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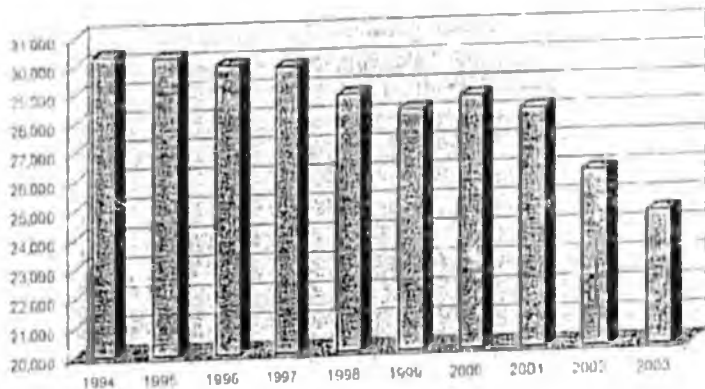
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COMMERCE

\$1.2 million from \$843,839. Plan development costs increased 4.51%, to \$1.9 million from \$1.8 million. Plan monitoring fees increased 47.11%, from \$706,684 to \$1.0 million.

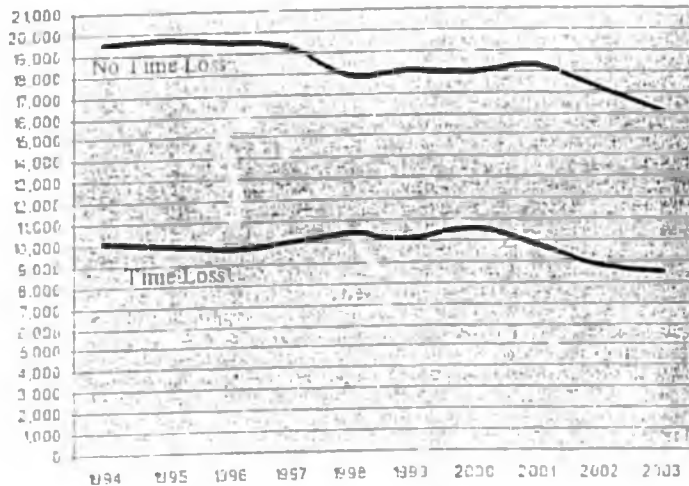
ANALYSIS OF WORKERS' COMP CLAIMS

Total Injury Notices Received

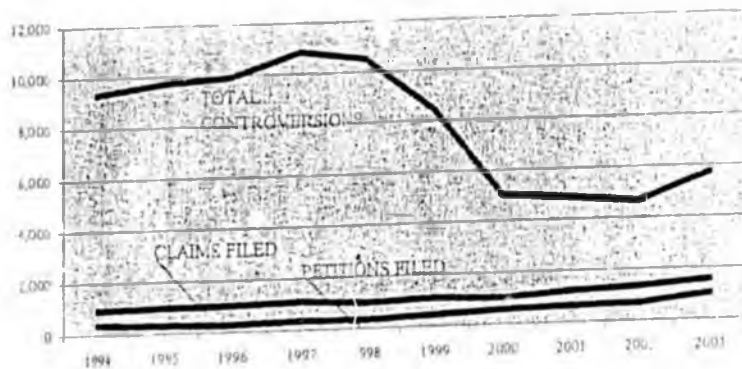


During calendar year 2003, the number of injuries and/or illness reported to the Workers' Compensation Division declined 5.53%, to 24,544, from 25,981 in 2002.

Of the case files set up by the Division in 2003, 16,032 were no-time loss cases, 8,472 were time-loss cases, 17 were fatalities, and 20 were jurisdictional claims.

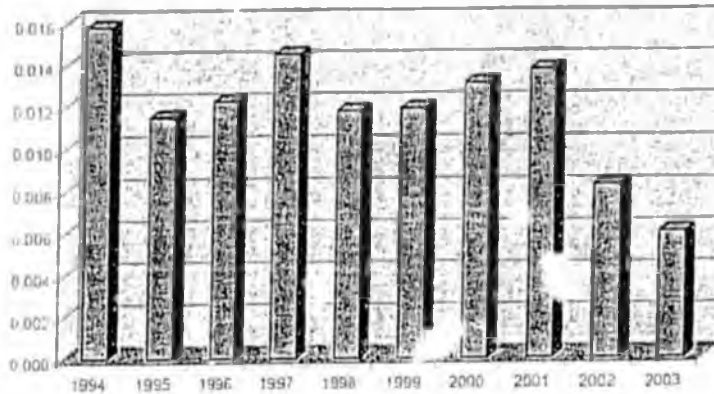


CLAIMS & PETITIONS



For the year, the number of claims filed increased 15.9%, from 1,333 in 2002 to 1,545 in 2003. The number of petitions filed increased 46.0%, from 685 to 1,000, and the total number of controversies filed increased 22.6%, from 4,654 to 5,708.

FATALITY RATE



Using the number of time-loss claims established by the Workers' Compensation Division, the time loss rate per 100 employees in 2003 was 3.0, compared to a loss rate of 3.13 in 2002.

Using the number of fatalities established by the Workers' Compensation Division, the fatality rate per 100 employees in 2003 was .0006, compared to .0008 in 2002, and the lowest rate in the past 10 years.

OTHER

The top twenty insurers paid \$163.2 million, or 73.2% of total workers' compensation benefits paid in 2003. This compares to \$147.0 million or 70.5% in 2002.

The top five insurers by benefits paid in 2003 were Alaska National Insurance Co. at \$51.8 million, up 17.8% from \$44.0 million in 2002; State of Alaska at \$16.1 million, up 20.0% from \$13.4 million in 2002; Alaska Insurance Guaranty Association at \$14.0 million, up 258.1% from \$3.9 million in 2002; Commerce & Industry Ins Co (AIG) at \$9.5 million, up 177.6% from \$3.4 million in 2002, and Liberty Northwest Insurance Co at \$7.0 million, up 107.1% from \$3.4 million in 2002.

For fiscal year 2003, the Division of Insurance reported 157 companies writing workers' compensation insurance in Alaska, with total net premiums written totaling \$238.2 million. This compares to 197 admitted insurers writing \$156.3 million in direct premiums in 2002. During the year, voluntary market premiums increases averaged 3.5%, and assigned risk pool premiums increased 7.6%.

During calendar year 2003, there were several major insolvencies - Fremont Industrial Indemnity Co., Home Insurance Co., and Legion Insurance Co.

MONEY Classified

Permanent Fund Dividends

F



Average total annual payout, 1982-2004: \$584 million
 Total received per Alaskan, 1982-2004: \$23,929.69
 Average payment size since 1982: \$1,040

ANCHORAGE DAILY NEWS • www.adn.com

WEDNESDAY, FEBRUARY 9, 2005

SECTION

Labor costs kill downtown La Mex

■ **RESTAURANT:** Owner took over chain from parents in 1990; other two stay open.

By SARANA SCHELL
 Anchorage Daily News

Anchorage's downtown La Mex restaurant, home of Grande Ronde and the Jalapeno Eating Contest during Fur Rendezvous, not to mention a major annual Cinco de Mayo party, is closed.

Owner Trina Johnson said she closed the location last week, after 30 years in business, because of rising labor costs.

La Mex's two other locations in Anchorage, in Spenard and on King Street in South Anchorage, remain open. They absorbed some of the downtown restaurant's 35 to 40 employees. Johnson laid off 26. She already had cut 12 positions after Christmas, she said.

"I feel bad," Johnson said, "but you have to start cutting your highest cost items."

Labor costs at La Mex went up \$200,000 in 2003, the year the state increased its minimum wage from \$5.65 to \$7.15 an hour, Johnson said.

The cost of workers' compensation insurance is tied to a company's

payroll, she said, and that went from \$22,000 to \$80,000 per year over the past two years.

A higher alcohol tax, a lowered legal breath-alcohol content limit and a smoking ban didn't help, Johnson said.

"People are drinking less," she said, and "your profit's in your alcohol."

La Mex raised prices by 5 percent two weeks ago, Johnson said, to offset rising food costs. She said she was reluctant to change menu prices.

"People are only going to pay so much for a taco," Johnson said.

To cut costs, the restaurants quit serving sizzle-making lemons with their fajitas, saving \$500 a month, Johnson

said, and started outsourcing kitchen prep work.

Tourist seasons were busy, Johnson said, but not enough to keep the largest of the three locations open.

"That's bad," said Jeramie Ford when he heard the restaurant on Sixth Avenue and I Street was closed. Ford, 28, said he started eating there as a 5-year-old, when he used to have to wait for a table. That hasn't been the case for years, he said, but Ford kept coming for the chicken fajitas.

"It's kind of sad to see it go," he said.

Johnson said her parents started La Mex in 1969 in a Mountain View log cab-

in that seated 12. There, she said, her mother made guacamole from scratch at customers' tables.

Johnson took over the business in 1990 and opened the South Anchorage location in 1999.

That location will take on the American fare that only the downtown restaurant carried, such as prime rib.

The Grande Ronde will be held La Mex in Spenard this year, Johnson said, while the King Street restaurant will host Fur Rondy events and the Cinco de Mayo party.

■ Daily News reporter Sarana Schell can be reached at sschell@adn.com.

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(FILE 2

ORIGINAL INVESTIGATION

Comparative Analysis of Individuals With and Without Chiropractic Coverage

Patient Characteristics, Utilization, and Costs

Antonio P. Legorreta, MD, MPH; R Douglas Metz, DC; Craig F. Nelson, DC, MS; Saurabh Ray, PhD; Helen Oster Chemicoff, MD, MSHS; Nicholas A. DiNubile, MD

Background: Back pain accounts for more than \$100 billion in annual US health care costs and is the second leading cause of physician visits and hospitalizations. This study ascertains the effect of systematic access to chiropractic care on the overall and neuromusculoskeletal-specific consumption of health care resources within a large managed-care system.

Methods: A 4-year retrospective claims data analysis comparing more than 700 000 health plan members with an additional chiropractic coverage benefit and 1 million members of the same health plan without the chiropractic benefit.

Results: Members with chiropractic insurance coverage, compared with those without coverage, had lower annual total health care expenditures (\$1463 vs \$1671 per member per year, $P < .001$). Having chiropractic coverage was associated with a 1.6% decrease ($P = .001$) in total annual health care costs at the health plan level. Back pain patients with chiropractic coverage, compared with

those without coverage, had lower utilization (per 1000 episodes) of plain radiographs (17.5 vs 22.7, $P < .001$), low back surgery (3.3 vs 4.8, $P < .001$), hospitalizations (9.3 vs 15.6, $P < .001$), and magnetic resonance imaging (43.2 vs 68.9, $P < .001$). Patients with chiropractic coverage, compared with those without coverage, also had lower average back pain episode-related costs (\$289 vs \$399, $P < .001$).

Conclusions: Access to managed chiropractic care may reduce overall health care expenditures through several effects, including (1) positive risk selection; (2) substitution of chiropractic for traditional medical care, particularly for spine conditions; (3) more conservative, less invasive treatment profiles; and (4) lower health service costs associated with managed chiropractic care. Systematic access to managed chiropractic care not only may prove to be clinically beneficial but also may reduce overall health care costs.

Arch Intern Med. 2004;164:1985-1992

IN THE UNITED STATES, BACK PAIN is the second leading cause of physician visits and is second only to childbirth for hospitalizations.¹ It is also the most prevalent chronic medical problem, the number one cause of long-term disability, and the second most common cause of restricted activity and use of prescription and

For editorial comment see page 1953

nonprescription drugs.^{2,3} Ten years ago health expenditures for chronic back pain were estimated to be \$50 billion to \$100 billion annually,⁴ and studies^{1,2} suggest expenditures have risen exponentially since that time. Epidemiologic studies also indicate an upward trend for back pain in both men and women,⁵ a trend that is likely to continue as the average age of the US population continues to increase.

EFFICACY AND SAFETY OF CHIROPRACTIC CARE FOR BACK PAIN

There is evidence supporting the efficacy of chiropractic care for back pain. A comprehensive review⁶ of the literature evaluating the efficacy of chiropractic treatments for low back pain and other conditions reported that randomized control trials "show spinal manipulation to be better, and no trial finds it to be significantly worse, than conventional treatment."⁶ (p2220) Despite a number of methodologic limitations in some of the investigations,⁶ an overview of the literature, including clinical trials, case-control studies, and meta-analyses, reflects favorably on the efficacy of chiropractic care relative to conventional medical treatment for back pain.^{1,2,7-14}

Although serious complications from spinal manipulation therapy have been re-

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ported in a small proportion of chiropractic patients,¹⁵ for most of the population, chiropractic treatment is associated with a relatively low risk level, on par with conventional medical treatments.¹⁶ On the other hand, comprehensive overview of the literature reveals that it is essentially unanimous in reporting that chiropractic care is associated with significantly higher patient satisfaction compared with patients who receive conventional treatments.¹⁷⁻²⁰

COST EFFECTIVENESS OF CHIROPRACTIC CARE

Several studies³ have produced preliminary evidence demonstrating cost-effectiveness of chiropractic compared with medical management. A series of studies by Stano and colleagues²¹⁻²⁴ and one study by Dean and Schmidts²⁵ report cost benefits of chiropractic care compared with conventional medical treatment for neuromuscular conditions in a review of current literature (mostly workers' compensation studies). For instance, a 1996 cost comparison study,²³ which adjusted for demographic, insurance, and condition variables, revealed higher total (30% to 217% higher) and outpatient (27% to 94% higher) mean payments of medical treatment relative to chiropractic treatment. These later studies support the applicability of findings to managed health care settings by including large sample sizes and examining existing fee-for-service health claims data.

In contrast, a study by Carey et al²⁶ found significantly higher health care costs for patients with chiropractic or orthopedic care for back pain (secondary to a greater number of visits) than for patients who received their back pain care from a primary care physician at a health maintenance organization. Patients were interviewed over the telephone for up to 24 weeks to assess use of health care services and outcomes of care. Patients who received care from doctors of chiropractic care (DCs) paid more per episode than patients who received care from primary care physicians (69% in urban setting and 3% in rural setting). However, in this study the analyses were limited to outpatient costs rather than total costs; the costs were estimated using average statewide charges for a large insurance carrier; and, although the analyses adjusted for sciatica, baseline functional status, and duration of pain,²⁰ the study did not specifically adjust for the variables comorbidities, severity, and type of diagnosis.

Another study^{6,27} that compared cost of care for episodes of back pain between various kinds of medical practitioners (orthopedists and chiropractors) found differential costs for care compared with care provided by a general medical practitioner. This study, however, based analyses on data collected up to 25 years ago and thus may not be applicable to today's health care market. In addition, these studies were characterized by small sample sizes, increasing the probability of type II errors (failure to find a real difference between groups). Given the discrepant cost-effectiveness findings and significant methodologic differences that limit study comparisons, the issue of the benefit of chiropractic care in today's health care system remains unresolved.

ACCESS TO CHIROPRACTIC CARE

Chiropractors now represent the third largest segment of health care practitioners in the United States,¹ with 50,000 practitioners in 2000 according to the Bureau of Labor Statistics.²⁸ According to the American Chiropractic Association, an estimated 21 million to 28 million people now receive chiropractic services each year, with approximately 192 million annual visits to DCs: between 1990 and 1997, chiropractic use increased from 10% to 11%.²⁹ With growing public demand,³⁰ the profession is also expected to increase 21% to 35% by 2008.¹⁶

A recent study³¹ of employers in large companies shows that chiropractic insurance coverage is now being offered to most American workers who are covered by health insurance and is increasingly being offered in all health plan types. This and other studies³² note that although health insurance for chiropractic services is expanding, insurers often restrict coverage to manage risk.

Chiropractic coverage is often limited in terms of referral restrictions, conditions covered, number of visits, maximum annual dollar benefit, requirement for physician referral, and amount paid per visit. Some plans do not provide covered benefits but instead offer a network program in the form of discounted services. Health plan designs may impede appropriate access to chiropractic clinical care and may diminish the strength DCs have in treating neuromusculoskeletal (NMS) disorders.

The disconnect between evidence regarding the efficacy and safety of chiropractic care, consumer demand, and the limited research on cost of chiropractic care in applied settings has served to hinder integration of chiropractic coverage in traditional health care services. To help bridge this divide, improve access to appropriate chiropractic services, and promote best practices of chiropractic care, there is a need for community-based research to ascertain the effect and benefits of chiropractic care and the associated utilization of health care resources.

The data analyzed in this study were obtained from a natural experiment setting. A natural experiment is an experiment conducted in real-life setting rather than the controlled environment, where researchers rely on truly naturally occurring events in which people have different exposures that resemble an actual experiment.^{33(p150)} In this case, the data were collected and analyzed from a naturalistic setting rather than a laboratory setting. Although this is not a true experiment, such an approach is common in health services research because of the high external validity and generalizability of the results obtained from studies that used natural experiment methods.

This study was conducted to identify and describe the demographics, disease, and utilization patterns of individuals with access to chiropractic care compared with individuals without such coverage. Toward this end, this study compared members of the same health plan, both with and without an additional chiropractic benefits rider. This natural experiment offers a particularly rich opportunity to understand the effects of supplemental chiropractic coverage on utilization of medical care because it employs members of the same health plan as a comparison group. Both groups studied were members of the same

large managed-care system with access to the same physician network; with the same or similar covered benefits; with the same rules on referral to specialty care, high-cost diagnostic tests, and hospital and surgery approval guidelines; and with the same exclusions and limitations.

METHODS

STUDY POPULATION

This 4-year study (April 1, 1997, to March 31, 2001) used administrative claims data from a large regional managed-care network in California. These data included inpatient and outpatient data for more than 1.7 million continuously enrolled members containing demographic and enrollment information in addition to diagnosis and procedure codes as classified under the *International Classification of Diseases, Ninth Revision (ICD-9)* and the *Current Procedural Terminology, Fourth Edition*. Administrative claims data from the largest chiropractic health plan in California, American Specialty Health Plans, were used to subsequently identify approximately 700,000 of the 1.7 million patients enrolled in the large managed-care organization who also received additional chiropractic coverage through an American Specialty Health Plans benefits rider. These 700,000 members who were enrolled in both plans and had access to a medical and chiropractic network of practitioners were compared with the 1 million members who were enrolled in the managed care network only. For those members enrolled in both plans, the administrative claims data from the 2 networks were merged into one unique administrative file, thereby creating 2 main comparative cohorts from the same large health plan: one with access to chiropractic care and the other without. The former group had benefits covering direct access to a DC without the need of a physician referral. Under this benefit plan the patient copay for a chiropractic office visit was the same as it would be in a medical clinic. The benefit allowed for a maximum of 40 office visits to a DC per year.

STUDY DESIGN

This study applied a retrospective, longitudinal, quasi-experimental, participant-nonparticipant design. The carve-out feature of the chiropractic insurance coverage offered by the managed-care health plan as an option to its employer groups was used to create retrospective control cohorts at 3 different levels. At the first level, managed care members with chiropractic insurance coverage were compared with the members in the same health plan without chiropractic coverage. At the second level, we compared members with and without chiropractic coverage but only if they had had NMS claims at any time during the study period. At the third level, we compared episodes of care for members with NMS conditions receiving care only from DCs against members with NMS claims receiving care only from medical doctors (MDs).

The effect of adding a chiropractic benefit on the health plan's overall resource consumption was assessed over a typical horizon for employer-sponsored health insurance. To achieve this, the observation period and analyses were annualized to a study period from January 1 to December 31, 2000, when assessing group differences in demographics, comorbidities, and total plan claim expenditures.

However, to comprehensively compare the effects of treatment for NMS conditions between DCs and MDs, a longer observation period was appropriate, because NMS conditions are typically time limited but recurrent and can manifest over multiple episodes spanning a longer period. Therefore, we expanded our analysis period across 4 years from April 1, 1997,

to March 31, 2001, to study the costs and utilization patterns associated with NMS episode-specific care.

To enable meaningful comparisons of utilization and costs of medical and chiropractic care for categories of NMS disorders based on anatomic and clinical similarity, a classification system grouping individual ICD-9 codes for NMS conditions into more aggregative diagnosis groups was developed for this study. The classification also took into account the severity of specific conditions such as neck and lower back diagnoses. A total of 654 ICD-9 codes, identified by separate panels of DCs and MDs as NMS conditions most commonly treated and eligible for insurance coverage, were sorted into the following categories: neck, lower back, thoracic spine and rib disorders, headache, upper extremity, lower extremity, myalgias or arthralgias, latent effects, and other. Additionally, severity distinctions were made for neck and lower back diagnoses by sorting into complicated and uncomplicated conditions, thus extending the diagnostic groups to 11. The ICD-9 codes for these diagnostic groups were comprehensively reviewed for possible inclusions, exclusions, and crossover by a panel of DCs and medical NMS experts.

To maximize comparability between medical and chiropractic coding, a subanalysis was performed to examine a small group of codes that would be equally applicable to chiropractic and medical practice. This set of codes was selected for its high frequency of occurrence in both medical and chiropractic cohorts. To level the playing field between chiropractic and medical care for these low back pain-specific analyses, cases that were associated with any claims for back surgery were excluded from the subanalysis, because such cases are likely to have complications for which chiropractic care would not be appropriate.

DEFINING EPISODES OF CARE

In addition to encounter-specific comparisons, entire episodes of care were of interest in the study. For each member with at least 1 NMS claim or a sequence of NMS claims, an episode of NMS care was determined by the diagnosis group of the sequence of claims and an allowable gap between any 2 consecutive claims of less than 45 days. Claims separated by 45 days or more were considered separate episodes. The 45-day interval was derived from a previous study^{20,21} that used the 9 most common ICD-9 codes for low back pain to evaluate the percentage of treatment encounters that were captured using different intervals to terminate an episode. The study found that for the most common ICD-9 code (724.2) an interval of 6 weeks (42 days) captured 86% of all encounters, and the remaining 8 diagnoses yielded values ranging from 42 to 49 days. A sensitivity analysis of these values demonstrated that there was little change in the overall study results if these values were moved upward or downward. Based on these results and on the clinical consensus of an expert panel of both DCs and MDs, a value of 45 days was judged to be appropriate. For neck- and back-related episodes, which were stratified into complicated and noncomplicated diagnosis groupings, any switch in diagnosis between uncomplicated and complicated neck-related conditions during the 4-year sample period triggered the entire sequence of claims to be identified within the complicated neck diagnosis grouping.

OVERALL EXPENDITURES AND UTILIZATION

The primary health care expenditures considered for this study were total health care claim expenditures, individual components of total health care claim costs such as those associated with inpatient and outpatient services, and costs associated with NMS care at the episode level. Utilization metrics included the following: outpatient services, plain radiographs, magnetic resonance (MR) images, lumbar spine surgical procedures, and in-

patient stays. Health risk characteristics, based on demographics and comorbidity rates, were used to compare the risk profiles for different groups. The health plan expenditures from inpatient, outpatient, and chiropractic outpatient paid amounts were used in the calculation of health care costs and reflect the dollar value of the payers' resource consumption in providing access to medical and chiropractic care to its members. Prescription claims and physical therapy claims were not included during this phase of the ongoing study, and therefore pharmacy and physical therapy costs were not included in health care costs.

STATISTICAL ANALYSIS

Descriptive statistics, including mean values, standard deviations, and column percentages, were computed and average differences between groups were evaluated. We used χ^2 tests to evaluate differences between categorical variables. This included variables with proportional values, such as sex, proportion of patients in the comorbidity and diagnosis groups, and proportion of complicated episodes. To test the difference in mean values for continuous variables, such as age and costs, and to account for the skewed distribution of variables, we applied nonparametric analysis of variance instead of conventional parametric tests such as *t* tests. We applied the Wilcoxon test when comparing 2 cohorts and the Kruskal-Wallis test when comparing 3 cohorts.

A semilogarithmic regression model was also used to estimate the effect of chiropractic insurance coverage on total annual health care expenditures. The total health care costs of plan members with positive utilization during calendar year 2000 were regressed on their chiropractic coverage status, after adjusting for their demographic, NMS, and comorbid characteristics using the following specification:

$$\text{Log}[(\text{Total Health Care Costs})/(\text{Total Health Care Costs})_{>0}] = \alpha + \beta_1 (\text{Chiropractic Coverage}) + \beta_2 (\text{Female}) + \beta_3 (\text{Age}) + \beta_4 (\text{Comorbidity Score}) + \beta_5 (\text{Neuromusculoskeletal}) + \epsilon$$

The logarithmic transform of the total health care costs was used as the dependent variable to correct for nonnormality and heteroscedasticity in the cost distribution. The comorbidity score, computed as the number of comorbid conditions that a member was identified with during the annual period, was used as a risk adjuster in addition to age, sex, and presence of a NMS condition. The primary independent variable of interest was the dummy variable, which was equal to 1 if the member had chiropractic coverage during the period and equal to 0 if otherwise. The antilog of the estimated regression coefficient, after accounting for its variance, was used to estimate the effect of chiropractic coverage on the annual total health care costs of the health plan as follows²⁴:

$$g = \exp\left(\hat{\beta}_1 - \frac{1}{2} \text{Var}(\hat{\beta}_1)\right) - 1$$

where $\text{Var}(\hat{\beta}_1)$ is the squared standard error of the estimated regression coefficient $\hat{\beta}_1$.

RESULTS

COMPARISON OF MEMBER COHORTS

Year 2000 claims for 707 690 health plan members with chiropractic coverage and 1 001 995 members without chi-

ropractic coverage were compared. Demographic characteristics and comorbid conditions for members with and without chiropractic insurance coverage are displayed in the **Table**.

Members with chiropractic coverage were younger (mean age, 33 years) than members without chiropractic coverage (mean age, 36; $P < .001$). The cohort without chiropractic coverage contained a slightly higher percentage of female members (52.1% female) than the cohort with chiropractic coverage (51.6% female, $P < .001$).

Members with chiropractic coverage also were less likely than members without chiropractic coverage to have comorbid medical conditions. The proportions of members who had specific comorbid conditions, including hypertension, diabetes, cardiac arrhythmias, heart failure, and nutritional disorders, ranged from 0.6% to 6.5% in the population with chiropractic coverage and 0.9% to 7.3% in the population without coverage ($P = .001$ for each comparison). In particular, heart failure (0.6% vs 0.9%), cardiac arrhythmias (1.6% vs 2.0%), and hypertension (6.5% vs 7.3%) were lower in relative occurrence in the member population with chiropractic coverage. Annual total health care claim costs of the member populations with and without chiropractic coverage for year 2000 are presented in **Figure 1**. The per-member-per-year (PMPY) cost of members with chiropractic coverage was \$1463, which was \$208 lower ($P < .001$) than the PMPY cost of members without the coverage (\$1671). This translates to a 12% reduction in annual costs incurred by the managed care organization on members with chiropractic coverage.

COMPARISON OF NMS PATIENT COHORTS

The 141 616 patients with NMS conditions who had chiropractic coverage were also compared to 189 923 NMS patients without chiropractic coverage. As with members with and without chiropractic coverage, NMS patients with chiropractic coverage were younger (mean age, 41 years) than NMS patients without chiropractic coverage (mean age, 44 years; $P < .001$). Similarly to members with and without chiropractic coverage, NMS patients with chiropractic coverage were less likely than NMS patients without chiropractic coverage to have comorbid medical conditions ($P < .001$ for each of the comorbid conditions previously mentioned).

The overall medical expenditures of the patients with NMS conditions during the year 2000, including the major components of the expenditures, are presented in **Figure 2**. The PMPY cost of NMS patients with chiropractic coverage was \$2345, which was \$361 lower ($P < .001$) than the PMPY cost of NMS patients without the coverage (\$2706). This translates to a 13% reduction in annual costs incurred by the health plan on NMS patients with chiropractic coverage.

Annual per capita hospital cost for NMS patients with chiropractic coverage (\$1224) was \$210 lower or 15% ($P < .001$) than that for NMS patients without chiropractic coverage. The annual per capita ambulatory cost for NMS patients with chiropractic coverage (\$1121) was 12% lower ($P = .01$) than the corresponding cost for NMS patients without chiropractic coverage (\$1272). The annual per capita cost of providing chiropractic care was

Table. Baseline Demographics*

Demographics	Members With ASHP Coverage, %	Members Without ASHP Coverage, %	P Value
Age group,†			
0-17	32	26	.001
18-21	5	4	.001
22-35	15	19	.001
36-55	34	33	.001
56-64	8	8	>.05
≥65	6	10	.001
Comorbid condition			
Coronary heart disease‡	0.55	0.86	.001
Cardiac arrhythmias‡	1.56	1.97	.001
Valvular disease‡	0.59	0.69	.001
Secondary circulation disorders‡	0.05	0.06	.001
Ischemic vascular disorders‡	0.40	0.55	.001
Hypertension‡	6.46	7.26	.001
Atherosclerosis‡	0.15	0.17	.001
Other neurologic disorders‡	0.49	0.56	.001
Chronic pulmonary disease‡	3.96	3.78	.001
Diabetes‡	2.77	3.01	.001
Hypothyroidism‡	1.54	1.51	.07
Renal failure‡	0.21	0.28	.001
Liver disease‡	0.29	0.31	.08
Hepatosplenic disease excluding bleeding‡	0.16	0.19	.001
MDS‡	0.06	0.16	.001
Lymphoma or leukemia‡	0.12	0.14	.001
Cancer or tumor‡	1.76	2.10	.001
Rheumatoid arthritis or collagen vascular diseases‡	0.63	0.65	.04
Glaucoma‡	0.17	0.19	.07
Endocrine or metabolic disorders (obesity or weight loss)‡	1.58	1.65	.001
Alcohol‡	1.29	1.44	.001
Alcohol and other drug abuse‡	0.22	0.23	.14
Psychosis‡	1.09	0.91	.001
Depression‡	1.93	1.64	.001
Tobacco‡	0.44	0.43	.32

Abbreviation: ASHP, American Specialty Health Plans.

*Members with chiropractic coverage were younger, overall and in the 65-year and older group, and had lower comorbidities for 20 of the 25 conditions. †Statistically significant at $P < .001$.

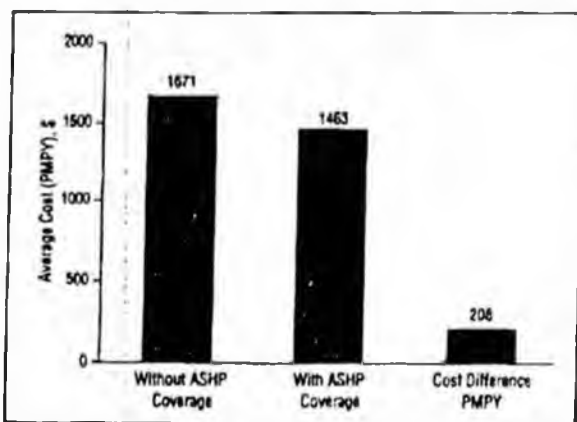


Figure 1. Annual total cost reduction. Members with chiropractic coverage were associated with \$208 lower per-member-per-year (PMPY) total health care expenditures for the year 2000 ($P < .001$). ASHP indicates American Specialty Health Plans.

\$31, which amounted to only 1% of the total dollar value of resources consumed (\$2376) by NMS patients between the 2 cohorts.

To adjust for age, sex, presence of an NMS condition, and comorbidity differences between cohorts, a semi-

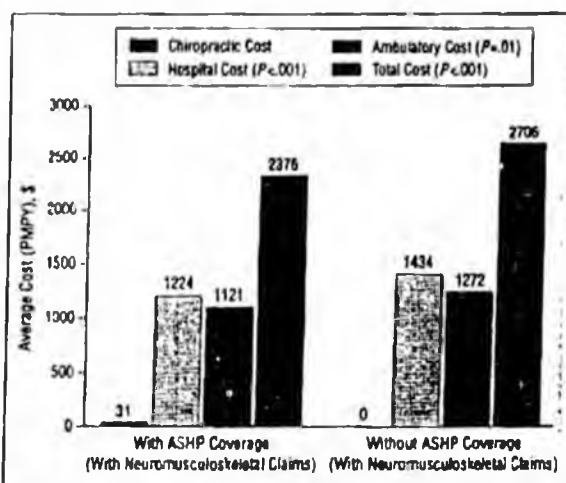


Figure 2. Overall medical expenditures. Patients with neuromusculoskeletal conditions who had chiropractic coverage were associated with \$330 lower per-member-per-year (PMPY) total health care expenditures for the year 2000. The lower cost is derived from both lower hospital cost by \$210 and lower ambulatory cost by \$151. P values were determined using the Wilcoxon test. Further regression analysis will be conducted. Hospital costs include outpatient hospital services, emergency department visits, and inpatient services. Total costs include hospital costs and ambulatory costs. ASHP indicates American Specialty Health Plans.

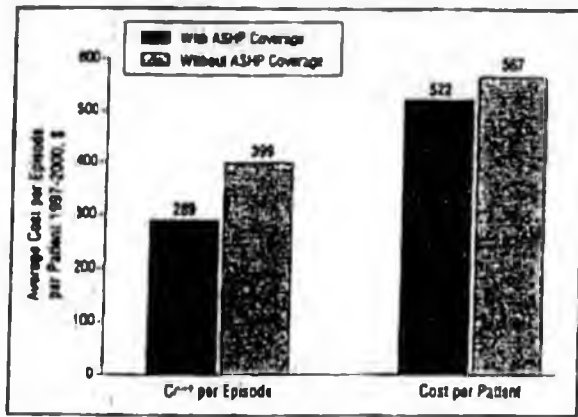


Figure 3. Episode of care utilization analysis for back pain patients. Presence of chiropractic coverage was associated with a \$110 reduction in cost per episode and a \$45 reduction in cost per patient for all episodes related to neuromusculoskeletal care during the 4-year period (April 1, 1997, to March 31, 2001) ($P < .001$). ASHP indicates American Specialty Health Plans.

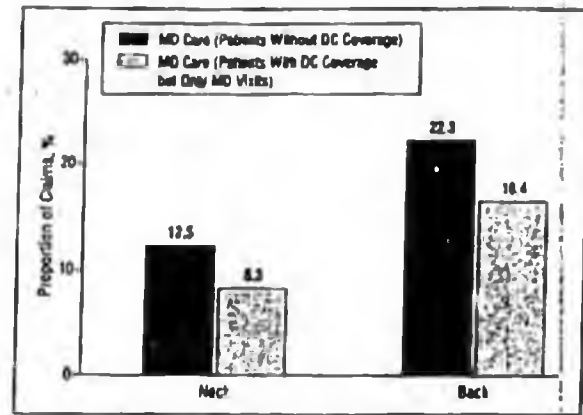


Figure 5. Medical care substitution. Presence of chiropractic coverage was associated with a shift in the case distribution away from medical doctors (MDs) to doctors of chiropractic care (DCs) for neck and back problems, indicating a substitution of chiropractic for physician care. All proportional differences are statistically significant at the $P < .001$ level.

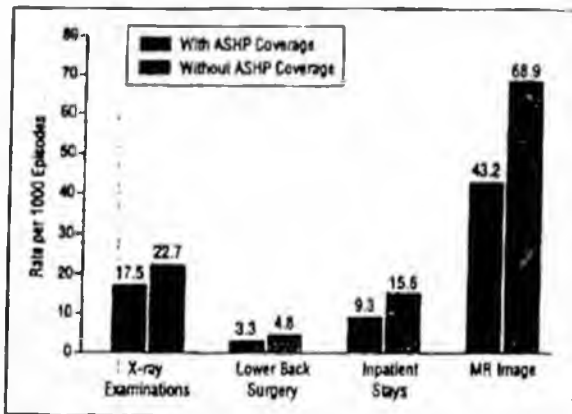


Figure 4. Breakdown by high-cost items. Access to chiropractic care was associated with lower rates of high resource-utilizing components of neuromusculoskeletal care ($P < .001$). ASHP indicates American Specialty Health Plans; MR, magnetic resonance.

log regression analysis was also used to estimate the impact of chiropractic care as a covered benefit on total health care costs of the health plan for year 2000. The estimated coefficient for chiropractic coverage indicator (β_1) was -0.0162 . The regression results indicate that the presence of chiropractic insurance coverage was systematically associated with an approximately 1.6% lower ($P = .001$) average total health care cost of members, after controlling for differences in age, sex, and the number of comorbidities. The 1.6% reduction in total health care costs per member is equivalent to approximately 13% of the \$208 PMPY observed cost difference reported in Figure 1. This translates to an approximately \$27 PMPY potential cost saving that can be attributed to the presence of chiropractic insurance coverage in the plan, after accounting for differences in demographic and comorbidity risks of the members.

BACK PAIN-SPECIFIC TREATMENT

Figure 3 presents data related to the cost of providing care for back pain, at an episode level, for the 4-year period (April 1, 1997, to March 31, 2001). The average cost

per back pain episode for patients with chiropractic coverage was \$289, which was \$110 or 28% lower ($P < .001$) than for back pain patients without chiropractic coverage. Aggregating episodes for each patient during the 4-year period, the average cost of back pain treatment for patients with chiropractic coverage was \$522, which was \$45 or 8% lower than the corresponding back pain treatment cost for patients without chiropractic coverage.

Furthermore, the proportion of complicated back pain episodes was only marginally higher (10% vs 8%, $P < .001$) for patients who received care only from MDs compared with the patients who received care only from DCs.

Utilization rates for back pain episodes presented in Figure 4 indicate significantly lower utilization of resources across all major high-cost areas for NMS patients with chiropractic insurance coverage compared with those without. Back pain patients with chiropractic coverage had fewer inpatient stays than did those without chiropractic coverage (9.3 vs 15.6 stays per 1000 patients, $P < .001$). The MR image rate was also lower for back pain patients with chiropractic coverage compared with those without chiropractic coverage (43.2 vs 68.9 MR images per 1000 patients, $P < .001$). The rate of lower back surgery among patients with chiropractic coverage was lower as well (3.3 vs 4.8 surgical procedures per 1000 patients, $P < .001$). Back pain patients with chiropractic coverage also received fewer radiographs (17.5 vs 22.7 per 1000 patients, $P < .001$) than did back pain patients without chiropractic coverage.

SUBSTITUTION EFFECTS

Figure 5 presents the distribution of NMS claims reported for neck and back pain episodes during the 4-year period. This table compares 2 groups of patients, both who sought care for NMS complaints from MDs only. However, members of one of the groups were limited by the absence of access to chiropractors within the plan due to lack of chiropractic insurance coverage. The proportion of neck complaints seen by MDs for patients with chiropractic coverage was 8.3%, 4 percentage points lower ($P < .001$) than for the corresponding proportion for patients without chi-

ropractic coverage. Similarly for back pain, the proportion of complaints seen by MDs for patients with chiropractic coverage was 16.4%, 6 percentage points lower ($P < .001$) compared with patients without coverage. Correspondingly, a very high rate (approximately 60%) was also observed for the proportion of neck and back complaints seen by the network DCs during the same period. This suggests a substitution of DC care for MD care for neck and back complaints.

COMMENT

The high prevalence and recurrent incidence of back pain, as well as the heavy economic and disability burden that it imposes on society as documented in the literature, point to a major area of public health concern. Simultaneously, there is growing evidence for the low risks associated with chiropractic spinal manipulation in most cases and favorable evidence for its effectiveness in treating low back pain. In addition, patients treated for back pain by DCs tend to be more satisfied than patients treated by MDs. However, despite this evidence for safety, effectiveness, and growing public demand, health insurance coverage for chiropractic care continues to remain restricted, relative to other health services, particularly in the managed care sector.

This restriction of access to health insurance for chiropractic care is not due to a lack of DCs, however. Rather, chiropractic care is becoming increasingly prevalent in the American health care system. The increasing acceptance of chiropractic care as a source of comprehensive complementary care for NMS problems is reflected in that the chiropractic field is the fastest growing among all doctoral-level health professions.¹⁷

To date, there has been little research linking chiropractic and medical utilization data at a patient level. Thus, a powerful opportunity to compare the effects of chiropractic and medical management of costly NMS conditions, such as back pain, in a real-world managed care setting has been underused. This study integrated and analyzed comprehensive administrative data from a large managed medical care organization and the chiropractic care plan that provided an additional chiropractic benefit to more than 40% of its members. By comparing members within the same medical managed care plan both with and without direct access to chiropractic care, this study provides additional information on the effect of chiropractic insurance benefits on the resource utilization within a managed care network.

For the managed care plan studied, the presence of a supplementary chiropractic insurance option was associated with favorable member selection by the plan. This is evident in that members with covered chiropractic benefits were significantly younger and had less comorbidity burden. This favorable selection could have been an artifact of 2 factors that reflect employer and employee preferences. The larger companies in particular, in the interest of maintaining a large productive workforce, may have been likely to offer additional benefits, such as supplementary insurance, to attract younger and healthier individuals. At the same time, potential employees, particularly those who maintain a healthier lifestyle may have

been more likely to seek employment in companies that offer benefits covering complementary care (eg, chiropractic or acupuncture) that can be perceived as less aggressive treatment modalities.

This study found that members with chiropractic coverage had a 12% lower annual medical care cost, not adjusting for member risk characteristics. After controlling for the cost-saving effects associated with favorable demographic and medical risk factors, the regression analysis found a statistically significant 1.6% reduction in total medical care costs that can be isolated to the presence of chiropractic coverage. Most of this 1.6% reduction in the plan's total medical costs is likely derived from the 13% reduction in the total medical costs observed for the subset of members with NMS conditions who also had chiropractic coverage. In our study population of 0.7 million members who had chiropractic coverage in the medical plan, we estimated an annual reduction of approximately \$16 million as a result of lower utilization of high-cost items. This is a conservative estimate of the cost savings for the plan that can be associated with members in the medical plan using their supplementary benefits to seek chiropractic treatment of their NMS problems. The estimated cost saving appears to more than offset the amount spent to cover the associated costs of the chiropractic benefit.

The analyses related to NMS episodes elucidate sources of these cost savings relating to chiropractic treatment of common NMS complaints, such as neck and back pain. Focusing on low back pain diagnoses that were selected specifically for comparability between medical and chiropractic practice, our analysis found that patients with chiropractic coverage had significantly lower rates of use of resource-intensive technologies, such as x-ray examinations, MR image, and surgery, and lower use of more expensive patient care settings, such as inpatient care. This is reflected in the significantly lower cost, at both the episode level and the patient level, of providing care for back pain. The difference in episode-specific and patient-level resource utilization did not seem to be due solely to a difference in severity of cases seen by DCs and physicians, since the estimated 2% difference in severity between chiropractic and medical patients of back pain did not constitute a clinically meaningful difference. In addition, the substitution of chiropractic for physician care evident from the shift in the case distribution between physicians and DCs when chiropractic coverage was present also contributed to the conservation of health care resources.

Although the results from the study may carry policy implications in the managed care industry, the limitations of this study are worth noting, especially since they also open up avenues for future research. This study only analyzes effects of chiropractic coverage in a large but specific managed care population. Future research covering geographically diverse populations across several plans is needed to ascertain and validate the effect of a chiropractic benefit on utilization patterns and cost effects, after controlling for differences arising from factors, including location, plan-specific benefit design, industry type, and other undetected biases, such as patient burden of disease. Comorbidity score and demographic characteristics such as age were controlled for in the regression model. However, the significantly more favorable profile of the plan mem-

bers who selected chiropractic coverage poses some concern regarding the generalizability of the results to a sicker, older population. Especially as the average age of the American population continues to increase in the next decade, the safety and appropriateness of chiropractic care for elderly patients will need to be more thoroughly evaluated. Further research is also necessary to quantify utilization and costs associated with DC vs MD care for other NMS conditions, and to ascertain clinical outcomes for specific NMS conditions.

The substitution of chiropractic utilization for medical care is central to the issue of providing cost-effective care for NMS conditions in a managed care environment, since the provision of chiropractic benefits as supplementary insurance raises the possibility of induced demand for medically unnecessary care. This study found evidence that a substantial portion of the chiropractic care sought by the members with insurance coverage was more often substituted for medical care rather than add-on care. Further research is needed to quantify this substitution effect. The effects of substitution of chiropractic care utilization for medical care could be further pursued by analyzing data on patients with episodes of NMS care comanaged by DCs and MDs, which was beyond the scope of this study. Although most back pain patients have nonspecific syndromes, a few back pain cases are caused by severe underlying conditions. Accurate diagnosis and appropriate referral are essential for this subset of low back pain cases and demand an integrative approach. This point is especially important in light of the substitution between DCs and internists found by this study. Finally, questions continue to remain regarding the effectiveness of chiropractic care relative to the cost of care and quality of the health care received. Future research using patient surveys (quality-of-life and patient satisfaction measures) in conjunction with medical record review are warranted to further evaluate the cost-effectiveness of chiropractic care in managed care settings.

This study provides additional information regarding the economic benefits and utilization patterns associated with systematic access to chiropractic care. Furthermore, it offers an integrated baseline (combining chiropractic and medical utilization claims data for a common cohort of members) for future research evaluating the effect of alternative clinical management approaches to medical conditions (ie, back pain specifically) with high direct and indirect consumption of medical resources and a high derivative societal cost given the absenteeism and burden of disease associated with them.

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News Release

Frank H. Murkowski, Governor
Greg O'Claray, Commissioner

P.O. Box 21149
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Telephone: (907) 465-2700
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Press Kit 2005 Workers' Compensation Reform Act

- Press release
- Synopsis of bill
- Five charts
 - "Where Your Workers' Compensation Benefit Dollars Go"
 - "Workers' Comp Annual Premiums Paid - Copy Express"
 - "Workers' Comp Annual Premiums Paid - McGraw's Custom Construction"
 - "Workers' Comp Annual Premiums Paid - Central Peninsula Gen. Hospital"
 - "Workers' Comp Annual Premiums Paid - Kodiak Island Borough"
- Excerpt from DOLWD Division of Worker's Compensation's 2003 annual report
- Anchorage Daily News clip, 2/9/05, "Labor costs kill downtown La Mex"
- Copy of bill

News Release

Frank H. Murkowski, Governor
Greg O'Claray, Commissioner

P.O. Box 21149
Juneau, Alaska 99802-1149
Telephone: (907) 465-2700
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Date: February 23, 2005
No: 05-49

FOR IMMEDIATE RELEASE
Media Contact: Dan Saddler, 632-1776

Workers' Compensation Bill Offers Needed Reform

Legislation Addresses Skyrocketing Costs of Employee Insurance

(Juneau) - Important reforms aimed at streamlining the delivery of workers' compensation benefits to injured workers, and easing the cost burden on Alaska businesses, will be sent to the Legislature this week by Governor Frank H. Murkowski.

"Workers' compensation rates in Alaska are the second-highest in the nation, imposing an unnecessary burden on our economy," said Greg O'Claray, commissioner of the Alaska Department of Labor & Workforce Development, which is taking the lead on the issue. "The reforms in this bill will make the workers' compensation system less expensive for employers and more efficient for workers."

State law requires employers to provide workers' compensation insurance so those injured on the job can get disability benefits while they recover, receive medical care and rehabilitation, and, if necessary, get retrained for a new line of work.

Private insurance companies base their rates on each industry's expense history, but in recent years rates have skyrocketed, increasing 36 percent on average over the past two years alone. Only California has seen rates increase higher than Alaska, increases that recently drove it to pass its own reform legislation, the governor said.

"We must act now to halt this dangerous trend in our state," Murkowski said. "It's clear the present system doesn't serve injured workers or employers as the original law intended. With legislative approval of my bill we could stabilize insurance rates by January 1, 2007. The longer we delay taking action, the more costs spin out of control."

O'Claray said costs for specific medical procedures demonstrate the trend. The cost for knee reconstruction surgery has nearly doubled from \$5,225 in 1999 to \$10,697 in 2004, and back surgery to repair a ruptured disk has risen from \$5,617 to \$6,947 in the same period, according to information compiled in state medical fee schedules.

O'Claray presented details of the legislation at Copy Express, a small duplication and office supply business in Juneau, which he called one of the many Alaska enterprises being squeezed by steep rate increases. The company's workers' compensation costs have risen from \$5,900 in 2002, to \$10,232 in 2005.

Labor Department records show similar rates of increase for other industries. Costs for McGraw's Custom Construction, a Sitka construction company, have risen from \$146,950 in 2002 to \$315,110 in 2004. Costs for the Kodiak Island Borough have more than doubled from \$43,275 in 2001 to \$95,234 in 2005. At Central Peninsula General Hospital in Kenai, costs have more than doubled, from \$390,566 in 2001 to \$984,833.

"By dealing with these increases, and making other needed improvements to the system, the governor's bill will keep Alaska's workers' compensation insurance system affordable for employers, effective for employees and efficient for the entire state," O'Claray said.

The bill's key elements include:

- Capping medical fees paid for injured worker services at the December 1999 level, and calling for a medical review committee to study the medical delivery system for workers' compensation and report to the labor commissioner by March 1, 2007
- Helping employers reduce medical costs by authorizing them to use a list of preferred providers and allowing employers to negotiate fee rate, while still letting employees choose providers outside the preferred list
- Adopting national peer-reviewed medical treatment guidelines
- Requiring physicians to use generic drugs - but allowing exemptions for medical reasons - and authorizing use of a preferred drug list
- Establishing an Appeals Commission to provide quicker, more consistent decisions of appeals than the Superior Court offers under current law
- Preventing workers from receiving more in combined disability benefits than they would earn if still on the job
- Streamlining the claim settling process by allowing parties to settle claims without requiring Workers' Compensation board approval, letting claimants opt for cash benefits instead of retaining benefits, and reducing delays in determining eligibility for retraining benefits
- Protecting workers against unscrupulous employers who fail to carry insurance coverage, by using fines collected from such violators to fund a pool to pay benefits to workers left uncovered
- Helping injured workers return to productive work more quickly

"The best workers' compensation is a good paying job on an accident-free workplace," Murkowski said. "But if someone is injured, these reforms provide needed help quickly and effectively. I encourage everyone interested in a healthy Alaska economy to work together with Commissioner O'Claray to craft a timely solution to a problem that has gone unresolved for far too long."

###

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Synopsis of 2005 Workers' Compensation Reform Act

The Murkowski Administration's workers' compensation reform legislation provides much-needed reforms aimed at keeping Alaska's system affordable for employers, effective for employees and efficient for the entire state. It addresses five major elements of the system:

Medical Costs and Benefits

- Rolls back state rates for reimbursement of medical services to injured workers to December 1999 levels, pending a medical review committee's study of the medical delivery system for workers' compensation to be delivered to the labor commissioner by March 1, 2007
- Reduces medical costs by authorizing employers to use preferred providers and allowing employers to negotiate fee rates - while still letting employees choose providers outside the preferred list
- Requires physicians treating injured workers to take advantage of the cost savings from generic prescription drugs - but allows exceptions for medical reasons
- Authorizes physicians to prescribe from a preferred drug list, to obtain the same system-wide cost reductions that such a list provides to the Alaska Department of Health and Social Services
- Adopts national peer-review medical treatment guidelines established by the American College of Occupational and Environmental Medicine

Workers' Rights

- Protects workers against unscrupulous employers who fail to offer insurance coverage, by using fines collected from such violators to fund a pool to pay benefits to workers left uncovered
- Eases worker access to legal advice, by allowing private attorneys to collect minimal fee (\$300) to advise clients with workers' compensation issues
- Authorizes state to contract with non-profit organizations to provide legal assistance to worker claimants and receive reimbursement from state

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Workers' Compensation System

- Establishes Appeals Commission to provide state-wide consistency in workers' compensation claim decisions, while preserving Workers' Compensation Board hearing process to speed resolution of contested claims
- Eliminates Second Injury Fund, an indemnification mechanism no longer necessary to protect once-injured employees against hiring discrimination from subsequent employers *4-1000 of all claims*
- Reduces delays in determining workers' eligibility for retraining benefits
- Allows injured workers the option to quickly receive cash benefits in lieu of retraining benefits *3-1000*
- Streamlines claim process by requiring immediate release of treatment records to employers
- Eases resolution of many claims by allowing parties with attorneys to settle cases without requiring review by workers' compensation board *why not if both party agree*
- Protects worker and employer privacy, and system integrity by banning commercial use of workers' compensation division's records *must use in court*
- Speeds shut-down of uninsured employers by eliminating requirement for hearing before workers' compensation board *must use in court*
- Increases fines against employers that fail to provide insurance
- Combats insurance fraud by authorizing Division of Workers' Compensation to investigate fraud, and to refer violators for prosecution under an improved criminal statute *must use in court*

Compensation

- Prevents workers from earning more in benefits than wages, by allowing coordination of benefits between employer-funded disability insurance and total disability compensation
- Caps compensation to nonresident workers at rate paid in Alaska, to Alaskans

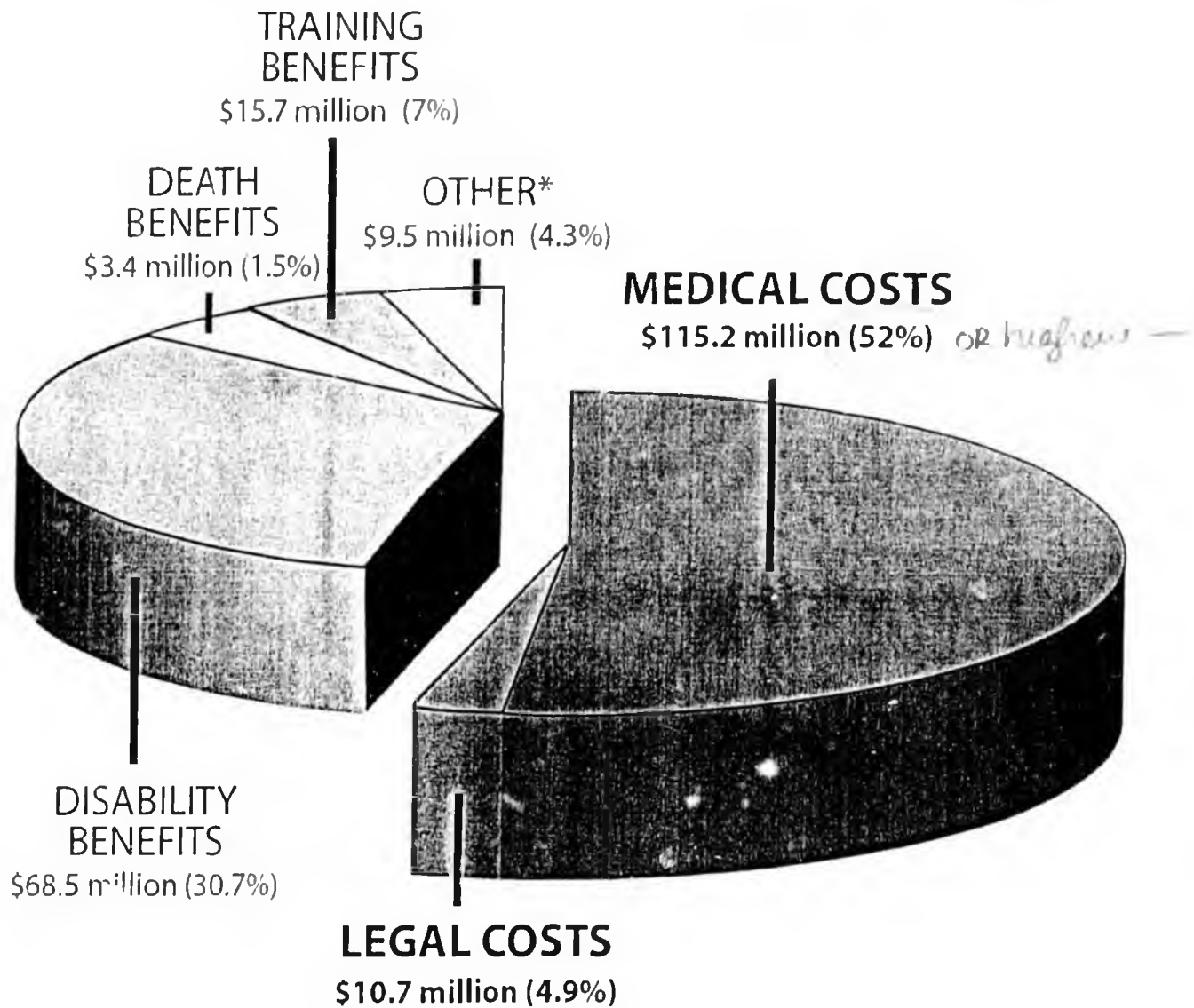
Insurance System

- Improves robustness of state workers' compensation insurance system by requiring insurers to create bonding pool to protect against individual firms' insolvency
- Clarifies that employees of limited liability corporations may opt into state workers' compensation system

Where Your Workers' Compensation Benefit Dollars Go

2003 Paid Costs/Benefits = \$223 million

Source: Workers' Compensation 2003 Annual Report



**ALASKA DEPARTMENT OF LABOR
& WORKFORCE DEVELOPMENT**

* Interest, Second Injury Fund, etc.

Suzanne Mullen

From: Daniel R Saddler [dan_saddler@gov.state.ak.us]
Sent: Wednesday, February 23, 2005 2:56 PM
Cc: Rep. Tom Anderson; Rep. Ethan Berkowitz; Sen. Con Bunde; Rep. Mike Chenault; Rep. Sharon Cissna; Rep. John Coghill; Sen. John Cowdery; Rep. Harry Crawford; Rep. Eric Croft; Rep. Nancy Dahlstrom; Sen. Bettye Davis; Sen. Fred Dyson; Sen. Johnny Ellis; Sen. Kim Elton; Rep. Richard Foster; Sen. Hollis French; Rep. Les Gara; Rep. Carl Gatto; Sen. Lyda Green; Rep. Max Gruenberg; Sen. Gretchen Guess; Representative_Jeanette_James@legis.state.ak.us; Rep. John Harris; Rep. Mike Hawker; Representative_Cheryll_Heinze@legis.state.ak.us; Sen. Lyman Hoffman; Rep. Jim Holm; Senator_Charles_Huggins@legis.state.ak.us; Rep. Reggie Joule; Rep. Mary Kapsner; Rep. Beth Kertula; Rep. Vic Kohring; Representative_Albert_Kookesh@legis.state.ak.us; Rep. Fete Kott; Senator_Georgianna_Lincoln@legis.state.ak.us; Rep. Bob Lynn; Rep. Lesil McGuire; Rep. Kevin Meyer; Representative_Carl_Morgan@legis.state.ak.us; Rep. Carl Moses; Lisa_Murkowski@murkowski.senate.gov; Sen. Donny Olson; Rep. Norman Rokeberg; Rep. Ralph Samuels; Sen. Ralph Seekins; Sen. Gary Stevens; Sen. Ben Stevens; Rep. Bill Stoltze; Sen. Gene Therriault; Sen. Tom Wagoner; Rep. Bruce Weyhrauch; Rep. Jay Ramras; Sen. Gary Wilken; Representative_Bill_Williams@legis.state.ak.us; Rep. Peggy Wilson; Rep. Gabrielle LeDoux; Rep. Kurt Olson; Rep. Mark Neuman

Subject: Dept. of Labor press release on Workers' Compensation Reform Wednesday

Alaska Department of Labor and Workforce Development

FOR IMMEDIATE RELEASE

Date: February 23, 2005

No: 05-49

Media Contact: Dan Saddler, 632-1776

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O'Claray presented details of the legislation at Copy Express, a small duplication and office supply business in Juneau, which he called one of the many Alaska enterprises being squeezed by steep rate increases. The company's workers' compensation costs have risen from \$5,900 in 2002, to \$10,232 in 2005.

Labor Department records show similar rates of increase for other industries. Costs for McGraw's Custom Construction, a Sitka construction company, have risen from \$146,950 in 2002 to \$315,110 in 2004. Costs for the Kodiak Island Borough have more than doubled from \$43,275 in 2001 to \$95,234 in 2005. At Central Peninsula General Hospital in Kenai, costs have more than doubled, from \$390,566 in 2001 to \$984,833.

"By dealing with these increases, and making other needed improvements to the system, the governor's bill will keep Alaska's workers' compensation insurance system affordable for employers, effective for employees and efficient for the entire state," O'Claray said.

The bill's key elements include:

- Capping medical fees paid for injured worker services at the December 1999 level, and calling for a medical review committee to study the medical delivery system for workers' compensation and report to the labor commissioner by March 1, 2007
- Helping employers reduce medical costs by authorizing them to use a list of preferred providers and allowing employers to negotiate fee rate, while still letting employees choose providers outside the preferred list
- Adopting national peer-reviewed medical treatment guidelines
- Requiring physicians to use generic drugs - but allowing exemptions for medical reasons - and authorizing use of a preferred drug list
- Establishing an Appeals Commission to provide quicker, more consistent decisions of appeals than the Superior Court offers under current law
- Preventing workers from receiving more in combined disability benefits than they would earn if still on the job
- Streamlining the claim settling process by allowing parties to settle claims without requiring Workers' Compensation board approval, letting claimants opt for cash benefits instead of retaining benefits, and reducing delays in determining eligibility for retraining benefits
- Protecting workers against unscrupulous employers who fail to carry insurance coverage, by using fines collected from such violators to fund a pool to pay benefits to workers left uncovered
- Helping injured workers return to productive work more quickly

"The best workers' compensation is a good paying job on an accident-free workplace,"


Murkowski said. "But if someone is injured, these reforms provide needed help quickly and effectively. I encourage everyone interested in a healthy Alaska economy to work together with Commissioner O'Claray to craft a timely solution to a problem that has gone unresolved for far too long."

###

ATTACHMENTS: Press release; Synopsis of bill; Five charts; DOLWD Division of Worker's Compensation's 2003 annual report excerpt; Anchorage Daily News clip 2/9/05, "Labor costs kill downtown La Mex"

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Anchorage Daily News

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Murkowski angers workers' comp group**BILL: Committee said it was assured governor would wait for its plan.**By LARRY PERSILY
Anchorage Daily News*(Published: March 1, 2005)*

JUNEAU -- A longtime committee of labor and industry representatives is upset at the governor for not waiting on them to finish their work and deciding instead to introduce his own legislation to attack the problem of rising workers' compensation insurance rates.

"We've been basically fired," said Richard Cattnach, executive director of the Associated General Contractors of Alaska and a member of the 12-member nonpartisan committee selected by industry and unions.

Committee members charged in a Feb. 22 letter to Gov. Frank Murkowski that his Labor Department commissioner had told the committee several times that the governor would not introduce his own workers' compensation bill this year and would wait for the committee to draft a legislative proposal.

The committee had been working since September -- at the governor's request -- to draft comprehensive workers' compensation legislation covering medical costs, vocational rehabilitation, return to work and other provisions.

The AFL-CIO selects the six union members on the committee, and an industry group called the Workers' Compensation Committee of Alaska selects six members too, Cattnach said. The joint committee has been around almost 25 years, restoring itself to active duty whenever needed to work on legislation.

"All workers' compensation legislation since the early 1980s has been agreed to by labor and management through the ad hoc (committee) process," the committee said in its letter to Murkowski. "It has proven to be the best way to build consensus."

The governor lost patience with the committee, Cattnach said. Murkowski introduced his own bill Friday.

That's basically the same story being told by Labor Commissioner Greg O'Claray.

"The governor was fully aware of the commitments I gave on his behalf," O'Claray said. "We felt we could not wait another year," especially since postponing action until next year would have meant fighting the battle during an election year, he said.

"The goal is to arrest the galloping (insurance) rates by February 2007," O'Claray said.

After deciding two weeks ago to submit his own bill, the governor wanted it done quickly, O'Claray said, commenting on a short meeting he had with Murkowski on the issue. "What he told me was, 'Why are you standing here? Why aren't you drafting a bill?'" O'Claray said.

But bailing out on the committee process will cost the governor support for his legislation. "(We) regret that we cannot support it," the members said in their letter to Murkowski.

Committee members are not the only ones holding back their support.

Murkowski's proposal to roll back the reimbursement rate for medical services to December 1999 levels is not going over well with doctors. "It is troubling to be required to provide care with 2005 and later technology at 1999 prices," the Alaska State Medical Association said in a prepared statement within minutes of O'Claray's press conference announcing the governor's bill.

"I think it is a very aggressive bill," especially the provision to pay for medical care at 1999 rates, House Majority Leader John Coghill said Monday. "As it goes through the process, it probably will be pared back some," the North Pole Republican said.

The tension between the governor and the labor and industry committee will not help the bill, he said.

"It sure doesn't make it any easier," said Anchorage Republican Sen. Con Bunde, chairman of the Senate Labor and Commerce Committee. Without organized labor pushing for passage of the bill, Bunde said, "I don't think this happens."

Regardless of who supports or opposes the 37-page bill, the 10 weeks left in the session will make it hard to move through such a complex and contentious issue as workers' compensation reform, Bunde said.

Lawmakers last year considered a workers' compensation bill sponsored by the governor, with senators approving it 11-9 before the measure died in the House in the final two weeks of the session. Another attempt died in last year's special session.

"I don't see any change in the House organization to predict a different outcome," Bunde said.

O'Claray said the governor cited a couple of reasons for submitting his own bill, rather than waiting for the committee to finish its work. He was getting pressure from the Legislature, the commissioner said.

Bunde confirmed he had told the administration he would start work on his own bill if the governor didn't submit a proposal by the end of February.

And the early February announcement that Anchorage's downtown La Mex restaurant was closing because, in part, of rising workers' compensation insurance costs "piqued the governor's interest" in the problem, O'Claray said.

Murkowski believed the committee's draft bill fell short by not addressing rising medical costs, an essential piece of any fix to workers' compensation rates, the commissioner said.

The average rate increase for employers was 21 percent last year and an additional 12 percent this year, said Linda Hall, director of the state Division of Insurance, which must approve all rates charged to employers. The insurance covers medical costs, lost wages and, if needed, retraining.

Rates depend on employees' job classifications -- the cost is higher for more dangerous professions. And companies charge more to employers with higher on-the-job accident rates.

One problem is that so few companies write policies in Alaska, with just three companies handling

most of the business, Hall said.

Cattanach acknowledges the committee's draft bill did not have answers for rising medical or vocational rehabilitation costs. Nor did it offer solutions for return-to-work problems, but neither does the governor's bill, he said.

Maybe the question should be to get a good bill, not a perfect bill, Bunde said. "Would you rather have 50 percent of something or 100 percent of nothing?"

Daily News reporter Larry Persily can be reached at lpersily@adn.com, or in Juneau at 523-9306.

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^{130 obligations}
Phase out of Second Injury Fund

no new claims
will gradually go away

AWDA - conceived of as an alternate way
- high recidivism - have to ask them about injuries

percentage of time loss
benefits

HB 180

UNITED -

News

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can end up w/ benefits
greater than the time
paid

Commercial use -

not to be

ambulance chasers calling people
up & asking them and giving lawsuit

litigation -

- insurance looking for loopholes

Jane Alberts

From: Lynne Smith
Sent: Friday, February 25, 2005 10:22 AM
To: Jane Alberts
Subject: Workers comp bill

Jane, Thought you might be interested in some questions that Anna has asked of Guy Bell regarding the new WC bill.

Guy,

I have some questions about the draft WC bill:

1. Will employers be required to use a list of preferred providers? I assume it works like the PDL and that with an additional note from the doctor to use another drug not on the list. And isn't it a conflict for using the PP and letting employers negotiate their own fee rates? Or can you explain how this works?
2. Can you give examples and let me know how often this happens: workers receiving more in combined disability benefit than wages?
3. How much savings do you estimate on the claimant opting out for cash benefits versus retraining (or is it retaining) benefits. And what percentage of claimants do you think would opt for the cash?
4. Allowing parties with attorneys to settle cases without requiring review by the WC board is a concern.
5. Can you provide a chart comparison betw WC Board and WC Commission?

also concerned about eliminating the Second Injury Fund--

Anna

The committee will review the medical benefit delivery system including current charges, as well as the causes for the sharp rise in charges and possible solutions, and make recommendations for appropriate improvements. The committee is charged with reporting its findings and recommendations by March 1, 2007; sufficient time for a thorough study of the costs and appropriateness of the delivery system.

To address the immediate impacts of the recent premium increases and rising direct costs to self-insured businesses, the bill "rolls back" maximum payments to those under the medical fee schedule in effect on December 15, 1999. The bill also authorizes the division to develop a preferred drug list and establishes a statutory preference for generic drugs unless a worker's physician specifies a name brand drug for medical reasons.

The division is assisted in this endeavor by input from employers, insurers, providers, and the use of national, peer-reviewed medical treatment guidelines. Under the current bill, employers, insurers, and providers may agree to charges for services in advance. Workers would be under no obligation to select a physician from this preferred provider list but the rates for these providers' services would be established by contract with the insurer or employer.

The bill also provides the division with guidance in overseeing the efficacy of the medical benefits system. The bill would adopt the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines as a benchmark for medical treatment. The Guidelines provide for quality care while promoting some standardization of medical services. However, if a condition is not addressed by the Guidelines or the worker's physician recommends alternative treatment, the physician has the opportunity to provide medical justification for treatment outside the Guidelines.

02-25-2005

House Journal

0433

In addition, the bill provides workers and employers greater flexibility over certain portions of the worker's claim. Currently, parties may not settle any portion of a worker's claim without board approval. The bill would allow parties represented by legal counsel to more quickly resolve a worker's claim by agreement without board approval, thereby freeing the board to focus on settlements needing more scrutiny such as those involving minors or workers unrepresented by counsel. It would also allow the parties to stipulate to a worker's eligibility for reemployment benefits without the expense and delay of a reemployment eligibility evaluation while also making it easier to exchange unwanted reemployment benefits for a limited cash benefit. This greater flexibility will make the reemployment process more efficient and satisfactory to both parties.

The bill further enhances the efficiency of the current system by expanding workers' access to legal counsel and including a limited release of medical information on the report of injury form. The bill allows the division to contract with non-profit organizations to provide legal services to injured workers unable to obtain private legal counsel. It also provides a limited medical release for medical records of treatment for the reported injury on the initial report of injury form. This second change is aimed at reducing unnecessary delays in payment resulting from a lack of supporting medical documentation for an injured worker's claim.

The bill also reduces insurers' costs by phasing out contributions to the Second Injury Fund. That Fund represents a limited mechanism for reducing impediments to the hire of workers with certain listed physical limitations. That mechanism has become outmoded due to developments in contemporary employment standards including the Americans with Disabilities Act. The Second Injury Fund will not accept new claims and will be phased out as currently accepted claims are paid.

The bill would increase the coordination of benefits between the workers' compensation system and other disability systems. This would minimize the instances where double compensation results in a

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 worker receiving combined disability benefits that exceed their take home pay. Finally, the bill would also cap the compensation rates of workers residing outside the State of Alaska to bring them in line with that paid to Alaska resident workers.

This bill represents a major step in bringing the existing system up to date with the current State of Alaska's work force. These changes to specific parts of the existing law are vital to the continuing survival of the workers' compensation system and the availability of a full range of benefits for injured workers in the future.

I urge your prompt and favorable action on this matter.

Sincerely yours,
 /s/
 Frank H. Murkowski
 Governor"

Bill Root:

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Journal Text for HB180 in the 24th Legislature



Full Journal

02-25-2005

House Journal

0429

HB 180

HOUSE BILL NO. 180 by the House Rules Committee by request of the Governor, entitled:

"An Act relating to a special deposit for workers' compensation and employers' liability insurers; relating to assigned risk pools; relating to workers' compensation insurers; stating the intent of the legislature, and setting out limitations, concerning the interpretation, construction, and implementation of workers' compensation laws; relating to the Alaska Workers' Compensation Board; establishing a division of workers' compensation within the Department of Labor and Workforce Development, assigning certain Alaska Workers' Compensation Board functions to the division and the department, and authorizing the board to delegate administrative and enforcement duties to the division; establishing a Workers' Compensation Appeals Commission; providing for workers' compensation hearing officers in workers' compensation proceedings; relating to workers' compensation medical benefits and to charges for and payment of fees for the medical benefits; relating to agreements that discharge workers' compensation liability; relating to workers' compensation awards; relating to

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reemployment benefits and job dislocation benefits; relating to coordination of workers' compensation and certain disability benefits; relating to division of workers' compensation records; relating to release of treatment records; relating to an employer's failure to insure and keep insured or provide security; providing for appeals from compensation orders; relating to workers' compensation proceedings; providing for supreme court jurisdiction of appeals from the Workers' Compensation Appeals Commission; providing for a maximum amount for the cost-of-living adjustment for workers' compensation benefits; relating to attorney fees; providing for the department to enter into contracts with nonprofit organizations to provide information services and legal representation to injured employees; providing for administrative penalties for employers uninsured or without adequate security for workers' compensation; relating to fraudulent acts or false or misleading statements in workers' compensation and penalties for the acts or statements; providing for members of a limited liability company to be included as an employee for purposes of workers' compensation; establishing a workers' compensation benefits guaranty fund; relating to the second injury fund; making conforming amendments; providing for a study and report by the medical services review committee; and providing for an effective date."

was read the first time and referred to the Labor & Commerce, Judiciary, and Finance Committees.

The following fiscal note(s) apply:

1. Zero, Dept. of Commerce, Community, & Economic Development

HOUSE BILL NO. 180

**IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-FOURTH LEGISLATURE - FIRST SESSION**

BY THE HOUSE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

Introduced: 2/25/05

Referred: Labor and Commerce, Judiciary, Finance

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to a special deposit for workers' compensation and employers' liability
2 insurers; relating to assigned risk pools; relating to workers' compensation insurers;
3 stating the intent of the legislature, and setting out limitations, concerning the
4 interpretation, construction, and implementation of workers' compensation laws;
5 relating to the Alaska Workers' Compensation Board; establishing a division of
6 workers' compensation within the Department of Labor and Workforce Development,
7 assigning certain Alaska Workers' Compensation Board functions to the division and
8 the department, and authorizing the board to delegate administrative and enforcement
9 duties to the division; establishing a Workers' Compensation Appeals Commission;
10 providing for workers' compensation hearing officers in workers' compensation
11 proceedings; relating to workers' compensation medical benefits and to charges for and
12 payment of fees for the medical benefits; relating to agreements that discharge workers'

1 compensation liability; relating to workers' compensation awards; relating to
2 reemployment benefits and job dislocation benefits; relating to coordination of workers'
3 compensation and certain disability benefits; relating to division of workers'
4 compensation records; relating to release of treatment records; relating to an employer's
5 failure to insure and keep insured or provide security; providing for appeals from
6 compensation orders; relating to workers' compensation proceedings; providing for
7 supreme court jurisdiction of appeals from the Workers' Compensation Appeals
8 Commission; providing for a maximum amount for the cost-of-living adjustment for
9 workers' compensation benefits; relating to attorney fees; providing for the department
10 to enter into contracts with nonprofit organizations to provide information services and
11 legal representation to injured employees; providing for administrative penalties for
12 employers uninsured or without adequate security for workers' compensation; relating
13 to fraudulent acts or false or misleading statements in workers' compensation and
14 penalties for the acts or statements; providing for members of a limited liability
15 company to be included as an employee for purposes of workers' compensation;
16 establishing a workers' compensation benefits guaranty fund; relating to the second
17 injury fund; making conforming amendments; providing for a study and report by the
18 medical services review committee; and providing for an effective date."

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

20 * **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section
21 to read:

22 **LEGISLATIVE INTENT.** It is the intent of the legislature by secs. 2 - 4 of this Act

23 (1) to reform the workers' compensation system in Alaska to ensure the
24 continued payment of benefits in the event of an insurer insolvency; and

25 (2) to reduce the overall costs of workers' compensation premiums to

1 employers.

2 * **Sec. 2.** AS 21.09.090 is amended by adding new subsections to read:

3 (e) In addition to and separate from the deposit required under (b) of this
4 section, an insurer that is authorized to transact workers' compensation and employer's
5 liability insurance as defined in AS 21.12.070(a)(3) shall deposit in this state, through
6 the director, for the protection of persons in this state covered by workers'
7 compensation insurance issued by the insurer, an amount no less than the greater of

8 (1) \$100,000; or

9 (2) an amount equal to the sum of the following less any credit for
10 reinsurance that the insurer may take under (f) of this section:

11 (A) the aggregate of the present value at four percent interest of
12 the total determined and estimated future loss and loss expense payment upon
13 each claim incurred under a policy written in this state more than three years
14 before the date of computation; and

15 (B) for each of the three years before the date of computation,
16 6% percent of the earned premium for the year less each loss and loss expense
17 payment made upon a claim incurred in the corresponding year, except that the
18 amount for any year may not be less than the present value at four percent
19 interest of the total determined and estimated future loss and loss expense
20 payment upon each claim incurred under a policy written in this state that year.

21 (f) In calculating the deposit amount required under (e)(2) of this section, an
22 insurer may take a credit for reinsurance if the reinsurer has deposited in trust in this
23 state, through the director, an amount at least equal to the credit to be taken, and no
24 less than the aggregate of all credits taken by each insurer under this subsection.

25 * **Sec. 3.** AS 21.24.130 is amended by adding a new subsection to read:

26 (f) If an insurer is found to be insolvent by a proceeding under AS 21.78 or by
27 a court of competent jurisdiction in any other state, the director shall take control of
28 the insurer's deposit made under AS 21.09.090(e). The deposit assets shall be
29 released, at the discretion of the director, to the Alaska Insurance Guaranty
30 Association (AS 21.80) to reimburse for a valid loss and loss expense claim payment
31 made by the association that is within the purpose of the deposit. The director shall

1 pay the remaining deposit assets to the receiver, conservator, rehabilitator, or
 2 liquidator of the insurer, or to any other properly designated official who succeeds to
 3 the management and control of the insurer's assets, after the director determines that
 4 all loss and loss expense liabilities have been paid that were incurred on the insurer's
 5 policies written in this state for which the deposit was required.

6 * Sec. 4. AS 21.39.155(a) is amended to read:

7 (a) The director may require insurers, except a reciprocal insurer formed [BY
 8 AND INSURING ONLY A GROUP OF MUNICIPALITIES OR NONPROFIT
 9 PUBLIC UTILITIES] under AS 21.75 [OR A RECIPROCAL INSURER FORMED
 10 UNDER AS 21.75 TO PROVIDE MARINE INSURANCE], as a condition of writing
 11 a line of insurance dealing with medical malpractice or workers' compensation, to
 12 participate in an assigned risk pool if the director finds that mandatory carrier
 13 participation is in the public interest.

14 * Sec. 5. AS 23.05.067(a) is amended to read:

15 (a) Each insurer providing workers' compensation insurance and each
 16 employer who is self-insured or uninsured for purposes of AS 23.30 in this state shall
 17 pay an annual service fee to the department for the administrative expenses of the state
 18 for workers' safety programs under AS 18.60 and the workers' compensation program
 19 under AS 23.30 as follows:

20 (1) for each employer,

21 (A) except as provided in (b) of this section, the service fee
 22 shall be paid each year to the department at the time that the annual report is
 23 required to be filed under AS 23.30.155(m) or (n); and

24 (B) the service fee is 2.9 percent of all payments reported to the
 25 Alaska Workers' Compensation Board under AS 23.30.155(m) or (n) [
 26 EXCEPT SECOND INJURY FUND PAYMENTS]; and

27 (2) for each insurer, the director of the division of insurance shall,
 28 under (e) of this section, deposit from funds received from the insurer under
 29 AS 21.09.210 a service fee of 1.82 percent of the direct premium income for workers'
 30 compensation insurance received by the insurer during the year ending on the
 31 preceding December 31, subject to all the deductions specified in AS 21.09.210(b).

1 * Sec. 6. AS 23.30 is amended by adding a new section to read:

2 **Sec. 23.30.001. Intent of the legislature and construction of chapter.** It is
3 the intent of the legislature that

4 (1) this chapter be interpreted so as to ensure the quick, efficient, fair,
5 and predictable delivery of indemnity and medical benefits to injured workers at a
6 reasonable cost to the employers who are subject to the provisions of this chapter;

7 (2) workers' compensation cases shall be decided on their merits
8 except where otherwise provided by statute;

9 (3) this chapter may not be construed by the courts in favor of a party;

10 (4) hearings in workers' compensation cases shall be impartial and fair
11 to all parties and that all parties shall be afforded due process and an opportunity to be
12 heard and for their arguments and evidence to be fairly considered.

13 * Sec. 7. AS 23.30.005(a) is amended to read:

14 (a) The Alaska Workers' Compensation Board consists of a southern panel of
15 three members sitting for the first judicial district, a northern panel of three members
16 sitting for the second and fourth judicial districts, four southcentral panels of three
17 members each sitting for the third judicial district, and one panel of three members
18 that may sit in any judicial district. Each panel must include the commissioner of
19 labor and workforce development or **a hearing officer designated to represent** [THE
20 DESIGNATED REPRESENTATIVE OF] the commissioner, a representative of
21 industry, and a representative of labor. The latter two members of each panel shall be
22 appointed by the governor and are subject to confirmation by a majority of the
23 members of the legislature in joint session. **The board shall by regulation provide**
24 **procedures to avoid conflicts and the appearance of impropriety in hearings.**

25 * Sec. 8. AS 23.30.005(b) is amended to read:

26 (b) The commissioner shall act as chairman and executive officer of the board
27 and chairman of each panel. **The commissioner may designate a representative to**
28 **act for the commissioner as chair and executive officer of the board. The**
29 **commissioner may designate hearing officers to serve as chairs of panels for**
30 **hearing claims. [IF THE COMMISSIONER DESIGNATES A REPRESENTATIVE**
31 **TO ACT FOR THE COMMISSIONER, THE REPRESENTATIVE SHALL SERVE**

1 IN THAT CAPACITY ON THE BOARD AND ON EACH PANEL.]

2 * **Sec. 9.** AS 23.30.005 is amended by adding new subsections to read:

3 (m) The department may in its discretion contract with a non-profit
4 organization to provide to employees information services and legal representation in
5 proceedings under this chapter.

6 (n) The board may by regulation delegate authority to the director to assist the
7 board in administering and enforcing this chapter.

8 * **Sec. 10.** AS 23.30 is amended by adding new sections to read:

9 **Sec. 23.30.007. Workers' Compensation Appeals Commission.** (a) There
10 is established in the Department of Labor and Workforce Development the Workers'
11 Compensation Appeals Commission. The commission has jurisdiction to hear appeals
12 from final decisions and orders of the board under this chapter. Jurisdiction of the
13 commission is limited to administrative appeals arising under this chapter.

14 (b) The commission consists of five members appointed by the governor and
15 confirmed by a majority of the members of the legislature in joint session. The
16 members shall be appointed as follows:

17 (1) a member appointed as chair who meets the requirements of (c)(2)
18 of this section;

19 (2) two members who, because of their employment or affiliations,
20 may be classified as a representative of employees covered by this chapter;

21 (3) two members who, because of their employment or affiliations,
22 may be classified as a representative of employers covered by this chapter.

23 (c) To be eligible for appointment under this section

24 (1) the member must

25 (A) be a citizen of the United States;

26 (B) be a resident of the state for the five years preceding the
27 appointment; and

28 (C) have not been convicted of either a

29 (i) felony; or

30 (ii) misdemeanor related to workers' compensation;

31 (2) the chair must

1 (A) meet the criteria specified in (1) of this subsection;

2 (B) be licensed to practice law in this state and be a member in
3 good standing with the Alaska Bar Association; and

4 (C) have engaged in the active practice of law for at least five
5 years with experience in work compensation in this state.

6 (d) A member may act and receive compensation under this section from the
7 date of appointment until confirmation or rejection by the legislature.

8 (e) The term of service on the commission is five years. A member may be
9 reappointed so long as the reappointment complies with the provisions of this section.

10 (f) The chair of the commission is in the exempt service under AS 39.25.110
11 and shall receive a monthly salary that is not less than Step A nor more than Step F of
12 Range 27 of the salary schedule in AS 39.27.011(a) for Anchorage, Alaska.

13 (g) A vacancy arising in the commission shall be filled by appointment by the
14 governor and confirmed by a majority of the members of the legislature in joint
15 session. Except as provided in AS 39.05.080(4), an appointee selected to fill a
16 vacancy shall hold office for the unexpired term of the member whose vacancy is
17 filled. A vacancy in the commission does not impair the authority of a quorum of
18 members to exercise all the powers and perform all the duties of the commission.

19 (h) An appeal to the commission shall be heard and decided by a three-
20 member panel of the commission. An appeal panel shall consist of the chair of the
21 commission and two members of the commission assigned by the chair, one member
22 classified as representing employees, and one member classified as representing
23 employers. At other meetings to conduct commission business, the number of
24 commission members classified as representing employees must equal the number of
25 commission members classified as representing employers. The chair of the
26 commission and two representative members of the commission, one classified as
27 representing employees and one classified as representing employers, constitutes a
28 quorum.

29 (i) A member of the commission may be removed from office by the governor
30 for good cause. To be removed for cause, a member of the commission shall be given
31 a copy of the charges and afforded an opportunity to be heard in person or by counsel

1 in the member's own defense upon not less than 10 days' notice. If the member is
 2 removed for cause, the governor shall file with the lieutenant governor a complete
 3 statement of all charges made against the member, the governor's findings on the
 4 charges, and the record of any proceedings. In this subsection, "good cause" includes

- 5 (1) misconduct in office or violation of AS 39.52;
- 6 (2) conviction of a felony;
- 7 (3) conviction of a misdemeanor related to workers' compensation;
- 8 (4) inability to serve, neglect of duty, incompetence, unjustified failure
 9 to handle the caseload assigned, or similar nonfeasance of office; and
- 10 (5) failure to continue to meet the requirements of this section relating
 11 to qualification for office.

12 (j) Representative members are entitled to compensation in the amount of
 13 \$200 a day for each day spent in actual hearing of appeals or on authorized official
 14 business incidental to their duties, and to transportation and per diem as provided by
 15 law. Compensation shall be paid pro rata for each portion of a day spent in actual
 16 hearing of appeals or on authorized official business.

17 (k) A member of the commission may not hear an appeal under this chapter if

- 18 (1) a party is an employee or was, in the past seven years, an employee
 19 of the commission member or of a business that employs the commission member;
 20 this paragraph does not apply to the chair of the commission when the State of Alaska
 21 is or was the employer of a party;
- 22 (2) a party is a member or was, in the past seven years, a member of
 23 the same union or employee association as the commission member;
- 24 (3) a party has a contractual relationship with the commission member,
 25 a business that employs the commission member, or a union or employee association
 26 of which the commission member is a member;
- 27 (4) the commission member is unable to be fair, impartial, and
 28 unbiased toward the appeal participants; or
- 29 (5) participation in the appeal is a violation of AS 39.52.

30 (l) If the chair of the commission is unable to hear an appeal for reasons of
 31 absence or illness in excess of 10 days, or for reasons set out in (k) of this section, the

1 commissioner of the department shall appoint a person who meets the qualifications of
2 this section to serve as chair to hear the appeal as chair pro tem. The person shall
3 receive the compensation provided in (j) of this section. Appointment of a chair pro
4 tem does not require legislative confirmation.

5 (m) Each member of the commission, before entering upon the duties of
6 office, shall take and subscribe to the oath prescribed for principal officers of the state.

7 (n) The offices of the commission shall be physically separate from the offices
8 of the division.

9 **Sec. 23.30.008. Powers and duties of the commission.** (a) The commission
10 shall be the exclusive and final authority for the hearing and determination of all
11 questions of law and fact arising under this chapter in those matters that have been
12 appealed to the commission, except for an appeal to the Alaska Supreme Court. The
13 commission does not have jurisdiction in any case that does not arise under this
14 chapter or in any criminal case. On any matter taken to the commission, the decision
15 of the commission is final and conclusive, unless appealed to the Alaska Supreme
16 Court, and shall stand in lieu of the order of the board from which the appeal was
17 taken. Unless reversed by the Alaska Supreme Court, decisions of the commission
18 have the force of legal precedent.

19 (b) The commission, in its administrative capacity, shall maintain, index, and
20 make available for public inspection the final administrative decisions and orders of
21 the commission and of the board. The chair of the commission may review and
22 circulate among the other members of the relevant commission appeal panel the drafts
23 of the panel's formal decisions and decisions upon reconsideration. The drafts are
24 confidential documents and are not subject to disclosure.

25 (c) The chair of the commission shall draft and propose, and the commission
26 in its administrative capacity may adopt, regulations implementing the commission's
27 authority and duties under this chapter, including rules of procedure and evidence for
28 proceedings before the commission under this chapter. The provisions of AS 44.62
29 (Administrative Procedure Act) apply to the adoption of regulations by the
30 commission.

31 (d) In an appeal, the commission shall award a successful party reasonable

1 costs and, if the party is represented by an attorney, attorney fees that the commission
2 determines to be fully compensatory and reasonable. However, the commission may
3 not make an award of attorney fees against an injured worker unless the commission
4 finds that the worker's position on appeal was frivolous or unreasonable or the appeal
5 was taken in bad faith.

6 (e) The commission, in its administrative capacity, may adopt and alter an
7 official seal and do all things necessary, convenient, or desirable to carry out the
8 powers expressly granted or necessarily implied in this chapter.

9 **Sec. 23.30.009. Powers and duties of the chair of the commission.** (a) The
10 chair of the commission shall exercise general supervision over the office of the
11 commission and over appeals, and shall direct the administrative functions of the
12 commission. The chair of the commission shall serve as the executive officer of the
13 commission and shall have authority in all administrative matters relating to the
14 members. The chair may

15 (1) employ and supervise commission staff and appoint a commission
16 clerk;

17 (2) establish and implement a time management system for the
18 commission members and staff and manage the calendar of appeals;

19 (3) assign the work of the commission members and staff so that
20 appeals are resolved as expeditiously and competently as possible;

21 (4) advise and cooperate with the board to develop appropriate
22 procedures for maintenance and transfer of hearing files and the preservation and
23 transfer of records on appeal; and

24 (6) prepare an annual budget of the commission.

25 (b) The chair of the commission shall preside over hearings and arguments on
26 appeals. The chair of the commission shall ensure that all functions of the commission
27 are performed with due regard for the rights of all parties and consistent with the
28 orderly and prompt resolution of appeals. The chair of the commission shall rule on
29 questions of procedure and advise the representative members of the commission on
30 matters of law.

31 (c) The chair of the commission shall, not later than March 15 of each year,

1 make available to the public and file with the lieutenant governor, a report regarding
 2 the commission, including data regarding time periods between initial receipt and final
 3 decisions on appeals.

4 (d) The chair of the commission shall devote full time to the duties of the chair
 5 of the commission and may not engage in any other employment or business. The
 6 chair of the commission may not hold any other office or position under the United
 7 States, this state, any municipality or political subdivision of this state, or any tribal
 8 government or corporation. The chair of the commission may not hold office or
 9 position in a partisan political organization or party.

10 * Sec. 11. AS 23.30.012 is amended to read:

11 Sec. 23.30.012. Agreements in regard to claims. (a) At any time after
 12 death, or after 30 days subsequent to the date of the injury, the employer and the
 13 employee or the beneficiary or beneficiaries, as the case may be, have the right to
 14 reach an agreement in regard to a claim for injury or death under this chapter [IN
 15 ACCORDANCE WITH THE APPLICABLE SCHEDULE IN THIS CHAPTER], but
 16 a memorandum of the agreement in a form prescribed by the director [BOARD] shall
 17 be filed with the division [BOARD]. Otherwise, the agreement is void for any
 18 purpose. Except as provided in (b) of this section, an agreement filed with the
 19 division discharges the liability of the employer for the compensation,
 20 notwithstanding the provisions of AS 23.30.130, 23.30.160, and 23.30.245, and is
 21 enforceable as a compensation order.

22 (b) If the claimant or beneficiary is not represented by an attorney
 23 licensed to practice in this state, or the beneficiary is a minor or incompetent, the
 24 agreement shall be reviewed by a panel of the board. If approved by the board, the
 25 agreement is enforceable the same as an order or award of the board and discharges
 26 the liability of the employer for the compensation notwithstanding the provisions of
 27 AS 23.30.130, 23.30.160, and 23.30.245. The agreement shall be approved by the
 28 board only when the terms conform to the provisions of this chapter and, if it involves
 29 or is likely to involve permanent disability, the board may require an impartial medical
 30 examination and a hearing in order to determine whether or not to approve the
 31 agreement. A [THE BOARD MAY APPROVE] lump-sum settlement may be

1 approved [SETTLEMENTS] when it appears to be to the best interest of the
2 employee or beneficiary or beneficiaries.

3 * **Sec. 12.** AS 23.30.015(e) is amended to read:

4 (e) An amount recovered by the employer under an assignment, whether by
5 action or compromise, shall be distributed as follows:

6 (1) the employer shall retain an amount equal to

7 (A) the expenses incurred by the employer with respect to the
8 action or compromise, including a reasonable attorney fee determined by the
9 board;

10 (B) the cost of all benefits actually furnished by the employer
11 under this chapter;

12 (C) all amounts paid as compensation [AND SECOND-
13 INJURY FUND] payments, and, if the employer is self-insured or uninsured,
14 all service fees paid under AS 23.05.067;

15 (D) the present value of all amounts payable later as
16 compensation, computed from a schedule prepared by the board; and the
17 present value of the cost of all benefits to be furnished later under
18 AS 23.30.095 as estimated by the board; the amounts so computed and
19 estimated to be retained by the employer as a trust fund to pay compensation
20 and the cost of benefits as they become due and to pay any finally remaining
21 excess sum to the person entitled to compensation or to the representative; and

22 (2) the employer shall pay any excess to the person entitled to
23 compensation or to the representative of that person.

24 * **Sec. 13.** AS 23.30.041(a) is amended to read:

25 (a) The **director** [BOARD] shall select and employ a reemployment benefits
26 administrator. The **director** [BOARD] may authorize the administrator to select and
27 employ additional staff. The administrator is in the partially exempt service under
28 AS 39.25.120.

29 * **Sec. 14.** AS 23.30.041(c) is repealed and reenacted to read:

30 (c) An employee and an employer may stipulate to the employee's eligibility
31 for reemployment benefits at any time. If an employee suffers a compensable injury

1 and, as a result of the injury, the employee for 45 consecutive days is totally unable to
 2 return to the employee's employment at the time of injury, the administrator shall
 3 notify the employee of the employee's rights under this section within 14 days after the
 4 45th day. If the employee is totally unable to return to the employee's employment for
 5 60 consecutive days as a result of the injury, the employee or employer may request an
 6 eligibility evaluation. The administrator may approve the request if the employee's
 7 injury may permanently preclude the employee's return to the employee's occupation
 8 at the time of the injury. If the employee is totally unable to return to the employee's
 9 employment at the time of the injury for 90 consecutive days as a result of the injury,
 10 the administrator shall order an eligibility evaluation, without a request, unless a
 11 stipulation of eligibility was submitted. If the administrator approves a request or
 12 orders an evaluation, the administrator shall, on a rotating and geographic basis, select
 13 a rehabilitation specialist from the list maintained under (b)(6) of this section to
 14 perform the eligibility evaluation.

15 * Sec. 15. AS 23.30.041(f) is amended to read:

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

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

22 (2) the employee previously declined the development of a
 23 reemployment benefits plan under (g) of this section, received a job dislocation
 24 benefit under (g)(2) of this section, and returned to work in the same or similar
 25 occupation in terms of physical demands required of the employee at the time of
 26 the previous injury;

27 (3) the employee has been previously rehabilitated in a former
 28 worker's compensation claim and returned to work in the same or similar occupation
 29 in terms of physical demands required of the employee at the time of the previous
 30 injury; or

31 (4) [(3)] at the time of medical stability no permanent impairment is

1 identified or expected.

2 * Sec. 16. AS 23.30.041(g) is amended to read:

3 (g) Within 15 days after the employee receives the administrator's notification
4 of eligibility for benefits, an employee [WHO DESIRES TO USE THESE
5 BENEFITS] shall give written notice under oath, on a form provided by the
6 division, to the administrator and the employer of the employee's election to
7 either use the reemployment benefits or to accept a job dislocation benefit under
8 (2) of this subsection. The following apply to an election under this subsection:

9 (1) An employee who elects to use the reemployment benefits also
10 shall notify the employer of the employee's selection of a rehabilitation specialist who
11 shall provide a complete reemployment benefits plan. Failure to give notice of
12 selection of a rehabilitation specialist required by this paragraph [SUBSECTION]
13 constitutes noncooperation under (n) of this section. If the employer disagrees with
14 the employee's choice of rehabilitation specialist to develop the plan and the
15 disagreement cannot be resolved, then the administrator shall assign a rehabilitation
16 specialist. The employer and employee each have one right of refusal of a
17 rehabilitation specialist.

18 (2) An employee who elects to accept a job dislocation benefit in
19 place of reemployment benefits and who has been given a permanent partial
20 impairment rating by a physician shall be paid

21 (A) \$5,000 if the employee's permanent partial impairment
22 rating is greater than 0 and less than 15 percent;

23 (B) \$8,000 if the employee's permanent partial impairment
24 rating is 15 percent or greater but less than 30 percent; or

25 (C) \$13,500 if the employee's permanent partial
26 impairment rating is 30 percent or greater.

27 (3) The form provided by the division for election shall specify
28 that the employee understands the scope of the benefits and rights being waived
29 by the election. The administrator shall serve a copy of the executed election
30 form on the parties within 10 days after receiving the form from the employee.
31 The election and waiver of unchosen benefits is effective upon service to the

1 parties. A waiver and election effective under this subsection discharges the
 2 employer's liability for the benefits or rights under this section that were not
 3 elected. A waiver may not be modified under AS 23.30.130.

4 * Sec. 17. AS 23.30.041(j) is amended to read:

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

14 * Sec. 18. AS 23.30.041(p) is amended to read:

15 (p) When the United States Department of Labor publishes a new edition,
 16 revision, or replacement for the "Selected Characteristics of Occupations Defined in
 17 the Revised Dictionary of Occupational Titles" referred to in (e) of this section, the
 18 director [BOARD] shall, not later than 90 days after the last day of the month in
 19 which the new edition, revision, or replacement standard is published, hold an open
 20 meeting under AS 44.62.310 to select the proposed date on which the new edition,
 21 revision, or replacement standard will be implemented to make all eligibility
 22 determinations required under (e) of this section. The date selected by the
 23 department [BOARD] for implementing the new edition, revision, or replacement
 24 standard may not be later than 90 days after the last day of the month in which the new
 25 edition, revision, or replacement standard is published. After the meeting, the
 26 director [BOARD] shall issue a public notice announcing the date selected by the
 27 department. The requirements of AS 44.62.010 - 44.62.300 do not apply to the
 28 selection or announcement of the date under this subsection.

29 * Sec. 19. AS 23.30.041(q) is amended to read:

30 (q) Notwithstanding AS 23.30.012, after medical stability has been determined
 31 and a physician has predicted that the employee may have a permanent impairment

1 that may cause the employee to have permanent physical capacities that are less than
 2 the physical demands of the employee's job at the time of injury, an employee may
 3 waive any benefits or rights under this section, including an eligibility evaluation and
 4 benefits related to a reemployment plan. To waive any benefits or rights under this
 5 section, an employee must file a statement under oath with the division [BOARD] to
 6 notify the parties of the waiver and to specify the scope of benefits or rights that the
 7 employee seeks to waive. The statement must be on a form prescribed or approved by
 8 the director [BOARD]. The division [BOARD] shall serve the notice of waiver on
 9 all parties to the claim within 10 days after filing. The waiver is effective upon service
 10 to the party. A waiver effective under this subsection discharges the liability of the
 11 employer for the benefits or rights contained in this section. The waiver may not be
 12 modified under AS 23.30.130.

13 * **Sec. 20.** AS 23.30.080(d) is amended to read:

14 (d) If an employer fails to insure or provide security as required by
 15 AS 23.30.075, the division may petition the board to [MAY] issue a stop order
 16 prohibiting the use of employee labor by the employer until the employer insures or
 17 provides security as required by AS 23.30.075. The failure of an employer to file
 18 evidence of compliance as required by AS 23.30.085 creates a rebuttable presumption
 19 that the employer has failed to insure or provide security as required by AS 23.30.075.
 20 If an employer fails to comply with a stop order issued under this section, the board
 21 shall assess a civil penalty of \$1,000 per day. The employer may not obtain a public
 22 contract with the state or a political subdivision of the state for three years following
 23 the violation of the stop order.

24 * **Sec. 21.** AS 23.30.080 is amended by adding new subsections to read:

25 (e) If a representative of the department investigates an employer's failure to
 26 file the evidence of compliance required by AS 23.30.085 and, after investigation,
 27 there is substantial evidence that the employer failed to insure or provide security as
 28 required by AS 23.30.075, the representative shall inform the employer. The
 29 representative may request the director to issue a stop order prohibiting the use of
 30 employee labor by the employer until the employer insures or provides security as
 31 required by AS 23.30.075. The director may issue a stop order, without a hearing,

1 based on the representative's investigation. The director shall dissolve a stop order
 2 issued under this subsection upon receipt of substantial evidence that the employer is
 3 insured or has provided security as required by AS 23.30.075(a). If an employer fails
 4 to comply with a stop order issued under this subsection, the division may petition the
 5 board to assess a civil penalty. The board may assess a civil penalty of \$1,000 per
 6 day. An employer who is assessed a penalty under this subsection may not obtain a
 7 public contract with the state or a political subdivision of the state for the three years
 8 following violation of the stop order.

9 (f) If an employer fails to insure or provide security as required by
 10 AS 23.30.075, the division may petition the board to assess a civil penalty of up to
 11 \$1,000 for each employee for each day an employee is employed while the employer
 12 failed to insure or provide the security required by AS 23.30.075. The failure of an
 13 employer to file evidence of compliance as required by AS 23.30.085 creates a
 14 rebuttable presumption that the employer failed to insure or provide security as
 15 required by AS 23.30.075.

16 (g) If an employer fails to pay a civil penalty order issued under (d), (e), or (f)
 17 of this section within seven days after the date of service of the order upon the
 18 employer, the director may declare the employer in default. The director shall file a
 19 certified copy of the penalty order and declaration of default with the clerk of the
 20 superior court. The court shall, upon the filing of the copy of the order and
 21 declaration, enter judgment for the amount declared in default if it is in accordance
 22 with law. Anytime after a declaration of default, the attorney general, when requested
 23 to do so by the director, shall take appropriate action to assure collection of the
 24 defaulted payment. Review of the judgment may be had as provided under the Alaska
 25 Rules of Civil Procedure. Final proceedings to execute the judgment may be had by
 26 writ of execution.

27 * Sec. 22. AS 23.30 is amended by adding a new section to read:

28 **Sec. 23.30.082. Workers' compensation benefits guaranty fund.** (a) The
 29 workers' compensation benefits guaranty fund is established in the general fund to
 30 carry out the purposes of this section. The fund is composed of civil penalty payments
 31 made by employers under AS 23.30.080, income earned on investment of the money

1 in the fund, money deposited in the fund by the department, and appropriations to the
 2 fund. Money appropriated to the fund does not lapse. Amounts in the fund may be
 3 appropriated for claims against the fund, for expenses directly related to fund
 4 operations and claims, and for legal expenses.

5 (b) The Department of Revenue shall provide the division every three months
 6 with a statement of the activities of, balances in, interest earned on, and interest
 7 returned to the fund.

8 (c) Subject to the provisions of this section, an employee employed by an
 9 employer who fails to meet the requirements of AS 23.30.075 and who fails to pay
 10 compensation and benefits due to the employee under this chapter, may file a claim for
 11 payment by the fund. In order to be eligible for payment, the claim form must be filed
 12 within the same time, and in the same manner, as a workers' compensation claim. The
 13 fund may assert the same defenses as an insured employer under this chapter.

14 (d) If the fund pays benefits to an employee under this section, the fund shall
 15 be subrogated to all of the rights of the employee to the amount paid, and the
 16 employee shall assign all right, title, and interest in that portion of the employee's
 17 workers' compensation claim and any recovery under AS 23.30.015 to the fund.
 18 Money collected by the division on the claim or recovery shall be deposited in the
 19 fund.

20 (e) If the money deposited in the fund is insufficient at a given time to satisfy
 21 a duly authorized claim against the fund, the fund shall, when sufficient money has
 22 been deposited in the fund and appropriated, satisfy unpaid claims in the order in
 23 which the claims were originally filed, without interest.

24 (f) The division may contract under AS 36.30 (State Procurement Code) with
 25 a person for the person to adjust claims against the fund. The contract may cover one
 26 or more claims.

27 (g) In this section, "fund" means the workers' compensation benefits guaranty
 28 fund.

29 * **Sec. 23.** AS 23.30.095(j) is amended to read:

30 (j) The commissioner shall [BOARD MAY] appoint a medical services
 31 review committee, or contract with an existing organization in the state or another

1 state, to assist and advise the department and the board in matters involving the
 2 appropriateness, necessity, and cost of medical and related services provided under
 3 this chapter.

4 * **Sec. 24.** AS 23.30.095 is amended by adding new subsections to read:

5 (n) A generic drug product must be used when dispensing a drug product to an
 6 employee under this chapter unless the prescribing physician provides justification in
 7 writing explaining the medical necessity for the name brand drug product. The
 8 department by regulation shall establish a preferred drug list and a procedure for
 9 establishing medical necessity to depart from the list and to use a name brand drug
 10 product. In this subsection, "generic drug product" has the meaning given the term
 11 "equivalent drug product" in AS 08.80.480.

12 (o) For purposes of this chapter, the medical treatment or services which the
 13 nature of the injury or the process of recovery requires, required by (a) of this section,
 14 means treatment or services that are within the recommended guidelines set out in the
 15 American College of Occupational and Environmental Medicine's Occupational
 16 Medicine Practice Guidelines in effect at the time the treatment or service is provided.
 17 The American College of Occupational and Environmental Medicine's Occupational
 18 Medicine Practice Guidelines shall be presumed correct on the issue of the nature,
 19 extent, and scope of medical treatment or services. The presumption may be rebutted
 20 by a preponderance of scientific evidence establishing that a variance from the
 21 guidelines is reasonably required by the nature of the injury or the process of recovery.
 22 For an injury not covered by the American College of Occupational and
 23 Environmental Medicine's Occupational Medicine Practice Guidelines, the treatment
 24 or services shall be in accordance with standards based on other scientific, evidence-
 25 based medical treatment guidelines generally recognized by the national medical
 26 community and adopted by the board by regulation.

27 * **Sec. 25.** AS 23.30 is amended by adding a new section to read:

28 **Sec. 23.30.097. Fees for medical treatment and services; payment of bills.**

29 (a) All fees and other charges for medical treatment or service are subject to regulation
 30 by the board consistent with this section. A fee or other charge for medical treatment
 31 or service may not exceed the lesser of

1 (1) the usual, customary, and reasonable fees for the treatment or
2 service in the community in which it is rendered, not to exceed the fees in the fee
3 schedule specified by the board in its published bulletin dated December 15, 1999; or

4 (2) the payment made by the employer as negotiated by the provider
5 and the employer under (c) of this section.

6 (b) An employer, or group of employers, may establish a list of preferred
7 physicians and treatment service providers to provide medical, surgical, and other
8 attendance or treatment services to the employer's employees under this chapter;
9 however,

10 (1) the employee's right to choose the employee's attending physician
11 under AS 23.30.095(a) is not impaired;

12 (2) when given to the employee, the employer's preferred physician list
13 shall clearly state that the list is voluntary, that the employee's choice is not restricted
14 to the list, that the employee's rights under this chapter are not impaired by choosing
15 an attending physician from the list, and that if the employee chooses an attending
16 physician from the list, the employee may, in the manner provided in AS 23.30.095,
17 make one change of attending physician, from the list or otherwise; and

18 (3) establishment of a list of preferred physicians does not affect the
19 employer's choice of physician for an employer medical examination under
20 AS 23.30.095.

21 (c) An employer, or group of employers, may negotiate with physicians and
22 other treatment service providers under this chapter to obtain reduced fees and service
23 charges, and may take such fees and charges into account when forming a list of
24 preferred physicians and providers. In no event may an employer, or group of
25 employers, attempt to influence the treatment, medical decisions, or permanent
26 impairment ratings by physicians in the course of the negotiations regarding a
27 preferred physician and provider fee list.

28 (d) An employer shall pay an employee's bills for medical treatment under this
29 chapter, excluding prescription charges or transportation for medical treatment, within
30 30 days after the date that the employer receives the provider's bill or a completed
31 report as required by AS 23.30.095(c), whichever is later.

1 (e) Unless the employer controverts a charge, an employer shall reimburse an
 2 employee's prescription charges under this chapter within 30 days after the employer
 3 received the health care provider's completed report and an itemization of the
 4 prescription charges for the employee. Unless the employer controverts a charge, an
 5 employer shall reimburse any transportation expenses for medical treatment under this
 6 chapter within 30 days after the employer received the health care provider's
 7 completed report and an itemization of the dates, destination, and transportation
 8 expenses for each date of travel for medical treatment. If the employer does not plan
 9 to make or does not make payment or reimbursement in full as required by this
 10 subsection, the employer shall notify in writing the employee and the employee's
 11 health care provider that payment will not be timely made and the reasons for the
 12 nonpayment. The notification must be provided on or before the date that payment is
 13 due under this subsection or (d) of this section.

14 (f) An employee may not be required to pay a fee or charge for medical
 15 treatment or service provided under this chapter.

16 * Sec. 26. AS 23.30.100(b) is amended to read:

17 (b) The notice must be in writing **and** [.] contain the name and address of the
 18 employee, [AND] a statement of the time, place, nature, and cause of the injury or
 19 death, **authority to release records of medical treatment for the injury or death,**
 20 and be signed by the employee or by a person on behalf of the employee, or in case of
 21 death, by a person claiming to be entitled to compensation for the death or by a person
 22 on behalf of that person.

23 * Sec. 27. AS 23.30.107(b) is amended to read:

24 (b) Medical or rehabilitation records in an employee's file maintained by the
 25 **division or held by the commission or the** board are not public records subject to
 26 public inspection and copying under AS 40.25. This subsection does not prohibit

27 (1) the reemployment benefits administrator, the **division, the office of**
 28 **the commission,** the board, or the department from releasing medical or rehabilitation
 29 records in an employee's file, without the employee's consent, to a physician providing
 30 medical services under AS 23.30.095(k) or 23.30.110(g), a party to a claim filed by
 31 the employee, or a governmental agency; or

1 (2) the quoting or discussing of medical or rehabilitation records
 2 contained in an employee's file during a hearing on a claim for compensation [,] or in
 3 a decision and order of the board or the commission.

4 * **Sec. 28.** AS 23.30.107 is amended by adding a new subsection to read:

5 (c) The division may not assemble, or provide information respecting,
 6 individual records for commercial purposes that are outside the scope of this chapter.

7 * **Sec. 29.** AS 23.30.122 is repealed and reenacted to read:

8 **Sec. 23.30.122. Credibility of witnesses.** The board has the sole power to
 9 determine the credibility of testimony presented by a witness. When credibility is
 10 disputed in a proceeding before the board, the board's determination of credibility
 11 must be supported by specific findings.

12 * **Sec. 30.** AS 23.30.125 is repealed and reenacted to read:

13 **Sec. 23.30.125. Administrative review of compensation order.** (a) A
 14 compensation order becomes effective when filed with the office of the board as
 15 provided in AS 23.30.110, and, unless proceedings to reconsider, suspend, or set aside
 16 the order are instituted as provided in this chapter, the order becomes final on the 31st
 17 day after it is filed.

18 (b) Notwithstanding other provisions of law, a decision or order of the board is
 19 subject to review by the commission as provided in this chapter.

20 (c) If a compensation order is not in accordance with law or fact, the order
 21 may be suspended or set aside, in whole or in part, through proceedings in the
 22 commission brought by a party in interest against all other parties to the proceedings
 23 before the board. The payment of the amounts required by an award may not be
 24 stayed pending a final decision in the proceeding unless, upon application for a stay,
 25 the commission, on hearing, after not less than three days' notice to the parties in
 26 interest, allows the stay of payment, in whole or in part, where the party filing the
 27 application would otherwise suffer irreparable damage. Continuing future periodic
 28 compensation payments may not be stayed without a showing by the appellant of
 29 irreparable damage and the existence of the probability of the merits of the appeal
 30 being decided adversely to the recipient of compensation. The order of the
 31 commission allowing a stay must contain a specific finding, based upon evidence

1 submitted to the commission and identified by reference to the evidence, that
 2 irreparable damage would result to the party applying for a stay and specifying the
 3 nature of the damage.

4 (d) Proceedings for reconsidering, suspending, setting aside, or enforcing a
 5 compensation order, whether rejecting a claim or making an award, may not be
 6 instituted, except as provided in this chapter.

7 * **Sec. 31.** AS 23.30 is amended by adding new sections to read:

8 **Sec. 23.30.127. Appeals to commission.** (a) A party in interest may appeal a
 9 compensation order issued by the board to the commission within 30 days after the
 10 compensation order is filed with the office of the board under AS 23.30.110. The
 11 director may intervene in an appeal. If a party in interest is not represented by counsel
 12 and the compensation order concerns an unsettled question of law, the director may
 13 file an appeal to obtain a ruling on the question by the commission.

14 (b) An appeal is initiated by filing with the office of the commission

15 (1) a signed notice of appeal specifying the compensation order
 16 appealed from;

17 (2) a statement of the grounds upon which the appeal is taken; and

18 (3) other material the commission may by regulation require.

19 (c) A cross-appeal may be initiated by filing with the office of the commission
 20 a signed notice of cross-appeal within 30 day after the decision is filed or within 15
 21 days after service of notice of an appeal, whichever is later. The notice of cross-
 22 appeal shall specify the compensation order appealed from and the grounds upon
 23 which the cross-appeal is taken.

24 (d) The office of the commission may charge a fee, not to exceed \$100, for
 25 filing appeals and cross-appeals, except that the office of the commission may not
 26 charge a fee if the appellant is the state or a political subdivision of the state. The
 27 commission may require an appellant to pay the costs of the transcript of hearing and
 28 the preparation of the record on appeal. The commission may require cross-appellants
 29 or intervenors to share in the costs.

30 (e) If a request for reconsideration of a board decision was timely filed with
 31 the office of the board, the notice of appeal must be filed within 30 days after the

1 reconsideration decision is mailed to the parties, or the date the request for
2 reconsideration is considered denied in the absence of any action on the request,
3 whichever is earlier.

4 (f) The commission may require written briefs and make other rules and
5 orders to facilitate the business of the commission and advance the prompt, fair, and
6 just disposition of appeals.

7 **Sec. 23.30.128. Commission proceedings.** (a) An appeal from a decision of
8 the board under this chapter, and other proceedings under this section, shall be heard
9 and decided by a three-member panel of the commission. An appeal panel of the
10 commission must include the chair of the commission. The chair of the commission
11 shall assign two members to each appeal, including one commission member
12 classified as representing employees and one commission member classified as
13 representing employers. Acts, decisions, and orders of the commission panel in the
14 appeal or related proceeding shall be considered the acts, decisions, and orders of the
15 full commission. The matter on appeal shall be decided on the record made before the
16 board, a transcript or recording of the proceedings before the board, and oral argument
17 and written briefs allowed by the commission. Except as provided in (c) of this
18 section, new or additional evidence may not be received with respect to the appeal.

19 (b) The commission may review de novo all discretionary actions, findings of
20 fact, and conclusions of law by the board in hearing, determining, or otherwise acting
21 on any compensation claim or petition. The board's findings regarding the credibility
22 of testimony of a witness are binding on the commission. The findings of the board, if
23 not set aside by the commission, are conclusive.

24 (c) The commission may hold hearings and receive evidence on applications
25 for (1) stays under AS 23.30.125; (2) attorney fees and costs of appeal; (3) waiver of
26 fees by indigent appellants; or (4) dismissal of appeals for failure to prosecute or upon
27 settlement. The commission may rely on new or additional evidence presented during
28 the hearing in making its decision on the application.

29 (d) The commission may affirm, reverse, or modify a decision or order upon
30 review and issue other orders as appropriate. The commission may remand matters it
31 determines were improperly, incompletely, or otherwise insufficiently developed. The

1 commission may remand for further proceedings and appropriate action with or
2 without relinquishing the commission's jurisdiction of the appeal. The administrative
3 adjudication procedures of AS 44.62 (Administrative Procedure Act) do not apply to
4 the proceedings of the commission.

5 (e) Within 90 days after written briefing on the appeal is completed or oral
6 argument is held, whichever is later, the commission shall issue a decision in writing.
7 The decision must contain a concise statement of reasons for the decision, including
8 findings of fact, if required, and conclusions of law. The commission shall serve each
9 party and the director with a copy of the decision. Appeals may be expedited for good
10 cause by the commission. Unless reconsideration is ordered under (f) of this section, a
11 decision under this subsection is the final commission decision.

12 (f) A party or the director may request reconsideration of a decision issued
13 under (e) of this section within 30 days after the date of service shown in the
14 certificate of service of the decision. The request must state specific grounds for
15 reconsideration. Reconsideration may be granted if, in reaching the decision, the
16 commission (1) overlooked, misapplied, or failed to consider a statute, regulation,
17 court or administrative decision, or legal principle directly controlling; (2) overlooked
18 or misconceived a material fact; (3) misconceived a material question in the case; or
19 (4) applied law in the ruling that has subsequently changed. The panel of the
20 commission hearing the request for reconsideration shall consist of the same members
21 of the panel that issued the decision. The commission may issue an order for
22 reconsideration of all or part of the decision upon request of a party or the director.
23 Reconsideration is based on the record, unless the commission allows additional
24 argument. The power to order reconsideration expires 60 days after the date of
25 service, as shown on the certificate of service, of a decision issued under (e) of this
26 section. If the commission does not issue an order for reconsideration within the time
27 allowed for ordering reconsideration, a request for reconsideration is considered
28 denied. If reconsideration is ordered, the commission shall issue a decision within 30
29 days after the close of the record on reconsideration. The commission shall serve each
30 party in the case with a copy of the decision upon reconsideration. The decision upon
31 reconsideration is the final commission decision.

1 (g) A decision of the commission becomes final on the

2 (1) 31st day after the date of service of a decision if reconsideration is
3 not requested;

4 (2) 61st day after the date of service of a decision if reconsideration is
5 requested but an order for reconsideration is not issued; or

6 (3) date of service of the commission decision upon reconsideration
7 under (f) of this section if reconsideration is requested and an order for reconsideration
8 is issued.

9 **Sec. 23.30.129. Judicial review of commission orders.** (a) Notwithstanding
10 the provisions of AS 44.62.560, orders of the commission may not be appealed to the
11 superior court. Consistent with AS 22.05.010(b), final decisions of the commission
12 may be appealed to the supreme court, and other orders may be reviewed by the
13 supreme court as provided by the Alaska Rules of Appellate Procedure.

14 (b) A finding by the commission concerning the weight to be accorded a
15 witness's testimony, including medical testimony and reports, is conclusive even if the
16 evidence is conflicting or susceptible to contrary conclusions. The commission's
17 findings of fact may be reversed on appeal if not supported by substantial evidence in
18 light of the whole record.

19 * **Sec. 32.** AS 23.30.175(b) is amended to read:

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

22 (1) the weekly rate of compensation shall be calculated by multiplying
23 the recipient's weekly compensation rate calculated under AS 23.30.180, 23.30.185,
24 23.30.190, 23.30.200, or 23.30.215 [,] by the ratio of the cost of living of the area in
25 which the recipient resides to the cost of living in this state;

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

29 (3) if the gross weekly earnings of the recipient and the resulting
30 compensation rate are determined under AS 23.30.220(a)(6), (7), or (10), the
31 calculation required by this subsection applies only to the portion of the recipient's

1 weekly compensation rate attributable to wages earned in the state;

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

4 (5) application of (1) - (4) of this subsection may not result in
5 raising a recipient's weekly compensation rate to an amount that exceeds the
6 weekly compensation rate that the recipient would have received if the recipient
7 had been residing in the state.

8 * Sec. 33. AS 23.30.175(c) is amended to read:

9 (c) The department [BOARD] shall provide by regulation for the
10 determination and comparison of living costs for this state and the other areas in which
11 recipients reside and for the [ANNUAL.] redetermination and comparison of these
12 costs every three years.

13 * Sec. 34. AS 23.30.205(e) is amended to read:

14 (e) The second injury fund may not be bound as to any question of law or fact
15 by reason of an award or an adjudication to which it was not a party or in relation to
16 which the director [COMMISSIONER] was not notified at least three weeks before
17 the award or adjudication, that the fund might be subject to liability for the injury or
18 death.

19 * Sec. 35. AS 23.30.205 is amended by adding a new subsection to read:

20 (g) Claims for reimbursement may not be submitted to the fund after
21 September 1, 2005. The fund shall continue to make reimbursement payments on
22 claims accepted before July 1, 2006, or ordered by the board, until the fund's liabilities
23 for the claim are extinguished.

24 * Sec. 36. AS 23.30 is amended by adding a new section to read:

25 **Sec. 23.30.224. Coordination of benefits.** (a) Notwithstanding other
26 provisions of this chapter, an employer's liability for payment of weekly compensation
27 under AS 23.30.180 or 23.30.185 to an employee eligible for a disability benefit under
28 AS 14.25.130 or AS 39.35.400 or 39.35.410 may not exceed the lesser of

29 (1) the difference between the disability benefit payable to the
30 employee under AS 14.25.130 or AS 39.35.400 or 39.35.410, converted to a weekly
31 basis, and 100 percent of the employee's spendable weekly wage as calculated under

1 AS 23.30.220; or

2 (2) the maximum compensation rate calculated under AS 23.30.175.

3 (b) An employer's liability for payment of compensation under
4 AS 23.30.041(k) to an employee eligible for a disability benefit payable under
5 AS 14.25.130 or AS 39.35.400 or 39.35.410 may not exceed the lesser of

6 (1) the difference between the disability benefit payable to the
7 employee under AS 14.25.130 or AS 39.35.400 or 39.35.410, converted to a weekly
8 basis, and 80 percent of the employee's spendable weekly wage as calculated under
9 AS 23.30.220; or

10 (2) 105 percent of the average weekly wage calculated under
11 AS 23.30.175(d).

12 (c) Notwithstanding other provisions of this chapter, the liability of an
13 employer for payment of compensation for an injury or illness under AS 23.30.180 or
14 23.30.185 to an employee who is covered by a union or group retirement system to
15 which the employer makes contributions under a collective bargaining agreement, or
16 by membership in a welfare or pension plan or trust, may not not exceed the lesser of

17 (1) the difference between 100 percent of the employee's spendable
18 weekly wage and an amount equal to the disability benefit, disability pension, or
19 medical retirement benefit that the employee is eligible to receive as a result of the
20 injury or illness, as calculated on a weekly basis, under the retirement system or
21 welfare or pension plan or trust; or

22 (2) the maximum compensation rate calculated under AS 23.30.175.

23 (d) If the union or group retirement system, pension plan, or trust referred to in
24 (c) of this section provides by its terms that its benefits are precluded or reduced if
25 benefits are awarded under this chapter, the limitation provided in (c)(1) of this section
26 is not applicable to the extent of the amount precluded or reduced.

27 (e) Notwithstanding other provisions of this chapter, the liability of an
28 employer for payment of compensation for an injury or illness under AS 23.30.041(k)
29 to an employee who is covered by a union or group retirement system to which the
30 employer makes contributions under a collective bargaining agreement, or by
31 membership in a welfare or pension plan or trust, may not not exceed the lesser of

1 (1) the difference between 80 percent of the employee's spendable
 2 weekly wage and an amount equal to the disability benefit, disability pension, or
 3 medical retirement benefit that the employee is eligible to receive as a result of the
 4 injury or illness, calculated on a weekly basis, under the retirement system or welfare
 5 or pension plan or trust; or

6 (2) 105 percent of the average weekly wage calculated under
 7 AS 23.30.175(d).

8 (f) If the union or group retirement system, pension plan, or trust referred to in
 9 (e) of this section provides by its terms that its benefits are precluded or reduced if
 10 benefits are awarded under this chapter, the limitation provided in (e)(1) of this section
 11 is not applicable to the extent of the amount precluded or reduced.

12 (g) If the employee receives a lump sum distribution of disability benefits,
 13 disability pension, or medical retirement benefits, the combined workers'
 14 compensation and weekly disability or medical retirement benefit specified in this
 15 section shall be calculated by assuming that the employee received weekly disability
 16 or medical retirement payments under the applicable plan from the date of eligibility
 17 for the disability benefit or medical retirement until the total of such weekly payments
 18 equals the amount of the lump sum, exclusive of that portion of the lump sum
 19 specifically set aside under the applicable plan for retraining expenses, medical and
 20 transportation expenses, and attorney fees or other legal costs.

21 * Sec. 37. AS 23.30.240 is amended to read:

22 **Sec. 23.30.240. Officers of corporations, municipal corporations, and**
 23 **nonprofit corporations, and members of limited liability companies,** as
 24 **employees.** An executive officer elected or appointed and empowered in accordance
 25 with the charter and bylaws of a corporation, other than an official of a municipal
 26 corporation or a charitable, religious, educational, or other nonprofit corporation, is an
 27 employee of the corporation under this chapter. However, an executive officer of a
 28 corporation may waive coverage under this chapter, subject to the approval of the
 29 **director** [COMMISSIONER OF LABOR AND WORKFORCE DEVELOPMENT],
 30 notwithstanding AS 23.30.245(b) Notwithstanding any other provision of this
 31 chapter, an executive officer of a municipal corporation or of a charitable, religious,

1 educational, or other nonprofit corporation may be brought within the coverage of its
 2 insurance contract by the corporation by specifically including the officer in the
 3 contract of insurance. The election to bring an executive officer within the coverage
 4 continues in force for the period the contract of insurance is in effect. During that
 5 period, an executive officer brought within the coverage of the insurance contract is an
 6 employee of the corporation under this chapter.

7 * **Sec. 38.** AS 23.30.240 is amended by adding a new subsection to read:

8 (b) Except as provided in this subsection, a member of a limited liability
 9 company organized under AS 10.50 is not an employee of the company under this
 10 chapter. Notwithstanding any other provision of this chapter, a limited liability
 11 company may bring a member of the company within the coverage of the company's
 12 insurance contract by specifically including the member in the contract of insurance.
 13 The election to bring the member within the company's coverage continues in force
 14 for the period the contract of insurance is in effect. During that period, a member
 15 brought within the coverage of the insurance contract is an employee of the company
 16 under this chapter.

17 * **Sec. 39.** AS 23.30.247(c) is amended to read:

18 (c) This section may not be construed to prohibit an employer from requiring a
 19 prospective employee to fill out a preemployment questionnaire or application
 20 regarding the person's prior health or disability history as long as it is meant to
 21 [EITHER DOCUMENT WRITTEN NOTICE FOR SECOND INJURY FUND
 22 REIMBURSEMENT UNDER AS 23.30.205(c) OR] determine whether the employee
 23 has the physical or mental capacity to meet the documented physical or mental
 24 demands of the work.

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

26 **Sec. 23.30.249. Fraudulent acts and false or misleading statements.** (a) An
 27 employer, insurer, or other person may petition for an order to reimburse a payment
 28 and the cost of compensation, medical treatment, or other benefit provided under this
 29 chapter obtained by a fraudulent act or false or misleading statement or representation.
 30 If the board, after a hearing as provided by AS 23.30.110, finds by a preponderance of
 31 the evidence that a person has obtained a payment, compensation, medical treatment,

1 or another benefit provided under this chapter by a fraudulent act or by knowingly
2 making a false or misleading statement or representation for the purpose of obtaining
3 that benefit or payment, the board shall order that person to make full reimbursement
4 of the payment or cost of all benefits obtained. Upon entry of an order authorized
5 under this subsection, the board shall also order that person to pay all reasonable costs
6 and attorney fees incurred in obtaining an order under this section and in defending
7 any fraudulent claim made for benefits under this chapter. If a person fails to comply
8 with an order requiring reimbursement of payment or cost of benefits, and payment of
9 costs and attorney fees, the employer, insurer, or other party may declare the person in
10 default and proceed to collect any sum due in the same manner as provided under
11 AS 23.30.170(b) and (c).

12 (b) Except as provided in (c) of this section, a person is not liable for civil
13 damages for filing a report with or furnishing other information, whether written or
14 oral, concerning a suspected, anticipated, or completed fraudulent act or false or
15 misleading statements or representation to

16 (1) law enforcement officials or their agents and employees;

17 (2) the division of workers' compensation, the division of insurance in
18 the Department of Commerce, Community, and Economic Development, or an agency
19 in another state that regulates insurance or workers' compensation;

20 (3) an insurer or adjuster or its agents, employees, or designees, or the
21 risk manager of a self-insured employer under this chapter.

22 (c) The provisions of (b) of this section do not preclude liability for civil
23 damages as described in (b) of this section if the liability arose as a result of reckless,
24 wilful, or intentional misconduct.

25 (d) An insurer, an adjuster, or a risk manager of a self-insured employer that
26 has reason to believe that a fraudulent workers' compensation demand or claim has
27 been made against it shall send the director a report disclosing information that the
28 director may require. An insurer or an adjuster or its employee or agent, or a risk
29 manager of a self-employed employer, or another person acting in good faith is not
30 civilly liable for damages resulting from the filing of the report or the furnishing of
31 information required by this section or by the director.

1 (e) The director may investigate facts reported under this section and may
2 refer facts indicating a possible violation of law to the appropriate prosecutor or
3 agency. If the director determines that there is credible evidence that a person
4 obtained a payment, compensation, medical treatment, or other benefit provided under
5 this chapter by a fraudulent act or false or misleading statement or representation as
6 provided in (a) of this section, the director shall notify the affected employer, insurer,
7 and adjuster upon conclusion of the investigation. If the fraudulent act or false or
8 misleading statement or representation was perpetrated against the division, the
9 director may file a petition as provided in AS 23.30.110 for an order of forfeiture
10 against the person, precluding, in whole or in part, the person from future payment,
11 compensation, medical treatment, or other benefit provided under this chapter.

12 (f) The papers, reports, documents, and evidence received under this section or
13 in an investigation arising from information received under this section are not subject
14 to public inspection for so long as the director considers confidentiality to be in the
15 public interest or reasonably necessary to complete an investigation or protect the
16 person investigated from unwarranted injury. Papers, reports, documents, and
17 evidence relative to an investigation under this section are confidential and not subject
18 to subpoena unless, after notice to the director and a hearing, a court determines that
19 the director would not be unduly hindered by public inspection.

20 (g) If the material that the director seeks to obtain is located outside the state,
21 the material may be made available to the director to examine at the place where the
22 material is located. The director may designate representatives, including officials of
23 the state in which the material is located, to inspect the material on behalf of the
24 director. The director may respond to a request from an official of another state for
25 similar material.

26 (h) In this section, "fraudulent act" includes

27 (1) to knowingly pretend injury or disability, with intent to defraud or
28 obtain a benefit under this chapter;

29 (2) to knowingly conceal, suppress, destroy, remove, or alter records,
30 with intent to defraud or obtain a benefit under this chapter;

31 (3) to knowingly assist or prepare another person to submit a false or

1 misleading statement in support of a claim for benefits under this chapter with reckless
2 disregard that the person is not entitled to benefits under this chapter;

3 (4) to use force against a person, damage the property of a person, or
4 threaten a person with intent to improperly influence the opinion of a witness, a
5 physician, or other health care provider;

6 (5) except as otherwise authorized under this chapter, to knowingly
7 confer, offer to confer, solicit, agree to accept, or accept property, services, or a
8 benefit

9 (A) to refer an employee to a physician or other health care
10 provider; or

11 (B) for providing medical treatment, services, medicines, or
12 supplies to an employee if the property, services, or benefit is in addition to
13 payment by the employer, insurer, or adjuster allowed under this chapter.

14 * **Sec. 41.** AS 23.30.250 is repealed and reenacted to read:

15 **Sec. 23.30.250. Penalty for fraudulent acts or false or misleading**
16 **statements or representations.** (a) A person is guilty of theft by deception as defined
17 in AS 11.46.180, and may be punished as provided by AS 11.46.120 - 11.46.150, and
18 is civilly liable to a person adversely affected by the conduct, if the person

19 (1) knowingly makes a false or misleading statement, representation,
20 or submission related to an injury, compensation, or benefit under this chapter;

21 (2) knowingly assists, abets, solicits, or conspires in making a false or
22 misleading submission affecting the payment, coverage, or other benefit under this
23 chapter;

24 (3) knowingly misclassifies employees or engages in deceptive leasing
25 practices for the purpose of evading full payment of workers' compensation insurance
26 premiums; or

27 (4) employs or contracts with a natural person or business organization
28 to coerce or encourage an individual to file a fraudulent compensation claim.

29 (b) In this section,

30 (1) "benefit" means a payment, compensation, medical treatment,
31 service, product, entitlement, or right available under this chapter;

- 1 (2) "knowingly" has the meaning given in AS 11.81.900.
- 2 * **Sec. 42.** AS 23.30.260 is amended by adding a new subsection to read:
- 3 (b) Notwithstanding AS 23.30.145 and (a) of this section, approval of a fee is
- 4 not required if the fee does not exceed \$300 and is a one-time-only charge to an
- 5 employee by an attorney licensed in this state who performed legal services with
- 6 respect to the employee's claim but did not enter an appearance.
- 7 * **Sec. 43.** AS 23.30.395 is amended by adding new paragraphs to read:
- 8 (35) "commission" means the Workers' Compensation Appeals
- 9 Commission;
- 10 (36) "commissioner" means the commissioner of labor and workforce
- 11 development;
- 12 (37) "department" means the Department of Labor and Workforce
- 13 Development;
- 14 (38) "director" means the director of the division of workers'
- 15 compensation in the department;
- 16 (39) "division" means the division of workers' compensation in the
- 17 department.
- 18 * **Sec. 44.** AS 37.05.146(c) is amended by adding a new paragraph to read:
- 19 (78) workers' compensation benefits guaranty fund (AS 23.30.082).
- 20 * **Sec. 45.** AS 39.25.110 is amended by adding a new paragraph to read:
- 21 (40) the chair of the Workers' Compensation Appeals Commission
- 22 (AS 23.30.007).
- 23 * **Sec. 46.** AS 39.25.120(c)(14) is amended to read:
- 24 (14) the rehabilitation administrator of the division of workers'
- 25 compensation [WORKERS' COMPENSATION BOARD];
- 26 * **Sec. 47.** AS 39.50.200(b)(31) is amended to read:
- 27 (31) Workers' Compensation Board (AS 23.30.005) and Workers'
- 28 Compensation Appeals Commission (AS 23.30.007);
- 29 * **Sec. 48.** AS 23.30.095(f), 23.30.095(l), and 23.30.095(m) are repealed.
- 30 * **Sec. 49.** AS 23.30.015(c), 23.30.040, 23.30.205, 23.30.395(27); and AS 37.05.146(c)(12)
- 31 are repealed.

1 * **Sec. 50.** The uncodified law of the State of Alaska is amended by adding a new section to
2 read:

3 **APPLICABILITY.** The amendment to AS 23.30.175(b) made by sec. 32 of this Act
4 applies to an injury occurring on or after the effective date of sec. 32 of this Act.

5 * **Sec. 51.** The uncodified law of the State of Alaska is amended by adding a new section to
6 read:

7 **TRANSITION: INITIAL TERMS OF MEMBERS OF WORKERS'**
8 **COMPENSATION APPEALS COMMISSION.** Notwithstanding AS 23.30.007(e), enacted
9 by sec. 10 of this Act, the terms of the initially appointed representative members of the
10 Workers' Compensation Appeals Commission, established by AS 23.30.007 enacted by sec.
11 10 of this Act, shall be set by the governor to achieve staggered terms in the manner provided
12 in AS 39.05.055.

13 * **Sec. 52.** The uncodified law of the State of Alaska is amended by adding a new section to
14 read:

15 **TRANSITION: STAFF.** (a) In order to ensure the smooth assumption of duties in
16 the shortest possible time, for a period of six months after the effective date of this section, the
17 director may, with the approval of the commissioner of labor and workforce development and
18 the chair of the commission, temporarily assign division employees to the commission and the
19 commission may reimburse the division for the temporarily assigned employees. Division
20 employees temporarily assigned to the commission shall continue in the same position and
21 rate of pay for the duration of the temporary assignment as the employees held at the division.

22 (b) In this section,

23 (1) "commission" means the Workers' Compensation Appeals Commission
24 established by AS 23.30.007, enacted by sec. 10 of this Act;

25 (2) "director" means the director of the division of workers' compensation in
26 the Department of Labor and Workforce Development;

27 (3) "division" means the division of workers' compensation in the Department
28 of Labor and Workforce Development.

29 * **Sec. 53.** The uncodified law of the State of Alaska is amended by adding a new section to
30 read:

31 **TRANSITIONAL PROVISIONS.** (a) Litigation, investigations, and other

1 proceedings pending under a law amended or repealed by this Act, or in connection with
 2 functions transferred by this Act, continue in effect and may be continued and completed,
 3 notwithstanding a transfer or amendment or repeal provided for in this Act.

4 (b) Certificates, decisions, and orders issued under authority of a law amended or
 5 repealed by this Act remain in effect for the term issued, or until revoked, vacated, or
 6 otherwise modified under the provisions of this Act. Contracts, rights, liabilities, and
 7 obligations created by or under a law amended or repealed by this Act, and in effect on the
 8 day before the effective date of this section, remain in effect notwithstanding this Act's taking
 9 effect.

10 * **Sec. 54.** The uncodified law of the State of Alaska is amended by adding a new section to
 11 read:

12 **TRANSITION: REGULATIONS.** (a) The Department of Labor and Workforce
 13 Development and the director of insurance in the Department of Commerce, Community, and
 14 Economic Development each may proceed to adopt regulations necessary to implement their
 15 respective provisions of this Act. The regulations take effect under AS 44.62 (Administrative
 16 Procedure Act), but not before the effective date of the statutory changes.

17 (b) In order to provide for the procedures and other administrative matters necessary
 18 to ensure the on-going implementation of the state's workers' compensation laws to meet the
 19 urgent needs of injured workers, and thus ensure the preservation of the public peace, health,
 20 safety, or general welfare, the Workers' Compensation Appeals Commission established by
 21 AS 23.30.007, enacted by sec. 10 of this Act, may adopt under AS 23.30.008, enacted by sec.
 22 10 of this Act, as emergency regulations, the regulations necessary to implement the changes
 23 made by this Act.

24 * **Sec. 55.** The uncodified law of the State of Alaska is amended by adding a new section to
 25 read:

26 **IMPLEMENTATION OF REPEAL OF SECOND INJURY FUND.** The balance of
 27 the second injury fund created by former AS 23.30.040 is transferred to the general fund on
 28 the effective date of this section.

29 * **Sec. 56.** The uncodified law of the State of Alaska is amended by adding a new section to
 30 read:

31 **TRANSITION: MEDICAL SERVICES REVIEW COMMITTEE STUDY AND**

1 REPORT. The medical services review committee appointed by the commissioner of labor
2 and workforce development under AS 23.30.095(j), as amended by sec. 23 of this Act, shall
3 proceed to study medical and related benefits provided under AS 23.30 to determine the
4 appropriateness, necessity, and cost of the benefits, and shall provide to the commissioner of
5 labor and workforce development, by March 1, 2007, a report of the results of the study.

6 * Sec. 57. Section 54(a) of this Act takes effect immediately under AS 01.10.070(c).

7 * Sec. 58. Sections 1 - 4, 32, and 56 of this Act take effect September 1, 2005.

8 * Sec. 59. Sections 5, 12, 39, 49, and 55 of this Act take effect on the date that the
9 commissioner of labor and workforce development certifies to the revisor of statutes and the
10 lieutenant governor that all liability for previously accepted claims to the second injury fund
11 created by former AS 23.30.040, and claims ordered to be paid from that fund, have been
12 satisfied.

13 * Sec. 60. Except as provided in secs. 57 - 59 of this Act, this Act takes effect August 1,
14 2005.

BILL NO.

**IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-FOURTH LEGISLATURE - FIRST SESSION**

BY THE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

**Introduced:
Referred:**

A BILL

FOR AN ACT ENTITLED

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* Section 1. The uncodified law of the State of Alaska is amended by adding a new section to read:

LEGISLATIVE INTENT. It is the intent of the legislature by secs. 2 - 4 of this Act

(1) to reform the workers' compensation system in Alaska to ensure the continued payment of benefits in the event of an insurer insolvency; and

(2) to reduce the overall costs of workers' compensation premiums to employers.

* Sec. 2. AS 21.09.090 is amended by adding new subsections to read:

(e) In addition to and separate from the deposit required under (b) of this section, an insurer that is authorized to transact workers' compensation and employer's liability insurance as defined in AS 21.12.070(a)(3) shall deposit in this state, through the director, for the protection of persons in this state covered by workers' compensation insurance issued by the insurer, an amount no less than the greater of

(1) \$100,000; or

(2) an amount equal to the sum of the following less any credit for

addict
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value
10.11.11
on deposit

reinsurance that the insurer may take under (f) of this section:

(A) the aggregate of the present value at four percent interest of the total determined and estimated future loss and loss expense payment upon each claim incurred under a policy written in this state more than three years before the date of computation; and

4% of average load on 3yr prior

(B) for each of the three years before the date of computation, 65 percent of the earned premium for the year less each loss and loss expense payment made upon a claim incurred in the corresponding year, except that the amount for any year may not be less than the present value at four percent interest of the total determined and estimated future loss and loss expense payment upon each claim incurred under a policy written in this state that year.

explain

(f) In calculating the deposit amount required under (e)(2) of this section, an insurer may take a credit for reinsurance if the reinsurer has deposited in trust in this state, through the director, an amount at least equal to the credit to be taken, and no less than the aggregate of all credits taken by each insurer under this subsection.

reinsurer

* Sec. 3. AS 21.24.130 is amended by adding a new subsection to read:

(f) If an insurer is found to be insolvent by a proceeding under AS 21.78 or by a court of competent jurisdiction in any other state, the director shall take control of the insurer's deposit made under AS 21.09.090(e). The deposit assets shall be released, at the discretion of the director, to the Alaska Insurance Guaranty Association (AS 21.80) to reimburse for a valid loss and loss expense claim payment made by the association that is within the purpose of the deposit. The director shall pay the remaining deposit assets to the receiver, conservator, rehabilitator, or liquidator of the insurer, or to any other properly designated official who succeeds to the management and control of the insurer's assets, after the director determines that all loss and loss expense liabilities have been paid that were incurred on the insurer's policies written in this state for which the deposit was required.

USE OF deposit

* Sec. 4. AS 21.39.155(a) is amended to read:

(a) The director may require insurers, except a reciprocal insurer formed ~~[BY- AND INSURING ONLY A GROUP OF MUNICIPALITIES OR NONPROFIT- PUBLIC UTILITIES]~~ under AS 21.75 ~~[OR A RECIPROCAL INSURER FORMED-~~

explain

1 ~~UNDER AS 21.75 TO PROVIDE MARINE INSURANCE~~], as a condition of writing
2 a line of insurance dealing with medical malpractice or workers' compensation, to
3 participate in an assigned risk pool if the director finds that mandatory carrier
4 participation is in the public interest.

5 * Sec. 5. AS 23.05.067(a) is amended to read:

6 (a) Each insurer providing workers' compensation insurance and each
7 employer who is self-insured or uninsured for purposes of AS 23.30 in this state shall
8 pay an annual service fee to the department for the administrative expenses of the state
9 for workers' safety programs under AS 18.60 and the workers' compensation program
10 under AS 23.30 as follows.

11 (1) for each employer,

12 (A) except as provided in (b) of this section, the service fee shall be
13 paid each year to the department at the time that the annual report is required to be
14 filed under AS 23.30.155(m) or (n); and

15 (B) the service fee is 2.9 percent of all payments reported to the Alaska
16 Workers' Compensation Board under AS 23.30.155(m) or (n)[, ~~EXCEPT SECOND~~
17 ~~INJURY FUND PAYMENTS~~]; and

18 (2) for each insurer, the director of the division of insurance shall,
19 under (e) of this section, deposit from funds received from the insurer under AS
20 21.09.210 a service fee of 1.82 percent of the direct premium income for workers'
21 compensation insurance received by the insurer during the year ending on the
22 preceding December 31, subject to all the deductions specified in AS 21.09.210(b).

23 * Sec. 6. AS 23.30 is amended by adding a new section to read:

24 **Sec. 23.30.001. Intent of the legislature and construction of chapter.** It is
25 the intent of the legislature that

26 (1) this chapter be interpreted so as to ensure the quick, efficient, fair,
27 and predictable delivery of indemnity and medical benefits to injured workers at a
28 reasonable cost to the employers who are subject to the provisions of this chapter;

29 (2) workers' compensation cases shall be decided on their merits
30 except where otherwise provided by law;

31 (3) this chapter may not be construed by the courts in favor of a party;

1 (4) hearings in workers' compensation cases shall be impartial and fair
 2 to all parties and that all parties shall be afforded due process and an opportunity to be
 3 heard and for their arguments and evidence to be fairly considered; NEW

4 (5) evidence shall be carefully and rationally examined and, except in
 5 the application of the presumptions in AS 23.30.120(a), doubt as to the substance of
 6 evidence may not be interpreted in favor of one party or the other.

7 * Sec. 7. AS 23.30.005(a) is amended to read:

8 (a) The Alaska Workers' Compensation Board consists of a southern panel of
 9 three members sitting for the first judicial district, a northern panel of three members
 10 sitting for the second and fourth judicial districts, four southcentral panels of three
 11 members each sitting for the third judicial district, and one panel of three members
 12 that may sit in any judicial district. Each panel must include the commissioner of
 13 labor and workforce development or a hearing officer designated to represent [THE
 14 DESIGNATED REPRESENTATIVE OF] the commissioner, a representative of
 15 industry, and a representative of labor. The latter two members of each panel shall be
 16 appointed by the governor and are subject to confirmation by a majority of the
 17 members of the legislature in joint session. The board shall by regulation provide
 18 procedure to avoid conflicts and the appearance of impropriety in hearings. NEW

19 * Sec. 8. AS 23.30.005(b) is amended to read:

20 (b) The commissioner shall act as chairman and executive officer of the board
 21 and chairman of each panel. The commissioner may designate a representative to
 22 act for the commissioner as chair and executive officer of the board. The
 23 commissioner may designate hearing officers to serve as chairs of panels for
 24 hearing claims. [IF THE COMMISSIONER DESIGNATES A REPRESENTATIVE
 25 TO ACT FOR THE COMMISSIONER, THE REPRESENTATIVE SHALL SERVE
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28 (m) The department may in its discretion contract with a non-profit NEW
 29 organization to provide to employees information services and legal representation in
 30 proceedings under this chapter. NEW

31 (n) The board may by regulation delegate authority to the director to assist the

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION



Central Microfilm Services
Department of Education & Early Development
State of Alaska

BILL NO.

**IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-FOURTH LEGISLATURE - FIRST SESSION**

BY THE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

**Introduced:
Referred:**

A BILL

FOR AN ACT ENTITLED

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* **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

LEGISLATIVE INTENT. It is the intent of the legislature by secs. 2 - 4 of this Act

(1) to reform the workers' compensation system in Alaska to ensure the continued payment of benefits in the event of an insurer insolvency; and

(2) to reduce the overall costs of workers' compensation premiums to employers.

* **Sec. 2.** AS 21.09.090 is amended by adding new subsections to read:

(e) In addition to and separate from the deposit required under (b) of this section, an insurer that is authorized to transact workers' compensation and employer's liability insurance as defined in AS 21.12.070(a)(3) shall deposit in this state, through the director, for the protection of persons in this state covered by workers' compensation insurance issued by the insurer, an amount no less than the greater of

(1) \$100,000; or

(2) an amount equal to the sum of the following less any credit for

under
...
...
on deposit

What is a job dislocation benefit.

unemployment period + ?
p 15

physical security? p 15

don't measure the new class
of... p 15

What is a CVS appeal? pp 22

US 11462 Administrative Tribunal Act
p 15

The... p 34, line 5

p. 34, line 5 — 5.10.11

reinsurance that the insurer may take under (f) of this section:

(A) the aggregate of the present value at four percent interest of the total determined and estimated future loss and loss expense payment upon each claim incurred under a policy written in this state more than three years before the date of computation; and

4% of average based on 3yr prior

(B) for each of the three years before the date of computation, 65 percent of the earned premium for the year less each loss and loss expense payment made upon a claim incurred in the corresponding year, except that the amount for any year may not be less than the present value at four percent interest of the total determined and estimated future loss and loss expense payment upon each claim incurred under a policy written in this state that year.

explain

(f) In calculating the deposit amount required under (c)(2) of this section, an insurer may take a credit for reinsurance if the reinsurer has deposited in trust in this state, through the director, an amount at least equal to the credit to be taken, and no less than the aggregate of all credits taken by each insurer under this subsection.

reinsurer

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(f) If an insurer is found to be insolvent by a proceeding under AS 21.78 or by a court of competent jurisdiction in any other state, the director shall take control of the insurer's deposit made under AS 21.09.090(e). The deposit assets shall be released, at the discretion of the director, to the Alaska Insurance Guaranty Association (AS 21.80) to reimburse for a valid loss and loss expense claim payment made by the association that is within the purpose of the deposit. The director shall pay the remaining deposit assets to the receiver, conservator, rehabilitator, or liquidator of the insurer, or to any other properly designated official who succeeds to the management and control of the insurer's assets, after the director determines that all loss and loss expense liabilities have been paid that were incurred on the insurer's policies written in this state for which the deposit was required.

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defined

1 ~~UNDER AS 21.75 TO PROVIDE MARINE INSURANCE]~~, as a condition of writing
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16 Workers' Compensation Board under AS 23.30.155(m) or (n)[, ~~EXCEPT SECOND~~
17 ~~INJURY FUND PAYMENTS~~]; and

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13 labor and workforce development or a hearing officer designated to represent [THE
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15 industry, and a representative of labor. The latter two members of each panel shall be
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21 and chairman of each panel. The commissioner may designate a representative to
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24 hearing claims. [IF THE COMMISSIONER DESIGNATES A REPRESENTATIVE
25 TO ACT FOR THE COMMISSIONER, THE REPRESENTATIVE SHALL SERVE
26 IN THAT CAPACITY ON THE BOARD AND ON EACH PANEL.]

27 * Sec. 9. AS 23.30.005 is amended by adding new subsections to read:

28 (m) The department may in its discretion contract with a non-profit NEW
29 organization to provide to employees information services and legal representation in
30 proceedings under this chapter. NEW

31 (n) The board may by regulation delegate authority to the director to assist the

1 board in administering and enforcing this chapter.

2 * Sec. 10. AS 23.30 is amended by adding new sections to read:

3 **Sec. 23.30.007. Workers' Compensation Appeals Commission.** (a) There
4 is established in the Department of Labor and Workforce Development the Workers'
5 Compensation Appeals Commission. The commission has jurisdiction to hear appeals
6 from final decisions and orders of the board under this chapter. Jurisdiction of the
7 commission is limited to administrative appeals arising under this chapter.

8 (b) The commission consists of five members appointed by the governor and
9 confirmed by a majority of the members of the legislature in joint session. The
10 members shall be appointed as follows:

11 (1) a member appointed as chair who meets the requirements of (c)(2)
12 of this section;

13 (2) two members who, because of their employment or affiliations,
14 may be classified as a representative of employees covered by this chapter;

15 (3) two members who, because of their employment or affiliations,
16 may be classified as a representative of employers covered by this chapter.

17 (c) To be eligible for appointment under this section

18 (1) the member must

19 (A) be a citizen of the United States;

20 (B) be a resident of the state for the five years preceding the
21 appointment; and

22 (C) have not been convicted of either a

23 (i) felony; or

24 (ii) misdemeanor related to workers' compensation;

25 (2) the chair must

26 (A) meet the criteria specified in (1) of this subsection;

27 (B) be licensed to practice law in this state and be a member in
28 good standing with the Alaska Bar Association; and

29 (C) have engaged in the active practice of law for at least five
30 years with experience in workers' compensation in this state.

31 (d) A member may act and receive compensation under this section from the

1121

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Employer
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Workers' Compensation
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1121

date of appointment until confirmation or rejection by the legislature.

(e) The term of service on the commission is five years. A member may be reappointed so long as the reappointment complies with the provisions of this section.

(f) The chair of the commission is in the exempt service under AS 39.25.110 and shall receive a monthly salary that is not less than Step A nor more than Step F of Range 27 of the salary schedule in AS 39.27.011(a) for Anchorage, Alaska.

Range 27
3,177 -
3,800
AS 39.10-46-1
12/1/04

(g) A vacancy arising in the commission shall be filled by appointment by the governor and confirmed by a majority of the members of the legislature in joint session. Except as provided in AS 39.05.080(4), an appointee selected to fill a vacancy shall hold office for the unexpired term of the member whose vacancy is filled. A vacancy in the commission does not impair the authority of a quorum of members to exercise all the powers and perform all the duties of the commission.

(h) An appeal to the commission shall be heard and decided by a three-member panel of the commission. An appeal panel shall consist of the chair of the commission and two members of the commission assigned by the chair, one member classified as representing employees, and one member classified as representing employers. At other meetings to conduct commission business, the number of commission members classified as representing employees must equal the number of commission members classified as representing employers. The chair of the commission and two representative members of the commission, one classified as representing employees and one classified as representing employers, constitutes a quorum.

(i) A member of the commission may be removed from office by the governor for good cause. To be removed for cause, a member of the commission shall be given a copy of the charges and afforded an opportunity to be heard in person or by counsel in the member's own defense upon not less than 10 days' notice. If the member is removed for cause, the governor shall file with the lieutenant governor a complete statement of all charges made against the member, the governor's findings on the charges, and the record of any proceedings. In this subsection, "good cause" includes

voluntary
(1)
COMMISSION

- (1) misconduct in office or violation of AS 39.52;
- (2) conviction of a felony;

1 (3) conviction of a misdemeanor related to workers' compensation;

2 (4) inability to serve, neglect of duty, incompetence, unjustified failure
3 to handle the caseload assigned, or similar nonfeasance of office; and

4 (5) failure to continue to meet the requirements of this section relating
5 to qualification for office.

6 (j) Representative members are entitled to compensation in the amount of
7 \$200 a day for each day spent in actual hearing of appeals or on authorized official
8 business incidental to their duties, and to transportation and per diem as provided by
9 law. Compensation shall be paid pro rata for each portion of a day spent in actual
10 hearing of appeals or on authorized official business.

11 (k) A member of the commission may not hear an appeal under this chapter if

12 (1) a party is an employee or was, in the past seven years, an employee
13 of the commission member or of a business that employs the commission member;
14 this paragraph does not apply to the chair of the commission when the State of Alaska
15 is or was the employer of a party;

16 (2) a party is a member or was, in the past seven years, a member of
17 the same union or employee association as the commission member;

18 (3) a party has a contractual relationship with the commission member,
19 a business that employs the commission member, or a union or employee association
20 of which the commission member is a member;

21 (4) the commission member is unable to be fair, impartial, and
22 unbiased toward the appeal participants; or

23 (5) participation in the appeal is a violation of AS 39.52.

24 (l) If the chair of the commission is unable to hear an appeal for reasons of
25 absence or illness in excess of 10 days, or for reasons set out in (k) of this section, the
26 commissioner of the department shall appoint a person who meets the qualifications of
27 this section to serve as chair to hear the appeal as chair pro tem. The person shall
28 receive the compensation provided in (j) of this section. Appointment of a chair pro
29 tem does not require legislative confirmation.

30 (m) Each member of the commission, before entering upon the duties of
31 office, shall take and subscribe to the oath prescribed for principal officers of the state.