and equitable distribution of the overall premium among individual employers. Classification experience also is used as a predictor of future premium needs for each group of employers. For this reason, the classification system is the foundation upon which workers' compensation pricing rests. To the extent that any business is misclassified, the underlying data for two classifications are incorrect, for the wrong payroll and losses are added to the experience of the classification wrongly assigned and the correct classification lacks the payroll and losses properly assignable to it.

Accordingly, the administration of the classification system is one of the most important functions of the NCCI. This duty is carried out in two ways. First, the local field office receives a copy of each policy indicating the classification assigned. These are compared with records of prior coverage for consistency and continuity. If a classification appears improper, further information is sought from the insurance carrier and appropriate action is taken.



The second way in which the classification system is administered is through a systematic inspection program. The inspection program is carried out by the local field office and involves a visit to the premises of the insured to obtain first-hand information concerning the nature of the business operation. At the local office, the inspection report then is reviewed by classifiers who issue classification notices to the insurance carrier. It has been NCCI's experience that no meaningful differences in classification develop from inspections in 80% of the cases. The remaining 20% divide almost equally between the need for higher or lower rated classifications. This indicates that while there is no inherent bias in the system to seek more business by underpricing, or higher premiums through misclassification, there is much room for reducing misunderstandings and misinterpretation.

The inspection program is designed to periodically review individual insureds subject to experience rating. Particular attention is given to situations where an inspection is necessary to resolve a classification assignment question. Concentration on the larger employers represents efficient allocation of resources because these businesses generate the bulk of the premium volume for most classifications. An inspection report, as can be seen in the example in Exhibit I, (see page 12) contains a description of the business operations, allocation of employees, machines in use, and a description of the finished products. The inspector also will look for interchange of labor and he obtains other basic identifying information needed for record keeping. Through the inspection program, the classification system is monitored continuously to ensure its proper application.

Conclusion

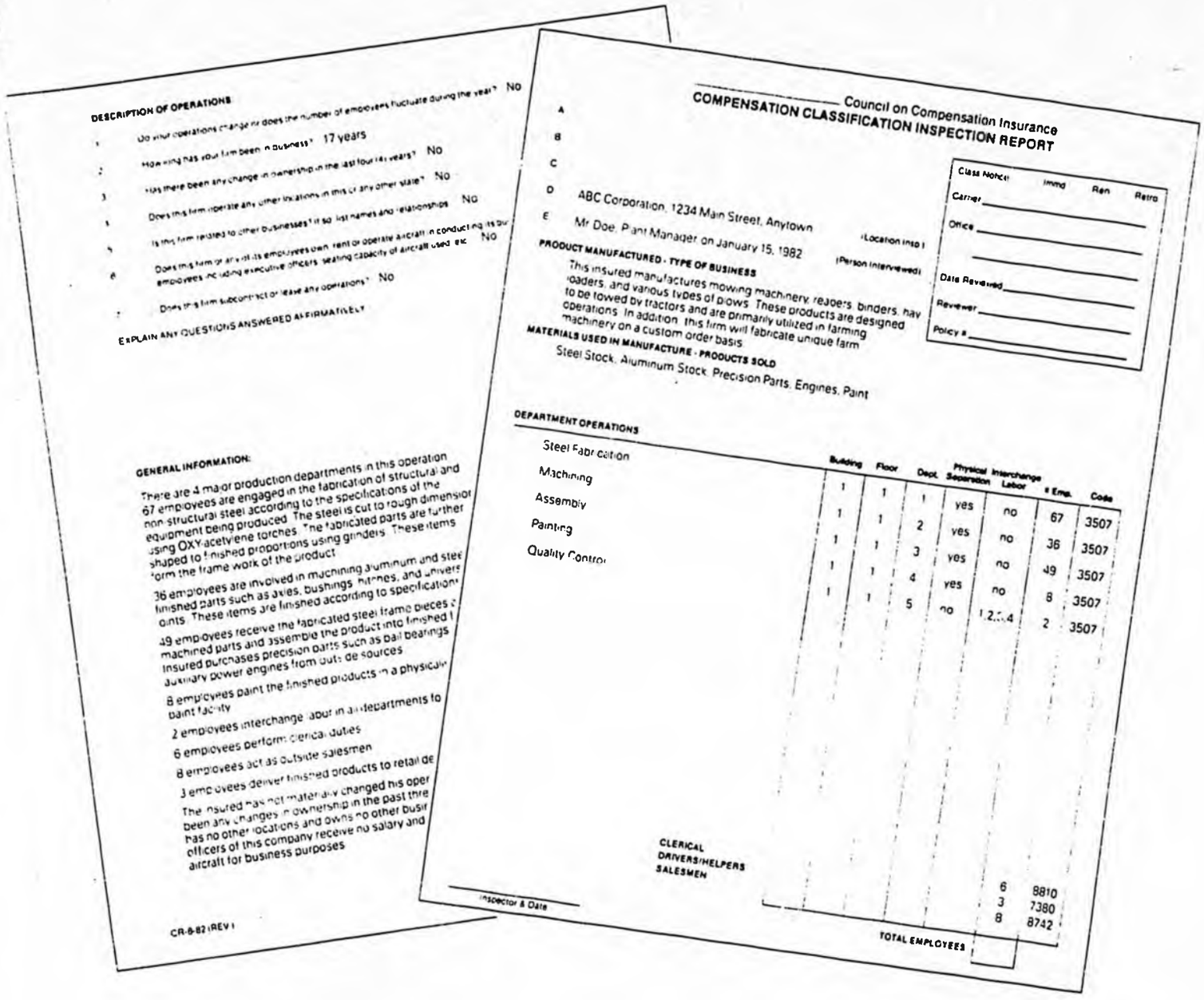
A properly functioning classification system is necessary both for a fair and equitable distribution of premium needs and for the development of the necessary statistical information to prepare manual rates. The average classification rate provides a reference against which individual employer experience is compared to develop a modification of the manual premium for employers subject to experience rating. This approach is a practical, proven system which produces a reasonable premium allocation. While other systems could be devised, the total premium needs would not be lessened and additional administrative costs might actually be greater.

The classification system places all employers conducting the same business in the same classification. This reflects the fact that employers engaged in the same business will have similar operations and employee distribution. The workers' compensation pricing programs are an interwoven system, with experience rating specifically designed to measure individual employer differences within a classification. The classification system is based upon sound insurance theory and is a practical, non-discriminatory procedure benefiting both the insurance buyer and seller by being cost efficient while promoting safety and loss prevention.

"The inspection program is designed to periodically review individual insureds subject to experience rating."

Compensation Classification Inspection Report

Exhibit I



Council on Compensation Insurance

COMPENSATION CLASSIFICATION INSPECTION REPORT

A

B

C

D ABC Corporation, 1234 Main Street, Anytown

E Mr Doe, Plant Manager on January 15, 1982 (Location insp.) (Person interviewed)

Class Notice: Immd Ren Retro

Carrier

Office

Date Received

Reviewer

Policy #

PRODUCT MANUFACTURED - TYPE OF BUSINESS

This insured manufactures mowing machinery, reapers, binders, hay loaders, and various types of plows. These products are designed to be towed by tractors and are primarily utilized in farming operations. In addition, this firm will fabricate unique farm machinery on a custom order basis.

MATERIALS USED IN MANUFACTURE - PRODUCTS SOLD

Steel Stock, Aluminum Stock, Precision Parts, Engines, Paint

DEPARTMENT OPERATIONS

	Building	Floor	Dept.	Physical Separation	Interchange Labor	# Emp.	Code
Steel Fabrication	1	1	1	yes	no	67	3507
Machining	1	1	2	yes	no	36	3507
Assembly	1	1	3	yes	no	49	3507
Painting	1	1	4	yes	no	8	3507
Quality Control	1	1	5	no	1,2,3,4	2	3507
CLERICAL						6	8810
DRIVERS/HELPERS						3	7380
SALESMEN						8	8742
TOTAL EMPLOYEES							

Inspector & Date

DESCRIPTION OF OPERATIONS

1 Do your operations change or does the number of employees fluctuate during the year? No

2 How long has your firm been in business? 17 years

3 Has there been any change in ownership in the last four (4) years? No

4 Does this firm operate any other locations in this or any other state? No

5 Is this firm related to other businesses? If so, list names and relationships No

6 Does this firm or any of its employees own, rent or operate aircraft in conducting its bu employees including executive officers, seating capacity of aircraft used, etc. No

7 Does this firm subcontract or lease any operations? No

EXPLAIN ANY QUESTIONS ANSWERED AFFIRMATIVELY

GENERAL INFORMATION:

There are 4 major production departments in this operation 67 employees are engaged in the fabrication of structural and non-structural steel according to the specifications of the equipment being produced. The steel is cut to rough dimensior using OXY-acetylene torches. The fabricated parts are further shaped to finished proportions using grinders. These items form the frame work of the product.

36 employees are involved in machining aluminum and stee finished parts such as axles, bushings, pitmes, and drivers joints. These items are finished according to specifications

49 employees receive the fabricated steel frame pieces a machined parts and assemble the product into finished f Insured purchases precision parts such as ball bearings auxiliary power engines from outside sources.

8 employees paint the finished products in a physicall paint facility.

2 employees interchange labor in all departments to

6 employees perform clerical duties.

8 employees act as outside salesmen.

3 employees deliver finished products to retail de

The insured has not materially changed his oper been any changes in ownership in the past thre has no other locations and owns no other busir officers of this company receive no salary and aircraft for business purposes.

CR-8-82 (REV.)

NCCI Locations

NCCI National Office, *New York City*

NCCI Rating Division and Data Processing Center, *New Jersey*

NCCI Midwest Regional Office, *1999 Wabash Avenue, Suite 205, P.O. Box 1238, Springfield, Illinois 62705*—Monitors NCCI Offices Servicing Illinois, Indiana, Iowa, Kansas, Missouri, Nebraska, Oklahoma and South Dakota

Illinois Council on Compensation Insurance, *1999 Wabash Avenue, P.O. Box 1666, Springfield, Illinois 62705*—Services Illinois

Indiana Compensation Rating Bureau, *5920 Castleway, West Drive, P.O. Box 50940, Indianapolis, Indiana 46250*—Services Indiana

Kansas Council on Compensation Insurance, *P.O. Box 1577, 3601 West 29th Street, Topeka, Kansas 66601*—Services Kansas

Missouri Council on Compensation Insurance, *10825 Watson Road, P.O. Box 8530, St. Louis, Missouri 63127*—Services Missouri

North Central Council on Compensation Insurance, *4685 Merle Hay Road, OakMoor II, Suite 101, Des Moines, Iowa 50323*—Services Iowa, Nebraska and South Dakota

Oklahoma Council on Compensation Insurance, *777 N.W. Grand Boulevard, Suite 100, Oklahoma City, Oklahoma 73118*—Services Oklahoma

Coal Mine Council on Compensation Insurance, *10825 Watson Road, P.O. Box 8530, St. Louis, Missouri 63127*—Services Coal Mines

NCCI Southern Regional Office, *320 Beacon Parkway, West, Box C-40, Birmingham, Alabama 35283*—Monitors NCCI Offices Servicing Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, South Carolina and Tennessee

Arkansas Council on Compensation Insurance, *307 Donaghey Building, 7th & Main, Little Rock, Arkansas 72201*—Services Arkansas

Florida Council on Compensation Insurance, *North Regency One, Suite 300, 9485 Regency Square Boulevard, P.O. Box 8899, Jacksonville, Florida 32211*—Services Florida

Louisiana Council on Compensation Insurance, *3501 North Causeway Boulevard, Suite 600, Metairie, Louisiana 70002*—Services Louisiana

South Carolina Council on Compensation Insurance, *3710 Landmark Drive, Suite 109, P.O. Box 4383, Columbia, South Carolina 29240*—Services South Carolina

Southeastern Council on Compensation Insurance, *320 Beacon Parkway, West, Box C-40, Birmingham, Alabama 35283*—Services Alabama, Georgia, Kentucky, Mississippi and Tennessee

NCCI Western Regional Office, *One Tamarac Square, Suite 500, 7555 E. Hampden Avenue, Denver, Colorado 80231*—Monitors NCCI Offices Servicing Alaska, Arizona, Colorado, Idaho, Montana, New Mexico, Oregon and Utah

Alaska Council on Compensation Insurance, *620 S.W. 5th Avenue, Suite 1110, Portland, Oregon 97204*—Services Alaska

Montana Council on Compensation Insurance, *620 S.W. 5th Avenue, Suite 1110, Portland, Oregon 97204*—Services Montana

Mountain States Council on Compensation Insurance, *One Tamarac Square, Suite 504, 7555 E. Hampden Avenue, Denver, Colorado 80231*—Services Arizona, Colorado, Idaho, New Mexico and Utah

Oregon Council on Compensation Insurance, *620 S.W. 5th Avenue, Suite 1110, Portland, Oregon 97204*—Services Oregon

NCCI Eastern Regional Office, *998 Old Eagle School Road, Suite 1210, Wayne, Pennsylvania 19087*—Monitors NCCI Offices Servicing Connecticut, District of Columbia, Maine, Maryland, New Hampshire, Rhode Island and Vermont

Mid-Atlantic Council on Compensation Insurance, *305 W. Chesapeake Avenue, Baltimore, Maryland 21204*—Services District of Columbia and Maryland

Northeastern Council on Compensation Insurance, *P.O. Box 60, 21 Wintonbury Mall, Bloomfield, Connecticut 06002*—Services Connecticut, Maine, New Hampshire, Rhode Island and Vermont

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Additional Copies May Be Obtained From
National Council on Compensation Insurance, Information Office,
One Penn Plaza, New York, N.Y. 10119

BROWN STUDY - PART III

November 8, 1985

Includes 1984 cases.

State/Territory	1984 AWW	1984 Ratio	No./Cases Dis.Ended	Percent	No./Cases Ongoing	Percent	Total Cases	Percent
Alabama	276	.511	1	.2%	0	-	1	.17%
Alaska	540		-	-	-	-	-	-
Arizona	304	.563	13	2.6%	4	4.3%	17	2.89%
Arkansas	258	.478	3	.6%	2	2.2%	5	.85%
California	343	.535	44	8.9%	8	8.7%	52	8.84%
Colorado	328	.607	5	1 %	3	3.3%	8	1.36%
Connecticut	338	.626	0	-	0	-	0	-
Delaware	336	.622	1	.2%	0	-	1	.17%
Dist. of Columbia	378	.700	1	.2%	0	-	1	.17%
Florida	280	.519	8	1.6%	2	2.2%	10	1.7 %
Georgia	286	.530	2	.4%	0	-	2	.34%
Hawaii	282	.522	0	-	0	-	0	-
Idaho	277	.513	6	1.2%	0	-	6	1.02%
Illinois	342	.633	4	.8%	0	-	4	.68%
Indiana	311	.576	1	.2%	0	-	1	.17%
Iowa	282	.522	1	.2%	1	1.1%	2	.34%
Kansas	291	.539	3	.6%	2	2.2%	5	.85%
Kentucky	295	.546	3	.6%	0	-	3	.51%
Louisiana	326	.604	9	1.8%	2	2.2%	11	1.87%
Maine	256	.474	0	-	0	-	0	-
Maryland	309	.572	0	-	1	1.1%	1	.17%
Massachusetts	311	.576	2	.4%	0	-	2	.34%
Michigan	362	.670	1	.2%	2	2.2%	3	.51%
Minnesota	313	.580	6	1.2%	1	1.1%	7	1.19%
Mississippi	253	.469	3	.6%	2	2.2%	5	.85%
Missouri	303	.561	9	1.8%	1	1.1%	10	1.7 %
Montana	277	.513	22	4.4%	6	6.5%	28	4.76%
Nebraska	267	.494	0	-	1	1.1%	1	.17%
Nevada	314	.581	2	.4%	1	1.1%	3	.51%
New Hampshire	275	.509	1	.2%	0	-	1	.17%
New Jersey	340	.630	0	-	0	-	0	-
New Mexico	289	.535	3	.6%	1	1.1%	4	.68%
New York	354	.656	4	.8%	0	-	4	.68%
North Carolina	263	.487	2	.4%	0	-	2	.34%

BROWN STUDY - PART III (Cont.) - Page 2

State/Territory	1984 AWW	1984 Ratio	No./Cases Dis.Ended	Percent	No./Cases Ongoing	Percent	Total Cases	Percent
North Dakota	278	.515	1	.2%	1	1.1%	2	.34%
Ohio	327	.606	4	.8%	0	-	4	.68%
Oklahoma	319	.591	11	2.2%	0	-	11	1.87%
Oregon	307	.569	46	9.3%	13	14.1%	59	10.03%
Pennsylvania	313	.580	5	1 %	1	1.1%	6	1.02%
Puerto Rico	180	.333	0	-	0	-	0	-
Rhode Island	275	.509	0	-	1	1.1%	1	.17%
South Carolina	261	.483	0	-	0	-	0	-
South Dakota	238	.441	2	.4%	0	-	2	.34%
Tennessee	277	.513	4	.8%	1	1.1%	5	.85%
Texas	332	.615	15	3 %	2	2.2%	17	2.89%
Utah	300	.556	2	.4%	0	-	2	.34%
Vermont	262	.485	0	-	0	-	0	-
Virginia	285	.528	1	.2%	0	-	1	.17%
Washington	337	.624	222	44.8%	27	29 %	249	42.35%
West Virginia	317	.587	0	-	0	-	0	-
Wisconsin	316	.585	6	1.2%	1	1.1%	7	1.19%
Wyoming	345	.639	17	3.4%	5	5.4%	22	3.74%
			496	99.8%	92	99.9%	588	99.98%

BROWN STUDY - PART IV

November 8, 1985

Includes 1984 Cases.

	Disability Ended	Disability Ongoing	Total Cols. 1 & 2
1. Compensation Paid at the Alaska Rate...	$2,133,977	$2,576,458	$4,710,335
2. Compensation That Would Have Been Paid Under AS 23.30.175 Before Brown.....	$1,430,839	$1,510,419	$2,941,358
3. Difference (Increased Compensation Liability Per Year After Brown).....			$1,769,077+++

§ 80. REVIEW OF AWARDS

§ 80.00 Judicial review of awards is usually confined to questions of law. Except in a minority of jurisdictions, the evidence supporting fact-findings is not weighed on review, such findings being conclusive if supported by any substantial evidence. Awards cannot, however, be based on speculation and conjecture, nor on a "preponderance of possibilities"; but the claimant's normal burden of proving his case is sometimes lightened by presumptions in his favor that have the effect of shifting the burden of proof once a prima facie showing of some connection between the injury and the employment has been made. The "jurisdictional fact doctrine," which held that a broader review, including weighing the facts and even perhaps making a new record, was appropriate in respect to facts upon whose existence the jurisdiction of the commission to act depended, is now largely discredited, and the normal substantial-evidence test is used for all fact findings in most jurisdictions.

§ 80.10 Normal review: substantial-evidence rule

Compensation acts provide in detail for judicial review of awards,[90] but with or without such provisions, there is an inherent right to the judicial review of questions of law.[91] Com-

[90] As to the necessity for adhering to the specific review procedures prescribed by the compensation statute, see § 80.50 N. 66 *et seq.*

[91] Crowell v. Benson, 285 U.S. 22, 52 S. Ct. 285, 76 L. Ed. 598 (1932).

Catron Beverages, Inc. v. Maynard, 395 So. 2d 261 (Fla. App. 1981). Frivolous appeals may, however, bring down sanctions both on the appellant and his counsel. In this case, the carrier had appealed a routine finding of fact that certain charges for medicine were reasonable—obviously a finding of fact not reviewable on appeal.

See also: Michigan Farm Bur. v. Bureau of Workmen's Comp., 75 Mich. App. 362, 254 N.W.2d 890 (1977). In April, 1974, the Director of the Bureau of Workmen's Compensation set new minimum compensation rates for total disability and death benefits pursuant to the 1973 decision in Jolliff v. American Advertising Distributors, Inc. § 61.12(1) N. 64.12 *supra*. The

plete destruction of the right of review would be unconstitutional,[92] except under the Federal Employees' Compensation Act, which is treated as creating outright grants to which Congress can attach any conditions it pleases,[93] and except,

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Farm Bureau requested that the Director rule on the validity of the rule. He refused. The Farm Bureau then charged that the announcement constituted the announcement of agency rules within the Administrative Procedures Act of 1969, and that the rules were subject to review by the circuit court. The Director contended that § 841 of the Workmen's Compensation Act vested exclusive authority to determine validity of rules in the Compensation Bureau. The Supreme Court held that the statutes must be read together, and that when the Compensation Bureau has declared a rule and then declines to issue a declaratory ruling thereon, the circuit court may review the validity of the rule.

[92] *Federal:* Davis v. United States, 415 F. Supp. 1086 (D. Kan. 1976). A former federal prison inmate sought compensation benefits, alleging that he contracted a disease as a consequence of his employment in a prison hospital. Through administrative procedures of the Bureau of Prisons, he was denied compensation. The procedures provided that a prisoner could appeal an adverse decision through written documents, but did not afford him the right to a hearing. The former inmate challenged these procedures as violative of his rights under the due process clause of the fifth amendment. The court held that due process required that the claimant have the right to a plenary hearing, including the opportunity to be heard in prison, to present witnesses and documentary evidence, and to cross-examine adverse witnesses. The claimant should also have the right to be represented by counsel and to present testimony, but the constitution was deemed not to mandate "their inclusion at government expense."

Florida: Cf. Scholastic Sys., Inc. v. LeLoup, 307 So. 2d 166 (Fla. 1975). The Supreme Court held that the IRC was a judicial body. Thus, within the requirements of due process, mandatory review by appeal to the Supreme Court could be and was abolished. The court held that henceforth its review of compensation cases was discretionary through issuance of writs of certiorari. For a general discussion of the commission as a judicial or quasi-judicial body, see § 77A.20 *supra.*

Massachusetts: Meunier's Case, 319 Mass. 421, 66 N.E.2d 198 (1948).

Michigan: Dation v. Ford Motor Co., 314 Mich. 152, 22 N.W.2d 252 (1946).

Minnesota: Hunter v. Zenith Dredge Co., 220 Minn. 318, 19 N.W.2d 795 (1945).

[93] Calderon v. Tobin, 187 F.2d 514 (D.C. Cir. 1951). The Federal Employees' Compensation Act makes the administrator's decision final as to

under state law, as to state employees[93.1] and state funds.[93.2]

Another exceptional situation is found in Ohio, an exclusive state fund jurisdiction. Its statute makes express provision for judicial review of "any injury case," but goes on to add "other than a decision as to extent of disability."[94] This ex-

(Text continued on page 15–426.304)

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both law and facts, and forbids review by any official or court by mandamus or otherwise. 5 U.S.C.A. § 793 (1964).

Waterman v. United States, 199 F. Supp. 496 (E.D.N.Y. 1961). Suit against United States, allegedly under the Tucker Act (28 U.S.C. § 1346(a) (1964)), was held to be an attempt to review a denial of compensation. Suit dismissed.

93.1 *Arkansas:* Boshears v. Arkansas Racing Comm'n, 258 Ark. 741, 528 S.W.2d 646 (1975). An employee of the Arkansas Racing Commission was struck by an automobile while crossing the street on his way to work. The referee denied compensation on the ground that the claimant was not in the course of his employment at the time of the injury. In the Supreme Court the claimant contended that the Workmen's Compensation Act violated the state and federal constitutions insofar as it allowed no judicial review over decisions of the Commission in cases in which the state is a defendant. The court upheld the constitutionality of the statute. It held that state employees constitute no "suspect class" and that there is no "fundamental right" to appellate review.

Illinois: Raschillo v. Industrial Comm'n, 265 N.E.2d 663 (Ill. 1971). Statutory provision denying state employees the right to appeal from a decision of the Industrial Commission held to be constitutional and not an invidious classification, since a constitutional sovereign immunity provision barred actions against the state in any court of law or equity.

Vermont: Howard v. Office of the Secretary of State, 140 Vt. 139, 435 A.2d 962(1981). The Vermont statute, 21 V.S.A. § 628, providing compensation benefits for state employees, says plainly that the decision of the board is final, and there is no provision in the statute for appeal. Moreover, there is no constitutional right to an appeal when the benefits are conferred by legislation.

93.2 In Maryland the Subsequent Injury Fund, which is a public fund, has been held to have no right of appeal. Subsequent Injury Fund v. Pack, 250 Md. 306, 242 A.2d 506 (1968). A hearing was held after which it was found that part of claimant's benefits should come from the Subsequent Injury Fund, which had not been represented at the hearing. The employer sought and obtained a rehearing, at which time the Fund did have representation. The Fund then sought to appeal from the rehearing. This was not permitted, since there was no statutory provision for appeals by the Fund.

94 Ohio Rev. Code § 4123.519 (1965).

Zavatasky v. Stringer, 384 N.E.2d 693 (Ohio 1978). This case deals authoritatively and in some detail with the unique Ohio rule on non-appealability of decisions on extent of disability. The main holding is that an order either granting or denying benefits for loss or impairment of specific bodily parts or functions is not a decision on extent of disability, and hence is appealable.

Hospitality Motor Inns, Inc. v. Gillespie, 66 Ohio St. 2d 206, 421 N.E.2d 134 (1981). A schedule award is not a decision as to extent of disability, and hence is appealable. But if it has not been appealed, a later determination of extent of disability is not appealable.

Green v. Stringer, 58 Ohio App. 2d 53, 389 N.E.2d 510 (1979). The claimant suffered an injury in the course of his employment and was declared to be permanently and totally disabled. The employer was ordered to pay the statutory amount to the claimant. The employer requested that the compensation benefits be reduced by the amount of total disability pension payments made by the employer pursuant to its own pension program. The Industrial Commission denied the motion. The employer appealed to the common pleas court, which held that the employer was entitled to a set-off. The court of appeals affirmed. The claimant argued that the court lacked jurisdiction because the Commission's decision was one concerning the extent of disability. The court of appeals held that the decision does not affect the extent of disability since the claimant is still receiving the maximum benefits prescribed by statute.

Gilbert v. Midland-Ross Corp., 67 Ohio St. 2d 267, 21 Ohio Ops. 3d 168, 423 N.E.2d 847 (1981). The claimant suffered back injuries in two separate, compensable incidents, the second of which occurred 11 days after his returning to work following recovery from the first. He applied for compensation for the second injury both as a new claim and as a reactivation of his first claim. The commission permitted the reactivation claim but refused to hear the other, which had been denied at lower levels. The court found that, because of the intervening time and trauma, the claimant's application did not go to the "extent of [his] disability [from the first injury]," appeal for which is barred by statute, but to causation of the second injury by the first. It was therefore appealable.

Cf. the following cases:

Ford Motor Co. v. Mosijowsky, 44 Ohio St. 2d 109, 338 N.E.2d 762 (1975). An order of the deputy administrator, as affirmed by the board of review, allowing an award for temporary and total disability was clearly not an absolute denial of the claimant's right to participate in the fund, but was a determination as to the extent of disability. The finding was therefore not appealable.

State *ex rel* General Motors Corp. v. Industrial Comm'n, 44 Ohio St. 2d 46, 337 N.E.2d 782 (1975). An award of permanent partial disability was held to be a determination as to the extent of disability and was not appealable. The employer's only remedy was an action in mandamus.

State ex rel. General Motors Corp. v. Industrial Comm'n, 42 Ohio St. 2d 278, 328 N.E.2d 387 (1975). In a back injury case, the Ohio Supreme Court held that a determination by the Industrial Commission that a claimant was totally and permanently disabled was a determination as to the extent of disability, and hence not appealable.

State *ex rel* Gonzales v. Patton, 42 Ohio St. 2d 386, 329 N.E.2d 104 (1975). The Supreme Court affirmed dismissal of a complaint filed by Ford Motor Company in the Court of Common Pleas seeking review of an award of disability benefits made by the commission.

State *ex rel.* Commercial Motor Freight, Inc. v. Stebbins, 42 Ohio St. 2d 389, 329 N.E.2d 102 (1975). The claimant sustained a back injury in 1966, for which he was awarded 10% permanent partial disability. A subsequent award in 1973 provided for temporary total disability for the same injury. The Ohio Supreme Court held that the 1973 order was a determination as to the "extent of disability." Therefore the order was not appealable, and the employer's only remedy to challenge the order was an original action in mandamus.

Mooney v. Stringer, 48 Ohio St. 2d 375, 358 N.E.2d 612 (1976). Although a deputy administrator granted the claimant benefits for thrombophlebitis, he disallowed her claim for other pre-existing conditions which were unrelated to the compensable injury. She appealed this determination to the Court of Common Pleas. Her employer raised a jurisdictional defense, which asserted that decisions as to the extent of disability were not appealable. The claimant contended that the administrator did not determine her disability, but instead denied the Commission's jurisdiction and her right to participate in the Compensation Fund. Hence, she argued that the decision was appealable. The Court of Common Pleas and the Court of Appeals denied the employer's motion to dismiss. The Supreme Court of Ohio reversed. It found that the grant of benefits for thrombophlebitis had established the claimant's right to collect for a disability, and that disallowance of additional claims merely determined the extent of the disability. As mandated by the applicable section of the Compensation Act (RC 4123-519), the decision could not be appealed.

Smith v. Krouse, 54 Ohio St. 2d 369, 377 N.E.2d 493 (1978). The court held that a decision as to the extent of disability was not appealable. A statute explicitly denied this right to one who "has participated and continues to participate in the Workmen's Compensation Fund."

State *ex. rel.* Board of Educ. v. Johnston, 58 Ohio St. 2d 132, 388 N.E.2d 1383 (1979).

State *ex. rel.* Dodson v. Industrial Comm'n., 58 Ohio St. 2d 399, 390 N.E.2d 1189 (1979).

Lotti v. Ternstedt Div., General Motors Corp., 113 Ohio App. 496, 178 N.E.2d 815 (1961).

ception has been found constitutional.[95] Moreover, Ohio has ruled that under this statute there can be no appeal to the courts in an occupational disease case,[96] even indirectly by mandamus,[97] and no appeal on apportionment of death benefits among dependents.[98]

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[95] Frank v. Youngstown Sheet & Tube Co., 83 Ohio L. Abs. 419, 152 N.E.2d 708 (1956).

[96] Szekely v. Young, 174 Ohio St. 213, 188 N.E.2d 424 (1963).

Lairson v. Young, 188 N.E.2d 333 (Ohio App.), *aff'd* 174 Ohio St. 213, 188 N.E.2d 424 (1961).

[97] State, *ex rel.* United States Playing Card Co. v. Industrial Comm'n, 49 Ohio App. 2d 351, 361 N.E.2d 509 (1977). The claimant filed an application for compensation for carpal tunnel syndrome, asserting that it stemmed from a specific injury. During the hearing process, her condition was reclassified as an "occupational disease." No reason was given for this change. The employer appealed the award of compensation. It stated that because it had based its presentation on the injury claim, the shift to "occupational disease" made the employer's defense inappropriate. As a result, the employer contended that it had been denied due process of law, since it was not given a full opportunity to meet the issues. It further contended that it was disadvantaged because occupational disease awards were not appealable to the Court of Common Pleas. The court agreed, and vacated the order of the Commission remanding the case for consideration as an injury. It first noted that the employer had been denied due process, since the preparation for injury and occupational disease claims differs considerably. The court then held that there was no evidence to support the Commission's finding of occupational disease. It found the claimant had not proved that her condition was peculiar to the employment, or that her employment exposed her to greater hazards or risks of contracting that condition.

State *ex rel.* Marshall v. Keller, 15 Ohio St. 2d 203, 239 N.E.2d 87 (1968). Claimant was denied benefits, and sought to compel an award by an action in mandamus against the Commission. This was not permitted, since the Commission had followed the correct procedure in arriving at its decision, and its findings of fact were not subject to review, either directly or by mandamus.

Cf. State *ex rel.* Hatfield v. Industrial Comm'n, 83 Ohio L. Abs. 114, 165 N.E.2d 211 (1960). A writ of mandamus to the Ohio State Compensation Commission was granted, ordering a determination of the amount of disability compensation and ordering commencement of payments pending the appeal by the employer.

[98] Berry v. Young, 86 Ohio L. Abs. 577, 178 N.E.2d 112 (1961). The statute precludes an appeal from the Commission's discretionary apportion-

A finding of fact based on no evidence is an error of law.[99] Accordingly, in compensation law, as in all administrative law, an award may be reversed if not supported by any evidence. Conversely, since the compensation board has expressly been entrusted with the power to find the facts, its fact findings must be affirmed if supported by any evidence, even if the reviewing court thinks the evidence points the other way. This statement is, without any close competition, the number one cliché of compensation law and occurs in some form in the first paragraph of compensation opinions almost as a matter of course.[1]

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ment of death benefits among wholly dependent survivors and other dependents. A partially dependent claimant may not appeal for an increase in the dependency allowance, but the claimant may appeal from the Commission's determination of partial dependency on the ground that the award should have been based upon total dependency. Appeal to the Court of Common Pleas sustained.

[99] Crowell v. Benson, N. 91 *supra*, this subsection.

Vilter Mfg. Co. v. Jahnke, 192 Wis. 362, 212 N.W. 641, 57 A.L.R. 627 (1927).

Accord, as to jury findings, Montoya v. American Employment Ins. Co., 426 S.W.2d 661 (Tex. Civ. App. 1968). Where no evidence was presented as to the duration of claimant's disability, nor a description of the nature of the injury, a jury finding of permanent disability was error.

See also: Parent v. Great Northern Paper Co., 424 A.2d 1099 (Me. 1981). The Maine statute states: "His [the Commissioner's] decision, in the absence of fraud, upon all questions of fact shall be final, but whenever in a decree the commission expressly rules that any party has or has not sustained the burden of proof cast upon him the said finding shall not be considered a finding of fact but shall be deemed to be a conclusion of law and shall be reviewable as such." 39 M.R.S.A. § 99. The record here contained a finding that the medical testimony failed to establish the necessary causal connection. This made the finding one of fact under the statute, and it was upheld.

And see Bouldware v. Delta Corp., 160 Ga. App. 100, 286 S.E.2d 333 (1981). The administrative law judge had limited the claimant's award to benefits for an injured arm, even though the claimant had established that he had pain in his shoulder. The judge's refusal to consider the pain in determining whether the claimant had sustained disability of his shoulder constituted an error of law and required reversal of the award.

[1] Citations for this truism are omitted here; a complete list would run to hundreds of cases.

Whatever adjectives are chosen to describe the minimum quantity, as distinguished from quality, of evidence necessary to support an award, the net result is about the same. Among the phrases encountered are "any evidence,"[1.1] "some evi-

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At this point may be noted a curiously anachronistic exception to this rule. New Mexico held that the creation of a commission whose findings of fact if supported by substantial evidence were to have the force and effect of judgments was an unlawful delegation of the judicial power, and hence the act was declared unconstitutional. State *ex rel.* Hovey Concrete Prods. Co. v. Mechem, 63 N.M. 250, 316 P.2d 1069 (1957). Three judges voted for the decision, two voted against, and two did not participate.

1.1 *Georgia:* Employer's Fire Ins. Co. v. Walraven, 130 Ga. App. 41, 202 S.E.2d 461 (1973). Under the "any-evidence" rule, the findings of the Board stand on a footing similar to a jury verdict, and should not be set aside absent some legal error or fraud. Here there was testimony by a doctor fully supporting the Board's action.

Kissel v. Aetna Cas. & Sur. Co., 136 Ga. App. 504, 221 S.E.2d 645 (1975). The court, citing the "any evidence" rule, affirmed a holding which denied compensation.

Fieldcrest Mills, Inc. v. Glass, 143 Ga. App. 222, 238 S.E.2d 125 (1977).

Arlington Apartments v. Johns, 140 Ga. App. 29, 230 S.E.2d 86 (1976).

Georgia Building Authority v. Stroup, 144 Ga. App. 522, 241 S.E.2d 630 (1978).

Continental Ins. v. Peardon, 132 Ga. App. 5, 207 S.E.2d 658 (1974). The superior court determined that one out of the six findings of fact by the hearing director was without sufficient competent evidence in the record to support it. Therefore the superior court recommitted this case to the full board. The judgment of the Superior Court was appealed. The court of appeals held that, since there was sufficient evidence to support the ultimate conclusion of the Workmen's Compensation Board's hearing, the dismissal of the employee's claim would be upheld. The mere fact that the evidence failed to support one or more findings of fact did not necessarily require a reversal, if the evidence supported a sufficient number of findings of fact, all of which taken together supported the judgment or order.

Georgia Power Co. v. Dodgen, 133 Ga. App. 715, 213 S.E.2d 18 (1975). The court held that the evidence was sufficient to support the workmen's compensation board's award, even though there was conflicting medical testimony. This conflict presents a question of fact which must be determined by the Board of Workmen's Compensation. The court further held that even assuming that there were errors in the findings of fact of the workmen's compensation award, a reversal was not required. The evidence supported a sufficient number of the findings of fact to authorize the award.

dence,"[1.2] "any credible evidence," "substantial evidence,"[2] "supported by evidence,"[2.1] and many others.[3] The United

(Text continued on page 15–426.309)

Fidelity & Cas. Co. of New York v. Singleton, 209 S.E.2d 684 (Ga. App. 1974).

Michigan: Fergus v. Chrysler Corp., 45 Mich. App. 196, 206 N.W.2d 521 (1973). The Appeal Board found that the employee, who had a heart condition and who had suffered four separate heart attacks previously, had failed to establish that his disability was causally related to his employment and was not a result of an unrelated diabetic condition. The court affirmed the Appeal Board's decision, on the ground that the court cannot overturn the findings of fact made by the Board when they are supported by any evidence. The Board's decision was 4-to-3, but the court emphasized the necessity of the court's accepting the findings of the majority.

Richardson v. Vemco Products, Inc., 101 Mich. App. 88, 300 N.W.2d 461 (1981). The court affirmed the compensation appeal board's ruling despite noting "the inadequacy of the testimony is exceeded only by the conflicting nature of it." It held that "the fact that the evidence is 'sparse' does not justify reversal where there is 'any' evidence to support the findings."

[1.2] Jones v. Utica Mutual Insurance Co., 144 Ga. App. 460, 241 S.E.2d 578 (1978). Since the Board's finding that the claimant sustained an injury in the groin area while working for the employer was supported by some evidence, the court affirmed the award.

[2] *Federal:* Colonna's Shipyard Inc. v. O'Hearne, 200 F.2d 220 (4th Cir. 1952). The Administrative Procedure Act (5 U.S.C. § 1001 *et seq.*) governs the Longshoremen's and Harbor Workers' Compensation Act and makes the ground for reversal failure of the finding to be supported by substantial evidence on the record considered as a whole. See also § 80.12 N. 20.1 for test of the 1972 amendment on this point.

Duluth, Missabe and Iron Range Railway Co. v. U.S. Dept. of Labor, 553 F.2d 1144 (8th Cir. 1977). An employee suffered neck and back injuries in an accident which occurred while he was loading an iron ore boat. The court found "substantial evidence on the record considered as a whole" to support a Benefits Review Board finding that the employee sustained a compensable accident in the course of his employment and that the employer had received statutory notice of the claim.

Director, Office of Workers' Comp. Programs, U.S. Dept. of Labor v. Bethlehem Steel Corp., 620 F.2d 60 (5th Cir. 1980). The review standard is: "substantial evidence in the record considered as a whole." By this standard, an award could not stand when supported only by a doctor who examined claimant 18 months after the injury, as against the great preponderance of testimony by doctors who had examined him within seven months of the injury.

Arkansas: Gordon v. J. A. Hadley Constr. Co., 509 S.W.2d 287 (Ark. 1974). The state Supreme Court may not reverse the Commission if the medical findings supporting the Commission's decision are substantial.

Kentucky: Tyree v. Brown, 564 S.W.2d 31 (Ky. App. 1978). Substantial evidence.

Mississippi: Miss-Lou Equip. Co. v. McGrew, 247 Miss. 142, 153 So.2d 801 (1963). Substantial evidence supported the Commission's award of 10% disability. Circuit court's judgment raising the amount to 50% disability reversed. Commission's award reinstated. But see also § 80.26(g) *infra.*

Missouri: Griffin v. Evans Elec. Constr. Co., 529 S.W.2d 172 (Mo. App. 1975). The court held that a workmen's compensation award by the Industrial Accident Commission was supported by substantial evidence and was not contrary to the overwhelming weight of the evidence. Substantial evidence was defined as "competent evidence, which, if believed would have a probative force upon the issues."

Gibson v. Greenfield, 561 S.W.2d 689 (Mo. App. 1978). Substantial evidence.

South Carolina: Lark v. Bi-Lo, Inc., 276 S.E.2d 304 (S.C. 1981), N. 4 *infra* this subsection.

Texas: Hurtado v. Texas Employers' Insurance Association, 563 S.W.2d 360 (Tex. Civ. App. 1978). Substantial evidence.

[2.1] *Arkansas:* Pate v. Hook, 262 Ark. 411, 557 S.W.2d 391 (1977). Supported by evidence.

Kentucky: Tackett v. Sizemore Mining Co., 560 S.W.2d 17 (Ky. 1977). Evidence supported finding.

Tennessee: Trane Company v. Morrison, 566 S.W.2d 849 (Tenn. 1978). Evidence supported finding.

Texas: Whaley v. Transport Ins. Co., 559 S.W.2d 451 (Tex. Civ. App. 1977). Evidence sustained finding.

Ramirez v. National Standard Ins. Co., 563 S.W.2d 837 (Tex. Civ. App. 1978). Sustained by evidence. See § 80.26(h) *infra.*

Cf. Abeyta v. Travelers Ins. Co., 566 S.W.2d 708 (Tex. Civ. App. 1978). Weight of evidence.

[3] See, for example, a list of ten categories found in Pennsylvania alone, set out in Schulman, "Administrative Procedure—A Survey of Suggested Reforms," 15 Temp. L.Q. 1 at 14 and 19 (1940).

Isherwood v. Township of Penn Hills, 13 Pa. Cmwlth. 187, 318 A.2d 767 (1974). The claimant, a policeman, presented evidence showing that he had slipped and been injured while carrying a stretcher. The township did not present any conflicting evidence, but impeached claimant's testimony by showing that he did not mention the slip to the treating physician. The referee and the Workmen's Compensation Appeals Board found for the township. The scope of review was limited in compensation cases, when the

States Supreme Court has expressly held that "substantial evidence" is not a larger quantity than "any evidence,"[4] and

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Board has affirmed the findings of the referee against the party having the burden of proof, to a determination whether the order can be sustained without a capricious disregard of competent evidence. A capricious disregard of competent evidence occurs when there is a wilful and deliberate disregard of evidence which one of ordinary intelligence could not possibly have avoided in reaching the result. The court said that, in the light of the impeachment of claimant's testimony, the referee did not commit such a flagrant disregard.

Scannella v. Salerno Importing Co., 2 Pa. Cmwlth. 11, 275 A.2d 907 (1971). The court invoked the Pennsylvania formula that, when a ruling in favor of the employer has been made by the Board, the sole question on review is whether there has been a capricious disregard of competent evidence in the record. See § 80.26(d) *infra*.

The term "scintilla" has gone out of fashion. See Black Mountain Corp. v. Hobbs, 308 Ky. 731, 215 S.W.2d 273 (1948), and Consolidated Edison Co. v. NLRB., 305 U.S. 197, 59 S. Ct. 206, 85 L. Ed. 126 (1938).

Cf. Mitchell v. Houston General Ins. Co., 620 S.W.2d 730 (Tex. Civ. App. 1981). The claimant appealed from a judgment awarding him compensation for medical expenses and temporary total benefits. He asserted that it was reversible error for the trial court not to submit to the jury issues requested by the claimant regarding partial incapacity resulting from his compensable disability. The appellate court held for the claimant and remanded this case for another trial. The court noted the presentation of evidence by the defendant insurance company which revealed that during the period of the claimant's alleged total incapacity, he had installed siding on a house, operated a chain saw, and dug up a tree stump. But the court stated that, in deciding to charge the jury as to the issue regarding partial incapacity, all evidence to the contrary should have been disregarded and a determination should have been made whether there there existed a "scintilla" of evidence that the claimant experienced partial disability. Here the scintilla existed, since the insurance company had agreed that the claimant had been incapacitated and its evidence of the claimant's physical capabilities raised the issue of disability other than total.

[4] Del Vecchio v. Bowers, 296 U.S. 280, 56 S. Ct. 190, 80 L. Ed. 229 (1935).

Forth v. Northern Stevedoring & Handling Corp., 385 P.2d 944 (Alaska 1963). Board's decision must be affirmed if supported by "substantial evidence in the light of the whole record." (Alaska Stat. § 44.62.010 (Supp. 1967). Lower court's decision, referring to "some evidence," upheld upon finding that "substantial evidence" existed. Termination of benefits sustained.

since these two phrases sound like the largest and smallest quantum described in the various phrases, presumably the others represent the same concept.[5] Of course, when one begins to speak of "any legal"[5.1] or "any competent"[5.2] evidence,

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[5] Cf. Lark v. Bi-Lo, Inc., 276 S.E.2d 304 (S.C. 1981). The court noted that adoption of the A.P.A. had the effect of substituting the "substantial evidence" standard of review for the "any evidence" rule. While stating that the "substantial evidence" rule gives courts more appellate authority, the court's role is still severely limited. The court said:

"While the 'substantial evidence' rule allows more appellate authority to the courts, we think the language of the statute clearly indicates that its application is only in those cases where a manifest or gross error of law has been committed by the administrative agency. The statute specifically states: 'The court shall not substitute its judgment for that of the agency as to the weight of the evidence on questions of fact.' In addition, the statute states that the decision under appeal must be 'clearly erroneous' in view of the substantial evidence on the whole record.

"We, therefore, caution the Bench and Bar as to the limitations upon the application of the 'substantial evidence' rule in reviewing the decision of administrative agencies. As stated in *Dickinson-Tidewater, Inc. v. Supervisor of Assess.*, 273 Md. 245, 329 A.2d 18, 25, the substantial evidence test 'need not and must not be either judicial fact-finding or a substitution of judicial judgment for agency judgment'; and a judgment upon which reasonable men might differ will not be set aside.

". . . The substantial evidence rule, prescribed in the statute, means that we will not overturn a finding of fact by an administrative agency 'unless there is not reasonable probability that the facts could be as related by a witness upon whose testimony the finding was based.' *Independent Stave Co. v. Fulton, 251* Ark. 1086, 476 S.W.2d 792, 793." 276 S.E.2d at 307.

[5.1] Moses v. Pitney Bowes, Inc., 368 So. 2d 545 (Ala. 1979). The court restated its standard of review for workmen's compensation cases: a finding of fact must stand if supported by "any legal evidence." Consequently, if the findings are supported by some evidence, a challenge in the appellate court can be directed only at the trial court's conclusions of law.

Newman Bros., Inc. v. McDowell, 354 So. 2d 1134 (Ala. Civ. App. 1977), cert. denied, 354 So. 2d 1138 (Ala. 1978). The appellate court would not reverse any trial court findings of fact, finding them supported by legal evidence and its reasonable inferences. It held that its only job was to determine whether the correct legal conclusions had been drawn from these facts. Treatise cited.

[5.2] Williams v. Warren Brothers Constr. Co., 412 A.2d 334 (Del. 1980). The claimant petitioned for additional compensation benefits for an alleged

one is no longer dealing with quantitative measurement, but is opening up all the questions about legal quality of evidence dealt with in the last section.

One comes back to this same standard of review whether the statute expressly adopts the substantial-evidence rule, or is silent on review, or even says that the commission's findings of fact shall be conclusive.[6] The frequently heard statement that such findings are "conclusive" must always be taken subject to the implied qualification "if supported by any evidence," since, in the absence of such evidence as indicated above, there is an error of law, and the court, without disturbing the commission's absolute preeminence in the realm of fact-finding, can still reverse for legal error.[7]

§ 80.11 Unreviewability for lack of finality

There is in compensation procedure, just as in any other judicial procedure, such a thing as a completely unreviewable

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recurrence of a previous compensable injury. Oral testimony was admitted for the purpose of impeaching the claimant's credibility by questioning the legitimacy of his original compensable injury. As the evidence was legally irrelevant and would tend to lead the trier of fact away from the central issue, which was the existence of pain during the period between injuries, its admission was reversible error. The court stressed that this evidence focused directly on the claimant's ability to prove the one factor that was crucial to his case. Since Delaware requires that there be substantial *competent* evidence to support an affirmance, the court could not affirm on this state of the record.

Lewis v. City of Liberty, 600 S.W.2d 677 (Mo. App. 1980). The Missouri standard of review requires that an award be supported by competent and substantial evidence upon the whole record. The claimant's medical evidence in a back case failed to meet this standard.

See also Griffin v. Evans Electrical Construction Co., N. 2 *supra* this subsection under *Missouri*.

[6] Some special statutory provisions that might seem to cut off review altogether may on closer examination be found to be less absolute than they appear. See, e.g., the provisions of finality of medical panel findings mentioned at § 80.12(h), N. 37, *infra*.

[7] Craddock's Case, 310 Mass. 116, 37 N.E.2d 508, 146 A.L.R. 116 (1941).

Wisconsin Labor Relations Bd. v. Fred Reuping Leather Co., 228 Wis. 473, 279 N.W. 673 (1938).

matter, as in the case of interlocutory decisions that are unreviewable for lack of finality,[8] or incidental decisions that

(Text continued on page 15-426.328)

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[8] *Federal:* United Fruit Company v. Director, Office of Workers' Comp. Programs, U. S. Dep't. of Labor, 546 F.2d 1224 (5th Cir. 1977). An order of the administrative law judge was reversed by the board and remanded to the judge for a determination of the extent of the claimant's disability and second injury fund liability. The employer attempted to appeal. The appeal was dismissed for lack of finality, since the case had been remanded to the administrative law judge.

See also Freeman v. Kohl & Vick Machine Works, Inc., 673 F.2d 196 (7th Cir. 1982). An employee who had been injured while working in Georgia sued the Illinois manufacturer of the machine he was operating at the time of injury. The manufacturer impleaded the plaintiff's employer for indemnity and the employer moved for summary judgment, contending that the action against it was barred by Georgia's compensation law. The district court judge denied the employer's motion for summary judgment, holding that Illinois law, which allows employer indemnity actions, applied. The employer appealed, contending that the denial of summary judgment was a collateral order denying its vested right of immunity under the Georgia law. The court dismissed the appeal, holding that, even if it were clear that Georgia law applied, that law did not grant employers immunity from suit but only immunity from recovery against them; therefore, the denial of summary judgment was a non-appealable interlocutory order.

Holmes & Harver, Inc. v. Christian, 1 Ben. Rev. Bd. Serv. 85 (1974). A decision of an administrative law judge denying a motion by an employer for summary judgment and remanding the case to the Deputy Commissioner is not a decision appealable to the Benefits Review Board within the meaning of the Longshoremen's and Harbor Workers' Compensation Act, since denial of summary judgment further contemplates a trial of the disputed facts.

Muldowney v. Lavino Shipping Co.; Lind v. Independent Pier Co.; and Parks v. Lavino Shipping Co., 1 Ben. Rev. Bd. Serv. 171 (1974). The decision of an administrative law judge which held that claims do come within the provisions of the Longshoremen's and Harbor Workers' Compensation Act, but which did not decide the issue of liability, is not a matter appealable to the Benefits Review Board, since the Board entertains appeals only from final, and not interlocutory, orders.

Baze v. Visiting Nurses Ass'n, 1 Ben. Rev. Bd. Serv. 256 (1974). A decision of an administrative law judge that claimant did not compromise her claim against a third party so as to extinguish the employer-carrier's liability is an interlocutory order that is not appealable pursuant to Section 21 of the Longshoremen's and Harbor Workers' Compensation Act.

Proposed insurance risk pool makes waves

Anch. Times 1/9/88

By Ann Chandonnet
Times Writer

An Eagle River woman is determined to change Alaska's health insurance law by making insurance companies provide health coverage to anyone who wants it.

"If Alaska can set up a risk pool for insurance for drunk drivers, why can't they have a risk plan for sick people, too?" asked Nina Magnusson.

But insurance companies warn such a plan might force cutbacks in benefits for all insurance customers.

A recent state Department of Health and Social Services study says that 10 percent of all Alaskans, or about 40,000 individuals, have no form of health insurance.

Under Magnusson's proposal, all health insurance companies would be required to form a pool, issuing medical insurance to all applicants.

A risk pool is a not-for-profit corporation that every insurer doing health insurance business in the state must participate in. For example, if Blue Cross or United of Omaha wanted to continue to do business in Alaska, it would have to do business in the high risk pool. An individual applying for coverage would purchase coverage through the pool only if that person were uninsurable through an ordinary insurance policy.

Magnusson plans to start a petition drive to place the issue on the ballot next fall. As her model she is using new legislation that recently went into effect in the state of Washington.

According to Joan Gaumer, vice president of governmental relations of Blue Cross in Seattle, if the overall costs of providing care for a year exceed the total premiums paid, losses accruing to the high risk pool would be shared by the insurance companies on a pro rata basis. If Blue Cross, for example, provided 20 percent of the insurance, it would embrace 20 percent of the losses.

Group coverage through employers would not be affected by the passage of a risk pool bill, Gaumer said.

"Many people who are not employed who try to buy insurance as an individual have health conditions that make them uninsurable," said Gaumer. "Those people would go to the high risk pool with proof that they have been turned down, and they would be eligible to purchase through the pool," said Gaumer.

Various versions of legislation would put a ceiling on premiums between 150 and 200 percent of the average.

Magnusson became interested in the subject of risk pool insurance when her own medical insurance was canceled. Magnusson, her husband and daughter had health insurance under the small business benefit plan of the Leland A. Wolf Company of California since 1983. It was canceled after her insurance company cited large claims from AIDS victims. "Because they got really stung with AIDS, they canceled everyone's policies," Magnusson said.

Magnusson knows the problem of high medical costs firsthand, having recently spent three days in a coronary care unit. Her room cost $1,500 a day. Physicians' fees, tests and other charges ran the total up to about $10,000.

She no longer had insurance to cover the costs. Leland A. Wolf had advised her in March that her premium would double to $660 a month. In July, the premium was increased to $690. In August, the family's insurance was canceled.

That was before she was hospitalized. Now that she has been diagnosed as having chronic obstructive pulmonary disease and may need further surgery, her condition is considered "a pre-existing condition" and its costs will not be covered even if she finds another insurance company willing to take her on as a client or obtains coverage through her husband.

Magnusson's proposal is not without controversy because it could affect all insurance customers.

"As the economy declines in Anchorage and the cost of health insurance goes up," Blue Cross' Gaumer said, "there are more and more companies saying they are going to cut back on benefits because we can't afford this. A risk pool law would cause more cutbacks because it does not apply to self-insured companies."

Along with Magnusson's petition drive, the campaign for risk pool insurance has several other fronts. Both Rep. Sam Cotton (D-Eagle River) and Rep. John Fund (D-Ketchikan) have sponsored risk pool legislation.

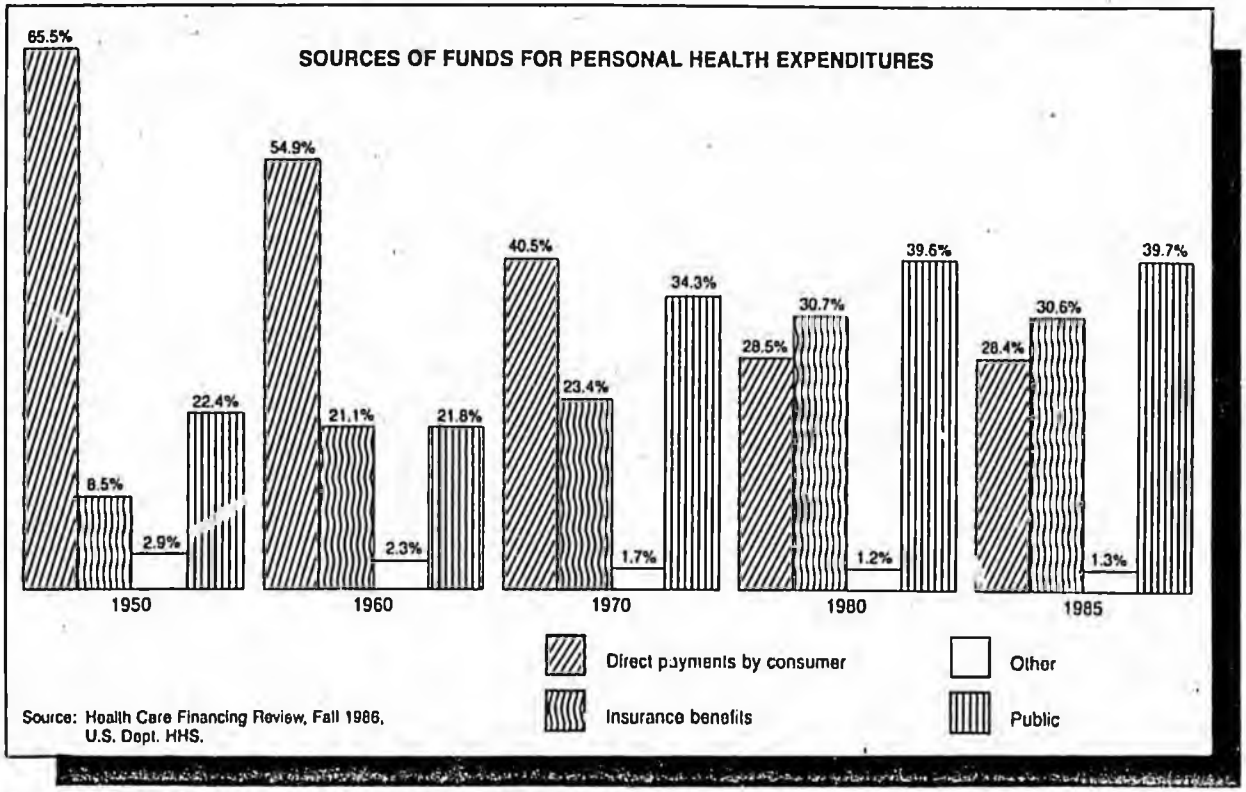
Cotton's bill, which hasn't yet been introduced to the legislature, is fashioned after the insurance law in Washington state, said Julie Krafft, Cotton's assistant. "Everyone in the state would be eligible to join," Krafft said. "It is an option for people who are uninsurable because of pre-existing medical conditions or can't get (health) insurance any other way."

Fund's bill was introduced to the state House of Representatives last year and is still in committee, said Blue Cross' Gaumer. Fund's bill is similar to model legislation drafted by the National Association of Insurance Commissioners, said Gaumer.

Despite her health problems, Magnusson has spent time in Olympia reviewing the Washington bill with officials there. She said that a lobbyist for the Washington law, podiatrist Richard E. Harmon of Olympia, is willing to come to Alaska to help the cause.

Local medical personnel have been less cooperative, she said: "I have talked to a lot of doctors here, but I have got a lot of flak. They think it's a welfare program. But it's not. People pay their own premiums."

See Health, page B-10



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Health

Continued from page B-5

An interim committee on health care recently appointed by Gov. Steve Cowper had its first meeting in December and is looking for ways to provide health care insurance not only for the uninsurable but for others looking for health care, said Gaumer.

There's one big issuing remaining in Washington, and that is the issue of tax offset, said Gaumer.

INFORMATION PAGE

Blank Insurance Company Policy No. _____

1. The Insured: — Individual — Partnership
   Mailing address: — Corporation or _____
   Other workplaces not shown above:

2. The policy period is from _____ to _____ at the insured's mailing address.

3. A. Workers Compensation Insurance: Part One of the policy applies to the Workers Compensation Law of the states listed here:

   B. Employers Liability Insurance: Part Two of the policy applies to work in each state listed in Item 3.A.
   The limits of our liability under Part Two are: Bodily Injury by Accident $_____ each accident
   Bodily Injury by Disease $_____ policy limit
   Bodily Injury by Disease $_____ each employee

   C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here:

   D. This policy includes these endorsements and schedules:

4. The premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All information required below is subject to verification and change by audit.

Classifications	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium

Total Estimated Annual Premium $

Minimum Premium $ Expense Constant $

Countersigned by: _____

INFORMATION PAGE NOTES

1. The sequence of Items 1 through 4 of the Information Page may not be changed except for Item 3.D. (See Note 11.) The format of each item may be rearranged and these suggested headings may be used: 1. Insured; 2. Policy Period; 3. Coverage; and 4. Premium.

2. The name of the insurer is to be shown prominently on the Information Page. Multi-company groups must, in addition, make appropriate reference to the name or the 5 digit NCCI carrier code of the member of the group providing the insurance. The inclusion of the 5 digit NCCI carrier code on the Information Page is desired in all independent bureau states.

   The address and kind of insurer (stock, mutual, or other) are to be shown on the Information Page, the policy, or a policy jacket.

3. The policy number must be shown on the Information Page. This number should be unique to the company and remain constant during the policy period. It should be used on all endorsements issued after the policy is issued.

   If the policy number displayed on the Information Page contains a policy symbol consisting of alpha-numeric digits that are not entered into the carrier's internal statistical records as part of the actual policy number, it is advisable to separate and appropriately label both the policy symbol and actual policy number.

4. Use appropriate text on the Bureau copy of a renewal policy Information Page to designate the prior policy by number. New business may be designated "New." At its option, the company may show this on the insured's copy of the Information Page.

   New Business must be designated "New" in California and New Jersey, and the policy number of a rewritten or replaced policy must also be on the Information Page in all of the independent bureau states.

5. On the Bureau copy of the Information Page, show the letters "AR" next to the title "Information Page" if the insured is an assigned risk.

6. Reserve space in Item 1 of the Bureau copy to show, if required, the insured's identification number. The company may also show this on the Information Page at its option. Commonly required numbers are listed here:

   Arkansas Workers Compensation File Number; Association File Number of Minnesota Assigned Risks; Bureau File Number for Minnesota and Texas; Hawaii Unemployment Number; Illinois Assigned Risk Unemployment Number, Interstate Identification Number, Intrastate Identification Number; Oregon Contract Number; and State Employer Number.

7. List in Item 1 or by schedule all usual workplaces of the insured that are to be covered by the policy. Also include the respective federal employer's identification number, appropriately labeled, for each entity included on the policy.

8. The effective date and hour of the policy, and its expiration date and hour must be shown in Item 2. The hour may be included as part of the printed form at the company's option.

9. List in Item 3.A. states where state workers compensation insurance is provided. If none is provided, "none" or "not covered" may be shown. See, for example, the notes to the Federal Coal Mine Health and Safety Act Coverage Endorsement.

10. Show limits of liability separately for bodily injury by accident and by disease in Item 3.B.

Information Page Notes—Continued

11. States may be shown in Item 3.C. by name or by designation, but do not name or designate a state listed in Item 3.A., a monopolistic state fund state, or a state where the insurer will not provide this coverage.

    The following entry may also be included: "All states except Nevada, North Dakota, Ohio, Washington, West Virginia, Wyoming, states designated in Item 3.A. of the Information Page and _____."

    If the company learns that the insured is conducting operations in a 3.C. state, and if the company agrees to continue coverage, the company should add that state to Item 3.A. and remove it from Item 3.C. Normal company procedures apply when the state is added to Item 3.A.

12. Item 3.D. may be omitted so long as the list of the policy's schedules and endorsements appears somewhere on the Information Page. Endorsements for which the company has not filed specimen copies with NCCI must be attached to the Information Page filed with NCCI, as provided in section II.B.2. of the Basic Manual for Workers Compensation and Employers Liability Insurance. Endorsements and schedules applicable to Wisconsin operations must be attached to the Information Page filed with the Wisconsin Bureau.

13. The content of Item 4 may be rearranged by the company. If the policy is issued for less than one year, the company may state whether the premium information is shown for the policy period or for an annual period.

14. In Item 4, the development of estimated annual premium shall be displayed separately for each classification by state. This same display of premium development must be shown on any classification schedules attached to the policy. Total Estimated Standard Premium must be shown by state on the Information Page or on a schedule attached to the policy.

    Item 4 must include and identify all charges or credits affecting the final estimated annual premium for the states of California, Delaware, New Jersey, New York and Pennsylvania. The final estimated annual premium as presented to the insured must be shown. Where statistical codes apply to an item in Delaware or Pennsylvania, the code should be entered in the classification field.

15. The experience rating modification factor shall be shown in Item 4 for risks subject to the experience rating plan, unless this factor is not available when the policy is issued. The company then may make an appropriate entry in Item 4 to show that the factor is not available. See the Experience Rating Modification Factor Endorsement for more information.

    In those states where a schedule rating plan has been filed and approved, report the schedule rating information in Item 4, as required by the filed plan.

16. Premium discount may be shown in Item 4, the Premium Discount Endorsement, or both. Premium discount does not apply in California.

17. Taxes, assessments, deposit premium, interim adjustments of premium, the rating plan, past experience, cancelation of similar insurance, date and place of policy issuance, date and place of countersignature, and other related information may be shown in Item 4. The deposit premium and the resultant premium adjustment periods must be shown in Item 4 in California, Delaware, New Jersey, New York and Pennsylvania.

    The policy issuing office and the date of issue must be shown on the Information Page in the states of California, Delaware, New Jersey, Pennsylvania and Wisconsin. The name of the agent or producer, if any, must be shown on the Information Page in Delaware, New Jersey and Pennsylvania. This is optional in California and New York.

Information Page Notes—Continued

18. Three Year Fixed Rate Policies must be so designated on the Information Page as required by Rule XI of the Basic Manual.

19. Other entries may be made on the Information Page as authorized by Notes to Standard Endorsements, including: Anniversary Rating Date; Defense Base Act Coverage; Nonappropriated Fund Instrumentalities Act Coverage; Partners, Officers and Others Exclusion; Pending Rate Change; Sole Proprietors, Partners, Officers and Others Coverage; and Voluntary Compensation Maritime Coverage Endorsements.

20. The company may place the execution clause at the end of the Information Page, at the end of the standard policy, or on a policy jacket.

    Refer to the sample Information Page in the New Jersey section of the Basic Manual for Workers Compensation and Employers Liability Insurance for a description of New Jersey requirements.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY
QUICK REFERENCE

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY
QUICK REFERENCE

IMPORTANT: This Quick Reference is **not** part of the Workers Compensation and Employers Liability Policy and does **not** provide coverage. Refer to the Workers Compensation and Employers Liability Policy itself for actual contractual provisions.

PLEASE READ THE WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY CAREFULLY.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

In return for the payment of the premium and subject to all terms of this policy, we agree with you as follows.

GENERAL SECTION

A. The Policy

This policy includes at its effective date the Information Page and all endorsements and schedules listed there. It is a contract of insurance between you (the employer named in item 1 of the Information Page) and us (the insurer named on the Information Page). The only agreements relating to this insurance are stated in this policy. The terms of this policy may not be changed or waived except by endorsement issued by us to be part of this policy.

B. Who Is Insured

You are insured if you are an employer named in item 1 of the Information Page. If that employer is a partnership, and if you are one of its partners, you are insured, but only in your capacity as an employer of the partnership's employees.

C. Workers Compensation Law

Workers Compensation Law means the workers or workmen's compensation law and occupational disease law of each state or territory named in item 3.A. of the Information Page. It includes any amendments to that law which are in effect during the policy period. It does not include the provisions of any law that provide nonoccupational disability benefits.

D. State

State means any state of the United States of America, and the District of Columbia.

E. Locations

This policy covers all of your workplaces listed in items 1 or 4 of the Information Page; and it covers all other workplaces in item 3.A. states unless you have other insurance or are self-insured for such workplaces.

PART ONE - WORKERS COMPENSATION INSURANCE

A. How This Insurance Applies

This workers compensation insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. Bodily injury by accident must occur during the policy period.
2. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

B. We Will Pay

We will pay promptly when due the benefits required of you by the workers compensation law.

C. We Will Defend

We have the right and duty to defend at our expense any claim, proceeding or suit against you for benefits payable by this insurance. We have the right to investigate and settle these claims, proceedings or suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance.

D. We Will Also Pay

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding or suit we defend:

1. reasonable expenses incurred at our request, but not loss of earnings;
2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the amount payable under this insurance;
3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

E. Other Insurance

We will not pay more than our share of benefits and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that may apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance will be equal until the loss is paid.

F. **Payments You Must Make**

You are responsible for any payments in excess of the benefits regularly provided by the workers compensation law including those required because:

1. of your serious and willful misconduct;
2. you knowingly employ an employee in violation of law;
3. you fail to comply with a health or safety law or regulation; or
4. you discharge, coerce or otherwise discriminate against any employee in violation of the workers compensation law.

If we make any payments in excess of the benefits regularly provided by the workers compensation law on your behalf, you will reimburse us promptly.

G. **Recovery From Others**

We have your rights, and the rights of persons entitled to the benefits of this insurance, to recover our payments from anyone liable for the injury. You will do everything necessary to protect those rights for us and to help us enforce them.

H. Statutory Provisions

These statements apply where they are required by law.

1. As between an injured worker and us, we have notice of the injury when you have notice.
2. Your default or the bankruptcy or insolvency of you or your estate will not relieve us of our duties under this insurance after an injury occurs.
3. We are directly and primarily liable to any person entitled to the benefits payable by this insurance. Those persons may enforce our duties; so may an agency authorized by law. Enforcement may be against us or against you and us.
4. Jurisdiction over you is jurisdiction over us for purposes of the workers compensation law. We are bound by decisions against you under that law, subject to the provisions of this policy that are not in conflict with that law.
5. This insurance conforms to the parts of the workers compensation law that apply to:
   a. benefits payable by this insurance;
   b. special taxes, payments into security or other special funds, and assessments payable by us under that law.
6. Terms of this insurance that conflict with the workers compensation law are changed by this statement to conform to that law.

Nothing in these paragraphs relieves you of your duties under this policy.

PART TWO - EMPLOYERS LIABILITY INSURANCE

A. **How This Insurance Applies**

This employers liability insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. The bodily injury must arise out of and in the course of the injured employee's employment by you.
2. The employment must be necessary or incidental to your work in a state or territory listed in item 3.A. of the Information Page.
3. Bodily injury by accident must occur during the policy period.
4. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.
5. If you are sued, the original suit and any related legal actions for damages for bodily injury by accident or by disease must be brought in the United States of America, its territories or possessions, or Canada.

B. **We Will Pay**

We will pay all sums you legally must pay as damages because of bodily injury to your employees, provided the bodily injury is covered by this Employers Liability Insurance.

The damages we will pay, where recovery is permitted by law, include damages:

1. for which you are liable to a third party by reason of a claim or suit against you by that third party to recover the damages claimed against such third party as a result of injury to your employee;
2. for care and loss of services; and
3. for consequential bodily injury to a spouse, child, parent, brother or sister of the injured employee;

provided that these damages are the direct consequence of bodily injury that arises out of and in the course of the injured employee's employment by you; and

4. because of bodily injury to your employee that arises out of and in the course of employment, claimed against you in a capacity other than as employer.

C. **Exclusions**

This insurance does not cover:

1. liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;
2. punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
3. bodily injury to an employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your executive officers;
4. any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;
5. bodily injury intentionally caused or aggravated by you;
6. bodily injury occurring outside the United States of America, its territories or possessions, and Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;
7. damages arising out of the discharge of, coercion of, or discrimination against any employee in violation of law.

D. **We Will Defend**

We have the right and duty to defend, at our expense, any claim, proceeding or suit against you for damages payable by this insurance. We have the right to investigate and settle these claims, proceedings and suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance. We have no duty to defend or continue defending after we have paid our applicable limit of liability under this insurance.

E. **We Will Also Pay**

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding, or suit we defend:

1. reasonable expenses incurred at our request; but not loss of earnings;
2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the limit of our liability under this insurance;
3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

F. **Other Insurance**

We will not pay more than our share of damages and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance and self-insurance will be equal until the loss is paid.

G. **Limits of Liability**

Our liability to pay for damages is limited. Our limits of liability are shown in item 3.B. of the Information Page. They apply as explained below.

1. Bodily Injury by Accident. The limit shown for "bodily injury by accident-each accident" is the most we will pay for all damages covered by this insurance because of bodily injury to one or more employees in any one accident.

A disease is not bodily injury by accident unless it results directly from bodily injury by accident.

2. Bodily Injury by Disease. The limit shown for "bodily injury by disease-policy limit" is the most we will pay for all damages covered by this insurance and arising out of bodily injury by disease, regardless of the number of employees who sustain bodily injury by disease. The limit shown for "bodily injury by disease-each employee" is the most we will pay for all damages because of bodily injury by disease to any one employee.

   Bodily injury by disease does not include disease that results directly from a bodily injury by accident.

3. We will not pay any claims for damages after we have paid the applicable limit of our liability under this insurance.

H. **Recovery From Others**

We have your rights to recover our payment from anyone liable for an injury covered by this insurance. You will do everything necessary to protect those rights for us and to help us enforce them.

I. **Actions Against Us**

There will be no right of action against us under this insurance unless:

1. You have complied with all the terms of this policy; and
2. The amount you owe has been determined with our consent or by actual trial and final judgment.

This insurance does not give anyone the right to add us as a defendant in an action against you to determine your liability.

PART THREE - OTHER STATES INSURANCE

A. **How This Insurance Applies**

1. This other states insurance applies only if one or more states are shown in item 3.C. of the Information Page.
2. If you begin work in any one of those states and are not insured or are not self-insured for such work, the policy will apply as though that state were listed in item 3.A. of the Information Page.
3. We will reimburse you for the benefits required by the workers compensation law of that state if we are not permitted to pay the benefits directly to persons entitled to them.

B. **Notice**

Tell us at once if you begin work in any state listed in item 3.C. of the Information Page.

PART FOUR - YOUR DUTIES IF INJURY OCCURS

Tell us at once if injury occurs that may be covered by this policy. Your other duties are listed here.

1. Provide for immediate medical and other services required by the workers compensation law.
2. Give us or our agent the names and addresses of the injured persons and of witnesses, and other information we may need.
3. Promptly give us all notices, demands and legal papers related to the injury, claim, proceeding or suit.
4. Cooperate with us and assist us, as we may request, in the investigation, settlement or defense of any claim, proceeding or suit.
5. Do nothing after an injury occurs that would interfere with our right to recover from others.
6. Do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE - PREMIUM

A. **Our Manuals**

All premium for this policy will be determined by our manuals of rules, rates, rating plans and classifications. We may change our manuals and apply the changes to this policy if authorized by law or a governmental agency regulating this insurance.

B. **Classifications**

Item 4 of the Information Page shows the rate and premium basis for certain business or

work classifications. These classifications were assigned based on an estimate of the exposures you would have during the policy period. If your actual exposures are not properly described by those classifications, we will assign proper classifications, rates and premium basis by endorsement to this policy.

C. **Remuneration**

Premium for each work classification is determined by multiplying a rate times a premium basis. Remuneration is the most common premium basis. This premium basis includes payroll and all other remuneration paid or payable during the policy period for the services of:

1. all your officers and employees engaged in work covered by this policy; and
2. all other persons engaged in work that could make us liable under Part One (Workers Compensation Insurance) of this policy. If you do not have payroll records for these persons, the contract price for their services and materials may be used as the premium basis. This paragraph 2 will not apply if you give us proof that the employers of these persons lawfully secured their workers compensation obligations.

D. **Premium Payments**

You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid.

E. **Final Premium**

The premium shown on the Information Page, schedules, and endorsements is an estimate. The final premium will be determined after this policy ends by using the actual, not the estimated, premium basis and the proper classifications and rates that lawfully apply to the business and work covered by this policy. If the final premium is more than the premium you paid to us, you must pay us the balance. If it is less, we will refund the balance to you. The final premium will not be less than the highest minimum premium for the classifications covered by this policy.

If this policy is canceled, final premium will be determined in the following way unless our manuals provide otherwise.

1. If we cancel, final premium will be calculated pro rata based on the time this policy was in force. Final premium will not be less than the pro rata share of the minimum premium.
2. If you cancel, final premium will be more than pro rata; it will be based on the time this policy was in force, and increased by our short rate cancelation table and procedure. Final premium will not be less than the minimum premium.

F. **Records**

You will keep records of information needed to compute premium. You will provide us with copies of those records when we ask for them.

G. **Audit**

You will let us examine and audit all your records that relate to this policy. These records include ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data. We may conduct the audits during regular business hours during the policy period and within three years after the policy period ends. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

PART SIX - CONDITIONS

A. **Inspection**

We have the right, but are not obliged to inspect your workplaces at any time. Our inspections are not safety inspections. They relate only to the insurability of the workplaces and the premiums to be charged. We may give you reports on the conditions we find. We may also recommend changes. While they may help reduce losses, we do not undertake to perform the duty of any person to provide for the health or safety of your employees or the public. We do not warrant that your workplaces are safe or healthful or that they comply with laws, regulations, codes or standards. Insurance rate service organizations have the same rights we have under this provision.

B. **Long Term Policy**

If the policy period is longer than one year and sixteen days, all provisions of this policy will apply as though a new policy were issued on each annual anniversary that this policy is in force.

C. **Transfer of Your Rights and Duties**

Your rights or duties under this policy may not be transferred without our written consent.

If you die and we receive notice within thirty days after your death, we will cover your legal representative as insured.

D. **Cancelation**

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancelation is to take effect.
2. We may cancel this policy. We must mail or deliver to you not less than ten days advance written notice stating when the cancelation is to take effect. Mailing that notice to you at your mailing address shown in item 1 of the Information Page will be sufficient to prove notice.
3. The policy period will end on the day and hour stated in the cancelation notice.
4. Any of these provisions that conflicts with a law that controls the cancelation of the insurance in this policy is changed by this statement to comply with that law.

E. **Sole Representative**

The insured first named in item 1 of the Information Page will act on behalf of all insureds to change this policy, receive return premium, and give or receive notice of cancelation.

GOVERNOR'S OVERSIGHT GROUP REPORT ON SB 322/HB 352

Workers' Compensation Act - AS 23.30

The Oversight Group consists of the following persons:

Darlene Norris, Chairperson. Ms. Norris is a paralegal working for the firm of Pletcher and Slaybaugh, and devotes her time almost exclusively to the handling of workers' compensation claims, principally on behalf of employers.

Richard Block. Mr. Block is currently a financial, insurance and risk management consultant, and is former Director of the State of Alaska's Division of Insurance, former Chief Executive for a property and casualty insurer in Alaska, which is a predominant market for workers' compensation insurance, and an attorney.

Chancy Croft. Mr. Croft is an attorney in Anchorage, specializing in the handling of workers' compensation cases on behalf of injured workers, and is a former state legislator.

Gordon DePue. Mr. DePue is a Fairbanks insurance agent with the firm of Alaska 100, Inc., and past president of the Independent Agent's and Broker's of Alaska.

Michael James, M.D. Dr. James is an Anchorage physician, specializing in rehabilitative medicine, and operates a rehabilitation and pain clinic catering especially to injured workers.

J. Anthony Smith. Mr. Smith is an Anchorage attorney and is currently serving as Commissioner of the Department of Commerce and Economic Development.

James Sampson. Mr. Sampson is a former labor union representative and is currently serving as Commissioner of the Department of Labor.

The Oversight Group has been served by several advisors and staff.

Paul Roller. Mr. Roller is an attorney and is currently serving as Deputy Director for the Division of Insurance.

Jackie McClintock. Ms. McClintock is currently serving as Director of the Division of Workers' Compensation.

Jan Hansen. Ms. Hansen is currently serving as Chief of the Administrative Hearing Section of the Division of Workers' Compensation.

Jon Deisher. Mr. Deisher is currently a private consultant in rehabilitation and is the former Rehabilitation Administrator in the Division of Workers' Compensation.

Spencer Bolesta. Mr. Bolesta is currently an employee with the Division of Insurance and was instrumental in the preparation of this report.

The Oversight Group met for close to 60 hours on these days:

January 6, 1988	(All Day)
January 12, 1988	(5 Hours)
January 13, 1988	(Subcommittee - 1 Hour)
January 19, 1988	(5 Hours)
January 26, 1988	(5 Hours)
February 6, 1988	(All Day)
February 11, 1988	(5 Hours)
February 13, 1988	(All Day)
February 19, 1988	(All Day)
February 20, 1988	(5 Hours)

The Oversight Group was chaired by Darlene Norris, and consisted of Richard Block, Gordon DePue, Michael James, M.D., Chancy Croft, J. Anthony Smith, James Sampson.

The meetings were open to the public, and in fact, representatives of labor, employers, health care providers, lawyers, rehabilitation specialists, injured workers and the insurance industry were present at nearly all of the meetings.

The Oversight Group took written and oral testimony from numerous contributors and witnesses. Where pertinent to the findings, they will be specifically identified further in this report.

The Problem

Average workers' compensation premium costs have increased as reflected by increased rate filings of 14%, effective in 1987, and 25%, effective in 1988. The number of workers' compensation injuries decreased from 30,000 in 1985 to 25,000 in 1987. The frequency of injuries reached a 10 year high in 1985. No figures for frequency are available yet for subsequent years.

According to the National Council of Compensation Insurers (NCCI), the majority of the increased costs were due to loss development. The largest factor was increased indemnity costs. Another portion was due to increased medical/rehabilitation costs. There are no statistics available from either the Department of Commerce and Economic Development or the Department of Labor to verify or substantiate these figures in their entirety.

The major increases are in employment areas such as oil and gas, and construction, which historically have had high frequency and severity of injury rates. Not all employers are equally effected. Some employers actually have a rate decrease this year.

The purpose of workers' compensation is to ensure that the cost of injury to workers - their wage loss, treatment and rehabilitation - is reflected in the cost to the product sold by the employer. To the extent that increased injuries are causing increased premiums, the solution is not to reduce benefits, but to reduce injuries.

Actuarial Study

It became clear at the outset that to do a proper job of analyzing the legislation from a cost standpoint, we needed data that had not been gathered, correlated, or studied by anyone up to the time of the first meeting. It was requested that an actuarial firm be hired to provide the Oversight Group with information on the costs incurred or saved by the proposed legislation, and to review the work of the insurance rating organization, which had done some costing for the insurance carriers.

We are most grateful to the Governor's Office, the offices of J. Anthony Smith, Commissioner of Commerce and Economic Development, and the Division of Insurance for responding quickly in providing the funding for the actuarial study.

The firm of Milliman & Robertson, consulting actuaries in Pasadena, California, did a thorough job in a very short period of time. Much of our conclusions on cost impact are based on their report to us.

Purpose

The Oversight Group took as its purpose the following charge:

> To review the subject legislation and report to the Governor on its merit in light of the following criteria:
>
> > The Act should result in a meaningful and immediate reduction of costs, either as self-insured costs or workers' compensation premiums, to Alaska's employers.
> >
> > The Act should result in making a benefit delivery system, including the resolution of differences between the injured worker and the employer, as efficient and cost effective as possible.
>
> The Oversight Group was not given a specific cost reduction target, so it has adopted the following:
>
> > Costs should be reduced such that there will be an immediate and measurable savings of 10% from the levels ultimately determined for the system as it currently exists.
>
> The Oversight Group determined that there should be an additional measure based on the merit of the legislative proposals as follows:
>
> > The Act should accomplish the other objectives without sacrificing fundamental fairness to either the injured worker or the employer, nor jeopardize the legitimate entitlements of the truly injured worker.

Findings

The proposed legislation is long and complex. It makes many changes to the existing statutes - some technical, some fundamental, and some with sweeping economic impacts on various classes and subclasses of persons.

It has not been the effort of the Oversight Group to address every change as if we were engaged as commentators to the legislative body. Rather, we focused on the fundamental concepts involved in the legislation. There are only two areas where the Oversight Group has taken the liberty of offering specific language as an alternative to the language of the legislation.

Intent

The legislation contains a comprehensive declaration of intent. The purpose is to limit the degree to which the Supreme Court or the inferior courts modify the understood intent of the legislature and change the benefit structure through judicial interpretation causing unpredictability in the costs.

The courts have traditionally construed workers' compensation statutes in the same way that all other changes in the common law have been construed - that is, to reflect their remedial purpose. In addition, the Supreme Court has clearly said that the statute must be interpreted so as to be fair to both employees and employers; State vs. Gronroos, 697 P.2d 1047 (Alaska, 1985). The bill's intent is also contrary to the legislative intent regarding insurance premium rating:

> "This chapter shall be liberally interpreted to carry into effect the intent of this section." (AS 21.39.101)

The intent language also attempts to eliminate civil litigation by affording a high degree of finality to the opinions of the administrative hearing process.

Finally, the intent language attempts to justify the inclusion in the legislation of the adjustment of benefits to injured workers who leave the state.

It is our belief that the intent language is drafted in such a way as to not fully accomplish the desired objectives, although we believe it is appropriate that intent language be included which would do what we believe the drafters hoped to accomplish. It is our opinion that the "any evidence" language in the intent wording will create an opportunity for perpetuating unfairnesses in Board rulings and the price in fairness is not worth the dollar savings, which we regard as minimal.

Recommendation

(1) The intent language be redrafted to accomplish the desired objectives more specifically. The "any evidence" concept should be replaced by an approach that regards "substantial evidence". We offer a draft of a proposed alternative. See Exhibit "A".

Second Injury Fund

The legislation includes substantial revisions in the way the assessment is collected from insurers to fund the Second Injury Fund.

(2) It is the consensus of the Oversight Group that the Second Injury Fund has outlived its usefulness and should be eliminated. We see potential savings to the system as well as to the State as an unnecessary function of State government may be eliminated by termination of the fund.

There will have to be an orderly means provided for running off existing claims in the Second Injury Fund.

Recommendation

The Second Injury Fund be terminated and an orderly means established for liquidating existing claims in the fund.

Medical Management

The legislation contains several proposals for containing the cost and utilization of medical care. Among the proposal are the following:

Giving the Board more oversight and control of medical utilization and service fees by establishing a standard of "usual and customary" for fees, and providing that the Board can employ peer review organizations to review medical provider services.

Creating limits on repetitive treatments without prior notice to employers.

(3) Limiting the ability of injured workers to "doctor shop" by limiting the number of times he or she may change physicians.

Establishing a more expeditious system for obtaining independent medical examinations, giving presumptive weight for their findings, and providing independent medical examiners with immunity from civil suit.

Changing the role of the physician in making findings pertinent to the benefit delivery system, e.g., instead of the physician being asked to determine if the employee can perform at a certain job, he or she need only find medically determinable factors, such as medical stability and physical capacities.

Immediate Payment of Claims

The legislation addresses a technical problem among employers or insurers that has resulted in a fundamental unfairness for injured workers. When a claim is brought against several employers because it is uncertain which of the employers is responsible, or against one employer for injuries that may have occurred in several different time periods covered by different insurers, no payments are made by anyone until the dispute among employers and insurers has been resolved. This bill requires the last insurer or employer to pay and administer the claim and then resolve the dispute with the other employers or insurers afterwards.

We believe this to be a useful addition to the Act.

Calculation of Compensation Rate

Provides for the maximum of $700 a week compensation benefits. This provision seems arbitrary and results in no significant cost savings. It provides a mechanism by which the minimum compensation can be raised from $110 to $154 a week. Some people have said this provision is an automatic raise but it in fact is not. It will require documentation of earning capacity. It is the feeling of the Oversight Task Force that the possibility of raising compensation from $110 up to approximately $190 per week is not worth the removal of the Board's discretion to determine wage earning capacity in other cases where people have a different - either higher or lower - earning capacity. The present Statute is a better method of insuring fairness, which is one of the goals of workers' compensation.

The compensation rate will be calculated by dividing the last two calendar year earnings by 100, which is current law, but with far fewer exceptions than is currently allowed by judicial interpretation.

Wages will include that portion of pension and profit sharing contributions made by the employer during the preceding two calendar years equal to the percentage the worker has vested at the time of injury. This portion of the compensation rate would be offset by pension or profit sharing benefits received because of the injury.

We make no recommendation since these provisions are simply the result of negotiations of labor and employer representatives. However, it is our finding that all the provisions taken together probably offer little or no aggregate savings and may potentially have a slight tendency to inc se costs.

Out of State Benefits

In 1976 a law was passed to reduce the benefits paid to injured workers who left the State. That law was found unconstitutional by the Alaska Supreme Court. There are provisions in this legislation that attempt to restore the provisions for reducing benefits to out of state claimants, but with language which the drafters believe solve the concerns the Supreme Court said made the earlier provision unconstitutional.

The Oversight Group makes no finding as to whether the legislation will stand up to further constitutional challenge, but we believe the provisions are appropriate from the standpoint of system fairness. The actuarial firms who testified before us and who thoroughly reviewed this bill, concluded there would be a rate savings of up to 2.2% if the legislation passed the test of constitutionality.

Approximately 30% of claimants live out of state. Milliman & Robertson estimate this section would result in a premium reduction of 2.2%.

Mental Stress

By judicial interpretation, a newly emerging class of claims threatens to materially increase the cost of the system, the claim for mental stress without physical trauma. Although there is little experience in Alaska with this phenomena, we recognize the concern of employers that this class of claim may become very expensive. This legislation precludes mental stress claims except in very limited cases.

The proposed language should be modified to read as follows:

> The work stress was the predominant cause of the mental injury; the amount of work stress shall be measured by actual events rather than misperceptions by the employee; a mental injury is not considered to arise out of and in the course of employment if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, termination or similar action, taken in good faith by the employer.[1]

Temporary Benefits

One of the most significant changes in the law proposed by this legislation is the limit on temporary benefits to two years. Studies done in other states suggest that the average healing period is about six months and that extended healing periods can last up to eighteen months. Since 1982, the adoption in Alaska of a comprehensive rehabilitation benefit scheme, a significant number of temporary benefit claims have lasted longer than two years.

Information received by the Oversight Group seems to suggest there is a correlation between the availability of extended temporary benefits and the availability of rehabilitation benefits that has contributed to the over-utilization of rehabilitation and the extension of the Temporary Total Disability (TTD) and the Temporary Partial Disability (TPD).

A limit of two years on TTD will not work an unfairness for injured workers in the vast majority of cases and will have both an indirect favorable impact on costs by reducing the incentive to utilize the rehabilitation benefit and have a direct savings on time loss payments which the actuarial firms suggest will result in an overall savings of about 3%.

[1] There was not unanimous agreement on this issue. See page 10 infra.

The Oversight Group believes that a definite mechanism must be included to provide temporary benefits beyond two years for the truly catastrophically injured worker and 2 of the 4 voting members believe temporary total should be paid during the entire rehabilitation process, the 7 year limit not withstanding.

REHABILITATION

Rehabilitation has probably been the focus of more attention during the debate on workers' compensation reform than any other single aspect of the bill. We believe the reason is that much of the dramatic increase in cost in the system occurred after the adoption of the present rehabilitation benefit scheme in 1982. It is perceived, by those active in the system, as the area of greatest subjectivity, and thus, potential abuse, and where there appears to be the most waste of benefit and ancillary dollars.

We did not regard it as our charge to devise a new system of delivering rehabilitation benefits, only to review the proposed system to see if it meets the Governor's criteria.

It is our finding that the current system requires modification. It is our further finding that many elements in the proposal will make the system more effective and somewhat more efficient, and to capture the efficiencies intended by the proponents, there must be changes in the language of the proposal.

Recommendation

The rehabilitation provisions be amended. We offer a proposed amendment attached to this report.

Assisted by John Deisher, the Oversight Group spent one full meeting redrafting the legislation with regard to vocational rehabilitation. The Oversight Group in fact, has drafted a specific section and it is attached as Exhibit "B".

A good rehabilitation system should contain these elements:

1. Services should start early;
2. The injured worker should be able to get out if rehabilitation is not desired or needed;
3. The cooperation of all the parties is obtained;
4. Determinations should be made quickly;
5. The goals are reasonable; and
6. The benefits are reasonable.

The basic approach of our proposed statute is to provide a system in which the initial determination as to whether or not vocational rehabilitation is necessary or desirable can be made quickly and inexpensively. The system that is created is optional with regard to the delivery of services. It sets goals for rehabilitation and provides a means to deliver those services promptly and in order of preference for return to work. Regardless of what happens with the rest of the proposed legislation, we believe the rehabilitation section will improve rehabilitation services to injured workers and should help reduce costs.

But any Statute is only going to be effective if it is implemented properly. Even this proposed Statute will require the adoption of regulations, and adoption of this Statute will still leave the existing Statute in need of regulatio since there will be almost six years of injuries which will be involved with the existing Statute rather than the new legislation. In other words, the success of any such legislation will depend upon regulations being promulgated with all deliberate speed.

In addition, we want to emphasize that any system of vocational rehabilitation is only going to be successful if services are initiated promptly in the event an employee has an impairment preventing return to customary or suitable employment, and disputes can be resolved in an expeditious and non-adversarial manner. Delays in the delivery of workers' compensation benefits hurts everyone throughout the system but they are particularly devastating when rehabilitation is involved.

We reviewed the results of the Menninger Study of the Alaska Vocational Rehabilitation System. We are concerned that the Menninger conclusions are based on information supplied by only three rehab firms. While these are competent firms, we are concerned the number of firms responding might be too small to provide absolutely reliable information. With that said, however, we note the Menninger Study found a 60% return to work rate in the existing vocational rehabilitation system. The major cause of concern with the existing system is the delay by the defendants of over one year in instituting vocational rehabilitation services. **We believe if services are instituted more quickly by the defendants, the cost of rehabilitation would be lessened and the success would be increased.**

Permanent Partial Benefits

Currently, the current law provides benefits based essentially on wage loss, for certain kinds of injury and on degree of disability, a combination of wage loss and impairment, for other classes of injury.

(10) This area is perceived to be the single most significant area of abuse and increasing cost. The bill attempts to remedy some of the abuses in two ways.

First, it requires that unscheduled injuries be evaluated by an objective schedule eliminating both the wage loss concept and the tendency to rely on subjective complaint in the evaluation.

Second, the bill reorders the distribution of the benefit to essentially eliminate any permanent partial benefit for slight injuries, reduce the benefit for modest injuries and substantially increase the benefit for the severely permanently injured worker.

A majority of the Oversight Group finds that it was the intent of the drafters to have the reordering of the benefit result in a cost neutral impact on the system. We find, however, that the scheme which has been devised results in a substantial increase in cost of this benefit with an overall cost increase ranging from 1.8% - 3.5%.

It is our further finding that if there is to be a significant reduction in benefits paid to injured workers that the area most appropriate for that reduction is in the area of permanent partial benefits.

We also believe that the scheme proposed in the bill works a fundamental unfairness in several ways because of the inequities inherent in the conversion table included in the bill used to adjust the benefits.

We have asked the actuarial firm to recommend a system for modifying the conversion schedule to eliminate some of the inequity in the distribution and to result in an overall cost savings.

Recommendation:

> The conversion table in the permanent partial benefit section be modified to preserve the intent of moving the benefit to the more severely injured but with a more modest impact on the moderately injured, to smooth out the incremental increases and to result in an overall rate savings of 6%. The recommendation of the actuarial firm is included. See Exhibit "C".

Call Chavez

A minority of the Oversight Group disagrees. This section injects a new concept in determining compensation for permanent partial disability. Historically most compensation has been based on loss of earning capacity. This section bases it solely on medical impairment. Some injured workers - ones who lose an eye, an arm, a leg, or a hand - may receive more compensation for permanent partial disability. However, when read in conjunction with other sections of the statute, the two year limit on temporary disability and the restriction of temporary disability to the medical impairment, it is likely that many severely injured workers will receive less total compensation under the new statute than under existing legislation. In addition, in many cases, severely disabled workers, that is, those who have a substantial loss of earning capacity, will likely receive less compensation under the new statute even if severely impaired. Those with substantial medical impairment might receive more under one section of the statute.

The original idea of workers' compensation was wage loss not medical impairment:

> "When we turn to the origins of workers' compensation in the United States, we again find that almost all of the earliest acts were wage-loss acts with no schedules." Larson, Sec 57.13

Then the concept of "scheduled" injuries and some compensation based on medical impairment appeared:

> "The story from this point on takes the form of the gradual erosion of the wage-loss principle in many jurisdictions by the schedule principle". Larson, Sec 57.14

Expanded use expanded the problems:

> "The next step was to extend the schedule beyond members, to include the back, the internal organs, the head, the voice mechanism, the body as a whole, and, for good measure, a catch-all clause including anything else that might have been overlooked. Combine this with partial loss of use, and it is no wonder that the problems both of disability evaluation and of proof became unmanageable." Larson, Sec 57.15

and

> "While these statutory and judicial departures may have the advantage of reconciling theory with actual practice in states where the expansion of the schedule principle has reached an advanced stage, this abrupt attempt to transform long-established underpinnings of the system with no corresponding adjustment of its remaining structure or details is bound to generate serious problems, three of which, selected because they appear to have had almost no attention up until now, will next be examined." Larson, Sec 57.17

All this leads Larson and many others to advocate a return to the wage-loss concept and a rejection of payment based solely on medical impairment.

> "There are two main motives behind the present movement to restore the wage loss principle. The first is reducing waste of the compensation dollar on non-disabling losses. The second is reducing waste of administrative, legal, and judicial time and resources." Larson, Sec 57.18

The provision that all determinations shall be made according to the American Medical Association Guidelines is also a problem. This provision is too arbitrary and the goal should be to make the best determination of impairment and not to have the most automatic determination possible.

For a critical analysis of the AMA Guides see "The Use of the AMA Guides in Workers' Compensation Cases: Babitsky and Shapiro (SEAK, Inc. 1986)

Compromise & Releases

(11) The provision with regard to Board approval of Compromise and Release's in workers' compensation cases, should be retained. However, there is no need for Board approval where the claimant is represented by an attorney and medical benefits are not being waived.

The Oversight Group proposes .012 be amended to provide that any time after death or after thirty (30) days subsequent to the date of the injury an employee may reach an agreement with regard to his claim and that agreement is valid and binding when signed, and upon payment of the money specified if the claimant is represented by an attorney, the attorney signs the agreement and medical benefits are not being released. The passage of this amendment seems particularly appropriate if the new legislation is enacted which removes any provision for furnishing vocational rehabilitation services automatically and provides for payment of permanent partial disability in a lump sum.

Section .095

The Oversight Group strongly suggests rewording of the proposed language of .095 (c) as follows:

(12) A claim for a course of treatment requiring continuing and multiple treatments of a similar nature is not valid unless the treatments are carried out under a written treatment plan prescribed before commencement of treatment, completed and signed by the attending physician, to include physical examination and history, and mailed to the employer within one week of the beginning of treatment.

In addition, any course of treatment which involves more than 90 days or more than $1500 in costs or in which the employee is likely to be disabled for more than 90 days shall be conveyed to the employee, the employer, and the workers' compensation insurance carrier or adjuster within 10 working days and before the commencement of treatment unless treatment is necessary in an emergency or the employee's condition will likely deteriorate. This would address a wider range of concern than the narrow one outlined in the legislation.

(d) unchanged by proposed bill

(e) should be rewritten to change "physician or surgeon" to "physician or panel of physicians"

(j) The majority of the committee felt this section was unnecessary

If another examination is done it should not be afforded any special weight. It should stand or fall on its own merit not because of a legislative mandate. Therefore (k) should be amended as follows:

(k) In the event of a medical dispute regarding determinations of causation, medical 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 independent medical evaluation, a second independent medical evaluation shall be conducted by a medical physician(s) selected by the board from a list established and maintained by the board. The cost of the examination and medical report shall be paid by the employer. The report of the independent medical examiner shall be furnished to the board and to the parties within 14 days after the examination is concluded.

Section .105 (13)

Section .105 changes the existing law to provide that any claim must be filed within two years after the last payment of lost time benefits. This has the advantage of clarifying the law.

Section .265(17) (14)

Two of the four voting members feel strongly that section (A) should be removed from the language so as to protect those workers who, by virtue of inherently stressful jobs, file workers' compensation claims for stress related injuries. The other 2 voting members felt strongly that section (A) is a very necessary part of the Workers' Compensation Act because of recent developments that certain jobs are inherently stressful and that the Workers' Compensation system is not the proper mode for compensating these types of injuries.

Section .155(m)

The Group recommends for Section .155(m) that these reporting requirements become effective for the calendar year 1989 and that the first report becomes due on March 1, 1990.

(15) We also recommend the Workers' Compensation Board consult with an actuarial firm and develop a system of information reporting and retrieval that will provide the Workers' Compensation Board with a data base to monitor the present Act, as well as the proposed legislation, if adopted.

ADDITIONAL PROVISIONS

In addition to the provisions addressed by the proposed legislation, the Oversight Group feels there are other matters of concern where legislative change might be helpful.

Section .095 (16)

One of the major problems with the expeditious handling of workers' compensation cases, which substantially impacts the Board's hearing schedule and which is not addressed by the pending legislation has been the use of medical reports and the necessity for depositions under what is known as the Smallwood case.

The Oversight Group proposes to amend the present statute by providing that the Board may rely on any medical report as evidence if the defendant previously paid compensation or continued paying compensation after the receipt of the report. It would not be necessary for any party to depose the author of the medical report if that report was received by the defendants more than 14 days prior to the filing of a Notice of Controversion.

This amendment would simply recognize the fact that if the defendants had paid compensation with knowledge of the report, then it would seem unreasonable to allow them at a later date to prevent the Board from considering it through the use of technical rules of evidence.

Additionally, the Group proposes that if the defense objects to the reports of the treating doctor and asserts a right of cross-examination, the claimant would have the right, at the expense of the defendants, to take the deposition of the treating doctor one time in the course of the litigation. This would be available only once.This makes the cost of obtaining the treating doctor's report a cost of medical treatment. It addresses the problem of the indigent claimant who might be unable to afford the expense of obtaining the doctor's testimony.

Section .110

(17) To facilitate the expeditions handling of decisions, the group proposes that the board and the Rehabilitation Administrator be allowed to issue bench orders for immediate decisions with regard to procedure and other matters.

CONCLUSION

There is a need to modify the system to reduce costs to employers. There are inefficiencies in the system and litigation could be reduced.

The Oversight Group finds that this legislation makes a good faith attempt to address these problems.

We find, however, the attempts to correct inefficiencies and reduce litigation will not be accomplished unless clarifications in language and some modification of the administrative proposals are included.

We also find that the legislation, as currently drafted, will not reduce costs, and that in fact costs will be increased. Accordingly the legislation should not be adopted unless our recommendations for changes in the permanent partial benefit area are included.

Exhibit A

PROPOSED CHANGES TO INTENT LANGUAGE OF HB 352/SB322

Section 1 (b)

It is the specific intent of the legislature that the definition of rights and obligations under this act be strictly construed in accordance with the clear and unambiguous language of this act. If there is any ambiguity, it is the intent of the legislature that the act be interpreted so that there shall not be any change, extension or broadening of rights of the employees or obligations of the employers except by act of the legislature.

It is further the intent of the legislature that the system, including the process of administrative hearings for resolving factual disputes, be fair and afford due process, but expeditiously settle factual differences. Accordingly, unless specifically provided otherwise in the act, factual disputes that cannot be resolved by the weight of the evidence, should be resolved by according favor to the position of the injured worker.

PROPOSED CHANGES TO A.S. 23.30.041

23.30.041 (a) The department shall select and employ a rehabilitation administrator, who shall be a part of the Division of Workers' Compensation and who shall have such additional staff as required to carry out the purposes of this section. The rehabilitation administrator is in the partially exempt service under AS 39.25.120.

(b) The rehabilitation administrator shall implement the provisions of this section, and study the issue of rehabilitation, both physical and vocational, on a continuing basis.

(c) If an employee suffers a compensable injury that may permanently preclude an employee's return to the employee's job at the time of injury, the employee or employer may request the treating doctor of medicine or independent medical examiner selected pursuant to AS 23.30.xxx to determine what the physical capacities of the employee will be when the employee reaches medical stability. The only capacities which may be determined pursuant to this paragraph are those required to make the determinations under paragraph (d).

(d) An employee shall be eligible for a full evaluation pursuant to paragraph (f) of this section if the physical capacities of the employee at medical stability determined pursuant to paragraph (c) are found to be less than the physical demands as described in the United States Department of Labor's "Selected Characterisitics of Occupations defined in the Dictionary of Occupational Titles" for:

(1) the employee's occupation at the time of injury; and

(2) other occupations that exist in the labor market that the employee has held within 10 years before the injury; and

(3) occupations that the employee has held following the injury for a period long enough to acquire the vocational preparation required for those occupations as specified in the "Selected Characteristics of Occupations defined in the Dictionary of Occupational Titles".

(e) An employee is not eligible for an evaluation pursuant to paragraph (f) if:

(1) the employer offers, or obtains for, employee remunerative employment the physical demands of which are not more than the physical capacities of the employee determined to exist at medical stability and the employment is in an occupation that generally exists in the labor market; or

(2) the employee has received rehabilitation benefits in connection with a prior industrial injury under this or any similar section of a Workers' Compensation Act, but, following the receipt of the benefits, was employed at the same or similar occupation as the occupation at the time of the prior injury.

(3) the employee has been paid any or all of his permanent impairment award pursuant to AS 23.30.190.

(f) When an employee is found eligible for and desires to have a full evaluation for rehabilitation the employee shall so notify the employer and the employee and the employer jointly shall select a rehabilitation specialist who shall provide a full re-employment evaluation, and, if appropriate, a complete re-employment service plan. If the employee and the employer cannot agree on a rehabilitation specialist, but not before thirty days after the employee notifies employer of his desire to have an eligibility for an evaluation, either party may request the rehabilitation administrator to assign a rehabilitation specialist. The employer and the employee each have the right to reject the assignment by the rehabilitation administrator for cause and shall have the right to one pre-emptive rejection.

(g) The full evaluation and rehabilitation service plan must include the following:

(1) an inventory of the employee's technical skills, physical capacities, intellectual capacity, academic achievement, emotional condition and familial support.

(2) a determination of the occupation which the plan establishes as the goal.

(3) a finding that:

i. the occupation established as the goal for the plan is one for which adequate employment opportunity exists in the labor market; and

ii. the employee's technical skills, physical capacities, intellectual capacity, academic achievement, emotional condition and familial support at commencement of the plan are such that the employee can reasonably be expected to satisfactorily complete the plan and perform in the new occupation; and,

iii. the plan can be completed within the time limitations imposed by this section.

(4) a detailed description and schedule of the plan.

(5) the cost estimate of the plan including provider fees, the amount of tuition, books, tools, supplies, transportation, temporary lodging or job modification devices.

(6) the date the plan will commence.

(7) the time that the employee will be medically stable as determined by the treating doctor of medicine or independent medical examiner.

(h) [(g) in the bill as currently drafted but within 10 working days.]

(i) If the rehabilitation specialist finds that any one of the required findings in subsection (g) (3) is not true, then the employee shall not be entitled to a re-employment plan and the rehabilitation specialist shall provide a report to the employee and the employer stating that fact including the reasons and information upon which such finding is made.

(j) [same as (h) current .041 law/statute.]

(k) The following time limitations shall apply to the entitlements and the obligations of this section:

(1) The re-employment plan must be scheduled so that it can be completed and the occupational goal achieved within two calendar years from date of plan approval/acceptance.

(2) and (3) remove

(4) - (6) [same as (4) - (6) in current draft of bill except change "re-employment services administrator" to "rehabilitation administrator" so that consistent terms are used throughout.]

(7) If the report or plan of the rehabilitation specialist is not approved by either the employer or the employee, either may petition the rehabilitation administrator for a modification of the report or plan in a manner set forth in the petition. If no petition is filed within ten days of submission of the report or plan to the employee and employer, the report or plan is deemed approved. If a petition is filed, the non-filing party shall have ten days to file a response. The administrator shall conduct a prehearing conference, then the administrator shall prepare a report within ten days following the conference with a recommendation as to the report or plan that ought to be approved. The petition, response, and report of the administrator shall be deemed the filing of a claim and notice of claim referred to in AS 23.30.110(a) and (b). The Board shall notice a hearing as provided in AS 23.30.110 to resolve the matter.

(l) Removed

(m) In this section:

(1) [as (1) in current bill but change (status) to capabilities.]

(2) "labor market" means the geographic areas where the employee lived and where the employee worked at the time of injury, unless, subsequent to the date of injury, the employee permanently changed resident from Alaska to outside the state, in which case the labor market is also anywhere in the state of new residence.

(3) Same as Bill

(4) Same as Bill

(5) and (7) [as (5) - (7) in the current bill.]

(b) Same as Bill

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February 19, 1988

Mr. Paul Roller
ALASKA DIVISION OF INSURANCE
3601 "C" Street, Suite 722
Anchorage, Alaska 99503

RE: MODIFIED PERMANENT PARTIAL DISABILITY AWARD SCHEDULE

Dear Paul:

M&R was requested by the Division of Insurance to test alternatives to the permanent partial disability award schedule contained in draft bills HB352 and SB322. Attached is one such alternative with the following characteristics:

1. We estimate that the attached schedule will develop approximately the same total dollars of permanent partial awards as the current Alaska workers' compensation law.

2. Combined with all other aspects of HB352 and SB322, we estimate that incorporation of the attached alternative schedule will result in an overall cost reduction of approximately 6%.

3. The proposed schedule is designed to smooth the award "adjustment factors" such that the factor becomes 1.000 at a 50% impairment rating. The awards begin to exceed those available under the current law at a 33% impairment rating.

4. The M&R cost estimate associated with this table assumes that the "whole man" value is maintained at $240,000.

M&R has also evaluated an alternative schedule developed by David Gottstein. This table is similar to the attached; however, the "adjustment factor" reaches 1.000 at a 35% impairment rating. We estimate that this alternative would result in a 14% increase in permanent partial awards. Combined with all other aspects of HB352 and SB322, we estimate that this alternative schedule would result in an overall cost reduction of approximately 2%.

We emphasize that the cost estimates presented herein reflect only M&R's evaluation. We do not know to what extent the NCCI evaluation may differ from our own.

Please contact me if you have any questions.

Best regards,

Michael A. McMurray

MAM:cap
Enclosure

cc: Mark Crawshaw

Exhibit 1

Degree of Actual Impairment	Adjustment Factor
0%	0.000
1	0.000
2	0.000
3	0.000
4	0.000
5	0.000
6	0.060
7	0.120
8	0.180
9	0.240
10	0.300
11	0.320
12	0.340
13	0.360
14	0.380
15	0.400
16	0.420
17	0.440
18	0.460
19	0.480
20	0.500
21	0.520
22	0.540
23	0.560
24	0.580
25	0.600
26%	0.620
27	0.640
28	0.660
29	0.680
30	0.700
31	0.720
32	0.740
33	0.760
34	0.780
35	0.800
36	0.820
37	0.840
38	0.860
39	0.880
40	0.900
41	0.910
42	0.920
43	0.930
44	0.940
45	0.950
46	0.960
47	0.970
48	0.980
49	0.990
50% or greater	1.000

SB

322

(FILE 12)

NARPPS

National Association of Rehabilitation Professionals in the Private Sector

SUBJECT: SB 322/HB 352 - WORKERS' COMPENSATION BILL

TO : SENATE LABOR AND COMMERCE COMMITTEE,
SENATOR TIM KELLY, CHAIRMAN

HOUSE LABOR AND COMMERCE COMMITTEE,
REPRESENTATIVE DAVE DONLEY, CHAIRMAN

FROM: ALASKA CHAPTER, NATIONAL ASSOCIATION OF REHABILITATION PROFESSIONALS IN THE PRIVATE SECTOR,
DENNIS J. JOHNSON, PRESIDENT

The National Association of Rehabilitation Professionals in the Private Sector (NARPPS) is the primary association of Rehabilitation Practitioners in private practice. The Alaska Chapter has a membership of about 35 individuals. This membership consists of Vocational Rehabilitation Counselors, Rehabilitation Nurses, Job Placement Specialists, and Occupational Therapists. The primary focus of the association is to promote the practice of ethically and procedurally sound rehabilitation services by qualified Rehabilitation Professionals. Since vocational rehabilitation has become an integral component of Workers' Compensation Laws, we have an obvious interest in the structuring of those Laws. I should point out that the practice of vocational rehabilitation has existed in society long before any attempt to incorporate its principles into the Workers' Compensation system. Some would have you believe that our profession was born from the Workers' Compensation Law and that our only concern is the exploitation of that Law. The only explanation for mischaracterizations of this nature is ignorance on the part of the accuser. In reality, Rehabilitation Practitioners are fair minded, well meaning, and principled people who find themselves attempting to mediate between the injured worker and the employer in a system that has become highly adversarial in nature. Currently, vocational rehabilitation in Alaska's Workers' Compensation system is not the "end benefit of a no-fault system" as it was originally designed, but rather it is a bargaining chip and discovery tool in the settlement and litigation process. Alaska NARPPS is concerned with the proper and ethical use of rehabilitation services as a legitimate Workers' Compensation Benefit. We also are concerned with promoting accountability and responsibility within the rehabilitation industry, independently of, and in conjunction with AWCB and/or legislative provisions.

In reviewing the current bills (SB 322/HB 352), we have surveyed our membership and we are able to take a position in certain areas pertinent to the Bill. There is unanimous agreement among our membership that vocational rehabilitation as it is currently administered under Section 041, of the existing statute is unsatisfactory. The points made hereafter, represent a consensus of our membership and that individual members may have opinions that diverge somewhat or that go beyond our comments here.

Timely (early) referral for assessment and initiation of services has always been a concern of the rehabilitation community. It has been the common experience of Rehabilitation Providers that cases are generally not referred until an injured worker is deeply entrenched in the Workers' Compensation process. Rehabilitation service is viewed by many insurance adjusters as a "last ditch" effort as opposed to a proactive effort. Recently, an independent and objective study by the Menninger Foundation was conducted to analyze the performance of private rehabilitation in Alaska. Two hundred and thirty three cases closed between May 1986 and May 1987, were analyzed. Among other findings, it was significant to note that the average length of time from injury to referral for rehabilitation services was found to be 1.4 years. (A copy of the entire Menninger Report is being included with our written testimony). This is rather surprising when considering that our current Statute requires referral for rehabilitation evaluation 90 days from injury. The simple fact is that referral for evaluation is currently not occurring on a timely basis even though our current system stipulates the 90 day referral time frame. The current Bill on the other hand requires that the injured worker submit a written request for eligibility evaluation within 60 days of the employer's notice of injury. If the worker has failed to do so, he/she has essentially forfeited their rehabilitation benefit. In practice, it has been our experience that injured workers most often do not confront the possibility of an inability to return to their previous occupation until sometime several months post-injury. The 60 day time constraint would also be affected by the injured worker's lack of experience or knowledge with the Workers' Compensation system. The injured worker is dependent upon the information provided by either the Department of Labor or the insurance carrier in order to make an informed decision. Our experience in the field causes us to be skeptical of this dependency. Our membership in general, recommends that referral for evaluation services be clearly mandatory at 90 days post-injury.

In general, Alaska NARPPS supports the proposed change that the Rehabilitation Administrator delegate referrals for eligibility evaluation. Additionally, we strongly encourage that the Alaska Department of Labor Division of Workers' Compensation be held responsible for prompt promulgation of effective regulations of a responsible nature. We strongly feel that the primary deficiency of the current system has been the lack of regulations pursuant to the statutory language. It is imperative that regulations be established and enforced as soon as possible. This we emphasize whether this bill is adopted or whether the current law remains in effect.

The eligibility criteria described in sub-Section d, has also caused concern among our membership. According to this sub-section, the physical demands representative of the employee's job at the time of injury will be extracted from the Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles for the employee's job at the time of injury and any jobs held within the last ten years. This becomes a theoretical assessment not requiring on-site job analysis of the specific job of injury and would not take into account any unique circumstances relevant to the particular job of injury. Also, the stipulations that all jobs held within the last ten years be considered seems arbitrary. In the practice of vocational rehabilitation as it is generally applied in the Workers' Compensation arena, employability is based upon an evaluation of the "whole person" which takes into account not only transferable work skills but also considers such factors as other noninjury related medical or psychological factors; social, personal, and family variables; and labor market considerations. The concern of our membership is that the eligibility criteria currently listed in the bill are based on theoretical analysis and may not represent an actual and valid evaluation of the worker's employability. Our recommendation is that ability to return to previous employment be evaluated according to actual on-site job analysis of that specific job. A second criteria for eligibility should be a determination of whether or not the injured worker is likely to benefit from a rehabilitation services plan taking into consideration all of those factors previously indicated.

Alaska NARPPS recognizes and fully supports the utilization of Qualified and Certified Rehabilitation Professionals. As has occurred in other professions, specialities are being developed within our profession. The specialization of rehabilitation is not well recognized by other industries or professional groups. Therefore, misunderstandings of our industry has resulted in skewed expectations of requested services. We encourage the

State, AWCB, physicians, and attorneys to utilize and request services appropriately and in accordance with statutory provisions. We support the definition of Rehabilitation Specialist that currently exists in the Bill. This language defines a Rehabilitation Specialist as a "person who is a Certified Insurance Rehabilitation Specialist or a person who has equivalent or better qualifications as determined under regulations adopted by the department." This wording allows the department to develop in-state qualifications and standards while at the same time emphasizing the specialized certification in insurance rehabilitation counseling.

Finally, it should be reemphasized that the Alaska NARPPS membership is particularly concerned over the fact that the Rehabilitation Provisions enacted in 1982, never became totally functional because of the lack of regulations needed to administer that Law. Rehabilitation Practitioners are naturally skeptical of any new statutory language for fear of the same circumstances. We strongly assert that a significant level of responsibility lies with the State itself in implementing and regulating rehabilitation services. As a professional association with particular concern in this area, we do offer our services or input.

THE MENNINGER REHABILITATION RESEARCH AND TRAINING CENTER ON PREVENTING DISABILITY DEPENDENCE

Analysis of Private Sector Rehabilitation Services: Alaska

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A. INTRODUCTION

In response to an obvious need of insurance carriers, private sector rehabilitation providers have multiplied during the last 15 years. During this time, the emphasis has been on striving to meet the need, rather than reflecting on what was being done. However, as the field has matured and established itself as an identifiable profession the time has come to do some self-examination.

As the major representative of private sector rehabilitation providers, the National Association of Rehabilitation Professionals in the Private Sector (NARPPS) was given the charge to undertake such a study. In order to comply with the wishes of the membership, NARPPS contacted the Rehabilitation Research and Training Center of The Menninger Foundation.

The Menninger Foundation Rehabilitation Research and Training Center has been established in order to develop programs and suggest policies which will help eliminate the financial dependence of workers who become disabled but are still capable of gainful employment. As a way of accomplishing these goals, the center agreed to undertake this evaluative research as an independent third-party.

The overall objectives of this research are as follows:

a. To determine if there is a significant improvement in return to work among claimants who are referred to rehabilitation professionals in the private sector.

b. To develop a model system for use by insurers in the cost-benefit analysis of vocational rehabilitation services.

c. To ascertain if certain types of vocational rehabilitation services are more likely to result in the client returning to work than are other services.

In addition to the major national study, certain state chapters have requested an overview of the services provided in their particular states for workers' compensation (WC) claimants. The results provided in these individual state reports are limited to the demographic characteristics of WC claimants, the types of services provided, the results of the services, and the costs of those services.

B. METHODOLOGY

For this report, we solicited data on closed cases from Alaska NARPPS member rehabilitation specialists. They were asked to provide demographic, service and closure information on each case they had closed between May 1986 and May 1987. We asked them to eliminate those cases in which the only service to be provided was expert witness testimony. The data collection form used in this study and instructions are shown in the Appendix.

Of the 16 rehabilitation companies contacted, three responded providing us with data on 233 closed cases. Of these, 209 involved worker injury cases, the remaining 24 cases were excluded from this analysis.

We entered the raw data as received into a computer file, doing only minimal coding. After all the data were entered and checked, some of the variables were recoded for analysis. The primary disability was coded

using a coding scheme, based on the part of the body involved, which is shown below:

Part of Body	Code
Cranial Injury	1
Facial, Mandibular	2
Neck	3
Back	4
Shoulders, Arm	5
Hand, Wrist	6
Trunk	7
Skin (Abrasions, Burns)	8
Knee	9
Ankle	10
Foot	11
Legs, Hip	12
Multiple	13
Mental, Emotional Disabilities	14
Not Otherwise Codable	15

Only seven of the 195 cases, in which a primary disability was reported, fell into the "Not Otherwise Codable" group.

The claimants' occupations were coded using the following system:

A. Managerial and Professional Specialty
Includes: Executive, administrative, and managerial workers, as well as professionals such as attorneys, doctors, and teachers

B. Technical, Sales and Administrative Support
Includes: Technicians, sales persons, administrative support personnel such as secretarial and clerical workers

C. Service Occupations
Includes: Domestics, protective service workers, barbers and other personal service providers

D. Precision Production, Craft, and Repair
Includes: Mechanics and repair persons, as well as construction trade workers

E. Operators, Fabricators, and Laborers
Includes: Machine operators, assemblers, transportation workers, laborers, and equipment cleaners

F. Farming, Forestry and Fishing.

Statistical analysis involved standard univariate tests, either X^2 or t-tests as appropriate.

C. RESULTS

3.0 Demographic Analysis

Of the WC claimants served, 77% are men and 23% women.

The majority (65%) were married at the time they were referred for services, while 27% were single. The remaining 8% were divorced, widowed, or separated.

The average worker served was 37.7 years of age (SD = 10.43) at the time of injury. The distribution of ages is shown in Table 1.

Table 1
Distribution of Ages at the Time of Injury

Age Cohort	Percentage
≤ 24	8%
25 - 34	34%
35 - 44	34%
45 - 54	16%
≥ 55	8%
Total	100%