REPORT OF THE WORKMEN'S COMPENSATION SUBCOMMITTEE OF THE HOUSE COMMITTEE ON LABOR AND COMMERCE

TO

THE GOVERNOR

AND

THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 39

COMMONWEALTH OF VIRGINIA
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MEMBERS OF SUBCOMMITTEE

William T. Wilson, Chairman
Warren G. Stambaugh
Norman Sisisky
Richard R. G. Hobson
Calvin G. Sanford

STAFF

Legal and Research - Division of Legislative Services

C. William Cramme', III - Staff Attorney
Hugh P. Fisher, III - Research Associate
Anne M. Parks - Secretary

Administrative and Clerical

Office of Clerk, House of Delegates

Report of the Workmen's Compensation Subcommittee
of the House Committee on Labor and Commerce
December, 1979

To: Honorable John N. Dalton, Governor of Virginia
and
The General Assembly of Virginia

INTRODUCTION

In the Commonwealth, responsibility for regulation of the State workmen's compensation system is shared by the Virginia Industrial Commission and the State Corporation Commission. Revenues for the administrative fund of the Industrial Commission are derived from a tax levied on workmen's compensation insurers in the State. The tax is levied on the premiums collected by all workmen's compensation insurance carriers. Additionally, the tax is assessed against all entities which self-insure for workmen's compensation coverage. In the case of self-insuring entities, the tax is levied on the amount of premiums which would be paid if the organization were not self-insuring for workmen's compensation coverage. The revenues from the tax are used to pay the salaries and operating expenses of the personnel of the Industrial Commission.

The Industrial Commission administers the State Workmen's Compensation Act, including the disposition of claims and the construction of policy forms. When any claim is filed, a report regarding the claim must be filed with the Commission. Although the Commission is authorized to hold a hearing concerning any claim, the Commission's practice is to hold a hearing, and render a decision, only if: (1) there is disagreement between the injured employee and his insurer regarding the amount or duration of benefits which are to be paid, or (2) the Commission believes that certain events surrounding a claim justify a hearing.

The State Corporation Commission sets workmen's compensation insurance rates in Virginia. Requests for changes in rates come from the Virginia Compensation Rating Bureau, a trade association for workmen's compensation insurance carriers in the State. When it feels that a change in workmen's compensation rates is needed, the Rating Bureau submits a rate filing to the Corporation Commission which contains various facts and figures the Rating Bureau feels justifies an increase in rates. The Commission's staff, as well as various interested parties, then analyze the rate filing and advise the Commission of their opinions. After hearing testimony from all interested parties, and after weighing all available evidence, the Commission issues its decision.

WORK OF THE SUBCOMMITTEE

Throughout the United States, rates for workmen's compensation insurance have increased dramatically during the last few years.

In an effort to learn more about the reasons for these rate increases, the House Committee on Labor and Commerce held a meeting on July 14, 1978. At that meeting Mr. John G. Day, then Commissioner of Insurance for the Commonwealth, testified before the Committee that since 1975 workmen's compensation rates within Virginia have been increasing at an alarming pace. Mr. Day presented data which showed that during 1972, 1973, and 1974, rate increases were a relatively modest 3.3%, 7.5% and 6.1%, respectively. However, during 1975 a rate increase of 12.4% was approved by the Corporation Commission. Further, during 1976, 1977, and 1978, rates increased by 21.1%, 21.1%, and 32%, respectively.

Moreover, Mr. Day told the Committee that it is very difficult to determine the underlying reasons for the recent large rate increases. He pointed out that benefit changes, although a factor, are not the only reason. In addition to benefit changes, the Commissioner held that in his opinion, the following factors also have played a key role in increasing rates:

(1) The increasing cost of medical care;
(2) An increasing claims consciousness;
(3) A more liberal interpretation of workmen's compensation laws.

Commissioner Day also stated that experts in the workmen's compensation field believe that other factors are also accounting for the large increases. However, he stressed, nobody is certain which factors are primarily responsible for the increases.

Mr. Day noted that a special task force, consisting of representatives from the Industrial Commission, the Corporation Commission, the State AFL-CIO, the Virginia Manufacturers Association, the workmen's compensation industry, and other organizations had been established to try to determine the root causes of the recent rate increases within the Commonwealth. He stated that the task force would meet periodically in an attempt to resolve the issue.

During the July 14, 1978, meeting, the Committee also heard from Mr. Robert P. Joyner of the State Industrial Commission. Mr. Joyner told the Committee that the Industrial Commission does not compile and retain data concerning frequency of claims in workmen's compensation cases. He held that the Commission does not have the personnel required to collect and interpret that type of data.

After Mr. Joyner had concluded his presentation, the Chairman of the Committee, Delegate Robert E. Washington, assigned to the Committee's Workmen's Compensation Subcommittee the task of working with the workmen's compensation task force Mr. Day had discussed. The Subcommittee shortly thereafter began working with the task force in an effort to identify ways of reducing future rate increases.

An organizational meeting of the Workmen's Compensation Subcommittee and the task force was held on September 6, 1978. At that meeting, the Chairman of the Subcommittee, Delegate William T. Wilson, stated that the Subcommittee and the task force should attempt to determine, to the extent possible, the degree to which certain factors influence workmen's compensation insurance rates.

During the meeting Insurance Commissioner Day pointed out that the task force had been divided up into seven subcommittees. Each subcommittee, he explained, was going to study a factor which might be partially responsible for the large rate increases. Mr. Day stated that the following subcommittees had been established:

(1) Data Systems
(2) Medical Costs
(3) Employer Practices and Benefit Utilization
(4) Standards of Service - Including Loss Control
(5) Industrial Commission - Law and Procedures
(6) Bureau of Insurance - Rate Procedures
(7) Self-Insurance Requirements

Each of those subcommittees met several times between September and December in an effort to do as much work as possible prior to the end of the year.

On December 20, 1978, another meeting of the Legislative Subcommittee and the task force was held. During that meeting the Subcommittee heard testimony from Mr. Joyner of the Industrial Commission. Mr. Joyner told the Subcommittee that the Commission presently collects and maintains certain basic, useful statistics. However, he further stated that the Commission does not collect the type of statistics which would give clues regarding the root causes of workmen's compensation rate increases.

It was the feeling of the Subcommittee that the Industrial Commission should thoroughly explore the feasibility of a data collection system which would allow the Commission to collect data which would give clues regarding the root causes of workmen's compensation rate increases. The Subcommittee indicated to Mr. Joyner at that time that the Commission should make a study of the types of data which should be gathered under such a system, estimate the costs of collecting and maintaing that data, and report its findings to the Subcommittee.

Also, during the December 20 meeting the Legislative Subcommittee received the year-end reports of the seven task force subcommittees.

Although representatives of most of the task force subcommittees told the Legislative Subcommittee that their study groups had not had sufficient time to complete their work, each subcommittee did offer various recommendations to the Legislative Subcommittee.

Consequently, the Subcommittee offered three pieces of legislation to the full Labor and Commerce Committee which resulted from recommendations made by two of the task force subcommittees. One piece of legislation incorporated a recommendation made by the Industrial Commission subcommittee that the Industrial Commission elect one of its members chairman for a three year term beginning on July 1, 1979, and each succeeding three years thereafter. This piece of legislation became Chapter 459 of the 1979 Acts of Assembly.

Another piece of legislation offered by the Legislative Subcommittee which resulted from its study was a bill incorporating a recommendation made by the Industrial Commission subcommittee that defines the term "Filed" as previously found in § 65.1-52 of the Code of Virginia so that it applies to the entire Workmen's Compensation Act. This legislation became Chapter 80 of the 1979 Acts of Assembly.

The third piece of legislation offered by the Legislative Subcommittee which resulted from its study was a bill incorporating a recommendation made by the Self-Insurance Requirements subcommittee that properly regulated and qualified groups of employers be authorized to self-insure under the Workmen's Compensation Act. The bill specified that before the Industrial Commission approves such a self-insuring agreement, the Commission must find satisfactory proof that each member of the group is solvent and that the group is financially able to meet its obligations in compensating for injuries. This bill became Chapter 463 of the 1979 Acts of Assembly.

Because the task force and the Legislative Subcommittee had not had sufficient time to complete their work during 1978, it was decided that the study would be continued for another year. House Resolution No. 38 of the 1979 General Assembly continued the study.

HOUSE RESOLUTION NO. 38

Requesting the Workmen's Compensation Subcommittee of the House Committee on Labor and Commerce to continue its study of the factors accounting for the accelerating increase in workmen's compensation insurance premiums.

WHEREAS, during the last three years there has been a demand for a ninety-eight percent increase in workmen's compensation insurance premiums in the Commonwealth; and

WHEREAS, only five percent of the ninety-eight percent increase has been attributable to law changes; and

WHEREAS, it is uncertain at the present time which factors are primarily responsible for the accelerating increase in workmen's compensation insurance premiums; and

WHEREAS, last year the House Committee on Labor and Commerce requested its Workmen's Compensation Subcommittee to study the factors which may be accounting for such increasing preminums and at the conclusion of its study to offer those recommendations, if any, which may lead to a decline in the rate of increase of such premiums; and

WHEREAS, the Subcommittee secured the services of various individuals with expertise in the workmen's compensation insurance field and assembled those individuals into an ad hoc committee to advise the Subcommittee; and

WHEREAS, although both the ad hoc committee and the Subcommittee have worked diligently during the past year and have offered certain recommendations to the Committee on Labor and Commerce, additional work remains to be done; and

WHEREAS, the members of the ad hoc committee have agreed to continue working with the Subcommittee during this year; now, therefore, be it

RESOLVED by the House of Delegates, That the Workmen's Compensation Subcommittee of the House Committee on Labor and Commerce is requested to continue its study of the factors accounting for the accelerating increase in workmen's compensation insurance premiums. The Subcommittee is requested to utilize the expertise of its ad hoc workmen's compensation committee during its study.

The Subcommittee is requested to present its findings, conclusions and recommendations to the Governor and the General Assembly not later than November one, nineteen hundred seventy-nine. All agencies of the Commonwealth shall assist the Subcommittee in its study.

Both the Subcommittee and the task force worked hard during the past year in an effort to find ways of improving the State's workmen's compensation system. During a meeting held on April 27, the Subcommittee and the Commonwealth's new Commissioner of Insurance, Mr. James W. Newman, decided that the task force would be reorganized into four subcommittees. It was agreed that the task force would be divided into the following subcommittees:

(1) The Law and Procedures Subcommittee
(2) The Rate Regulatory Procedures Subcommittee
(3) The Standards of Service Subcommittee
(4) The Data Systems Subcommittee

The Legislative Subcommittee requested that each task force subcommittee try to complete its work as promptly as possible.

Additionally, during the April 27 meeting the Subcommittee learned that the Industrial Commission recently had held a public hearing on the feasibility of employing a medical fee schedule in workmen's compensation cases. The Subcommittee learned that at that hearing, many arguments had been made both in favor of and against a medical fee schedule. While the Subcommittee indicated that the feasibility of the fee schedule concept needed to be studied in more detail, the Subcommittee also indicated that such a schedule, or some other type of medical cost control, might be an effective means of holding down future workmen's compensaton rate increases. The Subcommittee urged the Industrial Commission and the Law and Procedures task force subcommittee to more closely examine the possible impact on medical costs of such a schedule, as well as alternative means of medical cost control.

During the meeting the Subcommittee also learned that the Industrial Commission had hired a data processing expert to help the Commission determine what type of data collection system it should adopt.

Further, the Subcommittee was advised that the workmen's compensation insurance industry had developed and implemented a very large data collection system. The Subcommittee learned that the industry data collection system, which became effective April 1, 1979, might provide information about the causes of the dramatic increases in workmen's compensation loss costs.

During a meeting held on August 23, the Legislative Subcommittee heard progress reports from members of the respective task force subcommittees. The Subcommittee also received a progress report from Mr. Charles G. James, a representative of the Industrial Commission, concerning the data base which the Commission is developing. The Subcommittee requested that Mr. James meet with representatives of the Bureau of Insurance, the insurance industry, and the Medical Society of Virginia and attempt to reach a consensus regarding the specific types of data which should be collected and maintained by the Industrial Commission. During the meeting the chairman of the Law and Procedures task force subcommittee pointed out that his subcommittee has recommended that a peer review system be instituted in Virginia. He noted that such a system would seem to offer definite advantages over a medical fee schedule as a means of controlling medical costs. The Legislative Subcommittee, while not endorsing the concept of a peer review system at that time, expressed interest in the concept and asked the Law and Procedures subcommittee to further study the feasibility of a peer review system vis-a-vis a medical fee schedule.

Another topic discussed at the August 23 meeting was the role of the Attorney General's Office in workmen's compensation rate hearings. The Subcommittee learned that the Attorney General's Office did not have a representative present during the most recent rate hearing, which was conducted on July 19, 1979. It was noted that the hearing resulted in a 8.2% increase in rates.

A representative of the Attorney General's Office told the Subcommittee that there was a conscious decision by his office not to participate in that rate hearing. He indicated that two reasons for the decision not to participate were that the Attorney General's Office is presently somewhat short of manpower, and the fact that his office learned that the Virginia Manufacturers Association was going to represent the interests of the business community at the hearing. Further, he stated

that on some occasions, his office does not learn that a workmen's compensation rate hearing is going to be held until thirty days prior to the hearing date. Needless to say, he stated, this does not give the Attorney General's Office much time to prepare for the hearing.

The Subcommittee Chairman, Delegate Wilson, responded to those comments by saying that the Subcommittee believes that active participation by the Attorney General's Office will help ensure that workmen's compensation rate hearings are more adversary in nature than they presently are. He noted that the Attorney General's Office has the statutory duty to represent the interests of consumers in rate hearings, and he said the Subcommittee feels that the interests of consumers should be represented at such hearings. Additionally, the Chairman requested that in the future, the Bureau of Insurance give direct notice to the Attorney General's Office regarding the dates of workmen's compensation rate hearings.

Additionally, the Chairman requested that the Commissioner of Insurance, Mr. Newman, do all he can to make rate hearings more adversary in nature.

The Subcommittee's final meeting of 1979 was held on December 19. At that time, representatives of the task force subcommittees presented the final reports of their subcommittees.

Each member of the Legislative Subcommittee was given a copy of a report entitled "Worker's Compensation Study: 1979." This report contains a summary of all the recommendations proposed by the task force subcommittees, comments of the Bureau of Insurance and the Industrial Commission regarding those recommendations, copies of the subcommittee reports, and various appendices. Enclosed as the attachment to this report is the complete task force report.

At the conclusion of the meeting, the Legislative Subcommittee adopted the task force report.

During the meeting the Subcommittee heard testimony relating to Code Section 65.1-47.1, which states that "the death of, or any condition or impairment of health of, salaried or volunteer fire fighters caused by respiratory diseases, and the death of, or any condition or impairment of health of, salaried or volunteer fire fighters, or of any member of the State Police Officers Retirement System or of any member of a county, city or town police department, or of a sheriff, or a deputy sheriff, or city sergeant or deputy city sergeant of the city of Richmond, caused by hypertension or heart disease, resulting in total or partial disability shall be presumed to be an occupational disease suffered in the line of duty that is covered by this act unless the contrary be shown by a preponderance of competent evidence..."

The Law and Procedures task force subcommittee advised the Legislative Subcommittee that there be no broadening of coverage under Section 65.1-47.1. Consequently, the Legislative Subcommittee questioned Commissioner Robert P. Joyner of the Industrial Commission as to what constitutes a "preponderance of competent evidence." Commissioner Joyner told the Subcommittee that in the case of John R. Page v. City of Richmond (March 3, 1978) the State Supreme Court held that the statutory presumption of causal connection raised by Code Section 65.1-47.1 must be refuted by "competent medical evidence." Commissioner Joyner said the Court ruled that the statutory presumption of causal connection cannot be rebutted if a physician fails to give his opinion as to the cause of the disability. In other words, Commissioner Joyner said, the Court ruled that in order to rebut the statutory presumption of causal connection, a physician must give his opinion as to the cause of the disability rather than merely stating that he found no connection between the disability and the claimant's employment. Commissioner Joyner concluded by stating that there is no confusion now regarding the interpretation of the statute.

During its final meeting of the year the Subcommittee also heard testimony from a task force member regarding a possible change in the Industrial Commission's review process. The task force member advised the Subcommittee that the task force has recommended that either Section 65.1-96 or 65.1-97 of the Workmen's Compensation Act be amended to provide that when the decision of a Commissioner of the Industrial Commission is reviewed, that Commissioner not be allowed to sit on review. Rather, a Deputy Commissioner should be designated by the other members of the Commission to replace him. The Subcommittee discussed this recommendation and became aware that arguments could be made both in favor of and against it. Therefore, while not endorsing the recommendation during the meeting, the Subcommittee agreed that such a recommendation had sufficient merit to warrant further consideration.

Another topic of discussion at the December 19th meeting was the proposed peer review system. The Subcommittee learned that either a part-time or full-time administrator probably would be needed to perform much of the preliminary work for the system's regional committees. After being informed of that, the Subcommittee discussed the feasibility of authorizing the Industrial Commission's chief administrator to also administer the peer review system. Also, the Subcommittee and the task force agreed that an annual budget of approximately $125,000 would be needed to operate the system.

MAJOR RECOMMENDATIONS

The Subcommittee makes the following major recommendations:

(1) Amend the State Workmen's Compensation Act by providing for the establishment of a medical peer review system under the control of the Industrial Commission. It should be the function of the peer review system to help ensure that medical care costs are kept reasonable without adversely affecting the quality of health care. The advisory committee and regional committees of the peer review system should be given immunity from liability so long as action is not taken with malice. The legislation necessary to effect these changes in the Act is contained in Section III-B of the attachment to this report.

(2) The State Corporation Commission and the Industrial Commission should adopt the standards of service recommended by the standards of service subcommittee.

(3) Workmen's compensation rate hearings should be more adversary in nature. The Attorney General's Office should have present at all such hearings a representative who represents the interests of consumers. Also, the Bureau of Insurance of the State Corporation Commission should thoroughly scrutinize and critique any rate filing presented to the Corporation Commission by the Virginia Compensation Rating Bureau.

(4) The Subcommittee study should be continued for another year. A resolution to continue the Subcommittee study is contained in Section III-B of the attachment to this report.

OTHER RECOMMENDATIONS

The Subcommittee also makes the following additional recommendations:

(1) Amend the Virginia Workmen's Compensation Act to make the Industrial Commission's Second Injury Fund more operative and meaningful.

(2) Amend the Act to allow individual proprietors and members of partnerships to be covered under its provisions.

(3) Amend the Act so as to authorize the Industrial Commission to seek injunctive relief against uninsured employers who operate in defiance of the law.

(4) Amend Section 2.1-116 of the Code of Virginia so as to remove the Industrial Commission from the jurisdiction of the State Department of Personnel.

The legislation necessary to effect these changes in the State Code is included in Section III-B of the attachment to this report.

(5) Commissioners of the Industrial Commission should have reduced workloads insofar as original hearings are concerned, so that more of their time can be devoted to cases being reviewed by the full Commission.

(6) The Industrial Commission should develop and make available to employers, employees, and the general public brochures which cover pertinent provisions of the Workmen's Compensation law. Additionally, the Industrial Commission should develop a Claim Procedures Manual as soon as feasible.

(7) There should be no broadening of coverage under Section 65.1-47.1, which relates to disability or death from respiratory disease, hypertension or heart disease.

(8) The Virginia Department of Rehabilitative Services and the Industrial Commission should proceed with the development of a specialized program for treating industrially injured persons.

DISCUSSION REGARDING MAJOR RECOMMENDATIONS

Major Recommendation No. 1: Amend the State Workmen's Compensation Act by providing for the establishment of a medical peer review system under the control of the Industrial Commission. It should be the function of the peer review system to help ensure that medical care costs are kept reasonable without adversely affecting the quality of health care. The advisory committee and regional committees of the peer review system should be given immunity from liability so long as action is not taken with malice. The legislation necessary to effect these changes in the Act is contained in Section III-B of the attachment to this report.

The Subcommittee believes that within the peer review system, a State-wide advisory committee to the Industrial Commission should be created. The advisory committee should consist of at least one representative from each regional peer review committee, as well as representation from the insurance industry, the Virginia Hospital Association, employees and the medical profession.

The advisory committee would recommend to the Industrial Commission the regulations to be followed by each regional committe. Included in the regulations would be the criteria for determining which workmen's compensation claims must be turned over to the regional committee for review.

Regional peer review committees for each of the five health systems areas in the Commonwealth would be established. Each regional committee would consist of health care providers who practice in that area. The Industrial Commission would appoint the members of each regional committee, based upon the recommendations of the State-wide advisory committee.

It would be the duty of each regional committee to review workmen's compensation cases to determine any of the following aspects of health care:

(1) Whether it was appropriate for an injured worker to be hospitalized, and if so, whether the length of stay in the hospital was excessive;
(2) Whether the fees charged by the health care provider for treatment were excessive;
(3) Whether the frequency or duration of out-patient treatment was excessive;
(4) Whether the authorization for absence from work was excessive;
(5) Whether the quality of medical care was sufficient.

Each regional committee would be authorized to retain an appropriate group or person to review workmen's compensation cases and make recommendations to the committee.

The peer review system would be financed through funding by the Industrial Commission.

The General Assembly should statutorily establish the framework for the peer review system and the details of the system should be established by regulation.

Section VI-A of the attachment to this report contains a more detailed description of how the peer review system would operate.

The Subcommittee gave serious consideration to the advantages and disadvantages of a medical fee schedule vis-a-vis a peer review system. The Subcommittee ultimately chose the peer review system, because it appears such a system will not have the disadvantages of a fee shedule. The study group determined that a peer review system would help control the increase in health care costs in the workmen's compensation area without having an adverse affect on the quality of medical care. In contrast, one argument the Subcommittee heard against adopting a medical fee schedule is that such a schedule might deprive some injured workers of the high quality of care they deserve, because many of the better qualified doctors will not handle cases if physician fees are set too low. Additionally, the Subcommittee was advised that if medical fees are set too high

under such a schedule, employees will be unfairly burdened and workmen's compensation cases will attract many less qualified physicians.

Another reason why the Subcommittee recommends a peer review system over a medical fee schedule is that the peer review concept has the endorsement of the Medical Society of Virginia, while many physicians are in opposition to a fee schedule. The Subcommittee feels that the support of physicians is crucial to the success of any program designed to control medical costs. The study group is aware that some physicians greatly resent fee regulation and view such regulation as an infringement on their freedom to practice.

However, the Subcommittee would point out that while it believes the present is not the proper time to legislate a medical fee schedule, the adoption of such a schedule might have to be reconsidered at some future time. The study group believes that medical cost increases must be held down and that if, after a reasonable trial period of time, it is determined that a peer review system is not holding down costs, then it might be necessary to implement a stringent fee schedule.

Major Recommendation No. 2: The State Corporation Commission and the Industrial Commission should adopt the standards of service recommended by the standards of service subcommittee.

A draft of the suggested standards of service is contained in Section VI-C of the attachment to this report.

The Subcommittee would note that the suggested standards of service would be applicable to all insurance carriers in the State who write workmen's compensation coverage. The standards give the Corporation Commission and the Industrial Commission additional authority to supervise the activities of such carriers.

Section 65.1-117.1 of the Code of Virginia provides that "the State Corporation Commission in cooperation with the Industrial Commission shall establish minimum standards of service for insurers writing workmen's compensation policies in this State, including but not limited to the servicing of such policies, the establishment of offices within the State, and the payment of compensation."

The Subcommittee feels that the standards of service suggested by the standards of service subcommittee provide the proper strengthening of Section 65.1-117.1. The standards will help insure that carriers issuing workmen's compensation coverage in the Commonwealth are aware of their responsibilities to consumers. Further, the Subcommittee would point out that the same capabilities of service will be applicable to companies which self insure to meet their workmen's compensation requirements.

Major Recommendation No. 3: Workmen's compensation rate hearings should be more adversary in nature. The Attorney General's Office should have present at all such hearings a representative who represents the interests of consumers. Also, the Bureau of Insurance of the State Corporation Commission, and the Industrial Commission, should thoroughly scrutinize and critique the rate filing presented to the Corporation Commission by the Virginia Compensation Rating Bureau.

Section 2.1-133.1 of the Code of Virginia states that one of the duties of the Division of Consumer Counsel in the Office of the Attorney General shall be to "appear before governmental commissions, agencies and departments, including the State Corporation Commission, to represesnt and be heard on behalf of consumers' interest, and investigate such matters relating to such appearance."

The Subcommittee learned that during the most recent workmen's compensation rate hearing before the Corporation Commission, which was held on July 19, 1979, the Attorney General's Office did not have a representative present. The Subcommittee feels that in light of the language of Code Section 2.1-133.1, the Attorney General's Office has a statutory duty to represent the interest of consumers during rate hearings before the Corporation Commission. The Subcommittee believes it is very important that the Attorney General's Office represent consumers during such hearings. It is the study group's feeling that having such a representative present during rate hearings might make such hearings more adversary in nature.

A representative of the Attorney General's Office told the Subcommittee that often his office does not learn that a workmen's compensation rate hearing is going to be held until thirty days

prior to the hearing date. Needless to say, he told the Subcommittee, this does not give his office much time to prepare for the hearing. To help overcome this problem, the Subcommittee has asked the Bureau of Insurance of the State Corporation Commission to give direct notice to the Attorney General's Office regarding the dates of workmen's compensation rate hearings.

The Commonwealth's Commissioner of Insurance advised the Subcommittee that the consulting actuary of the Bureau of Insurance, and certain members of the Bureau's staff, perform an in-depth analysis of all rate filings submitted by the Virginia Compensation Rating Bureau. Further, the Commissioner advised the Subcommittee that the Bureau's consulting actuary testifies during the rate hearing regarding his analysis and conclusions. The Subcommittee was encouraged by this testimony, but the study group believes the Bureau of Insurance should take whatever additional steps it needs to take to ensure that rate hearings are truly adversary in nature.

The Subcommittee believes that the Rating Bureau's rate filing should be analyzed indepth by the Bureau of Insurance; and the study group believes the Bureau of Insurance should, in general, play as active a role as possible in any rate hearing.

Major Recommendation No. 4: The Subcommittee study should be continued for another year. A resolution to continue the Subcommittee study is contained in Section III-B of the attachment to this report.

Although the Subcommittee believes that it has accomplished a great deal this year, it feels that there is a need to continue its study of the factors accounting for the accelerating increase in workmen's compensation insurance rates. The Subcommittee is very interested in examining some of the data being collected by the insurance industry and the Industrial Commission. Therefore, the study group has requested that copies of some of that data be sent to the Subcommittee after it has been analyzed and critiqued by the Bureau of Insurance.

In addition, there are other elements of its study that the Subcommittee would like to monitor. For example, the study group is interested in following the progress of the special vocational rehabilitation program for industrially-injured workers which the Industrial Commission and the Department of Rehabilitative Services have been encouraged to establish.

In addition, the Subcommittee feels that it may scrutinize other aspects of the State's workmen's compensation system next year. For example, one possible area of analysis would be workmen's compensation benefits, an area the study group was unable to consider this year.

For these reasons, the Subcommittee believes its study should be continued for another year.

CONCLUSION

The Subcommittee believes it has accomplished a great deal this year. The study group would like to acknowledge the tremendous assistance the task force has provided the Subcommittee. The Subcommittee realizes that without the expertise and knowledge of the task force, its job would have been much more difficult.

The Subcommittee believes the adoption of its recommendations will lead to significant improvement in the State workmen's compensation system, and it encourages the General Assembly to adopt those recommendations.

Respectfully Submitted,

William T. Wilson, Chairman
Richard R. G. Hobson
Calvin G. Sanford
Norman Sisisky
Warren G. Stambaugh

ATTACHMENT

A REPORT TO

THE

WORKMEN'S COMPENSATION SUBCOMMITTEE

OF THE

HOUSE COMMITTEE

ON

LABOR AND COMMERCE

December 19, 1979

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SECTION I

Introduction

This report is a result of the study directive contained in House Resolution No. 38, agreed to at the 1979 session of the Virginia General Assembly, which provides as follows:

"HOUSE RESOLUTION NO. 38

Offered January 19, 1979

Requesting the Workmen's Compensation Subcommittee of the House Committee on Labor and Commerce to continue its study of the factors accounting for the accelerating increase in workmen's compensation insurance premiums.

Patrons-Wilson, Washington, Johnson, Glasscock, Sisisky, Creekmore, Fowler, Bagley, R. M., Robrecht, Sanford, Teel, Heilig, Stambaugh, Scott, E.F., and Hobson.

Referred to the Committee on Labor and Commerce

WHEREAS, during the last three years there has been a demand for a ninety-eight percent increase in workmen's compensation insurance premiums in the Commonwealth; and

WHEREAS, it is uncertain at the present time which factors are primarily responsible for the accelerating increase in workmen's compensation insurance premiums; and

WHEREAS, last year the House Committee on Labor and Commerce requested its Workmen's Compensation Subcommittee to study the factors which may be accounting for such increasing premiums and at the conclusion of its study to offer those recommendations, if any, which may lead to a decline in the rate of increase of such premiums; and

WHEREAS, the Subcommittee secured the services of various individuals with expertise in the workmen's compensation insurance field and assembled those individuals into an ad hoc committee to advise the Subcommittee; and

WHEREAS, although both the ad hoc committee and the Subcommittee have worked diligently during the past year and have offered certain recommendations to the Committee on Labor and Commerce, additional work remains to be done; and

WHEREAS, the members of the ad hoc committee have agreed to continue working with the Subcommittee during this year; now, therefore, be it

RESOLVED by the House of Delegates, That the Workmen's Compensation Subcommittee of the House Committee on Labor and Commerce is requested to continue its study of the factors accounting for the accelerating increase in workmen's compensation insurance premiums. The Subcommittee is requested to utilize the expertise of its ad hoc workmen's compensation committee during its study.

The Subcommittee is requested to present its findings, conclusions and recommendations to the Governor and the General Assembly not later than November one, nineteen hundred seventy-nine. All agencies of the Commonwealth shall assist the Subcommittee in its study."

SECTION II

Scope of Study

In September 1978, the Workmen's Compensation Subcommittee of the House Committee on Labor and Commerce, jointly with the Commissioner of Insurance, established a study committee composed of seven subcommittees to conduct a study of workmen's compensation insurance in Virginia; identify the causes for the substantial rate increases in recent years and recommend corrective measures. Following conclusion of the activities of the subcommittees, a consolidated report of the results of their studies was submitted to the Legislative Subcommittee on December 20, 1978. The report included a summary of the subcommittees' recommendations for corrective measures, consisting of recommended law changes, recommended changes in the regulatory rules and procedures and changes of an administrative nature in insurance industry procedures. While a number of the subcommittees had completed their assignments there were some issues requiring further study. Therefore, it was agreed that the subcommittees would be reorganized, reduced in number and continue to work on those matters which had had not been completed or resolved.

On April 27, 1979, at a meeting of the Workmen's Compensation Subcommittee of the House Committee on Labor and Commerce, the Commissioner of Insurance announced the revision of the study group into four subcommittees to complete the study. The following subcommittees were established:

Law and Procedures

Rate Regulatory Procedures

Standards of Service

Data Systems

Subsequent to the establishment of the Subcommittees and designation of various areas of study for each, the subcommittees were sub-divided into task forces with each task force studying a specific problem. Numerous meetings were held by both the subcommittees and task forces. In addition, there was frequent consultation with the Commissioner of Insurance and the Industrial Commission of Virginia.

The resolution called attention to premium increases of 98% during the last three years, which increases were as follows:

7-1-76	21.1%	1-1-78	9.8%
7-1-77	21.1%	8-1-78	22.2%

These changes result in a cumulative increase of 96.9%, including law benefit changes for the period. However, it should be noted that the premium adjustment approved effective August 1, 1979 amounted to an increase of 8.2%, somewhat less than those in the immediately preceding years.

Inflationary trends are, of course, a major contributor to the rise in costs as indicated by the 51% increase in the Consumer Price Index from 1974 to 1979. The average annual Consumer Price Index stood at 147.7 in 1974 and 223.7 as of September, 1979. The average annual Medical Care Consumer Price Index stood at 150.5 in 1974 and as of September 1979 stood at 244.7, an increase of 63%.

Increase in average claim costs as stated in the rate filing effective August 1, 1979, shows that the indemnity cost per case has risen more than 25%. This figure is based on the Unit Statistical Plan data for the policy periods beginning at March 1, 1971 to February 29, 1972 through March 1, 1975 to March 31, 1976.

In the policy period March 1, 1971 to February 29, 1972, the average indemnity cost per case was $1,001. In the period from March 1, 1975 to March 31, 1976, the indemnity cost per case was $2,540. This change is averaged out to more than 25% per year over this four year period.

Similarly, the medical cost per case is stated as rising approximately 17%. The policy periods used to determine this figure are the same as for the indemnity

cost per case. Policy periods March 1, 1971 to February 29, 1972 showed an average medical cost per case of $127. The period from March 1, 1975 to March 31, 1976 showed a $238 medical cost per case. Averaged out over the four year period, these figures show a rise of approximately 17% per year.

Another factor accounting for increased costs in recent years and measured in the premium increases, involves increase in the maximum weekly compensation benefits for the period July 1, 1974 to July 1, 1979, from $91.00 per week to $199.00 per week, an increase of 119%. (A ten year summary of major benfit changes in the Workmen's Compensation Law is shown in Section VII of this report.)

Special legislation providing additional benefits under Section 65.1-47.1 for firefighters and police officers have contributed to the rise in workers' compensation losses.

There appeared to be almost unanimous agreement that the Workers' Compensation system, with recent benefit increase, lacked the necessary incentives for early return to work. This problem is being addressed by proposals which recommend change in the Second Injury Fund and a pilot program to be conducted by the Virginia Department of Rehabilitative Services under the supervision of the Industrial Commission. (See Section VI-A).

While many hours of study and effort were put into the study, the Subcommittee could not isolate any one specific problem or the cause for rapid acceleration of loss costs. It appears that many areas contributed to the premium increases and the subcommittees are of the opinion that the recommendations being made and those made in 1978 could assist in slowing the rise in Workers' Compensation loss costs and the increased premiums resulting therefrom.

Specifically, the study has demonstrated the need for an ongoing detailed study of loss data to ascertain the reasons for the rising costs and as pointed out in Section VI-D, this system became effective in Virginia April 1, 1979 and initial results, while perhaps fragmentary, should be available in early 1980.

Appendix C to this report contains a list of the members of each subcommittee. The participants included members of the staff of the Bureau of Insurance and Industrial Commission, insurance company representatives, insurance agents and representatives of Virginia industry and labor. The Manager of the Virginia Compensation Rating Bureau and the Rating Bureau's Counsel also participated in many of the subcommittees' meetings.

Each of the four subcommittees involved in the study has rendered a report of its activities and these reports are attached (Section VI).

Section III of this report contains a summary of the subcommittees' recommendations, categorized as follows:

1. Recommendations for Statutory Changes
2. Recommendations for changes and additions to Regulatory Rules and Procedures.

Section III-A

Recommendations
(See Section VI-A)

A. Statutory Changes in the Virginia Workmen's Compensation Act

1. Amend the Act to accomplish some broadening in the Second Injury Fund to make the fund more meaningful and operative.
2. Amend the Section 65.1-96 of the Act to provide that where a review is taken from a decision of a full Commissioner, the original hearing officer not be permitted to sit on review but the remaining members of the Commission instead designate a Deputy Commissioner to replace him.
3. Amend the Act to provide for the establishment of a medical peer review system under control of the Industrial Commission to provide an effective mechanism to insure that hospital and other medical care costs are reasonable without any adverse impact on the quality of health care. Immunity from liability should be given to members of regional committees and the advisory committee of the peer review system so long as they did not act with malice.
4. Amend the Act to permit members of partnerships and individual proprietors to elect to be covered under the Act.
5. Amend the Act to give the Industrial Commission approval to seek injunctive relief against uninsured employers continuing to operate in defiance of the law.
6. Amend Section 2.1-116 of the Code of Virginia, to remove the Industrial Commission of Virginia from the jurisdiction of the State Personnel Department.
7. The Subcommittee recommends that there be no broadening of coverage under Section 65.1-47.1, Presumption as to death or disability from respiratory disease, hypertension or heart disease.

B. Regulatory Rules and Procedures

1. Industrial Commission

(a) Implementation of the recommendation made by the Vocational Rehabilitation Study Task Force.

(b) It is recommended that provision be made for the workload of full Commissioners to be reduced insofar as original hearings are concerned so that a larger percentage of their time might be devoted to considering cases on review by the full Commission.

(c) The Subcommittee recommends that the Industrial Commission designate one or more persons in their Claim Department as being resource persons available to answer questions from any and all interested parties, including claimants, employees, employers and insurers.

(d) The Subcommittee recommends that the Industrial Commission designate one person, or position, as having primary responsibility in administrative areas. It is further recommended that such a position or person be assigned no other primary responsibilities, and that appropriate staff and electronic data systems support be provided.

(e) The Subcommittee endorses and recommends implementation of the statement made in the 1978 report with regard to the development and distribution of brochures covering pertinent provisions of the Workers' Compensation law and procedures to be made available to the employees, employers, and the public generally and that the Industrial Commission go ahead with the development of a Claim Procedures Manual as soon as feasible.

B. Regulatory Rules and Procedures

2. State Corporation Commission and Industrial Commission

(a) The Standards of Service Subcommittee recommends adoption by the State Corporation Commission and the Industrial Commission of the standards of service as contained in Section VI-C.

SECTION III-B

SUGGESTED LEGISLATION

1 D 1/21/80 WC C 1/24/80 bhw

2 A BILL to amend the Code of Virginia by adding in Title 65.1
3 a chapter numbered 13, consisting of sections numbered
4 65.1-153 through 65.1-163, to create a medical costs
5 peer review system under Workmen's Compensation Act.

6

7 Be it enacted by the General Assembly of Virginia:

8 1. That the Code of Virginia is amended by adding in Title

9 65.1 a chapter numbered 13, consisting of sections numbered

10 65.1-153 through 65.1-163, as follows:

11 CHAPTER 13.

12 MEDICAL COSTS - PEER REVIEW.

13 § 65.1-153. Definitions.--As used in this chapter:

14 1. "Utilization review" means the initial evaluation of

15 appropriateness, in terms of the level, quality and duration

16 of health care and health services provided a patient based

17 on medically accepted standards. Such evaluation shall be

18 accomplished by means of a system which identifies any

19 utilization of medical services above the usual range of

20 utilization for such services based on medically accepted

21 standards;

22 2. "Peer review" means an evaluation and determination

23 by a regional peer review committee of the appropriateness

24 of the level, quality, duration and cost of health care and

25 health services provided a patient based on medically

26 accepted standards;

27 3. "Physician" means any person licensed to practice

1 medicine or osteopathyin this Commonwealth pursuant to
2 chapter 12 of Title 54 of the Code of Virginia;
3 4. "Hospital" means any facility in which the primary
4 function is the provision of diagnosis, of treatment and of
5 medical and nursing services, surgical or non-surgical, for
6 two or more nonrelated individuals, including hospitals
7 known by varying nomenclature or designation such as
8 sanitoriums, sanitariums and general, acute, short-term,
9 long-term and outpatient hospitals;
10 5. "Health systems area" means those cities, counties
11 and towns in the Commonwealth that are included within the
12 jurisdiction of the health systems agency for that portion
13 of the Commonwealth, as established by the U.S. Department
14 of Health and Welfare pursuant to United States Public Law
15 93-641; provided, however, that Scott County, Washington
16 County and the city of Bristol, Virginia shall be deemed to
17 be a part of Health Services Area III as established by the
18 U.S. Department of Health and Welfare.
19 § 65.1-154. Statewide Coordinating Committee.--There
20 shall be a Statewide Coordinating Committee composed of nine
21 residents of the Commonwealth appointed by the speaker of
22 the House of Delegates and the Lieutenant Governor. Five of
23 the committee members shall be physicians each of whom has
24 patients the cost of whose treatment is reimbursed in whole
25 or in part pursuant to this Title; each physician member
26 shall be appointed from and represent a different health
27 systems area. One member shall be a representative of
28 employers in the Commonwealth, one member shall be a

1 representative of employees in the Commonwealth, one member
2 shall be a representative of the Virginia Hospital
3 Association and one member shall be a representative of
4 insurance carriers that provide workmen's compensation
5 insurance in the Commonwealth. The physician members of the
6 committee shall be appointed from nominations submitteed by
7 The Medical Society of Virginia. The chairman of the
8 Statewide Coordinating Committee shall be a physician member
9 of and selected by the Committee.
10 Of the members first appointed to the Statewide
11 Coordinating Committee, three members shall be appointed for
12 a term of one year, three members shall be appointed for a
13 term of two years and the remaining members shall be
14 appointed for a term of three years. Thereafter,
15 appointments shall be made for terms of three years or the
16 unexpired portions thereof. A vacancy other than by
17 expiration of term shall be filled by the Governor for the
18 unexpired term. No person shall be eligible to serve more
19 than two consecutive three-year terms.
20 § 65.1-155. Compensation of members; expenses of
21 Committee.--Each member of the Statewide Coordinating
22 Committee shall receive fifty dollars for each day actually
23 employed in the discharge of his official duties, together
24 with all necessary expenses incurred. The compensation and
25 expenses of the members and the necessary expenses of the
26 Committee shall be paid out of the State treasury upon the
27 warrants of the Comptroller.
28 § 65.1-156. Regional peer review committees.--The

1 Statewide Coordinating Committee shall establish a regional
2 peer review committee in each health systems area. Each
3 regional peer review committee shall be composed of five
4 physicians appointed by the Statewide Coordinating Committee
5 from nominations submitted by The Medical Society of
6 Virginia. Each committee member shall practice in the
7 health systems area and have patients the costs of whose
8 treatment is reimbursed in whole or in part pursuant to this
9 Title. The term of each member of each regional peer review
10 committee shall be established by the Statewide Coordinating
11 Committee.
12 § 65.1-157. Utilization review.--The Statewide
13 Coordinating Committee shall develop a utilization review
14 program for services rendered by physicians that are paid
15 for in whole or in part pursuant to this Title. Each
16 regional peer review committee shall have responsibility for
17 implementing the utilization review program in its health
18 systems area.
19 § 65.1-158. Peer review.--The Statewide Coordinaitng
20 Committee shall develop a peer review program for services
21 rendered by physicians that are paid for in whole or in part
22 pursuant to this Title. The peer review program shall
23 provide for peer review of services rendered by physicians.
24 Each regional peer review committee shall have the
25 responsibility for implementing the peer review program in
26 its health systems area. Referrals may be made to the
27 regional peer review committee pursuant to the utilization
28 review program or by the Industrial Commission, any

insurance company providing coverage for the cost of any services paid for in whole or in part pursuant to this chapter or any employer who is self-insured pursuant to § 65.1-104 of the Code of Virginia.

§ 65.1-159. Corrective action.--If it is determined that a physician improperly overutilized or otherwise rendered or ordered inappropriate medical treatment or services, or that the cost or duration of such treatment or services was inappropriate, the regional peer review committee shall, in accordance with the standard set forth in § 65.1-89 of the Code of Virginia, adjust the amount of reimbursement to which the physician is entitled pursuant to this Title and, if the physician is entitled pursuant to this Title and, if the physician already has been paid, shall require such physician to repay any excess amount that was paid to him for rendering or ordering such treatment or services. Any such determination by any regional peer review commission shall be reviewable by the Industrial Commission, which shall have exclusive jurisdiction to effect any such review. Any review by the Industrial Commission shall be pursuant to § 65.1-102 of the Code of Virginia. To be entitled to review by the Industrial Commission, the physician must deliver to the Industrial Commission written notice of his request for review, which notice must be received within thirty days after notice of the decision of the regional peer review committee is received by the physician.

By accepting payment pursuant to this Title, (i) any

1 physician, any hospital and any employee shall be deemed to
2 have consented to the submitting of all records concerning
3 treatment of the employee to the Industrial Commission, to
4 the Statewide Coordinating Committee, to any regional peer
5 committee, or to any agent of any such committee, and (ii)
6 any physician shall be deemed to agree to comply with any
7 decision of the regional peer review committee, subject to
8 his right to have the decision reviewed by the Industrial
9 Commission.
10 § 65.1-160. Immunity.--Every member of the Statewide
11 Coordinating Committee and every member of a regional peer
12 review committee shall be immune from civil liability for
13 any act, decision, omission or utterance done or made in
14 performance of his duties while serving as a member of such
15 committee so long as such act, decision, omission or
16 utterance is not done or made in bad faith or with malicious
17 intent.
18 § 65.1-161. Privileged communications.--The provisions
19 of Chapter 21 (§ 2.1-340 et seq.) of Title 2.1 of the Code
20 of Virginia shall not be applicable to the Statewide
21 Coordinating Committee or any regional peer review
22 committee. The proceedings, minutes, records and reports of
23 the Statewide Coordinating Committee and each regional peer
24 review committee, together with all communications, both
25 oral and written, originating in or provided to any such
26 committees are privileged communications which shall not be
27 disclosed or obtained by legal discovery proceedings unless
28 a circuit court, after a hearing and for good cause arising

1 from extraordinary circumstances being shown, orders the
2 disclosure of such proceedings, minutes, records, reports or
3 communications.
4 § 65.1-162. Employment of staff; contract for
5 services, rules and regulations.--The Statewide Coordinating
6 Committee shall have the authority to employ a staff and to
7 contract with any organization in order to operate the
8 utilization review program in any health systems area. The
9 Committee shall have the authority to adopt and amend such
10 rules and regulations as may be necessary to implement the
11 utilization review and peer review programs provided for in
12 this chapter.
13 § 65.1-163. Funding.--The cost of developing and
14 administering the utilization review program and the peer
15 review program shall be paid for exclusively out of the
16 administrative fund established pursuant to § 65.1-129 of
17 the Code of Virginia.
18 #

1 D 1/15/80 HPF C 1/18/80 kse

2 HOUSE RESOLUTION NO.....

3 Requesting the Workmen's Compensation Subcommittee of the
4 House Committee on Labor and Commerce to continue its
5 study of the factors accounting for the accelerating
6 increase in workmen's compensation insurance premiums.

7

8 WHEREAS, during the last four years there has been a
9 demand for over a one hundred percent increase in workmen's
10 compensation insurance premiums in the Commonwealth; and
11 WHEREAS, only a small percent of that increase has been
12 attributable to law changes; and
13 WHEREAS, during nineteen hundred seventy-eight the
14 House Committee on Labor and Commerce requested its
15 Workmen's Compensation Subcommittee to study the factors
16 which may be accounting for such increasing premiums and at
17 the conclusion of its study to offer those recommendations,
18 if any, which may lead to a decline in the rate of increase
19 of such premiums; and
20 WHEREAS, the Subcommittee secured the services of
21 various individuals with expertise in the workmen's
22 compensation insurance field and assembled those individuals
23 into an ad hoc committee to advise the Subcommittee; and
24 WHEREAS, House Resolution No. 38 of the nineteen
25 hundred seventy-nine General Assembly continued the
26 Subcommittee and ad hoc committee study; and
27 WHEREAS, although both the ad hoc committee and the

1 Subcommittee have worked diligently during the past two
2 years and have offered numerous recommendations to the
3 Committee on Labor and Commerce, additional work remains to
4 be done; and
5 WHEREAS, the members of the ad hoc committee have
6 agreed to continue working with the Subcommittee during this
7 year; now, therefore, be it
8 RESOLVED by the House of Delegates, That the Workmen's
9 Compensation Subcommittee of the House Committee on Labor
10 and Commerce is requested to continue its study of the
11 factors accounting for the accelerating increase in
12 workmen's compensation insurance premiums. The Subcommittee
13 is requested to continue utilizing the expertise of its ad
14 hoc workmen's compensation committee during its study; and,
15 be it
16 RESOLVED FINALLY, That the Subcommittee is requested to
17 present its findings, conclusions and recommendations to the
18 Governor and the General Assembly not later than November
19 one, nineteen hundred eighty. All agencies of the
20 Commonwealth shall assist the Subcommittee in its study.
21 #

1 D 01/23/80 C 01/26/80 arb

2 A BILL to amend and reenact §§ 65.1-139, 65.1-140 and
3 65.1-144 of the Code of Virginia; to amend the Code of
4 Virginia by adding sections numbered 65.1-141.1 and
5 65.1-142.1; and to repeal §§ 65.1-141, 65.1-142 and
6 65.1-143 of the Code of Virginia all providing for the
7 Second Injury Fund under the Workmen's Compensation
8 Act.

9

10 Be it enacted by the General Assembly of Virginia:

11 1. That §§ 65.1-139, 65.1-140 and 65.1-144 of the Code of
12 Virginia are amended and reenacted and that the Code of
13 Virginia is amended by adding sections numbered 65.1-141.1
14 and 65.1-142.1 as follows:

15 § 65.1-139. Funding.--For the purpose of providing
16 funds for compensation for ~~total~~ disability as hereinafter
17 defined ~~and~~ _,_ medical treatment _and_vocational_
18 _rehabilitative_services_ , a tax of one quarter of one per
19 centum shall be assessed, collected and paid into the State
20 treasury by the same persons and in the same manner as set
21 forth in chapter 10 (§ 65.1-129 et seq.) of Title 65.1 of
22 this Code.

23 This tax shall be in addition to the tax for the
24 Industrial Commission administrative fund and shall be held
25 by the Comptroller of the Commonwealth solely for the
26 payment of awards against such fund.

27 In any fiscal year in which the Second Injury Fund has
28 to its credit a sum in excess of ~~two hundred fifty~~ _five_

1 hundred thousand dollars, the tax shall be suspended for the
2 ensuing fiscal years and its collection not resumed until
3 the balance in the fund is reduced below ~~one-hundred~~
4 ~~twenty-five~~_two_hundred_fifty thousand dollars.
5 § 65.1-140. Disability defined. For the purpose of
6 this chapter, disability shall mean: (a) the partial or
7 total loss_or_loss_of_use of an arm, hand, leg, foot, eye,
8 finger, toe, or any combination of two or more thereof in an
9 industrial accident, and (b) actual incapacity for work at
10 the claimant's ~~most-recent~~ average weekly wage~~, and (c)~~
11 ~~nonentitlement-to-compensation-under-any-other-provision-of~~
12 ~~this-Act~~ .
13 §_65.1-141.1.__When_awards_entered.--The_Industrial
14 Commission_shall_enter_awards_against_the_Second_Injury_Fund
15 in_favor_of_an_employer_or_carrier_only_upon_a_finding_that:
16 (a)_the_employee_has_prior_loss_or_loss_of_use,_supported_by
17 medical_evidence,_of_not_less_than_twenty_per_centum_of_one
18 or_more_of_the_members_set_out_in_§_65.1-140;_(b)_the
19 employee_has_suffered_in_an_industrial_accident_an
20 additional_loss_or_loss_of_use_of_any_one_of_the_members_set
21 out_in_§_65.1-140_of_not_less_than_twenty_per_centum;_(c)
22 the_combination_of_both_impairments_has_rendered_the
23 employee_totally_or_partially_disabled_as_defined_in_§
24 65.1-140;_(d)_the_carrier_or_employer_has_paid_the
25 compensation_due_under_§§_65.1-54_and_65.1-55,_and_the
26 permanent_partial_disability_due_under_§_65.1-56_and_the
27 medical_treatment_under_§_65.1-88;_and_(e)_the_employee_is
28 entitled_to_further_compensation_for_disability_which_has

1 been paid by the employer or carrier.

2 § 65.1-142.1. Award for compensation, medical

3 treatment and vocational rehabilitation.--Upon a

4 determination by the Commission that an employer or carrier

5 has paid compensation, medical expenses or vocational

6 rehabilitation services on behalf of an employee under

7 circumstances as set forth under § 65.1-141.1 and if notice

8 of a claim against the Second Injury Fund was given prior to

9 payment of the benefits, the Commission shall enter an award

10 from the Second Injury Fund in favor of such employer or

11 carrier for: (a) reimbursement on a pro rata basis of the

12 compensation paid for further disability as set forth in §

13 65.1-141.1 (e), such prorating to be computed according to

14 the number of weeks each impairment is allowed under the

15 schedule in § 65.1-56; (b) reimbursement of reasonable

16 medical expenses on the same basis as set forth in (a) of

17 this section, provided the second injury is to the same

18 previously impaired member but such reimbursement shall not

19 exceed seventy-five hundred dollars; and (c) reimbursement

20 of reasonable vocational rehabilitation training service on

21 the same basis as set forth in (a) of this section but said

22 reimbursement not to exceed seventy-five hundred dollars.

23 § 65.1-144. Payments by fraud; mistake or unreported

24 change in condition; recovery.--Any payment to ~~a claimant~~

25 the employer or carrier pursuant to this chapter which is

26 later determined by the Industrial Commission to have been

27 procured ~~by~~ through fraud, mistake or ~~an unreported change~~

28 ~~in condition~~ the improperly processing of the claim by the

1 carrier , shall be recovered from the ~~claimant~~ employer or
2 carrier and credited to the Second Injury Fund. Any
3 subrogation recoveries or other recoveries from a third
4 party or other source shall be shared by the employer or
5 carrier and the Second Injury Fund on a pro rata basis after
6 deducting all reasonable expenses in obtaining the recovery.
7 2. That §§ 65.1-141, 65.1-142 and 65.1-143 of the Code of
8 Virginia are repealed.
9 #

1 D01/20/80WC C01/23/80baj

2 A BILL to amend the Code of Virginia by adding a section
3 numbered 65.1-4.2, allowing certain persons to elect
4 workmen's compensation benefits.

5

6 Be it enacted by the General Assembly of Virginia:

7 1. That the Code of Virginia is amended by adding a section

8 numbered 65.1-4.2 as follows:

9 § 65.1-4.2. Sole proprietors and

10 partners.--Notwithstanding any other provisions of this

11 title, any sole proprietor or all partners of a business

12 whose employees are eligible for benefits under this title

13 may elect to be included as an employee under the workmen's

14 compensation coverage of such business if the insurer is

15 notified of this election to be so included. Any sole

16 proprietor or the partners shall, upon such election, be

17 entitled to employee benefits and be subject to employee

18 responsibilities prescribed in this title.

19 When any partner or proprietor is entitled to receive

20 coverage under this title, such person shall be subject to

21 all provisions of the act as if he were an employee,

22 provided, however, that the notices required under §§

23 65.1-51, 65.1-85 and 65.1-86 of this title shall be given to

24 the insurance carrier and that the panel of physicians

25 required under § 65.1-88 shall be selected by the insurance

26 carrier.

1 Whenever coverage is obtained pursuant to this section,
2 such coverage shall be primary over the coverage of any
3 other owner, contractor or subcontractor working the same
4 trade, occupation or business as the claimant.
5 #

1 D 1/25/80 WC C 1/25/80 rmw

2 A BILL to amend and reenact § 65.1-106 of the Code of
3 Virginia, which provides penalties for employers
4 failing to secure workmen's compensation insurance.

5

6 Be it enacted by the General Assembly of Virginia:

7 1. That § 65.1-106 of the Code of Virginia is amended and

8 reenacted as follows:

9 § 65.1-106. Penalty for violation of preceding

10 section.--If such employer refuses and neglects to comply

11 with the provisions of the preceding section (§ 65.1-105) he

12 shall be punished by a fine of not less than fifty dollars

13 nor more than one thousand dollars, and he shall be liable

14 during continuance of such refusal or neglect to any

15 employee either for compensation under this act or at law in

16 a suit instituted by the employee against such employer to

17 recover damages for personal injury or death by accident,

18 and in any such suit such employer shall not be permitted to

19 defend upon any of the following grounds:

20 (1) That the employee was negligent;

21 (2) That the injury was caused by the negligence of a

22 fellow employee; or

23 (3) That the employee had assumed the risk of the

24 injury.

25 The fine herein provided may be assessed by the

26 Commission in an open hearing with the right of review and

1 appeal as in other cases. _The_Commission_may_also_order_the
2 employer_to_cease_and_desist_all_business_transactions_and
3 operations_until_found_by_the_Commision_to_be_in_compliance
4 with_the_provisions_of_this_chapter._
5 #

1 D 01/24/80 WC C 01/26/80 jsl

2 A BILL to amend and reenact § 2.1-116 of the Code of
3 Virginia, which exempts certain employees from the
4 State Personnel Act.

5

6 Be it enacted by the General Assembly of Virginia:

7 1. That § 2.1-116 of the Code of Virginia is amended and

8 reenacted as follows:

9 § 2.1-116. Certain officers and employees exempt from

10 chapter.--The provisions of this chapter shall not apply to:

11 (1) Officers and employees for whom the Constitution

12 specifically directs the manner of selection;

13 (2) Officers and employees of the Supreme Court;

14 (3) Officers appointed by the Governor, whether

15 confirmation by the General Assembly or by either house

16 thereof be required or not;

17 (4) Officers elected by popular vote or by the General

18 Assembly or either house thereof;

19 (5) Members of boards and commissions however selected;

20 (6) Judges, referees, receivers, arbiters, masters and

21 commissioners in chancery, commissioners of accounts, and

22 any other persons appointed by any court to exercise

23 judicial functions, and jurors and notaries public, as such;

24 (7) Officers and employees of the General Assembly and

25 persons employed to conduct temporary or special inquiries,

26 investigations, or examinations on its behalf;

1 (8) The presidents, and teaching and research staffs of
2 State educational institutions;
3 (9) Commissioned officers and enlisted personnel of the
4 national guard and the naval militia, as such;
5 (10) Student employees in institutions of learning, and
6 patient or inmate help in other State institutions;
7 (11) Upon general or special authorization of the
8 Governor, laborers, temporary employees and employees
9 compensated on an hourly or daily basis;-and,
10 (12) County, city, town and district officers,
11 deputies, assistants and employees_;_and
12 (13)_The_employees_of_the_Department_of_Workmen's
13 Compensation,_Industrial_Commission_of_Virginia .
14 #

SECTION IV

COMMENTS AND RECOMMENDATIONS OF BUREAU OF INSURANCE

The staff of the Bureau of Insurance has actively participated in the study and concurs with the recommendations contained in Section III of this report. The Bureau of Insurance Staff is of the opinion, however, that there remains additional study with appropriate action necessary to effect improvements for workers' compensation insurance. The Bureau will work closely in this regard with the Industrial Commission, the insurance industry and buyers of workmen's compensation insurance.

We offer the following comments and recommendations:

Data Call and Tabulation

The prospective data collection system developed by the insurance industry, which is now in place, will provide information about the causes of the increased loss costs. It does not, however, contain the mechanism necessary to collect statistical data, including loss and expense data, which allows for verification of data contained in the workers' compensation rate filings. It is expected that a program will be developed for the collection, compilation and publication of statistical and other data as provided by Section 65.1-117 of the Virginia Workmen's Compensation Act and such program submitted to the Industrial Commission of Virginia for their agreement.

Rate Procedures

Procedures relative to the development of changes in premium levels (increases and decreases in insurance rates) will be further examined, as will be the frequency of such changes in all rate filings, including the regular industrial rates, coal mine rates, federal coverage rates and miscellaneous changes involving rates. The examination will include the derivation and appropriateness of factors used to modify the loss and expense data, expense loadings, the impact of investment income, trend factors, etc.. The examination will be of an ongoing nature and will be performed by the Actuarial Consultant retained by the Bureau of Insurance.

Individual Risks

The Staff of the Bureau of Insurance will review the pricing of individual employers' insurance to insure equity within the pricing system. Such review will include assigned risks, federal coverages, coal mine rates, insurance classifications, insurance manual rates, territorial differentials, risk merit rating systems, retroactive rate adjustments, rating bureau performance and other areas of pricing including alternate methods.

SECTION V
COMMENTS AND RECOMMENDATIONS OF THE INDUSTRIAL COMMISSION

The Industrial Commission response is directed to those recommendations set forth in Section III of this report and the numbers in this response correspond to the numbers in the Summary of Recommendations.

A. Statutory Changes in the Virginia Workmen's Compensation Act

1. The Commission has no objections to the recommendation regarding broadening the Second Injury Fund coverage nor increasing the Fund amount.

2. The Commission believes that the recommended change to have a Commissioner replaced on the Review Panel by a Deputy Commission when an opinion from a Commissioner is being considered is not necessary for the following reasons:

   The vote of the Commissioner whose opinion is being appealed is of no effect unless the remaining two Commissioners are divided in their opinion as to whether to affirm or reverse.

   This procedure was noted in the assignment of errors in one case which was appealed to The Supreme Court and was not commented upon by the Court in its written opinion.

   The Deputy Commissioner sitting on such a review panel might feel some reluctance to vote to reverse a Commissioner who, in turn, votes on his salary increases and other personnel matters affecting him.

   The Commissioner review caseload is increasing to the point that in the foreseeable future it will be necessary for Commissioners to devote full time to the review docket and will not be hearing cases at the trial level.

3. Regarding medical peer review, the Commission recommends that the State-wide Coordinating Committee be reduced in number from 9 to 5, with two representatives from the medical profession, one representative from industry, one representative of employees, and one representative of the general public and that committee, in turn, establish no more than two local Peer Review Committees as a pilot project. This program could then be funded by the

Commission at no sum greater than $50,000.00 per year for each year of the next biennium. We further recommend that the establishment of policies, guidelines and rules be the sole responsibility of the Statewide Coordinating Committee and that, except for funding, the Industrial Commission remain independent of these groups except to hear appeals from their decisions. In this way the Commission would maintain its independence and objectivity without the appearance of any conflict of interest in questions regarding medical charges which might come before it.

4. The Commission does not anticipate any administrative problems associated with making members of partnerships or individual proprietorships subject to The Act. However, provisions should be made for the same notice and time limitations that apply between employer and employee to apply between the sole proprietor or partner and the carrier. Provision for providing medical treatment should be applied in the same manner as now applicable to the employee and employer. The coverage of the sole proprietor or partner should be primary to the coverage of the owner, general contractor or sub-contractor.

5. A proposed Bill is attached which would authorize the Commission to order an employer who is subject to The Workmen's Compensation Act to cease operations if he has not purchased the required insurance or qualified as a self-insured employer. This order could then be enforced in a local circuit court as other orders and awards of the Commission.

6. A proposed Bill is attached which would add the Industrial Commission to a list of those agencies which are now exempt from the State Personnel Act. At the present time, the status of the Industrial Commission and the jurisdiction

of the State Personnel Department is unclear. A copy of the State Organizational Chart is attached showing the Industrial Commission between the Legislative and Judicial branches of government, both of which are exempt from the State Personnel Act.

7. The Commission has no comment on the recommendation regarding the broadening of coverage under 65.1-47.1 [Police & Firemen presumptions].

B. Regulatory Rules and Procedures

1. (a). The Commission does not concur in the recommendation that a Deputy Commissioner or other person in a similar pay bracket be made responsible for review of vocational rehabilitation cases. If this program is instituted as a pilot project, such supervision is not necessary at this time. If the program is instituted on a statewide basis, there is sufficient supervision at this time by Industrial Commission personnel and DRS personne. The cost to Industrial Commission of establishing such an office is approximately $50,000.00 per year and it is our opinion that any benefit derived from the establishement of such an office would not be in proportion to its cost.

(b). Regarding Commissioners to hear only Review cases, it is anticipated that the workload of Commissioners at the hearing level will be reduced during the 1980 calendar year by the addition of one Deputy Commissioner who took office on November 15, 1979. The steadily increasing number of cases on the review docket will require more of the Commissioner's time.

(c). The Industrial Commission Claims Department currently has six employees who spend a major portion of their time as resource personnel answering

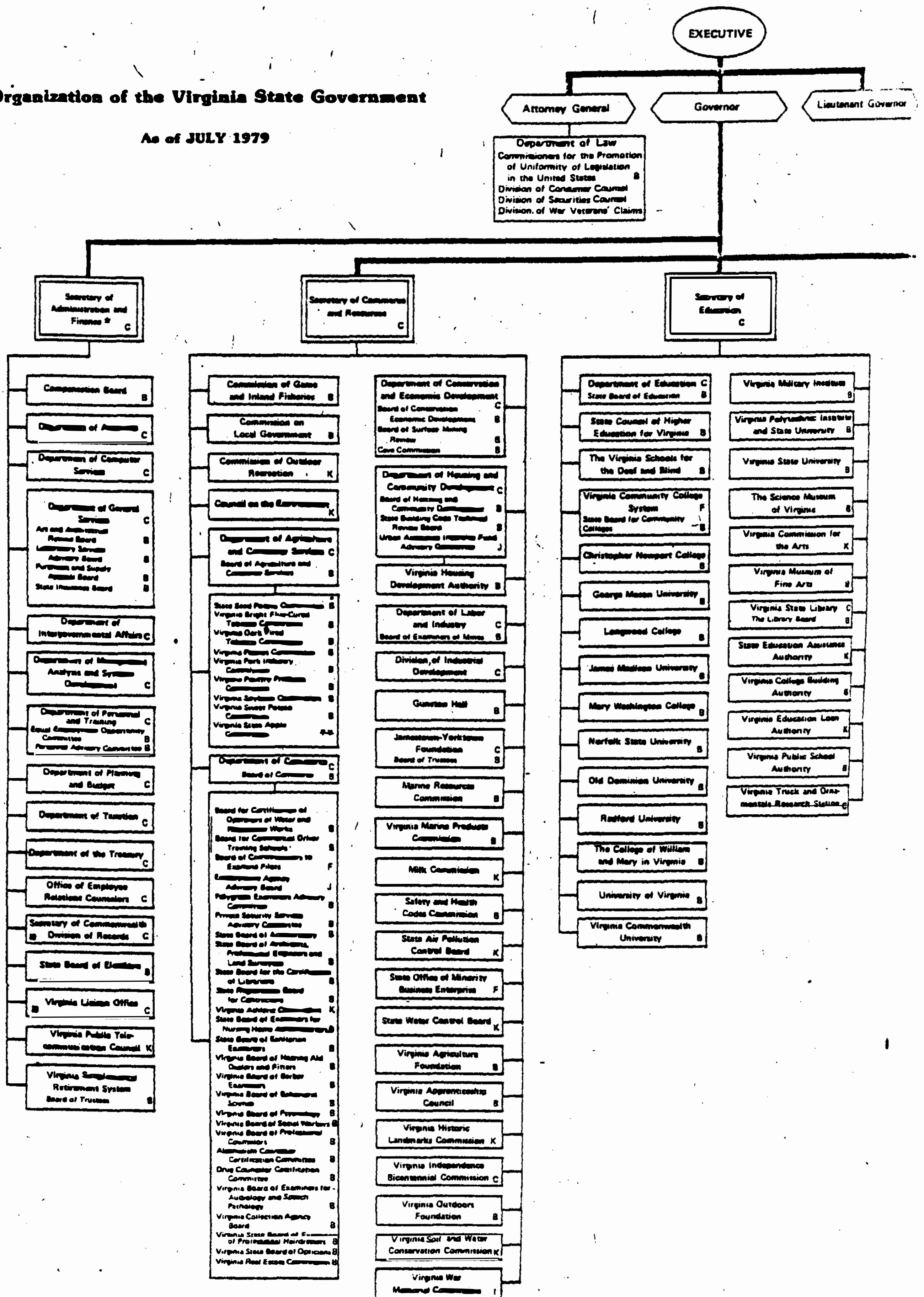
various questions and inquiries which come through the Claims Division. This workload cannot be assumed and handled properly by one person. However, additional personnel are needed for this purpose at this time.

(d). The Commission does not concur in the recommendation that a fulltime Administrator be appointed. This function currently is carried out by the Commission Chairman who currently serves a three-year term and the additional cost of an administrator and staff personnel could not be justified for this purpose.

(e.) The Commission concurs in the recommendation that brochures, etc. regarding workmen's compensation be prepared and distributed.

2. (a). The Commission has no objection to the recommendation set forth in Section VI-C, Standards of Service.

The House Labor & Commerce Workmen's Compensation Sub-Committee has previously indicated some concern regarding statistics maintained by the Industrial Commission. In this regard, please see the response of the Industrial Commission set forth in Section VI-D. To date no recommendations have been made to the Indsutrial Commission by any outside sources regarding additional statistics. However, we are advised that the Bureau of Insurance will shortly make requests for information needed for rate-making. In the meantime, the Commission began keeping certain additional statistics itemized in the Section referred to on July 1, 1979.



Organization of the Virginia State Government
As of JULY 1979
EXECUTIVE
Attorney General
Governor
Lieutenant Governor
Department of Law
Commissioners for the Promotion of Uniformity of Legislation in the United States
Division of Consumer Counsel
Division of Securities Counsel
Division of War Veterans' Claims
Secretary of Administration and Finance
Secretary of Commerce and Resources
Secretary of Education
Compensation Board
Department of Computer Services
Department of Intergovernmental Affairs
Department of Planning and Budget
Department of Taxation
Department of the Treasury
Office of Employee Relations Counselors
Secretary of Commonwealth
Division of Records
Virginia Liaison Office
Virginia Public Telecommunications Council
Commission of Game and Inland Fisheries
Commission on Local Government
Commission of Outdoor Recreation
Department of Conservation and Economic Development
Virginia Housing Development Authority
Department of Labor and Industry
Division of Industrial Development
Gunston Hall
Jamestown-Yorktown Foundation
Marine Resources Commission
Virginia Marine Products Commission
Milk Commission
Safety and Health Codes Commission
State Air Pollution Control Board
State Office of Minority Business Enterprise
State Water Control Board
Virginia Agriculture Foundation
Virginia Apprenticeship Council
Virginia Historic Landmarks Commission
Virginia Independence Bicentennial Commission
Virginia Outdoors Foundation
Virginia Soil and Water Conservation Commission
Virginia War Memorial Commission
Department of Education
State Board of Education
State Council of Higher Education for Virginia
The Virginia Schools for the Deaf and Blind
Virginia Community College System
Christopher Newport College
George Mason University
Longwood College
James Madison University
Mary Washington College
Norfolk State University
Old Dominion University
Radford University
The College of William and Mary in Virginia
University of Virginia
Virginia Commonwealth University
Virginia Military Institute
Virginia Polytechnic Institute and State University
Virginia State University
The Science Museum of Virginia
Virginia Commission for the Arts
Virginia Museum of Fine Arts
Virginia State Library
The Library Board
State Education Assistance Authority
Virginia College Building Authority
Virginia Education Loan Authority
Virginia Public School Authority
Virginia Truck and Ornamentals Research Station

LEGISLATIVE

General Assembly of Virginia
SENATE
HOUSE OF DELEGATES

JUDICIAL

Supreme Court D
JUDICIAL COUNCIL G
JUDICIAL INQUIRY AND REVIEW COMMISSION F
JUDICIAL CONFERENCES H

Secretary of Human Resources C

- Commission on the Status of Women B
- Department of Health C
  - State Board of Health B
  - Statewide Health Coordinating Council B
  - State Emergency Medical Services Advisory Council B
  - Virginia Voluntary Formulary Board B
- Department of Health Regulatory Boards C
  - Health Regulatory Commission B
  - State Board of Pharmacy B
  - Virginia Board of Veterinary Medicine B
  - Virginia Board of Dentistry B
  - Virginia Board of Funeral Directors and Embalmers B
  - Virginia State Board of Examiners in Optometry B
  - Virginia State Board of Medicine B
  - Virginia State Board of Nursing B
- Department of Mental Health and Mental Retardation C
  - State Mental Health and Mental Retardation Board B
  - Virginia Advisory Council on Substance Abuse Problems F
- Department of Rehabilitative Services C
  - Board of Rehabilitative Services B
  - Woodrow Wilson Rehabilitation Center
- Department of Welfare C
  - Board of Welfare B
- Division of Children C
  - Advisory Board B
- Division of Volunteerism C
  - Advisory Board B
- Office on Aging C
  - Advisory Board on Aging B
- Virginia Commission for the Visually Handicapped K
- Virginia Council for the Deaf K
- Virginia Developmental Disabilities Planning Council B
- Virginia Developmental Disabilities Protection and Advocacy Office F
- Virginia Employment Commission C
  - Governor's Manpower Planning Council F
  - Migrant and Seasonal Farmworkers Commission B
- Virginia Health Services Cost Review Commission B

Secretary of Public Safety C

- Commonwealth's Attorneys' Services and Training Council L
- Criminal Justice Services Commission K
- Department of Alcoholic Beverage Control
  - Alcoholic Beverage Control Commission B
- Department of Corrections C
  - Board of Corrections B
  - Virginia Parole Board B
- Department of State Police C
- Division of Capitol Police F
- Division of Justice and Crime Prevention C
  - Council on Criminal Justice B
- Office of Fire Services Training C
- Rehabilitative School Authority K
- Virginia State Fire Services Commission K

Secretary of Transportation C

- Department of Aviation C
  - Virginia Aviation Commission B
  - Virginia Airports Authority B
- Department of Highways and Transportation C
  - State Highway and Transportation Commission B
- Department of Military Affairs C
- Department of Transportation Safety C
  - Board of Transportation Safety B
- Division of Motor Vehicles C
- State Office of Emergency Services C
- Virginia Port Authority
  - Board of Commissioners B

Legislative agencies:

- Auditor of Public Accounts E
- Commission on Veterans' Affairs I
- Division of Legislative Services E
- Joint Legislative Audit and Review Commission F
- Revenue Resources and Economic Commission I
- The Solid Waste Commission I
- Virginia Advisory Legislative Council F
- Virginia Coal and Energy Commission I
- Virginia Code Commission I
  - Register Committee I
- Virginia Commission on Interstate Cooperation F
- Virginia Public Buildings Commission I
- Virginia State Crime Commission I

Other agencies:

- Department of Corporations
  - State Corporation Commission D
  - Administration
  - Bureau of Financial Institutions
  - Bureau of Insurance
  - Clerk's Office
  - Economic Research and Development
  - General Counsel
  - Motor Carrier Compliance and Services
  - Motor Carrier Operations
  - Motor Carrier Regulatory Planning and Control
  - Public Service Taxation
  - Public Utility Accounting and Finance
  - Public Utility Communications
  - Public Utility Energy Regulation
  - Railroad Regulation
  - Securities and Retail Franchising
- Department of Workmen's Compensation
  - Industrial Commission of Virginia D

Judicial agencies:

- Circuit Courts D
- District Courts D
  - General District Courts
  - Juvenile and Domestic Relations Courts
- Magistrate System F
- Public Defender Commission F
- State Board of Bar Examiners G
- Virginia State Bar G

LEGEND

Symbols

- BRANCH OF GOVERNMENT
- ELECTED OFFICIALS OR BODIES
- GOVERNOR'S SECRETARY
- SEPARATE AGENCY
- OFFICIAL LINE OF RESPONSIBILITY AND AUTHORITY

Notes

* The Secretary of Administration and Finance serves as Administrative Chairman of the Governor's Secretaries.

** [illegible]

[illegible]

● The Department of Agriculture and Consumer Services [illegible]

B—Board, Commission or Council appointed by the Governor and confirmed by the General Assembly.
C—Administrator, head appointed by the Governor and confirmed by the General Assembly.
D—Court or Commission with administrative power elected by the General Assembly.
E—Administrative head elected by the General Assembly.
F—Court, Commission, or administrative head appointed by the General Assembly or state official(s) other than the Governor.
G—Appointed by the Supreme Court.
H—All judges of Virginia Circuit and District Courts are members.
I—Court or Commission whose members are appointed in part by Governor and in part by the General Assembly.
J—Council or Committee appointed by Agency Director.
K—Board or Commission and administrative head appointed by the Governor and confirmed by the General Assembly.
L—Council composed of members designated by statute and [illegible]

Prepared by The Department of Management Analysis and Systems Development

A BILL to amend and reenact § 65.1-106 of the Code of Virginia to provide additional penalties for those employers who are subject to the Workmen's Compensation Act and who fail to insure their liability by one of the methods provided by law.

Be it enacted by the General Assembly of Virginia:

1. That § 65.1-106 of the Code of Virginia be amended and reenacted as follows:

§ 65.1-106. Penalty for violation of preceding section. — If such employer refuses and neglects to comply with the provisions of the preceding section (§ 65.1-105) he shall be punished by a fine of not less than fifty dollars nor more than one thousand dollars, and he shall be liable during continuance of such refusal or neglect to any employee either for compensation under this act or at law in a suit instituted by the employee against such employer to recover damages for personal injury or death by accident, and in any such suit such employer shall not be permitted to defend upon any of the following grounds:

(1) That the employee was negligent;

(2) That the injury was caused by the negligence of a fellow employee; or

(3) That the employee had assumed the risk of the injury.

The fine herein provided may be assessed by the Commission in an open hearing with the right of review ~~and appeal~~ as in other cases. (Code 1950, § 65-102; 1968, c. 660; 1970, c. 470; 1974, c. 314.)

The Commission may also order the employer to cease and desist all business transactions and operations until found by the Commission to be in compliance with the provisions of this Chapter.

A BILL to amend and reenact § 2.1-116 of the Code of Virginia, as amended, to provide that employees of the Department of Workmen's Compensation, Industrial Commission of Virginia, shall be included in the provisions of § 2.1-116.

Be it enacted by the General Assembly of Virginia:

1. That § 2.1-116 be amended and reenacted as follows:

§ 2.1-116. Certain officers and employees exempt from chapter. — The provisions of this chapter shall not apply to:

(1) Officers and employees for whom the Constitution specifically directs the manner of selection;

(2) Officers and employees of the Supreme Court;

(3) Officers appointed by the Governor, whether confirmation by the General Assembly or by either house thereof be required or not;

(4) Officers elected by popular vote or by the General Assembly or either house thereof;

(5) Members of boards and commissions however selected;

(6) Judges, referees, receivers, arbiters, masters and commissioners in chancery, commissioners of accounts, and any other persons appointed by any court to exercise judicial functions, and jurors and notaries public, as such;

(7) Officers and employees of the General Assembly and persons employed to conduct temporary or special inquiries, investigations, or examinations on its behalf;

(8) The presidents, and teaching and research staffs of State educational institutions;

(9) Commissioned officers and enlisted personnel of the national guard and the naval militia, as such;

(10) Student employees in institutions of learning, and patient or inmate help in other State institutions;

(11) Upon general or special authorization of the Governor, laborers, temporary employees and employees compensated on an hourly or daily basis; and,

(12) County, city, town and district officers, deputies, assistants and employees. (Code 1950, § 2-84; 1966, c. 677; 1973, c. 401.)

(13) The employees of the Department of Workmen's Compensation, Industrial Commission of Virginia;

Section VI-A

Subcommittee Assignments

Law and Procedures Sub-Committee

The Sub-Committee on Law and Procedures should review the Virginia Workmen's Compensation Act, Industrial Commission Rules and Procedures, Insurance Industry and Employer Procedures to develop and make available all pertinent data which have contributed to recent Workers' Compensation rate increases and to make recommendations with the view of improving conditions so as to prevent excessive rise in Workers' Compensation rates.

Among the specific items which should receive consideration in addition to the above, are:

Revised Second Injury Fund

Elimination of Award System in Non-controverted Cases

Deductible Insurance

Medical Cost Control

Extension of Act under Section 65.1-47.1 to Additional Persons

Employee Status (Sub-Contractors - Independent Contractors, etc.)

Extension of Coverage to Co-Partnerships and Individual Proprietors

Status Report on Recommendations made in 1978

THE TRAVELERS

Claim Department
H. V. Thornhill, Manager

November 30, 1979

Honorable James W. Newman
Commissioner of Insurance
P. O. Box 1157
Richmond, VA 23209

Dear Commissioner Newman:

RE: Final Report of the Law and Procedures Subcommittee

Attached is copy of final report of the Law and Procedures Subcommittee, covering the results of our studies, including Subcommittee recommendations for corrective measures.

I think, overall, our report reflects some real progress and, hopefully, it will be favorably received.

Respectfully submitted,

Harold V. Thornhill - Chairman
Law and Procedures Subcommittee

Enclosure

RICHMOND OFFICE OF THE TRAVELERS INSURANCE COMPANIES
3600 West Broad Street, P.O. Box 26426, Richmond, Virginia 23261 • Telephone: (804) 353-9451
Home Office: Hartford, Connecticut

FINAL REPORT OF THE LAW AND PROCEDURES STUDY COMMITTEE CONDUCTING WORKERS COMPENSATION STUDY FOR DELEGATE WILLIAM T. WILSON, CHAIRMAN OF THE WORKERS COMPENSATION SUBCOMMITTEE OF THE HOUSE COMMITTEE ON LABOR AND COMMERCE

The Law and Procedures Subcommittee presents its final report following its last meeting on November 28, 1979.

This Subcommittee, set up by Commissioner Newman of the Virginia Bureau of Insurance, was initially asked to review the Virginia Workmen's Compensation Act, Industrial Commission Rules and Procedures and Insurance Industry and Employer Procedures to develop data bearing on recent rate increases in Workers' Compensation insurance and to make recommendations on the following items:

Second Injury Fund

Elimination of Award System in Non-controverted Cases

Medical Cost Control

Extension of the Act under Section 65.1-47.1 to Additional Persons

Employee Status (Sub-Contractors - Independent Contractors, etc.)

Extension of Coverage to Co-Partnerships and Individual Proprietors

In addition, the Subcommittee was later asked to study a proposal of the Division of Rehabilitative Services regarding its handling of Workers' Compensation cases.

The initial work of the Subcommittee was handled by the following task forces: Second Injury Fund - Charles G. Avery, Jr., Chairman; Industrial Commission - J. B. Morton, Jr., Chairman; Medical Cost Control - Z. C. Dameron, Jr., Chairman; Legal Considerations - W. N. Gregory, Chairman; and Vocational Rehabilitation - D. E. Edwards, Chairman.

The task force chairmen subsequently submitted final reports, including their recommendations, to the Subcommittee for consideration and the task force recommendations have now been unanimously adopted by the full Subcommittee. Such recommendations are listed below by subject:

I. Industrial Commission Procedures

It is recommended that Section 65.1-96 be changed to provide that where a review is taken from a decision of a full Commissioner, the original hearing officer not be permitted to sit on review but the remaining members of the Commission instead designate a Deputy Commissioner to replace him.

The Subcommittee recommends that provision be made for the workload of full Commissioners to be reduced insofar as original hearings are concerned so that a larger percentage of their time might be devoted to considering cases on review by the full Commission.

It is recommended that the Industrial Commission designate one or more persons in the Claim Department as being resource persons available to answer questions from any and all interested parties, including claimants, employees, employers and insurers. It was felt that this strengthening of what is already being done would suffice without the need for the creation of an informal hearing procedure as such.

The Subcommittee recommends that the Industrial Commission designate one person, or position, as having primary responsibility in administrative areas. It is further recommended that such a position or person be assigned no other primary responsibilities.

The Subcommittee endorses and recommends implementation of the statement made in the 1978 report with regard to the development and distribution of brochures covering pertinent provisions of the Workers Compensation Law and procedures to be made available to employees, employers, and the public generally and that the Industrial Commission go ahead with the development of a Claim Procedures Manual as soon as feasible.

The Subcommittee decided not to recommend any change in the present Industrial Commission Award System at this time.

It is recommended that legislative approval be given the Industrial Commission to seek injunctive relief against uninsured employers continuing to operate in defiance of the law.

The Subcommittee recommends that the Industrial Commission be removed from the jurisdiction of the State Personnel Department by amending Section 2.1-116 of the Code of Virginia, to give the Industrial Commission the necessary flexibility to implement the above recommendations. Since the Industrial Commission is a specially funded quasi-judicial agency, the Subcommittee feels it should be exempted.

II. Second Injury Fund

The Subcommittee agreed that the present law is meaningless and felt that it should be changed, but only on a limited basis.

It is the Subcommittee's recommendation that Section 65.1-140 of the Act be amended by deleting the words "in an industrial accident" with further study to be given in the future to the relationship of back injuries to the Second Injury Fund.

It is also recommended that the statute be changed so that the second employer/carrier must give notice to and make claim against the Second Injury Fund rather than having the injured employee give such notice and make such claim and that the employer/carrier be permitted to recover medical and rehabilitation training services from the Second Injury Fund in the same percentage as recovery is made for compensation payments from the Fund, such recovery to be limited to $7,500 for medical and $7,500 for rehabilitation training services for each claim.

The Subcommittee recommends that Section 65.1-140(c), which relates to nonentitlement to compensation under any other provision of the Act, be deleted.

It is recommended that that portion of Section 65.1-39 relating to funding, be changed so that the maximum amount in the Second Injury Fund be increased to five-hundred thousand dollars and that collections be resumed when the balance in the Fund is reduced below two-hundred and fifty thousand dollars.

III. Medical Cost Control

Our recommendations under this topic are based on the following findings:

1. Virginia's workmen's compensation system does not contain an effective mechanism to insure that health care expenditures are reasonable.

2. Development and implementation of a detailed medical fee schedule, such as is found in sixteen other states, has advantages and disadvantages. A peer review system appears to avoid the disadvantages of a fee schedule. If the peer review system does not accomplish its objectives, a fee schedule may have to be considered.

3. Legislation to control health care costs in the workmen's compensation area should concentrate on health care provider costs, rather than hospital costs. Control of hospital costs is being effected through the Virginia Health Services Cost Review Commission, which is now in the development stages. The Commission will concern itself with rates charged to all hospital users, including patients covered by workmen's compensation. Special legislation restricted to hospital charges for workmen's compensation patients is not desirable.

Based on these findings, the Subcommittee recommends that the General Assembly take such action as is necessary to establish a medical peer review system under the control of the Industrial Commission in order to insure that persons covered by workmen's compensation will receive quality health care at reasonable cost. The peer review system should have the following characteristics:

1. A state-wide advisory committee to the Industrial Commission should be established with representation from each regional peer review committee, established pursuant to paragraph 2 below, as well as with representation from the insurance industry,

employers, employees, The Virginia Hospital Association, and the medical profession A representative of the medical profession should serve as Chairman.

The advisory committee would have the responsibility of recommending to the Industrial Commission regulations to be followed by each regional committee to conduct its peer review program. The regulations would include criteria for determining which workmen's compensation claims must be submitted to the regional committee for review. For example, the regulations might provide that every other workmen's compensation hospital admission should be submitted by the employer for review by the regional committee for the purpose of determining the appropriateness of both the admission and the length of the hospital stay. In addition, it might be provided that any out-patient case should be submitted to the regional committee for review if the medical bill exceeds "X" dollars or involves treatment over a period of more than "X" days. The regulations also could provide that an insurance carrier or self-insured would have the discretion to elect to have any workmen's compensation case reviewed by the regional committee. The regulations should initially be drawn in such a way as to limit the number of cases to be reviewed in order not to swamp the system during its infancy.

2. Establish a regional peer review committee for each of the five health systems areas in the State. Each regional committee would report to the Industrial Commission and would be made up of health care providers who practice in the health systems area. Each regional committee should be appointed by the Industrial Commission upon recommendation of the state-wide advisory committee. Members should serve only a fixed period of time and receive such compensation as is authorized by the Industrial Commission.

3. Each regional committee would have authority to review workmen's compensation cases to determine any of the following:

(a) quality of medical care;

(b) whether a hospital admission was appropriate, and if so, whether the length of stay was excessive;

(c) whether the frequency or duration of out-patient treatment and authorization for absence from work was excessive; and

(d) whether the fee charged by the health care provider for treatment was excessive.

4. Each regional committee would have the authority to retain an appropriate person or group to review workmen's compensation cases and provide recommendations to the committee. (At the present time, each health systems area has a professional standards review organization (PSRO) that is reviewing hospital admissions for patients covered by federal programs.) It is anticipated that the PSROs will be in a position to contract with the regional committees to review workmen's compensation cases and make recommendations.

5. Insofar as sanctions are concerned, a distinction must be made between hospitals and health care providers. If it is concluded that a hospital admission was inappropriate or a hospital stay was excessive, both of which determinations would be made while the patient was still in the hospital, the sanction would be to advise the patient, the physician and the hospital that, subject to an appropriate grace period, any further hospital costs will not be covered by workmen's compensation. When the regional committee determines whether a health care provider has rendered unnecessary treatment or charged excessively, the insurance carrier or self-insured would be obligated to reimburse the physician only up to the amount approved by the committee. If a greater amount already had been paid, the insurance carrier or self-insured would be entitled to demand a refund. In either event, the health care provider should have the right to appeal the decision to the Industrial Commission, but he should have the burden of proof before that body.

6. Each member of each regional committee and the advisory committee shall be given immunity from liability for any action taken so long as he did not act with malice.

7. The peer review system should be financed through funding from the Industrial Commission.

8. The framework for the peer review system should be established by the General Assembly. The actual mechanics of the peer review system should be established by regulation in order to provide flexibility.

We believe that a peer review system has a number of advantages, including the following:

(1) The system should help to control the increase in health care costs in the workmen's compensation area without any adverse impact on the quality of care. Simply having a review system in operation should, from a cost of care point of view, have a positive influence on health care providers treating workmen's compensation patients.

(2) With the regional committee set-up, the system should have sufficient flexibility to adapt to different conditions throughout the State.

(3) Through the state-wide advisory committee, all affected parties will have an input into the system.

(4) The system should have the capacity to expand or contract the scope of its activities as circumstances change.

(5) The additional administrative burden that will be imposed on the Industrial Commission should not be substantial.

IV. Industrial Commission - Virginia Department of Rehabilitative Services Cooperative Agreement Study

The objective of the Vocational Rehabilitation study was to evaluate a proposed cooperative agreement between the Virginia Department of Rehabilitative Services and the Industrial Commission. (See attached proposal)

The Subcommittee has some concern as to the manner of funding, particularly as to the degree of federal control that might be exercised if Workers' Compensation claimants' vocational rehabilitation is enhanced through the Virginia Department of Rehabilitative

Services, and further, is aware that traditionally, heavy emphasis has been placed by this Department on retraining industrially injured persons requiring vocational rehabilitation. Consequently, an education process for the Department of Rehabilitative Services staff would be required to more heavily emphasize placement activities.

Private enterprise has also entered this field of vocational rehabilitation and insurance carriers are already making substantial outlays to such enterprises for proper placement assistance. This raises the issue of competition between the State and private sector unless insurance carriers have options to decide between the private or State rehabilitative services.

Nevertheless, the Subcommittee recommends a three-part program:

A. The Virginia Department of Rehabilitative Services should be permitted to proceed with a specialized program for treating industrially injured persons. It is recommended that a separate division reporting directly to the Commissioner of the Department of Rehabilitative Services be established. This division should develop a program of approximately one year's duration beginning in 1980 in a localized area, such as Richmond, to test the feasibility of the approach. Later the program can be expanded as described in the proposal.

B. It is recommended that funding for this pilot program - and, if adopted, for the permanent program - be included in the Department of Rehabilitative Services normal operating budget for staffing, administrative costs, and operating costs. Direct support should be funded from the insurance carriers via fees for testing, schools, etc. as is the current custom.

C. Section 65.1-88 of the Workmen's Compensation Law places responsibility for rehabilitation on the Industrial Commission. It is important that a designated person be assigned the responsiblity for screening cases for rehabilitation efforts. This person should be at a Deputy Commissioner level or higher.

   The insurance carrier should be permitted to share in selecting the more appropriate rehabilitative service - either State or private. The Industrial Com-

mission designee should have the responsibility of coordinating the selection with the carrier prior to referral to the Department of Rehabilitative Services.

The Department of Rehabilitative Services liaison position should be continued as at present. This person should establish a reporting system to periodically appraise the Industrial Commission and insurance carrier of the effectiveness and progress of the rehabilitation efforts.

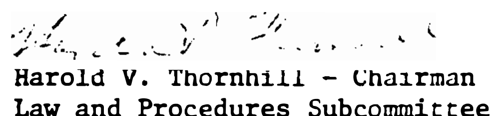
V. Extensions of the Act to Additional Persons

The Subcommittee recommends Section 65.1-47.1, creating a presumption in regard to heart and respiratory disease cases covering policemen and firemen not be expanded to cover any additional occupations or employees not already covered. It was the feeling of the Subcommittee that this special benefit legislation constitutes a perversion of the Workmen's Compensation Law and should be more properly handled under the Virginia Supplemental Retirement System and various private hospital, surgical, and disability benefit plans.

Finally, it is recommended that the Act be extended to afford benefits as employees, on an optional basis, to sole proprietors and co-partners, subject to such persons complying with the responsibilities imposed on other employees covered under the Act.

To aid in the implementation of the above recommendations, the Subcommittee submits herewith legislative drafts that it hopes will be useful.

Respectfully submitted,



Harold V. Thornhill - Chairman
Law and Procedures Subcommittee

HVT:dvz
Attachments

DRAFT

COOPERATIVE AGREEMENT BETWEEN THE
VIRGINIA DEPARTMENT OF REHABILITATIVE SERVICES
AND THE INDUSTRIAL COMMISSION OF VIRGINIA

I. PARTIES: The parties to this agreement are the Industrial Commission of Virginia, hereinafter referred to as the Commission and The Virginia Department of Rehabilitative Services, hereinafter referred to as the Department. Both parties are in compliance with Section 503 and 504 (PL 93-112) to the extent applicable, and with Title VI of the Civil Rights Act of 1964.

II. AUTHORITY: Virginia Workmen's Compensation Act (65.1-88, 65.1-129, 65.1-136 and 65.1-142 Code of Virginia), Public Law 93-112 known as the Rehabilitation Act of 1973 as amended, 45 CFR 1361.11 and 1361.13, Section 22-330.1 through 22-330.11 of Chapter 15.1 Code of Virginia as amended, the Virginia Department of Rehabilitative Services annual State Plan, and other Federal and State Laws as appropriate.

III. PURPOSE: The purpose of this agreement is to provide appropriate vocational rehabilitation services, particularly placement services, to disabled workers who are receiving compensation under the Virginia Workmen's Compensation Act and who meet the eligibility requirements of the Department.

IV. PROGRAM AND SERVICES PROVIDED:

The program shall have qualified staff in sufficient numbers to satisfactorily carry out the vocational rehabilitation functions required.

The program shall provide vocational rehabilitative services directed toward serving all eligible Commission claimants within the Department's policies and procedures.

A. THE DEPARTMENT AGREES TO:

1. Cooperatively participate with the Commission, insurance carriers/employers in developing comprehensive vocational rehabilitative programs for eligible disabled claimants/clients which would ultimately result in employment.

2. Define the vocational rehabilitative services to be provided by the Department.

3. Accept referrals of disabled claimants for evaluation.

4. Determine the eligibility of individuals to receive services from the Department.

5. Provide appropriate services to those individuals determined to be eligible.

6. Continue appropriate services to individuals who are determined ineligible under the Virginia Workmen's Compensation Act.

7. Provide one (1) Counselor and support staff in each office (excluding the five requested 100% Commission caseload) who will be responsible for Commission cases in the area covered by the particular Counselor. These Counselors will also cover other referral sources or programs. This will involve the re-assignment of 14 Counselors to cover these cases. It is estimated the Workmen's Compensation cases will average 5-10% of their total caseloads. The office assignments to be made are as follows:

1)	Buena Vista	One Counselor
2)	Chesterfield-Southside	Two Counselors
3)	Culpeper	One Counselor
4)	Danville	Two Counselors
5)	Hopewell	One Counselor
6)	Leesburg	One Counselor
7)	Petersburg	Two Counselors
8)	Richlands	Two Counselors
9)	Richmond	One Counselor
10)	Wytheville	One Counselor

8. Provide field staff who will deal only with Workmen's Compensation cases from the Virginia Industrial Commission, Federal Workmen's Compensation (OFEC/OWCP) and referral of Workmen's Compensation cases from other states in five selected geographic areas.

    1) Norfolk - Portsmouth, Virginia Beach

    2) Newport News, Hampton

    3) Alexandria, Mt. Vernon, Falls Church

    4) Arlington, Woodbridge

    5) Abingdon, Bristol

These positions would involve the transfer/hiring of five (5) Counselors and five (5) Secretaries.

9. Provide office space for the requested five (5) Counselor and five (5) Secretarial positions.

10. Provide supportive Supervision for these staff on the local level from the Department of Rehabilitative Services/Industrial Commission Supervisor.

11. Provide diagnostic, medical management and other appropriate vocational rehabilitation services for those clients determined eligible under the uninsured employers fund as outlined in the Virginia Workmen's Compensation Act.

B. <u>THE COMMISSION AGREES TO:</u>

1. Provide funding to the Department for five (5) Workmen's Compensation caseloads with supportive staff. Funding shall cover salaries, benefits, travel and case service monies not available from the carrier for diagnostic work up.

2. Provide funding and office space to cover the cost of DRS/IC office staff. This office staff will include:

    1) One Supervisor "B"
    2) One Counselor Aide
    3) One Clerk Steno "C"
    4) One Clerk Typist "B"

3. Initiate referral of Virginia Workmen's Compensation claimants to the Department through established referral procedure as utilized by the Department staff in the Commission office on those applicants who are in need of vocational rehabilitation services offered by the Department.

4. Provide a timely hearing on those cases where vocational training is the issue and the insurance carrier refused voluntary participation.

5. Actively encourage claimant/client to cooperate with the Department in developing a reasonable and necessary program when such request is initiated by the insurance carrier or their representative.

6. Develop, in cooperation with the Department, reporting back procedure to evaluate the impact of this program in increasing the effectiveness of the vocational rehabilitation of disabled individuals as covered under the Virginia Workmen's Compensation Act.

V. PROGRAM GOALS

The objectives of this joint effort are to:

A. Improve the system of reporting back to the Commission on data needed to evaluate the impact of Department services on Commission claimants.

B. Increase employer/insurance carrier awareness of Department services through periodic mailings, publishment of articles in various internal publications, and through meetings with local DRS staff. DRS will also contact insurance carriers and request staff training when available.

C. Provide post employment services to eligible clients who are experiencing vocational problems caused by their occupational injury. This will be an ongoing service for which an automatic monitoring system will be developed.

D. During Fiscal Year it is anticipated that time delay from referral to closure ineligible Status 08 will be reduced overall below the Department's statewide average.

E. During Fiscal Year it is anticipated that the total number of months from referral to ineligible Status 28 and 30 will be reduced overall below the Department's average.

F. During Fiscal Year it is anticipated that the total number of months from referral to closure employed (Status 26) will be reduced overall below the Department's average.

G. During Fiscal Year it is anticipated the five (5) caseloads will successfully close in employment 150 cases. Of these projected 150 cases successfully employed, at least forty (40)will be severely disabled.

H. During Fiscal Year it is anticipated that similar benefits received on cases from Industrial Commission and other sources will amount to $250,000.00.

I. During Fiscal Year it is anticipated that the caseloads not serving 100% Industrial Commission cases will successfully close in employment 75 cases. Of the projected 75 cases successfully employed, at least twenty (20) will be severely disabled.

VI. EVALUATION COMPONENT:

Responsibility for evaluation will rest with the Commission chairman and the DRS program supervisor. The plan for evaluation of the program will include:

A. Establishment of agreed upon data between Department and Commission to evaluate the impact of Department Services to Commission clients at least quarterly with an overall annual evaluation.

B. Quarterly and annual review of progress toward goal of decreasing number of months from referral to ineligible Status 08, 28 and 30 by

C. Quarterly and annual review of progress toward goal of decreasing number of months from referral to closure Status 26 employed by

D. Quarterly and annual review of progress toward goal of closing 150 cases in employment on and for the five (5) full service caseloads.

E. Quarterly and annual review of progress toward goal of securing similar benefits in the amount of $250,000.00 by

F. Quarterly and annual review of progress toward goal of closing 75 cases in employment on and for non-full service Industrial Commission caseloads.

VII. ADMINISTRATION:

This agreement covers the areas of duties and responsibilities of the Commission and the Department in the continuing development of the program. This agreement shall be evaluated annually in September and revised when necessary to meet changing needs. Actual administration of the program rests solely with the Department of Rehabilitative Services.

The Annual Budget (attached) will be broken down into an expenditure report on a monthly bases and presented to the Commissioner of the Virginia Industrial Commission and the Program Supervisor of the Department of Rehabilitative Services/ Industrial Commission Office. This report will be forwarded from the Data Processing Section of the Department. Attached, also, will be documentation of the cost sharing funds provided by the Commission for salaries for fourteen (14) Department Staff wholly or partially funded by the Commission.

Appropriate records will be available to designated DRS staff, Industrial Commission, insurance carriers and employers when it does not violate the confidential nature of the record and the proper release has been signed by the client.

The Program Supervisor of the Department will keep appropriate records and submit such reports as may be determined necessary to the Commission and the administrative head of the Department.

VIII. FACILITIES:

The Commission shall provide and maintain suitable quarters for Department/Industrial Commission Office staff for the operation

of the program including heat, lights and janitorial services at no cost to the Department. Other costs of the program including necessary office equipment, supplies and phone service shall be provided by the Department. The Department will provide suitable housing, office equipment, supplies and phone service to the five (5) full service Industrial Commission Counselors and five (5) supportive staff out of their local office "Operating Expense Budget".

IX. STAFFING:

A. The Department shall assign the following staff to the program:

Title	Percentage of Time Assigned to Program
Program Supervisor "B"	100%
Counselor Aide "B"	100%
Clerk Steno "C"	100%
Clerk Typist "B"	100%
5 Counselors "C"	100%
5 Clerk Stenos "C"	100%

B. The Department's local supervisors will provide the day to day supervison for the five (5) field service counselors and supportive staff.

X. BUDGET:

The Commission shall expend identifiable funds in the operation of the program in an amount to be determined by the Commission and the Department. The Department will make an annual commitment for financing its part of the program to ensure continuity of the Operation.

The Rehabilitative Services/Industrial Commission program budget is estimated to be the following.

Virginia Industrial Commission
Estimated

Title	Cost
Program Supervisor "B"	$17,150 - $17,900
Counselor Aide "B"	8,784 - 9,168
Clerk Steno "C"	8,400 - 8,784
Clerk Typist "B"	7,032 - 7,344
5 Counselors "C"	13,128 - 13,728
5 Clerk Stenos "C"	8,400 - 8,784

Salaries	$149,006
Fringe Benefits	20,860
Travel	10,000

Estimated Total: $179.866

XI. IMPLEMENTATION AND AMENDMENTS:

This Agreement shall remain in effect from through and shall be renewed prior to that date if the program is to continue. The parties to the Agreement may continue, amend or terminate the Agreement, with cause, by written notice of at least 30 days.

(Signature lines to be added on final copy)

Section VI-B

Subcommittee Assignments

Rate Regulatory Procedures Subcommittee

The Sub-Committee on Rate Regulatory Procedures should examine all aspects of the ratemaking procedure including the processing of basic data through the development of the rate levels and individual classification rates. Such examination should include the present methodology of ratemaking as well as consideration of alternative ratemaking procedures and/or pricing methods, such as competitive pricing, and development of pure premiums rates, etc.. The examination should include, but not be limited to the following specific areas:

Loss Trending and Development

Evaluation of Costs of Law Benefit Changes

Expense Loadings

Minimum Premiums, Loss and Expense Constants

Occupational Disease Rates and Loadings

Experience Rating Plan, Retrospective Rating Plans, Premium Discounts

Pricing of Assigned Risk Insurance

Pricing of Maritime Coverage (Jones Act) including jurisdiction, rates and coverages

Pricing of Deductible Insurance

Retroactive Rate Adjustments

Manual Rules, Classification Procedures, Low Credibility Classifications

Rating Bureau - Audit Procedures

WORKERS' COMPENSATION STUDY

RATE REGULATORY PROCEDURES SUBCOMMITTEE

I. Report

II. Appendix

III. List of Subcommittee Members
(See Appendix C to the full report)

Submitted by: Bernard M. Hulcher
2225 Brookwood Rd.
Richmond, VA 23235

August 23, 1979 (Interim Report)

December 6, 1979 (Full Report)

December 6, 1979

REPORT OF RATE REGULATORY PROCEDURES SUBCOMMITTEE

This Subcommittee set itself the task of examining Rate Regulatory Procedures in three broad categories, as follows:

A. Rate Making

B. Rating Plans

C. New Approaches

Approximately twelve (12) meetings of the Subcommittee as a whole, or parts of it (Task Forces) assigned certain areas of study, were held during the summer months. In addition, a great deal of individual research and study has gone into this work. Reports and final action by the Subcommittee are attached.

A. Rate Making

The Task Force assigned this area has examined the following subjects:

1. Loss Trending
2. Loss Development Factors
3. Evaluation of Law Benefit Changes
4. Expense loadings and Premium Discounts
5. Occupational Disease Rates and Loadings
6. Low Credibility Classifications
7. Territorial Ratemaking
8. Medical Fee Schedules

A copy of this report is attached (Appendix A).

B. Rating Plans - Report and Conclusions

The Task Force assigned to study rating plans has examined the following subjects:

1. Experience Modification
2. Retrospective Rating Plans
3. Retention Plans
4. Participating Plans
5. Loss and Expense Constants and Minimum Premiums
6. Payroll Limitations

See Appendix B, attached, for detailed report and conclusions of this Task Force.

C. New Approaches - Report and Conclusions

The following subjects were examined by the New Approaches Task Force:

1. Assigned Risk Pricing
2. Competitive Rating
3. Schedule Rating
4. Deductibles

See Appendix C, attached, for report and conclusions reached by this Task Force.

OVERALL CONCLUSIONS:

While refinements in the Rate Regulatory Procedures are suggested and may serve to make the system more equitable and responsive to all classes of employers, the Subcommittee was not able to point to modifications which it believed would materially change the present unsatisfactory results. The pricing system is in the process of responding to inflationary pressures. Better communication between employers, insurers, agents and physicians is a hopeful area and suggestions are made for education to obtain better understanding of just what is at stake for each party to the Workers' Compensation Contract.

Respectfully submitted,

Bernard M. Hulcher

Bernard M. Hulcher - Chairman
Rate Regulatory Procedures Subcommittee

BMH:dvz
Enclosures

APPENDIX

A. Rate Making Task Force Report

B. Rating Plans Task Force Report and Conclusions

C. New Approaches Task Force Conclusions, Recommendations and Memoranda

1. Deductible Workers' Compensation Insurance - Pros and Cons

2. Workers Compensation Schedule Rating

3. Memorandum - Workers' Compensation Assigned Risk Plans

4. Schedule of Assigned Risk Surcharges and Producer Fees - by State

APPENDIX A

PHILIP O. PRESLEY, F.C.A.S., M.A.A.A.
ACTUARIAL CONSULTANT
6-14 PENDLETON LANE
LONDONDERRY, NEW HAMPSHIRE 03053
(603) 432-3376

December 6, 1979

Mr. James W. Newman
Commissioner of Insurance
Virginia Bureau of Insurance
Box 1157
Richmond, Virginia 23209

Re: Workmens Compensation Study Committee
Ratemaking Subcommittee

Dear Mr. Newman:

This is the final report of the Ratemaking subcommittee of the Rate Regulatory Procedures Committee of the recent Workmens Compensation Insurance Study Group. This subcommittee was assigned the task of reviewing the ratemaking procedures used for this coverage to determine what impact, if any, these might have on the recent problems in this coverage in Virginia.

Before dealing with specific details, it was thought that a brief description of workmens compensation ratemaking procedures would be in order. These have evolved into a rather complicated technical system that might well confuse those who have not had the opportunity to study it closely. The broad principles involved, however, are reasonably straight-forward.

The basic objective is to develop rates that are adequate to cover costs when the new rates would be used, and to provide a reasonable, but not excessive, profit to insurers. The first step in accomplishing this is to calculate how much of a change in total premiums is necessary. The second is to determine how these changes should be spread among the various categories of employers.

The first step is accomplished by analyzing recent experience. This is taken as being the best guide to what might happen in the immediate future.

Two sources of data are used, and are given equal weight in the computations. The first is policy year data. This is comprised of the premium and loss experience under all policies that went into effect during the named year. For example, in the most recent Virginia rate case policy year 1977 was used.

The second is calendar year data. This is a summary of all transactions that occurred during a given twelve month period. Calendar year 1978 experience was used in the Virginia rate case earlier this year.

Certain adjustments to this data must be made to determine the necessary rate change. First of all, the experience premiums represent whatever rates were in effect when the policies were issued. These must be adjusted to the level of rates currently being used: the ratemaker is trying to determine how much those rates must be changed.

Secondly, the losses must be adjusted to what they will likely be when the new rates will be in effect. This involves several steps.

One recegnizes the fact that the final costs of recent claims may not be known for some time. While claims adjustors make the best estimates they can based on the facts available, medical conditions and the extent of disability can change over time. Moreover, insurers may not be aware of some claims until months after the injury. The effect of such changes is reflected through the application of "loss development factors," which are based on how the level of losses from previous years changed over time.

Secondly, the benefits that must be paid, as for example the maximum weekly indemnity benefit, change periodically. The past losses must therefore be adjusted to the level of benefits that will have to be paid in the future. This is accomplished by the application of "law amendment factors."

Finally, the claims environment is dynamic rather than static. There will be, over time, changes in claims

consciousness; medical advances will affect lengths of disability, as well as claims costs; new kinds of claims may be deemed compensable. Such changes are reflected by the application of a "trend factor."

If the anticipated losses after these adjustments, plus the estimated insurer overhead costs such as general administration, commissions and taxes, exceed the premiums that wouldbe collected using today's rates, a rate increase is indicated. If they are lower, an overall rate decrease is in order.

The second level of the ratemaking process, as was mentioned above, is the determination of how the proposed overall change should be distributed among the various occupational categories. Certain classes may require a greater than average change, others less. This is accomplished by looking at what the experience of each classification has been over a recent three year period.

Generally speaking, if the claims experience of a given classification has been more favorable than what was previously estimated, the change in its rates will not be as much as the overall average and might actually decrease even though a general rate increase was being requested. If that experience were worse, a greater than average change will be proposed. In order to avoid abnormally large swings in rates for individual classifications all requested changes are essentially limited to twenty-five percent above or below the overall average change.

With rates being proposed for approximately 600 individual classifications, it is clear that the Virginia experience available for some (actually most) will not be extensive enough to permit complete reliance on the experience indications. This is what actuaries call a low credibility problem.

In such instances the actual recent experience is combined with that underlying the current rate as well as certain national data. The latter has been adjusted to reflect the general level of costs in Virginia. It is important to recognize that this national data does not affect the aggregate level of premiums to be collected: that is based solely on Virginia results.

As a final step expenses are added and the resulting rates are adjusted so that they produce the overall change being proposed. This last is accomplished by applying what is called a "test correction factor."

This ratemaking process and the resulting rates are subject to close scrutiny by both the State Corporation Commission and affected employers. In several instances in the past these latter groups have retained their own actuaries to review the process. Where appropriate, the rate requests have been modified.

The subcommittee after its review found no major problems that could not be addressed and solved under current procedures. It could consider a number of points, however. The more significant are as follows:

1. Loss trending. The indicated trend factors used in Virginia are the highest, or among the highest, in the nation. While existing data clearly shows that such trends are warrented, there is currently little information as to what is causing them. These trends are the primary cause of the large rate increases in Virginia in recent years. The detailed claim data study being directed by another task force will helpfully shed some light on this question. In addition, the Bureau of Insurance is conducting studies of its own. The subcommittee encourages such efforts.

2. Evaluation of law benefit changes. While the tables used to estimate the effect of various changes in the compensation law are reasonably current, there is a growing belief that the continued improvement and expansion of available benefits may cause fundamental changes in the claims environment itself. An example might be a tendency for an injured worker not to return to work as promptly as possible because the high weekly benefits cause little or no economic incentive to do so. Such dynamic changes have heretofore not been considered in the evaluation of the effect of legislation, possibly misleading legislators as to the real effect of changes they might be considering. The sub-committee feels that this should be subjected to further review, possibly in conjunction with the detailed claim study now underway.

3. Expense provisions in the rates. Expense provisions in the rates are currently based on national experience (except in cases such as premium taxes where specific Virginia needs can be determined). They are distributed to each classification rate in direct proportion to anticipated loss costs. The former problem, the use of national experience, has been, and will be, addressed in rate hearings, and adjustments have been made where felt appropriate. The latter results in a situation where if a particular class' rate is twice that of another, it will contribute roughly twice as many expense dollars. The subcommitte felt that this could result in inequities and recommends that this question should be examined more closely. Complicating this picture somewhat is the fact that insurers are currently proposing changes in the way expenses are collected from insureds. This is under study by the State Corporation Commission and no final resolution has been made. It is therefore felt by the subcommittee that it would be premature to comment in this area.

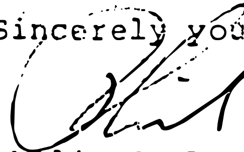
4. Occupational disease rates. The rates for certain classifications contain a flat amount to cover possible extraordinary or catastrophic occupational disease losses (more of less "ordinary" disease claims are reflected in the basic rate itself). These flat amounts were selected on a judgment basis many years ago, and have not been, to the knowledge of the subcommittee, adjusted to reflect actual experience. Secondly, new compensable diseases have emerged over the years, but corresponding flat loadings have not been established. This was considered in the most recent Virginia rate case, and, in line with the subcommittee's feeling, were eliminated until such time that experience support can be provided.

5. Territorial ratemaking. It has been suggested from time to time that the State might be divided into two or more geographic territories which would reflect differences in wage levels and the costs of medical care in such regions. After reviewing the practical administrative and technical difficulties this would create, the

subcommittee felt that no change from the current use of a single set of statewide rates should be made. It was noted that the experience rating plan, and the optional retrospective rating plan, would inherently reflect such underlying cost differences, eliminating at least some of the potential inequities.

Other aspects of the ratemaking process were considered. Some, such as the effect of medical fee schedules, were felt to be more properly within the domain of other subcommittees. The same was felt true for experience rating, retrospective rating and dividend plans which are used to modify a particular insured's premiums in line with its actual loss expereince. Thers were felt to be largely technical in nature, and are already under scrutiny in the course of rate review cases.

Sincerely yours,



Philip O. Presley, Chairman
Ratemaking Subcommittee

cc: Mr. Garland Hazelwood
Mr. Roy Kallop
Mr. F. H. Codding
Mr. Jeff Wells

REPORT TO:

Rate Regulatory Procedures Sub-Committee

FROM:

Rating Plans Task Force

PURPOSE:

I. To examine the various Worker's Compensation Rating Plans now available to the Insurance Buying Public and provide for education and analysis purposes, an explanation of such plans.

II. To make recommendations to the Sub-Committee for appropriate action.

PRICING SYSTEM:

The pricing of Worker' Compensation Insurance for an individual employer is based primarily upon the type of operations in which that employer is engaged and the hazards associated therewith to which the employees are exposed.

The type of employer operations are described through a system of classification representing over 600 different categories of industry. Each classification bears an identifiable code number in rates per $100 of payroll. The basis of exposure to hazard is reflected and measured by the payroll expended by the employer. The basic premium or costs of an employers' Worker's Compensation insurance is computed by the application of the payroll expended to the rate for the classification which describes the business of the employer. While this premium represents the basic cost of the employers' Workers' Compensation insurance, further adjustments may be made through the application of various individual risk rating plans, such as experience rating, retrospective rating and participating plans, which are designed to recognize the variation in hazards of operations among employers engaged in the same business described by the same classification.

I. EXPERIENCE MODIFICATION

As the name implies, experience rating is a rating plan which uses the "experience" of an insured as the basis for rating. Experience rating is intended to determine whether a specific insured presents a hazard for future insurance which is better or worse than the hazard of the average insured in the classification to which the risk has been assigned. Experience rating, by measuring and evaluating the experience of the insured, provides an incentive to the employer to be safety conscious and therefore, control accidents of his employees. The effect of a favorable loss record is reflected in the experience modification applicable to the premium. The favorable loss record will produce a credit experience modification and a savings in premium to the employer. A poor loss record will result in a debit experience modification, or an additional premium to the employer.

II. RETROSPECTIVE PLANS

Retrospective rating plans are available through some Insurance carriers as an additional incentive plan for employers to reduce their insurance costs through improved loss experience. There are several plans available for insureds based on standard compensation premiums varying with the size and type of insured. The basic retrospective rating plan operates on a "cost plus" basis between predetermined minimum and maximum premiums. If loss experience improves, the employer will have reduced his insurance costs. With poor experience, the employer will suffer an additional cost or penalty premium. (Reference: Retrospective Rating, John R. Stafford, J & M Publications, Palatine, Illinois, and pamphlet attached).

III. RETENTION PLANS

Retention programs are similar to retrospective rating plans but usually no penalty premium is involved. Premium discount applied immediately vs. Retrospective which discount is in the retrospective factors afterward.

IV. PARTICIPATING PLANS

Participating plans are rating plans that also place an incentive on the employer to reduce losses with the possibility of a return premium in the form of a dividend. Dividends are usually payable from companies' surplus at the direction of the Board of Directors of the Company. These plans may be on a fixed percentage dividend basis or may be on a variable percentage dividend basis based on loss experience. Normally, the dividend is calculated and paid at the conclusion of the policy period. This would be more attractive for the smaller risk.

V. LOSS & EXPENSE CONSTANTS & MINIMUM PREMIUMS

Loss and Expense Constants are predetermined amounts that are added to compensation premiums below $500 to offset increased acquisition costs and higher loss ratios of smaller insureds. Minimum premiums are the lowest amount for which a policy may be issued. Currently under study is a new expense program which would apply to all insureds regardless of size.

VI. PAYROLL LIMITATIONS

Payroll Limitation Rules have recently been revised in most states. For most classifications all payroll excluding overtime, is included to determine policy premium.

CONCLUSION

I. Changes in the existing rating system will not reduce premium costs regardless of the pricing approach. The burden rests primarily with the employer and his ability to control compensable accidents and their attendant costs.

II. EDUCATION

It is this committee's recommendation that the Bureau Staff be assigned the task of preparing and executing an educational program for the enlightenment of industry groups, business organizations and regulatory authorities as to the general subject of Worker's Compensation.

This can be accomplished through a speaker's Bureau, made up of qualified individuals from the insurance industry, self insureds and the State Insurance Department. Their activities could be coordinated through the Bureau.

RATE REGULATORY PROCEDURES SUBCOMMITTEE

NEW APPROACHES SUBCOMMITTEE TASK FORCE

Below are the recommendations of the Task Force on new approaches as agreed in the general meeting of the Rate Regulatory Procedures Subcommittee held August 1, 1979:

1. Assigned Risk Pricing

   We feel there should be a pricing differential between the voluntary and residual markets to insure that we don't get an increased inward flow of risk into the residual market. The removal of the surcharge would eliminate this differential and most likely result in an increased population in the assigned risk plan of Virginia which to date has not been a problem for the state.

   Efforts should be continued to seek a more equitable method to assure that those in the assigned risk plan are deserving of this price differential.

2. Competitive Rating

   We did not feel that this would alleviate the problem because there is not enough premium for companies to make an underwriting profit now in Virginia. The underwriting losses have been occurring for many years in our state.

3. Schedule Rating

   We do not feel that this approach will work in Virginia based on the fact that it has never worked anywhere else that it has been tried. Please refer to the attached discussion of schedule rating dated June 13, 1979.

4. Deductibles

   We do not feel that this is a proper approach for Workmen's Compensation because we are concerned with the ability of the employer to pay within the deductible area. The employee or claimant is the one that is hurt if payment is not made. I have attached some of the pros and cons and we feel the cons out weigh the pros of this method.

DEDUCTIBLE WORKER'S COMPENSATION INSURANCE

Eliminating loss dollars only and not reducing expenses will not create a substantial savings for the public. My proposal is that this be a medical only deductible in the first $100 or $200 per accident range. Legal requirements should be changed so that no reporting of claims is necessary within the deductible amounts, thereby saving expenses. A safeguard for employees has to be easily available for complaints by employees and I suggest that we have a notice requirement notifying employees of the deductible and the appeal route to the Industrial Commission.

PROS

1. Reduce cost of insurance to employers, primarily in the expense area.
2. Increased claim awareness by insured - more receptive to safety engineering assistance.
3. Frequency of loss is reduced to the carrier, making some accounts from an underwriting standpoint appear much more inviting to a carrier. Technically, the experience modifications would not be affected, because the experience rating plan would have to be changed.
4. This would eliminate some accounts going completely self-insured. It would afford some accounts with a limited form of self-insurance.

CONS

1. Would require legislative changes in the Virginia law, i.e. reporting requirements, obligations of carriers for payment to injureds.
2. Loss of control of claims by carriers that grow larger after the initial payment. Most medical only files are currently closed out after each payment and then re-opened as more bills are submitted.
3. It would be difficult to make rates. We would lose a lot of statistics within the deductible areas.
4. Establishment of a fair discount for each account for deductible levels would be difficult. It may actually require an underwriter to set a discount by account. Perhaps there could be a minimum discount. This would assure loss-free accounts a discount which would be fair.

PROS

5. A deductible might make an account acceptable to a carrier, but without the deductible it may have to go to the Assigned Risk Pool.

6. Insureds will watch more closely the amount of money they pay on medicals, i.e. is it a reasonable amount and did the insured actually have a Worker's Compensation claim? Currently, carriers do not have the time to investigate each medical only. They merely process the payment of bills submitted.

7. Deductibles would eliminate quite a bit of paperwork and expense for companies because of the tremendous number of these type of claims processed.

CONS

5. The financial ability of an account may preclude the faithful fulfillment of a deductible in certain cases.

6. Increased involvement of the Industrial Commission for abuses by employers of the system,i.e. not paying, or directing insureds to doctors not of the injured's choice.

7. If the deductible only applies to medical only, there will be a tendency to force indemnity payments to eliminate the deductible. We would probably have to make the deductible apply to the first $100 of medical cost regardless of whether or not an indemnity payment was to be made.

8. Payment problems between hospitals, doctors, patients and employers. Health facilities may have problems knowing where to go to collect their fees.

9. In case the insured and the company have to pay on the same injury, how would this be handled, i.e. reimbursement, or would we tell the doctor that the insured owed him the first $100?

SCHEDULE RATING

A Report Prepared By
The Worker's Compensation
Rate Regulatory Procedures
Sub-Committee
June 13, 1979

Schedule Rating is a premium modification technique that would allow further upward or downward adjustment to rates promulgated by the Compensation Bureau. The purpose of justing rates in this manner is to reflect such characteristics of a risk as are not reflected in its experience. This technique has worked extremely well in Virginia (since the advent of open competition) on various lines of commercial insurance other than Compensation.

	RANGE OF MODIFICATIONS		
	Credit		Debit
A. Premises - Conditions, care	10%	to	10%
B. Classification peculiarities	10	to	10
C. Medical Facilities	5	to	5
D. Safety Devices	5	to	5
E. Employees - selection, training, supervision .	10	to	10
F. Management:			
1. Cooperation with insurance carrier	5	to	5
2. Safety Organization	5	to	5
MAXIMUM ALLOWABLE MODIFICATION	25	to	25

This modification technique is commonly used on many lines of insurance, but has had extremely limited application on Worker's Compensation. It is available in one form or another only in California, Illinois, Indiana and Rhode Island.

In general, the entire rating structure for Worker's Compensation insurance, including Experience Rating, is actuarially more sound than the rating processes which apply to any other Casualty-Property line. With few exceptions, both intrastate and interstate Experience Rating Plans are based on proper principles and should generate an adequate premium level.

Experience Rating for Compensation is generally mandatory for those accounts that qualify, but the modification itself is not modified to reflect underwriting judgement.

In the states where some form of optional rating plan is available, Compensation results have consistently been less satisfactory than the states with mandatory plans.

Underwriters are generally cautioned to use flexible rating judiciously; aggregate premiums are to be adequate for the book of business as a whole.

The following is a brief summary of the various modification plans in the four states where it is allowed:

1. California Surcharge Plan: The Worker's Compensation rating requirements are unusual in that published manual rates are considered minimal in nature. Surcharges may be applied to the published manual rates provided they are not unfairly discriminatory. Risk surcharges have run from 10% to 100% higher than the manual rate under certain circumstances. When a risk is surcharged, the rate becomes known as " company rate " or " modified rate " It is not necessary to surcharge all rates on a given policy.

2. Illinois Experience and Schedule Rating: Compensation rates in this state are subject to an Experience Rating formula that is not as precise as the normal formula applicable to most other states. It does not recognize the impact of loss severity as closely as the normal formula, although it does recognize loss frequency. The Illinois plan allows rates for a particular risk to be modified by a percentage of the manual rates to reflect " underwriting practice and judgement ". When applied, this percentage shall be 5%, 10%, 15%, 20% or 25% credit or debit. This plan is being phased out.

3. Indiana Individual Risk Deviation Program: For an account with a significant Indiana exposure, you can use intra, rather than interstate loss experience as the sole basis of the modification which applies in Indiana. This option can be helpful to or detrimental to an insured, depending on whether his Indiana loss experience was more or less favorable than his multi-state loss results.

4. Rhode Island Schedule Rating: This particular state had its own Compensation Bureau until March of 1977, at which time the National Council on Compensation Insurance became licensed as the rating bureau for Rhode Island. Schedule rating had been allowed for a number of years, but by collective agreement,

this option is being phased out, by reducing either the 25% debit or 25% credit allowance by one half, to 12.5% by April 1, 1979. On the following renewal of the same risk, schedule rating will no longer be allowed.

There are only two basic circumstances under which the Schedule Rating approach might be justified:

a) as just cited, to more accurately measure a risk's peculiarities, or
b) to stimulate competition for Compensation business, and at the same time allow premiums to seek their own level.

While there are certain advantages to being able to exercise a further degree of judgement on the part of a trained underwriter by use of Schedule Rating Credits, there are a number of drawbacks. The most important drawback is that Worker's Compensation in Virginia has not produced a profit for the insurance industry in the last five years. According to the National Council's most recent figures, results are:

Calendar Year	Amount by Which Benefits Exceeded Premium Allocated To Pay Benefits
1974	$ 3,957,392
1975	12,586,796
1976	24,073,667
1977	27,909,861
1978	21,899,916
	$90,427,632

Therefore, it is difficult to rationalize the use schedule crediting techniques in mass fashion, when the loss results are extremely large. By the same token, use of schedule debits are met with overwhelming dissatisfaction on the part of agents and insureds as being discriminatory. Use of Schedule Rating in only limited fashion produces no measurable end result, and only serves to interrupt an otherwise orderly procedure.

It is worth mentioning that other lines of insurance readily lend themselves to Schedule Rating techniques because, unlike Worker's Compensation, the coverages and benefits are not legislatively mandated.

SUMMARY

In the context of what the Virginia Legislature is seeking, which is to search for ways to keep the costs of Worker's Compensation Insurance from rising dramatically, Schedule Rating would not be very appealing, were credits only to be applied to a published rate. The study done by the California Compensation Bureau on Assembly Bill 545, a bill that would repeal that state's minimum rate law and replace it with open competition states in part that open competition could cause an impairment of services provided by the insurance industry, to the detriment of the worker.

A copy of Section VII, Social Implications of an Open Pricing System, is attached for review.

Schedule Rating and other premium modification techniques beyond the historically-established guidelines might be more popularly used were it not for the continuing upward spiral of loss costs. It is difficult to think in terms of premium reduction when the industry is hard pressed to break even on this line of insurance, in a state where rate levels are generally considered adequate. The limited application of special rating plans to just four states appears to be an indication of general reluctance to tamper with what has been a satisfactory rating mechanism for many years in most jurisdictions.

According to the National Council on Compensation Insurance, Virginia Indemnity claim costs per case for the five year period previously cited have risen by more than 25% per year. Medical claim costs per case for these periods have risen by approximately 17% per year.

MEMORANDUM

WORKMEN'S COMPENSATION ASSIGNED RISK PLANS

The workmen's compensation assigned risk plans were originally formulated in the 1930's. They were developed as a means of providing coverage for employers who where unable to secure such coverage through the normal channels. Because of the compulsory features of this line of insurance, it was absolutely necessary that some mechanism be available whereby all employers in good faith entitled to insurance would be able to obtain coverage. To solve this problem, the insurance carriers adopted the so-called "voluntary" plans whereby all carriers licensed to write workmen's compensation insurance in a particular state voluntarily agreed to accept assignments on eligible risks. The assignments were to be distributed in accordance with the carrier's proportionate share of the total premium writings within the state. Today, in most jurisdictions, the workmen's compensation assigned risk plans continue to function on this voluntary basis.

Originally the assigned risk plans did not provide for the payment of any commission or service fee to the producer on the risk. Assigned risks as a group presented a problem of developing sufficient premium to pay for the losses and expenses they could be expected to generate. Obviously, there was a reluctance to pay commissions on business the carrier did not want and would not accept if offered directly through its own representatives.

It is necessary to discourage the use of the assigned risk plan as an easy means of placing workmen's compensation insurance and if commissions were to be paid on this business, it was feared that risks for which insurance could be obtained through greater effort on the part of the agent would be submitted for assignment.

Despite the foregoing, the insurance industry, starting shortly before World War II, was faced with a request in various jurisdictions for the payment of commissions on assigned risks to compensate the agent for services being provided to these risks having difficulty securing insurance. In meeting this request, the industry offered the 8% surcharge program, or the commission plan. Under this arrangement, 5% of the total premium goes for the commission to a producer designated by the insured. 2% of the total premium is charged for the field supervision costs of the insurer to whom the risk has been assigned, or of its general agent if the insurer operates through such an agency.

The reason that a surcharge of 8% rather than the 7% is needed is that the 5% and the 2% costs are percentages of the total premium charged and collected from the insured. Thus, these percentages, when related to premium prior to the surcharge, are somewhat greater than 5% and 2%. Furthermore, an additional premium tax is required on the increment over the original premium.

No particular comment is required on the 5% allowance to the producer designated by the insured. It is believed, however, that a few words on the basis of a field supervision allowance of 2% would be helpful. This allowance will be used in one of two ways. If a general agent is in the picture, it is available as an allowance to such agent for handling the assigned risk. Otherwise, the allowance will go to defray the field supervision expense directly incurred by the insurance company where a general agent is not involved. In this connection, it is important to note that only in rare instances is the producer designated by the insured an agent of the insurance company receiving the assignment.

Therefore, additional accounts relating to transactions with such producers must be created and maintained by the company. As a matter of fact, in the case of direct writers, a system of handling agents' accounts must be newly established.

Again, although there are no expense statistics available for assigned risks, there is strong reason to believe that the expenses associated with assigned risk business are considerably higher than those applicable to normal risks.

In many cases risks are assigned because their physical facilities do not include adequate loss preventive devices and controls. In order to make its underwriting commitment more palatable the carrier assigned one of these risks will have to scrutinize the operations more closely and incur higher than average safety engineering expenses in order to bring the risk up to standard requirements. As to the reasonableness of the 8% surcharge, a few facts and figures relating to the loss and expense potential of these risks might be appropriate.

The attitude of the management of the risk toward safety is equally as important as the actual physical devices it has installed. In many cases a risk is assigned because of laxity or lack of information on the part of management with respect to safety. The carrier on the risk will find it necessary to educate the management as to the importance of loss prevention in cutting down workmen's compensation costs.

Sometimes a risk is assigned because of the remote location of its operations. The remoteness of the location will cause additional expenses for the carrier servicing the risk.

Even if the risk is located in an area of the state normally serviced by some carriers, the carrier actually assigned the risk may not operate in this territory. This will require the carrier to incur additional expenses in setting up inspection, audit and field supervision facilities for this territory.

In underwriting voluntary workmen's compensation business, it is not unusual for one carrier to cover additional lines of insurance on an individual risk. This can result in savings in the inspection, audit and perhaps other expenses. In most cases, these savings would not be available if the risk were assigned because it would only be coincidental that the carrier assigned the workmen's compensation business would be the same carrier covering the lines voluntarily written.

The administration of the Assigned Risk Plan itself involves extra clerical expense on the part of the carrier. The Plan requires the processing of various papers such as applications and cancelation notices among the carrier, the risk and the administrative office.

The reasonableness of the 8% surcharge also receives convincing support from the adverse loss experience this class of business can be expected to produce.

While it is a reasonable charge for this class of business, the 8% additional premium also performs the very important function of a deterrent to an undue expansion of the assigned risk plan. Although the assigned risk plan is a necessary part of the workmen's compensation insurance system, it is at the same time an exception to the free competitive market. For this reason, the insurance industry has always considered it of utmost importance to maintain the volume of assigned risk business at as low a level as possible. The payment

of commission on assigned risks tends to reduce the incentive to place the risk in the voluntary market. On the other hand, the surcharge works in the opposite direction by creating an incentive on the part of the insured to obtain voluntary insurance. The 8% surcharge program is a significant part of this effort to avoid an unnecessary growth of the assigned risk plan.

There is another important value in the 8% surcharge program which is particularly a matter of public interest. The charging of 8% of the insured's premium provides an incentive to the insured to make himself a more desirable risk. Thus, he will be more inclined to develop effective safety programs which will ultimately be of benefit to his employees and the community at large.

Finally, as a matter of record, there are three states, within the National Council jurisdictions (Mississippi, Missouri and New Hampshire), which do not have a surcharge plan but do provide for a fee paid to the producer of record. Such is the case in Mississippi because of legal aspects. The Mississippi, Missouri and New Hampshire assigned risk plans provide for no surcharge but call for a graded scale of allowances to the producer of record, as follows:

First	$1,000	of	standard	premium	- 5%
Next	4,000	"	"	"	- 4%
Next	5,000	"	"	"	- 3%
Over	10,000	"	"	"	- 1%

SCHEDULE OF SURCHARGE AND PRODUCER FEE
(as of April 16, 1979)

State		Pool	Plan	Surcharge	Producers Fee
Alabama	(1)	National	Yes	-	Graduated (B)
Alaska		Alaska	No	8%	5%
Arizona		National	Yes	8%	5%
Arkansas		Arkansas	No	8%	5%
California		-	-		
Colorado	(3)	-	-		
Connecticut		National	Yes		Graduated (A)
Delaware		National	Yes	8%	5%
Dist. of Col.		National	Yes	8%	5%
Florida		National	Yes	8%	5%
Georgia		National	Yes	8%	5%
Hawaii		National	Yes	-	Graduated (C)
Idaho	(4)	-	-		
Illinois	(1)	Illinois	No	-	Graduated (D)
Indiana		National	Yes	8%	5%
Iowa	(1)	National	Yes	8%	5%
Kansas		National	Yes	-	Graduated (B)
Kentucky	(1)	National	Yes	8%	5%
Louisiana		National	Yes	8%	5%
Maine		National	Yes		Graduated (A)
Maryland	(2)	-	Yes		
Massachusetts		National	Yes	-	Graduated (B)
Michigan		National	Yes	8%	5%
Minnesota		Minnesota	No	-	Graduated (F)
Mississippi		National	Yes	-	Graduated (B)
Missouri		National	Yes	-	Graduated (B)
Montana	(3)	-	-		
Nebraska		National	Yes	8%	5%
Nevada		-	-		
New Hampshire		National	Yes	-	Graduated (A)
New Jersey		National	Yes	-	Graduated (G)
New Mexico		New Mexico	No	8%	5%
New York		-	-		
North Carolina		National	Yes	8%	5%
North Dakota		-	-		
Ohio		-	-		
Oklahoma	(3)	-	-		
Oregon		-	-		
Pennsylvania	(2)	-	-		
Rhode Island		National	Yes	-	Graduated (A)
South Carolina		National	Yes	8%	5%
South Dakota		National	Yes	8%	5%
Tennessee	(1)	National	Yes	8%	5%
Texas		Texas	No	-	Graduated (F)
Utah	(3)	-	-		
Vermont		National	Yes	-	Graduated (A)
Virginia	(1)	National	Yes	8%	5%
Wisconsin	(3)	-	-		
West Virginia		-	-		
Wisconsin		Wisconsin	No	-	Graduated (H)
Wyoming	(3)	-	-		

SCHEDULE OF SURCHARGE AND PRODUCERS FEE (CONT'D.)

Notes:

1. States where there is a separate coal mine Pool.
2. States where U. S. L. & H. and "Black Lung" coverage is provided. In Maryland only Federal "Black Lung".
3. States where only Federal "Black Lung" coverage is provided.
4. States where only U. S. L. & H. coverage is provided.

Graded Producer Fee

A. 8% on first $1,000, 5% on next $4,000, 3% on next $95,000 and 2% on standard premium in excess of $100,000. (Connecticut, Maine, New Hampshire, Rhode Island and Vermont.)

B. 7% on first $1,000, 5% on next $4,000, 3% on next $5,000 and 2% on standard premium in excess of $10,000. (Alabama, Mississippi and Missouri.)

C. 5% of standard premium not to exceed $50.00. (Hawaii)

D. New Business: 8% of the final annual premium up to the first $1,000, 2% on all premiums above $1,000 up to $10,000 final annual premium, and 1% on premiums over $10,000.

Renewal Business: 2% on the first $10,000 final annual premium, and 1/2% on renewal premiums in excess of $10,000. (Illinois)

F. 5% on first $1,000, 4% on next $4,000, 3% on next $5,000 and 2% on standard premium in excess of $10,000. (Minnesota and Texas)

G. 7% on first $1,000, 5% on next $4,000, 3% on next $95,000 and 2% on standard premium in excess of $100,000. (New Jersey)

H. 3% on first $1,000, 2% on next $4,000 and 1% on premium in excess of $5,000.
Minimum Producer Fee: $5.00
Maximum Producer Fee: $750.00 (Wisconsin)

Section VI-C

Subcommittee Assignments

Standards of Service Sub-Committee

The Standards of Service Sub-Committee should provide a clear and explicit outline of the standards which are to be promulgated as reflecting the minimum standards to which carriers must adhere. The standards should be quantified in such a manner as to be clearly understood.

The Sub-Committee should undertake a detailed study of the manner in which Workers' Compensation claims are handled. This should include the amount of investigation to determine validity of claims, validity of amount of medical costs, the accuracy of the employer reports, type of vocational rehabilitation provided when required. The study is to include the complete process from date of accident to date of award which will involve a study of the employers reporting procedures, insurance carrier procedures, Industrial Commission procedures, etc..

REPORT

STANDARDS OF SERVICE AND GUIDELINES

OF

PERFORMANCE SUBCOMMITTEE

August 23, 1979

LIBERTY MUTUAL

Suite 211, Wythe Building, 1604 Santa Rosa Road, Box K151, Richmond, Virginia 23288 • Tel. (804) 285-7441

RE: STANDARDS OF SERVICE AND GUIDELINES OF PERFORMANCE SUBCOMMITTEE

Mr. Chairman, the following report covers Standards and Guidelines for service for all insurance carriers desiring to actively solicit Workers' Compenation within the Commonwealth of Virginia.

These Standards and Guidelines furnish the State Corporation Commission and the Industrial Commission additional power to supervise the activities of the private insurance sector as it relates to its endeavor to stemming the flow of rising Workers' Compensation costs.

However, it is imperative that all parties concerned recognize that this endeavor is truly a joint venture of customer (the buyer) and supplier (the insurance carrier). Services offered to the buyer can only be effective if utilized by the buyer.

The Standards and Guidelines outlined in the following sections of this report provide the necessary strengthening of Section 65.1-117.1, Code of Virginia, Workers' Compensation Act. They will assure that any carrier doing business in the Workers' Compensation field is fully aware of its obligations to the consumer.

The same capabilities of service will apply to those firms seeking to utilize "self insurance" to meet the Workers' Compensation requirements of the Commonwealth of Virginia.

Respectfully submitted,

R. C. M. Butler
Chairman

Attachment

August 23, 1979

LIBERTY MUTUAL INSURANCE COMPANY • LIBERTY MUTUAL FIRE INSURANCE COMPANY • LIBERTY LIFE ASSURANCE COMPANY OF BOSTON
HOME OFFICES: BOSTON

EQUAL OPPORTUNITY EMPLOYERS

PREMIUM AUDIT:

Carriers licensed in the State of Virginia must be capable of providing trained personnel knowledgeable in the Workers' Compensation Manual and the Virginia rules, regulations and exceptions. Ongoing training must be provided to enable auditors to counsel and advise their policyholders of current Virginia rules and regulations.

AUDIT SERVICE:

1. The carrier will make an annual physical audit of all policies producing an estimated premium of $5,000 or more.
2. The carrier will make a physical audit of all policies producing an estimated annual premium of $750 to $5,000 at least once every three years.
3. The carrier will make an annual physical audit of 10% of those policies under $750 of estimated annual premium.
4. The carrier shall provide on new contracting risks a test audit within 120 days of inception. The auditor should be trained to such an extent as to provide sound counseling for the correct classification of operational codes and proper utilization of payroll limitations. This standard is applicable only if the estimated annual premium of the Workers' Compensation coverage is in excess of $10,000.
5. The carrier will provide a physical audit on any risk if requested by a policyholder and if based upon reasonable circumstances.

TEST AUDIT PROGRAM:

In our previous report, a Test Audit Program was recommended for implementation in Virginia to insure the accuracy and reliability of the insurance carriers' audits. Such a program, conducted by the Virginia Compensation Rating Bureau, will determine whether one insured is subsidizing another and whether incorrect payroll or classification has been applied.

The Rating Bureau will make a selection of employers' policies to be test audited through a random selection process to ensure an objective, unbiased and statistical sampling of policies issued within designated parameters during a specified period of time.

The employer to be audited will be given ample advance written notice of the date on which the test audit will be completed. The only information which the Rating Bureau auditor will have in his possession at the time of the audit will be a copy of the policy and classification inspection report. This procedure will assure that the test audit is completely independent and uninfluenced by the insuring carrier's audit.

After completion of the test audit, a copy of the insuring carrier's audit will be secured and compared with the Rating Bureau's test auditor's findings. The Rating Bureau Staff will then evaluate both and reconcile any differences by notifying the carrier involved and requiring any inaccuracy be corrected. Both the carrier and insured will have the rights of appeal to the Rating Bureau's findings as provided in the Bureau Constitution.

NOTE: Subsequent to the report presented to the Workmen's Compensation Subcommittee of the House Committee on Labor and Commerce on August 23, 1979, the Rating Bureau has planned to conduct test audits on approximately 200 accounts. To date (December 5, 1979), approximately 28 have been completed since the program was launched in August 1979. Obviously, it it is too early to have any meaningful findings. The program covering test audits on the 200 accounts should be completed by mid-summer 1980. When completed, a formal report of the findings will be submitted to the Commissioner of Insurance.

CLAIMS:

1. Carriers must use qualified and competent personnel who are knowledgeable in Workers' Compensation.
2. Carriers must accept the responsibility to educate their policyholders regarding Workers' Compensation claims.
3. The Industrial Commission shall require each carrier to appoint a representative at an officer level to be available to meet with a representative of the Industrial Commission regarding any complaints.
4. Carriers must obtain, on an annual basis, the Summary of the Workers' Compensation Act prepared annually by the Industrial Commission and distribute this brochure to their customers. Self Insurers must also obtain this brochure for their own information.

In the prudent handling of claims, carriers must follow the following guidelines:

Investigation:

a. Interview claimant, policyholder, doctor(s) and witnesses necessary to determine facts and obtain statements or other documentary information, as required by the nature and severity of the claim.
b. Obtain wage data to determine accurate compensation rate.
c. Investigate Social Security benefits for the possibility of an offset against Workers' Compensation benefits.

Medical:

a. Handle medical aspects of the claim to include and obtain appropriate medical evidence supporting claim payment(s) and authorizing medical treatment commensurate with injury.
b. The carrier must advise the employer of the statutory requirement to furnish a panel of three (3) physicians from which the employee can select the treating physician of his or her choice.
c. Provide timely rehabilitation, when appropriate.

CLAIMS: (continued)

Promptness of Handling:

a. Investigation must be made promptly in order to insure timely payment(s) or prompt denial if case is to be controverted.

b. Timely medical information should be required for screening, evaluating and determining whether such medical care is being furnished as may reasonably be required to cure or relieve from the effects naturally resulting from the injury.

c. Carriers must maintain a procedure for prompt and timely reserving, including changes in reserves immediately with new evidence. All reserves must be reviewed at no less than six months intervals.

d. Negotiate settlement of payment of all claims promptly on the basis of good, sound claims judgement and practices.

e. Provide vigorous defense of non meritorious claims.

Subrogation:

When appropriate such cases should be documented and pursued vigorously.

LOSS CONTROL:

1. The insurance carrier must, through its qualified representative, make available consultation on accident prevention programs, seminars, safety literature and other aids which will contribute to the safety of the insured's employees.
2. The insurance carrier must make available consultative services in employee health and industrial hygiene where the hazards of the insured's operations warrant such services.
3. The insurance carrier must maintain loss records to allow for analysis of accident causes and assist the insured in identifying accident trends.
4. The insured must be informed in writing by their insurance carrier, or authorized representative, of the impact of their potential losses on their Workers' Compensation insurance costs. The insured shall be so informed at the inception of their Workers' Compensation insurance with any carrier and again thus informed annually thereafter.
5. Loss data must be made available to the insured by the insurance carrier directly or through their authorized representative when requested by the insured. If not so requested, the insurance carrier shall provide loss data in writing directly or through their authorized resprsentative periodically but no less than annually provided the insured's estimated annual Workers' Compensation insurance premium is more than $5,000.

Section VI-D

Subcommittee Assignments

Data Systems Sub-Committee

The tasks assigned to the Data Systems Sub-Committee involve the following specific items:

1. To find a prospective data collection system that will provide information about the causes of the dramatic increases in Workmen's Compensation loss costs.

2. To investigate and report on the accuracy of statistics used to support Workmen's Compensation rate adjustments.

3. To develop a loss data system with the Industrial Commission to collect, compile, analyze and monitor loss developments. The system is intended to make available data which will be useful in evaluating causal elements of loss costs changes.

The first item has been completed with the development and introduction of an industry data collection program effective April 1, 1979. The Sub-Committee is asked to provide an interim report on the system at the earliest practical time.

A continuing review on the accuracy of statistics used in Workers' Compensation rate filings should remain a function of the Sub-Committee.

The cooperation of the Sub-Committee in assisting the Industrial Commission in developing a program of data collection and data compilation and tabulation is required.

DATA SYSTEMS SUBCOMMITTEE

The report of the Data Systems Subcommittee dated August 22, 1979, as furnished by Vice Chairman Bondurant follows. Also there follows a detailed report of the results of an examination of individual insured claim reports which were reconciled with insurance carrier and Industrial Commission records.

There is attached a progress report and explanatory memorandum covering the Call for Detailed Claim Information along with a copy of the Call.

A report of the efforts by the Industrial Commission of Virginia in the collection of statistical data was presented to the Workmen's Compensation Subcommittee of the House Committee on Labor and Commerce on August 23, 1979, and copy of their report dated August 22, 1979 is attached. Pursuant to the request of Delegate Wilson of the Legislative Subcommittee an additional meeting was held on November 20, 1979 and the material made available on that date is also attached.

DATA SYSTEMS SUBCOMMITTEE

Evaluation of Accuracy of Insurance Company Claim Reports

With respects to Item 2, the Subcommittee on Data Systems directed that a study be made to evaluate the accuracy of individual risk carrier claim reporting and statistical reporting procedures based on impartial selection of 20 to 25 claims to determine:

(a) Whether the amount of losses paid by the carrier is reconciled with the loss records of the Industrial Commission.

(b) Whether the amount of reserves established for non-closed cases is reasonable in the opinion of the Industrial Commision.

(c) Whether the classification loss coding was correct.

(d) Whether the accuracy of the unit statistical card when compared with the source data, i.e., Industrial Commission files and insurance carrier claim files, is correct.

The selection of cases to be examined was made by Chief Deputy Commissioner James of the Industrial Commission, who requested from the carriers their claim files. The Rating Bureau provided copies of unit statistical reports from its records.

The study group examined, in depth, 22 claim files, covering 22 compensable accidents involving 22 insured firms and 17 insurance carriers. Not all claims for these risks were studied, only one per firm as selected by the Industrial Commission. The insured firms had a paid annual premium of $348,828 for the period covered by the unit statistical reports. The losses studied involved either paid or reserved losses of $82,938 indemnity and $37,698 medical, for total losses of $120,636.

The study revealed in each instance (except as noted below) that the amount paid by the insurance carrier as shown by their claim file, the amount paid as

shown by the Industrial Commission file and the amount shown on the unit statistical report were in agreement. All loss coding proved to be accurate. Additionally, in those instances where there were open cases the amounts of reserve appeared to be reasonable. The one exception to the above involved one case where the insurance carrier did not report the claim on the unit statistical report. The loss payment was in order but the claim did not appear on the unit card. The carrier was asked to file a corrected report.

The examination by the Chief Deputy Commissioner of the Industrial Commission, the Assistant Commissioner of Insurance and the Rating Bureau Manager, led the participants to conclude that there is a high degree of accuracy in the reporting procedures.

Casualty & Surety Division
P O Box 26283
Richmond, Virginia 23260

Thomas L. Bondurant
General Manager

August 22, 1979

The Honorable James W. Newman, Jr.
Commissioner of Insurance
State Corporation Commission
Bureau of Insurance
Box 1157
Richmond, VA 23209

Dear Commissioner Newman,

FINAL REPORT OF THE SUBCOMMITTEE ON DATA SYSTEMS

Our report of November 14, 1978 outlined the two tasks of the subcommittee. They were:

1. to find a prospective data collection system that will provide information about the causes of dramatic changes in Workers' Compensation loss costs, and

2. to investigate and report on the accuracy of statistics used to support Workers' Comp rate adjustments.

The subcommittee has accomplished those tasks.

On June 4, 1979 the subcommittee submitted another report which explained that the National Council Call for Detailed Claim Information has been issued and the system for data collection is in place. Data is being collected on Virginia losses and the first preliminary reports based on unseasoned data will be available sometime during the first quarter of 1980. Accordingly, the subcommittee considers its work on Task 1 to be completed.

With respect to the second task, our report of November 14, 1978 explained that four approaches had been settled on:

Ætna Life Insurance Company / The Ætna Casualty and Surety Company / The Standard Fire Insurance Comp

1. reconciliation of Annual Statement financial data with statistical data reported to the NCCI by the twenty largest Compensation carriers in Virginia

2. examination by the Bureau of Insurance of company loss data to evaluate the propriety and quality of loss development and reserving practices

3. examination of the sources of data used by the NCCI in rate making, the reporting instructions issued to carriers and the various checks and tests performed on such data by the reporting companies and the National Council

4. tests of the accuracy of detailed unit statistical data reported to the NCCI.

As respects the first of these approaches, attached is a report of the reconciliation of 1977 financial data with NCCI statistical data for the twenty largest Compensation carriers in Virginia. The results show a remarkably close reconciliation, given the hundreds of millions of dollars of premiums and losses involved in that study.

We do not know the results of the Bureau of Insurance examination of company loss data.

In respect to data used in rate making, our November 1978 report concluded that based upon an examination and evaluation by the subcommittee of NCCI data tests and checks, the subcommittee was persuaded that "such tests are extensive and effective."

With respect to detailed unit statistical data, our November 1978 report said that in two separate tests conducted under different modes and involving different random samples, "The results showed that notwithstanding the detailed and complicated coding requirements, there is an extraordinarily high degree of accuracy in the actual coding, reporting and maintenance of statistics."

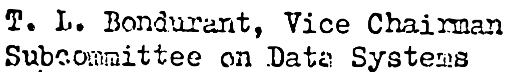
In summary, the subcommittee finds that according to all the tests we could reasonably make, the statistics used to support Workers' Compensation rate adjustments are exceedingly accurate and reliable.

As we proceeded in our work, the subcommittee took upon itself another task - that of cooperating with and assisting the Industrial Commission in the development of a program of data collection.

The subcommittee has provided that cooperation and assistance through a special sub-group of EDP experts from the Travelers Insurance Companies and Ætna Life & Casualty. Even after the dissolution of this subcommittee those company technicians will continue to give the Industrial Commission whatever assistance and advice is desired. It should be noted, however, that until some basic determinations are made as to the kinds of data to be collected by the Commission and the uses to be made of such data, the sub-group's assistance is, of necessity, limited in scope.

The subcommittee believes it has completed the work assigned it and wishes to express sincere appreciation to the National Council, the Bureau of Insurance, the Industrial Commission and all the individual members of the subcommittee for the assistance provided during its study.

Respectfully submitted,



T. L. Bondurant, Vice Chairman
Subcommittee on Data Systems
j/

cc: G. J. Hutchinson, Chairman
G. L. Hazelwood, Jr.
C. G. James
R. H. Kallop
L. R. Lyman
C. S. Metzner
P. O. Presley

NATIONAL COUNCIL ON COMPENSATION INSUNANCE

ONE PENN PLAZA, NEW YORK, N. Y.
212–560-1000

R. . KALLOP
Vice President and Actuary

July 26, 1979

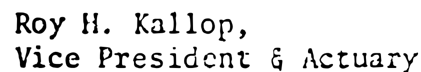
Mr. George J. Hutchinson
Liberty Mutual Insurance Company
175 Berkeley Street
Boston, Massachusetts 02117

Dear George:

Re: Virginia Subcommittee
Data Systems

I am attaching a draft of a memorandum relating to the reconciliation of data reported to the National Council with data included in the Insurance Expense Exhibit in Virginia.

Very truly yours,



Roy H. Kallop,
Vice President & Actuary

RHK:AW
Enc.

CC: Mr. R. Farmer, Manager
Virginia Bureau

VIRGINIA SAMPLE RECONCILIATION

At the meeting held in October 1978, the Subcommittee on Data Systems expressed an interest in a reconciliation of financial data with Insurance Expense Exhibit figures. The Committee was informed that the National Council on Compensation Insurance was developing a reconciliation form which will be released to all carriers prospectively for all states. Specifically, the form requests a breakdown of the experience shown in:

(1) The annual National Council Call for Calendar Year Experience,

(2) The annual call for "F" classification data and

(3) The Annual Call for Coal Mine data.

Also there is an additional section for excess policies and National Defense rojects Experience. Subsequent to the meeting, the form was completed and distributed to the membership on January 31, 1979. A copy of this release is attached.

The committee was also interested in a sample reconciliation for Calendar Year 1977. In this instance, the financial data reports of 20 leading writers in Virginia from the Insurance Expense Exhibit were compared with the calendar year experience from the National Council standard calls for calendar year data including data for the "F" classes and data for the coal mine classes. No call had been issued for the experience of excess policies or experience under the National Defense Project Rating Plan. These combined results were compared to the aggregates shown in the Insurance Expense Exhibit. The test is to ascertain if the loss ratios are comparable overall keeping in mind that the experience of the excess policies and experience under the National Defense Projects are included in the Insurance Expense Exhibit figures only. This test shows the following results:

	NCCI Combined Call (in 1,000's)	Insurance Expense Exhibit (in 1,000's)
Premium	103,088	105,046
Losses	91,372	91,225
Loss Ratio	.886	.868

In summary, a close reconciliation for the 20 leading carriers was achieved for calendar year 1977. Prospectively a reconciliation report will be submitted by all carriers each year in Virginia and in other states to compare calendar year data submitted to the National Council on Compensation Insurance with data reported in the Insurance Expense Exhibit.

IATIONAL COUNCIL ON COMPENSATION INSURANCE

ONE PENN PLAZA, NEW YORK, N. Y. 10001
212-560-1000

OY H KALLOP
Vice President and Actuary

JANUARY 31, 1979

CIRCULAR TO ALL MEMBERS AND SUBSCRIBERS
(Attention: Statistician)

Gentlemen:

Re: 1978 Calendar Year Reconciliation Report of the 1978 Annual Calls to the 1978 Insurance Expense Exhibit

In accordance with action taken by the Special Committee on Ratemaking, the National Council on Compensation Insurance is requesting the reconciliation, by state, of Calendar Year experience reported on the Annual Calls and experience from Part IV of the Insurance Expense Exhibit. A separate report should be completed for each state in which your company has experience.

In reconciling to Part IV of the Insurance Expence Exhibit the following data should be used: Annual Call, Annual Call for "F" Classifications, 1st 6 months and 2nd 6 months Underground Coal Mine, National Defense Projects Experience and xcess policies. If the aforementioned calls and Reconciliation items do not add up to Part IV of the Insurance Expense Exhibit an explanation for the difference is requested.

In order to facilitate reconciliation we request, if at all possible, that the Insurance Expense Exhibit, Annual Calls and the Reconciliation Reports be submitted on the same basis, (i.e. group report or individual company reports). It would also be appreciated if the reconciliation reports would be completed and sent to us on or before April 15, 1979.

Very truly yours,

Roy H. Kallop
Roy H. Kallop
Vice President and Actuary

1978 Calendar Year Reconciliation Report
(Due April 15, 1979)

Carrier(s)* ______________ State ________ State Code No. ________

*If this is a Group or Association report, list individually on each states report, carriers for which any experience is reported for the state.

This is to certify the reconciliation of 1978 Calendar Year Data reported to the National Council on Compensation Insurance and the data from the Insurance Expense Exhibit - Part IV.

	Net Direct Earned Premium	Incurred Losses
I. Data Reported to National Council		
(1) Annual Call (Industrial Classes)	________	________
(2) Annual Call for "F" Classifications	________	________
(3) Underground Coal Mine - 1st 6 months	________ **	________
(4) Underground Coal Mine - 2nd 6 months	________ **	________
(5) Subtotal lines (1) through (4)	________	________
II. Reconciliation Items		
(6) National Defense Projects Experience	________	________
(7) Excess Policies	________	________
(8) Total (5)+(6)+(7)	________	________
III. Insurance Expense Exhibit		
(9) Part IV - Column 2, Column 3	________	________
IV. Difference - explain below		
(10) (9)-(8)	________	________

Reason for differences:

**Net Direct Earned Premium should compare with the reported earned premiums, standard basis for underground coal mines of

1st 6 months ________

2nd 6 months ________

PROGRESS REPORT

NCCI CALL FOR DETAIL CLAIM INFORMATION

The New National Council call, representing the industry effort to gather detail claim information, was effective April 1, 1979. Insurance Companies which will be furnishing information under this call are currently in the process of identifying the claims to be reported on and are setting up whatever systems are required to report on those claims.

The National Council held a seminar in Atlanta, Georgia on February 27 and 28 at which the call was presented to industry representatives. The seminar consisted of both formal presentations as well as extensive question and answer sessions. Follow up documentation on the seminar in the form of a question and answer document covering the most commonly asked questions was sent out during March 1979.

The Virginia Compensation Rating Bureau held an abbreviated version of this seminar on March 21, 1979 to acquaint Virginia Insurance Department representatives, individuals serving on the Workers' Compensation study commission and interested local claims personnel with this data gathering system. At this seminar, opportunity for questions and answers was also provided so that the participants would obtain a clear understanding of the intent of this call.

Attached hereto is an overview of the call for detail claim information. This paper was presented to the NAIC (D-6) Task Force on Loss and Expense Measurement. Appendix B to the full report is the Call for Detail Claim Information as it was presented to the participants at the Virginia seminar.

The National Council is currently in the process of developing the various data processing systems needed to support this data gathering effort. Among such developments are the preparation of suitable machine edits, data files and report generating capabilities. The portions of the systems development effort relating to data capture will be completed in July, 1979. After this effort is completed, the various reports which are desired will be programmed.

The first deadline for submission of data by the various companies is within 60 days after October 1 (October 1 represents the first evaluation at the end of 6 months of claims occurring April 1979). It is anticipated that the first reports utilizing this data will be available some time during the first quarter of 1980. Such reports should be considered preliminary since only a few months of data will have been reported to the Council by that time.

Appropriate committees of the National Council are monitoring the progress of the data processing efforts and of the data collection effort. Should any problems arise with the collection of statistics under the call for detail claim information such committees will take whatever corrective action is required.

Attachment

NATIONAL COUNCIL ON COMPENSATION INSURANCE

CALL FOR DETAIL CLAIM INFORMATION

Claus S. Metzner, Chairman

NCCI DATA COLLECTION TASK FORCE

Associate Actuary, Casualty & Surety Division

Ætna Life & Casualty

Presented at NAIC - (D-6) Loss and Expense Measurement Task Force
Carson City, Nevada.

April 18, 1979

NATIONAL COUNCIL ON COMPENSATION INSURANCE
Call for Detail Claim Information

Introduction

Rapidly increasing loss costs under Workers' Compensation insurance contracts have resulted in large rate increases. It is not surprising that the need for a large rate increase is often questioned and that further information on the cause of the increasing losses is frequently asked for. The desire for additional information on causality of loss is not limited to regulators but is shared by insurance industry personnel, legislators and the various trade associations.

The NCCI staff and member company representatives on NCCI committees have been aware of the need for additional claim data for some time. The appointment and the work of the Data Collection Task Force during 1978 was the tangible recognition of this need.

The Task Force members represented the various technical disciplines - actuarial, underwriting, claim, statistical, data processing - involved in data gathering and data evaluation. The charge to the Task Force was to review the NCCI data gathering system and to recommend appropriate changes.

After review of the current NCCI data gathering efforts and the type of information that would be required in the future the Task Force members concluded that the greatest data need was for additional current loss infor-

mation. The additional loss information should be detailed enough to enable evaluation of the underlying causal elements of Workers' Compensation losses.

The Task Force members also adopted the following basic principles to guide them in the investigation of the need for additional data:

1) That basic ratemaking procedures will continue with a reliance on the Unit Statistical Plan for classification rate relativities and individual risk experience ratings.

2) The additional data collected must be broad enough in scope to provide responses to fundamental questions regarding shifts in claim costs.

3) The data required should be restricted to factual, objective data redily available from a normal claim file and should specify the cause of loss and part of body affected.

4) The data should be gathered on a prospective basis only.

5) Credible data should be captured as early as possible.

Type of Data to be Collected

The Task Force members developed a comprehensive list of additional loss data elements to be collected. This list was based upon both information previously gathered under various claim studies, such as the Florida resolved claim study, and information which actuaries, underwriters and claims adjustors would find useful in evaluating Workers' Compensation loss costs and their movement.

comprehensive list was later refined so that only the most important additional data elements would be captured. Without such refinement the cost of instituting a new data gathering system would have been prohibitive.

The call as issued requires that data be furnished under the following categories:

1) Common Information: information sufficiently unique to identify the claim in case follow-up information is required.

2) Claimant Description: objective information about the claimant such as the Injury Description Code (4 digit), date of injury, employment status, etc.

3) Indemnity Benefits and Payments: information on the types of benefits - temporary total, permanent partial, permanent total, etc. - and the actual or anticipated duration of payments.

4) Vocational Rehabilitation Benefits.

5) Medical Benefits: information on the types of benefits and frequency of use.

6) Claim Administration Details: information on method of disposition, whether a controversy with the claimant was involved, subrogation, etc.

All the data elements retained for the final call met the twin objectives of objectivity and necessity, i.e., the data was objective and it was deemed to be absolutely necessary for a proper evaluation of loss costs. Various

previous ad - hoc studies were reviewed to assure that the important questions raised in them could be answered by use of this data. Sufficient identifying information on each claim was retained so that if further investigation of a particular type of claim were required those claims could be readily identified.

Method of Gathering Data - Sampling

The amount of additional claim information the Task Force wanted to collect was very large. Consequently, a serious effort was undertaken to minimize the cost gathering the data. The data gathering technique adopted as being the most cost effective as well as most flexible was scientific sampling.

The advantages of sampling have been well demonstrated in such other areas as demographic studies, public opinion polls, and scientific studies. The Task Force decided that the approach would work equally as well in a study to analyze the causes of Workers' Compensation losses.

The sample is expressly designed to provide sufficient data to analyze the costs of permanent partial claims. The permanent partial claims are currently of the most concern because of their disproportionate cost and the potential for abuse of this aspect of the Workers' Compensation system.

Based upon unit card data and the distribution of claims by type of injury, an appropriate sampling ratio of all newly arising claims was derived for each of twelve states. Depending on the total claim volume, the sampling ratio ranged from a low of 5% for New York and Illinois to a high of 40% for Kentucky and Virginia. Other states included in the

original call are Connecticut (30%), Florida (10%), Georgia (30%), Massachusetts (15%), Michigan (20%), Minnesota (30%), Pennsylvania (15%) and Wisconsin (30%). The above states were selected either because of their relative size or because their Workers' Compensation experience had exhibited continuing adverse loss experience over the last several years. Furthermore, the Task Force concluded that not all states should be included in the call because the new data gathering system should remain as flexible as possible during this start-up period. Such flexibility and operation at reduced cost can be achieved best by limiting the number of states originally included in the Call for Detail Claim Information.

Uses of the Data

The detail claim data gathered can be used to:

1) Analyze movements in Workers' Compensation loss costs over time between injury types.

2) Analyze the impact of lengthening duration of disability versus the impact of higher relative compensation levels.

3) Analyze the relative differences in claims costs and the source of those differences between different states.

4) Provide benchmarks for companies' claims adjustors in order for them to more closely monitor claims costs.

5) Provide objective data for use in evaluating costs/benefits of proposed revisions to Workers' Compensation laws.

As the new data gathering system develops other uses for the data will probably suggest themselves. The National Council currently expects preliminary reports on claims arising after April 1979, valued at six months after arising, to be produced during the first three months of 1980. Periodic updating of the claim values will provide information regarding loss development and allow for comparisons of shifts in type of compensation benefits payable as a claim ages.

Summary

The National Council Call for Detail Claim Information is designed as a flexible tool to provide objective information on the causes of Workers' Compensation losses.

The Call is based upon scientific sampling techniques so as to maximize flexibility and utility of data gathered consistent with minimizing the costs of data gathering. Claims arising after April 1, 1979 will be sampled and followed for a period of 42 months to provide a continuous record of loss cost movement.

The National Council and its member companies will review the data gathered and utilize the resulting information on loss costs so that all interested parties will have an objective base of information available in assessing the movement in Workers' Compensation loss costs.

INDUSTRIAL COMMISSION DATA BASE

The attached sheets show the information that is presently being placed on computer with a listing of other items that will shortly be added when the fields are increased. This will be operative no later than January 1, 1980.

In addition, we have set forth a list of items or fields that will have to be added if we desire to have a data base similar to the North Carolina Industrial Commission. The North Carolina Commission has advised that their statistics are not used in any manner for rate making purposes but are simply used for their own internal operation.

The cost figures for each of these systems are listed but it must be kept in mind that approximately 60% of the listed cost is not directly for statistics but for obtaining coverage information from the Virginia Rating Bureau rathar than keeping manual records of all coverage.

It should be noted that any time additional fields are required there is tremendous expense involved and if there are any suggestions of any additions or deletions to the system this information should be made available to us by October 1, 1979.

Charles G. James
hr- August 22, 1979

Current Information Fields and Cost

Claim Number	Date Claim Established
Claimant	Employer Number
Employer	Date of Accident
Nature of Injury	Type of Accident
Type of Industry	Part of Body
Wage	Compensation Begin Date
Last Compensation	Compensation Total
Type of Disability	Death Benefit
Temporary Total	Compromise
Permanent Total	Third Party Settlement
Temporary Partial	Award Terminated Date
Parmanent Partial	Award Reinstatement Date
Number of times Award Reinstated	Last Medical
Medical Total	Medical Date
Cost of Living	Status (I. C. in House use)

Cost	Monthly	Yearly
Equipment	$ 804.00	$ 9,648.00
MASD	$ 667.50	$ 8,010.00
MIDTOWN COMPUTER CENTER	$ 7,472.67	$ 89,672.00

NOTE: Above cost reflect budget for 1979 - 1980.

This cost represents operational cost to enter information into the system and the following reports:

Claimant Name (Monthly with weekly update)

Employer insurance coverage (Yearly)

Statistical reports have not been established

Approximate Cost:

Development (MASD) $ 9,000

R. G. Umb

ssh/8-17-

Information Fields we will add to OUR CURRENT SYSTEM

Hospital Cost

Rehabilitation

Compensation Rate

County or City

Insurance Carrier

Claimant First Line Address

Claimant Second Line Address

We should be able to obtain information on a yearly basis as to the amount and kind of compensation paid on files closed during any past year. Within the coding we should be able to compare the cost of a particular type of injury from one year to the next, cost of hospital treatments, doctors, and other medical expenses as well as outside Rehabilitation costs for each year should be available. In addition, we should be able to pull certain files on certain types of injuries or industries for comparison purposes as to cost. A comparison of medical charges in different sections of the state should be available from the coding.

On all cases where compensation is awarded the carrier or self-insured will report each six months as to total doctors' bills and other medical expense paid, hospital charges and outside Rehabilitation costs.

On claims of under $500.00 medical expense, these will be reported monthly by name of employer, employee and total medical paid.

Cost

Reorganization of Data Base	$ 10,000.00
Development	11,900.00

Charles G. James
hr/ 8-22-79

Expansion of the Computer System
(Similar to North Carolina System)

Information fields TO BE added to our current System

County/City	Date Employer notified
Social Security No.	Claimant First Line Address
Sex	Claimant Second Line Address
Age	Occupation
Date of Death	Date First Report Receive
First Payment Date	Date Compensation Paid Thru
Hospital	Rehabilitation
Total Medical and Compensation	Date of Disability
No. of Loss Workdays	Attorney Fee
Lump Sum	Funeral Expense
Microfilm Cassette No.	Docket No.
Insurance Carrier	County of Hearing
Compensation Rate	Date of Hearing

What will be developed from adding the above Information Fields

- Coat per Injury
  - Hospital Cost
  - Rehabilitation Cost
  - Average Compensation Rate
  - By City or County
  - By Occupation
  - By Age Group
  - By Sex
  - Attorney Fee
  - Funeral Expense

Lost Workdays per Case

Number and Cost of Lump Sum Settlements

Cost Analysis

Compensation Hospital Rehabilitation Other Medical	Trend Cost Comparison Area Comparison

Computer Generated Acknowledgement Letters and Envelopes

Computer Generated Cancellation Letters

Cost	1980 - 1981
Development (MASD)	$ 47,900
MASD (Yearly Budget)	12,000
Midtown Computer Center (Yearly Budget)	213,470
Equipment	14,400
Total	$ 287,770

R. G. Umbel
ssh/8-17-79

DESCRIPTION CODES

NON-FATAL

NATURE OF ACCIDENT

02-Bruises, Contusions & Abrasions
03-Burns and Scalds
04-Concussions
05-Cuts & Lacerations
06-Fractures & Mashed
07-Punctures
08-Paralysis
09-Heart attack
10-Crushing
11-Heat Stroke
12-Frost Bite
13-Electric Shock
14-Shock
15-Hernia
16-Deafness
17-Dislocations
18-Sprains & Strains
19-Disfigurement
20-All Other-NOC

OCCUPATIONAL DISEASES

30-Dermatitis
31-Poisoning-Systemic
32-Infectious Diseases
33-Radiation Effects
34-Pneumoconiosis
35-Occupational Disease-NOC
40-Black Lung
41-Black Lung Phase 1
42-Black Lung Phase 2
43-Black Lung Phase 3
44-Black Lung Phase 4
45-Heart & Lung - Police
46-Heart & Lung - Firemen
47-Brown Lung
48-Heart Attack

FATAL

50-Fatal-NOC
52-Bruises, Contusions & Abrasions
53-Burns and Scalds
54-Concussions
55-Cuts and Lacerations
56-Fractures & Mashed
57-Punctures
58-Paralysis
59-Heart attack
60-Crushing
61-Heat Stroke
62-Frost Bite
63-Electrocution
64-Asphyxiation
65-Drown

OCCUPATIONAL DISEASES

70-Dermatitis
71-Poisoning-Systemic
72-Infectious Diseases
73-Radiation Effects
74-Pneumoconiosis
75-Occupational Disease-NOC
76-Black Lung
77-Heart & Lung - Police
78-Heart & Lung - Firemen
79-Brown Lung
80-Heart Attack

DESCRIPTION CODES

SOURCE

01-Machinery

02-Vechicles-Other Power

03-Explosion, Electric, Etc.

04-Slip or Fall of Person

05-Stepping on or Stricking Against

06-Falling objects not Handled

07-Handling of Objects

08-Hand Tools

09-Animinals, insects & Reptiles

10-Suffocation

11-Other Specify

12-Shock

13-Violence

O. D.

14-Respiratory Disease Toxic

15-Posioning Toxic

16-Physical Agents Disorder

17-Occupational Skin Diseases

18-Dust Disease-Lung

19-Occupational Disease-NOC

INDUSTRY

01-Agriculture

02-Coal Mining

03-All Other Mining
Metallergy & Quarrying

04-Mfg., Food, Tobacco, Etc.

05-Miscellaneous Mfg.

06-Construction-not Building Erection

07-Building Erection & Demolition

08-Shipbuilding

09-Stevedoring & Freight Handling

10-Cartage & Trucking

11-Public Utilities

12-Commerical Enterprises

13-Clerical & Proffessional Services

14-Operations & Maintenance

15-Miscellaneous Occupations

PART OF BODY

01-Brain

02-Eyes

03-Ears

04-Jaws

05-Teeth

06-Nose

07-Skull

10-Lungs

11-Arms

12-Hands

13-Fingers

14-Chest-Ribs

15-Abdomen

16-Hernia

19-Shoulders

20-Trunk-NOC

21-Legs

22 Knees

23-Feet

24-Toes

25-Back

THIS REPORT IS PREPARED EVERY MONTH ON A MANUAL BASIS

STATISTICAL REPORT

FOR

June 1979

	ACCIDENTS	O.D.	TOTAL	
TOTAL CASES REPORTED	6,954	58	7,012	
Monthly Reports	3,204		3,204	
Total New Cases (#3 Reports)...	3,750	58	3,808	-A-
Temporary Totals............	3,729	58	3,787	
Specifics	----		-----	
Fatals	21		21	
AGREEMENTS APPROVED	2,904	25	2,929	
CASES CLOSED	4,411	27	4,438	-B-
CASES SET .... [illegible] TERMINATED.................... CASES HEARD	3,901		3,901	
LUMP SUM	10 ($56,825)		10 ($56,825)	
OPINIONS RENDERED	305	26	331	
MEDICAL EXAMINATIONS & OPINIONS				
COMPROMISE SETTLEMENTS	90			

[illegible]

-A- 21 ÷ 3,808= 181

-B- 21 ÷ 4,438= 211

RECLOSED = 618
DUPLICATIONS= 17

RGU:ssh
7-13-79

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE WORKMEN'S COMPENSATION ACT.

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF WORKMEN'S COMPENSATION

INDUSTRIAL COMMISSION OF VIRGINIA

RICHMOND

REPORT OF MEDICAL COSTS

(Accident previously reported)

I.C. Claim No. ______________________ Date of Accident ____________

Name of Employer ______________________________________

Name of Injured ______________________ Social Security Number ____________

Name of Insurance Carrier ______________________ Policy Number ____________

Amount of Outside Rehabilitation Training Costs ______________________

Amount of Hospital Costs ______________ Amount of all Other Medical Costs ______________

If medical treatment is concluded within six (6) months from date of accident, file a report at that time. File additional reports at six (6) month intervals from date of last report or when concluded. Do not duplicate amounts in each report. Only include items which constitute benefits under the law.

Signature ______________________ Title ______________ Date ________

NOTE:

If medical previously reported on Form 45A, list the amount reported ______________________

FORM 45A 6 5 79 —20M

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF WORKMEN'S COMPENSATION
INDUSTRIAL COMMISSION OF VIRGINIA
P.O. BOX 1794, RICHMOND, VIRGINIA 23214

MONTHLY REPORT OF MINOR INJURIES

For Month Ending .... 19 ......
File By 15th Day of Month Following

Insurance Carrier ....

Claims Office filing this report ....

Signature and title of person accountable for this report ....

All accidents producing disability of seven days or less, or medical costs of $500.00 or less to be reported on this form, 45A. This report shall be filed in triplicate with the Statistical Division pursuant to law.

All cases involving the payment of compensation benefits, medical costs in excess of $500.00, or from the nature of the injuries will produce a disability of over seven days, shall be reported to the Claims Division on Form No. 3, The Employer's First Report of Accident. When cases previously reported on the Monthly Report Form develope into compensation cases, or medical costs in excess of $500.00, complete and file Form No. 3 with the Claims Division showing date the accident was reported on this form.

EMPLOYER	NAME OF EMPLOYEE	DATE OF INJURY	AMT. OF MEDICAL
		TOTAL MEDICAL	

If additional pages are required, attach supplemental sheets giving the same information as shown above.

SECTION VII

SUMMARY OF MAJOR BENEFIT CHANGES IN W. C. LAW

1970 - 1979 (Incl.)

The following constitutes a ten year summary of changes in the Virginia Workmen's Compensation Act, involving increased benefits. There were other amendments to the Act which, while not of a substantial nature, would have some effect on the increased cost of benefits.

7-1-70 - Maximum weekly compensation benefit increased from \$51 to \$62.

Total compensation payable under the Act increased from \$20,400 to \$24,800.

7-1-71 - Legislature not in session.

7-1-72 - Maximum weekly compensation benefit increased from \$62 to \$70.

Change in the weekly compensation base from 60% to 66 2/3% of injured employee's average weekly wages.

Total compensation payable under the Act increased from \$24,800 to \$31,500 (except for total incapacity as defined under Section 65.1-56 (18) benefits payable for life.)

Provision for medical attention, including prosthetic appliances, to be furnished for unlimited duration.

Burial expenses increased from \$300 to \$800.

7-1-73 - Maximum weekly compensation benefit increased from \$70 to \$80 and minimum increased from \$14 to \$25.

Total compensation payable under the Act increased from \$31,500 to \$40,000 (except for total incapacity as defined under Section 65.1-56 (18) benefits payable for life.)

7-1-74 - Maximum weekly compensation benefit increased from \$80 to \$91 and minimum increased from \$25 to \$27.

Total compensation payable under the Act increased from \$40,000 to \$45,500 (except for total incapacity as defined under Section 65.1-56 (18) benefits payable for life.)

6-1-75 - Volunteer firemen and volunteer lifesaving and rescue squad members brought under the Act. (Section 65.1-4.1).

7-1-75 - Maximum weekly compensation benefit increased from $91 to $149 and minimum increased from $27 to $37.25.

Dollar limit on maximum compensation payable under the Act removed but 500 week limitation retained except for total incapacity as defined under Section 65.1-56 (18); 65.1-56.1 (4) and 65.1-65.1 - benefits payable for life. (Compensation limited to State's average weekly wage - maximum is 100% of State's average weekly wage and minimum is 25% of maximum, not to exceed average weekly wage of injured employee.)

Maximum compensation $74,500 (500 x $149) except where lifetime benefits payable.

Cost of Living (COL) Supplements provided for total incapacity and dependents of deceased for accidents occurring on or after 7-1-75.

Second Injury Fund created effective 7-1-75.

7-1-76 - Maximum weekly compensation benefit increased from $149 to $162 and minimum increased from $37.25 to $40.50.

Maximum compensation $81,000 (500 x $162) except where lifetime benefits payable.

COL Supplements for accidents occurring between 7-1-75 and 7-1-76 amounted to 7% of the award.

Benefit for burial expenses increased from $800 to $1000 and reasonable transportation expense for the deceased, not to exceed $300, allowed.

Payment of benefits allowed for severely marked disfigurement of <u>any part of the body</u> under Section 65.1-56 (cases in which incapacity deemed to continue for specified periods).

Auxiliary and reserve police brought under the Act (Section 65.1-4.1).

Respiratory disease, hypertension and heart disease suffered by law enforcement officers and firefighters, presumed to be occupational disease covered by the Act unless contrary be shown by competent evidence (Section 65.147.1).

7-1-77 - Maximum weekly compensation benefit increased from $162 to $175 and minimum increased from $40.50 to $43.75.

Maximum compensation $87,500 (500 x $175) except where lifetime benefits payable.

COL Supplement for accidents occurring between 7-1-76 and 7-1-77 amounted to 4.8% of the award.

Time limitation as respects awards on change in condition was extended from 12 months to 24 months (Section 65.1-99).

Members of State Police Officers Retirement System was added to the schedule of law enforcement officers for whom death or disability caused by hypertension or heart disease presumed to be an occupational disease covered by the Act - retroactive to 1-1-74 (Section 65.1-47.1).

Uninsured Employers Fund created (Section 65.1-46 through 65.1-52).

7-1-78 - Maximum weekly compensation benefit increased from $175 to $187 and minimum increased from $43.75 to $47.75.

Maximum compensation $93,500 (500 x $187) except where lifetime benefits payable.

COL Supplement for accidents occurring between 7-1-77 and 7-1-78 amounted to 6.8% of the award.

Section 65.1-47.1 amended to require a preponderence of evidence to rebut the presumption as to death or disability from respiratory disease, hypertension or heart disease.

7-1-79 - Maximum weekly compensation benefit increased from $187 to $199 and minimum increased from $46.75 to $49.75.

Maximum compensation $99,500 (500 x $199) except where lifetime benefits payable.

COL Supplement for accidents occurring between 7-1-78 and 7-1-79 amounted to 9% of the award.

WORKERS' COMPENSATION INJURY DESCRIPTION CODES

DEFINITIONS:

I. TRAUMATIC INJURY: Injuries which are traceable to a definite accident during the Employee's present employment.

II. OCCUPATIONAL DISEASE: Injury caused by exposure to a disease producing agent in the Workers' Occupational Environment. Injuries of this type are not traceable to a definite accident during the Employee's past or present employment.

III: CUMULATIVE INJURY: Having occured from, or aggravated by, a repetitive employment related activity. Injuries of this type are not traceable to a definite accident during the Employee's past or present employment.

Use the appropriate combination of codes (from "Parts of Body" and from "Nature of Specific Injury") which best describes the primary cause of disability.

PART OF BODY (First Two Digits)

I. HEAD
- 10. Multiple head Injury
- 11. Skull
- 12. Brain
- 13. Ear(s)
- 14. Eye(s)
- 15. Nose
- 16. Teeth
- 17. Mouth
- 18. Other Facial soft tissue
- 19. Facial Tissue

II. NECK
- 20. Multiple Neck Injury
- 21. Vertebrae
- 22. Disc
- 23. Spinal Cord
- 24. Larynx
- 25. Soft Tissue
- 26. Trachea

III. UPPER EXTREMITIES
- 30. Multiple Upper Extremities
- 31. Upper Arm (inc. Clavicle & Scapula)
- 32. Elbow
- 33. Lower Arm
- 34. Wrist
- 35 Hand

III. (Continued)
- 36. Finger(s)
- 37. Thumb

IV. TRUNK
- 40. Multiple Trunk
- 41. Upper Back Area (Thoracic Area)
- 42. Low Back Area (incl. Lumbar & Lumbo-Sacral)
- 43. Disc
- 44. Chest (incl. Ribs Sternum,& Soft Tissue)
- 45. Sacrum & Coccyx
- 46. Pelvis
- 47. Spinal Cord
- 48. Internal Organs
- 49. Heart.

V. LOWER
- 50. Multiple Lower Extremities
- 51. Hip
- 52. Thigh
- 53. Knee
- 54. Lower Leg
- 55. Ankle
- 56. Foot
- 57. Toe(s)

IV. MULTIPLE BODY PARTS
- 90. Multiple Body Parts

NATURE OF SPECIFIC INJURY (Last Two Digits)

- 02. Amputation
- 03. Angina Pectoris (Painful Condition associated with Heart Disease)
- 04. Burn
- 07. Concussion
- 10. Contusion
- 13. Crushing
- 16. Dislocation
- 19. Electric Shock
- 22. Enucleation (To remove Ex: Tumor, Eye, etc.)
- 25. Foreign Body
- 28. Fracture
- 30. Freezing
- 31. Hearing Loss (Traumatic Only)
- 32. Heat Postration
- 34. Hernia
- 36. Infection
- 37. Inflamation
- 40. Laceration
- 41. Myocardial Infarction (Heart Attack)
- 43. Puncture
- 46. Rupture
- 47. Severence
- 49. Sprain
- 52. Strain
- 55. Vascular
- 58. Vision Loss

OCCUP. OR CONTAGIOUS DISEASE OR CUM. INJ.

- 6000 Dust Disease N.O.C. (All Other Pneumoconiosis)
- 6061 Asbestosis
- 6062 Black Lung
- 6063 Byssinosis
- 6064 Silicosis
- 6100 Respiratory Disorders (Gases, Fumes, Chemicals, etc.)
- 6200 Poisoning - Chemical
- 6300 Poisoning - Metal
- 6400 Dermatitis
- 6500 Mental Disorder
- 6600 Radiation
- 6700 [illegible]
- 6800 Loss of Hearing
- 6900 Contagious Diseases
- 70XX Cancer (Last two digits from part of body chart)
- 80XX All Other Cumulative Inj. (Last two digits from part of body chart)

WORKERS' COMPENSATION LOSS COVERAGE CODES*

Codes 11 - 29 are assigned as follows

1. Regular Coverage - in most cases this code will be assigned upon registration. It is changed only if there is Subrogation or a Liability Over action or if it was erroneously coded as to Injury or Disease
2. Subrogation - when it is determined that there is subrogation, change code from Regular Coverage to Subrogation.
3. Liability Over - if a Liability Over action is brought under the Coverage B provision, change the code from Regular Coverage or Subrogation to Liability Over.

Do not change the code to Regular Coverage regardless of the outcome of the Subrogation or Liability Over results.

Basis of Liability	Nature of Injury		Code
State Act	Traumatic Injury	Regular Coverage	11
		Subrogation	12
		Liability Over	13
	Occupational Disease	Regular Coverage	14
		Subrogation	15
		Liability Over	16
	Cumulative Injury	Regular Coverage	17
		Subrogation	18
		Liability Over	19
U.S.L. & H.W. Act	Traumatic Injury	Regular Coverage	21
		Subrogation	22
		Liability Over	23
	Occupational Disease	Regular Coverage	24
		Subrogation	25
		Liability Over	26
	Cumulative Injury	Regular Coverage	27
		Subrogation	28
		Liability Over	29

Codes 31 - 37 are assigned when an employee files a direct claim under Coverage B of the Compensation Policy.

Basis of Liability	Nature of Injury	Code
Employers' Liability	Tramactic Injury	31
	Occupational Disease	34
	Cumulative Injury	37

Codes below are assigned when the loss fits the described benefit. When applicable, these codes supercede all other previously assigned Coverage Codes.

Description		Jurisdiction (If applicable)	Code
Admiralty Benefits Payable			41
F.E.L.A. Benefits Payable			42
Joint Coverage Claims		California	00
District of Columbia Benefits Payable		Maryland Virginia	01
Second Injury Fund Reimbursement		Minnesota	02
Safety Device Penalty Award		New Mexico	04
Special Disability Fund		New York	05
Disease Loss Compensated under Penn. Occupation Disease Act		Pennsylvania	07
Black Lung benefits payable on a Non-Coal Mine Classification		Pennsylvania	08
Exemplary Damages		Texas	09
Oil, Gas, Mineral Operations on or over water	State Act	Texas	10
	U.S.L. Act		20
	Voluntary Comp.		30
	Admiralty		40

*NOTE: In cases where the indemnity involves vocational rehabilitation costs and reserves, the code which would otherwise have applied shall be increased by fifty and the resulting code shall be reported (e.g. State Act/Trauma/Regular Coverage/Vocational Rehabilitation use code 61).

DEFINITIONS

I. **TRAUMATIC INJURY:** Injuries which are ~~traceable to a definite accident~~ during the Employee's present employment.

II. **OCCUPATIONAL DISEASE:** Injury caused by exposure to a disease producing agent in the Workers' Occupational Environment. Injuries of this type are not traceable to a definite accident during the Employee's past or present employment.

III: **CUMULATIVE INJURY:** Being occured from, or aggravated by, a repetitive employment related activity. Injuries of this type are not traceable to a definite accident during the Employee's past or present employment.

MINUTES

Workmen's Compensation Subcommittee
of the House Labor and Commerce Committee
August 23, 1979
House Room C - General Assembly Building
10:00 a.m.

Present	Absent
William T. Wilson	Richard R. G. Hobson
Norman Sisisky	
Calvin G. Sanford	
Warren G. Stambaugh	
Robert E. Washington	

Staff: C. William Cramme', III, Hugh P. Fisher, III, and Anne M. Parks

* * * * * * * * * * *

The meeting was called to order at 10:00 a.m. by the Chairman, Delegate Wilson. After a few introductory remarks, the Chairman recognized Mr. James Newman, Commissioner of Insurance for the Commonwealth, and requested that Mr. Newman answer some questions from the subcommittee.

In response to one question, Mr. Newman stated that he was not present during the recent workmen's compensation rate hearing; but he said it was his understanding that the Attorney General's Office did not have a representative present during the hearing.

The Chairman replied that it is the subcommittee's feeling that there should be a representative of the Attorney General's Office present at all rate hearings for the purpose of representing the interests of consumers. Further, the Chairman said th having a representative of the Attorney General's Office present during rate hearings mi make such hearings more adversary in nature. He requested that in the future, the Bureau of Insurance give direct notice to the Attorney General's Office regarding the dates of workmen's compensation rate hearings.

Mr. Newman replied that he would see that direct notice regarding the dates of future rate hearings is communicated to the Attorney General's Office.

Regarding another subject, Mr. Newman stated that the Bureau of Insurance performs an in-depth study of all rate filings submitted by the Virginia Compensation Rating Bureau. In particular, he said, the consulting actuary of the Bureau of Insurance analyzes the rate filing and testifies during the rate hearing regarding his analysis and conclusions.

The next speaker was Mr. Anthony Gambardella, an Assistant Attorney General. Mr. Gambardella stated that often his office does not learn that a workmen's compensation rate hearing is going to be held until thirty days prior to the hearing date. Needless to say, he stated, this does not give the Attorney General's Office much time to prepare for the hearing.

In response to a question from the subcommittee, Mr. Gambardella noted that there was a conscious decision by his office not to participate in the last rate hearing before the State Corporation Commission. He held that two reasons for the decision not to participate are that the Attorney General's Office is presently somewhat short of manpower, and the fact that his office learned that the Virginia Manufacturers Association was going to represent the interests of the business community at the hearing. Further, Mr. Gambardella stated that he could assure the subcommittee that in the future his office would participate

in such hearings to the degree such participation is needed and to the extent his office is able to participate.

The Chairman responded by saying that the subcommittee believes that active participation by the Attorney General's Office will help ensure that workmen's compensation rate hearings are adversary in nature. The Chairman then noted that the Attorney General's Office has the statutory duty to represent the interests of consumers in rate hearings, and he said the subcommittee feels that the interests of consumers should be represented at such hearings.

The Chairman then stated that the next order of business would be presentations by representatives of the task force subcommittees.

The following individuals proceeded to present the reports of their respective subcommittees: Mr. Harold Thornhill, chairman of the law and procedures subcommittee; Mr. Bernard Hulcher, chairman of the rate regulatory procedures subcommittee; Mr. T. L. Bondurant, vice-chairman of the data systems subcommittee; and Mr. P. C. M. Butler, chairman of the standards of service subcommittee.

Copies of each task force subcommittee report were given to the legislative subcommittee members. For any legislative subcommittee member not in attendance at the meeting, enclosed is a copy of each subcommittee report.

The next speaker was Mr. Charles James, Deputy Commissioner of the State Industrial Commission. Mr. James distributed to each legislative subcommittee member a copy of a report concerning the data base which the Industrial Commission is developing. He then proceeded to summarize the report. For any legislative subcommittee member not in attendance at the meeting, enclosed is a copy of Mr. James' report.

The Chairman requested that Mr. James meet with representatives of the Bureau of Insurance, the insurance industry, and the Medical Society of Virginia and attempt to reach a consensus regarding what specific types of data should be collected

and maintained by the Industrial Commission. Mr. James replied that he would be glad to arrange such a meeting.

There being no further business, the meeting was adjourned.

#

LAW AND PROCEDURES SUBCOMMITTEE

Mr. H. V. Thornhill (Chairman)
Claims Department
Travelers Insurance Company
P. O. Box 26426
Richmond, VA 23261 Ph. (804) 353-9451

Mr. D. E. Edwards (Vice Chairman)
Insurance Company of North America
1506 Willow Lawn Drive
Richmond, VA 23230 Ph. (804) 285-7492

Mr. Z. C. Dameron, Jr. &/or T. L. Wright
Virginia Manufacturers Association
P. O. Box 412
Richmond, VA 23203 Ph. (804) 643-7489

Mr. C. G. James
Industrial Commission of Virginia
P. O. Box 1794
Richmond, VA 23214 (804) 786-3623

Mr. J. M. Oakey, Jr.
McGuire, Woods & Battle
Ross Bldg., 801 E. Main St.
Richmond, VA 23219 Ph. (804) 644-4131

Mr. E. F. Johnson, Jr.
Wells, Morano, Axselle, Johnson & Battle
201 N. Blvd.
Richmond, VA 23220 Ph. (804) 355-0691

Mr. P. C. M. Butler
Liberty Mutual Insurance Company
P. O. Box 8210
Richmond, VA 23226 Ph. (804) 285-7441

**Mr. A. C. Goolsby, III
Hunton & Williams (Lawyers)
P. O. Box 1535
Richmond, VA 23212 Ph. (804) 788-8289

***Mr. James E. McCaffer.
Royal-Globe Companies
101 Buford Rd.
Richmond, VA 23235 Ph. (804) 320-7800

Mr. G. L. Hazelwood, Jr.
Bureau of Insurance
P. O. Box 1157
Richmond, VA 23209 Ph. (804) 786-3666

Mr. J. F. Carper
Virginia State AFL - CIO
3315 W. Broad St.
Richmond, VA 23230 Ph. (804) 355-7444

Mr. W. N. Gregory, Jr.
Virginia Mutual Insurance Company
4015 Fitzhugh Ave.
Richmond, VA 23230 Ph. (804) 358-6731

Mr. J. B. Morton
Shomo & Lineweaver Insurance Agency
P. O. Box 929
Harrisonburg, VA 22801 Ph.(703) 434-1301

Mr. William E. O'Neill, Jr.
Attorney-At-Law
307 N. Washington St.
Alexandria, VA 22314 Ph. (703) 836-5757

Mr. Charles G. Avery, Jr.
Avery Insurance Agency
909 Mutual Bldg.
Richmond, VA 23219 Ph.(804) 643-6777

Mr. W. E. Hageman
Employers Mutual Liab. Ins. Co.
2000 Westwood Drive
Wausau, WI 54401 Ph.(715) 842-6817

*Mr. Paul G. Stickler
(Formerly of: Reynolds Metals Co.)
12 College Rd.
Richmond, VA 23229 Ph.(804) 288-1784

***Mr. J. M. Stevenson
Mutual Insurers, Inc.
517 W. Grace St.
Richmond, VA 23220 Ph. (804) 643-7311

*Added at 4-27-79 meeting.

**Added 5-9-79.

***Added 8-7-79

RATE REGULATORY PROCEDURES SUBCOMMITTEE

Mr. B. M. Hulcher (Chairman)
(Formerly of: Southern States Coop.)
2225 Brookwood Rd.
Richmond, VA 23235 Ph. (804) 272-1382

Mr. C. J. Cralle (Vice Chairman)
Henderson & Phillips, Inc.
P. O. Box 267
Norfolk, VA 23501 Ph. (804) 625-5353

Mr. J. H. Cronly, Jr.
Universal Leaf Tobacco Co., Inc.
P. O. Box 25099
Richmond, VA 23260 Ph. (804) 359-9311

Mr. C. G. James
Industrial Commission of Virginia
P. O. Box 1794
Richmond, VA 23214 Ph. (804) 786-3623

Mr. G. L. Hazelwood, Jr.
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209 Ph. (804) 786-3666

Mr. P. O. Presley
Actuarial Consultant - Bureau of Insurance
14 Pendleton Lane
Londonderry, N.H. 03053 Ph. (603) 432-3376

Mr. R. H. Kallop
National Council on Compensation Insurance
One Penn Plaza
New York, N.Y. 10001 Ph. (212) 560-1064

Mr. Jeff Wells
Hartford Accident & Indemnity Co.
4914 Radford Ave.
Richmond, VA 23230 Ph. (804) 358-0433

Mr. Z. C. Dameron, Jr.
Virginia Manufacturers Association
P. O. Box 412
Richmond, VA 23203 Ph.(804) 643-7489

Mr. F. H. Codding
Attorney-At-Law
P. O. Box 225
Fairfax, VA 22030 Ph.(703) 591-1870

Mr. Thomas Lincks, Jr.
Maryland Casualty Company
6606 West Broad St.
Richmond, VA 23230 Ph.(804) 288-7213

Mr. J. F. Carper
Virginia State AFL - CIO
3315 W. Broad St.
Richmond, VA 23230 Ph.(804) 355-7444

Mr. Donald W. Satterfield
Lumbermens Mutual Casualty Company
Long Grove, IL 60049 Ph. (312) 540-2424

Mr. M. D. Richardson
Travelers Insurance Company
P. O. Box 26426
Richmond, VA 23261 Ph. (804) 353-9451

APPENDIX C

STANDARDS OF SERVICE SUBCOMMITTEE

Mr. P. C. M. Butler (Chairman)
Liberty Mutual Insurance Company
P. O. Box 8210
Richmond, VA 23226 Ph. (804) 285-7441

Mr. E. J. Michael (Vice Chairman)
Bureau of Insurance
P. O. Box 1157
Richmond, VA 23209 Ph. (804) 786-3666

Mr. Grayson Kirtland
(Formerly of: A. H. Robins Co.)
15 Glenbrooke Circle, West
Richmond, VA 23229 Ph. (804) 288-3666

Mr. L. W. Hiner
Industrial Commission of Virginia
P. O. Box 1794
Richmond, VA 23214 Ph. (804) 786-3647

. Norman R. Fontaine
American Mutual Liability Insurance Co.
Wakefield, MA 01880 Ph. (617) 245-6000

Mr. John Newby
Commercial Risk Consultants
P. O. Box 606
Hampton, VA 23669 Ph. (804) 851-5854

Mr. D. E. Edwards
Insurance Company of North America
1506 Willow Lawn Drive
Richmond, VA 23230 Ph. (804) 285-7492

Mr. J. B. Boehling, Jr.
Travelers Insurance Company
P. O. Box 26426
Richmond, VA 23261 Ph. (804) 353-9451

Mr. E. Earl Bishop
Early Settlers Insurance Company
P.O. Box 27552
Richmond, VA 23261 Ph. (804) 788-1234

*Mr. T. G. Offterdinger
Lynchburg Foundry Co. (Div. of Mead Corp.)
Drawer 411
Lynchburg, VA 24505 Ph. (804) 528-8200

*Mr. Paul G. Stickler
(Formerly of: Reynold Metals Co.)
12 College Rd.
Richmond, VA 23229 Ph. (804) 288-1784

** Mr. Roland B. Chandler
(Formerly of: Travelers Insurance Co.)
3101 Abelia Road
Richmond, VA 23228 Ph. (804) 266-4661

*** Mr. James M. Stevenson
Mutual Insurers, Inc.
517 W. Grace St.
Richmond, VA 23220 Ph. (804) 643-7311

*Added at 4-27-79 meeting.

**Added 5-8-79

***Added 6-25-79

DATA SYSTEMS SUBCOMMITTEE

Mr. G. J. Hutchinson (Chairman)
Liberty Mutual Insurance Company
175 Berkeley Street
Boston,MA 02117 Ph. (617) 357-9500 Ext. 3492

Mr. T. L. Bondurant (Vice Chairman)
Aetna Casualty & Surety Company
P. O. Box 26283
Richmond, VA 23260 Ph. (804) 257-5211

Mr. R. H. Kallop
National Council on Compensation Insurance
One Penn Plaza
New York, N.Y. 10001 Ph. (212) 560-1064

Mr. C. G. James
Industrial Commission of Virginia
P. O. Box 1794
Richmond, VA 23214 Ph. (804) 786-3623

Mr. G. L. Hazelwood, Jr.
Bureau of Insurance
P. O. Box 1157
Richmond, VA 23209 Ph. (804) 786-3666

Mr. C. S. Metzner
Aetna Casualty & Surety Company
151 Farmington Ave.
Hartford, CT 06115 Ph. (203) 273-0123

Mr. P. O. Presley
Bureau of Insurance (Act. Consultant)
14 Pendleton Lane
Londonderry, N.H. 03053 Ph. (603) 432-3376

Mr. L. R. Lyman
Travelers Insurance Company
One Tower Square
Hartford, CT 06115 Ph. (203) 277-3176

APPENDIX B

CALL FOR DETAILED CLAIM INFORMATION

TABLE OF CONTENTS

I. OUTLINE OF SEMINAR PROGRAM

II. BLANK FORMS FOR SUBMITTING QUESTIONS AND COMMENTS

III. CALL FOR DETAILED CLAIM INFORMATION

IV. CLAIM SELECTION FOR SAMPLING

V. REPORTING FORM

VI. TRANSMITTAL FORM AND INSTRUCTIONS

VII. EDIT SYSTEM

VIII. ERROR CORRECTION AND SUBSEQUENT VALUATION REPORT PROCEDURES

IX. INJURY DESCRIPTION CODE SYSTEM

X. QUESTIONS AND ANSWERS

XI. BLANK PAGES FOR NOTES

XII. SEMINAR

NATIONAL COUNCIL ON COMPENSATION INSURANCE

SECTION I

CALL FOR DETAILED CLAIM INFORMATION

SEMINAR

February 26 - 28, 1979 - Atlanta Hilton Hotel - Atlanta, Georgia

First Day - Monday, February 26, 1979

5:30 - 6:30 P.M.	Registration
6:30 - 7:30 P.M.	Reception

Second Day - Tuesday, February 27, 1979

		Speakers
7:30 - 8:30 A.M.	Registration	
8:30 - 9:00	Introduction	
	Mr. George F. Reall, President, National Council on Compensation Insurance	
	Mr. Paul J. Scheel, Executive Vice President, United States Fidelity and Guaranty Company	
9:00 - 9:30	Overview of Data Elements	
	Mr. J. J. Holland, Director-Product Management Division, Travelers Insurance Company	
9:30 - 10:00	Sampling	
	Mr. Yakov Avichai, Director-Property & Liab.PricingResearch, CNA Insurance	
10:00 - 10:20	Coffee Break	
10:20 - 11:20	Identification & Explanation of Data Elements	
	Mr. Thomas D. Steele, Statistical Manager, Employers Insurance of Wausau	
	Mr. George W. Walley, Home Off. Claims-Field Operations Liberty Mutual Insurance Company	

Second Day - Tuesday, February 27, 1979 (Cont'd.)

11:20 - 11:40	Methods of Reporting Data
	Mr. L. Richard Lyman, Assoc. Director of Loss Accounting and Experience - Commercial Lines, Travelers Insurance Company
	Ms. Lisa Braun, Senior Statistical Plans Analyst, Liberty Mutual Insurance Company
11:40 - 12:00	Data Utilization
	Mr. Barry Llewellyn, Supervising Analyst-Actuarial Research National Council on Compensation Insurance
12:15 - 1:30	Lunch
1:30 - 2:30	Small Group Discussions
	Data Elements Sampling Techniques and Controls Utilization
2:30 - 2:45	Coffee Break
2:45 - 3:45	Small Group Discussions
	Data Elements Sampling Techniques and Controls Utilization

Third Day - Wednesday, February 28, 1979

8:30 A.M.-12:30 P.M.	Individual Company Conferences
	(To Be Specifically Scheduled)

SECTION III

CALL FOR DETAILED CLAIM INFORMATION

1. Scope of The Plan. This plan contains the necessary instructions for the reporting of experience on the direct business written by the carrier for workers' compensation, voluntary compensation and employers' liability insurance in all jurisdictions in the United States where the Call for Detailed Claim Information has been implemented.

2. Recording of Statistics. Carriers may use any method for the internal recording of statistics, including any type of record format convenient to their statistical or account procedures, and codes other than those set forth in this plan, provided only that statistics can be reported by the carrier within the required time using the codes and record format provided in this plan.

3. Preparation and Completion of Reports of Statistics.

   a. The reports of losses and allocated loss adjustment expenses, where required, must be reported in the record formats contained in this plan.

   b. The filing of statistics shall be accompanied by transmittal letters showing summary totals in accordance with the instructions recited in the Calls for Experience. The summary totals reported must be in agreement with the individual claim records of the company for the period covered.

   c. Prior to submission of statistics the carrier shall make an audit of the statistics being reported to detect and correct any errors in the assignment of statistical codes contained in the coding sections of this plan.

   d. The carriers shall refer to the Reporting Details and Data Elements for further details on reporting.

   e. All fields shall be right-justified with leading positions and empty fields left blank.

   f. State of jurisdiction will be the criterion used for inclusion in the universe of claims for sampling in the designated state.

4. Revisions To Plan. In the absence of supplementary instructions, these pages are applicable to selected loss transactions with recorded dates on or after the date indicated in the lower right corner of

the reprinted pages. (Changes will be highlighted by an asterisk (*) in the margin.)

5. Reinsurance. The statistics are to be reported for direct business only. Therefore, the reports of statistics shall not include losses paid to other carriers on account of reinsurance assumed by the reporting carrier; nor, shall any deductions be made by the reporting carrier for losses recovered from other carriers on account of reinsurance ceded.

6. Reporting of Losses. Losses should be reported using the following as guidelines to determining the data required:

a. Claims selected for sampling having a paid or reserve amount for indemnity should be reported. The amounts reported shall be your company's liability and shall be reported to the nearest whole dollar. DO NOT REPORT CENTS.

b. When a medical only claim becomes a claim with an indemnity amount it will be treated as if it were a newly arising indemnity claim with prior medical payments included.

c. Each claim in the sample shall be reported to the National Council at six, eighteen, thirty and forty-two months after the month and year the claim was recorded with the carrier. * These reports are due sixty days after the end of the month of evaluation (e.g. April, 1979 claims are due no later than December 31, 1979 for six month reports). Claims which close prior to the six month valuation, or between normal valuations may be reported upon closure or at the next normal valuation time, at the option of the carrier.

d. Losses will be reported showing a split between indemnity, vocational rehabilitation, medical, attorney and allocated expense.

e. When a claim which has already been reported to the National Council has been closed and reopened, the claim should be re-reported at the next regular interval.

7. Reporting Details and Data Elements.

A. COMMON INFORMATION

1. CARRIER CODE - Specific five-digit codes were provided in our letter of February 13, 1979.

A five-digit company number to identify the insurance organization providing coverage. It is obtained from the National Council on Compensation Insurance or the

Independent Bureau and varies by state for a few jurisdictions. Presently the carriers may be using their three digit codes on unit reporting. For this call the new five digit code must be used.

2. POLICY NUMBER

The unique identifying number assigned to each separate insurance contract written.

3. CLAIM NUMBER

This is the unique number assigned by the carrier to identify payments and/or reserve for payment to the injured party or his dependents for a loss under the terms of the workers' compensation policy.

4. REPORT TYPE

A code indicating whether the report to the National Council is at six months, eighteen months, thirty months or forty-two months after the month and year the claim was recorded by the carrier. If a closed claim is reported prior to a regular interval it should be assigned the code of that interval. Use following codes:

Six	Months -	1
Eighteen	Months -	2
Thirty	Months -	3
Forty-Two	Months -	4

5. TRANSACTION CODE

A code indicating whether the record is an original or revised report for the report type indicated. Use following codes:

Original	Reporting -	1
Revised	Reporting -	2

B. CLAIMANT DESCRIPTION

6. POLICY EFFECTIVE DATE (MMDDYY)

The effective date must match that shown on the policy declaration or endorsements attached thereto. In the case of an interstate policy endorsed after its effective date to provide coverage for an additional state, the effective date shown for the claim shall be the effective date of the policy.

7. EMPLOYEE SOCIAL SECURITY NUMBER

Identifying number assigned by the Social Security Administration to each individual. Report only if furnished.

8. DATE OF INJURY (MMDDYY)

Occurrence date of injury or disease. If the exact date is not known, the best estimate should be used. This is the date on which the claimant sustained his injury or, in the case of an occupational disease or cumulative injury, it is the last day claimant worked without the disability or the last day of coverage, whichever is earlier.

9. DATE REPORTED (MMYY)

The month and year the claim was recorded by the carrier.

10. STATE OF ACCIDENT - Refer to Unit Statistical Plan for codes.

The state in which the claimant sustained injury or contracted disease.

11. STATE OF JURISDICTION - Refer to Unit Statistical Plan for codes.

The state whose benefits are being paid (under whose jurisdiction claim falls). Use Code 98 for non-state jurisdictions.

12. CLASS CODE

The class code used should be the same as that used for unit statistical plan reporting.

13. INJURY DESCRIPTION CODE - See Section IX

14. LOSS COVERAGE CODE - Refer to Unit Statistical Plan for codes.

A code assigned to each claim to indicate the basis of liability under various types of laws, classify the accident into three main types of occurrences (Traumatic, O.D., and Cumulative Injury), and further classify accidents as to type of legal actions or jurisdictions. The code should be determined when claims are recorded, if possible, or from information in the claim file as developments occur. As the claim matures, this code may change.

15. AGE AT DATE OF INJURY

This is the actual age of the injured worker at the time of injury. For cumulative injury, use age at time claim is reported.

16. SEX

Indicator of whether the injured worker is male, female or unknown. Use following codes:

Male	- 1
Female	- 2
Unknown	- 3

17. MARITAL STATUS

An indicator of marital status, as of the date of the accident, of the injured worker: single, widowed or divorced, whether married, separated or unknown. Use following codes:

Single, Widowed or Divorced	- 1
Married	- 2
Separated	- 3
Unknown	- 4

18. EMPLOYMENT STATUS WHEN CLAIM REPORTED

This indicates whether the injured worker is a regular employee, retired employee, employee on strike, unemployed (due to plant shutdown), or former employee (all other) as of the date of recording the claim. Use following codes:

Regular Employee	- 1
Unemployed Due to Plant Shutdown	- 2
Unemployed	- 3
Employee on Strike	- 4
Disabled Employee	- 5
Retired Employee	- 6
Former Employee - All Other	- 7
Unknown	- 8

19. PRE-INJURY WAGE (AVERAGE WEEKLY WAGE)

The average weekly wage of the injured or deceased worker as determined by the applicable state law which the benefit level is based on.

20. METHOD OF DETERMINING PRE-INJURY WAGE

Indicate the method used to determine the pre-injury wage as follows:

Actual Wage	- 1
Estimated Wage	- 2
Wage Required for Minimum Weekly Benefit	- 3
Wage Required for Maximum Weekly Benefit	- 4

21. STATUS

Status of claim at time of reporting, whether claim is open and not resolved, open and resolved, or closed. Use following codes:

Claim Open and Not Resolved	- 1
Claim Open and Resolved	- 2
Claim Closed	- 3

A "resolved" claim is any case where an agreement between the parties has been reached, or where an award or judgement has been entered, reciting the specific terms of future payments. The incurred value of that claim is equal to the anticipated future payments so ordered or agreed to, plus the amount paid to date.

A "resolved" claim refers only to indemnity payments.

22. DATE RESOLVED (MMDDYY)

Enter the date that the claim was resolved, where applicable.

23. REOPENED INDICATOR

Use following codes:

Yes	- 1
No	- 2
Initially Recorded Medical Only	- 3

Code "3" is to be used for the initial reporting of a claim which has developed indemnity costs subsequent to the six month reporting interval.

C. INDEMNITY BENEFITS AND PAYMENTS (EXCLUDING VOCATIONAL REHABILITATION)

24. INCURRED DURATION OF BENEFITS (TEMPORARY TOTAL)

The period of time during which there are temporary

total disability amounts payable, until the worker has a change in status. Such duration shall include weeks paid to date plus weeks for anticipated future payments. The change could be a return to work or until his condition becomes stationary or permanent. Various state laws have specified healing periods or a specific amount of temporary total payable is indicated. Report to the nearest whole week.

25. TEMPORARY TOTAL INCOME BENEFITS INCURRED

The temporary total disability benefits paid to date plus anticipated future payments for the claim.

*26. TYPE OF BENEFITS

Type of benefits other than or in addition to temporary total benefits, whether only temporary total benefits paid or anticipated, permanent partial - scheduled, permanent partial - nonscheduled, temporary partial, permanent total or fatal. Use following codes:

*	Only Temporary Total	1
	Permanent Total (With or Without Temporary Total Benefits)	2
	Permanent Partial Scheduled (With or Without Temporary Total Benefits)	3
	Permanent Partial Nonscheduled (With or Without Temporary Total Benefits)	4
	Temporary Partial	5
	Death (With or Without Temporary Total Bendfits)	6
	Other (Including Combinations of the above)-	7

*27. LATEST WEEKLY BENEFIT

The latest weekly benefit payable.

28. INCURRED DURATION OF BENEFITS (OTHER THAN TEMPORARY TOTAL)

The number of weeks of benefits other than or in addition to temporary total benefits paid to date plus anticipated, based on schedule information where applicable. Life time cases should be coded "9999."

29. TOTAL INCURRED OTHER THAN TEMPORARY TOTAL BENEFITS

The incurred disability benefits (paid to date plus anticipated future payments) for the claim other than those incurred for temporary total disability.

30. OTHER INDEMNITY BENEFITS INCURRED

The total amount of miscellaneous indemnity benefits (paid to date plus anticipated future payments) such as payments to Second Injury Fund, Burial Allowance, etc. Exclude amounts reported under items 25 and 29 above.

31. TOTAL INDEMNITY BENEFITS PAID

The total amount of indemnity benefits paid to date. Exclude amounts for vocational rehabilitation or allocated loss expense.

D. VOCATIONAL REHABILITATION BENEFITS

Separate as follows:

32. TOTAL VOCATIONAL REHABILITATION COSTS INCURRED

Report the total of all vocational rehabilitation costs incurred, (paid to date plus anticipated future payments), whether or not the separate costs in (34), (35) and (36) are reported.

33. TOTAL VOCATIONAL REHABILITATION COSTS PAID

Report the total of all vocational rehabilitation costs paid to date.

34. VOCATIONAL REHABILITATION EVALUATION EXPENSE

All expenses incurred in testing and evaluating the claimant's ability, aptitude, or attitude in determining suitability for vocational rehabilitation or placement.

35. VOCATIONAL REHABILITATION INCURRED INDEMNITY

The temporary disability indemnity incurred (paid to date plus anticipated future benefits) as a maintenance benefit while the claimant is participating in a vocational rehabilitation program.

36. VOCATIONAL REHABILITATION EDUCATIONAL EXPENSES(INCURRED)

Direct training costs including, but not limited to, tuition, books, tools, transportation and additional living expense.

E. MEDICAL BENEFITS

37. PAID TO DATE HOSPITAL COSTS

Benefits paid to date for services billed by a hospital. Include the costs of both in-patient and out-patient services.

38. PAID TO DATE MEDICAL COSTS

Report the costs of all medical services other than those billed by a hospital. Report the total amount paid to date.

39. TOTAL INCURRED MEDICAL COSTS

Report the total incurred cost (paid to date plus anticipated future payments) of all medical benefits.

40. NUMBER OF DAYS CONFINED IN THE HOSPITAL - TO DATE

The actual number of days to date for which an in-patient charge is made in the hospital bill.

41. NUMBER OF DOCTOR VISITS - TO DATE

The total number of visits to date to the doctor by the injured person, excluding visits while an admitted patient in a hospital.

F. CLAIM ADMINISTRATION DETAILS

42. APPORTIONMENT BETWEEN CARRIERS

Indicate if there has been a distribution of the cost of a claim between two or more insurers. This is usually determined by action of the appropriate board. The amounts reported as indemnity and medical benefits should be your company's liability. Use following codes:

Yes - 1
No - 2

43. APPORTIONMENT FOR PRE-EXISTING CONDITIONS

Indicate if there has been an apportionment for pre-existing conditions. Use following codes:

Yes - 1
No - 2

44. CLAIMANT'S ATTORNEY OR AUTHORIZED REPRESENTATIVE

Was the claimant represented.

Yes - 1
No - 2

45. CLAIMANTS' ATTORNEY FEES INCLUDED IN AWARD

46. CLAIMANTS' ATTORNEY FEES IN ADDITION TO AWARD

47. CONTROVERTED CLAIM

Disputed or contested for compensation and/or disability by the insurer. Use following codes:

Was Claim Controverted

No - 1
Compensability - 2
Disability - 3
Multiple Reasons - 4

48. METHOD OF DISPOSITION

The manner in which a claim is settled; agreement, award to employee, award to employer, withdrawal of controversy by insurer, or withdrawal of claim by claimant. Use following codes:

Method of Disposition

Closed by Agreement - 1
Withdrawal of Claim by Claimant - 2
Withdrawal of Controversy by Insurer - 3
Award for Employee - 4
Award for Carrier (insurer) - 5
* None - 6

49. METHOD OF PAYMENT

The means of payment used for claimant's indemnity; periodic payments, lump sum payments, or both. Use following codes:

Method of Payment

Lump Sum - 1
Periodic - 2
Both - 3
* None - 4

50. SUBROGATION ACTION

The right of the insurance company to recover from a third party the amount paid or a portion of that amount, sometimes through policies for coverages such as automobile, products liability, or other. Indicate whether steps have been taken by the carrier to effect a subrogation recovery.

A. PRODUCT LIABILITY SUBROGATION

1. Use following codes:

Yes - 1
No - 2

B. AUTOMOBILE LIABILITY SUBROGATION

1. Use following codes:

Yes - 1
No - 2

C. OTHER SUBROGATION

1. Use following codes:

Yes - 1
No - 2

51. ALLOCATED LOSS EXPENSE (PAID)

Represents the expense of a carrier which can be directly allocated to a particular claim such as:

a. Attorneys' fees for claim in suit

b. Court and other specific items of expense such as:

Medical examination to determine the extent of company's liability
Expert medical or other testimony
Laboratory and x-ray
Autopsy
Stenographic
Witnesses and summonses
Copies of documents

The following shall not be included as allocated loss expenses:

c. Salaries and traveling expenses of company employees

d. Overhead

e. Adjusters' fees

52. DATE OF CLOSING (MMDDYY)

SECTION IV

CALL FOR DETAILED CLAIM INFORMATION

CLAIM SELECTION FOR SAMPLING

The present Call is designed to achieve a representative random sample of all indemnity claims from all selected carriers in each of the twelve states. The sampling ratio varies from state in order to assure a minimum of one thousand permanent partial claims in each state. This number of claims is required to provide the accuracy of the results needed for data analysis.

While scientific sampling is a most powerful tool in reducing the costs of collecting information (the present Call is based upon less than fifteen percent of all claims that would otherwise be required), it is important to recognize that such savings can be realized only if the drawing of the sample is performed in the most accurate fashion possible. In particular, in order to assure reliable and representative results, it is imperative that each carrier: (1) follows the definitions closely and supplies accurate information in all applicable categories, (2) files the required proportion of claims from each state according to the specified sampling ratio. The number of claims that each carrier is expected to file is given only for illustrative purposes - it is the proportion of all claims during each period of time that the carrier is responsible for in this Call. Also, since the sample is designed to provide continuous information and since different segments of time will be used in the analusis, the sampling procedure has to be a continuous one and must continue uniformly throughout the year (3) the sample must be <u>randomly</u> selected if it is to be of value at all.

A simple random sample is by definition a sample in which each individual claim has an equal probability of entering the sample. Any violation of this rule will automatically result in an unrepresentative sample of questionable utility. While there is no such thing as a perfectly representative sample, it is of utmost importance to achieve as representative a sample as possible. The two major areas of concern that need to be watched especially are: (1) the sample frame - the universe of all indemnity claims must be as complete as possible. Stated differently - in order for each claim to have the same probability of ending up in the sample, it must first of all be identified as such. This means that in the screening stage care should be exercised to assure that no indemnity claim is left out as a potential candidate for the sample. Claims that start off as medical only claims and are later recognized to be indemnity claims should be automatically included along with the regular indemnity claims and thus become candidates for sampling at the earliest possible moment. Similarly, any systematic exclusion should be carefully watched as it might seriously impair the resulting sample. A long remembered lesson regarding the error introduced by a systematic exclusion of part of the

sampling universe is served by the 1936 Literary Digest Election Poll that errored by 19% predicting Roosevelt's vote. (2) Once the mechanism that assures that each claim can potentially enter the sample is established, the actual drawing of the sample has to be done in such a way that no error is created in the process of selecting the sample itself. This is achieved by a random selection of claims designed especially for this purpose. While it is not difficult to exemplify possible departures from a random selection, and some may be very subtle indeed, the only way to make sure the selection is random is to design it as such.

Because of the central role played by the selection process in this Call and the need to positively document the randomness of such a selection, the following steps are taken:

1. Since the method by which a random sample is drawn is strongly dependent on the way in which the indemnity claims are identified and this in turn is a function of the particular record-keeping methods of the carrier, no efficient universal method of sampling can be devised.

2. Carriers are encouraged to devise their own method of selecting the random sample, consistent with their particular circumstances. Such a method may or may not employ a computerized system. In both cases, it is necessary that the carrier file with the National Council a statement documenting the selection process and receive prior approval to use it after it was verified by the National Council that it indeed produces a random sample.

3. Carriers that choose to may have the sample drawn for them by the National Council. That would entail sending to the National Council, on a monthly basis, the claim numbers of all indemnity claims received during the month. The National Council will promptly send back to the carrier the claim numbers selected for the sample.

4. The following is a procedure devised to achieve a random sample in each of the states: (a) Number all indemnity claims in the state in the order reported, (b) Any claim later identified to be an indemnity claim is assigned a sequential number in the prior list as soon as it is so identified, (c) From this universe the claims that enter the sample are selected. The chart below shows the states to be sampled, the sampling ratio, and the key numbers that were randomly selected. If the key number(s) are one digit, all claims ending in those digits should be in the sample and if the key numbers are two digits, all claims ending in those two digits should be in the sample.

State	Sampling Ratio	Key Numbers
Connecticut	.30	1, 7, 8
Florida	.10	6
Georgia	.30	1, 7, 8
Illinois	.05	12, 31, 59, 67, 82
Kentucky	.40	1, 2, 6, 9
Massachusetts	.15	04, 15, 16, 25, 32, 34, 45, 46, 58, 61, 70, 76, 82, 93, 98
Michigan	.20	2, 8
Minnesota	.30	1, 7, 8
New York	.05	12, 31, 59, 67, 82
Pennsylvania	.15	04, 15, 16, 25, 32, 34, 45, 46, 58, 61, 70, 76, 82, 93, 98
Virginia	.40	1, 2, 6, 9
Wisconsin	.30	1, 7, 8

(d) Carriers that choose to use this method are not exempt from filing the documentation referred to in (2) above.

POLICYHOLDER NAME

National Council On Compensation Insurance

CALL FOR DETAIL CLAIM INFORMATION

ADM. NO.

COMMON INFORMATION

INSURER:

1. CARRIER CODE

2. POLICY NUMBER

3. CLAIM NUMBER

4. REPORT TYPE (Check Below)
1 6 Months
2 18 Months
3 30 Months
4 42 Months

5. TRANSACTION CODE (Check Below)
1 Original Reporting
2 Revised Reporting

CLAIMANT DESCRIPTION

6. POLICY EFF. DATE — MO. DAY YEAR

7. EMPLOYEE SOC. SEC. NO.

8. DATE OF INJURY — MO. DAY YEAR

9. DATE REPORTED — MO. YEAR

10. STATE OF ACCIDENT

11. STATE OF JURISDICTION

12. CLASS CODE

13. INJ. DESCR. CODE

14. LOSS COVER. CODE

15. AGE AT DATE OF INJURY

16. SEX (Check Below)
1 Male
2 Female
3 Unknown

17. MARITAL STATUS (Check Below)
1 Single or Divorced or Widowed
2 Married
3 Separated
4 Unknown

18. EMPLOYMENT STATUS WHEN CLAIM REPORTED (Check Below)
1 Regular Employee
2 Unemployed Due to Plant Shutdown
3 Unemployed
4 Employee on Strike
5 Disabled Employee
6 Retired Employee
7 Former Employee—All Other
8 Unknown

19. PREINJURY WAGE (Avg. Weekly Wage)

20. METHOD OF DETERMINING PRE INJURY WAGE (Check Below)
1 Actual Wage
2 Estimated Wage
3 Wage required for Minimum Weekly Benefit
4 Wage required for Maximum Weekly Benefit

21. STATUS (Check Below)
1 Claim Open and not Resolved
2 Claim Open and Resolved
3 Claim Closed

22. DATE RESOLVED — MO. DAY YEAR

23. REOPENED INDICATOR (Check Below)
1 Yes
2 No
3 Initially Recorded as Medical Only

INDEMNITY BENEFITS & PAYMENTS (Excluding Vocational Rehabilitation) (Express in Whole Weeks and Whole Dollars)

24. INCURRED DURATION OF BENEFITS (TEMPORARY TOTAL) (Weeks)

25. TEMPORARY TOTAL INCOME BENEFITS INCURRED

26. TYPE OF BENEFITS (Check Below)
1 Only Temporary Total
2 Permanent Total (with or without Temp. Total Benefits)
3 Permanent Partial Scheduled (with or without Temp. Total Benefits)
4 Permanent Partial Non-scheduled (with or without Temp. Total Benefits)
5 Temporary Partial
6 Death (with or without Temp. Total Benefits)
7 Other (including combination of the Above)

27. LATEST WEEKLY BENEFIT

28. INCURRED DURATION OF BENEFITS (Other than Temporary Total) (Weeks)

29. TOTAL INCURRED OTHER THAN TEMPORARY TOTAL BENEFITS

30. OTHER INDEMNITY BENEFITS INCURRED

31. TOTAL INDEMNITY BENEFITS PAID

VOCATIONAL REHABILITATION BENEFITS (Express in Whole Dollars)

TOTAL VOCATIONAL REHABILITATION COSTS

32. INCURRED

33. PAID

34. VOCATIONAL REHAB. EVALUATION EXPENSE INCURRED

35. VOCATIONAL REHAB. INCURRED INDEMNITY

36. VOCATIONAL REHAB. EDUCATIONAL EXPENSES (INCURRED)

MEDICAL BENEFITS (Express in Whole Dollars)

37. PAID TO DATE HOSPITAL COSTS

38. PAID TO DATE OTHER MED. COSTS

39. TOTAL INCURRED MEDICAL COSTS

40. NUMBER OF DAYS CONFINED IN HOSPITAL —TO DATE

41. NUMBER OF DOCTOR VISITS—TO DATE

CLAIM ADMINISTRATION DETAILS

42. APPORTIONMENT BETWEEN CARRIERS (Check Below)
1 Yes
2 No

43. APPORTIONMENT FOR PRE-EXISTING CONDITIONS (Check Below)
1 Yes
2 No

44. CLAIMANT'S ATT'Y. OR AUTHORIZED REPRESENTATIVE (Check Below)
1 Yes
2 No

45. AMOUNT OF CLAIMANT'S ATT'Y FEES INCL. IN AWARD

46. AMOUNT OF CLAIMANT'S ATT'Y FEES IN ADDITION TO AWARD

47. CONTROVERTED CLAIM (Check Below)
1 No
2 Compensability
3 Disability
4 Multiple Reasons

48. METHOD OF DISPOSITION (Check Below)
1 Closed By Agreement
2 Withdrawal of Claim by Claimant
3 Withdrawal of Controversy by Insurer
4 Award for Employee
5 Award for Carrier
6 None

49. METHOD OF PAYMENT (Check Below)
1 Lump Sum
2 Periodic
3 Both
4 None

50. PRODUCT LIABILITY SUBROGATION (Check Below)
1 Yes
2 No

51. AUTOMOBILE LIABILITY SUBROGATION (Check Below)
1 Yes
2 No

52. OTHER SUBROGATION (Check Below)
1 Yes
2 No

53. ALLOCATED LOSS EXPENSE (Paid)

54. DATE OF CLOSING — MO. DAY YEAR

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SECTION VI

CALL FOR DETAILED CLAIM INFORMATION

METHOD OF TRANSMITTAL

Transmission of Data can be either manual or on magnetic tape according to the specifications of the Call for Detailed Claim Information.

DATE OF VALUATION AND FILING

The first report of Claim Data shall be completed at six months after the claim was reported with the carrier or at the time of closing if prior to six months. Subsequent reports shall be completed at 18, 30, and 42 months after the date reported, or at the time of closing if between any of these time frames. Closing reports can be submitted either with the regular monthly submission for the month in which the closing occurred or at the time the normal open claim valuation would have been filed. EXAMPLE: Claim Registered in April 1979.

- 6 month report completed in October 1979.
- 18 month report due to be completed in October 1980.
- Claim closes January 1980.
- Closing report can be completed and submitted with January 1980 data collected or with October 1980 data collected.

METHOD OF TRANSMITTAL

General

Reporting is preferred to be by individual company (as opposed to reporting for all companies within a group) for long run linkage to other data systems. Group reporting will be permitted, however, so long as the transmittal letters indicate the individual companies involved and the claims reports are submitted under the carrier code number shown.

Section A

Separate letters of transmittal shall be completed and forwarded for each month of arising claims. Such letters shall indicate the number of indemnity claims arising and the resulting number of claims to be sampled in accordance with the list of states which the carrier has been assigned to report for. If during a month a carrier has no indemnity claims it is still necessary to submit this information. Letters of transmittal shall be submitted sixty days after the close of each month (e.g. 6/30/70 for April, '79 arisings).

Section B

(a) Claim forms shall be submitted on a monthly basis, except that a carrier may submit forms more frequently if the carrier so desires.

(b) Claim forms must be received within sixty days after the evaluation month (claims reported in April, 1979...... evaluation month of October, 1979.....submission due to be received by NCCI by December 31, 1979).

National Council on Compensation Insurance
One Penn Plaza
New York, New York 10001

RE: Call For Detailed Claim Information - Transmittal Form

Section A

The following information details the sampling requirement indicated for our company (group) in accordance with the approved program.

Carrier(s):
Carrier Code:
Indemnity Claims Arising During ______ , ______
(Month) (Year)

	Indemnity Claims Arising	Claims To be Sampled		Indemnity Claims Arising	Claims To Be Sampled
Connecticut	______	______	Michigan	______	______
Florida	______	______	Minnesota	______	______
Georgia	______	______	New York	______	______
Illinois	______	______	Pennsylvania	______	______
Kentucky	______	______	Virginia	______	______
Massachusetts	______	______	Wisconsin	______	______

Section B

Enclosed herewith are claim forms completed under the Call For Detailed Claim Information as follows:

Carriers(s):
Carrier Code:
Number of Claims Submitted:

Name______________________

Signature______________________

Title______________________ Date______________________

SECTION VII

CALL FOR DETAILED CLAIM INFORMATION

EDIT SYSTEM

1. Carrier Code

   a. Must always be present.

   b. Verify against edit table.

2. Policy Number

   a. Must always be present.

3. Claim Number

   a. Must always be present.

4. Report Type

   a. Must always be present.

   b. Code must equal 1, 2, 3, or 4.

5. Transaction Code

   a. Must always be present.

   b. Code must equal 1 or 2.

6. Policy Effective Date (MMDDYY)

   a. Must always be present.

   b. Month must equal a numeric code 01 thru 12, day must equal a numeric code 01 thru 31, year must equal a two digit numeric code.

7. Employee Social Security Number

   a. When present must be numeric code.

8. Date of Injury (MMDDYY)

   a. Must always be present.

   b. Month must equal a numeric code 01 thru 12, day must equal a numeric code 01 thru 31, year must equal a two digit numeric code.

   c. This date must be equal to or later than #6 - Policy Effective Date.

8. Date of Injurv (MMDDYY) (Cont'd.)

   d. Injury date should not exceed 1 year and 16 days from policy effective date.

9. Date Reported (MMYY)

   a. Must always be present.

   b. Month must equal a numeric code 01 thru 12, year must be a two digit numeric code.

   c. This date must be equal to or later than #8 - Injury Date.

10. State of Accident

   a. Must always be present.

   b. Must be numeric code.

   c. Verify against code table.

11. State of Jurisdiction

   A. Must always be present.

   b. Must be numeric code.

   c. Verify against code table.

12. Class Code

   a. Must always be present.

   b. Verify again code table.

   c. Must be numeric code.

13. Injury Description Code

   a. Must always be present.

   b. Verify against code table.

   c. Must be numeric code.

14. Loss Coverage Code

   a. Must always be present.

   b. Verify against code table.

14. Loss Coverage Code (Cont'd.)

    c. Must be numeric code.

    d. Verify against #13.

15. Age at Date of Injury.

    a. Must always be present.

    b. Must be numeric code and greater than 12.

16. Sex

    a. Must always be present.

    b. Code must equal 1, 2, or 3.

17. Marital Status

    a. Must always be present.

    b. Code must be equal to 1, 2, 3, or 4.

18. Employment Status at First Report

    a. Must always be present.

    b. Code must equal 1, 2, 3, 4, 5, 6, 7, or 8.

19. Pre-Injury Wage (Average Weekly Wage)

    a. Must always be present.

    b. Must be numeric and less than or equal to 999.

20. Method of Determining Pre-Injury Wage

    a. Must always be present.

    b. Code must equal 1, 2, 3, or 4.

21. Status

    a. Must always be present.

    b. Code must equal 1, 2, or 3.

    c. When code equals 3, #54 must be present.

    d. When code equals 2, #22 must be present.

22. Date Resolved (MMDDYY)

    a. Must always be present when #21 is code 2.

    b. Month must equal a numeric code 01 thru 12, day must equal a numeric code 01 thru 31, year must equal a two digit numeric code.

    c. This date should be later than or equal to #9 - Date Reported.

    d. Must be blank when #21 is code 1.

23. Reopened Indicator

    a. Must always be present.

    b. Code must equal 1, 2, or 3.

    c. If code equals 3, #4 cannot equal code 1.

24. Incurred Duration of Benefits (Temporary Total)

    a. Must be numeric when present and less than or equal to 999.

    b. Must be present if #25 present.

25. Temporary Total Income Benefits Incurred

    a. Must be numeric when present.

    b. Must be present if #24 present.

    c. When equal to zero, #49 must equal code 4.

26. Type of Benefits

    a. Must always be present.

    b. Code must equal 1, 2, 3, 4, 5, 6, or 7.

    c. If code equals 1, then #24 and #25 must be present.

27. Latest Weekly Benefit

    a. Must always be present.

    b. Must be numeric and less than or equal to 999.

    c. Multiply by #24 if present. Product must be greater than or equal to 85% of #25 and less than or equal to 115% of #25.

    d. If #26 is not 1 and #28 = 9999, multiply by #28. Product must be greater than or equal to 85% of #29 and less than or equal to 115% of #29.

28. Incurred Duration of Benefits (Other Than Temporary Total)

    a. Must always be present if #26 is not code 1.

    b. Must be numeric.

    c. If #26 is code 1, then this must be blank.

    d. When equal to 9999, #26 cannot be code 1 nor code 5.

29. Total Incurred Other Than Temporary Total Benefits

    a. Must always be present if #26 is not code 1.

    b. Must be numeric.

    c. If #26 is code 1, then this must be blank.

30. Other Indemnity Benefits Incurred

    a. Must be numeric when present.

31. Total Indemnity Benefits Paid

    a. Must always be present.

    b. Must be numeric.

    c. Must be less or equal to sum of #25, #29, #30.

    d. If #23 is Code 3, #31 = #25 + #29 + #30.

32. Total Vocational Rehabilitation Costs Incurred

    a. Must be numeric when present.

    b. If #33, #34, #35 or #36 present, then must always be present.

    c. Edit against #14.

    d. Must be greater than or equal to sum of #34, #35, #36.

    e. Must be greater than or equal to #33.

    f. If #21 is code 3 and #'s 34, 35 and 36 are present, then #32 = #34 + #35 + #36.

33. Total Vocational Rehabilitation Costs Paid

    a. Must be numeric when present.

    b. Edit against #14.

33. Total Vocational Rehabilitation Costs Paid (Cont'd.)

    c. Must be less than or equal to sum of #34, #35, #36.

34. Vocational Rehabilitation Evaluation Expense

    a. Must be numeric when present.

35. Vocational Rehabilitation Incurred Indemnity

    a. Must be numeric when present.

36. Vocational Rehabilitation Educational Expenses (Incurred)

    a. Must be numeric when present.

37. Paid to Date Hospital Costs

    a. Must be numeric when present.

38. Paid to Date Other Medical Costs

    a. Must be numeric when present.

39. Total Incurred Medical Costs

    a. Must always be present.

    b. Must be numeric.

    c. Must be greater than or equal to sum of #37 and #38.

40. Number of Days Confined in the Hospital - To Date

    a. Must be numeric when present.

41. Number of Doctor Visits - To Date

    a. Must be numeric when present.

42. Apportionment Between Carriers

    a. Must always be present.

    b. Code must equal 1 or 2.

    c. If code equals 1, then #21 must equal 2 or 3.

43. Apportionment for Pre-Existing Conditions

    a. Must always be present.

    b. Code must equal 1 or 2.

43. Apportionment for Pre-Existing Conditions (Cont'd.)

    c. If code equals 1, then #21 must equal 2 or 3.

44. Claimant's Attorney or Authorized Representative

    a. Must always be present.

    b. Code must equal 1 or 2.

    c. When code equals 1, and #21 equals 2 or 3, then #45 and or #46 must be present.

45. Claimant's Attorney Fees Included in Award

    a. When present must be numeric.

    b. When present, #44 must equal code 1.

46. Claimant's Attorney Fees in Addition to Award

    a. When present must be numeric.

    b. When present, #44 must equal 1.

47. Controverted Claim

    a. Must always be present.

    b. Code must equal 1, 2, 3, or 4.

48. Method of Disposition

    a. Must be equal to 1, 2, 3, 4, 5, or 6.

    b. When code is 6, #21 = 1.

49. Method of Payment

    a. Must always be present.

    b. Code must equal 1, 2, 3, or 4.

50. Product Liability Subrogation

    a. When present, code must equal 1 or 2.

51. Automobile Liability Subrogation

    a. When present, code must equal 1 or 2.

52. Other Subrogation

    a. When present, code must equal 1 or 2.

53. Allocated Loss Expense (Paid)

a. Must be numeric when present.

54. Date of Closing (MMDDYY)

a. When present, #21 must equal 3.

b. Month must equal a numeric code 01 thru 12, day must equal a numeric code 01 thru 31, year must equal a two digit numeric code.

c. Must be blank if #21 does not equal 3.

d. When present, this date must be equal or later than #9 - Date Reported.

e. When present, this date must be equal to or later than #22 -

Date Resolved if #22 not blank.

SECTION VIII

CALL FOR DETAILED CLAIM INFORMATION

ERROR CORRECTION AND SUBSEQUENT VALUATION REPORT PROCEDURES

When initial claim reports are submitted for a 6 month evaluation, N.C.C.I. will validate all data based on the initial edit specifications and produce a hard-copy report titled "Call for Correction Claim Information." This report form will be generated only for claims that have failed one or more of the edit checks. It will closely resemble the original hard-copy form, and in addition;

1) Exhibit asterisks (*) in fields where possible error conditions exist.

2) Include an error summary area which will list all error types by data-element number and alpha letter which can be directly linked to the numbering scheme of the initial edit specifications.

3) Show all information as reported, with space provided for correction entry. Fields with numbered selectors will show the number that was originally checked (✓).

The "Call for Corrected Claim Information" form with all errors corrected should be submitted to N.C.C.I. as soon as possible.

At 60-30 days prior to subsequent claim evaluation time, (i.e. at 16, 28 & 40 months from reported date) a subsequent request report will be sent to all carriers for all open claims that were submitted on the previous report evaluation. This report, titled "Call for Subsequent Claim Information," will closely resemble the original hard-copy form and will show all the information for a claim that was reported on the previous report evaluation. By entering any changed or additional data in the proper areas on the report, this updated report, when submitted to N.C.C.I., will be the carriers subsequent reporting of the claim. The report will be printed with the proper report type entry for the upcoming report evaluation. At this time, common information (Carrier #, Policy #, and Claim #) can be changed by entering the revised data in the spaces provided.

Subsequent report submissions will be validated using the same procedures as on ititial report submissions, and "Call for Correction Claim Information" reports will be sent to carriers for all claims failing one or more edit specifications.

An Administrative File Number will be assigned to each claim at the 6 month submission time and will be printed on all N.C.C.I. generated reports. It is strongly urged that all carriers try to transcribe this number on all submissions when a N.C.C.I. generated form is not being used. (Initial 6 month reports excluded.)

Hard-copy forms are available for changing Common Information and can be used at any time after a claim is submitted at the 6 month report evaluation. N.C.C.I. confirmation notices will be generated and sent to carriers when changes have been made.

Closed claim submissions can be sent at any time and must contain the report type indicator of the next upcoming report evaluation.

Revised report submissions can be sent at any time and must contain the report type indicator of the report being revised and with the "Revised" Transaction indicator checked.

SECTION IX

CALL FOR DETAILED CLAIM INFORMATION

INJURY DESCRIPTION CODES

The Injury Description Codes are to be used to establish a four (4) digit code for the injury or disease which is the principal cause of disability as follows:

1. TRAUMATIC INJURIES to designate the part of the body injured, first 2 digits, and the nature of the injury, last 2 digits.

   EXAMPLES

   Skull Fracture - 1128

   (i.e. Skull is Part of Body Code 11 and fracture is Nature of Specific Injury Code 28)

   Brain Concussion - 1207

   (Brain, 12 plus concussion, 07)

   Code 90, which designates injury to multiple body parts should be used when there is no one specific injury which is clearly responsible for the major portion of the claim. For example, a severe burn of the face, neck and arms should be coded 9004. (Multiple Body Parts, 90, and Burns, 04). But if there were third degree burns of the face and only superficial burns of the neck and arms, the proper code would be 1804, (Other Facial Soft Tissue, 18, and Burns, 04) since the major cost of the claim would be generated by the facial burn.

2. OCCUPATIONAL DISEASES with the appropriate four (4) digit designator.

   EXAMPLES

   Asbestosis - 6061

   (Because of its significance at this time, this disease has been given a specific code.)

   Anthrax - 6700

   (This is an OD other than either a dust disease or one otherwise specifically coded.)

3. LOSS OF HEARING other than as the result of a specific trauma.

EXAMPLE

Hearing loss as a result of exposure to noise over a period of years - 6800

4. CONTAGIOUS DISEASES.

EXAMPLE

Tuberculosis - 6900

5. CANCER to designate part of the body affected.

EXAMPLE

Cancer of the larynx - 7024

(Cancer, 70, plus Part of the Body Code, 24, for larynx.)

6. ALL OTHER CUMULATIVE INJURIES not otherwise specifically coded, to designate part of body affected.

EXAMPLE

Heart disease caused by physical and mental stress over extended period of time - 8049

(All Other CI, 80, plus Part of Body Code for heart, 49.)

(NOTE: A myocardial infarct attributed to a specific short term stress would be coded as a traumatic injury, 4941.)

CALL FOR DETAIL CLAIM INFORMATION

INJURY DESCRIPTION CODES

PART OF BODY (First two digits)

I. HEAD

10. Multiple Head Injury
11. Skull
12. Brain
13. Ear (s)
14. Eye (s)
15. Nose
16. Teeth
17. Mouth
18. Other Facial Soft Tissue
19. Facial Bones

II. NECK

20. Multiple Neck Injury
21. Vertebrae
22. Disc
23. Spinal Cord
24. Larynx
25. Soft Tissue
*26. Trachea

III. UPPER EXTREMITIES

30. Multiple Upper Extremities
31. Upper Arm (inc: Clavicle and Scapula)
32. Elbow
33. Lower Arm
34. Wrist
35. Hand
36. Finger (s)
37. Thumb

IV. TRUNK

40. Multiple Trunk
41. Upper Bank Area - (Thoracic Area)
42. Low Back Area (inc: Lumbar and Lumbo-Sacral)
43. Disc
44. Chest (inc: Ribs, Sternum and Soft Tissue)
45. Sacrum and Coccyx
46. Pelvis
47. Spinal Cord
48. Internal Organs
49. Heart

V. LOWER EXTREMITIES

50. Multiple Lower Extremities
*51. Hip
*52. Thigh
*53. Knee
*54. Lower Leg
*55. Ankle
*56. Foot
*57. Toe (s)

VI. MULTIPLE BODY PARTS

90. Multiple Body Parts

NATURE OF SPECIFIC INJURY (Last two digits)

02. Amputation
03. Angina Pectoris
04. Burn
07. Concussion
10. Contusion
13. Crushing
16. Dislocation
19. Electric Shock
22. Enucleation
25. Foreign Body
28. Fracture
30. Freezing
31. Hearing Loss (Traumatic Only)
32. Heat Prostration
34. Hernia
36. Infection
37. Inflammation
40. Laceration
41. Myocardial Infarction
43. Puncture
46. Rupture
47. Severence
49. Sprain
52. Strain
55. Vascular
58. Vision Loss

OCCUP. OR CONTAGIOUS DISEASE OR CUM. INJ.

6000 Dust Disease NOC (All other Pneumoconiosis)
6061 Asbestosis
6062 Black Lung
6063 Byssinosis
6064 Silicosis

6100 Respiratory Disorders (Gases, Fumes, Chemicals, etc.)
6200 Poisoning - Chemical

6300 Poisoning - Metal

6400 Dermatitis

6500 Mental Disorder

6600 Radiation

6700 All Other OD

6800 Loss of Hearing
*6900 Contagious Diseases
70XX Cancer (Last two digits from Part of Body Chart)

80XX All Other Cumulative Inj. (Last two digits from Part of Body Chart)

SECTION X

CALL FOR DETAILED CLAIM INFORMATION

QUESTIONS AND ANSWERS

Q. Is it necessary to fill in the Policyholder's name at the top of the form?

A. No. That space was put there for the carrier's use only.

Q. What should be put in the block captioned "ADM.NO". at the top of the form?

A. Please leave it blank. This block is for National Council internal use only.

Q. What Report Type should be coded for a closed claim?

A. A closed claim should be coded the Report Type that would otherwise apply. For example, if a claim closed 3 months after it was reported to the carrier, it should be coded Report Type 1-6 months and Transaction Code-1 Original Reporting. If a claim closed 10 months after it was registered, it should be coded Report Type 2-18 months and Transaction Code 1-Original Reporting.

Q. When is a claim form to be coded an Original Report or a Revised Report?

A. Original Report should be coded the first time any claim is reported at any time interval. If a claim remains open, there will be an original report for each "Report Type." There will be a 6 month, 18 month, 30 month and 42 month Original Reporting transaction code.

"Revised Reporting" transaction code will only be used when an Original Reporting for a Report Type had an error on items 6 through 54 and you correct it without notification from the National Council.

Special correction procedures apply for correcting errors found by the National Council and errors on items 1-3.

Q. How should Employment Status be completed when the claim is reported?

A. A claimant is:

"Regular Employee" when the claimant had been continuously working until the time the claimant became disabled and filed the claim.

"Uemployed Due to Plant Shutdown" when the claimant had been unemployed because the plant in which the claimant worked was shut down at the time the claim is filed. There will usually be a time lag between the accident

date and the date the claim is reported to the company when this employment status applies.

"Unemployed" when the claimant is laid off, fired or quit so the claimant is not working at the time the claim is filed. There will usually be a time lag between the accident date and the date the claim is reported to the company when this employment status applies.

"Employee on Strike" when the claimant is on strike from work for any reason at the time the claim is reported.

"Disabled Employee" when claimant has a work related or an other than work related disability and out of work for some time before filing the claim. This includes climants who are out of work for non work related disabilities and subsequently file for an alleged disability.

"Former Employee - All Other" when claimant no longer works for the policyholder that the claim is against but works for another employer since working for that policyholder.

"Unknown" when claimant fits into none of the above categories.

Q. What amount should be shown as pre-injury wage if it is not clear?

A. The wage the compensation benefit was developed form should be shown and then indication should be made under "method of determining pre-injury wage: where the wage came from.

Q. Often the fields have more spaces than needed, how should the money amounts and weeks be coded?

A. Always complete the blocks that are the farthest right and leave the left blocks blank. Always use whole dollars and whole weeks.

Q. Where should emergency room costs be included?

A. Hospital bills of any kind should be included under Hospital costs.

Q. Where should clinic costs be included?

A. Clinic costs, if they are not billed by a hospital, should go in Other Medical Costs.

Q. Should a claim be coded a subrogation if the money has not been recovered?

A. Yes. A claim should be coded subrogation if the claimant has a third party action. This includes those cases where the carrier files a lien against the claimant's action.

Q. Where are penalties to be included?

A. Penalties should be included in the Other Indemnity or Medical blocks if they are considered Indemnity or Medical loss.

Q. Under method of disposition, what does "none" mean?

A. None means open with no disposition, the claim has not been disposed of.

Q. When coding an Injury Description, how should a stroke be coded?

A. Stroke should be coded 1255 - Brain - Vascular.

SECTION XII

OVERVIEW OF DATA ELEMENTS

Mr. J. J. Holland

Director, Product Management Division

Travelers Insurance Companies

SECTION XII

SEMINAR

OVERVIEW OF DATA ELEMENTS

The value of specific claim data in support of rate filings is not particularly new. In Kentucky, in 1977, we faced the need for a 20% rate increase in a climate that was more than a little hostile. In this case we bolstered our filing by abstracting the details from 20 to 30 case records where sizeable judgments, in excess of any objective reading of medical evidence, had been rendered by the Compensation Board. This is a touchy approach, no carrier is anxious to be the lightning rod credited with public criticism of a judge who may hear one of their cases the following day.

Happily, we were able to select cases where the judicial findings were a matter of public record and which were representative of a cross section of major carriers. At any rate, the ploy was successful. Full experience indications were approved and the insurance commissioner issued a scathing indictment of the way the act was administered. As a collateral benefit -- during the following year a number of procedural and personnel changes were introduced that have resulted in a more consistent interpretation of the Compensation statute.

Since then we have made increasing use of testimony from claim personnel during hearings on our rate filings. This can be very effective, but there are two particular drawbacks.

1. The testimony tends to be limited to subjective observations which are difficult to price, and

2. We continue to have the lightning rod syndrom, with the understandable reluctance of many companies to provide corroborative testimony.

We would be far better off to rely less on specific testimony and substitute a statistical base that is objective in quality, permits accurate pricing and cannot be personalized in terms of specific carriers. This should result in both a better presentation and a lessened discomfort index for local claim people who must live with the administrative systems they are asked to evaluate.

For better or worse we must recognize that our ratemeking process has the unique capacity to put a price tag on that combination of Statute, Administration and Judicial Discretion that is the living Workers' Compensation system in each state. Generally, there is little significant difference in statutory law between states -- it is in the Administrative area that we find the great swing between conservative

and liberal philosophy. Nor is this ever a stable situation. Administration is a living organism, continually evolving in response to political pressures, new leadership and a changing public mood. The result is a highly subjective, but dominant factor, that is difficult to evaluate on either a qualitative or quantitative basis.

The National Council is not in a position to make moral judgments -- evaluating Workers' Compensation systems as good, bad or indifferent, but we can, and do, translate the total cost of the system into an insurance rate that can be compared with similar rates, either countrywide or in neighboring states. Frequently, this creates problems when statutory provisions are relatively similar, but administration is more liberal in one jurisdiction than another. The burden is on the Council to prove that these differentials exist. In the absence of specific evidence to the contrary it is our ratemaking that is suspect not their administrative philosophy.

More and more we are finding Insurance Departments -- many of them sympathetic to the need for adequate rates -- unwilling and unable to accept gross industry profit and loss figures as the only support for substantive increases in rate level. We have little choice, if we are to achieve adequate rates, but to document the relative differences in administration in support of our pricing indications.

We recognize that there will be situations, once administrative costs have been priced, where the legislature will consider remedial action. That is an incidental by-product of the costing system -- the legislature striking a balance between the benefits the public wants and the benefits they are willing to finance. Our responsibility is to cost what they have, to break that cost into meaningful components, and to be prepared to cost alternative solutions that are advanced by either the legislature or other interested parties.

The most efficient and effective way to accomplish this is through a claim data bank that will permit us to compare the situation in a given state at a given time -- either with prior periods of time or with selected states. It is to meet this need that the supplementary data call is introduced.

It may be reassuring to realize that we are not blindly plowing new ground in this effort. During the last few years Compensation carriers have been involved in several claim data studies and have learned a great deal from the frustrations and accomplishments of those experiences. ISO's experience with Closed Claim studies has also been instructive.

We began our involvement in 1975 when the Federal Interagency Task Force commissioned Cooper and Company to undertake a countrywide Closed Claim study. While the industry cooperated somewhat reluctantly in this effort, the outcome was a real fiasco. If you're looking for a

textbook example of a monumental foul up -- look no further than this little beauty--

A. There was no homogeneity to the claims studied in terms of accident date, benefit level, etc. Closing dates governed. Some files that were reviewed were several years old, so that comparisons tended to be both confusing and meaningless. You may recall that the ISO Closed Claim study on Products Liability was also subject to criticism when it attempted to draw assumptions regarding current costs from claims of considerable vintage.

B. There was no real effort to educate claim people (who had to do most of the work) of the purposes served or the need from the company standpoint for a thorough and meaningful search for information. Much of the participation was half-hearted, if not actually rebellious at an extra demand imposed on people who already felt themsleves overworked.

C. Many of the questions were quite complex. Accurate information required a thorough search of files that were both old and voluminous -- only to find that, in many cases, the necessary data simply did not exist.

D. A number of questions could not be readily answered from information the claim man would normally develop and would have required additional investigation and follow-up. Details regarding post-injury employment, for instance, are not part of a normal claim file.

E. There were poor or ambiguous definitions. As a result, different people in the same office would have various understandings of the proper answers to critical questions.

F. The edit system was poor and obvious errors were accepted rather than returned for reconciliation. For that matter, the interest at the Company level in identifying errors and reconciling incompatible answers was rather underwhelming.

G. Finally, the industry had no control over the end product and the Feds were free to distort or misinterpret data to support preconceived positions (few of which were friendly to the insurance industry or its position in the Workers' Compensation delivery system).

The Cooper study was, of course, a political -- not a ratemaking -- effort. At the very least, however, it reinforced a basic reality -- good information, carefully drawn to be comprehensive and defensible, is a powerful instrument in understanding the Workers' Compensation

system and our role in this important Social program. At the same time, bad information -- particularly the inability to respond to inferences drawn from bad information -- leaves us extremely vulnerable to those who blame private enterprise for shortfalls in the system and are quick to urge governmental remedies that are frequently more cosmetic than substantive -- and almost invariably less palatable than the original aliment.

The next thrilling installment was a two-parter. In 1977, and again in 1978, the California Workers' Compensation Institute undertook a two month study of "Resolved Claims" involving Cumulative Injury. For the first time the phrase "Resolved Claims" surfaced, recognizing that a study which relies on adjusters' estimates to establish claim costs will raise questions as to the integrity of the input -- since estimates can be manipulated. At the other extreme, a study based on closed claims will involve long delays from the time of accident until the information is available. By introducing a definition of "Resolved" i.e., those claims where a judicial or administrative decision had been reached and the cost of the claim had been established on an objective basis, we were able to improve both the timeliness and the credibility of the study.

The C.W.C.I. study was a much more rewarding effort. For one thing, claim men were intimately involved in the design phase and in preliminary meetings held in key geographical centers to explain the purpose and discuss details. Secondly, there was a general recognition that the emerging problem of Cumulative Injuries presented a considerable challenge to the industry, both in developing adequate rates, and supporting appropriate legislative reform.

The initial C.W.C.I. study was released, to considerable fanfare, in October, 1977. Alan Tebb has a nice flair for dramatic packaging and the end product was widely distributed and well received -- enough so to justify an encore the following year. In its release the Institute stated:

> "The study's results establish the dimension and potential of the problem and demonstrate the rising costs of cumulative injuries. Whether these costs are acceptable, or equitable, is a public policy issue. The value of the Institute's research lies in providing baseline data to permit those concerned with the continued vitality of Workers' Compensation to address this issue affirmatively."

Two results can be traced, at least indirectly, to the C.W.C.I. study. In approving rates to be effective in January, 1978, the Insurance Commissioner gave considerable attention to the impact of Cumulative Injury on the experience and the need for meaningful data. A.B.155, enacted by the California legislature in late 1977, provided for a gradual phase-out of the apportionment provisions of the California statutes. Apportionment had made the handling of Cumulative Injury claims particularly difficult and was a significant contributor to above average claim costs.

Again, we learned from the experience. Certain questions on the first study were omitted from the second because the information developed, while interesting, served little purpose. Others were rephrased or redefined and one or two added to correct deficiencies that became apparent when we first begain to analyze the information available.

The most recent study involved Florida, our neighboring state to the south. Despite the fact that Florida rates have almost doubled over the last several years and are now the third highest in the country, they still are far from adequate, and we consistently face difficulty in achieving needed rate levels. At the same time, since the benefits dictated by statute rank 37th in the country, there is considerable political controversy and an intensive scrutiny of the insurance industry's role in the Compensation system.

In December, 1977, we initiated a two month study of Resolved Claims designed to identify and quantify the reasons that claim costs in Florida were much higher than average.

The results were released in a two volume report, totaling 211 pages, in February, 1978. In reviewing the findings the Florida Agents Association commented:

> "The study unequivocally identified several of the reasons why Florida rates are so high. They fall into three areas:
>
> (1) The Florida system is over used and abused.
>
> (2) There are too many law suits without justification.
>
> (3) The cost of permanent partial is excessive."

Unfortunately, the Florida study was simply a snap-shot in time -- a comparison of Florida costs with those in two other states during a two month period. Without a continuous study we could not identify changing conditions within the Florida system and build support for the trend factors needed to bring rates to adequate levels.

Again, there is a significant by-product from this study. Currently, the Florida legislature is actively considering a fundamental change in the handling of permanent partial claims. The Wage Loss concept may well offer a workable solution to one of the most critical problems facing the Workers' Compensation system in virtually every state. The Florida study was a crucial factor in narrowing the discussion in that state to the critical issues and permitting the National Council to price the various alternatives that the legislature has under study.

Notwithstanding the invaluable contributions of the Florida study, we found differing interpretations of certain questions and some

items that, in retrospect, contributed little of value. Equally important was the need to have valid bases of comparison, either between more states with similar economic structures or at separate points in time.

I offer this history -- not to suggest that we have perfection at hand, but to assure you that we understand that an undertaking of this magnitude creates ample opportunity for confusion, misunderstanding and inadequate definition. We have given considerable attention to prior efforts -- both to profit from their achievements and to avoid, to the extent we can, their shortcomings.

The Task Force that designed this study was appointed January 10, 1978 with membership embracing all of the concerned disciplines. Representatives of claim, underwriting, actuarial, statistical and data processing were involved in all deliberations from beginning to end. In addition, upward of twenty representatives of other interested companies, independent bureaus and the trade associations attended many of the meetings and made a number of valuable contributions to the final product.

We began by preparing a Laundry List in which we tried to identify every element of information that could be asked about a Workers' Compensation claim. We were concerned with cost factors, of course, but we wanted to look beyond pure statistics to a concern for causative factors. We already knew that claims for similar injuries cost more in some states that in others -- even though the benefit levels were roughly equal. Now we wanted indicators as to administrative differences, liberal decisions, etc.

The Florida study had also identified a number of popular myths that beclouded the real issues, but did not stand the test of statistical analysis. We wanted data that would permit us to quantify the effect of various factors that contribute to rising claim costs, identify critical issues and debunk the myths.

Thus, we looked for indicators in such areas as the degree of disability awarded, the extent of medical treatment, the impact of litigation, patterns of utilization that could be traced to changing demographic and social factors. There are no end to popular theories as to underlying flaws in the Compensation system. In preparing the Laundry List we tried to recognize each that came to our attention. At this point we weren't concerned with distinguishing the practical from the outlandish, we wanted the list to be exhaustive and comprehensive.

The next step was to prune that list to managable proportions. We agreed that there were three criteria which each item had to meet:

A. The question should be objective. We decided that we had to limit the study, wherever possible, to information that can be verified and validated. We cannot afford to have out data base prejudiced by allegations

that it is colored by judgmental values -- biased to suit our purposes.

B. The information had to be available to the claim adjuster during the normal management of the claim. There was some data that we would have liked to have (post-injury work status, for instance) that could require a significant follow-up after the claim had closed. We were not prepared to require claim people to assume the task of post claim investigation. Similarly, this criteria eliminated the possibility of developing engineering information regarding unsafe act, cause of the accident, etc., both because this required judgments that the claim adjuster was not in a position to make, and involved some elements of subjectivity.

C. The information had to be pertinent in terms of meaningful analysis (using previous surveys as prototypes) or in response to specific questions where we were satisfied information was or would be needed. We recognize that we cannot anticipate all future questions, and that any effort to do so will not only be futile, but would involve extensive collection of data that could eventually prove worthless. We concluded that this study should be limited to information that would be useful in the immediate future. At the same time, we included enough trailers and key indicators to easily identify claims that are pertinent to arising questions and would permit a limited call for additional data on a small segment of our sample.

There were seventy-two data elements in the original Laundry List. Forty-three survived the pruning process. Of the forty-three, some were extended to two or more items to assure clear definitions and one or two additional data elements were added to develop information at the policy level.

Now there was the danger of over-pruning. We could not afford to find that we had gone to considerable expense to introduce a program and then find critical questions (ones that should clearly have been anticipated) to which we could not respond. Reviewing the reports from the C.W.C.I. and the Florida Resolved Claim study, we were satisfied that we could produce the essence of either report from our data elements. We then asked the Council staff for an outline of the reports they visualized as helpful for research purposes in support of rate filings. We were in phase with their specifications. The Alliance of Mutual Insurers made a detailed analysis of our proposal and indicated that we had included appropriate responses to each critical need that they identified.

With this, we had agreement on the necessary data items. Now it was time to get into the nitty and gritty -- the How's and the When's. Claim people had played an active part in constructing and pruning the Laundry List. In designing the structure of the study they were the essential ingredient.

From the beginning it was clear that this effort would make new demands on the Claim-Adjuster -- but there was a general recognition of the vital need for this data and the claim file as the only logical source. Claim people insisted that we be cost-effective, avoid duplication and simplify procedures -- but above all they wanted to be sure that we did it right the first time.

The six month reporting date was determined by the convergence of two factors in claim management. We had recently cooperated with the Texas Insurance Department in a review of claim reserving procedures which indicated:

A. 70% of indemnity claims are closed within the first six months. Use of that report date gives us the optimum combination of early data while reducing subsequent reports to a minimum.

B. A number of carriers use statistical reserves as the claim is reported, updating these at six months after medical considerations have firmed up and difficult cases have been investigated in some detail. Thus, the data available at six months has achieved an optimum maturity in terms of the claim management procedures of a cross section of the industry.

Our claim people were also quick to convince us that it would be difficult to cull the data we needed from existing files, even those that were still open. Some data would have been buried, some, available at one time, would not have been recorded. There appeared to be universal agreement that maximum accuracy and efficiency would be best served if the data was collected as the file was built.

This led to two requirements:

A. The ability to identify subject claim files while preliminary information was being developed.

B. The need to wait six months after the study was launched before initial reports would be available.

The Injury Grid was also the product of Claim input. They found the Grid in the Unit-Stat Plan both cumbersome and inadequate for purposes of claim management. The Grid they designed has been tested

in a claim environment and structured to follow the thought process of the adjuster in describing the injury. Another pay-off from involvement in the design process, the people who must make this system work.

Definitions continue to be a vexing problem. At times it is mindful of ancient philosophers debating the optimum capacity in dancing angels on your average pin head. You are satisfied that everything is nailed down and someone finds an exception in South Abyssinia that doesn't quite fit. At the moment, we have exhausted our knowledge, imagination and patience in correcting ambiguities, inconsistencies and semantic differences. We have tested facing sheets and instructions against current files and made a second round of adjustments -- and I'll bet that before you leave here we will discover a half dozen items where our definitions should be expanded, clarified or started over. Which is as it should be -- this is a living business, changing and evolving as we discuss it today. What is vital, and here we are confident with our product, is that the structure be sound and able to accommodate variances in definition to meet local conditions -- provided those definitions are applied uniformly within that jurisdiction.

In examining the facing sheet -- one characteristic should be evident. We have avoided the temptation to over-crowd. If the claim people working with this form succumb to some variety of Cumulative Injury, it will not be from the lack of white space.

My colleagues will discuss specific data elements following the coffee break. I would remind you, in the meantime, that 75% of the claims reported will involve Temporary Disability only, will generally be closed at the time of first report, and will be devoid of controversy or litigation. For most of these, the form could virtually have been cut in half.

Which brings us to last October. We had a well defined and extremely urgent need. We had spent ten months in developing, testing and polishing a program that was remarkedly responsive to that need, and we could not expect results in less than three years at the best -- and quite possibly never.

For the cold fact was that only a handful of companies had the capacity to collect the needed data on a systematic basis -- it would take them at least two years to complete the necessary programming, and another six months to produce meaningful reports. Many carriers had not automated their claim history files and had little appetite for a major capital investment to accommodate the Task Force's program. The prospect of handling hard copy reports on the total claim activity of even a limited number of Council members created incredible logistical problems -- both for the Council and the participating companies. We were literally between the rock and the hard place. There was an urgent and immediate need for the data base, and conventional reporting procedures were inadequate for our purposes.

I believe it was the Firemen's Fund that first suggested the use of Sampling. Certainly, they hosted the October meeting at which Sampling techniques were explored in some detail. Up to now we had combined the best efforts of Claim, Actuarial and Underwriting disciplines to put together a professional insurance package. It was time to turn to a professional in another discipline to add the final dimension -- and help bring our efforts to a very effective and practical conclusion.