

**Comments
on the
Report to the Governor
from the
Superintendent of Insurance
Summarizing Workers' Compensation Data
and
Recommending Improvements in Data Collection
and
Development of a Research Structure for Public Policy**

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On March 3, 2008 the Superintendent of Insurance transmitted a Report to Governor Eliot Spitzer discussing certain workers' compensation data and making certain recommendations. This paper comments on the methodology, conclusions, and recommendations of the Report. Some different conclusions are drawn and alternative recommendations are made herein.

I. The Methodology of the Report.

The methodology used in the preparation of the Superintendent's report is troublesome. At the outset, the report states that the Insurance Department "consulted numerous parties involved in the workers' compensation system, including representatives from organized labor, private insurance carriers, the State Insurance Fund, the Workers' Compensation Board and representatives of other state's workers' compensation systems."¹ Notably absent from this list are injured workers, attorneys (either claimant or defense), physicians (either treating physicians or so-called "independent medical examiners" (IMEs), or non-organized labor worker rights organizations. The Department's list of consultants seems to have ensured that the Department would receive "the big picture" unleavened by practical advice from those who are engaged in the system on a day to day basis. This lack of practical advice shows, for example, in the Report's inability to correctly spell "carpal tunnel syndrome."² Another example appears in the Report's statement that from 2004 through 2006 54% of injured workers received the maximum weekly benefit rate of \$400 and that the "distribution" was \$334.90.³ The Report fails, however, to identify for what period of time any claimant actually received these figures. The experience of those who are

¹ Report to the Governor from the Superintendent of Insurance Summarizing Workers' Compensation Data and Recommending Improvements in Data Collection and Development of a Research Structure for Public Policy, March, 2008, p. 4.

² Id. at p. 47.

³ Id. at p. 37; see also Report, p. 96.

familiar with the practice of workers' compensation is that while many claimants may initially receive a high benefit rate, it is quickly reduced through carrier use of IMEs.

Second, the Report identifies the trend of "costs per claim growing significantly" as a crucial finding.⁴ Much of the balance of the report is then addressed to consideration of why "costs per claim" are growing, and finding a means to reverse this trend. As discussed below in subsection I.A., however, the issue of "costs per claim" is in fact almost irrelevant, and any action taking towards addressing this issue will in fact amount to a further unwarranted reduction in benefits for injured workers. The fact is that overall workers' compensation costs – the relevant issue – are not rising. If prior statements by the Governor and the Insurance Department are accurate, overall workers' compensation costs should actually fall by over \$1 billion per year (three-quarters of which is attributable to capping permanent partial disabilities) as a result of the 2007 statutory amendments.

Third, the Report is based largely on unreliable or unverifiable data which has been produced by entities with a vested self-interest in the process – the CIRB and the WCB. The specific issues created by the use of CIRB and WCB data are discussed below in subsections I.B. and I.C..

A. The Use of "Costs Per Claim" as a Basis for Analysis is Incorrect.

The Superintendent's Report focuses primarily on the "costs" of workers' compensation and methods by which these "costs" may be reduced, particularly on a "per claim" basis. Without explanation or substantiation, the Report states that "to evaluate system performance in terms of costs it is important to examine cost per claim rather than total system costs."⁵ To the contrary, we would suggest that the selection of "cost per claim" as the analytical starting point fundamentally undermines the utility of the Report. The essential purpose of the workers' compensation system is to deliver timely and adequate compensation to workers who are injured on the job. Employers are afforded a number of options to secure payment of benefits, including the purchase of a private insurance policy, obtaining coverage from the New York State Insurance Fund, and self-insurance. However, as long as there are work-related injuries, the complete elimination of "cost" is impossible. In the context of existing work-related injuries, the reduction of "costs" really translates into the reduction of benefits for injured workers.

In addition, focusing on "costs per claim" reflects a lack of comprehension of certain trends in New York State workers' compensation claims, and in the end distorts the result by leading to a conclusion that is the diametric opposite of reality.

The Report identifies the most significant trend in workers' compensation claims, which is that the frequency of "small claims" is decreasing rapidly.⁶ We note that neither NCCI nor the Superintendent provide an explanation of this trend, which we would

⁴ Report at page 4.

⁵ Id. at p. 85.

⁶ 2006 State of the Line: Analysis of Workers' Compensation Results, NCCI, Report at p. 24.

suggest is attributable to the fact that increasing barriers to workers' compensation benefits "disincentivize" workers with apparently minor claims to file for benefits, thus effectuating a cost transfer to private health insurers and union health and welfare funds. Regardless of the cause, however, the decreasing frequency of "small claims" results in an increase in average "per claim" costs, but does not result in an increase in total costs. Consider the following hypothetical illustration:

<u>Scenario A</u>		<u>Scenario B</u>	
10 claims = \$1,000	Total Cost = \$10,000	3 claims = \$1,000	Total Cost = \$3,000
5 claims = \$5,000	Total Cost = \$25,000	5 claims = \$5,000	Total Cost = \$25,000
4 claims = \$10,000	Total Cost = \$40,000	4 claims = \$10,000	Total Cost = \$40,000
1 claim = \$25,000	Total Cost = \$25,000	1 claim = \$25,000	Total Cost = \$25,000
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Total = \$100,000		Total = \$93,000	
Average = \$5,000		Average = \$7,153.85	

In Scenario A, the carrier has a total of 20 claims, evenly distributed among small claims (\$1,000 in our example) and non-small claims (\$5,000 and up in our example). Although the total cost to the carrier of the claims is \$100,000, the average cost is only \$5,000 due to predominance of small claims in the sample.

In Scenario B, the frequency of small claims has declined 70%, while the frequency and cost of all other claims has remained identical. The carrier's "per claim" cost has jumped over 40% from \$5,000 to \$7,153.85, yet its total cost has declined 7% from \$100,000 to \$93,000.

It will therefore be seen that while the decline in "small claims" causes the appearance of a skyrocketing "cost per claim" in the remaining claims, in fact it does not prove that the costs of any individual claim have increased. Further, the superficial (and illusory) increase in "costs per claim" may in fact be associated with declining overall costs to workers' compensation carriers.

We also question the Report's consistent use of "average" figures as opposed to "median" figures. In many instances, there is a significant divergence between the average of a group and its median (the point at which half are above and half are below). Averages may be easily skewed by outliers at the high or low end of a range; medians are less susceptible to such variability.

B. Reliance on CIRB Data is Misplaced.

Much of the Superintendent's Report relies upon data obtained from the New York Compensation Insurance Rating Board (CIRB). The CIRB is, of course, essentially a wholly owned entity of the private insurance industry, and exists (or to date has existed) for the purpose of submitting proposals for increases in insurance rates.⁷ Up until the

⁷ NY Ins. Law § 2313; see also Workers' Compensation: State of the System 2006, Robert Grey.

present time there has been no entity with the ability to independently verify the data or the submissions of the CIRB. It goes without saying that it has been in the interest of the CIRB to submit rate increase proposals that would maximize insurance industry profits. Reference may be made to the Opinion and Decision of the Insurance Department of July 17, 2006, when an application for a rate increase filed by CIRB was disallowed.⁸ At that point in time the Insurance Department made clear its distrust of the accuracy and reliability of the data submitted by CIRB, which is now accepted wholesale and without significant criticism.

The unreliability of the CIRB was considered so pervasive that the March, 2007 Workers' Compensation Reform Act eliminated the CIRB in its present form, and the Insurance Department was instructed to offer a plan for the creation of a new rate-making agency.⁹ This has subsequently been carried out by legislation requiring new governance of the CIRB as a transition measure to its elimination, which is mentioned in passing in the Report itself.¹⁰

In addition, as noted in the Report, the "CIRB data does not include any information from the self-insured portion of the marketplace, which is [one-third] of the market."¹¹ The Report attempts to compensate for this deficiency by simply adding one-third to its various assumptions. By way of example, at one point the report takes the 154,598 claims reported by CIRB for 2003 and arbitrarily adds one-third, thus arriving at an assumption that there were 206,079 claims in 2003.¹² Had the Superintendent simply looked at the WCB data for 2003 (included in the next subsection) it would have known that there were only 149,808 claims indexed by the WCB that year. Clearly there is a significant variation between the data reported by CIRB and the data reported by the WCB, as the WCB, which covers the entire marketplace, indexed fewer claims than reported by the CIRB, which covers only two-thirds of the marketplace. It is unclear whether this particular deficiency rests with the WCB or the CIRB (it seems likely that the WCB is failing to "index" a large number of claims), but clearly there is a significant question regarding the accuracy of the data. The Report provides a partial explanation of this discrepancy, noting that that CIRB recorded 97,949 "medical-only" claims whereas the WCB recorded only 27,817,¹³ but clearly further research is required before any satisfactory conclusions can be drawn.

Yet another limitation on the utility of the CIRB data is that it was culled from the 2003 policy year.¹⁴ While the Superintendent offers a number of valid reasons (mainly related to claim maturity issues) for the selection of the 2003 policy year, that does not change the fact that conclusions and recommendations are being drawn for the present based on data regarding claims from 5 years ago. A brief review of the charts included in the next

⁸ In the Matter of Workers' Compensation Insurance Rate Application of the New York Compensation Insurance Rating Board, Opinion and Decision of New York State Insurance Department, 7/17/06.

⁹ Insurance Law § 308.

¹⁰ Report at p. 18.

¹¹ Id. at p. 22.

¹² Id. at p. 24.

¹³ Id. at p. 25.

¹⁴ Id. at p. 23.

subsection regarding claim trends will immediately reveal that claim data in 2006 (the last available year due to the WCB's failure to produce a 2007 Summary Annual Report to date) is substantially different from 2003 data. Given the pattern shown on the charts through 2006, it is fair to assume the 2008 data is even more divergent from 2003 than was the 2006 data.

Given the fact that the veracity of the CIRB has been deemed so poor as to justify its elimination, and further given the age of the CIRB data used in the Report, the fact that it consists largely of "projections" instead of facts, and the substantial variation between the CIRB data and the WCB data, we question whether a Report built largely on unverified, self-reported data from the CIRB can itself be credible.

C. WCB Data is of Limited Value.

The other data source used by the Insurance Department in the preparation of the Report is information obtained from the Workers' Compensation Board (WCB). While some of the WCB data is consistent, verifiable, and reliable, other WCB data is of dubious value. This is particularly true in identifying "medical only" claims and "resolved" claims.

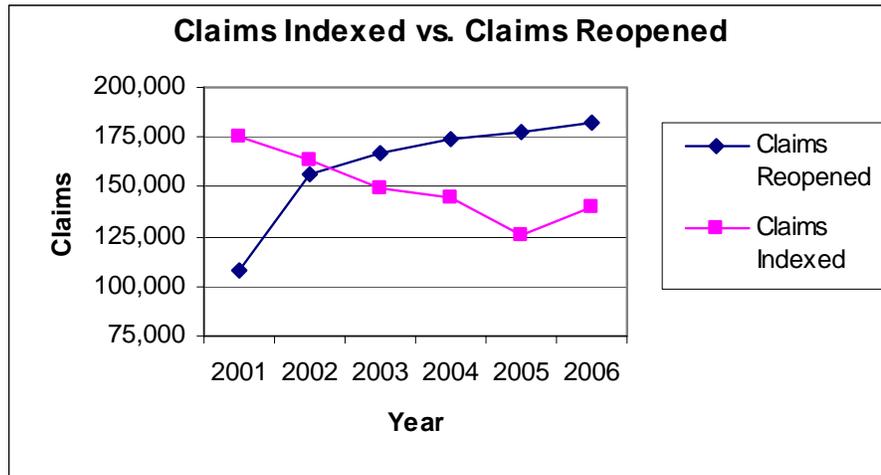
Until approximately the year 2000, the WCB identified the result of a hearing in one of three ways: "adjourned" (no substantive action taken); "continued" (substantive action taken but the claim is not fully resolved); and "closed" (case fully resolved). Under this system the status and progress of all claims could be easily identified, as well as the average amount of time it took for a claim to be fully resolved.

In 2000, the WCB eliminated the use of the word "closed," instead substituting the phrase "no further action is contemplated by the Board at this time" (NFA). WCL Judges, who were always encouraged to close as many cases as possible in order to build the WCB's statistics of "resolved" claims, were now encouraged to aggressively use the new "NFA" procedure wherever possible. As a result, claims in all stages of the process are now simply marked "NFA," with no distinction being drawn between claims that are fully resolved and those that have simply been "taken off of the calendar" only to be imminently reopened for further action. As a result, the WCB is unable to provide any accurate information regarding how many cases are actually fully resolved as opposed to how many cases have simply been made temporarily administratively inactive. Similarly, the WCB is unable to provide a meaningful answer to the question of how long it takes the average claim to become "fully resolved." The Report recognizes this issue (at least to some extent), observing that 43% of controverted claims are marked "resolved" at the pre-hearing conference simply due to the non-appearance of the claimant.¹⁵ Obviously these are not true "resolutions" because such claims can be (and frequently are) reopened.

The chart below illustrates the rise in the number of cases reopened by the WCB each year from 2001 through 2006 as compared to the number of claims indexed by the

¹⁵ Report at p. 68.

WCB in each of those years. It will immediately be observed that the number of claims reopened surpassed the number of claims indexed beginning in 2003. The trend line for claims reopened is directly attributable to the WCB’s use of the NFA procedure and clearly demonstrates the unreliability of WCB data regarding “resolved claims.” It also casts further doubt on the utility of using the year 2003 as a benchmark given the radical difference in trend after 2003 as opposed to the trend prior to 2003.



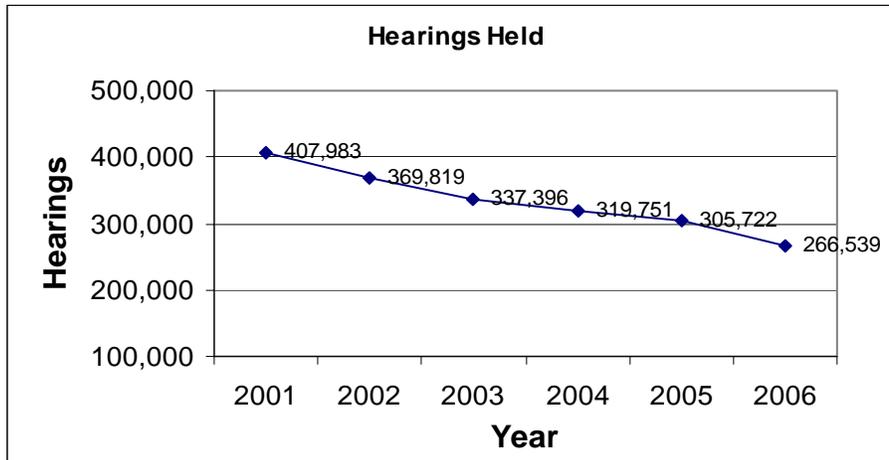
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Another WCB initiative that affects both statistics and the actual delivery of benefits is the use of administrative and proposed decisions. These decisions are typically issued without the benefit of a hearing, and are largely comprised of boilerplate language that is unintelligible to most injured workers.¹⁷ Furthermore, these decisions almost invariably conclude with an “NFA” finding.

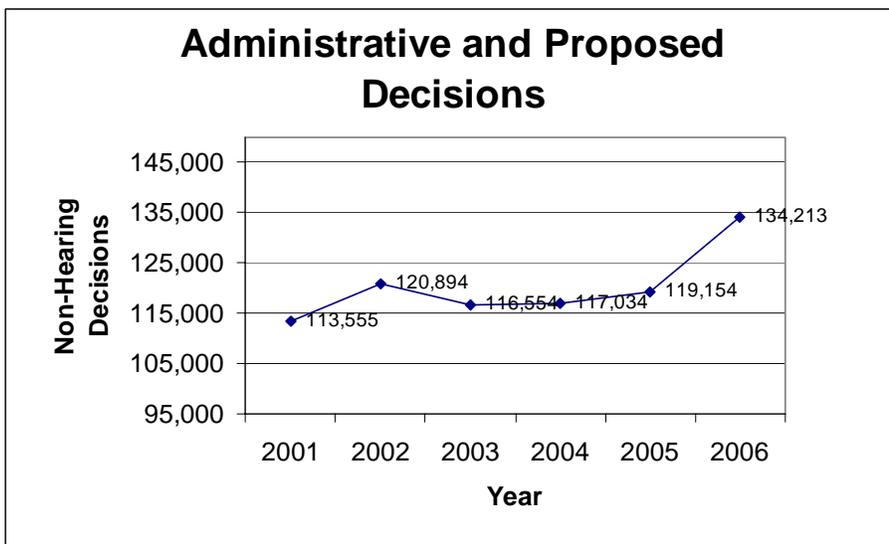
The practical effect of administrative and proposed decisions is to deny schedule loss awards (referred to as “PPD-SL” in the Superintendent’s Report) to many injured workers. Some of these claims involve no lost time beyond the statutory waiting period, thus permitting them to be identified as “medical only” claims. Others involve a limited period of lost time, thus permitting them to be identified as temporary disability (“TTD”) claims. However, in many instances the injured worker has a potential entitlement to a schedule loss award, but will not receive that award unless the worker takes affirmative action to pursue the claim before the WCB. The charts below show the WCB’s increased use of administrative and proposed decisions even as the WCB schedules fewer hearings each year.

¹⁶ Source, Workers’ Compensation Board Summary Annual Reports 2001 – 2006.

¹⁷ It is to be noted that these decisions are issued only in English, making it even less likely that they will be understood by non-English speaking workers.



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As a result of the WCB’s trend towards the use of administrative and proposed decisions, it cannot be determined how many claims are incorrectly categorized as “medical only” or “TTD” when the injured worker might have received additional benefits in the form of a schedule loss award had the worker had the benefit of legal advice or proper treatment by the WCB. Indeed, the Report notes (but professes that it cannot explain) an increase in representation of allegedly “medical only” claims from 25% to 36% from 2000 through 2006.²⁰ Since claimant’s workers’ compensation attorneys cannot currently receive a fee in a case involving medical treatment only, we would suggest that the increase in representation is tracking an increase in the misidentification by the WCB of schedule loss claims as “medical only” claims, which itself tracks the use of the administrative and proposed decision process to improperly categorize claims as “resolved” and “medical only” when in fact they are neither truly resolved nor medical only.

¹⁸ Source, Workers’ Compensation Board Summary Annual Reports 2001 – 2006.

¹⁹ Id.

²⁰ Report at p. 91.

It is also worth observing that the WCB's shift away from a hearing-based system has not only had the effect of denying benefits to many injured workers, it has also transferred much of the work previously performed by the WCB to the claimant's attorneys. Although the Report considers claimant's attorney's fees at various points, it does not consider the extraordinary transfer of work and responsibility to these attorneys that has occurred as a result of the WCB's use of "NFA" procedures, administrative decisions, and proposed decisions. The Report establishes that this transfer of responsibility has increased over time. From 2000 through 2006 unrepresented claimants averaged 1.7 hearings in their cases, while hearings for represented claimants dropped from 4.7 in 2000 to 2.7 in 2006.²¹ Those with experience in the system would suggest that unrepresented claimants have fewer hearings because they are unable to effectively pursue their claims in an adversarial system, whereas hearings for represented claimants have declined due to the WCB's refusal to schedule hearings where it is able to transfer the burden to the claimant's attorney.

Furthermore, the Report establishes that there is little value to the use of the conciliation process as compared to the hearing process in terms of claim resolution. From 2000 through 2006, the average time to "resolution" through conciliation was 120 days, compared to 133 days through the hearing process.²² Even the administrative decision process took 88 days,²³ which is again of dubious benefit compared to the hearing process, especially when the loss of benefits created by the process is taken into account.

D. Conclusions Regarding the Methodology of the Report.

We would therefore suggest that the methodology employed in the Superintendent's report is highly suspect. The selection of "average per claim cost" as a benchmark, and its identification as a problem to be solved, taints almost every other aspect of the Report. The simple fact is that the Report provides no evidence that the costs of individual claims are rising, or even that the aggregate costs of claims are rising. As demonstrated in subsection I.A. the "average per claim cost" can easily appear to skyrocket even as there is no change at all in the cost of individual claims and as the total cost of claims is actually declining.

Furthermore, the twin sources selected by the Superintendent for the provision of data, CIRB and the WCB, are both unreliable, although for different reasons. By excluding individuals with practical experience in the system from the preparation of the Report, the Superintendent neglected the inclusion of a valuable check on the information provided by these agencies – whether it passes "the smell test" or is contradicted by empirical experience.

²¹ Report at p. 77.

²² Id.

²³ Id.

The fact that using a flawed methodology is likely to produce a flawed conclusion need not be discussed at length. Having identified some of the methodological issues, however, we now turn to the Report's use of the substantially inaccurate data it received.

II. Conclusions of the Report.

The Report reaches a number of conclusions about the New York State workers' compensation system. Some of these conclusions may be justified, some remain unproven, and others are a product of the inaccurate data and faulty methodology discussed in Section I.

The primary conclusions reached by the report are that (1) costs per claim are rising; (2) New York's indemnity cost are higher and its medical costs lower than the national average as a percentage of total payments; (3) "the driving forces behind rising costs are PPD NSL claims" (permanently partially disabled workers who could be paid for an indefinite period of time prior to the March 2007 amendments); (4) Section 32 settlements are associated with lower-wage workers and higher legal fees, but not with improved prospects for return to work; (5) there are many controverted cases and they are not resolved speedily; and (6) there are significant delays in the delivery of benefits. We will address each of these conclusions in subsections II.A. through II.F..

A. Costs Per Claim are Rising.

The fallacy of evaluating the workers' compensation system based on "costs per claim" has been discussed at length in Section I.A..

This is graphically demonstrated in the Report, however, which claims that the "average cost per indemnity claim" has increased from \$18,240 in 1997 to \$28,117 in 2003.²⁴ Of course, this rising "average" cost has occurred during the same interval in which overall claims have been decreasing, and in particular during a period in which the rate of decline of "small" claims is dramatically greater than the rate of decline in all other claims. As a result, the so-called increase in "average cost per indemnity claim" is really a mirage created by the use of mathematical averages. In other words, there is no proof that a worker who is found to have a permanent partial disability today "costs" more than a worker who was so classified five years ago (or, for that matter, 15 years ago).

Indeed, given the fact that the maximum workers' compensation rate did not change for fifteen years from 1992 to 2007, and further given the fact that medical costs are governed by a fee schedule that has not undergone any significant modification, common sense would dictate that there has been no change in the "cost" of a permanent partial disability claim over the years. Rather, the fiction of the "rising cost of the average claim" is predicated on the fact that a much higher percentage of the remaining claim pool (which has been in a state of steady decline for many years) is serious injury

²⁴ Report at p. 26.

claims, and thus their “average” is higher than it was when a large number of smaller claims were also part of the pool. Overall, however, there is no evidence that costs to employers or carriers have dramatically increased.

The Report itself concedes that aggregate cost figures tend to rebut the “average cost per claim” theory: “Total indemnity costs ... look like they have been leveling off from 2000 to 2003 after growing significantly in the prior years.”²⁵ The report correctly attributes this to the fact that overall claims are declining, yet fails to draw the connection between the fact that overall claims are declining because of the rapid decline in “small” claims and the increase in “average claim cost.” Not only does the report show that total indemnity costs have leveled off, it specifically shows that total PPD costs did not increase substantially between 2000 and 2003.²⁶ The Report also provides data regarding the “average cost” of the “average PPD” from 2000 through 2003, and we find that the increase was about 5% (from \$149,521 to \$157,749 – about \$8,200).²⁷ However, almost two-thirds of that increase occurred between 2000 and 2001. We would again note here that no data is provided from 2003 through 2007, and the utility of five-year old data given the claim trends discussed herein is questionable. In any event, even if the data is accepted “as is,” an increase in cost of about 1% per year hardly seems significant.

In an attempt to buttress its argument that PPD costs are rising relative to temporary disability costs, the Report uses data regarding “the average indemnity cost per claim at 30 months of development” for PPD and TTD claims.²⁸ It is not surprising that after 30 months PPD costs are substantially higher than TTD costs, simply because the Workers’ Compensation Board Medical Guidelines call for a classification of PPD two years after an accident. Few claimants are still receiving awards for “temporary” disability two and a half years after the accident.

The report provides still additional data that contradicts its contention that costs are rising. Based on CIRB data, the report includes a table for the years 2000 and 2003 showing the number of claims filed for injuries to the back, neck, knee and shoulder, the total medical expense for those claims, and the average medical expense per claim.²⁹ The table demonstrates that the number of back injury claims fell by over one-third from 2000 to 2003, while claims in the other categories remained fairly constant. However, both the total and the average medical expense declined in every category from 2000 to 2003. For back injuries, it fell by over 45%. Given this data, it is hard to understand the Report’s contention that costs are rising.

²⁵ Report at p. 31.

²⁶ Id. at p. 33.

²⁷ Id. at p. 36.

²⁸ Id.

²⁹ Id. at p. 57.

B. New York's Indemnity Costs are High and Medical Costs are Low.

The Report states that “the average indemnity cost per claim of \$32,040 is almost twice the national average of \$18,996.”³⁰ However, the Report does not indicate what the total indemnity cost is for each state, nor the number of claims filed for each state either in the aggregate or as a percentage of the workforce. As a result, it is difficult to assess whether this “cost per claim” is meaningful in any way. Further, even assuming that New York’s indemnity costs are unreasonably high (which again has not been proven), this is offset by the fact that New York has the 11th lowest medical fee schedule in the country, and the second lowest for physical medicine services such as physical therapy and chiropractic treatment.³¹ Given that the report states that medical expenses account for 42% of total workers’ compensation costs, with indemnity accounting for 52%, it would seem that on balance New York’s low medical expenses and allegedly high indemnity costs should result in about average overall costs.³² However, the Report makes no comment about how New York’s overall costs relate to regional or national averages.

C. Non-Schedule Loss Permanent Partial Disability Claims are Driving Costs.

The Report provides a number of statements regarding the alleged costs of permanent partial disability claims (called PPD NSL claims in the Report). Many of these statements are consistent with press releases and other material distributed by the Business Council and other employer and carrier organizations prior to the March, 2007 amendments. A closer examination of the specific information in the Report reveals the questionable validity of these claims.

First, the Report states that “PPD NSL claims are estimated to represent 83% of PPD costs and 74% of total indemnity costs.”³³ In other words, of all workers’ compensation indemnity benefits paid, almost three-quarters of the money goes to injured workers who have been declared permanently partially disabled. In addition, the amount of money paid to permanently partially disabled claimants is almost five times as much (83% to 17%) than the amount of money paid in schedule loss cases (called PPD SL claims in the Report).

On the very next page of the Report, however, we are informed that “the costs of PPD NSL can not be easily tracked and they are the driving factor behind medical and indemnity claim costs.”³⁴ One wonders how it is possible to state unequivocally that PPD NSL costs are “the driving factor behind medical and indemnity claim costs,” to report the precise percentage of not only total indemnity but also of all permanent disability benefits these claims comprise, and to simultaneously report that they “can not

³⁰ Report at p. 6.

³¹ Id.

³² Id.

³³ Id. at p. 4.

³⁴ Id. at p. 5.

be easily tracked.” Even more surprisingly, the Report later informs us that a deficiency in the information it obtained from the CIRB is “that CIRB does not separate out PPD SL and NSL claims. Instead, CIRB splits PPD into major and minor categories. Separating PPD data as scheduled and non-scheduled is critical information.”³⁵

Further, the Report eventually reveals that the cases reported as PPDs by the CIRB are not even necessarily found to be such by the WCB. Rather, “the CIRB classifies the data as it is projected by the payor, i.e., when an insurer projects that a TTD case will become a PPD case, it reserves the case as a PPD and forwards the case data to CIRB as a PPD.”³⁶ In other words, CIRB reports the number and type of PPD cases not based on the actual result of any particular claim, but rather based on the carrier’s “projection” of the claim, which projection is directly tied to the carrier’s need or desire to set reserves aside. No effort is made to evaluate the extent to which these “projections” relate to the eventual reality of a claim.

As a result, the entire theory of the Report – that PPD cases are an overwhelming percentage of the costs in the workers’ compensation system- is completely undermined. Quite simply there is no basis to suppose that the claims reported as PPDs by the CIRB are in fact PPD claims. To accept the validity of the CIRB data, one would have to assume that (1) carriers are infallibly correct in their “projection” of claims that involve permanency (which would mean that they never under-reserve or over-reserve such claims); (2) all “major” PPD cases are PPD NSLs and all “minor” PPD cases are PPD SLs; and (3) the CIRB is correctly sorting the “major” and “minor” PPD claims to provide an accurate estimate of their costs.

This is plainly absurd. There is no evidence that carriers “project” permanency in claims with even remote accuracy. There is no evidence on the question of how many cases involving “major” and “minor” permanency are schedule losses or PPD NSLs. In a footnote, the Report states that the CIRB categorizes “PPD” claims as major or minor based solely on whether the carrier has set reserves anticipating a cost of more or less than \$22,000.³⁷ Assuming a claim with an average weekly wage of \$600 or more, schedule loss awards of 17.5% of an arm, 20% of a leg, 22.5% of a hand or 27.5% of a foot all exceed \$22,000. Thus, it is highly likely that a vast number of “PPD SL” cases have been incorrectly counted as “PPD NSL” cases by the CIRB in its campaign to overstate the cost of PPDs for the purpose of securing caps on these awards.

In addition, there is no evidence of the impact of Section 32 settlements on these projections. On this point, the Report finds that 78% of the cases resolved by Section 32 settlement between 2000 and 2006 did not involve permanency.³⁸ It is likely that a large percentage of these claims (involving a total of 12,645 cases) were matters in which the carrier “projected” permanency but was able to settle the claim before that finding occurred (thus avoiding the “projected” future payments). Just as in the case of including

³⁵ Report at p. 22.

³⁶ Id. at p. 29, emphasis added.

³⁷ Id. at p. 22, footnote 24.

³⁸ Id. at p. 103.

many schedule loss cases in the “cost of PPD NSL” figures, the failure to subtract cases in which the carrier “bought out” its PPD liability prior to classification renders the CIRB’s estimate of the number of PPD NSLs and their cost a work of fiction.

Even if some of the Report’s assumptions regarding the number of PPD claims are credited, the Report concedes that the number of these claims has been steadily diminishing, consistent with the trend of fewer claims overall.³⁹ At most, the Report establishes that PPD claims are decreasing less rapidly than claims for temporary disability.⁴⁰ Of course, this in no way supports the contention that PPD claims are “driving costs” – it simply means that their costs are not declining as rapidly as some would like.

Further, if its figures are to be credited at all, the Report establishes that the number of PPD NSL claims is a miniscule percentage of all claims. The Report claims that cases involving indemnity payments are only 36.6% of all claims.⁴¹ It further states that claims involving permanency are only 34.1% of all indemnity claims.⁴² This would mean that claims involving permanency are 12.48% of all claims (34.1% of 36.6 = 12.48). Finally, the Report claims that PPD NSL claims are 14.4% of all claims involving permanency.⁴³ This yields the conclusion that PPD NSL claims are 1.8% of all claims (14.4% of 12.48 = 1.8). Using the figures of claims indexed by the WCB (which appear to be substantially lower than all claims given the fact that the CIRB numbers cover only two-thirds of the marketplace and are still higher than the WCB’s figures), there would have been about 3,150 workers in 2001 who went on to be PPD NSLs, and only 2,150 in 2005 – a decline of over 30%.

Given the small and apparently declining number of injured workers who are found to be permanently partially disabled, it is highly unlikely that this tiny group of claims accounts for the overwhelming percentage of indemnity costs or that it is this group that is “driving costs.” In addition, the entire discussion of the “high cost” of PPD NSL’s overlooks a fundamental issue involved in these cases: other than permanent total disability and death claims (which make up an even more miniscule percentage of all claims), workers who are permanently partially disabled are the most seriously injured and disabled claimants in the system. Thus, it should make sense (and should not offend anyone’s sense of justice) that these workers receive a significant portion of the limited benefits available under the law.

Furthermore, any skepticism regarding the validity of permanent partial disability claims is (or should be) dispelled by the Report, which states that while “there has been an on-going belief that older workers file more claims to ‘supplement’ their retirement ... the data appears to disprove that theory.”⁴⁴

³⁹ Report at p. 28.

⁴⁰ Id.

⁴¹ Id. at p. 25

⁴² Id. at p. 27.

⁴³ Id. at p. 30.

⁴⁴ Id. at p. 44.

D. Section 32 Settlements.

The Report devotes some consideration to the impact of Section 32 settlements, in which the injured worker may stipulate to a resolution of some or all of the issues in the claim. The Report assumes (as does the WCB) that all Section 32 settlements are a full and final resolution of all issues in the claim. While this may be generally true, it is far from universally true. Again, this is an area in which the Report suffered from the absence of participation by those with practical experience in the system.

The Report reaches three major conclusions regarding Section 32 settlements. First, low wage-earners are more likely to arrive at a Section 32 settlement of their claim than high wage-earners.⁴⁵ Second, PPD NSL claimants who resolve their claim by way of a Section 32 settlement do not tend to return to work post-settlement at a higher rate than PPD NSL claimants who do not settle.⁴⁶ And third, claimant attorney fees average about 12% in connection with a Section 32 settlement, compared to about 5% in other types of claims.⁴⁷ The Report offers no explanation for these findings, other than to note that they disprove the theory that claimants wait to settle their cases before returning to work.⁴⁸

Those who have experience in the system can provide a number of explanations for the conclusions drawn by the Report, as well as some additional conclusions that are implicit in the Report but are not spelled out.

With regard to the fact that low wage-earners are more likely to settle their claims than high wage-earners, it is likely that this is a result of the fact that high wage-earners have a greater ability to withstand carrier resistance to their claims for a longer period of time, and thus have less need to settle their claims in order to avoid financial ruin. To the contrary, many low wage-earners are simply starved out of the system. When employed, many of these individuals live paycheck to paycheck. While they may be able to continue for a short time while receiving awards for temporary total disability, the inevitable reduction or suspension of benefits based on IME reports, followed by prolonged litigation (none of which is addressed by the Rocket Docket) leaves them victims of the system. Even if they are ultimately “successful” in their claims, they are left with little alternative but to settle and hope for the best.

The fact that claimants who arrive at Section 32 settlements do not tend to return to work is also unsurprising. The Report posits a similar theory about PPD NSL claimants – that they wait to be “classified” before returning to work – and disproves that as well.⁴⁹ The simple fact is that most injured workers who have permanent partial disabilities are in fact unemployable, and the fact that they do not return to work

⁴⁵ Report at p. 5.

⁴⁶ Id. at p. 104.

⁴⁷ Id. at p. 90-92.

⁴⁸ Id. at p. 104.

⁴⁹ Id. at p. 98.

following “classification” or settlement only provides further proof of that fact. Under the circumstances, it is deplorable that the benefits paid to this category of worker are identified as “costs” to be “reduced” for the purposes of “system efficiency” instead of recognizing that payment of these benefits is precisely the reason that the workers’ compensation system exists. “The statute was enacted for humanitarian purposes, framed, in the words of Chief Judge Cardozo, to insure that injured employees might ‘be saved from becoming one of the derelicts of society, fragment of human wreckage.’”⁵⁰ The report makes the case that workers who are permanently partially disabled who do return to work generally earn less than half of their pre-injury wages.⁵¹ Under the circumstances it would appear that the system does a poor job of carrying out the humanitarian purposes for which it was enacted.

The Report also fails to recognize the additional work performed and responsibility undertaken by claimant’s attorneys in connection with Section 32 settlements, as well as the fact that – contrary to the Report’s conclusion – the legal fee in connection with the Section 32 settlement is often not additional to a fee associated with classification as a permanent partial disability. The Report indicates that between 2000 and 2006 only one-fifth of all Section 32 settlements involved workers who have been found permanently partially disabled.⁵² Therefore in 80% of the cases that were resolved by way of a Section 32 settlement, the attorney did not receive a fee associated with a PPD classification, and very likely received only nominal fees for appearing at hearings. Furthermore, the Report makes no comment about the fact that claimant’s attorneys’ fees are based on compensation awarded, and that while the amount of compensation awarded has remained unchanged for 15 years the expenses and obligations of these attorneys have steadily increased. In addition, these expenses and obligations have been systematically increased by the Board through the use of NFA procedures, administrative decisions, proposed decisions, and depositions, among other initiatives. This situation was discussed in Section I.C..

E. Controverted Cases.

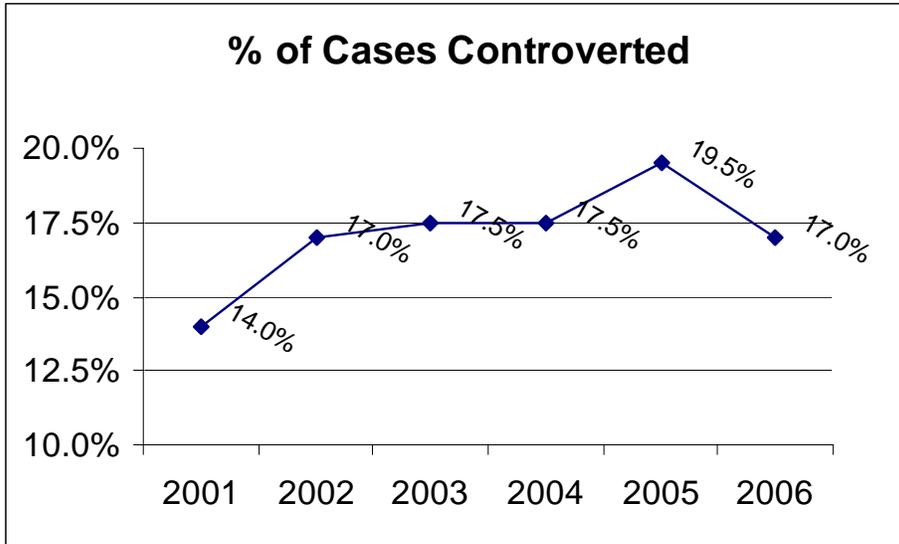
The Report identifies controverted cases as a significant problem in the workers’ compensation system, and makes reference to the proposed Streamlined Docket (known generally as “the Rocket Docket”) as a vehicle to resolve this alleged problem. The Report claims that the percentage of claims that are controverted has been rising, from 15% in 2000 to 17% in 2005.⁵³ The actual statistics are revealed in the chart below.

⁵⁰ Richardson v. Fiedler Roofing, Inc., 67 N.Y.2d 246, 502 N.Y.S.2d 125, 493 N.E.2d 228 (1986).

⁵¹ Report at p. 100-101.

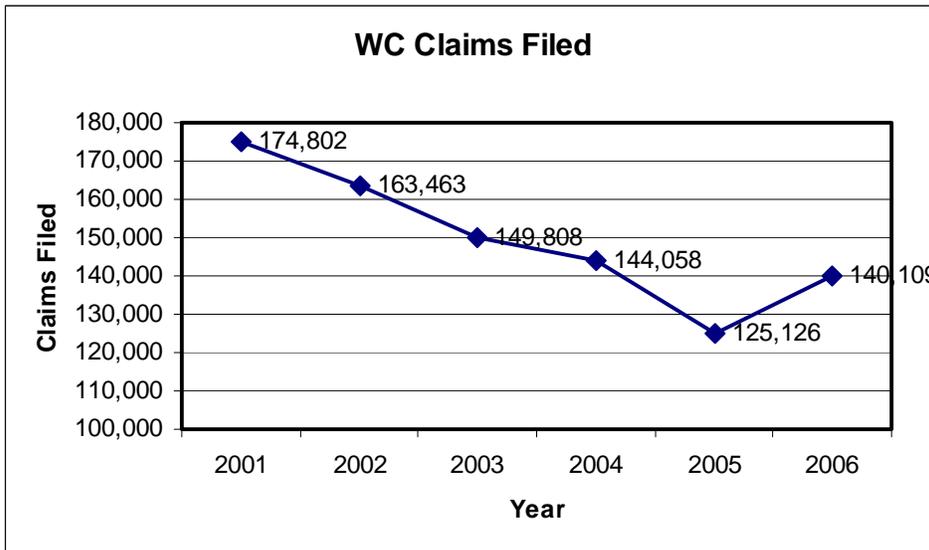
⁵² Id. at p. 103.

⁵³ Id. at p. 5.



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However, the percentage of claims controverted must be considered with reference to the decline in the number of claims filed, which is depicted on the chart below.

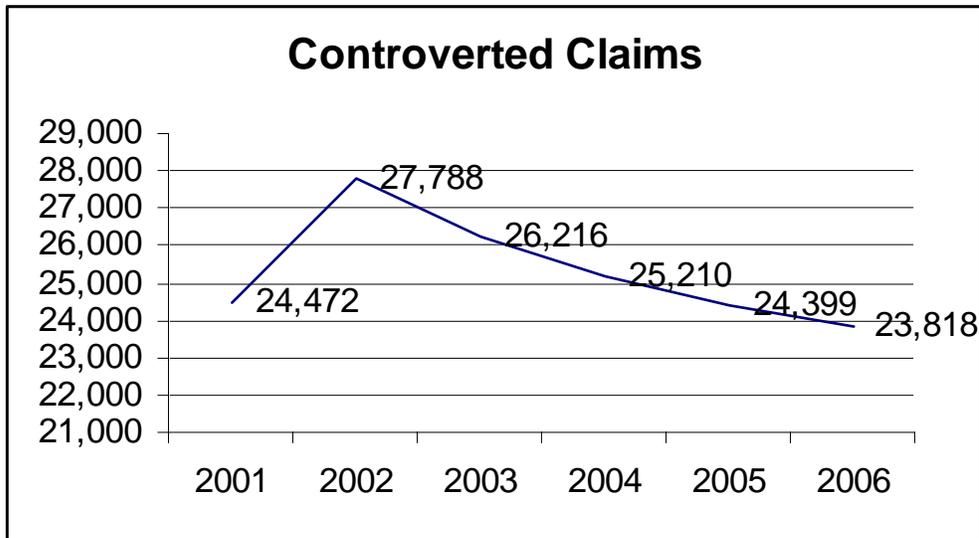


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When the percentage of controverted claims is compared to the number of claims filed, we find that the raw number of claims controverted is actually in decline. It may be presumed that the spike in controversies in 2002 was due to claims filed secondary to the events of September 11th, 2001, although this would require additional verification from the WCB.

⁵⁴ Source, Workers' Compensation Board Summary Annual Reports 2001 – 2006.

⁵⁵ Id.



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As the Report fails to observe the declining number of controverted cases, it does not offer any hypothesis as to the cause. We would suggest that the explanation is similar to the explanation for the decline in “small claims”: workers who have claims that are likely to be contested have been conditioned to accept defeat and delay, and are therefore increasingly less likely to file in the first place.

This is identified in the Report as the “frictional cost” associated with the defense of claims, and the Report notes that “one indicator of high frictional costs in New York State is the relatively high percentage of claims using independent medical examinations (“IME”).” The report goes on to state that carriers in New York use IMEs at more than twice the rate of 13 other states studied by the Workers’ Compensation Research Institute (WCRI).⁵⁷ This is discussed further in subsection II.F..

Turning to the comments that the Report does make about controverted cases, it concludes that it took an average of 348 days in 2000 to resolve a controverted case, and that this figure had declined by over 30% to 240 days in 2004.⁵⁸ The Report identifies neither the factors that contribute to these delays, nor the steps that caused such a significant reduction in the time required for resolution. In addition, the numbers used by the Report are averages, which means that one or more categories of especially complex claims that require longer resolution times may significantly affect these figures. The median figures are not provided.

The Report does divide controverted cases into occupational disease and accident claims, and finds that only 7.7% of accident claims are controverted compared to 46.7% of occupational disease claims. Further, between 2000 and 2006 it took an average of 246 days to establish occupational disease claims, and only 156 days for accident

⁵⁶ Source, Workers’ Compensation Board Summary Annual Reports 2001 – 2006.

⁵⁷ Report at p. 5.

⁵⁸ Id.

claims.⁵⁹ It would therefore appear that the generalized statement regarding the length of time it takes to resolve controverted claims requires further analysis so that a distinction is made between extraordinarily complex claims and more typical claims. Further, the Report only provides the average length of time for resolution of these types of claims between 2000 and 2006; not the trend during this period. If the trend is the same as the overall trend from 2000 to 2004 discussed above, it is reasonable to assume that controverted accident claims currently take far less than 156 days to resolve. Absent further data, however, it is difficult to assess whether there is in fact any need for the implementation of the “Rocket Docket.” We would also observe that the fundamental principle underlying the Rocket Docket is that providing “payors at an early stage in the process with more information” should reduce controversies.⁶⁰ Those with practical experience in the system question the validity of this assumption, which rests upon the proposition that employers and carriers generally controvert claims for “good faith” reasons such as lack of information. This is discussed further in subsection II.F..

The Report also attempts to consider the outcome of controverted cases, but again is hampered by the lack of reliability of WCB data. Nearly half of all controverted cases are established in favor of the injured worker.⁶¹ However, this does not mean that the other half are resolved against the injured worker – the WCB simply does not provide data on the nature of the non-established controverted claims. Many are simply not prosecuted. In addition, no information is provided on the results of controverted claims in which the claimant has an attorney as compared to those in which the claimant is unrepresented.

In addition, the Report recognizes that “there are equally significant delays in providing timely benefits to claimants with non-controverted claims.”⁶² Given this statement, one wonders whether it might not be more prudent to consider the overall performance of the WCB in adjudicating claims instead of focusing solely on the issue of controverted claims, which appear to be declining in any event. The Report specifically addresses delays in authorization for medical treatment, and points out that the WCB has failed to provide any data regarding use of the MD-1 procedure and the associated delays.⁶³

F. Delays in Delivery of Benefits.

The Report observes that New York is below the median of states studied in length of time from date of injury to first indemnity payment, length of time from

⁵⁹ Report at p. 47

⁶⁰ Id. at p. 66

⁶¹ Id. at p. 74

⁶² Id. at p. 7

⁶³ Id. at p. 65. Workers’ Compensation Law § 13-a(5) requires a carrier to either authorize a specialized test request in excess of the statutory authorization amount (now \$1,000) or to obtain an IME and deny authorization based on the IME report within 30 days. As a matter of practicality, a worker who has neither an authorization nor a denial is unable to obtain such treatment. As a result, the WCB has implemented an “MD-1” procedure which obligates the treating physician to file additional forms and which has the effect of extending the statutory period of 30 days to 90 days or more.

accident to employer notice to carrier, length of time from employee notice to employer to employer notice to carrier, and length of time from notice to carrier to first indemnity payment.⁶⁴ However, the Report fails to identify any causes for this phenomenon.

The Report further addresses significant delays in authorization for medical care and in payment to health care providers, again without identifying any of the causes of this situation.⁶⁵

The Report's failure to identify or address the causes of delay in delivery of benefits is consistent with the Report's theory that more complete disclosure in controverted cases would reduce the number of controversies. We suggest that the Superintendent's lack of familiarity with the workers' compensation system has resulted in a naïve view of the root cause of these problems. Those experienced in the system would suggest that claims are controverted, payments are delayed, and health care providers are not paid as part of a generalized effort to reduce the number of claims filed, to limit the prosecution of those claims which are filed, and to minimize the amount of benefits paid in those claims that are filed and prosecuted. The effectiveness of these tactics can be seen in the steady decline in claims filed, and particularly in the reduction of "small" claims (when the worker concludes that the "hassle" of the system is "not worth it") and controverted claims (when the worker doesn't file on the assumption that he or she "will lose anyway").

The Report makes some effort to identify the defense costs associated with workers' compensation claims. It concludes that "New York State's costs per claim are in line with other states but the utilization of medical-legal consultants is much higher, thus generating higher adjudication costs."⁶⁶ The Report estimates that 25.5% of claims have IME reports within the first year, 37.2% of claims have IME reports within the first 3 years, and 37.3% of claims have IME reports within the first 5 years.⁶⁷ It is unknown where the data that provided these conclusions was drawn from, but the consensus among practitioners is that close to 100% of claims have IME reports within the first 6 months, and that most claims extending one year or longer have multiple IME reports. As there are a limited number of IME vendors registered with the WCB, one means of obtaining more accurate information might be to obtain figures from these vendors of the number of IMEs performed each year, and to compare those figures to the number of claims filed or the number of hearings.

Similarly, the Report makes an effort to identify defense attorney expenses "for claims with defense attorney expenses greater than \$500." The Report concludes that only 2.5% of claims have such costs within the first year (average cost \$1,031), 12.2% have such costs within the first 3 years (average cost \$1,352), and 13.6% have such costs within the first 5 years (average cost \$1,401).⁶⁸ Again, these figures do not remotely

⁶⁴ Report at p. 51.

⁶⁵ Id. at p. 55-64.

⁶⁶ Id. at p. 94.

⁶⁷ Id.

⁶⁸ Id. at p. 95.

correlate with reality of actual practice in the workers' compensation system. Applying simple arithmetic to these figures to arrive at the supposed "total defense costs" in the system and then dividing that total by the number of workers' compensation defense attorneys in New York State would result in a conclusion that all such attorneys (and every member of their staff) are employed at a figure substantially less than minimum wage.

In short, the Report fails to assess the true causes of delay in benefit delivery, and its conclusions regarding the nature and extent of defense costs appears to be completely divorced from reality. As these factors are inextricably intertwined, a more rigorous analysis of this issue is needed.

III. Recommendations.

The Report makes a number of recommendations to obtain additional information about the "performance of major players in the claim administration system."⁶⁹ Many of these recommendations are sound and should be adopted. In fact, given the breadth and scope of the recommendations for the collection of further data, it is apparent that the Superintendent lacked an adequate basis upon which to develop the methodology or to arrive at the conclusions that are contained in the Report. We would suggest that instead of starting with a theory (average costs per claim are too high and must be reduced) and then developing a methodology and arriving at conclusions designed to support that theory, the Superintendent should have simply identified the areas in which sufficient data was not available and made recommendations for the collection of that data. In its present form, the Report puts the cart (methodology and conclusions) before the horse (factual information upon which to arrive at a methodology and a conclusion).

The Report divides its recommendations into "measurements" for carriers (called "payers" in the Report), judges, treating health care providers, claimant attorneys, and employers.⁷⁰ There are a number of glaring omissions from this list. As demonstrated in the charts included in subsection I.C., the WCB holds fewer hearings each year (a 35% reduction from 2001 to 2006), and increasingly substitutes non-hearing administrative action for hearings. As a result, in order to assess the activity and efficiency of the WCB, the performance of the entire agency – not just judges – must be measured.

Similarly, the Report includes claimant attorneys and treating doctors in the list of "players" to be measured, but excludes defense attorneys and IMEs. Even if the highly doubtful information contained in the Report regarding defense attorney and IME costs is credited, it cannot be said that they are so insignificant as to be unworthy of measurement. If our proposition (that defense attorneys and IMEs are the single greatest sources of delay and controversy in claims) is accepted, then these are the groups for whom measurement and evaluation is most important.

⁶⁹ Report at p. 106.

⁷⁰ Id.

A. Payors.

The Report proposes that carriers be measured in 8 categories: (1) average number of days from date of injury to first indemnity payment; (2) percentage of indemnity claims in which that payment is made within 21 days; (3) average number of days from submission of bill to payment; (4) number and percentage of claims which are controverted and then not established; (5) average number of days from date of controversion to resolution; (6) number and percentage of medical bills that are disputed; (7) number and percentage of medical bills resolved in favor of payor; (8) number and percent of request for pre-authorization approval for medical care that are disputed, and the percent of the disputes that are resolved in favor of the payor.⁷¹

These categories can and should be refined and supplemented. With regard to the number and percentage of claims which are controverted and then not established, the Report has already noted that “not established” does not equate to “disallowed.” Therefore, the data on controverted claims should include claims established, claims disallowed, claims not resolved on the merits, and claims not pursued.

With regard to the use of the pre-authorization procedure, the critical component is not whether the dispute is resolved in favor of the payor (they almost never are) but rather the length of time it takes to resolve such disputes. As noted elsewhere in this paper, although the statutory time period for carrier response to a pre-authorization request is 30 days, routine carrier disregard of the law has compelled the WCB to institute the MD-1 procedure, which has the effect of extending the statutory 30 day period to 90 days or more.

None of the proposed carrier measurements are concerned with actual carrier behavior in the processing of either controverted or non-controverted claims. Although the Report notes that significant delays exist even in non-controverted claims, the recommendations for carrier measurements include nothing that would address this issue.

Carrier behavior in the defense of claims (both controverted and “accepted”) can best be measured with reference to defense attorney costs and the use of IMEs. As noted above, it is felt that both of these factors are extraordinarily minimized in the Report. Therefore, the following additional measurements should be made of carriers:

- (1) Number and percentage of claims in which there are defense attorney costs.
- (2) The total defense attorney costs, as well as the average and median defense attorney cost per claim.
- (3) The number and percentage of claims in which IMEs are used.
- (4) The total number of IME reports obtained, the total cost of those reports, and the average and median numbers of IME reports per claim.

⁷¹ Report at p. 107.

We understand that it may not currently be possible for either the WCB or the Insurance Department to directly collect and measure data on defense attorney fees in the same way that the Report suggests that claimant attorney fees be tracked. However, it may indeed be possible to require the submission of defense attorney billing to the WCB either by statutory amendment or by simple regulation, in which event these “costs” could be tracked in the same manner as the proposed tracking of claimant attorney fees. This would prove either the Report’s hypothesis that defense attorney costs are minimal, or our hypothesis that these costs are extraordinary (and growing at a rapid pace due to the continued decline in hearings for represented individuals and the Board’s transfer of responsibility to attorneys for the parties).

We would also suggest that the performance of IME companies and individual IMEs should be monitored. It is generally accepted that IMEs are used by carriers for the purpose of obtaining leverage in litigation, as opposed to obtaining an honest opinion about the injured worker’s disability and need for treatment. The validity of this proposition can easily be tested by tracking:

- (1) The number of IME reports generated by each IME company and each IME.
- (2) The total and average cost of the IME reports generated by each IME company and each IME.
- (3) The number and percentage of reports from each IME company and each IME that:
 - (a) find no disability
 - (b) find each “degree” of partial disability (mild, moderate, marked)
 - (c) find a total disability
 - (d) authorize some medical care
 - (e) authorize no medical care.

This data should then be cross-referenced to carriers to determine whether certain carriers tend to use certain IMEs and IME companies more often and whether the use of such IMEs and IME companies correlates to the carrier’s claim controversy rate and defense attorney costs.

B. Judges

The report suggests seven categories of measurement for WCL Judges, including (1) number of cases adjudicated; (2) number and percentage of decisions appealed; (3) number and percentage of decisions affirmed on appeal; (4) number and percentage of claims that have adjournments; (5) average number of adjournments per claims that have adjournments; (6) for claims that have adjournments, average number of days between hearings; (7) number and percentage of claims in which the judge applied the medical guidelines in deciding the medical dispute.⁷²

⁷² Report at p. 108.

The first three of these categories are worthwhile and may well be productive of significant information. We would suggest that these categories should be supplemented to identify the number and percentage of cases in which the judge and the Office of Appeals decide in favor of the worker and the carrier.

The remainder of the categories, however, are essentially meaningless in current workers' compensation practice. As discussed in Section I.C., the Board's use of "no further action" has virtually eliminated "adjournments" (at least to the extent that they cannot be identified). Rather than "adjourn" a case, a WCL Judge will almost invariably mark a file "no further action," thus ensuring that it will be counted as a "resolution" and not an "adjournment." This can only be corrected by removing the impetus for WCL Judges to build statistics through false "resolutions" and by restoring the former categories of "adjourned," "continued" and "closed" (or "no further action") to permit proper measurement of the progress of claims through the system.

In addition, we do not accept as a premise the concept that adjournments or continuances are inherently unwarranted or worthy of condemnation. A workers' compensation claim follows the medical progress of the injured worker, and as a result there are of necessity times in the claim where adjournments or continuances are warranted.

Limiting the WCB measurements to judges also fails to consider the WCB's overall treatment of claims. We have hypothesized that a significant number of claims are closed by administrative decisions and marked "no further action," resulting in inappropriate categorization of these claims as "medical only." Likewise, the charts show that "claims reopened" have been rising even as hearings have declined. Finally, we have pointed out that use of the "no further action" procedure makes it impossible to tell how long it truly takes a case to arrive at a true "final resolution" after being indexed.

These situations can be remedied by eliminating the administrative decision and "no further action" processes, which would allow the collection of the missing data. [We also observe that the Report demonstrates no advantage to the conciliation process over the regular hearing process, and thus it too should be eliminated.]

Absent the elimination of these processes, however, certain data should be obtained to determine the extent to which benefits to injured workers are being delayed and denied. In the case of administrative decisions, data should be obtained identifying the nature of the injury established by administrative decision. This would permit some analysis of the extent to which schedule loss injuries are being addressed by administrative decision. All WCB determinations, whether by administrative decision, proposed decision, or hearing determination, that result in a conclusion of "no further action" should be tracked to determine how long the claim remains inactive before an application is made to reopen the claim. This could be easily accomplished simply by following the filing of RFA-1 and RFA-2 applications in cases marked NFA. Suggested intervals would be 3 months, 6 months, and 1 year. One might assume that if no application to reopen was filed within 1 year of an NFA finding, the resolution was a true

closure, whereas if the application is filed within 3 or 6 months of the NFA finding the “resolution” was illusory.

C. Health Care Providers, Claimant Attorneys, and Employers.

The recommendations for data collection regarding these participants in the process generally seem reasonable.

With regard to claimant attorneys, however, the collection of data in some categories may lead to erroneous conclusions. We assume, for example, that the interest in “average settlement award for Section 32 settlements” and “average legal fees per claim” is intended to determine whether a particular law firm is “good” or “bad,” or whether the firm is “overcharging.” We would caution that all claimant’s attorneys do not represent the same homogenous population. Like injured workers, claimant’s attorneys are distributed geographically throughout the state. Data shows that the average weekly wage of workers in many upstate locations is significantly lower than those downstate (indeed the State of New York pays “location pay” to its employees with this in mind). In addition, the nature of employment in upstate areas is, on the whole, significantly different from the distribution of employments in the metropolitan area. As a result, it may well be that upstate attorneys have lower fees than downstate attorneys.

Even within the same geographic area, different attorneys have different “niches” in practice. Some represent primarily low-wage earners, others represent a higher percentage of high-wage earners. Some are more willing to accept representation in complex claims than others. Not only do these issues factor into the amount of attorney fees, they also play a role in the average number of adjournments and the length of those adjournments. In many instances, the fact that a claim requires a number of hearings before reaching a final resolution is simply a sign that the attorney is aggressively pursuing the claim on behalf of the claimant, which is of course to be encouraged.

We note here that there is no reason why the same measurements that are applied to claimant attorneys cannot and should not be applied to defense attorneys for the purpose of identifying not only more litigious carriers (who contribute significantly to “frictional” costs) but also more litigious defense firms. It is the empirical observation of many in the workers’ compensation system that while the interest of the claimant’s attorney is generally perfectly aligned with that of the claimant (the speediest and most beneficial resolution with a minimum of “friction”), there is a far lower degree of identification of interest between the carrier’s attorney (who is paid for litigation) and the carrier (which may often benefit from resolution).

IV. Conclusion.

The Report makes a number of valuable recommendations for the collection of data about the workers' compensation system. In addition, we agree with the Report's suggestion that this data collection should be performed by a university institute.⁷³

It is unfortunate that the Report chose to pose a hypothesis, develop a methodology designed to support that hypothesis, and to arrive at conclusions without awaiting the data that it suggests should be collected. As outlined in this paper, the hypothesis of "average per claim cost" is erroneous, the methodology used to support that hypothesis is severely flawed due largely to the unreliability of existing data sources, and as a result the Report's conclusions are either incorrect or so tainted by the process as to be unreliable.

We therefore suggest that the Report's recommendations be adopted with the modifications and additions suggested in Section III., and that the issues be revisited (without a preconceived hypothesis) once reliable data is available.

⁷³ We would suggest the Cornell University School of Industrial and Labor Relations.

To review current compensation structure for internal equity and external competitiveness and to recommend changes to compensation structure based on results of FLSA review. Page 6 of 7. EXAMPLES OF DUTIES (illustrative only)

- Conducts research and provides daily operational support in a variety of human resources areas such as employment law, labor relations, recruitment, classification, salary and benefits administration, employee relations, training, organizational development, and risk management.
- Provides consultation on organizational development issues and develops short- and long- range organizational development plans.
- Designs and conducts needs assessment surveys and develops appropriate interventions.

Data Collection is an important aspect of any type of research study. Inaccurate data collection can impact the results of a study and ultimately lead to invalid results. Data collection methods for impact evaluation vary along a continuum. At the one end of this continuum are quantitative methods and at the other end of the continuum are Qualitative methods for data collection. The Quantitative data collection methods, rely on random sampling and structured data collection instruments that fit diverse experiences into predetermined response categories. They produce results that are easy to summarize, compare, and generalize. Quantitative research is concerned with testing hypotheses derived from theory and/or being able to estimate the size of a phenomenon of interest. Overview: Data Collection and Analysis Methods in Impact Evaluation. Greet Peersman. Unicef office of research. While an impact evaluation aims to look at the longer-term results of a programme or policy, decision makers often need more timely information and therefore data on shorter-term outcomes should also be collected. For example, it is well known that the results of interventions in education emerge only over a protracted period of time.