

ALASKA LEGISLATURE COMMITTEE FILLES 1987-1988 8672
5399 SLAB SB 322 (file 16) - (file 17) 971

Page Six
February 17, 1988

Please bear in mind when a federal judge awards millions of dollars to an injured person you can believe that the award is not based upon passion, prejudice or sympathy; it is based upon solid judgment and the law.

In summary, there simply should be no cap on the damages suffered by the individual whether they are economic or non-economic damages. Caps arbitrarily discriminate against those few individuals who are seriously injured. Such legal discrimination would constitute oppression of the worse kind by the majority of our society against the minority. If we are going to impose caps on certain types of damages it would be more fair to abolish the system totally and implement a new system that across the board takes care of injured individuals which society pays for.

The amendment to the punitive damage provision is simply a red herring and a waste of time. Even before the 1986 statute pertaining to punitive damages, in order for an injured person to recover punitive damages against a wrongdoer he had to prove that the wrongdoer had acted with willful, wanton and reckless disregard for the rights of the plaintiff. Willful, wanton and reckless disregard has also been described as malice, gross negligence or reckless misconduct. What I am saying is that the amendment proposed adds nothing to the law as it exists now and has existed for years.

The amendment which references damages resulting from commission of a crime is another red herring. However, it does have greater significance than amendments regarding punitive damages. I can conceive of a situation where the statute would lead to a grave social injustice. For instance, if a person was driving while intoxicated, (a criminal act) just over the legal limit, and another more intoxicated person ran a stop light and collided with him the first person would recover nothing and an argument would be made that the victim's intoxication prevented him from avoiding the accident. Is this a good social policy? I think the language contained in this section was the subject of a lot of negotiation in 1986 and it should not be changed.

The suggested amendment to AS 09.17.040(d), requiring that a court may at the request of either party order periodic payments of a judgment is simply wrong. Why should a guilty defendant have anything to say about how an innocent plaintiff receives payment of a debt owed? If we are going to enact this type of law for personal injury plaintiffs, we should also enact the same

sort of payment scheme in all lawsuits. When a bank files suit based on a promissory note and successfully obtains a judgment, would it be appropriate to allow the judgment debtor to then ask that future damages be paid by periodic payments rather than as a lump sum? What about a dispute between businesses over a breach of contract? I believe that if the statute is amended to provide that either party may request judgment be paid on a periodic payment that this will make the statute unconstitutional as a violation of the equal protection clause.

Furthermore, what guarantees would there be that the judgment debtor would be able to make the periodic payments in the future. Why should the plaintiff who has fought the battle to prove the debt is owed have to risk the defendant going broke in the future.

Also, the major purpose behind litigation is to resolve disputes once and for all and let the parties go on about their respective lives. If the injured party is continually receiving payments from the party responsible for the injury there is no resolution. Instead the unpleasant experience continues and continues and continues. This is not beneficial to our society.

The amendment to AS 09.17.050(a) providing that members of boards of directors or officers of electrical or telephone cooperatives are immune from suit is not particularly offensive so long as the underlying organization would be liable for any misconduct by the director or officer acting within his official capacity.

The next issue addressed by SB 211 is the collateral source rule. The 1986 statute regarding the collateral source rule was a result of a compromise which to date has not had an opportunity to be tested. The primary difference that I see between the 1986 statute which I thought was outrageous when it was passed, and the amendment which has been proposed was that no consideration whatsoever is given for the costs incurred by the plaintiff in collecting the debt (the attorney's fees). I continually must ask myself why somebody who suffers an injury innocently and then must incur costs and attorney's fees in order to collect the damages should not be fully compensated for the reasonable attorney's fees that they have incurred. At least the 1986 collateral source rule attempted to take the attorney's fees and cost factors into consideration. The 1988 amendment does not.

Instead, it simply allows the wrongdoer to benefit from collateral sources which the victim through his or her own foresight has put into place to protect themselves.

If this amendment were applicable in the case described above, the federal government would have to pay less future wage loss to my client because of the disability benefits that he paid for though his employment before he was injured. Why should the guilty defendant be able to benefit one bit from the thoughtfulness of a responsible person who protects himself from accidental loss of his earnings.

Applying this statute or for that matter even the 1986 statute to my client who was hit by the 747, we would find that the Federal Government would reduce its liability to my client by the amount my client will receive for permanent disability benefits under the State disability program which he paid for. This would be a windfall to the government. Since the government did not pay the premiums nor decide to provide for that coverage they should not be entitled to receive the windfall.

Next is the issue of joint and several liability. SB 211 creates several liability. What this means is that when more than one person is responsible for an accident the jury shall determine the percentage of responsibility and enter a judgment only against the particular defendant for his respective percentage of fault. This sounds fair at first blush but there are some serious problems with it. First, what happens if one of the defendants has no money? The answer is simple. The plaintiff does not get compensated from that defendant. Thus what the change in law will do is shift the risk of injury by a judgment proof defendant from his co-defendants to the innocent victim. This is even less fair than an arrangement where a wrongdoer who is 10% at fault has to bear all the costs because the wrongdoer who was 90% at fault has no money. The 1986 amendment provided some relief to the defendant who was less than 50% at fault, though it still left payment responsibility on the shoulders of that partially responsible defendant. This seems like a reasonable compromise between pure joint and several liability and several liability. It shouldn't be tampered with.

Even if the Legislature in its wisdom decides that on a social policy basis it is better to make the innocent plaintiff suffer the consequences of being hurt by a judgment proof

defendant than to make his fellow wrongdoers suffer the consequences, an even more practical reason exists to not adopt the several liability provision.

Under pure several liability if a person has even one percent of responsibility they will have to be named in the lawsuit. Any time an attorney files a lawsuit without naming everyone who may have responsibility he would be committing malpractice. If a party with some responsibility is omitted and the case goes to trial those who are named in the suit will be pointing a finger at the "empty chair" and doing their best to shift as much responsibility onto the empty chair. This means that every general surgeon, anesthesiologist, nurse, emergency room technician, emergency room doctor, ambulance crew, and hospital will have to be named in a lawsuit arising out of an automobile accident where someone died and it looks like they would have lived if they had received just a little bit better medical care. This will make lots of money for defense attorneys, take significantly longer to try cases, and make simple cases even more complex. I predict under a pure several liability system the civil justice system as we know it today will suffer many, many more problems than we see currently.

Last but not least was the movement in SB 211 to amend Title 9 §60.010 abolishing rule 82 attorney's fees. This effort makes absolutely no sense if we want Alaska's civil justice system to fairly compensate people who are damaged. If I owe the bank a debt and they have to incur substantial costs and attorney's fees to attempt to collect that debt which I have agreed to pay they ought to be paid their reasonable collection costs. That is what Rule 82 does. Not only in personal injury cases but also in breach of contract actions and all other civil disputes.


The existence of Rule 82 deters many plaintiffs from pursuing claims which are weak or non-meritorious. They simply do not want to take a chance that they will lose and then have to pay the other side's costs and attorney's fees. Without Rule 82 they would have no risk and there would be no reason for them not to pursue any lawsuit that has a colorable chance of surviving. By the same token a defendant either an insurance company or an individual is going to be more willing to resolve the case out of court if he knows that he is going to lose in court and if he knows that he will have to pay Rule 82 attorney's fees.

Alaska State Legislature
Page Ten
February 17, 1988

I would point out that in Federal Court attorney's fees are only awarded under certain specific statutes. In the case described above regarding my client who was hit by the 747, the trial Judge denied my request for attorney's fees because Judge Holland does not believe that the law permits him to make such an award. It is my firm conviction that the United States would have made a more reasonable settlement offer and would have avoided trial in that case if they had known that an additional award for attorney's fees would be imposed against them. As it is the government had no threat of attorney's fees being awarded against them hanging over their head and accordingly they have acted with utter disregard for my clients' rights. Also punitive damages may not be awarded against either the Federal government or the State government. Therefore, the attorney's representing governmental entities could act in the most irresponsible manner imaginable.

In summary I would like to reiterate some of the following points. First, there is simply no evidence that making the changes described in SB 211 which will seriously impact the rights of individuals who suffer injuries will provide the rest of us with any relief in insurance rates. If there was reliable evidence of this fact then there might be some justification for the sacrificing of the rights of injured for the good of the rest of us. But there simply is no such evidence and there will not be any such evidence until the laws regulating the insurance industry are changed requiring accurate reporting of losses, earnings, claims and other information. Second, it is appalling that a civilized society would change the law that gives full monetary recovery to people who have suffered horrendous injuries while not making any change to the law which though effecting a greater number of people, effects people who have less significant injuries. That is the legislative equivalent of the robber who steals the purse of the rape victim. The act amending joint and several liability to just several liability will be known as the 1988 attorney's welfare act because it will create more employment for attorney's than any legislation enacted in modern times. Last but not least, the abolition of Rule 82 attorney's fees will result in more litigation, fewer settlements and less money ending up in the pockets of victims with more ending up in the pockets of the defense attorneys. This legislature should leave well enough alone; it should leave the 1986 tort reform act in place without amendments until we can see what effects that has had.

Yours very truly


Elliott T. Dennis

w/c
g

Rene Bales
4859 Wesleyan
Anchorage, Alaska 99508
February 5, 1988

Dear Senator:

We all agree the system is not working. We all agree too much money is spent to keep the present system. But a wrong doesn't make a right! Things that need to be changed should equally be done for the good of all and not the good of some. Injustices have to stop. For by whatever name they are called they do exist and are causing a lot of hurt. I for one would like to see costs down but not at the expense of the worker and family. They are the real victims. The insurance raises premiums, the employer pays, but what does the worker do when he is injured, unable to work or make wages that are not able to put food on the table? It is well and good to say that people are using the system for monetary gain, but let's be sensible, who stands to gain by all of this, surely not the injured worker. If you really check claims you will see that most of the money goes to the doctor, rehabilitation, therapy and defense attorney. Only after people can't afford to have to hold out any longer they submit and accept too soon and settle. I know of many of such cases.

It is a known fact that doctors are being influenced prior to doing an IME requested by defense attorneys. They are told what they want to hear and some doctors very unprofessionally comply even at the point of asking such questions as how much money the injured workers' spouse makes, why are they doing this (meaning going to hearing). Vocational Rehabilitation doesn't help. They go through the motions but they know there is no industry or job that will employ injured workers with limitations. They collect all that is in the kitty and more and after harassment, lies, etc., they throw you to the wolves. As for the word stress, you can be sure that by the time they get through with you if you were a normal, unstressed person, you aren't after they are finished. Some doctors treat us like criminals and by the time vocational rehabilitation gets through with you we are nothing. But that's OK with them. They can blame stress that may have been pre-existing and try to get away from the main issue that you are injured. You are not OK and will never be again. Your life has changed and it is easy for those who are not in your shoes to say forget the continuous harassment. The injured worker has trouble getting an attorney when by law they only get 10% on top of the benefit awarded. Thus very few attorneys who are willing to stay in workers' compensation cases because there is little money in it but the defense attorney have the right to

set fees and they can afford to spend unlimited amounts to find reasons as to why claimants shouldn't receive the money due him or her even after proof of injury. IME's only serve for the purpose of finding a willing doctor to lie or twist the truth and we have quite a few in this town that are doing just that. If this situation exists now it can only worsen by giving insurance carriers power without repercussion when mistakes are made deliberately. It is ironic that insurance companies want to take steps to stop doctor shopping by workers, for the reverse is true. IME's are intended for just that and injured workers are usually being sent to them even after medical proof on disability. In my particular case the doctor's deposition in my favor I ended up paying for \$660 for wasn't even introduced.

I go on with life for me it will never be the same. I have lost 6½ years of my life, the years when I should have been the happiest. I feel like an old lady already unable to do the things I like. All they can say is chronic pain - Give me a break! Why would I want to not work? The money I get now isn't even enough to go out to dinner or pay for the help in my house that I need. I was a very happy energetic person before. I enjoyed work and independence. I have nothing to gain from this except misery. I would gladly give you the \$35.00 a a week if I could gain my health back.

Sincerely,

RENE BALES

A handwritten signature in cursive script, appearing to read "Rene Bales", written in dark ink.

ALASKA CLEANERS

January 29, 1988

Senator Tim Kelly, Chairman
& Members of the Senate
Labor & Commerce Committee

Representative Dave Donley, Chairman
& Members of the House
Labor & Commerce Committee

As a service industry we are very labor intensive and very sensitive to the cost of maintaining that labor.

During 1985 our Workers Compensation premium costs were \$ 548.27/employee; by 1987 this had risen to \$ 840.83/employee and now is projected to be \$ 1115.43/employee for 1988. This represents an enormous increase of over 103% in just four years and represents a considerable real dollar increase in our expenses when applied to our 165 employee labor force.

In a memorandum, dated October 22, 1987 prepared by Don Koch, a Special Deputy for the Alaskan Division of Insurance, the following statement was made:

"Recently, I had occasion to look at losses isolated from the premium and I had a bit of a shock. In 1983 worker's compensation losses were \$70,678,000; in 1984, they were \$89,789,000; in 1985 they were \$124,447,000; and in 1986 they were \$150,294,000. That is more than doubled in a four year period and with a decreasing payroll base to boot."

In analyzing our claims during recent years I am of the belief that somewhere between 30 & 40% of the claims are the result of problems that are not directly caused or occasioned by employment. Bursitis, rheumatoid arthritis, osteoarthritis, hypertension, depression, coronary heart disease and even hemorrhoids are but some of the many pre-existing conditions that can result in a worker's compensation claim.

While it is unfortunate that individuals have to suffer with these and other disabling diseases, ailments and infirmities, it must be recognized that many of these and other ailments and infirmities are related to diseases, ageing, diet and other environmental factors other than those of employment in and of itself.

The original purpose of the worker compensation law was to insure a speedy and humanitarian remedy for injured workers. The key phrase here is "injured workers" not those with diseases, ailments and infirmities that are not directly or substantially caused or occasioned by

employment and certainly not those that were in existence prior to employment.

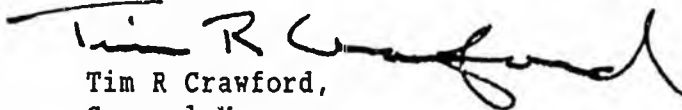
Therefore, I would propose that the following addition to AS 23.30.120 (insert between line 4 and 5 on page 16) be made by the Legislature:

"(a)(5) The injury, illness, infirmity or ailment was, wholly or substantially, directly caused as a result of employment. Further, that, the injury, illness, infirmity or ailment was not a pre-existing condition."

It is my belief that this one single action will have a far greater impact on premium reduction than any other single action. It certainly leaves intact the basic purpose of the law which is to insure a speedy and humanitarian remedy for injured workers.

It is imperative that the employers in this State receive some Statutory relief and that Alaskan Jobs be protected, therefore, if the legislature does not agree with the wisdom of my proposed change then I pray that at the very least SB 322 and HB 352, which represent an unusual alliance of both labor and management, will be passed, thereby helping to aid all the citizens of our Great State along the road of economic recovery.

Thank you,



Tim R Crawford,
General Manager
Alaska Cleaners



Alaska State Legislature

9

Please enter into the record my testimony to the Joint House Senate Labor Com.
 committee name
HB 352 - SB 352
 committee on workman's comp, dated 2/12/88
 bill/subject

My testimony concerns my own personal treatment by Alaska Timber Insurance Exchange. I work for Wrangell Forest Products - Wrangell and incurred a knee injury 7/5/87 with required a subsequent knee surgery 12/29/87 - this claim has been judged valid by A.T.I.E. however it has been 47 days since my knee surgery and I have not received any weekly compensation or any compensation at all. I feel this is an unreasonable amount of time to delay payment of benefits. I am single, have a child in school and no financial support to fall back on other than my personal savings and I don't see this as speedy response

Signed: Joan Orr to a just claim and this
 Testifier
Self has created an undeserved
 Representing (Optional)
PO Box 952 Wrangell hardship on me
 Address
907 874-3760
 Phone No.

P.S. I would like a response to my letter, please.
 Thank you
 Joan Orr

9

February 22, 1988

To: All Legislators, in the State of Alaska

In response to Senate Bill No. 332 before the Labor & Commerce and Judiciary Committee:

It seems to be a collective opinion among suppliers, subcontractors, and general contractors that the adoption of this bill would be detrimental to sound business practices and in direct opposition to responsible legislation. Please consider the following:

- 1) Liens are not placed on a construction project until all other avenues of payment collection has been exhausted and payment promises have not been kept.
 - a) we know that if a lien is placed against a project that we may never work for that builder again
 - b) it is time-consuming and costly to place a lien on the project in the first place
- 2) Some of us have had promises of payment within 7-10 days from an aggressive approach in our collection efforts, only to find out that we had given them enough time to transfer from a construction loan to a long-term loan.
 - a) a lien on property in long-term financing means nothing until the property sells again, and we know that may take 1 to 20 years until we get our money.
 - b) without civil court action, the builder who failed to pay construction costs is removed from responsibility.
 - c) the bank is also removed from responsibility, even though they were expected to insure that all monies in the construction loan were spent for that purpose.
 - d) the bank should make sure that there is no chance of a lien before long-term financing is considered.

The result of current laws has left the buyer and the subcontractor alone (without court action) to settle any problems resulting from the failure of the bank to verify that all involved in the construction project were paid and they are offering a lien-free building.

Your legislation No. 332 is going in the wrong direction since it supports those who do not pay their bills in a timely manner, and would give them additional time to avoid their responsibility. (SEE #2 ABOVE)

Again, we only lien as a last resort and this irresponsible legislation will force all of us to file an intent to lien before the work actually commences (which we can't do unless the builder also owns the land, which is not always the case).

May I suggest some responsible legislation? I feel that the State of Alaska would be acting responsible if there were legislation requiring all lending institutions to receive a lien clearance from all construction participants upon completion and final payment for their charges on that project, before any long-term financing is completed.

- a) this would prevent the person(s) receiving the construction funds from using it for other purposes.
- b) this would insure the buyer(s) that the project would not be liened at a later date. (now they, theoretically, can receive a guaranteed title policy -lien free- dated "July 1, 1988" and then receive notice that on "July 2, 1988" a lien was filed since the construction costs for the project had not been paid; leaving no recourse except through legal channels)
- c) this would keep the lending institutions, the builder, the subcontractor, the supplier, and the new owner all in a position to settle any differences; rather than, as stated previously, relieving the bank and builder from any responsibility (these two should have had responsible control of the construction funds in the first place)

Again, it would seem like such a simple solution to require the bank to have signed lien releases from all contractors, subcontractors, and suppliers before transferring from a construction loan to a permanent, long-term loan.

I would also recommend that on the lean release form, all contractors and subcontractors be completely identified in order to verify they are duly licensed, bonded, and insured as per State requirements. They way it is now, there is no better way to enforce your own past legislation.

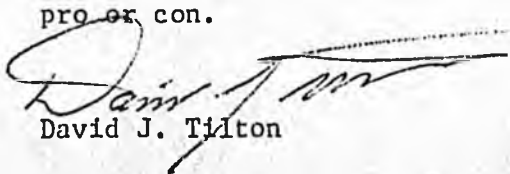
My opinion, which is shared by many others, is that the State is irresponsible in these areas. I would be happy to face any committee with this charge, as it is based upon 13 years as a subcontractor in Alaska.

I will maintain a complete record of all of your personal responses to me about this matter, and, although there are a great number of people involved in the construction trade in Alaska, I will do my best to forward your information and comments to them. This will let us know who we feel is working for us and which of you oppose us.

I would rather feel that my suggested legislation will increase responsibility, confidence, better construction and communication by meeting the needs of all Alaskans.

Please be interested enough to respond and express your opinion,

pro or con.


David J. Tilton

P.O. Box 83770
Fairbanks, Alaska 99708

February 23, 1988

Dear Senator:

Will you Please consider sponsoring legislation to address the following:

I feel that the state is inconsistant when they legislate laws that plumbers and electricians be tested and licensed as craftsmen, but do not verify that when Alaska Housing monies are spent that the work is actually being preformed by those fully qualified craftsmen, as the state mandates.

Many times an individual who receives a construction loan and hires out or preforms the work themselves, are doing substandard work (because they just are not qualified, as mandated by the state). They then sell the new house and its construction problems to some poor individual, who thought that since the Alaska Housing had provided the funds, they had a quality built dwelling. Your present legislation doesn't protect the unsuspecting buver. Your state inspectors will tell you that new buildings have safety violations and maintenance problems built in. Let's close the loop holes.

Legislate laws that would require all lending institutions to insure that at least the electrical and plumbing installations were performed by state mandated licensed plumbers and electricians (espically when using state monies). If you feel that the owner has a right to do all the work himself, then require him to have a craftsman inspect his work and sign their approval in case the property is sold at a future time. Or, you could increase your current number of state electrical and plumbing inspectors and staff and require they inspect before the bank or lending institution closes the construction loan. This makes sure that the buyer gets what he believes he is getting, from relying on the state requirements.

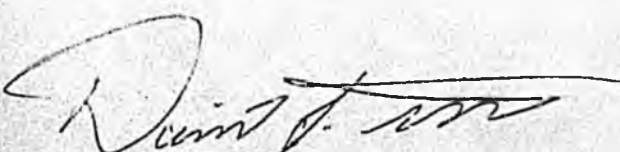
Someone, other than the new buyer, should be held responsible for poor construction. It should not be a buyer-beware purchase, but a transaction with responsibility for all parties concerned. Let's protect everyone.

Your present mandate, that plumbers and electricians be licensed, is really only holding the ones that are fulfilling all state requirements responsible. To the meantime, at least half of the work performed outside of the city limits ^{BY} performed less than qualified craftsmen. You may check with the state plumbing and electrical inspectors to verify this point.

I feel that you should repeal the licensing OR fully enforce it by closing all loop holes. As noted, currently you basically target only licensed craftsmen. This is because you don't have the banks and lending institutions helping you hold responsible the unknowns who are not registered.

I would bet that every legally licensed plumbing company in Alaska has been called into a new home to correct the problems created by unlicensed craftsmen in the past two years. Let's hold those unlicensed people responsible for the problems they create for the new home owner. The only way you would be able to do this is to enforce your own mandate, having that craftsman on record.

Will you please write me whether or not you have decided to create such legislation on this matter. I also would like you to include all your thoughts and comments (pro and con).



David J. Tilton
P.O. Box 83770
Fairbanks, AK. 99708

February 2, 1988

Dear Senators and House Members:

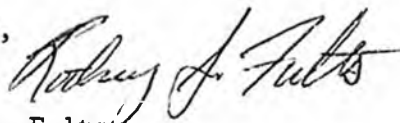
This letter references the proposed new Workman's Compensation Bill (Senate Bill No. 322 and House Bill No. 352). After attending the recent teleconference hearings and testifying before the committee at the public hearing held in Anchorage on January 29, I decided to send each of you a copy of my speech.

I am not a public speaker, nor am I a politician. I am an injured worker who has been through some of the bad faith methods the insurance company practices. This bill made me so mad that I recently registered to vote and have joined a group that will campaign against anyone who votes for the bill as is.

The proposed bill has been tailored to benefit insurance companies and employers, while the employee is often left in the cold. I feel you were elected to serve as the people's voice and to represent the public interest, not the concerns of big money. I am asking for your support in ensuring that worker's needs will be met.

In closing, please feel free to call me if you have any questions or feel I am off base in my statements. If you have already decided to vote against this bill, please disregard this letter. In any case, thank you for your time.

Sincerely,



Rodney Joe Fults
6311 Debarr Road, #124
Anchorage, Alaska 99504
(907) 333-2576

Hello. My name is Rodney Fults and I am speaking as an injured worker that knows the Workman's Compensation System. I've been through it... The reason I got involved with this bill? I read this in the paper...

Worker's Comp committee has office
The Worker's Compensation Committee of Alaska, a statewide employers' organization, has opened a headquarters office in Anchorage. According to a spokesman of the group, WCCA's major goal is the revision of workers' compensation statutes to lower insurance costs while better serving injured employees. The address is 2204 Cleveland Ave., 99517. The phone number is 248-7630.

Well, I went to the Legislative Affairs Building, got a copy of the bill, and read it when I got back to my truck. After I read it, I got out of the truck and walked back to see if I had dropped part of the bill, because I couldn't find the part that "better served the worker."

FIRST OF ALL, I would like to comment on the part that states "the board poses the greatest possible authority in the exercise of its fact finding responsibilities and that the board's decisions be conclusive if supported by any evidence." This means you can't take it to the courts if you feel you've been wronged. The words "any evidence" could mean "wrong evidence" or "bad evidence." This is a clear violation of the 14th Amendment of our constitutional rights...the right to due process. What's wrong with the WCCA? Don't they have any faith in the Alaska Court System? They trust twelve board members but not twelve honest people and a judge? I feel this gives the Comp Board too much power. We need a check and balance system.

Section #9
page 1
House Bill
#352

SECOND...the part of the bill that states changes of benefits according to what state you live in...I believe this will encourage out-of-state hiring, especially for self-insured companies. It would be cheaper if you had a job going and some worker from Mississippi was injured than if an Alaskan worker was injured. Alaskans would be discriminated against more than they are now. Imagine living in Anchorage and having to get a post office box in Seattle so you could get a job in Alaska...

Sec. #21
page 19

THIRD...The Independent Medical Exam...This bill talks about cutting medical cost, yet at the request of the insurance company an injured worker must go to a doctor, hand picked by the insurance company, for an exam. This doctor is paid very well--\$500 to \$1,000 for 30 to 45 minutes. If the doctor doesn't give the report the insurance company wants, they discontinue future use of this doctor for Independent Medical Examinations. If he gives them the report they want to hear, they've found themselves a "new friend." As a normal doctor visit only averages \$50.00, I feel this should be looked at as a bad faith method.

Sec. #10
page 13

FOURTH...Litigation...Litigation is brought on by the insurance company's lawyers to try and get out of the responsibility, not the injured worker trying to get on workers compensation. Defense lawyers are paid two to three times the amount the lawyer for the injured worker receives. Lawyers fees for the injured worker have to be okayed by the Comp Board. If they are not okayed, they will not be paid. The defense lawyers, on

the other hand, do not have to be okayed and they can make up any excuse to litigate a case--literally "starving out" the injured worker in the process. This should be changed to where all lawyers fees need to obtain approval from Board. This needless waste of money should be stopped.

FIFTH...I would like to see a breakdown in cost. What are the litigation costs listed under? Rehabilitation? Medical? Wages? I also feel that before anyone votes on this bill, insurance companies should show their profit margins for last two years as premiums have gone up 40 to 60% in that period. A lot of costs seem to be hidden or not monitored. As one committee member said in the public hearings in Juneau last week..."they have a difficult time getting that information." If only 30 cents of \$1.00 goes to the injured worker, I think we should know exactly where the rest goes...

SIXTH...The subject of a Rehabilitation Specialist...They want to cut cost, but yet they speak of hiring more people through the State. This would not only give one person too much power over another person's future, but would also add cost to the State. I feel rehabilitation should be a voluntary program. This certainly needs to be re-examined.

Sec. #6
page 4

SEVENTH...Cooperation...If you don't cooperate with the Rehabilitation Specialist you lose your benefits. That means if you don't agree with what they say about your future, you're screwed. If you don't attend designated programs, your benefits stop. Does this mean if a person gets the flu and misses a week of school, they're out of the program? These things are worded too vaguely. It leaves too many loopholes that are not to the injured worker's advantage.

Sec. #6
page 7

EIGHTH...Requires the most recent employer to make the compensation payments if there is a dispute of liability. This should not even be in this bill. There is already a law that covers the "last injurious exposure". All this would do is discourage anyone from hiring you if you've ever been injured before.

Sec. #19
page 17

NINTH...Section 9 deals with a "written plan for continuing medical treatment" within seven days of treatment from your attending physician. I don't know about you, but I'm not a damn car going to the body shop for an estimate. Doctors don't always know what you're going to need in a week.

Sec. #9
page 13

TENTH...I don't agree with this bill, but I do agree with a maximum of \$700.00 per week. I don't know many workers who can't make it on that amount.

Sec. #21
page 18

In summary, I've listened to several people in Juneau stand up and beg for the legislature to pass this bill "as is" because the WCCA worked so hard putting it together. Hard work isn't the issue here. Jesse James worked hard, but that doesn't make what he did right. I've also heard Workman's Comp referred to as a runaway train. You don't stop a runaway train by shooting the passengers.

Next time the WCCA decides to write a bill of this nature, I hope they talk to the workers and ask for their input.

BENJAMIN B. TALLEY
Brig. Gen. U. S. Army, Retired
HC 67, Box 600
Anchor Point, AK 99556-9702

Tel: 907 235-7473

31 January 1988

Senator Tim Kelly
P. O. Box V
Juneau, AK 99811

Dear Tim:

Thanks for your letter of January 27th pertaining to committee hearings on the Workers' Compensation Reform questionnaire.

I will try to attend the Committee hearing in Anchorage on February 12th.

The fact that only 30% of funds appropriated for workers' compensation actually reaches the injured workers does not surprise me too much. I believe this can be improved.

May I cite one improvement made in New York City. Originally, relief checks were mailed to recipients at their New York City addresses. The procedure in New York was changed, and recipients were required to call in person for their checks. The number of recipients dropped by more than 12%. Many no longer lived in New York but had moved to Florida, to Hawaii and elsewhere.

If feasible, I would like to discuss this with you or someone on your staff at the Legislative Office in Anchorage in mid-afternoon of 11 February. In anticipation of this, please send me a copy of the Questionnaire.

Sincerely,

B. Talley

BENJAMIN B. TALLEY
BRIG. GEN. U. S. ARMY, RETIRED
STAR ROUTE BOX 600
ANCHOR POINT, AK 99556
(907) 235-7473

10 February 1988

COMMENTS OF B. B. TALLEY, BG, USA (RET)
ON WORKERS' COMPENSATION REFORM
FOR HEARING BY ALASKA LEGISLATURE
SENATE & HOUSE LABOR & COMMERCE COMMITTEE
February 12th, 1988

These comments are based on my own experience during the period I was responsible for spending \$350,000,000 on military construction in Alaska during WWII, and more than \$1 billion on military and civil works for the Corps of Engineers while District Engineer at Huntington, West Virginia and at Louisville, Kentucky, as Division Engineer, North Pacific Division, New York, and Mediterranean Division, Nouasseur Air Base, Casa Blanca, Morocco.

It is not too surprising that only thirty cents of each dollar appropriated for Workers' Compensation reaches the injured workmen. I am not familiar with the details of the Workers' Compensation legislation, but I accept the fact it was enacted in good faith and with the best of intentions.

Then, why has it gotten out of hand? There may be many reasons. The more likely will be discussed.

The first is a spirit of laissez-faire; meaning, among other things, non-influence in matters of economics and business, or, more simply, "Don't rock the boat." Over a period of time, these can result in a situation such as the Reform Questionnaire is endeavoring to correct.

Also: there is the question of politics, which I will comment on from what two of us were told in 1946 by then Governor Gates of Indiana. The official from Washington who was with me said to the Governor: "Then, there's the question of politics." The Governor replied, "It is my experience that the best politics is 'Good Government'."

In each organization of which I was in charge, I had a comptroller who was a watchdog over expenditures and the efficiency of operations. My door was always open to him, and I listened to his comments and recommendations.

-2- Talley Comments

Here are some of the results.

In Alaska, our "overhead" for operations by civilians was approximately 5%.

In the Mediterranean Division, I refused to accept approximately 124 pickup trucks which had been ordered from "available funds." Also, when the U.S. was given responsibility for heavy construction by their respective governments in Iran and Pakistan, initial cadres of personnel for Corps of Engineer Engineer Districts at Tehran, Iran, and Karachi, Pakistan, came from "available" personnel in Morocco, together with the trucks mentioned above.

In North Atlantic Division, New York, after WWII, when we were demobilizing, we received a quarterly personnel ceiling showing our future authorized quarterly strength. When the first ceiling came, the comptroller told me we were already below that ceiling. We stayed below it in succeeding quarters without a "RIF". We met it by normal attrition and a reshuffling of personnel.

The problems of handling Workers' Compensation are different from those mentioned, but the principle is the same. It is based on the will to do what is required to accomplish the necessary result.

New York City had a similar problem. Relief rolls were exhorbitant. Relief checks were sent through the mail. This was changed by requiring the recipient to call in person for his or her check. Relief payments dropped by about 12%. Many no longer lived in New York, and checks were being forwarded by the Postal Service. Many were sent to Florida, California and Hawaii.

Now, what to do about the workmen who have left Alaska?

It may be possible for the State to examine the Federal income tax returns of recipients of disability compensation, or to ask the individual recipient to furnish a copy of the return. The returns would show whether wages are being received for work done by the recipient of the workers' compensation. The return would also show the address which the recipient used for tax purposes. The legality of obtaining returns from the federal government should be investigated.

The question of continuation of payment of disability compensation at Alaska rates for those who have left the state can, I believe, be handled equitably.

Residents of Alaska who are eligible for the Longevity Bonus must apply for it each month. If they are out of the state for more

-3- Talley Comments

than one month, they do not receive the Bonus payment for the period they are absent. If they are out of the state for more than three months, they are disqualified for payments until they are again residents for one year. Also, checks cannot be forwarded from the Alaska address to which they are sent.

An analogous solution can be applied to the payment of workers' compensation, either by eliminating payment to those whose income as shown by data on their income tax return shows they are employed and are no longer dependent on workers' compensation for their livelihood, or it can be reduced to compensation at rates similar to those in the locale where they are living.

January 19, 1988

John J. Breyer
P.O. Box 141845
Anchorage, AK 99514

Senator Tim Kelly
Senate Labor & Commerce Committee
P.O. Box V
Juneau, AK 99811

Dear Senator Kelly:

I have enclosed the Workers' Compensation Reform Survey and am also including some additional comments that I believe you will find helpful.

Not all, but most, unions and employers turn their backs on their injured workers and those workers are left to fend for themselves. I believe the unions and employers should work more in conjunction with the State in retraining the injured worker. If this is not possible, then the injured worker should be trained in a new field.

The amount of workers' compensation benefit should not be reduced. The benefit is based on the injured workers' past wages and, in many cases, is far lower than they were making when they were actively employed. Neither should the injured worker be penalized for moving outside for retraining as this could be the only way he can keep his head above water.

A year should be enough time before the worker is determined to be permanently disabled depending on the injury suffered and the amount of time anything medical has been done.

I believe that one of the main reasons costs are getting out of hand is not the benefit being paid the injured worker but all the people involved in the administration of his case, i.e. rehab counselors, adjusters, IME doctors. The private rehabilitation counselor should be replaced with a State rehabilitation counselor who could perform the same function of the private counselor at a much lesser expense.

Injured workers should not be limited to just one doctor. The claimants should be allowed to be treated by a physician that they have confidence in and feel comfortable with. The insurance adjusters have a group of doctors that they use. These doctors will almost always come up with an IME report that will contradict the claimant's treating physician. I know of one doctor in Anchorage who testified in court that he makes \$60 to 80,000 a year, just from the work he performs for the insurance adjusters. How can this opinion not be biased?

To place a limit on the rehabilitation program could be very discriminating. It is much easier to retrain someone who was making \$7.00 an hour and is 24 years old versus someone who made \$20.00 an hour and had 20 years work experience in one field. The worker who was earning more at the time of injury would need training that would restore him to something close to his former earning capacity. To limit the voc-rehab plan to two years with a cap of \$10,000 would be very unfair and in many cases placing a limit on retraining programs would limit those programs to only low paying positions.

If total temporary disability were limited to two years, I believe the adjuster would drag his feet until the two years were almost up and then dump the worker without any retraining being given. Temporary partial disability should not start being paid until the worker has been retrained and back to work, if that is the case.

The adjuster should be restricted as far as his reasons for cutting off benefits to an injured worker. When you are on workers' compensation the harshest thing you deal with, aside from your injury, is the uncertainty. Not knowing whether the adjuster has decided that this was the week to cut you off without having any legitimate reason.

I agree that the system needs to be overhauled. The inequities that are present in the system are both unfair to the worker and very costly to the employers. The real problem, as I view it, is all the other persons who make a living off the injured worker's claim, i.e. adjusters, rehab counselors, doctors who give IMEs.

I believe that within the statutes there should be guidelines set down that all parties would have to abide by. (When the worker is able to start retraining, deciding on the voc-rehab plan, etc.)

At the present time, the injured worker is in the weaker position compared to the adjuster who seems to have all the control and, in many cases, uses it unmercifully.

Sincerely,

A handwritten signature in black ink, appearing to read "J. L. Berry", with a long horizontal flourish extending to the right.

ROY W. WILLIAMS
P.O. BOX 671011
CHUGIAK, ALASKA
99567

January 20, 1988
Senator Tim Kelly

This letter is in response to your questionnaire concerning workers compensation.

My first impression is one of anger in light of the limited structure of this questionnaire, and the disregard it shows for professional opinion and comment.

My feeling is that you have not pursued the insurance carriers for the reasons causing these rate increases. Should you do this with dedication I feel you will find gross mismanagement of their funds and a feeling that the easy way to cover their losses is to raise rates and cut services.

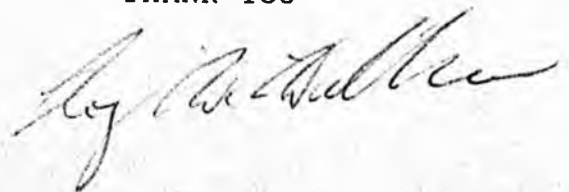
I have never filed a claim for injuries with workers comp. but I do work heavy construction and oil field service where the possibility of major injury is always a mis step away. Also you must consider the lesser revenue causes these companies to make cuts in safety practices; even though no one wants to admit to it; neverthe less it is the real situation and will continue to get worse as time goes by.

Before you set out to penalize the working people of ALASKA for trying to earn an honest living , please reflect on the cost of babysitting the criminal element you so readily protect . Also consider the amount of money this state controls but offers no kind of health insurance for the people, or partnership proposal to address this problem.

Also consider that working people already pay for 3 health coverages, Medicare, medicaid, Veterans and then we pay for our own without the benefit of tax relief until we spend at least 7% of our income.

In summary I hope you and your committee will reflect on the fact that you represent the people that voted for you to represent them... Companies and Insurance agencies do not vote.

THANK YOU



Dear Senators and House Members:

This letter is in regard to House Bill 352 which proposed changes in the Workers' Compensation law. On page one of this proposal at line 14-15, it states "The legislature declares that the Workers' compensation laws must not be construed by the courts in favor of any party." This part denies the worker to take any dispute to the courts. Has the legislature found our courts wanting or needing.

Page 6, line 5, part E states "an employee is not eligible for re-employment benefits if" (see part 2 line 11) the employer has been previously rehabilitated in a former workman's comp claim and returned to work in the same or similar occupation in terms of physical demands." My question is, if the injury is clearly a new injury, why do you not want to give the injured worker his right to re-employment benefits or have you guys decided to have this as a once-in-a-lifetime benefit. What a sorry commerce kissing plan.

Page 7, line 14-19 - If an employee is in the re-employment part of workmen's compensation, an employee will be considered non-cooperative if he fails to maintain average grades (C) in any schooling they propose, and if you don't maintain an average C grade, you are history. Any one who can see through a ladder can see that this new piece of legislation is definitely not for your average worker. If the average construction hand could hold down average graded (C), or better, he darn sure would not be a blue-collar worker.

Page 9, line 4-6, the cost of the re-employment plan incurred under this section shall be the responsibility of the employer, but may not exceed \$10,000. It will take a lot more than \$10,000 to re-employ a man physically incapacitated, especially if a limb is missing.

As the law states, a person doesn't even have to have a degree to be a rehabilitation specialist. I believe they should.

Page 9, line 26, your definition of "employability" is an amazing snow-job designed to dump the worker off workmen's comp. You are aware of this and I plan to make the workers and voters in my voting district aware of this in the next election. Rest assured of this fact. I will also organize other voters in other districts come next election.

Page 10, line 6, if you are injured and on workman's compensation and a job in Timbuktu is available, you must take that job - 3,000 miles from home, family, friends, future union benefits, relatives, possessions, or whatever, or you are off workman's compensation. If by now you have discovered I am mad ----- you are right!

Page 12, line 7-9, this next one really blows my mind. The bill states "the employee may not make more than one change in the employee's choice of attending physician without the written consent of the employer." The injured worker has never been the one who is doctor shopping. It has always been the insurance companies who search (doctor shop) for a doctor who will give them a favorable report or diagnosis and the insurance companies pay well, and I mean well if this new found prostitute will examine you and report back with the right words. They are paid \$700 to \$900 for a 45-minute exam of the injured worker, and if they don't give the insurance company the right report about the injured worker, they are no longer used by the insurance company for independent medical exams. They then are back into honest medicine.

You may not know it, but there are only a few (10 or 12) doctors in town who will prostitute themselves and these are used a lot by insurance companies. Most doctors will give an honest IME, but that is not what the insurance company wants.

Scenario: A man is injured and is sent to town and is usually coerced into seeing the company's doctor or the one recommended by the insurance company. Then he can make only one more change and then must get permission from his past employer (who by now is mad cause this man got hurt) and will not get their permission and must stay with his second choice irregardless of the doctor's field of expertise and specialties.

You are either ignorant or you think the voters are ignorant if you think we will take this piece of legislation as is. Your opinion of the general public must be at a new low if you think we believe this new law is for the injured worker. Don't forget who you are supposed to represent.

Page 13, line 8-9. "The initial treatment plan may not include more than 20 visits in the first 60 days." Why limit the visits to 20 the first 60 days and 4 per month in the next month unless you have completely disregarded the injured worker's needs and rights to fair treatment.

Page 13, line 15-29, more money will be spend by the insurance company on IME than the employees will spend on treatment. And, yet, the insurance company is screaming that too much money is spent on doctors. What a farce!

Page 14, line 1-3, the employee must submit to "[ANY]" examination by the 10 or 12 doctors (prostitutes) or his compensation is suspended. These exams are electro-milogram which is where they stick 2 inch needles into your muscles and they turn the electricity on and see if the muscle moves, which is a hideous thing if a person is afraid of being shocked. And, if needed, the electricity can be turned up to make you do an uncontrolled dance if needed. Usually one visit is all that is needed to get the injured worker to drop workers compensation and find self-help.

Page 14, lines 17-22, here you have limited the injured worker to going to doctors who are average in price for services, but no limit was put on IME doctors. Whose side are you on anyway? All you want is average care for the injured worker.

Page 15, line 1-13. This bill states th t if a dispute between the injured worker's doctor and the insurance company's doctor (prostitute) exists, the insurance company's doctor will be presumed to be the correct one. My, my, my, does our prejudice show! You are so narrow-minded and prejudice that a gnat could sit on your nose and kick both of your eyes out.

Same page next lines, same paragraph. You have the audacity to write into this bill these words, "a person may not seek damages from an independent

medical examiner caused by the rendering of an opinion or providing testimony under this subsection, except in the event of fraud." If IME are caught prostituting for the insurance company with a false statement, they will plead ignorance which doesn't constitute fraud.

You have made it an air-tight case for the insurance company. Shame on you! If you had a part in making or drafting this bill, then plead ignorance-----it works for the IME doctor, but don't vote for it.

Page 16, lines 9-11. It reads as follows: "Subject to an employer's or employee's burden of proof, a finding of fact made by the board as a part of a compensation order is conclusive if supported by any evidence." What have you got against the court system in Alaska? Are you afraid of judges and jury's decisions? Our court system may not be perfect at times, but its better than a group of hand-picked workman's comp board members whc are also slanted and prejudiced in favor of big commerce and insurance companies.

Page 20, lines 21-23. "Failure to achieve remunerative employability as defined in AS 23.30.04(n)(7) does not, by itself, constitute permanent total disability." In my mind and to anyone else who has been on workman's compensation, we know what your motives are.

Jerry Brinkley
4106 Northwood
Anchorage, Alaska 99517
Phone: 248-0266

February 5, 1988

Senator Tim Kelley, Chairman
Senate Labor and Commerce Committee
Alaska State Legislature
P.O. Box V (M.S. 3100)
Juneau, Ak. 99811

Dear Senator Kelley:

Re: S.B. 322

I strongly support the recommendations of the Management/
Labor ADHOC Committee for Workers' Compensation Reform.

I encourage you and your fellow senators to pass S.B. 322.

Sincerely,

Karen Morris
Karen Morris



Conoco Inc.
3201 C Street
Suite 200
Anchorage, AK 99503
(907) 564-7600

January 26, 1988

Mr. John Ringstad
Senator Tim Kelly's Office
Alaska State Legislature
P. O. Box V (MS 3100)
Juneau, Alaska 99811

Dear John:

As we discussed in Juneau on January 19, I had asked both Conoco and DuPont personnel who are directly involved with Worker's Compensation plans to review the proposed legislative changes. I have attached copies of their comments for your information. Both reviewers have favorable comments on the proposed legislation, the only suggestion was that the provisions for the Review Committee in AS23.30.095 could be better defined.

I hope this information is useful to you. I'm looking forward to seeing you and Ann on my next trip to Juneau.

A. E. Hastings

cl
File: 801.25

*News Paper Ad
Full Page*

Date: 2.5.88

Draft

**HL: WHAT YOU SHOULD KNOW ABOUT THE PROPOSED WORKERS'
COMPENSATION LEGISLATION.**

The proposed law now before the legislature came about as a result of a year long effort conducted by a statewide labor-management task force.

If passed, the new law would do the following:

1. Increase disability benefits for seriously injured workers.
2. Increase temporary total disability benefits for workers employed in low paying jobs to match at least minimum wage.
3. Provide for voluntary rehabilitation for workers who want to prepare for future employment.
4. Encourage cooperation between injured workers and rehabilitation counselors.
5. Establish minimum qualification standards for rehabilitation counselors, and offer a referral service to workers and employers.
6. Allow physicians to charge only "reasonable" fees for specific services.
7. Provide for unbiased and cost effective settlements in medical disputes.
8. Encourage patients to seek quality medical care that promotes recovery rather than dependency.
9. Require health care providers to show cause for continuous multiple treatments. It does not, however, limit treatment if it can be proven to promote recovery.

10. Make it unlawful for an employer to discriminate against a job applicant who has previously filed for workers' comp benefits.

11. Protect workers from loss or delay of benefits in the event of a dispute where an insurance carrier is ultimately liable.

12. Allow for the reduction of benefits for workers who relocate to an area with a lower cost of living.

13. Set a standard under which stress claims may be judged valid.

14. Allocate a greater portion of worker compensation dollars directly to injured employees.

15. Provide for a cost effective, equitable program that provides incentives to injured workers to return to work.

We support this legislation because it is fair to injured workers, cost effective for employers and will save jobs in Alaska.

ANCHORAGE SCHOOL DISTRICT

ARCO *Alaska, Inc.*

STANDARD ALASKA PRODUCTION

SCOTT WETZEL SERVICES

ALASKA AIRLINES

WESTMARK HOTELS

ALASKA TIMBER INSURANCE EXCHANGE

ANGLO ALASKA PETROLEUM

CARR-GOTTSTEIN

CIMARRON HOLDINGS

COMPREHENSIVE REHAB SERVICES

ARCTIC FOUNDATIONS, INC.

NORTHERN ADJUSTORS

ALASKA STATE MEDICAL ASSN.

ALASKA NATIONAL INSURANCE

MARKAIR

HOLLAND AMERICA

NORTHERN AIR CARGO

ALASKA STATE CARGO
ALASCOM
TOTEM OCEAN TRAILER EXPRESS
ANCHORAGE REFUSE
ALASKA CLEANERS
KLUKWAN, INC.
LYNDEN INC.
HICKEL INVESTMENT
REEVE ALEUTIAN
NATIONAL BANK OF ALASKA
GCI
DOYON DRILLING
CENTRAL PLUMBING AND HEATING
SPENARD BUILDING SUPPLY
UNOCAL
ALASKA OIL MARKETERS ASSN.
ALASKA PULP CORPORATION
RAIN PROOF ROOFING
MARATHON OIL
USIBELLI COAL MINE
ALASKA STATE CHAMBER OF COMMERCE
RESOURCE DEVELOPMENT COUNCIL
RG & B CONTRACTORS
MECHANICAL CONTRACTORS OF FAIRBANKS
A & B TOOL
ACME FENCE
PACIFIC MOVERS
SAUPE ENTERPRISES
ALYESKA AIR SERVICES
SMYTH MOVING SERVICES
BAILEY'S RENT ALL
MIDAS MUFFLER

ALASKA STATE AFL-CIO
WESTERN ALASKA BUILDING AND CONSTRUCTION TRADES COUNCIL
FAIRBANKS BUILDING AND CONSTRUCTION TRADES COUNCIL
CARPENTERS LOCAL 2162
CARPENTERS LOCAL 1281
PUBLIC EMPLOYEES UNION LOCAL 71

377-5454

INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS LOCAL 1547
LAUNDRY AND DRYCLEANING LOCAL 333
LABORERS INTERNATIONAL UNION LOCAL 341
LABORERS INTERNATIONAL UNION LOCAL 942
PAINTERS AND ALLIED TRADES LOCAL 1140
PAINTERS AND ALLIED TRADES LOCAL 1555
INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL 302
UNITED TRANSPORTATION UNION LOCAL 1626
UNITED FOOD AND COMMERCIAL WORKERS LOCAL 1496
ROOFERS AND WATERPROOFERS LOCAL 190
TEAMSTERS UNION LOCAL 959
SHEETMETAL WORKERS LOCAL 23
FIREFIGHTERS LOCAL 1264
BRICKLAYERS LOCAL 1

510
3111
C

WORKERS COMD

PEOPLE WANTING TO TESTIFY

SUE ROTH - JUNE 1/21

BERT MASON - JUNE 1/19

TOM SLAEGLE 586-3340

DANSON

UNION

GROUP

BUREAU

LABOR

BILL SWEDER - AGC RESA

NADY CORSE

TIM & PAT ALLEN

Comments on the Workers' Compensation Bill HB #352
and what is wrong with the existing laws

Source of Problems: Presently there exists a rehabilitation program, however vague, it does not work well. The reason for it is that the client becomes lost in the paper work between the Rehab. firm, the employer's lawyer and the Department of Labor's inability to settle disputes quickly.

Several Rehab. outfits are existing in the Juneau area for instance, but I know one that is totally incompetent in handling injured people. I have been a witness to one case over two years and have since done research on this issue. Injured people have special problems, they suffer from depression, are inclined to become alcoholics and suicidal. Without the proper care these people are not able to become contributing members of this society.

The present so-called rehab. program does not provide enough training that will reemploy an injured party at a reasonable economic bases. What does a 43 credit diploma get you? Not much unless you win a lottery to supplement your income.

Presently 61 cases are pending for review by the Department of Labor's Administrator. There is only one administrator and it can take as long as 7 months to get a hearing. This is unacceptable.

Employer's attorneys play often god, doctor etc. without recourse to the injured party. Some rehab. outfits need not proof any particular training or schooling to ensure quality work, yet we let them lose on injured people, who are often incapable of making proper decisions because of pain and stress. Torts against the injured party are therefore committed again without any recourse to the injured party. A very sad state of affairs at a high cost.

What to do about it?

As a witness I can testify to several viable means of operation and will cost less money and will provide better services for these injured parties.

First of all license these rehabilitation outfits, you cannot live without them, or you could appropriate the moneys back to the Department of Education, Voc., Rehab. Without standards of conduct you have nothing to measure against.

Secondly, I would suggest that you do not use a 2 year term for rehabilitation, some people take longer than that. Restrict the employer's lawyer to use vindictive methods of operations, operating often on the premise of falsehood

and misinformation.

Perhaps establish a trustee status, a qualified individual who would serve with little cost to the client and would help as a good Samaritan to the injured party.

Employ more Administrators to handle the cases quickly. There should not be a waiting period longer than one month.

Attorney's ought to not be allowed to make medical judgments and disallow medical care when reasonably related to the injury.

The injured party must be evaluated in whole, not in part, for rehabilitation purposes, body, sole and injury. You can't rehabilitate an injured party unless you know how to handle the personality etc.

I feel in whole if you implement some of the above items that you will bring the costs down and at the same time have a better rehabilitation program in effect.

If you need further information or wish to talk to me, I will be happy to do so.

Maria Iverson
10742 Horizon Drive
Juneau, Alaska 99901

Phone no. 465-2253

MITCH

WCCA BILL

SECTION A.S. 23.30.095(a):

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

RATIONALE: This passage is objectionable for several reasons:

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

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

The employee may not make more than one change of attending physician within the employee's attending physician's specialty without the written consent of the employer.

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

CORRECTION

**THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY**

MITCH

WCCA BILL

SECTION A.S. 23.30.095(a):

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

RATIONALE: This passage is objectionable for several reasons:

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

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

The employee may not make more than one change of attending physician within the employee's attending physician's specialty without the written consent of the employer.

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

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

Upon procuring the services of an attending physician, etc.

- (4) Add sentence to end of present section stating:

With the exception of the above, no party shall attempt to interfere with or restrict by any means the employee's right to select a physician of his or her choice.

SECTION A.S. 23.30.095(c):

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

RATIONALE: This passage is ill considered:

- (a) because there is no definition of what is considered "continuing and multiple treatments" and health care providers must necessarily guess;
- (b) because there is no designation of who will approve the plan and what standards will be employed and upon what facts or basis the review will rest;
- (c) because the process of review will occur simultaneously with the provision of treatment and, according to the current language, the health care provider must bear the financial risk of disapproval;
- (d) because there are no provisions for amendment of the plan should the need arise; and,
- (e) because the provision imposes maximum limits arbitrarily.

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

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

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

SECTION A.S. 23.30.95(e):

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

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

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

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

SECTION A.S. 23.30.95(f):

DELETE (UNDERLINED) changes.

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

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

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

SECTION A.S. 23.30.99(1):

DELETE changes. AMEND CURRENT LANGUAGE.

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

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

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

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

We suggest the following language REPLACE Section (j):

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

SECTION A.S.23.30.095(k):

(1) AMEND proposed language.

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

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

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

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

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

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

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 medical evaluation, an independent medical evaluation shall be conducted by a physician or physicians of the same

physicians licensed in the State of Alaska or the state that treatment was rendered from a list established by, with the aid and advice of the medical advisory board, and maintained by the Board. Both the employee and employer shall have the right to challenge one appointment. In the event of a challenge, the next physician on the list will be appointed. The contents of the list and the order of its contents shall be kept confidential by the Board. The report of the independent medical examiner shall be furnished to the Board and both parties within 14 days after the examination is concluded. The opinion of the independent medical examiner shall, in the absence of clear and convincing evidence to the contrary, be presumed to be correct. A person may not seek damages from an independent medical examiner caused by the rendering of an opinion or providing testimony under this subsection, except in the case of fraud, misrepresentation or gross negligence.

SECTION A.S. 23.30.155(c):

DELETE Added language.

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

SECTION A.S. 23.30.155(m):

DELETE changes.

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

For the employee who is caught within the exception's parameters, however, there is little relief. If the filing requirements did not incorporate notifications to the employee and were, in fact, only ministerial, there might be some justification for the proposal, although it is not readily apparent even in that situation. However, the reports do require notification to the employee and, in the absence of receiving timely reports, the employee may well make decisions that he might not should he receive a timely notification that the employer was either going to controvert, suspend or terminate his compensation. In essence then, the employer is, according to this section, allowed to escape penalties for failing to comply with the employee notification provisions in Subsection (c).

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

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

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

SECTION A.S. 23.30.265 (34):

AMEND proposed language.

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

First, hinging a definition of medical stability on whether or not the patient will improve disregards situations where continued treatment is necessary to prevent a diminishment of medical status, or to prolong the patient's medical status.

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

SECTION ENTITLED LEGISLATIVE INTENT, SUBSECTION (b):

AMEND proposed language.

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

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

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

AACD

ALASKA ASSOCIATION FOR COUNSELING AND DEVELOPMENT

ALASKA
- STATE BRANCH -
AMERICAN
ASSOCIATION FOR
COUNSELING AND
DEVELOPMENT

*Jim -
your support is
very much needed!
Best wishes,
Pat*

Fifth Avenue Bldg. • Suite 500
900 W. 5th Avenue
Anchorage, Alaska 99501 U.S.A.
Telephone: (907) 258-3077

1-24-88

TO: SENATOR TIM KELLY

FROM: Pat Reeves, Legislative Chair
Alaska Association for Counseling and Development

In Re: Proposed Addition: p. 10, (6) REHABILITATION SPECIALIST
WORKMEN'S COMP BILL - SB322/HB352

The Alaska Association for Counseling and Development strongly supports the inclusion of other nationally certified professionals to be listed in SB322/HB352, p. 10 (6) as rehabilitation specialists.

You have selected only one group to be listed: certified insurance rehabilitation specialists aka CIRS(or CIRSC). We are aware that there are other equal or more qualified certified groups that need to be listed in this bill. Why "determine" criteria at a future date?

The present bill reads (p.10 (6)) as follows:

"(6) "rehabilitation specialist" means 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."

It could be surmised that the "certified insurance rehabilitation specialists" have been approved to provide reemployment services and other groups have not been sanctioned.

A letter dated 12-10-87 from Eda Holt, Executive Director of the CIRSC (CIRS) - certified insurance rehabilitation specialist - Board states: (copy attached)

". . . As you can see by the standards, a person certified as CIRS may not necessarily do vocational counseling "

Further, the application for the "certified insurance rehabilitation specialists (CIRS/CIRSC), page 1, clearly states: (copy attached)

"The holder of the CIRS credential has demonstrated a minimum acceptable level of knowledge pertaining to

disability compensation systems as determined by the commission. THE CIRS DESIGNATION, IN AND OF ITSELF, HOWEVER, NEITHER IMPLIES NOR REPRESENTS THAT ITS HOLDER POSSESSES KNOWLEDGE AND SKILLS IN A SPECIFIC DISCIPLINE (e.g. ADMINISTRATION, COUNSELING, NURSING, VOCATIONAL EVALUATION, WORK ADJUSTMENT, JOB PLACEMENT,) THAT MAY BE NECESSARY TO PROVIDE REHABILITATION SERVICES TO ELIGIBLE DISABLED INSURANCE RECIPIENTS.

Why was this certificated group (10-11 in Alaska) set up as the standard to deliver reemployment (rehabilitation) services at the exclusion of equal or more qualified groups? Their own certification (as quoted above) "neither implies nor represents that its holder possesses knowledge and skills . . . that may be necessary to provide rehabilitation services to eligible disabled insurance recipients."

Other professionals in Alaska spend time, effort and money to maintain higher professional credentials (national certification status).

We request that you include the following professionals among the groups qualified to provide reemployment services to Alaska's injured workers:

NATIONAL CERTIFIED COUNSELORS (NCC), credentialed by the National Board of Certified Counselors.
Requirements for Certification: Masters Degree; Annual Fee; Supervised Practicum; Work Experience; References; Written four-hour examination; Annual continuing education units to maintain professional knowledge.

AMERICAN BOARD OF VOCATIONAL EXPERTS (ABVE) - Fellow or Diplomate status. Certificate requires Masters Degree; Rehabilitation experience; Board Annual Review/Approval; Written four-hour examination; Fee; 14 Annual Continuing Education Units.

Vocational Expert (VE) - Certified by U.S. Government Health & Social Services, Social Security Division, Board of Hearings & Appeals. Requirement: Rehabilitation experience/training/approval and annual evaluation. Serves at request of Administrative Law Judge for Social Security Disability Hearings as Vocational Expert.

Your compliance with this request will be greatly appreciated by the professional organization and by those who will be receiving the reemployment services.

Thank you for this consideration.



BOARD FOR REHABILITATION CERTIFICATION

1156 Shure Drive, Suite 350, Arlington Heights, Illinois 60004 (312) 394-2104

December 10, 1987

Dear

In response to your letter sent to the NRA. The letter was forwarded to me at CRCC and CIRSC for handling.

Enclosed, please find applications for CRC and CIRSC.

Please read the eligibility standards for each process carefully.

Please send our office a copy of the Workers Compensation Law. As you can see by the standards, a person Certified as CIRS may not necessarily do vocational counseling.

The grandparenting period for CIRS occurred over 18 month period, from October, 1984 through October, 1985-three field test examinations with 3,465 applicants.

The CRC and CIRS Certifications are separate and distinct. No, the CIRS was not designed to replace the CRC.

Should you desire further information, please feel free to contact me.

Sincerely,

Eda Holt, Executive Director
EH/pc

The Board is Composed of Appointees from the Following Organizations:
ACCD, ARCA, CORE, CSAVR, NANWRW, NARF, NARPPS, NRCE and NRCA.

Betty S. Hedgerman, Ph.D., CRC, PRESIDENT
Lex Frieden, VICE-PRESIDENT
Lawrence J. Deneen, Ph.D., CRC, TREASURER
Ruth White, CRC, SECRETARY
Eda Holt, EXECUTIVE DIRECTOR

Barbara Banks, CRC
Ethel Briggs, CRC
Alan Goldstein
Michael Willis, M.S., CRC
Grace Gianforte, M.S., CRC

Lawrence Warnock, CRC
William H. Graves, Ed.D., CRC
G. Berk Lynch, II, Ph.D., CRC
H. Gene McDowell, CRC
David Myers

Ken Olson, M.A., CRC
Stanford Rubin, Ed.D., CRC
Peter Griswold

Comments on the Workers' Compensation Bill HB #352
and what is wrong with the existing laws

Source of Problems: Presently there exists a rehabilitation program, however vague, it does not work well.

The reason for it is that the client becomes lost in the paper work between the Rehab. firm, the employer's lawyer and the Department of Labor's inability to settle disputes quickly.

Several Rehab. outfits are existing in the Juneau area for instance, but I know one that is totally incompetent in handling injured people. I have been a witness to one case over two years and have since done research on this issue. Injured people have special problems, they suffer from depression, are inclined to become alcoholics and suicidal. Without the proper care these people are not able to become contributing members of this society.

The present so-called rehab. program does not provide enough training that will reemploy an injured party at a reasonable economic bases. What does a 43 credit diploma get you? Not much unless you win a lottery to supplement your income.

Presently 61 cases are pending for review by the Department of Labor's Administrator. There is only one administrator and it can take as long as 7 months to get a hearing. This is unacceptable.

Employer's attorneys play often god, doctor etc. without recourse to the injured party. Some rehab. outfits need not proof any particular training or schooling to ensure quality work, yet we let them lose on injured people, who are often incapable of making proper decisions because of pain and stress. Torts against the injured party are therefore committed again without any recourse to the injured party. A very sad state of affairs at a high cost.

What to do about it?

As a witness I can testify to several viable means of operation and will cost less money and will provide better services for these injured parties.

First of all license these rehabilitation outfits, ^{if} you cannot live without them, or you could appropriate the moneys back to the Department of Education, Voc., Rehab. Without standards of conduct you have nothing to measure against.

Secondly, I would suggest that you do not use a 2 year term for rehabilitation, some people take longer than that. Restrict the employer's lawyer to use vindictive methods of operations, operating often on the premise of falsehood

and misinformation.

Perhaps establish a trustee status, a qualified individual who would serve with little cost to the client and would help as a good Samaritan to the injured party.

Employ more Administrators to handle the cases quickly. There should not be a waiting period longer than one month.

Attorney's ought to not be allowed to make medical judgements and disallow medical care when reasonably related to the injury.

The injured party must be evaluated in whole, not in part, for rehabilitation purposes, body, sole and injury. You can't rehabilitate an injured party unless you know how to handle the personality etc.

I feel in whole if you implement some of the above items that you will bring the costs down and at the same time have a better rehabilitation program in effect.

If you need further information or wish to talk to me, I will be happy to do so.

Maria Iverson
10742 Horizon Drive
Juneau, Alaska 99801

Phone no. 465-2253

LAW OFFICES
FINDLEY & PALLEMBERG
THE VALENTINE BUILDING
119 SEWARD STREET, SUITE 1
JUNEAU, ALASKA 99801

THOMAS W. FINDLEY
PHILIP M. PALLEMBERG

January 11, 1988

TELEPHONE 586-3811
AREA CODE 907

The Honorable Tim Kelly
Chairman,
Senate Labor and Commerce Committee
P.O. Box V
Juneau, Alaska 99811

SUBJECT: S.B. 322/H.B. 352--Proposed amendments to Alaska Workers' Compensation Act

Dear Senator Kelly:

As an attorney representing injured workers in workers' compensation cases, I have viewed with interest the recent efforts to reform the Alaska workers' compensation laws. It has long been clear to everyone involved in the system that changes are necessary. Costs are out of control, numerous abuses are occurring on both sides of the system, and too much money is going to individuals other than the most deserving injured workers. It is even more important, however, that the rush to make those changes does not result in a bill that deprives injured workers of basic fairness, and does not achieve the needed savings. I have reviewed the amendments contained in S.B. 322 and H.B. 352, and I am appalled at some of the proposed changes. Cost savings should not be achieved at the expense of fundamental fairness.

It must be remembered that workers' compensation benefits are not handouts. Workers' compensation was devised as a trade-off--workers were allowed benefits, without regard to fault, to compensate them in part for their losses resulting from on-the-job injuries, in exchange for losing their right to sue their employers for negligence. If employers are to continue to be immune from suit, their employees have a right to receive fair and adequate benefits in return.

Clearly, the bill represents a great deal of effort by a large number of people. While much of the proposal is a constructive approach to the problem, I feel that many of the proposed amendments are discriminatory, unfair, or simply unworkable.

The bill's tone is set by its first section, which states that its intent is to assure the "quick, efficient, and predictable" delivery of benefits. While these are worthwhile goals, there is no mention of fairness--not only to the injured worker, but also fairness to the employer.

The major structural changes in the statute are in the areas of rehabilitation and computation of permanent partial disability benefits. I will first discuss my concerns about the rehabilitation provisions.

Although I have other concerns about the rehabilitation section of the bill, I am most concerned about a few items. First, under new section 041(j)(2), the injured worker is ineligible for vocational rehabilitation unless he or she requests a rehabilitation eligibility determination within 60 days after the injury. This will automatically deprive many needy workers of rehabilitation, since 60 days after their injury most employees don't know whether they will be able to return to their old jobs. Most workers that I speak to are almost totally unaware of their right to rehabilitation benefits. The average injured worker does not want rehabilitation after 60 days, since he expects to return to his previous job. It is only after the worker discovers that he will not recover fully that rehabilitation becomes necessary. The 60 day requirement of new section 041(j)(2) sets a trap for the unwary injured worker.

New section 041(i) defines "noncooperation" with rehabilitation, which disqualifies the worker from further rehabilitation benefits. The proposal needs to define noncooperation more carefully. This section could be interpreted to provide that an injured worker forfeits his or her reemployment benefits if he or she misses one meeting with the rehabilitation specialist. The statute should contain the requirement that the noncooperation be unreasonable. It is also not fair to deprive a worker of his or her benefits for failure to maintain average grades. By definition, half of all students are above average, and half are below average. It seems somewhat elitist to suppose that any student who does not maintain average grades is not cooperating.

The rehabilitation section eliminates the provision in present law that an employee's ability to return to work be judged by the availability of work in his or community, or the place of work at the time of injury. Instead, it is judged by the existence, not availability, of work anywhere in the state. Under this rule, a Petersburg resident who is injured would not be eligible for rehabilitation if a job exists anywhere in the state, whether in Petersburg, Anchorage, or Nome, which he is capable of performing--regardless of whether the job is available to him.

The new statute also eliminates any payment of temporary compensation as maintenance during rehabilitation. Employees instead are expected to live on their permanent partial disability award during rehabilitation. Maintenance would be awarded only after the worker has exhausted his or her PPD award. I find it unfair to require an employee to live off his or her permanent partial disability settlement during the period of rehabilitation. Coupled with the changes in permanent partial disability awards, this will leave many workers with no money after they complete their rehabilitation programs. This is inconsistent

with the purpose of permanent partial disability, which is to partially compensate injured workers for their permanent loss of earning capacity.

I am very concerned about the changes in permanent partial disability (PPD) awards. PPD is intended to be compensation for an employee's permanent loss of earning capacity. For the typical worker with a back injury (or any "unscheduled" injury), the existing system attempts to base compensation on actual loss of earnings. The new statute eliminates any attempt to calculate actual loss of earnings. Instead, the award is based on the arbitrary disability ratings established in the AMA Guides to the Evaluation of Permanent Impairment. Most physicians will agree that the AMA Guides are a poor way of evaluating many injuries. They are particularly arbitrary when it comes to evaluating back injuries. The gross unfairness with this system is that the arbitrary award is paid whether or not the injury affects the employee's ability to work. A longshoreman with a 5% impairment of his back may be unable to do his job, but he would receive an award of \$250. An attorney with a 40% disability may be fully able to work, but he or she would receive \$96,000. While this may meet the stated intent of "quick, efficient and predictable" delivery of benefits, it is far from fair--to either side.

Section 190 contains another curious provision. After the injured worker's impairment is rated, the rating is "adjusted" by multiplying it by an "Adjustment Factor", ranging from zero for impairments of 5% or less, to one for impairments of 31% or greater. This will result in the following payments for permanent disabilities:

<u>Impairment</u>	<u>Payment</u>
5%	\$250
10%	\$4,800
15%	\$14,400
20%	\$28,800
25%	\$42,000
30%	\$57,600
50%	\$120,000

While workers with large impairment ratings will receive large sums of money, the new schedule, for some reason, sharply discounts the awards to workers with small disabilities. If a worker with a 5% impairment is onetenth as impaired as one with a 50% impairment, it is not clear why the second worker should receive an award four hundred and eighty times as large. The use of the "Adjustment Factors" to discount small awards is discriminatory.

It is interesting to note that, at the same time that Alaska seems to be moving toward a purely scheduled system, the general trend nationwide is away from such systems. This state would do well to heed the example of other states such as Florida, which abandoned a scheduled disability scheme when it found, according to Professor Arthur Larson, the national authority on workers' compensation, that 79 percent of administrative and legal time

was consumed arguing about disability ratings. I predict that, if this section is adopted, there will be just as many disputes about disability ratings as there are now about earning capacity.

Another provision of the bill which I find unduly harsh is the two year limit on temporary total benefits contained in new section 185. While benefits generally are not paid for more than two years, there are instances in which an injured worker has not fully recovered in two years. Occasionally, an employee's condition is not properly diagnosed right away. If an employee needs major surgery, or complications develop, he or she may well be left destitute, while still under medical treatment.

Under new section 095(k), medical disputes are to be submitted to a physician selected from a list kept by the Board. The determination of this physician is presumed to be correct, in the absence of clear and convincing evidence to the contrary. In many cases, all three doctors may be on the Board's list. There is simply no reason to decide a case solely on the basis of the opinion of one doctor who has seen the worker just once. This is just another way of making the process more arbitrary, and less fair.

Under new section 020, a worker is totally ineligible for benefits if he or she misrepresented the worker's physical condition at the time of hire, and the employer relied thereon. It would appear that, under this section, a worker who denied a previous back injury would go uncompensated if he or she aggravated the previous injury on the new job. The consequences of this section for many workers will be disastrous.

In many industries, such as the logging industry, it is very difficult, if not impossible, for a worker with even a minor back injury to return to work. No logging company, if given a choice, will hire a worker with a back problem. Under this section, a logger with a prior back injury will have to make a choice between mentioning his injury, and probably not getting a job, and not mentioning it, and forfeiting his workers' compensation benefits if he is reinjured. While the new statute does contain a toughened anti-discrimination section, such provisions are very difficult to enforce. It is usually impossible to prove discriminatory intent.

This section illustrates the peril of assuming that labor interests can speak for injured workers. A union worker, dispatched through a hiring hall, would not be harmed by this section. The employer could not discharge the worker if his preemployment health questionnaire reflects an injury. A nonunion worker, such as a logger, does not have this protection.

New section 220 revises the procedure for calculation of compensation rates. Under section 220(1), which is unchanged from existing law, rates are based on wages during the two years preceding the injury. Under existing law, if those wages do not

fairly represent the employee's wages at the time of the injury, the Board may adjust the wages by considering the employee's work and work history. This "escape hatch" has been substantially enlarged in recent years by the Supreme Court. The new section would limit this "escape hatch." The rate could only be adjusted if the employee had no earnings, or was "voluntarily" absent from the labor market for 18 months or more during the two years. I can see no justification for limiting this section to voluntary absences. The main justification for the "escape hatch" of section 220(2) has always been to allow the Board to adjust the compensation rate when the employee was absent from the labor market for a portion of the previous two years due to previous illness, disability, or other circumstances beyond the employee's control. Under the new language, such involuntary absences from the labor market would not qualify an employee for an adjustment. This cannot be justified.

Under new section 265, an employee is presumed to have reached medical stability if he or she goes 45 days without objective medical improvement. Medical stability becomes all the more important under the new rehabilitation provisions, since it marks the point at which an employee's temporary benefits end. While the standard of objective medical improvement has some merit, 45 days is much too short a time to judge stability. Many workers go more than 45 days between follow up visits after major surgery. It is not fair to throw an injured worker back in the labor market simply because his injury is slow to recover.

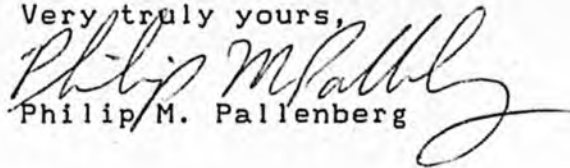
I would suggest four basic reforms which would substantially cut the costs of the system. First, lower the maximum benefit, as S.B. 322 and H.B. 352 do. Second, restore the adjustment of benefits for out of state claimants, as S.B. 322 and H.B. 352 do. Third, return the calculation of compensation rates in section 220 to what the Legislature originally intended, which is that the rate be based on the employee's historical wages. Finally, and most importantly, rewrite the vocational rehabilitation provisions to require a quick, fair determination of an injured worker's entitlement to rehabilitation. Too many workers draw temporary benefits for many months or even years while waiting for a rehabilitation to be completed. I can provide more specific proposals along these lines if necessary.

Clearly, the present system has major flaws. Too much money and time is expended in litigation. Too much money is wasted on meaningless rehabilitation. Too many workers are being financially devastated by injuries while other workers receive excessive benefits. The existing statute is an attempt, although not an entirely successful one, to compensate injured workers for their lost wages, and to return them to work. The proposed bill would abandon that effort, and instead pay settlements based solely on the impairment of the body--without regard to earnings. We must not let the need to cut litigation costs and promote certainty eliminate fairness. Fairness, after all, means only that benefits have some relation to what a worker has lost as a result

January 11, 1988

of an injury. That is what the system is supposed to do--and can do, if we are willing to make it work. I sincerely hope that this Legislature will not be remembered as the one which stripped injured workers of their right to be fairly compensated for their injuries.

Very truly yours,


Philip M. Pallenberg

cc: Governor Cowper
Members of the Senate Labor and Commerce Committee
Members of the House Labor and Commerce Committee
Senator Duncan
Representative Hudson
Representative Ulmer

MASON & GRIFFIN
ATTORNEYS AT LAW

550 W. 7th Avenue • Suite 285
Anchorage, Alaska 99501

Robert B. Mason
Admitted in:
Alaska, Texas
Robert L. Griffin
Andrew J. Lambert

(907) 274-5546

January 11, 1988

Senator Tim Kelly
Capitol Bldg., Room 101
Juneau, Alaska 99803

Dear Senator Kelly:

First of all, I would like to thank you for providing me with a copy of the draft legislation regarding the Alaska Workers' Compensation Act. I have reviewed this legislation in detail, and attached is a memorandum that I have done in regard to the changes. This memorandum was principally designed to identify the changes for myself and my clients. There are some comments as to what I perceive to be problem areas within the legislation.

As I mentioned to you on the phone quite some time ago, I am principally concerned with trying to obtain an amendment to the Act that would require disability benefits to be calculated upon the employee's wages at the time of the injury. To that effect, I have drafted a change to AS 23.30.220, which is attached. The definition of spendable weekly wage remains the same. The change is based on how to calculate the gross weekly earnings of the employee.

If the employee has worked for the employer in excess of forty weeks, his actual wages during the prior forty weeks will be divided by forty to determine his gross weekly earnings. This provision would eliminate many of the disputes that are now encountered in determining the compensation rate. In addition, the computation of disability benefits based upon the employee's wages at the time of injury would seem to more accurately reflect what the employee needs to survive on during the duration of his disability. Computing benefits in this manner would also follow the economic trends in the state of Alaska. During a down swing, benefits would drop, but during upswings, benefits would tend to increase. In addition, insurance carriers compute the premium to be paid based upon the actual wages paid.

Under the present system, it is not uncommon at all to find an employee who is making \$10 an hour when he was injured receiving disability benefits that amount to \$12 or \$14 an hour or more. Under such a system, the employee has no economic incentive to return to work. In addition, the carrier is then faced with paying for a loss that he did not and could not anticipate when

Senator Tim Kelly
Page 2
January 11, 1988

he wrote the insurance policy.

The proposed legislation goes on to provide provisions for employees who have not worked for forty weeks, and have irregular paychecks. For those working overtime hours, the amount of overtime hours will be computed and added into the gross weekly earnings. The same is true for commissions for salesmen or other people that get paid based upon the actual amount of work performed. Monthly salaries are to be divided by 4.3 to determine the weekly wage.

The current provisions regarding minors or trainees is retained. The only difference is that there is a limitation so that the compensation rate of the employee does not exceed his actual spendable weekly wage at the time of his injury.

The current provision regarding ambulance attendants, policemen or firemen is retained.

I have inserted here the language regarding contributions by an employer to pension or profit sharing plans that was added to AS 23.30.265(15).

I do not represent any particular insurance company or adjusting company in regard to this proposed legislation. It is my own idea, and one that I have harbored for quite some time. I do believe that it will result in a more equitable situation for both the employee and the employer. In some cases, it will result in lesser benefits for the employee, but in other cases, it will result in more benefits. The major benefit that will be derived by both the employer and the employee is that there will be little room for dispute as to what the compensation rate shall be.

In order to present this concept to your committee, I would appreciate it if you could schedule me to testify to the committee for at least thirty minutes. In addition, I would appreciate the opportunity to address some other issues that are contained in the proposed amendments to the Act. If I could obtain an additional thirty minutes of time before the committee, I would certainly appreciate that opportunity. I will be available on both January 19 and 20 to testify. I will come by your Senate offices on January 18. Thank you very much for your cooperation, and if I can answer any questions or otherwise be

Senator Tim Kelly
Page 3
January 11, 1988

of help, please do not hesitate to give me a call. My home phone number is 694-9520.

Sincerely,

MASON & GRIFFIN

Robert B. Mason

RBM:mrm
Enclosures

MEMORANDUM

RE: Proposed Amendments to Workers
Compensation Act

DATE: 1/11/88

This memo is intended to provide a brief overview of the significant changes in the proposed workers' compensation legislation that will be considered this session. This memo is not intended, nor does it purport to cover all aspects of the proposed changes. The section numbers referred to below refer to the sections of AS 23.30 and not the sections as identified in the Senate bill. There are several groups and committees who have reportedly drafted provisions/amendments that differ significantly from the ones presented here.

Section 1.

-- Workers' compensation cases are to be considered and decided upon the merits and the Act is NOT to be construed in favor of any party. The obvious exception to this is the presumption of compensability contained in Section 120.

-- The Board is to have virtually exclusive fact-finding responsibilities and decisions will be conclusive if supported by "any evidence."

Section 5.

-- The Department of Labor is empowered to adopt lists and procedures for selection, retention and removal of vocational rehabilitation counselors and/or physicians under Sections 41 and 95 of the Act.

Section 20.

-- If an employee makes a false statement regarding his physical condition on an employment application or questionnaire, he is not entitled to any benefits under the Workers' Compensation Act if the employer relied upon the false representation and that reliance was a substantial factor in hiring the employee, and there was a "causal connection" between the false representation and the injury. It is unclear what would constitute a substantial factor in the hiring and what would constitute a causal connection between the false representation and the injury. I would anticipate a substantial amount of litigation on these issues to determine their meaning and the result would be an application of a test to the facts in each and every case. The concept is good, but language could be

inserted in the Act to clarify the intent.

Section 40.

-- Requires the contribution to Second Injury Fund be made at the time of the report filed with the Department of Labor as required by Section 155(m).

Section 41.

-- There are substantial changes in the rehabilitation provisions within the Act. In addition, there seems to be a change in intent from "rehabilitation" to "reemployment."

-- The reemployment services administrator (RSA) has numerous responsibilities, including an annual report that is aimed at determining the cost of providing rehabilitation services. These reports should be distributed to interested parties.

-- Within 60 days of filing of the notice of injury, the employee may request an evaluation to determine whether he is eligible for reemployment benefits. The RSA will select the counselor to perform this eligibility evaluation from a rotating list which will deprive the carrier from having an input as to who they will hire for rehabilitation services. The counselor performing the eligibility evaluation is not necessarily the counselor that will provide rehabilitation services through the course of the claim.

-- The RSA has the authority to extend the 60-day period if he determines that "unusual and extenuating physical limitations of the employee preclude the employee from making a timely request." Thus, it would seem that the employee must request the rehabilitation counseling within 60 days of his injury; however, the employer can also request that such an evaluation be made. It is unclear whether the employee would waive his right to rehabilitation if he does not make the request within 60 days.

-- The eligibility evaluation is to be performed and apparently the report filed within thirty days following the initial referral. The RSA can grant an additional thirty days.

-- The employee shall be eligible for rehabilitation upon the employee's written request and if a physician determines or predicts that the employee will ultimately have physical capabilities that are less than those required to perform the job as described in the United States Department of Labor's "Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles," for the employee's job at the time of the

injury, and for any other job that the employee has held within ten years before the injury, or employment following the injury that has been sufficient enough to establish the employee's ability to function in that labor market. Thus, the employee has to make a written request for rehabilitation, and a doctor has to determine that he has a physical impairment that will preclude him from his normal occupation or occupations that he has had in the past. This is very significant when coupled with the definition of reemployability. Further, the burden of requesting reemployment benefits lies with the employee.

-- The employee is not eligible for rehabilitation if the employer offers him a job within his physical capabilities at at least 60 percent of his "gross hourly wages at the time of injury," and there is a labor market for those skills.

-- In addition, the employee is not eligible for rehabilitation benefits if he has been previously rehabilitated in a workers' compensation claim and returned to work "in the same or similar occupation in terms of physical demands." This does not require the same occupation, but only an occupation that requires the same physical capabilities.

-- Once eligible, the employee can select his own rehabilitation specialist. If the employer disagrees with the employee's choice, and the disagreement is not resolved, then the RSA shall assign the case to a third rehabilitation specialist. The employer and employee each have one right of refusal of the counselor selected by the RSA.

-- The reemployment plan requirements are essentially the same as they were before.

-- The priority of retraining is the same as it was before.

-- Non-cooperation will result in a termination of benefits as of the date of the non-cooperation. Non-cooperation is defined to mean failure to keep appointments, maintain average grades, attend programs, maintain contact with the counselor, cooperate in developing a plan and participating in activities relating to reemployment, comply with the requirements of the plan, or comply with the request of the RSA.

-- Benefits, which presumably includes disability benefits, will not extend past two years from the date of the acceptance of the plan.

-- The employer and the employee have ten days after it has been determined he is eligible for reemployment benefits to select a rehabilitation specialist. There are no provisions to determine how this will work or what happens if the ten days lapses, or who has to make the first choice. I can see some disputes developing here, although they should not be major ones.

-- The reemployment plan must be formulated and approved by the parties within 90 days of the determination of eligibility. I feel that this 90 day requirement is going to be impossible to meet in many cases, and there are no provisions for an extension of this time. It would seem that if the parties would agree to an extension of time there would be no problem. In addition, I would suspect that the RSA could extend the time within his reasonable discretion. This 90 days would expire within the first 180 days after the injury if the other time requirements are met. In some cases, six months is not long enough for the doctors to determine what the employee's physical capabilities will be, and the Plan cannot be formulated until that is determined.

-- The plan shall be initiated when the physician determines that the employee is physically able to engage in the plan. There should be a provision for extending the 90-day limitation added to this clause.

-- If a plan cannot be agreed upon, either party may submit a plan to the RSA. The RSA shall approve or deny a plan within fourteen days after it is submitted, and within ten days of that decision, either party may seek a review of the decision by hearing pursuant to Section 110. The Board shall uphold the decision of the administrator unless there is an abuse of discretion. This puts a great deal of power in the hands of the administrator. In addition, it opens up the rehabilitation field to employee and employer oriented firms. The natural prejudices of the individual counselors involved will be hidden under the guise of impartiality, but it is quite clear to me that the battle lines will be drawn within six months. This will put too much control in the hands of one person, whose personal beliefs and philosophies can cause a great deal of dispute. The abuse of discretion standard should be changed.

-- The cost of the plan cannot exceed \$10,000, which apparently does not include disability benefits.

-- If the employee becomes medically stationary before completion of the plan, the carrier will begin paying PPD as opposed to TTD. However, if PPD benefits are exhausted before the completion or termination of the reemployment plan, the employer must pay up to 60 percent of the employee's spendable weekly wages, not to exceed \$525, until the plan is completed. At the end of the plan, any PPD benefits remaining unpaid shall be paid in a lump sum.

-- The fees of rehabilitation counselors are paid by the employer, and this would include the cost of the one hired by the employee, and are not included in the \$10,000 limitation of the cost of the plan. Thus, in many cases, there will be three rehabilitation counselors hired to assist the employee, not

counting the eligibility evaluation.

-- There is a limitation placed upon who can perform rehabilitation work, and if he is not a rehabilitation specialist, he must be employed by a firm that is. There should be a distinction drawn between rehabilitation specialists and job developers.

-- Employability means having the ability to engage in employment that is consistent with the employee's physical capabilities, "but not necessarily the opportunity." This would mean that once the person is retrained and has marketable skills, he is employable. This definition applies only to the rehab section. Once the employee becomes employable, rehab benefits would cease, as would temporary total disability benefits.

-- Labor market means the geographical area where the employee resides, the area of last employment, the state, other states. This provision does not limit the labor market that would be used in determining the employability of the injured employee. I can foresee some difficulties and intense litigation in the case where the employee moves to an economically depressed area and says "this is my area of residence." The definition of employability does not include the opportunity, but a labor market survey in the area of residence would indicate that there are very few skills that would provide a job opportunity for the injured employee. I am not sure what was intended by defining the labor market area in this manner, and it would appear to me that this section of the Act will cause a great deal of litigation and clarification is needed.

-- Physical capacity means "objective and measurable physical traits" such as lifting, carrying, etc.

-- Physical demand means the physical requirements of the job.

-- Reemployment benefits that are limited to \$10,000 would include the cost of the eligibility determination and the plan development, but would not include provider fees. It does not say this, but it is quite clear that this would also not include PPD or TTD.

-- Rehabilitation specialist is defined to mean somebody who is a "certified insurance rehabilitation specialist" or someone with equal or better qualifications, as determined by the Board.

-- Renumerative employability means having the skills to allow a worker to earn wages equivalent to at least 60 percent of the worker's wages at the time of injury. If the employment is found out of state, it shall be adjusted to reflect the difference between the average weekly wages of the two states.

It is important to note that this is a comparison of the wages after return to work to the wages at the time of injury, and not necessarily the wages used to determine the compensation rate.

Section 55.

-- Deals with the exclusive remedy provisions, which stay essentially the same. The liability of the employer is exclusive even if the employee's claim is barred because of a misrepresentation on his job application.

Section 95.

-- In regard to medical care, the employee is to designate a physician inside the state where he resides, and cannot make more than one change in his choice of attending physicians without the written consent of the employer. Referral to a specialist is not a change. Notice of changing attending physicians will be given before the change. There is nothing in here that states the penalty or repercussions for multiple changes or failing to provide notice of a change beforehand. It must be assumed that the employee would not be entitled to have his medical benefits paid if he does not comply with the statute. If he provides notice of the change after the fact, I would assume that the employer would be responsible for medical costs after notice of the change is received.

-- Where a course of treatment requires multiple treatments of a similar nature, a claim for the cost of those treatments is not valid unless the treatments are carried out pursuant to a written plan detailed and prescribed before the commencement of such treatment. In addition, the plan must be signed by the physician and mailed to the employer within one week of the beginning of the treatment. Again, there are no provisions as to what happens if this is not complied with. I would assume that the employer would not have to pay for any treatment up until the time the plan is received. If the plan is not developed before the treatment starts, the employer would presumably be only liable for treatments within the plan after the plan is completed.

-- The plan must include the objectives to be reached, the frequency of the treatment, and the method, manner and means of the treatment. The treatment plan cannot include more than twenty visits within the first 60 days, or four visits a month after the first 60 days. If this is not sufficient, the physician must document the need for services in excess of the guidelines contained herein. This sounds good, but it is not going to affect long range treatment plans, particularly by chiropractors. They will simply have a standardized plan drawn up and put inside their computerized typewriters. They will be

punched out with new names and some slight changes. I suspect there will be some litigation over this issue.

-- Specific penalties and repercussions for failure to comply with the above provisions should be delineated. If not, it will require Board interpretation to determine what happens, which will result in extensive litigation.

-- The employer can request an IME no sooner than 14 days after the injury, and every thirty days thereafter. Requests for an IME shall be presumed to be reasonable, and the employee should submit to the examination without dispute. If he refuses, his rights to compensation shall be suspended until the refusal ceases.

-- Fees charged for medical treatments are currently limited to "charges that prevail in the same community." Fees will be subject to the regulation by the Board "and may not exceed usual, customary, and reasonable fees for the treatment or service in the community in which it is rendered, as determined by the Board," pursuant to the change.

-- The Board is authorized to appoint a medical services review committee or to contract with somebody to provide such services as necessary to assist and advise the board in medical issues.

-- If there is a dispute regarding causation, medical stability, degree of impairment, functional capacity, the necessity of treatment, or compensability between the employee's attending physician and an IME doctor, a second IME shall be conducted by a physician selected by the Board. The cost of such IME shall be paid by the employer. The opinion of this doctor shall "in the absence of clear and convincing objective evidence to the contrary" be presumed to be correct. In other words, the IME as directed by the Board will in essence be conclusive. I can foresee a significant battle in identifying and determining which doctor will provide the IME. The battle lines of defense and plaintiff's doctor, which already exist, will be emphasized even more with this provision. Since neither party can object to the appointment of a physician, it would appear that the Board would have a great deal of control over who should perform the IME.

-- This doctor is protected from liability, except in the case of fraud.

Section 120.

-- The presumption of compensability does not apply to mental injuries.

Section 155.

-- When benefits are controverted solely because of the last injurious exposure rule or that another employer/carrier are responsible for whatever reason, the most recent employer or insurer who is a party to the claim and who may be liable is responsible to make the TTD benefit payments until the case is resolved. Upon a final determination, reimbursement is required to the prevailing party of the benefits paid, including interest and costs and fees. This payment shall be made within 14 days of the decision.

-- The statute does not specifically provide for the payment of attorney's fees to a prior employee who is brought in by a subsequent employer. However, it is safe to assume that what is good for the goose is good for the gander, and that costs and fees will become an expense to be awarded to the prevailing employers in a last injurious exposure rule claim.

Section 155(m)

-- Provides for the filing of annual reports and a reduction in the amount of penalties assessed for late filing of reports.

Section 175

-- The maximum compensation rate has been established at \$700. The minimum compensation rate, initially, may not be less than \$110. However, if it is determined that the employee's spendable weekly wage is less than \$110 per week, "or less than \$154 per week in the case of an employee who has furnished documentary proof of the employee's wages" the minimum compensation rate will be adjusted to equal the employee's spendable weekly wages. If 80 percent of the spendable weekly wages are less than \$154, the employee's compensation rate shall be \$154. I am not sure why there is a distinction between wages computed to be \$110 a week pursuant to Section 220 and where the employee furnishes proof of \$154 a week wage. In any event, the minimum comp rate has been changed to equal the employee's actual spendable weekly wages, or if the spendable weekly wages are greater than \$154, and 80 percent of that figure is less than \$154, the compensation rate shall be \$154.

-- Overpayments will be deducted from unpaid compensation "in the manner the Board determines." This would indicate that in each situation, if the parties cannot agree, then they must go to the Board to determine how to recover the overpayment. The 20 percent deduction, now in effect, would seem to be the appropriate method to accomplish this.

-- For injured employees who reside out of the state of Alaska, their compensation rate shall be determined by multiplying the ratio of the cost of living in that state divided by the cost of living in Alaska. In theory, if the cost of living in the state where the injured employee resides is greater than Alaska, his comp rate could be increased.

-- In any event, the minimum comp rates will apply.

Section 180.

-- The definition of permanent total disability has not changed. However, in making the determination of whether the employee is permanently and totally disabled, the labor market to be considered is the area of residence, area of last employment, and the state. This would appear to mean that the first labor market considered is where the employee is currently residing, be it in Alaska or out of Alaska. The second area to be considered, in that priority, is the area of last employment, and the third is the state of Alaska. There are no provisions to state at what point you can change priorities, and therefore, it must be assumed that it would be based upon the reasonable probabilities of obtaining employment in each separate area.

-- Inherent in this provision is the concept that you can force an employee to move to accept employment or terminate his PTD benefits. It is unclear to me as to what this particular provision in this section and other sections is intending to accomplish. It should be defined in more definite terms. Failure to meet the wage goals as established in the rehabilitation provisions, that the employee have the skills that would allow him to earn wages that equate to at least 60 percent of his wages at the time of the injury (reduced proportionately if he is residing outside the state of Alaska) does not in and of itself constitute permanent total disability.

-- I am concerned that the establishment of the priorities for the labor market in this and other sections will be interpreted by the board and/or the courts to mean that you must rehabilitate the employee so that he has skills that would allow him to return to work in his area of residence. If that cannot be accomplished, and the employee is not willing to return to his area of last employment or to relocate to another portion of Alaska or the state where he currently resides, that he will be found to be unemployable. Again, the provisions listing the labor market throughout this proposed legislation should be explained in more detail.

Section 185.

-- TTD is to be paid based on 80 percent of the employee's spendable weekly wages for a maximum of two years, "regardless of the continuance of the disability." In addition, TTD benefits will not be paid after the employee is determined to be medically stable. At that point, PPD benefits kick in.

Section 190.

-- The concept of permanent partial disability has been completely revised, and it is entirely based upon a schedule with a presumed loss of wage earning capacity. In some cases, this will greatly increase the amount of benefits one person will receive without the need for such benefits, and greatly reduce the amount of benefits that another would receive when he is in dire need of such benefits. A journeyman carpenter and an attorney will receive the exact same amount of money for the loss of an arm, where it would have little impact on the attorney's ability to return to his prior employment, while precluding the carpenter from doing so. I have always favored the idea of permanent partial disability benefits being paid based upon the actual loss of wage earning capacity suffered by the injured employee. The use of a schedule will reduce the amount of dispute and litigation stemming from permanent partial disability, but it will result in some inequity in the system, and in some cases, a severe inequity.

-- PPD is based upon a total payment of \$240,000, to be multiplied by the "percentage of net permanent impairment of the whole person." The payment is to be made in a lump sum and will not be discounted for present value.

-- Net permanent impairment is determined by multiplying the actual degree of permanent impairment as determined by the AMA Guide times the adjustment factor listed in the statute. A person with a 5 percent disability of the whole person would receive no permanent partial disability benefits. The factor increases with each 5 percent of impairment by .2. Thus, an employee with a 6 percent impairment rating for the whole man would receive 1.2 percent of \$240,000, or \$2,880. A person with an impairment of 30 percent would receive \$57,600. For any impairment in excess of 30 percent, the employee would receive that percentage times \$240,000. Thus, an individual with a 31 percent disability rating would receive \$74,400.

-- The AMA Guides will be used to determine the impairment rating and the impairment rating is not to be rounded off to the nearest 5 percent. The board may adopt a supplemental schedule for injuries that cannot be rated by these guidelines.

-- The minimum payment for a permanent impairment is \$250.

-- The percentage of impairment as determined under this section will be reduced by the percentage of permanent impairment that existed before this compensable injury. However, this reduction of an impairment rating will not preclude finding the employee to be permanently and totally disabled.

Section 200.

-- For temporary partial disability benefits, payments will be made based upon 80 percent of the difference between the employee's spendable weekly wages before the injury and the wage-earning capacity of the employee after the injury, for a period of not more than five years. This should be changed so that you are comparing the employee's actual weekly wages before the injury to the wage-earning capacity after the injury, as has been done in other sections.

-- TPD benefits are not to be paid after the employee has reached medical stability.

-- There is a contradiction in this statute where the proposed language says that TPD benefits will not be paid for more than two years regardless of the continuance of the disability. This is inconsistent with the five year period stated above.

-- The wage earning capacity is to be determined by the actual spendable wage if that figure fairly and reasonably represents the wage earning capacity of the employee. The board may use other factors if it does not fairly and reasonably represent the wage earning capacity of the employee. This is likely to cause some dispute, and it would seem, as noted above, that the actual wages before the injury should be compared to the actual wages after the injury.

Section 220.

-- The spendable weekly wage at the time of injury is the basis for computing compensation. This would equal the gross weekly earnings minus payroll tax deductions. Gross weekly earnings are computed by dividing the gross earnings in the two prior calendar years by 100.

-- If the employee has no earnings during the two calendar years or was voluntarily absent from the labor market for 18 months or more of the two calendar years, the board shall determine the gross weekly earnings by considering the nature of the employee's work and work history, but the compensation may not exceed the employee's earnings at the time of injury. This does not mean that the gross weekly earnings cannot exceed it, it means that the compensation rate cannot exceed it. Therefore,

in cases of a declining economy, it would not be unusual for an employee to have a compensation rate that equals his actual earnings at the time of injury.

Section 225.

-- If employer contributions to a pension or profit plan have been included in determining the gross earning and the employee is receiving pension or profit sharing payments, benefits are reduced by the amount so paid or payable. The amount of this reduction may not exceed the increase in compensation benefits caused by the inclusion of these contributions.

Section 247.

-- The employer cannot discriminate against a person who has filed a claim for workers' compensation. This is not to be construed as prohibition for an employer to require the completion of a preemployment questionnaire or application regarding the prospective employee's health or disability history, so long as this document is meant to either document written notice for the Second Injury Fund or to determine whether the employee is physically capable of doing the job. This statute should go further and allow employers to require prospective employees to fill out such a form. Many employees are refusing to fill out questionnaires.

Section 265(15).

-- The definition of gross earnings has been revised to include the total amount of contributions made by an employer to a pension or profit sharing plan during the two plan years preceding the injury, multiplied by the percentage of the employee's vested interest in the plan at the time of injury.

Section 265(17).

-- Injury does not include mental stress unless it is established that the work stress was extraordinary and unusual and the work stress was a predominant cause of the mental injury. The amount of work stress shall be measured by the actual events rather than the misperceptions of the employee. Mental injury does not arise out of the course and scope of employment if it results from a disciplinary action, work evaluation, job transfer, lay off, demotion, termination or similar action taken in good faith by the employer.

Section 265(34).

-- Medical stability means that point at which further objectively measurable improvement is not reasonably expected to be achieved from additional medical care or treatment, notwithstanding the possible need for additional care for the possibility of improvement or deterioration resulting from the passage of time. Medical stability shall be presumed in the absence of objectively measurable improvement for a period of 45 days. This presumption can be overcome only by clear and convincing evidence.

1. AS 23.30.220 is repealed and reenacted to read:

Section 23.30.220. Determination of Spendable Weekly Wage. (a) The spendable weekly wage of an injured employee at the time of an injury is the basis for computing compensation. It is the employee's gross weekly earnings minus payroll tax deductions. It is the intent of the legislature that the gross weekly earnings be computed as closely as possible to reflect the actual wages the employee was earning at the time of his injury. The gross weekly earnings shall be calculated as follows:

- (1) If the employee has worked for the employer for a period of time in excess of forty weeks, the gross weekly earnings will be computed by dividing the total wages and/or commissions earned and dividing by forty. In the absence of clear and convincing evidence to the contrary, this shall be the employee's gross weekly earnings.

- (2) The gross weekly earnings will include wages received for overtime hours. If the employee is working overtime hours on an irregular basis, an average of such overtime hours and the corresponding wages will be used to determine his gross weekly earnings. This average will be computed by determining the number of overtime hours per week worked in the twenty weeks immediately preceding the injury. If the employee has not worked for that employer for twenty weeks, then the number of overtime hours will be determined by first the number of overtime hours worked by the person that the employee replaced, or secondly, the number of overtime hours worked by employees of the same employer in the same job function.

- (3) If the employee receives commission based on sales achieved or the amount of work performed, such commissions will be included in the determination of his gross weekly earnings. The average of such commissions will be computed by determining the number of commissions received in the twenty weeks immediately preceding the injury, or if the employee has not worked for that employer for twenty weeks, by determining the reasonable amount of such commissions to be earned by the employee over a twenty week period and dividing by twenty weeks.

- (4) If the employee is being paid based upon a monthly salary, regardless of whether payments are made on a weekly, bimonthly or other basis, the gross weekly earnings shall be the monthly salary divided by 4.3.

(5) If an employee when injured is a minor, an apprentice, or a trainee, as determined by the Board, whose wages absent such injury would automatically increase during the period of disability, the projected increase will be included in computing the gross weekly earnings of the employee. This increase will be limited so that the compensation rate of the employee will not exceed his actual spendable weekly wage at the time of the injury.

(6) If the employee is injured while performing duties as a voluntary ambulance attendant, policeman or fireman, the gross weekly earnings for calculating compensation shall be the minimum gross weekly earnings paid a full time ambulance attendant, policeman or fireman employed in the political subdivision where the injury occurred, or if the political subdivision has no full time ambulance attendants, policemen or firemen, at a reasonable figure previously set by the political subdivision to make this determination, but in no case may the gross weekly earnings for calculating compensation be less than the minimum wages computed on the basis of forty hours per week.

(7) Gross weekly earnings will include the amount of contribution made by an employer to a qualified pension or profit sharing plan, to be computed on a weekly basis. The gross weekly earnings will be increased by the amount of such contribution on a weekly basis, multiplied by the percentage of the employee's vested interest in the plan at the time of injury.

(b) The Commissioner shall annually prepare formulas that shall be used to calculate an employee's spendable weekly wage on the basis of gross weekly earnings, number of dependants, marital status, and payroll tax deductions.

2. Section 23.30.225 is amended by adding a new subsection to read:

(c) If employer contributions to a qualified pension or profit sharing plan have been included in the determination of gross earnings and the employee is receiving pension or profit sharing payments, weekly compensation benefits payable under this chapter shall be reduced by the amount paid or payable to the injured worker under the plan for any week or weeks during which compensation benefits are also payable. The amount of the reduction may not in any week exceed the increase in weekly compensation benefits brought

about by the inclusion of employer contributions to a qualified pension or profit sharing plan in the determination of gross earnings.

SB

322

(FILE 17)

THE FOLLOWING PAGES WERE TREATED AS
A UNIT IN THE ORIGINAL FILE.

WCCA

Workers'
Compensation
Committee of
Alaska, Inc.

Steve Haag
President

11401 Olive, Anchorage, AK 99515

(907) 344-1577

WCCA

WHAT DRIVES THE COST OF WORKERS' COMPENSATION

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

Here are some examples:

- * Alaska is one of two states which provide that the benefits paid to an injured worker will be based on 200 percent of the statewide average weekly wage. That means a North Slope worker whose job ends and who then finds a job in another location at lower pay and who then becomes injured may draw as much as \$4,500 per month in workers' compensation.
- * Benefits are calculated on the basis of the past two years' earnings. A drop in the economy or in the wages of a worker may result in an injured person actually making more from compensation than from wages.
- * Vocational rehabilitation is mandatory for workers whose injuries keep them from returning to employment within 90 days. Even when an injury is known to require 6 months to heal, expenditures must be made to meet the letter of the law.
- * Alaska's relatively small range of occupations limits the potential for placement of workers who have permanent partial disabilities.
- * Unlike many other states, Alaska has no provision for periodic review nor standards for treatment of injured workers by medical or rehabilitation providers, nor any guidelines for fees.
- * Unlike many states, injured workers do not pay any portion of their medical costs.
- * Unlike many states, few types of injuries are scheduled -- that is, lump sum payments are mandated for very few injuries.
- * Unlike many states, pensions are not calculated to offset workers' compensation payments. Only social security payments can be offset.

WCCA

OFFICERS AND EXECUTIVE COMMITTEE

President	Steve Haag Controller Udelhoven Oilfield Services
Vice President	Wesley Nason Construction Manager H.C. Price and Price/CIRI Anchorage
Secretary	Michael Anodeo Safety Engineer Enserch Alaska Anchorage
Treasurer	Eric Tollefson Personnel Director Carr-Gottstein Enterprises Anchorage
Member-at-large	Richard Cattanach Vice President Unit Company Anchorage

BOARD OF DIRECTORS

Ray Schalow
Executive Director
Alaska State Medical Society
Anchorage

Millie Edwards
Personnel Director
Humana Hospital
Anchorage

Richard Stone
Certified Rehabilitation Counselor
Vocational Evaluation and
Rehabilitation Consultants
Anchorage

Marjorie Linder
Vocational Rehabilitation Counselor
MTL Services
Anchorage

WCGA

For Release October 14, 1987

Contact: Steve Haag
344-1577

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

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

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

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

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

- more -

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

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

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

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

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

#