Approved: February 25, 1997
date

MINUTES OF THE SENATE COMMITTEE ON COMMERCE.

The meeting was called to order by Chairperson Alicia Salisbury at 8:00 a.m. on February 24, 1997 in Room 123-S of the Capitol.

Members present: Senators Salisbury, Barone, Brownlee, Feleciano, Gooch, Jordan, Ranson, Steffes, Steineger and Umbarger.

Committee staff present: Lynne Holt, Legislative Research Department
Jerry Donaldson, Legislative Research Department
Bob Nugent, Revisor of Statutes
Betty Bomar, Committee Secretary

Conferees appearing before the committee:
Seth G. Valerius, AFL-CIO
Stephen W. Durrell, Assistant Attorney General, Fraud & Abuse Investigations Section, Division of Workers Compensation
Philip S. Harness, Director, Workers Compensation Division

Others attending: See attached list

Upon motion by Senator Barone, seconded by Senator Steffes, the Minutes of the February 21, 1997 meeting were unanimously approved.

SB 285 - Sole proprietorship without employees exempt from workers compensation coverage

Seth G. Valerius, AFL-CIO, testified in opposition to **SB 285,** stating it is contrary to the provisions contained in **SB 137**, which received unanimous support of the Advisory Council and has been passed out of this Committee. Attachment 1

SB 289 - Workers compensation disability changes

Mr. Valerius, testified the AFL-CIO is opposed to all the provisions of **SB 289**, it is regressive and unreasonable, as the goal of lower rates has been achieved as a result of 1993 legislation. Section 1. allows employers the right to control medical care after denying the compensability of a claim; Section 2. reduces benefits to injured workers in most circumstances and strikes the incentive for employers to return injured workers to comparable wage; Section 3. penalizes employees as it precludes including fringe benefits when calculating pre-injury wages and post-injury wages; Section 4. denies employees legal representation during review and modification of a claim and shortens the time for payout of an award; Section 5. denies claimant the right to legal representation by denying attorney fees if an additional award is not granted. The AFL-CIO would support a change in appointment of administrative law judges, but only if there is a corresponding pay increase. Attachment 2

SB 321 - Conforming workers compensation act to provisions of the Americans with Disabilities Act

Mr. Valerius, AFL-CIO, testified in support of **SB 321**, stating AFL-CIO opposes the open records policy currently existing within the Division of Workers Compensation. The AFL-CIO supports the concept of **SB 321,** however, believes exceptions should be listed, specifically including accident reports and medical records. The AFL-CIO suggested an amendment to **SB 321** requiring the employer/insurance carrier be asked to pay some benefits prior to medical records and accident reports being obtainable by the employer against whom the claim is made. Attachment 3

SB 346 - Supplemental workers compensation advisory council recommendations

Mr. Valerius, AFL-CIO, testified in support of **SB 346**, stating each provision was unanimously supported by the Advisory Council with five votes from labor and five votes from business. Attachment 4

SB 347 - Workers compensation reform

Mr. Valerius, AFL-CIO, testified in partial support of **SB 347.** Mr. Valerius stated the AFL-CIO supports the provisions of Section 1, granting retirement benefits to members of the Workers Compensation Appeals Board; supports the increase of attorney fees in Section 2, except for the language on Page 5, Lines 26 - 28 requiring the claimant or respondent to pay attorney fees if a claim results in a denial of additional compensation; opposes the granting of police powers to the Fraud and Abuse Investigative Section, as did the Advisory Council; opposes Section 5 recommending only final awards be appealable; opposes Section 6 increasing the number of members on the appeal board; supports Section 7, return to former law relative to payments made while a case is pending in the Kansas Court of Appeals. Attachment 5

Stephen W. Durrell, Assistant Attorney General, Fraud & Abuse Investigation Section, Division of Workers Compensation, testified in support of **SB 347, Section 3**, which provides investigators with the authority of peace and police officers. The Fraud and Abuse Section has been in existence for three years and has investigated over 800 alleged fraudulent or abusive acts. Mr. Durrell stated the Section has difficulty in obtaining medical, employment and insurance records to conduct its investigations and does not have quick access to criminal histories. The request process takes a number of weeks and with the passing of **SB 137**, which reduces to180 days time to investigate a claim and to make a decision as to whether prosecution is warranted and the Section needs the additional authority. Mr. Durrell stated there are presently six states whose Fraud & Abuse Sections have police authority: Oklahoma, Kentucky, Nevada, Maryland, Connecticut and Florida. Mr. Durrell stated the breakdown of those requesting investigations are: claimants - 50%; employers - 45% and medical, legal, etc. - 5%. Attachment 6

Philip S. Harness, Director of Workers Compensation, testifed on **SB 347,** stating the Advisory Committee was opposed to providing the Fraud & Abuse Section police authority. Mr. Harness stated the Advisory Committee did not endorse the provision on Page 13, Lines 29 - 40, allowing an appeal from an interlocutory order, but prefers the method contained in **SB 346,** Page 10, Line 43, Page 11, Lines 1-2, 9-11, and 22, which allows appeals only in the area of final orders, awards, modifications of awards or preliminary awards.

Mr. Harness testified in support of **SB 346**, stating the provisions were those recommended by the Advisory Council at its meeting February 10. Section 1. provides for a continuance of a workers compensation case upon mutual agreement of all parties; Section 2. provides for maximum medical fees to be revised at least every two years; Section 3. grants the Kansas Workers Compensation Fund the status of a party to request a determination of benefits or compensation due to an injured workers; Section 4. limits the time available to certify overpayments by an employer or insurance carrier and sets a time limit for the employer or its insurance carrier to make such a request; Section 5. allows appeals only in the area of final orders, awards, modifications of awards, or preliminary awards; Section 6. permits the Director to contract with the Secretary of the Department of Health and Environment to collect information necessary for the maximum medical fee schedule and require the submission of certain medical information by procedure; charge and zip code. The Advisory Council requests the language on Page 13, line 24 "without competitive bid" be stricken; Section 7. provides a time period in which a claim can be dismissed; Section 8. requires a 20-day notice to implead the fund; Section 9. provides for a waiver of assessments of $10.00 or less. Attachment 7

The Chair asked Mr. Harness to provide the Committee with recommendations of the Advisory Committee, after its March 10 meeting, regarding the following: 1) open records; 2) definition of "work disability", and 3) appointment of administrative law judges.

Mary Barry submitted written testimony in support of **SB 347**. Attachment 8

Merlino & Schofield submitted a "Review of Kansas Workers Compenation Closed Claim Study", an attachment to the testimony of Mark Helbert on February 21, 1997. Attachment 9

The meeting adjourned at 9:00 a.m.

The next meeting is scheduled for February 25, 1997.

SENATE COMMERCE COMMITTEE GUEST LIST

DATE: February 24, 1997

NAME	REPRESENTING
Terry Leatherman	KCCI
Bud Grant	KCCI
Rick Guthrie	Health Midwest
ART BROWN	MID-AM LUMBERMANS
Hal Hudson	NFIB/KS
Pat Morris	K.A.I.A.
Theresa Schenewerk	State Farm
Susan M. Baker	Heim & Weir
Danny Kuckelman	KDHR - Work Comp
Diane Doak	Div of Work Comp
Jim Huff	Div. of Work. Comp.
George Schareman	" " " "
Stephen Durrell	A.G.
Les Vogel	DOA
John M. Ostrowski	KS AFL-CIO
Seth G. Valerius	" " "
Jim W. Hoff	KS AFL-CIO
Wayne Maichel	KS AFL-CIO
Jessa Gospil	TLRC

SENATE COMMERCE COMMITTEE GUEST LIST

DATE: February 24, 1997

NAME	REPRESENTING
Dennis Jackson	TOPEKA Tourettes Group
Lin Hastings	Ironworkers Local # 10
Phil Harness	KDHR - Div. of Work. Comp.
David Shufelt	" " " "
[illegible]	Ks Self. Insurers Assn.
Helen M. Stanley	Ks. Trial Lawyers Assn.
Roger Fraude	KGC
Scott Hill	KSBOE

TESTIMONY OF KANSAS AFL-CIO
TO COMMITTEE ON COMMERCE

BY
JOHN M. OSTROWSKI
AND
SETH G. VALERIUS

FEBRUARY 20, 1997

SENATE BILL 285 - The Kansas AFL-CIO opposes the passage of SB 285.

Senate Bill 137 has already been passed by this Committee. A portion of Senate Bill 137 related to the issue of contractor/subcontractor and coverage under the Workers Compensation Act. This Committee acted favorably on the recommendation of Rep. Michael O'Neal.

As this Committee will recall, Senate Bill 137 was an Advisory Committee bill. The section related to contractor/subcontractor was approved unanimously by the Advisory Committee. It is believed that the Advisory Committee supported Rep. O'Neal's bill because it lent protection to general contractors and avoided employers being "double billed" for the same coverage. In other words, a general contractor would no longer have any exposure below him, such that a premium could not be charged. As a side note, Senate Bill 137 would reduce litigation on this point in that liability would clearly fall for all injured workers below the general contractor on the shoulders of the subcontractors.

Senate Bill 285 completely eliminates the actions of Senate Bill 137, and the Kansas AFL-CIO does support Senate Bill 137.

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TESTIMONY OF KANSAS AFL-CIO
TO COMMITTEE ON COMMERCE

BY
JOHN M. OSTROWSKI
AND
SETH G. VALERIUS

FEBRUARY 20, 1997

SENATE BILL 289 - The Kansas AFL-CIO opposes in its entirety SB 289.

Section 1. At page 5 of the bill is a change which would allow the employer the right to control medical care after denying the compensability of the claim. Under current practice, this issue is decided on a case-by-case approach. That practice establishes a "balancing act" between the employee's rights and the employer's.

Quite simply, there is some "risk" involved if the employer contests the claim. This risk often forces the insurance carrier to more fully evaluate a claim for compensation prior to issuing a denial. If they improperly deny the claim, they might lose control of the medical.

In claims where the employer has denied compensability, the claimant seeks out his own medical care. It is often illogical to then disapprove the physician who has been treating the claimant for a period of time. In some cases, this can be quite detrimental to the claimant's recovery, and the proposed legislation gives no discretion to the judge to continue that physician as the treating physician.

Conversely, if there is little or no damage to the claimant's recovery, the administrative law judge may allow the employer to substitute a different physician.

The present procedure is working somewhat successfully and does not need to be tampered with in favor of the employer.

Section 2. At pages 8 and 9 of the bill, the KCCI proposes "major reform" in terms of work disability. The resultant changes would further reduce benefits to injured workers in almost all circumstances. Since there is no "crying out" about premiums, it seems inappropriate to continue to slash benefits for workers as was done in 1987 and 1993.

In addition, the provisions would virtually strike the incentive for employers to return injured workers to comparable wage. Under the KCCI's proposal, if the employee is not earning a dime, the judge and board can simply "impute" a wage. Thus, the employer can receive the same benefit of no "work disability"

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assessed whether the worker is retained or terminated by the employer.

When the legislature abolished vocational rehabilitation, it was coupled with a strong incentive for employers to retain injured workers in their employment. It is suggested that under the current law, more workers are being returned to comparable wage because employers want to pay less in work disability cases. **There is simply no reason to remove these incentives at this time.**

Additionally, the 1993 legislation sought to remove the vocational experts from testifying as to hypothetical wages which could be earned by a worker. This was a very specific and overwhelming concern of the legislature. The proposed legislation by the Chamber returns to the hypothetical imputation of wages and would therefore be a return to vocational expert testimony.

Section 3. At page 11 of the bill, Section 3 concerns itself with fringe benefits. Apparently, the Chamber proposes that we do not count fringe benefits under certain circumstances as part of the preinjury wage, but do count fringe benefits in the post-injury wage calculation for comparison purposes. This is simply "double dipping", and there is no need for such legislation. The current statute compares apples to apples by taking into account fringe benefits pre and post-injury. Such a comparison is obviously "fair".

Furthermore, the proposed legislative change will vastly increase litigation. In each case, we will be obligated to litigate the reasons for the termination. Clearly, the employer's version will differ from the claimant's.

Section 4. At page 15 of the bill is found a major change from current legislation. This major change is unjust for the workers and will also delay the resolution of all claims.

The proposed change seeks to end "review and modification" of an award once the "original" compensation has been paid. It is critical to recognize that payments for general bodily disabilities have been accelerated by the 1993 amendments, thus shortening the time for payout of any award.

Assume the worker with an 8% general body disability from a herniated disc. The doctors want him to avoid surgery if at all possible. They encourage him to try an extensive program of reconditioning. This worker's payment of compensation would end in roughly 32 weeks (400 weeks times 8% equals 32). If the claimant follows the doctor's recommendation and attempts to avoid surgery, he cannot resolve his workers' compensation claim without severe jeopardy. That is, under this proposal, after a mere 7 months, he would be forever bound by the compensation accepted. If the claimant subsequently required surgery, he would receive no temporary total disability during the recovery period. If the surgery was unsuccessful, and even catastrophic, he could receive

no additional compensation.

Some case scenarios would even be worse depending on the type of injury. For example, a worker could attempt to avoid amputation of a finger, even though the finger is currently rated a 50% disability. If the worker did not make the decision within 7 weeks as to whether to amputate or not, he would again be denied full benefits.

There is simply no reason for this harsh amendment to pass. There is no abuse under current law, it is merely a matter of allowing workers to fully evaluate their injuries and attempt to obtain maximum medical improvement through slow term conservative measures. Furthermore, medical predictions are sometimes overly optimistic and the full extent of the injury is not known for a period of time. It is a struggle to understand why we would not want people to get well, or exercise the best medical judgment.

Section 5. At page 18 of the bill is a change regarding attorney's fees on post-award matters. This provision was specifically put in the law many years ago to serve as an incentive for insurance carriers to provide medical care after the award without litigation. It is utilized mostly in situations where medical is being improperly denied by an insurance carrier (sometimes for the stated reason that the insurance carrier wants to settle in a lump sum and close out claimant's medical rights).

The claimant's attorney is often in a conflict situation, not being able to justify time and expense to obtain the medical on behalf of his client, having already litigated the case to an award. The insurance carrier has the advantage in simply denying care, no matter how routine or inexpensive.

Again, this balance has worked well over the years, and there exists no reason to change the statute. Recall that at this stage of the proceeding, the claimant has fully proven his right to this medical compensation by having proven a compensable accident.

Section 6. The Kansas AFL-CIO opposes Section 6, page 19 of the bill without a corresponding pay increase. At the current time, and as was discussed at length in the Advisory Committee, administrative law judges are underpaid, and accordingly, there is difficulty in attracting the most qualified, and most industrious applicants for vacant positions.

Removal of civil service status without a corresponding pay increase will further diminish the pool from which qualified applicants can be chosen. The law requires that attorneys have five years of practice experience to be administrative law judges. No one should be expected to interrupt their career for a four year appointment at the current pay level.

TESTIMONY OF KANSAS AFL-CIO
TO COMMITTEE ON COMMERCE

BY
JOHN M. OSTROWSKI
AND
SETH G. VALERIUS

FEBRUARY 20, 1997

SENATE BILL 321 - Labor supports the conceptual position of SB 321.

Labor vehemently opposes the open records policy which currently exists within the Division of Workers Compensation. Labor supports the proposition that medical records and accident reports should not be obtainable unless a workers' compensation claim is being actively pursued by an injured worker. Labor believes that it is simply more logical to state that all records are open, and then list the "exceptions" to the open records; specifically including accident reports and medical records.

One difficulty with Senate Bill 321 is defining the "trigger" for the opening of medical records on a need-to-know basis. Labor believes that the trigger should not be merely notice of an accident, or the filing of a written claim. Many accidents are reported, and many claims are filed, merely to preserve the time limits. It would have a "chilling effect" upon workers to file claims to protect themselves on time if it meant their medical records instantly became available to the employer.

Labor has proposed legislation in the past, and attaches a copy of the proposed legislation. Conceptually, it would require that the employer/insurance carrier be actually asked to pay some benefits prior to medical records and accident reports being obtainable by the employer against whom the claim is being made.

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K.S.A. 44-550b(1). Records open to public inspection, exceptions. (a) All records provided to be maintained under K.S.A. 44-550 and amendments thereto shall be open to public inspection, except as follows: 1) records relating to financial information submitted by an employer to qualify as a self-insurer pursuant to K.S.A. 44-532 and amendments thereto; 2) records which relate to utilization review or peer review conducted pursuant to K.S.A. 44-510 and amendments thereto; 3) medical records, Form 88's, and accident reports pursuant to K.S.A. 44-557 and amendments thereto unless the employee is pursuing a claim for compensation. When a claim for compensation is being pursued, the employer against whom the claim is being pursued, and its insurance carrier or representative, shall have access to any and all accident reports and medical records. The employer or its representative shall certify in writing, with appropriate documentation, that a claim is being pursued and is unresolved at the time of the request for inspection. "Pursuing a claim" is defined herein as 1) the actual payment of compensation (medical or otherwise) by the employer or its representative or 2) the employee's request for payment of compensation (medical or otherwise) or 3) the filing of an Application for Hearing. Giving notice of accident or filing a written claim for compensation shall not, in and of itself, constitute the pursuit of a claim for purposes herein. Nothing herein shall prevent an individual or the individual's representative from obtaining their own records. No employer or prospective employer shall ask an individual to waive the provisions of this section and any violation of this provision shall be punishable as a Class 9 nonperson felony in addition to any other penalties under any other statute. (b) The Workers Compensation Division shall have access to records for purposes of investigating fraud. In addition, the above records will be open to public inspection upon court order or as otherwse specifically provided by the Workers Compensation Act.

TESTIMONY OF KANSAS AFL-CIO
TO COMMITTEE ON COMMERCE

BY
JOHN M. OSTROWSKI
AND
SETH G. VALERIUS

FEBRUARY 20, 1997

SENATE BILL 346 - The Kansas AFL-CIO supports SB 346.

Senate Bill 346 is an Advisory Committee bill. As such, four votes were obtained from "each side of the table" prior to the recommendations being made to the legislature.

The Director of Workers Compensation, Mr. Phil Harness, has already explained to the Committee the rationale of each section of Senate Bill 346. The Kansas AFL-CIO concurs in the rationales expressed by the Director, and has nothing to add to the presented testimony.

We would point out that each provision of Senate Bill 346 was unanimously supported by the Committee with five votes from "each side of the table."

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TESTIMONY OF KANSAS AFL-CIO
TO COMMITTEE ON COMMERCE

BY
JOHN M. OSTROWSKI
AND
SETH G. VALERIUS

FEBRUARY 20, 1997

SENATE BILL 347 - The Kansas AFL-CIO supports in part, and opposes in part, SB 347.

Section 1. Senate Bill 347 at pages 1 and 2 grants retirement benefits to the members of the Workers Compensation Appeals Board. The Kansas AFL-CIO supported such a proposal in the Advisory Committee, and continues to support the same. Retirement benefits were not specifically addressed when the Appeals Board was created.

Section 2. At pages 2 and 3 of Senate Bill 347, attorney's fees for claimants are restored to their previous levels.

The reduction in claimant's attorney's fees, coupled with the reduction in benefits generally, has resulted in claimants being denied representation, or being denied effective representation. The "sliding scale" relative to attorney's fees is unwarranted in that the later dollars paid on an award are the hardest to obtain. This creates a conflict of interest between the attorney representing the claimant, and the claimant. No justification was ever given for the reduction in claimant's attorney's fees, and said contracts of employment have not placed more compensation in the claimant's pockets.

At page 5 of Senate Bill 347, the review and modification section is amended for post-award applications. This is somewhat of a tradeoff, and dovetails with the changes found on page 3. Such a "trade" was discussed generally in the Advisory Committee, and labor supported the changes. However, the Kansas AFL-CIO opposes lines 26 through 28 on page 5. The amendment suggests that claimants could be forced to pay respondent's attorney's fees if there is a denial of additional compensation. The intent seems to be to prevent a "frivolous" claim by claimant. Such a safeguard is unnecessary, unless one assumes that a claimant's attorney is willing to invest multiple hours without hope of payment.

Section 3. At pages 5 and 6 of Senate Bill 347, police powers are granted to investigators of abusive and fraudulent practices. The Kansas AFL-CIO opposes the police powers.

In the Advisory Council, it was admitted by the representative from the Attorney General's office that the powers being requested were greater than what was actually needed. However, the granting of police power was a matter of convenience. It is generally the

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position of labor that only those powers needed should be granted, and if that must be done on a piecemeal basis, such is appropriate.

It should be pointed out that the Advisory Committee voted unanimously against recommending police powers for investigators.

Section 4. Labor takes the same position with regard to Section 4 as with Section 1.

Section 5. At pages 13 and 14, it is suggested that interlocutory appeals can be taken from actions of the administrative law judge. Labor opposes such a piecemeal appeal process.

Labor supports the position taken by the Advisory Committee in Senate Bill 137 recommending that only final awards be appealable.

Section 6. The bill proposes that an additional board member be appointed, and that the appeals panel could then be split into groups of three to decide cases. The presumed intent is to handle the current backlog of cases submitted to the Appeals Board. (Technically, the language at page 17, lines 34 through 36, needs to be amended if such is the intent in that under the language presented, the Appeals Board could be broken into three groups of two members.)

Although labor is concerned with the backlog, it is our firm belief that the backlog is a temporary problem which is resolvable now that a certain "learning curve" has passed relative to the massive1993 legislative changes. Much discussion was had at the time the Appeals Board was created. It was decided that a five member Board was the best possible number for many reasons. Any more than five creates undue confusion. If there are as few as three, one member needs only to convince one member of his/her position, and the matter is decided. In other words, a "strong voice" can be controlling. Finally, with one Board, there is consistency of decisions. Under the proposal, panels sitting in different sessions could reach diametrically opposed positions, and there is no *en banc* provision.

Labor believes it would be more appropriate to appoint a sixth member in cases of emergency, and handle the backlog in that fashion (with two separate panels), rather than creating a permanent sixth position.

Labor again does not support the language relative to interlocutory appeals as described *supra*.

Section 7. Labor supports the changes found in Section 7 at page 18 of Senate Bill 347. This is return to former law relative to payments made while a case is pending in the Kansas Court of Appeals.

STATE OF KANSAS
DEPARTMENT OF HUMAN RESOURCES

Bill Graves, Governor

Wayne L. Franklin, Secretary

Fraud & Abuse Investigation Section
DIVISION OF WORKERS COMPENSATION
800 S.W. Jackson Street, Suite 600, Topeka, KS 66612-1227
PHONE ..... (913) 296-6392
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Comments before the Senate Commerce Committee
Stephen W. Durrell, Assistant Attorney General
February 19th, 20th, or 21st, 1997

Senate Bill #347

Madame Chairperson, and members of the committee,

I would like to thank you for the opportunity to address you this morning. I come to you on an issue which has become important to me over the last several months, and I believe must be addressed.

In 1993, the Legislature created the Fraud and Abuse Investigation Section of the Division of Workers Compensation. We were mandated to investigate and prosecute violations of the Workers Compensation Act. There were 20 acts which were deemed as being "fraudulent" or "abusive", under K.S.A. 44-5,120. There were also acts deemed as being criminal under K.S.A. 44-5,125, with some acts being defined as felony crimes.

Through the course of three years of existence, the Fraud and Abuse Section has investigated over 800 alleged fraudulent or abusive acts. During that time, one thing has become clear. There are times that our job has become difficult, if not impossible, to perform. We have difficulty obtaining records from companies regarding individual claimants, from insurance companies regarding employers, and from doctors regarding patient's medical histories. We also need to have quick access to criminal histories so that we may know the types of individuals we are attempting to investigate, and to ascertain if they have committed or attempted to commit a fraud related crime in the past. Under the current system, we must make formal requests to a law enforcement agency to run these records. There are considerable delays in using this process.

Valuable time is lost waiting for responses to our inquiries. It is a long, drawn out process to investigate cases to their conclusion, obtain records, and prosecute. And now, with the Senate's passing of Senate Bill 137, we have only **180 days** to investigate a claim and decide what we are going to do with it before we can have a party petition to take a case away from us, and to a civil proceeding.

These problems could be easily eliminated with one simple step, the granting of law enforcement powers upon Workers Compensation Fraud Investigators by this Legislature. This would allow them to obtain and serve district court subpoenas for records, and to secure that information into the chain of evidence. It would allow them to access criminal history data banks

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themselves for an instantaneous review of records. Also, in extreme circumstances it would allow them to conduct warrants and obtain evidence if no other alternatives were available.

The ability to perform these tasks is important when you consider that not only are these investigators called on to investigate workers compensation fraud, but they also run across other crimes as well. There are many crimes which go "hand in hand" with workers compensation fraud. Forgery, criminal altering of documents, forging of prescriptions, violations of immigration law, perjury, mail fraud, theft, social security fraud, theft of services, and even assault and battery are all crimes that our section has been exposed to in our three year existence. They are often times so intertwined with our cases that we have no choice but to investigate them as well.

There are even issues of safety to consider. Investigators are frequently called upon to interview individuals in their homes, at night, alone from any sort of support or assistance. They are sometimes required to conduct surveillance at odd hours, in potentially dangerous neighborhoods. The danger element to their jobs is real and should not be taken lightly. They are investigating **crimes**, a duty that all of us appreciate as being dangerous and potentially life threatening. The perception is that these are "white collar crimes" and therefore the danger element should not be great. The truth is that the individuals committing these crimes are not necessarily of the "white collar" variety. They often times have criminal histories that are long and sometimes violent. To ask these people to go into these situations and conduct investigations under these circumstances is not fair to them. They do their jobs effectively and professionally, but could not protect themselves if they ever had the need to do so.

This bill has support. It is openly supported by the **Secretary of K.D.H.R., Wayne Franklin**; the **Kansas Peace Officer's Association**; and the **Attorney General, Carla Stovall**. They all believe that this is a necessary step in the fight to reduce Worker's Compensation Fraud.

The legislature has proven that it takes the idea of prosecuting workers compensation fraud very seriously. It has been evidenced by your creation of our section. You have already granted law enforcement authority to other state agencies, and also to other investigators in the Attorney General's Office. I urge you to now follow the lead of other states who see Worker's Compensation Fraud Investigation as warranting these powers, and grant these investigators the authority they need to do their jobs.

Thank you very much for your time, I'd be happy to answer any questions you might have.

Kansas Peace Officers' Association

INCORPORATED

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Senate Bill 347

Madam Chairman and Members of the Committee:

My name is Doug Peck and I am President of the Kansas Peace Officers Association, the largest professional law enforcement association in the state. We support SB 347 and urge the committee to report it favorably.

As introduced, SB 347 would grant the special investigation unit of workers compensation the power and authority to act as LEOs. These investigators are currently assigned to investigate workers compensation fraud. In other words, they are investigating criminal activity and criminals. They do not, however, have the power of arrest; the authority to conduct searches and seizures; or the authority to carry firearms to defend themselves in the event that, when encountering persons involved in criminal activity, they are attacked.

Simply put, SB 347 resolves the dilemma these investigators face: that of being charged with the duty to investigate crimes and criminals *without* having the most fundamental law enforcement authority. Granting as it does the powers of arrest, search and seizure, and the ability to carry defensive weapons; SB 347 enables these investigators to more efficiently fulfill their duties. If passed, it will also allow these investigators to deal with non-workers compensation crimes when, in the course of investigating workers compensation crimes, they encounter them. Without that ability, investigators are in no better position than a private citizen.

Again, we respectfully urge the committee to report SB 347 favorably.

Thank you for this opportunity and I will stand for questions.

In Unity There Is Strength

TESTIMONY BEFORE THE SENATE COMMERCE COMMITTEE
ON SENATE BILL NO. 346

BY PHILIP S. HARNESS, DIRECTOR OF WORKERS COMPENSATION
FEBRUARY 20, 1997

Madame Chair and committee persons:

Thank you for allowing me the opportunity to address you on the provisions of Senate Bill No. 346, which is a compilation of legislative recommendations made by the Workers Compensation Advisory Council, pursuant to K.S.A. 44-596.

1. Section One (Page 1, Lines 27 and 28) provides for a continuance of a workers compensation case (technically known as a terminal date extension) upon mutual agreement of all parties.

2. Section Two (Page 3, Line 23) provides for the schedule of maximum medical fees to be revised as necessary at least every two years, rather than the present statutory "annual review." While medical fees do fluctuate, it was not felt that it is necessary to review the schedule annually but that a bi-annual revision is more appropriate.

3. Section Three (Page 8, Line 22) grants the Kansas Workers Compensation Fund the status of a party to request a determination of benefits or compensation due to an injured worker. Under present law, only the employer, worker, or insurance carrier has standing to make such a request.

4. Section Four (Page 10, Lines 31-33) limits the time available to certify overpayments by an employer or insurance carrier to the Division to one (1) year from the date of the final order. K.S.A. 44-534a provides that, if workers compensation has been paid by the employer or its insurance carrier either voluntarily or pursuant to an award and, after a full hearing on the claim, the amount of compensation to which the employee is entitled is found to be less than that which was paid, the employer or its insurance carrier is entitled to be reimbursed from the Workers Compensation Fund. Procedurally, the Division of Workers Compensation certifies to the Insurance Commissioner the amount to which the employer or insurance carrier should be reimbursed and, upon receipt of such certification, the Insurance Commissioner then pays that amount to the employer or its insurance carrier. This proposed amendment sets a time limit for the employer or its insurance carrier to make such a request.

5. Section five (Page 10, Line 43; Page 11, Lines 1-2, 9-11, and 22) is intended to address the issues presented by the decision of the Court of Appeals in the *Shain* case. Specifically, that case concluded that any decision made by an administrative law judge, whether it be a final decision disposing of the case, or even a ruling on evidence, may be appealed to the Workers Compensation Board. The proposed amendment allows appeals only in the area of final orders, awards, modifications of awards, or preliminary awards.

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Attachment 7-1 thru 7-2

6. Section six (Page 12, Lines 32-34) provides that the Director may contract with the Secretary of the Department of Health and Environment to collect information necessary for the setting of the maximum medical fee schedule. Currently, the Secretary of Health and Environment collects data for the Insurance Commissioner under the auspices of the health-care data governing board.

Section six also proposes an amendment (Page 13, Lines 5-15) to require each workers compensation pool, insurance carrier, and health care provider to submit certain medical information, by procedure, charge and zip code, in order to facilitate the gathering of data for the purposes of setting the maximum medical fee schedule. Under current law, there is no method of compulsion for reporting that data, and the Division of Workers Compensation must rely on the voluntary submission and generosity of others to submit information in order to set the maximum medical fee schedule.

7. Section seven (Page 14, Lines 40-43; Page 15, Lines 1-14) provides that in those cases where the Workers Compensation Fund has been properly impleaded and where an award has been entered deciding all the issues in the employee's claim against the employer, but leaving unresolved those issues between the employer and the Workers Compensation Fund, the Workers Compensation Fund may file an application requesting that it be dismissed from the case. The employer would have a period of six (6) months from the filing of such an application in which to complete its evidence on the fund liability issues and submit the case to the administrative law judge for decision. If the employer would fail to complete its evidence and submit the case within that six (6) month period, the fund would be dismissed.

8. Section eight (Page 17, Line 24) requires a 20-day notice to implead the fund. Under current law, there is no minimum time requirement prior to the first full evidentiary hearing for the fund to be impleaded.

9. Section nine (Page 18, Lines 6-7) provides for a waiver of assessments (used to pay for the cost of the Workers Compensation Division) of $10.00 or less. Currently, the Division levies an assessment of approximately two percent of the paid losses suffered by insurance carriers, self-insured employers, and group pools. While those payors number in the hundreds, there are approximately a dozen which pay a very low assessment, usually related to writing only one workers compensation policy in the state. Time spent on calculating those extremely low assessments, sending out the bill, and making sure it is paid outweighs the less than $40.00 that the Division would otherwise receive from these dozen or so payors.

Thank you for your courtesy in receiving this testimony and the Division is, of course, happy to answer any questions regarding it.

Testimony of Mary Darlene Barry.
Shawnee, Kansas
(913) 631-7218

Senate Bill 347
Senate Commerce Committee

My name is Darlene Barry. I support the change in attorney fees introduced in Senate Bill 347. Why? I currently have an appeal of my own case on file with Worker's Compensation. I have no lawyer. I tried and tried, and couldn't find one. I represent myself and have heard nothing about the case from the Division in months.

My case was turned down by four lawyers all of whom told me that the Kansas law controlled the way they could charge me for their legal services under the Workers Compensation Act. The last lawyer told me that because I had a settlement offer from the Insurance Company, he couldn't earn enough money from my case to justify his time and to cover the costs of the case like the cost of medical records. He also told me I truly did need a lawyer, because It is important to me to keep the possibility of future medical benefits alive and that is not part of the settlement offer from the Insurance Company.

In fact, it is so important to me to keep my claim open for future medical benefits that, like I said, I have filed a claim on my own. However, it is very scary and frustrating to represent myself against the whole Workers Compensation System and the Insurance Company. I don't know all the ins and outs and legal jargon. Without a lawyer, there's no one to explain my rights. This worries me.

As I said, my case is not resolved, and therefore I am not comfortable talking about the specifics of it. I will simply say that after 15 years of employment with the Shawnee Journal, and without missing a day, I had an injury covered under the Workers Compensation Act. To make it short, the nerves in both my arms popped one day because I had used them too hard over the years on the paper's computer typographical machine. As one of the doctors said, it was just like stretching a rubber band over and over and over again. After so many times, the rubber band snaps in two. That is what the nerves in my arms did. They snapped in two. I can no longer use my fingers, hands, or arms for anything but the simplest of tasks. I can no longer drive any significant distance, just to the grocery store and back. My arms are in constant pain and I have a lot of trouble with burning in my arms.

Senate Commerce Committee
February 24, 1997
Attachment 8-1 thru 8-2

Since I am in my 50's, I am very worried that this injury will get worse over time. That's why I must be allowed to have compensation for medical benefits in the future.

I was sent to doctor after doctor after doctor, and none of them told me what to do to get relief.

Maybe, if I could have found representation, they would have insisted on some diagnostic testing early in the process.

Maybe, if I could have found representation, this case would not be dragging on so long, I would have gotten the cost of future medical benefits handled earlier and the case could have been resolved quicker, saving the taxpayers money in the administration of my claim through the Workers Compensation System.

If I could have found representation, maybe I wouldn't be so angry now that a state law has prevented me from contracting with the lawyer of my choice and from getting fairly treated for my injury.

You can't change this experience for me, but you can change it for other people who, like me, get injured on the job in the future. I hope you remember my story when you decide what to do on this bill.

Please pass SB 347.

Mary Darlene Barry

Mary Darlene Barry

MERLINO & SCHOFIELD, INC.
CONSULTING ACTUARIES

MATTHEW P. MERLINO, FCAS, MAAA, MCA

DAVID A. SCHOFIELD, FSA, MAAA, CLU, FLMI, ChFC

January 12, 1993

Mr. Richard H. Mason
Executive Director
Kansas Trial Lawyers Association
Jayhawk Tower
700 S.W. Jackson Suite 706
Topeka, Kansas 66603-3731

Re: Review of Kansas Workers' Compensation Closed Claim Study

Dear Mr. Mason:

Merlino & Schofield, Inc. (M&S) was requested by representatives of the Kansas Trial Lawyers Association (KTLA) to review an actuarial study prepared by Martin A. Lewis of Tillinghast, Towers/Perrin (Tillinghast). The report titled Kansas Workers' Compensation Closed Claim Study was performed by Tillinghast on behalf of the National Council on Compensation Insurance (NCCI). Our participation includes the review of the methods used by Tillinghast in reaching the conclusions contained in this study. We did not perform the additional analysis required to provide alternative conclusions regarding the items addressed in the report. However, in certain instances we described procedures that in our opinion would improve the accuracy of the results. We did not however obtain the data required to implement these alternative procedures.

The material provided to us for review included a bound report titled "Kansas Workers' Compensation Closed Claim Study" and a separate document labeled "Interpretive Analysis of the Kansas Workers' compensation Closed Claim Study". These two documents were dated July 15, 1992 and July 16, 1992 respectively.

The data used in this study consist of a sample of 1,033 Kansas workers' compensation claims closed during the period January 1, 1990 through December 31, 1991. The claims selected were defined as being of a permanent injury nature. Commercial insurers contributed 909 claims and a self-insured claims administrator contributed 124 claims. While the claims included were closed during calendar years 1990 and 1991, the underlying accident dates ranges from 1979 to 1991. However, all of the claims contributed by the self-insured administrator have accident dates between 1987 and 1991. Thus the insured and self-insured categories do not have similar accident year distributions.

Senate Commerce Committee
February 24, 1997

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Attachment 9-1 thru 9-9

The remainder of this letter summarizes our conclusions regarding the above mentioned report. Our comments are segregated into those related to the general procedures used in the analysis of the data and alternatively into specific observations regarding the conclusions contained in the Interpretive Analysis section of the report.

One shortcoming of the study is a result of inherent limitations related to studies performed on a data base consisting only of closed claims. Since closed claim studies are by definition based on a sample of claims closed during a particular time period, the sample may not be representative of claims expected to be incurred during a given time period. For example, claims closed during a particular time period may contain a relatively smaller or larger percentage of serious claims in comparison to less serious claims depending upon the growth rate of the underlying population or the particular accident years included in the study. This occurs because while claims closed in a particular period will consist of both large and small claims, generally the smaller claims will result from recent accident years whereas on average the larger claims will result from older accident years.

For example, if we have two groups of claims closed in 1991 but in which one (#1) contains claims occurring in 1987-1990 and the other (#2) contains claims occurring in 1975-1990 we would expect the average claim size for the later group (#2) to be greater than the former (#1), simply due to the difference in distribution by accident year.

Thus when using various subgroups of claims closed during a particular time period to test the significance of some variable it is important that the distribution by accident year within each of the two groups is relatively similar. Otherwise the difference in the two categories may be a result of differences in the distribution by accident year rather than the variable under consideration.

The second limitation related to closed claim studies is caused by the impact of inflation. Since claims closed in a particular time period consist of claims occurring over many accident years and include payments made over various time frames, the impact of inflation can result in two significantly different total payment amounts for two similar claims occurring in different accident years. This impact of inflation will also distort a comparison of claims closed during two different time periods. Inflation alone will result in an increase in the average closed claim size over time. For example, in the comparison of pre-Hughes versus post-Hughes claims, we would expect the inflation impact

alone to result in an increase in post-Hughes decision claims of perhaps 9 to 11 percent.

Thus in using claims closed in a particular time period to test the impact of selected variables, it is important to recognize the impact of loss inflation and potential differences in the distribution by accident year. We were unable to locate any reference to adjustments or consideration of these items in the report under review.

Methodology

The most significant shortcoming of the approach used to test the relationship between specific items and the average claim size results from a failure to remove the impact of other variables. Specifically, with regard to measuring the impact of the characteristics listed below the underlying data was not sorted in a fashion that would isolate the variables under review.

- o Self-Insured vs. Commercial
- o Attorney Involvement vs. No Attorney Involvement
- o Pre-Hughes vs. Post-Hughes

For example, in order to identify the correlation between average claim size and attorney involvement, it is necessary to eliminate other variables which may impact the average claim size. Instead of comparing an average of claims with and without attorney involvement, claims with similar characteristics other than the presence or absence of attorney representation must be selected. Otherwise we are unable to identify the impact of one variable at a time. If claims are selected at random and placed into two groups (attorney involvement and no attorney involvement) it is impossible to measure the difference in claim size attributable to attorney involvement and the difference related to other items such as injury type, accident year, impairment rating etc. That is, it may be that in general more serious claims are more likely to require attorney involvement and thus we are not measuring the impact of attorney involvement but instead are measuring the differences in the average claim size of more versus less serious claims.

Thus in this example a more accurate measure would result if we identified claims with similar characteristics other than the item under consideration and test the significance of the item under various conditions. While the type of claim is an important variable to consider when measuring attorney vs. non-attorney, other variables may be important when measuring other characteristics. In the case of pre-Hughes vs. post-Hughes the distribution by accident year and average date of payment is an important variable that must be considered before an accurate measure of the

Hughes decisions can be obtained. Additional information on the impact of plan design is described in the remainder of this letter.

An additional potential for misleading conclusions results when the data is sorted into various groups based upon differences in one characteristic without attempting to neutralize the impact of other variables. That is, when measuring the impact of one variable, the potential effect of other variables must be eliminated. Thus instead of sorting the entire data base into two groups based on the presence or absence of one variable, a sample of claims with similar characteristics other than the variable being measured must be used to test the significance of the variable under consideration.

Self-Insurance vs. Commercial Carriers

The plan design used in the report to measure the difference between self-insured and commercial insured claims administration illustrates the problem described above. Specifically, if the objective is to measure the efficiency of claims handling for self-insured programs compared to commercial carriers using the average claim size as the measure of efficiency, it is necessary to eliminate the impact of other factors that may affect average claim size. Without eliminating these other factors, it is impossible to distinguish the impact of the variable under consideration from the impact of other variables.

Potential factors, other than self-insured or commercial carriers, that may impact the average claim size would include differences in the industrial composition of entities contained in the self-insured claims data base as compared to the insured claims data base. For example, in the event the self-insured population contains on average industries with less hazardous operations, we could expect a relatively larger percentage of less severe claims than those contained in the insured population.

It would appear that a more appropriate method would be to compare claim size (in addition to other characteristics that are assumed to be indicators of the quality of claims handling) for claims with similar severity characteristics. That is, select claims with similar type of indemnity (e.g. permanent total), body part, impairment rating, etc. and then use this subset of claims to test the one variable under consideration.

An additional shortcoming associated with the analysis of the self-insured claims as compared to the commercial carriers claims includes the potential differences of the underlying hazards of the insureds and difference in the accident years involved. As shown on Exhibit II, Sheet 1 of the report, the self-insured claims data

does not include claims with accident dates prior to 1987, whereas the insured data includes claims with accident dates from 1979-1991. As shown on this exhibit, it appears the average closed claim size is on average smaller for the more recent accident years. As a result of the difference in the distribution by accident year for self-insured and commercial carrier categories, we would expect the average claim size for commercial carrier claims closed during the study period to be larger than the average claim size for self-insured claims.

On pages 3 and 4 of the "Interpretive Analysis" section it states self-insured claims exhibit shorter lag times to closure and fewer days from injury to return to work. Again, it does not appear that differences in the accident date distribution have been considered before these conclusions were reached. It would appear that accident date would affect both of the above mentioned items.

Further, due to the limited number of claims contained in the self-insured data set (124), differences in the underlying hazards of the industries contained in the self-insured data as compared to the insured data could result in differences in the average claim-size. We were unable to locate any reference to potential similarities or differences in the industries insured. This could be examined using payroll by rating classification for the groups.

Attorney Involvement

The primary limitation in plan design with regard to the evaluation of the impact of attorney involvement is the failure to control the impact of other variables. That is, factors with potential impact on cost other than attorney involvement were not equivalent or approximately equivalent. In order to test the impact of attorney involvement it is necessary to compare claims with similar characteristics other than the characteristic under consideration. Otherwise, it is impossible to distinguish whether the difference in outcome is a result of the factor under consideration or some other factor.

The impact of the above limitation is mentioned on page 18 of the "Interpretative Analysis" accompanying the Kansas Workers' Compensation Closed Claim Study. In this section of the report, Tillinghast states that whether (1) attorneys become involved in more serious cases, (2) attorney involvement causes high claim costs, or (3) there exists a combination of these two factors is not readily determinable from the data.

However, on the following page (i.e. page 19) of the "Interpretative Analysis" section, it is stated that "lag time from date of injury to return to work is also increased by attorney involvement". In our opinion a more accurate statement might be that attorney representation and settlement time appear to be correlated. However, even this statement cannot be conclusively supported due to the limitation in plan design mentioned previously. That is, does attorney involvement result in longer settlement lags or, alternatively, is it that more serious claims are more likely to seek attorney representation, and since more serious claims (with or without attorney representation) generally require a longer time to reach settlement, claims with attorney representation also require a longer time to reach settlement? Thus without measuring the impact one variable at a time, the effect of the independent variable cannot be determined.

In summary, in order to estimate the impact of one variable (e.g. attorney involvement or pre vs. post-Hughes), it is necessary to develop a comparison of claims with similar characteristics other than the specific item under consideration. In the event all other characteristics are not equal, an effort to adjust for differences should be incorporated before interpreting the results. Specifically, in the case of measuring the impact of attorney involvement the other characteristics contained in the data base that may potentially impact claim size include:

- o accident year- (i.e. trend, benefit level changes)
- o impairment rating
- o indemnity type (e.g. temporary total, permanent total, etc.)
- o injury cause (e.g. burn, strain, etc.)
- o age
- o sex
- o body part(e.g. head, trunk, etc.)

For example, rather than comparing the average claim with attorney involvement (i.e. $29,029) to the average without attorney involvement ($17,445) for all claims, a more accurate indicator would be to compare claims with similar indemnity type, injury cause and impairment rating from a similar accident year, or alternatively claims with similar characteristics other than accident year but after adjustment for inflation and benefit level changes.

A simplified example of this type of approach would be to compare the average claim size for back claims with and without attorney involvement at similar impairment ratings levels. A sample calculation using claims with impairment ratings ranging from 51-100% results in average indemnity of $51,310 and $85,559 for attorney and non-attorney involvement, respectively (See

Exhibit XXV, Pages 1 and 2). Due to the relatively small number of claims contained in this subset of the data sample, this result is not statistically significant. However, this comparison does illustrate the concept described above, with the exception there is no adjustment for loss inflation and benefit level changes. In any event, the results seem to indicate the potentially misleading results of comparing simple average claim sizes.

Hughes Decision

As mentioned previously, the comparison of simple averages without adjusting for changes other than the variable under consideration (i.e. in this example the Hughes decision) will potentially result in misleading conclusions. On page 6 of the "Interpretive Analysis" section of the Tillinghast report, this type of approach appears to be used to estimate the impact of the Hughes decision. One limitation of this approach is that using claims closed pre-Hughes to develop an average claim size to compare to the average claim size calculated using claims closed after the Hughes decision ignores the impact of inflation. In addition, the two groups of claims used (i.e. pre-Hughes and post-Hughes) are inconsistent with regard to the average lag between the accident date and the settlement date. Both sets of claims were incurred during the same accident years yet the pre-Hughes claims were closed approximately one year earlier.

With regard to the distortion resulting from the impact of loss inflation, we would expect claims closed on the average one year later to settle at a level equal to the annual trend rate (inflation) for workers' compensation in Kansas. In addition, since both groups of closed claims (before and after Hughes) included claims incurred in accident years 1979 through 1990, we would expect the claims closed after the Hughes decision to be relatively older claims and on average more expensive claims. For example, accident year 1986 claims included in the study and closed prior to the Hughes decision would have been closed sometime during the time period 1/1/90 to 11/26/90 and thus would on average have a lag between accident date and settlement date of slightly less than four years, whereas the 1986 accident year claims included in the post-Hughes average claim calculation would have been closed during the time period 11/27/90 to 12/31/91 and thus have an average lag between accident date and settlement date of slightly less than five years. As shown on Exhibit II, Page 1, the average claim size for claims closed during the time period selected for the study appear to be larger for the older accident years. That is, the average closed claim size and settlement lag appear to be positively correlated.

Thus, even ignoring the inflation impact, we would expect the post-Hughes average closed claim to be larger than the pre-Hughes

average closed claims due to the difference in settlement lag for the claims contained in each of the two groups. In order to illustrate the impact of these two items (i.e. trend and settlement lag), we have adjusted the averages as shown on Page 6 of the "Interpretive Analysis" section of the Tillinghast report.

In the report, Tillinghast states that the post-Hughes average claim based on accident years 1986-1990 is $24,525 as compared to the pre-Hughes average claim size of $21,411. Due to the difference in settlement lag a more appropriate comparison would be to use accident years 1986-1990 for pre-Hughes ($21,411) and accident years 1987-1991 for post-Hughes($26,410). Also the pre-Hughes average ($21,411) should be adjusted for one year of loss inflation. Assuming an average annual trend rate (inflation) of 9% the adjusted pre-Hughes average would be ($23,338). Thus the increase resulting from the data would be +13% rather than the +33% shown in the Tillinghast report.

Statistical Analysis

As stated previously, due to the failure to properly segregate the claims data the conclusions summarized in the later pages of the "Interpretive Analysis" section of the report are not conclusively supported. For example, the table shown on page 28 of the "Interpretive Analysis" section which summarizes the results of the statistical test performed on the closed claim data is subject to misinterpretation. Due to the failure to hold additional variables constant, the test used does not result in a conclusion regarding a specific correlation between the specific variable noted and the dependent variable (e.g. average claim size). That is, the test used only results in a measure of the probability that there is a difference in the two claim samples. However, due to the number of variables other than the specified variable potentially contributing to the difference in average claim size, the test does not result in a conclusion with regard to the impact of one particular variable. For example, the application of the t-test to the data sorted into attorney involvement and no attorney involvement groups does not result in a conclusion with regard to the impact of attorney involvement on claim size, but instead, only concludes that there is a difference in the average claim size of claims with attorney involvement versus claims with no attorney representation. The test does not offer any conclusion with regard to a cause and effect between attorney representation and average claim size because other variables such as indemnity type, impairment rating, injury cause, etc. have not been held constant. Thus there may be a positive correlation between attorney involvement, average claim size and one or more other variables. Without investigating each potential variable individually, the

correlation between the specific variable and the average claim size cannot be measured.

The other applications of the t-test shown in this table do not offer definitive conclusions since again other variables that may impact average claim size have not been held constant. In order to test the significance of the impact of each characteristics, a more specific sample of claims must be selected. Otherwise it is not possible to reach a conclusion regarding the impact of a particular variable with any degree of certainty.

SUMMARY OF FINDINGS

1. Failure to Account for the Impact of Other Variables - The most significant shortcoming of the methodology employed to test the relationship between specific items and the average claim size is the failure to remove the impact of other variables.

2. Only Closed Claims Studies - Since closed claims studies are by definition based on a sample of claims closed during an isolated period, the sample may not be representative of claims expected to be incurred during that period.

3. Inflation Ignored - Our understanding is that the claims data was not adjusted for loss inflation. This is important, particularly when attempting to compare pre and post-Hughes claims, since the inflation impact alone could result in a post-Hughes increase of 9-11 percent.

4. Self Insured V. Commercial Carrier Comparison Flawed - No attempt was made to look at the industrial composition, the degree of hazardous occupations, etc. of the businesses represented by the self-insured and commercial carriers.

5. Misleading Implications of Test Results Related to Attorney Involvement - The plan design used does not result in any definitive conclusion regarding the impact of attorney involvement. In order to test the impact of attorney involvement, it is necessary to compare claims with similar characteristics. Placing random claims in only two groups (those with and without attorneys) makes it impossible to measure the impact, if any, on average claim size.

Sincerely,

George W. Turner, FCAS, MAAA