ALASKA LEGISLATURE COMMITTEE FILES, 1989-1990 8672

5688 HOUSE HEALTH, EDUCATION & SOCIAL SERVICES

The Self-Sufficiency Trust

Innovation in Life-Care Planning for the Disabled

H. DeOre, with funding in part from the Illinois Department of Mental Health. In September 1986, the Self-Sufficiency Trust was enacted into law (P.A. 84-1373) by unanimous vote of the Illinois Legislature.

The Trust model was seen as an "estate planning" option that would avoid conflict with existing rules that penalize families for providing direct services to their disabled dependents eligible for federal assistance under the Supplemental Security Income and Medicaid programs. Further, the Trust would encourage the flow of money from private sources, focusing on expanded supplemental services to the disabled. This new private-public initiative encourages parents, state government, and service providers to work together to plan now for a secure future for the disabled.

The Self-Sufficiency Trust model includes private and public trust components. It is governed by a volunteer Board of Trustees that works first with the family co-trustees to control the Private Fund to which families may contribute the assets (money, securities, property) designated by private trusts for life-care services of named disabled beneficiaries. Secondly, the Board of Trustees controls the Charitable Trust which accepts residual and donated assets for use in providing service to low-income and indigent persons with disabilities who are unable to participate in a private trust.

Further, the Board of Trustees controls the disbursement of funds as defined in each "life-care plan" of the named disabled beneficiaries, and ensures that necessary supplemental services are provided each beneficiary. Finally, the Board of Trustees works with the Illinois Department of Mental Health and Developmental Disabilities to ensure that the repository of donations from the Charitable Fund are used to expand existing governmental supported services to benefit people with disabilities where the greatest need exists.

What Are SST Life-Care Plans?

Each "private trust" within the Self-Sufficiency Trust is operationally based upon the individual "Life-Care Plans" developed by the parents or family and the knowledgeable trust staff. The Life-Care Plan becomes the document that governs the administration and disbursement of each "private" trust fund and identifies those supplemental services that the family or parent desires for their disabled dependent. Identifying future needs and costs is difficult. Therefore, a computerized data-base that assesses present need, projects changing future service needs, and correlates present and future costs of those services helps each family to plan realistically, based on their capacity to fund supplemental service needs through estate planning. Principal assets are individually calculated that will provide a flow of interest income sufficient to fund present and/or future supplemental service needs.

Initiation of private trusts will vary for families, depending on the assets required to fund their plan. Some families may establish a trust within the Self-Sufficiency Trust while they are living by depositing assets in a private trust at one time or over several years. Others may make provisions to deposit their disabled heir's share of the parent's estate into a Self-Sufficiency Trust via a trust clause in their will. Some may choose a combination, but regardless of the funding approach taken, families will have carefully constructed a "life-care plan," defined the supplemental services desired, and initiated estate planning for the benefit of their disabled dependent.

What Role Does Parent/Grantor Play in SST?

Upon the establishment of a Self-Sufficiency Trust account, the donor or grantor of the private trust may serve as co-trustee or may designate someone else. The co-trustee retains the right to disapprove or delay implementation of the disabled beneficiary's "life-care plan." Until disbursement for services is made from each representative beneficiary's Self-Sufficiency Private Trust Fund account, the grantor (parent or other) may withdraw from participation and recover his or her original contribution minus a penalty based on the number of years of participation in the SST Private Fund. The SST Private Trusts are considered irrevocable, meaning that the original intent of the grantor of the trust cannot be changed.

Additionally, the Self-Sufficiency Trust model provides that at least 50% of the principal remaining in the Private Trust at the death of the disabled beneficiary be left to the Charitable (Remainder) Trust, with the balance returned to the heirs of the Trust grantor. These residual assets, combined with private donations, allow the Board of Trustees to service the indigent.

How Are Funds Disbursed?

Once the individual SST Private Trust is established and funded, the disbursements that benefit each disabled beneficiary may be completed in one of two ways. First, monies (interest) may be "donated" by design in the Life-Care Plan to a counterpart SST State Fund operated by the

Paul Medlin is involved in setting up the Self-Sufficiency Trust nationwide. For additional information about SST call (312) 941-3438 or write The National Foundation for the Handicapped, 340 W. Butterfield Rd., Elmhurst, IL 60126

Department of Mental Health and controlled by the State Treasurer. This "donation" process transfers the assets required to purchase the needed supplemental services to an individual account maintained for each beneficiary entitled to benefits from that government department. Vouchers are then processed via the state treasurer to pay for the desired supplemental service. While many find this step in the process unsettling, it has the distinct advantages of preserving public entitlements and avoiding invasion of the trust. Disbursements by the Department of Mental Health via the state treasurer are made to regular service providers.

Monies deposited for this purpose may not revert back to a private trust or charitable trust account, unless it is determined by that department that the funds cannot be used to purchase the services for which they were designated in the agreement. At that point, funds may be returned.

The second disbursement process involves direct payments to private vendors, human service providers, advocates, or successor guardians who are monitoring the welfare and condition of the beneficiary. This service provision sets the Self-Sufficiency Trust apart from generic trusts devoid of life-care monitoring. Families may build into the life-care plan a personalized, non-profit organization or group to look out for the best interests of each disabled beneficiary and to act as either an "advisor" to the Board of Trustees, ensuring that Trust assets are meeting valid needs, or purchasing quality services. They may also seek a successor guardian to assume legal consent authority at some point in the future. The peace of mind that is desired by all families with dependents who are disabled is offered, not as an option, but as a major component of the Self-Sufficiency Trust model.

So far we have discussed the Self-Sufficiency Trust from the standpoint of its mechanics as a "pooled-income" trust. What does it contribute to the overall improvement of services for our nation's disabled? What makes it desirable to families with dependents who are disabled? How is it unique in its approach to estate planning?

Historically, government and the private sector have joined together to carry out the mandate of services to people with disabilities. Using its resources, each state has developed a system of services to fulfill its mandated responsibilities. The Self-Sufficiency Trust concept evolved from the realistic acknowledgement that a state's capacity to provide these needed services is diminished by increased demand, the changing economic climate, and national policies. The SST embodies the search for alternative service capabilities and the generation of resources necessary to provide them in the future.

The Self-Sufficiency Trust research found that most states face the following problems:

- Fluctuations in tax revenues have an impact upon services provided to people with disabilities. It is unreasonable to expect state tax revenues to support the increasing needs of the population.
- Unmet housing needs unfairly affect a segment of the disabled population.
- Increased life spans intensify chronic housing shortages.
- Reduced Federal program support further increases the stress on state treasuries.
- Deinstitutionalization places heavier demand on the private provider networks to supply services and housing to the disabled.
- Fluctuations in governmental grants place severe strain on the capacity to continue these services and to survive funding shortfalls.

All these factors add to the uncertainty of future services for the disabled and hinder effective estate planning by families that might supplement their disabled dependent's future care needs. Estate planning for the disabled had to be more than a trust that could withstand invasion. Rather, it had to address the real situations that could negatively effect future services and their fundng. The Self-Sufficiency Trust combined private (family) concern with public (state) financing needs into a legislatively-based mechanism that seeks to resolve problems confronting the service delivery system as a whole.

The Self-Sufficiency Trust has been enacted into law in Illinois and Maine. To date, an additional ten states have expressed interest. The potential benefit of a nationwide Trust network is, of course, economy of scale, resulting in trust management savings, larger principal investment and return, and most importantly, increased private sector (parent and family) voice in services and financing of those services for the disabled. However, several advantages accrue to each state in which it is enacted:

- New sources of private funding to expand services for disabled people.
- A computerized data collection system to identify type, scope, and time projection of need-specified services (i.e., residential) with which to plan future services for disabled people.
- Potentially reduced dependence upon federal support, which carries with it red tape and the expense of obtaining those federal funds.
- Private-public partnership which actively involves each in working toward improved/expanded services for disabled people.

For families, several major advantages are incorporated into the SST model. Several years and close to a million dollars of research have carefully evolved into a trust which encompasses the "state of the art" in estate planning for the disabled. Disincentives have been eliminated, specifically in the areas of safeguarding public entitlement benefits.

Medicaid Eligibility

The Health Care Financing Authority (HCFA) of the Department of Health and Human Services have ruled that neither principal nor interest held in a SST Private Trust will be counted in determining Medicaid eligibility. Many families fear the loss of the medical benefits or related state support of residential care if they contribute assets to their disabled adult children, or that assets they wish to set aside for future needs will have to be spent down before their children will become eligible again. Under this ruling, parents may establish a Self-Sufficiency Trust without affecting their disabled son or daughter's eligibility.

Similarly, the Council General's Office of the Social Security Administration for Region V (Illinois and upper Mid-West) has determined that SST principal and interest will not be counted as resources in determining eligibility under the Supplemental Security Income (SSI) program.

For most persons with disabilities who depend upon public entitlement support, these rulings will ensure that parental estate planning efforts become supplemental to, and not replacement of, public benefits. Additionally families participating in a Self-Sufficiency Trust will not face the requirement of spending down or exhausting private assets in order to regain eligibility for public benefits. WAYS

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION : CS SB 50 (Rules)
PUBLISH DATE : 3/16/90

FISCAL NOTE

REQUEST:

Revision Date:
Title : Trust for persons who are handicapped or mentally ill
Sponsor : Senator Duncan
Requestor : Senate Finance

Agency Affected : Health & Social Services
BRU : Institutions & Administration
Components : Mental Health Administrati

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS : (Attach a separate page if necessary)

Rick Uehling

Prepared by : Senator Rick Uehling, Co-chairman
Division : Senate Finance Committee
Phone : 465-4821
Date : 2/28/90

Approved by Commissioner :
Date :
Agency :

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
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TOTAL OPERATING	0	0	0	0	0	0
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REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
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TEMPORARY	0	0	0	0	0	0

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MODEL ACT

An Act to provide for a Self-Sufficiency Trust for the developmentally disabled, mentally ill and physically handicapped.

STATE OF ____________________

BE IT ENACTED by the People of the State of ____________,
as follows:

SECTION 1: Sections 1, 2 and 3 are added to the _________ __________________(detail the State law section dealing with the disabled), the added sections to read as follows:

(A) CREATION. There is hereby created the Self-Sufficiency Trust Fund. The State Treasurer, ex officio, shall be custodian of the Trust Fund, and the Comptroller shall direct payments from the Trust Fund upon vouchers properly certified by the (Director or Commissioner) of (name appropriate state agency). The Treasurer shall credit interest on the Trust Fund to the Trust Fund, and the Director shall allocate such interest pro rate to the respective accounts of the named beneficiaries of the Trust Fund. For the purposes of this section, the term "self-sufficiency trust" means a trust created by a nonprofit corporation which is a 501-C-3 organization under the United States Internal Revenue Code of 1954 and which was organized under the Nonprofit Corporation Act, Chap.___ Section_____for the purpose of providing for the care, or treatment of one or more developmentally disabled, mentally ill or physically handicapped persons or persons otherwise eligible for department services.

(B) RULES. The department shall adopt such rules and procedures under the ________ Administrative Procedures Act, Title _____, chapter _______, as may be necessary or useful for the administration of the trust fund.

SECTION 2: ADMINISTRATION OF FUND

(A) NAMING BENEFICIARIES. The Department of (appropriate state agency) may accept money from a self-sufficiency trust for deposit in the trust fund pursuant to an agreement with the trust naming one or more beneficiaries who are developmentally disabled, mentally ill or physically handicapped persons or persons otherwise eligible for department services residing in this State and specifying the care, or treatment to be provided for them. The department shall maintain a separate account in the trust fund for each named beneficiary.

(B) CARE OF BENEFICIARIES. The money in these accounts shall be spent by the department, pursuant to its rules, only to provide care and treatment for the named beneficiaries in accordance with the terms of the agreement.

(C) RETURN OF MONEY. In the event that the director determines that the money in the account of a named beneficiary cannot be used for the care or treatment of the beneficiary in a manner consistent with the rules of the department and the agreement, or upon request of the self-sufficiency trust, the remaining money in that account, together with any accumulated interest on that account, shall be promptly returned to the self-sufficiency trust which deposited the money in the trust fund.

(D) OTHER BENEFITS NOT AFFECTED. The receipt by a beneficiary of money from the trust fund or of care or treatment provided with that money, shall not in any way reduce, impair or diminish the benefits to which the beneficiary is otherwise entitled by law.

SECTION 3: SPECIAL FUND

The fund for the disabled is created as a special fund from the State Treasury. The director may accept money from any source for deposit into the fund. The money in the fund shall be used by the department, subject to an appropriation, for the purpose of providing for the care, and treatment of low-income developmentally disabled, ment lly ill and physically handicapped persons, or low-income persons otherwise eligible for department services, as defined by the department.

SELF-SUFFICIENCY TRUST

SELF-SUFFICIENCY TRUST OF ILLINOIS

DISABLED POPULATION PROFILE SYSTEM

DISABLED POPULATION PROFILE SYSTEM

OVERVIEW

There are two purposes for the Disabled Population Profile System:

1) It is the first step in forming a life-care plan for a disabled individual;

2) It is a planning tool which provides a system to collect information on the needs of the disabled population that are in need of services now and those needing services in the future. This information can be compiled state-wide and eventually nation-wide. Until now, there has been no successful system to accurately show these needs.

The service application will give the following information:

1) Parent demographic information;

2) Disabled person demographic information;

3) Functional disabilties of the disabled person - very basic "yes - no" function not an in-depth clinical review;

4) Scales for level determination - these scales will be used later to determine what level of residential care and day programming is needed by the disabled person. All costs associated with the level are also calculated (current year or future year costs). The system then takes these costs and produces an Income Earnings Projection which is the starting point for the financial planning for a parent for the needs of their son or daughter;

5) Current living arrangements and services;

6) Immediate needs of the disabled person;

7) Future needs - This is when the system takes the Life-Care needs, matches them to the level determination and costs for those needs, in any given year.

WHEN CAN I ENROLL IN THE SELF-SUFFICIENCY TRUST?

When it is time to deliver services under the Life Care Plan developed for your beneficiary who is disabled, you can enroll in and fund the Self-Sufficiency Trust (the "SST"). Depending upon your wishes, then, enrollment can occur currently, on a future set date, or at your death.

The Self-Sufficiency Trust has only two enrollment procedures. The first is for donors who desire services CURRENTLY; the second is for donors who desire services on a FUTURE SET DATE or AT THEIR DEATH.

CURRENT ENROLLMENT PROCEDURES

If the Life Care Plan for your beneficiary who is disabled has been completed and you have determined that services are to be purchased immediately, then your enrollment in the SST will be completed at once.

As you work with the SST Interviewers, your attorney and advisors, you will complete the Life Care Plan (which defines the services and the timing of their delivery to be provided to your disabled beneficiary), the Transfer Document (which is the agreement you sign with the SST), and the Appointment of Special Trustee (which gives you or your appointee a voice in the provision of services to your disabled beneficiary).

A summary of your file is then prepared for presentation to the Board of the Self-Sufficiency Trust. This file is identified only by the social security number of the disabled individual and contains a summary of the Life Care Plan, a verification of the financial projections, a verification that a Provider has been identified to provide services, and a verification that the Transfer Document and Appointment of Special Trustee have been executed by the donor.

If all these items are in order, the Board of Trustees will accept the enrollment pending funding. Immediately after that acceptance, the original Transfer Document and Appointment of Special Trustee are presented to the President of the Board for signature.

Now that enrollment has been approved, your file is returned to staff who will write to you giving instructions on how your funds are to be deposited into the SST. You will also be given copies of the fully signed Transfer Document and Appointment of Special Trustee.

When your funds are received and cleared, your enrollment is complete. Your disabled beneficiary becomes a Participant in the SST, and services will begin. Of course, we'll be interfacing with your Special Trustee as needed thereafter.

FUTURE/COMMITTED ENROLLMENT PROCEDURES

If you have completed the Life Care Plan for your beneficiary who disabled and determined that services are to be purchased at a Future Set Date or after your death, then your enrollment will be completed at that future time. However, it is important to both of us that your enrollment be COMMITTED. This allows you to depend upon and plan for your enrollment, and it allows us to plan for the future of the SST and your beneficiary.

Enrollment for future services is accomplished through testamentary devices, primarily through your Will and/or through life insurance.

As you work with the SST Interviewers, your attorney and advisors, you will complete the Life Care Plan. Then, if you intend to fund the Trust through your Will, you will prepare a new Will which includes the paragraphs necessary to enroll in and transfer funds to the SST and to appoint a Special Trustee.

If you intend to fund the Trust through life insurance, you will make the Self-Sufficiency Trust of Illinois the beneficary of your policy for the sum need to fund your Life Care Plan, and you will complete a <u>Transfer Document</u> and an <u>Appointment of Special Trustee</u>. As an alternative, you can flow the insurance proceeds through your estate and enroll in the SST through your Will, as discussed above.

We then ask that you give the SST a photocopy of your Will (just the pages that relate to the SST) and of your life insurance beneficiary designation with a letter stating that you intend to enroll your disabled beneficiary in the SST at a future time. This tells us that you are COMMITTED to enrollment in the SST.

Once we have all these documents, a summary of your file is prepared for presentation to the Board of the Self-Sufficiency Trust. This file is identified only by the social security number of the disabled individual and contains a summary of the Life Care Plan, a verification of the financial projections, and a verification that your financial/estate planning and documentation is in order so that future funding and enrollment can occur.

If all these items are in order, the Board of Trustees will <u>recognize</u> the enrollment pending future funding.

It is then necessary for us to meet annually to update your file and review the needs of your disabled beneficiary. This is very important; we need to know that you are still committed to the SST so that we can plan for the time when your disabled beneficiary will need us. We will gladly accomodate these reviews via the telephone or mail if that is easier for you. [Please see the SST handout entitled <u>UPDATE PROCEDURES</u>].

At your death, we will work with your Executor and Special Trustee to complete enrollment as described in the first part of this handout.

If you make arrangements for this kind of testamentary enrollment and decide in future years that you want services to begin even though you are still alive, just arrange to meet with an SST Interviewer. That change can be easily accomplished and services begun at that time.

Suppose for a moment that you know now that you want services to begin on a SET FUTURE DATE --for example, if you want services to start when you retire in 1999-- the SST requires that you go through the testamentary enrollment procedure. Then if you die before 1999, your beneficiary is protected through your Will or life insurance. If you survive until 1999, we will arrange for immediate enrollment at that time.

As you learn about the Self-Sufficiency Trust of Illinois (the "SST"), you will see that the goal of the SST is to fund services to meet identified needs of individuals with disabilities for defined periods of time.

It is important that you clearly understand each element of this goal as you evaluate your own participation in the SST.

When you meet with the SST Interviewers, the goal of the meetings is mutually to define service needs and when the needs are likely to occur. During the first interview, you will complete the computer-based Disabled Population Profile System ("DPPS") by answering a variety of questions. These will range from identification information (such as name, address, social security number) to level-of-functioning information. You will be asked about a variety of services (such as residential, day programming, advocacy, and guardianship) and whether or not your disabled beneficiary will need these services. You will also be asked when you think these services should begin.

After your first interview, our computer will process your answers in a number of different ways, and we will begin to develop a Life Care Plan for the individual with disabilities.

From your identification answers, the DPPS will apply a geographic descriptor as formulated by Illinois Department of Mental Health and Developmental Disabilities ("DMH-DD").

From your level-of-functioning and program needs answers, the DPPS will identify the residential and day program setting appropriate to your disabled beneficiary within the program parameters established by DMH-DD.

From your service timing answers, the DPPS will determine the number of years each service is to be provided. In doing this, DPPS examines the current age of your disabled beneficiary and the date you want services to begin, and it factors in an average life span of eighty-one years.

Service cost information from DMH-DD, the Department of Rehabilitation Services, advocacy groups, guardianship services, and others are also accessed by the DPPS program.

Under the Mental Health Code of Illinois, the SST must make appropriate placement determinations when identifying services for individuals participating in the SST. All of our efforts are to this end, and you play a large part in our success by supplying complete and objective information about your beneficiary who is disabled.

continued

At your second SST interview, we will review the computer-projected costs of various programs for your beneficiary who is disabled. All of these projections will be based upon the level-of-functioning information and start-up date which you provided in the first interview. If the information you have given us is inaccurate, then the projections may be inaccurate.

That's why we call them "projections". These figures give us both an estimate of the cost of services and allows you to begin financial planning.

Actual enrollment in the SST will take place only when services are to be delivered to the individual with disabilities. In all cases, a Provider of those services will be identified prior to enrollment. If applicable to the services to be supplied, the Provider will be asked to do a complete evaluation of your disabled beneficiary. If the results of this evaluation differ from the information you have given us, then there is the potential that the actual cost of services will differ from the projections.

Some donors are not interested in securing services under the SST right away. They may have minor beneficiaries or they may want to keep their adult beneficiaries home a few more years. In these cases, the donors might want to work with the SST and other SST donors in developing new housing for future occupancy, or the donors might wish simply to contact the SST in the future when they are ready for services. [Please see the SST handout entitled SELF-SUFFICIENCY TRUST RESIDENTIAL INITIATIVES.]

In many instances, the donors will want to use the SST to make plans for after their own death. In this event, we ask that a qualified third party make a level-of-functioing assessment, and based upon that evaluation we will cost out service as if it were to begin today. These figures can then be used by the donors to make estate plans and life insurance decisions. Each anniversary thereafter, the donors should meet with the SST Interviewer to update their file. At that time, the cost figures will be verified to reflect any significant changes in the condition of the beneficiary. The donors can then adjust their estate plans or life insurance beneficiary designations. [Please see the SST handout entitled ANNUAL UPDATE PROCEDURES.]

As you car see, you and your input are a vital part of the SST effort <u>to fund services</u> <u>to meet the identified needs</u> of your beneficiary with a disability <u>for a defined period of time</u>.

COMMITMENT TO EQUAL ACCESS

It is the commitment of the Board of Trustees of the Self-Sufficiency Trust of Illinois to offer equal access to all citizens of the State of Illinois to meet with Trust Interviewers.

INTAKE PROCESS FEES

All donors with a beneficiary who is disabled are encouraged to come in for one interview and enroll their beneficiary in the Disabled Population Profile System computer database. This information will be shared with the State of Illinois for planning purposes. Of course, confidentiality is strictly preserved.

Fee for one interview to enroll in the
Disabled Population Profile System.....................NO CHARGE

Families who wish to learn more about the Self-Sufficiency Trust may choose to come in for a second and third interview for this purpose. It is possible to complete all enrollment steps in these two interviews, however, remeber that you are not obligated in any way and that you may discontinue the process at any time.

Fee for second and third interviews to evaluate and
possibly enroll in the Self-Sufficiency Trust..........NO CHARGE
Additional interviews: Cook and collar counties $90.00 per hour
All other counties...... $60.00 per hour

TRUST MANAGEMENT FEE

After you have enrolled in the Self-Sufficiency Trust, the Trust charges a management fee of 1.4% (one and four-tenths percent) of annual principal and accrued interest to cover management costs.

Of this figure, 1% (one percent) is paid to the Self-Sufficiency Trust or its designated agent for account maintenance and administration. The remaining 0.4% (four-tenths percent) is paid to the bank for its management and investment of the Trust acccounts.

UPDATE FEES

Families are encouraged to update their Disabled Population Profile System file in the event that there is a dramatic change in the condition or needs of their beneficiary who is disabled. In most instances this update can be handled through the mail.

Fee to update the Disabled Population Profile System...NO CHARGE

Families who are enrolled in and receiving services from the Self-Sufficiency Trust who wish to augment those services are invited to meet with us. Remember that you are not obligated in any way and that you may discontinue the process at any time.

Fee to augment current services, two interviews........NO CHARGE
Additional interviews: Cook and collar counties $90.00 per hour
All other counties...... $60.00 per hour

Families who have neither completed current enrollment nor committed to future enrollment in the the Self-Sufficiency Trust and who wish to update their financial projections or to modify their Life Care Plans are invited to do so.

Update fee for donors who are neither currently enrolled nor committed to future enrollment in the SST,
maximum of two interviews................................$100.00
Additional interviews: Cook and collar counties $90.00 per hour
All other counties...... $60.00 per hour

FUTURE/COMMITTED ENROLLMENT UPDATE FEES

Families who have committed to future enrollment in the Self-Sufficiency Trust are entitled to a one-year Annual Membership which includes the "SST Newsletter" free of charge. After the first year, the Annual Membership will cost $100.00 per year and, in addition to the newsletter, includes one one-hour conference to review accounts and keep records up to date. Additional conference time is billable as follows:
Cook and collar counties $90.00 per hour
All other counties...... $60.00 per hour

JOINT EMERGENCY SERVICES FUND

The Board of Trustees of the Self-Sufficiency Trust is empowered to levy a variable nominal fee against each particpant's account to fund a pooled Joint Emergency Services Fund. This Fund is available to all participants on an emergency first come, first served basis in the event that an unexpected change in the participant's condition results in a greater need than originally funded by the individual trust account

NOTICE: THE FEES HEREIN MAY BE CHANGED BY RESOLUTION OF THE BOARD OF TRUSTEES OF THE SELF-SUFFICIENCY TRUST WITHOUT NOTICE OR OBLIGATION.

3. You should update your Disabled Population Profile System computer file and your financial projections annually if you are participating in the Self-Sufficiency Trust as a Future Commmitted Enrollment through your Will or Life Insurance.

You will be given new financial projections for cost of service based upon your beneficiary's age and condition, and upon your Life Care Plan at the time the projections are prepared. This information can then be used to update your Will and/or your Life Insurance Beneficiary designations.

There is an annual Membership Fee for donors participating in the Trust in this manner. Please see the handout entitled FEE INFORMATION.

HOW DO I UPDATE MY SST RECORDS?

It's simple. Just call your local office or agent for the Self-Sufficiency Trust of Illinois. If you want to update your DPPS file only, chances are we will be able to do it through the mail. If you want to update your DPPS file and review new financial projections, then we will schedule a mutually convenient time to meet and discuss the necessary revisions.

Self-Sufficiency Trust of Illinois
Elmhurst Headquarters Telephone: 312/941-3498
Springfield Office: 217/744-9208

Chicago Agent: PACT, Inc. 312/641-6363

Aurora Agent: Association for Individual Development
312/892-1199

WHO IS ELIGIBLE TO PARTICIPATE?

To be eligible to participate in the Self-Sufficiency Trust of Illinois, an individual must meet two criteria.

First, the individual must be developmentally disabled or otherwise entitled to receive services from the Illinois Department of Mental Health and Developmental Disabilities.

Second, the individual beneficiary of the Trust account must reside in the State of Illinois. There is no requirement that the Donor(s) live in Illinois.

[See: Illinois Revised Statutes Chapter 91 1/2, Section 5-118.]

ARE THERE OTHER LIMITATIONS ON WHO CAN PARTICIPATE?

There are no other legal restrictions. However there are some practical considerations.

One of the primary goals of the Self-Sufficiency Trust of Illinois is to preserve entitlements received by an individual who is handicapped.

The Health Care Financing Administration (H.C.F.A) has stated that the Self-Sufficiency Trust of Illinois will not jeopardize Medicaid benefits in all but the following instances. Medicaid benefits would be jeopardized if the Trust account is set up by the disabled individual or his/her spouse using the disabled person or the spouse's funds. Medicaid benefits would also be jeopardized if a guardian or legal representative set up a Trust account for a disabled individual using funds that are the property of the disabled person.

Although individuals falling in these categories are eligible under Illinois law to participate in the Self-Sufficiency Trust, it might not be a wise financial decision to do so.

[See: Letter of January 6, 1988, from the Health Care Financing Administration to the National Foundation for the Handicapped, reprinted in the Appendices of the Illinois Self-Sufficiency Trust ATTORNEY HANDBOOK.]

WHAT ABOUT BENEFITS PAID BY SOCIAL SECURITY?

The Regional Commissioner of the Social Security Administration has determined that, based on current regulations, Self-Sufficiency Trust Assets will not count as resources in determining eligibility under the Supplemental Security Income (SSI) program.

[See: Letter of June 29, 1987, from the Office of the Regional Commissioner, Social Security Administration to Daniels and Sheen, counsel for the National Foundation for the Handicapped, reprinted in the Appendices of the Illinois Self-Sufficiency Trust ATTORNEY HANDBOOK.]

Mental Health ADVOCATE

Winter 1989

NEWSLETTER OF THE MENTAL HEALTH ASSOCIATION IN ILLINOIS, INC.

New Trust Offers Secure Future to DD Children

Parents of an autistic, schizophrenic, or mentally retarded child all share a common concern: providing their developmentally disabled child with continuity of care, treatment and personal advocacy in the event of their deaths.

Efforts to help parents of disabled children attain their long-term estate planning goals have been greatly aided by the passage of an Illinois state law. This law establishes a self-sufficiency trust fund in the public sector that will receive moneys from private sources.

The term "self-sufficiency trust" is used to describe a trust established by a non-profit association for the purpose of providing for the care, support or treatment of a disabled individual who would be eligible for services by the Department of Mental Health and Developmental Disabilities.

When it established the nation's first self-sufficiency trust fund in 1986, Illinois became a leader in removing obstacles that families have traditionally faced when financially planning for the care of their disabled child. Chapter 91 1/2, Sections 5-118 and 5-119 of the Illinois Revised Statutes. Public sector funding for programs and services has steadily decreased and governmental support has also failed to keep pace with the growing costs and demands for the care of the disabled. At present, it appears that state and federal funding allow for only basic maintenance of the system of care in place. Minimal annual increases would provide cost of living adjustments at best, but would not cover sufficiently the expansion of needs.

> **The SST has found a way to make private-sector funds available to supplement the limited and often insufficient public dollars available to expand the service delivery system for disabled children.**

Implementation of the state law began early in 1988 with the federal HCFA approval of a specific document called the Self-Sufficiency Trust Model. According to James DeCre, Executive Director of the National Foundation for the Handicapped and creator of the Self-Sufficiency Trust concept, the SST Model is unique in its structure and specific in its intent. The SST has found a way to make private sector funds available to supplement the limited and often insufficient public dollars available to expand the service delivery system for disabled children. Historically, the disabled have faced loss of public entitlement support if inherited assets were made directly available to them. In addition, if trusts were established, they were potentially subject to invasion by government creditors who had provided services in the past. In some cases, disinheriting a disabled dependent and leaving instructions for that dependent's care with other beneficiaries seemed the only estate planning option available to parents.

Now, the SST offers another alternative and makes it easier for parents to actively finance supplemental care of their disabled child without disrupting Supplementary Security Income (SSI) and Medicaid benefits. The intent of the Self-Sufficiency Trust is to augment these federal sources and not supplant them, thus making new funds available to enhance the service delivery system and meet the special needs of the child who is disabled.

As a result of this new estate planning option, parents can now assess their disabled child's needs and then decide what supplemental services they want provided in the future. The services provided could be recreational, educational, social or even training programs to assist in managing activities of daily living.

Parents who are considering the Self-Sufficiency Trust for their disabled child can discuss programs and services with specially-trained advisors. As SST applicants, they can input into the unique Disabled Population Profile System. This specialized database determines the dollar amount needed to provide the specific supplemental services that parents select for their disabled beneficiary. At this point, an attorney or financial planner could advise the family on ways to develop an estate or investment plan.

Thus, the self-sufficiency trust concept works by encouraging parents to determine the specific dollar amount that is necessary to generate a flow of income to pay for the supplemental services needed during the life of the disabled beneficiary. This is identified as the Life Care Plan. It allows parents to provide the quality of life that they have carefully determined is appropriate for their disabled child. DeCre points out that the SST's usefulness or benefits are individualized and based on the needs of the disabled beneficiary and the priorities of the family who is funding it.

Although the parents must have the principle necessary to fund their chosen priorities, the SST does not require a minimum dollar amount. The actual amount put in trust is proportional to the supplemental service priorities of the family involved.

In addition to supplying supplemental services to a disabled beneficiary, the SST is structured to act as an advocate for that beneficiary during his or her lifetime. DeCre states, "The SST incorporates fiduciary management and social service advocacy not traditionally found in trust structures

Continued on page 5

SST, cont. page 4

within banking institutions." The SST model also gives its Board of Trustees and contractual agents the capacity to assess the on-going quality of service delivery and to adapt to the changing needs of the disabled beneficiary.

The unique qualities of the self-sufficiency trust make it an estate planning option worthy of investigation by parents of disabled dependents. The National Foundation for the Handicapped, developers of the SST model, are active in the implementation of the SST model nation-wide. Locally, the Board of Trustees of the Self-Sufficiency Trust have contracted with PACT, Inc., to implement the SST in Illinois. Families making contact with one of four PACT offices in Illinois will deal with counselors who assist in the applicaton process and provide information about the SST.

Editor's Note: If you are interested in more information or wish to make an appointment to discuss the Self-Sufficiency Trust, please contact:

Self-Sufficiency Trust of Illinois
340 West Butterfield Road, Suite 3C
Elmhurst, IL 60126
(312) 941-3498

FINANCIAL PLANNING WHEN YOUR CHILD IS DISABLED

THESE INSURANCE, TAX AND ESTATE PLANNING STRATEGIES WILL HELP ASSURE THE FUTURE FOR YOUR DISABLED CHILD

Families with disabled children face special challenges when arranging their finances. Any financial plan must cover day-to-day living expenses for the family as well as the long-term needs of a child who may need to have individual care for a lifetime.

Thirteen-year-old Aaron Leaf of Minneapolis is such a child. He was born profoundly deaf and with numerous facial, spinal and internal problems that required extensive—and sometimes unexpected—medical and disability-related care. Aaron's needs for multiple operations strained the family income, so his parents took steps to set up a financial plan.

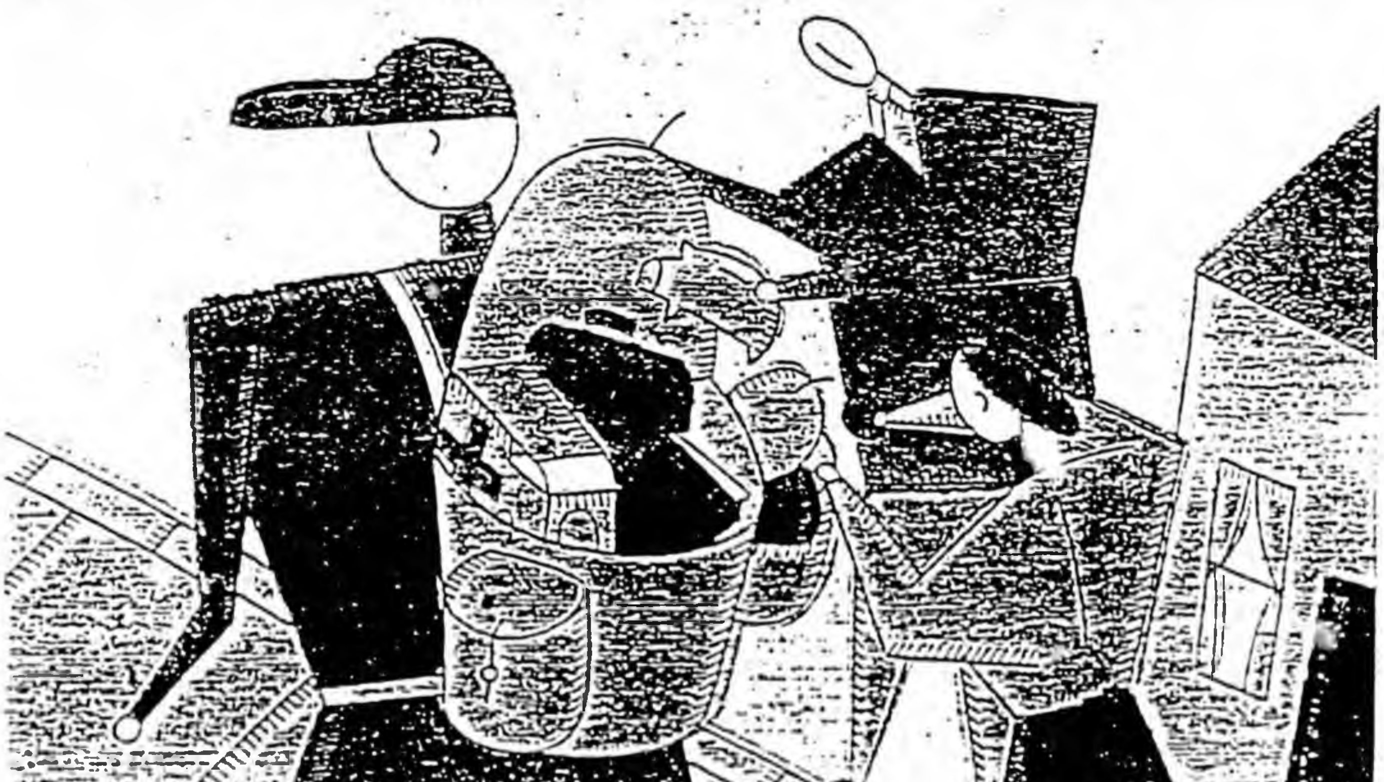
COVERING DAY-TO-DAY EXPENSES

Of course, no two family plans are exactly alike because each must take into account the severity of and prognosis for the child's disability as well as the family's financial resources. But a number of important issues are common to all families with disabled children.

REVIEW YOUR INSURANCE. Analyze what would happen to your income and cash flow under different scenarios. For example, if only one parent works outside the home, consider how you would manage if the breadwinner died or became disabled. When both parents work, what would happen if one income were cut off? Is your disability insurance or life insurance adequate to cover the loss?

Parents of a child with a handicap need more disability insurance than others. If you have a disability policy through your employer, it may only be tied to your base salary. Consider buying an additional policy to cover any overtime or bonuses.

Your life insurance needs will dif-



fer, too, because you may need to keep up higher life insurance coverage longer than other parents. Term insurance is a cost-effective way to build an insurance estate while you are young and healthy. For example, $250,000 worth of term insurance for a 35-year-old man who does not smoke might cost around $230 for the first year and about $1,140 for the first five years' premiums. For a nonsmoking woman of the same age the premiums would be a bit less.

But term insurance premiums can get prohibitively expensive as you age. And unless your policy will be automatically renewed without checking your health, it may not be available when you need it most. A good rule of thumb, says Washington, D.C., insurance broker Andrew Gross, is to switch to a permanent type of insurance by age 50. Gross favors universal life insurance for each parent. Another possibility is a whole life policy with a last-to-die provision, which pays off when the surviving spouse dies. Insurance proceeds then go into a trust set up for the disabled child. With this type of insurance you may need an additional policy to cover the rest of the family if one parent dies.

Children who are born with disabilities are automatically covered under their parents' group health insurance policies. But coverage might not last indefinitely; typically it ends at age 19, or 23 for full-time students. Some group policies continue to cover permanently disabled children no matter how old they are, and some states require group carriers to extend such coverage beyond age 19. But you might lose coverage under some policies (and in some states) unless you notify the insurance company of the disability by that age.

A parent facing a job change should get assurances and a detailed explanation, in writing, of a child's coverage under the new employer's group health insurance policy. Often, if you join a new employer's medical plan within a certain number of days, all family members will be automatically covered. "Don't count on the disability being covered, though," says Rianne Leaf, Aaron's mother, whose search for information resulted in a career as a financial planner with IDS Financial Services in Minneapolis. "Some policies exclude preexisting conditions, which could mean your child would be covered for a broken leg but not his or her disability-related costs."

For those who cannot insure a child any other way, there are special-risk insurers. Whether it would be worth the considerably higher costs would depend on your child's disability. As a last resort, more than a third of the states have a statewide insurance pool through which you can buy health insurance for a disabled child. Call your state insurance commissioner to find out if such a pool is available.

DEDUCTIBLE MEDICAL EXPENSES CAN INCLUDE THE FULL COST OF SOME STRUCTURAL CHANGES TO YOUR HOME, SUCH AS A RAMP, AND PART OF THE COST OF OTHERS, SUCH AS AN ELEVATOR FOR A CHILD WHO CAN'T CLIMB THE STAIRS.

BUILD AN EMERGENCY FUND. A good health insurance policy is a must, but it won't cover all your health costs. One family with a severely mentally retarded and physically handicapped son had to absorb more than $4,000 of medical costs last year that their health insurance simply didn't cover.

You should create an emergency fund you can quickly convert to cash, recommend planning experts like CPA Bruce Shanker, a financial planner with the Wallace Financial Group in Bethesda, Md. Three months' expenses is adequate for most families, but those with a disabled child should strive for a six-month to a one-year nest egg.

Put the assets in safe, flexible or short-term investments, such as money-market and bond funds, certificates of deposit (divided among three-, six- and nine-month maturities) and Treasury bills with 30-, 60- and 90-day maturities. You could also consider a conservative stock fund from which you can withdraw your money without penalty.

DOUBLE-CHECK STATE RESOURCES. Review the social services available through state agencies to ensure that your child is receiving the financial and therapeutic help he or she is entitled to. Families faced with a move to a new state through a job transfer, for example, should find out well in advance whether a child can get similar special services at the new location. Check whether the state will pick up as much of the cost as your current state.

GETTING THE IRS TO HELP

You can deduct only those medical expenses that exceed 7.5% of your adjusted gross income, but many other related expenses qualify. For example:

- ▶ the cost of special schooling;
- ▶ health insurance premiums;
- ▶ most of your travel expenses to hospitals, including any lodging (up to $50 per day each for one parent and child), transportation and meals at medical facilities;
- ▶ and all mileage to and from doctors' offices and special-education facilities at 9 cents per mile (or the actual expenses of using your car), plus parking and tolls.

Schedule elective surgery, deductible equipment purchases and other tax-deductible expenditures in the same year whenever possible. Suggest to grandparents or others who want to help that they buy nondeductible items, such as a TV, so you can buy deductible items such as a TV caption decoder. And, of course, keep receipts and make meticulous records as you go along. The rules can change at any time. Leaf keeps receipts for everything that might be deductible and then sorts them out at tax time.

Your medical expenses can also include the full cost of certain structural changes to your home, such as widening doorways for wheelchairs, building ramps and installing bathroom grab bars. Others are generally deductible only to the extent that their costs exceed the increase in value of your home. For example, a $6,000 elevator for a child who cannot climb stairs might increase the value of the home by $3,500. You deduct $2,500. Get a written recommendation from the child's doctor and before-and-after ap-

A Helping Hand

A growing number of private organizations will watch out for the child when the parents can't. Some are guardianship programs that serve as surrogate families; others are trust programs. And some provide both services.
Typically, the family works out a detailed future-care plan with the help of the organization. If it's primarily a guardianship-type program, the family will contract for such services as monitoring living arrangements, serving as an advocate for the child and working with attorneys, guardians and trustees. A trust program will provide for supplemental services that will not jeopardize eligibility for government benefits.

► *Foundation for the Handicapped* (1550 West Armory Way, Suite 205, Seattle, Wash. 98119). Washington: disabled orphans or abandoned people.
► *National Continuity Program* (The Anchorage, 253 Riverside Ave., Westport, Conn. 06880). Connecticut, New Hampshire and California: all disabilities.
► *PACT Inc.* (166 W. Washington St., Suite 300, Chicago, Ill. 60602). Cook County and surrounding counties: all disabilities.
► *Permanent Planning* (2530 University Ave., Waterloo, Iowa 50701). Black Hawk County and surrounding counties: mentally retarded.
► *Planned Lifetime Assistance Network (PLAN*—5001 W. Broad St., No. 28, Richmond, Va. 23230). Virginia: all disabilities. *Planned Lifetime Assistance Network of Maryland–D.C.* (912 Thayer Ave., Suite 108, Silver Spring, Md. 20910). Maryland and the District of Columbia: mentally ill.
► *The Self Sufficiency Trust, National Foundation for the Handicapped* (240 W. Butterfield Road, Suite 3C, Elmhurst, Ill. 60126). Illinois: all disabilities.
► *Star Systems Consultation and Training* (1011 70th Ave., Philadelphia, Pa. 19126). Pennsylvania, New Jersey and Delaware, plus national referrals: all disabilities and elderly disabled.
► *Virginia Beach Community Trust* (Pembroke Six, Suite 218, Virginia Beach, Va. 23462). Virginia Beach: for developmentally disabled.

An excellent source of information on all relevant issues is *Alternatives: A Family Guide to Legal and Financial Planning for the Disabled*, by L. Mark Russell (First Publications Inc., P.O. Box 5072—Dept. TC, Evanston, Ill. 60204; $18.95). Also available from First Publications is the Parent Planning Guide ($10), an extensive checklist that helps you assess how well prepared you are.

praisals to defend any IRS challenge.

The dependent-care credit, also used for child care, is applicable as well. This credit against your income tax offsets up to $2,400 in expenses for one dependent and $4,800 for two or more. It applies to the cost of caring for a child, spouse or other disabled dependent while you work.

PLANNING FOR THE FUTURE

Estate planning is a minefield for people with disabled children. Qualifying for state or federal programs, such as medicaid and supplemental security income, is a financial necessity for most. So a critical goal of estate planning is to protect eligibility.

You must also protect the financial resources you intend for your child. Many state programs expect the disabled person or whoever is responsible for that person to pay to the extent possible. If your child has assets of his or her own from gifts or inheritance, those become the source of the so-called cost-of-care funds, leaving little or nothing for extras. Possibly even worse, your child could also lose his or her government benefits completely. Re-establishing eligibility once disqualifying assets are gone can mean months with no benefits.

You may not have to disinherit your child to get around this problem, as many parents of disabled children fear. One of the most popular solutions is a trust that you set up during your life or in your will funded by some of your assets or by your life insurance proceeds. This "discretionary trust" names a trustee, who may be a relative, friend, lawyer, private guardianship program, a bank or trust company, or some combination. Most parents select at least one trustee who knows the [illegible] procedures. Then if you need surgery in the future, you can present the information in advance, to avoid a recurrence.

FAMILY DOCTOR

ALAN E. NOURSE, M.D.

Many of you have asked for details about the Illinois Self-Sufficiency Trust program mentioned in my August column. This project seeks to help families provide long-term care for disabled family members without reducing their eligibility for government aid. For more information write:

The Self-Sufficiency Trust of Illinois
340 West Butterfield Rd.
Suite 3C
Elmhurst, Ill. 60126.
Or you may call:
(312) 941-3498 (for inquiries about the Illinois trust);
(312) 832-9700 (for inquiries about projects in other states).

HYSTERECTOMY UPDATE

For years there was concern that many unnecessary hysterectomies were being performed. Then things seemed to improve: it appeared that physicians were becoming more conservative in recommending this surgery. But that may be only partly true. According to recent studies, the hysterectomy rate has dropped in some areas of the country—particularly the Northeast—but has remained high in other areas. In the Northeast, for example, the rate is only 5 per 1,000 women (only 3.3 per 1,000 in New York City), compared to 8 per 1,000 women in the South. The American College of Obstetricians and Gynecologists is currently studying which reasons for hysterectomy are valid—uterine or cervical cancer, for example, or treatment of severe endometriosis. And which reasons—nonsymptomatic fibroid tumors or heavy menstrual bleeding—might better be treated by nonsurgical means. Meanwhile, it is wise (and sometimes necessary for insurance purposes) for a woman to obtain a second opinion before agreeing to the operation.

QUESTIONS FROM READERS

BIZARRE "DREAMS"

Recently, following gallbladder surgery, I hallucinated for four days. I have never had such an experience in my life. What could have caused it? Is there any way to prevent it if I need surgery in the future?

You were probably experiencing a reaction to the anesthetic or to some other pre-op or post-op medicine you were given. In any event, this is highly unusual. If you haven't done so already, you should report it directly to your surgeon, the anesthesiologist, and the hospital administration. In addition, you should obtain an [illegible]

EMBARRASSED SON

My 13-year-old son has a low-grade fever and needs his temperature taken [illegible] day. The doctor says rectal temps for accuracy. The boy says "no way." What can I do?

A 13-year-old boy might well object to his mother's taking his temperature rectally. But why can't he take and record it himself, in privacy? The major hurdle is to convince your son that accurate temps are really important—to you, the doctor, or both. (If he understands why, he won't cheat.) Then, the rest is just mechanics, which the doctor can explain.

AT RISK FOR POLIO

My mother is on chemotherapy for breast cancer. When my 18-month-old son had his oral polio vaccine, the doctor said that Mother shouldn't even visit our home for at least two months. Why?

The oral polio vaccine is made from live, though weakened, polio viruses. It works by giving the person inoculated a minor, controlled polio infection. Polio viruses are then shed from the nose, throat and bowel for about eight weeks, during which time other people can [illegible] contact with them. Since your mother's immune system may not be working well due to the effects of her cancer and the chemotherapy for it, she may be at high risk of catching polio from the vaccine virus your son sheds. This doesn't happen often, but it can—and that's what your doctor is worried about.

SHAVING PROBLEM

Every time I shave my legs, I get a rash as well as infected hair follicles. Am I doing something wrong?

Possibly. Many women shave their legs in the shower or just afterward, without using any lubricant. You might try washing with an antibacterial soap to [illegible] skin bacteria, then use a foaming shaving cream, rinsing, and drying thoroughly when you're finished. If that doesn't solve your problem, try shaving before your shower with an electric shaver, using a pre-electric-shave powder first. This may not result in as close a shave, but may not do as much damage either.

You may address questions on medical problems or treatment to Alan E. Nourse, M.D., GOOD HOUSEKEEPING, 959 Eighth Avenue, New York, N.Y. 10019. Only questions chosen for use in his column will be answered.

The New York Times

NEW YORK, MONDAY, APRIL 4, 1988

Illinois Project Gives Families a New Way To Aid Disabled Kin

By KATHLEEN TELTSCH

Special to The New York Times

CHICAGO — Danny and Fay Moore have lived with anxiety since the births of their daughter and their son, both mentally retarded as a result of the genetic disorder Down's syndrome. The Moores shape their family life around providing special schooling and counseling for Stacey, 7 years old, and Aaron, 4, who are growing into adventurous, fun-loving children.

"Our concern is what happens to the children when we die," said Mr. Moore, a 35-year-old food service manager. "We're not wealthy people."

Some of the Moores' worries — and those of other families here in Illinois — have now eased with the beginning of an innovative trust fund to provide long-term care for the mentally or physically disabled.

The aim is to offer families a way to make a sound investment for their children's future, without affecting eligibility for government disability aid, impoverishing the family or adding a huge new burden on the state treasury.

It is an idea already being explored by other states to help millions of Americans who are mentally ill, physically incapacitated or developmentally disabled. Maine expects to enroll families in a program based on the Illinois model later this year.

The Illinois program, the Self Sufficiency Trust, is not intended as a substitute for Social Security disability or Medicaid benefits — what social workers sometimes refer to as the "sheets and eats" government services. Rather, it seeks to insure the extra care that would enhance the quality of life such as special therapy, transportation or recreation.

Avoiding a Catch-22

The concept of the Self Sufficiency Trust was developed by the National Foundation for the Handicapped, based in the Chicago suburb of Elmhurst. According to James H. DeDre, the group's executive director, the aim was to eliminate a Catch-22 situation that hampered relatives from bettering the lives of disabled family members. Many wanted to provide income or make bequests, but doing so risked a cutoff or reduction of government aid restricted to those with limited resources.

At least four million disabled Americans now receive Federal benefits, but the Federal Department of Health and Human Services has estimated that the country has 23 million disabled residents.

Illinois's Self Sufficiency Trust actually consists of three trust funds. Participating families put part of assets into a federally insured Private Trust Fund for investment. The interest earned on these investments will be transferred to a State Trust Fund and spent on services for the disabled family members, beginning soon after enrollment in the program. A Charitable Trust Fund is being set up for families not financially able to invest.

Developing a Care Plan

In joining the program, relatives or guardians and the trust's guidance counselors develop a life-care plan for the disabled family member. The program uses a computer data base in assessing the disabled participant's abilities and needs and in projecting the cost of current and future services.

The family then decides, in consultation with the program officials, what services are wanted for the disabled family member. The amount of the investment and whether it is immediate or delayed, lump sum or periodic, are determined in these negotiations. There is no minimum investment required, but families who want more services would have to invest more.

The services provided to the disabled family member are not regarded as "income" and thus do not affect eligibility for other government help.

Eight families are expected to be enrolled in the Private Trust Fund by mid-April and 50 families by the year's end, when assets in the Private Trust Fund are expected to reach $10 million.

Charity Fund for Others

The Charitable Trust Fund will provide equivalent services for low-income or indigent disabled individuals who do not have financial support from relatives to enroll them in the Private Trust Fund. This fund is being built on contributions from foundations, corporations and private donors. In addition, when participants in the Private Trust Fund die, at least half the principal from the family contribution is turned over to the charity fund. The rest of the principal reverts to the family.

The legislation was sponsored in Illinois by Lee Daniels, a state legislator who has a handicapped 23-year-old daughter. The program was inaugurated at ceremonies March 29 when Dr. Dennis O'Connell, superintendent of a Chicago school district, contributed $16,090 to the trust for his 23-year-old son, John.

Young Mr. O'Connell has Tourette's syndrome, a neurological disease afflicting 100,000 Americans and characterized by involuntary muscular spasms, verbal outbursts and intense restlessness. He works for a food distributor and receives Social Security disability aid. He now lives with his parents at home, but because of the trust program, in July he and 14 other handicapped residents will move into a new supervised housing complex.

"The prospect of living on his own with friends is exciting," he said.

The Moores also plan to create the maximum possible independence for their children when they grow up. They want them to live in some semi-supervised environment but to know "they still have family," Mr. Moore said.

Plans for More Group Homes

For now, the opportunities for placement in group residences are limited, and there is a waiting list. However, Mr. DeDre said the foundation was seeking grants and loans to develop at least four additional group homes.

Developing the trust so that a disabled participant's entitlement to government benefits will not be jeopardized involved satisfying a dozen agencies and working through a tangle of 2,000 pages of rules and regulations, said Ann Kiley, director of the Illinois Department of Mental Health and Developmental Disabilities.

The department helped pay for the foundation's development of the trust concept. A number of state agencies, including the Attorney General's office with its legal expertise, are supervising the operations.

An incidental benefit of the program is that the computer data base being used will give Illinois officials a more accurate picture of the state's disabled population and its needs, thereby allowing improved government assistance.

Illinois has been praised for pioneering the trust concept, but critics say the state lags behind many others in providing group residences for the mentally ill and mentally retarded.

'More Than the Bare Minimum'

Larry Russell, executive director of the National Alliance for Research on Schizophrenia and Depression, said five state agencies had been sued for failure to provide adequate care. The suit, brought by the Association for Retarded Citizens of Illinois, charges that 2,000 retarded adults are inappropriately "warehoused" and receiving inadequate care in nursing homes meant for elderly people.

Mr. Russell intends to enroll his 19-year-old son, Jon, in the trust program.

He said the son now lived in a group home in Austin, Tex., because there was no such place for him in Illinois.

Harold Unger, a Chicago chemical engineer who is the trust program's secretary, said he and his wife, Dorothy, were preparing to enroll their 24-year-old daughter, Carol Ann, who has Down's syndrome. She works in a sheltered workshop operated by Ray Graham Association for the Handicapped and in her spare time enjoys playing the piano.

"We want a quality of life for her that will supply more than the bare minimum," said Mr. Unger. "That is what the Self Sufficiency Trust is all about."

News Summary

National

A trust fund to help the disabled in Illinois allows families to make investments to provide long-term care of mentally and physically handicapped relatives without affecting eligibility for Federal aid. A1

Chicago Sun-Times
An Independent Newspaper

Robert E. Page, President & Publisher
Kenneth D. Towers, Executive Editor & Vice President [illegible]
[illegible], Editor of the Editorial Pages [illegible]

Partnership offers help to disabled

A quiet revolution has begun in Illinois—an unusual private-public partnership that could help thousands of families provide long-term care for the mentally or physically disabled. It deserves continued support from the state and from the private sector.

The Self Sufficiency Trust program, inaugurated on March 29, offers families a way to invest for their children's future without affecting eligibility for government assistance, bankrupting the family or adding a huge new burden to the state treasury.

And it's not a program just for the wealthy. Too good to be true? An innovative program in Illinois? No, and yes.

Developed by the National Foundation for the Handicapped, based in Elmhurst, the new trust program could eliminate the barriers that restrict relatives of disabled people from giving them extra help.

In the past, many parents who wanted to provide additional income or make bequests to their disabled children could not. Doing so risked a cutoff or reduction of government aid. So only those people who did not need any government aid could afford to provide special services.

The new program creates three trust funds: a Private Trust Fund that pools assets from participating families; a State Trust Fund, which spends the investments from the Private Fund for services for the disabled family members, and a Charitable Trust Fund that is being built on contributions from corporations and private donors, to help those unable to participate in the Private Fund.

What does the program do? That depends on each disabled person's abilities and needs. It could assist in financing the cost of special schooling and counseling or any extra care, such as special therapy, transportation and recreation—all services that can build independence.

Credit for the cooperative venture goes to the National Foundation for the Handicapped that developed the concept. Legislation sponsored by Rep. Lee A. Daniels (R-Elmhurst), the House Republican leader, was necessary to start up the trusts. And state agencies, particularly the Department of Mental Health and Developmental Disabilities and the attorney general's office, sorted through the rules and regulations to satisfy the dozen or so state and federal agencies involved.

If this kind of cooperation is possible, why can't it happen again to provide better residential care for the state's mentally ill and developmentally disabled?

Instead of settling for the bare minimum for disabled people, this new program allows families to supply more help. We hope this model program encourages other states to develop similar trust programs. It also should encourage Illinois lawmakers to develop other badly needed solutions in the state's own troubled programs.

Chicago Tribune
25¢ City and suburbs Wednesday, March 30, 1988

Fund lets parents plan lifetime care for disabled child

By Constanza Montana

A Lombard family Tuesday became the first participants in a state-administered trust fund that allows parents to provide long-term care for their developmentally disabled children.

"The trust has enabled us to do long-range planning for John," said Dennis O'Connell, 50, superintendent of the Roselle Elementary School District and father of a developmentally disabled son. "I hope this allows other parents to provide for the special needs of their children" now as well as after the parents die, he said at a press conference at the State of Illinois Building, 100 W. Randolph St.

Illinois became the first state to establish such a fund, called the self-sufficiency trust, nearly two years ago. Before the law was passed, government assistance was restricted to handicapped individuals with limited assets and income who were not beneficiaries of an estate. The fund, financed by contributions from families and private organizations, allows families to supplement government services without reducing state and federal aid for their disabled relatives.

The trust establishes two separate pools of money, a private trust and a charitable fund. The private trust holds contributions from relatives of handicapped persons and guarantees lifetime care for the handicapped person.

The charitable trust is designed to help low-income disabled individuals.

It is supported by contributions from private donors and assets transferred from the private trust when the beneficiary dies.

For example, when John O'Connell dies, 50 percent of the principal invested by his family in the private trust will be transferred to the charitable fund. The other 50 percent will go to his heirs.

The Elmhurst-based National Foundation for the Handicapped, which developed the concept for the plan, has donated about $20,000 to the fund, said Director James DeOre. "We duplicated John's program ... for a low-income person" or what it would cost to maintain for a lifetime a mildly handicapped individual in a residential setting beyond what government grants would provide.

"Hopefully what we see today is a beginning, the beginning of what parents, the families of disabled citizens and private sector assistance and government can do [illegible] one another to assist and be[illegible] our state," said Ann Kiley, dire[illegible] of the Illinois Department of M[illegible] tal Health and Developmental D[illegible]abilities.

For John O'Connell, 25, the [illegible]mediate gain is that he can le[illegible] his parents' home and move int[illegible] supervised apartment complex [illegible] other disabled individuals. For parents, "the long-term benefit [illegible] to do with the financial security [illegible] program provides for John a[illegible] we're gone," Dennis O'Conn[illegible] said. "Without this program [illegible] would become the resp[illegible]ility [of] the state."

Parents of handicapped children must do financial planning

On your money

By Grace Weinstein

This is the second of two columns by Grace W. Weinstein on financial planning for the handicapped.

Aaron Leaf, now 12 years old, was born both severely deformed and profoundly deaf. His parents, in learning to cope with the medical and emotional needs presented by his birth, learned to develop financial resources as well. His mother, Rianne Leaf, learned so well that she is now a financial planner with IDS Financial Services in Minneapolis, helping others facing similar problems.

Trusts established by parents are often suggested as a way to ensure a financially secure future for children who are disabled or chronically ill. The new Illinois Self-Sufficiency Trust described in my last column removes the uncertainty of private trusts and serves as a model for other states developing similar programs.

But parents must also consider the present. If you are the parent or grandparent of a disabled child, these hints may help:

• A rule of thumb in financial planning is the need for cash reserves sufficient to cover three months' expenses. "With a handicapped child, cash reserves should be much larger. The Leafs, for example, had to travel some distance for Aaron's treatment, incurring hotel and food costs as well as medical bills. They had to hire a registered nurse as a baby sitter, on the rare occasions when they both left the house.

• Both life and disability income insurance are critical. "There's usually only one breadwinner, because the other parent is caring for the child," Leaf points out. "If that parent dies or is unable to work, you must have some source of income for the family."

With life insurance, too, "you must look very carefully at how beneficiary designations are made: they must coincide with what you've done in your will." Leaving money outright to a handicapped child can make the child ineligible for needed Social Security and Medicaid benefits. It's often preferable to designate a trust to disburse insurance proceeds.

Because it will probably be impossible to buy life insurance on the disabled dependent, Leaf recommends invoking the automatic child's rider on the parents' whole life insurance policies. It may be "gruesome to think about," she says, but a $10,000 rider could provide enough cash for burial expenses.

• Health insurance, which most people have through their jobs, is clearly a necessity. If the insurance-carrying breadwinner in a family with a disabled dependent is even thinking about a job change, Leaf points out, it's vital "to be up-front about the child and find out ahead of time if the health plan will provide coverage." Don't make assumptions.

Where a previously healthy dependent suffers a disabling accident or illness as adulthood nears, remember that group health insurance often ends for children at age 19 or age 23. Check your coverage, before the designated age cutoff, to see if the indiv[idual] can be kept on the policy as a [disa]bled dependent."

• Take advantage of the Inte[rnal] Revenue Code where you can. [For] example, medical expenses a[re no] longer deductible except to [the] extent that they exceed 7.5 per[cent] of adjusted gross income. That [is a] pretty high figure for most [fami]lies. Grouping medical proced[ures] within a calendar year, howe[ver,] perhaps by scheduling necess[ary] surgery for January [or] December, can make it possib[le to] claim some deductions. If you [make] structural changes to [your] house to accommodate a ha[ndi]capped person, such as by wi[den]ing doorways for a wheelcha[ir or] by adding a ramp, the cost is deductible. (Other improveme[nts,] such as a swimming pool [illegible]

■ PARENTS, Page [illegible]

Parents of handicapped must do financial planning

■ PARENTS
Continued from Page C1

scribed for therapy, are deductible only to the extent that they don't improve the market value of the property.)

• A will is essential, including a carefully thought-out designation of a guardian for the handicapped child. That child may have special needs, Leaf points out, and a guardian you've named for other children may be unwilling or unable to take the responsibility for a child with birth defects.

Tip for today: For more information about the Illinois Self-Sufficiency Trust, write to 340 W. Butterfield Rd., Elmhurst, Ill. 60126, or call (312) 941-3498.

"The Lifetime Book of Money Management," Grace W. Weinstein's comprehensive and useful financial resource for all ages and incomes, is available through her column. Send $12.95 plus $1.50 for postage and handling to "The Lifetime Book of Money Management," in care of this newspaper, P.O. Box 419150, Kansas City, Mo. 64141. Make checks payable to Andrews and McMeel.

ALAN E. NOURSE, M.D.

FAMILY DOCTOR

A woman writes that when she had a mammogram, the compression applied to her breasts was so painful she was left in tears—and black and blue. I've heard similar reports from other women, and I think there is no excuse for this. While a moderate amount of pressure to the breast is necessary to obtain a good low-radiation mammogram, the X ray should not be more than mildly uncomfortable. If you suffer real pain, report it at once to the facility's administrator—and also to the doctor who referred you.

ACCUTANE UPDATE & ALERT

In January 1986 I reported an FDA warning that women who were pregnant or became pregnant while taking the potent antiacne drug Accutane ran an extremely high risk of having a baby with major birth defects. Now that a number of birth deformities attributable to the drug have been reported, the FDA feels that the warning isn't being heeded. As we went to press, the agency was weighing new, tighter regulation of the drug.

Whether or not new regulations are enacted, doctors and patients can ensure safe use of Accutane. First, make sure the drug is really needed—Accutane is not for uncomplicated adolescent acne, but for cases of severe, disfiguring [illegible] acne that don't respond to other, safer treatments. Second, [illegible] who might [illegible] become pregnant should [illegible] use an effective contraceptive, such as the Pill, for a month before starting Accutane (and should continue throughout treatment). The woman should have a pregnancy test immediately before starting the medication, and when she finishes treatment, she should ask her doctor how long to wait before trying to conceive, to be sure her body is free of the drug.

QUESTIONS FROM READERS

PAP ACCURACY

I'm 25 and very faithful about Pap smears, but lately I've been hearing that the reports themselves may not be accurate. How can I be sure that my results are correct?

One way is to tell your doctor you're worried. Ask him or her what lab reads your tests, what assurance you have that reports are accurate, and what measures are taken to assure that samples are adequate—for example, does the lab tell the doctor when a given sample can't be properly read, so that it can be taken again? Sooner or later, uniform nationwide quality controls must be established for this important test, but meanwhile, direct pressure on doctors from their rightfully concerned patients—and on labs from physicians—can help improve standards immensely.

ADULTS AND STREP

Are strep throats as serious for adults as for children? Will the instant strep tests in doctors' offices be available for use at home?

Strep throats are always potentially dangerous. Adults may not end up with rheumatic fever as often as children do, but they can surely develop scarlet fever, throat abscesses, or septicemia (blood poisoning). As for the new "instant" strep tests, they may be on the market soon. But, while these tests are a fine office aid for doctors looking for the right antibiotic with which to treat a severe sore throat, what would you do with such a test at home? Ignore any

(continued on page [illegible])

sore throat that wasn't positive for strep? You could be ignoring an equally dangerous staph infection or even diphtheria. I feel these tests are only as good as the doctor's advice you get with them—and attempting self-diagnosis of severe sore throats is just not a very smart idea.

PROJECT FOR THE DISABLED

The Illinois legislature has launched an innovative pilot project to help families provide long-term quality care for disabled family members without reducing eligibility for government aid.

Basically, Illinois families with physically or mentally disabled children can invest modest sums of money in a specially sheltered Self-Sufficiency Trust Fund. Income from the trust can then be spent for long-term care, sheltered homes, special therapy, and other services to provide higher quality of life for the disabled—"more than the bare minimum," as one project leader described it. A special Charitable Trust funded by foundations, corporations, and private donors will provide equivalent services for disabled individuals whose families are unable to contribute. And unlike income from a private-savings plan, trust-fund help will not reduce a patient's entitlement to other government aid—a major benefit.

Just off the ground, this pioneering self-help program is already being studied by other states, including Maine, which are considering similar legislation. And Connecticut has enacted a similar plan for families with mentally retarded children.

BABY'S SEX

Could you please tell me who determines the sex of a baby, the mother or the father?

The father—every time. A woman has two nearly identical "sex chromosomes" in each of her cells—an X and another X. This means that when she ovulates, every egg cell, which contains half her chromosomes, has an X chromosome. The man, on the other hand, has two different sex chromosomes in each cell—an X and a Y. His sperm cells, which carry half his chromosomes, contain either an X chromosome or a Y. If an X-bearing sperm fertilizes the X-bearing egg, the result will always be an XX baby—a girl. If a Y-bearing sperm fertilizes the X-bearing egg, the result will be an XY baby—a boy.

You may address questions on medical treatment or problems to Alan E. Nourse, M.D., GOOD HOUSEKEEPING, [illegible] Eighth Avenue, New York, N.Y. [illegible]. Only questions chosen for use in this column will be answered.

Orientation

STATE OF ILLINOIS

PUBLIC ACT 84-1373

SELF-SUFFICIENCY TRUST

SUMMARY Rev 5-20-88 ©™

SELF-SUFFICIENCY TRUST SUMMARY

The Self-Sufficiency Trust © is a comprehensive life-care planning option designed to meet the supplemental service needs of people with disabilities now and in the future.

More than a pooled income trust, the Self-Sufficiency Trust is an innovative private sector service financing mechanism which allows parents and families to plan a secure future for their disabled dependent without the fear of loss of governmental benefits or invasion of their trust principal.

The Self-Sufficiency Trust provides a mutually beneficial public/private working relationship between families of disabled individuals, the state, and the community-based human service network. Enacted into state law, the Self-Sufficiency Trust becomes a stable financing mechanism which operates through individualized programs (Life-Care Plans) to arrange for supplemental services from existing provider networks. The existing service delivery system is supplemented and thus expanded ---all for the need-specific benefit of individuals with disabilities.

The Self-Sufficiency Trust evolved from the research and support of the National Foundation for the Handicapped under the direction of Mr. James DeOre, with partial funding from the Illinois Department of Mental Health and Developmental Disabilities. In 1986, the Illinois Legislature by unanimous vote established the first Self-Sufficiency Trust in the country [Illinois Revised Statutes Chapter 91 1/2, Sections 5-118 and 5-119]. Maine followed in the spring of 1987 (HP 331-L.D. 430). In both cases, the Self-Sufficiency Trust was seen as a major development in non-traditional estate and future care-planning which would replace the usual "catch 22" problems faced by families with a viable and comprehensive means to impact the present and plan for the future of the individual with disabilities.

HOW DOES THE TRUST WORK?

* Two wholly separate pooled-income trust funds exist as part of the SST structure. Each of the two funds has a public sector or State Trust Fund by virtue of the public law enacted by each state.

* A volunteer Board of Trustees is appointed from the private sector (parents and professionals) to manage and control the Private Trust Fund. The parent or family member who establishes a trust is called the Grantor, and his/her dependent is the Trust Beneficiary. The Grantor or his designee serves as Co-Trustee and shares in trust disbursement decisions.

* The Private Trust Fund accepts, holds, and invests the "pooled" assets of each family participating in the SST. Although assets are comingled, all returns on investments are credited proportionately to each "private trust". Interest earnings on Private Trust Fund assets are transferred at the direction of the Trustees and the parents or guardian, who serve as Co-Trustee, to the counterpart State Trust Fund which immediately disburses the assets for the supplemental goods or services to be provided the Trust Beneficiary. The state's Mental Health Department may be designated to hold the State Trust Fund and these funds are generally disbursed by the state treasurer. Technically, funds disbursed from the State Trust Fund become "state" monies and are not viewed as earned or unearned income to the disabled Trust Beneficiary, therefore not affecting public entitlement eligibility under Supplementary Security Income (SSI) or Medicaid.

* A segment of the trust fund controlled by the Board of Trustees is the Charitable Trust Fund. This fund is a repository to accept residual and donated assets earmarked for low-income and indigent persons with disabilities who are unable to participate in the Private Trust. This important part of the Self-Sufficiency Trust model is supported by:

  1) Assets left to the Charitable Trust Fund by grantors of private trusts at the death of the disabled beneficiary;

  2) Contributions from private donors, bequests, corporations or foundations;

  Earnings on the principal of the Charitable Trust Fund can be transferred to the State Trust Fund allowing participation of low-income and indigent disabled individuals in the concept.

* A Life-Care Plan is developed for each Trust Beneficiary which embodies the wishes of the parent (Grantor) and defines the scope and nature of supplemental services to be provided the disabled individual. Trained Self-Sufficiency Trust counselors provide the direction for parents to develop a realistic and need-specific plan.

* The Self-Sufficiency Tr[illegible]puterized data base assesses each Trust Beneficiary's [illegible] functional abilities and service needs, projects future [illegible] requirements and correlates present and future costs based on existing residential per diem schedules. This process provides each family with a realistic projection of the principal necessary to provide a flow of interest income sufficient to fund the individual supplemental service Life-Care Plan.

  This data collection system is also very important to the States.

1) Via the SST intake process, disabled persons of all ages who are not currently identified within the provider system may now be accounted for and identified by disability (type, severity), age, residential and day-mode program needs.

2) The data generated will allow each state to more accurately plan for state services based on valid need. Appropriations may be sought using real statistics.

* The universal concern of parents and families with disabled dependents, "who will care for my dependent when I am gone?", has been addressed by the Self-Sufficiency Trust. Personalized advocacy and successor guardianship services are an intregal part of the Trust operation ensuring consistency and quality of care. In Illinois, PACT, Inc., a private and independent guardianship agency is under contract by the Board of Trustees to broker and monitor the supplemental services and ongoing care of Self-Sufficiency Trust Beneficiaries.

In total, the Self-Sufficiency Trust offers permanency and flexibility to adapt to changing governmental policies, estate planning and management expertise, security against loss of eligibility for public entitlement benefits, and peace of mind that concerned and knowledgable professionals will ensure the quality personalized care that will be provided for your disabled dependent now and/or in the future.

HOW DOES PARTICIPATION AFFECT PUBLIC BENEFITS?

The Health Care Financing Authority (H.C.F.A.) of the Department of Health and Human Servises, Washington, D.C. has ruled that in most cases Self-Sufficiency Trust principal and interest <u>will not</u> count in determining Medicaid eligibility.

Region V of the Social Security Administration has determined that, based on current regulations, the SST assets <u>will not</u> count as resources in determining eligibility under the Supplemental Security Income (SSI) program.

These two federally-funded entitlement programs are the primary sources of support to the disabled population.

TOTAL LIFE-CARE PLANNING OPTIONS

The Self-Sufficiency Trust creates incentives for a family to begin financial and care planning for their dependent who is disabled.

A Self-Sufficiency Trust permits families to:

1. Enhance services with family resources.
2. Help secure the quality of care they desire.
3. Help maintain continued quality of lifestyle after the family itself can no longer do so.
4. Enhance access to housing.

The Self-Sufficiency Trust enables the family to contribute assets -- savings, investments, real estate, insurance, etc. -- for the benefit of their relative who is disabled and others who have similar disabilitites.

ADVOCACY CARE

Lifelong care and the quality of that care is a primary concern for all families with relatives who are disabled. Families naturally desire the assurance that their disabled relative receives all the services to which he or she is entitled. Families also want to improve the lifestyle of the disabled person by providing extras to meet individual personal needs, leisure-time activities, training, clinical services, and transportation.

Self-Sufficiency Trust participation can provide a disabled dependent enhanced care and a personal advocate, even after the death of a parent or guardian.

In Illinois, PACT, Inc. an experienced private surrogate family model organization which provides personal case management and guardianship services, is under contract to provide advocacy and successor guardianship service to Trust Beneficiaries when these services are requested by the Grantor. Families can contract with the Self-Sufficiency Trust and PACT, Inc. as a personal advocate and advisor to broker and monitor supplemental services and assure that programs are being properly provided to their relative with a disability.

RESIDENTIAL NEEDS

Another key component of the Self-Sufficiency Trust is that families can create housing alternatives through private efforts.

This may enable a family to overcome long waiting lists for existing facilities and permits location near the family's home.

Through this program, families not only help make a residential facility available, but also determine the quality of that residence.

Parents could provide the capital needed for purchasing a house. Where necessary, affiliates of the National Foundation for the Handicapped would negotiate with the appropriate state agency to determine the Trust portion and the state portion of funding the cost of care within existing state licensure and rate methodology guidelines. Contracts would also be negotiated with existing provider agencies to provide management for the residence.

STATEWIDE DATABASE

The Trust will collect information about individuals with disabilities and their current and future needs. This information will be compiled in the Disabled Population Profile System © and presented in a confidential manner to the Department of Mental Health and Developmental Disabilities, to allow the state to plan effectively for future needs.

In addition, a computer program has been developed which uses federal functional disability criteria to perform need-specific assessment of present and future residential configurations and their costs. Families may use this data in preparing an estate plan sufficient to generate the necessary annual income needed to purchase the supplemental services desired for the Trust participant.

FINANCING

Families can finance their participation in the Trust by making a transfer of cash or other assets, either immediately, over time as various services are initiated, or through a will. Life insurance provides another means for families to fund the program and to participate in the Trust.

SUMMARY

Program funding for people with disabilities becomes more difficult to obtain each year. This uncertainty threatens the stability of the state's provider network and concerns the families of individuals with disabilities.

Unmet housing needs for a significant portion of the disabled population is a widespread dilemma. Longer lifespans of people with disabilities and the aging of responsible family members increases anxieties concerning long-term care and future housing needs.

The Self-Sufficiency Trust creates a stream of money which may be channeled through the state to help provide for the needs of people with disabilities.

Finally the Self-Sufficiency Trust provides families of the disabled a strong voice and potentially powerful role in the present and future decisions which impact their disabled family members. Planning today for a secure tomorrow is within the reach of most families with disabled dependents through the Self-Sufficiency Trust.

FOR MORE INFORMATION:

For families and guardians seeking additional information:

Headquarters: The Self-Sufficiency Trust of Illinois
340 W. Butterfield Road, Suite 3C
Elmhurst, IL 60126
312/941-3498

Chicago Office: PACT, Inc.
166 W. Washington, Suite 300
Chicago, IL 60202
312/641-6363
312/641-6524 (TDD)

For providers and state officials throughout the United States:

Paul L. Medlin
Senior Vice-President
Corporate Development
National Foundation for the Handicapped
340 W. Butterfield Road
Elmhurst, IL 60126
(312) 832-9700

SELF-SUFFICIENCY TRUST

PRIVATE SECTOR

* Governed by a Volunteer Board of Trustees Selected for individual commitment to and understanding of the needs of PEOPLE with DISABILITIES and THEIR FAMILIES.

- Appointed by the National Foundation for the Handicapped.

** The Board of Trustees:
Set policy for the operating of the Private and Charitable Trust Funds.

- Select and contract with Corporate Fiduciary Agent (Bank) to invest and manage all trust assets.

- Select and contract with a Social Service Agent to complete all necessary intake processes, including the development of each Life-Care Plan.

- Approve each Life-Care Plan and vote on participation of each family Trust/ Life Care Plan.

- Use discretionary trustee powers in cooperation with the Special Trustee to modify or approve expenditures within the guidelines of each Life Care Plan.

*** The Board of Trustees must comply with the TRUST and TRUSTEES ACT of Illinois (Ill. Rev. Stat. Ch. 17, Par. 1651-1690).

PUBLIC SECTOR

* 1986 passaged into law of Public Act 84-1373 creating a mechanism to receive private trust assets to expand, enhance and supplement services for disabled eligible for services under the Illinois Department of Mental Health and Developmental Disabilities.
- Established Chapter 91 1/2 Sections 5-118 and 5-119 of the "Mental Health and Developmental Disabilities Code".

- Empowers the State Treasurer as ex-officio and custodian of the public sector fund.

- Provides for the Comptroller to direct payments from each account within the "fund" upon receipt of certified vouchers approved by the Director of DMH-DD.

- Requires DMH-DD to adopt rules and regulations for the administration of the public sector "fund".

- Monies shall be spent pursuant to existing department rules governing expenditures for services and based upon the individual trust agreements (Life-Care Plan) for each eligible Beneficiary.

- If Director determines monies cannot be expended pursuant to department rules or service availability, funds and accrued interest will be returned to the beneficiary's Private Trust Fund.

** The receipt of monies from the Self-Sufficiency Trust (Private Fund) will not in any way reduce, impair or diminish the benefits each beneficiary would otherwise be entitled to under law.

*** Establishes a "Fund" for the Disabled to accept monies from any source which, subject to appropriations, will be used for services to low income disabled eligible for DMH-DD services.

STATE HEALTH REPORTS
MENTAL HEALTH, ALCOHOLISM, & DRUG ABUSE
Intergovernmental Health Policy Project

In This Issue: o System Integration o Self-Sufficiency Trusts

No. 46 March 1989

States Look At System Integration

Spurred by reports documenting fragmentation of services, a shortage of community residential programs, an over-reliance on inpatient care, and gaps in community support services, state lawmakers have come to recognize major changes are needed in the way mental health services are organized and delivered.

At least three states (Washington, Pennsylvania, Kansas) are considering proposals that would significantly alter the delivery of mental health services. A forth state (Montana) is planning to develop a proposal to reorganize their mental health system. The common thread in all of these initiatives is "decentralization" -- transferring authority, accountability and responsibility for providing a range of community and inpatient treatment and rehabilitation services from the state to local agencies. It reflects a shift from state control to greater participation by local governments and usually involves a redistribution of funds directly to communities for community and inpatient services. Among several states that have already moved in this direction are Wisconsin, Ohio and Virginia.

Washington. After a year of study and evaluation, the state of Washington is considering a proposal to revamp its mental health system (SHB 1876). A recent report to the legislature documents a shortage of residences for mentally ill individuals and describes the current administration and delivery of mental health services as fragmented and overly focused on providing expensive inpatient acute care. It also reports on current national trends and models of integrated, community-based mental health systems, which have assisted in stabilizing state hospital populations and provided incentives for the development of community residential options.

Consistent with these national trends, testimony from several public hearings indicated that counties, mental health providers, consumers, and advocates wanted to design and participate in an integrated, decentralized, community-based delivery system that provides the entire continuum of care.

Based on the testimony, the report recommends that the authority and responsibility for delivering mental health services be decentralized to the local communities, along with adequate funds to expand residential facilities and supports.

Early versions of the bill would have vested almost total authority at the local level for state hospital and community-based services. As it stands now, however, the bill has been modified somewhat, giving counties some but not all authority for public mental health services. As of this writing, it is proceeding through the legislative process with the possibility of more amendments.

HB 1876 attempts to pool the various mental health funds into block grants to counties and authorizes the formation of 10 or fewer regions of counties, called Regional Support Networks (RSNs). The bill calls for assumption of the block grant by regional networks according to

SPONSOR'S INFO. SEE PAGE 3

HB 2016, drafted by the Special Committee, would transfer responsibility for both inpatient and outpatient mental health services to the counties. The committee emphasized in its report that it is responding to the federal mandate of PL 99-660, the State Comprehensive Mental Health Services Planning Act, which requires states to establish community-based systems of care, including case management services for chronically mentally ill individuals.

Under the proposal, effective February 1991, each county or group of counties would be mandated to establish a mental health authority responsible for providing an array of services to the chronically mentally ill. These services would be provided either directly or indirectly by the local authority. All court ordered commitments would be made to county mental health authorities rather than to state hospitals. The counties would make the determination as to where patients would be placed.

County authorities would act as "gate-keepers" by screening all admissions to state hospitals and assuring those denied admission would receive appropriate services in the community. In addition, the counties would assist in discharge planning by making sure patients receive necessary support services in the community.

HB 2016 would establish a pilot program in one state catchment area by February, 1990 to test the proposed system. The goal would be to reduce the size of one state hospital by one ward, or approximately 35 beds. Additional funds would be provided to the counties in the pilot area to finance the additional services required.

The bill also mandates that community support services be provided in all counties and specifies adult chronically mentally ill individuals as the priority population. As of this writing, no firm appropriation has been attached to the bill.

The measure has been assigned to the House Appropriations Committee, where a special subcommittee has been appointed to study it further. Because there has been negative reaction to the bill from various agencies and organizations in the state, the special subcommittee is now considering alternative proposals addressing different methods of financing and service provision.

Montana. Although there was talk among providers, advocates and some legislators to revise the organization and funding of the state mental health system this year, the issue is now being examined in the long-range planning process. Montana's new draft mental health plan for FY 1990-93 contains an objective stating that a proposal will be developed to restructure the mental health system through the mental health system planning process. The proposal which must be completed by October 1990, in time for consideration by the 1991 legislative session, will include increased incentives for serving people locally and mechanisms for local (CMHC) decision making on appropriate services for adults with severe mental illness.

Financing Issues: Self-Sufficiency Trusts

An innovative idea in estate planning, established first in the state of Illinois, removes the complications that have traditionally stymied effective estate planning efforts by parents with disabled children. The Self-Sufficiency Trust ("SST") is the first trust of its kind to provide a mechanism to facilitate the coordination and integration of private family financing for individuals with disabilities while maintaining their eligibility for government entitlement programs. As a truly private sector initiative, the SST makes possible the flow of private monies into the state's network of publicly-sponsored programs to supplement, enhance and expand services to all disabled residents.

Conceived in Illinois, the "SST" evolved from research by the National Foundation for the Handicapped under the direction of James H. DeOre. Funded in part by the Illinois Department of Mental Health, the "SST" was enacted into law (P.A. 84-1373) by a unanimous vote of the Illinois Legislature in September 1986. Maine is the only other state to enact such legislation but this year eight states (Alaska, Indiana, Kansas, Massachusetts, Michigan, Montana, New York, Oregon) have introduced model "SST" legislation, and twelve others have expressed interest and are in various stages of pre-legislative review. Legislation with similar goals, has also been introduced in Missouri.

though technicalities of the trust deviate from the Illinois model.

The SST is an irrevocable, "pooled-income trust" with spendthrift and discretionary trust language and clearly defined "charitable" and "private" trust provisions. Its structure and benefits are uniquely designed to facilitate active parental financing of supplemental care of the disabled without disruption of SSI and Medicaid.

Two wholly separate pooled-income trust funds make up the structure of the SST. The first, a Private Trust Fund, accepts, holds, and invests the "pooled" assets of each participating family. Although assets are commingled, all returns on investments are credited proportionately to the private trust. Interest earned on the private trust is transferred to the counterpart State Trust Fund, which immediately disburses the assets for supplemental goods or services that are to be provided. Because monies technically become State Trust Fund monies, they are not viewed as earned or unearned income to the disabled beneficiary, therefore do not affect entitlement eligibility.

Monies may also be disbursed to non-profit vendors such as advocacy groups or human service providers who will monitor the status and condition of the designated beneficiary. This service provision sets the SST apart from generic trusts devoid of life-care monitoring.

A second fund controlled by the Board of Trustees is the Charitable Fund. This fund is a repository to accept residual and donated assets earmarked for low-income and indigent persons with disabilities who are unable to participate in the Private Trust. Upon the death of the beneficiary, 50 percent of the residual principal of each private trust is donated to the Charitable Fund. The fund is also financed by donations.

A Volunteer Board of Trustees is appointed from the private sector to manage and control the Private and Charitable Trust Funds. Parents or family members serve as co-trustees and share in decisions concerning disbursements. A Life-Care Plan developed for each participant embodies the wishes of the parent and defines the intent and nature of supplemental services that will be provided to the beneficiary. Trained Self-Sufficiency Trust Advisors provide direction for parents to develop a realistic and need-specific plan. A Life-Care Planning Service Survey helps families target the services they want and reinforces areas that the SST is unable to finance.

SST fund monies may be spent for social services, recreational programs, rehabilitation services, educational services, rehabilitation and remedial services and training programs to assist in managing activities of daily living. The major restriction on the SST is that the dollars cannot be used to meet the same needs as those intended to be met through available public assistance programs.

The Self-Sufficiency Trust concept evolved from the realistic acknowledgement that a state's capacity to provide these services is diminished by increased demand, the changing economic climate and national policies. The SST embodies the search for alternative service capabilities and the generation of resources necessary to provide them in the future.

The National Foundation for the Handicapped's goal is to see the SST available in all 50 states, allowing transferability and universal benefits for all disabled individuals. The potential benefit of a nationwide trust network is economy of scale, resulting in trust management savings, larger principal investment and return and, most importantly, a stronger private sector (parent and family) voice in services and financing of those services for the disabled.

For states, the advantages are: new sources of private funds to expand services; a computerized data collection system to identify type and scope of services; potentially reduced dependence on federal support; and a private-public partnership that actively involves each working toward improved and expanded services for disabled people. For the families, the trust fund gives them the peace-of-mind that their loved ones will be adequately cared for when they are not able to do so. [*This feature was prepared from excerpts of previous articles written by Paul L. Medlin, Senior Vice President for Corporate Development, National Foundation for the Handicapped, Elmhurst, Illinois (312) [illegible]*

SB

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HOUSE COMMITTEE REPORT

(7)
Date Referred: March 6, 1989 FURTHER REFERRALS: LABOR & COMMERCE

Date of Committee Action: 4/12/89

The HEALTH, EDUCATION, & SOCIAL SERVICES Committee considered: CSSB 51(HESS)

CS FOR SENATE BILL NO. 51 (HESS)
[WORKERS' COMP:REHABILITATION SPECIALISTS]
"An Act extending the time period for a person to become a certified workers' compensation rehabilitation specialist; and providing for an effective date."

RECOMMENDATIONS:
[ ] be replaced with ________ [ ] the same title [ ] a new title
[ ] have attached amendment(s)
[X] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[ ] additional referral to the ________ Committee

ADOPTS: ________ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept)
[ ] fiscal impact ________
[ ] zero fiscal note ________
[ ] zero with analysis ________

APPROVES PREVIOUS: (Date/Dept)
[ ] fiscal note(s) ________
[X] zero fiscal note(s) 2/8/89 Labor
[ ] zero fn/analysis ________

SIGNING DO PASS:

[signatures]

SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend
Cheri Davis		✓	

[signature]
Chairman's signature

Alaska State Legislature

SENATOR JIM DUNCAN

P.O. BOX V JUNEAU, ALASKA 99811-3100

(907) 465-4766

COMMITTEES:
FINANCE
VICE CHAIR – HEALTH EDUCATION & SOCIAL SERVICES
BUDGET & AUDIT
BANKING & ECONOMIC DEVELOPMENT

MEMORANDUM

MARCH 9, 1989

TO: REPRESENTIVE JOHNNY ELLIS, CHAIR
HOUSE HEALTH, EDUCATION & SOCIAL SERVICES COMMITTEE

FROM: SENATOR JIM DUNCAN

SUBJECT: CS SENATE BILL 51 (HESS), AN ACT EXTENDING THE TIME FOR A PERSON TO BECOME A CERTIFIED WORKERS' COMPENSATION REHABILITATION SPECIALIST, AND PROVIDING FOR AN EFFECTIVE DATE.

I REQUEST THAT YOU SCHEDULE CSSB 51 (HESS), EXTENDING THE TIME FOR A PERSON TO BECOME A CERTIFIED WORKERS' COMPENSATION REHABILITATION SPECIALIST FOR A FLOOR VOTE AS SOON AS POSSIBLE.

A PROBLEM HAS ARISEN FOR A CONSTITUENT OF MINE AS THE RESULT OF THE RECENTLY REVISED WORKERS' COMPENSATION STATUTES. SECTION 47 OF CHAPTER 79, SLA 1988, ALLOWS A ONE YEAR GRACE PERIOD FOR PRACTICING REHABILITATION SPECIALISTS TO CONTINUE WITHOUT THE REQUIRED CERTIFICATION FROM JULY 1, 1988 TO JUNE 30, 1989. AFTER THAT PERIOD, CURRENTLY PRACTICING REHABILITATION SPECIALISTS WILL NOT BE ALLOWED TO CONTINUE IN THEIR WORK UNLESS THEY ARE CERTIFIED BY THE INSURANCE REHABILITATION SPECIALISTS COMMISSION.

IN PARTICULAR, A CONSTITUENT OF MINE OWNS A LOCAL REHABILITATION SERVICE AND HAS WORKED AS A VOCATIONAL REHABILITATION COUNSELOR SINCE JANUARY 1, 1984. TO MEET THE BACHELORS DEGREE REQUIREMENT FOR A CATEGORY TWO REHABILITATION SPECIALIST, SHE IS NOW TAKING 17 CREDIT HOURS IN ADDITION TO CONTINUING HER WORK AS A REHAB SPECIALIST. AT THE TIME OF ENACTMENT OF THE LEGISLATION, SHE STILL NEEDED TWO YEARS TO ATTAIN HER BACHELOR'S DEGREE. THIS MEANS THAT ON JUNE 30, 1989, SHE WILL BECOME INELIGIBLE TO CONTINUE HER WORK AS A REHABILITATION SPECIALIST IN SPITE OF THE FACT THAT SHE IS DOING AN EXCELLENT JOB AND HAS REFERENCES WHICH BEAR THIS OUT.

CS SB 51 (HESS) WILL EXTEND THE GRACE PERIOD TO ATTAIN CERTIFICATION UNTIL JUNE 30, 1992, BUT ONLY FOR INDIVIDUALS WHO WERE ACTIVELY EMPLOYED FOR AT LEAST ONE YEAR BEFORE JUNE 30, 1988 AS REHABILITATION SPECIALISTS.

IF YOU HAVE ANY QUESTIONS ON THIS BILL, PLEASE CONTACT ROXANNE STEWART OF MY STAFF AT 465-4766.

ATTACHMENTS

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: CSSB 51 (HESS)
PUBLISH DATE:

FISCAL NOTE

REQUEST:

Revision Date:
Title: "An Act extending the time period... to become a...workers' compensation...specialist..."
Sponsor: Duncan & Kerttula
Requestor: Senate HESS

Agency Affected: Labor
BRU: Workers' Compensation
Components:
Workers' Compensation

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND&STRUCTURES						
GRANTS,CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

Prepared by: Jacquelyn McClintock
Division: Workers' Compensation
Phone: 465-2790
Date: 2/7/89

Approved by Commissioner: Jim Sampson
Agency: Department of Labor
Date: 2/7/89

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

Bill No CSSB 51 (HESS) **Date:** February 23, 1989

Title: "An Act extending the time period for a person to become a certified workers' compensation rehabilitation specialist; and providing for an effective date."

Contact: J. L. McClintock
465-2790

One of the major concerns addressed by the Labor/Management Task Force in last year's workers' compensation legislation was to assure that quality vocational rehabilitation services be provided by skilled professionals to assist Alaska's injured workers in their return to the work place, thereby reducing liability for long-term disability for Alaska employers. To accomplish this, specific standards for professional vocational certification were included in the 1988 workers' compensation bill. These standards require that a person be a certified insurance rehabilitation specialist (CIRS) or a certified rehabilitation counselor (CRC), or the equivalent in jurisdictions without CIRS or CRC certification standards, in order to be placed on the Workers' Compensation Board's list of rehabilitation specialists.

The 1988 legislation provided a one-year period, until June 30, 1989, for persons who had been providing rehabilitation services to obtain the required certification. CSSB 51 would extend the time period for obtaining certification by an additional three years. At this time, the Department is aware of four individuals who will not be able to meet the certification requirements by the June 30, 1989 deadline.

The Department has no objection to this extension which will provide those who have been providing rehabilitation services the additional time needed to meet the certification requirements.

APPROVED:

Jim Sampson, Commissioner
Department of Labor

POSITION PAPER/Department of Labor

LAWS OF ALASKA

1988

Source CCS SB 322

Chapter No. 79

AN ACT

Relating to workers' compensation, and providing for an effective date.

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

THE ACT FOLLOWS ON PAGE 1, LINE 9

UNDERLINED MATERIAL INDICATES TEXT THAT IS BEING ADDED TO THE LAW AND BRACKETED MATERIAL IN CAPITAL LETTERS INDICATES DELETIONS FROM THE LAW; COMPLETELY NEW TEXT OR MATERIAL REPEALED AND RE-ENACTED IS IDENTIFIED IN THE INTRODUCTORY LINE OF EACH BILL SECTION.

Approved by the Governor: May 31, 1988
Actual Effective Date: Sections 42 and 50 take effect June 1, 1988. Sections 1 - 41, and 43 - 49 take effect July 1, 1988

AN ACT

Relating to workers' compensation; and providing for an effective date.

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* Section 1. LEGISLATIVE INTENT. (a) It is the intent of the legislature that AS 23.30 be interpreted so as to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of AS 23.30.

(b) The legislature declares that the workers' compensation laws must not be construed by the courts in favor of any party. It is the specific intent of the legislature that workers' compensation cases be decided on their merits, except when otherwise provided by statute. It is also the intent of the legislature that the board possess the greatest possible authority in the exercise of its fact finding responsibilities and that the board's decisions be conclusive unless the court finds that a reasonable person could not have reached the conclusion made by the board.

(c) It is the intent of the legislature in amending AS 23.30.175 regarding benefits payable to recipients not residing in the state to

(1) recognize the levels of workers' compensation benefits brought about by the high cost of living that exists in the state as compared to other localities;

(2) increase the incentives to return to work; and

(3) remove obstacles to the utilization of vocational rehabilitation that may be brought about by the payment of workers' compensation

benefits at the high levels provided by the Alaska workers' compensation law to individuals residing in localities with living costs lower than those in Alaska.

(d) It is the intent of the legislature to encourage employers to improve safety practices in the workplace and to use improved safety practices to reduce work related injuries.

(e) It is the intent of the legislature in amending AS 23.30.075(b) and 23.30.155 that the division of workers' compensation, division of insurance, and Department of Law strictly enforce the punishment authorized under AS 23.30.075(b) and the reporting requirements and penalties for noncompliance under AS 23.30.155. Strict enforcement is necessary because

(1) the state has failed to impose the punishment authorized under AS 23.30.075(b) against those employers who fail to obtain workers' compensation insurance or to qualify as a self-insurer; and

(2) there is a lack of specific data from the division of workers' compensation and division of insurance to adequately assess the efficiency and costs of the workers' compensation system.

* Sec. 2. AS 21.39.155 is amended by adding a new subsection to read:

(c) An insurer may impose a surcharge not to exceed 25 percent of the premium for assigned risk pool insurance, except that a surcharge may not be applied to the first $3,000 in premium in any policy year.

* Sec. 3. AS 21.89 is amended by adding a new section to read:

Sec. 21.89.015. WORKPLACE SAFETY PROGRAM. An insurer who provides workers' compensation insurance in this state shall establish and maintain a workplace safety rate reduction program, subject to the approval of the division of insurance.

* Sec. 4. AS 23.30.005(h) is amended to read:

(h) The department shall [MAY] adopt [IDENTICAL] rules for all

panels, and procedures for the periodic selection, retention, and removal of both rehabilitation specialists and physicians under AS 23.30.041 and 23.30.095, and shall [MAY] adopt regulations to carry out the provisions of this chapter. Process and procedure under this chapter shall be as summary and simple as possible. The department, the board or a member of it may for the purposes of this chapter subpoena witnesses, administer or cause to be administered oaths, and may examine or cause to have examined the parts of the books and records of the parties to a proceeding that relate [WHICH RELATED] to questions in dispute. The superior court, on application of the department, the board or any members of it, shall enforce the attendance and testimony of witnesses and the production and examination of books, papers, and records.

* Sec. 5. AS 23.30.020 is amended by adding a new subsection to read:

(b) An employee who knowingly makes a false statement as to the employee's physical condition on an employment application or preemployment questionnaire may not receive benefits under this chapter if

(1) the employer relied upon the false representation and this reliance was a substantial factor in the hiring; and

(2) there was a causal connection between the false representation and the injury to the employee.

* Sec. 6. AS 23.30.025 is amended by adding a new subsection to read:

(c) An insurer extending coverage required under this chapter by specifying Alaska in the other states section or similar provision of the insurance policy shall provide notice to the department under AS 23.30.085.

* Sec. 7. AS 23.30.030 is amended by adding a new paragraph to read:

(8) An annual insurance premium that exceeds $2,000 may be paid on an installment basis of not fewer than two payments, if

requested by the insured. Premiums paid by installment must be structured to reflect seasonal peaks in the basis of the premium. The insurer shall include this provision in the insurance policy in a manner that clearly informs the insured of the provision.

* Sec. 8. AS 23.30.040(b) is amended to read:

(b) If an employee suffers a compensable injury that results in temporary total disability, temporary partial disability, permanent partial disability, or permanent total disability, the employer or insurance carrier shall contribute to the second injury fund. The contribution shall be made annually at the time of the report filing required by AS 23.30.155(m) [BY ONE YEAR FROM THE DATE OF THE INJURY OR ON TERMINATION OF THE EMPLOYEE'S CLAIM, WHICHEVER IS SOONER. IF THE CLAIM IS NOT TERMINATED WITHIN ONE YEAR, SUBSEQUENT CONTRIBUTIONS SHALL BE MADE YEARLY UNTIL THE TERMINATION OF THE EMPLOYEE'S CLAIM]. The amount of the contribution is the product of the compensation to which the employee is entitled for temporary total disability, temporary partial disability, permanent partial disability, or permanent total disability and the applicable contribution rate set out in column A of this subsection. Payment need not be made to the second injury fund if the total contribution under this subsection is less than $20. By December 15 of each year the commissioner shall determine and make available to the public the applicable contribution rate for the following calendar year according to the reserve rate of the second injury fund in column B of this subsection:

Column A Second Injury Fund Contribution Rate (Percent)	Column B Reserve Rate At Least (Percent)	But Less Than (Percent)
6	0	50

5	50	75
4	75	100
3	100	125
2	125	150
1	150	175
0	175	

* Sec. 9. AS 23.30.040(h) is amended to read:

(h) Administration expenses of the state under this section and AS 23.30.205 must [SHALL] be paid from the second injury [GENERAL] fund.

* Sec. 10. AS 23.30.041 is repealed and reenacted to read:

Sec. 23.30.041. REHABILITATION OF INJURED WORKERS. (a) The board shall select and employ a reemployment benefits administrator. The board may authorize the administrator to select and employ additional staff. The administrator is in the partially exempt service under AS 39.25.120.

(b) The administrator shall perform the following functions:

(1) enforce regulations adopted by the board to implement this section;

(2) recommend regulations for adoption by the board that establish performance and reporting criteria for rehabilitation specialists;

(3) enforce the quality and effectiveness of reemployment benefits provided for under this section;

(4) review on an annual basis the performance of rehabilitation specialists to determine continued eligibility for delivery of rehabilitation services;

(5) submit to the department, on or before January 1 of each year, a report of reemployment benefits provided under this

section for the previous fiscal year; the report must include a general section, sections related to each rehabilitation specialist employed under this section, and a statistical summary of all rehabilitation cases, including

(A) the estimated and actual cost of each active rehabilitation plan;

(B) the estimated and actual time of each rehabilitation plan;

(C) a status report on all individuals completing or terminating a reemployment benefits program including a return to work date;

(D) the cost of reemployment benefits;

(6) maintain a list of rehabilitation spe ialists who meet the qualifications established under this section;

(7) promote awareness among physicians, adjusters, injured workers, employers, employees, attorneys, training providers, and rehabilitation specialists of the reemployment program established in this subsection.

(c) If an employee suffers a compensable injury that may permanently preclude an employee's return to the employee's occupation at the time of injury, the employee or employer may request an eligibility evaluation for reemployment benefits. The employee shall request an eligibility evaluation within 90 days after the employee gives the employer notice of injury unless the administrator determines the employee has an unusual and extenuating circumstance that prevents the employee from making a timely request. The administrator shall, on a rotating and geographic basis, select a rehabilitation specialist from the list maintained under (b)(6) of this section to perform the eligibility evaluation.

(d) Within 30 days after the referral by the administrator, the rehabilitation specialist shall perform the eligibility evaluation and issue a report of findings. The administrator may grant up to an additional 30 days for performance of the eligibility evaluation upon notification of unusual and extenuating circumstances and the rehabilitation specialist's request. Within 14 days after receipt of the report from the rehabilitation specialist, the administrator shall notify the parties of the employee's eligibility for reemployment preparation benefits. Within 10 days after the decision, either party may seek review of the decision by requesting a hearing under AS 23.-30.110. The hearing shall be held within 30 days after it is requested. The board shall uphold the decision of the administrator except for abuse of discretion on the administrator's part.

(e) An employee shall be eligible for benefits under this section upon the employee's written request and by having a physician predict that the employee will have permanent physical capacities that are less than the physical demands of the employee's job as described in the United States Department of Labor's "Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles" for

(1) the employee's job at the time of injury; or

(2) other jobs that exist in the labor market that the employee has held or received training for within 10 years before the injury or that the employee has held following the injury for a period long enough to obtain the skills to compete in the labor market, according to specific vocational preparation codes as described in the United States Department of Labor's "Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles."

(f) An employee is not eligible for reemployment benefits if

(1) the employer offers employment within the employee's

predicted post-injury physical capacities at a wage equivalent to at least the state minimum wage under AS 23.10.065 or 75 percent of the worker's gross hourly wages at the time of injury, whichever is greater, and the employment prepares the employee to be employable in other jobs that exist in the labor market;

(2) the employee has been previously rehabilitated in a former workers' compensation claim and returned to work in the same or similar occupation in terms of physical demands required of the employee at the time of the previous injury; or

(3) at the time of medical stability no permanent impairment is identified or expected.

(g) Within 10 days after the employee receives the administrator's notification of eligibility for benefits, an employee who desires to use these benefits shall give written notice to the employer of the employee's selection of a rehabilitation specialist who shall provide a complete reemployment benefits plan. If the employer disagrees with the employee's choice of rehabilitation specialist to develop the plan and the disagreement cannot be resolved, then the administrator shall assign a rehabilitation specialist. The employer and employee each have one right of refusal of a rehabilitation specialist.

(h) Within 90 days after the rehabilitation specialist's selection under (g) of this section, the reemployment plan must be formulated and approved. The reemployment plan must include at least the following:

(1) a determination of the occupational goal in the labor market;

(2) an inventory of the employee's technical skills, physical and intellectual capacities, academic achievement, emotional

condition and family support;

(3) a plan to acquire the occupational skills to be employable;

(4) the cost estimate of the reemployment plan, including provider fees; the amount of tuition, books, tools, and supplies; transportation; temporary lodging; or job modification devices;

(5) the estimated length of time that the plan will take;

(6) the date the plan will commence;

(7) the estimated time of medical stability as predicted by the physician;

(8) a detailed description and plan schedule; and

(9) a finding by the rehabilitation specialist that the inventory under (2) of this subsection indicates that the employee can be reasonably expected to satisfactorily complete the plan and perform in a new occupation within the time and cost limitations of the plan.

(i) Reemployment benefits shall be selected from the following in a manner that ensures remunerative employability in the shortest possible time:

(1) on the job training;

(2) vocational training;

(3) academic training;

(4) self-employment; or

(5) a combination of (1) - (4) of this subsection.

(j) The employee, rehabilitation specialist, and the employer shall sign the reemployment benefits plan. If the employer and employee fail to agree on a reemployment plan, either party may submit a reemployment plan for approval to the administrator; the administrator shall approve or deny a plan within 14 days after the plan is submitted; within 10 days of the decision, either party may seek review of the decision by requesting a hearing under AS 23.30.110; the board shall uphold the decision of the administrator unless evidence is submitted supporting an allegation of abuse of discretion on the part of the administrator; the board shall render a decision within 30 days after completion of the hearing.

(k) Benefits related to the reemployment plan may not extend past two years from date of plan approval or acceptance, whichever date occurs first, at which time the benefits expire. If an employee reaches medical stability before completion of the plan, temporary total disability benefits shall cease and permanent impairment benefits shall then be paid at the employee's temporary total disability rate. If the employee's permanent impairment benefits are exhausted before the completion or termination of the reemployment plan, the employer shall provide wages equal to 60 percent of the employee's spendable weekly wages but not to exceed $525, until the completion or termination of the plan. A permanent impairment benefit remaining unpaid upon the completion or termination of the plan shall be paid to the employee in a single lump sum. The fees of the rehabilitation specialist or rehabilitation professional shall be paid by the employer and may not be included in determining the cost of the reemployment plan.

(l) The cost of the reemployment plan incurred under this section shall be the responsibility of the employer, shall be paid on an expense incurred basis, and may not exceed $10,000.

(m) Only a rehabilitation specialist may accept case assignments as a case manager and sign eligibility determinations and reemployment plans. A person who is not a rehabilitation specialist may perform rehabilitation casework if the work is performed under the direct supervision of a rehabilitation specialist employed in the same firm

and location.

(n) After the employee has elected to participate in reemployment benefits, if the employer believes the employee has not cooperated the employer may terminate reemployment benefits on the date of noncooperation. Noncooperation means unreasonable failure to

(1) keep appointments;

(2) maintain passing grades;

(3) attend designated programs;

(4) maintain contact with the rehabilitation specialist;

(5) cooperate with the rehabilitation specialist in developing a reemployment plan and participating in activities relating to reemployability on a full-time basis;

(6) comply with the employee's responsibilities outlined in the reemployment plan; or

(7) participate in any planned reemployment activity as determined by the administrator

(o) Upon the request of either party, the administrator shall decide whether the employee has not cooperated as provided under (n) of this section. A hearing before the administrator shall be held within 30 days after it is requested. The administrator shall issue a decision within 14 days after the hearing. Within 10 days after the administrator files the decision, either party may seek review of the decision by requesting a hearing under AS 23.30.110; the board shall uphold the decision of the administrator unless evidence is submitted supporting an allegation of abuse of discretion on the part of the administrator; the board shall render a decision within 30 days after completion of the hearing.

(p) In this section

(1) "administrator" means the reemployment benefits

administrator under AS 23.30.041(a);

(2) "employability" means possessing the ability but not necessarily the opportunity to engage in employment that is consistent with the employee's physical status imposed by the compensable injury;

(3) "labor market" means a geographical area that offers employment opportunities in the following priority:

(A) area of residence;

(B) area of last employment;

(C) the state;

(D) other states;

(4) "physical capacities" means objective and measurable physical traits such as ability to lift and carry, walk, stand or sit, push, pull, climb, balance, stoop, kneel, crouch, crawl, reach, handle, finger, feel, talk, hear or see;

(5) "physical demands" means the physical requirements of the job such as strength, including positions such as standing, walking, sitting, and movement of objects such as lifting, carrying, pushing, pulling, climbing, balancing, stooping, kneeling, crouching, crawling, reaching, handling, fingering, feeling, talking, hearing, or seeing;

(6) "rehabilitation specialist" means a person who is a certified insurance rehabilitation specialist, a certified rehabilitation counselor, or a person who has equivalent or better qualifications as determined under regulations adopted by the department;

(7) "remunerative employability" means having the skills that allow a worker to be compensated with wages or other earnings equivalent to at least 60 percent of the worker's gross hourly wages at the time of injury; if the employment is outside the state, the stated 60 percent shall be adjusted to account for the difference

between the applicable state average weekly wage and the Alaska average weekly wage.

* Sec. 11. AS 23.30.055 is amended to read:

Sec. 23.30.055. EXCLUSIVENESS OF LIABILITY. The liability of an employer prescribed in AS 23.30.045 is exclusive and in place of all other liability of the employer and any fellow employee to the employee, the employee's legal representative, husband or wife, parents, dependents, next of kin, and anyone otherwise entitled to recover damages from the employer or fellow employee at law or in admiralty on account of the injury or death. The liability of the employer is exclusive even if the employee's claim is barred under AS 23.30.020(b). However, if an employer fails to secure payment of compensation as required by this chapter, an injured employee or the employee's legal representative in case death results from the injury may elect to claim compensation under this chapter, or to maintain an action against the employer at law or in admiralty for damages on account of the injury or death. In that action the defendant may not plead as a defense that the injury was caused by the negligence of a fellow servant, or that the employee assumed the risk of the employment, or that the injury was due to the contributory negligence of the employee.

* Sec. 12. AS 23.30.075(b) is amended to read:

(b) If an [AN] employer [WHO] fails to insure and keep insured employees subject to this chapter or fails to obtain a certificate of self-insurance from the board, upon conviction the court shall impose a fine of $10,000 and may impose a sentence of [, IS PUNISHABLE BY A FINE OF NOT MORE THAN $1,000, OR BY] imprisonment for not more than one year [, OR BY BOTH]. If an employer is a corporation, all persons who, at the time of the injury or death, had authority to insure the

[SAID] corporation or apply for a certificate of self-insurance, and the person actively in charge of the business of the [SUCH] corporation shall be subject to the penalties prescribed in this subsection [HEREIN] and shall be personally, jointly, and severally liable together with the corporation for the payment of all compensation or other benefits for which the corporation is liable under this chapter if the [SAID] corporation at that [SUCH] time is not insured or qualified as a self-insurer.

* Sec. 13. AS 23.30.095(a) is amended to read:

(a) The employer shall furnish medical, surgical, and other attendants or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. However, if the condition requiring the treatment, apparatus, or medicine is a latent one, the two-year period runs from the time the employee has knowledge of the nature of the employee's disability and its relationship to the employment and after disablement. It shall be additionally provided that, if continued treatment or care or both beyond the two-year period is indicated, the injured employee has the right of review by the board. The board may authorize continued treatment or care or both as the process of recovery may require. When medical care is required, the injured employee may designate a licensed physician to provide all medical and related benefits. The employee may not make more than one change in the employee's choice of attending physician without the written consent of the employer. Referral to a specialist by the employer's attending physician is not considered a change in physicians [INSIDE THE STATE TO RENDER THE CARE EXCEPT IN CASES WHERE, IN THE JUDGMENT OF THE BOARD, CARE OR TREATMENT OR BOTH CAN BEST BE

ADMINISTERED BY THE SELECTION OF ANOTHER PHYSICIAN]. Upon procuring the services of a physician, the injured employee shall give proper notification of the selection to the employer within a reasonable time after first being treated. Notice of a change in the attending physician shall be given before the change [IF FOR ANY REASON DURING THE PERIOD WHEN MEDICAL CARE IS REQUIRED THE EMPLOYEE WISHES TO CHANGE TO ANOTHER PHYSICIAN, THE EMPLOYEE MAY DO SO IN ACCORDANCE WITH REGULATIONS ADOPTED BY THE BOARD].

* Sec. 14. AS 23.30.095(c) is amended to read:

(c) A claim for medical or surgical treatment, or treatment requiring continuing and multiple treatments of a similar nature is not valid and enforceable against the employer unless, within 14 days following treatment, the physician or health care provider giving the treatment or the employee receiving it furnishes to the employer and the board notice of the injury and treatment, preferably on a form prescribed by the board. The board shall, however, excuse the failure to furnish notice within 14 days when it finds it to be in the interest of justice to do so, and it may, upon application by a party in interest, make an award for the reasonable value of the medical or surgical treatment so obtained by the employee. When a claim is made for a course of treatment requiring continuing and multiple treatments of a similar nature, in addition to the notice, the physician or health care provider shall furnish a written treatment plan if the course of treatment will require more frequent outpatient visits than the standard treatment frequency for the nature and degree of the injury and the type of treatments. The treatment plan shall be furnished to the employee and the employer within 14 days after treatment begins. The treatment plan must include objectives, modalities, frequency of treatments, and reasons for the frequency of treatments.

If the treatment plan is not furnished as required under this subsection, neither the employer nor the employee may be required to pay for treatments that exceed the frequency standard. The board shall adopt regulations establishing standards for frequency of treatment.

* Sec. 15. AS 23.30.095(e) is amended to read:

(e) The employee shall, after an injury, at reasonable times during the continuance of the disability, if requested by the employer or when ordered by the board, submit to an examination by a physician or surgeon of the employer's choice authorized to practice medicine under the laws of the jurisdiction in which the physician resides [STATE IN WHICH THE EMPLOYEE MAY BE FOUND], furnished and paid for by the employer. The employer may not make more than one change in the employer's choice of a physician or surgeon without the written consent of the employee. Referral to a specialist by the employer's physician is not considered a change in physicians. An examination requested by the employer not less than 14 days after injury, and every 60 days thereafter, shall be presumed to be reasonable, and the employee shall submit to the examination without further request or order by the board. Unless medically appropriate, the physician shall use existing diagnostic data to complete the examination. Facts relative to the injury or claim communicated to or otherwise learned by a physician or surgeon who may have attended or examined the employee, or who may have been present at an examination are not privileged, either in the hearings provided for in this chapter or an action to recover damages against an employer who is subject to the compensation provisions of this chapter. If an employee refuses to submit to an [ANY] examination provided for in this section, the employee's rights to compensation shall be suspended until the obstruction or refusal ceases, and the employee's compensation during

the period of suspension may, in the discretion of the board or the court determining an action brought for the recovery of damages under this chapter, be forfeited. The board in any case of death may require an autopsy at the expense of the party requesting the autopsy. An autopsy may not be held without notice first being given to the widow or widower or next of kin if they reside in the state or their whereabouts can be reasonably ascertained, of the time and place of the autopsy and reasonable time and opportunity given the widow or widower or next of kin to have a representative present to witness the autopsy. If adequate notice is not given, the findings from the autopsy may be suppressed on motion made to the board or to the superior court, as the case may be.

* Sec. 16. AS 23.30.095(f) is amended to read:

(f) All fees and other charges for medical treatment or service [ARE LIMITED TO THE CHARGES THAT PREVAIL IN THE SAME COMMUNITY FOR SIMILAR TREATMENT OF INJURED PERSONS OF LIKE STANDARD OF LIVING AND] shall be subject to regulation by the board but 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. An employee may not be required to pay a fee or charge for medical treatment or service.

* Sec. 17. AS 23.30.095(j) is repealed and reenacted to read:

(j) The board may appoint a medical services review committee, or contract with an existing organization in the state or another state, to assist and advise the board in matters involving the appropriateness, necessity, and cost of medical and related services provided under this chapter.

* Sec. 18. AS 23.30.095 is amended by adding a new subsection to read:

(k) In the event of a medical dispute regarding determinations of causation, medical stability, ability to enter a reemployment plan, degree of impairment, functional capacity, the amount and efficacy of the continuance of or necessity of treatment, or compensability between the employee's attending physician and the employer's independent medical evaluation, a second independent medical evaluation shall be conducted by a physician or physicians selected by the board from a list established and maintained by the board. The cost of the examination and medical report shall be paid by the employer. The report of the independent medical examiner shall be furnished to the board and to the parties within 14 days after the examination is concluded. 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 or gross incompetence.

* Sec. 19. AS 23.30.105(a) is amended to read:

(a) The right to compensation for disability under this chapter is barred unless a claim for it is filed within two years after the employee has knowledge of the nature of the employee's disability and its relation to the employment and after disablement. However, the maximum time for filing the claim in any event other than arising out of an occupational disease shall be four years from the date of injury, and the right to compensation for death is barred unless a claim therefor is filed within one year after the death, except that if payment of compensation has been made without an award on account of the injury or death, a claim may be filed within two years after the date of the last payment of benefits under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215. It is additionally provided that, in the case of latent defects pertinent to and causing compensable disability, the injured employee has full right to claim as shall be determined by the board, time limitations notwithstanding.

* Sec. 20. AS 23.30.110(c) is repealed and reenacted to read:

(c) Before a hearing is scheduled, the party seeking a hearing shall file a request for a hearing together with an affidavit stating that the party has completed necessary discovery, obtained necessary evidence, and is prepared for the hearing. An opposing party shall have 10 days after the hearing request is filed to file a response. If a party opposes the hearing request, the board or a board designee shall within 30 days of the filing of the opposition conduct a prehearing conference and set a hearing date. If opposition is not filed, a hearing shall be scheduled no later than 60 days after the receipt of the hearing request. The board shall give each party at least 10 days' notice of the hearing, either personally or by certified mail. After a hearing has been scheduled, the parties may not stipulate to change the hearing date or to cancel, postpone, or continue the hearing, except for good cause as determined by the board. After completion of the hearing the board shall close the hearing record. If a settlement agreement is reached by the parties less than 14 days before the hearing, the parties shall appear at the time of the scheduled hearing to state the terms of the settlement agreement. Within 30 days after the hearing record closes, the board shall file its decision. If the employer controverts a claim on a board-prescribed controversion notice and the employee does not request a hearing within two years following the filing of the controversion notice, the claim is denied.

* Sec. 21. AS 23.30.120 is amended by adding a new subsection to read:

(c) The presumption of compensability established in (a) of this section does not apply to a mental injury resulting from work-related stress.

* Sec. 22. AS 23.30.125 is amended by adding a new subsection to read:

(f) 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 unless the court specifically finds that a reasonable person could not have reached the conclusion made by the board.

* Sec. 23. AS 23.30.1[illegible](a) is amended to read:

(a) Upon its own initiative, or upon the application of any party in interest on the ground of a change in conditions, including, for the purposes of AS 23.30.175, a change in residence, or because of a mistake in its determination of a fact, the board may, before one year after the date of the last payment of compensation benefits under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215, whether or not a compensation order has been issued, or before one year after the rejection of a claim, review a compensation case under [IN ACCORDANCE WITH] the procedure prescribed in respect of claims in AS 23.30.110. Under [IN ACCORDANCE WITH] AS 23.30.110 the board may issue a new compensation order which terminates, continues, reinstates, increases, or decreases the compensation, or award compensation.

* Sec. 24. AS 23.30.155(c) is amended to read:

(c) The insurer or adjuster [EMPLOYER] shall notify the board and the employee on a form prescribed by the board that the payment of compensation has begun or has been increased, decreased, suspended, terminated, resumed, or changed in type. An initial report shall be filed with the board and sent to the employee within 28 days after the date of issuing the first payment of compensation. If at any time 21 days or more pass and no compensation payment is issued, a report notifying the board and the employee of the termination or suspension of compensation shall be filed with the board and sent to the employee within 28 days after the date the last compensation payment was issued. A report shall also be filed with the board and sent to the

employee within 28 days after the date of issuing a payment increasing, decreasing, resuming, or changing the type of compensation paid. If the [EMPLOYER FAILS TO NOTIFY THE] board and the employee are not notified within the 28 days prescribed by this subsection for reporting, the insurer or adjuster [EMPLOYER] shall pay a civil penalty of $100 for the first day plus $10 for each day thereafter that the [EMPLOYER FAILED TO GIVE] notice was not given. Total penalties under this subsection [SECTION] may not exceed $1,000 for a failure to file a required report. Penalties assessed under this subsection are eligible for reduction under (m) of this section. A penalty assessed under this subsection after penalties have been reduced under (m) of this section shall be increased by 25 percent and shall bear interest at the rate established under AS 45.45.010.

* Sec. 25. AS 23.30.155(d) is amended to read:

(d) If the employer controverts the right to compensation the employer shall file with the board and send to the employee a notice of controversion on or before the 21st day after the employer has knowledge of the alleged injury or death. If the employer controverts the right to compensation after payments have begun, the employer shall file with the board and send to the employee a notice of controversion within seven days after an installment of compensation payable without an award is due. When payment of temporary disability benefits is controverted solely on the grounds that another employer or another insurer of the same employer may be responsible for all or a portion of the benefits, the most recent employer or insurer who is party to the claim and who may be liable shall make the payments during the pendency of the dispute. When a final determination of liability is made, any reimbursement required, including interest at the statutory rate, and all costs and attorneys' fees incurred by the

<u>prevailing employer, shall be made within 14 days of the determination.</u>

* Sec. 26. AS 23.30.155(e) is amended to read:

(e) If any installment of compensation payable without an award is not paid within seven days after it becomes due, as provided in (b) of this section, there shall be added to the unpaid installment an amount equal to <u>25</u> [20] percent of it. This additional amount shall be paid at the same time as, and in addition to, the installment, unless notice is filed under (d) of this section or unless the nonpayment is excused by the board after a showing by the employer that owing to conditions over which the employer had no control the installment could not be paid within the period prescribed for the payment.

* Sec. 27. AS 23.30.155(f) is amended to read:

(f) If compensation payable under the terms of an award is not paid within 14 days after it becomes due, there shall be added to that unpaid compensation an amount equal to <u>25</u> [20] percent of it which shall be paid at the same time as, but in addition to, the compensation, unless review of the compensation order making the award is had as provided in AS 23.30.125 and an interlocutory injunction staying payments is allowed by the court.

* Sec. 28. AS 23.30.155(m) is repealed and reenacted to read:

(m) On or before March 1 of each year the insurer or adjuster shall file a verified annual report on a form prescribed by the board stating the total amount of all compensation by type, the number of claims received and the percentage controverted, medical, and related benefits, vocational rehabilitation expenses, legal fees, including a separate total for fees paid to attorneys and fees paid for the other costs of litigation, and penalties paid on all claims during the

preceding calendar year. If the annual report is timely and complete when received by the board and provides accurate information about each category of payments, the commissioner shall review the timeliness of the insurer's or adjuster's reports filed during the preceding year under (c) of this section. If during the preceding year the insurer or adjuster filed at least 99 percent of the reports on time, the penalties assessed under (c) of this section shall be waived. If during the preceding year the insurer or adjuster filed at least 97 percent of the reports on time, 75 percent of the penalties assessed under (c) of this section shall be waived. If during the preceding year the insurer or adjuster filed 95 percent of the reports on time, 50 percent of the penalties assessed under (c) of this section shall be waived. If during the preceding year the insurer's or adjuster's reports have not been filed on time at least 95 percent of the time, none of the penalties assessed under (c) of this section shall be waived. The penalties that are not waived are due and payable when the insurer or adjuster receives notification from the commissioner regarding the timeliness of the reports. If the annual report is not filed by March 1 of each year, the insurer or adjuster shall pay a civil penalty of $100 for the first day the annual report is late, and $10 for each additional day the report is late. If the annual report is incomplete when filed, the insurer or adjuster shall pay a civil penalty of $1,000.

* Sec. 29. AS 23.30.155 is amended by adding new subsections to read:

(n) If the employer is self-insured or uninsured, the requirements of (c) and (m) of this section apply to the employer.

(o) The board shall promptly notify the division of insurance if the board determines that the employer's insurer has frivolously or unfairly controverted compensation due under this chapter. After receiving notice from the board, the division of insurance shall determine if the insurer has committed an unfair claim settlement practice under AS 21.36.125.

* Sec. 30. AS 23.30.175 is repealed and reenacted to read:

Sec. 23.30.175. RATES OF COMPENSATION. (a) The weekly rate of compensation for disability or death may not exceed $700 and initially may not be less than $110. However, if the board determines that the employee's spendable weekly wages are less than $110 a week as computed under AS 23.30.220, or less than $154 a week in the case of an employee who has furnished documentary proof of the employee's wages, it shall issue an order adjusting the weekly rate of compensation to a rate equal to the employee's spendable weekly wages. If the employer can verify that the employee's spendable weekly wages are less than $154, the employer may adjust the weekly rate of compensation to a rate equal to the employee's spendable weekly wages without an order of the board. If the employee's spendable weekly wages are greater than $154, but 80 percent of the employee's spendable weekly wages is less than $154, the employee's weekly rate of compensation shall be $154. Prior payments made in excess of the adjusted rate shall be deducted from the unpaid compensation in the manner the board determines. In any case, the employer shall pay timely compensation.

(b) The following rules apply to benefits payable to recipients not residing in the state at the time compensation benefits are payable:

(1) the weekly rate of compensation shall be calculated by multiplying the recipient's weekly compensation rate calculated under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215, by the ratio of the cost of living of the area in which the recipient resides to the cost of living in this state;

(2) the calculation required by (1) of this subsection does not apply if the recipient is absent from the state for medical or rehabilitation services not reasonably available in the state;

(3) if the gross weekly earnings of the recipient and the resulting compensation rate is determined under AS 23.30.220(a)(2), the calculation required by this subsection applies only to the portion of the recipient's weekly compensation rate attributable to wages earned in the state;

(4) application of this subsection may not reduce the weekly compensation rate to less than $154 a week, except as provided in (a) of this section.

(c) The board shall provide by regulation for the determination and comparison of living costs for this state and the other areas in which recipients reside and for the annual redetermination and comparison of these costs.

* Sec. 31. AS 23.30.180 is amended to read:

Sec. 23.30.180. PERMANENT TOTAL DISABILITY. In case of total disability adjudged to be permanent 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the total disability. If a permanent partial disability award has been made before a permanent total disability determination, permanent total disability benefits must be reduced by the amount of the permanent partial disability award, adjusted for inflation, in a manner determined by the board. Loss of both hands, or both arms, or both feet, or both legs, or both eyes, or of any two of them, in the absence of conclusive proof to the contrary, constitutes permanent total disability. In all other cases permanent total disability is determined in accordance with the facts. In making this determination the market for the employee's services shall be

(1) area of residence;

(2) area of last employment;

(3) the state of residence; and

(4) the State of Alaska.

Sec. 32. AS 23.30.180 is amended by adding a new subsection to read:

(b) Failure to achieve remunerative employability as defined in AS 23.30.041(p) does not, by itself, constitute permanent total disability.

Sec. 33. AS 23.30.185 is amended to read:

Sec. 23.30.185. COMPENSATION FOR TEMPORARY TOTAL DISABILITY. In case of disability total in character but temporary in quality, 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the disability. Temporary total disability benefits may not be paid for any period of disability occurring after the date of medical stability.

Sec. 34. AS 23.30.190 is repealed and reenacted to read:

Sec. 23.30.190. COMPENSATION FOR PERMANENT PARTIAL IMPAIRMENT. (a) In case of impairment partial in character but permanent in quality, and not resulting in permanent total disability, the compensation is $135,000 multiplied by the employee's percentage of permanent impairment of the whole person. The percentage of permanent impairment of the whole person is the percentage of impairment to the particular body part, system, or function converted to the percentage of impairment to the whole person as provided under (b) of this section. The compensation is payable in a single lump sum, except as otherwise provided in AS 23.30.041, but the compensation may not be discounted for any present value considerations.

(b) All determinations of the existence and degree of permanent impairment shall be made strictly and solely under the whole person

determination as set out in the American Medical Association Guides to the Evaluation of Permanent Impairment, except that an impairment rating may not be rounded to the next five percent. The board shall adopt a supplementary recognized schedule for injuries that cannot be rated by use of the American Medical Association Guides.

(c) The impairment rating determined under (a) of this section shall be reduced by a permanent impairment that existed before the compensable injury. If the combination of a prior impairment rating and a rating under (a) of this section would result in the employee being considered permanently totally disabled, the prior rating does not negate a finding of permanent total disability.

Sec. 35. AS 23.30.200 is amended to read:

Sec. 23.30.200. TEMPORARY PARTIAL DISABILITY. In case of temporary partial disability resulting in decrease of earning capacity the compensation shall be 80 percent of the difference between the injured employee's spendable weekly wages before the injury and the wage-earning capacity of the employee after the injury in the same or another employment, to be paid during the continuance of the disability, but not to be paid for more than five years. Temporary partial disability benefits may not be paid for a period of disability occurring after the date of medical stability.

Sec. 36. AS 23.30.200 is amended by adding a new subsection to read:

(b) The wage-earning capacity of an injured employee is determined by the actual spendable weekly wage of the employee if the actual spendable weekly wage fairly and reasonably represents the wage-earning capacity of the employee. The board may, in the interest of justice, fix the wage-earning capacity that is reasonable, having due regard to the nature of the injury, the degree of physical impairment, the usual employment, and other factors or circumstances in case that may affect the capacity of the employee to earn wages in a disabled condition, including the effect of disability as it may naturally extend into the future.

* Sec. 37. AS 23.30.220(a) is amended to read:

(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. The gross weekly earnings shall be calculated as follows:

(1) The gross weekly earnings are computed by dividing by 100 the gross earnings of the employee in the two calendar years immediately preceding the injury.

(2) If the employee was absent from the labor market for 18 months or more of the two calendar years preceding the injury [THE BOARD DETERMINES THAT THE GROSS WEEKLY EARNINGS AT THE TIME OF THE INJURY CANNOT BE FAIRLY CALCULATED UNDER (1) OF THIS SUBSECTION], the board shall [MAY] determine the employee's gross weekly earnings for calculating compensation by considering the nature of the employee's work and work history, but compensation may not exceed the employee's gross weekly earnings at the time of injury.

(3) If an employee when injured is a minor, an apprentice, or a trainee in a formal training program, as determined by the board, whose wages under normal conditions would increase during the period of disability, the projected increase may be considered by the board in computing the gross weekly earnings of the employee.

(4) If the employee is injured while performing duties as a volunteer 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 wage computed on the basis of 40 hours work per week.

* Sec. 38. AS 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.

* Sec. 39. AS 23.30.244 is amended to read:

Sec. 23.30.244. CIVIL DEFENSE AND DISASTER RELIEF FORCES AS STATE EMPLOYEES. A resident of Alaska temporarily engaged in a civil defense or disaster relief function in another state or country under [THE PROVISION OF] AS 26.23.130 or as a volunteer in this state is considered an employee of the state for purposes of this chapter.

* Sec. 40. AS 23.30 is amended by adding a new section to read:

Sec. 23.30.247. DISCRIMINATION PROHIBITED. (a) An employer may not discriminate in hiring, promotion, or retention policies or practices against an employee who has in good faith filed a claim for or received benefits under this chapter. An employer who violates this section is liable to the employee for damages to be assessed by the court in a private civil action.

(b) This section may not be construed to prevent an employer from basing hiring, promotion, or retention policies or practices on considerations of the employee's safety practices or the employee's physical and mental abilities; nor may this section be construed so as to create employment rights not otherwise in existence.

(c) This section may not be construed to prohibit an employer from requiring a prospective employee to fill out a preemployment questionnaire or application regarding the person's prior health or disability history as long as it is meant to either document written notice for second injury fund reimbursement under AS 23.30.205(c) or to determine whether the employee has the physical or mental capacity to meet the documented physical or mental demands of the work.

* Sec. 41. AS 23.30.265(15) is amended to read:

(15) "gross earnings" means periodic payments, by an employer to an employee for employment before any authorized or lawfully required deduction or withholding of money by the employer, including compensation that is deferred at the option of the employee, and excluding irregular bonuses, reimbursement of expenses, expense allowances, and any benefit or payment to the employee that is not fully taxable to the employee during the pay period, except that the total amount of contributions made by an employer to a qualified 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, shall be included in the determination of gross earnings; the value of room and board if taxable to the employee may be considered in determining gross earnings; however, the value of room and board that would raise an employee's gross weekly earning above the state [ALASKA] average weekly wage at the time of injury may

not be considered;

* Sec. 42. AS 23.30.265(17) is amended to read:

(17) "injury" means accidental injury or death arising out of and in the course of employment, and an occupational disease or infection which arises naturally out of the employment or which naturally or unavoidably results from an accidental injury; "injury" [, AND] includes breakage or damage to eyeglasses, hearing aids, dentures, or any prosthetic devices which function as part of the body and further includes an injury caused by the wilful act of a third person directed against an employee because of the employment; "injury" does not include mental injury caused by mental stress unless it is established that (A) the work stress was extraordinary and unusual in comparison to pressures and tensions experienced by individuals in a comparable work environment, and (B) the work stress was the predominant cause of the mental injury; the amount of work stress shall be measured by actual events; a mental injury is not considered to arise out of and in the course of employment if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, termination or similar action, taken in good faith by the employer;

* Sec. 43. AS 23.30.265 is amended by adding a new paragraph to read:

(34) "medical stability" means the date after which further objectively measurable improvement from the effects of the compensable injury is not reasonably expected to result from additional medical care or treatment, notwithstanding the possible need for additional medical care or 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 may be rebutted by clear and convincing evidence.

* Sec. 44. AS 23.30.210 and 23.30.265(28) are repealed.

* Sec. 45. TRANSITIONAL PROVISIONS. Notwithstanding AS 23.30.040(b), as amended by sec. 8 of this Act, and AS 23.30.155(m), as amended by sec. 28 of this Act, on or before March 1, 1989, each employer that is subject to those sections shall file a report and make the appropriate contribution for all claims existing as of December 31, 1988. The period covered in the report shall be from the date of the termination report or the last anniversary report filed, if one has been filed, through December 31, 1988.

* Sec. 46. TEMPORARY RATE REDUCTION; FUTURE FILINGS. (a) Notwithstanding AS 21.39.030, workers' compensation rates filed by rating organizations for use in the state may not be increased before January 1, 1990.

(b) Rate filings made after December 31, 1988, must fully reflect the legal effect of changes made to the workers' compensation system by this Act.

* Sec. 47. TRANSITIONAL PROVISION. Notwithstanding AS 23.30.041(p), as enacted by sec. 10 of this Act, for the period from July 1, 1988, until June 30, 1989, the term "rehabilitation specialist" as used in AS 23.30.041 includes a person who was actively employed for at least one year before June 30, 1988, in providing rehabilitation services to an injured worker receiving benefits under AS 23.30.

* Sec. 48. APPLICABILITY. Except for secs. 8, 24, 28, 29, 42, and 46 of this Act, this Act applies only to injuries sustained on or after July 1, 1988.

* Sec. 49. Section 2 of this Act applies to assigned risk pool insurance policies that are entered into or renewed on or after July 1, 1988.

* Sec. 50. Section 42 of this Act applies to injuries sustained on or after the effective date of sec. 42 of this Act.

* Sec. 51. Sections 42 and 50 of this Act take effect immediately under AS 01.10.070(c).

* Sec. 52. Sections 1 - 41, and 43 - 49 of this Act take effect July 1, 1988.

HOUSE LABOR AND COMMERCE COMMITTEE
March 8, 1988
2:00 p.m.

MEMBERS PRESENT

Rep. Dave Donley, Chairman, arrived late
Rep. Niilo Koponen, Vice Chair
Rep. H. A. "Red" Boucher
Rep. Cliff Davidson
Rep. Johnny Ellis
Rep. Walt Furnace
Rep. Curt Menard, arrived late

COMMITTEE CALENDAR

HB 310: "An Act relating to payment under public construction contracts."

HB 485: "An Act amending provisions relating to a solicitation for offers to purchase or operate the Alaska Railroad; an providing for an effective date."

HB 536: "An Act relating to the sale, pricing, and marketing of alcoholic beverages; and prohibiting persons from being on premises involving alcoholic beverages under certain circumstances."

HB 352/SB 322: "An Act relating to workers' compensation; and providing for an effective date."

Discussion of potential committee legislation.

WITNESS REGISTER

Rep. Bill Hudson
District 4A
P.O. Box V
Juneau, Alaska 99811
465-3744
Position Statement: Offered an amendment to CSSB 322.

Mr. Doug Rickey
Assistant
Rep. Grussendorf
P.O. Box V
Juneau, Alaska 99811
465-3720
Position Statement: Supported HB 310.

Mr. Loren Rasmussen
Chief of Design & Construction Maintenance Standards
Alaska Dept. of Transportation
P.O. Box Z
Juneau, Alaska 99811
465-2960
Position Statement: Supported HB 310.

PREVIOUS ACTION

HB 310:	Jrn-Date	Jrn-Pg		Action
	05/12/87	1348	(H)	Read the first time with referral(s)
	05/12/87	1348	(H)	L&C then JUD, FIN

Previous committee consideration and testimony of HB 310 was held on 2/18/88.

HB 485:	Jrn-Date	Jrn-Pg		Action
	02/15/88	2216	(H)	Read the first time with referral(s)
	02/15/88	2216	(H)	Transportation then Labor & Commerce
	02/26/88	2366	(H)	TRA RPT CS(TRSP) New Title 6DP
	02/26/88	2366	(H)	Zero Fiscal Note published 2/26/88

HB 536:	Jrn-Date	Jrn-Pg		Action
	03/02/88	2424	(H)	Read the first time with referral(s)
	03/02/88	2424	(H)	L&C, HESS, Judiciary

HB 352:	Jrn-Date	Jrn-Pg		Action
	01/11/88	1847	(H)	Read the fist time with referral(s)
	01/11/88	1847	(H)	L&C then JUD

Previous committee consideration and testimony on HB 352 was held on January 19, 21 and 29 and February 12 and 16, 1988.

SB 322:	Jrn-Date	Jrn-Pg		Action
	01/11/88	1840	(S)	Read the first time with referral(s)
	01/11/88	1840	(S)	L&C
	02/23/88	2376	(S)	L&C RPT CS 5DP
	02/23/88	2376	(S)	Zero Fiscal Note published
	02/25/88	2416	(S)	Rules to calendar
	02/25/88	2419	(S)	Read the second time
	02/25/88	2420	(S)	L&C CS adopted unan consent

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

HOUSE LABOR AND COMMERCE COMMITTEE
March 8, 1988
2:00 p.m.

MEMBERS PRESENT

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Rep. H. A. "Red" Boucher
Rep. Cliff Davidson
Rep. Johnny Ellis
Rep. Walt Furnace
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COMMITTEE CALENDAR

HB 310: "An Act relating to payment under public construction contracts."

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HB 352/SB 322: "An Act relating to workers' compensation; and providing for an effective date."

Discussion of potential committee legislation.

WITNESS REGISTER

Rep. Bill Hudson
District 4A
P.O. Box V
Juneau, Alaska 99811
465-3744
Position Statement: Offered an amendment to CSSB 322.

Mr. Doug Rickey
Assistant
Rep. Grussendorf
P.O. Box V
Juneau, Alaska 99811
465-3720
Position Statement: Supported HB 310.

Ms. Resa Jerrel
Lobbyist
Associated General Contractors of Alaska
134 North Franklin St.
Juneau, Alaska 99801
586-1740
Position Statement: Offered suggestions to HB 310.

Mr. Paul Roller
Acting Director
Division of Insurance
Alaska Dept. of Commerce and Economic Development
P.O. Box D
Juneau, Alaska 99811
465-2515
Position Statement: Opposed proposed mandatory rate decrease for CSSB 322.

Mr. Dick Cattanach
Management Side
Labor/Management Ad Hoc Committee
1001 Old Seward Hwy.
Anchorage, Alaska 99503
349-6666
Position Statement: Offered suggestions on the proposed House CS for CSSB 322.

Mr. Robert Anders
Labor Side
Labor/Management Ad Hoc Committee
900 W. Northern Lights Blvd.
Anchorage, Alaska 99503
561-5288
Position Statement: Offered suggestions on the proposed House CS for CSSB 322.

Mr. Don Koch
Special Deputy
Division of Insurance
Alaska Dept. of Commerce and Economic Development
P.O. Box D
Juneau, Alaska 99811
465-2577
Position Statement: Offered alternatives to a mandated rate reduction.

Ms. Denise VanDerPol
Vocational Rehabilitation Specialist
130 Seward St. Rm. 212
Juneau, Alaska 99801
586-6462
Position Statement: Supported proposed amendment 5-1514Be for CSSB 322.

Mr. Loren Rasmussen
Chief of Design & Construction Maintenance Standards
Alaska Dept. of Transportation
P.O. Box Z
Juneau, Alaska 99811
465-2960
Position Statement: Supported HB 310.

PREVIOUS ACTION

HB 310:	Jrn-Date	Jrn-Pg		Action
	05/12/87	1348	(H)	Read the first time with referral(s)
	05/12/87	1348	(H)	L&C then JUD, FIN

Previous committee consideration and testimony of HB 310 was held on 2/18/88.

HB 485:	Jrn-Date	Jrn-Pg		Action
	02/15/88	2216	(H)	Read the first time with referral(s)
	02/15/88	2216	(H)	Transportation then Labor & Commerce
	02/26/88	2366	(H)	TRA RPT CS(TRSP) New Title 6DP
	02/26/88	2366	(H)	Zero Fiscal Note published 2/26/88

HB 536:	Jrn-Date	Jrn-Pg		Action
	03/02/88	2424	(H)	Read the first time with referral(s)
	03/02/88	2424	(H)	L&C, HESS, Judiciary

HB 352:	Jrn-Date	Jrn-Pg		Action
	01/11/88	1847	(H)	Read the fist time with referral(s)
	01/11/88	1847	(H)	L&C then JUD

Previous committee consideration and testimony on HB 352 was held on January 19, 21 and 29 and February 12 and 16, 1988.

SB 322:	Jrn-Date	Jrn-Pg		Action
	01/11/88	1840	(S)	Read the first time with referral(s)
	01/11/88	1840	(S)	L&C
	02/23/88	2376	(S)	L&C RPT CS 5DP
	02/23/88	2376	(S)	Zero Fiscal Note published
	02/25/88	2416	(S)	Rules to calendar
	02/25/88	2419	(S)	Read the second time
	02/25/88	2420	(S)	L&C CS adopted unan consent

02/25/88	2420	(S)	Advanced to third reading unan consent
02/25/88	2420	(S)	Read the third time CSSB 322 (L&C)
02/25/88	2420	(S)	L&C Letter of Intent adopted by Senate
02/25/88	2421	(S)	Passed Y15 N- X5
02/25/88	2421	(S)	Effective date same as passage
02/25/88	2424	(S)	Transmitted to (H)
02/26/88	2358	(H)	Read the first time with referral(s)
02/26/88	2358	(H)	Labor & Commerce then Judiciary

Previous committee consideration and testimony on SB 322 was held on January 19, 21, 29 and February 12, 1988.

ACTION NARRATIVE

TAPE ONE, SIDE ONE
Number 000

The House Labor and Commerce Committee meeting was called to order by Vice Chairman Koponen at 2:20 p.m. Members present were Representatives Koponen, Donley, Ellis, Boucher, Davidson, Furnace and Menard.

Vice Chairman Koponen announced that proposed committee legislation, W.O. 5-2031A drafted by Cramer, was the first order of business. He explained that the proposed legislation permitted employees access to information in their personnel file and provided penalties to employers who delete or alter information in the employee's file. He added that the proposed committee legislation would be taken up at the next meeting.

Vice Chairman Koponen announced that the next order of business was HB 310, an act relating to payment under construction contracts. He stated that there was a proposed committee substitute in the member's file.

Number 040

Mr. Doug Rickey, assistant to Rep. Grussendorf, sponsor of HB 310, stated that HB 310 was designed to help smaller subcontractors on statewide construction projects. He pointed out that there had been a number of complaints that subcontractors were not being paid for their services and that was the reason for introducing HB 310. He continued that the proposed committee substitute did two things. One, it clarified the intent of the legislature as related to the "Little Miller Act, which was the state's version of the federal Miller Act. He further stated that the Miller Act required that prime contractors on public construction projects post payment and performance bonds and that the U.S. Supreme Court had restricted the coverage of the Miller Act to first tier subcontractors. He continued that the State Supreme Court had not ruled, to his knowledge, on how broad the coverage extended for subcontractors and HB 310 would provide that subcontractors of subcontractors would be covered under the prime contractor's bond. He noted that the payment bond was the main concern addressed in HB 310 and it guaranteed that all labor and materials would be paid. He further stated that the proposed committee substitute would enable all persons who provided materials and labor on a public construction project to go to the bond posted by the prime contractor if payment was not received. He pointed out that Section 2 of the committee substitute required a subcontractor to give notice to the prime contractor, within ten days of starting the job, indicating they were on the project. The intent of Section 2 was for the prime contractor to know throughout the project how many subcontractors were potential claimants against his bond.

Number 119

Vice Chairman acknowledged that Rep. Donley arrived at 2:25 p.m. and had resumed the Chair.

Chairman Donley reminded the committee members that the listen only teleconference being transmitted to Anchorage, Soldotna, Ketchikan and Sitka would begin when the committee took up CSSB 322, the workers' compensation bill.

Rep. Koponen moved to adopt the committee substitute for HB 310 (L & C). Rep. Furnace objected and asked Mr. Rickey if the intent was to put stronger requirements in the state law than the federal law. Mr. Rickey replied that was correct.

Rep. Furnace asked what happened in the case where the state or municipality was the prime contractor, did HB 310 apply to state and political subdivisions.

Mr. Rickey responded that he did not know but assumed it did.

Rep. Furnace suggested that a section be added to HB 310 stating that the bill not only applied to private sector contractors but to the state and political subdivisions when they were the prime contractor. He removed his objection to the motion that the committee adopt the committee substitute.

Number 170

Chairman Donley asked if there were any other objections to the motion and being none, the motion passed. He called for the first witness.

Number 180

Ms. Resa Jerrel, lobbyist for Associated General Contractors (AGC) of Alaska, suggested that Section 2, line 26 of CSHB 310 be expanded upon to address what happened if a subcontractor of a subcontractor did not notify the prime contractor of their presence on a project. She suggested a penalty such as a forfeiture of a percentage of the amount the claim was for, against the prime contractor. She stated that the AGC was willing to work out another committee substitute in the Judiciary Committee.

Number 197

Rep. Furnace made a couple of suggestions for amendments to CSHB 310. The first being to Section 1, line 13 - 16, where a subcontractor had 90 days from the last date on which the person performed labor or provided materials to make a claim. He suggested that the time frame be changed to 30 days.

Rep. Menard arrived at 2:30 p.m.

Number 220

Chairman Donley stated that the motion was to amend CSHB 310 on Section 1, line 14 from 90 days to 30 days.

Rep. Koponen stated that he opposed the motion and pointed out that the 90 day stipulation was from existing statute.

A discussion followed concerning the subcontractor's time restraints for filing an action against the payment bond of the prime contractor and the notice requirement of the sub contractor to the prime contractor.

Rep. Furnace stated that for the first and second tier subcontractors, he felt that the 90 day requirement was fine but reiterated his opinion that the subcontractor of a subcontractor should have a 30 day time limit for filing a claim.

Number 265

Mr. Doug Rickey stated the 90 day requirement had been in existing law since 1953. He commented that the problem with a 30 day requirement was that a subcontractor might not know in 30 days if they had a claim or any trouble at all.

Number 278

Chairman Donley explained that the motion before the committee was to change CSHB 310, Section 1, line 14 from "90 days" to "30 days."

Rep. Koponen stated that 30 days was not enough time to establish if there was a claim or not.

Rep. Furnace withdrew his original motion of changing 90 days to 30 days and made a motion to change Section 1, line 14 from "90 days" to "60 days" and asked unanimous consent.

Chairman Donley asked all those in favor of changing Section 1, line 14, from "90 days" to "60 days" to raise a hand. There were two members in favor and four opposed, the motion failed.

Number 310

Rep. Furnace suggested amending CSHB 310 to ensure that state and local political subdivisions, as prime contractors, would have the same requirements under CSHB 310 as private sector contractors. He informed the committee that he needed time to check with the drafters to see if they were already included and if not, to work out some language to include them.

Mr. Rickey stated there were three committees of referral and perhaps the amendments could be worked out in one of the other committees.

Rep. Furnace asked for one day to check out the question of whether the state and local entities were subject to CSHB 310.

Number 334

Rep. Boucher moved CSHB 310 to the next committee of referral with individual recommendations. Rep. Furnace objected to the motion. Chairman Donley asked for discussion on the motion to move the bill.

Rep. Davidson stated that as Chairman of the subcommittee for HB 310 he wanted the committee to understand that time was of the essence and that the subcommittee as well as the sponsor of CSHB 310 wanted it in place because of the Jobs Bill that recently passed. He reminded the committee that there were three further committees of referral and urged that the amendments be worked out in one of those committees.

Rep. Furnace stated that he felt that the Labor and Commerce Committee was the proper committee to address the issues of coverage under the Miller Act and the time requirement for filing claims with the prime contractors bonding company.

Mr. Rickey asked the representative from the Dept. of Transportation if state and local political subdivisions acting as the prime contractor were subject to CSHB 310.

Number 370

Mr. Loren Rasmussen, Chief of Design and Construction Maintenance Standards for the Alaska Dept. of Transportation, stated that he did not know the answer but assumed that it did.

Rep. Furnace stated that he did not want the committee to move CSHB 310 on an assumption.

Rep. Boucher stated that he thought the Judiciary Committee could work it all out and maintained his motion to move CSHB 310 to the next committee of referral.

Number 387

Chairman Donley asked the members in favor of moving CSHB 310 to the next committee of referral with individual recommendations, to signify by raising their hands. There were four in favor and two opposed, so the motion carried.

Number 395

Chairman Donley stated that the next order of business was HB 536, an act relating to the sale, pricing, and marketing of alcoholic beverages; and prohibiting persons from being on premises involving alcoholic beverages under certain circumstances. He pointed out that there was not anyone signed up to testify and the committee had discussed HB 536 last week when the committee voted to introduce it as a committee bill.

Rep. Koponen moved HB 536 to the next committee of referral with individual recommendations, there being no objections the motion passed.

Number 404

Chairman Donley announced that HB 485, an act amending provisions relating to a solicitation for offers to purchase or operate the Alaska Railroad; and providing for an effective date, was next on the agenda. He invited Rep. Bette Cato, sponsor of CSHB 485, to join the committee.

Rep. Bette Cato testified in support of CSHB 485 (Transportation). She provided the committee with a history of the purchase of the railroad from the federal government and the formation of the Alaska Railroad Corporation (ARRC). She discussed the state and federal reversion clauses in both the state and federal acts and then explained the intent of CSHB 485.

Rep. Cato informed the committee that by deleting the requirement to document at least three attempts to sell the corporation, CSHB 485 broadened the language which would allow the legislature to properly evaluate all offers made to ARRC and thus make an informed decision that was in the state's best transportation and financial interest. She reiterated her support of CSHB 485 and explained that the Labor and Commerce committee substitute returned the title as closely as possible to its original form.

Number 487

Rep. Boucher moved CSHB 485 to the next committee of referral with individual recommendations. The were objections and Chairman Donley called for discussion.

Rep. Koponen asked why the original HB 485 was changed in the Transportation Committee.

Rep. Cato stated the reason the Transportation Committee changed HB 485 was because it would not enable the legislature to look at all offers for sale that might come forth.

Number 503

Rep. Koponen moved to adopt the Labor and Commerce committee substitute for CSHB 485. There being no objections, the motion passed.

Rep. Furnace asked for further explanation of CSHB 485.

A discussion followed concerning the reasoning for changing the provision that required at least three offers of sale to be included in the documented analysis and how the railroad would be able to establish criteria for all sale offers.

Rep. Furnace asked if there had been any formal offers for sale of the railroad. Rep. Cato answered that there hadn't been any formal offers yet, but a few inquires.

Rep. Furnace stated that he was still confused as to how CSHB 485 would tender the process of removing state ownership of the railroad and putting the ownership into the private sector.

Rep. Cato clarified CSHB 485 specifically Section 1, subsection (b).

A discussion followed on the differences between existing statute and the changes in CSHB 485.

Rep. Koponen pointed out that CSHB 485 stipulated that all offers for sale must come through the ARRC for screening before being submitted to the legislature.

Number 557

Rep. Cato stated that reversion clauses of the state and federal act gave criteria to any offers for sale. Any offers would have to include reversion clauses existing in statute and she cited an example of corporations that were in the business of purchasing other businesses. The state would not consider an offer by a company that wanted to divest itself of the property.

A discussion followed concerning the rational of deleting the language that required documented analysis of at least three offers to sell the ARRC.

Number 615

Rep. Furnace pointed out that the legislature did not confirm ARRC's Board of Directors appointments and he felt that CSHB 485 removed from the legislature any additional contact by taking away the requirement of documentation. He stated that it removed control from the legislature.

Number 627

Rep. Boucher stated his support of CSHB 485 and pointed out that he sat on both committees and there was a strong legislative presence especially when the railroad reported through the Transportation Committee.

TAPE ONE, SIDE TWO
Number 005

Rep. Furnace pointed out that there were no statutory controls supporting CSHB 485.

Rep. Davidson noted that it was unnecessary to have the ARRC offer itself for sale every five years because he believed that if there was a buyer for the railroad, they would come forth. He stated his support for CSHB 485.

Number 053

Rep. Boucher moved CSHB 485 (L&C) to the next committee of referral with individual recommendations. Rep. Furnace objected for the record. Chairman Donley asked those in favor of the motion to raise their hand. There were four members in favor of the motion, so the motion passed.

Number 066

Chairman Donley announced that the next order of business was CSSB 322, an act relating to workers' compensation and he informed the committee that this portion of the meeting was being teleconferenced to Anchorage, Soldotna, Sitka and Ketchikan. He pointed out that the teleconference was listen only because of the time constraints on the committee members and mentioned that there had been six previous meetings where public testimony was accepted.

Number 086

Rep. Furnace mentioned the memorandum, dated March 7, 1988, which listed the proposed House CS changes to CSSB 322. It was prepared by Rep. Donley's staff and included in the committee members file (House Labor and Commerce Committee file item #3). He asked if there was a House committee substitute available for the meeting.

Chairman Donley answered that the committee substitute was not available for today's meeting and the memorandum was the list the committee members would go through to discuss the items of concern that had been brought to the attention of the committee. He further stated that the committee would accept any suggested written amendments that were presented to the committee.

Number 103

Chairman Donley summarized the process the subcommittee on CSSB 322 went through to come up with the seventeen items listed in the memorandum. He stated that it was the Chair's wish to have the Labor/Management Ad Hoc Committee (Task Force) representatives come before the committee and go through the list of proposed changes and get their impressions on the issues. He noted that Rep. Hudson had a proposed amendment to submit to the committee and asked him to join the committee.

Number 138

Rep. Bill Hudson, representing district 4A, stated that he was submitting the proposed amendment, W.O. 5-1514Be drafted by Ford, (included in the House L & C committee file, item #7), on behalf of a constituent who would be totally disfranchised from her private business if CSSB 322 passed without the proposed amendment. He explained that the proposed amendment would add a new bill section inserted after line 25, on page 29 of CSSB 322. The new bill section would read, "Section 39. The term 'rehabilitation specialist' defined in AS 23.30.041(p) as repealed and reenacted in Sec. 9 of this Act, includes a person who, by September 1, 1988, has requested the Department of Labor to determine that the person is qualified as a rehabilitation specialist and who the department determines (1) was actively employed from at least July 1, 1987, until June 30, 1988, in providing rehabilitation services to an injured worker receiving benefits under AS 23.30; and (2) possesses the skills necessary to meet the minimum qualifications for a rehabilitation specialist." Then renumber the remaining bill sections accordingly. He explained that the proposed amendment would take care of the rehabilitation specialist who had been practicing in the state but did not have the necessary certification that was required by CSSB 322. He asked the committee to consider and hopefully adopt the proposed amendment.

Number 190

Chairman Donley explained that the committee would make final decisions on the proposed amendment on Thursday, March 10. He asked for further discussion or questions for the witness.

Rep. Hudson pointed out that Ms. Denise VanDerPol, the rehabilitation specialist that would be disfranchised by CSSB 322, was present to testify if requested.

Number 212

Ms. Denise VanDerPol, rehabilitation specialist, identified herself and offered to answer questions.

Rep. Davidson asked if she had been left out of CSSB 322 as it was presently drafted.

Ms. VanDerPol answered, "Yes" and stated that if CSSB 322 was passed the way it was currently worded, she would be out of business because she did not meet the qualifications for certification required by CSSB 322.

Rep. Davidson asked what it would take for her to become qualified to meet the requirements of CSSB 322.

Ms. VanDerPol explained that CSSB 322 required that rehabilitation specialists have their Certified Insurance Rehabilitation Specialist (CIRS) certification or a Certified Rehabilitation Counselor (CRC) certification. She stated that rehabilitation specialists should be allowed time to complete the certification program to meet the requirements of CSSB 322.

Rep. Davidson asked what the procedure was for a specialist to become certified.

Ms. VanDerPol explained that it was a national certification that was given at specific times throughout the year and administered throughout the nation. She continued that in order to qualify to take the certification test, a specialist had to have certain academic requirements. She explained that she was currently pursuing the academic requirements to qualify for the certification test.

Chairman Donley informed the committee members that the section of the bill that they were dealing with was on page 11, Section 6, lines 27-29 and continuing on to page 12. He pointed out that in addition to the two specified qualifications, there was a provision stating "or a person who has equivalent or better qualifications as determined under regulations adopted by the department." He suggested that the provision was an opportunity for dealing with the regulations and would allow those specialists not certified a way to still conduct business in the state.

Number 244

Rep. Furnace asked how long Ms. VanDerPol had been in business.

Ms. VanDerPol replied that she had been in business in Juneau for one and a half years and had been practicing vocational rehabilitation in the state for four years.

Number 273

Rep. Menard asked how many rehabilitation specialists were in her situation.

Ms. VanDerPol noted that there were several other individuals.

Chairman Donley stated that former testimony from Rep. Collins indicated that there were approximately 30 percent of the rehabilitation specialists who would fall into that category.

Number 284

Mr. Paul Roller, Acting Director for the Division of Insurance, Alaska Dept. of Commerce and Economic Development, stated that the proposed change that concerned the division the most was the mandated rate decrease for workers' compensation premiums. He continued that it was the division's belief that mandated rate decreases would have the opposite effect and eventually increase rates. He submitted a packet of material outlining the mandated rate decrease on workers' compensation premiums that occurred in Maine. He explained that in 1985, the Maine legislature decided on a mandated rate decrease of eight percent. In 1986 there was a mandated moratorium on rates and in 1987 and 1988 there was a ten percent mandated maximum cap on rates. He continued that at the end of 1987 the Governor of Maine was forced to call a special session in order to modify the workers compensation bill. He advised that the effect of a mandated rate decrease would be that insurance carriers would leave the state and there would be a lack of coverage. The lack of carriers would force more employers into the assigned risk pool and at higher rates. He emphasized that carriers would not write policies at a loss to them. He continued that the carriers would force into a higher risk pool, at a rate of 120 percent, companies that were marginal, as far as risk was concerned. He stated that Maine was faced with a 75 to 100 percent rate increase before they got their rates back up to being adequate. He continued that mandated rate decreases were a departure from other states' laws which require rates to be adequate so that insurance companies were solvent and able to pay claims.

Mr. Roller stated that item #2 of the proposed changes, which called for intent language to be added to Section 1, which required including incentives for improving workplace safety and mandating that insurers shall offer a rebate of not less than 5% of the annual premium costs to any employer that had no safety violations during the year covered by the premium. He stated his belief that item #2 was a form of a mandated rate decrease. He cautioned that there was not a correlation between lack of safety violations and the number of workers compensation claims. He pointed out that in 1986 there was a five percent decrease in industrial accidents and yet Alaska's workers' compensation claims had risen. He suggested that a system where credit was given for a mandatory safety program was an alternative. He stated that item #6 was a particularly good idea and elaborated on litigation costs. He pointed out that item #15 requirements were already on the books and included a provision that bank drafts for payment of workers' compensation benefits had to be negotiable in Alaska. The one problem he had with item #15 was that 30 percent of the Alaska workers' compensation claimants reside outside the state.

Number 380

Chairman Donley asked the Labor/Management Ad Hoc Committee (Task Force) representatives to join the committee.

Mr. Dick Cattanach introduced himself and stated that he was on the management side of the Task Force.

Mr. Bob Anders introduced himself and stated that he was co-chair of the labor side of the Task Force.

Mr. Cattanach stated that they would go through the proposed changes in the memorandum item by item and answer any questions. He stated that the first item they wanted to address was the proposed letter of intent on the last page of the memorandum. He called attention to the second paragraph, second to the last line, where it said, "incentives for prompt and fair settlement of disputes" and suggested it be changed to "incentives for prompt and fair resolutions of disputes." He stated that they would go to the front page of the memo and start with item #1. He commented on Mr. Roller's testimony, pointing out Maine was a unique situation and that Alaska's problems weren't like Maine's. He expounded on Maine's problem and the reasons that caused the problems. He did not think that Alaska would have to deal with the same kinds of problems as Maine's. He reminded the committee that expert testimony suggested that Alaska's workers compensation system could produce savings on premiums but the insurance company experts said there were not any savings at all. He wondered who to believe. He stated that the management side of the Task Force did not agree with mandated rate decreases or roll backs but would not oppose them either.

Mr. Anders stated that last summer an insurance underwriter came to Alaska looking at a four to six percent reduction in the workers' compensation rates but went away after a meeting allowing only a two percent reduction. He stated that the Task Force did not feel that the insurance industry had given CSSB 322 proper recognition of the soft dollar savings that were built into it. He pointed out that the Task Force was asked by the insurance industry to change a number of items, which they did, but they still didn't recognize any more savings. He stated that as far as the labor side was concerned, a ten percent mandated reduction was not out of the question.

Number 439

Mr. Cattanach stated there wasn't a problem with the first paragraph in item #2 of the proposed changes. He noted that the second paragraph calling for a five percent premium reduction contingent on no safety violations, he had a problem with. He pointed out that Occupational

Safety and Health Administration (OSHA) would determine the safety violations and they didn't inspect every contractor. He continued that they only inspect about ten percent of the businesses in the state and they were typically construction, mining, lumber companies and fish canneries. He stated that these industries were being penalized while giving an almost automatic reduction to the rest of the businesses and he didn't think it was fair.

Chairman Donley asked what he thought about Mr. Roller's suggestion of a reduction for those businesses that institute a safety program. He explained that there were two levels of citations issued for safety violations (one for serious offenses and one for less serious offenses) and suggested eliminating the higher level penalties.

Mr. Anders offered a third alternative to the committee. He suggested a ten percent rebate for employers in the assigned risk pool who didn't have any accidents or injuries for the past premium year. Mr. Cattanach pointed out that employers in the assigned risk pool tend to be the smaller companies that had to pay higher rates because an insurance carrier didn't want to cover them and he didn't think it was fair.

Number 480

Mr. Cattanach explained that the Task Force didn't have a problem with item #3 but he worried that it could create a false sense of security in that a company that could not afford workers' compensation insurance premiums probably couldn't afford a $10,000 fine either. He indicated there was a problem in Alaska with uninsured employers and one that needed to be addressed.

Rep. Furnace asked if there were currently in statute fines for not carrying workers' compensation coverage.

Chairman Donley stated there was a $1,000 fine.

Rep. Furnace suggested a $5,000 fine as opposed to the $10,000 fine that was suggested in item #3.

Mr. Cattanach explained what happened to the system when an injured worker's employer didn't have workers' compensation insurance.

Number 504

Mr. Anders stated that the Task Force reviewed item #4 and did not have a problem with it.

Chairman Donley stated that the Chair had a problem with item #5 and called attention to the memorandum dated March 8 (House L&C committee file item #4) which was an addendum to the proposed committee substitute items.

Mr. Anders stated that there were still problems with item number 5 and that it didn't take care of the problem as management viewed it. He stated that CSSB 322 was a comprise where both sides gave in on certain items and item number 5 was one that management felt they needed and labor was in support of that. He continued that if a person could not find similar work in the area where the injury occurred, item number 5 would allow the determination of permanently total disabled when that was not the intent of the workers' compensation system. He reiterated that it was necessary to include the whole state as the labor market.

Number 537

Mr. Cattanach stated that in regard to item #6 the Division of Workers' Compensation had already adopted their annual report and it broke down attorney fees and most of the costs of a claim.

Mr. Cattanach stated that item #7 still had problems. The Task Force didn't find the 90 days stipulation a problem but they felt the language "unusual and extenuating physical limitations" needed to be reworked. The Task Force also felt that increased litigation would result by allowing the language, "employee knew or should have known" in regard to not being able to return to their previous occupation. He pointed out that the attending physician could have written their findings in a report but didn't inform the injured worker and that was the kind of case that would be litigated. He further stated that an administrator who determined when an employee had "unusual and extenuating physical limitations" was sufficient enough to extend the time period.

Mr. Anders stated that labor supported management on item number 7.

Mr. Anders stated that there wasn't a problem with item #8.

Mr. Cattanach pointed out that item #8 could cause problems when a doctor died, went out of business or left the state. He wondered how the system would deal with that. He stated that as long as the treating physician had the right of referral, management could live with it. He suggested that it should be addressed through regulations.