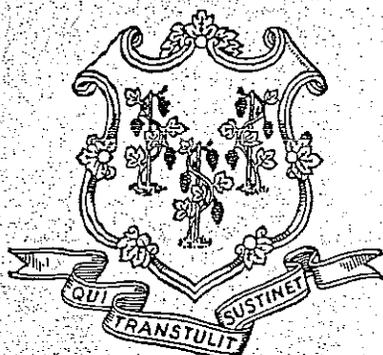


**WORKERS'
COMPENSATION**

**Connecticut
General Assembly**



LEGISLATIVE
PROGRAM REVIEW
AND
INVESTIGATIONS
COMMITTEE

JANUARY 1991

CONNECTICUT GENERAL ASSEMBLY

LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" performance reviews. The committee was given authority to raise and report bills in 1985.

The program review committee is composed of 12 members. The president pro tempore of the senate, the senate minority leader, the speaker of the house, and the house minority leader each appoint three of those members.

1989-1990

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**WORKERS' COMPENSATION
IN CONNECTICUT**

**LEGISLATIVE PROGRAM REVIEW AND
INVESTIGATIONS COMMITTEE
JANUARY 1991**

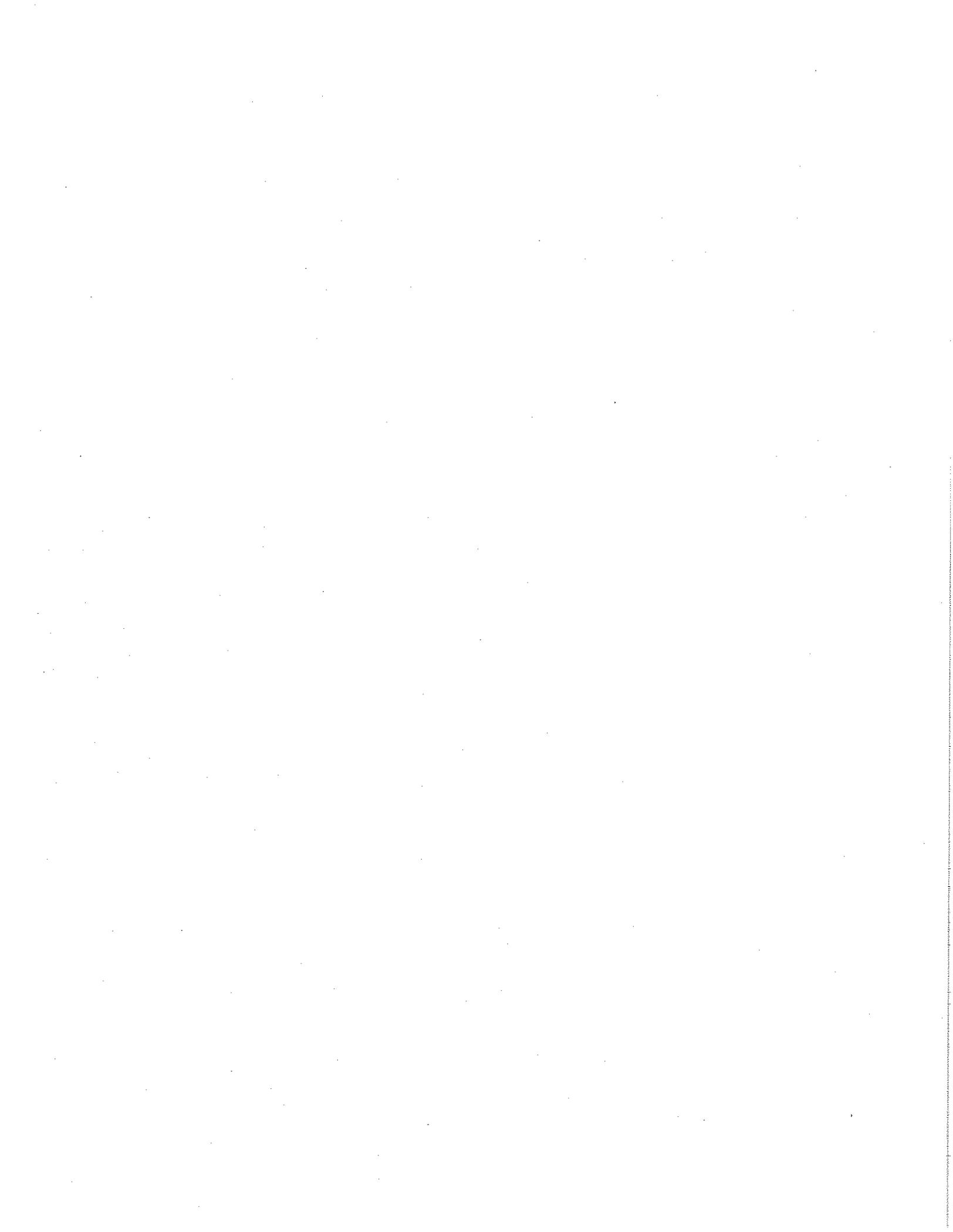


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SUMMARY

WORKERS' COMPENSATION IN CONNECTICUT

Under Connecticut's workers' compensation law, persons disabled by an occupational injury or disease are provided medical and wage replacement benefits through a no-fault system overseen by the state's Workers' Compensation Commission. Benefit costs, which are paid by employers or insurers on their behalf, totalled more than half a billion dollars in 1989. In February 1990, the Legislative Program Review and Investigations Committee initiated a comprehensive study of nearly all aspects of the system from administration to benefit costs.

The committee's review revealed a number of serious problems in the organization, operations, and benefit structure of the Connecticut workers' compensation system. Overall, it was found that the system's current administrative structure is not responsive to the concerns of either employers, who pay for benefits, or employees, who receive benefits. Management is weak and accountability is lacking. District offices vary significantly in terms of outcomes and efficiency, and their operating policies and procedures are not uniform. Administrative resources for central and district office operations are inadequate, particularly given the dramatic growth in workload, and backlogs and delays in case processing are widespread.

The committee also found that benefit costs are rapidly escalating, with little response from the system to contain them. Furthermore, the methods of calculating compensation rates create inequities in the distribution of wage replacement compensation, as well as in benefit levels for permanent partial disabilities and disfigurements.

In response to these findings, the program review committee developed a series of recommendations intended to achieve the following goals: stronger management and improved accountability; more efficient processing of disputed claims; a more equitable benefit structure; and better control over rising benefit costs. A complete listing of the workers' compensation system recommendations adopted by the committee, organized by topic, follows.

RECOMMENDATIONS

1. BOARD OF DIRECTORS

A) Establishment. There shall be a Workers' Compensation Board of Directors whose purpose shall be to develop policy and oversee the operation of the workers' compensation system. The board shall consist of eight

members, four representing employees and four representing employers. The board shall elect its own chairperson and vice chairperson. Board members shall receive no compensation but shall be reimbursed for necessary expenses.

B) Terms. The initial employee and employer appointments shall be for one-, two-, three-, or four-year terms and shall be nominated by the governor and confirmed by both houses of the General Assembly on or before March 15, 1992. All appointments to full terms subsequent to the initial appointments shall be for four years. Vacancies shall be filled for the expiration of the term of the member being replaced in the same manner as original appointments.

C) Powers and duties. The Workers' Compensation Board shall meet at least monthly. The board may meet at such other times as the chairperson and vice chairperson deem necessary. Any action taken by the board shall require affirmative vote of at least five members to take effect.

The Board shall have the power to:

- * adopt such rules as it deems necessary for the conduct of its internal affairs;
- * adopt regulations in accordance with Chapter 54 to carry out its responsibilities under this chapter;
- * adopt an annual budget and plan of operation;
- * prepare and submit an annual report to the governor and the legislature;
- * allocate resources within the system as it sees fit;
- * establish an organizational structure and such divisions as deemed necessary for efficient and prompt operation of the workers' compensation system;
- * establish policy in all areas of the workers' compensation system, including rehabilitation, education,

statistical support, and administrative appeals;

- * appoint such advisory panels as it deems necessary and helpful;
- * establish standards for the approval and removal of physicians, surgeons, podiatrists, and dentists from a list of persons who may examine and treat employees under provisions of this chapter;
- * establish standards for approving all fees for services rendered under this chapter by attorneys, physicians, surgeons, podiatrists, dentists, and other persons;
- * approve applications for employer-sponsored medical care plans, based on standards recommended by a medical advisory panel; and
- * establish procedures to hire, dismiss or otherwise discipline, and promote employees within the workers' compensation system, subject, where appropriate, to provisions of the state's civil service system.

2. CHIEF ADMINISTRATIVE OFFICER

A) Appointment. The board shall on or before July 1, 1992, and every four years thereafter, appoint a full-time Chief Administrative Officer. The Chief Administrative Officer may be removed by the board for cause. Any vacancy in the position shall be filled for the balance of the vacated term. The Chief Administrative Officer shall be exempt from classified service and receive such compensation as determined by the board.

B) Powers and duties. The Chief Administrative Officer shall be the administrative head of the workers' compensation system, and shall be responsible for the efficient operation of the system and prompt disposition of workers compensation cases. The Chief Administrative Officer shall be responsible for:

- * directing and supervising all administrative affairs of the workers' compensation system in accordance with the directives of the board;
- * attending all board meetings, keeping a record of all board proceedings, and acting as custodian of all board documents, minutes, etc.,
- * preparing the budget and annual operating plan for the board's approval;
- * reporting monthly to the board on operations in the workers' compensation system;
- * assigning and reassigning staff, including workers' compensation law judges, to each of the district offices;
- * controlling the hearing calendars of the workers' compensation law judges in order to facilitate timely and efficient processing of cases;
- * collecting and analyzing statistical data concerning the administration of the workers' compensation system;
- * directing and supervising implementation of a uniform case filing and processing system in each of the district offices;
- * entering into contracts with consultants and such other persons as are necessary for the proper functioning of workers' compensation system; and
- * establishing staff development, training and education programs designed to improve the quality of service provided in the workers' compensation system.

3. COMPENSATION COMMISSIONERS

A) Title. Beginning July 1, 1992, the position of workers' compensation commissioner shall be titled workers' compensation law judge. Workers' compensation law judges shall be qualified members of the Connecticut bar, who shall be full-time, not otherwise employed, and sworn to the faithful performance of their duties.

B) Appointment. Beginning July 1, 1992, the Board of Directors shall on or before the date of expiration of the term of a workers' compensation commissioner or upon the occurrence of a vacancy appoint a person to fill the position. The term of appointment shall be for five years or the unexpired portion of a vacant term. An appointee may be removed or suspended for cause by the board.

The board may appoint acting workers' compensation law judges on a per-diem basis from among former workers' compensation law judges or qualified members of the Connecticut bar.

C) Jurisdiction. The existing requirement that an appointee reside within the jurisdiction for which he or she is appointed shall be repealed and all appointees shall be granted statewide jurisdiction.

Workers' compensation law judges shall be relieved of their administrative responsibilities related to the operation of a district office.

D) Chief Compensation Law Judge. The board shall designate one workers' compensation law judge to serve as chief of the Compensation Review Division with complete responsibility for the day-to-day operation of the division. The chief of the Compensation Review Division may, as the board permits, be assigned to other duties by the chief administrative officer.

4. FUNDING

A) The Board of Directors shall approve and submit a budget for the operation of the entire workers' compensation system including the central office, district offices, and the divisions of workers' education and rehabilitation to the appropriate budget agencies.

B) There shall be one comprehensive assessment on employers for funding the operation of the entire workers' compensation system. The assessment shall not

in any state fiscal year, exceed 5 percent of the amount expended by employers or private insurers on behalf of employers in payment of workers' compensation liability for the prior year. The assessment shall be levied in accordance with the provisions of C.G.S. Section 31-345, as amended by Public Act 90-311. The separate assessments on employers to finance the Division of Worker Education and the Division of Workers' Rehabilitation specified in sections 31-283h and 31-283b, respectively, shall be repealed.

5) DIVISION OF WORKER EDUCATION

Funding for the occupational health clinics to conduct activities outlined in P.A. 90-226 shall be allocated from the Workers' Compensation Commission budget at the level specified in the act, until June 30, 1992.

6) DISTRICT OFFICES

A) A district manager position shall be established to serve as the administrative head of each district office. The district manager should be a professional position. District managers should report to the chief administrator and be responsible for all office administrative functions related to budget development, purchases, personnel and payroll, equipment, office procedures, and staff supervision. In addition, district managers should oversee the management and processing of cases in each office.

B) Appropriate support staff levels for each district office shall be determined by the chief administrator in accordance with workload and performance standards. Furthermore, the chief administrator shall develop job descriptions, and if necessary, new classifications, to insure that staff resources are appropriately matched with the tasks to be performed.

7) CASE PROCESSING

A) A standard form for requesting hearings should be developed and standard policies regarding limits on the numbers of informal hearings that will be allowed and the number of hearing postponements that will be accepted before a formal hearing is held to resolve a case should be adopted;

B) A central system for monitoring case processing should be established and provide, at a minimum, data on the number of cases with multiple hearings, the numbers of hearings postponed, and hearing schedules, on an office-by-office basis;

C) Guidelines for expediting disputed cases should be developed and district office staff should be trained in techniques for screening hearing requests;

D) Medical providers who fail to submit required reports in a timely manner be subject to removal from the approved workers' compensation provider list; and

E) By statute, interest at the rate provided for in C.G.S. Section 37-3, currently 10 percent per annum, should be applied automatically to the unpaid amount of benefits due a claimant beginning on the date the employer contested liability or discontinued or reduced payment.

8) ATTORNEY FEES

A policy requiring commissioners to approve all attorney fees charged to claimants should be established.

9) WAGE REPLACEMENT

Beginning October 1, 1991, the weekly rate of compensation paid to the employee for total incapacity to work shall be equal to 80 percent of his or her earnings after deducting for federal income tax and FICA (Social Security) taxes. This rate would apply to all workers whose current compensation rate is established at 66 2/3 percent of gross pay.

10) DEPENDENCY ALLOWANCE

The dependency allowance, as contained in Section 31-308b of the Connecticut General Statutes, shall be repealed.

11) COST-OF-LIVING ADJUSTMENT

The annual cost-of-living adjustment for workers' compensation benefits shall be an individual's current weekly rate multiplied by the rate of change in the average weekly earnings of production workers in manufac-

turing in Connecticut, as determined by the labor commissioner.

12) PERMANENT PARTIAL DISABILITY

Section 31-308 shall be amended as follows:

the weekly compensation rate for a partial incapacity that is determined to warrant 13 weeks or less of compensation shall be fixed at 25 percent of the average weekly wage of production and related workers in manufacturing;

the weekly compensation rate for a partial incapacity that is determined to warrant more than 13 weeks, but not more than 104 weeks of compensation, shall be fixed at 50 percent of the average weekly wage of production and related workers in manufacturing; and

the weekly compensation rate for a partial incapacity that is determined to warrant more than 104 weeks of compensation shall be fixed at 100 percent of the average weekly wage of production and related workers in manufacturing.

13) DISFIGUREMENT AWARDS

Compensation for disfigurement shall be limited to permanent and significant scarring or disfigurement that occurs on the head or face. It is further recommended that the compensation rate be set at 100 percent of the state average production worker wage for all recipients of disfigurement awards.

14) MEDICAL COSTS

Beginning July 1, 1992, allow employers, or insurers on their behalf, to submit a plan for its workers' compensation medical care to the Workers' Compensation Board of Directors for its approval. The plan must be submitted 120 days before the employer intends to have the plan become effective, and must be resubmitted and receive board approval every two years from its initial effective date. The information required in the submitted plan shall be determined by the board, but shall include: 1) a list of the names of all individuals who will provide services, and appropriate evidence of compliance with any licensing or certification requirements for that individual to practice in

Connecticut; 2) a description of the times, places, and manner of providing services; and 3) a description of how the quality and quantity of medical care will be managed.

The approval of such plans shall be based on standards set by the board, with advice from a medical panel established by the board. Standards shall include, but not be limited to: 1) provision of all medical and health care services that may be required under workers' compensation in a manner that is timely, effective, and convenient for the worker; 2) inclusion of all categories of medical service, with an adequate number of providers for each type of medical service in accessible locations, to ensure that workers are given adequate choice; 3) provision of appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service; 4) some method of fee screening, peer review, service utilization review, and dispute resolution to prevent inappropriate or excessive treatment; and 5) a manner in which information on medical and health care service costs and utilization could be reported to the board, upon its request, so that the plan's effectiveness can be determined.

Section 31-305 of the Connecticut General Statutes, concerning independent medical examinations shall be changed to allow an employee, upon the employee's request or at the direction of a workers' compensation law judge, to be examined by a reputable physician or surgeon, other than one listed in the plan sponsored by the employer or the insurer. The costs of such examination shall be paid by the employer.

15) SECOND INJURY FUND TRANSFER

A) Transfer to the Second Injury Fund shall be limited to claimants for whom a signed and approved acknowledgement of physical defect is on file with the workers' compensation commission. Further, any transfer to the SIF due to a second injury would take place after the expiration of 104 weeks of benefits paid by the employer. The current statutory reference allowing immediate transfer where acknowledgements exist would be repealed.

B) The procedure and time limits for application for transfer to the Second Injury Fund, as well as the requirement for all medical reports and a copy of the voluntary agreement or award to be sent to the custodian of the fund, would remain as currently required in statute. However, the employer or insurance carrier

would also be required to furnish the signed acknowledgement.

The statute shall require that the employer, or insurer on his behalf shall be the respondent party to the claim until the transfer to the Second Injury Fund has been completed.

16) SECOND INJURY FUND ASSESSMENTS

Beginning July 1, 1992, the mandatory assessments for the Second Injury Fund shall be extended to include the State of Connecticut.

INTRODUCTION

Workers' compensation is a no-fault system financed by employers that replaces wages and pays for medical care when employees are unable to work because of occupational injury or disease. The system is intended to deliver adequate benefits promptly and with little need for litigation as well as promote occupational health and safety.

In Connecticut, broad-based dissatisfaction with the system's administration, which is overseen by the state Workers' Compensation Commission, and concerns over rapidly escalating costs led to requests for a comprehensive review by the Legislative Program Review and Investigations Committee. In February 1990, the committee authorized a study of all aspects of workers' compensation in Connecticut.

Scope. The scope of the study included the structure, administration, and financing of the workers' compensation system for all employees, public and private. As the study progressed, research focused on three major objectives: effective, accountable administration; fair and efficient case processing; and effective benefit cost containment.

A wide range of alternative organizational structures, policies, and procedures for improving system operations were evaluated. One area the committee did not consider modifying was the permanent partial disability rating process since it was the subject of recent legislative changes (under P.A. 90-116) that had yet to go into effect. Issues related to automation were also excluded from in-depth review as the commission's project to computerize central and district office functions was being implemented at the time of the committee study. In examining benefit costs, the committee concentrated on ways to both control payout and promote equity in compensation levels.

Methods. A variety of sources and research methods were used in conducting study of workers' compensation. State statutes, compensation commission reports and documents, and the relevant literature were reviewed. (For a complete listing of sources consulted, see Appendix F). Other states were contacted for detailed information on their laws and programs. Committee staff attended seminars on workers' compensation issues sponsored by the Workers Compensation Research Institute and the National Conference of State Legislatures and the annual state disabled workers' symposium.

Local experts from the legal and medical professions, insurance industry, labor organizations, business community, academic institutions, and the legislature were interviewed. Committee staff also met with groups representing workers'

compensation claimants and employers to discuss specific problems and suggested improvements. The committee obtained input from nearly all parties involved in the system at a public hearing held in August 1990.

Structured interviews were held with members of the compensation commission, district and central office staff, including the directors of education and rehabilitation, and personnel from the insurance department, attorney general's office, and Second Injury Fund. Field visits of all district offices were conducted and hearings, commission meetings, and appeals sessions were observed.

Statistics from the Workers' Compensation Commission, workforce information from the U.S. and state labor departments, and cost data from the National Council of Compensation Insurance (NCCI) were compiled and analyzed. In addition, committee staff gathered and analyzed case processing and benefit information from a sample of district office case files.

Organization. The report is organized into three chapters. The first contains background information and an overview of the system's administrative structure, benefit structure, claims process, and costs. The second presents findings based on the committee's analysis of the eight major components of the system: central administration; district offices; case processing; worker education; workers' rehabilitation; administrative appeals; Second Injury Fund; and benefit costs. The third chapter outlines the recommendations adopted by the program review committee to improve system administration and operations and to contain benefit costs.

A written response to the committee's report from the chairman of the Workers' Compensation Commission is contained in Appendix A. It is the policy of the Legislative Program Review and Investigations Committee to provide state agencies subject to a study with the opportunity to review and comment on recommendations prior to the publication of the final report. Agency responses, if submitted, are then included in the published document.

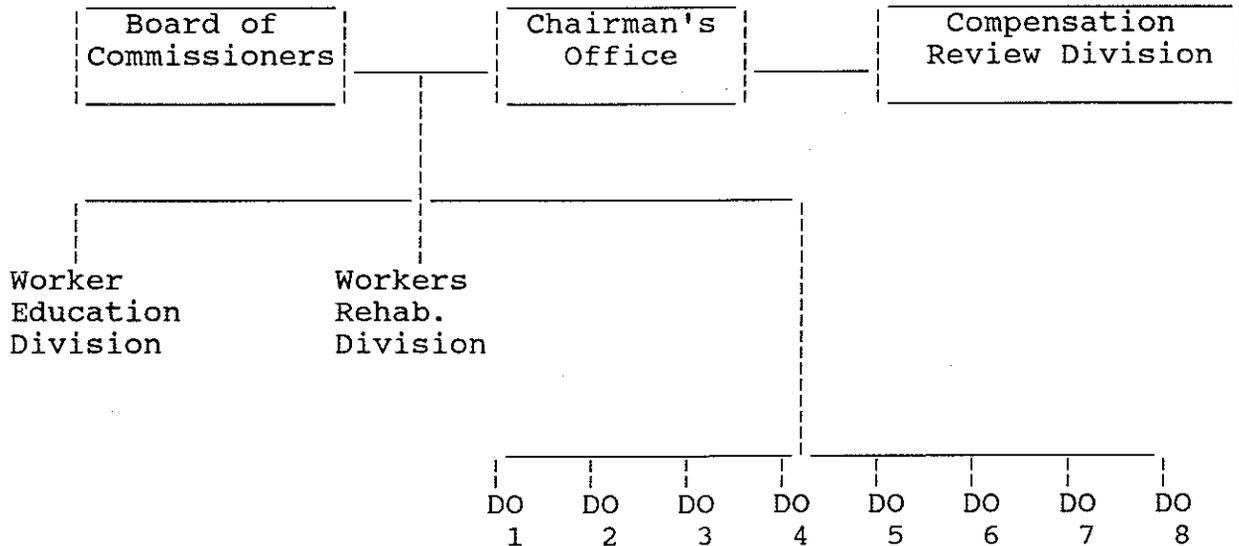
CHAPTER I: SYSTEM OVERVIEW

Under Connecticut's workers' compensation system, which began operating in 1914, a person who suffers an occupational disease or injury is provided wage replacement and medical benefits. The system is based on a no fault concept, meaning that as long as the injury or disease is work-related the employee is entitled to benefits regardless of fault. In return for being required to provide compensation, the employer cannot be sued by the employee because of the occupational injury or disease.

ORGANIZATION

Connecticut's workers' compensation laws are administered by the Workers' Compensation Commission (WCC), a body comprised of 13 commissioners including one who serves as chairman. All commissioners are appointed to five-year terms by the governor and confirmed by the legislature. The structure of the commission is shown in Figure I-1 below.

Figure I-1. Structure of the Workers' Compensation Commission.



DO = District Office

Source: LPR&IC staff analysis

Acting together as a board, the commissioners are responsible for adopting policies, rules, and procedures deemed necessary to carry out the law. Individually, eight commissioners each head district offices while four hold at-large district assignments. A map identifying the eight statutorily established workers' compensation districts in the state is presented in Appendix A. The district and at-large commissioners have direct responsibility for adjudicating disputed benefit claims and insuring that injured workers receive the medical and wage replacement benefits which they are legally entitled to in a fair and timely manner.

The chairman's office has overall responsibility for managing the processing of compensation cases and for supporting the district office operations. The chairman, with the assistance of central business office and statistical division staff, also prepares the commission budget and various reports.

The chairman's office, along with the commissioners acting as the board, additionally oversees three statutory divisions--Worker Education (DWE), which provides outreach and information to employees and employers, Workers' Rehabilitation (DWR), which provides retraining and reemployment services to injured employees, and Compensation Review (CRD), which is an administrative appellate body. Another part of the system separate from the Workers' Compensation Commission is the Second Injury Fund administered by the Office of the Treasurer. Operations of each major component of the commission and the Second Injury Fund are described in detail in the following chapter.

BENEFITS

Under Connecticut's worker's compensation law, employees disabled by work-related accidents or illnesses are entitled to medical treatment, payments to replace lost wages (indemnity benefits), and vocational rehabilitation services. Employees are also entitled to have certain fringe benefits (e.g., group health insurance coverage) continued while they are receiving workers' compensation.

Types. The major types of Connecticut worker compensation benefits are summarized in Table I-1. As the table indicates, injured workers are entitled to all reasonable or necessary medical care including physical rehabilitation with the medical provider of their choice, although medical fees are subject to a commissioner's approval.

In contrast, the levels and duration of indemnity benefits vary depending on the degree (total or partial) and the nature (permanent or temporary) of the worker's disability. In general, total disability compensation is not limited in duration. Benefits

for permanent partial disability, however, are paid for a set number of weeks, either as prescribed by statute or determined by a workers' compensation commissioner. Current guidelines for awarding permanent partial disability benefits are contained in Appendix B.

In addition to the more common benefits listed in Table I-1, Connecticut workers who are employed, but at a lower paying job due to temporary partial disability, may receive wage replacement benefits (equal to two-thirds of the difference between the actual wage they earn and the current wage paid for a position comparable to the one they held prior to their injury) for a period of up to 780 weeks. At a commissioner's discretion, permanently partially disabled workers who have exhausted all other compensation may be provided additional temporary wage replacement benefits (equal to two-thirds of the difference between the wages paid for a position comparable to that held prior to becoming disabled and what the worker would probably be able to earn) based on factors outlined in C.G.S. Section 31-308a.

Worker's compensation benefits are not taxable. An individual's compensation rate is based on average weekly earnings prior to the onset of the work-related injury or illness and subject to statutory maximum and minimum levels. Since 1987, the maximum weekly benefit rate in Connecticut has been set at 150 percent of the state average production worker's wage, which is determined annually by the state labor commissioner. As of October 1, 1990, the maximum workers' compensation rate was \$719 per week, not including any dependency allowance. Temporary total disability benefits also are subject to an annual cost-of-living adjustment each October 1.

Payment. Benefit costs are paid by employers who are required by law to insure their workers' compensation liability. Employers are permitted to self-insure or obtain coverage through insurance carriers. Most Connecticut employers purchase workers' compensation policies although the state, many municipalities and a number of large private employers self-insure.

The state-administered Second Injury and Compensation Assurance Fund, which is financed by an assessment on employers, pays workers' compensation benefits, under certain conditions, to handicapped or previously disabled employees who are reinjured. The fund also provides benefits on behalf of employers who are uninsured and unable to compensate their injured workers. In some cases, employers may be permitted to transfer responsibility for certain worker compensation costs to the Second Injury Fund (SIF).

Table I-1. SUMMARY OF MAJOR WORKERS' COMPENSATION BENEFITS.

Type	Benefit Rate	Maximum/Minimum	Duration
MEDICAL: payment for medical treatment related to occupational injury/illness	full payment of all medical expenses	no maximum	as long as medical services/ treatment needed
TEMPORARY TOTAL: wage replacement until able to return to work	2/3 of average weekly wage earned prior to disability and subject to annual cost of living adjustment (COLA)*	Max. = 150% of average weekly production wage in state Min. = 20% of maximum not to exceed 80% of av. weekly wage prior to injury	begins after 3rd day of disability and continues to point able to return to work (or maximum medical improvement)**
PERMANENT TOTAL: wage replacement when at point of maximum medical improvement still totally disabled	same as Temporary Total	same as Temporary Total	no limit (lifetime)
DEATH: wage replacement paid to beneficiary(ies) up on death due to work-related accident/illness	same as Temporary Total plus \$4,000 burial allowance	same as Temporary Total except surviving spouse minimum benefit = \$20 per week	paid for spouse's lifetime or until remarriage, or to dependent child(ren) until no longer dependent
DEPENDENCY: allowance for eligible children of those receiving total disability benefits	\$10/dependent (includes child under 18 or unmarried, full-time student up to age 22, and handicapped child any age)	not to exceed 50% of basic benefit; total benefits with dependency not to exceed 75% of av. weekly wage	provided for period that total disability benefits received

Table I-1. SUMMARY OF MAJOR WORKERS' COMPENSATION BENEFITS.

Type	Benefit Rate	Maximum/Minimum	Duration
PERMANENT PARTIAL: compensation for permanent loss of a body part or function as determined by physician at point of maximum medical improvement	weekly benefit rate as calculated for Temporary Total is multiplied by the number of weeks allowed for the specific loss of body part or function (with a partial loss compensated on a proportional basis)	maximum and minimum total benefit amount varies depending on duration allowed for specific loss and number of losses (i.e., for multiple losses, benefits for each added together) weekly rate minimum = \$20; maximum same as Temporary Total;	varies depending on body part or function lost; maximum number of weeks of benefits in statute for 18 specified losses and range from 13 to 520 weeks; weeks for all other losses determined by commissioner in accordance with informal guidelines and range from 1 to 780 weeks
DISFIGUREMENT: compensation for permanent and significant scar(s) resulting from injury or related surgery	weekly benefit rate as calculated for Permanent Partial is multiplied by number weeks allowed by commissioner after viewing scar and in accordance with statutory criteria and regulations	same weekly rate maximum as Permanent Partial; no total benefit amount to exceed weekly rate x 208 weeks	usually one-time payment and provided no sooner than one year after scar formed

NOTES:

* Total disability weekly rate increases to 75% in certain cases where OSHA violations existed; for certain public employees (hazardous duty), weekly rate is set at 100%

** If period of total disability lasts more than seven days, benefit payment is retroactive to first day of disability

Source: LPR&IC staff analysis of Connecticut statutes

CLAIMS PROCESS

The claims process carried out by the workers' compensation commissioners is geared toward resolving disputes between employers and employees over the payment of benefits. Disputes may arise at any point in the process and concern a wide range of issues such as the compensability of the injury or illness, the extent of disability, the employee's ability to return to work, or the timely payment of benefits.

If a worker and employer are in agreement about a claim and benefits are paid in accordance with statutory requirements, a commissioner's involvement in the process is limited to approving the settlement that was reached. When parties are unable to reach agreement on their own, the commissioner with jurisdiction over the claim is notified and usually attempts to mediate a settlement through one or more informal hearings. In general, formal proceedings are initiated to adjudicate a matter only when informal efforts fail to resolve issues in dispute.

At the conclusion of the formal proceedings, unless the parties have reached a settlement in the meantime, commissioners issue findings and orders, for example, to award compensation or dismiss a claim. Decisions of workers' compensation commissioners can be appealed, first to the commission's Compensation Review Division and then to the courts. In addition, a commissioner may also reconsider a decision issued after a formal hearing.

The majority of claims and most disputes are settled by workers and employers or their insurers without the need for formal proceedings. Settlements reached by the parties, either before or after a commissioner's involvement, may occur in the form of a voluntary agreement or a stipulation. Under a stipulation, like an out-of-court settlement, the claimant essentially agrees to drop the case in exchange for some payment. Voluntary agreements and stipulations must be filed with and are subject to the approval of the commissioner.

Establishing a claim. The initial point of the workers' compensation process is the establishment of a claim. If an occupational injury or illness results in three or more days of lost work time, the employee may make a claim for workers' compensation benefits. To establish a legal basis for compensation, the injured worker files a written notice of claim with the employer or any workers' compensation commissioner.

A notice of claim must be filed within one year of the date of injury or three years of the diagnosis of an occupational disease. The claim notice can be filed through a letter to the commissioner or on a form provided by the commission (Form 30-C).

A legal claim can also be established without written notice if following an injury, medical care was provided by the employer or a voluntary agreement regarding payment of compensation was reached. Benefits are often paid and claims are frequently established without the worker filing a written notice of claim. Figure I-2 outlines the steps in establishing a claim for temporary total disability, usually the first benefits sought by an injured worker.

Contested claims. Figure I-2 also illustrates how disputed claims are resolved. An employer can contest liability to pay workers' compensation by filing a disclaimer form (Form 43) within 28 days of receiving the worker's notice of claim. If no form is filed, liability for the injury or disease is presumed and the employer forfeits the right to dispute compensability. As shown in the figure disputes over compensability are resolved through informal and, if necessary, formal hearings and the appeals process.

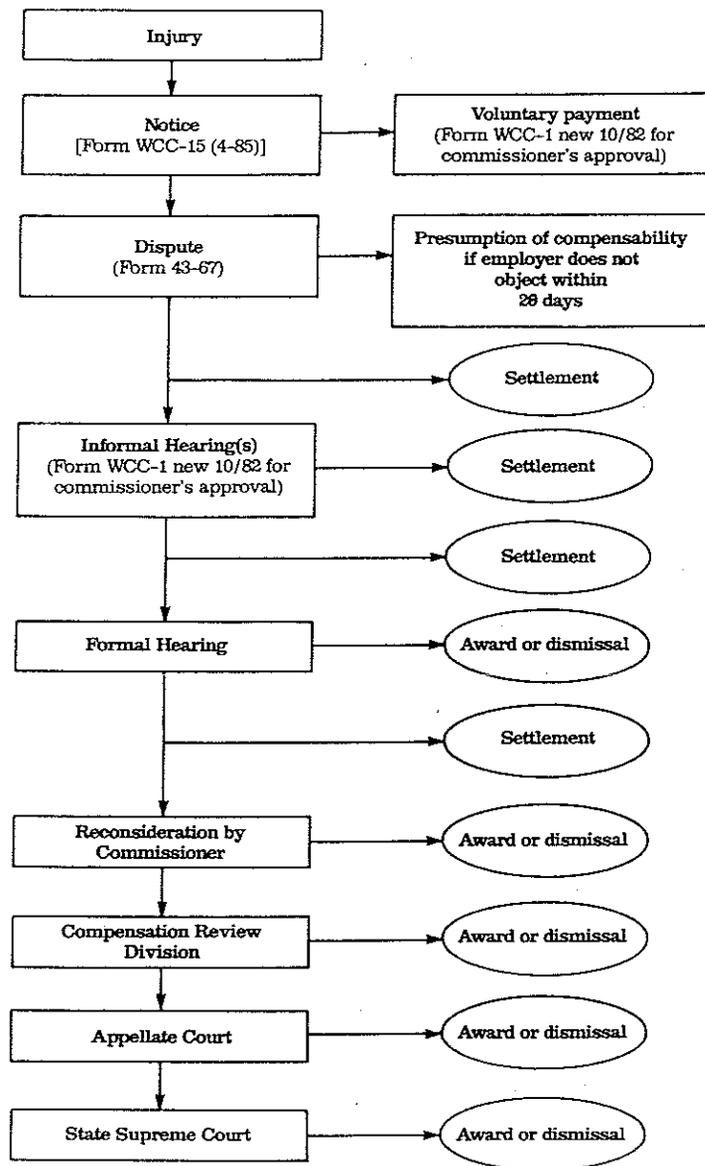
Terminating benefits. Employers or their insurers can discontinue paying workers' compensation benefits only with the approval of a commissioner. Figure I-3 shows the steps for terminating temporary total disability benefits.

Prior to discontinuing payments when an injured employee is able to return to work, a form (Form 36) must be filed the commissioner who has jurisdiction over the claim and a copy sent to the employee. The form contains the intended benefit termination date, the reasons for discontinuance, and certification of the worker's ability to return to work from the attending physician.

Termination of benefits is approved unless contested by the employee within 10 days. If a worker contests termination, an informal hearing is scheduled, usually within a few days, to review evidence of continuing disability. As Figure I-3 illustrates, disputes over benefit termination may be settled at the informal hearing or resolution may require formal proceedings.

Permanent disability and disfigurement. When temporary benefits for total or partial disability end or when maximum medical improvement (MMI) is reached, a worker may be eligible for permanent disability benefits. If a worker claims to have sustained a permanent partial loss of a body part or function, compensation can be awarded through the process depicted in Figure I-4.

Figure I-2. Establishing a Claim for Temporary Total Disability Benefits.



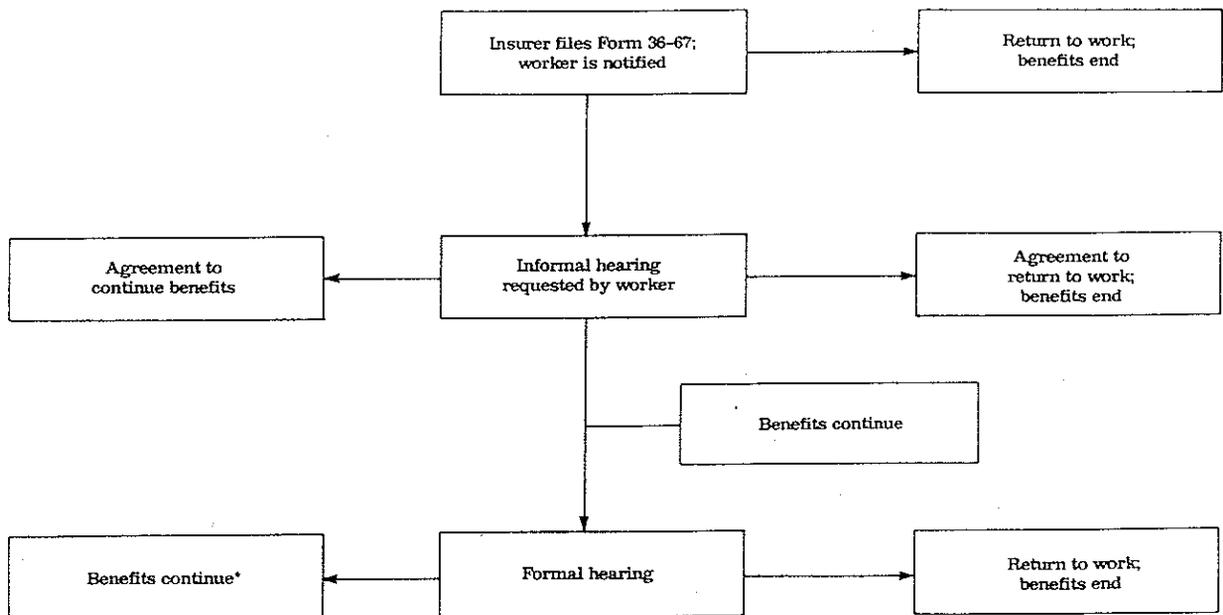
Source: Peter S. Barth, Workers' Compensation in Connecticut (Workers' Compensation Research Institute, 1987), p. 14

In cases where there is no dispute over the existence or degree of permanent partial disability, the parties submit the settlement they have reached to the commissioner for approval. When there is disagreement, hearings will be scheduled to resolve the matters in dispute.

The commissioner relies on medical reports supplied by the parties' physicians to determine the extent of disability. When ratings of disability supplied by the parties' doctors vary significantly, the commissioner may order an independent medical examination (IME) by an impartial physician. If a settlement on permanent partial compensation cannot be reached through one or more informal hearings, the commissioner will either award or deny benefits after holding a formal hearing.

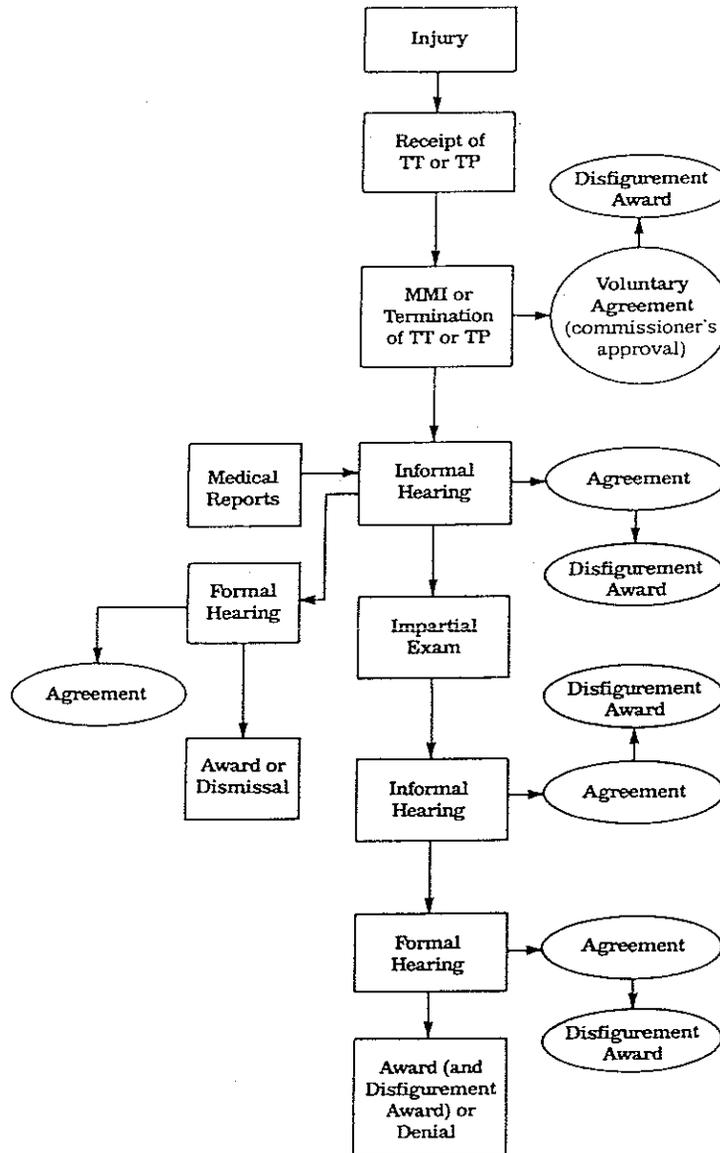
As Figure I-4 indicates, in addition to permanent partial disability benefits, compensation is available for permanent disfigurement (scarring) that results from an occupational injury or related surgery. Workers can request a disfigurement award hearing one year after a scar is formed. At the hearing, the commissioner views the scar and determines what, if any, compensation will be awarded.

Figure I-3. Terminating Temporary Total Disability Benefits.



Source: Peter S. Barth, Workers' Compensation in Connecticut (Workers' Compensation Research Institute, 1987), p. 16.

Figure I-4. Permanent Partial Disability and Disfigurement Awards Process.



Source: Peter S. Barth, Workers' Compensation in Connecticut (Workers' Compensation Research Institute, 1987), p. 18.

WORKLOAD

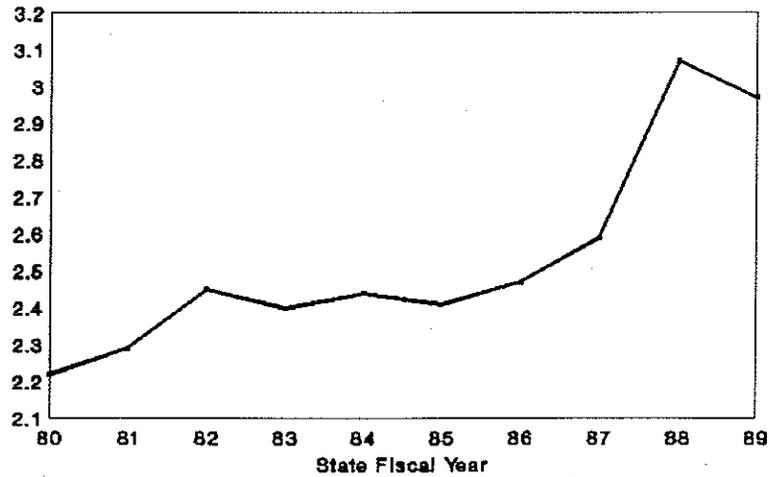
Information on reported accidents--the best available estimate of workers' compensation claims requiring commission involvement--for state fiscal years 1986 through 1990 is presented in Table I-2. Direct measures of the commission's activity including numbers of informal hearings, formal hearings, and dispositions (i.e., claims disposed of through approved voluntary agreements, stipulations, and awards or dismissals) for the past five years are also shown in the table.

Table I-2. Workers' Compensation Commission: Selected Workload Data, State Fiscal Years 1986 - 1990.				
Fiscal Year	Reported Accidents	Informal Hearings	Formal Hearings	Dispositions
1986	39,073	34,061	2,069	22,793
1987	42,180	37,125	2,022	23,775
1988	50,974	38,147	2,066	26,137
1989	50,096	39,771	2,175	27,137
1990	50,822	43,684	2,676	30,565

Source of Data: Conn. Workers' Compensation Commission.

As Table I-2 indicates, the number of work-related accidents reported to the commission rose 30 percent (from 39,073 to 50,822) between fiscal years 1986 and 1990. The number of work-related accidents reported to the commission has been growing more rapidly than has the state's workforce. As Figure I-5 indicates, the number of accidents reported per 100 workers generally rose over the past decade, from about 2.2 in 1980 to 2.9 in 1989.

Figure I-5. Reported Accidents
Per 100 Workers: FY 1980 - 89



Sources of Data: Conn. WCC and
Governor's Econ. Report 90-91.

As more cases have entered the system, more demands have been placed on the commissioners to act as mediators and arbitrators for disputed claims. This is evidenced by the 37 percent increase in the number of informal hearings conducted (34,061 to 46,684) and the 29 percent increase in formal hearings held (2,069 to 2,676) between FY 86 and FY 90. Table I-3, which provides a breakdown of types of benefit claim dispositions over the last five years, also shows that commissioners are being called upon to decide more claims and approve more stipulations, an indication of the growing litigiousness of the system.

Table I-3. Claim Dispositions, State Fiscal Years 1986 - 1990.

Year	Voluntary Agreements	Stipulations	Awards/ Dismissals	Disfigurement Awards
1986	20,021	2,267	505	8,848
1987	20,028	2,534	813	9,221
1988	22,318	2,714	1,105	8,484
1989	23,620	2,787	1,040	7,761
1990	25,719	3,653	1,193	9,718

Source of Data: Conn. Workers Compensation Commission.

While the vast majority of claims continue to be settled through voluntary agreements, which usually require only minimal involvement by commissioners, the total number submitted to the district offices for approval grew 28 percent over the five year period shown in Table I-3. From FY 86 to FY 90, the number of awards and dismissals issued by commissioners more than doubled, rising from 505 to 1,193, the number of stipulations approved increased 61 percent, and the amount of disfigurement benefits awarded grew by 10 percent. During this same period, more than twice as many appeals of commissioner decisions were taken to the Compensation Review Division (80 in FY 86 versus 174 in FY 90).

An understanding of the workload facing each district office can be gained from the Table I-4 below. The data cover the 1990 state fiscal year and are broken down into three categories.

The first category shows the number of reported accidents, which represents a district's potential for becoming involved in claim-related disputes and generating records that must be filed. The second category relates to the number of documents that are received and must be approved by a commissioner and filed by district staff. Included in this group are voluntary agreements, stipulations, and acknowledgements of pre-existing injuries. Other items falling into this category, but not accounted for in the table, are hundreds of notices of intent to file claims, terminate benefits, or deny liability.

Hearings comprise the third data group presented in the table. Hearings, whether formal or informal, require considerable staff time to notify participants and assemble and refile records. Because one claim may involve multiple hearings, the total number of hearings held can exceed the number of reported accidents.

Table I-4. Measures of Workload by District Office for FY 90.

Category	Dist #1	Dist #2	Dist #3	Dist #4	Dist #5	Dist #6	Dist #7	Dist #8
Reported Accidents	8,936	8,279	7,989	5,171	7,140	5,191	4,426	3,690
Documents	9,477	4,336	5,288	5,076	5,774	5,654	2,740	2,182
Hearings	9,018	6,503	7,036	9,884	6,302	4,633	3,290	2,694

Source of Data: Conn. Workers' Compensation Commission.

ADMINISTRATIVE COSTS

The workers' compensation system administrative costs are paid by employers. The dispute resolution activities, as well as administrative support functions of the commission's central office and the district offices are financed through the General Fund, which is then reimbursed by all employers except the state of Connecticut. Each employer is assessed proportionately for the commission's operating expenses based on the total amount of workers' compensation benefits paid to employees over the prior year.

Employers are additionally assessed two percent of their prior year's worker compensation benefits payments to fund the Division of Workers' Rehabilitation. Almost 90 percent of this revenue is used for direct training and rehabilitation efforts, while about 10 percent is allocated for division administrative costs. Another separate assessment of 0.2 percent is used to pay for the activities of the worker education division.

Commission expenditures over the past five fiscal years are shown in Table I-5. Direct administrative costs for operating central and district offices rose from \$2.3 million in FY 86 to \$3.4 million in FY 90, a 48 percent increase. During the same time period, the combined budgets for the workers' education and rehabilitation divisions also increased about 50 percent (from \$6.1 to \$9.4 million) while indirect costs, which include fringe benefits expenses for commissioners and central office personnel as well as certain support service charges, grew about 85 percent. In total, overall administrative costs for the commission were approximately \$15 million in FY 90.

Table I-5. Workers Compensation System Administrative Expenditures: FY 86 - FY 90. (\$ in millions)					
Fiscal Year	CENTRAL & DISTRICTS Direct / Indirect		DWR	DWE	TOTAL
1986	\$2.3	\$1.3	\$5.6	\$ 0.5	\$ 9.8
1987	\$2.7	\$1.8	\$5.3	\$ 0.6	\$10.4
1988	\$3.5	\$2.1	\$5.8	\$ 0.8	\$12.3
1989	\$3.3	\$2.8	\$6.7	\$ 0.7	\$13.6
1990	\$3.4	\$2.4	\$8.6	\$ 0.8	\$15.3

Source of Data: Auditors of Public Accounts and Conn. Workers' Compensation Commission.

BENEFIT COSTS

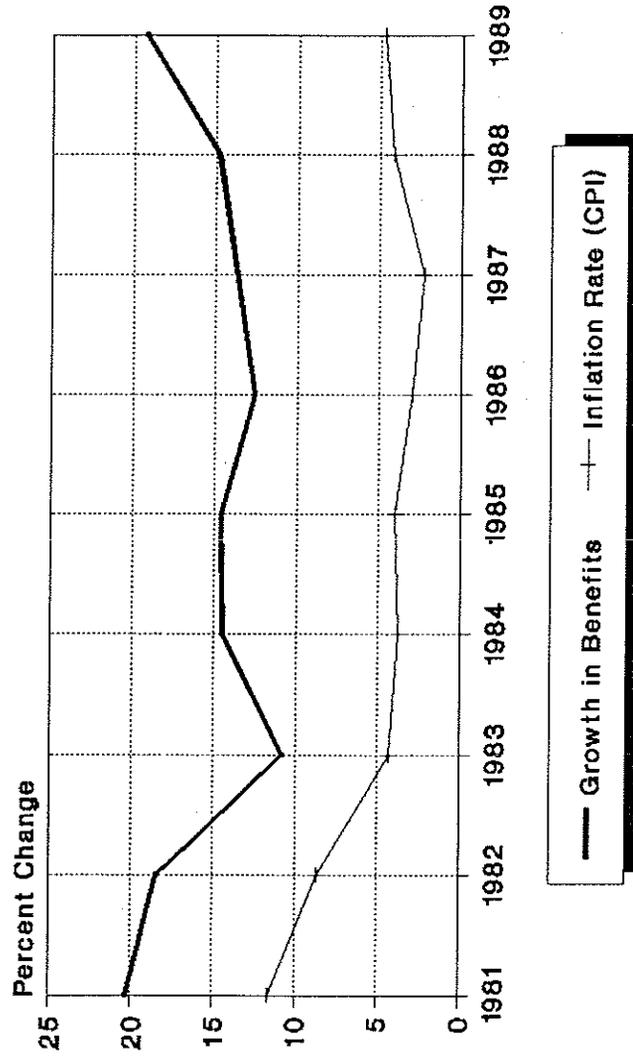
Workers' compensation benefits paid in Connecticut for 1989 totalled more than half a billion dollars. Table I-6 shows total benefit payouts from 1985 to 1989 along with the annual growth rate. As the table indicates, in the past five years benefit costs have almost doubled and increased almost \$100 million in the last year shown alone. On a per-worker basis, workers' compensation costs in Connecticut rose from \$218 in 1986 to \$345 in 1989, a 58 percent increase in four years.

Table I-6. Connecticut Workers' Compensation Benefit Payouts: 1985 - 1989		
Year	Total Payouts	Annual % Increase
1985	\$303,819,628	-
1986	\$342,043,718	12.5
1987	\$423,687,103	23.8
1988	\$486,500,000	14.8
1989	\$580,252,719	19.2

Source of Data: Conn. Workers' Compensation Commission.

In Connecticut, the rate of increase occurring in workers' compensation benefit costs has been greater than the rate of inflation. Figure I-6, which compares growth in the inflation rate with the growth rate of total workers' compensation benefit payments during the 1980s, shows that benefit costs grew at two to four times the inflation rate.

FIGURE I-6. Comparison of Growth Rates
for Benefit Payouts and Inflation



Note: Comparable benefit data not available for 1987

CHAPTER II: FINDINGS

In reviewing workers' compensation in Connecticut, the Legislative Program Review and Investigations Committee examined nearly every aspect of the system from administration to costs. The committee's analysis and findings concerning each major system component are contained in this chapter. Information is organized into eight sections: 1) central administration; 2) district offices; 3) case processing; 4) worker education; 5) workers' rehabilitation; 6) appeals; 7) the Second Injury Fund; and 8) the overall costs of providing compensation benefits.

Each section on operational aspects contains a short description of activities, resources, and management structure, followed by a series of committee findings concerning outcomes, efficiency, and accountability. The section on case processing presents information on how claims are handled at the district offices based on data obtained from a sample of actual case files while the cost section describes trends in benefit payouts and summarizes committee analysis of factors contributing to costs.

CENTRAL ADMINISTRATION

Responsibility for statewide operation of the workers' compensation system is divided between the chairman of the commission and all of the system's 13 commissioners acting together as a board. Although differences in responsibilities are not clearly defined in statute, the chairman's duties tend to be more administrative and the board's more policy orientated.

Board. The board of commissioners has the power to change rules and procedures affecting the operation of the system. It can designate a commissioner to act in another district in the event the sitting commissioner is unable to carry out his or her duties. The board is also empowered to establish fees for medical services and standards for maintaining an approved list of medical providers.

The board meets monthly to review and discuss issues affecting the workers' compensation system such as personnel and budgetary requirements of the state bureaucracy, court decisions, and changes in the law. The board seldom takes formal positions choosing instead to convey its desires through the chairman, or to allow individual commissioners to use discretion in their own districts.

Chairman. The commission's chairman is responsible for overall administration of the workers' compensation system. He assigns the system's at-large commissioners to district offices and has the authority to appoint temporary commissioners when he determines they are needed.

The chairman is aided in meeting his responsibilities by a central office that includes the business office, statistical division, at-large commissioners, and Compensation Review Division. Current central office staff levels are shown in Table II-1.

Table II-1. Authorized Staff Positions As of June 30, 1990.					
	Chair. Office	Business Office	Stats. Division	At-Large Comm.	Comp.Rev. Division
Professional	1	2	2	4	3
Clerical	2	2	3	-	1
Total	3	4	5	4	4

Source of Data: Conn. Workers' Compensation Commission.

In the past five fiscal years, the number of staff in the central office increased by nearly 50 percent. Two-thirds of the increase is accounted for by the addition of an attorney and a paralegal in the Compensation Review Division and two at-large commissioners. The remaining increase is the result of clerical positions being added to the statistical division and chairman's immediate staff.

Business Office. A major function of the business office is to assemble the portion of the commission's operating budget that is subject to the state's appropriation process. In completing this task, staff calculate changes in ongoing expenditures such as salaries and leases, and solicit requests for new equipment and other items from the district offices. Significant increases in equipment or staff are included in the budget only at the direction of the chairman.

Another function of the business office is to serve as a liaison between the commission, particularly the district offices, and the state bureaucracy. In fulfilling this role, staff of the business office monitor expenditures from the commission's general fund appropriation to insure proper procedures are followed and records are kept on all financial and personnel matters.

Statistical Division. The statistical division is responsible for compiling and maintaining data concerning the operation of the system and the occurrence of occupational injuries and diseases. It produces monthly and annual reports summarizing the data and comparing it with previous time periods.

Over the past five years the division has focused its efforts on developing a computerized information system. The system is presently being implemented in the district offices. When operational, it will provide management information as well as data to analyze the occurrence of injuries and diseases.

At-large commissioners. Although organizationally attached to the central office, at-large commissioners are actually a part of district office operations. With the exception of office administration, at-large commissioners have the same powers and duties as a district commissioners. They are assigned to district offices by the chairman based on his perception of a district's need.

In addition to the chairman's administrative duties, he serves as head of the Compensation Review Division. The division's operation are detailed in later section of Chapter II.

Also statewide in scope are the divisions of education and rehabilitation. Both divisions are reviewed in later sections of this chapter.

Findings

Administration of the workers' compensation system is weak. In the opinion of the program review committee, the problem stems from structural deficiencies and reluctance or indifference on the part of the chairman and board of commissioners to exercise leadership. The result is a system where accountability is diffused and overall direction is lacking.

A major impediment to effective administration is the fact that a majority of the commission's resources are beyond the control of either the chairman or the board. In addition, use of management information to guide the operation of the system is virtually non-existent. Observations and illustrations to support these conclusions are listed below.

Structure

1) The authority to set direction for the system does not rest with a single body. It is ambiguously divided between the chairman and the board of commissioners. For example, the chairman controls the budget and the board can change rules and procedures.

2) A stalemate exists between the chairman and the board of commissioners with respect to their authority to direct the workers' compensation system. The problem is that neither party can be held accountable by the other. Only the governor and legislature acting through the

appointment and impeachment processes can hold a commissioner accountable for his or her actions.

3) In this environment the chairman has not shown any inclination to hold districts accountable for their performance and seems reluctant to provide direction without concurrence from the board. In turn, commissioners, with few limits on their powers when acting individually, have virtually no incentive to act collectively.

Management Information

4) The program review committee found only limited uses being made of management data. Reports produced by the statistical division are largely workload descriptions and seem to be used solely for purposes of assigning at-large commissioners. Detailed analyses of the data comparing the efficiency of district office operations are neither produced nor requested.

5) The importance of statistical information to managers of the system can be gauged from the fact that it has taken five years to develop and begin implementing a computer system. Also, a statutory requirement for a plan outlining how the statistics division should operate has been ignored. Finally, no one within the commission's management structure seems troubled by the fact that the governor has never appointed a statutorily mandated advisory panel to review information produced by the statistics division and make recommendations to interested parties.

Control of Resources

6) The allocation of 31 percent of the commission's staff and 75 percent of its financial resources is beyond the control of either the chairman or the board. This occurs because funding for the divisions of education and rehabilitation is determined by a statutory formula and is not subject to review. In addition, there is no clear statutory language indicating who is responsible for overseeing the operation of either division.

DISTRICT OFFICES

Workers' compensation claims are handled in district offices. There are eight such offices, each serving a statutorily specified geographic area. Each office is headed by a commissioner who has jurisdiction over all claims arising within the district.

The allocation of staff and other resources to the districts is controlled by the central office, largely through its authority over the commission's budget. The number of authorized staff permanently assigned to each office as of July 1, 1990, is shown in Table II-2 below.

Table II-2. Allocation of Authorized Staff As of July 1, 1990.								
CATEGORY	Dist #1	Dist #2	Dist #3	Dist #4	Dist #5	Dist #6	Dist #7	Dist #8
Commissioner	1	1	1	1	1	1	1	1
Paralegal	2	1	1	1	1	1	1	1
Clerical	6	5	6	5	4	6	3	3
Total	9	7	8	7	6	8	5	5
Source of Data: Conn. Workers' Compensation Commission.								

District commissioners have considerable discretion in administering their offices. However, as a result of their heavy involvement in the judicial aspects of their jobs, commissioners tend to delegate their administrative responsibilities to either an administrative assistant or someone who functions as one.

The primary activities performed by district offices are maintaining records on claims and holding hearings to resolve disputes. Considerable time is also spent responding to inquiries concerning how to pursue a claim or checking the status of one already in the system.

Operationally, the focus of the district office is to resolve disputes arising from compensation claims. Selected measures of the relative output and efficiency of each office in settling disputes are displayed in Table II-3.

The measures take into account differences between offices in volume of claims and staff resources. Thus, output is defined as dispositions per reported accident rather than simply the number of dispositions. Measuring efficiency as hearings per disposition is based on the assumption that a unit of staff activity, in this case, a hearing, can be related to an outcome, here a disposition.

Table II-3. Average Annual Output for FY 86 through FY 90.

Category	Dist #1	Dist #2	Dist #3	Dist #4	Dist #5	Dist #6	Dist #7	Dist #8
Dispositions Per Accident	.54	.55	.54	.54	.51	.88	.46	.49
Hearings Per Disposition	1.77	1.96	1.60	2.01	1.72	1.03	1.32	1.24
Informal Per Formal Hear.	35.7	20.2	25.5	16.8	11.6	21.2	7.5	16.3

Source of Data: Conn. Workers' Compensation Commission.

Table II-3 reveals considerable variation among the district offices. For example, in District #6, there were 88 dispositions for every 100 reported accidents as compared to 46 per 100 in District #7. Districts #2 and #4 held approximately two hearings for ever disposition they recorded, while District #6 required only one per disposition.

The greatest discrepancies occur in the ratio of informal to formal hearings. For example, District #1, which holds 35.7 informal hearings for every formal one, far surpasses District #7, with 7.5 informal per formal hearings.

Findings

In general terms, the program review committee found district offices to be poorly administered. This conclusion is based on the observation that most operating procedures had not changed in years, appeared inefficient, and often seemed to be for the convenience of office staff and not the public.

The committee found that district office resources have not kept pace with increases in workload. Compounding this problem is an allocation scheme that does not relate staff resources to workload.

Finally, objective measures of district office performance revealed significant variation among offices. As a result, it is highly probable that similar cases are handled very differently among the districts. Observations and brief analyses supporting these conclusions are listed below.

Administration and Procedures

- 1) District commissioners focus on handling cases and not managing their offices. The management task is generally left to support staff who by necessity have developed short-term strategies for coping with the daily crush of mail, phone inquiries, and hearings.
- 2) There is no recognizable long-range management planning taking place in the district offices and, as a result, operating procedures have changed little over the years.
- 3) Operating procedures vary widely among offices. For example, each office has its own filing system. Also, in some offices hearings are scheduled upon request, while in others, hearings are not scheduled unless the requesting party indicates that reasonable efforts have already been made to resolve the problem.
- 4) Among districts, the rate at which case files, identified by program review committee staff at random from each office's index card system, could not be found varied from approximately two to five percent.
- 5) As of September 1990, six to seven weeks were required to schedule a routine informal hearing and seven to ten weeks for a formal hearing. It may actually take longer especially for formal hearings. Some offices will not schedule such hearings more than two to three months in advance resulting in a backlog of 150 to 200 requests waiting to be scheduled.
- 6) A review of log books in six district offices found that 10 to 20 percent of all scheduled hearings were either canceled or postponed. Most changes were at the request of claimants or respondents, not district office staff.
- 7) With the exception of Waterbury, district offices seemed to place a priority on serving the public. In Waterbury, staff were observed on several occasions to place incoming phone lines on hold for long periods of time, thereby denying the public telephone access to the office. In addition, staff in the Waterbury office are not visible to the public and visitors to the office must ring a bell to obtain service.

Resources

8) District office resources have not kept pace with increases in the workload. Between FY 86 and FY 90, authorized staff increased by 13.5 percent compared to an increase in reported accidents of 30.2 percent during the same period.

9) Because two at-large commissioners were added to the system while the support staff remained constant, the ratio of support staff to commissioners in the districts actually declined from 4.2/1 to 3.9/1 between FY 86 and FY 90.

10) The ratio of support staff (including authorized and temporary) to workload as measured by reported accidents, documents processed, and hearings held indicates a misallocation of staff resources among the district offices. For example, as shown in Table II-4 below, Districts #1 and #4 have approximately twice the number of reported accident per staff as Districts #2, #3, and #5. Also, the table shows the ratio of hearings to staff ranges from 549/1 up to 1,050/1.

Table II-4. Activity Per Support Staff By District (FY 90).								
ACTIVITY	Dist #1	Dist #2	Dist #3	Dist #4	Dist #5	Dist #6	Dist #7	Dist #8
Accidents	558	1,183	1,141	572	1,190	649	738	923
Documents	592	619	755	529	962	707	475	546
Hearings	563	929	1,005	988	1,050	579	549	674

Source of Data: Conn. Workers' Compensation Commission.

11) Certain staff positions may be underutilized. For example, in some district offices, paralegal staff are used largely to perform clerical functions such as keeping abreast of the daily docket, while in others they check and verify documents submitted for approval.

Performance

11) There is significant variation among district offices in output and efficiency. Output, measured as average dispositions per reported accident over the past five fiscal years, ranged from 0.46/1 up to 0.88/1. Efficiency, measured as the average ratio of hearings to dispositions between FY 86 and FY 90, ranged from 1.03/1 to 2.01/1. (see Table II-3 above)

12) The relative use of informal versus formal hearings as a means of resolving disputes also varied widely among offices. Between FY 86 and FY 90 the average ratio of informal to formal hearings in the districts ranged from 7.5/1 to 35/1.

CASE PROCESSING

The Workers' Compensation Commission collects information on the numbers of accidents reported, hearings held, claims disposed of, and method of disposition. Beyond these gross statistics, little is known about how cases are processed at the district offices and there is virtually no monitoring of district office efficiency.

To obtain information on a per-case basis, such as the length of time required to resolve claims, the degree of contact with the system, benefits received, and an estimate of the number of individual claimants involved, actual case files were examined by the program review committee staff. Committee staff also reviewed district office daily hearing dockets and interviewed district staff regarding procedures for handling cases, particularly hearing requests.

In total, 745 case files, selected on a random basis and representing the distribution of claims among the district offices, were reviewed and used to develop a database on the types and amounts of benefits paid as well case processing information such as numbers of hearings requested, scheduled, held and postponed or canceled. The sample was drawn from cases that became active during calendar year 1987 and, therefore, likely to be resolved at least in part at the time the data were collected. A copy of data collection sheet for gathering the case file information is contained in Appendix C.

The 745 cases represent about 1,139 total claims distributed as follows: temporary total disability benefits 49 percent; permanent partial disability benefits 25 percent; disfigurement (scarring) awards 15 percent; and all other 11 percent. Other includes claims for payment of medical bills, vocational rehabilitation financial benefits, and cases where compensation was

paid through a stipulation that did not specify the type of benefit claimed.

In about 38 percent of the cases included in the sample, more than one type of benefit was claimed, usually both temporary total and permanent partial disability benefits. In another 40 percent of the cases, temporary total disability was the only benefit claimed while in 10 percent of the cases just disfigurement benefits were claimed and the remaining 11 percent involved claims for only permanent partial disability or medical or other benefits.

The occupational breakdown of the claimants represented by these cases was: 33 percent manufacturing; 27 percent construction/laborer; 14 percent service (e.g., retail clerk); 9 percent direct care (e.g., nursing); 5 percent office/professional; and 11 percent other. Nearly all of the cases in the sample (97 percent) involved physical injuries, about one-third of which concerned the back. Occupational disease and psychological conditions accounted for only 3 percent of the total cases included in the sample. Information on benefit amounts, dispositions, processing times and hearings developed from these cases are highlighted below.

Benefits

The maximum weekly benefit rate in effect for most of the cases in the sample was \$408, not including dependency allowances. A small portion of cases involved injuries occurring after September 30, 1987, and, therefore, were subject to a maximum weekly rate calculated at 150 rather than 100 percent of the average state production wage, or \$643. In addition, some claimants (i.e., public employees in hazardous jobs if injured in the line of duty) could exceed either maximum due to eligibility for weekly benefit rates equal to 100 percent of their wages. Weekly benefit amounts received, however, were significantly less than maximum rates, averaging \$269 for temporary total disability recipients. In the sample, only 13 percent of the individuals who received temporary total disability benefits were at or above the weekly rate of \$408.

The total amount received in temporary total disability benefits averaged \$5,082 for cases in which payment had been completed at the time the sample was collected. If cases where the claimant was still receiving such benefits were included, the average would undoubtedly increase. The duration of benefits in the closed temporary total disability cases averaged 18 weeks and ranged from less than 1 to 110 weeks.

On average, total permanent partial disability benefits received were greater than the temporary total benefits received in the cases included in the sample. Permanent partial disability

benefits received averaged \$10,445 per case. The average duration of permanent partial disability benefits was 37.6 weeks and ranged from less than 1 to 233.6 weeks.

Disfigurement awards received in the cases included in the sample ranged from \$83 to \$20,808 and averaged \$2,115. Over 90 percent of the scarring benefits awarded were under \$5,000. The number of weeks of disfigurement benefits granted, which indicates the severity of the scarring involved, ranged from 1 to 51 weeks and averaged 7.7 weeks.

Processing Methods

The majority of the 1,139 claims were settled voluntarily and required little involvement by either the commissioner or office staff. Eighty-seven percent of temporary total and 95 percent of permanent partial disability benefits were resolved through voluntary agreements, while only 13 percent and 5 percent, respectively were settled through stipulations or awards. Two-thirds of the permanent partial benefit claims and an even greater proportion of temporary total claims (86 percent) were processed without any need for a hearing, either informal or formal.

Processing Times

Analysis of the sample cases revealed that a significant number of claims take years to finalize. About half of the temporary total disability benefit claims included in the sample were resolved within 3 months of the date of injury; however, 10 percent took over 1 year to resolve. The time between date of injury and resolution of permanent partial disability benefits averaged more than 20 months (617 days) and 25 percent of the permanent partial claims in the sample took 2 or more years resolve.

Based on the sample data, processing times for claims that involve hearings with commissioners are substantially longer than those resolved by parties on their own. On average, temporary total claims settled after an informal hearing took almost three times as long to finalize as claims that were resolved without hearings (428 versus 151 days). For permanent partial disability claims, the average time between date of injury and date resolved for those settled before a hearing was about 18 months while those resolved after an informal hearing took an average of about 24 months to finalize.

Hearings

Formal hearings, which are the most time-consuming case processing activity, were held for very few of the 745 cases included in the staff sample--just 3 percent. Half of these cases involved only one formal hearing but a quarter required at least two and up to four formal hearings to resolve disputed issues.

In contrast, the sample indicated that about one out of three cases handled at the district offices involves at least one informal hearing. Over half of these cases (54 percent) required more than one informal hearing to resolve disputes. Overall, cases in which multiple informal hearings were held made up only 17 percent of the sample but accounted for 80 percent of all hearings held. Thus, while cases that require hearings are small in number, they place considerable demands on district office resources.

The sample data showed that, on average, 10 weeks elapsed between the time an informal hearing was requested and the date it was held. Backlogs in hearing schedules are a serious problem in all offices. As of September 1990, 6 to 7 weeks were required to schedule a routine informal hearing and formal hearings were being scheduled at least 7 to 10 weeks in advance.

The program review committee found that postponements and cancellations, which are common, contribute to hearing backlogs. Review of selected daily hearing dockets in six district offices showed that 10 to 20 percent of all hearings scheduled were postponed or canceled. Forty percent of the initial informal hearings scheduled for cases included in the sample were postponed at least once; 7 percent were rescheduled 2 to 3 times. A total of 109 initial informal hearings were postponed, with claimants responsible for 33 percent of the postponements, respondents 11 percent, and for the remainder (55 percent), responsibility could not be determined. The program review committee staff also noted that missing or incomplete medical reports were often cited as a reason for delays in proceedings.

Despite often lengthy processing times and the frequency of last minute cancellations and postponements, there was little evidence in the files reviewed by committee staff that commissioners imposed the penalties available under current law for undue delay. As a formal hearing is necessary to order the payment of fines and dockets are already filled months in advance, the reluctance of commissioners to impose penalties to speed up cases is due in part to hearing backlogs.

The case processing data gathered by the committee suggest that district office efforts to screen hearing requests are insufficient and that in a number of cases, hearings are requested unnecessarily. From the staff review of case files, it appeared

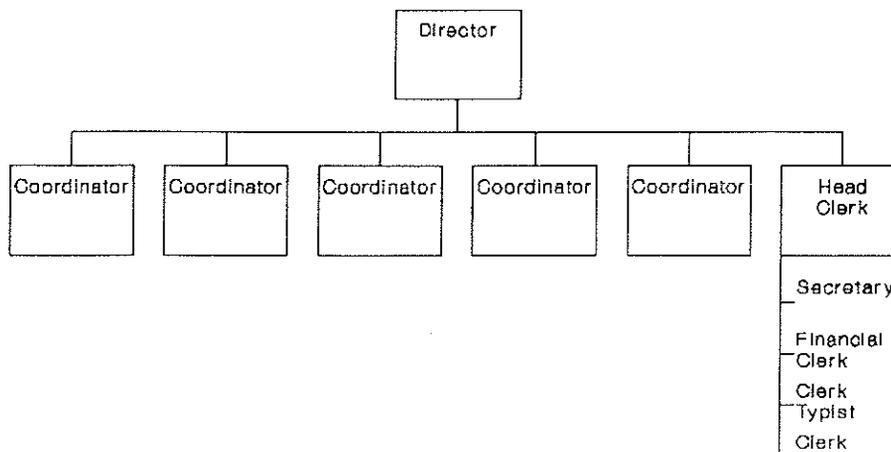
that hearing requests were often vague. While some offices attempt to determine the nature of the dispute prompting the hearing request and whether parties have made reasonable attempts to resolve the problem prior to adding a hearing to the docket, other districts schedule hearings on demand.

DIVISION OF WORKER EDUCATION

The Division of Worker Education (DWE) was created to provide educational services to employees in order to help prevent occupational injury and disease, to inform non-management employees about workers' compensation procedures and their rights under the system, and to provide employers information about known or suspected work place hazards. Public Act 90-226 also gave DWE a role in educating employees and employers regarding an occupational disease database, which the act requires be established.

Currently, the Division of Worker Education is staffed by a director, who is appointed by the chairman of the Workers' Compensation Commission, five professional staff, and five clerical and support staff. Figure II-1 below depicts the organization of the division.

Figure II-1. Organization of Worker Education Division



The Division of Worker Education is funded through an assessment on employers of 0.2 percent of their prior year's workers' compensation payouts. The Treasurer makes the assessments and issues all disbursements. The funds for the division are statutorily required to be kept separate from other state funds. Table II-5 shows the assessments for FY 86 through FY 90, and the percentage increase for each year.

Table II-5. Division of Worker Education Assessments.

Fiscal Year	Assessment	% Increase Over Previous Year
FY 86	\$535,746	15.4
FY 87	\$601,646	12.3
FY 88	\$726,623	20.7
FY 89	\$826,460	13.7
FY 90	\$997,674	20.7

Sources of Data: Auditors of Public Accounts and Office of the State Treasurer

The Division of Worker Education performs the following functions:

- * mails a package of information to each person who files an accident report with the Workers' Compensation Commission informing the worker of his or her rights under the workers' compensation system, and outlines the procedures that must be followed to file a claim;
- * operates a toll free number during normal business hours, which handles an average of 80 inquiries a day about workers' compensation;
- * prepares and distributes educational materials (over 400,000 pieces in FY 90), including three newsletters -- 1) a monthly newsletter to businesses employing more than 19 persons that discusses workplace safety issues and lists educational tools (e.g. videos) DWE provides; 2) a monthly newsletter to individuals and groups that provides information on workers' compensation, including any changes in the laws or benefits; and 3) a quarterly publication distributed to licensed physicians and other medical professionals that focuses on occupational health and medicine;
- * provides a lending library of videos and books on accident prevention and safety, and workers'

compensation procedures (loaning 136 such items during FY 90) and produces a television program on safety and benefit procedures that is shown on about 15 different cable channels several times a week;

- * conducts certain testing, such as air and noise monitoring or asbestos sampling, at work sites (conducting 45 such tests during FY 90); and
- * develops outreach programs including establishing safety and health committees at large work sites, sponsoring state and regional seminars, honoring businesses and labor organizations with good safety records, and distributing pamphlets and videos to libraries, workers' compensation district offices and other locations (with over 3,600 workers attending some type of division-sponsored training during FY 90).

Findings

Findings dealing with the Division of Worker Education presented below are categorized into two general areas. The first concern the performance of DWE, including the effectiveness of its prevention programs. The second area deals with the resources of the division and how those are spent.

Performance

1) The effectiveness of the Division of Worker Education is difficult to determine because the outcomes of its two major goals are conflicting. DWE's prevention activities should result in fewer work-related accidents. However, the division's other objective--to educate the worker on procedures, and their rights in the system--could result in a greater number of workers filing accident reports and claims because of an increased awareness of workers' compensation.

2) The program review committee found that if the total number of work-related injuries is used as a measure of the effectiveness of DWE's prevention activities, the division has not been effective. The total number of those accidents, as reported to the workers' compensation commission, is increasing. There were 39,073 work-related accidents in FY 86 and 50,822 in FY 90, a 30 percent increase in the past five years.

3) Another yardstick to measure workplace safety, and whether DWE prevention efforts are working, is the number of accidents per 100 employees. This ratio has also

risen, from 2.5 accidents per 100 workers in 1986 to 2.9 accidents in 1989.

4) The growth in work-related accident reports, if viewed as a measure of the division's success in educating workers about the system and the benefits they are entitled to, suggests that the Division of Worker Education has been effective in its education efforts.

5) The division spends the majority of its staff time and financial resources on informing workers about the system and procedures, and their rights within it. These activities include the mailings, seminars offered to injured workers, and the operation of the toll free number.

6) The Division of Worker Education is unable to focus its prevention activities where they may be most needed because no data currently exist on where accidents or occupational diseases are occurring. When the occupational disease database, mandated by P.A. 90-226, becomes operational it should provide such occurrence information. Also, during the summer of 1990, the division computerized its telephone call intake form. In the future, DWE hopes to analyze the intake results to focus its prevention activities.

7) There is a perception by the business community that DWE is anti-employer. Businesses point to illustrations, wording, and referral sources in some division literature to support this claim.

8) Some of the activities performed by the Division of Worker Education appear to duplicate or overlap those performed by other entities. For example, the Occupational Safety and Health Administration of the state Department of Labor conducts inspections and provides consultant services to businesses on safety and potential hazards at the workplace. Insurance companies also conduct safety inspections in conjunction with loss control efforts for those facilities they insure for workers' compensation.

9) The statutory responsibilities of DWE include educating employers about known and suspected hazards in the workplace, providing information to workers about safety, and informing employees about their rights in the workers' compensation system. Even given that broad mandate, it is unclear how activities such as environmental testing and developing a newsletter for distribution to the medical community meet those functions.

10) Responsibility for overseeing the Division of Worker Education is unclear. The DWE director is appointed by the chairman, but the statutes give the compensation commissioners the authority to adopt regulations to implement the provisions of the division. Those regulations, which might address such accountability issues, have not been developed.

11) A number of claimants have stated, and the director of DWE confirmed, that the division does not give information to claimants who are represented by attorneys.

Resources

12) The funding of the Division of Worker Education has grown by 86 percent between FY 86 and FY 90. The DWE's budget has increased at a faster pace than the commission's central and district offices, or the Division of Worker Rehabilitation Division, whose budgets grew 49.3 and 46.0 percent respectively.

13) The DWE's revenues come entirely from assessments on employers, based on 0.2 percent of their prior year's payouts in workers compensation. Due to its funding source, the division's budget grows as claim payouts grow. There are no checks to ensure that DWE actually needs the assessed amounts to run its operations.

14) The DWE's budget does not clearly reflect the division's actual expenses. Some of DWE's expenditures have little relation to the education of workers or employers. For example, the commissioners' \$23,719 out-of-state travel expense for FY 90 came out of the DWE budget and may only be allocated to DWE because the division has more revenue than it needs, and because there is no oversight of DWE's expenditures. Other expenses that are clearly related to DWE activities, such as the 800 line equipment, are paid out of the compensation commission budget.

15) The efficiency of staffing the 800 number by professional-level employees is questionable. In district offices, a similar function is performed, at considerably less expense, by clerical workers.

16) The resources in workers compensation are not allocated according to workload in the system, but rather on funding formula only. For example, DWE has no caseload, or hearing dockets as do the district offices, however the number of clerical and support staff in DWE is greater than in four of the eight district offices.

DIVISION OF WORKERS' REHABILITATION

The Division of Workers' Rehabilitation (DWR) was established to provide rehabilitation programs to employees whose compensable job-related injuries disable them from performing their most recent or customary work. Participation in division programs is voluntary and services are provided at no cost to clients.

DWR services include eligibility screening, aptitude testing, vocational counseling, training, and direct job placement. Workers accepted for training programs are also eligible for financial benefits including tuition, fees, books, supplies, training equipment, travel reimbursement, and a subsistence allowance for basic living expenses equivalent to 80 percent of their temporary total disability compensation rate.

The division's main activities are evaluating referrals, arranging and monitoring participation in formal and on-the-job training programs, and overseeing job placement of retrained workers. Statistics on the number of workers who completed DWR sponsored training and the number subsequently employed over the past five fiscal years are presented in Table II-6.

The table also shows the total number of individuals served, a measure of all workers who have had contact with the division. Workers served includes active cases (e.g., those being evaluated, in training, or awaiting placement) and cases terminated over the year such as referrals who declined services and workers who completed training and were reemployed.

Table II-6. Division of Workers' Rehabilitation Activities: FY 86 - FY 90.					
Year	No. Served	No. Completed Training	No. Trained & Employed	% of Served Trained	% of Trained Employed
FY 86	2,552	262	203	10%	77%
FY 87	2,962	286	218	10%	76%
FY 88	2,950	320	187	11%	58%
FY 89	3,987	366	323	9%	63%
FY 90	4,547	478	264	11%	55%

Source of Data: Division of Workers' Rehabilitation.

Under division policy, eligibility for training programs is limited to workers whose compensability has been established under an award or an approved voluntary agreement or stipulation. The division also declines services to those with: 1) insufficient disability (i.e., the disability does not prohibit the performance of the worker's most recent or customary work, or the worker has transferable skills and could function in an alternative occupation that has significant employment opportunity); or 2) insufficient capacity (the worker's disability is so significant that successful completion of training and reemployment cannot be reasonably expected). Of the 2,512 cases closed by the division in FY 90, 13 percent were terminated due to ineligibility.

Subject to funding availability, subsistence payments are provided to all workers engaged in full-time vocational training programs sponsored by DWR unless they are receiving or eligible for temporary total disability payments. Division policy does permit workers receiving permanent partial disability benefits to receive rehabilitation subsistence allowance during their training periods. All DWR trainees are eligible for travel reimbursement at the rate of 24 cents per mile.

Money for subsistence benefits is allocated among districts in the form of "slots" for eligible individuals. The number of slots per district is derived from a formula based on numbers of reported accidents and active rehabilitation caseload, although in recent years, additional slots created by increased division funding have been distributed equally among the districts. On occasion, the director has allocated extra "slots" to districts with special needs.

The director of workers' rehabilitation, who is appointed by the commissioners, establishes division programs and oversees the 20 division employees. The staff is comprised of 11 rehabilitation professionals including a rehabilitation services supervisor, 8 fiscal, clerical, and support personnel who handle administrative and claims processing functions, and a building maintainer. Eight of the rehabilitation staff are assigned to work directly with clients in each of the workers' compensation districts while two counselors specialize in hard-to-place cases referred by the district coordinators.

District coordinator caseloads ranged from 208 for the least experienced counselor to 323 as of September 1990. To keep each individual's workload manageable, cases are shifted from personnel in the larger districts to those in the smaller districts by the director as needed. In addition, the director and the rehabilitation supervisor are currently handling about 75 and 150 cases, respectively. The division's goal is 200 cases per district coordinator.

Using June as a representative month, the division's active monthly caseload has averaged 1,603 over the past five years. Active caseload data each year from 1986 to 1990 are presented in Table II-7. The table also presents information on the number of trainees who received a subsistence allowance during the month. Between 56 and 65 percent of those in training have received subsistence benefits, according to June monthly caseload statistics from the past five fiscal years. The average subsistence payment in June 1990 was approximately \$288 per week.

Table II-7. DWR Active June Caseload: 1986 -1990.							
Year	Total Cases*	No. in Eval.	No. in Train.	No. Pending Place.	No. Inact.	No. in Train. Paid Subs.	% of Train Paid Subs.
6/86	1,222	790	358	74	**	233	65%
6/87	1,397	945	352	100	**	217	62%
6/88	1,703	1,021	363	117	202	218	60%
6/89	1,660	1,008	400	122	130	225	56%
6/90	2,035	1,189	474	214	158	295	62%

* total = sum of evaluation, training, placement, and inactive (e.g., temporarily withdrawn from training for medical reasons)

** inactive included in other categories for these years

Source of Data: Division of Workers' Rehabilitation.

The division and its programs are financed by an annual assessment on employers (other than the state and municipalities belonging to an interlocal risk management agency) of two percent of workers' compensation benefits paid in the previous year. The assessment is collected by the state treasurer's office and held in a trust fund for the division's use.

As a result of being linked to benefit payout, the division's budget has been steadily growing. As Table II-8 indicates, from FY 86 to FY 90, DWR expenditures increased more than 50 percent, from \$5.6 million to nearly \$8.6 million. The table also shows, in terms of gross division expenditures, costs on a per worker served, trained, and employed basis.

Table II-8. Division Expenditures: FY 86 - FY 90.

Year	Total Expenditures	Exp. per Case Served	Exp. Per Case Trained	Exp. Per Case Employed
FY 86	\$5,632,389	\$2,207	\$21,498	\$27,746
FY 87	\$5,323,567	\$1,797	\$18,614	\$24,420
FY 88	\$5,853,025	\$1,984	\$18,291	\$31,300
FY 89	\$6,670,284	\$1,673	\$18,225	\$28,751
FY 90	\$8,571,563	\$1,885	\$17,932	\$32,468

Source of Data: Division of Workers' Rehabilitation.

Over the past five years, total division expenditures divided by either the numbers of workers served or by the numbers of workers reemployed have fluctuated while division expenditures per-worker-trained have shown a small but persistent decline. This seems due to the fact that only the number of workers trained has shown a steady upward trend, and appears to reflect the division's emphasis on its training function.

Findings

The goal of DWR is to return disabled employees to suitable work. The division serves a small portion of claimants and spends significant sums to do so. Over the past five years, the division has, on average, spent \$ 6.4 million per year to serve 3,400 workers, of whom 342 complete training and 220 are placed in the jobs.

The division's programs may not be meeting the needs of injured workers, indicated in part by the fact that referrals who decline the services make up the majority of closed cases. In addition, DWR seems to be less effective in returning clients to work as job placement rates have been dropping since 1987. Detailed findings regarding the performance, resources, and management of the Division of Workers' Rehabilitation are presented below.

Performance

1) Demand for division services is increasing. The number of new DWR cases opened increased 47 percent, from 1,549 in calendar year 1986 to 2,274 in 1989 and was more than 1,900 for the first nine months of 1990.

2) The division is providing services to increasing numbers of injured workers. However, they still represent a small portion of the workers' compensation population. From FY 86 to FY 90, the total number of workers served by the division grew 78 percent, from 2,552 to 4,547. Using the number of accidents reported in the previous year as a proxy for number of potential claimants, the division served nine percent of the workers' compensation population in FY 90, compared with seven percent in FY 86.

3) Over the past five fiscal years, the number of workers completing division-sponsored training grew more than 80 percent from 262 to 478. However, as a portion of total clientele (all workers served), those who complete training programs has remained relatively stable at 9 to 11 percent.

4) In recent years, the division has been less successful in placing its trained workers in suitable jobs. While the number of workers who were employed after completing their training programs rose 30 percent, from 203 in FY 86 to 264 in FY 90, such workers as a portion of the total number trained declined from 77 to 55 percent.

5) Many claimants referred to DWR decline the services offered, indicating that either referrals are often inappropriate or that division programs are not meeting client needs. Nearly three-quarters (72 percent) of the 2,512 cases closed in FY 90, were terminated because the worker decided not to participate in DWR programs.

6) DWR services are focused on formal retraining for a new occupation despite division policy that states this approach is expensive and should be considered a last resort. In 1986, the commissioners directed the division to put greater effort toward getting injured workers rehired with the same or similar employers and less emphasis on formal retraining programs. However, the majority of division training still occurs at academic institutions (e.g., community colleges) and proprietary schools (e.g., computer training institutes). Of the approximately 500 individuals in training at present,

only about 10 percent are in on-the-job-training (OJT) programs.

7) The emphasis on formal training excludes certain types of workers from the bulk of division programs. DWR has initiated special programs to serve workers with minimal English skills or deficient academic backgrounds and other hard-to-place clients. However, the capacity for such services is limited to approximately 50 individuals and waiting lists have developed.

Resources

8) The division consistently spends nearly 90 percent of its budget on benefits to clients. In FY 90, more than half of division expenditures went directly to clients for subsistence allowance (48 percent) and travel reimbursement (8 percent) while 33 percent went to pay training fees. Administrative costs, primarily salaries and fringe benefits, accounted for only 11 percent of the division budget.

9) The DWR workload has grown at a faster rate than its personnel resources. Division staffing increased by one-third (from 15 to 20 positions) between June 1986 and June 1990, while active monthly caseload, based on June statistics, increased about two-thirds (from 1,222 in 1986 to 2,035 in 1990). Higher caseloads may be diminishing the staff's effectiveness in providing vocational rehabilitation services.

Management and Policy

10) Accountability for division operations is diffused since the director is appointed by the commission and, in theory, is responsible to each commissioner. The division operates independently from the central office and with little oversight by the commissioners.

11) All services, including the award or denial of subsistence allowance benefits, are provided in the absence of regulations. While policies have been drafted and some have been approved by the commission, regulations for division operations have not been promulgated despite a statutory mandate to adopt them by October 1, 1986.

12) Evaluation of the division's overall performance, since it is given little attention by either DWR or the commission, appears to be a low priority. Information

that could indicate efficiency and effectiveness such as profiles of workers served as well as referrals and terminations, average training costs, and data on outcomes by type of program, is neither compiled nor analyzed on a regular basis. Certain key data are not even collected. For example, division staff do not follow up on reemployed workers to determine placement success.

13) Under the division's present allocation policy, subsistence benefits are not equally available among the districts. As shown in Table II-9 below, active rehabilitation cases per allocated subsistence "slot" ranged from just under four in District 7 to nearly nine in District 5.

Table II-9. Subsistence Slots and Rehabilitation Caseload by District.			
District	Allocated Subsistence Slots (1990)	Active Rehab. Caseload (6/90)	Slots Per Rehab. Case
D.O. 1	43	312	7.26
D.O. 2	43	331	7.70
D.O. 3	48	299	6.23
D.O. 4	38	232	6.11
D.O. 5	43	386	8.98
D.O. 6	43	187	4.34
D.O. 7	29	111	3.83
D.O. 8	28	177	6.32
Total	315	2,035	6.46
Source of Data: Division of Workers' Rehabilitation.			

COMPENSATION REVIEW DIVISION

The Compensation Review Division (CRD) provides for administrative review of decisions made by workers' compensation commissioners that prior to 1980 were appealed directly to court. The division was intended to build a body of administrative case law to guide future decisions and promote uniformity as well as to reduce the judicial branch workload and the expense of appeals.

By statute, the CRD only hears appeals concerning legal inconsistencies or errors in factual findings; cases are not heard de novo. In addition to affirming or reversing decisions on the award or dismissal of claims, orders, and rulings on procedural motions, the division may remand a case to the trial commissioner for further proceedings.

Three-member panels, which consist of the commission chairman and two other commissioners that he assigns for each session, meet one day per month to hear appeals scheduled for oral argument. CRD sessions are usually held 11 times a year. Commissioners who have been involved in a case are prohibited by law from hearing its appeal.

Petitions for a CRD review must be filed within 10 days of the trial commissioner's decision. There are no costs to the parties to bring an appeal. State law requires the division to issue its decision within one year of the appeal's filing date.

The division is staffed by an attorney, two paralegals, one full-time and one part-time (about 60 percent), and a senior clerk, at an estimated cost of about \$165,000 per year including fringe benefits. According to the chairman, about half of his time is devoted to CRD matters.

Division paralegal and clerical staff review petitions, prepare case summaries, keep the calendar, set dockets, and send notices. The CRD attorney's primary function is to assist the chairman by researching and drafting decisions. The chairman writes approximately 95 percent of all CRD decisions. Nearly all decisions have been unanimous.

Almost every major provision of the workers' compensation act has been the subject of appeal. Among the issues most frequently addressed in CRD decisions through December 1988 are the following: the appeals process itself (e.g., timeliness of the appeal, division jurisdiction); police and fire personnel heart and hypertension benefits; preclusion of employer liability; whether the injury arose out of the course of employment; and proper notice of injury/initial medical treatment.

Findings

The Compensation Review Division, as intended, is producing administrative case law to guide decisions, especially in some of the most complex areas of the workers' compensation statutes. While the division has not significantly reduced the court's workload, its process is less costly than a court appeal. Furthermore, it is possible, although rare, for a party to bring an appeal to the CRD without an attorney.

The direct costs of the division--personnel expenses--are not significant compared to the overall commission budget. However, the CRD takes up a considerable portion of the chairman's time and takes away already limited resources from district office operations in terms of trial commissioner time for conducting hearings. Detailed findings regarding the performance and administration of the Compensation Review Division follow:

- 1) The portion of total findings and awards appealed to the CRD has remained fairly constant, ranging from 12 to 16 percent over the past 10 years. (See Table II-10)
- 2) Respondents (employers or their insurers) file appeals more frequently than claimants. In FY 89, respondents accounted for 69 percent of the 143 appeals with complete information and another 3 cases were cross-appeals.
- 3) About half of the appeals filed with the CRD are subsequently withdrawn. Analysis of appeals disposed of by the division during calendar years 1986 through 1989 shows that of the 419 appeals handled, 206 (49 percent) were withdrawn while 213 went forward. (See Table II-11)
- 4) The commissioners sitting on CRD panels have shown a willingness to overturn their colleagues' decisions. During calendar years 1986 through 1989, reversals and remands (in part or in whole) accounted for almost one-third (31 percent) of the division's written dispositions (67 of 213 cases).
- 5) "Error rates", measured as reversals and remands of decisions, vary among commissioners, ranging from 9 to over 40 percent for commissioners with 20 or more active appeals disposed of by the CRD during 1986 through 1989.
- 6) About one-quarter (52) of the CRD decisions made during 1986 through 1989 were appealed to court. In general, the courts have upheld CRD decisions. During the period 1986 through 1989, the Appellate Court reversed 3 of the 23 CRD actions it reviewed, while the Supreme Court reviewed 12 and overturned 2.

Table II-10. Compensation Review Division Statistics: FY 80 - FY 90.

FY	No. New Appeals	No. Trial Comm. Awards	Appeals as Percent of Awards	No. Dispositions	No. Written Dispositions	No. With-drawn	Percent Written Dispositions	Percent With-drawn
79-80	36	420	9%	7	4	3	57%	43%
80-81	56	456	12%	19	18	1	95%	5%
81-82	73	492	15%	48	20	28	42%	58%
82-83	93	566	16%	63	35	28	56%	44%
83-84	88	608	15%	43	18	25	42%	58%
84-85	80	559	14%	71	32	39	45%	55%
85-86	80	505	16%	57	23	34	40%	60%
86-87	116	813	14%	127	82	45	65%	35%
87-88	135	1,105	12%	132	78	54	59%	41%
88-89	147	1,040	14%	154	82	72	53%	47%
89-90	174	1,193	15%	171	98	73	57%	43%

Source of Data: Compensation Review Division.

Table II-11. Appeals by Trial Commissioner: Action by the Compensation Review Division, 1986 - 89.

	Total No. Appeals	No. With-drawn	% With-drawn	No. Acted on by CRD	No. CRD Affirm	No. CRD Reverse or Remand	% Rev. or Rem.
D.O. 1	18	9	50%	9	8	1	11%
D.O. 2	55	34	62%	21	15	6	27%
D.O. 3	29	12	41%	17	9	7	41%
D.O. 4	40	17	43%	23	21	2	9%
D.O. 5	30	15	50%	15	7	8	53%
D.O. 6	30	17	57%	13	9	4	31%
D.O. 7	84	31	37%	53	37	16	30%
D.O. 8	33	12	36%	21	17	4	19%
At-Large	68	38	56%	30	17	13	43%
At-Large	22	14	64%	8	5	3	38
Other*	10	7	70%	3	0	3	100%
Total	419	206	49%	213**	145	67	31%

* Other includes chairman and a temporary district commissioner

** One case forwarded directly to court

Source of Data: Compensation Review Division

7) The division reduced the judicial workload by about 40 cases per year over the past four calendar years. This estimate is based on the assumption that in the absence of the CRD all 160 cases it decided that were not appealed, would have gone directly to court.

8) The cost per case decided by the CRD in FY 90, in terms of personnel expenses (for division staff and the chairman), was about \$2,255.

9) There are considerable non-monetary costs attached to the Compensation Review Division. Assuming that panel members other than the chairman spend between one and two days per CRD assignment and typically handle 20 to 25 hearings per day in the district offices, approximately 500 to 1,000 hearings per year are foregone while trial commissioners serve on CRD panels.

10) As Table II-10 indicates, a significant backlog of cases--approximately 200--developed at the division through FY 86. Since then, with the assistance of a staff attorney hired during 1986, the division generally has been disposing of more appeals than are received new.

11) The division is not meeting its statutory deadline of issuing written decisions within one year of filing an appeal, which could be evidence of understaffing or inefficient case processing. At present, it is estimated that most cases are decided within 16 to 17 months.

SECOND INJURY FUND

The Second Injury Fund (SIF) was established by statute in 1945 to provide an incentive to employers to hire workers with physical handicaps or prior injuries. State law permits employers to transfer their liability for paying workers' compensation benefits to the fund when such disabled employees suffer subsequent, job-related injuries.

In general, second-injury cases may be transferred to the SIF only after the employer pays benefits for two years. However, if the second injury is related to a pre-existing condition or previous injury that the employee has acknowledged through a signed document (an acknowledgment of physical defect), then immediate transfer to the fund is permitted. Once a case has been transferred to the SIF, the employer relinquishes all financial and administrative responsibility for that claim.

Over the years, the role of the Second Injury Fund has been statutorily expanded to ensure payment to individuals who are entitled to workers' compensation but, due to a variety of circumstances, might not receive benefits. The statute requires that the SIF pay:

- * payments to claimants whose employers were uninsured and who failed to pay awarded benefits;
- * benefits to claimants whose cases are under appeal;
- * a portion of the benefits in situations where an employee held more than one job at the time of injury; and
- * payment for continuing fringe benefits for totally disabled workers after the first two years, or if the employer has moved out-of-state or ceased operating.

Cost-of-living adjustments to totally disabled workers and to dependents of deceased claimants, whose injuries or deaths occurred prior to certain dates are also paid by the Second Injury Fund.

The Second Injury Fund is financed through assessments on all employers (or insurers on their behalf) except for the State of Connecticut. Any single assessment is limited in total to no more than five percent of total workers' compensation benefit payouts for the prior year. However, there is no limit to the number of times employers may be assessed up to this cap to fund the SIF during a one-year period.

A division of the Office of the State Treasurer administers the fund. The division's responsibilities include examining and processing claims, paying claimants and vendors, investigating claims, performing medical case management, and assessing employers or their insurers for underwriting the fund. At the time of the committee review, the division had 44 staff positions, 3 of which were vacant. Administrative costs, which are paid directly from the fund, were budgeted at \$2,876,408 for FY 91.

The Office of Attorney General provides legal services for the Second Injury Fund. The Attorney General's costs for providing services, estimated at \$990,000 for FY 91, are paid from the fund. The unit that serves the Second Injury Fund also represents state agencies in workers compensation matters and consists of eight attorney, eight paralegals, and eight clerical staff.

Total benefit costs paid by the Second Injury Fund for calendar years 1985 through 1989, along with annual percentage increases in payout, are presented in Table II-12. Over the five year period shown in the table, payouts from the fund increased about 120 percent, from almost \$20 million to over \$40 million.

The largest portion of SIF payouts is made to claimants who have suffered a subsequent injury, as Table II-13 indicates. The table shows SIF costs for FY 90 by the following payment categories: benefits to claimants with subsequent (second) injuries; death benefits; benefits to claimants whose employers were uninsured; additional benefits for claimants whose permanent partial disability benefits have run out; cost-of-living adjustments (COLAs); benefits to claimants with multiple employers; benefits for claimants who request compensation while their cases are on appeal; benefits to claimants with acknowledged physical impairments; and continuation of claimant fringe benefits. In FY 90, benefits paid in second injury cases totalled 35.6 million or 78 percent of total SIF payouts. In comparison, Second Injury Fund payouts for subsequent injuries in 1986 comprised 69 percent of total benefits costs or nearly \$16 million.

Table II-12. Second Injury Fund Payouts: 1985 - 1989.		
Calendar Year	Payouts	% Increase Over Prior Year
1985	\$19,417,926	28.0
1986	\$23,064,529	18.8
1987	\$26,118,324	13.0
1988	\$32,500,000	24.5
1989	\$43,285,292	33.1

Source of Data: Conn. Workers Compensation Commission.

Table II-13. Second Injury Fund Payouts by Category: FY 90

Category	Payout	% of Total
Second Injury	\$35,591,470	78
Death Benefits	\$ 3,010,129	6
Uninsured Employers	\$ 2,098,476	4
Additional Benefits	\$ 1,325,854	3
COLAs	\$ 1,218,435	3
Multiple Employers	\$ 1,122,936	2
Appeals	\$ 996,944	2
Acknowledgments	\$ 943,084	2
Fringe Benefits	\$ 569,758	1
Total	\$46,877,086	100

Source of Data: Office of the State Treasurer.

Findings

Program review committee findings related to the Second Injury Fund focus on the fund's explosive growth. Growth in payouts is largely due to increasing utilization by claimants who have suffered a subsequent injury and therefore are eligible for transfer to the SIF. Statutory provisions, as discussed below, allow for this increased usage because of the broad way in which pre-existing conditions are defined.

Costs

- 1) Payments from the SIF during 1989 totalled \$43.3 million, which is 7.5 percent of all payouts for workers' compensation in Connecticut.
- 2) The Second Injury Fund's payouts have more than doubled in the past 5 years, as indicated in Table II-12, above.
- 3) During the period 1985 through 1989, the SIF payouts have grown 40 percent more rapidly than have workers' compensation payouts overall.

4) The SIF payouts per employed person in the state almost doubled between 1986 and 1989. In 1986, the payouts per worker totalled \$14; in 1989, they had risen to \$27.

5) Payouts both directly to claimants and to vendors on their behalf (insurance carrier reimbursements, medical payments, etc.) are currently about \$1 million per week. To cover these expenses, employers were assessed twice--at 5 percent of total workers' compensation payouts each time--during FY 90. Staff in the treasurer's office anticipated that 3 SIF assessments would be needed during FY 91.

6) The largest percentage of SIF payouts are for claimants who have suffered a subsequent injury. While the fund's statutory responsibilities to pay benefits in other types of circumstances contribute to the overall growth of SIF costs, they are declining as a percentage of total fund payouts.

7) The potential for growth of the Second Injury Fund payouts is significant. As of June 1990, there were 10,976 active subsequent injury claims covered by the SIF; 16,124 such claims were pending decisions on transfer. While all of the pending claims may not be found eligible for transfer or even pursued by the employers or insurers involved, they indicate the great demand facing the SIF.

Statutory Provisions

8) Connecticut is one of 15 states that require only that the second injury or disease, when combined with any pre-existing condition, result in a permanent disability greater than from the second injury alone. Other states are generally more restrictive in that they either require the second injury to be either the loss of an eye or body part or to result in permanent total disability.

9) Connecticut has no requirement that the employer have prior knowledge of the condition or injury in order for the SIF to pay after the first 104 compensable weeks. Thus, a first job-related injury may result in a SIF claim if a post-injury medical examination reveals a pre-existing condition.

10) Signing acknowledgments of physical defect is not supposed to jeopardize a workers' claim to compensation. However, according to the Attorney General's staff, delays in claim processing can occur in cases where acknowledgements exist. This is because some employers

or insurers on their behalf take the position that the SIF and not the employer should be the party initially accepting or denying the compensability of the claim.

11) The State of Connecticut, as an employer, is not assessed for the financing of the Second Injury Fund although it does transfer claimants. If the state were included, its assessment for 1989 would have been about \$4 million.

12) The Second Injury Fund has no future reserves. Instead, it operates on a "pay-as-you-go" basis. Public Act 86-35 required the state treasurer to adopt regulations describing what constitutes a "...proper and sufficient plan for payment into the fund...." These regulations have not been developed as yet, but the SIF division indicates they are being worked on.

BENEFIT COSTS

Workers' compensation is a benefit system where workers are paid a portion of their lost wages when they cannot work because of a job-related injury. In addition to wage replacement, the system pays all medical expenses incurred as a result of an occupational illness or injury. Like most other states, Connecticut provides benefits beyond indemnity and medical care such as dependency allowances, cost-of-living adjustments in certain cases, benefits for scarring, and compensation for any permanent disability that results from a job-related injury.

The costs of providing workers' compensation benefits are escalating rapidly, and appear uncontrollable. One of the primary aims of the program review committee was to identify factors driving benefit costs and recommend ways to curb the growth. Committee analysis and findings related to workers' compensation benefit costs follow.

Insurance Costs

Most employers in Connecticut insure their workers' compensation risks with private insurers. In 1988, there were approximately 162 insurance carriers writing \$100,000 or more of workers' compensation insurance in Connecticut. The cost to state businesses to insure their workers' compensation risks in 1988 was approximately \$700 million.

Insurers write and charge for policies based on the amount of exposure or liability. In the case of workers' compensation, the exposure is the aggregate payroll for a given employer. Table II-14 shows total payroll for all Connecticut employers covered by private insurance, and the annual increases for a five-year period

ending in 1987 (the last year for which the payroll data are available). The table also displays standard earned premiums (actual premiums charged, but prior to dividends) charged to businesses in Connecticut for the same period. With the exception of 1984, premiums charged grew at a brisker pace than did payroll covered, indicating that not all the growth in premiums was due to escalating wages.

Table II-14. Workers' Compensation Insurance: Payroll Covered and Premiums Charged, 1983-1987.				
Year	Payroll Covered (\$ 000)	Percent Increase	Premiums Charged (\$ 000)	Percent Increase
1983	\$17,908,001	--	\$348,545	--
1984	\$19,991,329	11.6	\$372,487	6.8
1985	\$20,995,430	4.8	\$448,037	20.2
1986	\$23,145,010	10.4	\$519,397	15.9
1987	\$26,358,463	13.8	\$601,316	15.7

Sources of Data: NCCI Unit Statistical Plan and National Assoc. of Insurance Commissioners (profitability data).

Insurance Rates

To price workers' compensation insurance, insurance carriers classify jobs according to their risk. There are more than 600 job classifications. The more hazardous the job, the higher the rate charged for that classification. For example, a construction company pays significantly more to insure its roofers than its clerical staff. The rate charged for a job classification is typically multiplied by each \$100 of payroll to arrive at the premiums that a business is charged. Insurance premiums can be modified for a business based on several factors, including its safety programs, and its past claim experience.

Businesses in Connecticut claim that the rates they are charged for workers are higher than those charged in other states. According to a study produced by the Grant Thornton Management Consulting Firm, Connecticut's workers' compensation insurance costs for manufacturers are higher than the national average. The report, which assesses manufacturing climates in different states, provides an index of states' workers' compensation insurance premiums for manufacturers in all 50 states. Using that index, which gives a value of 1.00 for the average premiums charged nationally, Connecticut ranks 13, with a rating of 1.318.

The program review committee examined the rates for 11 job classifications suggested by the Connecticut Insurance Department, and compared the rates charged in Connecticut, Rhode Island, New York and Massachusetts. It must be noted that Connecticut's rates as shown in the table are estimated, since state law prohibits the rating bureau's published rate from including general expenses, taxes, and profits. Individual companies in Connecticut add their own expenses. To make a general comparison with the other states, committee staff added 25 percent (generally the expense portion nationally in workers' compensation) to the published rate for expenses. The results are shown in Table II-15.

Table II-15. Insurance Rates Charged for Selected Job Classes: Four State Comparison.				
Job Classification	Rhode Island	Conn.	New York	Mass.
Iron/Steel Worker	\$25.66	\$44.25	\$17.14	\$21.44
Tool Mfg.	\$ 3.70	\$ 3.78	\$ 4.36	\$ 4.39
Metal Goods Mfg.	\$14.24	\$ 8.56	\$13.75	\$ 9.21
Machine Shop	\$ 7.46	\$ 6.72	\$ 6.63	\$ 5.21
Concrete Construction	\$19.56	\$30.38	\$15.36	\$33.73
Carpenter	\$16.25	\$29.31	\$14.08	\$30.31
Trucking	\$14.25	\$18.62	\$15.30	\$18.85
Store (whole-sale)	\$ 6.09	\$ 7.60	\$ 6.07	\$ 9.41
Clerical	\$.52	\$.40	\$.47	\$.39
Hospital Professional	\$ 2.90	\$ 1.96	\$ 2.27	\$ 2.69
Hospital Other	\$ 5.65	\$ 4.77	\$ 5.73	\$ 7.71
Source of Data: Rating Bureaus Published Manual Rates (1989 or 1990)				

As Table II-15 shows, Connecticut's rates are the lowest in three of the categories (the two hospital worker classes and metal goods manufacturing), the highest in the iron/steelworker category, and second or third in the remainder. However, comparing rates alone can be misleading.

It is possible to draw incorrect conclusions from the rate data shown in table if the amount of labor used by similar businesses operating in different states is not considered. For example, although the rate for iron/steel workers in Connecticut is about 42 percent higher than the rate in Rhode Island, it is conceivable that a Connecticut firm could have lower total workers' compensation costs than a competing Rhode Island firm. This result can occur if a Connecticut company uses fewer workers than a Rhode Island firm in accomplishing the same task.

To illustrate, suppose both the Connecticut and Rhode Island firms pay the same wages, but the latter uses seven workers to every four employed by the Connecticut company. Under this circumstance, the total workers' compensation costs of the Rhode Island firm would be higher.

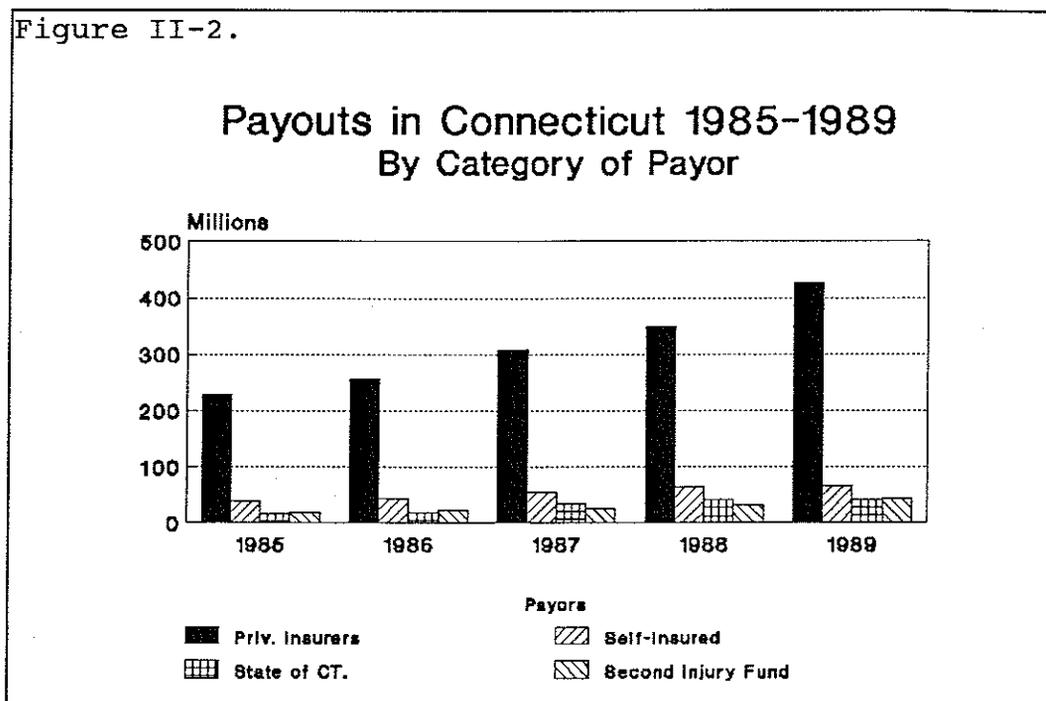
Another factor that should be considered in examining the data in Table II-15 is the importance of relative rather than absolute differences in rates among job classes. The point can be illustrated by examining differences between Connecticut and Rhode Island in the machine shop and clerical categories.

In absolute terms, the differences between the states are \$0.74 in the machine shop and \$0.12 in the clerical categories, however in relative terms Connecticut's rates are nearly three times lower in the clerical category than in the machine shop class. Therefore, Connecticut firms may actually have a greater advantage in the clerical as opposed to the machine shop area. Of course, this would again depend on the relative labor intensity of the competing firms.

Payouts

One of the reasons insurance costs are high in Connecticut is that total payouts are large. Figure II-2 shows the total payouts by all payors--private insurers, self-insured employers, the State of Connecticut, and the Second Injury Fund. As the figure shows, the total payouts are growing dramatically, and in 1989 were \$580,252,719. This represents a 19.3 percent growth over 1988 payouts, and an increase of 91.2 percent in the five-year period shown in the graph.

Figure II-2.



Medical Benefit Costs

Benefits in workers' compensation are paid either directly to the worker or to medical providers for treatment related to on-the-job injuries and illnesses. In Connecticut, most of the overall payouts are for direct compensation to workers, and not for medical treatment.

However, as Table II-16 shows, actual dollar costs of providing medical services in workers' compensation have increased sharply over the past several years. The table also shows that medical costs as a percentage of total costs have shown small but persistent increases in recent years. It should be noted that these medical cost data, for privately insured workers' compensation risks, are for policy years 1984 through 1988, and are developed into the future, meaning the amounts include expected future losses from claims generated in that particular policy year.

Table II-17 depicts the nominal and inflation-adjusted annual rates of increase in workers' compensation medical costs. As the table indicates, even after adjusting for the rate of medical inflation in the Northeast, medical costs grew significantly. Between 1984 and 1988, the adjusted increase was 44.6 percent, far more than could be accounted for by the 11.9 percent growth in the Connecticut's workforce during the same period.

Table II-16. CT. Workers' Compensation Expected Indemnity and Medical Costs.

Year	Indemnity Losses (\$ millions)	Percent of Total	Medical Losses (\$ millions)	Percent of Total
1984	\$265.5	73	\$101.5	27
1985	\$326.8	71.6	\$129.7	28.4
1986	\$359.8	71	\$147.6	29
1987	\$429.5	70.5	\$180.0	29.5
1988	\$466.7	68.9	\$211.0	31.1

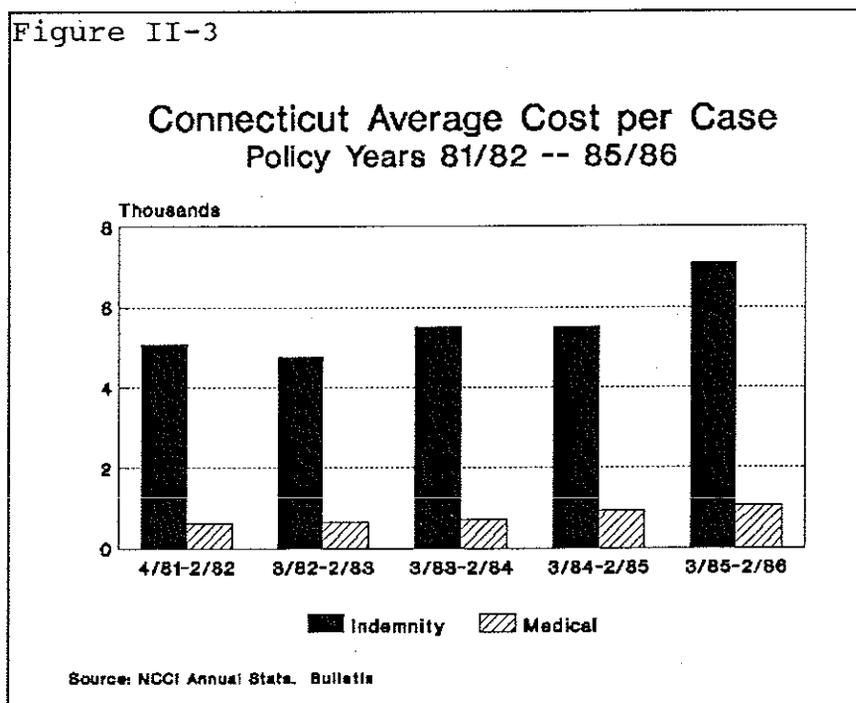
Source of Data: NCCI 1991 rate filing with the Connecticut Insurance Department.

Table II-17. Annual Growth in Workers' Compensation Medical Costs

Year	Nominal Rate	Inflation-Adjusted Rate*
1984	11.7	--
1985	27.7	14.1
1986	13.8	4.2
1987	21.9	16.7
1988	17.2	9.6

* Based on Northeast region medical inflation rate
Sources of Data: Data Resources Inc. and National Council on Compensation Insurance Data.

Compensation cost data also show that Connecticut's medical costs for injured workers, on an average per-claim basis, are increasing. Figure II-3 presents the average indemnity and medical costs per case for policy years 4/81-2/82 through 3/85-2/86, as reported by NCCI. The graph indicates that, while average per-claim medical costs are lower than indemnity costs, medical costs are growing at a faster rate. During the period shown, average per-claim medical expenses, unadjusted for inflation, grew by 71.8 percent, while average per-claim indemnity increased by only 40.2 percent.



Medical costs in Connecticut, while proportionately low, may be difficult to contain for two reasons. First, there is no medical fee schedule in Connecticut. The Workers' Compensation Commission has the statutory authority to establish one, but has not done so. There are fears that a medical fee schedule would seriously limit the availability of medical services and reduce the number of qualified medical providers who would treat workers compensation cases.

Second, Connecticut is one of about 30 states that currently allows employees the right to select a medical provider of their choice, thereby limiting the use of employer-provided health maintenance organizations, preferred provider organizations, and the like. Finally, the nature of the Workers' Compensation System, which depends on medical decisions to determine such things as whether the worker can return to work and in what capacity, and the

percent of permanent partial disability, may itself be a cost-driver.

Indemnity Benefit Costs

The other category of benefit payments, and by far the largest in Connecticut, is for direct compensation to the injured worker. No data exist on the amount paid in wage loss benefits from all sources. However, payments made on behalf of privately insured employers for direct wage loss benefits for 1988 are expected to total almost \$467 million. As shown in Table II-16 above, the indemnity costs for those employers who are privately insured account for more than two-thirds of the total in each year of the 1984-1988 period.

The costs to provide wage loss benefits have been rising at a rapid pace. Indemnity costs, adjusted for inflation, for those who are privately insured in Connecticut have risen 48.6 percent during the 1984-1988 period.

Incidence of Workplace Injuries

One explanation for the tremendous growth in workers' compensation payments is that there has been a general increase in private sector workplace accidents in Connecticut over the past several years. (Only the private sector incidence rates were used, since national data on the public sector are not reported). Table II-18 below shows the number of workplace accidents and illnesses involving lost workdays for every 100 workers. As the table shows, Connecticut's incidence grew from 3.9 in 1986 to 4.4 in 1987, then declined to 4.2 per 100 workers for both 1988 and 1989.

Table II-18. Comparison of Lost Workday Cases per 100 Private Sector Workers		
Year	Connecticut	National Rate
1986	3.9	3.6
1987	4.4	3.8
1988	4.2	4.0
1989	4.2	4.0

Sources of Data: Connecticut and U.S. Departments of Labor, Bureaus of Labor Statistics

The incidence or frequency of these lost-workday cases in the private sector has been higher in Connecticut than nationally. As Table II-18 indicates, Connecticut has had a higher rate than the nation for each of the four years examined.

Lost workdays. Data generated by the federal Department of Labor also indicate that workers injured on the job in Connecticut stay out longer than workers in other parts of the country. As Table II-19 shows, Connecticut's lost workdays--which includes both days away from the job, and days of restricted activity--per 100 private sector workers have consistently been higher than the national rate for the 1986 to 1989 period. Also worthy of note is that the trend in lost workdays is increasing both in Connecticut and nationally. The data appear to indicate that Connecticut workers are more likely to suffer workplace accidents, and to miss more worktime because of those injuries and illnesses, than are workers nationwide.

Table II-19. Comparison of Lost Workdays per 100 Private Sector Workers		
Year	Connecticut	National Average
1986	70.5	65.8
1987	76.5	69.9
1988	77.8	76.1
1989	81.3	78.7

Sources of Data: Conn. and U.S. Depts. of Labor, Bureaus of Labor Statistics.

To examine whether Connecticut workers use the workers' compensation system more than other states, program review committee staff took the estimated number of privately insured workers for 10 selected states and divided the estimate by the number of wage loss claims reported for each state by NCCI¹. The resulting statistic is the number of workers for each wage loss claim generated. Thus, the lower the number, the greater the utilization. The results are presented in Table II-20, and show that utilization in Connecticut is higher than in every other state examined except Maine.

¹Estimates of privately insured workers is based on the percentages of payouts by private insurers in workers' compensation as published by the National Foundation for Unemployment Compensation and Workers' Compensation in 1989.

Table II-20. Indemnity Claims: Selected State Comparison.					
State	Privately Insured Workforce	1983 Total Cases	1983 Workers per Claim	1984 Total Cases	1984 Workers per Claim
Conn.	1,399,100	37,059	37.7	36,364	38.4
Vermont	270,580	5,249	51.5	4,565	59.2
New Hampshire	476,365	9,449	50.4	11,279	42.2
Mass.	2,766,190	57,180	48.3	n/a	n/a
Maine	440,250	11,943	36.8	12,740	34.5
Rhode Island	422,268	9,111	46.3	9,465	44.6
New Jersey	3,183,600	51,908	61.3	n/a	n/a
Maryland	1,212,486	27,069	44.7	27,697	43.7
Virginia	2,100,000	26,123	80.3	22,187	94.6
National Average	1,382,346	24,563	56.2	20,995	65.8
National Median	1,054,000	19,705	53.4	18,385	57.3
Source of Data: National Council of Compensation Insurance.					

Benefit Levels

There are several possible explanations for greater utilization in Connecticut, including, as discussed earlier, a greater number of on-the-job accidents where days were lost from work. Another possible reason is that Connecticut workers are better-informed of their rights under workers' compensation than are workers in other states. Connecticut workers are apprised of benefits due them via the Division of Worker Education, and often assisted in seeking those benefits by a labor union representative.

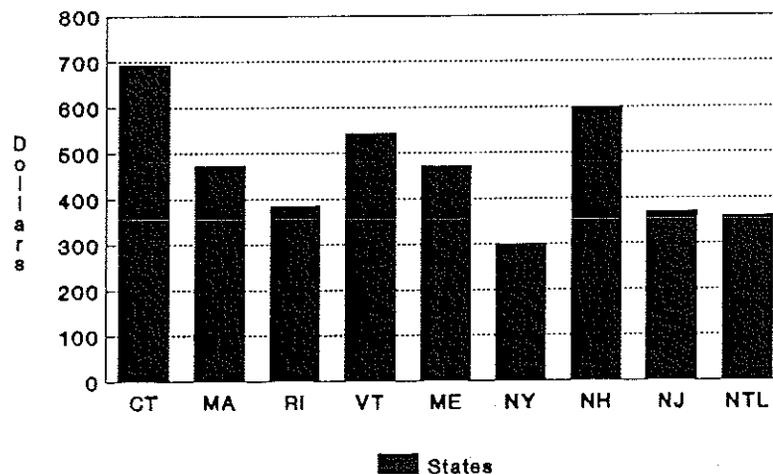
In addition, Connecticut workers may file more claims for lost wages because they don't have to be out of work as long as workers in other states in order to file a claim. In Connecticut, workers must miss three workdays before filing a claim, and if the worker

is out seven or more days, the compensation is retroactive to the date of injury. In most other states, the initial waiting period is five days or longer, and the retroactive period is two weeks.

Connecticut's workers' compensation system also provides generous benefits, which may also spur greater use of the system. The state calculates its compensation rate as most other states do, by taking two-thirds of the worker's gross pre-injury wage. However, the maximum rate in Connecticut is 150 percent of the average production workers' wage, whereas most states place the upper limit at 100 percent of the statewide average weekly wage. With 150 percent as the upper limit, Connecticut's 1989 maximum weekly benefit was the second-highest in the country at \$693; only Alaska had a higher weekly benefit of \$700. Figure II-5 shows the 1989 maximum weekly benefits for the Northeastern states and the average weekly maximum nationwide. As the graph indicates, Connecticut's 1989 maximum weekly compensation rate was over \$300 higher the nationwide average.

Figure II-5. Maximum Weekly Benefits for 1989 -- A State Comparison

Northeast and National Comparison



U.S. Chamber of Commerce, 1990 WC Laws

* Connecticut's maximum weekly compensation rate was raised to \$719. on October 1, 1990.

Workers' compensation benefits are tax free, so that the compensation paid is the worker's actual spendable income. A study on wage replacement to temporarily injured workers in various states, conducted by the Workers' Compensation Research Institute, showed that in Connecticut no workers receive less than 80 percent of their after-tax income, while 19 percent of the workers in the state receive over 100 percent of their pre-injury, after-tax wages.

The results of that selected state comparison are shown in Table II-21. What the table indicates is that in Connecticut there is generally little financial incentive to return to work because limited economic hardship is imposed on the injured worker who receives workers' compensation benefits as wage replacement.

Cost-of-living adjustments. Every October 1, workers receiving total disability payments, or dependents receiving death benefits, are granted an automatic cost-of-living adjustment (COLA). Connecticut's method of calculating the COLA leads most recipients to receive a greater change in their benefit levels than the actual percentage change in the manufacturing wage upon which the adjustment is based. This occurs because in calculating the COLA, the annual rate of change in the production workers' wage is applied to the maximum weekly benefit rate in effect for the time period in which the claimant's injury occurred. The dollar amount of any increase this procedure yields is then added to the weekly rate of every recipient in the affected category. Adding a constant dollar amount to the benefit rate for all recipients in that category results in all but those at the maximum receiving a greater rate change than actually occurs in the production workers' wage.

For example, workers injured in 1986 and collecting total disability benefits between October 1, 1989 and September 30, 1990 were subject to a maximum weekly benefit cap of \$462. As a result of the October 1, 1990 COLA, the weekly benefit cap was increased to \$477. For recipients at the maximum, the additional \$17 was equal to the 3.7 percent increase in the production wage. However, for recipients at half the maximum rate (\$231) the increase represented a 7.5 percent gain.

Type of Claims

Most claims in workers' compensation, other than for medical treatment only, are filed by workers who are temporarily totally disabled from working. According to National Council of Compensation Insurance data, however, these claims make up only a small percentage (about 10%) of total payouts to claimants in Connecticut. The largest portion (slightly over 50%) of total payouts go to those workers who suffer a permanent partial

Table II-21. State Comparison of Wage Replacement Rates

REPLACEMENT RATES	PERCENT OF WORKERS' COMPENSATION RECIPIENTS IN															
	CT	IL	MA	MN	OH	PA	TX	CA	FL	GA	LA	NY	NC	WA	WI	MI
Over 100 percent	19	17	13	38	16	25	29	9	1	0	2	0	2	0	5	5
Because of																
High minimum benefit	3	4	1	31	9	20	—	9	—	—	2	—	—	—	—	—
High maximum benefit	16	13	10	7	7	5	—	—	1	—	—	—	2	—	5	5
Other factors*	—	—	2	—	—	—	29	—	—	—	—	—	—	—	—	—
Under 80 percent	0	5	5	1	6	4	32	42	21	52	30	22	18	59	12	3
Because of																
Low gross replacement rate	—	5	2	—	4	—	—	6	17	14	15	10	18	37	7	—
Low maximum benefit	—	—	3	1	2	4	32	36	4	38	15	12	—	22	5	3

* Other factors include dependents' allowances (Massachusetts) and the method of calculating the worker's average weekly wage for the purpose of computer benefits (Texas). In Texas, the group of workers noted in the table received 99 percent, which we regard as essentially equivalent to 100 percent for our purposes here.

Source: Workers' Compensation Research Institute 1990 Annual Report

disability--the loss of a body part or function. Data reported in NCCI's 1989 statistical bulletin rank Connecticut 4th of 45 states in terms of the percentage of total payouts that are allotted for permanent partial injuries.

Connecticut does not appear out of line with other states if average costs per permanent partial case are considered. Those average costs in Connecticut were \$21,194 in policy year 3/85-2/86 compared with a nationwide median cost-per-case of \$19,684 for a similar policy period.

Connecticut workers, however, are more likely to file these type of claims than are workers nationwide, leading to higher overall costs for this category of injury. For the 3/85-2/86 policy period, Connecticut had 857 such claims filed for every 100,000 privately insured workers, while the median state, Rhode Island, had 571 claims per 100,000 insured workers.

Similar to Connecticut's higher frequency of indemnity claims overall, a likely explanation is the benefit structure in this state. Connecticut's statutorily scheduled benefits for permanent partial disabilities are considered to be very generous. Permanent disability benefits are calculated on the same basis as temporary total injuries (two-thirds of pre-injury wage) and that rate is then multiplied by the weeks allowed for that loss.

The program review committee believes that tying the rate for permanent partial disabilities (and scarring awards) to a person's wages does two things. First, it sets up a system where workers whose injuries are even marginally permanent will file a claim because it is worth it monetarily. For example, even a 2.5 percent partial disability of the back is worth 6.5 weeks. If a claimant's weekly compensation rate is \$500, the benefit for the disability would be \$3,250.

Second, relating permanent partial benefits to weekly wages compensates those at higher salary levels more for an identical loss than those at lower salaries. Further, the benefit system for permanent partial disabilities does not take into account in any meaningful way an injured worker's ability to return to his/her job. The benefits are calculated on the loss of body part or function only, and not on how the loss disables a person from performing a previous occupation.

CHAPTER III: RECOMMENDATIONS

The Legislative Program Review and Investigations Committee study of workers' compensation in Connecticut revealed a number of serious problems in the organization, operations, and benefit structure of the system, discussed in detail in the previous chapter. Overall, it was found that the system's current administrative structure is not responsive to the concerns of either employers, who pay for benefits, or employees, who receive benefits. Management of the system is weak and accountability is lacking.

Committee research showed that workers's compensation district offices vary significantly in terms of outcomes and efficiency and their operating policies and procedures are not uniform. Administrative resources for central and district office operations were found to be inadequate, particularly given the dramatic growth in workload. Analysis of a sample of claim files in all district offices indicated that backlogs and delays in case processing are widespread.

Benefit costs are rapidly escalating, with little response from the system to contain them. The committee found that current methods for calculating compensation rates create inequities in the distribution of wage replacement compensation, as well as in benefit levels for permanent partial disabilities and disfigurements.

In response to its findings, the program review committee developed recommendations intended to achieve the following goals: stronger management and improved accountability; more efficient processing of disputed claims; a more equitable benefit structure; and better control over rising benefit costs. The committee's recommendations for improving Connecticut's workers' compensation system, along with a brief discussion of their underlying rationale, are presented in this chapter. Recommendations are organized into the three sections: 1) system organization; 2) case processing; and 3) benefit costs.

SYSTEM ORGANIZATION

ADMINISTRATION AND ACCOUNTABILITY

A major problem cited by all parties involved in the workers' compensation system is the lack of accountability. The program review committee found administration of the system to be weak and fragmented. In the committee's view, the problem is rooted in structural deficiencies and complicated by an absence of aggressive leadership on the part of either the commissioners acting together as a board or the chairman. Furthermore, in the committee's opinion, existing accountability mechanisms are too external to the system, and extreme in their application, to be effective. Only the governor and the legislature acting through their roles in the appointment and impeachment processes can hold a commissioner answerable for his or her actions.

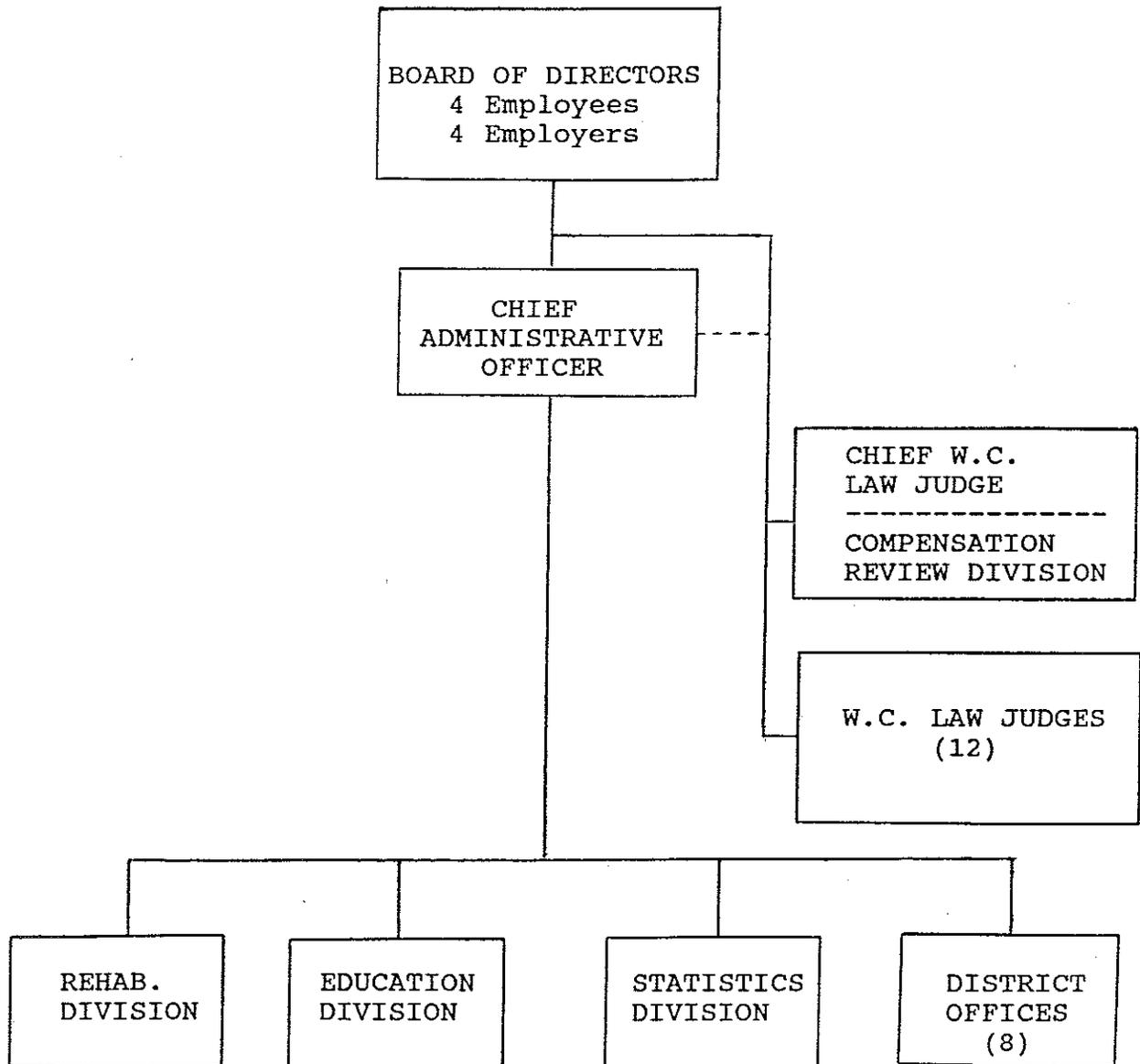
To strengthen administration and focus accountability, the program review committee recommends a major restructuring of the workers' compensation system. Under the proposed structure, shown in Figure III-1, the Board of Commissioners would be replaced by a Board of Directors composed of representatives of business and labor. The board would be given the statutory authority to direct the overall operation of the system. Administrative responsibilities now carried out by the chairman would be transferred to a newly created chief administrative officer position.

All commissioners would be appointed by the Board of Directors and answerable to it. The role of the commissioners would be focused on quasi-judicial duties and their administrative responsibilities would be eliminated. The formula funding method now in effect for the divisions of workers' education and rehabilitation would be replaced with a comprehensive budget covering the whole system. Detailed recommendations regarding the new board of directors, the chief administrative officer, funding, and the commissioners, and a discussion of the impact of each proposal follow.

Board of Directors

Establishment. There shall be a Workers' Compensation Board of Directors whose purpose shall be to develop policy and oversee the operation of the workers' compensation system. The board shall consist of eight members, four representing employees and four representing employers. The board shall elect its own chairperson and vice chairperson. Board members shall receive no compensation but shall be reimbursed for necessary expenses.

Figure III-1. Proposed Workers' Compensation System Organization.



Terms. The initial employee and employer appointments shall be for one-, two-, three-, or four-year terms and shall be nominated by the governor and confirmed by both houses of the General Assembly on or before March 15, 1992. All appointments to full terms subsequent to the initial appointments shall be for four years. Vacancies shall be filled for the expiration of the term of the member being replaced in the same manner as original appointments.

Powers and duties. The Workers' Compensation Board shall meet at least monthly. The board may meet at such other times as the chairperson and vice chairperson deem necessary. Any action taken by the board shall require affirmative vote of at least five members to take effect.

The Board shall have the power to:

- * adopt such rules as it deems necessary for the conduct of its internal affairs;
- * adopt regulations in accordance with Chapter 54 to carry out its responsibilities under this chapter;
- * adopt an annual budget and plan of operation;
- * prepare and submit an annual report to the governor and the legislature;
- * allocate resources within the system as it sees fit;
- * establish an organizational structure and such divisions as deemed necessary for efficient and prompt operation of the workers' compensation system;
- * establish policy in all areas of the workers' compensation system, including rehabilitation, education, statistical support, and administrative appeals;
- * appoint such advisory panels as it deems necessary and helpful;

- * establish standards for the approval and removal of physicians, surgeons, podiatrists, and dentists from a list of persons who may examine and treat employees under provisions of this chapter;
- * establish standards for approving all fees for services rendered under this chapter by attorneys, physicians, surgeons, podiatrists, dentists, and other persons;
- * approve applications for employer-sponsored medical care plans, based on standards recommended by a medical advisory panel; and
- * establish procedures to hire, dismiss or otherwise discipline, and promote employees within the workers' compensation system, subject, where appropriate, to provisions of the state's civil service system.

Discussion. The program review committee believes the recommended organization will strengthen accountability by placing policy-making and oversight authority in a central body. Further, this body is made up only of employers and employees, the two essential parties in this system, and the ones for whom the system was created. Employers are paying the administrative and benefit costs, while employees have given up their rights to sue their employers in order to receive prompt compensation for work-related injuries. All other parties operate in the system because of this basic agreement between employers and employees. Thus, employees and employers are the two groups that have the greatest interest in seeing the system work promptly and efficiently.

The proposed structure also clarifies lines of authority in the workers' compensation system. The board of directors establishes policy and is ultimately accountable for those who work in the system. Unlike the present administrative structure, the proposed board will set policy, while others, under its direction, will implement it.

The four divisions mandated by current law--worker education, workers' rehabilitation, statistics, and compensation review--are retained in the committee's proposed administrative structure. However, each division will now be clearly accountable to the central policy body. Control over activities carried out by the

divisions is increased by the new board's authority to adopt regulations, hire division personnel, and allocate resources.

The Compensation Review Division would continue to function, without significant procedural changes, as the administrative appeals body for workers' compensation decisions. Its important role in promoting uniformity by building a body of case law and providing accountability for commissioners' judicial activities would not change under the committee proposal.

Chief Administrative Officer

Appointment. The board shall on or before July 1, 1992, and every four years thereafter, appoint a full-time Chief Administrative Officer. The Chief Administrative Officer may be removed by the board for cause. Any vacancy in the position shall be filled for the balance of the vacated term. The Chief Administrative Officer shall be exempt from classified service and receive such compensation as determined by the board.

Powers and duties. The Chief Administrative Officer shall be the administrative head of the workers' compensation system, and shall be responsible for the efficient operation of the system and prompt disposition of workers compensation cases. The Chief Administrative Officer shall be responsible for:

- * directing and supervising all administrative affairs of the workers' compensation system in accordance with the directives of the board;
- * attending all board meetings, keeping a record of all board proceedings, and acting as custodian of all board documents, minutes, etc.,
- * preparing the budget and annual operating plan for the board's approval;
- * reporting monthly to the board on operations in the workers' compensation system;
- * assigning and reassigning staff, including workers' compensation law

judges, to each of the district offices;

- * controlling the hearing calendars of the workers' compensation law judges in order to facilitate timely and efficient processing of cases;
- * collecting and analyzing statistical data concerning the administration of the workers' compensation system;
- * directing and supervising implementation of a uniform case filing and processing system in each of the district offices;
- * entering into contracts with consultants and such other persons as are necessary for the proper functioning of workers' compensation system; and
- * establishing staff development, training and education programs designed to improve the quality of service provided in the workers' compensation system.

Discussion. The Chief Administrative Officer (CAO) is responsible for the day-to-day operations and everyone in the system reports to that person. In turn, the CAO reports monthly to the Board of Directors on operations in the system. If the board is unhappy with operations in the system it can require that the CAO implement changes, and if the changes are not forthcoming the board can discipline or dismiss the CAO.

This proposal establishes a clear line of authority from the policy board, through the Chief Administrative Officer, to all workers' compensation divisions and offices, thus eliminating the current problems with fragmented and diffuse accountability.

Compensation Commissioners

Title. Beginning July 1, 1992, the position of workers' compensation commissioner shall be titled workers' compensation law judge. Workers' compensation law judges shall be qualified members of the Connecticut bar, who shall be full-time, not otherwise employed, and sworn to the faithful performance of their duties.

Appointment. Beginning July 1, 1992, the Board of Directors shall on or before the date of expiration of the term of a workers' compensation commissioner or upon the occurrence of a vacancy appoint a person to fill the position. The term of appointment shall be for five years or the unexpired portion of a vacant term. An appointee may be removed or suspended for cause by the board.

The board may appoint acting workers' compensation law judges on a per-diem basis from among former workers' compensation law judges or qualified members of the Connecticut bar.

Jurisdiction. The existing requirement that an appointee reside within the jurisdiction for which he or she is appointed shall be repealed and all appointees shall be granted statewide jurisdiction.

Workers' compensation law judges shall be relieved of their administrative responsibilities related to the operation of a district office.

Chief Compensation Law Judge. The board shall designate one workers' compensation law judge to serve as chief of the Compensation Review Division with complete responsibility for the day-to-day operation of the division. The chief of the Compensation Review Division may, as the board permits, be assigned to other duties by the chief administrative officer.

Discussion. The committee believes the direct and immediate accountability provided by having the board appoint and discipline workers' compensation law judges will increase their responsiveness to implementing policies and procedures established by the board. This will result in more administrative control over the system and greater uniformity in its operations.

Under the recommendation, workers' compensation law judges would have the same authority to resolve claims and questions of law as the compensation commissioners do now. Current quasi-judicial powers to conduct hearings, impose penalties, award or dismiss claims would not be altered. Similarly, the authority to approve voluntary agreements between parties, stipulated agreements, commutation of benefits, the discontinuance or reduction of benefits, acknowledgements of physical defects, and other legally binding documents and actions would also continue unchanged.

The compensation law judges would no longer be responsible for the day-to-day administration of a district office, but instead

would be able to concentrate on matters that require legal expertise and substantive knowledge of the system. With compensation law judges able to devote full time to the resolution of disputes, cases should move more quickly. In addition, since jurisdiction would not be confined to a single district, the board would be free to rotate all the compensation law judges in order to address workload fluctuations as well as vacancies, vacations, or illnesses.

Under the new administrative structure, the chief of the Compensation Review Division would be designated from among the compensation law judges by the board. Like other division heads, the chief compensation review judge would report to the chief administrator for administrative purposes. The chief's duties would be those currently performed--assigning panels to hear appeals, receiving and reviewing appeal petitions, and directing division staff regarding legal matters arising from appeals. In addition, the chief would be available for assignment to cases at the district level on an at-large basis.

Administrative Funding

The Board of Directors shall approve and submit a budget for the operation of the entire workers' compensation system including the central office, district offices, and the divisions of workers' education and rehabilitation to the appropriate budget agencies.

There shall be one comprehensive assessment on employers for funding the operation of the entire workers' compensation system. The assessment shall not in any state fiscal year, exceed 5 percent of the amount expended by employers or private insurers on behalf of employers in payment of workers' compensation liability for the prior year. The assessment shall be levied in accordance with the provisions of C.G.S. Section 31-345, as amended by Public Act 90-311. The separate assessments on employers to finance the Division of Worker Education and the Division of Workers' Rehabilitation specified in sections 31-283h and 31-283b, respectively, shall be repealed.

Discussion. Making one assessment on employers that will pay for the entire administration, rather than having separate statutory formulas for workers' rehabilitation, worker education, and administrative functions, will give the policy board the authority over all system resources. The board can then allocate funds where it believes the need is greatest and where resources will be used most effectively.

DIVISIONS OF WORKERS' REHABILITATION AND EDUCATION

To date, there has been little oversight or evaluation of the activities of either the workers' rehabilitation or worker education divisions. Each year, millions of dollars (2.2 percent of total workers' compensation benefits paid over the prior year) are targeted for education and rehabilitation programs in the absence of formal policy and without external review of whether activities are meeting needs, cost efficient, or generally effective. Committee findings, detailed in the previous chapter, raised questions about the performance of both divisions.

The committee's proposed reorganization, which will result in greater accountability and stronger central control over funding and policy, offers opportunities to improve both vocational rehabilitation and worker education efforts. For example, through the board's annual planning process recommended by the committee, the rehabilitation division director could be required to annually submit specific goals (e.g., the percentage of clients to be trained and reemployed, the portion of clients trained through on-the-job versus academic programs, etc.) and the strategies for achieving them. To monitor DWR performance, the board could also require that program measures such as average cost and placement success of each type of training program, numbers of clients still employed six months after placement, and profiles of workers referred, terminated, and served, be collected and reported each year.

Two areas of particular concern revealed by the committee review of the rehabilitation division can be addressed by the new policy board through its authority to adopt regulations and establish both budgetary and operating policies. First is the fact that millions of dollars have been spent on training fees, travel reimbursement, and basic living expenses (subsistence) for clients without formally established policies to guide the award or denial of rehabilitation benefits. The second area is that subsistence benefits, which consistently account for half of the division's annual expenditures, are not equally available to all claimants.

The workers' compensation policy board also will have the authority to establish what it wants accomplished from an education division, to set clear goals and objectives for the division, and to measure its performance against them. A lack of statistics, which has hampered the ability of the worker education division to focus its prevention activities on where job accidents are occurring, however, remains a concern.

The legislature has clearly seen a need for better prevention of occupational diseases and injuries. In 1990, the General Assembly passed Public Act 90-226, aimed at improving the state's ability to detect occupational hazards, assess workplace exposure, and conduct medical surveillance, including the collection and

analysis of data on injuries and disease. The act also created a role for both the statistics and education divisions, within the workers' compensation system. The statistics division is responsible for receiving and analyzing the data from the occupational health clinics, hospitals, and other medical facilities specified in the act. Both the statistics and education divisions are required to educate unions, employers and individual workers on the data and how it will be used.

The program review committee believes the coordination of efforts in preventing workplace accidents and diseases mandated by this act is an important first step that ought to be maintained. The General Assembly authorized General Fund revenues of \$750,000 to support the legislation's purpose through June 30, 1991. As financial support after that date is unclear, the program review committee recommends that:

Funding for the occupational health clinics to conduct activities outlined in P.A. 90-226 shall be allocated from the Workers' Compensation Commission budget at the level specified in the act, until June 30, 1992.

Discussion. Under the committee recommendation, funding for the act's important prevention activities will be assured for one additional year. At that time, the Board of Directors for Workers' Compensation can examine all prevention and worker education efforts to determine program objectives, how to best achieve them, and the level of resources needed. Committee findings point to a clear need to bolster the Division of Worker Education's prevention activities, and in a manner that targets where the potential for injury or disease is greatest.

The occupational clinics program can provide the data needed by the worker education division to focus its efforts. The legislature, through Public Act 90-226, requires that all parties in the system work together to help prevent occupational disease and injuries. The committee proposal will maintain this consolidated prevention program through June 1992, thus permitting more accurate evaluation by the board.

Under the committee's proposed central administration structure, the director of worker education, like the director of workers' rehabilitation, will be report directly to the Chief Administrative Officer, while the board will set all policy and control all administrative costs. The new structure's reporting requirements and strong oversight of spending, coupled with the prevention activities of the occupational clinics program, will significantly improve accountability of both the education and rehabilitation divisions.

DISTRICT OFFICES

From its review, the program review committee concluded that improved district office operations require both structural and staffing changes. The committee found that, other than the commissioner, no position in a district office has overall supervisory authority. Management responsibilities are delegated by district commissioners to a variety of support staff on an ad-hoc basis. While all district offices are staffed by paralegal and clerical support personnel, staffing levels and structures vary widely.

To date, no efforts have been made to determine what type and amount of staffing would best carry out the functions of a district office. Analysis of staff-to-workload ratios indicates inequities in the allocation of personnel resources among district offices. Both clerical and paralegal workers spend most of their time processing paperwork and moving the daily docket of hearings. The case management and legal research duties envisioned for paralegal staff are often superseded by their assignment to clerical activities. Few staff resources are available for working with parties to prevent disputes although the benefits of such efforts in terms of reducing the need for hearings are widely recognized. To address these problems, the program review committee recommends the following:

A district manager position shall be established to serve as the administrative head of each district office. The district manager should be a professional position. District managers should report to the chief administrator and be responsible for all office administrative functions related to budget development, purchases, personnel and payroll, equipment, office procedures, and staff supervision. In addition, district managers should oversee the management and processing of cases in each office.

Appropriate support staff levels for each district office shall be determined by the chief administrator in accordance with workload and performance standards. Furthermore, the chief administrator shall develop job descriptions, and if necessary, new classifications, to insure that staff resources are appropriately matched with the tasks to be performed.

Discussion. Systematic review of staffing needs will result in the proper allocation of resources to each district. Ideally, each office should have a sufficient number of staff to carry out basic case-processing functions in a timely way and permit more emphasis on dispute prevention as well as better use of paralegal staff skills. Additional support staff positions may be needed to

achieve this goal, although the automated case-processing system now being implemented in the districts is expected to reduce the time devoted to clerical functions.

At a minimum, the committee recommendation will require 8 new office manager positions at an estimated annual cost of \$370,000 to \$470,000, including fringe benefits. The committee believes stronger management and, ultimately, better service to parties involved in the workers' compensation system justify the additional investment in district staffing. The fact that resources have not kept pace with workload over at least the past five years has contributed to the backlogs and costly delays the system is now experiencing.

In addition to improving accountability for district operations, the proposed administrative restructuring can address two major problems revealed by the committee review: the lack of uniformity in district office policies and procedures and the inefficient use of district staff resources, particularly the commissioner's time. The time commissioners now spend on office management could be devoted to the critical judicial aspects of the system--holding hearings, mediating and arbitrating disputes, and enforcing agreements and awards.

CASE PROCESSING

POLICIES AND PROCEDURES

More efficient case processing is a goal of all involved in the workers' compensation system. Prompt processing of benefit claims is critical to an effective workers' compensation system. Delays, particularly in resolving disputes over employer liability or the claimant's ability to return to work, can result in financial hardship to workers and unnecessary expense to businesses.

Although all offices have policies for holding hearings for emergency cases within several days of a request, a system that requires parties to wait months for their cases to be heard clearly is not responsive to the interests of either workers or employers. When commissioners cannot intervene early in disputed cases, disagreements between parties may escalate and attempts at mediation are impeded. Given the current backlog, one of the most effective tools for achieving prompt resolution of disputes--the commissioner's ability to immediately schedule a formal hearing to order parties to act when attempts at mediation fail--is unavailable in practical terms.

The increased district office staffing recommended earlier, along with implementation of the district office automation project, will promote the goal of more efficient case processing.

However, the committee believes the hearing backlogs and processing delays described in the previous chapter will continue to be a problem unless stronger case management policies and procedures are instituted as well. Therefore, it is recommended that:

- * a standard form for requesting hearings should be developed and standard policies regarding limits on the numbers of informal hearings that will be allowed and the number of hearing postponements that will be accepted before a formal hearing is held to resolve a case should be adopted;
- * a central system for monitoring case processing should be established and provide, at a minimum, data on the number of cases with multiple hearings, the numbers of hearings postponed, and hearing schedules, on an office-by-office basis;
- * guidelines for expediting disputed cases should be developed and district office staff should be trained in techniques for screening hearing requests;
- * medical providers who fail to submit required reports in a timely manner be subject to removal from the approved workers' compensation provider list; and
- * by statute, interest at the rate provided for in C.G.S. Section 37-3, currently 10 percent per annum, should be applied automatically to the unpaid amount of benefits due a claimant beginning on the date the employer contested liability or discontinued or reduced payment.

Discussion. The committee's series of case processing recommendations have two main purposes--to avoid unnecessary hearings and to provide greater incentives for resolving claims quickly. Several offices have been successful in reducing the need for both informal and formal hearings by contacting requesting parties by phone to determine what issues are in dispute and what efforts have been made already to resolve points of disagreement.

In one office, clerical staff have been trained by the paralegal to screen requests; in another, a checklist is used to evaluate the need for hearings. In some cases, follow-up by clerical and paralegal staff resolves the issues in dispute. By developing efforts to reduce the number of hearings scheduled in

all offices, the system can be more responsive to cases that can only be resolved with a commissioner's involvement.

At present, there is no set format for requesting hearings, and policies on scheduling and cancellations vary among offices. A standard form that requires details on the reasons a hearing is necessary and what actions parties have taken on their own to resolve disagreements will permit staff to quickly evaluate whether a hearing is needed. Fewer unnecessary hearings will be scheduled and less staff time will be spent gathering information that is missing from letter and phone requests that are received now. The committee also believes that strict policies on multiple informal hearings and canceled hearings, uniformly applied in all districts, will result in fewer postponements and more productive hearings overall.

Statistics produced through the proposed case processing monitoring system will enable system administrators to identify problem areas and develop strategies, including reallocation of district resources, for addressing backlogs and delays. District staff will also have more incentive to handle cases efficiently as the monitoring system will permit evaluation of each office's performance.

At present, sanctions that could address late or incomplete medical reporting are lacking although medical information is key to many decisions on claims. Current law permits providers now to be removed for cause from the approved list. The committee recommendation would clearly establish untimely or incomplete reporting of information necessary to the resolution of workers' compensation claim as cause for removal. The possible loss of authorization to treat workers' compensation claimants would be a strong incentive to respond to the needs of the system for prompt and complete medical reports.

Finally, unlike workers who may be without income, employers and insurers have little interest in speeding up processing when benefits are in dispute and may, in fact, be earning interest on monies that will eventually be paid to claimants. Under the committee proposal, any economic advantage to delays in payment would be reduced. The interest charge, because it is applied automatically in all cases of delayed benefits, also would be imposed without the need for a formal hearing and order from a commissioner.

ATTORNEY FEES

Another matter of concern raised during the committee review of case processing is the monitoring of attorney fees. Fees charged by all service providers including attorneys in workers' compensation cases are subject to the approval of commissioners. For claimants, who frequently pay lawyers on a contingency basis

from the benefits they receive, the commissioner's review can insure against excessive or unreasonable charges.

In interviews with committee staff, commissioners reported that, in general, attorney fees are checked in cases settled through awards or stipulated agreements and usually limited to 20 percent. The staff, however, found little evidence in the case files it examined that commissioners are monitoring legal fees. While about half of the claimants in the caseload sample were represented by attorneys, documentation of the commissioner's approval of legal fees existed in only 2 percent of the case files. The program review committee believes the interests of workers' compensation claimants would be better protected if commissioners took an active role in monitoring legal fees. Therefore, it is recommended that:

A policy requiring commissioners to approve all attorney fees charged to claimants should be established.

Discussion. Attorney fees, even if limited by informal agreement to 20 percent, can represent a significant portion of a claimant's benefits. Under an earlier recommendation, the committee proposed that the new board of directors be authorized to establish standards for fees charged by all service providers including attorneys. Establishing a policy that requires commissioners to monitor legal fees actually charged will promote compliance with standards the board may adopt and will protect claimants from unnecessary expense in the processing of their cases. The policy on approving attorney fees would be set by the board; no statutory changes would be required. As many commissioners report that legal fees are monitored in certain cases now, the recommendation is primarily intended to bring a consistent approach to the process by providing uniform guidelines on review and approval.

BENEFIT COSTS

Connecticut's benefit structure in workers' compensation is extensive. Thirteen different benefit features are offered including dependency allowances, paid group health while on workers' compensation, disfigurement awards, automatic cost-of living adjustments, and additional benefits after permanent partial benefits have run out. As discussed in previous sections of this report, the costs of providing these benefits is increasing dramatically. Workers' compensation benefits paid in Connecticut for 1989 totalled more than half a billion dollars, and costs are growing annually at double digit rates. Even after adjusting for inflation, total benefit payouts from 1985 to 1989 increased 61 percent.

The program review committee believes that efforts must be made to curtail the high growth rate in workers' compensation costs. Recommendations contained in this section encompass three major areas--wage replacement, medical expenses and the second injury fund--and are aimed at reining in the growth in costs, eliminating any disincentives to return to work, while still providing injured workers with a fair and equitable wage replacement system. The proposals include changing the method of calculating indemnity or wage loss benefits from gross to after-tax income; eliminating dependency allowances; restricting eligibility for disfigurement benefits; and setting a flat rate for those eligible. Similarly with permanent partial disability benefits, the committee proposes changing the current wage-based method of calculating benefits with a three-tiered flat rate system, based on injury severity.

Cost-of-living adjustments would also be altered to more closely reflect actual increases in wages in the state. Finally, the program review committee recommends employer-sponsored medical health plans, with prior board approval, be implemented as a way to contain medical costs, and that eligibility for the Second Injury Fund be limited to those claimants whose employers' knowledge of a preexisting condition is documented.

WAGE REPLACEMENT

The majority of benefit costs go toward directly compensating injured workers, while a lesser amount pays medical expenses on behalf of injured workers. In Connecticut, as in most other states, the compensation rate for totally disabled workers is calculated by taking $66 \frac{2}{3}$ percent of a worker's gross wage. However, as discussed in the previous chapter, because workers' compensation benefits are not taxed, and because of the nature of the tax structure, 20 percent of the workers in Connecticut receive 100 percent or more of their pre-injury take-home pay, and no one in this state receives less than 80 percent of their disposable income.

The Workers' Compensation Research Institute conducted a study of benefit structures for those workers receiving temporary total benefits in various states, including Connecticut. Table III-1 summarizes the results of this study and shows that, depending on the workers' status (e.g., married, single, two-income family and wage level), the percentage of the worker's income that is replaced by compensation benefits varies widely. Even among the same categories of workers, large disparities exist in the percentage of income replaced. For example, an unmarried worker making \$20,000 gets 86 percent of his or her spendable income replaced, while another single worker making \$35,000 gets 104 percent of his or her take-home pay.

Table III-1. Income Replacement Levels in Connecticut.

Predisability Annual Income	Marital Status			
	Single	Married	Married	Married
			Spouse earns \$15,000	Spouse earns \$25,000
\$5,000	87%	87%	103%	103%
\$9,347	103%	87%	103%	103%
\$10,000	97%	81%	97%	97%
\$11,216	86%	81%	97%	97%
\$15,000	86%	95%	95%	95%
\$20,000	86%	93%	93%	93%
\$25,000	86%	92%	92%	110%
\$30,000	104%	91%	91%	109%
\$35,000	104%	90%	108%	109%
\$40,000	104%	90%	108%	109%
\$45,000	104%	89%	108%	109%
\$50,000	104%	106%	108%	109%

Note: All replacement rates are based on a 4-week disability.

Source: Workers' Compensation Research Institute, November 1990 Research Brief.

The 1972 report of the National Commission on State Workmen's Compensation Laws, generally viewed as the pivotal study of states' workers' compensation benefits systems, established standards for adequacy and equity of benefits. The commission's broad standard for adequacy was that lost earnings should approach the pre-injury standard of living, while also encouraging safety consciousness and return-to-work incentives. The commission defined equity as providing equal benefits or services to workers in identical circumstances.

Measured against these standards, the program review committee believes that Connecticut's current method of calculating wage replacement creates inequities and reduces incentives to return to work. A more equitable approach would be to calculate a worker's compensation rate on his or her after-tax earnings. In the three states and the District of Columbia where this method is used, the compensation rate is pegged to 80 percent of a workers' take-home pay. Therefore, the program review committee recommends that:

Beginning October 1, 1991, the weekly rate of compensation paid to the employee for total incapacity to work shall be equal to 80 percent of his or her earnings after deducting for federal income tax and FICA (Social Security) taxes. This rate would apply to all workers whose current compensation rate is established at 66 2/3 percent of gross pay.

Discussion. Under this proposal, other components that affect a workers' compensation rate--the weekly maximum and minimum, the definition of total wages, and the time periods for determination and waiting--as currently specified in C.G.S. Sections 31-295, 31-309, and 31-310 would not be altered. However, the calculation of the compensation rate would require that the amounts deducted for federal income tax withholding and social security payments be subtracted prior to multiplying the remainder by 80 percent.

The program review committee believes that this proposal will provide for a more equitable system of compensating those who are temporarily totally disabled. First, as Table III-2 indicates, using 80 percent of spendable income as the compensation rate will reduce, by almost half (from 20.9 to 10.9 percent), the percentage of workers who receive more in compensation than they did while working, thereby strengthening the incentive to return to work for those additional ten percent of workers.

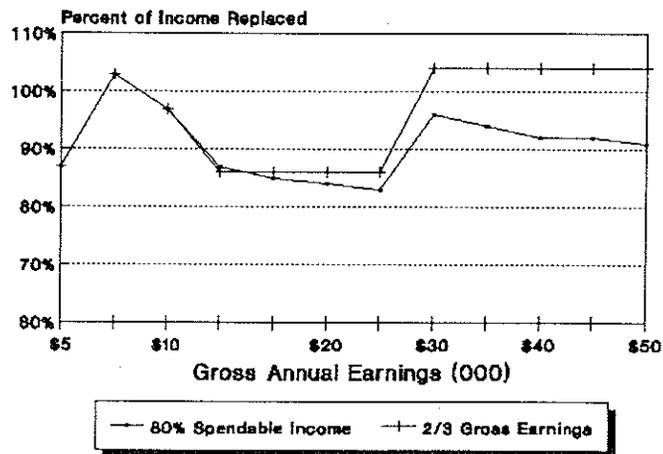
There are, most likely, factors other than monetary ones that prompt people to return to their jobs. However, certainly for those workers who receive the same disposable income from workers' compensation benefits as they would if they were on the job, the incentive is not an economic one. The additional advantage is that by pegging the rate to 80 percent of after-tax income, no one will receive less than the minimum paid under the current system.

Table III-2. Income Replacement Levels: A Comparison of Gross and After-Tax Methods		
Percent of Disposable Income Replaced	Present System (66 2/3 of Gross)	Proposed System (80% of Net)
	Percent of Workers	
Above 100%	20.9%	10.9%
Between 80% and 100%	79.1%	89.1%
Below 80%	0.0%	0.0%

Source of Data: Workers' Compensation Research Institute

Another outcome of the recommendation is that it lessens the variation in replacement levels that currently exist as a result of the tax structure, as Figure III-2 demonstrates. While complete uniformity in replacement levels is not possible the gap in replacement rates narrows under the 80 percent of spendable income proposal. This indicates that there is less variation among workers in what portions of their take-home pay compensation benefits replace.

FIGURE III-2. INCOME REPLACEMENT



unmarried workers, four week disability

DEPENDENCY ALLOWANCE

Connecticut is one of nine states that provides an additional allowance for dependents of workers' compensation recipients. In general, if a worker in this state is totally disabled, either temporarily or permanently, he or she receives an additional \$10 a week for each child under 18, within certain limits (i.e., the total dependency allowance cannot exceed certain percentages of wages or compensation rates). The dependency allowance is considered a supplementary benefit, and is not affected by the statutory weekly maximum benefit rate. For example, a claimant with three children, eligible for the current weekly maximum of \$719, would receive an additional \$30 per week, bringing the worker's weekly compensation to \$749.

The dependency allowance is another benefit that can create an economic disincentive to return to work, when it brings the worker's total compensation benefits close to his pre-injury take-home pay. The program review committee recommends that:

The dependency allowance, as contained in Section 31-308b of the Connecticut General Statutes, shall be repealed.

Discussion. The program review committee believes it is important that wage replacement benefits, under workers' compensation, provide sufficient financial support to enable workers to maintain their pre-injury standard of living. In the committee's opinion, Connecticut's system ensures this by statutorily setting weekly high minimums and maximums. However, if workers with families are maintaining a certain standard of living on their wages while working, it goes beyond the simple wage replacement concept underlying workers' compensation to provide a larger disposable income for that family when the worker is disabled. Removing the dependency allowance will establish a wage replacement system with more definite parameters and, again, one that reduces economic incentives to extend disability beyond what is medically necessary.

COST-OF-LIVING ADJUSTMENT

In Connecticut, on each October 1, claimants receiving workers' compensation because of a total disability, or dependents collecting death benefits, receive cost-of-living adjustments. The adjustment is based on a dollar amount increase in the production workers' wage. The actual increase varies depending on the date of injury. For example, on October 1, 1990, the compensation rate for those whose injuries occurred after September 30, 1987 was adjusted upwards \$26 no matter what the claimant's prior compensation rate was. This method of adjustment is more generous than one that

increases compensation rates by a percentage across the board. The program review committee recommends that:

The annual cost-of-living adjustment for workers' compensation benefits shall be an individual's current weekly rate multiplied by the rate of change in the average weekly earnings of production workers in manufacturing in Connecticut, as determined by the labor commissioner.

Discussion. The recommendation equates the change in benefits paid to the percentage change in the production wage. The proposal would limit the change in total expenditures on benefits related to cost-of-living adjustments to the actual rate of change in the average production workers wage in Connecticut. Assuming continued growth in the production wage, the result would be a slight decline in total expenditures. Under the committee's proposal, the ability of all workers' compensation benefit recipients to purchase goods and services would increase proportionally to the increase experienced by the average employed manufacturing worker.

PERMANENT PARTIAL DISABILITY

Most workers' compensation claims, other than medical only, are filed by individuals who are temporarily totally disabled from working. However, data from the National Council on Compensation Insurance indicate that such claims make up only about 10 percent of total workers' compensation payments in Connecticut. The largest portion, slightly over 50 percent, goes to workers who suffer a permanent partial loss of a body part or function. Using NCCI data as a guide, Connecticut's permanent partial disability payments totalled about \$200 million in 1987.

Committee staff analysis of roughly 2 percent of the workers' compensation cases that became active in calendar 1987 found that, through June 30, 1990, a total of 281 out of a possible 745 cases involved a permanent partial disability claim. For 260 cases in which resolution data were available, the amount of money obligated to workers ranged from approximately \$200 to \$63,650 and averaged just under \$10,460.

The 260 cases accounted for nearly \$2,720,000 in payment obligations, which if projected to the entire population of cases would total about \$155 million. The discrepancy between the two data sets is most likely due to the fact that the sample data are limited to the amount of money obligated specifically for the permanent partial disability payments, while NCCI's data include this type of payment amount plus other benefits, such as temporary total and disfigurements, paid to permanent partial disability

recipients. The important point is that estimated total payments are large regardless of the data source.

In Connecticut, permanent partial disability benefits are designed to compensate workers for physical impairments and loss of earning capacity. The level of compensation is based on the proportion of the loss of a body part or function as determined by a physician at the point where the worker reaches maximum medical improvement following an injury.

The benefit amount is computed by multiplying two-thirds of a worker's average gross wage in the 26 weeks prior to the onset of the injury or disability, by the number of weeks allowed for loss of the specific body part or function, with a partial loss compensated on a proportional basis. The allowable weekly rate is subject to a maximum, which is set at 150 percent of the wage for production workers in manufacturing, and a minimum that is set at 20 percent of the maximum, provided the resulting amount does not exceed 80 percent of the worker's pre-injury weekly wage.

The number of weeks of benefits varies depending on the body part or function lost. A schedule, setting the maximum number of weeks for 13 specified body parts, is written in state statute. The number of weeks ranges from 13 for loss of a toe to 520 for total incapacity of the back. The number of weeks allowed for all other losses are set by the workers' compensation commissioners on a case by case basis, and can range from 1 to 780 weeks.

The Connecticut system, by including the worker's weekly wages into the formula for calculating his or her permanent partial benefit level, compensates workers more at higher salary levels for an identical loss than those in lower salary ranges. For example, a worker at the maximum compensation rate of \$719 who suffers a 10 percent permanent disability of the thumb on his or her master hand will receive \$6,830, while a worker at half the compensation rate (\$360) will be given only \$3,415 for the same injury. The inequity can be compounded if the lower salaried worker's ability to perform his or her previous occupation is affected by the disability, while the other worker's is not.

Fortunately, this inequity can be partially ameliorated by benefits allowable under Section 31-308a of the Connecticut General Statutes. The additional benefits for a permanent partial disability, awarded at the discretion of a commissioner under section 31-308a, are designed to compensate a worker for his or her lost earning capacity. Of course, the existence of section 31-308a benefits raises questions about the need for a permanent partial disability program as generous as the one Connecticut has.

Another question about the compensation program for permanent partial disabilities relates to the substantial amount of benefits received by workers whose injuries, as measured by the number of

weeks of compensation provided, may not be severe. This view is supported by data from the committee's sample showing that in 25 percent of the cases the number of weeks of compensation for a permanent partial disability was 13 or less. The cases accounted for about 6 percent of the obligated benefits, which if projected to all cases would amount to approximately \$9.2 million.

The high cost of Connecticut's permanent partial disability program, its inequities, and the existence of benefits under Section 31-308a led the committee explore changes in the current system. As a result, the program review committee recommends Section 31-308 be amended as follows:

the weekly compensation rate for a partial incapacity that is determined to warrant 13 weeks or less of compensation shall be fixed at 25 percent of the average weekly wage of production and related workers in manufacturing;

the weekly compensation rate for a partial incapacity that is determined to warrant more than 13 weeks, but not more than 104 weeks of compensation, shall be fixed at 50 percent of the average weekly wage of production and related workers in manufacturing; and

the weekly compensation rate for a partial incapacity that is determined to warrant more than 104 weeks of compensation shall be fixed at 100 percent of the average weekly wage of production and related workers in manufacturing.

Discussion. The committee proposal is designed to decrease overall payments for permanent partial disability benefits. It is also intended to shift benefits from less severely injured workers to those more seriously injured.

Table III-3 shows the effect of the program review committee recommendation on the sample of permanent partial disability cases contained in the committee's sample of cases that become active in 1987. The column on the left identifies weekly time parameters outlined in the recommendation. The second column cites the number of cases in the sample that fall into each time class. The third and fourth columns show the dollar amount obligated to each time class under the system in effect in 1987 and the committee proposal.

Table III-3. Effects of Recommendation on Current System.

Weeks	Number in Class	Total Benefits Current System	Total Benefits Recommendation
< 14	66	\$154,021	\$57,160
14-104	176	\$1,920,873	\$1,456,864
> 104	13	\$512,011	\$764,833
Total	255	\$2,586,905	\$2,278,857

The committee recommendation would reduce overall benefit obligations in the sample data by 11.9 percent. Total payments would decrease by 62.9 percent in the under 14 week category and by 24.9 percent in the 14 to 104 week category. Payment obligations in the above 104 week grouping would rise 49.4 percent.

The effect of the proposal on individuals within each group varies depending the relationship of their weekly compensation rate to the applicable fixed rate contained in the staff recommendation. Of the 251 cases in the sample, 181 claimants would have benefits reduced, 68 would receive an increase, and 2 would experience no change. The average benefit per case would fall from \$2,334 to \$866 in the under 14 week group and decline from \$11,167 to \$8,273 for the middle group. Average per case payments in the above 104 week category would increase from \$42,668 to \$58,883.

It should be noted that the recommendation's effect on current cases should result in greater cost savings. First, the maximum weekly rate under this proposal would be limited to 100 percent of the average production worker's wage instead of the current 150 percent. Second, the increase in the overall wage level since 1987 means that workers' compensation rates have also moved upward. Unfortunately, there are no hard data on current weekly compensation rates being paid, and therefore the committee cannot calculate precisely what the exact savings would be. However, based on the 1987 sample data it is reasonable to estimate savings in benefit payments in the neighborhood of 12 percent.

DISFIGUREMENT AWARDS

Connecticut, like most states, provides benefits to compensate workers for disfigurement and scarring related to on-the-job injuries. The majority of states limit such benefits to permanent scars on the head, face, or exposed body parts or require that employability be affected by the disfigurement; some states require

that both conditions be met. In general, Connecticut only requires that compensable scars be permanent and significant as determined by a commissioner.

Available benefit payout data do not isolate the money awarded for scarring and disfigurement. The committee staff's sample of workers' compensation cases that became active in 1987 indicated that one claimant in four received disfigurement benefits. While individual awards in the sample were relatively small, averaging just over \$2,100, total costs were significant. Based on its sample data, the program review committee staff estimates that scarring and disfigurement payouts in 1987 were in the range of \$19.5 million.

By statute, the maximum benefit duration for scarring is 208 weeks. The highest number of weeks awarded in the committee staff sample was 51. Workers receiving scarring benefits for four weeks or less accounted for nearly half (49 percent) of the 170 disfigurement award cases in the sample; 75 percent of the cases received disfigurement benefits for 10 weeks or less.

Analysis of the sample data provides evidence that benefits are frequently awarded for scarring from occupational injuries that did not result in any lost work time. Disfigurement awards were the only benefits claimed by about 44 percent of the 175 workers in the sample who received them. The program review committee also found that because disfigurement awards, like permanent partial disability benefits, are related to weekly wage rates, those earning high salary levels are compensated more than low wage earners for equally severe scarring.

The inequities in scarring benefits due to disparities in weekly earnings were vividly illustrated by the program review committee sample data. Weekly wage rates for disfigurement award cases averaged \$281 but ranged from \$61 to \$690. The largest disfigurement award in the sample--\$20,808--was paid to a worker with a weekly rate of \$408 for scarring evaluated at 51 weeks. In contrast, another worker with a 50-week scar award but with a compensation rate of \$160 received a total of \$8,000 in disfigurement benefits. Of the 29 cases in the sample involving disfigurement awards with a 2-week duration, total benefit amounts ranged from \$176 (\$88 per week) to \$1,390 (\$690 per week).

In the opinion of the program review committee, the dollars provided for disfigurement benefits should be provided in an equitable manner and aimed at workers who have suffered the most damaging scarring. Therefore, it is recommended that:

Compensation for disfigurement shall be limited to permanent and significant scarring or disfigurement that occurs on the head or face. It is further recommended

that the compensation rate be set at 100 percent of the state average production worker wage for all recipients of disfigurement awards.

Discussion. The primary purpose of workers' compensation is to replace lost wages. Linking scar benefits to head and facial disfigurements, which are the most likely to affect employability, is consistent with this intent. Current policy on disfigurement benefits already incorporates the thrust of the recommended restriction. Existing regulations require that commissioners give lesser importance to scars rarely or never visible. Furthermore, under current law, no compensation is given for hernia or spinal surgery scars. In the committee's opinion, the proposed change in how disfigurement benefits are calculated will produce fairness by insuring that scars of equal severity are compensated at the same rate.

Many in the system believe that serious burns are not adequately compensated under the present scarring benefit structure. While under the committee recommendation, only burns on the head or face will be eligible for disfigurement awards, compensation for more extensive burns is not precluded. The committee believes that serious burns can and should be recognized as organ (skin) losses under the unscheduled permanent partial disability structure and thus be eligible for up to 780 (rather than 208) weeks of benefits.

Under the program review committee proposal there will be substantially fewer scarring awards, but the cost per claim paid will be higher since the weekly rate for all recipients would be pegged to the state's production worker wage. Overall, disfigurement compensation that is received will be provided at a higher level and directed at the most serious cases.

The fiscal impact of the recommended changes in disfigurement awards is difficult to estimate since it is not known what portion of the current beneficiaries would be excluded by the new limits. However, in the opinion of the program review committee staff, the reduction in payouts would be substantial and should easily exceed 75 percent. The staff bases this view on its recollection that very few head or facial disfigurement awards were encountered when reviewing files to collect a sample of compensation cases.

MEDICAL COSTS

Nationally, it has been documented that workers' compensation medical costs are growing about 30 percent faster than health care costs in general. Countrywide, workers' compensation medical expenses are approaching 40 percent of all benefit costs in

workers' compensation, and are projected to be half of all benefit costs by the year 2000.

Program review committee analysis of workers' compensation medical costs in Connecticut found that, while total workers' compensation medical costs are proportionately lower than most other states, medical costs are growing faster than wage loss costs in Connecticut. Committee findings also showed that during the policy years 1982 through 1986, the average per-claim medical costs grew by 71.8 percent, while average indemnity costs grew by only 40.2 percent.

The growth rate in total medical costs in workers' compensation is also more rapid than the increase in actual benefits. Table III-4 below shows the total amounts that private insurers expect to pay in wage loss and medical payments for the policy years 1984 through 1988. The annual increases in medical costs outpaced wage loss costs in each of the four years, and in total grew by 107.8 percent, while actual benefits to claimants grew by 75.7 percent. Expressed another way, for every \$100 paid to a worker in wage benefits, almost another \$50 is paid for medical services.

Table III-4. Annual Growth in Wage Loss and Medical Benefits				
Policy Year	Indemnity Losses	Percent Annual Growth	Medical Losses	Percent Annual Growth
1984	\$265,534,006	--	\$101,530,671	--
1985	\$326,791,957	23	\$129,697,218	27.7
1986	\$359,755,835	10	\$147,642,703	13.8
1987	\$429,459,632	19.3	\$180,021,154	21.9
1988	\$466,688,749	8.6	\$211,011,022	17.2

Source of Data: NCCI 1991 Rate Filing with Conn. Ins. Dept.

As the committee's findings indicated, workers' compensation medical costs may be difficult to contain. The Workers' Compensation Commission has the statutory authority to establish a fee schedule, but has not done so. In addition, Connecticut is one of about 30 states where employees may select a medical provider of their choice, thereby limiting the use of employer-sponsored health maintenance organizations and the like.

With no system-wide external controls on medical costs in workers' compensation, coupled with the lack of deductibles and co-

pays that exist in most other medical plans, neither patients nor providers have any incentive to exercise restraint. Many experts even suggest that there may be shifting of medical costs from other sources (e.g. group health, medicaid, and medicare) into workers' compensation because of efforts to control medical costs in those programs. Thus, it is imperative that some efforts be made to contain medical costs in workers' compensation.

Medical cost-containment options. The program review committee examined both fee schedules and provider-sponsored medical care as options in containing medical costs. Fee schedules list maximum charges for medical services and products. About 23 states have fee schedules in place. However, there is no conclusive evidence that fee schedules by themselves lower medical costs. A study released by the Workers' Compensation Research Institute (WCRI) in December, 1989, entitled Medical Costs in Workers' Compensation, ranked states by their annual percentage growth in medical costs. The results showed that states with fee schedules in place for at least 15 years during the period between 1965 and 1985 fared no better than those without schedules. In fact, the study found no relationship between the growth rate in medical costs and the use of fee schedules ($r = -0.08$).

One of the basic shortcomings of fee schedules is that they do not control utilization. Additional administrative mechanisms must be put in place to ensure that the quantity of medical services are not increased to make up for the lowered price of the service set in the schedule.

Second, setting a fee schedule creates a dilemma of what the appropriate price for each good or service should be. A level is set too low can severely limit the number of providers willing to offer the service. For example, according to the Connecticut Department of Income Maintenance, only about one-quarter of the 7,000 physicians in Connecticut actively treat medicaid patients, while approximately another 1,000 treat a medicaid patient occasionally.

Massachusetts, which has a workers' compensation fee schedule, had the lowest annual growth in workers' medical costs between 1965 and 1985, according to the WCRI study. However, staff in that state's rate setting commission indicate that they receive complaints that there is a shortage of medical specialists willing to treat workers' compensation patients for the set fee.

If, on the other hand, the scheduled rates are set too high, the new fees often become the ones charged by most medical providers. The use of fee schedules may also lull the system into a sense that medical costs are being contained when they are not. The WCRI study results show this nationally.

Another study, Health Care Costs and Cost Containment in Minnesota Workers' Compensation, was conducted by that state's Department of Labor and Industry, and released in March 1990. The study's research showed that, despite Minnesota's use of a medical fee schedule in workers' compensation, medical costs for treating injured workers were twice as high overall as charges for Blue Cross. For all the above reasons, the program review committee concluded that use of medical fee schedules is not the best option to contain medical costs in workers' compensation.

The program review committee also examined another alternative to containing medical costs--allowing some degree of employer choice in the selection of treating physicians. This would permit employers, or insurers on their behalf, to negotiate with providers to treat their employees, injured on the job, at previously agreed-upon rates. At the same time, the committee recognizes that there have to be some checks in place to ensure the adequacy of the quality and the quantity of the providers enlisted by the employers; otherwise employees may not receive adequate medical care. The program review committee recommends that:

Beginning July 1, 1992, allow employers, or insurers on their behalf, to submit a plan for its workers' compensation medical care to the Workers' Compensation Board of Directors for its approval. The plan must be submitted 120 days before the employer intends to have the plan become effective, and must be resubmitted and receive board approval every two years from its initial effective date. The information required in the submitted plan shall be determined by the board, but shall include: 1) a list of the names of all individuals who will provide services, and appropriate evidence of compliance with any licensing or certification requirements for that individual to practice in Connecticut; 2) a description of the times, places, and manner of providing services; and 3) a description of how the quality and quantity of medical care will be managed.

The approval of such plans shall be based on standards set by the board, with advice from a medical panel established by the board. Standards shall include, but not be limited to: 1) provision of all medical and health care services that may be required under workers' compensation in a manner that is timely, effective, and convenient for the worker; 2) inclusion of all categories of medical service, with an adequate number of providers for each type of medical service in accessible locations, to ensure that workers are given adequate choice; 3) provision of appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service; 4) some method of fee screening, peer

review, service utilization review, and dispute resolution to prevent inappropriate or excessive treatment; and 5) a manner in which information on medical and health care service costs and utilization could be reported to the board, upon its request, so that the plan's effectiveness can be determined.

Section 31-305 of the Connecticut General Statutes, concerning independent medical examinations shall be changed to allow an employee, upon the employee's request or at the direction of a workers' compensation law judge, to be examined by a reputable physician or surgeon, other than one listed in the plan sponsored by the employer or the insurer. The costs of such examination shall be paid by the employer.

Discussion. The program review committee believes that if this recommendation is implemented, it will be an essential first step in establishing medical cost containment measures in workers' compensation in Connecticut. The committee recognizes that the approach presented here offers only an opportunity to control costs, not a guarantee. Indeed, the Workers' Compensation Research Institute study cited above showed that states with employer choice of physician had growth rates in workers' compensation medical costs that were both as high and as low as those states with employee choice. However, the most recent data examined were from 1985, before prevalent use of preferred provider organizations and the like.

The program review committee considers this recommendation a balanced approach to controlling costs in that it offers the employers, or their insurers, some latitude in establishing a medical plan that may provide some cost savings, while still allowing employees a reasonable choice of treating physician. Further, since the recommendation would allow either employers, or their insurers, to establish a medical plan it offers opportunities for both large and small businesses to participate. Some employers may realize additional savings if they are able to negotiate with the same providers for their employees' group health care.

Further, by making the plan, including the physician list, subject to board approval there will be an outside check on the integrity of the employer/insurer to establish a medical model with the employee's best interests in mind. Establishing such plans is at the option of the employer/insurer, and provider participation in these plans is voluntary, thus this recommendation should not create overall shortages in the number of medical providers. Further, the recommendation adds the protection of the board's approval to ensure adequacy of the quantity and quality of those physicians in any plan.

Under the committee's proposal, rates for medical goods and services would be negotiated between the provider participants and the employer or insurer, rather than set in a schedule, allowing the parties to the agreement to decide what fees are reasonable. Also, the rates would be adjusted each time the contract was renewed, allowing for some degree of self-regulation.

The recommendation also addresses the need for controlling utilization, requiring that information on usage and costs be kept, and reported to the board upon its request, so that the effectiveness of cost and utilization control can be evaluated. Finally, the program review committee believes this recommendation will move toward controlling costs while still preserving the worker's right to have all medical costs paid without deductibles or copayments.

SECOND INJURY FUND

Benefit Costs

Committee findings on the Second Injury Fund showed that the fund paid out over \$43 million in calendar year 1989, a 130 percent increase in the past five years. The SIF payouts have grown 40 percent more rapidly than workers' compensation overall and payouts now equal about \$27 per year for each employed worker in the state.

It was also found that 78 percent of the payouts from the SIF are for subsequent injuries, while the remainder is used to provide cost-of-living adjustments (3%), group health benefits (1%), payments to claimants whose cases are being appealed (2%), and benefits to workers where their employers were uninsured (4%). The potential demand for the SIF to pay for subsequent injuries is significant.

At present, pending claims are one-and-a-half times the number of claims currently being paid in this category. As discussed in the previous chapter, not all pending claims are transferred, either because they are never acted upon or are denied. However, the number pending is an indication of the potential claims that may have to be picked up by the Second Injury Fund.

Connecticut statutes are broad in their interpretation of who is eligible for transfer to the Second Injury Fund. Connecticut is one of 15 states that requires only that the second injury or disease, when combined with any preexisting condition, results in a permanent disability greater than that which would have occurred from the second injury alone. Such transfers in Connecticut are allowed after the employer has paid benefits to the claimant for two years.

In addition, Connecticut statutes allow immediate transfer to the Second Injury Fund if the worker has signed a document entitled an acknowledgement of physical defect, and the subsequent injury is related to the acknowledged defect. Other states are more restrictive concerning subsequent injuries in one of two ways: 1) they require the second injury to be a permanent total disability or be the loss of an eye or member part; or 2) they require that the employer be knowledgeable about the preexisting condition or prior injury in order for the second injury claim to be transferrable.

The Second Injury Fund expense data show that the rapid growth in the SIF is due largely to benefits paid to claimants who suffer a second injury. In FY 86, the SIF paid about \$15.9 million for subsequent injuries; by FY 90 that payment category had grown to \$35.5 million, or 78 percent of all SIF benefit payments.

The program review committee believes that this growth in the subsequent injury category of the fund is likely to continue for two reasons. First, eligibility for the SIF is broad, allowing high utilization of the fund. Almost anyone suffering a work-related injury can be transferred to the fund if a preexisting condition can be found and the injured worker receives benefits for the required 104 weeks. Second, there are no deterrents, like user fees, for employers or carriers to use the fund. In fact, there is an incentive for an individual employer to shift that liability to the SIF, where the payments of benefits for that injury become the responsibility of the pool of employers rather than the individual employer.

The program review committee concluded that to limit utilization of the fund the statutes must be changed to restrict eligibility. Therefore, it is recommended that:

Transfer to the Second Injury Fund shall be limited to claimants for whom a signed and approved acknowledgement of physical defect is on file with the workers' compensation commission. Further, any transfer to the SIF due to a second injury would take place after the expiration of 104 weeks of benefits paid by the employer. The current statutory reference allowing immediate transfer where acknowledgements exist would be repealed.

The procedure and time limits for application for transfer to the Second Injury Fund, as well as the requirement for all medical reports and a copy of the voluntary agreement or award to be sent to the custodian of the fund, would remain as currently required in statute. However, the employer or insurance carrier would also be required to furnish the signed acknowledgement.

The statutes shall require that the employer, or insurer on his behalf shall be the respondent party to the claim until the transfer to the Second Injury Fund has been completed.

Discussion. The program review committee believes that this recommendation to limit eligibility to the Second Injury Fund is necessary in order to curtail the fund's tremendous growth, and maintain the long-range viability of the fund. The proposal is in keeping with the original purpose of the Second Injury Fund -- to encourage employers to hire handicapped workers or those who had experienced prior injuries, by diminishing the risk to employers if the worker experienced a job-related injury. Indeed, the committee concludes that in order for that purpose to be achieved it is essential that employers at least recognize the employees' handicaps or prior injuries.

The committee believes that employers will not be accepting unlimited liability by hiring someone with a prior injury or disease, since the employer will only be responsible to pay benefits to the claimant for the first two years. After that period, the benefits would be paid from the Second Injury Fund.

This recommendation may encourage employers to conduct pre-employment and employment physical examinations to determine any preexisting conditions workers might have. At the same time, these physical examinations may inform workers of conditions they were previously unaware of and that they may be able to control--e.g., heart disease or diabetes--contributing to a healthier workforce.

Assessments

To finance the Second Injury Fund, employers are assessed five percent of all workers' compensation benefits paid by them in the preceding year. Each assessment is limited to five percent, but there are no limits on the number of times an employer can be assessed in a one-year period.

Prior to the 1990 legislative session, both the State of Connecticut and municipalities that insured their workers' compensation risks with the Connecticut Interlocal Risk Management Agency (CIRMA) were exempt by statute from the assessment, but neither was excluded from using the fund. Public Act 90-311 required that the municipalities in CIRMA be assessed for their portion of the SIF, but the State of Connecticut currently remains exempt. Based on the total workers' compensation benefits paid by the State in 1989, the State's annual assessment in FY 90 would have been approximately \$4 million.

Neither does the State contribute to the administration of the fund. Until recently, the costs of administering the Second Injury Fund came out of the Workers' Compensation Commission budget. However, P.A. 87-277 required that costs incurred by the state treasurer in administering the Second Injury Fund be paid from the fund itself. Thus, other than providing the office space that houses the SIF administrative personnel, the State does not contribute to the Second Injury Fund.

Further, the State's use of the SIF has been growing, according to those in the system. Program review committee staff examined data available on state usage of the SIF as of February, 1990 and found that there were 129 claimants who were receiving benefits for a second job-related injury. However, there were an additional 110 claims pending in this category. As discussed above, all pending cases do not result in transferred cases, but it is an indication of the number that the State considers meet the eligibility criteria.

The program review committee believes that all employers that pay workers' compensation benefits, including the State of Connecticut, ought to be assessed for use of the Second Injury Fund. Therefore, the committee recommends that:

Beginning July 1, 1992, the mandatory assessments for the Second Injury Fund be extended to include the State of Connecticut.

Discussion. The program review committee believes that having the State pay into the Second Injury Fund will make a fairer assessment system than the one currently in existence. First, the State of Connecticut uses the Second Injury Fund for its eligible claimants like any other employer in the state. Further, the State paid workers' compensation benefits totalling about \$40 million during calendar year 1989, which would have translated into a \$4 million annual assessment for the Second Injury Fund.

Second, it is difficult to justify why other employers who pay the assessments for the fund must share the burden of the State's portion as well. For example, if the State had been assessed for its portion of the fund's payouts in 1989, it would have saved all other employers about ten percent on their assessments. State responsibility for its use of the fund would spread the costs to all citizens who benefit from the State's services, and not just to those businesses that pay out workers' compensation benefits.

APPENDICES

APPENDIX A
Agency Response



COMMENT ON LEGISLATIVE PROGRAM REVIEW
AND INVESTIGATIONS COMMITTEE REPORT ON
WORKERS' COMPENSATION IN CONNECTICUT

by John Arcudi
Chairman, WCC

At the outset, I wish to compliment the high level of professional competence and staff work demonstrated in all phases of the Committee's Report. Speaking from the viewpoint of my own professional experience, forty-two years as a lawyer and sixteen years on the commission, I was surprised that the staff was able in so short a time to acquire such a thorough knowledge of a complex system. Certainly the Report asks the right questions even if I don't agree with many of its answers. All of its recommendations merit respectful consideration.

Of most concern to me are the recommendations relating to the commission, its organizational structure, personnel requirements, funding, administration, dispute resolution and case management procedures and control and accountability of its various elements and divisions. Underlying the Report's consideration of those aspects are two basic themes:

(1) the commission is underfunded and understaffed for the tasks it needs to perform, and (2) the present commission structure and laws fail to distinguish adequately between the commission's administrative and adjudicative functions. Since 1981 when the full time Chairman's position was created, it has been my duty each year before the General Assembly

to address those themes and to seek with only very moderate success to remedy these deficiencies.

The basic statute defining the Chairman's role, Sec. 31-280, gives very little real authority over the system. That law states the Chairman's duties shall be administrative in nature, the Chairman shall have control over the hearing calendars of the commissioners and further that the Chairman may hear any matter. However, Sec. 31-278 gives district commissioners jurisdiction of all claims and questions arising in their respective districts. Sec. 31-280 does also give the Chairman the duty to prepare the annual budget. That constitutes a vague and limited definition of authority. Within those limits I have attempted to create the semblance of a centralized system for administration, but what little has been done in that regard has only been through moral suasion rather than through legal authority. The Report recognizes this, but it also seems to criticize the commission and the Chairman for failing to do what the law and insufficient budget allocations will not permit it to do. I pointed out in my August 14 testimony before the Committee that for Connecticut to reach the average staffing level prevailing among all state worker compensation agencies in the United States, we would need to have a staff of more than two hundred persons, triple the seventy positions we now have allocated.

The Report proposes increases in staff throughout the commission, a chief administrative position in the central office and a chief administrative position in each of the

districts with authority over the administrative process. To implement that recommendation further the Report contemplates additional support staff in the central office and the districts. I disagree with the Report in giving the central administrator total authority over the whole system, including its adjudication function. But I agree that basic administrative and management procedures need to be strengthened.

What the Report fails sufficiently to note is that the commission was basically created as a court to resolve and adjudicate disputes. If the legislators in 1913 gave any thought at all to the concept, they must have imagined that the uncontested cases would process and administer themselves. Therefore, they crafted a law which dealt almost exclusively with the adjudication function. It only gave a passing glance to administration.

That 1913 view persisted through the next eight decades. When the General Assembly added amendments to the law, it concentrated on the same adjudication function. The Report recommends strengthening administration instead. However, in doing that, it should not submerge the adjudicatory duties.

There is no reason why an adjudicator should not continue to remain as the head of the system. The judicial department is a prime example of how Connecticut solved the problem in the courts. It created a chief court administrator under the Chief Justice. My recommendation then would be to adopt the Report's concept of a chief administrator, but that administrator should be a deputy to the adjudicator chief of the

system. I also approve the concept of a chief administrative position, a district manager, in each of the districts.

However, I strongly disapprove the recommendation that there be an unpaid eight-member board meeting monthly with authority over the whole system. The duties which the Report assigns to that board (Chapter III, pp 4-5) cover one and a half pages. The Committee cannot seriously contemplate that such an array of tasks will be accomplished by an unpaid board meeting once a month. Obviously, it will be the chief administrator who performs that work. The board will simply have a veto if it chooses to exercise it. The chief paid position in the system will then have real power over a system controlling expenditures approaching three quarters of a billion.

That chief position with such power should be directly responsible to the Governor and the legislature. In a democracy the power and control over such a person should lie directly with those elected by the people, the Governor and the General Assembly. There is room for a tripartite advisory commission representing employers, employees and the general public, but such a body should have advisory functions only.

In a way the Report contradicts itself. It recommends that the present commissioners should be members of the bar and be called compensation judges. Then it wants to have them appointed by this unpaid board. Yet the Governor and the General Assembly are the entities which now select judges for the judicial branch. The present selection system should continue. However, like the judges, commissioners should

be selected from a list of names approved by the Judicial Selection Commission. Similarly, discipline and control over sitting commissioners should reside in the Judicial Review Council.

The case processing recommendations are good ones. However, as with most of the recommendations, there must be sufficient additional staff and budget resources allocated to the commission to accomplish these improvements. With present staff it would be impossible to implement most of these recommendations.

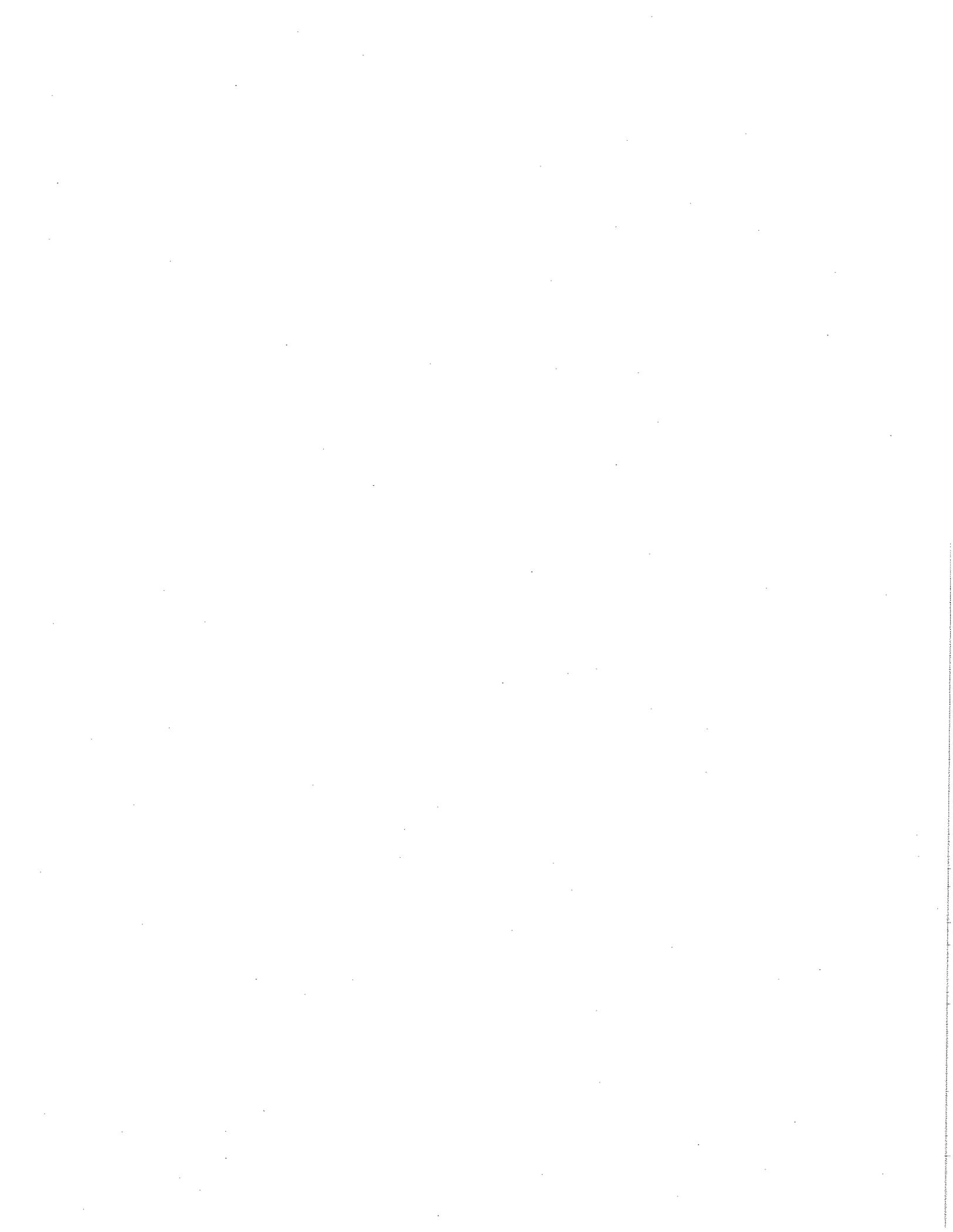
Compensation Review Division recommendations do not need much comment. The Report recognizes that the CRD established in 1979 has performed well in creating a uniform body of law. We do not conform to the one year statutory time limit for issuing decisions since we are taking sixteen to seventeen months. With more staff, this period could be shortened, especially if the chief administrative deputy could relieve the CRD Chairman of many administrative duties or if an additional commissioner could be appointed to devote more time to CRD functions.

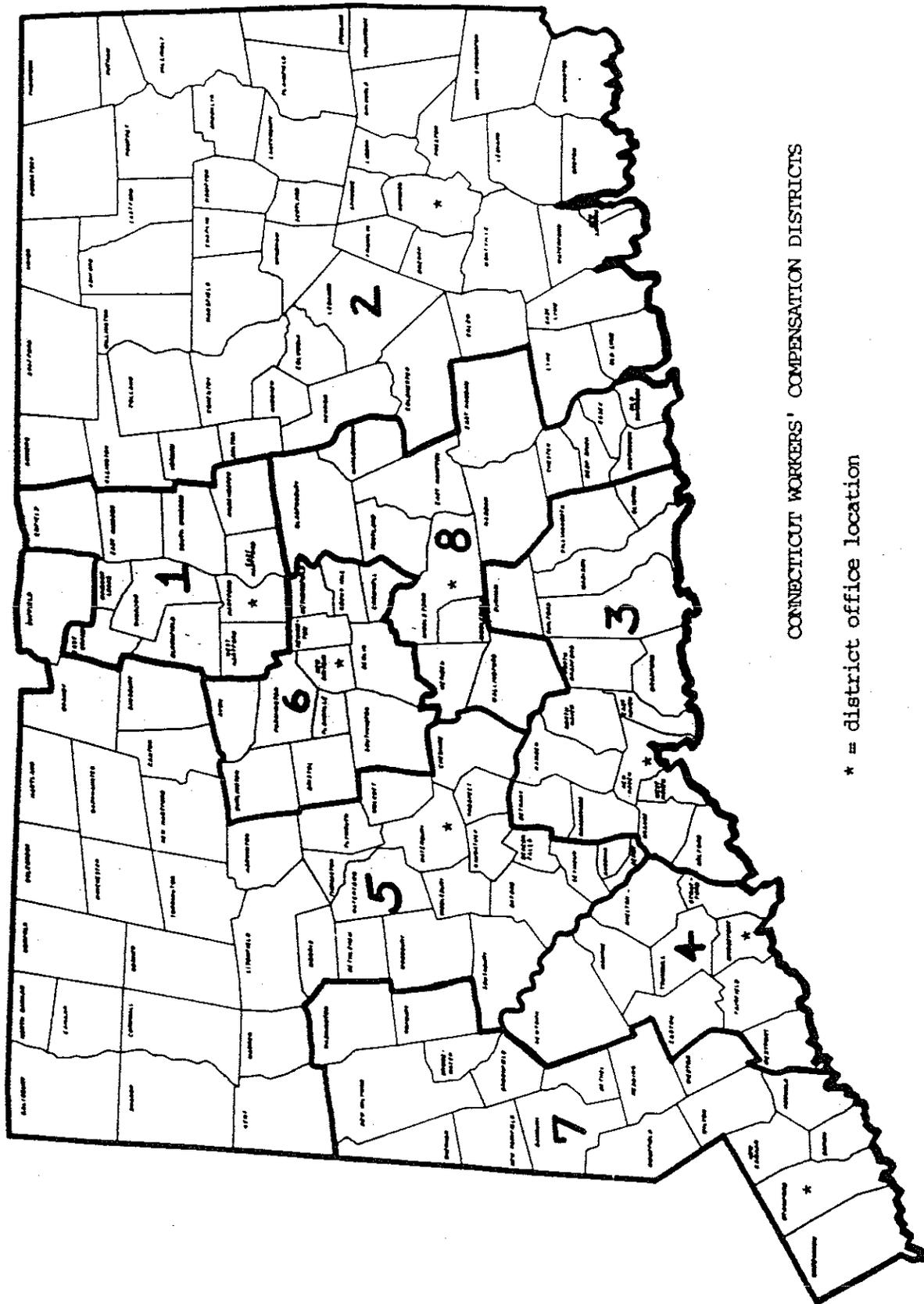
The funding device recommended by the Report is essentially the same that I proposed to the 1990 General Assembly session, one assessment for the commission and all its divisions, not to exceed five (5%) percent of the previous year's payout in indemnity payments and medical costs. The enactment of P.A. 90-311 should facilitate such a change. Then the head of the system would have control over all the agency funds and would be able to allocate resources more effectively.



APPENDIX B

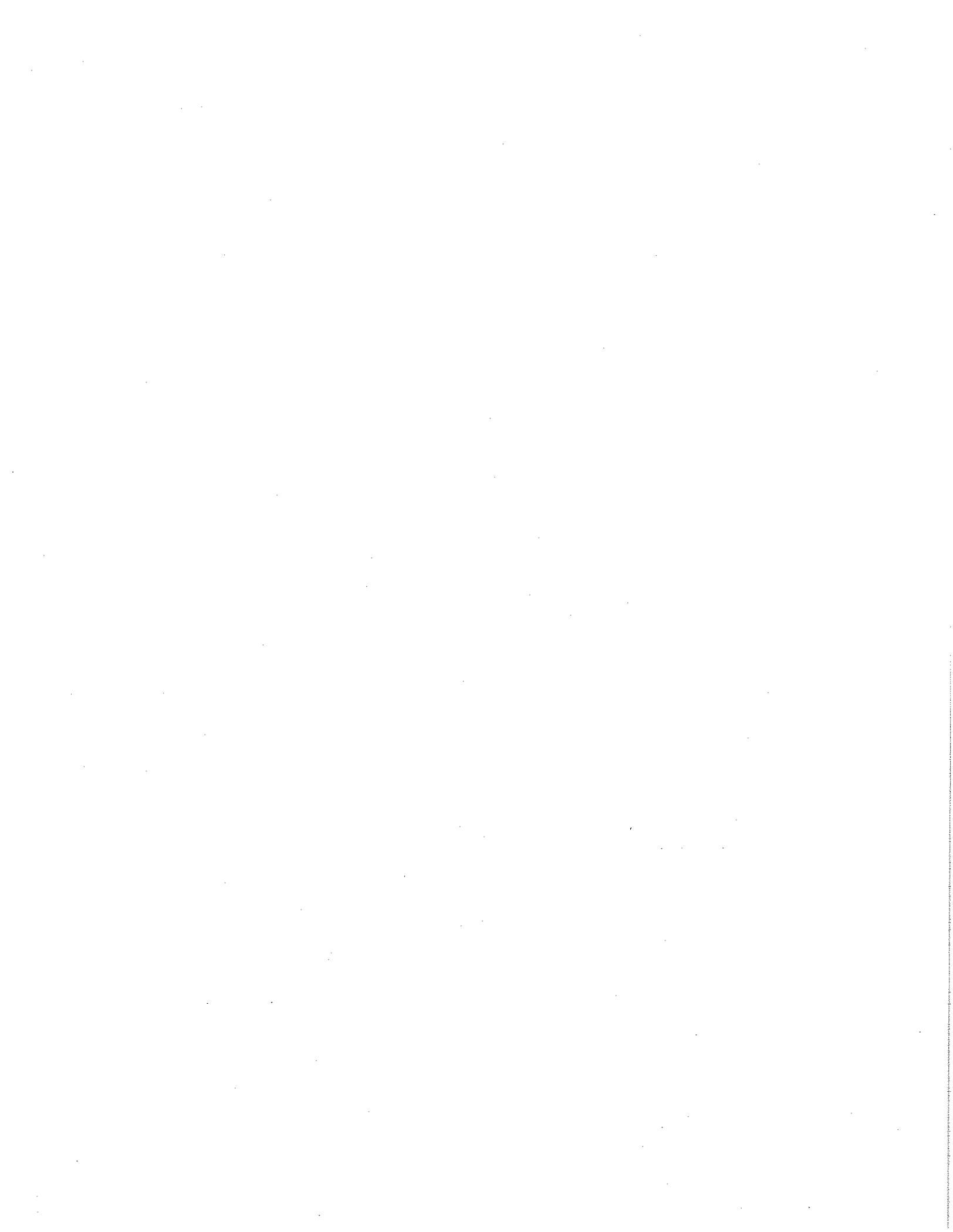
Workers' Compensation Districts





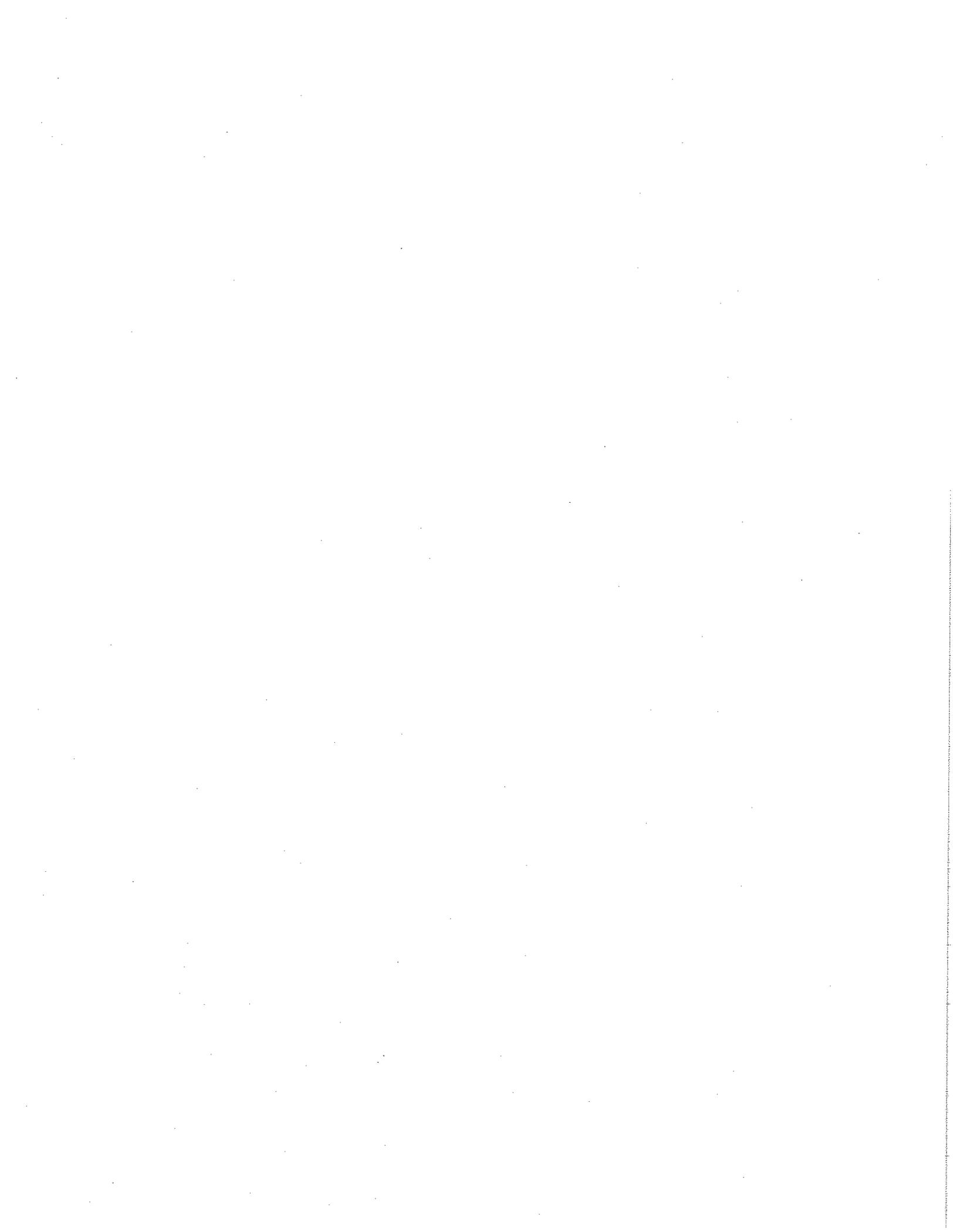
CONNECTICUT WORKERS' COMPENSATION DISTRICTS

* = district office location



APPENDIX C

Permanent Partial Disability Rating Schedule



MAXIMUM BENEFITS SCHEDULE FOR PERMANENT PARTIAL DISABILITY Section 31-308

Master Arm	312 Weeks	<p>NOTE</p> <p><i>Reduction in sight to 10% or less of normal vision is treated as 100% loss of sight.</i></p> <p><i>The loss or loss of use of one phalanx of a thumb will be considered a 75% loss of use.</i></p> <p><i>The loss or loss of use of one phalanx of a finger will be considered a 50% loss of use; of two phalanges, 90% loss of use.</i></p> <p><i>The loss or loss of use of a phalanx of the great toe will be considered a 66⅔% loss of use.</i></p> <p>ADDITIONAL NOTE:</p> <p><i>If a worker remains totally disabled despite having reached maximum medical improvement, the worker should continue to receive benefits for TEMPORARY TOTAL DISABILITY.</i></p> <p><i>Permanent partial disability should not be paid in lieu of temporary total disability benefits when total incapacity continues.</i></p>
Other Arm	291	
Master Hand	252	
Other Hand	232	
Leg	238	
Foot	188	
Binaural Hearing	156	
Hearing, One Ear	52	
Sight, One Eye	235	
Thumb, Master hand	95	
Other Thumb	81	
First Finger	54	
Second Finger	44	
Third Finger	31	
Fourth Finger	26	
Great Toe	42	
Any Other Toe	13	
Back	520	

REVISED LIST OF RECOMMENDED NORMS FOR NON-SCHEDULED LOSSES

Heart	780 Weeks	Nose (sense & respiratory function)	52 Weeks
Brain	780	Jaw (mastification)	52
Carotid Artery	780	Penis	52-156
Pancreas	624	Coccyx (actual removal)	52
Liver	520	Sense of smell	26
Stomach	390	Sense of taste	26
Loss of Bladder	350	Spleen (in addition to scar)	20
Speech	275	Gall bladder	20
Lung	175	Tooth (minimum)	1
Cervical Spine	175	Loss of drainage duct of eye (if corrected by prosthesis)	25 for each
Kidney	175	Loss of drainage duct of eye (if uncorrected by prosthesis)	50 for each
Rib Cage (bilateral)	104	Pelvis	% of back
Testis	52		
Mammary	52		

APPENDIX D

Legislative Program Review & Investigations Committee
Workers' Compensation Case File Data Collection Form

LPR&IC DATA COLLECTION SHEET FOR WORKERS' COMPENSATION CASE REVIEW

ID NO. _____ DISTRICT: 1 2 3 4 5 6 7 8 DATE OF INJURY: ___/___/___

EMPLOYER: _____ TYPE JOB: _____ KEY: 1 = construction/trades/laborer
 2 = manufacturing
 3 = direct care
 4 = office/professional
 5 = service
 6 = other

INSURANCE: 1 = self 2 = private

CARRIER: _____

PHYSICAL: 1 = yes/back 3 = no DISEASE: 1 = yes 2 = no PSYCH: 1 = yes 2 = no

BENEFITS: ***** Key: CON ***** Key: RES HOW ***** Key: RES PT *****
 1 = yes/contested 43 1 = VA 1 = Before Informal 5 = After CRD
 2 = yes/contested 36 2 = Award 2 = After Informal 6 = After Courts
 3 = yes/other issue 3 = Dismiss 3 = After Formal 9 = DK
 4 = no 4 = stip. 4 = After Reconsider
 5 = Other

	CLM 1 = Yes	REC 1 = Yes 2 = No 9 = DK	CON see key	CONTEST DATE	RES 1 = Yes 2 = No 9 = DK	RESOLVE DATE	RES HOW see key	RES PT see key	\$ AMT WEEKLY	NO. WKS	\$ AMT. TOTAL
TEMP. TOTAL				___/___/___		___/___/___					
PERM. PARTIAL				___/___/___		___/___/___					
DISFIG.				___/___/___		___/___/___					
MEDICAL				___/___/___		___/___/___					
OTHER*				___/___/___		___/___/___					

(* other _____)

(ID NO. _____)

SUBJECT(S) IN DISPUTE:

- YES NO
- 1.. 2...Liability (of employer)
 - 1.. 2...Ability to return to work
 - 1.. 2...Timely payment of benefits
 - 1.. 2...Perm. partial--existence
 - 1.. 2...Perm. partial--extent
 - 1.. 2...Medical (payments/treatment)
 - 1.. 2...Transfer to SIF
 - 1.. 2...Other:

INFORMAL HEARINGS*****

DATE REQ.	WHO REQ. 1= Clmt. 2= Emp/ 9= DK	DATE SCHED	NO. TIMES POSTPONED (none = 0)	NO. CLMT POSTPONED (none = 0)	NO. EMP/INS POSTPONED (none = 0)	DATE HELD
INF 1		___/___/___	1 2 3 4 5 6 7 8 9 / ___	1 2 3 4 5 6 7 8 9 / ___	1 2 3 4 5 6 7 8 9 / ___	___/___/___
INF 2		___/___/___	1 2 3 4 5 6 7 8 9 / ___	1 2 3 4 5 6 7 8 9 / ___	1 2 3 4 5 6 7 8 9 / ___	___/___/___
INF 3		___/___/___	1 2 3 4 5 6 7 8 9 / ___	1 2 3 4 5 6 7 8 9 / ___	1 2 3 4 5 6 7 8 9 / ___	___/___/___
INF 4		___/___/___	1 2 3 4 5 6 7 8 9 / ___	1 2 3 4 5 6 7 8 9 / ___	1 2 3 4 5 6 7 8 9 / ___	___/___/___
INF 5		___/___/___	1 2 3 4 5 6 7 8 9 / ___	1 2 3 4 5 6 7 8 9 / ___	1 2 3 4 5 6 7 8 9 / ___	___/___/___

TOTAL NO. INFORMALS HELD: _____ DATE LAST INFORMAL HELD: ___/___/___

(ID NO. _____)

FORMAL HEARINGS*****

	DATE REQ.	WHO REQ. 1= Clmt. 2= Emp/ 9= DK	DATE SCHED	NO. TIMES POSTPONED (none = 0)	NO. CLMT POSTPONED (none = 0)	NO. EMP/INS POSTPONED (none = 0)	DATE HELD
FOR 1	___/___/___		___/___/___	1 2 3 4 5 6 7 8 9 / ___	1 2 3 4 5 6 7 8 9 / ___	1 2 3 4 5 6 7 8 9 / ___	___/___/___
FOR 2	___/___/___		___/___/___	1 2 3 4 5 6 7 8 9 / ___	1 2 3 4 5 6 7 8 9 / ___	1 2 3 4 5 6 7 8 9 / ___	___/___/___
FOR 3	___/___/___		___/___/___	1 2 3 4 5 6 7 8 9 / ___	1 2 3 4 5 6 7 8 9 / ___	1 2 3 4 5 6 7 8 9 / ___	___/___/___
FOR 4	___/___/___		___/___/___	1 2 3 4 5 6 7 8 9 / ___	1 2 3 4 5 6 7 8 9 / ___	1 2 3 4 5 6 7 8 9 / ___	___/___/___
FOR 5	___/___/___		___/___/___	1 2 3 4 5 6 7 8 9 / ___	1 2 3 4 5 6 7 8 9 / ___	1 2 3 4 5 6 7 8 9 / ___	___/___/___

TOTAL NO. FORMALS HELD: _____ DATE LAST FORMAL HELD: ___/___/___

HOW CLAIMANT REPRESENTED: 1 = self 2 = attorney 3 = other _____

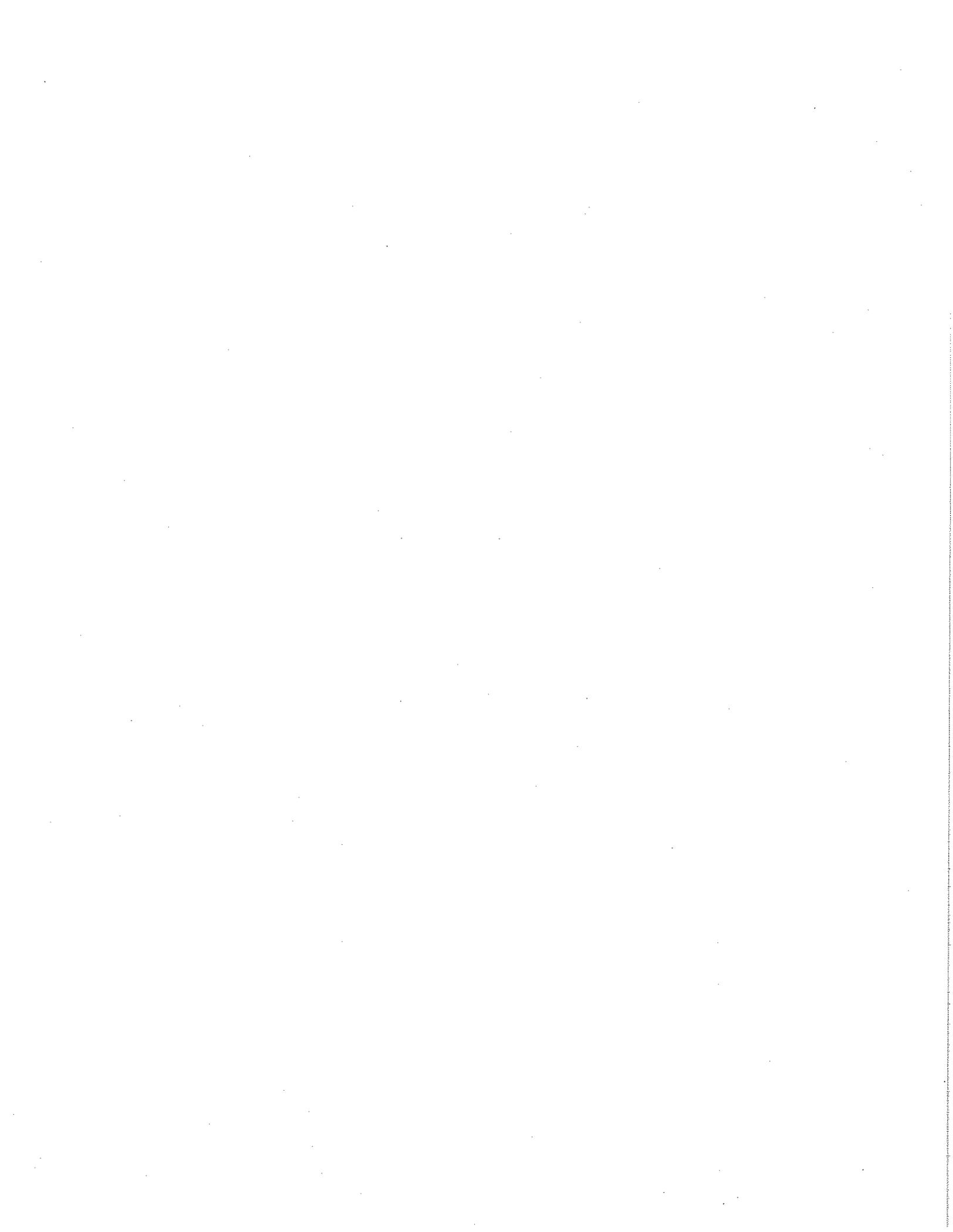
HOW EMPLOYER/INSURER REPRESENTED: 1 = self 2 = attorney 3 = other _____

ANY RECORD ATTORNEY FEES APPROVED BY COMMISSIONER: 1 = Yes



APPENDIX E

Estimated Fiscal Impact of Committee Recommendations



ESTIMATED FISCAL IMPACT OF COMMITTEE RECOMMENDATIONS

Estimated Costs

Board of Directors expenses (annual)	\$ 10,000
Additional administrative staff positions (annual salary & fringe benefits):	\$ 630,000
Occupational Health Clinics (P.A. 90-226), one year:	\$ 750,000
	<hr/>
Total:	\$1,390,000

Estimated Savings

Wage Replacement at 80 Percent:	Unknown
Dependency Allowances:	\$1.9 million
Cost-of-Living Adjustment (COLA):	Unknown
Permanent Partial Disability:	\$24 million
Disfigurement Awards:	\$13.6 million
Medical Costs:	Unknown

DERIVATION OF ESTIMATES

Administrative Costs

Additional Staff (annual salary plus & 45% fringe benefits):

1 Chief Administrative Officer:	\$ 120,000
1 Support Staff Position to CAO:	\$ 30,000
8 District Office Manager Positions @ 60,000 each:	\$ 480,000
Board misc. expenses (e.g., travel reimbursement:	\$ 10,000
Occupational health clinics (P.A. 90-226) one-year funding:	\$ 750,000
	<hr/>
Total	\$1,390,000

Dependency Allowance

Assumptions

Based on reported accident data from the Workers' Compensation Commission, the staff estimates there are about 50,000 cases per year

Based on data from the case sample, the staff estimates that 75 percent of all workers' compensation cases involve temporary total disability.

Based on data from the case sample, the staff estimates that 25 percent of persons claiming temporary total disability benefits have eligible dependents. (The estimate was derived by comparing weekly compensation rates of claimants who received both permanent partial and temporary total benefits.)

Based on data from the case sample, the average number of dependents claimed was 2.

Based on national data, the staff estimates the average duration of a temporary total disability case is four weeks.

Calculation

50,000 cases x .75 = 37,500 temporary total (TT) cases
37,500 TT cases x .25 = 9,375 TT cases with dependents
9,375 cases x 10 weeks (sample median) = 93,750 weeks
93,750 weeks x \$20 (2 dependents at \$10 a week) = \$1,875,000

Disfigurement Awards

Assumptions

Based on statistics reported by the Workers' Compensation Commission, the staff estimates the average annual number of disfigurement awards to be approximately 8,800. (Average for the past five years.)

Using data from the case sample and adjusting for the rise in wages, the staff estimates the current average disfigurement award to be \$2,500.

Based on recall of cases reviewed while collecting data the staff estimates the number of disfigurement awards related to head and facial scarring to be between 5 and 10 percent of the total.

Based on knowledge gained while collecting data, the staff estimates the average duration of a disfigurement award under the recommendation adopted by the committee would be 20 weeks. (Median duration for cases in sample = 10 weeks; head and facial assumed to be among the more severe disfigurements and, therefore, generally evaluated at a higher number of weeks.)

Calculation

8,800 cases x \$2,500 = \$22,000,000 (estimated cost under current system)

8,800 cases x .10 = 880 (estimated number of cases under the committee's recommendation)

\$479 (state average weekly earnings of production and related manufacturing workers as of October 1, 1990) x 20 weeks (average duration= \$9,580 (estimated average cost per case under the committee's recommendation)

\$9,580 x 880 = \$8,430,400 (estimated cost under the committee's recommendation)

\$22,000,000 - \$8,430,000 = \$13,570,000

Permanent Partial Disability Awards

Assumptions

Based on reported accident data from the Workers' Compensation Commission, the staff estimates there are approximately 50,000 compensation cases per year.

Based on data from the case sample, the staff estimates that 35 percent of all workers' compensation cases involve a permanent partial disability claim.

Using data from the case sample and adjusting for the rise in wages, the staff estimates the current average permanent partial award to be \$11,900.

Using on data from the case sample and adjusting it the rise in wages, the staff estimates the average permanent partial award under the committee's recommendation would be \$10,500.

Calculation

50,000 cases x .35 = 17,500 permanent partial disability cases

17,500 x \$11,900 = \$208,250,000 (estimated annual obligation incurred under the current system)

17,500 x \$10,500 = \$183,750,000 (estimated annual obligation incurred under the committee's recommendation)

\$208,250,000 - \$183,750,000 = \$24,500,000

APPENDIX F

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