Approved: 2-17-93
Date

MINUTES OF THE HOUSE COMMITTEE ON LABOR AND INDUSTRY.

The meeting was called to order by Chairman David Heinemann at 9:10 a.m. on February 4, 1993, in Room 526-S of the Capitol.

All members were present except: Representative Cornfield (excused)

Committee staff present: Jerry Ann Donaldson, Legislative Research Department
Kay Scarlett, Committee Secretary

Conferees appearing before the committee:

Senator Alicia Salisbury

Others attending: See attached list

Senator Alicia Salisbury who chaired the National Council of State Legislatures' Blue Ribbon Advisory Panel on Workers Compensation spoke to the committee. She explained that the NCSL has two arms. One being the State and Federal Assembly which is the policy making, approval group within the NCSL. The second is the Assembly on the Legislature which is the group that studies issues.

The Blue Ribbon Panel was formed to provide assistance to the NCSL Task Force on Workers Compensation. Five areas were chosen to be studied by the panel: 1) Delivery of Medical Services, 2) Permanent Partial Disability, 3) Administration of State Workers Compensation Programs, 4) Insurance Economics, and 5) Work Place Safety and Health Public Policy.

A copy of just the NCSL Blue Ribbon Panel Report on Workers compensation is attached. A complete copy of the report with Appendices can be obtained from the Legislative Research Department. (Attachment 1)

The meeting was adjourned at 10:40 a.m. The next meeting is scheduled for February 5, 1993.

GUEST LIST

COMMITTEE: HOUSE LABOR AND INDUSTRY DATE: 2-4-93

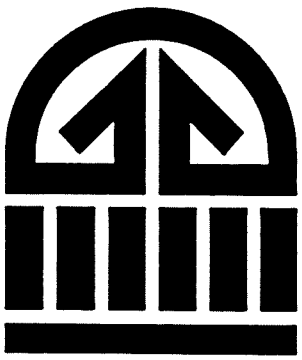
NAME	ADDRESS	COMPANY/ORGANIZATION
DICK THOMAS	TOPEKA	DHR/WORK COMP
Billy E. Newman	Topeka	State Self Ins.
Bill Morrissey	"	DHR/Work Comp
[illegible]	"	DHR/Work Comp
Jill Meyer	Lawrence	KU-Intern
Harry D. Kelser	Wichita	Ks AFL-CIO
[illegible] English	Coffeyville	Leadership Coffeyville
JOHN OYLE	COFFEYVILLE	LEADERSHIP COFFEYVILLE
David OBrien	O.P.	Intern
Maria Dikeman	Topeka	Lt. Gov.
Lisa Unruh	Topeka	DOB
BERNICE WOLF	COFFEYVILLE	City Commissioner
Ray Wolf	Coffeyville	Leadership Coffeyville
David Frankel	Lawrence	KTLA intern
SHELBY SMITH	Wichita	EL-IT
Bill Buster	Topeka	Flowers Co.
[illegible]	TOPEK	KS CATV Assn
Cameron Brewer	Topeka	KTCA
Joe Tuzanic	Topeka	KCA
Rich McKee	"	KS Livestock Assoc
Tom Tunnell	Topeka	Kansas Grain & Feed Assn
Art Brown	— —	KS. Lumber Dealers Assn
Tom Slattery	Top	AGC of KS

NATIONAL CONFERENCE OF STATE LEGISLATURES

BLUE RIBBON PANEL

ON WORKERS' COMPENSATION

RECOMMENDATIONS TO THE NCSL TASK FORCE ON WORKERS' COMPENSATION



House Labor and Industry
Attachment 1
2-4-93

NCSL Blue Ribbon Panel on Workers' Compensation

Senator Alicia Salisbury, Kansas
Chair

John H. Lewis, Florida
Consultant

Brenda A. Trolin
Staff

July 1992

Conclusion:

Workers Compensation Insurance has filled a valuable social need in our country for approximately 80 years. Unfortunately, the cost of providing the product is now far exceeding the revenue authorized for the line. At current levels, the private sector will soon be unable to afford to continue to provide the product in many jurisdictions. Benefit restructuring, cost containment, administrative efficiency, and rate adequacy must be quickly addressed by state legislators if workers compensation insurance is to survive.

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NATIONAL CONFERENCE OF STATE LEGISLATURES

1560 BROADWAY SUITE 700 DENVER, COLORADO 80202
303-830-2200 FAX: 303-863-8003

TRANSMITTAL LETTER

Honorable Ladies and Gentlemen:

The attached reports and recommendations are the products of the deliberations of a Blue Ribbon Panel formed under the auspices of the National Conference of State Legislatures (NCSL) to provide assistance to the NCSL Task Force on Workers' Compensation. In other contexts, the groups represented have sometimes been adversaries and may well be in the future. However, their concern for the serious problems confronting state workers' compensation systems and the impact on business and labor provided the basis for the cooperative efforts of this somewhat unlikely alliance. The list of members is attached.

Each member of the panel is recognized as an expert in the field of state workers' compensation. Each has come to respect the expertise of the others. Each has come to understand the legitimate interests of the broad range of stakeholders, including labor, management, the insurance industry, the legal profession, the medical community, and administrators of the state programs. It is probably no coincidence, in the face of a mounting crisis, that a degree of camaraderie and mutual respect has grown up within this group because it would not have been possible to achieve this final work product without it.

The Blue Ribbon Panel must now go on record with a statement of the fundamental philosophy underlying this effort. There are three components to that philosophy.

First, five topics were selected for review: the delivery of medical services, permanent partial disability, administration of the system, insurance economic issues, and occupational health and safety. These represent five issue areas that the group considered major problem areas in state systems. They are not the only policy areas of interest to state legislators, but do represent critical components to be considered in any analysis of a state workers' compensation system.

A second component of the philosophy is that no individual paper should be considered apart from the whole. To provide meaningful reforms, each of the issue areas addressed in the papers must be reviewed and analyzed. In addition, the recommendations must be considered within the text of each paper and not simply by itself. The workers' compensation system is just that: a system. Tinkering with parts of it and failing to view the various components and their relationships will result in failure to create a healthy, viable system.

WASHINGTON OFFICE 444 NORTH CAPITOL STREET, N.W. SUITE 500 WASHINGTON, D.C. 20001 202-624-5400 FAX: 202-737-1069

The third cornerstone is that these recommendations are for consideration by the NCSL task force and any state experiencing difficulties with their system. It is not the intent of the Blue Ribbon Panel to suggest that these recommendations be used in any state in which the legislature is content with current law. Instead, these recommendations are offered to the NCSL task force and those states desiring to amend their laws in a way likely to find support among all the competing interests.

While we have completed work on the enclosed papers, the group will remain intact to respond to any questions that task force members may have. In addition, we welcome the opportunity to continue to work with the task force -- by drafting additional papers at the request of the task force, by participating at task force meetings, or in any manner the task force deems appropriate.

Respectfully submitted,

The NCSL Blue Ribbon Panel
on Workers' Compensation

NATIONAL CONFERENCE OF STATE LEGISLATURES

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PRESIDENT OF THE SENATE
KANSAS
PRESIDENT NCSL

TERRY C. ANDERSON
DIRECTOR
LEGISLATIVE RESEARCH COUNCIL
SOUTH DAKOTA
STAFF CHAIR NCSL

WILLIAM POUND
EXECUTIVE DIRECTOR

March 19, 1992

MEMBERS OF THE BLUE RIBBON PANEL ADVISING THE NCSL TASK FORCE ON WORKERS' COMPENSATION

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University of Connecticut
Storrs, Connecticut

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William Hager, President
National Council on Compensation Insurance
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John Hodges, President
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Business
Washington, D.C.

Casey Young
Administrative Director
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San Francisco, California

MEDICAL ISSUES IN WORKERS' COMPENSATION AND THE DELIVERY OF MEDICAL SERVICES

National Conference of State Legislatures
Blue Ribbon Panel on Workers' Compensation

When workers' compensation programs were first instituted in this country, the general health care delivery system was quite different from what it is now. In most instances health care was obtained through the family physician or the local hospital, on a fee for service basis, without most of the third party payor programs and private and governmental cost containment mechanisms that now dominate the health care system. The literature of the time gives reason to believe that the need to make medical decisions, particularly those involving treatment, was not expected to result in much dispute or litigation. Experts for hire were virtually nonexistent, and fee schedules were the cutting edge of medical cost containment.

The landscape is now quite different. The cost, quality and availability of health care have become front-page issues across the country. The workers' compensation system coexists with a myriad of health care programs. Cost-shifting from one program to another has become a major issue. Workers' compensation now deals with a far broader range of medical issues than it once did, many of them extremely complex. Access to quality health care has become a concern for workers' compensation benefit recipients in some areas, due to the reluctance of health care providers to participate in a system that they believe pays inadequate rates and burdens them with paperwork and frequent litigation. The entire workers' compensation system has become much more expensive, driven in large part by its medical services component and the expense of resolving disputed medical issues. All of these developments have made it essential that we look critically at each of the system's components, to determine whether there are more effective ways of meeting its responsibility to provide quality health care at a reasonable cost.

For many years debates over the direction of the medical segment of the workers' compensation system have taken place as if it existed in a vacuum. While massive changes were occurring in the general health care system (and equally massive problems being recognized), workers' compensation remained focused on fee schedules and choice of physician issues as means of controlling costs and maintaining quality. It should now be clear that the workers' compensation system cannot continue to rely solely on these limited mechanisms in its efforts to control the cost and quality of medical services.

Workers' compensation is a minor piece of a very troubled and controversial health care system. It is doubtful that workers' compensation can simply go its own way, unaffected by what is occurring elsewhere. Certainly any escalation of costs in the general health care system will drive workers' compensation costs higher, and to date the workers' compensation system has proven even less effective than others in moderating these increases. It is highly likely that the workers' compensation system would benefit through greater use of at least some of the cost and quality control tools that are common to the rest of the health care network.

Over the years most insurance carriers and self insurers have implemented health care cost containment processes on their own, often without legislative mandate or support. Recently, however, legislatures and administrators in a number of states have attempted to force all of the participants in the workers' compensation system to use some of the techniques that are commonplace in the general health care system. Fee schedules have existed for a long time in a few workers' compensation programs, but they are now becoming commonplace. Utilization review, treatment standards, case management, second opinions, independent medical examinations and similar techniques are being employed by state agencies and insurers in some workers' compensation programs, and are likely to become more prevalent.

Through all of the discussions and debates, we should remember that the health care goals of any workers' compensation system are the same as those of the general health care system. They are to provide good medicine at a reasonable cost. We believe that because the goals are the same, and because it uses the same medical care delivery resources as the far bigger general health care system, wherever possible workers' compensation should seek to avoid duplication of effort. It must take advantage of economies of scale that can come about by working with rather than being independent of the general health care delivery system.

This is not an easy task, because of the multitude of programs involved in health care delivery (various private programs, Medicare, Medicaid, etc.) and the extent of their differences as compared to workers' compensation. Rather than take on this whole range of programs, we will focus on the relationship between workers' compensation and the health care benefits provided by employers to a segment of the employed population.

Approximately 89 percent of the work force is provided with some form of health care coverage for non-occupational conditions through their employment. In many instances coverage is also provided for family members. These programs are typically paid for through a combination of employee and employer contributions. Considerable variation exists in all aspects of the programs, including the levels of deductibles, co-insurance, reimbursement and aggregate maximums.

Many of the general health care programs utilize the controls that are now being brought to bear on the workers' compensation system. Because these programs are for the most part established and controlled by contractual agreements rather than by laws and regulations, they are better able to utilize cost and quality control mechanisms, and have implemented them to a far greater extent than has the workers' compensation system. Whether or not the mechanisms have been effective in controlling costs and assuring quality of care remains a matter of considerable debate. Unfortunately, there is greater reason for concern over their potential when considering their use in workers' compensation.

Workers' compensation remains a system in which medical issue disputes are subject to a litigation-based resolution process, and one in which the relationship among employer, employee and medical provider is driven by a set of statutory and regulatory provisions, rather than a consensual arrangement. It is further hampered by the fact that decisions involving medical care can affect entitlement to substantial cash benefits. Thus, the parties to a workers' compensation dispute may have greater incentives to fight over medical issues

that could be easily resolved or would not even occur in general health care delivery systems.

Notwithstanding these concerns, the Panel believes that it is in the best interests of the parties to the workers' compensation compact to bring many of the techniques previously described into the workers' compensation system, and to partially integrate them with similar programs already in existence in the general health care system. That is, state workers' compensation programs should recognize and work with some of the actual delivery and control programs that are operating in various health care delivery and payment systems, rather than simply adopt the techniques they use to control the quality and cost of services.

This does not necessarily require the adoption of what is often referred to as "24-hour coverage," involving the merger of the workers' compensation system's health care component with a general health care program. It simply means that in those instances in which an employer provides general health care coverage for its employees, medical care for work-related injuries and diseases should be provided within the same mechanisms and subject to the same controls. They include limited provider panels, utilization review, managed care, PPOs and HMOs, case management, and additional levels of administrative-style review within the program.

The use of an employer's cost containment program in conjunction with the delivery of workers' compensation medical services will raise legitimate concerns over the potential for abuse. Because they are often designed and implemented by the employer and its insurer without the active participation of employees or their representatives, such programs may be viewed as totally responsive to employer interests. As a result, some parties fear that they may be used to deny workers proper care for their work-related injuries, through the adoption of overly stringent limitations on treatment in the guise of legitimate cost and quality controls.

There are at least two ways to prevent this problem from developing. The first is to require certification of the employer's program, to minimize the likelihood that it will be used inappropriately. This can be accomplished by the workers' compensation authority or another state agency that has the expertise and resources to evaluate and monitor this type of program.

The second is a protection that must exist in any event, to meet the due process requirements that apply to every workers' compensation system. It is the review authority of the workers' compensation agency, exercised both informally and through the litigation process. Just as is presently the case in most instances of disagreement over medical treatment, the workers' compensation agency's dispute resolution process can be used to review any disagreements arising out of limitations contained in the employer's program and decisions made by its review process, in the same manner as it would deal with any other medical issue dispute.

This does not mean that every disagreement over medical treatment, whether it first goes through some outside review process or comes directly to the workers' compensation agency, should be immediately placed into the formal litigation process. The same techniques used in the private programs -- certification, review, case management, etc. --

should be utilized by the workers' compensation agency, in its efforts to resolve medical issue disputes quickly and with the highest level of expertise. Each workers' compensation agency should have in place, either through its own staff or by contract with an outside provider, all of the medical cost control and quality assurance mechanisms that can be shown to have legitimate value. If the employer, its general health care insurer or its workers' compensation insurance carrier also has such mechanisms in place, the agency's program would act as a reviewing body. If they do not have such programs, the agency's program would be the first line of control, making initial decisions concerning medical treatment disagreements.

This approach is intended to obtain two results. First, it should encourage the private sector programs to insure that the control mechanisms they use are fair and can withstand scrutiny through both a certification process and a review process. Secondly, through the adoption of its own expert-based control and review processes, the agency will be in a position to prevent medical issue disputes from occurring in some cases, and to more quickly and appropriately resolve them when they do arise.

No matter how well the system operates, there is no reason to believe that every medical issue will be resolved without the need for invoking the litigation process. When that occurs, there are steps that workers' compensation agencies should take to bring litigation to a prompt and correct conclusion. The use of health care professionals who have been identified by the workers' compensation system as having the highest level of competence and the ability to render opinions without partisanship, to conduct independent examinations or review conflicting medical opinions, will help reach these goals.

In some states the use of so-called independent medical examinations does not involve neutral experts, but rather the selection of an expert by one side or the other. This choice of terminology should not confuse matters. Each state should adopt laws and regulations which will permit it to structure a true independent medical examiner program and ensure its effectiveness. This requires considerable attention to issues such as how the agency should select independent examiners, how they should be assigned to a case when the parties cannot agree to a specific examiner, and how much weight should be given to the IME's opinions in order to strike a balance between the need for IME opinions to have significant impact without making them binding.

A workers' compensation system can go even farther in structuring its medical issue dispute resolution process. Many of the issues that are decided on a case-by-case basis through the litigation process, such as the weight to be given to a particular diagnostic technique or to a theory of disease causation, can be better dealt with through the use of rules, established through the rule-making process, to establish decision criteria that are binding on all cases. When properly utilized, this process permits the agency to obtain the best possible medical opinions involving specific issues, rather than relying on the resources and abilities of the parties in individual cases to determine what medical evidence will be made available to the fact-finder. Not every issue is amenable to this type of approach. For those that are, and are likely to come up time and again, it has significant value, providing uniformity and predictability, and avoiding multiple litigation of the same issue. This proposal should not be interpreted as meaning that workers' compensation agencies be permitted to use their rule-making authority to make decisions on baseline issues of compensability, such as whether heart attacks or carpal tunnel syndrome should be compensable.

If all of the processes described in this document are further developed on the basis of valid medical concepts and are professionally implemented, it is likely that they will be supported by the ultimate arbiter, the formal litigation and appellate review process. (If they are not supported, there may be good reason to question the validity and effectiveness of the dispute resolution process.) Once this occurs, the result will be higher quality and more cost-effective medical care, and a reduction in the medical disputes that now permeate the workers' compensation system.

The recommendations are intended to develop a system that limits the exercise of discretion, makes many decisions in the aggregate rather than on a case-by-case basis, attempts to prevent disputes by providing clear directions, and resolves disagreements in most instances with something less than full-blown litigation. It requires a workers' compensation agency that is adequately financed and professionally staffed. Without the necessary resources, there is no reason to believe that an agency can exercise proper and effective control over its medical care delivery system.

Some parties view the workers' compensation system as a litigation process rather than a delivery system. They believe that the way to get the right result is to permit the parties to do battle as they would in a civil trial, with a full range of testimony and expert witnesses, and almost total discretion on the part of the fact-finder to determine what medical treatment is appropriate, what it should cost, and what cash benefits should be provided. Those who subscribe to that model will not be supportive of the approach described in these recommendations.

This discussion has not dealt with the difficult questions of how or even if the deductibles, co-insurance and aggregate maximums which are often found in general health care insurance programs should be permitted in workers' compensation. The possibility of their use involves very significant issues which have not been resolved during the committee's discussions, other than to recognize that with the exception of one unimplemented experimental provision in the Florida law, no state's law permits the use of these tools in its workers' compensation program.

The committee has also not attempted to reach a decision on another major issue, that of choice of provider. Most of the parties to the debate over who should choose the treating physician have strongly held positions. The proponents of employer choice claim that it provides lower cost and higher quality care, and argue that the party paying for the care should have control over it. Employee choice is alleged to be correct on grounds that it gives control to the one individual most directly affected by the care being provided, prevents employers and insurance carriers from having undue influence over the treatment process, and results in lower costs. Various medical services providers often view one version or another as likely to increase the volume of their business, and lawyers are likely to believe that having control of physician choice provides their clients with control over much of the claim and furnishes an advantage should litigation occur.

There is also a secondary aspect of the physician choice issue, that of the right to change treating physician. Either party may wish to implement a change for very legitimate reasons, such as concerns over the quality and appropriateness of the care being received, or a lack of rapport with the treating physician. However, there are other reasons as well,

such as doctor shopping to find a "treating" physician who will support a particular litigation-related position. A few states now expressly limit an employee's absolute right to change treating physician, and in some the employer or insurance carrier's right to force a change without either the employee's agreement or the intervention of the administrative agency is limited through court decision or custom.

The claims and allegations made over the significance of one method of choosing medical providers versus another are seldom backed up with hard evidence, particularly with regard to quality and cost. Even when studies are undertaken, they often result in conflicting or questionable conclusions. Nonetheless, the question of provider choice continues to play a prominent role in many workers' compensation reform efforts, and gives the impression that it is a crucial issue in every case. However, this is not true. Many, if not most, injured workers are satisfied with the medical care that they receive, irrespective of how their health care providers were chosen. Many employers permit their employees to choose their own physicians, even when the law provides for employer control, and many employees use physicians designated or suggested by their employers, even when the law permits employee choice.

There is no consensus within the Panel regarding the resolution of this issue. However, the Panel believes that most of the problems associated with choice of physician occur in only a limited number of cases, despite the fact that the issue is the cause of considerable debate and disagreement in many states. The problems that do exist are exacerbated by laws which give one party or the other virtually total control over treatment, and systems in which medical issues are resolved solely through the formal litigation process. The importance of control over provider choice for quality and cost reasons is lessened when an effective managed care and utilization review system is in place, when there is flexibility in the physician selection process, and when the administrative agency is able to quickly and appropriately respond to treatment questions raised by the party not involved in making the choice. Concerns should be reduced even further when the system does not permit either party to use "doctor shopping" for litigation-related reasons.

Progress in this direction can be made when medical issue disputes are resolved through reliance on truly independent expert practitioners, or some other procedure that is trusted by both parties.

The choice of physician question is closely related to another issue that will not be resolved here, that of the role of particular types of health care providers, most notably chiropractors. Few states have been able to avoid the intense political pressure that arises when efforts are made to limit or control their involvement in the workers' compensation system. Although the committee has reached no conclusion as to the appropriate role for chiropractic care in the workers' compensation system, there is considerable support for the approach taken by Oregon in its 1990 legislative enactments. That is to provide a form of utilization control by requiring the involvement of an M.D. or D.O. as primary treating physician and limiting the total number and frequency of chiropractic treatments unless additional services are agreed to by the primary treating physician or the employer/carrier.

In addition to the major concerns that have been discussed, there are a number of less controversial issues that surface in many states and which can be dealt with relatively easily. One of the most prevalent is the practice of "balance billing," through which a medical

provider seeks payment from the injured worker for that part of its bill which the workers' compensation system has determined should not be paid because the services were unnecessary or the charges too high. Several states have established statutory rules and procedures that prevent this from occurring, and the Panel supports their efforts.

There are also concerns over the entire process of billing and reporting as it affects medical service providers, the employer or insurance carrier, and the workers' compensation agency. Similar concerns are also found in the debates over the future of the general health care system as well. Workers' compensation agencies must review their billing and reporting procedures, to meet three goals. The first is the development of "user friendly" methods of communication. Bills and reports should be in formats that are easily understood by the sender and the recipient and which match as closely as possible their counterparts in the general health care system. One suggestion that has been made is that workers' compensation adopt the HCFA billing form.

Next, physicians must be educated regarding the specific informational needs of the parties to the workers' compensation system, so that their reports can match those needs. Reports that are delayed because the physician erroneously believes that a great deal of information is required impair the benefit delivery system, as does a report that contains insufficient information.

Finally, just as more attention has been focused on timely payment of medical bills, similar attention must be paid to the furnishing of reports. Not only should reasonable time frames for reporting be established, but they must also be enforced. Much of the cost containment activity that this report recommends can be substantially hampered when the providers' reports are not received in a timely fashion. Similarly, injured workers suffer when benefit payments are delayed due to lack of medical information, and carriers may overpay for the same reason.

POLICY STATEMENT
ON PERMANENT PARTIAL DISABILITY

National Conference of State Legislatures
Blue Ribbon Panel on Workers' Compensation

It is widely agreed that states encountering a variety of difficulties with their workers' compensation programs usually face problems with a category of cases known as permanent partial disabilities. States seeking to reform their laws often grapple with the task of identifying more suitable alternatives to their own system of compensating workers with these disabilities. A number of states have undertaken these changes only to find, eventually if not immediately, that the problems persisted or recurred. Specifically, efforts to hold down costs and litigation rates in this area were generally unsuccessful.

The evidence regarding the problematic nature of permanent partial disability claims is clear. Compared with temporary total disability claims, permanent partial disability claims require about six times the medical expense, but 17 times the average indemnity expense. Based on one study of experience in 13 states over a recent five-year period, about 3 percent of temporary total disability claims involved attorneys, whereas over 31 percent of the partial disability claims involved lawyers. It is these sorts of issues that have brought greater attention to this category of claims.

Perhaps it is because of the difficulties that many states have had with their permanent partial disability programs, that so much interstate variation exists. Few, if any, areas of workers' compensation exhibit so much variation in approach, allowing these to serve as experiments in operating these benefit programs. It is the policy setter's challenge to draw from this pool of experience those techniques that can be best adapted to their own particular state settings.

Minimally, goals must be established for any permanent partial disability program. An understanding must exist regarding the reasons for which benefits are to be paid, and the circumstances of those workers who receive the benefits ought to correlate with those reasons. The panel accepts the principles that the benefits should be adequate and distributed equitably among benefit recipients in the same factual situation. Agreement also exists that after the worker's condition has been stabilized, the benefits should be delivered promptly and with low transaction costs.

As noted above, states have adopted many different approaches to compensating workers with these disabilities. Variations exist regarding the basis on which compensation is to be paid and what factors are to be considered regarding benefit amounts. Broadly speaking, particular benefit approaches can be fitted into three categories:

> Impairment. Providing compensation based upon physical or mental loss of use of bodily function. This concept focuses on such factors as loss of motion and loss of strength.

Wage loss. The compensation benefit is based on the actual loss of earnings experienced as the result of the permanent impairment, with the amount of the compensation calculated and paid as the loss is actually experienced.

Loss of wage earning capacity. This approach takes into consideration the impact that factors such as age, education and work experience, when combined with a permanent impairment, have on the worker's ability to compete in the labor market. In some states, it is viewed as a predictor of the earnings loss that is expected to occur as the result of the permanent injury.

We believe that there is widespread acceptance of the proposition that the most important justification for compensation in such cases is actual loss of income. In a limited benefit system such as workers' compensation, it is appropriate to attempt to correlate the dollars paid for permanent partial disability (PPD) with the economic loss incurred.

The income replacement or "wage loss" approach to PPD compensation is the most direct method used to meet this goal. It involves monitoring post-injury earnings and replacing all or part of the income loss attributable to the permanent injury.

Another method which on its face appears to offer some opportunity to deliver benefits to those who are likely to experience income loss is the loss of earning capacity system. Unlike wage loss, it is intended to predict who will suffer income loss in the future as the result of their permanent injuries, or, in some states, to compensate for the worker's loss of ability to compete for jobs.

Because the impairment based approach determines benefit amounts through the evaluation of loss of physical (and possibly mental) function, on its face this approach may appear to have little value in a system that seeks to replace lost income. However, it may actually accomplish this. The dollar value accorded to a degree of impairment can be considered as the compensation level deemed appropriate to compensate for the average income loss sustained by a person with such impairment. Historical evidence indicates that the development of scheduled impairment benefits was based upon this concept. In addition, impairment is as good a predictor of who will suffer income loss as the combination of factors which are used in the loss of earning capacity approach.

Each of the basic compensation approaches has significant flaws:

Wage loss systems can provide significant disincentives to workers to return to full employment. Additionally, it can be extremely difficult, if not impossible, to determine if the loss of wages suffered years after the injury is due to the injury, as contrasted with economic conditions. This is particularly true in cases involving minor impairments. In a pure wage loss system, there is often a sense of unfairness about a scheme that gives a worker nothing even for a serious permanent impairment if he/she sustains no actual loss of earnings after the end of the healing period. There is also a sense of unfairness where very substantial compensation is awarded to persons whose injuries result in very minor physical impairments, although they experience sizable earnings loss.

The calculation of loss of wage earning capacity is inherently subjective, and generates the need for attorney involvement and litigation. In addition, there is little evidence that this approach is a very accurate predictor of future earnings loss.

Impairment benefits do not respond directly to the economic impact of the injury. The pianist and the attorney both receive the same benefits for the loss of a finger.

Each approach also has certain advantages:

Wage loss probably comes closest to the historic purpose of workers' compensation, replacement of lost income, and has the maximum potential for getting the highest proportion of permanent partial dollars to the people with the greatest economic need, those suffering actual loss of income. Theoretically, this approach should also encourage employers to rehire workers after injury, and to provide vocational rehabilitation when necessary.

Loss of wage earning capacity allows for consideration of both impairment and the potential for loss of income. Its subjectiveness can give administrators considerable flexibility.

Impairment can (though it need not) be estimated with relative ease, and with small disparities among evaluators, especially if the evaluators use the same standards.

Having described in very basic form each of the three approaches, it must be observed that variations on each theme exist. For example, adoption of the impairment concept does not require that impairment be the only factor considered. More complex alternatives are available. A state might choose to accept the impairment approach but modify the basic impairment rating by adding to or reducing the assessed degree of impairment through the application of factors relating to the worker's age, educational attainment level and other objective and, perhaps, subjective elements.

Another possible modification of the basic impairment benefit system is to provide substantially greater benefits for cases involving high levels of impairment, because they are the ones that are more likely (but not guaranteed) to result in loss of income. Under this approach, for example, a 20 percent impairment might be compensated at three times the value of a 10 percent impairment, rather than the more customary method which would provide twice as much compensation.

Using any of these three basic approaches, the determination of the actual benefit amount can be calculated in different ways. States that compensate based on impairment tend to provide greater indemnity benefits for higher paid workers, assuming similar impairment ratings. This occurs where the compensation rate is linked by formula to the worker's pre-injury earnings level. Where the maximum wage rate for purposes of partial disability compensation benefits is a low one, there is more uniformity in the benefit amounts paid to workers with similar rates of impairment. This situation is especially likely to occur in those states where the maximum weekly benefit for a permanent partial disability is below the maximum set for temporary total disabilities. In a small number of states that are impairment based, permanent partial disability benefits are not linked to previous earnings,

but instead are provided as a fixed number of dollars per point or degree of assessed impairment.

It has been difficult for the Blue Ribbon Panel to reach consensus on a preferred approach to permanent partial disability compensation. Some find that the wage loss approach was proven to be flawed when implemented and as interpreted by the courts in Florida, yet the experience in Michigan has been more favorable. Others argue that the widespread use of lump sum settlements to close out cases means that Michigan does not actually practice a wage loss approach. In the absence of such settlements, administering such a scheme is difficult and prone to contention. Impairment-based approaches should be the simplest to administer, but the experience in states like Oklahoma and New Jersey proves that the approach is not guaranteed to function easily. In the absence of common evaluation guidelines, agreed standards and impartial medical examiners, impairment-based schemes can also involve litigation, delays and inconsistent outcomes.

Perhaps the most serious reservation about an impairment system is that it can result in a grave injustice in those limited instances where there is a very serious, if not catastrophic economic loss suffered by a person which is far out of proportion to the degree of impairment (and, therefore, the compensation). Some states that use the impairment approach have tried to deal with that. In Wisconsin, Minnesota and Colorado, for example, benefits are based on impairment unless the worker has not been able to return to his/her pre-injury level of wages. In states such as Connecticut and Massachusetts, benefits are paid for impairment and additional amounts can be paid for earnings losses.

There is a concern that schemes that pay for impairment and allow also for earnings loss may evolve so as to regularly pay both types of benefits. (Massachusetts comes to mind here.) Instead, it would seem desirable, in most cases, to limit benefits to be paid for impairment, with the door left ajar for those rare instances where an egregious injustice has occurred. In those instances, the worker would be paid, initially, an impairment-based benefit, and when those benefits expired, a supplemental income award based on their actual wage loss. The challenge becomes how to limit these awards to those cases where serious economic harm has been done. The following represent possible ways that effective limits may be imposed:

> If the worker enters into a compromise and release agreement (lump sum settlement), eligibility for any supplemental benefit would cease. This option would discourage some workers from taking lump sum settlements, but it would lead insurers to pay a premium over and above the pure impairment value of the scheduled benefit to get closure of the case. A variant of this is to allow C&Rs for the scheduled loss only where the claimant has returned to work. In that case the insurer would not have to pay a significant bonus to achieve closure, since the worker has demonstrated a willingness and ability to return to and hold employment.
>
> The state might opt to provide income replacement benefits only where the impairment is a serious one. Texas and New York are examples here. This option has two virtues. First, it would keep the numerous minor injuries from clogging the adjudicatory mechanism, and second, it would prevent those minor cases from drawing funds from the system. In turn, more dollars would remain available for the more serious cases. Two problems exist here. The threshold becomes a focal point

for litigation as the parties battle to be on the right side of the margin. Second, no matter how low the threshold, it is possible that some workers who fall below it will be harmed economically by their "minor" impairment. Note, however, that this situation already widely prevails where schedules are employed.

A time limit could be instituted so that there would be no supplemental income award if the required level of income loss does not occur within that time after maximum medical improvement is achieved. This provides employers and insurers with some degree of predictability -- in most cases.

A supplemental income award could be limited to instances where the worker met a vocational rehabilitation requirement. For example, the worker's entitlement would be based on having submitted to an evaluation of the value of rehabilitation, and possibly requiring participation in a recommended vocational rehabilitation program.

Eligibility for the supplemental income award would be reviewed regularly -- at least at one-year intervals, unless the agency believes that these reviews are academic.

The supplemental income award would terminate at some specific age, perhaps linked to a common age of retirement.

Use of an impairment approach, even when coupled with other objective factors, also raises questions of if and how pain and suffering and related factors are to be used in the permanent disability benefit system. Workers' compensation, as originally designed, was not intended to compensate for pain and suffering, and none of the existing systems explicitly provides payment for that element of loss. We believe that the original decision not to deal with pain and suffering was and is appropriate, and that no changes should be made. Any attempt to directly compensate for pain and suffering would turn workers' compensation into a tort-like system that would have substantially higher friction costs. It is unlikely that the system would be able to provide the prompt and relatively efficient delivery of benefits that is its goal.

That does not mean that consideration of pain and suffering is not already a factor in some aspects of the compensation system, or that this will not continue in the future. Many judges, hearing examiners and commissioners have expressed privately that they cannot disregard the pain and suffering that a worker has experienced or continues to sustain when the worker is rated. In states that compensate for loss of wage earning capacity, so much flexibility (or subjectivity) exists in the setting of rating that pain and suffering may be compensated implicitly, even where the statute makes no provision for it.

When a state uses an impairment-based benefit system, there may appear to be no room for compensating for pain and suffering. However, it can be argued that considerations of pain and suffering are built into the schedule. The impairment award can be considered the state's determination of the appropriate benefit to compensate for both income loss and pain and suffering for the average case, though in reality some individuals will be overcompensated and some will be undercompensated. And the AMA guides used to evaluate the extent of impairment expressly recognize that pain can contribute to impairment.

Only in pure wage loss systems is pain and suffering ignored as a possible subject of compensation, but even here their existence and extent will influence decisions as to whether an individual is capable of working. In those jurisdictions, workers receive no compensation if they sustain no earnings loss after temporary total disability has ended, and the benefit entitlement is determined solely by the amount of the loss. As a result, there is little opportunity for increasing an award to reflect the judge's concern over the claimant's pain and suffering. However, some wage loss jurisdictions also provide impairment benefits under certain circumstances, thereby providing compensation for non-economic losses.

During 1990-1991 at least 11 states addressed the issue of permanent partial disability. Though New York and California raised benefits, most changes reflect an attempt to contain the cost of permanent partial benefits by either adopting provisions to better measure the degree of impairment or by reducing the duration and/or maximum amounts of benefits payable.

With respect to the type of permanency benefits, only Texas adopted a major change. It eliminated the loss of wage earning capacity approach and shifted to one that is impairment based. Additionally, it provides for a supplemental income benefit in certain instances where there is wage loss and the impairment rating is at least 15 percent. The remaining 10 states -- Massachusetts, Rhode Island, New York, New Mexico, Colorado, California, Connecticut, Oregon, Florida and Maine have essentially maintained existing statutory provisions with modest to substantial modifications relating to eligibility, duration or maximum payments or a combination thereof.

States that increased either the weekly amount or duration of partial disability benefits include New York, Colorado, Oregon and California (Colorado and Oregon added provisions to more credibly determine impairment). States that reduced the duration and/or amount of wage loss or loss of earning capacity or impairment benefits include Massachusetts, Rhode Island, Florida, Maine, Texas and Connecticut. Policymakers considering the issue of PPD in the future may want to review the experience in the above states that led to their changes.

With the passage of the Americans with Disabilities Act, considerable uncertainty exists regarding its impact on compensation for permanent partial disabilities. There cannot be any certainty how the law will evolve with future court decisions and regulations. Employers are likely to be under an increased obligation to reemploy their injured or sick workers. For that reason, disability benefits paid based on the (prospective) loss of wage earning capacity may decline, relatively. Alternatively, these benefit payments could increase in those states where employers do not reemploy such workers, since such an action would be presumed to indicate the existence of a very severe occupational disability.

The A.D.A. provides yet an additional incentive in states using a wage loss approach for employers to reemploy their disabled workers. Consequently, costs to employers of compliance with the law could be somewhat offset by lower workers' compensation costs.

For states that base their permanent partial disability awards on impairment alone, the A.D.A. may not have an immediate impact on compensation costs. However, the likelihood that the new law will lead to greater employment opportunities for workers with

handicaps could prompt some states to modify (reduce) the size of their impairment benefits. All of this is speculative, but the Panel is confident that the long-term consequences of the law can be significant for state workers' compensation programs.

For many persons, permanent partial disability compensation is related to another contentious issue. Many states award benefits for disfigurement. Except in the rare case, this benefit cannot be justified on the basis of earnings or economic loss. In a few states the benefits may be large, but in many they are perceived to be almost a nuisance award. There, a good case can be made that payments that are being made to workers with relatively minor injuries occur at the expense of those with more serious impairments. Others argue, however, that these benefits are simply frosting on a pretty skimpy piece of cake. In almost all states, issues of disfigurement rarely lead to litigation.

THE ADMINISTRATION OF STATE WORKERS' COMPENSATION PROGRAMS

National Conference of State Legislatures
Blue Ribbon Panel on Workers' Compensation

Inherent in the workers' compensation concept is the obligation to assure injured workers that the correct amount of benefits will be provided in a timely manner, with a minimum amount of dispute or need for litigation. When disagreements do arise, they must be resolved quickly, efficiently and fairly. The only way that these goals can be met is through the existence of a strong administrative agency overseeing the operation of the program and providing a forum for the resolution of disputes.

This philosophy is not necessarily accepted by the entire workers' compensation community in every state. Many of the arguments concerning the appropriate role of government in other aspects of economic life can be applied to workers' compensation. However, the Panel believes that the need for a strong, proactive administration is clear, and that any disagreements should be over the details of administration rather than the fact of its existence.

It is also important to note that an agency's ability to administer a workers' compensation system is dependent not only upon the financial resources that it is given, but also the quality of law that it is asked to enforce. A law that is well written and which establishes a system that is relatively simple to understand and implement is likely to have greater success than one that is highly complex.

1. The structure of the workers' compensation agency

A. The agency should be directed by a professional administrator, appointed for a fixed term that is long enough to minimize the influence of political pressures. The appointment should be made by either the governor or the governor's appointee to whom the administrator is to report, with customary legislative involvement.

B. The agency staff, including senior management, should consist of qualified persons selected through civil service procedures. They should be remunerated at levels consistent with the need to ensure that skilled personnel will work at the agency. Their work should be reviewed annually in a manner comparable to that in other state agencies, to promote high levels of professional competence.

C. There should be recognition that the workers' compensation agency has significant responsibilities beyond merely providing a forum for litigation. Its primary obligation is to administer the law and to see to it that appropriate benefits and services are provided promptly, thereby avoiding the opportunity and need for litigation.

D. Formal dispute resolution should be dealt with through professional hearing officers, appointed by the administrator for fixed terms. Appointment and reappointment should be on a non-political basis, with the involvement of employee and employer representatives. Hearing officers need not be attorneys but require access to a staff

attorney. They also require educational support, at the time of appointment and on a continuing basis.

E. There should be a level of administrative review of individual case decisions within the workers' compensation agency, to provide consistency among the decisions of the hearing officers. Review within the agency will also furnish interpretations of the law by a body with significant workers' compensation expertise, rather than solely by courts that may have little understanding of workers' compensation and less desire to deal with it. Members of the review body should be appointed by the governor or through a process following the procedures used to appoint appellate judges.

F. The agency and its staff should be accessible to worker and employers. Consequently, agency offices should be distributed across the state consistent with the location of employments. Adequate numbers of toll free telephone lines, serviced by knowledgeable agency staff, should be available from all locations in the state.

G. The agency should be structured in divisions that can provide appropriate services for each of the agency's functions, such as:

1. Oversight of the benefit delivery process.
2. Coordination of all activities related to the delivery of medical services, including review of quantity, quality and cost of services, approval of service providers, provision of advice and assistance to the parties, and assistance to the dispute resolution process.
3. Supervision of vocational rehabilitation services.
4. Informal dispute resolution facilities, such as an ombudsman and informal mediation.
5. Collection and assembly of data to be used for management information, program evaluation and research activity.
6. Development of linkages between occupational safety and health programs and the workers' compensation agency.

2. Funding of the agency

A. There must be recognition of the need for adequate funding of all of the agency's responsibilities. Failure to maintain adequate funding will result in the agency being unable to meet its obligations. This is likely to decrease the quality of benefit delivery to injured workers and increase the cost of the system to employers. A labor-management advisory committee can be employed to oversee the agency's budget and to act as an advocate when necessary.

B. Consideration should be given to revenue sources other than general revenues, to assist the agency in maintaining the required level of services during periods of state budgetary restrictions. Currently, 35 states fund their agency primarily from assessments on carriers and self insured employers (this includes six exclusive state fund states). Two states levy assessments only on insurance carriers while one state assesses only employers and another levies assessments on both employers and employees. Additionally, many state agencies utilize funds collected in fines, penalties and interest charges that are not paid as damages to a party for administrative funding purposes.

For those states that use a percentage assessment mechanism, the Panel supports an assessment base that relates to workers' compensation experience. That is, the assessment should be a percentage of workers' compensation benefits paid, or of premiums, or some other experience-related amount, rather than a percentage of payroll.

3. Education

A. A workers' compensation system will function most effectively if all parties understand their rights and responsibilities. A state workers' compensation agency should design and actively utilize programs to educate and inform all of the participants in the system.

B. When the agency is notified of a workplace injury or occupational disease, the injured worker or his/her family should be given information regarding program entitlements and limits in the clearest possible terms. At a minimum the agency should provide pamphlets that explain the law in simple terms (and in languages other than English where that is appropriate) and which direct people to a toll free telephone number through which more information and assistance can be obtained.

C. State agencies should use public service announcements on radio and television and any other means available in order to inform the public about workers' compensation programs. Where possible, it is desirable for these announcements to be sponsored jointly by labor and business groups.

D. The agency's educational program should include efforts to inform the parties about the importance of prompt reporting of injuries by workers to employers, by employers to their insurance carriers, by self insured employers and insurance carriers to the state agency, and by medical providers to other appropriate parties.

E. The agency should regularly provide educational programs for employee lay representatives, health care providers, attorneys, claims adjusters, their respective support staffs, and all others who must routinely deal with the workers' compensation agency. It should work in conjunction with state and local organizations and societies that could carry out agency-sponsored educational programs, which would allow broader dissemination without stretching the agency's own resources. A periodic newsletter may also be utilized to keep all parties informed as to the operation of the system.

4. Enforcement

A. The workers' compensation agency has the duty to actively enforce all of the requirements of the state workers' compensation law. It should not be a passive entity responding only when a complaint is made or the need for litigation arises.

B. The workers' compensation agency, in conjunction with state licensing and revenue departments, must enforce the provisions of the law which require that employers either obtain workers' compensation insurance coverage or secure the approval of the appropriate agency to self-insure its workers' compensation obligations. Where appropriate, the workers' compensation agency should refer illegal avoidance of the

insurance obligation to the state attorney's office, and be empowered to seek the immediate closure of illegally uninsured operations. Further, the workers' compensation agency should work with the insurance department to eliminate insurance fraud by employers that deliberately misrepresent their employee classifications and payroll when securing insurance. In addition, employers must not be permitted to evade their responsibilities through the misuse of independent contractor status or employee leasing arrangements.

C. The agency should monitor employer and carrier compliance with the law's reporting and benefit payment requirements, and compile and periodically publish data which show their compliance records. The agency should be authorized to establish penalties where appropriate, and must actively and routinely enforce those penalties. Repeated violations should result in a suspension of the right to self insure or to write workers' compensation insurance.

D. The agency must also take steps to ensure that workers use the system in the manner it was intended.

E. The agency should scrutinize closely all lump sum settlements, where permitted, and enforce any statutes and regulations pertaining to them.

F. The system is not well served if attorney fees are set so low as to eliminate the ability to retain competent counsel, nor should they be so high as to encourage unnecessary attorney involvement and reduce net benefits to workers. The agency should assure that fees are consistent with statutes and regulations, and adjudicate any disputes regarding fees.

G. The state agency should monitor the conduct of attorneys, medical providers, vocational rehabilitation providers, insurance agencies and brokers, third party administrators and others to ensure that they perform in accordance with the requirements of the law. The agency should have the authority to take appropriate steps when violations occur, including cooperation with other regulatory bodies.

H. The workers' compensation agency or other entity responsible for regulating self insurers should have either on staff or available by contract sufficient actuarial and financial expertise to ensure that only those employers who are financially secure are permitted to self insure, and that the bonds, excess insurance and other security arrangements required by law are in place and in the proper amounts. The state should also establish a guarantee fund to provide benefits in the event of default by a self insurer.

5. Dispute resolution

A. States are encouraged to implement reasonable structural changes which preempt disputes in the first instance. These include laws, rules and regulations that are comprehensive and relatively simple to understand and implement, and which provide all of the parties with a clear understanding of their rights and obligations. The use of the educational programs previously described, coupled with active enforcement of the law's requirements, will help prevent the mistakes and delays which account for much litigation.

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The existence of ombudsmen and other forms of assistance can also help prevent and resolve problems before they become real issues.

B. When a dispute arises, an informal dispute resolution procedure should be utilized as early as possible. The parties should be able to effectively participate in this procedure with or without being represented by attorneys, at their option. A specialized mediation facility may be provided. In the alternative, hearing officers should seek to mediate between parties but, where unsuccessful, be permitted to issue findings and orders, and otherwise adjudicate the dispute in a formal manner. Concerns have been expressed by some Committee members that the roles of mediator and adjudicator are mutually exclusive and that a judge cannot and should not do both. Mediation requires willingness by the parties to communicate more freely than they would in formal proceedings, and in their view, open discussions might lead to the entry of an order. This may inhibit or destroy opportunities for effective mediation. There is no disagreement that informal dispute resolution procedures should be used by the agency.

C. When the need for dispute resolution occurs, efforts should be made to identify the issues as soon as possible and to exchange information between the parties. There should be a formal procedure in place to ensure that this occurs.

D. If a dispute is not settled informally, the parties should be given the option of utilizing an alternative dispute resolution procedure, inside or outside of the agency. The decision of the arbitrator should be final and binding on the parties. Procedures for electing alternative dispute resolution should be established by the agency, for use on a case-by-case election basis, or through collective bargaining. Availability of arbitration will permit the parties to choose a somewhat less formal approach to dispute resolution when they deem it appropriate, and will provide them with an alternative when the state fails to provide a prompt and equitable means of dispute resolution.

E. Disputes must be resolved promptly. Each state should establish and monitor standards for the timing of dispute resolution, and publish the results. Steps should be taken in each jurisdiction to ensure that hearing officers and commission members work productively and efficiently and that they decide cases in an unbiased and consistent manner. Each state should initiate procedures to achieve these goals. These might include the appointment of a bipartite review committee, the publishing of data concerning productivity, and the establishment of standards by which judges would be examined at the end of their terms. A procedure similar to that used by judicial screening committees might be considered.

F. In disputed cases the parties are entitled to a full and fair hearing of the factual issues involved in the dispute, on the record. Some jurisdictions have allowed a retrial of factual issues at an administrative or judicial appellate level. Most of the Panel members believe that the system should be designed to limit the resolution of factual issues to the hearing officer, with review only of legal issues (including the question of whether the hearing officer's findings of fact were supported by the evidence) by the administrative review body and the courts. A variation of this approach is to permit the administrative review body to consider the factual decisions made below, but reverse them only when they are clearly extreme when compared to the findings made by other hearing officers in cases involving similar factual situations.

At least one member of the Panel believes that the review body should have the absolute right to make its own findings of fact, to prevent wide variations in the results of cases involving similar facts. Other Panel members are concerned that this approach encourages the losing party in every case to seek administrative review in order to get "another bite at the apple." There was no disagreement, however, that appeals from the review body level to the court system should be on matters of law only.

Written opinions should be provided at each level, to fully inform the parties as to why a particular decision was reached. Judges and hearing officers should be trained in decision writing to enhance their ability to promptly write clear, concise and well-reasoned opinions that do not take so long to write that they delay the dispute resolution process.

There is some support within the Panel for initial decisions that do little more than announce the result, since they are quick, and may be sufficient for many cases, particularly those that involve relatively simple issues such as extent of impairment. The other side of the argument is that decisions that do not provide reasoning are unfair to the parties, and encourage appeals. One solution is to permit the parties to request a short-form order in those cases in which they feel they are appropriate.

6. Disputes over medical issues

A. Many disputes in workers' compensation involve medical issues such as the extent of impairment and the need for specific types of medical treatment. Each state should identify and use medical experts from various fields to provide impartial analyses and opinions on disputed issues.

B. Where there are medical issues in dispute, the parties should be permitted and encouraged to select an Agreed Medical Expert (AME). The findings of the AME should control the resolution of those issues.

C. When the agency requests that an impartial expert be used and the parties cannot agree to one, the impartial expert should be selected from a pre-established list. The findings of the impartial expert should be given great presumptive weight. Some members of the Committee believe that each party should be free to utilize their own experts, and that no particular weight should be given to any testimony unless the factfinder determines that it is deserving of additional weight. This reflects in part differences of opinion as to whether workers' compensation should act as a structured benefit delivery system as opposed to a litigation-based delivery system similar to the civil trial courts.

D. The agency's medical staff or consultants may be used by the agency to assist it in deciding disputed medical issues. This must be done in conjunction with established procedures which ensure that the parties are aware of this involvement and are given due process of law.

E. The cost of the AME or the impartial expert should be borne by the insurer or by the agency. Payment by the agency helps avoid perceptions that the party paying for an opinion has influence over it, and is the preferred option.

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F. Standardized reporting by health care providers should be required. The agency may also develop regulations to ensure that established criteria are used in the resolution of issues which arise repeatedly. These issues include the value of various diagnostic procedures, determination of the compensability of conditions due to occupational exposure, the propriety of specific treatment modalities, etc. In the same manner it may provide for uniform assessment of impairment.

In establishing regulations of this nature the agency may in some instances be making policy decisions. These must be reflective of legislative intent, and not result in the extension of administrative authority to the determination of basic issues, such as those dealing with the types of conditions for which compensation will be paid. In others the agency will use the rule-making process to consider a wide range of high quality medical opinion to make medical judgments in the aggregate, rather than on a case-by-case basis. For example, it may decide that one theory of causation relating to a particular causation has greater validity than other competing theories, and require that theory to be used in all cases, rather than leaving the decision to individual judges in individual cases. Once again this raises questions as to whether workers' compensation is a structured delivery system or a litigation-based system.

Some Committee members expressed concern over exclusive reliance on the American Medical Association Guides to the Evaluation of Permanent Impairment in workers' compensation matters. The Guides are not intended to be used in making disability-based (as contrasted with impairment) evaluations. Further, these Guides do not evaluate every conceivable medical impairment.

The reason for using the AMA Guides or any other set of guidelines is to bring more uniformity to the rating of impairment or disability. With this goal in mind, states should review the AMA Guides as well as guides established by other professional organizations or by other states, to determine the extent to which any of them meet the state's intentions and needs. Appropriate adjustments can be made, and a uniform set of guidelines put in place. This is best done through the rule making process rather than by statute, to permit periodic review and improvement.

7. Data collection

A. It is impossible for any workers' compensation agency to meet its responsibilities without having access to relevant, accurate, consistent and timely data. Data are also necessary in order for the parties to the system to understand how the system is performing and what it costs.

B. Each state workers' compensation agency should work with organizations such as NAIC (its model legislation is attached), IAIBC and the Occupational Safety and Health Administration to classify and store its data in a manner consistent with the methods recognized by those entities. This will help reduce the burden on employers and carriers that must provide the data, by making reporting requirements similar if not identical across state lines. This approach will also permit more accurate comparisons among states. States should begin work immediately on these programs, but should confer with the parties to their system as well as other states and professional organizations to ensure that the programs are designed and implemented properly.

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C. Each state agency should share its data on a regular basis with these other organizations, so as to foster, in principle, the spirit of cooperation and to promote, in particular, accuracy, uniformity and completeness of data among the states.

D. Data programs should be periodically evaluated to ensure that they are reliable, of value to the law's administration and improvement, and operated in a cost-effective manner. Where valid independent data sources exist outside the workers' compensation agency, they should be used to supplement the agency's efforts and to evaluate their effectiveness and accuracy.

8. Advisory councils

A. Each state should have an advisory council or committee which provides continuing oversight and allows for input to the state agency and the legislature. The council would monitor the activities of the workers' compensation system, to determine whether it is meeting its goals. The council would also be utilized to consider revisions in the statutes or regulations. The voting members should be an equal number of representatives of labor and management. Other parties, such as insurers, medical providers, attorneys and others may be specifically included as non-voting members, or brought in when needed at the request of the council members.

B. An advisory council should have sufficient staff support to permit it to perform its assigned functions. This support can come from the workers' compensation agency, preferably with a specific budgetary allocation, or through the establishment of its own staff. The latter approach permits more independence, and if adequately funded, provides the council with the resources necessary to conduct its own investigations, independent of the influence and control of the entity that it is monitoring.

C. The existence of an advisory council does not necessarily guarantee success in amending or improving a state's workers' compensation system. If individuals who understand the system and can speak for their respective interest groups are actively involved in monitoring the system, rational improvements are more likely.

D. The continuing presence of such an advisory group does not preclude the utilization of other advisory groups by the legislature or the agency. Such bodies can be used, as needed, to study specific issues or make recommendations in technical or specialized areas. There is also a very significant need for a monitoring program directed specifically at legislative and administrative changes. It is important for any state that seeks to modify any aspect of its workers' compensation program that it identify the changes in results or behavior that it expects to occur, and monitor the operation of the compensation system to permit it quickly to learn whether or not the actual results meet the intent. This information will permit policy makers to fine tune their efforts and correct problems before they have a major impact on the system.

INSURANCE ECONOMICS

National Conference of State Legislatures
Blue Ribbon Panel on Workers' Compensation

In every state, employers who are subject to the workers' compensation law or who elect to come under its provisions are required to secure the payment of workers' compensation benefits through one of several alternatives. In almost every state, larger employers are permitted to self-insure their obligations. In over half, employers may join together to form group self-insurance programs, which in many respects operate in a manner similar to a mutual or reciprocal insurance company. In 44 states, commercial companies provide a market for workers' compensation coverage, and in 14 of those there is also some form of state-sponsored competitive insurance program. In the remaining six states, insurance coverage is provided by a state fund, although in most of these self-insurance is offered as an option. This paper deals with a number of issues arising from the use of the insurance mechanism, and excludes self-insurance from consideration. Many of these issues apply to group self-insurance and exclusive state funds, as well as commercial insurance carriers and competitive state funds.

The insurance mechanism is an integral part of every workers' compensation system. Through commercial insurance companies and state funds, it plays a number of vital roles. These include:

- Spreading of risk
- Allocation of cost among employers in different industries and with different job classifications
- Professional management of health care and disability benefits
- Loss control (safety) and loss mitigation (rehabilitation)

In recent years rate setting, which involves the first two roles, has attracted considerable attention. Most states are annually faced with the task of determining whether insurance rates (including those charged by state funds) are appropriate in terms of their relationship with benefit costs. Premiums that do not provide enough underwriting and investment income to pay for the benefits that the system provides must eventually lead to the collapse of the insurance mechanism.

It is important to distinguish between "rates" and "costs." The costs of the system are the benefits costs that are incurred as the result of providing the medical, indemnity and other benefits that injured workers are entitled to. These benefit costs provide the basis for determining insurance rates. Costs will be high or low, relatively speaking, as a result of factors such as accident rates, injury severity, benefit levels, system utilization and administration. When insurance rates accurately reflect underlying costs, providing enough revenue to pay the benefits and permit an acceptable level of profit, they may be perceived as "high" or "low" by those paying them, but they are appropriate from the standpoint of system costs. However, it is also possible for rates to be "too low," when they raise insufficient revenues to pay the benefits provided by the system, or "too high," when they generate excess profits or permit inefficient insurance operations.

Rates are "excessive" because they allow insurers unreasonably high profits relative to system costs, but they are simply "high" when they reflect underlying system costs that are high, even though these rates may actually be insufficient to cover system costs. The former is a matter of "high rates," whereas the latter is a matter of "high costs." No matter what the system costs, insurance rates should adequately reflect them. This is the goal of the regulatory process. Of course, when costs are high, more public attention to ratemaking is to be expected, and there must be public confidence that this regulatory responsibility has been fulfilled properly.

Insurance regulators have the duty to assure that rates are not excessive, but that they fully reflect underlying system costs. Rate determinations cannot be predicated on erroneous assumptions or wishful thinking about future system costs. Rate decisions based on the hope that costs will somehow be lower because of system changes that have not been fully implemented and which may not be implemented as expected, or which have been given a value far in excess of their true worth, can create rate inadequacies that will sooner or later place the system in crisis.

When costs increase rapidly or are perceived as too high, businesses may have a competitive disadvantage. Workers will also be adversely affected, because of the economic impact on wages and job availability. Consequently, high costs will trigger a public debate about whether adjustments are needed to restore or reset the balance.

Unfortunately, in its present form the workers' compensation rate setting process is an arcane one, fully understood by only a tiny number of specialists. As a result, excessive resistance to carrier rate requests can be rationalized more easily by those who seek political gain in appearing to protect consumer interests. Conversely, though desirable it is difficult for even the most well-intentioned policy maker to fully appreciate how the system works and whether the rates being charged are appropriate.

Rate making is further complicated by the nature of the workers' compensation system itself. If rates are to accurately reflect the cost of the claims that will be incurred during a given year, they must predict with reasonable accuracy the frequency and severity of those claims, and determine the ultimate costs that will be incurred over the many years that it will take before the claims are fully paid. It is obvious that there are many factors that might change the cost of workers' compensation claims, often in ways that are difficult to forecast. Changes in the law or practice brought about by the legislature, the courts or the administrative agency can affect the number and types of conditions that are to be compensated, as well as the benefits that are to be paid in individual cases. The cost of medical services has tended to rise faster than forecasts in recent years. Changing economic conditions are likely to affect system utilization and thereby costs. Interest rates will also change. They have a significant effect on rates, since they are a consideration in determining the present day dollars which, together with investment return, will be required to provide the benefits that will be paid over the 15 to 20 years, and often more, that will pass before all the benefit costs incurred during a policy year are fully paid.

Despite or perhaps as a result of this uncertainty, there is considerable pressure to moderate rates, for both political and economic reasons. Rate judgments may be based

more upon what regulatory hope will happen than upon more likely but also more pessimistic possibilities. As a consequence, rate setting is far from an objective process, but rather one in which subjective evaluations and political and economic pressures have significant influence.

The clear trend in the United States has been the expansion of workers' compensation costs. Benefit levels and utilization have increased, the scope of coverage is broader than in the past, and increases in workers' compensation medical costs have outpaced those in the general health care system. These changes have brought with them significant pressures on the pricing system, as well as pressures to reduce benefit levels and utilization.

Rapid cost increases in recent years have placed employers and the insurance industry under considerable stress. In some states the traditional alliance between insurers and employers has been weakened by insurer requests for higher rates. Employers, responding to pressures emanating from an economic slowdown and heightened interstate and international competition, have organized directly or through trade organizations to resist these rate hikes. Unable to achieve rates that are adequate, insurers have watched their surplus being reduced, placing some carriers in precarious positions and forcing others to withdraw from the market or go out of business. One commentator estimates that insurers lost $7.3 billion in 1987-89 due to rate suppression. (Orin S. Kramer, *Rate Suppression and Its Consequences: Private Passenger Auto and Workers' Compensation Experience*, Insurance Information Institute Press, 1991.) In each year from 1987 to 1990, the combined ratio, the ratio of expenses plus losses to premiums, for private insurance carriers was 118 percent. In 1991, it rose to 123 percent.

When an insurance regulator fails to respond adequately to an economically justified rate request, several things will happen. Just as no other business is prepared to sell its product at a loss for a sustained period, there is little reason to believe that insurers are any different. They will eventually cut back on their writing, or rely more heavily on retrospectively rated or deductible policies that place a greater portion of the risk on the insured. Large scale cutbacks in voluntary writing are now commonplace. The question "If they are really losing money why don't they just stop writing?" is now being answered by carriers doing just that.

One manifestation of rate inadequacy is the enormous growth of the residual market in some states. In pools administered by the National Council on Compensation Insurance, the proportion of direct premiums written in them nationally increased from 6.2 percent in 1983 to 25.0 percent in 1991, with some states at much higher levels. These markets were originally intended to provide coverage for a small number of employers, who, because of the nature of their business or loss history, found it impossible to obtain insurance coverage in the voluntary market. In recent years, in some states the residual market (assigned risk pool) has become the leading provider of workers' compensation insurance, as the result of insurers declining to provide voluntary coverage for large numbers of employers with relatively good loss experience and nonhazardous operations, because they view these accounts as inherently unprofitable due to inadequate rates, or too risky because of the volatile nature of the compensation system.

Residual markets are very unpopular with many employers, who seek unsuccessfully to avoid them. Rates there are often higher, and the quality of safety and claims services is potentially inferior to that in the voluntary market. Some employers like these pools, where they are beneficiaries of subsidized rates. Incentives for both insurer and insured to prevent accidents and reduce costs are also affected, because there may be lesser or no financial payoffs to doing this in these markets. An insurance carrier servicing assigned risk pool accounts is not directly affected by their performance, other than through the assessments that all carriers writing voluntary business are subject to in order to make up any pool deficits. For many employers in the pool, insurance premiums are unaffected by their current experience, although some pools are moving toward a rate structure that puts most of their accounts in premium plans that reflect current experience.

Increased utilization of the residual market mechanism may not provide relief for insurance carriers as a group, even if individual carriers can shift some of their own burdens. Assigned risk pools typically operate at a deficit. In 1991, operating losses in the residual market were estimated to be $2.7 billion. Someone must pay for this. It is done through assessments on insurance carriers based upon their voluntary writings. The carriers then attempt to pass on at least a portion of these assessments to their policyholders. This can induce some employers to opt for self-insurance or group self-insurance programs, which do not have to pay these assessments. In any case, some firms are forced to subsidize others. In addition, it may not be possible to fully pass on the cost of assessments. As a result, insurance company profits are reduced or losses increased. Money to pay assessments may even have to come from insurance company revenues generated through their operations in other states and from other lines, thereby creating a subsidy from one or more states to another state. In any case, there is no sound reason why insurers, or any others, are called upon to subsidize those firms assigned to pools. The Blue Ribbon Panel recognizes that a need exists to provide insurance to all employers in the state. Assigned risk pools are one of several possible vehicles that can be used to make insurance available. Providing a mechanism, however, is not a justification to subsidize certain employers at the expense of other businesses or taxpayers.

Another consequence of inadequate rates is that insurers respond by reducing their administrative costs. In some instances this means cutting back on services, an evident consequence of the closing of local offices, and elimination of field and home office staff. Though such cuts may be effective in reducing short-term administrative costs, they may also result in increased claims costs over time, when there are insufficient personnel and other resources available to provide required services. A somewhat related consequence is the destruction of the consensual relationship between insurance carrier and insured. When the relationship is forced, by virtue of the employer becoming an assigned risk, the likelihood of cooperation between the two may be greatly reduced, and with it the opportunity for optimum safety and workers' compensation experience.

Ultimately, some insurance carriers may be forced out of business if rates are not sufficient to support benefits. (It is of course also possible for an insurer to contribute to its own demise, through poor operations, bad investments and the like.) Texas Employers Insurance Association (TEIA) is often cited as a good example of bad results. TEIA was a one-line, one-state insurance company that provided workers' compensation coverage in Texas. This meant that it had no opportunity to subsidize its Texas workers' compensation

operations with revenues from other states and other lines of insurance. Its rates were mandated by the State Board of Insurance, with no deviations permitted. From 1983 to 1989, TEIA went through $1.3 billion in premium income and $111 million in surplus, and became insolvent. This occurred during a period of rapidly escalating benefit costs, rapidly increasing insurance rates, insurer claims of inadequate rates, assertions by trial lawyers and others that rate increases were being driven by insurance company profiteering, an expanding assigned risk pool, and a very substantial assigned risk pool deficit leading to significant assessments.

When workers' compensation insurance carriers fail, workers' benefits are likely to be assured through the existence of guarantee funds. However, since the money for these funds comes from assessments on other insurance carriers, any financial burden brought about by a failing carrier will be placed on other carriers, some of whom may themselves be on a weak financial footing. Even if guarantee assessments do not threaten the stability of other carriers, they do create another form of subsidy, with the remaining carriers and their insureds being forced to assume the responsibilities of the failed carrier and its insureds.

Throughout the debates and disputes that focus on rates and the rate-setting process, the methods and motives of the organizations that present insurance industry data and proposals to individual state insurance rate regulators have been the focus of scrutiny and attack. These entities (the National Council on Compensation Insurance in 32 states and independent rating bureaus in the other 12 states that do not have exclusive state funds) are established and run by the insurance industry. This fact, coupled with the complexity of the ratemaking process itself, at times makes their recommendations and objectivity the focus of controversy, and may place roadblocks in the way of even the most justified rate increases.

It is of course possible to establish rating bureaus that are operated by someone other than the insurance industry, such as the state, or to establish parallel facilities. However, no matter who runs the bureau, the underlying data needed to establish rates must come from the insurance carriers. Since it is always possible for the ratemaking authority or other interested parties to review methodology, this puts a premium on ensuring the integrity of the data that are collected.

During 1990-91, the National Association of Insurance Commissioners conducted an audit of NCCI data collection, data quality and rate making procedures. Its results were released in December of 1991. In its executive summary, the report stated the following:

> Broadly speaking, for the elements studied, our conclusion is that the NCCI ratemaking system is not as good as it could be, but that it is a sophisticated system that can ordinarily be expected to produce reasonably accurate results. Many of our recommendations relate to aspects of the current NCCI ratemaking system that we believe are basically reasonable but which can be improved. Only a small number of aspects of the current system were found to generally result in underestimation or in overestimation of the overall rate level.

The Blue Ribbon Panel is not in a position to comment on the scope, quality and reliability of this study, or to interpret and evaluate their findings and conclusions. States working either individually or in concert should act to evaluate this material and reach their own conclusions.

There are several points the Panel can comment on. One involves the need to eliminate the negotiations and political influences that permeate the rate making process in some states. Workers' compensation is not free, someone must pay for it. Avoiding the reality of the system's costs through denial of justified rate increases, whether for a competitive insurance market or an exclusive state fund, can do little more than distort the system and provide short-term relief. At some point what comes out of the system has to be put into it.

If regulatory authorities or the legislature have reason to believe that requested rate increases are not justified, they have an obligation to the public to accurately determine the true state of affairs. If the political belief is that the insurance industry or a state fund is willing or even able to provide workers' compensation coverage at a loss, the fact is that it is becoming less likely that they will or that they can. No state can expect to operate its workers' compensation system without paying for it.

The Blue Ribbon Panel discussed the advisability of eliminating administered pricing for workers' compensation insurance. It can be noted that no states allowed competitive rating before 1980, and that since 1982 16 states have adopted one form or another of this practice. In the limited time available to the Panel, no consensus emerged on this issue. Still, very substantial support was given to the general principle that market forces be allowed to operate as fully as possible in all areas of workers' compensation insurance. This implies eliminating subsidies and cross-subsidies, and encouraging competition among the participants.

Increased competition will not necessarily bring with it immediate lower rates in some states. Policy makers who are considering moving in this direction can look at recent rate filings, the level of assigned risk activity and the size of the assigned risk pool deficit to get some idea of whether competitive rating is likely to bring higher or lower rates, at least in the short term.

Some employers, particularly those concerned with an immediate problem of business survival, may believe that the lowest absolute rate is the best one. Others, using a longer term perspective, recognize the desirability of maintaining a healthy insurer environment and take a more sophisticated view. For many of these employers, however, rate adequacy does not mean that insurance carriers be automatically granted any increases requested by their rating bureaus. Instead, they believe that insurers carry a significant responsibility to pursue practices that will limit cost increases.

Discussion of each of these positions could generate an entire series of papers. The most important point they demonstrate is that there is no single position which, if responded to, will result in employer acceptance of a particular rate-setting mechanism or philosophy. Once again, there is no simple answer to the concerns of the employer community.

Although needed benefit improvements and inflation have contributed, the major sources of cost increases are the result of state government, i.e., the governor, legislators, courts and/or the workers' compensation agency. However, the insurance mechanism is more than a passive mechanism that turns premium dollars into benefits. On the contrary, workers' compensation insurance companies and state funds are in many respects the delivery mechanism. Their actions in providing safety services affect the incidence of occupational injuries and disease. The manner in which they investigate claims, provide medical treatment and pay benefits affects the quality of the benefits that injured workers receive, and the cost of those benefits.

Business persons with a long-term view argue that in an environment of explosive cost increases, all the major participants should be under pressure to keep costs in check. That, in their view, will make insurers a part of the solution to the workers' compensation system. While insurance carriers do not control all aspects of the system, they do play a substantial role. If they do not fulfill their obligations properly, they cannot expect to be rewarded. When they do, they are entitled to the premium rates that are required to deliver the benefits and sustain the insurance mechanism.

The Blue Ribbon Panel believes that a sound workers' compensation system must depend upon a healthy and effective insurance sector, be it publicly or privately provided. Unwarranted rate suppression even for a few years will result in a deterioration in the quality of claims management and loss control services, enlarged amounts of destructive cross-subsidies, growing residual markets, insurer flight from states or product lines and, eventually, insurer bankruptcies and resort to guaranty funds. Insurers must bear some responsibility for keeping costs from growing as rapidly as they have. State government, however, is in the best position to deal with cost increases that society deems to be unacceptable. For specific suggestions as to how that can be accomplished, please note the accompanying reports on administration, medical care and cost containment, permanent partial disability benefits, and occupational safety and health.

TOWARD A WORKPLACE SAFETY AND HEALTH PUBLIC POLICY

National Conference of State Legislatures
Blue Ribbon Panel on Workers' Compensation

Preventing accidents and illness in the workplace is a key element in seeking to reduce human suffering and to achieve lower workers' compensation insurance costs. Injury and illness rates and the number of work-related fatalities can be lowered in jurisdictions that implement reasonable but aggressive safety and health programs. Many individual businesses have been able to lower their workers' compensation premiums by putting effective safety and health programs in place. Legislators and regulators recognize that a public policy which improves workplace safety and health can spread these gains across a broader spectrum of business and commerce.

The primary responsibility for workplace safety and health rests upon employers. Employees should observe established safety and health standards and practices, including the use of provided safety devices and appliances. Joint efforts by employers and employees can enhance workplace safety and health. In addition, there are a variety of federal, state and local government programs and legislation aimed at improving workplace safety and health. These range from the federal Occupational Safety and Health Act (which requires employers to "furnish to each of his employees employment...free from recognized hazards that are causing or are likely to cause death or serious physical harm") to state OSHA plans, from federal and state labor standards to local building and fire codes, from hazardous materials handling laws to state and local ordinances dealing with a wide variety of issues.

The workers' compensation insurance system provides employers with a financial incentive to invest in workplace safety and health. To the extent that workers' compensation premiums reflect the likelihood of workplace injury and illness, employers with good safety programs pay less than similar employers with poor safety programs. Financial incentives arising through the insurance mechanism affect employers differently. Where premiums are large, relative to the cost of safety programs, and where losses directly affect the employers' premiums, workers' compensation insurance provides a strong safety incentive. As these impacts diminish, safety incentives also diminish.

Various states have attempted to use workers' compensation statutes or other laws to encourage a "pro-active" stance to prevent job injury, illness and death. These programs vary in concept, approach and funding but have as their goal the prevention of injury and pain and the reduction of the economic costs of workers' compensation through safer and healthier workplaces. Such efforts include mandatory safety and health committees, safety plans or programs, specific loss prevention undertakings, deductible plans, education programs and research.

The absence of a universally accepted model program for states interested in improving workplace safety and health emphasizes the need for consideration and analysis of public policy options. The limits to occupational safety and health public policy are not insurmountable obstacles. Rather, they are factors to bear in mind when setting realistic

goals and considering alternatives. Developing effective public policy to improve workplace safety and health will require a considerable amount of analysis and experimentation. We recommend that legislators and regulators focus their attention in the following areas:

- Legislators need to recognize that attempts to address workers' compensation costs are incomplete if the prevention of injuries and illnesses in the workplace is not considered. Workplace injuries and illnesses are the basic factors giving rise to workers' compensation costs. Focusing cost reduction efforts exclusively on how workers are compensated once they are injured overlooks significant opportunities to control costs and, just as importantly, ignores the social responsibility of the workers' compensation system to promote a safe and healthful workplace.

- Improve data collection to identify and describe occupational injury and illness within states and to target prevention efforts.

  There are several reasons for gathering data. Two are directly relevant to safety and health, and two can improve services provided to employers and workers:

  - Data can be used to prevent future injuries and occupational disease. For this purpose, information should be gathered concerning the incidence, cause and nature of injuries, illnesses and fatalities.

  - Information is also gathered by state regulatory agencies and insurers for rate making and to experience-rate employers. This requires information about the losses in each job classification, as well as information about the experience of individual employers.

  - Data can be used to administer a state workers' compensation system and resolve disputes that arise. This requires gathering data about what payments have been made, when, and by whom, as well as other information about the performance of the state system.

  - Data can be used to analyze the performance of a state workers' compensation system and make comparisons between systems in different states. This requires comparable information about where the money is going, what the problems are, and what the likely result is of proposed changes.

The Occupational Safety and Health Administration, the Bureau of Labor Statistics, the National Council on Compensation Insurance, the National Association of Insurance Commissioners, and the International Association of Industrial Accident Boards and Commissions are developing models for collecting workers' compensation data which can be used in establishing priorities and evaluating occupational safety and health public policy.

States should work with these organizations to develop a uniform data collection system which can be used for safety and health purposes and to avoid duplicative efforts and lessen the reporting burden of employers.

- Improve the means of identifying high-hazard employers and develop targeted programs to mitigate injury and illness.

  Several states identify employers whose workers' compensation losses are significantly above those of similar groups of employers. States may require these employers, once identified, to have a safety consultant survey their operations, provide safety training to their employees, undergo a safety inspection, or implement a safety program. States should continue to consider equitable and effective methods for selecting high-hazard employers and examine the most effective approaches to protecting employees in these worksites.

- States should explore all available means to encourage safer and healthier workplaces.

  Commitment to improving workplace safety and health is a first and basic step in implementing a safety program. Committed employers and employees know the worksite better than anyone else. They are the most effective way to improve workplace safety. Legislation and regulation can provide penalties for unsafe conditions, require or encourage special insurance premium reductions for policyholders implementing safety programs, and lower safety costs by providing government safety services. Government can also play a role in raising awareness and understanding of the value of investing in occupational safety and health. Education, research, information, publications, public service promotions, and special events all serve to raise the level of action and concern about workplace safety. State governments should continue to explore ways to help employers and employees become more committed to working in a safe and healthful manner. Existing programs need to be carefully evaluated to see if they make sense and are accomplishing their objectives. Particular attention should be given to developing awareness and commitment for groups, such as small employers, who do not have access to the same range of safety and health tools as other employers.

- States should encourage technical engineering, loss control, and environmental health support for employers.

  State programs which provide consultation services to employers make a significant contribution. As well, states with particular concentrations of industry can benefit safety and health by supporting research to enhance the understanding of specific industrial hazards or the best ways to prevent injury and illness from these hazards.

- States should coordinate the safety and health activities of both private and public parties to maximize the use of safety and health resources, to minimize duplication, and to address new problems.

Under the auspices of state government, groups of employers, various federal, state and local government agencies, labor, academics, insurers, and safety and health professionals can be organized to establish priorities and monitor the effectiveness of safety and health public policy.