THE HANDLING OF WORKMEN'S COMPENSATION CLAIMS
BY THE OHIO INDUSTRIAL COMMISSION

DISSERTATION

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BY

WILLIAM ELBERT BIGGS, B. A., L L. B., M. A.

*****

The Ohio State University
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Approved by:

[Signature]
Harvey Walker, Adviser
Department of Political Science
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INTRODUCTION

Workmen's compensation laws are designed to remove industrial injuries and occupational diseases from court litigation based on fault or negligence and to substitute benefits which vary only in relation to the nature of the injury or disability. Workmen's compensation is based upon a public policy which postulates the liability of the employer, without fault on his part, to pay compensation to an industrially disabled employee or his dependents or survivors.

All workmen's compensation laws are based upon the application of insurance principles to the payment of benefits to the industrially disabled worker in order to distribute the risk and provide for the security of deferred payments. No two states have identical laws. Three types of alternatives are offered to employers in the several states: (1) employers are required to insure with a monopolistic state insurance fund; (2) employers must rely upon private insurance companies to insure their compensation risk; (3) employers have the option of selecting the state fund or a private insurance carrier. In addition, some states permit the employer to self-insure with the permission of some state official. In some states the employer
has a choice as to whether he will operate under a workmen's compensation plan or continue to deal with his disabled employees under common law rules; in others, operation under a workmen's compensation plan is compulsory.

In Ohio, workmen's compensation insurance is compulsory for all employers, with minor exceptions. An exclusive state insurance fund has been established. The employer's only choice is to insure through the state insurance fund or to become a self-insurer under close governmental supervision. Until late 1955, the state insurance fund was operated by the Ohio Industrial Commission, and the supervision of the workmen's compensation system was under its general jurisdiction. Thus the commission had a dual function of operating the insurance fund and acting as the administrative tribunal which decided the rights of claimants to receive workmen's compensation benefits, which in most cases were paid from the fund which it administered.

When an employer has insured his workmen's compensation obligation with a private insurance carrier, the disabled employee generally reports the disability to the employer, who in turn reports it to the insurance carrier. The carrier makes whatever records and investigation deemed necessary, and enters into direct contact with the claimant. If the claim is found to be valid, the payments required by the workmen's compensation law are begun, and a report of the action taken is forwarded to the state governmental
agency administering the law. If the claim is contested, the claimant may file an application with the designated administrative tribunal for a hearing and determination of the merits of the claim. The administrative determinations are subject to some degree of judicial review.

When an employer has insured his workmen's compensation obligation with a state insurance fund, the disabled employee must file his claim with the governmental agency which administers the fund. Either the employer or the staff of the agency may question the validity of the claim. In such a case, the agency must collect the facts needed for an interpretation of the merits of the claim under the workmen's compensation statute. This may be done by correspondence, field investigation, or informal hearing. At this point in the procedure the governmental agency is performing an administrative function similar to that of the private insurance carriers in the states where they are permitted to operate. However, once the hearing process has begun, the governmental agency must perform the function of an administrative tribunal.

Such an exclusive state insurance operation has no overhead selling expense for agents and insurance salesmen. It is not taxed as a private insurance company would be. No profit motive is involved. As a result, it is generally conceded that an exclusive state insurance fund, if efficiently managed, can operate at a lower premium cost to the employer
than can a private insurance carrier. Since there is no competitor to an exclusive state insurance fund, no easy yardstick is available for measuring its administrative efficiency. When a governmental monopoly of this type is established, several factors exist which may tend to take the place of competition in increasing administrative efficiency. One of these is the pressure of public opinion or of organized interest groups (such as employer, employee, medical or legal groups) exerted through either the executive or legislative branches. A second factor which may serve as a substitute for competition may be that of legislative supervision exercised through budget control or through investigations. A third factor should be a system of constant internal self-examination and reappraisal designed to take advantage of new techniques and technologies.

The purpose of this dissertation is to determine how fully the administration of the Ohio workmen's compensation law by the Industrial Commission has met the needs and relieved the hardships which led to the adoption of the workmen's compensation system, and to determine whether the Industrial Commission achieved the practical maximum of efficiency and equity in processing claims for benefits, and whether substantial improvement could be made.

Most of the material for this dissertation was obtained by the writer while serving as a special consultant for the Ohio Legislative Service Commission during the sum-
mer of 1954. The scope of the writer's investigation was limited to an examination of the organization and procedures of the Ohio Industrial Commission for handling claims for workmen's compensation benefits. The files of the Legislative Service Commission contained mimeographed statements of the general procedures followed in each of the ten sections of the staff of the Industrial Commission. These prepared statements were consulted and supplemented by detailed interviews by the writer with employees in each section of the staff of the Industrial Commission involved in the processing of claims.

The Industrial Commission made available to the writer unpublished internal records of the time consumed by most of the steps required for processing clearly compensable claims and of the workloads of all employees involved in handling claims. These records were consulted by the writer and data extracted for the period of January through June, 1954.

The writer was given complete latitude by the Legislative Service Commission in the methods of research followed, and all information accumulated was made available to this commission. By agreement with the Legislative Service Commission, the writer covered all phases of the processing of claims for workmen's compensation benefits filed with the Industrial Commission with two exceptions: statistical information relating to claims for permanent partial
benefits and to the handling of "rehearings" of contested claims was obtained by other members of the staff of the Legislative Service Commission under the supervision of Albert G. Giles, research attorney. The writer participated in the planning, but not in the execution, of the permanent partial and rehearing field studies. During the summer of 1954, the writer attended meetings at which members of the General Assembly, who were also members of the Legislative Service Commission, were briefed on the results of all the field studies of the administration of the workmen's compensation law. Information obtained in all field studies of workmen's compensation administration conducted during the summer of 1954 was used in a research report published by the Legislative Service Commission in April, 1955.\(^1\) In all cases where the results of the research of other members of the staff of the Legislative Service Commission is used in this dissertation, the published report of the Legislative Service Commission will be cited for documentation. Any other references to the field study of 1954 will be to the results of the writer's own research.

The test of any administrative operation is its effectiveness in the execution of the public policy underlying it. Continuing criticism of the administration of the Ohio

workmen's compensation system over a period of forty years raised the question whether the interest of the employer, employee and general public were cared for with greater equity and efficiency under the workmen's compensation law than under the pre-existing common law and statutory provisions. With such a question, the problem was to identify the public policy intended in the adoption of the Ohio workmen's compensation law and to measure the efficiency of the operation in effecting such public policy.

In an effort to measure the overall effectiveness of such administrative operations, the extent and nature of their failure, and the prospects of their success in Ohio, the following factors were considered:

1. The history of workmen's compensation programs, in Ohio and elsewhere, indicates that such programs were developed to fulfill specific needs of the worker, the employer, and the public, and to alleviate certain hardships previously borne by these three interests. The greater the degree of efficiency and equity in the processing of claims, the more fully will the workmen's compensation program fulfill the needs and alleviate the hardships. The validity of the workmen's compensation principle itself depends upon efficiency and equity in the processing of claims. This is assumed and stated by private insurance carriers who must process claims with a relatively high measure of efficiency and equity in order to survive in a highly competitive field.
2. In the past the Ohio Industrial Commission has operated through organization and administrative practices which fail in substantial measure to attain the highest practical maximum of efficiency and equity in the processing of claims. This is demonstrated by an examination of the organization and practices of the commission and by contrasting the results with obviously valid standards of good insurance practice in the workmen's compensation field. It may be said that the economic, actuarial, and philosophical validity of workmen's compensation in Ohio are undermined insofar as the processing of claims fails to attain the practical maximum in efficiency and equity. This is true from the point of view of the worker, the employer, and the public.

3. Substantial improvement in the processing of claims in Ohio requires innovations and modifications with respect to statutory law, constitutional law, and administrative organization and practice. All of these three types of innovation and modification are impeded seriously by the custom of bargaining between employer and employee interests in the process of developing and adopting such innovations and modifications. This is illustrated graphically by the experience of the 101st General Assembly of Ohio in its attempt to reorganize the Industrial Commission and revise its practices by means of statute. In this instance, the resulting legislation provided ample opportunity for substantial
improvement in efficiency and equity, but there is little assurance that such improvement will occur; this is due in part to the custom of the agreed bill, and in part to the fundamental infirmity of statutory law as an instrument for control of administrative practice.

The two standards adopted of efficiency and equity are difficult to define precisely. Efficiency is taken to mean not only speed of operation, but also to include economy, simplicity, standardization and uniformity of administrative operation, or, in a negative sense, a minimum of overlapping, duplication, waste and delay. Equity is taken to include concepts of fairness, justice, and equality of treatment of all persons affected by the workmen's compensation law. A lack of equity might be shown by such things as a variation of the amount of award for the same type injury or by a variation in the speed of payment for invalid or capricious reasons.

The organization of a regulatory agency can not be judged only in terms of efficiency and economy of operation. Consideration must also be given to the objective of providing equitable solutions for the "consumers" of administrative services. The structure of the organization must be designed to meet the claim of equal treatment of each citizen entitled to a common public service. During the process of developing the standards necessary for translating a program into action in an equitable manner, the whole admini-
strative process is likely to become highly centralized at the expense of efficiency and speed. In studying the organization and procedures of the Ohio Industrial Commission for handling workmen's compensation claims, the writer made an effort to distinguish the mere ministerial functions, to which standards of efficiency alone could be applied, from the discretionary operations to which additional standards of equity must be applied.

In the literature of workmen's compensation, there are no universally accepted criteria of efficiency and equity for measuring the handling of claims for workmen's compensation benefits. There is no other governmental agency in Ohio which can be used as a standard of comparison. In those states where private insurance carriers are permitted to compete with a state insurance fund in underwriting workmen's compensation responsibilities of the employer, the private carriers are at a disadvantage in the amount of their premium charges because of their greater overhead and selling costs. As a result, such carriers have attempted to maintain themselves competitively in the field by recognizing the responsibility of discharging the obligations provided by the workmen's compensation laws promptly, efficiently, and in complete accordance with their spirit. The

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Association of Casualty and Surety Companies has issued a statement of nine principles for claims management and practice in the field of workmen's compensation, which comes the closest to furnishing a yardstick for judging the claims handling operations of the Ohio Industrial Commission, and they were used as such for the purposes of this study. The nine principles referred to are as follows:

First: All legitimate claims should be paid promptly and fully. In order to accomplish this, an immediate investigation of the facts and coverage should be made upon receipt of notice of injury. As far as possible, all questions should be covered thoroughly in first interviews. If any doubt exists as to the amount due, the claimant should be paid the sum which, in the judgment of the claims representative, fairly represents the value of the claim, subject to whatever subsequent adjustment may be found necessary. It should always be remembered that receipt of a compensation check on the day it is due is of great importance to the claimant.

Second: A frank and friendly attitude should be adopted towards all claimants. If there is any question of compensability, he should be told of the insurer's position at the earliest possible moment.

Third: The best medical and surgical attention possible should be provided in those states whose laws permit the carrier to select the physician and surgeon. The insurer's objective and that of the injured man are identical in this respect. By receiving the best medical care, the worker, in the average case, will be rehabilitated and returned to full earning capacity more promptly. The physician should never feel that he must "favor" the carrier in order to retain its business.

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Fourth: Only when necessary should cases go to hearing. Full use of informal conferences, where possible, should be made. Only real issues should be raised. Adjournments should be avoided and cases fully prepared before hearings. Appeals should be taken only when reasonable grounds exist—not simply because of disappointment.

Fifth: Payments should be made directly to beneficiaries. They should be made through the employer only when that method will expedite receipt of payment, or be more convenient to the injured man or his dependents. After payment of compensation has started, following an agreement or award, it should not be discontinued because of change in the status of the disability, except when otherwise provided by law, until the injured party is so advised or returns to work.

Sixth: Employers should be given every assistance in obtaining an adequate understanding of the proper operation of the Workmen's Compensation System. The necessity for promptly reporting the occurrence of injuries should be impressed upon them by agent or broker, working in close cooperation with the Claim Department. It should be explained, when necessary, why certain claims may have to be contested and why, in other instances, payment must be made. Employers should not be advised that the employment of handicapped workers, for tasks they are fitted to perform, is undesirable.

Seventh: There should be complete cooperation with the agencies administering the Workmen's Compensation Laws. Personal contact with them should be established and periodical conferences held to learn at first hand of any possible complaints or criticisms. Full compliance with the provisions of the Workmen's Compensation Laws must be observed. The high level on which the business of Insurance is conducted should be apparent through the fair dealing and efficiency of its representatives.

Eighth: Dishonest claims should be fought. It is a duty the carrier owes its policyholders, honest claimants, and itself. But intent to defraud should be clear before it is concluded that the claimant is dishonest.

Ninth: The great and exacting responsibility of insurance companies in the proper, economical and
efficient administration of workmen's Compensation Laws must be freely accepted by those engaged in claims management. Through their actions, they should continue to demonstrate the ability of insurance companies to retain the confidence of employers, employees, compensation administrators and the public as a whole. The insurance business, thus conducted on a high level of social awareness and motivated by a complete appreciation of its responsibilities, will stand the test of scrutiny from all other points of view.

This study was conducted by the writer primarily as a field study of the claim handling procedures of the Ohio Industrial Commission during the summer of 1954. In the first three chapters an attempt will be made to give a brief history of the development of the workmen's compensation principle in the state and to discuss the scope of the workmen's compensation law in terms of its coverage and benefits. This will be done in an effort to establish the effectiveness of administrative operations in the fulfillment of the public policies sought to be achieved by the passage of the law.

The next seven chapters will be devoted to the results of the field study conducted during the summer of 1954 of the claims handling organization and procedures of the Industrial Commission. The material for this field study was obtained by the writer while serving as a special consultant for the Ohio Legislative Service Commission during that period. The next three chapters which follow these will give a discussion of the forces which were in operation in the adoption of the 1955 laws revising the organi-
zation and practices involved in handling workmen's compensa-

tion claims in the state, and the probable results of this

new law in increasing efficiency and equity. The final chap-
ter will include a summary and recommendations.
CHAPTER I

THE EVOLUTION OF WORKMEN'S COMPENSATION SYSTEMS

Workmen's compensation laws provide benefits for the occupationally disabled employee payable without regard to fault on the part of the employer. The extent of the benefit is limited by the provisions of the basic statute. Workmen's compensation laws were designed to alleviate a maladjustment which had developed in the legal relationship of the employer and the employee during the nineteenth century. In the development of the Anglo-American common law during the period of the great industrial growth in the last half of the nineteenth century the relationship of master and servant, which had been developed in almost a family manner, seems to have been applied to the relationship of employer and employee in an industrial society.

During the nineteenth century the courts of both England and the United States issued new interpretations which were favorable to the employer and which had little regard for the economic plight of the disabled worker. Finally, public pressure forced the legislatures to adopt a new principle of compensation regardless of fault. This concept had no clear basis in any of the pre-existing common law doc-
trines, but since the adoption of workmen's compensation laws some efforts have been made to rationalize this concept in legal and economic terms.

Workmen's compensation laws in the United States have evolved from a series of social adjustments to meet a social need. They have passed through three major phases:

(1) The pre-compensation period when the worker's only recourse was to a personal injury damage suit under the common law, later modified by employers' liability statutes; (2) the period of popular rejection of the common law and its statutory modifications, and the struggle for nation-wide enactment of compensation legislation; (3) the period of widespread legislative action and the institutionalization of workmen's compensation.¹

The Pre-Compensation Period

Before the adoption of workmen's compensation laws, the only recourse of a worker injured on his job was a common law suit for damages based upon the employer's fault and liability. In such suits the odds were heavily weighted against the worker. The employer's legal liability to his own employees was based upon the negligence aspects of tort law, which implied that in occupational accidents someone was at fault. If the employer alone were found by the court to have been negligent and at fault, the court would award

damages to the worker. If the worker were at fault, even partially, such contributory negligence deprived him of any claim upon the employer, regardless of the extent of the employer’s negligence. The legal burden of proof for establishing the employer’s negligence fell upon the plaintiff-worker. The employer had at least one of three defenses, which made it difficult for the worker to prove his case: contributory negligence, the fellow-servant doctrine, and voluntary assumption of risk. Under the fellow-servant doctrine the employee could not recover from the employer if the injury had been caused by the negligence of a fellow worker. Under the third defense, the injured employee could not recover damages if the injury were caused by an inherent hazard of the job which was known to, or should have been known to, the employee.

The doctrine of voluntary assumption of risk and the fellow servant doctrine developed from an 1837 English case, Priestly v. Fowler, 3 Meeson & Welsby 1. This was a suit against an employer brought by an employee who had been injured as a result of the negligence of another employee in overloading a wagon. In denying damages the court held that the negligence of the fellow employee could not be attributed to the employer and that the injured employee could have declined any employment which he felt would be dangerous. This decision, which reduced the responsibility of the employer, was issued at a time of great change in the use of
powered industrial equipment. Yet it speaks of conditions where a master has a few servants living and working in his household. It has been cited as an example of the individualistic tendency in the common law to assume that an employee was free to contract and was not bound to risk injury to himself in any particular job, and also as an example of the desire of judges to encourage large industrial establishments by making the burden on them as light as possible.\(^2\)

Shortly thereafter, the portion of Priestly v. Fowler, stating the right of the worker to refuse to accept dangerous work, was expanded by an American court into the doctrine of voluntary assumption of risk. This doctrine held that a servant who accepted employment also assumed all the ordinary risks incident to this work, Farwell v. Boston & Worcester R.R. Co., 4 Metcalfe (Mass.) 49, 1842. The doctrine was quickly adopted by courts in both England and America.\(^3\)

A shift from the fellow-servant rule was made in Ohio as early as 1851 in Little Miami R.R. Co. v. Stevens, 20 Ohio 415. This case adopted the "vice-principal" exception


whereby a supervising or directing employee was not a fellow servant. The employer in such a case could not use the defense of the fellow servant doctrine in escaping liability. This idea was based on the theory that the supervisor was the alter ego of the employer. The courts in several other states followed the Ohio rule. Although concepts such as that of the alter ego softened the defenses of the employer, he still had a great advantage. A large share of work injuries were left without legal relief.

**Employers’ Liability Laws**

Early legislative efforts to help the legal position of the employee initially took the form of employers’ liability laws, which attempted to abrogate or modify one or more of the three common law defenses of the employer. The first such law was the Employers’ Liability Act passed by the English Parliament in 1880. This act gave a right of action relating to defective working conditions. This act, in effect, introduced the vice-principal doctrine, but it did not do away with the fellow-servant rule. The defense of assumption of risk was somewhat modified, but the defense

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By 1910 most of the states of the United States had adopted some form of an employers' liability law. They differed considerably in terms and extent. The vice-principal rule appeared in practically all of them. The defenses of the fellow-servant rule and assumption of risk were often modified or even repealed, and the doctrine of "comparative negligence" was often substituted for the defense of contributory negligence. The doctrine of "comparative negligence" permitted the employee to recover when his contributory negligence was slight and that of the employer was gross. In 1904 and 1910 the Ohio General Assembly passed employers' liability laws. The first of these was the so-called Williams Bill, which eliminated the doctrine of assumption of risk in those situations where the employee continued doing hazardous work even when the employer was violating state or federal safety laws requiring the use of safety devices.

At the session of the General Assembly in 1910 two further laws were passed on April 30. These were the so-called Norris and Metzger Acts. The Norris Act modified

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7 Ibid., p. 46.
8 95 Ohio Laws 114, passed April 23, 1904.
9 House Bill 24, 101 Ohio Laws 195, General Code (henceforth referred to as G.C.) 6242.
the common law rules so that the fellow-servant and assumed risk defenses were practically abolished, and the defense of contributory negligence was entirely abolished. The doctrine of comparative negligence was substituted. The Norris Law applied only to certain dangerous employments. The law provided that the entire question as to the amount of damages was to be decided by the jury and that the decision was not subject to appeal. The Metzger Act was designed to correct abuses developing from the conduct of private insurance carriers in the defense of employers' liability suits. This same legislative attitude toward private insurance carriers was shown the following year when a state-operated insurance fund was created under the workmen's compensation law.

These employers' liability laws, with all their changes in favor of the employee, succeeded only in modifying the defenses available in industrial accident cases. It was still necessary for the employees to resort to court action and to prove fault on the part of the employer. The courts tended to interpret these new statutes liberally and to revise their conceptions of the common law. Nevertheless, it became increasingly clear that a new approach was

11 Senate Bill 135, 101 Ohio Laws 191, 9510 G.C.
needed. From 1909 to 1913 federal and state investigatory commissions were established in forty different jurisdictions to consider whether workmen's compensation systems should be adopted to govern the rights and responsibilities of employees and employers in cases of occupational injuries.\textsuperscript{12}

The objectives of the advocates of workmen's compensation laws have been summarized by Somers,\textsuperscript{13} as follows:

\textbf{PREDETERMINED, ADEQUATE, AND PROMPT BENEFITS.}\nProvision was to be made for a fixed scale of benefits for each injury, the amount depending upon such objective features as the nature of the disability, the wages of the injured worker, and the number of his dependents. Instead of lump-sum damages as retribution for a personal injury, payments were to be made in regular periodic installments, as income. It was believed that prompter settlements would result. . . .

\textbf{ELIMINATION OF WASTEFUL LITIGATION AND LEGAL FEES.}\ The optimistic statement of the New York Commission was typical: "The main savings of litigation . . . lies in the fact that by broadening the basis of liability and taking away the so-called defenses, there will be no questions left to litigate save, first, is the injured workman within the act, second, what shall be the compensation for his injury within the limits of the act . . . ."

\textbf{CERTAINTY OF PAYMENT.}\ Employers had, during the decade prior to the enactment of compensation laws, increasingly insured their risks under employers' liability statutes. It was widely felt that general extension of such insurance would protect the injured worker's compensation from the hazards of the employer's bankruptcy, withdrawal from business or other inability to meet his obligation.

\textsuperscript{12} Somers, op. cit., pp. 21-22.

\textsuperscript{13} Ibid., pp. 27-28.
PROMOTION OF SAFETY AND HEALTH ACTIVITIES. Many authorities believed that the stimulation which would be given to the reduction of industrial accidents was the primary objective of an adequate compensation law.

LOWER OVERHEAD RATIOS. By broadening the insurance basis and reducing the number of litigious issues it was hoped that a higher proportion of premium costs to the employer would reach the injured worker through minimization of legal fees and insurance overhead.

ASSURANCE OF MEDICAL SERVICES AND REHABILITATION. Most of the early laws provided very little for medical service, and the concept of rehabilitation did not emerge until after the First World War. However, it is no longer questioned that these are essential elements of workmen’s compensation.

Other by-products anticipated from adequate workmen’s compensation legislation were the elimination of some of the causes of friction in employer-employee relationships, and the reduction of the public and private relief burden.

Since the adoption of workmen’s compensation laws, efforts have been made to justify their provisions. Downey advanced the doctrine of "occupational risk", the principle that "the risk of economic loss through personal injury in the course of production shall be borne by industry itself". He further contended that the principle applied to occupational diseases as well as to occupational injuries, and that the compensation system should apply to all industries, all persons employed therein, and all personal injuries which arise in the course of the industrial process.¹⁴

Edwin E. Witte, former secretary of the Wisconsin workmen’s

¹⁴ Ibid., p. 21.
compensation commission, has further formulated the principle of "least social cost", which maintains that the justification for workmen's compensation is that it reduces to a minimum the economic loss resulting from industrial accidents.15

The Period of Widespread Adoption of Workmen's Compensation Laws

During the era of the "muckraker" and the birth of the "New Freedom", influential writers dramatized conditions of workers, magazines were filled with stories of working conditions and of society's failure to take care of the injured. In this period of reform, leadership and popular support developed for three related movements--workmen's compensation, industrial safety, and hygiene. Between 1910 and 1915, thirty states enacted workmen's compensation laws.16 Prior to this period, in 1902, Maryland had passed a workmen's compensation law.17 After two years the Maryland law was declared unconstitutional by a Baltimore court and no appeal was taken.18 In 1909, Montana passed a work-

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men's compensation law\(^19\) which was also declared unconstitutional.\(^20\) Nevertheless, the fate of these two earlier laws did not discourage the states.

The investigating commissions which examined the legal relief afforded to the injured employee almost unanimously recommended the abolition of common law defenses and the reliance upon employers' liability statutes in favor of systems of workmen's compensation.\(^21\) These investigations emphasized the fact that the common law had been based upon an untenable assumption that an industrial accident was necessarily due to someone's guilt. Actually they found that a large portion of such accidents were due to the inherent hazards of industry.\(^22\) The investigations also disclosed a number of serious weaknesses in the existing system of providing relief for such injuries: (1) Court actions led to uncertain and inadequate recoveries, for even under employers' liability laws a great majority of injured workers received little or nothing; (2) Court procedures frequently required years to reach a final judgment; (3) the existing system, based on common law defenses, was waste-

\(^{19}\) Montana Laws 1909, Ch. 67.

\(^{20}\) Cunningham v. Northwestern Improvement Co., 44

\(^{21}\) Somers, op. cit., p. 22.

\(^{22}\) Downey, op. cit., p. 8.
ful since less than half of the premiums paid for employers' liability insurance were paid out to workers and a portion of the payments received by a worker was required for attorney's fees; (4) Neither the settlements nor awards paid to workers followed any consistent pattern or standard. All the reports of the investigating commissions in the states recommended one underlying principle; namely, that liability for industrial accidents should be fixed upon the employer regardless of who might be at fault in the accident.

At the 1910 session of the Ohio General Assembly, a resolution provided for the appointment of a commission to inquire into the question of employers' liability and other matters. James H. Boyd, of Toledo, served as chairman of the commission. This commission made a rather extensive survey which was submitted to the General Assembly in three parts at various times during 1911. The commission held thirty-one executive sessions and twenty-seven public hearings throughout the state, at which witnesses representing

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working-men and employers were examined. The commission employed three investigators to make a study of the economic effects of certain types of industrial injuries in Cuyahoga County during the years 1905-1910. The report of this investigation of cases involving fatal injuries showed that only in thirty-six per cent of the cases was any recovery made, and that among those who made a recovery the average amount was $838.61. Approximately one-half of the money paid in settlements went to only twelve per cent of those receiving settlements, while the remaining half went to the other eighty-eight per cent. Approximately one-fourth of the amount recovered was paid out for plaintiff's attorney fees and court costs. The average length of time for making a settlement out of court was eight months, and, for making a settlement through the courts, thirteen and one-half months. A check was made of the dependents of deceased workers, and it revealed that fifty-six per cent of the widows visited, and eighteen per cent of the children, were forced to go to work to earn a livelihood as a result of the industrial accident.

The study commission in January, 1911, submitted to

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26 E. E. Watson, Report to the Legislature of the Investigation Made for the Ohio Employers' Commission (Columbus: F. J. Heer Printing Company, January 11, 1911), Part I, p. 10. Watson was chief investigator for the study commission.

27 Ibid., p. 36; and Boyd, op. cit., pp. 63-68.
the General Assembly a recommended draft bill designed to establish a compulsory system of workmen's compensation operating through an exclusive state insurance fund, and a bill closely patterned after the recommendation was introduced into the General Assembly.

While the Ohio General Assembly was considering the compulsory workmen's compensation bill recommended by the study commission, a similar law in New York was declared unconstitutional. As a result the bill was redrafted and designed to meet the new constitutional difficulties. As redrafted, the workmen's compensation law was passed on May 30, 1911, and became effective January 1, 1912. It was elective in form and applied to employers of five or more employees. It established an exclusive state insurance fund for the writing of workmen's compensation insurance, but it made no provision whereby an employer through regulated self-insurance could acquire the limited liability of the law without insuring through the state insurance fund. The State Liability Board of Awards was created to administer the fund. The board was given jurisdiction to hear and determine all claims for compensation made against

28 Watson, op. cit., pp. 63-77, contains the complete proposed bill.


30 Senate Bill 127, 102 Ohio Laws 72, 1465 G.C.
the insurance fund and was authorized to disburse from the fund to claimants such amounts of weekly compensation benefits and medical and funeral expenses as were indicated by the act. The board also was authorized to classify all employments in the state with respect to their degree of hazard and to fix rates of premiums for each of the classes so created. Any employer of less than five persons could elect to come under the provisions of the act and pay similar premiums.

Employers of five or more persons who did not elect to operate under the provisions of the act were liable in a court action to their employees for damages suffered by reason of personal injury sustained in the course of the employment "caused by the wrongful act, neglect or default of the employer, or any of the employer's officers, agents or employees". In such actions, the defendant could not use the defense of the fellow-servant rule, assumption of risk, or contributory negligence.

As soon as the law was passed, the commercial liability insurance companies and their agents in the state raised the question of its constitutionality, in an effort to dissuade employers from participating in the fund. A test suit was filed, and on January 16, 1912, an opinion was written affirming the constitutionality of the elective act.31

31 State ex rel Yaple v. Creamer, Treasurer 85 Ohio St. 349.
Because of the questions which had been raised by the Ives decision in New York, an election was held in Ohio on September 3, 1912, at which an amendment to the state constitution expressly permitting a compulsory workmen's compensation law was submitted to the voters. This amendment was adopted and became effective January 1, 1913, as Section 35 of Article II of the Constitution.32

For a few years after the adoption of workmen's compensation in Ohio, a controversy between proponents of private insurance versus those of public-operated workmen's compensation insurance raged. In recent years only the insurance agents have been active in seeking legislation in Ohio which would permit private insurance carriers to compete in insuring the employer's obligation. They have received little support from the organized employer and employee groups, or from the insurance companies themselves.

The Industrial Commission as an Independent Agency; 1913-1921

In 1913 the so-called Green Bill was introduced to the General Assembly by State Senator William L. Green (later to be the president of the American Federation of Labor). In his message to the General Assembly, Governor James M. Cox had strongly advocated a compulsory law. The

Green Bill received the indorsement of labor generally throughout the state.\(^{33}\) The act was passed on March 4, 1913.\(^{34}\) The substantive rights and benefits of the covered employee were changed very little, but the compulsory features of the law were applied to all employers of more than five people, and self-insurance was permitted. A few days later, the General Assembly passed another law\(^{35}\) which created the Industrial Commission of Ohio and provided that on or after September 1, 1913, the commission would supersede the State Liability Board of Awards.

By the end of 1914, the Industrial Commission had established divisions of auditing, rating, and claims for the purpose of handling its functions under the workmen's compensation law.\(^{36}\)

The Industrial Commission Within the Department of Industrial Relations: 1921-1934

In 1921, the legislature passed the so-called Administrative Code designed to increase the administrative powers of the governor by consolidating all the administrative operations of the state government into a limited number of

\(^{33}\) Ibid., p. 71.  
\(^{34}\) 103 Ohio Laws 72, 1465 G.C.  
\(^{35}\) 103 Ohio Laws 95, 871 G.C., passed March 12, 1913.  
departments, each under a director directly responsible to the governor. As a part of the state-wide reorganization, which became effective July 1, 1921, the Industrial Commission became a part of the Department of Industrial Relations.37 "All clerical, inspection and other agencies for the execution of the powers of the Industrial Commission" were vested in the Department of Industrial Relations. The Industrial Commission retained and continued to exercise those judicial and legislative powers which had been given it under the workmen's compensation act. The principal function of the commission was to act as an administrative court on claims under the workmen's compensation act. Among its regulatory functions were the powers to formulate rules and to make requirements for the installation of safety devices for the protection of employees. The reorganization followed closely the recommendations of a legislative Joint Committee on Administrative Reorganization.38 The commission was made a part of the department through the device of making the Director of Industrial Relations the ex officio secretary of the commission.

The work of the commission and its staff consisted of

37 House Bill 249, 109 Ohio Laws 105, 154-45 G.C.

38 Report of the Joint Committee on Administrative Reorganization Pursuant to the Senate Joint Resolution No. 36, adopted by the General Assembly of Ohio, April 9, 1919 (Columbus: The F. J. Heer Printing Company, 1921).
the adjudication of contested claims against the state insurance fund, surveys to determine the cause of time lost in non-fatal compensation claims, actuarial work in connection with the fund, extension and revision of the merit rating system, auditing work with regard to the payment of premiums and accident prevention work. 39

In some of the earlier efforts of the commission to punish employers for infractions of safety regulations, a question arose over its legal right to assess additional penalties for the violation of specific safety regulations. In 1924, Article II, Section 35 of the Ohio Constitution was amended so as to permit such penalties. The following year the legislature established a "safety bureau" within the Industrial Commission. The function of this unit was to implement the new powers given by the constitutional amendment. 40

Events Leading to the Reestablishment of the Commission as an Independent Agency

Economic conditions in the late 1920's and early 1930's caused a questioning of the future ability of the state insurance fund to pay workmen's compensation claims.

39 First Annual Report of the Department of Industrial Relations of Ohio for fiscal year July 1, 1921 to June 30, 1922, pp. 3 ff.

40 Amended Senate Bill 238, 111 Ohio Laws 226-227, 1465-98a G.C.
This situation was dramatized by actuarial reports and legislative investigations in the early 1930's, which led to the removal of the Industrial Commission from the department and to its restoration as an independent agency, in May, 1934. The first indication of the developing condition appeared in the sixth annual report of the department, which stated:

Probably no business is more sensitive to or more accurately reflects industrial conditions in Ohio than does the state insurance fund. . . . Whenever there occurs a general industrial depression or an appreciable slowing up of industrial activities throughout the state, a reaction is noticeable.

. . . There were . . . 553 more cancellations in the year covered by this report than in the year immediately preceding . . . .

These facts in our opinion show a sagging in industrial lines in the year just ended, which did not call for an indefinite suspension of business by a large number of employing concerns, but which caused a general curtailment of production and employment.

It is interesting to note that while there has been a decrease in the amount of premiums collected, compensation payments increased approximately $658,000.41

During the next several years the premiums received by the fund continued to decrease and the disbursements continued to increase. The first deficit of $61,274 was reported for

41 Sixth Annual Report of the Department of Industrial Relations of Ohio for fiscal year July 1, 1926 to June 30, 1927, p. 8.
the fiscal year of 1929-30. In the next year, disbursements from the state insurance fund exceeded receipts by the vastly increased amount of $2,160,274.13, even though the number of claims filed had decreased from 234,314 to 185,075, or more than thirty per cent. As a partial explanation of this it was said:

A period of depression develops conditions that serve to increase disbursements, such as giving previously injured workers who had been able to resume employment in a more or less crippled condition but during the depression are unable to obtain employment, an opportunity to make claim for the remaining compensation due them as a result of their injury. It is also found that physicians, hospitals, etc., now have time in which to check up their records and file bills for services rendered during periods of high industrial activity, which they had previously overlooked.

As a result of the increase in disbursements from the fund, effective July 1, 1931, the average basic rate level was increased approximately ten per cent. The commission listed as one of the causes for the increase the "increased liberality in the interpretation of the law by the courts on appealed cases previously disallowed by the commission".

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One year later it was necessary to raise the average basic premium rate level approximately seventeen per cent. In the last report made on workmen's compensation by the Department of Industrial Relations reference was made to another actuarial audit of the fund by Miles M. Dawson, consulting actuary. On the basis of Dawson's recommendations, premium rates were raised approximately another 28.8 per cent over the previous year. The actuarial audit by Dawson in 1933 found the state insurance fund to be solvent. However, during the five years 1929-33 the excess of disbursements over receipts was slightly more than $17,000,000. In November, 1934, another actuarial audit was made of the fund by Richard Fondiller for the Governor's (White) Investigating Committee. He reported that prompt and vigorous action was necessary if the fund was to be put in a sound financial condition.

In addition to these actuarial surveys for the commission itself and for the Governor's Committee, both the Ninetieth and Ninety-First General Assemblies conducted investigations of the workmen's compensation act and of the

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45 Eleventh Annual Report of the Department of Industrial Relations of Ohio for fiscal year July 1, 1931 to June 30, 1932, p. 15.

46 Twelfth Annual Report of the Department of Industrial Relations of Ohio for fiscal year July 1, 1932 to June 30, 1933, p. 69.

47 Dodd, op. cit., p. 551.
state insurance fund. Also in 1935 the Ohio Government Surveys, under the supervision of Colonel Sherrill, acting at the request of Governor Davey, conducted an investigation of the subject. The number and the character of these investigations is an indication of the general concern at the time with the administration of the workmen's compensation Act.

The second of the legislative investigations placed a large share of the blame for the condition of the state insurance fund upon the Revised Merit Rating System, which was adopted on December 31, 1927 by the actuary of the fund. This system greatly reduced the rate of premiums. The last full year of operation of the fund under the previous system, which was the fiscal year 1927, produced a surplus of $903,000, while the first year of operation under the Revised Merit Rating System, which was the fiscal year 1929, produced a deficit of $287,000. This report quoted the actuary as admitting that it was true that a sufficient surplus had not been maintained during the prosperous years, but that the reason was the constant pressure exerted by large and influential employers' groups for lower premium rates.48

The preliminary report of the investigating committee appointed by Governor White in 1934 concluded that under the

48 Report of Subcommittee on Workmen's Compensation, Created Under Authority of Senate Resolution No. 69, Ninety-First General Assembly, issued by Ohio Senate, 1935.
act of 1921 the responsibility for the administration of the workmen’s compensation law had been divided. This situation had proved unsatisfactory even though the Director of Industrial Relations and the Industrial Commission had sought to cooperate with each other. The investigating committee recommended that the portion of the Administrative Code of 1921 dealing with workmen’s compensation be repealed and that the administration of the workmen’s compensation law be restored to the Industrial Commission, giving it sole power to select, appoint, prescribe the duties of, control, promote, supervise, and remove its employees, and to fix their salaries or compensation. The recommendation for change was concurred in by the Director of Industrial Relations. The Second Special Session of the Ninetieth General Assembly, on May 3, 1934, restored all administrative control to the Industrial Commission. An emergency clause in the bill made it effective May 15, 1934.

The governor’s committee had also recommended that the function of the commissioners should be primarily the investigation and adjudication of claims, the making and enforcement of laws and regulations, general supervision, and the consideration of policies, and that all other duties and

49 Dodd, op. cit., pp. 791-792.

50 House Bill 110, 115 Ohio Laws (part 2) 242-244, 154-45 G.C., 4121.12 Revised Code, henceforth referred to as R.C.
responsibilities should be assigned to a manager especially qualified for the duties by experience, competence and temperament, and that his tenure should be permanent unless disqualified for just cause.\textsuperscript{51} However, no provision for such a permanent general manager was made by the Act of 1934.

From 1934 until 1955 all authority under the workmen's compensation act centered in three members of the Industrial Commission. In 1955, the General Assembly created a Bureau of Workmen's Compensation and transferred many administrative functions to the Administrator of this Bureau. This will be discussed more fully in later chapters.

In adopting a workmen's compensation law the legislature abandoned the old common law methods of basing payments to disabled workers upon the results of negligence suits in court, and substituted a new policy of liability without fault upon the part of the employer. By adopting a separate administrative agency, the legislature attempted to establish a mechanism which could balance the respective rights and responsibilities of the employer, employee, and general public more speedily than the courts, while at the same time demonstrating the essential fairness and justice to the parties involved, and to the general public, which

\textsuperscript{51} Dodd, \textit{op. cit.}, p. 792.
has characterized the operation of the courts under the common law.

The adoption of the workmen's compensation law was the culmination of an effort to balance several interests. From the standpoint of the employer the purpose of the law was to spread his risk among employers collectively and to make the amount of its annual cost more predictable, while at the same time improving labor relations. From the standpoint of the worker the law was meant to assure fast and sure payment of legislatively-determined benefits. The general public was to be served by a decrease in the number of public charges resulting from industrial disabilities and by a decrease in the number of industrial injury suits on the court dockets.

The alternatives to the system of workmen's compensation as established by the legislature and maintained for more than forty years would be a change either in the direction of a return to a system whereby the rights of all three groups would be established by a combination of common and statutory law operating entirely through the regular courts, or else a change in the direction of abolishing all common law rights and having administrative decisions without any form of judicial review. The extent to which the present arrangement, which substitutes an administrative agency operating primarily under administrative law for a court system under common law, should be retained depends primar-
ily upon whether or not the workmen's compensation system achieves the public policies sought by its proponents. There have been two full swings of the pendulum between basing the administration of the system upon either a multiple executive or a single executive. This would seem to indicate that the organizational form alone does not assure achievement of the public policies sought when the system was adopted. Under any form of organization it is necessary that the rights of all parties affected be disposed of with efficiency and equity before the principles of workmen's compensation can be defended against alternate proposals for balancing the various public interests involved by industrial disabilities. It is against this backdrop of the public policies sought in the adoption of the workmen's compensation principle that the question of whether optimum efficiency and equity of administration have been achieved needs to be examined.
CHAPTER II

COVERAGE AND BENEFITS
UNDER THE OHIO WORKMEN'S COMPENSATION LAW

A. COVERAGE

The extent to which various employers, employees, and types of disabilities are covered by the workmen's compensation system and the amount of the benefits due are determined by the state legislature. The proportion of workers in the state covered by the provisions of the workmen's compensation act affects the volume of claims reported, and the volume of claims affects the mechanism needed for the investigation, determination, hearing and appeal of claims by the agency administering the workmen's compensation law. Special procedures are needed for the separation and processing of claims made by the employees of (1) employers insured by the state insurance fund, (2) self-insured employers, and (3) non-complying employers. This chapter will be concerned primarily with the first of these three categories of claims. The other two categories will be covered in APPENDIX A.

The amount of benefits available to the disabled worker creates few administrative problems beyond the mathematical problem of increasing the amount of payments to be made from the state insurance fund and adjusting the amount
of premiums charged the state-fund employer. Nevertheless, the benefit structure has constantly been a subject which has held the interest of labor groups. In the agreed bills which have been developed by the Ohio Manufacturers Association and the unions, the amount of benefits has been one of the chief points for negotiation, continually since 1911.

Excluded Employments

The only exclusion of employers in Ohio is in terms of the number of employees of the same employer. Thirty-one states make such exclusions. The majority of the states draw the line at either three or five employees, although the number ranges from two in Oklahoma to fifteen in South Carolina. The original compulsory law in Ohio placed the dividing line at five employees. In 1924, the number was reduced to three. Even though domestic servants and agricultural employees are not expressly excluded from coverage under the law, this section has the effect of denying coverage to most of them.

These exclusions have generally been explained on the grounds of administrative difficulty in reaching small employers. However, there is not complete agreement on this

1 Somers, op. cit., p. 46.

2 1465-60(A)2 G.C.
Somers' point. Somers concludes that, if the law is conscientiously enforced, the administrative difficulty of watching a large number of small employers creates as much administrative work as checking to see that all employers are properly insured or self-insured. Another factor is that insurance companies have shown a reluctance to underwrite the small employer. They claim that the overhead cost of selling and servicing him is out of proportion to the premium he pays (even though higher rates are charged small policyholders), that he fails to take adequate safety measures, and that he frequently fails to keep adequate payroll records upon which to base the premiums.

The only expressly excluded class of employee in Ohio are blind persons in certain circumstances. By a 1919 amendment, a blind employee may waive in advance any compensation which might otherwise become due him for any injury because of blindness. In such cases the Industrial Commission had the right to adopt and enforce rules governing the employment of such persons and to inspect their places of employment. This was designed to meet a reluctance of employers to hire blind people.

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3 Somers, op. cit., pp. 46-47.
4 Loc. cit.
5 House Bill 424, 108 Ohio Laws 324, 1465-94 G.C.
Excluded Injuries

Even when the employer and the type of employment are covered, there are still several requirements with regard to the injury itself which must be met before the worker's right to compensation can be established. First, the disability must be the result of conditions which come within the act's definition of an "injury" or be classifiable as an "occupational disease" within the meaning of the statute. Secondly, there is the problem of whether the disability arose "out of and in the course of the employment". Lastly, there are the requirements that the worker make his claim within the time limits specified and that the disability be of sufficient duration so as not to be barred by a waiting period.

The wording of the acts of the different states varies, but many contain some such phraseology as "accidental injury" or "personal injury". In cases where a blow is received by the body and definite physiological changes result, it easily can be classified as an accidental injury. At the other extreme, many diseases are easily classified as such rather than as injuries. However, in between there are many conditions which are difficult to classify as one or the other.

Two forces have been at work in the direction of expanding coverage for the worker in these borderline areas. Most legislatures have liberalized the original laws, es-
pecially in the direction of expressly covering many, or all, occupational diseases. In addition, the statutory terms have been subject to constant judicial expansion.

The courts have been quite liberal in extending coverage to situations in which death or disability results from the aggravation of a pre-existing condition, such as a heart attack while on the job or the manifestation of some latent disease. As a general pattern the courts require that there be a substantial aggravation of the pre-existing condition beyond its natural progress, that this must have arisen out of and in the course of the job, and that the aggravation must have resulted from some specific incident or injury as defined by the act.6 Thus if a man who has a latent heart condition and who normally does only clerical work is called upon to help move new office furniture and shortly thereafter has a heart attack, it would generally be sustained by the court as coming within the definition of an injury.

It is in the area of aggravation that there is the possibility for considerable overlapping between workmen's compensation benefits and other forms of old-age benefits, since it is the aged who are most likely to have conditions which can become aggravated by their work. Much of the law of aggravation was developed by the courts before the adop-

6 Somers, op. cit., pp. 48-49.
tion of the other forms of social insurance. Inequities may arise if some older workers are able to obtain two different types of compensation and others are not. England has settled this problem by including workmen's compensation with the other forms of social insurance in a comprehensive law.

**Occupational Diseases**

Shortly after the beginning of the operation of the workmen's compensation laws, it became apparent that occupational diseases created a specialized situation. The Massachusetts law was the only one which covered occupational diseases from the beginning. In 1917, California and Wisconsin followed suit, and by 1954 all but two of the states had made some provisions for occupational diseases. Some of the states enumerated certain diseases as being covered, whereas others gave so-called blanket coverage to all occupational diseases. In 1921, Ohio expanded its law to cover certain listed occupational diseases. From time to time other diseases were added, and in 1939 a blanket provision was added to cover all diseases "peculiar to a particular industrial process, trade or occupation and to which an employee is not ordinarily subjected outside of or

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7 Ibid., pp. 49-50.
8 House Bill 47, 109 Ohio Laws 181.
"Out of and in the Course of Employment"

Drafters of the workmen's compensation acts did not intend that they cover injuries not related to the employment of the worker, such as an injury while at home or on vacation. For that reason the acts required that the injury occur while the employee was at work and also that it be directly related to his work. The phrase most often used in the acts is "out of and in the course of employment". The interpretation of this phrase probably has been the most troublesome problem of the courts in relation to workmen's compensation laws. Most jurisdictions have built up a large body of judicial interpretation of the meaning of the words, with a great variation among jurisdictions. Interpretations are called for in such cases as where an employee is injured on the way to or from work, or during the lunch hour; where the injury is the result of horseplay on the part of other employees or of himself, or where the injury is the result of intoxication or willful misconduct on the job.

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9 Amended Senate Bill 297, 118 Ohio Laws 425, 1465-68a G.C.

Exclusion of Claims Not Filed in Time

All states set up time limits for filing a claim after an accident. There is considerable variation from state to state. The Ohio act as originally passed contained no such time limit, but in 1919 a two-year limit was adopted.11

Exclusion of Short-Period Disabilities

Most states require a "waiting period" before an employee is entitled to compensation payments for time lost from the job. In Ohio the period is seven days, which is the most common among the states. The general purpose of the waiting period is to lighten the administrative load so that a lot of small checks will not have to be issued.

In 1951, the act was amended so that in cases where disability lasts more than five weeks the compensation will be paid retroactively for the first week, the so-called waiting period.12

B. BENEFITS

Types of Benefits

There are three types of compensation benefits in workmen's compensation: (1) cash, (2) medical, and (3) re-

11 House Bill 424, 108 Ohio Laws 319, 1465-72a G.C.
12 Amended Senate Bill 249, 124 Ohio Laws 812, 1465-78 G.C.
habilitation. They are available to the injured worker or
his dependents, in case of death. Most of the original
benefits were cash. However, today, medical benefits repre-
sent about one-third of the total. Rehabilitation benefits
are still small, but they may become much greater as laws
are expanded in this area.\(^\text{13}\)

**Cash Benefits**

Benefits are paid for four types of compensable in-
juries: (1) A temporary-total disability is one in which
the claimant is totally incapacitated from work, but is
later able to return to work without any permanent impair-
ment. (2) A permanent-total disability is one whereby the
injury totally and permanently disables the worker from per-
forming gainful employment. In most states double amputa-
tions and blindness are automatically considered to be in
this category. (3) A permanent-partial disability involves
the permanent loss of some part of the body, or the loss of
use thereof, in any degree less than permanent-total dis-
ability. (4) Fatalities.

The questions of the extent and the specific amount
of benefits under a workmen's compensation system have been
controversial from the beginning and probably will continue
to be so indefinitely. In this report no effort will be

\(^{13}\) Somers, *op. cit.*, p. 59.
made to deal with the general problem of the adequacy of benefits, except in the most general terms. From the beginning, benefit rates have been low. Two factors at work here were the fear that the payment of benefits comparable to the worker's regular pay would encourage malingering and that high benefits would put too great a burden on industry. Each state has tended to feel that, if its rates were much higher than those of comparable industrial states, its own industry would be put to a competitive disadvantage.

Most of the benefits provided by the Ohio act are found in Section 80 (1465-80 G.C.). The 1912 act provided for the payment of two-thirds of the weekly wage up to a maximum payment of twelve dollars. The same provisions were made for permanent-total disability, temporary-total disability and temporary-partial disability. In the latter two categories (and also in the case of a death claim) there was a ceiling of $3,400 as total compensation. In the case of persons totally and permanently disabled, the weekly payments were to be for the rest of their lives. The act also provided a maximum of $150 for funeral expenses and $200 for medical expenses.

The original act made no provisions for the payment of compensation in the cases of permanent injuries which only partially disabled the worker. However, in 1914 a permanent-partial section was added in the form of a schedule relating to the loss of the sight of one eye or
the loss of the members of the body. A worker with such a permanent-partial injury received two-thirds of his weekly pay, up to the maximum weekly award, for a specified number of weeks (for two hundred weeks for the loss of an arm; 175 weeks for the loss of a leg; 150 weeks for the loss of a hand; 125 weeks for the loss of a foot; and one hundred weeks for the loss of an eye). The length of time of the weekly payments had no legal relation to the time when the injured worker was able to return to his old job or some other job.

The benefit rates have been increased twelve times since 1912. In 1955, the amount of the weekly maximum payment was raised from $32.20 to $40.25.\footnote{Amended Substitute House Bill 700.}

**Permanent-Partial Disability Benefits**

One of the thorniest problems with which the General Assembly has had to deal has been that of the benefits which are to be paid for permanent-partial disabilities. In the earlier days, the schedule of specific injuries listed in the statute gave specific entitlements, as for the loss of a leg. There was also a provision that if there were economic loss, as where the permanently injured man had to return to lighter and lower-paying work, a portion of the difference in income would be paid from the
state insurance fund by way of compensation. However, these provisions did not cover the situations where there might be a permanent injury, such as to the head or the back, which would not be covered by the schedule. If the worker were able to return to work at the previous wage, he would have no entitlement under the act. In 1941, Section 80b was added to the act, which permitted the rating of such an injury on the basis of a percentage of disability to the body as a whole and payments accordingly.\textsuperscript{15} At every subsequent session of the legislature, this section has brought forth a battle between employers and unions. The details of the section have been shifted back and forth countless times. No effort will be made in this report to follow the many changes made to this section. In essence, the employers argue that compensation should be paid only for actual economic loss, whereas representatives of employees maintain that where there has been a permanent injury there should be some money payment, more or less as damages, even though the worker returns to the same work and same pay. This problem will be dealt with at greater length in APPENDIX C.

**Benefits for Permanent-Total Disability**

When a claimant has been determined to be permanently and totally disabled for life, he is paid in accord-

\textsuperscript{15} House Bill 558, 119 Ohio Laws 570, 1465-80b G.C.
ance with the benefits applicable at the time of the accident. Thus some claimants have received weekly payments for years at a benefit rate much lower than the current rate. With rising costs of living, hardship cases developed. In an effort to meet this problem, a separate Disabled Workmen's Relief Fund was created in 1953, from which supplemental payments could be made to those permanently and totally disabled. The money for the operation of this new fund came from the state treasury, since there were actuarial objections to having it taken from the state insurance fund.16

Death Benefits and Dependency

The law as originally passed permitted the recovery of death benefits by the dependent only when death occurred within two years after the injury. In 1921, this was changed to permit recovery when the disability had been continuous for more than two years before the death, provided the death was attributable to the injury.17

In the early depression days, the status of the dependents of a deceased injured employee was clarified. Any child under sixteen, living with the parent or for whose

16 Ibid., pp. 508-509, 4123.412-418 R.C.
17 House Bill 378, 109 Ohio Laws 291, 1465-80 G.C.
support the parent was legally liable at the time of his death, was a dependent. 18

In the area of dependency, a presumption was established that surviving natural parents with whom the decedent was living at the time of his death are entitled to receive a total minimum award of $1,000. Provision was also made that the commission could take into consideration any circumstances which, at the time of the death of decedent, clearly indicated prospective dependency on the part of the claimant and potential support on the part of the decedent. 19 These were designed primarily to cover unusual situations where unmarried workers were still living with their parents. Otherwise no one could have qualified as a dependent and nothing would have been owed from the state insurance fund in such cases.

Methods of Figuring the Weekly Wage

For those persons whose wage is low, two-thirds of the weekly wage is less than the maximum weekly cash payment permitted. During the depression many people were working only a part of the year. Therefore, their average weekly wage for an entire year would often be much lower than the

18 Amended Senate Bill 186, 114 Ohio Laws 37, 1931, 1465-82(d)2 G.C.
19 Substitute House Bill 69, 117 Ohio Laws 111-112, 1937, 1465-82(D)2 G.C.
wage they were being paid at the time of injury. By an amendment in 1937, compensation payments were to be based upon the full weekly wage at the time of injury for the first twelve weeks of disability, and after that they were to be based on the average annual wage. 20

Medical Benefits

Since 1917, it has been possible to spend more than the $200 medical limits provided for in the original workmen's compensation law, provided the express permission of the Industrial Commission was obtained. 21 As a matter of routine the commission would grant this when requested. In 1949, all medical limits were abolished, 22 thus relieving the commission of the paper work involved in granting permission for medical expenses in excess of $200.

Duration of Benefits

In the workmen's compensation law as it originally was written, there was no time limit upon the reopening of a claim when there had been a re-occurrence of disability or of the need for medical benefits after the claimant had recovered and returned to work. During the depression days

20 Amended Substitute House Bill 80, 117 Ohio Laws 252-253, 1465-84 G.C.
21 Senate Bill 69, 107 Ohio Laws 528, 1465-89 G.C.
22 Amended House Bill 531, 123 Ohio Laws 257, 1465-89 G.C.
there were instances in which a worker might be released from employment because of some residual disability which had not prevented his returning to work after the period of total temporary disability. In 1931, a time limit of ten years was placed on the reopening of claims. In other words, at the end of ten years after the date of the last payment of compensation or for medical benefits, the claimant's rights expired. If no payments had been made, the claimant's rights expired ten years after the date of the injury.

The determination of the extent of benefits under the workmen's compensation law is primarily the type of political problem that can best be decided by a body of elected legislators. Several factors influence the result of the decision of the legislators. They must consider the needs of the disabled worker and his dependents or survivors. But they must also consider the possibility of placing too great a financial burden upon the industry of the state to the extent that it will be put at a serious disadvantage in competing with the industry of other states with a lower benefit scale.

In the early days, there was considerable fear of encouraging malingering. Because of the low benefit rates

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23 Amended Senate Bill 186, 114 Ohio Laws 38, 1465-86 G.C.
adopted, this fear has not been borne out. Exact figures are not available of the percentage of wage loss which is met by workmen's compensation payments. In 1954, the Social Security Administration estimated that approximately two-thirds of the wage loss in temporary disability cases was being left unmet and that an even greater proportion was being left unmet in cases involving fatally and permanently injured workers.24

Unions have tended to enter into direct negotiations with employers for the inclusion of additional occupational disability benefits in wage contracts. These additional benefits are paid directly to the worker in addition to his workmen's compensation benefits. This procedure has relieved some of the pressure for the alteration of the workmen's compensation benefit structure through legislation.

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CHAPTER III

THE POWERS AND ORGANIZATION OF
THE OHIO INDUSTRIAL COMMISSION: 1954

Legislation in 1934 placed all administrative, judicial and regulatory powers under the workmen's compensation law of Ohio in the hands of the three members of the Ohio Industrial Commission. Over a period of years, a staff of some seven hundred employees was developed to assist the commissioners in the exercise of their powers. The members of the commission had the responsibility for administering three main programs: compensation, prevention of disabilities through safety activities, and rehabilitation. This paper deals primarily with the first of these programs.

Compensation relates to furnishing medical services and making money payments to replace lost wages in part in cases of occupational disability. In administering this program the members of the commission had powers to adjudi-

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1 It is a common practice for persons who deal with the Ohio workmen's compensation system to refer to the entire organization as the Industrial Commission. An effort is made in this Chapter to distinguish between the three-member commission and the entire agency. In later Chapters, unless otherwise indicated, the words Industrial Commission will be used to indicate the entire agency.
cate claims for workmen's compensation benefits and to manage the state insurance fund.

Safety activities are designed to aid in preventing accidents by educating employers and employees of the dangers inherent in certain work practices and by developing and publicizing safety equipment. Increased knowledge of occupational diseases has also led to the development of industrial hygiene for their prevention. In Ohio these two are administered jointly. Rehabilitation has been developed much more recently. It seeks to restore the economic capacity of the disabled person through re-training or the use of artificial appliances. The activities of the commission, as an agency, have been primarily in the areas of compensation and safety. Although some recognition is given by the workmen's compensation law to rehabilitation, the commission has served primarily as a referral agency for disabled employees who could profit from rehabilitation work performed by other agencies of the state government. No direct rehabilitation work has been performed by the commission, as an agency.

A. THE POWERS OF THE INDUSTRIAL COMMISSION

Some of the work performed by the Industrial Commission, as a three-member body, was purely administrative, involving supervision of programs of operation and establishment of policies in the area of insurance fund management,
compensation payment, and safety work. In addition, the three commissioners had powers to promulgate regulations and to adjudicate claims for compensation.  

Some of the powers the three commissioners had were clearly administrative in nature, such as the right to employ its personnel, assign them their duties, and supervise their work, or to submit reports annually to the governor.

Among the more definitely legislative activities of the commissioners were: (1) the power to make, and sometimes to enforce, safety rules, and (2) the power to set the premium rates charged for workmen's compensation insurance by the state insurance fund. Included in this latter function of rate-fixing was the work of classifying occupations and industries in accordance with the hazard involved in their performance, which, in turn, had a bearing upon the premium rate per $100 of payroll involved.

It is difficult to draw an exact line between those functions of operating a workmen's compensation system which are administrative and those which are judicial. Dodd treats as administrative the enforcement of requirements that accidents be reported, the investigation and approval

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2 Unless otherwise indicated, the discussion of the powers and organization of the Industrial Commission will be those which existed during the summer of 1954, when they were studied.

of agreements to settle uncontested claims, supervision to insure that periodic payments are made in accordance with prior agreements or awards, and supervision of self-insurers to make sure that there is financial security for the obligations they assume. Somers adds: the dissemination of information and publicity, supervision of uncontested claim settlement, supervision of rehabilitation provisions, promotion of safety and industrial hygiene, and the collection and analysis of complete records of accidents, claims, settlements and benefit payments.

More clearly judicial in nature is the action of the administrative body in passing upon contested claims, the approval or disapproval of compromises or lump sum settlements, and the reviewing of compensation awards for increasing, diminishing, terminating or otherwise modifying previous awards. This involves notice and hearing in accordance with the application of due process to administrative agencies. The activity of approving or disapproving the request of an employer to operate as a self-insurer is probably more nearly judicial than administrative.

Powers to Determine Claims for Workmen's Compensation Benefits

The members of the commission had the power to re-

4 Somers, op. cit., p. 143.
5 Dodd, op. cit., p. 101.
ceive claims for benefits under the workmen's compensation law, to investigate them and to adjudicate them subject to judicial review. Most claims received for such benefits were against the state insurance fund. Also, the commissioners had power over the relations between a self-insurer and its employees. The commissioners had a right to receive reports from the self-insurer of all occupational disabilities in excess of seven days' duration and of the disposition made of them. In any cases where a disagreement arose between the self-insurer and the employee, the latter had the right to apply to the commissioners for a determination of his entitlement.

Upon occasions, employers who were affected by the provisions of the workmen's compensation act of Ohio failed to become insured by the state insurance fund or to qualify as self-insurers. The employee of such a non-covered employer had an election of suing the employer in a civil action under the state employers' liability act, or of receiving benefits under the workmen's compensation law on the same basis as he would have received them had the employer been covered. If he elected to take his rights under the workmen's compensation act, the commission had the power to determine the claim in the same manner as any other claim.6

6 The procedures followed by the agency in processing claims against self-insured and non-complying employers are covered in APPENDIX A.
The commission had power over all employees of the agency engaged in the determination of claims, and had the right to determine its own rules of procedure. It could issue subpoenas, hold hearings, and regulate practice before it. Various authorities relating to these functions are listed in TABLE I (page 65, Infra).

Powers of Insurance Management

The employers of Ohio are permitted to insure their financial responsibilities under the workmen's compensation act. For this purpose the state insurance fund, in which employers may participate, was created by legislation and placed under the management of the members of the Industrial Commission.\(^7\) The constitutional sections permitting workmen's compensation legislation provide for such an exclusive state fund and mention that it will be administered by a "board". This word has cast doubt upon whether the management of the state insurance fund can be given to a single administrator by legislation. Legislation has provided that separate funds be established for public-employees, public-works-employees, and occupational-disease claims, in addition to the fund which handles all other claims. This is primarily a bookkeeping distinction, and, unless otherwise

\(^7\) Under certain circumstances an employer may qualify to operate as a self-insurer. However, private insurance carriers are not permitted to sell workmen's compensation insurance in the state.
### TABLE I

**JUDICIAL POWERS OF INDUSTRIAL COMMISSION, 1953**

<table>
<thead>
<tr>
<th>Power To:</th>
<th>G. C. Section</th>
<th>R. C. Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administer oaths, etc.</td>
<td>1465-47</td>
<td>4123.08</td>
</tr>
<tr>
<td></td>
<td>871-30</td>
<td>4121.15</td>
</tr>
<tr>
<td>Adopt rules of procedure</td>
<td>871-10</td>
<td>4121.11</td>
</tr>
<tr>
<td>Appoint special prosecutor</td>
<td>871-36</td>
<td>4101.09</td>
</tr>
<tr>
<td>Apportion compensation in injury and occupational disease claims, when</td>
<td>1465-68c</td>
<td>4123.70</td>
</tr>
<tr>
<td>Authorize therapeutic treatment of occupational diseases of respiratory tract, when</td>
<td>1465-80d</td>
<td>4123.57(D)</td>
</tr>
<tr>
<td>Cause depositions of witnesses to be taken</td>
<td>1465-50</td>
<td>4123.09</td>
</tr>
<tr>
<td></td>
<td>871-32</td>
<td>4121.20</td>
</tr>
<tr>
<td>Commute payments of comp. to lump sums</td>
<td>1465-87</td>
<td>4123.64</td>
</tr>
<tr>
<td>Compel attendance</td>
<td>1465-87</td>
<td>4123.64</td>
</tr>
<tr>
<td>Compromise action against non-complying employer</td>
<td>1465-85</td>
<td>4123.62</td>
</tr>
<tr>
<td>Consider age and experience of employee in fixing average weekly wage</td>
<td>1465-84</td>
<td>4123.75</td>
</tr>
<tr>
<td>Determine whether injury, disease or death resulted from failure to comply with specific requirement</td>
<td>Const. Art. II Sec. 35</td>
<td></td>
</tr>
<tr>
<td>Enjoin operation of non-complying employer</td>
<td>1465-75a</td>
<td>4123.79</td>
</tr>
<tr>
<td>Exercise discretion in fixing average weekly wage, when</td>
<td>1465-84</td>
<td>4123.61</td>
</tr>
<tr>
<td>Fix attorney fees</td>
<td>1465-111</td>
<td>4123.06</td>
</tr>
<tr>
<td>Hold hearings</td>
<td>871-5</td>
<td>4121.06</td>
</tr>
<tr>
<td>Issue subpoenas</td>
<td>871-30</td>
<td>4121.15</td>
</tr>
<tr>
<td>Make investigations</td>
<td>1465-47</td>
<td>4123.08</td>
</tr>
<tr>
<td>Make rules to prevent solicitation</td>
<td>1465-111</td>
<td>4123.06</td>
</tr>
<tr>
<td>Modify former findings or orders, when</td>
<td>1465-86</td>
<td>4123.52</td>
</tr>
<tr>
<td>Pay compensation due and accrued at the time of death, when</td>
<td>1465-83</td>
<td>4123.60</td>
</tr>
<tr>
<td>Permit employers to pay compensation direct, when</td>
<td>1465-69</td>
<td>4123.35</td>
</tr>
<tr>
<td>Revoke finding as to permanent total disability, notwithstanding judgment, when</td>
<td>1465-90</td>
<td>4123.51</td>
</tr>
<tr>
<td>Suspend representatives from practice</td>
<td>1465-111</td>
<td>4123.06</td>
</tr>
</tbody>
</table>

pertinent, they will all be referred to collectively as the state insurance fund.

The three commissioners were granted the power to set the premium rates, to classify occupations as to the risk involved, to collect the premiums from all employers covered by the act (except qualified self-insurers), and to disburse funds from the state insurance fund as directed by the workmen's compensation law. Much of the legislation on workmen's compensation in Ohio has related to the details of the management of the state insurance fund.

In an effort to make employers more safety conscious a system of experience-rating, or merit-rating, was established. Under it the premiums of employers in the same classification, on the basis of risk, would vary up or down on the basis of the number and size of the awards which had been made to their respective employees. The introduction of the experience-rating gave employers a greater stake in the results of claims, which has had an effect upon the adversary nature of the processing of claims and the amount of litigation of claims before the commission.

**Safety Powers and Procedures of the Industrial Commission**

The members of the Industrial Commission had the power to make regulations designed to prevent industrial accidents and to promote industrial hygiene. However, the
enforcement of these regulations remained with the Department of Industrial Relations when the commission was separated from that department in 1934. The powers of the commission, or its staff, are limited to making inspections and suggestions to employers.

In 1914, the members of the commission entered upon active accident prevention work with the appointment of a safety engineer. All statistics relative to the frequency and severity of industrial accidents were centered in the actuarial section of the commission's staff, making it possible for employers to compare the accident experience of their operation with that of similar operators. Records showing unusually high frequency and severity rates were investigated.8

Under a 1925 amendment to the state constitution a safety fund was established for the support of this work. A portion of all premiums paid, not to exceed one per cent, was put into this fund and self-insurers made comparable contributions. This constitutional amendment also provided that in cases in which a disability was the result of the employer's violation of a specific, as distinguished from a general, safety regulation, the disabled employee might apply for a supplemental award of from fifteen per cent to

fifty per cent of the basic award. These penalty awards were given a separate hearing.

The administration of the safety program primarily was delegated by the members of the commission to the safety and hygiene section of its staff, which was the one segment of the workmen's compensation administration specifically provided for by legislation. A large portion of the staff of this section operated in the field rather than in Columbus. The equipment of the safety and hygiene section was used for processing statistical data from application forms in 1954. Occasionally, the determination of a claim for a supplemental award for the violation of a specific safety regulation was referred to this section for an investigation of the working conditions by a safety engineer. However, beyond these two things most of the safety work was peripheral to the problems of determining compensation claims.

B. TYPES OF ORGANIZATIONS FOR ADMINISTERING WORKMEN'S COMPENSATION LAWS

Although the organization established to administer the workmen's compensation law has varied considerably from jurisdiction to jurisdiction, a few patterns have emerged. Some few states have not established an administrative organization, but have relied upon the courts for the enforcement of the law. Most states have established some form
of administrative agency headed either by a single person or by a multi-member board or commission.

**Court Administration**

In adopting workmen's compensation acts some jurisdictions gave the whole problem of the administration of the law to the regularly constituted courts of the state. This system requires the employer and the employee to be familiar with their respective rights and responsibilities under the law and to act accordingly. The sanction behind the law is the right of the disabled employee to sue for the benefits given him by the law in those situations in which the employer has not fulfilled his legal obligation. Court administration is still followed in New Hampshire, Wyoming, Tennessee, Louisiana and New Mexico. It was begun and later abandoned in New Jersey, Minnesota, Nebraska, Kansas and Rhode Island. One of the objections to the administration of the law by the courts is that they do not have the facilities for seeing that the law is observed and enforced and can operate only when a case is brought before it by the suit of a claimant. Courts are usually not organized for the receipt of reports or for the analysis of reports of accidents. Another objection

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9 Dodd, *op. cit.*, Chapter 4.
to court administration is that the courts do not possess an administrative mechanism for acquainting the employers and employees of their rights and responsibilities.

In recent years, court decisions have become increasingly liberal in the awards granted. Therefore, employers and insurance carriers have become more critical of court administration, and labor groups are less interested in changing it. In New Mexico, in 1953, labor opposition was able to defeat a carrier-sponsored bill to introduce commission administration.\textsuperscript{10} A similar alignment of forces could be seen in Ohio in 1955 when an effort was made to eliminate the appeal from the Industrial Commission to a jury.\textsuperscript{11}

\textbf{Administrative Agency Supervision of Workmen's Compensation}

All other states have established special agencies for the administration of the workmen's compensation laws. The most usual provision is a three- to five-member commission or board. However, the size ranges from a single director to a thirteen-member board in New York. In some states an effort is made to separate administrative and

\textsuperscript{10} Somers, \textit{op. cit.}, pp. 149-150.

\textsuperscript{11} Based upon attendance at Senate Committee Hearings on Amended Substitute House Bill 700, June 22, 1955.
quasi-judicial functions and to place them in separate agencies.\textsuperscript{12} When the agency also administers a state compensation insurance fund, there are additional problems. In one role, the agency is required to guide the injured worker and protect him in the pursuit of his rights. In another role, it is responsible for the solvency of the insurance fund. Yet it is expected to act as an impartial judge on claims which the worker makes against the fund. However, such difficulties are not insuperable.\textsuperscript{13}

There is no necessary correlation between the wisdom of a law and how well it is administered. Poor administration can cripple the best of laws, while a competent administrator can get unexpectedly good results from a poor law. If a great many administrative details are incorporated into legislation, it may give the administrator needed guidance when passed, although it may place later administrators in a legislative strait-jacket as times and needs change. The effect of legislative detail in the Ohio workmen's compensation law upon its administration will be examined more fully in later chapters.

In almost all cases the administrators of the work-

\textsuperscript{12} The term "quasi-" is vague in its meaning. It has been used by the courts to approve functions which are in effect legislative or judicial in character, but which the courts have held may be exercised by executive officers without violating concepts of separation of powers.

\textsuperscript{13} Somers, \textit{op. cit.}, pp. 143-144.
men's compensation law are appointed rather than elected. Various devices are used to minimize political pressure upon the administrators and to maximize competence and experience. In some jurisdictions, the members of a multi-member commission have overlapping terms to assure a degree of continuity. Generally, too much policy formation is felt to be involved to justify placing the administrative position within the classified civil service.

One of the great failures of workmen's compensation administration is the frequent failure of the administrator to remember that its purpose is to provide prompt benefit payments, to provide adequate and competent medical services, to rehabilitate the worker, and to work for accident prevention. It is important for the administrative agency to follow an injury from the first report to the final closing of the case. In only a few states does the administration get in touch with the injured worker soon after the injury has been reported to advise him of the benefits to which he is entitled. Many states do not insist upon prompt reporting of accidents by employers, prompt payments of compensation benefits, and on final reports in which employers or their insurance carriers spell out the amount paid and how these amounts were computed.  

14 Max D. Kossoris, "Workmen's Compensation in the United States", mimeographed, undated, no place or publisher shown, p. 2.
Many states see no need for detailed administrative statistical information. Only a few states make a systematic effort to find reliable answers to such questions as how promptly workers are paid, whether the amounts provided by the law were paid, to what extent the compensation paid offset lost wages, how completely medical costs were paid, how many cases were contested and appealed, what issues caused the most litigation, and where the bottlenecks were in the process of making decisions on claims and in hearing contested cases. Wisconsin, for example, has achieved very good results by publishing statistics on how promptly various insurance carriers make payments. Illinois routinely checks the files on the accuracy of payments made. Statistics from a few states show that medical costs consume an increasing share of compensation costs. However, such statistical information is rare.15

C. THE ORGANIZATION OF THE

OHIO INDUSTRIAL COMMISSION AS AN AGENCY: 1954

Ohio has always used an administrative agency for the administration of its workmen's compensation law, rather than relying upon the courts for the enforcement of the law. At the time of the reorganization of 1934,

15 Loc. cit.
the Industrial Commission, as a three-member body, was given the power to administer the workmen's compensation law, including the maintenance of the state insurance fund, and to control the employees necessary to perform the work.\textsuperscript{16} The commission, itself, had a secretary who was appointed by the governor, with the advice and consent of the senate. The volume of work was so large that it was necessary for the members of the commission to employ an additional staff, which by 1954 numbered approximately seven hundred. The staff was divided into ten operating sections as shown on CHART I (page 75, Infra). The titles of the various sections of the staff are largely self-explanatory. The functions of these sections involved in the processing of claims for compensation benefits will be discussed in greater detail below. The number of employees in each of the ten sections is shown in TABLE II, below:

\begin{table}[h]
\centering

\textbf{TABLE II}

\textbf{NUMBER OF EMPLOYEES IN EACH SECTION OF COMMISSION}
(As of September 29, 1953, unless otherwise indicated)

\begin{tabular}{|l|l|}
\hline
Cashier-Paymaster & 19  \\
Medical & 31  \\
Legal & 96  \\
Actuarial & 39  \\
Field Auditing & 64*  \\
Accounts & 116*  \\
Claims & 159  \\
Field Investigation & 120  \\
Safety & Hygiene & 83*  \\
Underwriting & Compliance & 52  \\
\hline
\end{tabular}

\textsuperscript{*Personnel as of August 23, 1954.}

\textbf{SOURCE:} Office of Secretary of the Industrial Commission.

\textsuperscript{16} 154-45 G.C., 4121.12 R.C.
The volume of claims for workmen's compensation benefits filed with the commission, as an agency, required careful supervision. The statute placed this responsibility upon the three members of the commission. The commissioners devoted most of their time and attention to the consideration and review of a relatively small number of contested claims, and gave very little time to any direct supervision of the administration of the agency. The extent to which they delegated supervisory functions to members of their staff will be considered below.

The volume of claims for benefits filed with the commission each year from 1948 to 1953 is shown in TABLE III, (page 77, Infra). These figures show that the volume of claims has slowly been growing during that period. The greatest volume has consisted of claims against the state insurance fund. This has usually run close to ninety percent. Approximately 30,000 to 38,000 of the claims filed annually against the state insurance fund involved more than seven days of disability, and required the payment of direct benefits to the employees from the fund. It will be noted that there was a sharp drop in the number of medical-only claims reported by self-insurers between 1949 and 1950. Prior to 1950 the reporting of such minor injuries by the self-insurer was required, but after that time it has been optional.
### TABLE III

**CLAIMS FILED WITH THE INDUSTRIAL COMMISSION, 1948 to 1953**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STATE FUND</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comp.</td>
<td>38,233</td>
<td>36,655</td>
<td>38,046</td>
<td>32,271</td>
<td>30,996</td>
<td>36,024</td>
</tr>
<tr>
<td>Med.</td>
<td>282,650</td>
<td>272,250</td>
<td>261,150</td>
<td>212,250</td>
<td>211,050</td>
<td>236,050</td>
</tr>
<tr>
<td>Occ.Dis.</td>
<td>5,190</td>
<td>5,262</td>
<td>4,793</td>
<td>4,012</td>
<td>4,175</td>
<td>4,743</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>326,073</td>
<td>314,167</td>
<td>303,929</td>
<td>248,533</td>
<td>246,211</td>
<td>276,817</td>
</tr>
<tr>
<td><strong>PUB. EMPLOYEE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comp. &amp; Med. Occ.Dis.</td>
<td>12,224</td>
<td>11,536</td>
<td>11,744</td>
<td>10,790</td>
<td>10,905</td>
<td>9,541</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>12,354</td>
<td>11,689</td>
<td>11,865</td>
<td>10,936</td>
<td>11,024</td>
<td>9,668</td>
</tr>
<tr>
<td><strong>SELF-INSURER</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comp.</td>
<td>5,721</td>
<td>5,194</td>
<td>5,236</td>
<td>4,900</td>
<td>5,080</td>
<td>5,714</td>
</tr>
<tr>
<td>Med.</td>
<td>2,573</td>
<td>2,858</td>
<td>3,005</td>
<td>2,755</td>
<td>12,626</td>
<td>8,321</td>
</tr>
<tr>
<td>Pub. Employee Occ.Dis.</td>
<td>249</td>
<td>244</td>
<td>315</td>
<td>45</td>
<td>54</td>
<td>56</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>8,580</td>
<td>8,103</td>
<td>8,482</td>
<td>7,924</td>
<td>18,012</td>
<td>14,400</td>
</tr>
<tr>
<td><strong>PUB. WORK RELIEF</strong></td>
<td>6</td>
<td>6</td>
<td>17</td>
<td>68</td>
<td>29</td>
<td>11</td>
</tr>
<tr>
<td><strong>NON-COVERAGE</strong></td>
<td>169</td>
<td>160</td>
<td>165</td>
<td>177</td>
<td>185</td>
<td>157</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>347,182</td>
<td>334,344</td>
<td>324,458</td>
<td>267,638</td>
<td>275,471</td>
<td>301,053</td>
</tr>
</tbody>
</table>

**SOURCE:** Extracted from the annual reports of the Chief, Claims Section, to the Industrial Commission, for the years 1948 to 1953, inclusive, typewritten, unpublished. On file in the Office of the Secretary, Industrial Commission. (Henceforth, the report for 1953 will be referred to as Annual Claims Report, 1953.)
The legislation which created the Industrial Commission provided that it should be a three-member body composed of one representative of the general public, one representative of employers, and one representative of labor. No more than two members may be of the same political party. The members are appointed by the governor by and with the consent of the senate, at an annual salary of $8,000 (1954) for a term of six years, and may be removed only for cause. A field study made of the entire agency in the summer of 1954 indicated that the three members of the commission spent relatively little time together for the consideration of administrative matters.

The Function of the Secretary of the Industrial Commission

The secretary of the commission was immediately answerable to the three members of the commission. The workmen's compensation law made little mention of the secretary. He had the power to "administer oaths, certify to official acts, issue subpoenas, and compel attendance of witnesses and the production of papers, books, accounts, documents and testimony"—all of which are judicial powers.

Once each month the heads of the ten sections filed a monthly report for their section with the secretary of

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17 The Industrial Commission Law is Chapter 871 of the old General Code, and Chapter 4123 of the Revised Code.

18 871-30 G.C., 4121.15 R.C.
the commission. Once a month the secretary and the ten section heads met with the three members of the commission. The secretary of the commission generally consulted individually with the members of the commission during the first hour of each working day. It was generally impossible for him to consult with them as a group other than at the monthly business meeting.19

Other duties of the secretary included attending district safety meetings to deliver speeches, which required him to travel extensively throughout the state. It was also his responsibility to secure office space for branch offices of the commission. He had certain duties with regard to the licensing of lay practitioners before the commission; he prepared and administered their examination. The secretary handled all personnel matters for the agency and was in general charge of the cashier-paymaster section. Hiring for the commission was done by the secretary on the basis of lists of eligibles submitted by the Civil Service Commission. If no lists were available, provisional appointments were made for thirty to ninety days until an examination could be given and a list prepared.20 It is not clear how much independence from the commission the secretary had

19 Interview, Warren D. Schumacher, Secretary of the Ohio Industrial Commission, August 13, 1954.
20 Loc. cit.
in filling vacancies in the agency. There were some unveri-
fi ed implications in conversations with employees of the
commission that the three members were consulted in rota-
tion upon vacancies in order to maintain the tripartite
aspect of the agency. The field study in the summer of
1954 gave little indication that the secretary had had dele-
gated to him any administrative authority other than in the
"housekeeping" areas. The ten section heads seemed to have
developed a high degree of autonomy in the actual operation
of their sections, with little responsibility to the secre-
tary other than filing reports.

Sections Involved in Processing a Claim for Benefits

The primary work of processing claims for benefits
was done by the claims, investigation, medical and legal
sections. These will be discussed in greater detail below.
In addition, the actuarial, accounts and safety and hygiene
sections had peripheral functions in the processing of the
claims.

The main work of processing the mass of uncontested,
clearly compensable claims took place in the claims sec-
tion. It was divided into five units. The index unit
maintained the one central permanent file of all claims
filed with the commission, and it sent the acknowledgment
of the receipt of a new claim at the time it was indexed.
The examiners unit included the claims examiners who made the initial determination upon the merits of a new claim, and the checkers who were experienced examiners and double-checked all awards. The correspondence unit carried on a mass of correspondence where missing information could be obtained by the use of form letters, and where a claimant needed to be notified of certain rights under the law. Included in this unit was a typing pool which also did the typing work for the examiners unit. The filing unit stored the files, kept a record of all files checked out, and destroyed files ten years after they became inactive. The self-insurer, or section 22, unit did all work in connection with the reports submitted by self-insurers. If a dispute arose between self-insurer and employee, this unit arranged to put the claim in the stream of the hearing process. This latter unit was virtually autonomous in its operation from the rest of the section, other than for being directly responsible to the chief of the section. All personnel of this section worked in Columbus.

The investigation section was highly decentralized. It had fifteen branch offices in the more populous cities of the state. There was a small central office in Columbus to which the reports from the branches were sent. There were some field investigators officed in Columbus, who made investigations in the Columbus area. However, they reported to a manager of the Columbus branch rather than
directly to the section superintendent.

The two main functions of the medical section consisted of (1) examining files containing reports from examining physicians and rendering medical opinions based upon the files, and (2) of making actual physical examinations of some of the claimants. Only a small percentage of claimants were examined by the commission's physicians. The section maintained four branch offices outside of Columbus, which were primarily for conducting physical examinations of claimants.

The legal section did the legal work for the commission. The attorney examiners in this section performed several different types of work. One group of them, known as legal reviewers, examined files and rendered legal opinions. Some of the attorneys in the section served as hearing officers of various types. Two of them were permanently assigned to the three commissioners to serve as deputy hearing officers at informal hearings for the Columbus area, and four others had specialized functions. Others generally known as referees, served as hearing officers at the administrative appeal known as a rehearing. In addition, there were a few attorneys in the claims section who reviewed files and rendered legal opinions in certain specialized types of claims. They were also known as legal reviewers.
The Functions of Supplemental Hearing Bodies

In 1937, four boards of claims were created by legislation to assist the commission, and its staff, in holding informal hearings on questioned claims for benefits. The boards of claims were independent tripartite bodies to which the commission could assign claims for informal hearings. The commission could refer any claim to one of these boards and could withdraw the case from it at any time. As a matter of custom, geographic sections of the state were assigned to each of the four boards, and they rode circuit in their area. In theory, the area around Columbus received informal hearings from the three commissioners, but in practice two attorney examiners were assigned to this duty. The boards were appointed in the same manner as the commission, and had the same rights to subpoena. Decisions of the boards were subject to an application to the commission for a reconsideration of the decision, or, alternatively, the dissatisfied party could apply for a rehearing, which was a formal *de novo* hearing of the case.21

Medical boards of review were established in 1939, which could be used by the commission to review certain medical questions. Originally, the decisions of the commission in occupational disease claims were not subject to any form of review, either within the agency or by the

21 1465-44a G.C., 4123.14 R.C.
courts. The medical boards of review were established to make available an intra-agency reviewing body for such claims. Their decisions on the cases referred to them by the commission were binding upon the commission, and not subject to judicial review by the courts.  

D. AN EVALUATION OF THE ORGANIZATION AND OPERATION OF THE AGENCY

For effective administration, continuing supervision of the operation of all parts of the organization is needed. An examination of the organization chart of the Industrial Commission (CHART I, page 75, Supra) would suggest that this supervision was given by the secretary of the commission. However, several weeks of observation within the agency during the summer of 1954 gave little evidence that the secretary independently directed the administration and procedural practices of the agency, although he received the reports. Administrative changes were initiated by the commission, or by the secretary under direction of the commission. They usually were issued, a few times a year, in the form of a resolution or general order of the commission. The work of the secretary was of a ceremonial and housekeeping nature, involving direct work on his part, rather

22 Amended Senate Bill 297, 118 Ohio Laws 426, 1465-68d G.C.
than being managerial or executive. During a seventeen-year period, there were thirteen different secretaries. With such a rapid turnover, a secretary probably could not substantially influence the management and procedures of the commission, even if he were so authorized and so disposed.

Other than for the individual polling of the members of the commission by the secretary, the only meetings held which were of a policy-forming nature and which could serve for the coordination of activities within the commission were the monthly meetings of the members of the commission, the secretary, and the ten section heads.

Conversations with some of the section heads gave the recurring impression that each had developed his own empire and was willing to try to make some improvements within it, but was reluctant to suggest any changes which would disturb or inconvenience any of the other sections. On some occasions where possible changes in claim handling procedures were discussed with one of them, the section heads would indicate that they could not make all of the changes themselves and that the other sections would frown upon their making changes which would affect them.

The only management element which was in a position to control and coordinate the activities of the ten sections was the commission itself. It seemed to act on administrative matters only when a decision was forced upon it. The
ten sections would have constituted an excessively broad span of control, even for a single administrator.

The commission was so organized that at least two of its major functions were distributed among several relatively independent units. There was no grouping of units or personnel in such a way that unified leadership could plan and control the procedures for performance of these major functions. For example, claims administration involved the claims, actuarial, accounts, and safety and hygiene sections before a claim was given an initial examination. If it were questioned upon its first examination it was sent through further steps involving the legal, medical and investigations sections, in addition to the claims section. If an informal hearing were required, another portion of the legal section or a claims board was involved. If a rehearing was requested, still another portion of the legal section and the commission members themselves were involved before the claim could be appealed to the courts. This will be discussed in much greater detail in later chapters.

In a less extreme case, the very important insurance administration function was distributed among the actuarial, accounts, field auditing, and underwriting and compliance sections.

Fact-finding and inquiry to ascertain the exact facts relating to doubtful claims were scattered among the
correspondence unit of the claims section, the "legal X" unit of the legal section, the medical section, and the investigations section.

In successive steps, a doubtful or contested claim had to pass through several steps where it could either be allowed or passed on to someone else before being finally disallowed. Every claim would start with a claims examiner in the claims section. From there it would pass to a reviewer in the same section, to a special examiner in the "legal X" unit of the legal section, or to a regular attorney examiner in the legal section. Any of the three could either approve payment or else have the claim set for an informal hearing after notice. Such hearings would be before a deputy commissioner or a claims board, or, in rare cases, by the commission itself. If the claim were denied there, a rehearing before a referee in the legal section could be requested. If there were a recommendation against payment by the referee, a final administrative denial by the commission could result.

The agency was over-centralized in Columbus and relied heavily upon form correspondence and mail-order techniques. Yet seven of the sections carried on extensive field operations with varying numbers of branch offices. The field investigation section with fourteen branch offices outside Columbus, was the most widely-spread. In addition, there were the four claims boards. In all cases
the claim went first to the central office in Columbus, and then it might go to one or more field offices and back to Columbus before there could be the payment of an award or a denial.

Within the agency there was no directing brain giving coordination to the whole. There was a resulting fragmentation into separate sections. However, no one of the section supervisors could control or alter the entire output. A glacier of paper developed, with each piece of paper moving with the same inevitableness and with the same speed.
CHAPTER IV

OHIO'S CLAIM HANDLING PROCEDURE
COMPARED WITH OTHER JURISDICTIONS

In establishing a procedure for handling workmen's compensation claims there is the problem of finding a workable balance between two administrative goals: (1) to provide a simple and inexpensive procedure for the settlement of the great mass of uncontested claims, and (2) to provide adequate protection for the injured worker by reasonable supervision over any settlement to make sure that he receives his full entitlement. The procedure must also be conditioned by the fact that any one of these claims may become disputed and require administrative hearings or a court appeal.¹

Claim procedures vary widely among the states. In those states in which private insurance carriers are permitted to write workmen's compensation insurance, three general patterns have emerged: (1) the agreement method, (2) the Wisconsin or "direct payment" method, and (3) the hearing method. In all three of these there is a direct

¹ Somers, op. cit., pp. 150-151.
relationship between the claimant and the employer or the employer's insurance carrier, which distinguishes them from the situation where there is an exclusive state insurance fund and the claimant must deal directly with the agency administering the law in the status of a claimant. Such latter systems are found in Ontario and Ohio. In state-fund jurisdictions, additional administrative problems are created as safeguards are established to protect the insurance fund from improper claims.

Under any system there should be a goal of reducing the time lag in instituting payments in valid claims to the minimum of the waiting period provided by the law, while at the same time maintaining equitable procedures which will protect the legitimate concern of the employer that invalid claims not be paid. In devising the procedure, consideration must also be given to the question of whether the interest of the general public is best served by a system which puts a premium upon speed in commencing payments at the calculated risk of making a few payments on invalid claims.

A. OTHER SYSTEMS OF CLAIMS PROCESSING

All other systems of claims handling have distinguishing features which may not make them applicable for the administration of the Ohio law, but a comparison of the systems of the states with the Ohio system
indicates several points of similarity that may suggest possibilities of improvement in the Ohio claims handling procedure.

The Agreement Method

Under the agreement method, which is used in most states, reliance is placed upon the employee and the employer, or his insurance carrier, dealing directly with each other and reaching an agreement as to the extent of the claimant's entitlement under the provisions of the workmen's compensation law. The agreement is then submitted in writing to the body administering the workmen's compensation law for its approval. Generally, the settlement is proposed by the employer or insurance carrier. If the employee accepts, he signs the agreement and payments begin. However, if there is any disagreement about the extent of his entitlement under the law, payments are withheld until the employee enters into an agreement with the employer or carrier without a contest or until he receives an adjudication after a contest. Generally, the administrative body does not investigate and does not intervene unless the case is contested. In a few states all agreements are checked by the agency to verify that full payment under the law is being made. However, in many states using the agreement system

\[2\] Dodd, \textit{op. cit.}, p. 135.
the agreement papers are routinely approved and filed without any such check.\(^3\)

There is inherent in such a system the possibility of underpayment of the benefits provided in the workmen's compensation law. Often the employee is ignorant of the full extent of his rights, and the prospect of delay, if he protests the offer, may seem a worse hardship than accepting a smaller amount. The employer can afford to wait since this system puts no premium upon speed, either to reach an agreement or to begin payments. Time tends to be in the favor of the person who possesses the money and seeks to effect an advantageous compromise settlement of a claim.

In Ohio, the agreement system is followed with regard to the relationship between self-insured employers and their employees. Unless such a claim becomes contested, the function of the agency is little more than that of receiving, checking and filing reports. In cases where such a claim becomes contested, it is handled by the Industrial Commission the same as any other contested claim. The procedures followed in Ohio where self-insured employers are involved is covered in greater detail in APPENDIX A.

**The Wisconsin or "Direct Payment" Method**

The method initiated in Wisconsin is characterized

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\(^3\) Somers, _op. cit._, p. 151.
by an emphasis upon commencing payments promptly without the necessity of any agreement being reached between employee and employer or his carrier at any time. This is backed by a very aggressive policy upon the part of the administrative agency in informing every claimant of his rights and in checking upon the speed and amount of payments made. The system is generally referred to in the literature on workmen's compensation as the "direct payment" method. However, this can lead to confusion, since both the agreement and the hearing methods involve the making of payments directly from the employer to the employee.

Under the Wisconsin system, uncontested cases are handled on the basis of written reports without requiring or using a formal agreement between the parties. The administrative agency receives notice of the accident and of the making of the first payment. Certain interim reports and a final report of total payments made are required. Carriers are expected to begin payments to the injured employee on their own initiative and without the necessity of any agreement as to what he will ultimately receive. Uncontested claims are never settled, but may be reopened by the claimant at any time within six years from date of last payment. When the first payment becomes due after eleven
days it may be paid without the necessity of the delay involved in the submission and approval of an agreement. The case may be contested if the claimant becomes dissatisfied with the amount or the duration of the award.  

It is the commission's policy not to approve final settlements in uncontested cases. In case of a valid dispute, the parties may compromise their differences and submit a proposed settlement to the commission. If approved, the settlement is held for another year by the commission for possible review. If no further action is taken within that year, the settlement becomes absolutely final. Compromises and final settlements are approved only when there is a genuine dispute which is a proper subject matter for compromise. The parties seeking the compromise are required to submit supporting statements and an investigation may be carried on by the commission to make sure that the dispute is one which warrants compromise.

The commission on its own initiative writes to every injured employee, advising him of his rights under the law. It also investigates the case to see whether proper payments were made in accordance with the law; however, pay-

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4 Dodd, op. cit., p. 136.

5 Marshall Dawson, The Development of Workmen's Compensation Claims Administration in the United States and Canada, 1951, issued by the International Association of Industrial Accident Boards and Commissions, p. 27.
ments are not held up pending this investigation. This pro-
cedure assumes that the commission has a responsibility for
seeing that the compensation provided by law is in fact paid
in full rather than placidly sitting back and adjudicating
disputes brought to its attention by a contest. This is a
system which is built upon confidence and presupposes obtain-
ing cooperation from all the participating agencies and
groups--employers, insurance carriers, doctors, lawyers, and
labor unions. It does not give the claimant the utmost pos-
sible protection in settling his claim, but it gives all the
protection that is deemed necessary. The operation of the
system has the advantage of being simple, prompt, fairly
adequate, and economical.

The responsibility for going forward is placed upon
the employer or insurance carrier as soon as it has actual
notice of the occurrence of the disability, whereas, in
Ohio, and under the agreement system as well, the respon-
sibility was upon the claimant for pressing his claim to a
conclusion, until 1955. Emphasis is placed on promptness
in beginning payments, rather than the building up and com-
pleting of a record or determining total liability. In
1955, Ohio adopted many of the features of this plan (see
Chapter XII, pp. 265-268, Infra).

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6 Somers, op. cit., pp. 151-152.
7 Dawson, op. cit., p. 22.
The key to the Wisconsin solution of the problem of prompt payment is the recognition that the injured worker is not the proper party upon whom to place the burden of the paper work required for starting the administrative process, and that the right of the injured employee to compensation is created by the fact of the injury, not by the filing of a claim. In 1943, Michigan abandoned the agreement method and adopted the direct payment method. Before the change, first payments were made within the statutory limit of fourteen days in only sixteen per cent of uncontested claims. After the change, first payments were made within fourteen days in seventy-eight per cent of the uncontested cases, and within twenty-one days in eighty-five per cent of the uncontested cases.

The administration of the act is underwritten by a comprehensive, systematic and continuous public relations program with all parties concerned. The commission has attempted to educate the employers to concede payment on a reasonable basis. As to carriers, attention is given not only to the performance in individual cases, but to the character and adequacy of the performance as a whole. Statistical information is systematically circulated, as an instrument of administration, concerning the relative

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8 Ibid., p. 23.
9 Ibid., p. 30.
performance of carriers and employers as to their promptness in reporting injuries and in making first payments.\textsuperscript{10}

\textbf{The Hearing Method}

The third method is the "hearing" method which is found only in the State of New York. Under it, a hearing is held on every compensable accident case. It is similar to the Wisconsin method in that payments do not await a decision of the commission or even the filing of a claim. Payments must begin within eighteen days, even though the extent of liability remains to be determined. The main difference is that the case cannot be closed without a hearing. This great amount of supervision is designed to protect the injured employee from an unjust settlement; however, it can lead to congested hearing dockets, and it is responsible for much time being wasted by witnesses and doctors in attending routine hearings where there is no real contest. Effective April 1, 1954, the procedure was changed to one where hearings are not held unless there is an issue to be determined. It was estimated at the time this change was adopted that one-third to one-half of the referee hearings would be eliminated.\textsuperscript{11} This hearing device placed all the safeguarding responsibility on the administration, but at

\textsuperscript{10} \textit{Ibid.}, pp. 25-26.

\textsuperscript{11} Somers, \textit{op. cit.}, pp. 152-153.
a sacrifice of administrative time.

The Ontario Method

The system found in Ontario and the other Canadian provinces differs from the systems in the United States. Under the Ontario plan, an administrative body has complete authority for the administration of the workmen’s compensation law, without any recourse to the courts. The board sets the premium rates for the exclusive provincial funds, and it is not dependent upon the legislature for appropriations for administrative operation. It has complete control over the caliber of medical treatment given, which includes the right to start rehabilitation treatment at the outset of the medical treatment. It is still necessary that a claim be filed by the injured worker before any action is taken. In any case in which the claimant is not satisfied with the handling of his claim, he has the opportunity to come in and tell his story before a hearing officer in an informal manner. Since 1935 there has been a review board, which holds very informal hearings. Testimony is not transcribed, but notes are taken by the secretary of the board. No form of judicial review is permitted. In this atmosphere of freedom from budgetary and judicial control, monetary payment of compensation goes hand in hand with the supervision or execution of remedial services.12 It is

12 Dawson, op. cit., pp. 5-12.
these two freedoms which make the system differ from anything found in the United States.

B. CLAIMS PROCESSING IN OHIO

The claims handling procedures in Ohio, in 1954, were characterized by centralization and mail-order techniques in the handling of uncontested, clearly compensable claims, and by unjustifiable delays in the completion of the administrative appeals known as "rehearings". This was conditioned to an extent by the fact that the members of the Industrial Commission served the dual role of managers of the exclusive state insurance fund and of final administrative arbiters of the merits of claims for benefits from this fund. Since it was an exclusive fund, the coverage information regarding all Ohio employers affected by the act (with the exception of self-insurers) could be assembled in a single set of records. This also created a sufficiently large volume of claims for benefits under the act that a division of labor and mass-production techniques could be applied to their processing.

From the beginning, most of the work of processing uncontested claims was centralized in Columbus. The burden of reporting an accident or disability was placed upon the disabled employee. In addition, the claimant had the burden of assembling and submitting to the commission all the medical and factual information needed for an adjudi-
cation of the merits of his claim. For this purpose a single form was devised which required a report from the employee, the employer, and the attending physician.

When a claim was received by the agency in Columbus, it was checked against its records to verify that the employer concerned had paid his premiums and was properly covered by the state insurance fund as of the time of the accident. A claim number was then assigned, the claim was recorded in the agency's records, and pertinent information was extracted from the report for safety and accident prevention purposes before the claim report was delivered to a claims examiner for an evaluation of its merits. There was an average elapsed time of two and one-half days from the arrival of the claim in Columbus until it was placed in the hands of a claims examiner. This will be considered more specifically in Chapter VI, Infra.

The claims examiners were authorized to issue an order, in the name of the three commissioners, authorizing the payment of benefits on uncontested, clearly compensable claims. The examiner's written authorization was translated into a typed order and rechecked by a group of experienced claims examiners. If it were found to be correct, the pay authorization was transmitted to the auditing section where a check was issued, provided the waiting period had elapsed. There was an average elapsed time of from six to eight working days between the arrival of a claim and
the issuance of the first payment on uncontested and unquestioned claims. (See Chapter VII, *Infra*.)

There was a more elaborate procedure followed for those claims which were questioned by an examiner or contested by an employer. This might involve obtaining additional information through correspondence or a field investigation, or it might involve submitting the claim to the commission’s medical or legal staff for a professional opinion on the merits of the claim. The claims then were sent to a group of employees, known as legal reviewers, who had greater authority than the claims examiners in passing upon the merits of a claim. If the legal reviewers were unable to authorize payment, arrangements were made to hold an informal oral hearing after notice before a hearing officer, acting for the commissioners. If either employer or claimant were dissatisfied with the results of this hearing, they could request that there be a rehearing of the claim. This rehearing was a formal process, with the possibility of several hearing sessions scattered over a period of months or years. If a claimant were dissatisfied with the results of the rehearing, the claim could be appealed to a trial court where the transcript of the rehearing was read to a jury. The jury had the right to determine whether the claimant could participate in the insurance fund, but not the amount.

The Ohio Industrial Commission took a much greater
interest in the facts and merits of a claim than the ad-
ministrative agencies took on uncontested claims in the
states using the agreement method. In the states using the
agreement system, the agency seemed to rely upon the ad-
verse interests of the employer or his insurance carrier to
detect and contest unjustified claims. To an extent, the
Ohio employer insured in the state fund could be relied
upon to serve this function, but to a much greater extent
this burden was assumed by the commission, and its staff,
in executing the role of managers of the state insurance
fund. In states using the agreement, the administrative
agency could be looked to for a remedy to over-zealous con-
testing of claims. Within the organization of the Ohio com-
mission, there was no formalized separation of functions
or institutionalized arrangement to keep separated the
functions of insurance-fund management and the adjudica-
tion of claims upon the fund. There were many indications
that in the administration of the agency the interest of
protecting the solvency of the fund took precedence over an
interest in swift payment of uncontested claims.

Once payments were begun on a claim against the Ohio
commission, this amounted to an acknowledgment of the merits
of the claim, even though it might have been only the pay-
ment of a small medical bill. If, later, a serious dis-
ability developed, the commission could only challenge the
connection between the injury and the later disability.
Thus the situation sometimes arose where lengthy correspondence or investigation took place before medical expenses were paid in accidents which involved less than eight days lost from work. Once the commission had made a specific award to a claimant, it had only limited authority to reduce or cancel the award. Thus the very finality of the commission's decisions placed an administrative burden upon it to protect the interests of the employers that invalid claims receive no payment until thoroughly examined. This factor distinguished the Ohio system from the Wisconsin system in which promptness of initial payment did not prejudice the right of the employer or carrier later to contest the validity of the claim.

It was the adopted policy of the Industrial Commission to arrange an informal oral hearing in virtually all cases where the employer persisted in objecting to the merits of a claim. In addition, where the claims examiners or the legal reviewers were unable to authorize the payment of a claim within the limits of the discretion delegated to

13 Such accidents will be referred to in this paper as "medical-only" claims, and those where eight days or more were lost from work will be referred to as "lost-time" claims.

14 The workmen's compensation law specifically provided that where a claimant had been adjudged totally and permanently disabled, and a weekly amount of compensation had been awarded to him for life, the commission had the right to reopen the award and modify it in case of a change in the claimant's condition, 1465-90 G.C., 4123.51 R.C.
them by the commissioners, arrangements were made for the
holding of an informal oral hearing after notice to the
interested parties. It was further the policy of the com-
mmissioners rarely to permit the denial of a lost-time claim
without automatically setting it for an informal oral hear-
ing on its merits. Thus the goal sought in the New York
hearing system of making an informal oral hearing after
notice readily available was largely achieved in Ohio with­
out the necessity of holding a hearing in a large number of
claims where there was no true issue involved as to the
merits of the claim.

One of the chief objections to the Ohio claims pro-
cedure as it existed in 1954 was its failure, generally
speaking, to reduce time lags to a minimum, thus failing in
this way to provide maximum efficiency and equity as required
by the underlying public policy. In the following three
chapters a detailed examination will be made of the delays
in the adjudication of clearly compensable claims which
were neither contested by the employer nor questioned by
the claims examiners. This will involve an analysis of
both the delays in reporting the claim to the commission
and the delays entailed between the time the claim was re­
ported and the time that a first payment was made. In this
latter category, an effort will be made to distinguish
those steps in the procedure which were purely administra­
tive, or ministerial, and those which involved the exercise
of discretion on the part of the staff of the commission, since discretionary acts must be measured by the dual standard of efficiency and equity.
An examination of the record of the speed of handling claims for workmen’s compensation benefits in Ohio indicates a continuous delay in the reporting of claims to the agency and in the adjudication of the claims once they were reported. The greater portion of the delay has been in the interval between the occurrence of the accident and the reporting of the accident. However, the agency can not be absolved from all blame for the delay in reporting accidents, since there can be a relationship between the length of delay in reporting a claim and the degree of difficulty involved in making the necessary report. The difficulty in making a report may be increased by the very nature of the forms required or by the lack of knowledge on the part of the claimant as to what is expected or required of him in initiating an application for benefits under the statute.

One of the primary goals of the early advocates of the workmen’s compensation principle was the establishment of an informal and non-technical procedure for the swift
payment of readily determined benefits where a claim was clearly compensable under the provisions of the statute. The achievement of such a goal will be aided by a procedure of reporting and processing claims which is simple and understandable to all persons involved. The time required for processing a clearly compensable claim after it has been received by the agency requires a balance between a concern for expediting its payment and a concern for maintaining orderly procedures, which do not favor any one claimant, and accurate records.

The Amount of Delay Before a Claim was Filed With the Commission

The original procedure under the old State Liability Board of Awards for the filing and processing of a claim began with the injured employee of an employer subscribing to the fund, filing a preliminary application, or notice, with the board, which then returned by mail a supplemental application blank containing the claim number assigned to his claim. When the commission received the second form from the claimant, blank forms were mailed to the physician; a case could not be set for a hearing until the physician's report had been filed.¹

Thus, from the earliest days of the operation of

workmen's compensation in Ohio, the primary burden was placed on the injured employee to initiate and continue the paper work connected with obtaining compensation. The claimant had to complete the application and also secure the affidavits of his employer, attending physician, one or two fellow servants, and certified bills of physicians, hospital, druggist, etc. He had to file all of these papers at the same time in order that one examination by the staff of the board might be sufficient. If any information were lacking, the employee was notified to furnish it. Once the proof was complete, the case was set for hearing one week in advance and the injured man notified in order that he might appear in person or by agent or attorney. The worker was notified that in case he did not wish to appear he should notify the board and the case would be advanced on the docket. Once the case was docketed it came before the full State Liability Board of Awards for hearing and decision.²

At the time of its creation in 1913, the Industrial Commission adopted the claim filing procedure of the old board. A study made of 1,000 cases for the years 1916, 1917, and 1918 showed that there was a mean average interval of fourteen days between the date of the accident and

the date the first notice was filed by the claimant, and a mean average interval of twenty-five days between the date the first notice was filed and the date the application was filed. Thus there was a delay of thirty-nine days between the date of the accident and the date the application was filed.3

On May 15, 1920, a drastic change was made in the method of reporting accident claims to the commission. The commission adopted a single form for the reporting of claims. This is the so-called three-part form which was continued to 1955 with very little modification. It was an effort to get all the information which a claims examiner would need for an initial decision condensed into a one-page form. One portion was a statement by the claimant concerning the accident. The other portions of the form were to be filled in by the employer and the attending physician. The burden was placed upon the claimant, as the party in chief interest, to secure the completion of the medical statement by the physician and deliver the form to the employer for the latter's statement of concurrence in or protest to the claim.

The adoption of the new form in 1920 was largely dictated by the lack of administrative staff for handling the

3 Report of the Joint Committee on Administrative Reorganization pursuant to the Senate Joint Resolution No. 36, Columbus, The F. J. Heer Printing Company, 1921, p. 251.
correspondence and filing required by the original method. It was, however, an effort by the commission to make administrative reforms within the context of an inadequate administrative budget. It did relieve the claims section of much work, but the net effect was to pass to the claimant the burden of compiling in a single document all the necessary information for the commission. Such a reporting system can work well only when the employee is well educated as to what he is to do and when there is a high degree of cooperation between all three parties involved in completing the form.

In the middle 1940's, Frank Lang, of the Division of Research, Association of Casualty and Surety Executives, studied the time lag in paying claims in Ohio. TABLE IV (page 111, Infra), taken from his book, was based upon original data furnished to him by the safety and hygiene section of the commission, and it reveals that the median average time in filing an application was between thirty and thirty-nine days.

A continuing problem of claim administration in Ohio has been the delay involved in the receipt by the Industrial Commission of a properly completed form. Data compiled by the commission for the year 1953 on lost-time compensation claims showed that there were 36,329 such claims

4 Somers, op. cit., p. 154.
TABLE IV

TIME LAG FROM DATE OF ACCIDENT TO DATE OF FILING APPLICATION

<table>
<thead>
<tr>
<th>NUMBER OF DAYS ELAPSING</th>
<th>% OF TOTAL CLAIMS OCTOBER, 1942</th>
<th>% OF TOTAL CLAIMS JUNE, 1943</th>
<th>% OF TOTAL CLAIMS APRIL, 1944</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 9</td>
<td>5.1</td>
<td>4.9</td>
<td>4.5</td>
</tr>
<tr>
<td>10 - 19</td>
<td>16.6</td>
<td>17.4</td>
<td>16.1</td>
</tr>
<tr>
<td>20 - 29</td>
<td>19.3</td>
<td>19.3</td>
<td>18.7</td>
</tr>
<tr>
<td>30 - 39</td>
<td>14.9</td>
<td>14.4</td>
<td>14.2</td>
</tr>
<tr>
<td>40 - 49</td>
<td>11.3</td>
<td>10.2</td>
<td>9.8</td>
</tr>
<tr>
<td>50 - 59</td>
<td>7.3</td>
<td>7.4</td>
<td>6.7</td>
</tr>
<tr>
<td>60 - 69</td>
<td>5.7</td>
<td>5.5</td>
<td>5.1</td>
</tr>
<tr>
<td>70 - 79</td>
<td>4.0</td>
<td>3.7</td>
<td>3.8</td>
</tr>
<tr>
<td>80 - 89</td>
<td>3.0</td>
<td>2.7</td>
<td>2.9</td>
</tr>
<tr>
<td>90 - 99</td>
<td>2.2</td>
<td>1.7</td>
<td>2.3</td>
</tr>
<tr>
<td>100 and over</td>
<td>10.5</td>
<td>12.8</td>
<td>15.9</td>
</tr>
<tr>
<td></td>
<td>99.9</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>


filed and that there was a cumulative delay of 2,202,922 days in filing the claims. This was a mean average delay of 60.6 days in each case.\(^5\) Under the Ohio statute, workmen's compensation claims may be filed at any time within two years after the injury. Therefore, the above figure would be affected by an unknown number of claims which were between one and two years old when reported. No figures were available for the year 1953, which would show the number of cases in this category. Such cases affect the mean average, and the figures given must be treated with reserve.

\(^5\) Information based upon a mimeographed sheet prepared by the claims section of the commission.
The Median Average Time in Reporting Accidents: 1945-1948

During the years 1945 to 1948, inclusive, the Safety and Hygiene Section of the Industrial Commission maintained sufficiently detailed records of the time lag in reporting claims that the median average, as well as the mean average delay in reporting claims could be calculated. During this four-year period for which the detailed records were available, the monthly mean average delay in reporting ranged from 51.95 days to 74.82 days; however, for most months the mean average was between sixty and sixty-nine days. The distortion caused by a small number of long-delayed claims was indicated by the fact that during the same period the median average time lag in reporting was between thirty and thirty-nine days. The distribution of these medians by types of injury and ten-day groups is indicated in TABLE V, page 113, Infra.

When the figures in TABLE V were considered on the basis of the type of injury coupled with the delay in reporting the accident to the commission, it was shown that

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6 On a monthly basis, the records divided the time lag into ten-day groups: 01-19, 10-19, 20-29, 30-39, 40-49, 50-59, 60-69, 70-79, 80-89, 90-99, and 100 and over. A distinction was also made as to the type of injury: fatal, permanent-total disability, permanent partial disability, temporary-total disability of seven days or less, temporary-total disability of more than seven days, and injuries in which no time was lost from work. The median average time for each type of injury and each month was calculated and the results reduced into the form of a table.
## Table V

**Median Average Delay**

In Reporting Accidents to the Commission: 1945-48

<table>
<thead>
<tr>
<th>Range (Days)</th>
<th>Fatal</th>
<th>Permanent Total Disability (Indiv)*</th>
<th>Permanent Partial Disability</th>
<th>Total Temporary - Over 7 Days</th>
<th>Total Temporary - 7 Days or Less</th>
<th>No Time Lost</th>
<th>Total Claims Filed</th>
</tr>
</thead>
<tbody>
<tr>
<td>01-09</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>xxx</td>
<td></td>
<td>xxxx</td>
<td>xxxx</td>
<td>xxxxxxx</td>
<td></td>
<td>xxxxxxx</td>
</tr>
<tr>
<td></td>
<td>xx</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>xxx</td>
<td></td>
<td>xxx</td>
<td>xxx</td>
<td>xxxxxxx</td>
<td></td>
<td>xxxxxxx</td>
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<tr>
<td></td>
<td>xx</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>xxxxxxx</td>
</tr>
<tr>
<td>40-49</td>
<td>xxx</td>
<td></td>
<td>xxx</td>
<td>xxx</td>
<td>xxxxxxx</td>
<td></td>
<td>xxxxxxx</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50-59</td>
<td>xxx</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-69</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>70-79</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>80-89</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90-99</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100 &amp; Over</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

x - indicates a month in which the median average time lag was within this ten-day group for this type of injury.

* - due to the small number of permanent-total disability claims reported, the number of claims for the month, rather than the median average, is given.

**Source:** Abstracted from data on file in the Safety & Hygiene Section of the Ohio Industrial Commission.
on total-temporary disability in excess of seven days, the median average for each of the forty-eight months was between thirty and thirty-nine days. With total-temporary disability of seven days or less, the median ranged between forty and forty-nine days during two months, and between thirty and thirty-nine days during forty-six months. On cases involving no time lost from work, there was slightly greater delay in reporting the claim; during ten months the median was between forty and forty-nine, and, during the other thirty-eight, it was between thirty and thirty-nine.\(^7\)

The greatest speed in reporting claims was involved in permanent-partial claims. During thirty months the median was between twenty and twenty-nine, and, during eighteen months, it was between thirty and thirty-nine. During the four-year period there were only thirty-four claims which were originally coded as being permanently and totally disabling. This is an extremely small sample and the time spans in reporting the claims varied widely from between 09 and 09 to over 100, with some falling in almost all of the ten-day spans, but with the median between thirty and thirty-nine days.\(^8\)

The time lag in reporting claims involving fatali-

\(^7\) TABLE V, Supra.

\(^8\) Loc. cit.
ties was almost as varied as that for permanent-total claims. Among the fatal cases, the median was between twenty and twenty-nine in seven months; between thirty and thirty-nine in twenty-two months; between forty and forty-nine in fifteen months; between fifty and fifty-nine in three months, and between sixty and sixty-nine days in one month.  

Even when the delay in reporting claims to the commission is considered in terms of the median average delay rather than the mean average, more than a month elapsed. Under the workmen's compensation statute in Ohio, the disabled worker is entitled to receive his first payment of compensation benefits after the fourteenth day of disability. From this it seems obvious that the drafters of the act did not foresee that such great delays would develop in the reporting of claims. Critics have placed a large share of the blame for the delay in reporting claims upon the cumbersomeness of the three-part reporting form.  

Ohio has been the only state requiring the three-part reporting procedure. Labor groups especially have been opposed to it, on the grounds that it puts an unfair burden on the incapacitated worker, and serves as a bottleneck in the payment of claims. Without constant emphasis being focused from some source upon the need for speed in

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9 Loc. cit.

reporting cases there tends to be a gradual increase in the time lag involved. The Ohio agency has had no systematic program for acquainting the disabled worker with his responsibility for the completion of all three parts to the form, nor with the procedures for obtaining and mailing the completed form. The amount of assistance the claimant received varied from employer to employer.

The dissatisfaction finally culminated in legislation in the summer of 1955 which opened the way for the administrator of the newly-created Bureau of Workmen's Compensation to abandon the three-part form and to begin tentative payments upon a report of injury mailed in by any party. This will be discussed in greater detail in Chapter XII, Infra.

The Amount of Delay in Making Initial Determination of a Claim

The sparse literature on the subject seems to indicate that for a long period of time the commission, as an agency, took from six to eight working days in issuing a check in a clearly compensable claim after the application for benefits was finally received in Columbus. The reasons for this delay in 1954 will be considered in greater detail

11 Amended Substitute House Bill 700.
in the two following chapters.

In the actuarial report made in 1919 by Dawson and Downey, the latter noted that first payments of compensation took from five to eleven weeks, and that once payments were begun they were frequently interrupted unnecessarily until a medical re-examination or an employer's wage report could be obtained. The lack of field investigations and proper examination apparently was a valid charge. The members of the commission seemed to have been aware of it, but claimed that the lack of appropriations for staff hampered their activities. 12

The joint committee on administrative reorganization, appointed in 1919, reported that from six to eight days elapsed between the arrival of an application for benefits and the first consideration of the claim upon its merits by the staff of the commission. 13

A study of the office lag in 1927 indicated that 47.5 per cent of a total of 560 cases taken in a random sample showed a lapse of more than fifteen days between the date of the receipt of the claim and the time of its first examination on its merits. This same process took


from eight to fourteen days in 1943.  

In May of 1926 an actuarial audit was made of the fund by Miles M. Dawson & Son, consulting actuaries of New York City. The part of the audit report which checked upon the handling of claims showed that the elapsed time between the date of the injury and the date of the first hearing on a claim was between thirty-seven and thirty-eight days. An average of twenty-seven days elapsed between the date of the injury and the date the claim was filed. An average of ten to eleven days elapsed from the date on which the report of the injury was received and the date of the first hearing on it.  

The promptness with which first payment was made in a simple uncontested claim is one of the most important elements in the handling of workmen's compensation claims. In 1930, Louis Levine of the Ohio State University made a study of 580 uncontested compensation claims in Ohio for the Commonwealth Fund. The results were incorporated into Dodd's book. The results showed that the claims, properly signed by all three parties, were received by the com-

14 Lang, op. cit., p. 68.

15 Fifth Annual Report of the Department of Industrial Relations of Ohio, op. cit., p. 10.

16 Dodd, op. cit., pp. 152-153. This information is also contained in an appendix to Levine's dissertation, op. cit.
mission within fourteen days after the accident in thirty-six per cent of the cases examined, within thirty days in seventy-two per cent of the cases, and within forty-five days in ninety-two per cent of the cases. The average time taken by the commission in checking the claims and ordering payments was eight days.\textsuperscript{17}

This procedure may be compared with the sixth point in the statement of principles of private workmen's compensation carriers\textsuperscript{18} which is, "Employers should be given every assistance in obtaining an adequate understanding of the proper operation of the workmen's Compensation System. The necessity for promptly reporting the occurrence of injuries should be impressed upon them by agent or broker . . . ." If there is a need for impressing these things upon an employer, where the responsibility is upon the employer to report accidents, there is an even greater need for educating employees who are not experienced in making reports. Periodically, members of the staff of the commission made speeches to industrial personnel and medical groups concerning the importance of prompt reporting.\textsuperscript{19} Report forms could be made available to employers upon their request.

\textsuperscript{17} Loc. cit.
\textsuperscript{18} P.12, Supra.
\textsuperscript{19} Interview, C. C. Grubbs, Assistant Supervisor, Claims Section, July 7, 1954.
However, no very effective procedure was ever attempted which would go directly to the individual worker and educate him regarding his rights and responsibilities under the statute and procedures of the commission.

The acceptance by the commission and its staff of long periods of delay in reporting claims to it gives rise to a question whether or not it had achieved the "high level of social awareness" and "complete appreciation of its responsibilities" as the operators of an insurance fund such as the private insurance carriers had set for themselves in the handling of workmen's compensation insurance.

This record indicates that over a long period of time excessive delays in the reporting and processing of claims for benefits under the workmen's compensation statute have been permitted to persist. A portion of the delay in reporting claims can be attributed to the policy of the members of the commission of placing upon the disabled worker the burden of assembling and forwarding all the information that would be needed for an initial determination of the merits of the claim. This policy, in turn, was conditioned by the smallness of the appropriations granted for the administration of the act. An amendment in 1953 permitted two-thirds of the administrative cost to be taken from premiums, but the legislative appropriation still put a ceiling on the maximum expenditure.

The time taken by the commission, as an agency, in making the relatively simple decision of whether to pay a
claim or to submit it to further procedures remained approximately the same during a period of forty years. In the following two chapters the procedures followed in 1954 in processing clearly compensable claims will be examined in terms of the work done and the time consumed. Chapter VIII will critically examine this 1954 procedure to see if the Industrial Commission, if it had tried, could have revised its procedures to the point where the initial determination of the merits of the claim and the issuance of the first check for valid claims could have been expedited without a great increase in costs or a sacrifice of the interests of the employer or of the general public.
CHAPTER VI

RECORD KEEPING PROCEDURES PRIOR TO
THE INITIAL ADJUDICATION OF LOST-TIME CLAIMS

To determine the compensability of a claim for workmen's compensation benefits, the agency administering the law needs to know the details of the accident or occurrence which caused the disability, as well as medical information establishing the extent of disability. The receipt of a claim necessitates the establishment of procedures for verifying the coverage of the employer by the state insurance fund, for evaluating the claim on its merits, for recording and filing it.

The Ohio Industrial Commission applied mass-production techniques and kept all the lost-time claims for benefits, which arrived on a specific day, together for a series of eleven steps before any claim received individual attention by a claims examiner who had the delegated authority to exercise discretion in evaluating the validity of the claim. Each of these eleven preliminary steps was non-discretionary, or ministerial. They consistently required a total of two and one-half working days. During the period when the new lost-time claims were kept together in a group, they

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were accompanied by a mimeographed "claim flow sheet" upon which the time the group arrived at and left each successive station in the claim flow was recorded. These claim flow sheets were studied for the period of January through June, 1954, inclusive, and the time taken for each step was calculated.

Record keeping is necessary for any governmental agency, large or small. However, it should be secondary to the main mission of the agency. It should be neither too little nor too great, but should be adjusted to the general level of activity which is required for the job. Optimum record keeping should be adjusted to the total operation with an eye to its correct timing and sequence so as to avoid interference with the substantive work to be achieved by the agency.

Each year the Industrial Commission received approximately forty thousand claims in which the employee had an occupational disability lasting more than seven days. The advantages of division of labor dictated the development of a routine through which each new claim must pass before even the clearly compensable claims could be authorized for payment. The procedure followed in the summer of 1954 was to keep together all the new lost-time claims for a sequence of steps before they received a

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1 The volume of claims in 1953 is shown in TABLE III.
preliminary adjudication, which was the so-called "first hearing" by the claims examiners. The group of claims passed from one of the sections of the commission's staff to another section seven times before this first exercise of discretion. Where such a division of labor and procedure of steps in established there is always danger of congestion and malfunction at any one of the steps. Thus the whole process could be delayed. The claim flow for clearly compensable claims is shown in CHART II.

There is no other agency, either in the state or elsewhere, whose problems are sufficiently similar to the Industrial Commission that it could be used as a yardstick to measure the time consumed in the commission's routine procedure. Therefore it was incumbent upon the commission to develop its own time goals and to develop sufficient supervision to see that these goals would be met once they were established.

In setting these time goals, the three members of the commission had to balance the needs of a lost-time claimant for the fastest payment of his claim possible against the need of developing an administrative organization in which issuing the first payment in a lost-time claim was only one of numerous functions. The fact that workmen's compensation laws create an exclusive remedy for the injured worker in place of the unlimited recovery possible under the common law, and that therefore the compen-
CHART II
CLAIM FLOW OF CLEARLY COMPENSABLE CLAIMS

<table>
<thead>
<tr>
<th>Days</th>
<th>Unit</th>
<th>Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mail-Supply</td>
<td>1. Claim received; forwarded to claim section</td>
</tr>
<tr>
<td>1</td>
<td>Claims</td>
<td>2. Mail sorted; disposition determined</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Inspected for signatures; sorted</td>
</tr>
<tr>
<td>2</td>
<td>Actuarial</td>
<td>4. Inspected for coverage; manual code, risk no.</td>
</tr>
<tr>
<td></td>
<td>Accounts</td>
<td>5. Sorted; inspected for coverage</td>
</tr>
<tr>
<td>2</td>
<td>Claims</td>
<td>6. Claim number assigned and entered</td>
</tr>
<tr>
<td></td>
<td>(index unit)</td>
<td>7. Permanent record; docketing; notice to B.U.C.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8. Acknowledgment and fee bills sent</td>
</tr>
<tr>
<td>3</td>
<td>Safety-Hygiene</td>
<td>9. Safety statistical data coded and recorded</td>
</tr>
<tr>
<td></td>
<td>Claims</td>
<td>10. File folder, file location designated</td>
</tr>
<tr>
<td></td>
<td>(examining unit)</td>
<td>11. Claimant's weekly wage determined</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12. Claim evaluated and allowed or disallowed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13. Information sheet authorizing payment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>14. Hearing date entered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15. Weekly rate, period of compensation computed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>16. Typewritten award sheets prepared</td>
</tr>
<tr>
<td></td>
<td></td>
<td>17. Recheck for error</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18. Award sheet forwarded; claim filed</td>
</tr>
<tr>
<td>5</td>
<td>Accounts</td>
<td>19. Inspected for coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20. Figures rechecked, accrued amount computed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21. Check written, recorded on warrant register</td>
</tr>
<tr>
<td>6</td>
<td>Actuarial</td>
<td>22. Check proofread against award sheet</td>
</tr>
<tr>
<td></td>
<td></td>
<td>23. Notice of award prepared</td>
</tr>
<tr>
<td></td>
<td></td>
<td>24. Check and notices of award mailed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25. Posting of accounts</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>26. Entered in employer's record as merit system data</td>
</tr>
</tbody>
</table>
sation payment as a substitute for wage income may often be the sole financial resource of the claimant, would be one strong factor in favor of granting a much higher priority to this function of the agency than to other functions.

Each step in the work flow procedure should be analyzed by a good administrator in terms of its proper place in the sequence and in terms of whether it should be performed at all. Once it is approved and placed in the sequence a time goal should be set for it, based upon past experience and the possibilities of quicker action. Supervisory techniques should be established to determine whether time goals are being met.

A prominent writer on administrative law has described the handling of uncontested claims by a claim agency as follows:

The huge volume of small cases handled by claims agencies present in exaggerated form the necessity for institutional methods. It is worth repeating that anyone who examines even superficially the group system of the Social Security Board will be readily convinced that personalized decisions would be unthinkable. Ninety percent or more of the claims are finally handled by deft fingers and quick eyes of carefully trained clerks whose work is checked by other clerks. Problem cases may go to superior clerks, who in turn may send them on to appropriate specializing groups or even to high policy-forming officers. The primary function of the chiefs becomes one of executive management of a large staff.2

These remarks were borne out in the procedures followed in the handling of workmen's compensation claims in Ohio. The procedures used for processing clearly compensable claims can be divided into three periods: (1) the time from the arrival of the claim until it had been verified for coverage, recorded, statistical information extracted, and delivered to the claims examiners, (2) the period in the examining unit while it was approved and a pay authorization delivered to the accounts section, and (3) the preparation and mailing of the first check to the claimant.

The first of these periods is covered in this chapter. During this period the group of new lost-time claims was sent through eleven steps involving verification of whether the employer had paid premiums into the state insurance fund, the assignment of a claim number and the acknowledgment of the receipt of the claim, and the extraction of statistical data regarding the claim. These steps were followed in a rigid fashion with only a few variations for exceptional cases.

During the summer of 1954, the writer made a field study of the procedures followed and the time used during each of the eleven steps preceding the examination of the claim by the claims examiner. While the group of claims was being moved through the steps, it was accompanied by a mimeographed sheet upon which the time of arrival and departure from each of the units was to be marked. These
mimeographed sheets were available for each of the one hundred fifty-one days of January through June, 1954 that claims were received. Desk interviews were used in each section or unit to obtain the information relative to procedures followed. The various steps through which these claims passed are shown in CHART II, page 125, Supra, along with a time scale. The amount of time elapsing in each step, and between steps, is shown in TABLE VI, page 138, Infra, and in more detail in TABLES XI through XXIV, inclusive, in APPENDIX B, Infra. The purpose of each step and the procedures used will be discussed in order:

Opening and Sorting the Morning Mail for the Commission

The incoming mail for the entire commission was picked up at 7:00 each morning Monday through Saturday, by personnel of the mail and supply unit of the cashier-paymaster section. It was sorted and delivered to the other sections before the latter opened at 8:00 a.m. This same unit had the responsibility of picking up outgoing mail from the other sections three times a day. At 4:00 p.m. each day personnel of the unit delivered such mail to the Columbus post office. The exact time consumed in this step was not recorded on the mimeographed claim-flow sheet.

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3 Interview, Otis C. Massie, head of the mail and supply unit, Ohio Industrial Commission, July 8, 1954.
Sorting Mail in the File Room of the Claims Section

All mail relating to a claim for workmen's compensation benefits was delivered to the file room of the Claims section. From 8:00 a.m. to approximately 8:30 a.m. all the personnel in the file room assisted in opening and sorting the mail. All mail relating to self-insurers was separated from the claim flow and sent to the self-insurer unit of the claims section. The further processing of these claims is discussed in APPENDIX A, Infra. From eight hundred to nine hundred new medical-only claims and approximately one hundred new lost-time claims were received each day.\(^4\) The mail was divided into three categories of (1) new claims (2) fee bills in old cases, and (3) all other correspondence. The new claims were divided further into lost-time claims and medical-only claims.\(^5\)

Sorting New Claims by the Index Unit

The new lost-time claims were alphabetized accord-

\(^4\) The number of new lost-time claims frequently ran as high as two hundred on Saturday, due to the tendency of employers to accumulate them and mail them at the end of the week. There was a small number on Monday, usually numbering about thirty, but on the other days of the regular week the number was generally around one hundred. The opening and sorting of the claims was the only work of processing claims done on Saturday, and they were sent to the next step in the sequence on the following Monday.

\(^5\) Interview, Lawrence Bates, head of the file unit, Claims section, Ohio Industrial Commission, July 8, 1954, and observation of the process over a period of several days during July, 1954.
The transportation of the new lost-time claims from the recording unit to the next step in the actuarial section was done on a mechanical conveyor which took only a matter of seconds. However, the range of time (TABLE XIII) shown on the mimeographed claim-flow form varied considerably whenever the conveyor was used. The time lapse was due either to a delay in putting the claims on the conveyor after they were finished in one section or in beginning on them after they arrived. It was impossible from the control sheet to determine where to assess this delay or how to divide it.

Ascertaining Manual Code and Risk Number by the Actuarial Section

The actuarial section had the only alphabetical record in the commission of all employers who had ever been insured by the state insurance fund. There was a card on each insured employer which showed the manual code which had been assigned to him. Various types of occupations had been classified on the basis of experience in terms of in---

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6 Interview, Paris Woolery, Chief, Index Unit, Claims Section, Ohio Industrial Commission, July 9, 1954.
juries suffered within the classification. The manual code assigned to the employer showed his classification in terms of hazard, which in turn affected the employer's premium rate. The risk number identified the individual employer. If there were no card in the file for the employer, it was not necessarily proof that he was not insured since the files in the actuarial office were not kept up-to-date by the accounts section which had the official information. The addition of the manual code and the risk number had to be done before the claims were sent to the latter section because there the coverage information was filed according to the last two digits of the risk number assigned to the employer.  

The Check of Coverage by the Accounts Section  

When the claims arrived at the accounts section they were sorted numerically according to the last two digits in the risk number. Coverage information was kept in four large ledgers, divided numerically according to numbers from 00 to 99, with twenty-five numbers to each ledger. The claims were then checked against the coverage information in the ledgers. Coverage or non-coverage was noted on the form. Non-covered claims stayed with the

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7 Interview, William C. McAuliffe, Assistant Chief, Actuarial Section, Ohio Industrial Commission, July 15, 1954.
rest of the claim flow until the next step.  

The time that the claims arrived at and left the accounts section was never entered upon the mimeographed claim-flow form. For that reason the figures given in TABLE XVI, APPENDIX B, Infra, include the transportation time before and after the work was done in the accounts section. The new lost-time claims were returned to the index unit of the claims section about mid-day on the day of their arrival with the commission.

**Assigning Claim Numbers, Docketing the Claim, Preparing a Permanent Index Card**

When the group of new lost-time claims was returned to the claims section at mid-day, it was delivered to a single clerk who had the responsibility of assigning a claim number to each. The claim number assignments were numerically consecutive. Any claim on which non-coverage had been discovered had "-27" added to the claim number. Non-coverage claims were removed from the flow and sent to the correspondence unit. In addition, the single clerk prepared a sheet for the permanent docket ledger. This sheet became the permanent record upon which the dates of all hearings on the claim would be recorded from time to time. Two carbon copies were made of the docket sheet.

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The first carbon was on an index card which was later filed in the one central index of claims filed with the commission. This permanent index file was arranged alphabetically according to the name of the employee. The second carbon copy was sent to the Ohio Bureau of Unemployment Compensation to be used for a cross-check as to whether an employee was drawing both workmen's compensation and unemployment compensation benefits for the same period of absence from work.9

The entire claim flow was halted for a median average time of six hours, forty-five minutes, while this work was being performed by a single clerk. There was nothing so specialized about this work that it could not have been divided among several clerks for shorter periods. The entire step in the claim flow appears to have become virtually the full-time job of a single employee.

Sending Acknowledgments and Fee Bills to Persons Concerned

After the docketing process had been completed, the docketing clerk turned the files over to four clerks, whose desks were nearby. It was the duty of these clerks to send a postcard both to the claimant and to the employer, acknowledging receipt of the claim and informing them of the claim number assigned, along with a request that the claim

9 Interview, Woolery, op. cit.
number be placed on all correspondence related to the case. On the acknowledgment card there was a further statement that two weeks were required to process the claim after its receipt and that the claimant should not ask for the status of his claim within three weeks, since it would take the claim out of the routine of hearing and delay its consideration.  

The four clerks checked the claim form and mailed a fee bill to everyone who was listed as having rendered any medical services or having furnished any medical material. A special form was available for the doctor, since it required considerable detailed information about the treatment, progress, diagnosis, and prognosis of the case in addition to his fee bill.

From five to six hours were required for the accomplishment of this step. However, the hours listed on the claim flow sheet indicated some overlapping between the time the docketing was finished and the time the clerks began sending the cards, which would indicate that a portion of the group of claims changed hands on some of the days before the docketing of the entire group was finished. For this reason the total time consumed in the two steps is shown in TABLE XX. Slightly less than twelve working hours,

10 Loc. cit.
11 Loc. cit.
or one and one-half working days were consistently re-
quired so that the sending of the acknowledgment cards was
generally finished at the end of the second day that the
new claims were with the commission.

Coding of the Claims Statistically by the Safety and
Hygiene Section

In the safety and hygiene section a single clerk
translated the information on the form according to a
schedule into numbers. This related to the age, sex, and
number of dependents of the claimant, the occupation in-
volved and the number of days lost. In other places on the
form there was space for coding the date of the injury, the
date the report was filed, the lag in reporting, the hear-
ing lag and the payment lag. However, since the reports
were coded before the claim was examined by the claims ex-
aminers and a decision made on its merits, only the infor-
mation relating to the reporting lag was coded. After the
information had been translated into numbers and entered
in the blocks on the claim form, the forms were taken to
punch-machine operators who punched the information into
I.B.M. cards.¹² The account of the procedures used in the
1930's, which is given by Dodd,¹³ indicates that at that

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¹₂ Interview, Scott Kallenbaugh, Assistant Superintendent, Safety and Hygiene Section, Ohio Industrial Com-

¹³ Dodd, op. cit., pp. 139-142.
time this step was performed after the claims had been adjudicated by the claims examiners.

Placing the Claim Applications in Folders

The new lost-time claims then were returned to the file room for official filing. Each claim was placed in a separate folder and at the same time a charge-out card was prepared bearing the claim number. The files were charged to the examining unit and the charge-out card was filed in the place in the file room where the file would eventually go. The new file was then placed on a file truck to be taken to the examining unit for further processing.\(^{14}\)

The total amount of time used for this series of steps consistently was two and one-half working days. With the exception of the check for coverage none of the processing involved added anything which would affect the decision of the claims examiner upon the claim. It was easier for the various clerks to work on the entire group of claims together rather than having them in small groups. The standardized procedure assured that all of the work would be done on all the claims. However, it is seriously questioned whether the convenience of handling was justified in the light of the resulting delay in the adjudication.

\(^{14}\)Interview, Bates, op. cit.
TABLE VI
TIME LAG IN STEPS PRECEDING EXAMINATION OF NEW LOST-TIME CLAIMS BY A CLAIMS EXAMINER. JANUARY THROUGH JUNE, 1954

<table>
<thead>
<tr>
<th>PROCESSING STEPS</th>
<th>SECTION RESPONSIBLE</th>
<th>TIME RANGE:</th>
<th>MEAN AVERAGE TIME ELAPSED</th>
<th>MEDIAN AVERAGE TIME ELAPSED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sorting Mail</td>
<td>Claims (file)</td>
<td>1 hr. 15 min.</td>
<td>38.44 min.</td>
<td>35 min.</td>
</tr>
<tr>
<td>Inspected; Sorted</td>
<td>Claims (index)</td>
<td>1 &quot; 50 &quot;</td>
<td>39.96 &quot;</td>
<td>35 &quot;</td>
</tr>
<tr>
<td>Transportation to Actuarial Coverage; Code: Risk no.</td>
<td>Actuarial</td>
<td>3 &quot; 00 &quot;</td>
<td>1 hr. 20.58 &quot;</td>
<td>1 hr. 17.5 &quot;</td>
</tr>
<tr>
<td>Checking Coverage</td>
<td>Accounts</td>
<td>1 hr. 15 min.</td>
<td>35 min.</td>
<td>35 min.</td>
</tr>
<tr>
<td>Docketing and Recording</td>
<td>Claims (index)</td>
<td>10 &quot; 30 &quot;</td>
<td>41.05 &quot;</td>
<td>45 &quot;</td>
</tr>
<tr>
<td>Transportation to Typists *</td>
<td>Claims (index)</td>
<td>46 &quot; 25 &quot;</td>
<td>-16.44 &quot;</td>
<td>-55 &quot;</td>
</tr>
<tr>
<td>Acknowledgments Sent</td>
<td>Claims (index)</td>
<td>10 &quot; 37 &quot;</td>
<td>57.17 &quot;</td>
<td>15 &quot;</td>
</tr>
<tr>
<td>Transportation to Safety Section</td>
<td>Claims (file)</td>
<td>2 &quot; 00 &quot;</td>
<td>14.04 &quot;</td>
<td>10 &quot;</td>
</tr>
<tr>
<td>Statistical Data Coded</td>
<td>Safety-Hygiene</td>
<td>6 &quot; 05 &quot;</td>
<td>40.10 &quot;</td>
<td>40 &quot;</td>
</tr>
<tr>
<td>Transportation to File Room</td>
<td>Claims (file)</td>
<td>5 &quot; 20 &quot;</td>
<td>32.13 &quot;</td>
<td>20 &quot;</td>
</tr>
<tr>
<td>Claim Put in Folder</td>
<td>Claims (file)</td>
<td>1 &quot; 255 &quot;</td>
<td>25.09 &quot;</td>
<td>25 &quot;</td>
</tr>
</tbody>
</table>

TOTAL MEAN AVERAGE ELAPSED TIME (12 STEPS) 2 days, 4 hours, 28.18 minutes

*Involves some overlapping between units, which are marked with a minus sign.

SOURCE: Based upon daily work flow sheets for the period, filed in the Claims Section, Ohio Industrial Commission.
tion and possible payment of the claim. An alternate procedure for handling a centralized claim flow will be discussed in Chapter VIII, Infra.

All the steps described in this chapter were purely ministerial in their nature. They can be evaluated in terms of efficiency alone. At none of these points were members of the staff permitted to exercise any discretion delegated to them by the members of the Industrial Commission. Little, if any, of the processing of the claims during this period of two and one-half days had any influence upon the determination of the merits of the claim. This amount of delay for the performance of ministerial operations before any exercise of discretion by members of the staff of the agency is not in accordance with the first principle of good claims handling announced by private insurance carriers that "all legitimate claims should be paid promptly and fully".

In the following chapter additional steps in the procedure followed for all clearly compensable claims will be described. These latter steps involved a combination of record-keeping and decision-making, so they must be evaluated both in terms of efficiency and of equity.
CHAPTER VII

THE ADJUDICATION AND
PAYMENT OF CLEARLY COMPENSABLE CLAIMS

The variation of complexity of claims for workmen’s compensation benefits made it possible for the Industrial Commission to delegate different amounts of discretion to two sets of employees to make an award in the name of the commission. In a large proportion of claims filed against the state insurance fund, sufficient discretion was delegated to a group of claims examiners to award benefit. In a portion of the remaining claims a group of legal reviewers made an award. The remainder received a hearing after notice by the commission or someone designated by it.

The initial examination by the claims examiner was a desk operation based upon the file. No oral testimony was received. It was customary for the staff of the commission to refer to these initial desk examinations of a claim as a “first hearing”. The claims examiners were strictly limited to a check of whether the claim conformed with the provisions of the workmen’s compensation statute. If it did he was limited to directing the award of the benefits provided by the statute. If the case involved any medical
or legal questions he had to refer it to others on the commission's staff for more detailed examination before the initial decision was made. If any requisite facts were missing in the application for benefits, the examiner had no authority to assume them nor to draw inferences from the facts given.¹

The steps involved in the processing of a clearly compensable claim from the time it reached the examining unit until a check was mailed are shown in CHART II (page 125, Supra). During the summer of 1954 a field survey was also made of these steps. Information regarding the procedures used in the claims and accounts sections was obtained through desk interviews. These steps will be discussed in succession.

Wage Setting

In cases in which the claimant lost more than seven days from work, the amount of workmen's compensation benefits paid him was contingent upon his wage up to the statutory maximum. During the first twelve weeks of disability, the disabled worker's benefits were calculated on the basis of his full wage at the time of the injury. After the disability had continued more than twelve weeks the worker's benefits were calculated on the basis of his average weekly

¹ Interview, C. C. Grubbs, Assistant Supervisor, Claims Section, July 7, 1954.
wage for a year prior to the disability.²

While the new lost-time claims were still in a group from the file room they were delivered to an examiner who had the responsibility for determining the "full" wage of the employee at the time of the accident. Except for adding tips and payments in kind, the figuring of the full wage was a simple matter and could be done rapidly. On the first examination of a total-temporary claim there was no need to consider the average weekly wage unless the report was made extremely late and the claimant had already suffered twelve weeks of total temporary disability. In all cases in which payments were based upon the average weekly wage it was necessary to obtain detailed information of the claimant's weekly earnings for the previous year. The group of new lost-time claims usually arrived at the desk of the wage setter about mid-day. This step could usually be completed in less than an hour.³

The "First Hearing" by the Claims Examiner

The new lost-time file generally contained only the three-part claim form when it was delivered to the desk of a claims examiner. However, in some cases it might include a more detailed physician's report, a statement from the

² 1465-84 G.C.

³ Interview, George Thompson, Chief, Claims Section, Ohio Industrial Commission, July 7, 1954.
employer or employee amplifying the information on the form, or a letter from an attorney or representative of one of the parties. Since the file was brief it could be read and considered rapidly. In approximately eighty-five per cent of the cases no problem appeared and it was merely necessary to read the file over to see that the facts furnished met the requirements of the law.

The description of the accident had to indicate that it was incurred in the course of the employment; this was checked against the nature of the employer's business. The nature and location of the injury had to show a connection with the accident. One of the questions on the employer's part of the report had to be checked to see if he agreed with the claimant's statement or what the points of disagreement were. The physician's prognosis of the probable length of total-temporary disability was important because if the case were compensable, the length of the award would be based on the date the physician felt the claimant could return to work. The claims could be examined rapidly and it rarely took an examiner longer than five minutes to make the initial basic decision either that the award should

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4 Interview, George Thompson, September 1, 1954.

5 Of the claims filed in 1953, 67.76% were claims involving only medical expenses in which payments were authorized by the claims examiners, and 18.64% were lost-time claims disposed of in a similar manner.
be authorized or that it should be referred elsewhere for further consideration or investigation. It is difficult to generalize on the length of time required for such exceptional cases.  

The claims examiner decided whether a claim in a lost-time case was meritorious and within the provisions of the statute. If so, he filled out an authorization to the claim-sheet typists to make out an award sheet to be sent to the accounts section authorizing payments. On the form so used by the claims examiner there were spaces in which the date of the injury, date disability began, date of return to work, nature of the injury, and full weekly wage were filled in. There was also space in which any medical bills could be authorized for payment, but these bills were usually submitted later. At the bottom of the form the claims examiner wrote the inclusive dates for and rates at which payments were to be made.

Each of the claims examiners maintained a detailed record of his daily work load, which showed, among other things, the number of first hearings and subsequent hearings on both lost-time and medical-only claims. An examination of these monthly reports of the examiners re-

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6 Based upon conversations with most of the claims examiners over a period of several days.

7 Loc. cit.
vealed that out of the total of approximately forty examiners in the unit, the bulk of the first hearings on lost-time claims were handled by from twelve to fourteen of them. The others worked on medical-only claims or had specialized jobs. The work reports of this small group of claims examiners who generally received most of the lost-time first hearings were studied for the months of January through June, 1954. This indicated that their work load remained quite constant. A more detailed examination was made for the month of May, 1954, which showed that the number of lost-time first hearings examined and approved for payment each day ranged from one to sixty. The mean average number was 12.52 claims per day and the median average was ten per day. The new lost-time claims were generally distributed among the small group of claims examiners without any regard to the content of the claim. Occasionally the supervisor of the claims section personally looked through the group of new claims ready for distribution to the examiners and made the distribution on the basis of giving more difficult claims to more experienced examiners.

When the delay in making a first payment of compen-

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8 Based upon a field study, 1954.

9 Interview, C. L. Barber, Chief Examiner, Claims Section, Ohio Industrial Commission, July 12, 1954.
sation benefits was causing hardship to the claimant, the initial decision on the claim was expedited. This was usually the result of a personal visit to the claims section by a claimant urgently in need of compensation which had accrued but which for some reason had been delayed in the processing of the claim. In other cases the claim might be called to their attention by the Red Cross, a community organization, or a minister. If the claimant appeared in person he was interviewed by the supervisor or assistant supervisor as soon as the file was located. If quick payment was authorized, the file was referred to a specific claims examiner. It was examined and, if payment was found to be in order, the necessary forms were prepared at once and given a high priority at all steps in the payment process. They were generally paid in a few hours.10

There was one other instance of special referral of a type of fee bill to a specific examiner. By a special agreement reached with the nurses of the state during World War II, whenever a nurse's bill was received it was sent to a specific file clerk who was not bound by routine channels in the return of a file which had been checked out. As soon as the file was located it was brought to a specific claims examiner who gave it priority over other

10 Interview, Thompson, op. cit., September 1, 1954.
work on the desk. The examiner expedited the preparation of the award sheet and its delivery to the accounts section for payment.\textsuperscript{11}

There were many cases in which the examiner approved the claim for immediate award, but felt that additional correspondence should be sent to the claimant after the file had been processed for the first payment under the award. In such a case the claims examiner put a memorandum to the correspondence unit in the folder. After the award sheet had been sent to the accounts section, the file was charged out to the correspondence unit as soon as it was returned to the file room. Thus if it appeared from the file that the claimant would suffer some degree of permanent-partial disability, a form letter outlining his rights to apply for additional benefits was available. However, in August, 1954, the custom of sending such a letter after the adjudication of the claim was discontinued.\textsuperscript{12} In cases in which it appeared that the claimant would suffer more than twelve weeks of total-temporary disability, a form letter notified him that, unless he furnished the wage information upon which his average weekly wage for the year prior to disability could be figured, his payments would cease after twelve weeks. In other cases in which a more

\textsuperscript{11} Interview, Bates, \textit{op. cit.}

\textsuperscript{12} Interview, Thompson, \textit{op. cit.}, September 1, 1954.
specialized letter should be sent to the claimant or employer, the claims examiner drafted a few brief directions from which the clerks in the correspondence unit composed a letter.13

**Docketing**

Four or five times a day the clerk in charge of the docket ledger toured the desks of the claims examiners and picked up the new lost-time claims which had been authorized for payment and placed in a special out-box on the examiners' desks. This docket clerk then arranged the files numerically according to claim numbers and stamped a "hearing" date on the file jacket and in the box on the docket sheet. The date that was stamped was not the date that the file was actually examined by the claims examiner, but the date when it would later be examined by one of the claims checkers. There was frequently a two-day differential, and sometimes it was greater. The docket sheet was designed to show at a quick glance the date of all official considerations of the claim. This included not only the desk "hearing" by the claims examiners but also included certain types of orders issued in the legal section in the name of the commission, oral hearings before a referee board or commis-

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13 Interview, Harriet Wylie, Acting Head, Correspondence Unit, Claims Section, Ohio Industrial Commission, July 8, 1954.
sion, and the more formal rehearing. When the group of new lost-time claims was entered in the docket ledger, the docket clerk took the group to a clerk who used a comptometer to figure the exact amounts payable under the authorization of the examiner. This delivery was made four or five times a day.\textsuperscript{14}

**Exact Figuring of Amounts Due**

At the figuring stage, a clerk translated the inclusive dates for which an award had been authorized into full weeks and sevenths of a week. If the rate at which payment was to be made was below the maximum, the clerk checked the mathematics of the claims examiner on a comptometer and then multiplied the rate by the period of payment to figure the total amount of the disability benefits authorized. It took the clerk no more than a minute to figure each of these. This was only a portion of the work done each day by the comptometer clerk, but she gave priority to the calculation of the mathematics of new lost-time claims and set them aside in a special place on her desk where they could be picked up and taken to the correspondence unit for the next step. Sometimes this was done by the regular clerk from the file room who made periodic tours delivering and picking up files in the claims section, and at other

\textsuperscript{14} Interview, Thompson, \textit{op. cit.}, September 1, 1954.
Preparation of the Payment Authorization (Form C-7)

The new lost-time claim files upon which an authorization had been made were placed in a bin in the correspondence unit from which they were picked up by the chief of the unit and distributed to the claim-sheet typists in a typing pool of twenty-five typists. Normally such files were distributed to eight or nine of the typists. Each typist submitted a work sheet each day showing how many claims she had handled and their type. These work sheets were examined for a period of several days and it was indicated that on some occasions fifty to seventy-five of the new lost-time authorizations of first payment on a claim were given to only two or three of the typists.

It usually took the typist about three to four minutes to translate the information contained on the authorization by the claims examiner onto an individual form C-7, which was the official authorization to the accounts section to make payments of benefits. The typing was a routine matter and any of the typists in the pool could do it. If a typist were to work all day on typing such forms, the production of one hundred fifty such forms

15 Loc. cit., and observation of the working of the section.

16 Interview, Wylie, op. cit.
would be considered a standard day's work. The more widely they were divided among the typists, the shorter would be the production time. Several times a day the claim-sheet typists took the files containing the completed C-7's to a set of four metal four-drawer filing cabinets where they were placed to await an examination by one of five claims checkers who reviewed the file to see that the work done on it complied with the statute and the regulations of the commission.¹⁷

In order to maintain the legal fiction of a hearing in accordance with the requirements of due process, the form C-7 authorizing payment was drafted as a motion made by a member of the commission authorizing the issuance of payment to the payee named. The form showed the hearing date and bore the stamped signature of the secretary of the commission.

**Examination by the Claims Checkers**

Five of the older, more experienced claims examiners checked the file after the C-7 authorization of payment had been prepared. They performed a similar function on files where subsequent action or "hearing" had been taken by a claims examiner, legal reviewer, board, or the commission. From the standpoint of the claims checker,

¹⁷ *Loc. cit.*
the checking of the first hearing of a lost-time claim could be done more rapidly than the checking of a subsequent action on a claim because the file was smaller and less complicated. It generally took from two to three minutes to check a first hearing by the claims examiner. One checker could handle one hundred fifty first hearings in a half day. The volume of first hearings handled by the claims checkers each day was regulated by the clerk who stamped the dates in the docket. The daily work load determined for the five claims checkers was six hundred files, which included about one hundred fifty first hearings on lost-time claims. When the quota for a specified date had been stamped onto the folders and docket sheet, this clerk changed the date stamp to the next working day and began stamping the new date. Markings were placed on the file drawers to indicate the hearing date and whether the action taken was a first hearing or a subsequent hearing on a lost-time claim. The files were placed in the drawers accordingly by the claim-sheet typists after the completion of the form C-7. When an error was discovered by a claims checker, the file was returned to the claims examiner or typist who had made the error for correction.18 There was no evidence that priority was given to the checking of

18 Interview, W. Stanton Hanners, claims checker, Claims Section, Ohio Industrial Commission, July 15, 1954.
first hearings on lost-time claims over the checking of the subsequent actions. The five claims checkers worked from the drawers without a definite pattern other than that all of the claims for a specific hearing date were checked before work was done on the files for the next hearing date. On some occasions all one hundred fifty new lost-time files were checked by a single claims checker and on others several of them checked a portion of them. Whenever the checkers finished all the claims assigned for the current date, they began on the claims in the drawers for the next day. There was frequently a time lag of two or more days between the examination by the claims examiners and the re-examination by the claims checkers.

Recheck of Mathematics

As the checking was completed, the files were carried by the checker to a comptometer operator who rechecked the correctness of the mathematical calculations made in connection with the claim. This was a different clerk from the one who had made the original calculations. This re-check could be made as rapidly as the original comptometer

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19 Based upon examination of the work load reports.

20 Based upon observation in the examining unit during July, 1954.
calculation. It is submitted that this second check of the mathematics involved was of questionable value, since this operation was performed again later in the accounts section.

Separation of the Form C-7

After the mathematical recheck, the file was delivered by the clerk from the file section to a clerk who separated the files according to first and subsequent hearings. Each C-7 was then separated with the carbon copy remaining in the file. In a similar manner the payment authorizations from the subsequent hearings were separated. The pay authorizations were removed from the files and arranged numerically by claim numbers into two groups for first and subsequent hearings. Each group of payment authorizations was counted by the clerk, who then took the two groups to the accounts section along with a slip of paper which showed the number of first and subsequent hearings in the respective groups and the time of their delivery to the accounts section. A clerk in the accounts section signed the slip. The head of the accounts section later reported to the head of the claims section the exact time that the processing of the forms was completed and the

21 Interview, Hanners, op. cit.

22 Based upon observation and conversations with the clerks performing these functions.
checks were ready for mailing.

The claim file itself was picked up by a clerk from the file room and returned to that point. It was then either placed on the file shelf or sent to the correspondence unit for further action. 23

The Time Lag in Processing Claims in the Examining Unit

The claims section maintained another mimeographed record sheet which showed the time each group of new lost-time claims arrived in the claims section and the time the group was transmitted to the accounts section for payment. These forms were examined for the period of January through June, 1954. The previously-discussed claim-flow form showed the time elapsing from the arrival of the claims until they were ready for transmission to the examining unit. This latter form showed that the elapsed time was quite consistently two and one-half days (Chapter VI, Supra). By subtracting the shorter period, it was possible to obtain detailed information on the time lag between the arrival of the claims in the examining unit and the time of their transmission to the accounts section. The elapsed time for the entire time span varied widely during the six-month period from six working days, four hours and 26.8 minutes in January, 1954, to three working days, seven hours

23 Interview, Bates, op. cit.
and 43.8 minutes in May, 1954. When the two and one-half working days used for processing is subtracted, it shows that the time span in the examining unit varied widely from one and one-half to four working days. There was no comparable variation in the volume of claims handled which would account for this wide variation in elapsed time.

Criticism of Procedures in the Examining Unit

The steps in the claim flow from the time the new lost-time claim arrived at the desk of a claims examiner until the time when the form C-7 was sent to the accounts section involved a combination of discretionary and non-discretionary steps. However, the discretionary steps involved a relatively circumscribed amount of discretion. It was necessary that the claims examiners be thoroughly familiar with the requirements of the workmen's compensation statute bearing upon the compensability of a claim and the amount of benefits authorized. The key to the activity of the claims examiners was accuracy. The re-examination of the file by the claims checkers was a justifiable check of the accuracy of the claims examiners made by more experienced employees. The exercise of discretion should not be rushed, nor subject to a time-schedule. However, little priority was given to the handling of new lost-time claims by the claims examiners and checkers in
relation to their other work. The key to the non-discretionary steps in this portion of the claim flow was speed and accuracy.

The claims examiners usually received new lost-time claims in the early afternoon. During the morning they had received a work load of files which had required a second, or subsequent, examination for such things as the authorization of the payment of a medical bill. There was no requirement that the claims examiners give a priority to "first hearings" over the other work on their desks. The same can be said of the work load of the claims checkers. Although the exercise of discretion should not be rushed, the giving of a priority relative to the type of decision-making function which shall be performed first should not be confused with a sacrifice of fairness and equity to speed. There is no harm in assigning several operations to the claims examiners and checkers, but the members of the commission or the appropriate member of their staff can be criticized for their failure to give a greater priority to this exercise of discretion. Further research and analysis would be required to determine whether the failures in the timing of the exercise of discretion can be attributed to the section supervisor or whether they should be attributed to deficiencies of the administrators at a higher level.

The non-discretionary steps in this phase of the
claim flow called for speed and accuracy. Actually each of these steps required that little time be devoted to any one claim. During most of the one and one-half to four days, the individual claim was in "storage" awaiting detailed attention. The production line was adjusted to a rate which was accepted by the administrators as a standard day's work. When there was an increase in the work load above that point backlogs of work developed. This was most clearly illustrated by the fact that at times there were two or more days' work in the file cabinets awaiting the attention of the claims checkers. It is suggested that a better utilization of the limited personnel of the examining unit could have maintained a more uniform claim flow at this point in the process. Also, improvements could have been made at each of the non-discretionary operations which would have speeded the claim flow by making a wider distribution of that portion of the claim flow relating to new lost-time claims among several similar clerks.

In those two steps where the claim was examined by the claims examiner and the checker, greater speed and accuracy could have been obtained by more standardized procedures which would have funneled some of the more difficult decisions to other places in the staff of the commission.

The delays involved during the period before the
C-7 was forwarded to the accounts section for payment hardly matches the first principle adopted by the private workmen's compensation insurance carriers (page 11, Supra) that "All legitimate claims should be paid promptly and fully. . . . It should always be remembered that receipt of a compensation check on the day it is due is of great importance to the claimant." The very mail-order nature of the claim handling procedures of the commission made it difficult for the employees of the agency to be conscious of the second goal of the private insurance companies that "A frank and friendly attitude should be adopted towards all claimants. If there is any question of compensability, he should be told of the insurer's position at the earliest possible moment."

At first glance, it would appear that the seventh principle of the private carriers was inapplicable, namely, "There should be complete cooperation with the agencies administering the Workmen's Compensation Laws. Personal contact with them should be established and periodically conferences held to learn at first hand of any possible complaints or criticisms. . . ." (page 11, Supra). It is true that the roles of administrative agency and insurance company were combined. However, there was no apparent internal mechanism established within the agency to furnish the type of objective criticism of any defects in the claim handling procedure which would have been obtained
from a systematic meeting of the viewpoint of the claims adjuster and of the administrator. Since any form of self-criticism was lacking, it was eventually necessary for the representatives of claimants, and of workers in general, to work for a legislative investigation and criticism of the claim handling processes for uncontested claims.

B. THE PROCESSING OF THE C-7 BY THE ACCOUNTS SECTION

When the award sheets (form C-7) arrived at the accounts section a recheck was made of the coverage books to verify that the employer had paid his premiums to cover the date of injury. Next the group of new first compensation payment authorizations were delivered to an auditing clerk who checked to see that the span of dates for which disability payment had been authorized was correct, that it was made at the proper rate, and that the mathematics involved were correct. It was also necessary for this clerk to figure how much of the total award had accrued. Awards of weekly payments which were to extend a considerable period into the future were set up on a pension system and checks were issued every other Monday. On a continuing award the amount of the first check was figured ahead to the next pension-payment date, which might be as much as two weeks in the future. The award sheets were sent next to a group of clerks who wrote the checks. Special machines were used in writing and recording the check on a warrant
register. The prepared checks were proofread by clerks against the form C-7. At this stage a form notice was prepared in duplicate which showed the claim number, the total amount of the award in terms of number of weeks' compensation, and the weekly rate, and the amount of first payment of compensation. The original copy of this notice was mailed with the check and the carbon copy was mailed to the employer.  

Using the C-7 award sheet as the working record, the required posting of the information was made subsequent to the preparation and mailing of the check. This was done only with regard to the processing of the first award on a lost-time claim. A record was kept in the accounts section which showed the time of arrival of each group of first and subsequent authorizations of benefit payment and the time when the checks were ready for mailing. A copy of this record was sent each week to the supervisor of claims. An examination of these weekly reports from the accounts section for the months of January through June, 1954, showed that the average time consumed in preparing the checks both for the first payments and for subsequent payments averaged between fifteen and twenty working hours during the first four months of January through April. There was slight

variation in the time required for the two types of payments even though the volume of subsequent payments was much higher. On May 1, 1954, the procedures were changed in the accounts section so that the posting of information was made after the check was prepared, rather than before, in all cases involving the issuance of the first check in a lost-time claim. As a result of this change the time required for the first payments dropped to approximately one-quarter of the time required for subsequent payments. In cases where the group of C-7's were delivered to the accounts section before 10:30 a.m. the checks for first payment could be prepared in time to be placed in the mail which was delivered to the post office at 4:00 p.m. of the same day.

Posting of Award Information by the Actuarial Section

After the required posting of information in the accounts section had been completed, the C-7's were delivered to the actuarial section where the amount of payment authorized was entered on the record of the employer where it could be used in calculating his loss experience, which in turn affected his premium rate. When this was completed, the C-7's were returned to the accounts section where they were filed.25

The Payment of Medical-only Bills

Claims which involved only the payment of medical expenses were sent through the same procedures of record keeping that were applied to claims involving payments of compensation benefits. However, they were processed and sent to the claims examiners in groups of fifty. If any medical-only claim was questioned it was removed from the group for special handling and the remainder of the group sent to the claim-sheet typists where the authorization for payment was made on a single sheet holding fifty claims, with the claims arranged alphabetically according to the name of the payee. When these payment authorization sheets arrived at the accounts section the amounts of authorization were entered upon a ledger sheet which was maintained for each doctor, hospital, etc., which rendered medical services. A carbon copy of the entry was made and sent to the employer. Once each month a check was issued to the person or institution which had rendered medical services, accompanied by a copy of the ledger sheet which gave an itemization of the amounts paid on the various claims.26

The Total Elapsed Time Required for Payment of Clearly Compensable Claims

The processing of the uncontested case in which the

26 Loc. cit.
claimant was clearly entitled to compensation benefits under the statute involved an administrative procedure which consumed from six to eight working days from the time the claim was filed with the commission until the time the check was ready to be placed in the mails. For a few minutes, the claims examiner examined the merits of the claim, made his decision either to authorize the payment of benefits or to refer the claim elsewhere for further action, and prepared the authorization of the award. The claims checker repeated this process, in a short time also. The remainder of the interim period was used for administrative processing of the papers involved. This administration included verifying whether the employer was covered under the state insurance fund, applying manual code and risk number to the claim form, making permanent records of the claim, extracting statistical data regarding the claim, preparing an award sheet, and issuing the check. In this process, the papers connected with each claim were handled in more than a score of successive steps which were followed in a rigid fashion with only a few variations for exceptional cases. Each step was highly standardized. With the exception of the time when the file was being considered by the claims examiner or the claims checker, the other steps involved little more than the application of clerical skills. The actual work hours expended on each individual uncontested, clearly compensable claim were small. The rest of the six
to eight working days before the check was mailed was consumed in the file being transported from one place to another or being stored in one place awaiting further action as the rest of the claims in the group received attention at the particular step. The possibilities of an alternate procedure for handling the claims under the same organizational structure and the changes in organizational structure and procedures which will be permitted under the 1955 act, will be discussed in the next chapter.

The examination of the claim-handling procedure used in 1954 indicated that as long as the six to eight days speed of the 1920's and 1930's was maintained, all persons in a supervisory position were satisfied. Because of the passage of the group of claims back and forth between sections, no one section supervisor was able to do too much toward affecting the entire claim flow. Other than for the accounts section, no one section supervisor attempted to speed procedures within his section. There was little evidence that great consideration of the problem, in its entirety, was given by the commission itself, and there was no other locus of authority. There was no apparent delegation of supervisory authority over the claim flow given to the secretary of the commission. By general agreement the personnel of one section refrained from giving an outside re-appraisal of the operation of another section which might have called the attention of the commission
or of the proper supervisor to any evidence of congestion of the claim flow.
CHAPTER VIII

POSSIBLE PROCEDURES FOR
HANDLING UNCONTESTED, CLEARLY COMPENSABLE CLAIMS

In the three previous chapters several criticisms have been raised of the 1954 procedure for handling uncontested and unquestioned claims by the Industrial Commission and its staff. These procedures have involved those portions of the claim handling process where simple efficiency is the most important consideration. It is possible to speculate upon changes of procedure which could have been made which would have increased efficiency. Such changes have been put together in a sequence. They are proposed only as an illustration of one possible procedure which might have been followed and not as an alternate procedure. As a result the illustration is patterned to meet the criticisms which have been raised in the previous chapters. Changes which were made by the 1955 legislation will possibly so far affect the organization and procedures for handling workmen's compensation claims that none of the suggestions in the illustration could or should be adopted.

In order to fashion such a possible procedure, the various steps in the 1954 procedure for handling clearly
Compensable claims were analyzed in considerable detail in an effort to determine what work was done, who did it, and why, where, how and when it was done. On the basis of this analysis the hypothesis of an alternate procedure was developed. The goal was to shorten the time lag between the arrival of an application for benefits and the time the check was put into the mails in clearly compensable cases, to find instances of duplication of work, and to find instances of unnecessary congestion of the claim flow. Although the time lag is not the only basis for measuring efficiency of administrative operation, it is of high importance in lost-time claims, since in most cases the compensation check is the employee's only or primary source of income during the disability.

In the development of the alternate procedure efforts were made: (1) to determine what steps were most important and to move them forward in the sequence of operations, (2) to eliminate or consolidate steps which were of questionable value, (3) to eliminate congestion of the claim flow by spreading the performance of a particular step for simultaneous action, and (4) wherever possible to postpone steps in the procedure to a later point in the sequence, so that they could be performed after the decision had been made by the claims examiner on the merits of the claim, and, if approved, after the award sheet had been prepared and its original sent to
the accounts section. Then if the carbon copy of the award sheet and the claim application were used, these previously omitted steps could be performed in the record-keeping process in other parts of the commission simultaneously with the preparation of the warrant making payment of the claim in the accounts section. This procedure was based upon the premise that every bit of time saved in the issuance of the first check was worthwhile unless it increased the cost of operations too much or unless it disrupted the payment of medical-only bills and subsequent actions in lost-time cases to too great an extent.

Each change also had to be measured in terms of whether it would give too many and too varied duties to employees, whether skills would be used properly, whether the broader work distribution would cause too many interruptions and would lead to the performance of too many unrelated tasks by a single person. The possible alternate changes were premised upon performing the work on the same centralized basis in one claim office in Columbus and using the same personnel, the same claim application form, and the same equipment. A much more intensive study by a team of skilled organization and management experts would involve an appraisal of the basic organization of the various sections of the administrative agency, of the forms used, and of the possibility of changing the filing system and introducing more I.B.M., or similar, equipment. The
suggested alternate procedure would be little more than the patching of the old procedure, but it was evolved in an effort to test the permanent value of the system in use in the first half of 1954.

Of the various steps which took place in the 1954 procedure for handling clearly compensable claims, only two involved the use of any great amount of discretion and knowledge of the law. One was the "first hearing" by the claims examiner and the other was the review of the claim file by the claims checkers, which required even greater discretion and knowledge. This latter was done by one of the older and more experienced examiners, but it was virtually the same operation. For these steps it is difficult to justify any change or any hastening of the decision-making work. The other steps in the observed procedure were primarily clerical. The suggested alternate procedure is shown in CHART III (page 170, Infra). The various steps in the proposed procedure will be discussed in sequence with attention being paid to possible advantages and criticisms of the place of the procedure in the sequence.

**Claims Received**

No changes could have been suggested in the procedures used in the receipt of the mail for the entire commission and the forwarding of claims to the mail room of the claims section.
CHART III

ALTERNATE PROCEDURE FOR CLEARLY COMPENSABLE CLAIMS

<table>
<thead>
<tr>
<th>Unit</th>
<th>Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mail-Supply</td>
<td>1. Claim received: forwarded to claim section</td>
</tr>
<tr>
<td>Claims</td>
<td>2. Medical-only and Lost-Time divided</td>
</tr>
<tr>
<td>Actuarial</td>
<td>3. Inspected for coverage; manual code, risk number</td>
</tr>
<tr>
<td>Accounts</td>
<td>4. Check coverage</td>
</tr>
</tbody>
</table>

Claims

5. Claims listed in duplicate; assigned to examiners
6. Claimant's weekly wage ascertained
7. Claim inspected; evaluated; allowed or disallowed
8. Information sheet, authorizing payment prepared
9. Weekly rate and period of compensation computed
10. Typewritten award sheet prepared
11. Claim number assigned; claim checked off lists

Award sheet to accounts

12. Inspected for coverage
13. Figures rechecked; amount computed
14. Check written and recorded
15. Check proofread
16. Notices of award prepared
17. Checks and notices of award mailed
18. Posting of account

Claim to docket clerk

12. Permanent record; docketing; B.U.C.
13. Fee bills sent out
14. File folder; completed file placed in file room

Accounts

Safety-Hygiene

15. Statistical data coded and recorded

Actuarial

19. Entered in employer's record as merit system data
Mail Sorted in the File Room

No changes could have been suggested in the procedure of separating the lost-time and medical-only new claims and alphabetizing the lost-time claims according to the name of the employer.

Manual Code and Risk Number Added to the Application

The practice of sending the new lost-time claims to the actuarial section for the addition of the manual code and risk number to the claim form could have been retained. This information added nothing to the file that was of use to the claims examiners in making a determination of the merits of the claim, but it would have been necessary before the accounts section could have checked the coverage of the employer under the system of filing in use in the accounts section. If the accounts section had maintained a duplicate file according to the names of employers, this step would not have been necessary. However, the time and expense involved in creating and maintaining an alphabetical file in the accounts section possibly would not have justified the saving of time.

Coverage of Employer Verified

The claims could then have been forwarded to the accounts section where the coverage could have been checked in the same manner. A question can be raised as to the necessity of checking the coverage of the employer before
the claims were examined by the claims examiners. One advantage would have been that it would have been possible to separate claims which were not covered at the next step and start the procedure in cases of non-coverage at once. Otherwise, the fact of non-coverage would not have been discovered until after a payment authorization had been prepared. In such cases, where non-coverage might have been discovered, it would have been possible to destroy the authorization of payment, change the claim number and follow the usual procedure for non-covered claims. Less than one per cent of new lost-time claims involved non-coverage and a criticism could have been raised that the entire claim flow should not have been delayed for a half day in order to speed action on the non-covered claims. The other advantage of having coverage checked before the determination of the merits of the claim would have been in giving a double check on the question of coverage. Since a mistake was made in the coverage check in only one case in ten thousand, the early coverage check could not have been justified for this reason alone. There was greater justification for the check of the coverage before the adjudication than there was for the other record-keeping steps performed before the claims were forwarded to the claims examiners. If the step of having the coverage checked had been eliminated from the procedure, the preceding step of having the manual code and risk number added
Claims Listed in Duplicate and Assigned to Examiners

After the group of new lost-time claims had been returned from having the coverage checked, they could have been delivered to a group of clerks in the index unit of the claims section, who could have divided them and assigned them to claims examiners without the addition of a claim number to the application for benefits. After the assignment of the claims to specific claims examiners, the clerks could have made a list of the claims so assigned to each claims examiner in several copies. This would have been required as a precaution against the claim having become lost before it was determined and returned for the preparation of permanent records.

The addition of a claim number added nothing to the claim which affected the claims examiner's decision upon its merits. Under this suggested procedure, there would have been no file folder on the claim, but in most cases the sole contents of the file folder was the three-part form. In cases where additional papers accompanied the three part application form they could have been securely fastened to the form and a notation could have been made on the list of claim assignments as to the number of papers attached. Even though there would be no permanent record of the claim during the first one or two days, little in-
convenience would have resulted so long as a record was kept of the physical location of the claim within the claims section.

**Wage Setting**

It is suggested that all the claims could have continued to be sent to a single claims examiner to have the wage information checked. The individual claims examiners could have done it as a part of the determination of the merits of the claim. However, the wage-setting was more of a mechanical than a decision-making function. By having a single person do it, the other claims examiners would have been relieved of performing a routine function. The extent to which the wage setting could have become a bottleneck in the claim flow would have depended upon how well the work of the clerks who listed the claims was arranged in order to give a steady flow of claims to the wage-setter during the mid-day period.

The transportation of the listed claims to and from the desk of the wage-setter could have created a problem. The distances were relatively short. One solution would have been to put the responsibility upon the persons finishing the work of listing and wage checking to leave their desk and carry the files to the next person in the claim flow. This would have caused considerable interruption in their work. Another solution would have been to assign an
office boy or file clerk the primary responsibility of keeping the claims moving from index unit to wage-setter to specific claims examiner during the mid-portion of the day.

### Evaluation of New Lost-Time Claims on Their Merits

When the new claims arrived at the desk of the examiner, their examination could have been given priority over the other files on his desk involving subsequent hearings of claims which had already been given an adjudication. The initial examination of the merits of a new lost-time claim rarely took an examiner more than five minutes. Therefore, even if the policy of giving the bulk of such claims to twelve to fourteen of the claims examiners had been continued, they would have received only about ten. Within an hour each could have made his decision to authorize a payment on the claim and have made out the forms authorizing payment, or else he could have decided to refer the claim elsewhere in the agency for more information or professional advice. Questioned claims in this latter category could have been set aside on his desk until he could have considered the whole group and taken as many unquestioned cases as far as he could. When he had disposed of the clearly compensable claims, the cases he had not been able to dispose of could have been taken to the docket clerk who had the list of cases charged to the examiner and have them charged off. On the small number of claims so returned
without an adjudication, a claim number could have been assigned and the 1954 procedure applied. This would have included docketing, sending acknowledgment cards, and the extraction of statistical information. Then the files could have been referred for correspondence, investigation, or professional opinion in accordance with the memorandum which the claims examiner had attached to the claim.

As for the preponderance of claims which would have been accepted on their merits upon their first consideration, it would no longer have been necessary to send them to the docket ledger for entry of action, since they had not yet been assigned a claim number and docketed. When they were later docketed, the date of the first hearing could have been put on the docket sheet at the same time that the docket sheet was prepared. It would also have been a more accurate date than under the 1954 procedure. As soon as the claims examiner had finished preparing the authorization of payment on the claims he had approved, he, personally, could have carried his group of approved claims to the comptometer operator.

**Weekly Rate and Period of Compensation Computed**

No change in the system of having the weekly benefit rate and period of compensation computed could have been suggested, except that both comptometer operators could have been used. Also the comptometer operators could have taken
the new claims directly to the chief clerk of the correspon-
dence unit as soon as a few of the groups had accumulated,
rather than waiting for a file clerk on a routine tour to
pick them up and carry them over.

**Typewritten Award Sheets Prepared**

The claims with the authorization of payment from
the claims examiners could have been distributed to the
typists in the pool for the preparation of the form C-7
authorizing payment of benefits by the accounts section.
A definite policy of wide distribution of the work load
among the typists and of high priority over other typing
work could have been adopted to expedite the performance of
this step.

**Re-Examination of the File by the Claims Checkers**

The actual work of the claims checkers in re-examin-
ing the files could have been performed in the same manner.
However, by giving greater priority to the new lost-time
claims, the bottleneck which sometimes appeared at the point
where claims were waiting to be considered by the claims
checkers could have been eliminated. This could have been
done by a rule that all, or at least certain, of the claims
checkers should dispose of new lost-time claims before turn-
ing to check subsequent actions on claims. The work of the
checkers involved discretion, so they should have been given
as much time as they needed for the checking of each claim.
When the checkers had finished the checking of the claims they could have taken them, without the second check of mathematics, to the clerk in the index unit. This clerk would have had a copy of the list of claims charged out to the claims examiners in order that the claims could be accounted for. It would have been necessary that someone be responsible for each claim at all times before the claim number was assigned. This problem could have been met by having a listing form prepared with multiple sheets and inserted carbons, whereby several copies of the list of claims assigned could be prepared. As the claims were moved from the claims examiner to the clerk who assigned the claim numbers, the claims examiner, comptometer operator, claim-sheet typist and checker could have one of the copies signed by a person at the next stage in the claim flow to give a record that the claims had been delivered. The claims withdrawn from the claim flow at the claims examiner's desk could have been marked off.

**Claim Number Assigned and Claim Checked Off Claims Examiner's List**

When the new lost-time claims were delivered to the clerk who was in charge of the lists of claim assignments they could have been charged off and a claim number assigned to each claim. The claim number assigned should have been stamped on all papers in the file, and especially on the
original of the C-7 which was to go to the accounts section. The original copies could have been accumulated and taken in a group to the accounts section. In order to prevent congestion, more than one clerk could have been allowed to assign claim numbers. By this procedure the accounts section could have been making payment on the claim from the original of the C-7 while the paper work of posting the file and making permanent records could have been done at the same time without delaying payment in any way.

Further Record-Keeping from the Claim File

After the claim number had been assigned and the form C-7 forwarded to the accounts section, the docket sheets could have been prepared and fee bills could have been mailed to those listed as rendering medical service. The claims could then have been put into folders and sent in a group to the safety and hygiene section for the extraction of statistical data.

Since the notification of both claim number and the amount of the award would have been made by the accounts section on the same day that the claim was docketed, it would no longer have been necessary to send acknowledgment cards from the index unit in approximately eighty-five percent of the new lost-time claims. This would largely have freed the time of the four clerks to assist in the extra
work which would have been involved in listing the assign­ment of claims upon arrival and checking them off when they were returned from the claims checkers. Not only would the elimination of sending acknowledgment cards save many hours of working time, but it would also save a great deal in stationery and mailing costs.

Payment of Benefits by the Accounts Section

The examination of the procedures used in the accounts section in issuing the checks indicated that it was efficient because of the procedure whereby the posting and record-keeping was performed after the first payment on a new time-lost claim was made. It is doubtful if any appreciable time could have been cut in the performance of this function, with the possible exception of continuing the second check of the coverage ledgers after the return of the C-7’s from the claims section.

In view of the changes made in the workmen’s compens­sation law in 1955, it can be predicted that more radical changes will be made in the handling of uncontested work­men’s compensation claims in Ohio.
CHAPTER IX

THE PROCESSING OF QUESTIONED CLAIMS

The validity of a claim for workmen's compensation benefits could be questioned either by the employer or by the staff of the Industrial Commission. Only a small portion of the new lost-time claims filed with the Industrial Commission could not be authorized for payment by the claims examiners within the amount of discretion delegated to them. Nevertheless, questioned claims required a much greater amount of administrative time per claim. Such questioned claims deal with an area in which efficiency (time lag and cost) is still important, but in which equity to the employee, employer and general public becomes supremely important. The rights of the employee would be injured if a valid claim were denied or unnecessarily delayed because of invalid objections to the claim. The rights of the employer would be injured if a binding award were made on an invalid claim without giving the employer an opportunity to contest it at a proper hearing held after notice. The interests of the general public might be harmed if premium rates were inflated by invalid awards merely because neither the employer or the agency examined the application closely enough.
to detect the invalidity. Unless the administrative agency can achieve an equitable balancing of all the interests involved, there is little justification for the substitution of the agency for the courts, operating within statutory standards, in the adjudication of workmen’s compensation claims.

Questioned claims fell within two rough categories of (1) claims which required additional information for a decision and (2) claims which required professional interpretation by the medical and legal staffs of the commission. Decisions on such claims required a higher level of discretion than was permitted at the consideration of the claim by the claims examiners. Approximately fifteen percent of the claims filed fell in the category of a questioned claim.¹

After the needed information and professional opinion had been obtained in questioned claims, they were submitted to legal reviewers to whom had been delegated a higher level of discretion for an additional desk review of the merits

¹ This figure is based upon the fact that 347,182 claims were filed in 1933. During this year the claims examiners referred 12,729 claims to the legal reviewers for further action, 17,269 to the medical section, 2,260 to the investigation section, and 33,967 to the correspondence unit. This would be 19% of the claims filed. However, only about 10% of those referred to the correspondence unit for further action actually delayed the adjudication of the claim, see page 186, Infra. Statistics based upon Annual Claims Report, 1953, op. cit.
of the claim without hearing, notice or testimony. This
greater discretion was based in part upon their greater
knowledge of the interpretations of the workmen's compensa-
tion statute which had been developed by the commission,
itsel, or by the courts through judicial review. In the
more clearly compensable and the more clearly non-compen-
sable cases these legal reviewers were permitted to issue
a "special order" in the name of the commission, either al-
lowing or disallowing the claim. By commission policy the
legal reviewers could issue a negative order denying the
validity of a claim only on medical-only claims and claims
where the commission clearly had no jurisdiction under the
workmen's compensation statute, as where the two-year time
limit for filing a claim had expired. 2

The claims examiner was likely to refer a claim
which he did not adjudicate to one of the following: (1)
if information were lacking, to the correspondence unit
within the claims section for the dispatch of a letter de-
signed to obtain the information needed; (2) if he felt a
field investigation was needed, to the so-called "Legal X"
unit in the legal section for expediting and screening as
to the necessity of an investigation; approximately one-
third of these were referred to the field investigation

2 Interview, George Thompson, Chief, Claims Section, Ohio Industrial Commission, September 1, 1954.
section; (3) if a medical question were involved, to the medical section; (4) if a legal question were involved, to the legal reviewers. The work of the medical and investigation sections and of the correspondence unit was purely advisory, and special orders could be issued only by the legal reviewers in the legal and claims sections.  

Claims Referred to the Correspondence Unit of the Claims Section

In 1953, the claims examiners referred 33,967 claim files to the correspondence unit. This included both lost-time and medical-only claims and both first and subsequent hearings (subsequent hearings usually involved authorizing the payment of some medical expense entailed in a claim). Only a small portion of these referrals involved a delay in the first decision of a lost-time claim on its merits.

In more than half of the cases referred for correspondence it was possible to use form letters. Form C-46 was the most prevalently used form letter. It was used primarily to get additional information concerning the cause of an injury to the body as a whole or aggravation

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3 The legal reviewers consisted of sixteen attorney examiners in the legal section and five attorneys in the claims section. The latter carried on specialized functions on certain types of claims.

4 The information on procedures in this section is based primarily upon an interview with Harriet Wylie, acting head of the correspondence unit, July 8, 1954.
CHART IV

FLOW CHART OF CLAIMS WHICH COULD NOT BE ADJUDICATED BY CLAIMS EXAMINERS

Symbols of action taken:
White - For Opinion
Black - For Information
Crosshatched - For Decision
of a latent condition, such as back injuries or heart conditions. 5

No specific record was kept of the portion of new lost-time claims which were referred by the examiners for correspondence before they could be decided on their merits. However, there were indications that it was approximately ten per cent. The most accurate indication of the number of referrals could be obtained from the pending file which contained new claims that could not be adjudicated until an answer was received. A clerk made, and kept for a few months, a record of the number of files pending at the end of the month. This figure did not include claims which were written on and answered within the month. During the months of April through June, 1954, the relation of remaining files pending at the end of the month to first lost-time adjudications during the month ranged from 5.3 per cent to 8.8 per cent. 6

The correspondence unit had many sound practices, such as the predominant use of form letters. However, such centralized operation can do little more than apply mail-order techniques to its work. Other than for a once-a-month check of the correspondence in the pending file,

5 Loc. cit.

6 Based upon examination of records in the claims section, August, 1954.
there was no device for following through on the response received from their letters. This appeared to be inadequate.

**Screening of Investigation Referrals by the "Legal X" Unit**

Preceding the 100th Ohio General Assembly an investigating committee of the Ohio Program Commission studied the Industrial Commission. In connection with this study the Industrial Commission, on April 28, 1952, submitted a report on the problems of claims investigation. The report was prepared by a three-member committee composed of one investigation branch office deputy and two attorney examiners. This report made several suggestions for reducing the number of claims referred for investigation. These included:

1. **Claims being referred for investigation by the examiners should be screened with a view to sifting out unnecessary referrals.**

2. **Greater use should be made of the telephone, especially where only one point of information was needed.**

3. **The number of general investigations should be limited and the examiner in referring a claim should be required to list specifically what points of information were needed for an adjudication.**
These suggestions were reflected almost at once in instructions to claims examiners directing them to give careful consideration to a claim file before referring it for investigation. They were further instructed that correspondence should be used wherever possible to avoid claims being referred indiscriminately to field investigation. In any case of a referral, the examiner was to make a specific item-by-item request of the information sought, rather than to transmit a general ambiguous request.  

A few months later the "Legal X" unit was inaugurated (effective September 25, 1952) as a screening device for all claims referred to the field investigation section. The unit was placed within the legal section and under the direct supervision of the supervisor of that section. Two attorney examiners were assigned to the unit, with secretarial help. They were personally responsible for all telephone calls for information made from the office and for keeping a complete and accurate record of the content of the calls. When the needed information was obtained a note was placed in the file and it was returned to the forwarding section.  

7 Memorandum 665 from Supervisor of Claims to Examiners, Reviewers and Correspondence Unit, dated April 28, 1952.  

8 Memorandum from Secretary of the Commission to all Department Heads, dated September 23, 1952.
This technique was used in several situations, such as cases in which the employer’s verification or his agreement to withdraw objections could be obtained by telephone. In other cases it was used to obtain a doctor’s opinion as to the end of disability or as to the causal connection between an accident and an injury. In all cases it was necessary to refer death claims and contested self-insured claims for an investigation.9

Whenever an employer protested the validity of a claim on the form or in separate correspondence, it was referred to the “Legal X” unit. In cases of extensive disability in which there was a definite questioning of a claim by the employer, he was called by telephone. If the employer agreed to a claim after discussing it with the attorneys, they placed a memorandum in the file and transferred it to a legal reviewer for processing. If the conversation developed information seriously questioning the validity of the claim, it was referred for investigation. In cases of minor disability the “Legal X” unit corresponded. In cases in which an answer was not received within a very few days, a more emphatic letter was sent.10

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9 The material in this section is based primarily upon a joint interview with R. Carter Irvin and David T. Postance, attorney-examiners in the “Legal X” unit, August 4, 1954.

10 *Loc. cit.*
During the period from August 1, 1953 through July 31, 1954, inclusive, 14,673 claims were handled by the "Legal X" unit. Of these, 30.63% were referred to the field investigation section; 62.52% were referred to the other sections for further professional processing, and 6.86% were adjudicated by the "Legal X" unit and referred for payment or hearing. A total of 894 toll telephone calls were made at an annual cost of $1,219.05. The average cost of toll calls was $1.36 each. In terms of the total claims handled, the telephone cost was 8.3¢ each.\footnote{This information is based upon a consolidation of the bi-monthly reports of the "Legal X" unit to the supervisor of the legal section.}

The "Legal X" unit proved to be an effective device for gaining information and for eliminating field investigations on claims. It is to be noted that this improvement was the result of a self-appraisal brought on by legislative inquiry. The impression that the results achieved by the unit made upon the legislature is shown in the authorization in the 1955 act of the use of the telephone for obtaining any form of needed information.

\textbf{Field Investigation Section}

Investigations are needed to determine whether a specific accidental injury was sustained while the claimant was in the course of his employment, whether a compensable occupational disease was contracted, to determine the period
of disability, or to fix the average weekly wage of the employee.

In conducting an investigation under the procedure used in 1954, the investigator generally first made contact with the claimant and obtained his affidavit which contained a description of the circumstances of the accident as well as a history of any previous injuries or illnesses which might have a bearing on the present disability. The proper official of the employer was also contacted for any information which the employer might have about the claim. Affidavits were taken from witnesses.12

Medical information was developed by securing affidavits from physicians who had treated the claimant, and, in cases where the relationship of the disability to the injury or occupational disease was in issue, the investigator had to obtain all other available medical proof bearing on the prior existence of the disability.13

Certain types of claims required special handling or additional information:

1. When the employer was a non-complying em-

12 The information in this section is based primarily upon an article in Industrial News, Vol. I, no. 7, August 1951, pp. 9-10, by Charles F. Mulligan, Chief Claims Investigator, supplemented by an interview with Mr. Mulligan on August 5, 1954. Mr. Mulligan has been with the commission since 1913.

13 Loc. cit.
ployer, the investigator had to check to obtain special information to establish the employer's amenability to the law.

2. In investigations of death claims there were problems of marital proof from a widow-claimant, and it was necessary to secure medical evidence reflecting upon the relation of death to the injury or occupational disease and also to obtain proof of dependency of all persons who claimed to be dependent upon the decedent for support.

3. In some cases it was necessary to determine if the claimant were an employee or an independent contractor.

The investigation of these claims had to be tailored to meet the information needed in order to answer the legal points involved.\textsuperscript{14}

An investigation into the facts of every death claim was made because of the additional factors of establishing the relationship of persons who might qualify for benefits as dependents of the deceased. In certain types of applications for lump sum payments in lieu of the usual weekly payments, the money was requested by the claimant so that real property could be purchased either for a home or a business. In such a situation the investigator had to verify

\textsuperscript{14} \textit{Loc. cit.}
the value of the property from the local records. This was a very simple investigation. Virtually all other investigations were classified in the section’s records as "special" investigations.

**TABLE VII**

**SUMMARY OF WORK ON HAND IN FIELD INVESTIGATION OFFICES AT THE END OF EACH MONTH DURING 1953 WITH INDICATIONS OF THOSE HELD OVER TWO WEEKS**

<table>
<thead>
<tr>
<th>1953</th>
<th>DEATHS</th>
<th>SPECIALS</th>
<th>LUMP SUMS</th>
<th>TOTAL ON HAND AT END OF MONTH</th>
<th>CLAIMS HELD OVER TWO WEEKS</th>
<th>% OF CLAIMS ON HAND OVER TWO WEEKS OLD</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>156</td>
<td>701</td>
<td>29</td>
<td>886</td>
<td>663</td>
<td>74.83%</td>
</tr>
<tr>
<td>February</td>
<td>135</td>
<td>562</td>
<td>26</td>
<td>723</td>
<td>484</td>
<td>66.94%</td>
</tr>
<tr>
<td>March</td>
<td>157</td>
<td>443</td>
<td>14</td>
<td>614</td>
<td>393</td>
<td>64.01%</td>
</tr>
<tr>
<td>April</td>
<td>139</td>
<td>418</td>
<td>24</td>
<td>581</td>
<td>351</td>
<td>60.41%</td>
</tr>
<tr>
<td>May</td>
<td>169</td>
<td>467</td>
<td>29</td>
<td>665</td>
<td>388</td>
<td>58.35%</td>
</tr>
<tr>
<td>June</td>
<td>147</td>
<td>398</td>
<td>31</td>
<td>576</td>
<td>339</td>
<td>58.85%</td>
</tr>
<tr>
<td>July</td>
<td>139</td>
<td>373</td>
<td>17</td>
<td>529</td>
<td>302</td>
<td>57.09%</td>
</tr>
<tr>
<td>August</td>
<td>148</td>
<td>512</td>
<td>39</td>
<td>699</td>
<td>404</td>
<td>57.80%</td>
</tr>
<tr>
<td>September</td>
<td>143</td>
<td>494</td>
<td>31</td>
<td>688</td>
<td>399</td>
<td>59.73%</td>
</tr>
<tr>
<td>October</td>
<td>146</td>
<td>434</td>
<td>20</td>
<td>600</td>
<td>398</td>
<td>66.33%</td>
</tr>
<tr>
<td>November</td>
<td>125</td>
<td>411</td>
<td>25</td>
<td>561</td>
<td>363</td>
<td>64.71%</td>
</tr>
<tr>
<td>December</td>
<td>123</td>
<td>414</td>
<td>23</td>
<td>560</td>
<td>332</td>
<td>59.29%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1,717</td>
<td>5,627</td>
<td>308</td>
<td>7,632</td>
<td>4,816</td>
<td>63.10%</td>
</tr>
<tr>
<td><strong>MONTHLY AVERAGE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>143</td>
<td>468</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SOURCE:** Statistics in 1st, 2nd, 3rd, and 5th columns taken from Annual Report of Chief Investigator to Industrial Commission for 1953.

At the branch offices the claims were assigned to the investigators on the basis of the difficulty of the investigation and the known experience and ability of the investigator. Generally, the branch deputies personally handled
some of the difficult investigations. The chief investigator handled some in Columbus.\textsuperscript{15}

It was the policy for the investigator to go to the witness rather than calling the witness or widow-claimant to the branch office to give information. Local telephone calls were used only to locate a witness, not to take information. Doctors were interviewed between patients.\textsuperscript{16} Even after the "Legal X" unit began the practice of obtaining medical information by long-distance telephone, the investigation section would not permit its investigators to obtain medical or other information by telephone.

Each investigator was required, by civil service requirements, to keep a daily time record which was used to figure sick leave. He also made a report of the persons seen, cases worked on and the time and expenses spent on the case during the day.\textsuperscript{17} Apparently no use was made of this data. Although records were systematically kept of the number of claims which had been in the field more than two weeks, no concern seemed to have been given to the fact that fifty-eight per cent to seventy-four per cent (see TABLE VII, page 193, Supra) had been held beyond the deadline for returning a file. This situation would indi-

\textsuperscript{15} Interview, Mulligan, \textit{op. cit.}
\textsuperscript{16} \textit{Loc. cit.}
\textsuperscript{17} \textit{Loc. cit.}
cate either than an unrealistic time goal had been set or that no real desire was present to meet a reasonable deadline.

When a file was delivered to the office of the chief claims investigator from the "Legal X" unit, an index card was prepared for the section's use in locating the file while it was charged to that section. Information from slightly more than one thousand index cards covering all investigations closed between May 28 and August 17, 1954, was obtained and examined. This information was classified both according to the type investigation conducted and according to the type of claim and is presented in TABLE VIII (page 194, Infra). The mean average time taken for investigations was a little less than two months. By type of claim, the mean average ranged from 43.88 days for claims involving a public employee, to 98.80 days for the claims involving non-complying employers. Since the merits of the claim were not decided until the investigation was completed, this delay seems excessive.

The experience in Wisconsin and Michigan, where the administrative agency keeps a close watch on the delays of private companies in making initial payments, indicates that when publicity is given to the time lag in starting payments conditions improve (page 96, Supra). However, there were no indications that any great concern was shown about this delay either by the claims section or by the
TABLE VIII
TIME LAG IN RETURNING FINISHED INVESTIGATIONS TO COLUMBUS
(BY TYPE OF INVESTIGATION AND BY TYPE OF CLAIM INVOLVED)

<table>
<thead>
<tr>
<th></th>
<th>SPECIAL</th>
<th>DEATH</th>
<th>LUMP SUM</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Private Fund Claims:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of claims</td>
<td>302</td>
<td>58</td>
<td>138</td>
<td>615</td>
</tr>
<tr>
<td>Total Days Delay</td>
<td>20,073</td>
<td>5,274</td>
<td>2,021</td>
<td>33,442</td>
</tr>
<tr>
<td>Mean Average - Days</td>
<td>66.47</td>
<td>64.84</td>
<td>14.64</td>
<td>54.38</td>
</tr>
<tr>
<td><strong>Self-Insurer Claims:</strong></td>
<td></td>
<td></td>
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<tr>
<td>Number of claims</td>
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<td>9</td>
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<td>Total Days Delay</td>
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<tr>
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<td><strong>TOTAL:</strong></td>
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<td>Number of claims</td>
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NOTE: The date of mailing was not included in the figures.

SOURCE: Index cards in Investigation Section, Ohio Industrial Commission.
Industrial Commission. The time lag seemed to have been accepted as justified.

A report made to the secretary for 1948, 1949, and 1950 showed approximately fourteen thousand claims were assigned and investigated each year. The annual report of the section for 1953, the first full year after the creation of the "Legal X" unit, showed that 11,518 investigations were made. This figure did not show what percentage of these investigations reported were reassignments from one branch to another or reinvestigations.

The statistics from the "Legal X" unit showed that only about 4,500 files were referred during this same year. Only a part of the requests for an investigation came through the "Legal X" unit, since some came directly from the medical and legal sections and from the commission and claims boards. The investigations required in connection with an application for a lump sum were sent directly to the investigation section without screening through the "Legal X" unit. These accounted for approximately 1,500 during 1953. This still left a discrepancy of about six thousand investigations in these statistics taken from different sources within the commission. The 11,518 figure was based upon the total of investigations reported by

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18 Report from Charles F. Mulligan to Richard W. Morse, Chairman of the Commission, dated August 17, 1951.
individual investigators. A certain amount of reinvestiga-
gations could be involved, such as duplicate death inves-
tigations and referrals from branch to branch. The sample
of approximately one thousand index cards indicated that
these were few in number. One possible explanation might
be that investigators padded their reports to make their
work load show more nearly the amount of work they did be-
fore the creation of the "Legal X" unit.

The three-member study group mentioned that there
was a backlog of three to four per cent of cases building
up each year. After the creation of the "Legal X" Unit,
three additional inspectors were added to the section and
this backlog was eliminated.19 This fact may be the ex-
planation of the great number of investigations completed
in 1953.

The refusal of the investigating section to use the
telephone for gaining information and its insistence upon
taking all information in the form of a sworn affidavit
indicate inflexibility within the section. Such affidavits
could not be used at rehearings, and it is doubtful that
such a formal document was needed for the informal oral
hearings. The fact that the chief of the section found time
personally to conduct some of the more complicated investi-
gations would seem to indicate that not much time was de-

19 Interview, Mulligan, op. cit.
voted to administration of the section.

Medical Section

There is a medical aspect in every claim. In the vast majority of controversial claims the controverted issue is a medical one. In this professional area the commission had to rely almost entirely upon medical reports and opinions contained in the claim files. It was the responsibility of the medical section to approve or disapprove the medical basis for claims for compensation; to examine claimants and render opinions as to the degree and duration of disability; to render opinions as to causal relationship, to approve medical, nursing and hospital bills; and to authorize such rehabilitation measures as were indicated.20 The work done in the medical section by the commission’s staff physicians fell into two main categories: (1) reviewing files in order to give a medical opinion and (2) examining claimants in order to give a report and opinion on a medical question. Medical care is not given by the commission’s staff doctors.

The medical section was organized with a central office in Columbus and four branch offices. Each branch

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20 The material in this section is based primarily upon an undated, unsigned mimeographed document prepared (apparently in 1951) for the use of the Ohio Program Commission, and upon an interview with Dr. A. L. Kefauver, Supervisor of the Medical Section, August 4, 1954.
office had clinical facilities. As of August, 1954, there were seventeen physicians on the staff, including four on a part-time basis. Eight of these, including two part-time doctors, reviewed files in Columbus but had no physical examining duties. Over a period of many years the section has had difficulty in filling vacancies and the turnover in personnel has been high.\(^{21}\)

Most of the references to the section for medical opinion came from the claims section, although some came from the legal section and from the hearing officers. Until 1948 free use was made of personal consultation between the claims examiners and the staff physicians. However, effective April 8, 1948, a directive was issued that all requests for medical opinion be screened by two of the claims examiners and taken in a group once a day to the medical section by the chief claims examiner.\(^{22}\) When a mass production-line technique is adopted, such channeling procedure sometimes becomes inevitable for uniformity and most effective use of professional time. It is an example of the compartmentalization which had developed in the commission during a period of years.

In practice this device did not work. It was used

\(^{21}\) Loc. cit.

\(^{22}\) Memorandum from the Supervisor of Claims to the Claims Section, dated April 7, 1948.
primarily when the claims examiner had difficulty deciding if a medical opinion was needed. Clearer cases were transferred directly by the claims examiner without consultation with the chief claims examiner.²³ Nevertheless, there still could no longer be a desk-to-desk consultation between the claims examiner and the doctor for a quick decision on a point.

In 1953, a total of 17,269 claims were referred by the claims examiners for medical review. This number was 0.59% of the files handled by the claims examiners.²⁴ It was rare for a staff medical examination to be made in the early stages of the duration of total-temporary disability. Instead, the staff physicians relied upon the reports of the attending physician in the file. If more medical information was needed from the attending physician, the medical section referred the file to the "Legal X" unit rather than attempting to write directly to the physician.²⁵

When an examination of a claimant by a staff physician was needed, about two weeks' advance notice was given to the claimant. After an examination of the claimant the file was either sent to the "Legal X" unit for further information or to one of the legal reviewers for an evalu-

²³ Interview, Thompson, op. cit., August 17, 1954.
²⁴ Percentage based upon Annual Claims Report, 1953, op. cit.
²⁵ Interview, Kefauver, op. cit.
Outside specialists were relied on for a physical examination in most cases in which a rehearing was being held. Doctors were needed for witnesses at the rehearing and the commission was reluctant to use its staff physicians for witnesses at its hearings. As long as the results of the staff examination are made known to the claimant so that he can rebut it, then the claimant has no justification for objecting to the use of staff experts at a hearing.

Payments for medical, hospital, and nursing care are governed by rules and regulations adopted by the commission upon the recommendation of the Ohio State Medical Association. The cooperation of the doctors in submitting reports quickly has a strong bearing upon the speed with which a case can be adjudicated. This latitude which the profession is given in setting the fee schedule has been one of the administrative devices for seeking the cooperation of the profession in furnishing reports expeditiously.

26 Loc. cit.
27 Loc. cit.
28 Loc. cit.
Legal Section

The attorney examiners in the legal section served a dual function of rendering legal opinions on a claim in a desk operation and upon occasions serving as hearing officers at informal hearings. This latter function will be discussed more fully in the next chapter.

The vast majority of referrals for a legal opinion came from the claims section. If upon examination by the attorney examiner the information necessary for a legal opinion was lacking the claim was sent to the “Legal X” unit. In some cases the medical and legal problems were so intertwined that it was necessary to send the file to the medical section first for its opinion. 29

When the file was sufficiently complete for a legal opinion, it was rendered by one of sixteen legal reviewers in the legal section. If the claim was clearly compensable, they had the authority to issue a special order in the name of the commission, setting forth the claimant’s entitlement. 30

The types of legal questions which they had to pass upon were varied, involving many of the branches of substantive law, including domestic relations and dependency, evi-

29 The material in this section is based primarily upon an interview with Thomas Brock, Assistant Supervisor, Legal Section, July 29, 1954.

30 Loc. cit.
dence, agency and independent contractors. Some of the more frequent problems were:

1. Whether a specific injury occurred within the course of the employment;
2. Whether the disability was the result of the accident;
3. Whether the claimant was an employee or an independent contractor;
4. Whether an injury was self-inflicted;
5. Whether a death was the result of an injury or of other causes;
6. Whether there was a marital relation between the decedent and a claimant;
7. Whether parents were potentially dependent upon a decedent;
8. Whether a non-covered employer was amenable to the act.

If the examiner felt that a claim should be allowed, a form authorizing payment by the accounts section was prepared. However, this form did not go directly from the legal section to the accounts section. It was sent to the claims section where a record of a special hearing was made on the docket. In cases in which the legal reviewer felt that a claim should not be paid, he prepared a statement of facts and conclusions of law, which was designed to assist the hearing officer in the handling of the hearing on the
claim. The statement of facts was also designed to take the place of pleadings, in framing issues, before a court trial. This statement of facts and conclusion of law was much longer and detailed than the order used for an award for this reason. A copy of the statement of facts was sent to the parties in interest along with a notice of the hearing date set for the claim.31

The work of the legal section in rendering legal opinions has been performed in a competent professional manner. A check of three hundred index cards used to check files in and out of the section in June, 1954, indicated that a mean average time of nine days and a median average time of eleven days elapsed while the file was in the section.

Much of the action taken upon a claim after it was questioned by a claims examiner or by an employer and before a decision was made upon it by a legal reviewer was administrative in nature. The individual questioned file might move in a criss-cross fashion among four sections of the agency, depending upon what any one of several persons might think needed to be done to it in order to obtain requisite information or professional opinion. There was no centralized control of the routing of the claim and few mechanisms to check upon the necessity for all of the referrals. The most effective clearance device was the es-

31 Loc. cit.
establishment of the "Legal X" unit to examine the necessity for field investigations.

There were few control devices to examine whether excessive time was being taken on files in the medical, legal and investigation sections. In the investigation section a deadline was established for the return of a file from the field and records were kept on the subject. The high percentage of files consistently kept beyond this deadline indicated that the breach of the rule was not considered serious.

Once action was taken on a file by the correspondence unit, there were only monthly checks upon whether the correspondence had been answered. This same cannot be said of the "Legal X" unit, however, for it kept accurate records of the elapsed time following the mailing of its letters, and mailed more urgent inquiries on unanswered correspondence in accordance with fixed policies.

The actions taken upon an application for workmen's compensation benefits by the claims examiners and by the legal reviewers were not hearings but legal fictions to satisfy the due process clause of the Fourteenth Amendment. Such legal fiction can be justified in terms of the public policy of substituting a system which would keep legal formalism to a minimum. One of the essentials of due process is notice to all parties who will be adversely affected immediately by the action proposed. The only notice that the
employer received was by reading the first part of the claim application form, which had been completed by the claimant, before he completed the employer's portion of the form. One question in the employer's portion was expressly designed to give him an opportunity to signify his disagreement with the information given by the claimant, or, inferentially, to object to any aspect of the claim. If the employer did object to the validity of the claim, there was nothing in the law which assured him that a hearing would be held on the claim. However, as a matter of policy the agency always arranged an informal oral hearing whenever the employer made known, and persisted in, his objection to the claim.

In those cases where an invalid claim might have been filed and the employer made no objections, either through ignorance of the facts or a humanitarian feeling, an award would be made unless the invalidity showed upon the face of the application and was noted by the claims examiner or legal reviewer.

The workmen's compensation statute did not require an informal oral hearing before a claim was denied. However, the rules adopted by the members of the commission always required this, with two minor exceptions. In general the procedures of the commission for handling questioned claims were leisurely, but not open to serious criticism except for the length of time taken for field
investigations. The rights of either party in interest to obtain an informal oral hearing of the merits of a claim seem to have been reasonably protected by the policies of the commissioners, although not by the statute itself.
CHAPTER X

HEARINGS AFTER NOTICE

Since workmen's compensation is based upon liability without fault, a workmen's compensation hearing should be simpler than a civil trial based upon negligence. In an effort to reduce the adversary aspect of a workmen's compensation hearing most early statutes directed that the hearings be informal, simple and free from technical rules of procedure. In most cases this objective has not been achieved, for commissions have adopted more and more legalistic procedures. There is usually an initial hearing with the possibility of an administrative review and a judicial review. In Ohio, at the administrative review it was necessary to develop a record of the proceedings which could be used as the basis of a court review before a jury. In order to present the administrative decision in the best manner, it was necessary to conduct the administrative review under the rules of civil procedure. This method of review was adopted, and has been maintained, with the support of employee groups, even though it has contributed to the adversary aspect of the hearings. In Ohio the initial hearing has always been informal, but for
a long period the administrative review was almost as formal as that of a court, without the advantages of the speed of completion of a court trial.

At the Ohio workmen's compensation hearings there are three parties in interest, the employee, the employer, and the workmen's compensation agency as the representative of the state insurance fund. However, the place of each in the adversary process has not always been clear.

Administrative procedure, to be equitable, must retain the essential elements usually associated with a "fair trial", such as giving an opportunity for the full presentation of a party's case and fair consideration of the just rights of the party. The achievement of administrative fair play is fundamentally a task committed to the agencies themselves. However, because of differences between administrative and judicial techniques, many of the requirements covered by the constitutional guaranty of a fair trial are applied either before or following an administrative hearing. There are three fundamental requisites of a fair trial: (1) an opportunity to be informed fully of the nature of the charge in time to prepare to meet it; (2) the decision must be that of the person or persons to whom the responsibility of deciding has been delegated by the legislature and who must reach that decision on the basis of personal knowledge of the evidence; and (3) the party on trial must be given an opportunity
fully to present his evidence and arguments before an un­
biased tribunal.¹

Notice does not always precede a hearing. Sometimes
the hearing procedure itself is used as a means of giving
information to a person involved. The second requirement
that the one who decides must act on the basis of a perso­
nal knowledge of the evidence is frequently disassociated
from the hearing procedure itself. In administrative pro­
ceedings the process of determination is normally a post­
hearing procedure. The third requirement that the party
be given an opportunity fully to present his contentions
is more directly connected with the hearing itself. Nor­
mally, the basic characteristics of trial procedure in the
courts are not imposed on administrative tribunals. While
administrative agencies have developed hearing procedures
with reference to judicial standards, only the rudimentary
requirements of fair play have been required upon judicial
review of administrative decisions. The reason for allow­
ing wide departures from court hearing procedures grows
from a desire for brevity and speed. These goals, however,
are not always realized.²

The amount of formality or informality of procedure

¹ Frank E. Cooper, Administrative Agencies and the
Courts (Ann Arbor: University of Michigan Law School,
1951), pp. 149-151.

² Ibid., pp. 150-152.
needs to vary from agency to agency. One writer has phrased it thus:

... In lengthy hearings on closely contested technical issues of fact and law, where the contentions of the opposing parties are presented by skilled attorneys, the cause of good administration is furthered by the adoption of customary judicial techniques in conducting the trial of cases. In other instances, as where a wounded veteran seeks disability benefits, or an aged applicant seeks an old-age allowance under the Social Security Act, or an unemployed worker seeks unemployment benefits, an atmosphere of sympathetic conversation is perhaps best conducive to proper administration. There, the rule that informal hearing procedures are proper, so long as the rudimentary requirements of fair play are observed, has just and fitting application... 3

In Ohio, the first oral hearing of a workmen's compensation claim frequently achieved this "atmosphere of sympathetic conversation". However, a dissatisfied employer or claimant could request as a matter of right a further "rehearing" of a claim. This rehearing had to be conducted in accordance with the rules of civil procedure applicable to the conduct of a civil trial in the courts. In case there was a further appeal from the determination based upon the rehearing, the transcript developed at the rehearing served as the basis for a jury trial in a regular court to decide the right of the claimant to participate in the state insurance fund.

3 Ibid., p. 153.
A. INFORMAL ORAL HEARING AFTER NOTICE

Those questioned claims which could not be disposed of by the legal reviewers were set for a hearing before a hearing officer after reasonable notice to all parties in interest. In 1953, there were 18,455 first hearings on the merits by the legal reviewers. It was necessary for them to set for hearing 6,962, or 37.72%, of these claims. Of the claims given an informal oral hearing, 3,535, or 50.78%, were allowed, and the rest disallowed.\(^4\) The even balance between the number of cases allowed and disallowed at this stage would indicate the success of the system of screening cases first by the claims examiners and then by the legal reviewers in order to eliminate all but the most difficult cases.

Pleadings, Parties and Notices

Although pleadings are important before court trial in order to define the matters at issue between the adversaries, they were not considered to be important in the period preceding an informal initial hearing after notice on a workmen’s compensation claim in Ohio. The claimant had to file only an application for benefits. If the claims examiners and legal reviewers did not feel that they could award benefits on the basis of the application, a

\(^4\) Annual Claims Report, 1953, op. cit.
tentative statement of facts and conclusions of law was prepared by the legal reviewer and sent to the parties in interest.

while a defendant's answer in a court action was detailed and legalistic, the document prepared by the legal reviewer was a short and non-technical attempt to explain to the parties the objection to the claim. 5 Pleadings are characteristically considered unimportant in the American process as long as the parties involved receive fair notice of the type of litigation that is to be involved. 6 Although the documents prepared by the legal reviewers did not constitute a detailed statement of the issues involved, the later hearing was not limited in any manner to the subject matter listed. The hearings themselves were sufficiently informal that any element of surprise resulting from inadequate pleadings could be taken into account at the hearing.

Notices of the reasons and of the date of the hearing were sent to the claimant, the employer, and any attorney or lay representative of record in the claim. The hearing was generally set for about two weeks in the future in order to give ample notice to the parties involved. It generally was not heard by the members of the industrial commission unless a party in interest so requested. Normally it was

5 Interview, Brock, op. cit.
6 Davis, op. cit., pp. 278-279.
heard by other hearing officers acting for the commissioners. 7

**Time and Place of Informal Oral Hearings**

The commission itself or, more usually, its two deputy hearing officers always heard cases in Columbus for the adjacent area. The rest of the state was divided into four geographic areas in which claim boards rode circuit. However, a board of claims would sometimes hold hearings outside its area if for some reason it was more convenient for the claimant to have it held elsewhere in the state. The hearings were always public although they were usually attended only by the parties, their witnesses, and representatives.

In Columbus, certain days of the week were set aside for certain types of claims. The setting of claims before the boards was purely geographic. When a number of claims of any sort developed in a county, a hearing date for all of them was set in the county seat. In Columbus, about seventy a day were scheduled for the two deputy commissioners. 8

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7 Interview, Thompson, op. cit., August 17, 1954.

8 Memorandum from Supervisor of Claims, dated January 28, 1952.
Informal Oral Hearing Methods and Records

The atmosphere at the hearings before the boards of claims, the commission, or the commission's deputies, was most informal. The parties in interest and their representatives who appeared sat around a table with the hearing officers and discussed the case. Witnesses were not sworn nor was any record made of the testimony. In Columbus, the two hearing room examiners sat at opposite ends of a long table with a single secretary between them. At the end of the hearing they dictated their decision to the secretary in the presence of the parties. Each of the claims boards had elected one member to serve as board secretary, and he marked the decision in the file after they had discussed it before the parties and arrived at their decision. Written notice of the decision was mailed to all parties in interest.

The commission and the boards of claims possessed the power to subpoena witnesses and records. However, this was rarely done. If at a hearing pertinent information appeared to be missing, the hearing was continued until an attorney examiner could take the testimony under oath, after the issuance of a subpoena. The informal hearing of a workmen's compensation claim was in marked contrast

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9 Based upon attendance at both types of hearings.

10 Interview, Brock, op. cit.
to the general method of conducting a court trial, and it was considerably less formal than the rehearing before a referee of the commission.

One of the goals of those who advocated the adoption of the workmen's compensation principle at the turn of the century was to establish a system by which an injured employee could obtain speedy relief or adjudication without the necessity or expense of legal counsel. There has been success in establishing a system whereby most lost-time claims are paid even without any form of hearing with notice. However, in those cases in which the claimant received a notice that a hearing would be held on his claim, he appeared with representation in 65.5% of the cases, while the employer was represented in 37.5% of these hearings. In only 23.5% of the cases heard was neither the employee nor the employer represented.

It is now generally acknowledged that workmen's compensation has not removed litigiousness. During a survey made in 1951, a questionnaire was sent on the subject of legal representation at hearings to workmen's compensation commissioners. The returned questionnaires revealed that

11 In 1953, slightly in excess of forty-five thousand lost-time claims were filed with the commission and approximately seven thousand hearings after notice were held to determine the merits of a claim.

12 Percentages based upon statistics in Annual Claims Report, 1953, op. cit.
the commissioners generally frown upon employee’s appearing without counsel and that many of them will not permit laymen to represent claimants before them.\textsuperscript{13} The atmosphere of litigation in workmen’s compensation cases has slowly created a vicious circle. Litigation causes delay in settling claims, while delay in itself tends to provoke more litigation.\textsuperscript{14}

The Hearing Officer at Informal Oral Hearings

The Industrial Commission had the power to hold an informal oral hearing on any claim filed for workmen’s compensation benefits. In the early days it attempted to hear them all. In 1929, the act was amended to permit it to designate referees to hear cases.\textsuperscript{15} For a time, it used ten referees for this purpose. They were sent out to various parts of the state.\textsuperscript{16} In 1937, four boards of claims were created and made available to the commission for this purpose. The Commission itself developed the practice of holding first hearings only in claims involving permanent-

\begin{enumerate}
  \item \textsuperscript{13} Joseph Bear, “Survey of the Legal Profession - Workmen’s Compensation and the Lawyer”, \textit{Columbia Law Review}, December, 1951, p. 969.
  \item \textsuperscript{14} Somers, \textit{op. cit.}, p. 179.
  \item \textsuperscript{15} Amended Senate Bill 245, 113 Ohio Laws 262-263, 1465-47a G.C.
  \item \textsuperscript{16} Dodd, \textit{op. cit.}, p. 287.
\end{enumerate}
total disability and facial disfigurement. The other hearings were delegated either to two deputy hearing officers who were employees of the commission or to one of the four boards of claims.

In all states having an administrative agency, the volume of work requires some delegation of the hearing of contested cases. The two main patterns are either to use an employee with civil service status or to have some form of political appointment of the hearing officer. The first system gives the advantage of tenure which frees the hearing officer of outside pressures. The other system gives the advantage of sensitivity to the various publics which will be affected by the decision. In Ohio the 1937 decision of the commission to use the newly created boards of claims only in part of the state seems to be a historical outgrowth of the previous system of using attorney examiners, then known as "referees", from the legal section as hearing officers throughout the state.

Any claimant or employer dissatisfied with a deci-

17 Interview, Brock, op. cit.

18 In 1953, approximately 39% of the first hearings involving the question of the right to participate in the fund were held in Columbus by the two deputies; approximately 15% by the Cleveland board; approximately 16% by the Canton board; approximately 16% by the Dayton board, and approximately 13% by the Toledo board. Percentages based upon statistics in the Annual Claims Report, 1953, op. cit.
sion at one of these oral hearings might apply to the com-
mission itself for reconsideration, review, or modifica-
tion of the award within eight days after receipt of notice
of the award. This was not a prerequisite to asking for a
rehearing. Only in a fraction of one per cent of the cases
was a reconsideration requested. At the reconsideration
an informal de novo hearing was held.

The volume of cases is the probable reason for put-
ting the burden on the dissatisfied party to request a re-
consideration or rehearing rather than providing some mecha-
nism for an intra-agency review of each informal hearing.
Such a review would also have required a written record of
the hearing. Since in any hearing the decision of the hear-
ing officer might become final, the officer served a real
decision-making function rather than serving as a monitor
or presiding officer, as sometimes develops where the hear-
ing officer can not make even a recommended decision.

B. REAPPLICATIONS FOR ADDITIONAL OR MODIFIED BENEFITS

when a new claim for workmen's compensation benefits
was filed with the commission, the primary matter to be
adjudicated was the applicant's right to participate in

\[19\] 1465-44a G.C., 4123.14 R.C.

\[20\] Based upon statistics in Annual Claims Report, 1953, op. cit.
the state insurance fund or to receive equivalent benefits from his employer. If that were decided affirmatively, the next question was the extent of the benefits to which he was entitled, which in turn generally hinged upon the extent of the injury.

The rights of the parties were not closed when these first decisions were made, and a claimant who had been granted an award had the right to file other applications. The processing of these applications for additional or modified benefits involved both the legal reviewers and the hearing officers. In some cases the legal reviewers served a function in preparing the reapplication for a hearing, and in other cases some of the legal reviewers were given additional duties to serve as hearing officers, much in the manner that two attorneys from the section were used on a full-time basis for conducting first hearings on the merits of claims arising in the Columbus area.

The various types of reapplications were:

1. Application for determination of percentage of permanent-partial disability;
2. Application to modify a previous award;
3. Application for additional award beyond the date of last payment;
4. Cases in which the right to continue to receive compensation was in issue;
5. Applications for lump sum payments and lump
sum settlements;

6. Applications for extra benefits because of specific safety violations;

7. Appeals upon medical questions involved in a claim.

The procedures involved in these various types of reapplications are discussed in greater detail in APPENDIX C, Infra.

A very limited analogy can be drawn between the type of information obtained at an informal oral hearing of a workmen's compensation claim in Ohio and the type of information that would be obtained by a claims investigator for a private insurance carrier in handling such a claim. In the latter case the claims investigator would seek out the information bearing on the merits of the claim. The Ohio informal oral hearing placed the burden upon the employee and upon the employer of arranging for the presence of witnesses, and thus decreased the work of the agency. However, it gave the advantage to all parties in interest of hearing and rebutting adverse testimony.

This procedure of the agency of holding a hearing in all doubtful cases does not conform to the fourth principle of the private insurance companies in handling workmen's compensation claims which was that "only when necessary

\[21\] Page 12, Supra.
should cases go to hearings. Full use of informal conferences, where possible, should be made". However, it was a way of always conforming to the eighth principle that "dishonest claims should be fought", but it furnished no criteria for separating the dishonest from the honest claims.

C. ADMINISTRATIVE APPEALS

In the early days when the members of the Industrial Commission attempted to hear all claims themselves an appeal could be made from their decisions directly to a court of common pleas for a trial de novo before a jury in any case in which the commission denied an award upon any ground "going to the basis of the claimant's right". In 1921 an amendment declared that upon appeal to the court the evidence should be limited to the commission's record, but in spite of this amendment new evidence could still be introduced at the trial.

In 1925, the workmen's compensation law was revised to provide for an administrative appeal within the agency as a prerequisite to a court appeal. At this administrative

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23 House Bill 378, 109 Ohio Laws 291, 1465-90 G.C.

24 Dodd, op. cit., p. 353.
"rehearing" the conduct of the hearing was to be with "the evidence for and against the allowance of the claim submitted as in the trial of civil actions". A complete record had to be prepared at the rehearing and no additional evidence could be taken to the jury which had not been produced before the commission. This procedure was designed to enhance the function of the commission and to reduce the function of the court and the jury. However, the influence of the jury was not reduced as much as had been anticipated. The jury could not re-examine the extent of the injury, but it could determine the right of the claimant to "participate in the fund" even though it could not determine the exact amount. However, once the door was opened for participation in the fund, the determination of the exact amount by the commission was pretty well circumscribed and indicated by the other provisions of the act.

In 1937, the grounds for an application for a rehearing were limited to eight specific items. Unless the claim was denied on one of these grounds, there was no right for a rehearing. In 1947, there was a change in the rehearing process designed to improve the position of the employer who paid premiums into the state insurance fund, which permitted

25 111 Ohio Laws 228, 1465-90 G.C.

26 Amended House Bill 79, 117 Ohio Laws 86-89, 1465-90 G.C.
the employers to have his own counsel assist the assistant attorney general assigned to the defense of the fund at the rehearing.\footnote{Amended Senate Bill 262, 122 Ohio Laws, 1465-90 G.C.}

The Rehearing

During the eighteen-month period between January, 1953, and June, 1954, 4,895 applications for a rehearing were filed. Of these, $28.38\%$ were dismissed without any form of a hearing after notice on the right to have a rehearing.\footnote{Based upon a consolidation of the monthly reports from the rehearing unit to the supervisor of the legal section for the period.} This percentage needs to be qualified. In cases in which the order of the claims board or commission denying an award was too vague to serve as pleadings for the rehearing, the order was vacated without prejudice to the claimant and a more specific order issued in its place from which a new request for a rehearing could be made. Also in cases in which the claim was settled during the rehearing, it was listed in the monthly reports as being dismissed.\footnote{Interview, Paul J. Drugan, head of the rehearing unit of the legal section, Ohio Industrial Commission, July 30, 1954.}

Pleadings and Notice Before a Rehearing

Under the rehearing process the order of the commis-
sion or of a board of claims disallowing the claim served in place of pleadings in narrowing the issues. It was customary for the head of the rehearing unit to consult with the attorney for the claimant and with the attorney general before setting the first hearing date.  

**Parties at a Rehearing**

Since 1947, the employer has had the right to be represented by counsel at a rehearing. The Ohio Legislative Service Commission study in 1954 indicated that the claim was allowed on rehearing in 63.1% of the state fund cases defended by the attorney general or his assistant, and allowed in 13.2% of the self-insurer rehearings. These figures would indicate either that few employers took advantage of this provision or that their counsel working with the assistant attorney general was not as effective as the counsel of the self-insurer in defending claims upon rehearing. The writer participated only indirectly in the field study of rehearings. The Legislative Service Commission’s report will always be cited to document such indirect information. Information from the 1954 field study, not so documented, is from the writer’s direct research.

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30 Interview, Drugan, *op. cit.*

Place of Rehearing Sessions

The rehearing was generally held in the county seat most convenient to the witnesses who were to testify. Since the rehearing was conducted on several hearing dates, the successive hearings were not necessarily held in the same place. The rehearing involving medical specialists were usually held in the larger cities where they practice.  

Continuances and Delay of Proceedings

A rehearing was rarely completed in one session. It was the custom to give each side as many separate dates as were needed. However, effective March 1, 1952, the commission limited each side to two hearing dates. In order to receive additional time, the party had to petition the commission itself. The general pattern was for each side to present its lay witnesses at its first hearing date to establish the facts of the accident and to present its medical testimony at its second.  

There was great delay in completing the rehearings. The mean average number of days shown in a 1954 study was 726 days, or just less than two years, in state fund rehearings, and 977 days, or about two and three-quarters years,  

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32 Interview, Drugan, op. cit.  
33 Loc. cit.
in self-insurer rehearsings. The following table indicates the distribution of delay at different stages of a rehearing:

**TABLE IX**

**DELAY BETWEEN HEARING DATES IN REHEARINGS**

<table>
<thead>
<tr>
<th>DAYS BETWEEN:</th>
<th>STATE FUND</th>
<th>SELF-INSURER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application for Rehearing and First Hearing</td>
<td>111.6 Days</td>
<td>127.1 Days</td>
</tr>
<tr>
<td>Successive Claimant's Hearings</td>
<td>77.6 Days</td>
<td>75.6 Days</td>
</tr>
<tr>
<td>Claimant and First Defense Hearing</td>
<td>131.5 Days</td>
<td>60.6 Days</td>
</tr>
<tr>
<td>Successive Defense Hearings</td>
<td>100.9 Days</td>
<td>67.5 Days</td>
</tr>
</tbody>
</table>

SOURCE: Study made by the Ohio Legislative Service Commission, 1954, p. 5. (See p. 226 regarding documentation.)

In situations in which hearings are held without prior defining and narrowing of issues by means of pleadings, the element of surprise is minimized if each side has ample time after hearing the testimony presented by the opposite side to prepare for the presentation of evidence to refute it. For instance, it was customary for the attorney general to

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34 Ohio Legislative Service Commission Study, op. cit., Part III, pp. 4-5. (See p. 226 regarding documentation.)
wait until the claimant's medical proof had been presented in open hearing before an effort was made to have the claimant examined by an outside physician for the commission. Since the policy of granting continuances and of the length of continuances is closely inter-related with the amount of notice given to the parties of the nature of the opposition's case through pleadings, the speed at which the rehearing proceeded was influenced by the lack of advance defining of the issues.

**Hearing Methods and Records on Administrative Appeal**

The presiding officer at a rehearing was an attorney examiner from the legal section, who was generally referred to by the title of "referee". One of his chief functions was to rule upon questions of the admissability of evidence. The referee and an assistant attorney general were assigned to a rehearing only for a specific hearing date. In a 1954 study it was found that in almost three out of the approximately four hearing dates per rehearing a different referee presided. There was also a high turnover of assistant attorneys general during each rehearing.

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35 Interview, Drugan, *op. cit.*

36 Ohio Legislative Service Commission Study, *op. cit.*, Part III, p. 1. (See p. 226 regarding documentation.)

37 *Loc. cit.*
There was also little connection between the referee who heard the case and the referee who wrote the report to the commission summarizing the claim and recommending the action to be taken. In over one-fourth of the claims, the referee assigned to write the report and recommendation had not attended any of the hearings, and in only one-sixth of the cases had he attended all the sessions of the rehearing. The recommendation of the referee to the commission went only to the point of whether or not the claimant was entitled to participate in the state insurance fund or receive equivalent benefits from the employer. The extent of participation was to be decided by the commission. When the recommendation was prepared, a date for consideration of the recommendation was set and notices sent to the parties in interest about two weeks in advance. The recommendation was generally not available to the parties in interest until the day the hearing was set. The consideration of the recommendation was made by a deputy commissioner. At this hearing no presentation of evidence or briefs was permitted but oral arguments might be presented after the recommendation had been read in open session. By custom an appeal was allowed to the full commission from a decision of a rehearing claim by the deputy commissioner. The referee's recommen-

38 Loc. cit.

39 Interview, Brock, op. cit.
dation was accepted in more than ninety-five per cent of the cases. 40

D. COURT APPEALS

In Canada, complete and exclusive jurisdiction is given in workmen's compensation claims to the administrative board without recourse to the courts. In the United States the decisions of virtually all administrative tribunals are subject to judicial review. Over a period of several decades the courts have tended to limit the scope of the judicial review that they give to a review of a board's interpretation of the common and statutory law involved and of the substantiality of evidence adduced at the administrative hearing to support the board's findings of fact. 41

Under the 1954 procedure in Ohio, an appeal could be made only by the claimant from the decision of the commission after the rehearing to the court of common pleas with a jury upon request. This court trial was based on the transcript of the rehearing which was read to the jury in what sometimes developed into a reading contest between lawyers. In state fund cases, more than ninety per cent

40 Ohio Legislative Service Commission Study, op. cit., Part III, p. 9. (See p. 226 regarding documentation.)

41 Cooper, op. cit., pp. 350-354.
of the cases denied upon rehearing were appealed to the courts, and only a small proportion of these were won by the commission in the courts. The following table indicates the action taken after disallowance in 1954:

**TABLE X**

ANALYSIS OF REHEARING CLAIMS DISALLOWED

<table>
<thead>
<tr>
<th></th>
<th>STATE FUND CASES</th>
<th>SELF-INSURER CASES</th>
<th>ALL CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appealed to Common Pleas Court</td>
<td>93.4%</td>
<td>39.4%</td>
<td>79.2%</td>
</tr>
<tr>
<td>Not Appealed to Common Pleas Court</td>
<td>6.5%</td>
<td>60.6%</td>
<td>20.8%</td>
</tr>
<tr>
<td>Settled Prior to Judgment</td>
<td>43.5%</td>
<td>0%</td>
<td>32.0%</td>
</tr>
<tr>
<td>Judgment for the Claimant</td>
<td>2.2%</td>
<td>6.1%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Judgment for Defense</td>
<td>5.4%</td>
<td>0%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Cases Pending in Common Pleas Court</td>
<td>42.4%</td>
<td>33.3%</td>
<td>40.0%</td>
</tr>
</tbody>
</table>

**SOURCE:** Study made by The Ohio Legislative Service Commission, 1954, Part III, p. 10. (See p. 226.)

The fact that the Industrial Commission was willing to negotiate a compromise settlement in 43.5% of the cases—whereas the self-insurers were unwilling to settle prior to judgment in any of the cases—could be a strong factor in the greater number of state fund cases being appealed to the courts. This whole sequence of informal hearing, rehearing and court appeal indicated that if the claimant would persist in taking all of the appeals which were available, a decision could be obtained against the state insur-
ance fund in ninety-five per cent of the cases given a hearing after notice.\textsuperscript{42}

The workmen's compensation principle was developed to fulfill specific needs of the worker, the employer and the public, and to alleviate certain hardships previously borne by these three interests. The achievement of success depended upon the efficiency and equity of any system of processing claims substituted for the pre-existing court adjudication of suits by disabled workers.

The previous chapters indicate that in the past the Ohio Industrial Commission has operated through an organization and administrative practices which have failed in substantial measure to attain the highest possible level of efficiency and equity in the processing of claims. Within the framework of the workmen's compensation law of Ohio as it existed in 1954, considerable improvements could have been made in the procedures of the agency which would have speeded the adjudication of all types of claims, both contested and uncontested. The validity of the workmen's compensation principle was thus undermined to the extent that the practical maximum in efficiency and equity was not obtained. Substantial improvement in the processing of claims could have been achieved by innovations and modi-

\textsuperscript{42} Ohio Legislative Service Commission Study, \textit{op. cit.}, Part III, p. 10. (See p. 226 regarding documentation.)
fications in the administrative organization and practices of the agency. Some of these improvements could have been achieved by administrative action by the members of the commission.

Other changes needed for optimum handling of workmen's compensation claims in Ohio would require constitutional amendment or statutory changes by the General Assembly. In the following three chapters the statutory changes effected by the 101st General Assembly in the operation of the workmen's compensation law will be discussed and the possible effect of these changes in improving the efficiency and equity of workmen's compensation claim handling in Ohio will be speculated upon.
CHAPTER XI

THE 1955 LEGISLATIVE REORGANIZATION OF THE ADMINISTRATION OF WORKMEN'S COMPENSATION

In 1955, the Ohio General Assembly passed legislation which created a separate Bureau of Workmen's Compensation to which much administrative power was given. The 1934 legislation returning administrative power under the workmen's compensation statute to the Industrial Commission was repealed and most of the administrative power was given to the administrator of the new bureau. However, because of provisions in the state constitution certain powers relative to the operation of the state insurance fund were retained by the members of the Industrial Commission in a rather indefinite manner. The commission retained its powers to give a final administrative review to contested claims for workmen's compensation benefits.

The 1955 legislation permitted the administrator of the new Bureau of Workmen's Compensation to simplify and decentralize the organization and procedures for handling workmen's compensation claims. Possible changes in claim handling procedures will be discussed in the following chapter.
A. VARIOUS FACTORS LEADING TO THE 1955 LEGISLATION

In the early 1950's, members of the General Assembly began feeling pressure from a steady stream of complaints from constituents, concerning inefficiency on the part of the Industrial Commission in its administration of the workmen's compensation program. This pressure reflected a grass-roots interest rather than the concern of the organized employer and union groups which for a long time had been the sole clienteles showing interest in securing legislation relevant to workmen's compensation.

After the adoption of the exclusive state fund system in Ohio, interest in the subject of workmen's compensation largely died out except in groups affected. During the period when the original workmen's compensation legislation was being considered, the Ohio Manufacturers' Association and the Ohio State Federation of Labor cooperated in supporting the legislation. During the following years these two groups organized a Joint Committee on Workmen's Compensation composed of five representatives from each group. This joint committee conducted study and a series of meetings before each session of the General Assembly which produced an agreed proposed workmen's compensation law amendment which was presented to the legislature. The two employer and employee groups had a "gentlemen's agreement" to support the bill agreed upon in the joint committee and to oppose any other workmen's compensation legisla-
tion introduced into the General Assembly regardless of its merits. The preparation of such an "agreed bill" was clothed in secrecy and it was usually adopted by the General Assembly with little effective interference from other groups or from the public. After the creation of the C.I.O. in the mid-1930's, there was both C.I.O. and A.F. of L. representation among the five labor members of the joint committee on workmen's compensation. Other organized interest groups such as the Ohio Chamber of Commerce, the Ohio State Medical Association and the Ohio State Bar Association maintained study groups on workmen's compensation legislation but they were not as influential in shaping legislation on the subject as the O.M.A.-labor union groups were.¹

Both groups were greatly interested in the amount of money disbursed from the fund. The labor groups sought higher benefit rates and broader coverage of workers, along with procedural changes which would increase the possibility or size of an award of benefits. The Ohio Manufacturers' Association sought to reduce the amount of money paid from the fund and favored low premiums through merit rating and any changes which would prevent abuses in awards. Both groups were motivated by economic self-interest. The usual bill presented to the legislature by the joint committee

¹ Levine, op. cit., pp. 226-228.
was a patchwork dealing with various details of the system, to bring it up to date in the light of the legal and administrative developments of the biennium. The permanent-partial disability benefit provisions were an example of this interplay. Neither side participating in the joint committee seemed to be greatly interested in the quality of the administration of the workmen's compensation system. Even though payments have always been slow, the unions preferred to concentrate on the amount of benefits. Since both employers and employees had representation on the Industrial Commission they seemed to have had a friendly, or at least non-antagonistic, attitude toward the commission as a body.

There was no strong criticism developed of the administration of the law for a long time, either from the clienteles of the agency or from the general public. As a result the Industrial Commission and its staff did little self-analysis and few efforts were made to adopt newer administrative techniques which were being adopted by other governmental agencies during the period. There were occasional questions raised by the General Assembly but the commission quietly and courteously justified doing things as they had always been done.

The General Assembly traditionally moved slowly in passing legislation, especially with regard to items of legislation which would affect the internal organization
and procedures of the agency. Instead the legislature attempted to limit itself to general policy matters and meanwhile authorized at least two investigations of the operation of the agency. In addition the required actuarial audit of the operation of the state insurance fund was made in 1953. After all three of these studies, reports were published which were critical of certain aspects of the operation and signalled the need for extensive change.

The Periodic Actuarial Audit

Actuarial errors in setting premium rates affected the solvency of the state insurance fund during the depression. In 1937, the general assembly directed that an outside actuarial audit be made in every five-year period.\(^2\)

In 1953, the periodic actuarial audit was made of the state insurance fund by Joseph Froggatt & Co., Inc., consulting actuaries of New York, for the calendar years 1948 to 1952, inclusive. One recommendation in this report was for the creation of a new "housekeeping" unit or section.\(^3\) The report also recommended that a "Claim Clerical Division" be created to centralize claim activity, acceleration

\(^2\) Substitute House Bill 617, 117 Ohio Laws 505, 1465-55a G.C., 4123.47 R.C.

ate the issuance of warrants, and place a closer control over such expenditures. The report also suggested, in re­spect to claim files, that district offices (within specified limits) be permitted to open and maintain the claim files and to draw and issue warrants. Copies of these war­rants would be coded and sent to Columbus for processing just as if the warrant had been issued by the central of­fice.4

The report further recommended that the single three­part form for reporting accidents be replaced by separate reports from the claimant, employer, and physician, each to be forwarded individually to the claims section. Upon receipt of any one of the three notices of accident, the claims section would assign a claim number, a nominal re­serve, and create a claim file. An abstract of the infor­mation would be prepared and duplicated for distribution to other sections of the commission which needed the infor­mation for tabulating and record-keeping purposes. The claim file would be held in "suspense" until the other two reports were received. It would then be processed through examiners, awards granted, and advices sent to the Claims Clerical Division (or the Auditing Section) for the issuance of warrants.5

4 Ibid., pp. 67-68.
5 Ibid., p. 64.
The Ohio Program Commission Study

The Ohio Program Commission was a study and planning group with joint executive and legislative composition. It had a membership of twenty-one, including certain state officials, certain members of the General Assembly, and members appointed by the governor. It has since been supplanted by the Ohio Legislative Service Commission.

The 99th General Assembly directed the Ohio Program Commission to study the operations of the Industrial Commission. This commission used the task force approach. During the biennium 1951-1952, it appointed ten study committees on a wide range of topics, one of which was the Industrial Commission Investigating Committee. When the committee was organized it was divided into sub-committees. The sub-committees held public hearings which were in most respects similar to open legislative committee hearings. The entire committee made a report to the commission, which was accepted in part. The report of the committee and the changes made by the Program Commission were published.

6 The President of the Senate, the Administrator of the Bureau of Unemployment Compensation, the Director of Welfare, the Director of Highways, the Director of Public Works and the Tax Commissioner; the President pro tempore of the Senate and five members appointed by the President pro tempore thereof; the Speaker of the House of Representatives and five members of the House of Representatives appointed by the Speaker thereof; and three members appointed by the governor. Ohio Program Commission, (Fifth) Biennial Report 1951-1952, p. 10.

7 Ibid., pp. 76-92.
fact-finding staff was employed.

Among the suggestions relating to organization and administration was a recommendation that the administrative costs be paid from the money of the state insurance fund and, in turn, added to the cost of premiums. This procedure was adopted in part by the next legislature, which decided that two-thirds of such costs should be so defrayed. There was also a recommendation that "the insurance fund and the business side of the Industrial Commission be under the supervision of an administrator." This suggestion did not receive the approval of the 100th General Assembly, but it was adopted in part in 1955 by the 101st. It was also recommended that the Industrial Commission be permitted to use three separate reports from claimant, employer, and physician. Another recommendation suggested that the law be changed so that the commission, prior to a determination of compensability, could commence the payment of compensation and nursing expense and could guarantee the payment of medical and other expense immediately upon receipt of any one of the three forms, whenever it appeared that the claim was probably compensable. No action was taken on this in 1953, but the 101st General Assembly took action in 1955

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8 Ibid., p. 79.
9 Ibid., p. 81.
10 Ibid., p. 83.
which permitted tentative payments without foreclosing a later denial of compensability and a cessation of further payments.\textsuperscript{11}

The report of the Ohio Program Commission did not produce a great amount of workmen's compensation legislation in the 100th General Assembly. However, its report, when supplemented by other reports and studies, was adopted in part in the extensive reorganization of the administration of the law which was adopted in June, 1955.

\textbf{The Ohio Legislative Service Commission Study}

The Legislative Service Commission is composed of fourteen members of the legislature, with seven from each house. It employs a full-time research staff which makes interim studies as directed by resolutions of the Assembly.

By House Resolution 207 of the 100th General Assembly the Legislative Service Commission was directed to appoint a committee of members of the General Assembly to study, investigate, and report upon the operation and administration of the Ohio workmen's compensation law. This study was made by the staff of the Legislative Service Commission primarily during the summer of 1954.\textsuperscript{12}

The staff study was designed to make available to

\textsuperscript{11} 4123.514 R.C.

\textsuperscript{12} The writer was connected with those portions of this study relating to organization and administration and to claims appeal procedures, serving as special consultant.
the study committee factual material upon which it could make recommendations to the general assembly or upon which members could act by introducing bills. The reports of the staff were purely factual and made no recommendations either to the full Legislative Service Commission or to the Committee to Study the Ohio workmen's Compensation Law. However, during the summer and fall of 1954, staff members met with the legislators on the committee and the commission to brief them on the material developed by the study. The information collected was primarily for the legislative use of the members, and it was not released to the public until April, 1955, after the chief legislative committee hearings on workmen's compensation legislation were completed.

The chairman of the study committee was Representative Roger Cloud, who was later elected Speaker of the House of the 101st General Assembly. Representative Gilbert Bettman was chairman of the subcommittee on Claims and Appeal Procedure; Representative Horace Troop, of the subcommittee on Organization and Administration; and Senator Charles J. Carney, of the subcommittee on Benefits and Safety.

**Legislative History of Amended Substitute House Bill 700, 101st General Assembly**

At the beginning of the 101st General Assembly in January, 1955, several bills were introduced relative to
workmen's compensation. Two bills introduced into the House dealt with the administration of workmen's compensation. House Bill 700 was introduced by Representative Charles C. Wheeler, member of the Industry and Labor Committee, and House Bill 554 was introduced by Representative Horace Troop, chairman of that committee. Both bills were referred to the Industry and Labor Committee and then assigned to a sub-committee on workmen's compensation of which Representative Gilbert Bettman was chairman. This subcommittee held extensive hearings during a three-month period in the spring of 1955. A combined bill emerged from the subcommittee, Substitute House Bill 700 (also known as the Wheeler-Troop-Bettman Bill), which dealt with many more matters than a reorganization of the administration of workmen's compensation.

The reorganization bill was debated in the House on June 14, 1955 and was passed, with only one major change, by a vote of 123 to 8. The bill as reported from committee had provided that appeals from the Industrial Commission should go to the court of appeals for review of questions of law and of the substantiality of the evidence. On the floor of the House this was changed so that the old form of appeal, whereby the case could go by transcript to a jury in a court of common pleas, was written into the bill. A few days of hearings were given to the bill in

the closing days of the session by the Senate Commerce and Labor Committee. The bill was reported from that committee on June 25, 1955, with a further change in the appeals procedure, whereby the appeal could be heard de novo before a common pleas jury, rather than by having the transcript of the rehearing before the Industrial Commission read to the jury. In this form it was passed by the Senate and the changes were concurred in by the House on June 24, 1955, the last night of the session. It was signed by the governor on July 6, 1955 to be effective October 5, 1955.

In the 101st General Assembly, in 1955, the basic workmen's compensation law was drafted in committee, after extensive hearings, rather than outside the legislature by a joint employer-employee committee of private citizens. Both employer and employee groups were present at these hearings and both sides offered many suggestions, many of which were adopted. In consequence the bill finally reported out by the committee contained many features which were not present when it was introduced. Although neither the employer groups or the employee groups were enthusiastic about the major administrative changes proposed in the bill they were not actively opposed to them. In consequence the bill evolved in the House committee contained administrative changes devised by the legislators along with the

provisions which had been agreed upon by the joint employer-employee committee prior to the session. The primary credit for the administrative change goes to a small group of legislators who had made their own independent study of the operation of workmen's compensation in Ohio and who developed their own independent views as to the kind of legislation needed for its improvement. Since they were working outside the support of labor and employer groups, it became necessary for them to compromise on some phases of the proposed measure in order to secure sufficient support for the passage of their proposed changes. It might be mentioned that this small group of legislators may have given more attention to complaints emanating from the general public than from the employer-employee groups which in the past had largely directed the course of workmen's compensation legislation. The 101st General Assembly instructed the Legislative Service Commission to conduct further investigations in the next biennium, which would indicate a continuation of legislative interest in the administration of the law.

B. REORGANIZATION OF THE ADMINISTRATION OF WORKMEN'S COMPENSATION IN 1955

Various methods of administering workmen's compensation were established in most states in the second
decade of the present century. Although they differed widely from each other, each method seemed to have developed a sufficiently satisfied clientele to protect it from administrative changes. As a result, changes have been extremely rare in the last thirty-five years. In 1921, New York switched from the agreement system to the hearing system of adjudication and in 1943 Michigan changed from the agreement system to the direct payment system. For this reason, the rather drastic reorganization in Ohio in 1955 probably surprised most students of workmen’s compensation.

Separation of Authority Between the Industrial Commission and the Administrator

The statute of 1934 specifically gave to the Industrial Commission the power to administer the workmen’s compensation law, including the power to maintain the state insurance fund and make disbursements therefrom; to appoint necessary employees; and to control all agencies and employees devoted to the administration of workmen’s compensation. The 1955 law repealed this grant of power.

The 1955 act created a Bureau of Workmen’s Compensation, to be administered by an Administrator of Work-

16 154-45 G.C., 4121.12 R.C.
17 Section 2, Amended Substitute House Bill 700.
men's Compensation. The administrator is to be appointed by the governor with the advice and consent of the Senate, for a six-year term at an annual salary of $12,000. The administrator may be removed only for cause.\textsuperscript{18} He is made responsible for the discharge of all the duties imposed upon the Industrial Commission in Chapter 4123 of the Revised Code, except such powers and authority as are vested in the commission in section 4121.13. He is to employ, direct, and supervise all deputies and other employees required in connection with the performance of the duties assigned to the bureau. He is directed to reorganize the work of the bureau of workmen's compensation, its sections, departments and offices to the extent necessary to achieve the most efficient performance of its functions. Included in this power is the authority to change or abolish positions and assign and reassign the duties and responsibilities of the employees of the bureau.\textsuperscript{19}

The powers reserved to the commission in section 4121.13 R.C., relate to safety and the operation of the state insurance fund. These include, for constitutional reasons, the right to prescribe safety regulations, to prescribe and require the adoption of safety devices, and to prescribe reasonable standards necessary to render places of

\textsuperscript{18} 4121.121 R.C.

\textsuperscript{19} 4121.122 R.C.
employment safe. In addition the commission retained the power to investigate, ascertain, and determine such reasonable classifications of persons, employments and places of employment as are necessary.  

In section 4121.131 of the new act, eleven specific powers, authorities and duties of the three commissioners are listed, in addition to those in section 4121.13 R.C. The reserved powers of the commission were those relating to safety work and the management of the state insurance fund, which could be interpreted as being based in the two constitutional amendments, and those relating to its role in making the final determination of a disputed claim subject, however, to judicial review by the courts.

The new act attempts to meet these constitutional limitations by providing that the personnel and staff needed for the insurance fund operations should be under the administrator, who should prepare and submit information to the commission.  

There is considerable indefiniteness with regard to the dividing line between the powers and authority of the administrator and the commission due to the words in section 4121.122(A) R.C. that the grant to the administra-

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20 871.22 G.C., 4121.13 R.C.

21 Section 4121.122, subsections (E) through (J), inclusive.
tor of the powers of the commission did not divest the commission of the right "to exercise such authorities and powers in the discharge of its own responsibilities and any authority or power which is vested in the commission or the administrator . . . may be exercised by either to the extent necessary to effect the discharge of their respective responsibilities". This line was put into the bill by the legislators in an effort to avoid constitutional contests of the respective powers of the two and to give greater flexibility to the powers of the administrator.\textsuperscript{22}

The Division of Employees Between the Commission and the Bureau

All employees of the commission who are transferred to the bureau of workmen's compensation are "transferred to the bureau . . . in their respective classifications but subject to reassignment as the administrator may determine to be in the interest of efficient administration. The civil service status of any person employed by the industrial commission shall not be affected by the provisions of this section."\textsuperscript{23} The administrator is given the

\textsuperscript{22} Interview, Representative Horace Troop, chairman of the House committee, Ohio General Assembly, July 13, 1955.

\textsuperscript{23} 4121.122 (C) R.C.
power to discipline, suspend, demote or discharge any employee of the bureau for misfeasance, malfeasance or non-feasance. This is in accord with the general discharge procedures under the civil service system of the state.

The administrator has much broader powers of removing employees who carry on investigative and deciding functions within the bureau. The new act states: "In the case of any deputy administrator, or of any employee assigned to the investigation or determination of claims, the finding of the administrator that such person is not efficient, impartial, or judicious, if supported by any evidence and not promoted by personal, political, racial or religious discrimination, shall be accepted as a fact justifying the action taken by the administrator". The breadth of the removal power has drawn the objection of representatives of Ohio public personnel organizations. Once the administrator has established a policy as to what types of claims should be paid, this procedure gives him strong control over his deputies and subordinates to see that the policy is carried out. However, the provision that any finding of the administrator that the employee is "not efficient, impartial or judicious" will be upheld "if supported by any evidence" sets

24 4121.123 R.C.
25 Loc. cit.
26 Statement based upon attendance by the writer at Senate committee hearings on the bill, June 22, 1955.
up a standard of the burden of proof, which easily could lead to litigation.\textsuperscript{27}

Another portion of the law relates to the division of the old staff of the commission between the bureau and the commission. Section 4121.122(C) states that the administrator and commission shall jointly determine which of such employees will be assigned to each of them, and in case of a disagreement as to any employee the matter shall be referred to the state civil service commission, who will make the assignment.

Prior to the 1955 law, the only legislative provision relating to internal organization of the commission was the provision that the commission should employ a superintendent and the necessary staff for the operation of a bureau for the prevention of industrial accidents and diseases.\textsuperscript{28} The sections of 4121.122 which give to the administrator the power to prepare and submit information to the commission on certain subjects makes no mention of safety activities. There is a strong likelihood that when the personnel is divided between the commission and the bureau, the safety and hygiene section will remain under the direct supervision of the commission.

\textsuperscript{27} Interview, Representative Charles C. Wheeler, Ohio General Assembly, July 13, 1955.

\textsuperscript{28} 1465-89a G.C., 4123.17 R.C.
Organization of the Bureau of Workmen's Compensation

The 1955 act contained more legislative detail directly affecting the internal organization and procedures of the new bureau than is usually found in legislation. Section 4121.122(K) directs that "as promptly as possible in the course of efficient administration" the administrator should decentralize and relocate such personnel and activities of the bureau as may be appropriate to the end that "the receipt, investigation, determination and payment of claims may be undertaken at or near the place of injury or the residence of the claimant and for that purpose establish regional offices". It can be assumed that there will be regional offices in the more populous centers under the direction and supervision of a deputy administrator, with claims examiners and, in all probability, legal and medical personnel.

In the study of the administration of workmen's compensation in the spring of 1955, the House subcommittee used the Bureau of Unemployment Compensation of Ohio for comparative purposes.29 There are some comparisons which validly can be made between the administration of the Ohio workmen's compensation and unemployment compensation programs in that

29 Interview, Representative Gilbert Bettman, chairman of the subcommittee on workmen's compensation, Ohio General Assembly, July 13, 1955.
both involve claims for money payments from a state-administered fund. However, the fact that the workmen's compensation claimant often is disabled and unable to come to the agency's office creates administrative problems not faced by the Bureau of Unemployment Compensation. Nevertheless, the influence of the comparative study by the legislators can be detected.

In the unemployment compensation system an effort has been made to separate administrative functions from the functions of quasi-judicial review of disputed claims. The Bureau of Unemployment Compensation is headed by a single administrator who is appointed in the same manner as and with similar powers to the new administrator of workmen's compensation. However, the administrator of the Bureau of Unemployment Compensation has broader and more complete powers over the unemployment insurance fund.

The claims operation of the Bureau of Unemployment Compensation is highly decentralized. As of the summer of 1954, there were fifty-six full-functioning branch offices and forty-four itinerant points, which were open from one to three days a week for the purpose of taking claims. Authority has been delegated to personnel in the branch offices to determine whether a claimant is entitled to unem-

30 1346 G.C., 4141.02 R.C.
31 1345-13 G.C., 4141.13 R.C.
ployment benefits, and if so, how much and when. The administrator of the Bureau of Workmen's Compensation is authorized to decentralize claim handling procedures in a similar manner.

In order to give an independent review of claims within the agency an unemployment compensation board of review was created, consisting of three full-time members appointed by the governor with the advice and consent of the Senate, for terms of six years. They may be removed only for cause. The board may hear appeals arising from claims for unemployment compensation. The board, with the approval of the governor, may appoint as many referees as are necessary to serve as hearing officers at the initial hearing of these appeals. This board of review does not have any control over the operation of the insurance fund involved.

The 1955 legislation created a workmen's compensation advisory council, which was obviously patterned after the advisory council of the Bureau of Unemployment Compensation. The new advisory council has access to all the records of the bureau and to the reasonable services of

33 1345-3 G.C., 4141.06 R.C.
34 1345-2 G.C., 4141.09 R.C.
the employees of the bureau. It may conduct research, make and publish reports and make recommendations to the governor, the legislature, the administrator and the commission. There is a provision that the administrator shall provide the council with competent assistants who shall be subject to the approval of the council.35

In another organizational change the medical board of review, whose findings were binding upon the Industrial Commission, was abolished and replaced by a medical advisory board to which medical questions could be submitted.36

Several changes were made in the organization for hearing claims. The 1955 act repealed the old section of the workmen’s compensation law which had provided for the referees, who had been used primarily to preside at rehearings. Also the four boards of claims, which had conducted the informal first, or “special”, hearings of a questioned claim, were abolished.37 Instead procedures were authorized for the deputy administrators, or others in the regional offices, to conduct the informal original hearings on a claim.38 Five new “boards of review” were established to conduct a hearing upon appeals from the decision of the ad-

35 4121.124 R.C.
36 4123.152 R.C.
37 Section 2, Amended Substitute House Bill 700.
38 4123.515 R.C.
The hearings before the board of review replace the old rehearing, although it is impossible to predict whether such new hearings will be as formal and as slow as the rehearings. Each regional board of review will have three members: a representative of labor, a representative of employers, and an attorney, who shall serve as chairman.

In other changes in the 1955 legislation, the benefit scale was altered by increasing the maximum weekly benefit from $32.20 to $40.25. Still further changes were made in the so-called section 80b, which deals with permanent partial injury where there has been no economic impairment to the worker’s earning capacity. It was provided that in cases where there were no reasonably demonstrable medical or clinical evidence of the injury, but where there is only the testimony of the claimant without corroboration by objective medical findings, the commission shall cause a medical advisory board to determine whether the employee is physically disabled. The determination of the medical advisory board including its determination, if any, of the percentage of permanent physical disability of the employee is binding upon the commission. Thus, in effect, the

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39 4123.14 R.C.  
40 4123.56 R.C., and other places in 4123 R.C.  
41 4123.57 R.C.
controversial determination of the percentage of permanent-partial disability was delegated to members of the medical profession.

It is difficult to predict to what extent the reorganization and decentralization of the claim determination work of the administration of workmen's compensation will be carried out and how it will affect the medical staff. It would be impossible to determine the claims without having medical advice available. If the medical section were to remain centralized in Columbus much mailing of files would be necessary in order to obtain a medical opinion. Having at least one physician in each branch office would be advantageous. In all likelihood there will not be enough physical examinations required to warrant a full-time examiner in any except the largest cities. However, it would be possible to schedule only certain hours in the day for physical examinations and have the doctor devote the rest of the day for desk work. One of the greatest difficulties in the past has been in obtaining physicians who are willing to work on a salary rather than conducting their own practice. One solution might be to employ part-time doctors in the regional offices, either as the sole source of medical knowledge or as a supplement to full-time physicians. It is difficult to predict just how extensively the staff doctor in the branch office will be used in connection with the administrative hearing.
It is problematical how extensively the legal section will be decentralized under the 1955 reorganization. The employment of attorneys does not create as pressing a personnel problem as the employment of physicians. An optimum condition would be to use attorneys for all jobs involved in the determination of a claim, either as investigators or deputy administrators. Budgetary considerations and the civil service status of present claims examiners would hamper this, at least at first. Certainly, there should be at least one attorney in each branch office, and there seems to be little justification for continuing to centralize all the legal staff in Columbus.

The form of organization is not an end in itself, but must be adapted to the work which has to be done. As the work and other conditions change the organization needs to be adapted since administrative work largely determines the efficiency of service in the large mass of uncontested claims. It is not likely that an effective staff can be created or maintained for long without adequate supervision from above. Under the former administrative organization the commission itself was the only body with power to supervise operations. Its supervision consisted primarily of a meeting once a month with the ten section chiefs. Much of the dissatisfaction of the 101st General Assembly was based upon the results being achieved under a commission form of administration operating primarily from a central office.
As a solution they transferred administrative functions to a single administrator and authorized decentralized claim adjudication and payments. It might be that had the legislature found similar unsatisfactory operation under an administrator using a decentralized organization, they could have found reasons and sufficient justification for changing to centralized operation under a commission. Alert and efficient supervision can achieve surprising success under any form of organization, but it is conceded that administrative work can best be directed by an individual since it offers unity of command and centers responsibility. In those cases where a single individual or commission has both executive and judicial functions, the mass of administrative detail is likely to over-shadow adjudication or vice versa.

There is little magic in reorganization alone. With any physical decentralization of the claims adjudication and payment there will be increased need for internal reporting to the administrator and for a permanent special staff close to the administrator which will be able to interpret the reports and to detect poor performances and which will constantly be looking for improvements in methods of handling claims. There will be a need for an active inspection section. This is the negative side of supervi-

42 Interview, Bettman, op. cit.
sion. In addition it will be necessary for the administrator to delegate broad powers to the deputy administrators in charge of the branch offices in the investigation, determination and payment of claims. For effective delegation it will be necessary that the administrator develop clearly defined policies on such matters as the speed of adjudication, the use of the new tentative orders, and the extent to which questionable claims will be compromised or resisted.

The 1955 legislation permits moving much of the administration needed for workmen's compensation claims to the field. It remains to be seen to what extent medical and legal staffs will be moved to regional offices. If such a decentralization of the professional staffs should be made, it could break down the tendency to compartmentalization which has grown up around the medical and legal sections of the Industrial Commission and lead to a more informal desk-to-desk consulting between those adjusting claims and the professional staffs without having to go through the old formal channels. Because of the nature of workmen's compensation, once the full facts are obtained professional advice is frequently needed also. This involves personnel problems of obtaining the professional staff and organizational problems of placing the staff where it will be most effective. In the past the organizational approach to the complicated claim has been func-
tional, with some resulting compartmentalization between the four sections of the commission involved. Under the 1955 legislation, the emphasis can be changed to geographic. There is a likelihood that the pattern which will evolve is that of a regional office with a manager, answerable to the administrator, operating an office with little functional division and much desk-to-desk consultation.

The section chiefs in the agency as it functioned in 1954 showed an institutionalized unwillingness to achieve administrative procedural modification as a collective body or individually, except for the chief of the accounts section. This unwillingness furnishes an argument that reorganization of the sections is precisely what was needed. There are indications that the members of the legislature desired a reorganization from the top which would shatter such institutional patterns. Such ripper legislation is indicated by their suggestion of a geographic organization in place of a functional organization and by their granting the administrator extremely broad powers to dismiss executive personnel, page 252, Supra.
CHAPTER XII

POSSIBLE CLAIM PROCEDURES OF
THE BUREAU OF WORKMEN'S COMPENSATION

The legislation creating the Bureau of Workmen’s Compensation in 1955 gave to the administrator of that bureau the right to make a determination of the validity of all claims for workmen’s compensation benefits. The administrator was authorized to begin action upon the report of a disability without waiting for a written report from the employer or physician. The administrator was given authority to issue a "tentative" order beginning payments of benefits before the completion of the investigation of a claim. In any case where a claim became disputed the administrator, or his staff, was required to grant an informal hearing after notice to the parties in interest. After this administrative hearing a dissatisfied party in interest could appeal the claim to a regional board of review and thence to the Industrial Commission. The appeal procedures from a decision of the administrator will be discussed more fully in the following chapter.
A. CHANGES IN REPORTING PROCEDURES

The organization for handling workmen's compensa-
tion claims from 1920 through 1954 centered in the three-
part reporting form, which placed the burden of furnishing
the information needed for a determination of the validity
of a claim upon the claimant. This procedure made possible
the disposition of most claims on a mail-order basis from
a central office in Columbus. Two provisions of the 1955
act indicated a strong wish of the legislature that (1) the
three-part form be abolished in favor of a system whereby
action would be taken by the administrator upon the basis
of a report from any person, and (2) the organization of
the new bureau be decentralized so that the power to re-
ceive, investigate, determine and pay claims could be dele-
gated to deputies in charge of regional offices.

In 1920, the three-part form was adopted as an ad-
ministrative expedient to relieve the limited staff of the
commission of the necessity of conducting extensive cor-
respondence to obtain the information needed. The 1955
act provides that:

The administrator of the bureau of workmen's compensa-
tion shall prepare and furnish blank forms of appli-
cation for benefits or compensation from the state
insurance fund . . . and shall provide in his rules
for their preparation and distribution so that they
may be readily available and so prepared that the
furnishing of information required of any person with
respect to any aspect of a claim shall not be delayed
by a requirement that information with respect to
Legislatures in drafting statutes find it difficult to word a law in such a manner as to make administrative action obligatory. One method of achieving such a result is to make it impossible for the administrator to do otherwise. In section 4123.07 R.C. the legislature made it virtually impossible for the administrator of the Bureau of Workmen's Compensation to continue the use of the old three-part reporting form. It is easily predictable that a failure of the administrator to simplify reporting forms would draw strong protests from employee groups.

**Action to be Taken Upon the Receipt of a Report From the Claimant Alone**

The 1955 act gives the administrator, or his deputies, broad discretion in the handling of an application for workmen's compensation benefits from the claimant only. It only requires that the employer be notified of the receipt of the claim and of the facts alleged therein, and it gives broad latitude in the manner of obtaining needed information.  

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1 4123.07 R.C.
2 4123.512 R.C.
Action Upon the Receipt of a Report From a "Person Other Than the Claimant"

If the administrator shall receive "from a person other than the claimant information indicating that an injury . . . has occurred . . . the administrator shall notify the employee and the employer of such information". Such notice of an injury from a person other than the claimant shall not be considered by the administrator as an application for compensation benefits by the injured worker, and presumably a claim number will not be assigned. But if the employer, on the basis of the notice received, shall notify the administrator that the employee has a valid claim, the administrator shall investigate and determine whether the employee is entitled to an award without waiting for the filing of the employee's written application for compensation. If an award is made it will be unnecessary for the employee to file a written application thereafter. The other person who sends information concerning the injury could be a friend, physician, or even a union steward. Under this section, it would be possible for a working arrangement to be developed between unions and the employer whereby the employee could be relieved completely of any duty of reporting a claim.

3 Loc. cit.
4 Loc. cit.
Under the 1956 legislation, it would be possible for the administrator to adopt many aspects of the Wisconsin, or "direct payment", system, except that in Ohio the burden of going forward after the receipt of any form of notice is placed upon the personnel of the state bureau rather than upon a private insurance carrier. Such a system presupposes the cooperation of the employee, employer, physician, witnesses and union officials. This spirit has been engendered in Wisconsin from the beginning of the law and has been maintained through an effective public relations policy.

Decentralization of Claim Determination

Without organizational and procedural changes, the abolition of the three-part form could lead to a return to the procedures followed prior to 1920. A blueprint of organizational and procedural change is contained in the 1955 act in more detail than is generally found in legislation. A section of the new law states:

The administrator shall, as promptly as possible in the course of efficient administration, decentralize and relocate such of the personnel and activities of the bureau of workmen's compensation as may be appropriate to the end that the receipt, investigation, determination and payment of claims may be undertaken at or near the place of injury or the residence of the claimant and for that purpose establish regional offices, in such places as he may deem proper, capable of discharging as many of the functions of the bureau of workmen's compensation as is practicable so as to promote prompt and efficient administration in the processing of claims.\footnote{4123.122(K) R.C.}
Under this grant of power it clearly would be possible for the administrator to establish local offices and delegate authority to the deputy administrators to receive reports and to investigate, adjudicate and pay them, without any action other than that of supervision and record-keeping being carried on in Columbus. The provision contains an escape clause which would permit considerable delay in putting the provision into effect or which might even result in a failure to put it into effect at all.

Section 4123.122(K) R.C. resulted from legislative thinking rather than from pressure from any organized group. The only way that a legislature can be assured that permissive legislation will be put into effect is to make it impossible for the administrative officer to do otherwise. The language in the above section is not that strong. However, it is assumed that some form of decentralization of claim-handling organization will be established. Whether it would be best to decentralize the coverage information records and the check-issuing functions to regional offices no doubt will be given serious consideration by the first administrator. However, the decentralization of those two functions might create more problems than the decentralization of the function of receiving reports, investigating, determining, and authorizing payment of simple unquestioned and uncontested claims would create.

Moving the claim offices closer to the claimant
would shorten mailing time for the claimant. For those who live in the same town as a regional claim office, the claimant’s report could even be delivered in person. Having a claims examiner within easy telephone range to answer questions and to give a report on the status of a claim could lessen some of the uncertainty which sometimes leads to the employment of counsel by the claimant.

The 1955 act indicates that the administrator should assign all claims to the office of the bureau by which the investigation and determination could be made most expeditiously. Investigations of the facts concerning an injury may be ascertained in whatever manner may be most appropriate. The statements of the claimant, employer, physician, and witnesses may be obtained in writing or may be made to the investigator orally or by telephone or telegraph as the circumstances may justify. Thus the regional offices may use the techniques which have been developed in the “Legal X” unit of the Columbus office.

B. CLAIM HANDLING BY THE BUREAU OF WORKMEN’S COMPENSATION

If the three-part reporting form is abolished, virtually all reports of disability received will be in a category similar to the incomplete reports received by the Industrial Commission which were discussed in Chapter.

6 4123.512 R.C.
IX, Supra. It is doubtful if the old methods of obtaining missing information, with the exception of the techniques of the "Legal X" unit, would stand up under the increases in the number of incomplete claims. If the organization of the Bureau of Workmen's Compensation is decentralized, the burden will be placed upon the branch offices to obtain all needed information. It will be necessary to develop techniques for the handling of a large number of incomplete claims by these offices. If a policy is adopted of making wide use of the telephone in the local offices for obtaining sufficient information for the determination of a claim, most of these claims can be determined speedily.

Several new techniques are available to speed determinations of claims: (1) The adjudicators in the branch offices will have the power to grant an award even without any report from the employer; a payment will begin ten days later or upon receipt of the employer's acknowledgment of the validity of the claim, whichever is sooner;⁷ (2) In those cases where an investigation is incomplete, but where it looks as if the claimant is entitled to an award, the adjudicator may make a tentative order, which will go into effect unless the employer objects within a limited time;⁸ (3) If an employer protests after payments have be-

⁷ 4123.513 R.C.
⁸ 4123.514 R.C.
gun, and a later appeal establishes that payments were improperly made, the amounts paid will be charged to the surplus fund rather than against the employer's loss experience. The agency may modify a tentative order at its own initiative at any time. All of these tools will give to the adjudicators in the branch offices facilities for the speedy determination of claims, even at the cost of limiting investigative safeguards as to the validity of a claim. A few mistakes are apparently anticipated, and legislation has provided for the widest distribution of the costs of incorrect payments by having them charged to the surplus fund.

Much will depend upon the extent to which the administrator of the Bureau of Workmen's Compensation accepts the responsibility of obtaining the information necessary for a determination in a prompt manner. If routine notices are sent and then there is a long wait before taking any further action, the old delays will remain and be lengthened by the additional ten days allowed by the new law, unless the cooperation of employers in acknowledging valid claims can be secured.

9 4123.515 R.C.
10 Loc. cit., and 4123.519 R.C.
The "Determination" of a Claim by the Administrator or His Deputy

Upon the receipt of a claim from a disabled employee, the administrator of the Bureau of Workmen's Compensation must notify the employer of the claim and of the facts therein. The administrator must assign all claims to the branch office from which investigation and determination may be made most expeditiously.11 The new act further states:

If the administrator of the bureau of workmen's compensation determines that a claimant is entitled to an award of compensation he shall notify the employer of such claimant in writing of such determination. Payment of such award shall begin on the day of the receipt of the employer's statement that the claim is valid or on the tenth day after the day of mailing of notice to the employer by the administrator of his determination that the claimant is entitled to an award, whichever day is the earlier.12

As long as the employer has not actively protested the validity of a claim, the administrator or his deputy may make an award, as soon as bureau channels of investigation are completed, and so notify the employer. Payments on such an award begin no later than ten days after the notice is received.13 After such a "determination" is

11 4123.512 R.C.
12 4123.513 R.C.
13 Loc. cit.
made, the employer may appeal and secure a hearing, but this procedure does not automatically stop the payment during the appeal. If upon appeal a binding decision is made that the award was improperly made, further payments will cease and the amounts which have been paid improperly will be charged to the surplus fund.\textsuperscript{14} This procedure seeks to strike a balance between the public interest in seeing that compensation payments begin as quickly as possible, even in doubtful cases, and the public interest that the premiums of the individual employer shall not be increased by an improper award. This procedure is distinguishable from the "tentative order" which can be issued before the end of an investigation. In the latter case payments begin only if the employer does not protest within a limited time after receiving notice of the tentative order (See page 276, \textit{infra}).

This new method of determining a claim upon the basis of the employee's statement and an investigation has several parallels to the procedures used by the Bureau of Unemployment Compensation. In this latter bureau an initial determination of a claim for unemployment compensation is made on the basis of the statement of the claimant and the reply of the employer. If the latter does not reply within eight days after notification of the claim, a deci-

\textsuperscript{14} 4123.515 R.C.
sion is made without his statement. Once an initial determination is made, notice is sent to both parties in interest. Either party has ten days in which to file a request for a reconsideration. This reconsideration of the claim is most informal and it is not necessary that both employer and employee be present.

When the administrator of the Bureau of Workmen's Compensation, or his deputy, receives a notice from a claimant alone, the power is given to investigate in any manner and to reach a determination. If, prior to the determination by the administrator or his deputy, the employer protests the validity of the claim, certain provisions for a hearing after notice are made, and no payments will be begun until a final award is made at a hearing. However, if the administrator or his deputy determine that the claim is valid before any protest is made by the employer, they may issue a binding order. If the employer protests after the award is made, hearings after notice are given, but payments on the award continue while the hearings and any appeals are being held. The new procedure will permit an award of benefits without any report or acknowledg-

15 Interview, Lunsford, op. cit.

16 Interview, Beman Pound, Chief, Benefits Section, Unemployment Compensation Division, Bureau of Unemployment Compensation, July 26, 1954.

17 4123.513 R.C.
ment of the validity of the claim on the part of the em-
ployer. The employer's inaction can at the most delay the
payment for ten days after the mailing of notice of the
determination to award benefits. However, if the employer
protests before a determination is announced, payments are
held in abeyance until there is a final decision, after
hearing, by the administrator or at a higher appeal level.
Although the interest of the employer to protest a claim
and the very adversary nature of all claims has been in-
formally recognized in the policy of the Industrial Commis-
sion for a long time, this section is the first statutory
recognition of the right of the employer to protest the
validity of a claim and thereby obtain a hearing after no-
tice with the possibility of an appeal from the hearing by
the employer.

The Issuance of a "Tentative Order" by the Administrator

Another new 1955 provision is to the effect that if
prior to the conclusion of the investigation of a claim it
appears to the satisfaction of the administrator that the
claimant is probably entitled to an award, the administra-
tor may make a "tentative order" for the payment of compen-
sation based upon the probability of compensability. The
administrator is required to notify the claimant's employer
of the proposed award. Unless the employer notifies the
administrator in writing, within ten days, of his objections,
the tentative order will go into effect. If the employer
does so object within ten days, the claim is to be handled as any other disputed claim. The tentative order seems to be distinguishable from the regular decision, or "determination", of the administrator or his deputy upon which payments can be made despite the objections of the employer made after the award is announced. The new statute is not clear as to whether or not a tentative order may be issued by a deputy administrator.

Possible Claim Procedure Under the 1955 Act

The internal organization which could be established for the regional offices and for the central office in Columbus is not definite. If there are established as many as ten regional claim offices, the number of new lost-time claims received at each would be small enough that there would be little need for the use of an institutional, division-of-labor approach in processing them. If priority were given to them each morning over medical-only claims and other correspondence, it should be possible to complete any necessary recording and claim-number-assigning rapidly so that they could be on the desk of the claims examiner by mid-morning or earlier. However, the claims which will be received will be less complete than the information furnished by the three-part form.

18 4123.514 R.C.
If the policy adopted by the administrator is merely to open a file and to mail form notices and requests for information to the employer and the physician involved, without further administrative action, little will be gained over the three-part reporting form. Intensive and continuing public relations with the employers and the physicians in the local area can do much to hasten the mailing of needed reports and the furnishing of information through other channels. Much will depend upon the extent to which the administrator accepts the responsibility to obtain any needed information expeditiously and molds his organization and procedures accordingly.

The Probable Effects of the 1955 Legislation

A reorganization of the administration of the workmen's compensation law will not necessarily be effected by the legislation passed in 1955. The General Assembly gave indications, in several areas, of its wishes for changes in the organization and procedures to be effected in the administration of the law. However, there is little that is mandatory in the law except for the appeals procedure. Even the distribution of administrative authority between the administrator and the commission and of the personnel between the bureau and the commission is shadowy. Furthermore, almost all the changes which the legislature made in 1955 could have been put into operation by the Industrial
Commission under the old law had it seen fit to do so. The fact that the person who has been appointed to be the first administrator of the Bureau of Workmen's Compensation was a former secretary of the Industrial Commission possibly may have an effect upon the speed at which any changes are made.

The new law states that as soon as feasible, the personnel of the bureau shall be decentralized into regional offices, but it is not probable that such an action could be forced through mandamus proceedings. If the administrator is an individual who wishes to decentralize all discretionary and investigatory activities and if he is able to generate sufficient administrative and political force to disrupt the mail-order operation altogether, then the various things that the legislators authorized and intended to be done will come to pass. The fact that the new administrator has to be confirmed by the General Assembly may make him highly susceptible to the legislative wishes in the interim period, but there is no assurance of this since the force which brought about the administrative changes was generated in the House rather than in the Senate.

There is no necessary connection between the change of administrative power from a commission to a single administrator and the change from a centralized to a decentralized organization for the receipt, investigation and determination of claims. If it were not for the fact that the new legislation relative to the application form makes
it impossible to continue using the three-part form, it would be relatively simple for the new administrator to continue the centralized form of organization and procedure under the new legislation, and he could even do this under the new legislation at the cost of a greatly increased volume of correspondence. Such a latter course would probably lengthen rather than expedite the handling of all types of claims. It is highly desirable that the administrator decentralize the personnel of the bureau along the lines indicated by the 1955 legislation and that the power to receive, investigate and determine claims be delegated to the personnel of the regional offices, subject to the reconsideration by the administrator of any determination. Such decentralization of claim handling will speed the adjudication of claims, but it will create new administrative problems. It will necessitate the adoption by the administrator of a clear policy concerning the minimum factual information upon which a determination or tentative order can be issued by his deputies and the establishment of methods of supervision to assure that these standards are met before a decision is made. It will also necessitate the establishment of an internal reporting system. One method would be to establish a permanent special staff, answerable directly to the administrator, which would be able to interpret the reports from the branch offices and detect poor performances. This staff
should also have broad powers of inspection of all phases of the operation of the bureau. The nature of such a reporting and inspection system is an area requiring further research.

C. ADMINISTRATIVE HEARINGS AFTER NOTICE BEFORE THE ADMINISTRATOR OR DEPUTY

The 1955 amendment to the law moved the power to make the initial determination of the merits of a claim for workmen’s compensation benefits from the Industrial Commission to the administrator of the Bureau of Workmen’s Compensation. The reports of disability are to be made to the administrator and an administrative--as distinguished from a quasi-judicial--decision will be made on their merits. A new hierarchy of administrative appeals is provided, but these appeals can not be taken until after the administrator or one of his deputies has rendered an administrative decision.

The new law, by remaining silent, gives the administrator broad flexibility in the procedure and methods he establishes for the investigation and determination of the merits of claims. It indicates that there are to be regional offices, each under a deputy administrator, to whom the power to make decisions can be delegated. The only mention made of the necessity of a hearing by the administrator or his deputies is in the eventuality of a "dis-
puted" claim. In case a claim is disputed, the administra-
tor or his deputy is required to afford to the claimant and
the employer an opportunity to be heard after reasonable
notice. At such a hearing, the administrator or his deputy
is not bound by the common law, statutory rules or evidence,
or technical or formal rules of procedure. There is no
need for preserving notes or memoranda of the proceedings
of the hearing. The hearing is to be held in one sitting,
unless more than one session is granted to prevent hardship.
After the hearing the administrator is to state his deci-
sion and the reasons therefor concisely and mail copies to
the claimant and employer.\textsuperscript{19}

No definition is given of a "disputed" claim which
requires an administrative hearing after notice. In cases
in which the employer objects to the validity of a claim
and so notifies the administrator or his deputy prior to
an administrative determination of a claim, it would clear-
ly be a disputed claim and require a hearing after notice.
However, there will be situations in which the claim will
be questioned by the staff of the administrator rather
than by the employer. In fact, if the state fund is to be
protected, this must be so. The new law is not clear as to
whether the administrator or his deputy must set the claim
for an oral hearing in every case before denying it or

\textsuperscript{19} 4123.515 R.C.
whether a negative order may be issued without a hearing, thus placing the burden on the claimant of making a further appeal to keep the claim alive. However, section 4123.515 states, "before making or denying an award in a disputed claim the administrator . . . or one of his deputies shall afford to the claimant and the employer an opportunity to be heard . . . ." This is the only place in the new act in which a denial of a claim is mentioned. Under the administration of the commission, negative orders were issued without a hearing in medical-only claims and in claims in which it seemed apparent that there was no jurisdiction. In case the interpretation is given that the questioning of a claim by the administrator does not make it a disputed claim, the claimant may appeal the decision to the Industrial Commission within twenty days after the date of the mailing of the notice of the original negative decision of the administrator.

In every disputed claim there must first be a decision by the administrator or one of his deputies. After the hearing by the deputy administrator, a dissatisfied party has the option of requesting a reconsideration by the administrator, but this procedure is not a prerequisite to an appeal to the commission. The administrator has wide latitude in the method of determining the validity of a claim. He may assign claims to branch offices. The deputy administrator in charge of the office is responsible for
and must supervise and direct the prompt disposition of all claims and investigations assigned to his office.\textsuperscript{20}

The new act is not clear as to whether the deputy who presides at the hearing, after notice, of a disputed claim must be the deputy administrator who is in charge of the office. Presumably it does not have to be the same person. In reference to the supervision of the disposition of assigned claims, the act states, "the deputy administrator who is in charge . . . ."\textsuperscript{21} whereas the section which refers to hearings of disputed claims states that, "the administrator . . . or one of his deputies" shall afford a hearing after notice.\textsuperscript{22} It would seem to be better administrative policy for the administrator of the Bureau of Workmen's Compensation to use different sets of employees for the respective positions of branch managers and hearing officers. Whether the hearings would be held only at the branch offices or at a greater number of points closer to the location of the parties in interest will depend to a degree upon the number of branch offices established. Whether there will be several hearing officers to a branch and whether they may be moved from one regional area to another will be an administrative determination which will

\textsuperscript{20} 4123.512 R.C.

\textsuperscript{21} 4123.512 R.C.

\textsuperscript{22} 4123.515 R.C.
hinge in part at least upon the volume of disputed claims which require an administrative hearing.

Chronologically, the oral hearing after notice before the deputy of the administrator replaces the informal oral hearings before a board of claims, or before a deputy commissioner in Columbus. Besides the supervision of these hearings, which is primarily administrative, the administrator must also oversee the daily routine of receiving claims, investigating and determining their merits, docketing doubtful cases and arranging hearings. Through such supervision the general policies of the administrator (such as how quickly a hearing should be held) can be implemented.

The hearings before the deputy of the administrator are to be informal and without sworn testimony or record. The administrator or his deputy after the hearing is to state concisely his decision and the reasons therefor and mail it to the parties. This does not make any changes from the 1954 procedure with regard to the first hearing after notice, although it will always be before a single administrative officer whereas heretofore board hearings have been before a tripartite body.

The workmen's compensation principle was adopted in an effort to devise a system which would protect the interests of the employee, the employer and the general public while at the same time lessening certain hardships pre-
viously borne by all three interests. This can best be achieved by a system which produces the practical maximum of efficiency and equity in the processing of claims for workmen's compensation benefits. The validity of maintaining a separate workmen's compensation system depends upon the degree to which it achieves and maintains this practical maximum of efficiency and equity. The Ohio Industrial Commission, as it operated in 1954, was felt to have failed in substantial measure to achieve optimum efficiency even within the framework of the existing law.

The changes which were made in the Ohio workmen's compensation law in 1955 will permit substantial improvement in administrative organization and practices. However, there is little assurance that such improvements will occur. Much will depend upon the administrator of the Bureau of Workmen's Compensation, himself. He will be hampered by constitutional provisions which led to statutory provisions that make the limits of the administrator's power ambiguous, by appropriations which may make extensive reorganization and decentralization difficult, by inertia on the part of the personnel transferred from the commission, and by general lack of interest in administrative improvement by the groups which traditionally have drafted workmen's compensation legislation. On the other hand, there are few restrictions placed on the operation of the bureau, and the authorization of the tentative order which may be re-
scinded at the option of the administrator gives a new latitude for equitable and efficient operations.
CHAPTER XIII

APPEALS FROM DECISIONS OF THE
ADMINISTRATOR OF WORKMEN'S COMPENSATION

Under the 1955 act, the rehearing procedure, after
the initial oral hearing, was abolished, and a new adminis-
trative appeals system was established with a set of re-
gional boards of review to which an appeal can be taken
from the decision of the administrator of the Bureau of
Workmen's Compensation as a matter of right by any dis-
satisfied party. There is a requirement of a pre-hearing
conference before the regional board of review hearing
to refine the issues. In addition the Industrial Commiss-
ion, at its option, may accept an appeal from a decision
of a regional board of review.

After the administrative review of the decision of
the administrator, an appeal may be taken by a dissatisfied
party from a decision of the Industrial Commission, or
from a decision of the board of review if the commission
has declined to review, to a court of common pleas where
a trial de novo before a jury will be held on the right of
the claimant to participate in the state insurance fund.
Pre-Hearing Conferences

Under the 1955 act, an appeal from the decision of the administrator of the Bureau of Workmen’s Compensation to one of the newly-created regional boards of review may be made by a dissatisfied party. However, prior to the hearing of such an appeal the regional board of review may require the claimant and the employer to confer with it:

... in an endeavor to agree upon uncontroverted facts, define the controverted issues and attempt to resolve disputes concerning them, to agree upon the documents, reports and records which shall be considered without further identification or proof and to make such agreements and arrangements as may expedite the hearing and determination of the appeal.¹

However, this pre-hearing conference may be dispensed with, if it will serve no useful purpose.² Pre-hearing conferences held several weeks before a hearing are more effective in shortening the hearing than one held at the beginning of the hearing.³ Because the regional boards of review in all likelihood will be assigned to geographic areas and will ride circuit on them, there may be difficulty in making the arrangements for the pre-hearing conferences well in advance of a hearing. Nevertheless the institution

¹ 4123.517 R.C.
² Loc. cit.
of these pre-hearing conferences may serve as an effective substitute for pleadings in narrowing issues and in shortening the hearing time required in an appeal. In the administration of the District of Columbia workmen’s compensation law almost ninety per cent of the appeals were disposed of by pre-hearing conferences. If the new pre-hearing conferences prove successful, they may substitute for the part which the continuances between hearing dates served in giving time to prepare to meet the opposition’s case in the rehearing.

Hearings Before a Regional Board of Review

A claimant or an employer who is dissatisfied with a decision of the administrator of the Bureau of Workmen’s Compensation may appeal therefrom to the Industrial Commission within twenty days after the date of the mailing of the notice of the decision. The appeal will be assigned for a hearing before the regional board of review most convenient to the claimant. The decision of the regional board will be the decision of the Industrial Commission unless the commission grants an appeal made within twenty days by the claimant, the employer or the administrator of the Bureau of Workmen’s Compensation.

Hearings are held by the regional boards of review

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after a reasonable notice to the claimant, the employer, and the administrator of the bureau. There is a statutory requirement that the parties proceed promptly and without continuances "except in cases of hardship prejudicial to a party and due to the lack of time afforded by the notice of the hearing or to other cause which the party could not be expected to foresee and provide against". The attorney general, or one of his assistants, will represent the administrator before a regional board of review. The provision against the continuance of such a hearing has an extremely broad escape clause. However, the provision against continuances does not impose any burden of planning and arranging for the presence of witnesses which is not incurred in a regular court trial.

There is no requirement as to legal formalities in hearings before a regional board of review, and there is no requirement that a transcript be kept of the testimony. At the end of a hearing, the board is only required to state concisely its decision and any award and mail copies of the decision to the claimant and employer.

Appeals to the Industrial Commission

An appeal from a decision of a regional board of

5 4123.518 R.C.
6 Loc. cit.
7 Loc. cit.
review to the Industrial Commission within twenty days is mandatory in order to preserve the right of court appeal. The commission may grant the appeal at its option. A notice of the order of the commission permitting or refusing to permit the appeal is mailed to the parties in interest. The 1955 legislation, as finally enacted, made no provision for the conduct of the hearing before the commission in accordance with the rules of civil procedure nor for the preparation of a transcript of the proceedings. Presumably the commission will have to give a de novo hearing since no record will have been prepared of the testimony at the hearing before the board. If the commission should adopt the policy of accepting all, or a large number, of the appeals from the boards a bottleneck could develop at this point. It is possible that the commission will pattern its activities along the lines of choosing only the more important or novel cases for the additional hearing and review, thus advancing the interpretation of the law.

Under the old rehearing procedure it was necessary to prepare a transcript of testimony of evidence in accordance with the rules of civil procedure because of the possibility that it might have to be read to a jury. Under the 1955 act there is a de novo trial before a jury. Thus the transcript is not needed for a judicial review.

It is difficult to predict how closely the board and commission hearings will develop along the lines of
the old informal oral hearings before a board of claims or a deputy commissioner. The two distinguishing features of the new act which may lead to formal hearings are that the new hearings will have the presence of an assistant attorney general representing the state insurance fund and the boards of review will have an attorney as chairman. There are two factors which may influence an informal atmosphere at the board of review and commission appeal hearings. There is a strong chance that the employer and union groups will recommend to the governor the appointment of members of the abolished boards of claims for membership on the newly-created boards of review. The other factor is that the hearings which in the past have been held by the commission itself have been of an informal rather than a formal type. The habit patterns established at informal oral hearings may influence the development of the new administrative appeals procedure.

**Court Appeals**

The claimant or the employer may appeal within sixty days a decision of the Industrial Commission to a court of common pleas in any injury case, other than a decision as to the extent of disability. A similar appeal may be taken from a decision of a regional board from which the commission has refused to permit an appeal to the commission. The administrator of the bureau is made a party to such an
appeal and is represented by the attorney general or one of his assistants at the trial. The court of common pleas hearing must be held in accordance with the rules of civil procedure. "The court, or the jury under the instructions of the court, if a jury is demanded, shall determine the right of the claimant to participate or to continue to participate in the fund upon the evidence adduced at the hearing of such action".  

The Wheeler-Troop-Bettman bill, as drafted in the house committee, provided for an appeal on the transcript from the commission directly to the court of appeals only on the questions of law and the substantiality of evidence supporting decisions of fact. However, this was stricken from the bill, presumably because of opposition to the change on the part of representatives of unions who testified against the proposed appeal procedure at committee hearings. It was necessary to make this change in order to obtain sufficient support for the passage of the bill. In the procedure finally adopted, there is no safeguard which requires the claimant to develop his whole case before the administrative tribunal. There is the possibility that the presentation of evidence upon administra-

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8 4123.519 R.C.
9 Substitute House Bill 700, lines 519-523.
tive appeal may not be so well-prepared and so complete as it would be before the jury. The new administrative appeals procedure is an improvement over the old rehearing process since it eliminates the legal formalism which was of questionable value in the adjudication of claims. However, the biggest defect in the new appeals procedure is the lack of finality of the board and commission decisions on either questions of law or of fact. This condition is a move from the trends found elsewhere of limiting judicial review of decisions of administrative tribunals to the findings of law and the existence of substantial evidence to support the findings of fact by the administrative tribunal.11

In the 1955 amendment, the section dealing with the right of a court appeal expressly excludes the right to appeal a decision of the commission as to the extent of disability.12 Formerly if an award were granted in a permanent-partial claim, the application to modify the award could be used to re-open the claim and increase the award if the court were sympathetic. Under the new system, the application to modify and increase the award can be appealed no further than the commission. The amount of awards granted in permanent-partial claims has been one

12 4123.519 R.C.
of the points which has disturbed employer groups. The fact that the new section limiting court appeals on the extent of disability was added by the Senate committee at the same time as the section which gives the right of a trial *de novo* before a court of common pleas would seem to indicate that this was one of the compromises which was reached under the agreed bill system.

The appeals procedure, as drafted in the House committee, would have supplied a double administrative appeal procedure which would have been adequate for the determination of facts. It would have clothed the administrative tribunal decision with sufficient finality to assure that the claimant's and employer's attorneys would make a full presentation of evidence at the administrative appeal hearings, and yet it would have been faster and more informal than the old rehearing process and would have assured tripartite consideration of all appeals. Had it been adopted it would have been a step forward which would have made the appeal procedure similar to that applicable to federal administrative tribunals and similar to the procedure for the appeal of workmen's compensation cases in most states.

One of the biggest defects in the new appeals procedure, from the standpoint of the employer, seems to be the lack of finality of the board and commission decisions. Basically, however, the commission's decision was as lacking in finality under the old system as it will be
under the new. Under either appeals system, the decision of the commission had virtually no vestige of finality unless the claimant wished to abide by it. Under the new appeals system the commission's decision becomes even less final since now the employer may also appeal to the courts.

The generosity of juries has been a factor in recent years in the growing regard by labor groups for a jury review of workmen's compensation claims. Even if some increased value can be developed for the complete adjudication of claims by a court and jury, a serious question can be raised whether three administrative hearings after notice are needed before the court hearing, in terms of the time consumed. Most of the benefits which could have been gained from the new agency review system are dulled by the lack of finality caused by the method of judicial review finally adopted by the Senate at the last minute in 1955.

Comparison of Hearing and Appeal Procedures Before and After 1955

The old rehearing procedure followed by jury trial and court review of facts created delay in paying claims especially since most claims were eventually allowed. It increased not only the cost of administration, but, more important, the cost to the individual claimant was increased because of legal fees which had to be paid, since the legal
formalism necessitated the employment of counsel.

The 1955 procedure for contested claims created a separate hierarchy of hearing officers ending with the Industrial Commission. There are advantages in having hearing officers for administrative intra-agency appeals whose decisions will be uninfluenced and unimpeded by the business function of operating a large insurance fund so that the temptation to determine a claim's validity on the basis of the insurance fund's cash balance will be eliminated. Because of constitutional questions, however, the Industrial Commission was not completely divorced from the management of the insurance fund. The 1955 organization and procedure has the seeds of considerable delay inherent in it, if the appeal hearings are patterned after the old rehearings. Several factors will tend to mitigate this since there is no requirement that the formal rules of evidence be used or that a record be prepared and since there is a possibility that the hearing officers will prefer an informal around-the-table type of hearing. It is difficult to predict the procedures which will be adopted for the hearings before the deputy administrator, regional board of review, or the commission. It is possible that the commission will pattern its review activities along the lines of choosing only important cases for review. If it does not, a bottleneck may develop at this point. Another cause of delay may be the wait while the claim is on the docket of the
court. A 1951 study made by the Industrial Commission indicated that there was a time lag of 353.8 days, or slightly less than one year, at this point. If the possibility of a jury trial de novo attracts a greater number of court appeals, the delay while awaiting a court trial may increase.

Many criticisms have been made of the old rehearing system followed by a jury trial and court review of the facts. Such a system created delay especially since most claims were eventually allowed. "The provision of jury trials upon appeal, found in several jurisdictions, has only made an unsatisfactory situation worse, through overburdening administration and slowing down processing claims." It increases not only the cost of administration but, more important, the cost to the individual claimant is increased because of legal fees which must be paid out of the claimant's award.

In establishing the workmen's compensation system, a primary goal was to provide a simple, convenient and inexpensive method of settling the claims of disabled work-

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13 Based upon records on file in the court unit of the legal section.

14 U.S. Department of Labor, Division of Labor Standards, Bulletin No. 70, How Good is Your Workmen's Compensation Law? (1944), pp. 11-12.
The national organization of the C.I.O. has gone on record as being opposed to reliance upon court appeals:

Court appeal is not the logical answer to workmen's compensation needs. The underlying point of workmen's compensation originally was to avoid the law's delay and cost and provide a quick and certain administrative process. Workmen's compensation must pull itself out of this morass of administrative encumbrances if it is to serve its social purpose. We can look to Ontario for guidance. With full fairness and protection to the worker, with simplicity and speed, without courts and lawyers, and without expense to the injured worker Ontario has found the answer to the pitfalls of Administration.16

However, representatives of the Ohio C.I.O. were opposed to changes in the court appeals procedure which would have reduced the role of the jury.17

Some improvements have been made in the administrative procedure for handling contested claims. There will be a hearing after notice before a representative of the administrator geographically near to the claimant's residence. This should be primarily a fact-finding hearing at which the hearing officer should help the claimant if he is unrepresented by counsel. Much of the success of this new


17 Based upon attendance at hearings before the Senate Committee on Commerce and Labor, June 22, 1955.
type hearing will hinge upon the policies adopted by the administrator. The benefit of doubt should be given to the claimant, but the administrator should adopt a strong policy of resisting all obviously invalid claims.

There is merit in the establishment of a review of the administrator's decision by a regional board of review which is entirely independent of the administrator. The five regional boards permit the hearing of a large number of appeals, nevertheless there is value in retaining the Industrial Commission as a final administrative tribunal with power to establish uniform quasi-judicial interpretations of the workmen's compensation statute. However, as long as there is a jury trial de novo at the end of the rainbow these administrative reviews may be regarded by claimants and counsel as little more than formalities which must be exhausted.

The appeals procedure developed by the House committee permitting appeals to the court of appeals only on questions of law and of the substantiality of evidence was superior to the appeal procedure finally adopted. In most states the agency administering the law has exclusive jurisdiction over the determination of facts, with appeals to the courts limited to questions of law.\(^{18}\) The National Conferences on Labor Legislation have recommended that

\(^{18}\) Labor Bulletin No. 99, \textit{op. cit.}, p. 27.
appeals to the courts in workmen's compensation cases be allowed on questions of law and should be carried directly to the highest court of the state. This finality of determinations of fact was achieved only with regard to the determination of the percentage of permanent-partial disability in the so-called 80b claims, which had made up a large portion of the rehearing cases.

Unfortunately the appeals procedure became one of the bargaining points between the groups which traditionally have worked out an agreed bill and presented it to the General Assembly. The influence of the members of the House committee which drafted the first appeal procedure in 1955 was not sufficiently strong to resist influence of the organized employer and employee groups and the appeals procedure was altered on the floor of the House and in the Senate committee to the point where it was impossible to even maintain the status quo of the old appeal procedure.

In the past, the possibility of a jury trial has influenced the investigating and hearing procedures of the commission. The whole approach to field investigations was colored by the possibility that every claim might be subjected to a formal rehearing. If so, a transcript had to be prepared for a jury and the investigator attempted

19 Labor Bulletin No. 70, op. cit., p. 12.
to put into the file the type information which would be of aid to the assistant attorney general. Although the rehearing has been abolished, there still remains the eventuality of a jury trial *de novo* which may color the approach to investigations. Once a claim has been appealed to a court of common pleas, there is ample time for such a legalistic investigation while it is waiting on the docket. There is no need for such an investigation in the preliminary stages of gaining information for an administrative determination. It would be easy for the personnel transferred from the Industrial Commission to the new Bureau of Workmen's Compensation to slip back into the old investigative patterns. The establishment of a new simplified fact-finding procedure within the bureau involves problems of administration and supervision more than it does legal problems of obtaining information. However, the retaining of the jury trial in the appeals process will make it difficult to make drastic changes in the investigating and hearing procedures.

**The Adversary Process in Workmen's Compensation**

The hearing process followed under the common law is based upon the adversary process which relies upon written pleadings filed with the court prior to the trial of a case to reduce the controversy to manageable proportions and then upon the presentation of evidence by opposing parties
in interest to bring forth the many facets of conflict in sufficient detail so that a single individual, or a group of them on a jury, can decide the truth of the facts involved.

Most states in adopting workmen's compensation acts set up an administrative agency with power to adjudicate and sought to eliminate the adversary aspect of the process to some degree. The early laws of Ohio and the early procedural regulations of the Industrial Commission provided for the rights of the claimant for a hearing and appeal, but little if any mention was made of the right of the employer to participate at a hearing or to make an appeal.

The introduction of the experience rating, or merit rating, principle in the establishment of premiums gave the employer a greater stake in the outcome of a claim. Yet he had no statutory right to obtain an informal oral hearing and he had no right to make an appeal to the courts when he was dissatisfied with the results of a rehearing. An interest in securing these reviews developed among employers and this became one of the goals for which they bargained in the agreed bills. Changes in this direction were usually exchanged for increased benefits in the legislation.

Although it was not required by statute, the commission developed the procedure, in all cases where the em-
ployer questioned the validity of a claim either in the three-part report or in separate correspondence, of having an investigation to determine the soundness of the protest. If the objection had any basis, the commission had the policy of setting the claim for a hearing, after notice, in the usual method. However, no provision was made for the employer to appeal the results of a rehearing to the courts.

In 1955, two legislative changes were made on this subject. The first was a provision that a determination should not be made in a disputed claim without a hearing after notice. Thus the policy of the commission of giving the employer an informal oral hearing was incorporated into the statute. The second major change in 1955 was the granting to the employer of the right to appeal to the courts from a decision of the Industrial Commission granting an award or refusing to review an award by the regional board of review. The employer is now a party to all court appeals, made by any party, and has a right to be represented by his own counsel before the courts as well as at the rehearing. Thus the adversary process has been established all the way from the initial informal hearing to the court review between the employee and the employer, as well as between the employee and the state insurance fund.

The success of the adversary method in developing
the facts of an issue has been established over the centuries by the development of the common law. Since workmen's compensation claims may be contested, issues must be decided by the method best suited to that purpose. In workmen's compensation claims the adversary process has always been present, even though an effort was made to minimize it in the beginning.

Essentially the adversary nature of the proceeding was not changed in 1955, except with regard to the parties involved. The employer is now clearly recognized as a party in interest at all stages of a contested claim with power to defend his interests at hearings, whereas once he was excluded. It is possible that this expansion of the number of parties in interest to three may increase litigation. However, the facilities of the employer can now be used for investigation and defense and a truer alignment of adversary parties will be achieved.
CHAPTER XIV

CONCLUSIONS AND RECOMMENDATIONS

Workmen's compensation laws replaced a system in which the industrially disabled employee's right to obtain indemnity for an industrial injury was dependent upon his suing in a regular court action and winning the suit. These new laws were based upon a new approach to the problem of the distribution of the social and economic costs of industrial disabilities. The question of negligence or fault in causing the disability was eliminated.

All workmen's compensation laws are based upon the application of insurance principles to the payment of benefits to the industrially disabled employee. In Ohio, workmen's compensation insurance is compulsory for all employers, with minor exceptions. An employer affected by the law must insure his financial obligation under the statute with an exclusive state-operated insurance fund or else become a self-insurer under close governmental supervision. The state insurance fund, until late 1955, was under the direct supervision of the Ohio Industrial Commission. This commission had the dual function of operating the state
insurance fund and acting as the administrative tribunal which decided the rights of claimants to receive workmen’s compensation benefits, which in most cases were paid from the state insurance fund.

The history of workmen’s compensation programs, in Ohio and elsewhere, indicates that they were developed to fulfill specific needs of the worker, the employer and the public and to alleviate certain hardships previously borne by these three interests. The disabled employee gave up his common law right to obtain an unlimited judgment in a court in exchange for the right to receive adequate, prompt and predetermined benefits. The employer was required to accept a limited liability without fault under a system that made it possible for him to calculate his liability on an actuarial basis and add it to the cost of his production. The general public received benefit by a reduction in the number of public charges that had resulted from industrial disabilities and by an improvement in employee-employer relationships. The success of the workmen’s compensation system in Ohio needs to be assessed in terms of how fully it has met the needs and alleviated the hardships which led to the adoption of the program.

A. ACHIEVEMENT OF GENERAL GOALS

The drafters of the workmen’s compensation statute had several objectives in establishing the new legal rela-
tionship between the employer and the employee with regard to industrial disabilities. They sought to establish an adequate and predetermined scale of benefits for each disability. The claimant would have to prove only that his disability was connected with his employment and the extent of the disability. It was believed that more prompt settlement would occur and that the delay and cost of litigation would be eliminated. It was hoped that a higher proportion of the insurance premium costs to the employer would reach the disabled worker through minimization of legal fees and insurance overhead and that certainty of payment would be established.¹

The Ohio workmen’s compensation law is so drafted that the maximum benefit to the claimant is predetermined by the legislation.² The chief variables are (1) whether there is a connection between the disability and the employment and (2) the extent of the disability. Since there are these variables, however, a certain amount of litigation has continued. A large portion of the litigation is attributable to the nature of the appeals procedures provided by the statute.³

No effort has been made in this paper to assess the

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¹ Pages 22-23, Supra.
² Chapter II, Supra.
³ Chapters X and XIII, Supra.
adequacy of the benefits provided by the workmen's compensation statute. The benefit structure is primarily the type of political problem which is best solved by an elected body attuned to the desires and needs of the electorate rather than being an administrative problem. Nevertheless, the question of benefits is at the heart of many of the problems of workmen's compensation legislation. It has continually been one of the items of negotiation in the agreed-bill system of developing workmen's compensation legislation in Ohio.

All Ohio employers covered by the workmen's compensation statute, with the exception of approved self-insurers, must pay premiums into the state insurance fund. This fund does not have any overhead costs for selling the insurance, and until 1953 all the costs of administering the fund were paid by money appropriated from the state treasury rather than from money collected from premiums. Such savings have created support for the state insurance fund system from employers. From time to time efforts have been made to secure legislation permitting private insurance companies to compete in the sale of workmen's compensation insurance in the state as a means of improving the service rendered to claimants. Such efforts have received little support from employers or employees. The attention of organized employee groups has been directed more toward increasing the benefit rates than toward improvement of services in the administration
of the workmen's compensation program. Instead, in 1955, the General Assembly showed an inclination to approach the problem of deficient claims service in the administration of the workmen's compensation law by passing legislation designed to change the organization and procedures of the workmen's compensation agency rather than by permitting competition. There is little, if any, evidence of a legislative desire to abandon the workmen's compensation system for any other method of achieving the same goals or to combine the system with the administration of other forms of social insurance.

B. DEFICIENCIES IN ADMINISTRATION

The validity of retaining workmen's compensation as a separately administered form of state-operated social insurance can best be justified if the practical maximum of efficiency and equity is maintained in processing claims for benefits. A field study of the organization and administrative practices of the Ohio Industrial Commission, made by the writer in the summer of 1954, revealed that this governmental agency had failed in substantial measure to attain the practical maximum level of efficiency and equity in the processing of compensation claims. Evidence of this was found in the organization and procedures adopted and followed by

4 Chapter XI, Supra.
the commission in processing claims for workmen's compensation benefits.

Organization of the Industrial Commission

The internal organization of the staff of the Industrial Commission required the initial determination of the merits of all claims in a central office in Columbus, with field investigations, where necessary, from branch offices. The entire process became divided among several specialized sections of the agency, which sections tended, over a period of years, to become separate empires within the agency. The commission itself did not give sufficient supervision to the various sections to correlate them, and there was no other locus of authority for supervision and correlation of claim activities. A system of internal reporting required a written monthly report to the commissioners from the head of each section. Neither the commissioners nor the secretary of the commission had a staff to analyze these reports. There were indications that these reports merely passed across their desks and were filed.\(^5\) The members of the commission exerted no executive leadership in maintaining or improving efficiency in processing claims, nor did they delegate the authority to do so to anyone else. The section chiefs developed an institutionalized unwillingness to achieve organizational or pro-

\(^5\) Chapter III, Supra.
procedural modifications as a collective body or individually, except for the chief of the accounts section.

Compartmentalization is difficult to document, but there was evidence of a lack of communication between the heads of the various sections and the personnel of the various sections involved in the processing of claims. Specialized procedures were developed in some sections without regard to duplication in other sections. Reports of time-lag were developed by section chiefs to defend themselves from criticism rather than to serve a more constructive purpose.

A large number of employees had been with the agency for long periods. Most section chiefs had risen from the ranks and had been with the agency from twenty to forty years. The personnel from the top almost to the bottom of the organization had become accustomed to and satisfied with the existing organization and procedures. There was little evidence of self-criticism at any level in the agency. Criticism from the outside was either rationalized or admitted and blamed upon a lack of appropriations.

Administrative leadership is difficult to define or detect. One evidence of it is a recognition that good administration is a continuous and on-going affair and that any organization needs frequent evaluation in terms of whether it can benefit by the adoption of new techniques.
and new technologies. Yet, the organization and procedures revealed by the writer's field study differed only minutely from the organization and procedures reported twenty years before by Levine and Dodd.⁶

Decentralization of the organization is not necessarily the solution to the problems of the agency. The investigations section was thoroughly decentralized. Yet it was unjustifiably slow in completing investigations. It maintained an elaborate reporting system, imposed under civil service requirements, but little beneficial use was made of it.⁷ Thus an amount of delay in completing investigations continued which few private insurance carriers would have tolerated. Reports are of little value unless the people receiving them want them and use them.

A periodic actuarial audit was made at the direction of the General Assembly. The reports of these audits contained suggestions for modifications of the organization and methods used by the agency. Outside study groups made other suggestions. Such suggestions from outside the agency rarely received acceptance. Only when the agency was receiving heavy criticism was any effort made to conduct self-criticism, and then it was limited to the matters receiving criticism. No one on the staff of the commission

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⁶ Levine, op. cit.; Dodd, op. cit.
⁷ Page 194, Supra.
had the responsibility for conducting continuous, or even periodic, study of the entire organization.\textsuperscript{8}

The entire organization needed to be shaken from top to bottom. This the Ohio General Assembly attempted to do in 1955 by creating a new bureau headed by a single administrator with broad powers to reorganize the operation and revise the procedures followed in processing claims for benefits under the workmen’s compensation law.\textsuperscript{9}

The greater the degree of efficiency and equity in the processing of claims, the more fully will the workmen’s compensation program achieve the goals set for it. In the past the Ohio Industrial Commission has operated through organization and administrative practices which failed in substantial measure to achieve the highest practical maximum of efficiency and equity under the existing statutes.

**Promptness in Determining the Merits of Claims**

Promptness in determining the merits of claims and beginning payments on clearly compensable claims is not the only measure of efficiency, but it is an item that closely affects the claimant involved. Claimants have always been slow in reporting disabilities. A portion of this delay results from the policy of the commission which placed the

\textsuperscript{8} Chapter XI, \textit{Supra}.

\textsuperscript{9} Chapters XI and XII, \textit{Supra}. 
burden upon the disabled claimant to accumulate and submit all the information needed for a determination of the merits of the claim. 10

The centralization of the first consideration of a claim in Columbus required considerable reliance upon the use of the mails, supplemented by field investigations in a small number of claims. The volume of claims filed made it possible to use standardized mass-production techniques, especially in the record-keeping phase. In this phase, all new state-fund lost-time claims were kept together in a group for processing before being sent to a claims examiner for the first inspection of the merits of the claim. In the writer's survey of these record-keeping steps, bottlenecks were found in instances where the performing of one operation on all the claims which had arrived in a day's mail had become the full-time job of a single clerk or an inadequate number of clerks. Even without changing the order of any of the steps in the claim handling procedure, time could have been saved by dividing these particular jobs among several clerks for shorter periods. 11

When the various steps for processing claims were critically examined, little justification could be found for performing most of the record-keeping steps before the merits of the claim were examined and steps taken to start

10 Chapter V, Supra.

11 Chapter VII, Supra.
payments on those which were clearly compensable. Without any changes in legislation and with few changes in job assignments, procedural changes could have been effected which could have reduced the time needed for the payment of clearly compensable claims by days rather than by hours.\textsuperscript{12} It is conceded that unquestioned claims were paid faster than under the system existing before the passage of workmen's compensation legislation in Ohio. Nevertheless, much could have been done to speed the reporting of disabilities and the determining and paying of claims once they arrived.

An elaborate system was developed for the small portion of lost-time claims which required additional information or a professional evaluation.\textsuperscript{13} This system required the cooperation of several sections within the agency, and it was affected by the compartmentalization which existed within the organization as a result of its particular form of organization. This kept to a low minimum any personal contact between personnel of different sections working on the same claim. There was no one central place in the agency where responsibility was focused for knowledge of the current status of every questioned claim. The only time schedule for completion of a step in the process was the schedule which the section then dealing with the claim imposed upon itself, with the exception of the "Legal X"

\textsuperscript{12} Chapter VIII, \textit{Supra}.

\textsuperscript{13} Chapter IX, \textit{Supra}.
unit. Since discretion was involved when professional opinions were rendered, it is difficult to assess the efficiency of such steps in terms of promptness of action.

An informal oral hearing after notice was required for a small portion of the new lost-time claims. These hearings were reasonably prompt and informal and were conducted in an atmosphere of sympathetic conversation. They were almost always completed in one session. However, the appeals procedure following the initial oral hearing was marked by considerable delay under the administration of the Industrial Commission. Such rehearings of the claim were marked by extreme legal formality because of the statutory requirement that the transcript of the rehearing be so prepared that an appeal to a court and jury could be made based upon it. Approximately two years were required for the completion of a rehearing. One of the chief causes of delay was the custom of permitting a series of hearing sessions during the course of the rehearing. In part this was made necessary by the fact that the issues in the claim were not clarified before the rehearing began. It is not possible to assess exactly what portion of this delay was justified, but it led to sufficient dissatisfaction that the rehearing process was abolished by the legislature in 1955.

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14 Chapter X, Supra, and Ohio Legislative Service Commission, op. cit., Part III.
Equitableness in Processing Claims

Few standards are available for measuring the equity of the workmen's compensation system. One criterion is the extent of variation of the amount of award for the same type injury. In only a few cases was the state insurance fund successfully defended before a common pleas court or jury. In addition, the members of the commission tended to settle a large portion of appealed cases out of court.15 In this sense, the system was unjust to the claimant who accepted the denial of his claim without exhausting all of the appeal procedures available to him. This policy of settling claims is also a factor in the atmosphere of litigation which is more prevalent with workmen's compensation insurance than with other forms of social insurance.

Another criterion of equitableness is whether one party in interest is favored over another. Early workmen's compensation legislation in Ohio gave little recognition to the interests of the employer in a claim. The introduction of the experience rating, or merit rating, principle in the establishment of the amount of the employer's premium gave the employer a greater stake in the outcome of a claim. Yet he had no statutory right to protest the validity of a claim when it was filed, to obtain an informal oral hearing of the merits of the claim or to make further appeals if an

award were made. Thus if the commission, or its staff, made an improper award, there might be an unjust increase in the employer's premium which he must absorb himself or add to the cost of the product or service he offered to the general public.

Although it was not required by statute, the commission developed the procedure, in all cases where the employer questioned the validity of a claim either in the three-part report or in separate correspondence, of having an investigation to determine the soundness of the protest. If the objection had any basis, the commission had the policy of setting the claim for an informal oral hearing after notice but the employer did not have any right of appeal if benefits were awarded at the end of an informal hearing or a rehearing. This was changed by legislation in 1955 which requires that the employer be notified of all claims filed and given the opportunity to protest. If the employer protests he is entitled to a hearing after notice before the administrator or his deputy. If an award of benefits is made, the employer is granted the right to appeal to a board of review, to the Industrial Commission, or to a court of common pleas. The employer has the right to be

16 Chapter IX, Supra.
17 Chapter XII, Supra.
represented by his own counsel at any hearing. If the award is overturned upon appeal, all amounts paid under the award are charged to the surplus fund rather than to the employer. Thus the adversary process has been established by statute, all the way from the filing of the claim to the court review, between the employee and the employer, as well as between the employee and the state insurance fund. Essentially the adversary nature of the proceeding was not changed in 1955, except with regard to the parties involved. The employer is now clearly recognized as a party in interest at all stages of a contested claim with power to defend his interests at hearings. Thus possible inequities to the employer have been reduced. It is possible that this expansion of the number of parties in interest to three may increase litigation. The facilities of the employer, however, can now be used for investigation and defense and a truer alignment of adversary parties will be achieved.

Comparison With the Goals of Private Workmen's Compensation Carriers

Efforts have been made by private insurance companies writing workmen's compensation insurance to evolve

18 Chapter XIII, Supra.
19 Chapter XII, Supra.
criteria for claims management and practice. Not all of these criteria were applicable to the organization and practices of the Ohio Industrial Commission during the summer of 1954, especially the seventh principle which relates to relationships between the carrier and the agency administering the workmen's compensation law. The commission met a few of the criteria, such as the third, relating to the caliber of medical and surgical attention furnished, and the fifth, relating to direct payments to the beneficiaries. The mail-order nature of the operation of the commission made it difficult to determine whether the second principle, relating to frank and friendly attitude toward all claimants, applied. In other places the standards of the private companies were not completely applicable. Nevertheless, in all other cases where the private carriers' standard clearly applied, the procedures of the Industrial Commission were deficient.

C. WORKMEN'S COMPENSATION LEGISLATION IN 1955

Substantial improvement in the processing of claims in Ohio requires innovations and modifications with respect

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20 Pages 11-13, Supra. No effort is made in this paper to evaluate the success of the private carriers in achieving these principles in their handling of workmen's compensation claims.
to statutory law, constitutional law, and administrative organization and practices. All of these three types of innovation and modification have been impeded seriously by the custom of bargaining between employer and employee interests in the process of developing and adopting such innovations and modifications. This was illustrated by the experience of the 101st General Assembly of Ohio in its attempt to change the administrative organization and revise the practices for processing workmen's compensation claims by means of statute. In this instance the resulting legislation provided ample opportunity for substantial improvement in efficiency and equity, but there is little assurance that such improvement will occur.

Traditionally the Ohio General Assembly does not legislate in terms of the internal organization and procedures of the Industrial Commission as an agency. During the early 1950's, members of the legislature received many complaints from constituents about the operation of the workmen's compensation system. During this period two investigations of the operation of the commission and an actuarial audit were conducted.21

For a period of forty years most workmen's compensation legislation had been drafted by a joint employer-union committee which had presented an agreed bill to the General

21 Pages 236-44, Supra.
Assembly. In 1955, members of the House introduced bills which involved organizational and procedural changes in the operation of the workmen's compensation system in much greater detail than is usually found in such legislation. The House sub-committee which held extensive hearings on workmen's compensation legislation added many of the features of the usual agreed bill to the bills which had been introduced by the members who had been studying workmen's compensation problems in the state. The combined bill which was evolved did not mobilize sufficient legislative support in the form in which it was reported from the House committee. In order to obtain sufficient support it was necessary for those members of the legislature sponsoring administrative reforms to accept several changes in the workmen's compensation appeals procedure. \(^{22}\)

**Administrative Changes**

In 1955 the General Assembly of Ohio created a Bureau of Workmen's Compensation headed by a single administrator. This legislation attempted to transfer most administrative functions under the workmen's compensation law to the new administrator. However, certain constitutional provisions caused the legislature to be ambiguous as to how completely the administrative power was transferred. Most of the person-

\(^{22}\) Chapters XI and XIII, *Supra*. 
nel of the commission is to be transferred to the new bureau. It is difficult to predict how completely the three commissioners will relinquish managerial functions to the administrator and limit themselves to the review of contested claims. The administrator is given unusually broad powers to remove any deputy administrator or other employee assigned to the investigation or determination of claims.

Changes in Organization and Procedures

The new legislation directs that "as promptly as possible in the course of efficient administration" the administrator shall decentralize and relocate such personnel and activities of the bureau as may be appropriate to the end that the receipt, investigation, determination and payment of claims be undertaken in regional offices. The escape clause in this provision, however, is sufficiently broad that the administrator could ignore or greatly delay putting this form or organization into effect.

The 1955 act authorizes the administrator to prepare new forms to be used in applying for workmen's compensation benefits and virtually forbids the continued use of the three-part reporting form. This provision shows a legis-

23 Chapter XI, Supra.
24 4121.122(K) R.C.
25 Page 266, Supra.
relative intent that the burden of going forward with the accumulation of information should be placed upon the personnel of the bureau after the receipt of any form of notice of the disability, thus relieving the claimant of this burden.

The administrator and his staff are furnished with several techniques to speed the determination of claims. An investigation of a claim may proceed upon the basis of a notice from any person. An award may be made without a formal report from the employer, and in some cases without a report from the claimant. If an investigation is unduly delayed, payments can be begun under a tentative order which is not binding upon the administrator if it later develops that the claim is without merit.\textsuperscript{26} The tentative order gives greater flexibility and offers a solution of prompt payment in claims which require extensive investigation. Nevertheless, it can be abused and used as a substitute for adequate investigation and the proper exercise of discretion.

The administrator is given broad discretion in devising an organization and procedures for obtaining the information necessary for prompt adjudication of the merits of a claim. If an employer protests after an award is made, a hearing will be granted, but the payment of benefits will

\textsuperscript{26} Chapter XII, Supra.
continue until a final determination is made that the claim is without merit. In cases where payments have been made under an improper award, the amount will be charged to the surplus fund rather than against the employer.\textsuperscript{27} If the agency, in the process of expediting claims, makes too many mistakes which are later charged to the surplus fund there will be reaction from employers, which may lead to further investigations or legislation. Under the newly-created system the costs of mistakes in expediting awards will be borne more evenly by employers and eventually by the consuming public.

The administrator still needs approximately the same information as the commission needed for the adjudication of a claim. Much will depend upon his acceptance of the burden of obtaining it and his ability to devise simple and efficient methods of obtaining information, while at the same time protecting the interests of the claimant, the employer and the public.

The legislature drew a blueprint for organizational and procedural changes in the processing of claims in much greater detail than is usually found in legislation. In most cases the legislation is permissive or there are escape clauses. Experience has indicated that the only way a legislature can be assured that permissive legislation ...
will be put into effect is to make it impossible for the administrative officer to do otherwise. The legislature did this only with regard to the abolition of the three-part reporting form. Even with this required change it would be possible for the administrator to continue the 1954 centralized organization and procedures under the new legislation, but at the cost of a greatly increased volume of correspondence and investigation.

Bureau Hearings After Notice in Disputed Claims

A hearing after notice before the administrator, or his deputy, is required for any disputed claim. This replaces the informal oral hearing before a board of claims or a deputy commissioner under the old act. These are to be informal and without any written record.28 Either the employer or the employee may appeal the administrator's decision to an administrative tribunal entirely independent from the administrator.29 This represents little change in hearing procedure.

Appeals from Decisions of the Administrator

The rehearing before a referee has been replaced by a hearing after notice before a newly-created board of review. There is no requirement that this hearing be con-

28 Loc. cit.
29 Chapter XIII, Supra.
ducted in accordance with the rules of civil procedure or that a transcript be made. If the employee, employer or the administrator is dissatisfied with the decision of the board an appeal may be made to the Industrial Commission, which may grant or deny the appeal at its option. There is no requirement that a hearing before the Industrial Commission be formal or that a record be kept. If any of the three parties is still dissatisfied an appeal may be taken to a court of common pleas, where a trial de novo, with a jury if requested, will be held.30

Under this new appeals system, the decisions of the Industrial Commission are as lacking in finality as they were before. There is an exception that questions of the degree of disability can not be appealed to the courts.

The house committee which drafted the 1955 workmen’s compensation law recommended a different appeals procedure, which would have made decisions of the Industrial Commission subject to appeal only on questions of law and the substantiality of the facts supporting decisions of fact. Such an appeal would have been made to a court of appeals rather than to a trial court.31 This change in appeals procedure was opposed by organized labor groups and defeated. The appeals procedure proposed by the committee would have given greater finality to decisions of the commission.

30 Loc. cit.
31 Chapter XI, Supra.
In the 1954 field survey it was found that the possibility of an appeal to a jury upon the transcript of the hearing required a legal formalism which delayed the completion of the rehearing and also affected the nature of the investigations conducted by the agency. It is possible that the retention of the jury trial will have a similar effect upon the conduct of hearings under the new hearing process and may color the nature of the investigations of claims within the new bureau.

Prospects of Success

The 1955 legislation provides ample opportunity for substantial improvement in efficiency and equity in the processing of workmen’s compensation claims, but there is little assurance that such improvement will occur; this is due in part to the fundamental infirmity of statutory law as an instrument for control of administrative practice, and in part to the infirmity of the agreed bill system of formulating workmen’s compensation legislation, and to the fact that the old employees must be used. Much will depend upon the executive leadership furnished.

Alert and efficient administration can achieve success under any form of organization, but administrative work can best be directed by an individual since it offers unity of command and centers responsibility. In this respect the administrator will have an advantage. Neverthe-
less, he will be hampered by many factors. The new statute leaves indefinite the scope of his powers vis-a-vis the members of the commission. He must deal with the inertia of employees who have spent long years under the old system. He must manage within appropriations, which may make extensive reorganization and decentralization difficult, and he may be hampered by a general lack of interest in administrative improvement by the organized interest groups which traditionally have drafted workmen’s compensation legislation in Ohio.

The extensive reorganization desired by the legislature will require considerable advance planning. Funds for such an organization and methods study by outside expert consultants are available in the appropriation for the Ohio Legislative Service Commission for 1955-1957. A request for such a study from this appropriation could be made. Such a study has the advantage that the results and recommendations of the special study would be available equally to the administrator and to the legislature. The fate of many organization and methods studies is that they are never implemented or if they are the results are never studied and submitted to further analysis. Any study made should include not only the organizational structure and claims procedure but also the forms needed and the reporting system required. Assistance can also be obtained from the new Workmen’s Compensation Advisory Council and its
staff.

If the administrator is an individual who wishes to make changes in organization and procedure and if he is able to generate sufficient administrative and political force to disrupt the mail-order operation altogether, then the various things that the legislators authorized and intended to be done will come to pass.

D. RECOMMENDATIONS

1. Before any decentralization of organization or any extensive revision of claim handling procedures is made a thorough organization and methods study by a staff of expert consultants should be made.

2. If a new organization and procedures are established, the administrator should establish an internal reporting system best suited to serve the needs of this organization. Consideration should be given to the feasibility of establishing a permanent staff, reporting to the administrator, to examine these reports and make continuing studies looking toward improvements in the methods of handling claims.

3. The administrator should adopt a firm policy against settling claims, during the period they are being appealed, in order to dispose of them. All invalid claims should be resisted from their inception and all questioned claims should be submitted to the hearing process. As a
corollary to this every effort should be made to expedite the determination and payment of the unquestioned claims.

4. The Industrial Commission and the boards of review should make use of the pre-hearing conference procedure and should adopt informal procedures as long as their decisions are subject to review by a jury trial de novo.

5. Statutory changes should be made in the appeals procedure to the extent that decisions of the Industrial Commission may be reviewed only on questions of law and of the substantiality of evidence.

E. AREAS FOR FURTHER STUDY

1. Discovery of the adequacy of workmen's compensation benefits to replace the economic loss of a disabled worker and determination of the proper relationship between the amount of weekly benefits and the wage scale or the economic loss of the employee.

2. Examination of the causes of litigation of workmen's compensation claims in Ohio, its extensiveness, and the proportion of workmen's compensation benefits which are paid for legal fees.

3. Determination of which, if any, of the criteria applicable to optimum workmen's compensation claims service by a private insurance carrier are applicable to the conduct of a state workmen's compensation insurance fund as a
public enterprise, and a comparative study of private and public workmen's compensation administration if such criteria can be found.

4. Study of the extent to which the functions of receiving, investigating, determining, and paying claims for workmen's compensation may effectively be decentralized to regional offices by the administrator of the Bureau of Workmen's Compensation in Ohio.

5. Development of a reporting system best suited to meet the needs of the organization and procedures adopted for the Ohio Bureau of Workmen's Compensation.

6. The scope and effectiveness of the safety program of the Ohio Industrial Commission.

7. Exploration of possible rehabilitation techniques in connection with workmen's compensation benefits to determine which will be most effective in reducing economic loss.

8. How well the experience developed under workmen's compensation insurance systems in settling claims through an administrative tribunal rather than through the courts may be applied to other programs involving compulsory insurance, such as automobile liability insurance.

9. Study of the influence of executive leadership upon the operation of the Ohio workmen's compensation system.
APPENDIX A

SELF-INSURED AND NON-COMPLYING EMPLOYERS

The two categories of claims which require adjudication under the workmen's compensation law, but which do not involve direct claims against the state insurance fund are those involving the employees of self-insurers and non-covered employers who are amenable to the workmen's compensation law.

These two types of claims are few in number when compared with the number of state fund claims. However, they are sufficiently peculiar that it has been necessary for the Industrial Commission to set up special procedures for their handling.

The role of the commission in self-insurer cases was similar to that of the administrative agency in agreement states. It did little more than receive, check and file reports in uncontested lost-time claims, while a direct relationship was established between the employer and employee. In cases of the contest of a claim, there was the necessity of putting the claim in motion so that it would pass through the same hearing and appeal process as any state fund claim. For this purpose a separate unit was established within the
claims section of the commission.

Where a case of non-coverage was reported, the role of the commission was one of notifying the disabled employee of his alternate rights under the workmen's compensation law or in the civil courts and await his election. Once he elected workmen's compensation the claims were sent to a single attorney examiner who arranged for a hearing, after notice, on the claim. If an award were made, this attorney examiner had further duties, once the award became final, of determining whether the award was paid. If it were not paid by the non-covered employer, the claimant could be paid from the state fund and the claim turned over to the attorney general to secure reimbursement of the fund through a civil suit against the employer.

The Self-Insurers Unit of the Claims Section

Under certain circumstances an employer may qualify to furnish the benefits guaranteed under the workmen's compensation act to his employees without participating in the state insurance fund. Such employers are required to post bond to guarantee the proper payment of benefits. In cases where the employee and employer agree what benefits are due and payable, the function of the commission is merely a policing one. Reports are submitted to it and a check is made to see that what is being done conforms to the law. In this area the function of the commission is similar to that of workmen's compensation commissions in states where
the employer's insurance is entirely or mostly furnished by private insurance companies. In cases where the parties are unable to reach agreement, the employee may file an application to have the commission determine the matter at issue. The employer is served with notice and given ten days in which to file an answer. If the matter to be decided involves compensability, the claim is referred for investigation. The claim is then referred either to the medical or legal departments, depending upon the question that is to be decided. If the matter at issue is the extent of disability, the claim is referred to the medical section for a consideration of the medical proof in the record or a physical examination. The claim then goes to the legal section for review and report. The claim is then submitted to the commission or a claim board for an informal oral hearing. The hearing and appeal procedure is the same as that followed for a state fund case.\(^1\)

The self-insurer is required to report to the commission all compensable injuries resulting in seven days or more of total disability and occupational disease cases, as well as death cases resulting from injury or occupational

\(^1\) Unless otherwise indicated, the information in this section is based upon a mimeographed letter from Walter A. Maushund, Supervisor, Self-Insurers Unit, to Richard W. Morse, Chairman, Industrial Commission, dated July 13, 1951, which was submitted to the Ohio Program Commission; and an interview with Walter M. Magers, Assistant Supervisor, Self-Insurers Unit, July 12, 1954.
disease. Formerly they were also required to report medical-only cases. As a matter of practice some self-insurers still report all such claims. Others report only those medical-only claims that seem to show some prospect that some degree of permanent-partial disability will result. The number of self-insurers has been approximately one hundred seventy-five for many years.

The personnel of the unit consisted of two claims examiners, who were the supervisor and assistant supervisor, five secretaries and one file clerk. When the new reports arrived each morning the lost-time and medical-only reports were separated. Only a few medical-only reports arrived in a day. Early in each lost-time case the employer had to file a form which was a joint agreement between employer and employee as to the date and facts of the injury, dates of disability and payment. It also included an acknowledgment of payments already made on the part of the employer. The reverse side of the form was designed for use as a supplemental report from the attending physician. The report would not be accepted unless the physician’s report was included.

In some cases the two reports were filed together and in other cases the joint agreement was filed later. The employer was required to file the first report by the tenth of the month following injury or disability. Thus there could be a considerable time lag in filing the reports.
About five hundred such claims were filed a month. When a new claim arrived a claim number was assigned to it by one of the clerks. They were sent in a group to the actuarial section, which section in turn sent it to the safety and hygiene section for coding. When they returned they were entered in the docket book which was maintained within the unit. A separate folder was made up on each lost-time report and notice of receipt of the report was sent to both employer and employee. The claims were then scrutinized by the examiners to ascertain if proper payments had been made. If not, the employer was informed as to any discrepancy and directed to correct same by paying such additional compensation as was found to be due the employee. In such cases the employer was required to file a supplemental report of the compensation payments made.

In docketing self-insurer claims, two carbons were kept, on perforated cards. One of these went to the central files in the claim section, and the other remained in the unit where it was filed alphabetically according to the employer.

In lost-time cases, where all that was submitted was the first report, without the preliminary agreement affecting the rights of the claimant, the file was placed in a pending file, where it was filed numerically according to the claim number. In each case of continuing disability, the employer was required to file a monthly report which
stated whether the employee was still off, gave the amounts being paid and the total amount paid to date. The unit had form letters which were designed to be sent to the employer who failed to submit the monthly reports regularly. When a monthly report was submitted the file was removed from the pending file and placed in the continuing file. Shortly after the tenth of each month the examiner went through the continuing files to see if any showed a lapse of more than six months in filing a monthly or final report. Most of the older claim numbers in the continuing file involved permanent-total claims which required a report only once a year.

In all self-insurer cases where compensation was due the injured person by reason of permanent-partial disability resulting from the injury, an agreement was executed by the parties and submitted to the commission for consideration, and both parties were later notified as to whether it had been approved or rejected. This same procedure was also followed in all death claims, by an agreement being executed by the employer and the dependent and submitted to the commission for the necessary approval.

When the total temporary disability had ceased, the parties were required to submit a final agreement. On the reverse side of this agreement there was a supplemental physician’s report, showing any permanent injury to the employee. If the final report was in accordance with the law it was approved and noted on the docket, and the file went
into the "disposed of" file.

In the event the employer did not recognize a claim as compensable or refused to give a claimant further recognition after having originally admitted liability, the claimant was privileged to ask the commission for a determination of the matters at issue. In such an event he had to file an Application for Adjustment. If such an application were filed, it was noted on the docket and the employer notified. A copy of any medical report submitted was sent to the employer. The employer was given ten days in which to file an answer, a copy of which was forwarded to the claimant. The ten days given to the employer to answer was a flexible deadline for the employer to correspond by, and it was not strictly enforced by the section. Sometimes the employer acknowledged the injury, in which case it was handled in the regular manner. There was no set form for the answer, but most employers used a fairly legalistic form in preparing the answer. It was generally submitted in duplicate. If not, a copy was made in the unit and sent to the claimant.

Where no immediate agreement was reached by the parties, further action was taken. If the matter at issue involved the question of compensability, the file was sent to the "Legal X" unit for quick transmission to field investigation. If the matter at issue involved the extent of disability, the claim was referred to the medical section for
consideration of the medical proof in the file or for a physical examination of the claimant. The investigation might take from one to several months, but on the average it took about two months. The investigation report was returned in triplicate so that copies might be sent to the parties. After the investigation the claim record was referred to the legal or medical sections, depending upon the question that was to be decided.

If a legal interpretation of the facts as developed was needed, the file was sent to the legal section along with copies of the investigation and medical report, if any. An attorney examiner wrote a statement of facts and made a recommendation of allowance or disallowance. This report did not go to the parties. The file then returned to the self-insurers unit where it was set for a hearing before the commission or a district claims board, and notices prepared. They were generally set for at least two weeks in advance. On some occasions one side would request that the hearing be delayed, pending efforts to negotiate a settlement. On other occasions the hearing officer would continue the case in order to give both sides the chance to submit further proof. After the claim was heard, it was returned with the decision of the hearing officer or board marked on a hearing sheet which was labeled "Memorandum of Findings and Orders". A clerk in the unit translated this information onto a form used for Findings of Facts, copies of which were
mailed to the parties.

All claims that were heard by a district claims board were subject to a review by the commission, should either the claimant or employer be dissatisfied with the decision; in which case an Application for Reconsideration, Review or Modification had to be filed within eight days from date notice of the decision was received. The claimant also could request a rehearing.

A copy of the order of allowance was sent to the employer by registered mail. Copies were sent to the claimant and to any representatives of the parties. On a disallowance, the claimant was notified by registered mail. If compensation was ordered, the employer was required by statute to comply within ten days from receipt of the order, or show cause why the same should not be carried out. Failure on the part of the employer to carry out a directive of the commission jeopardized his self-insurance rights, as well as being faced by court action which was brought by the Attorney General of Ohio at the request of the commission to collect the compensation that had been awarded. In a situation of this kind the commission had one other alternative which was to convert the bonds (which the self-insurer was required to post before he was given authority to operate) into cash. This cash would be credited to the state insurance fund, from which the compensation due the claimant might then be paid.
As a matter of practice, the commission made no follow-up to see that payment of the award was made. The claimant had a copy of the award, and he was relied upon to call any failure of payment to the attention of the commission. In the majority of cases, after an award to the claimant, the employer filed a final report with the commission.

When a claimant who had received payment for total-temporary disability or had received medical benefits filed an application for determination of percentage of permanent-partial disability, the claim was handled the same as any such state-fund application. A physical examination was ordered by the commission’s medical staff and the case was automatically set for an oral hearing before the commission or a claims board. In a similar manner all applications for a lump sum settlement were handled the same as a similar application from a state-fund claimant. The same rights for a rehearing existed in self-insurer cases as in state-fund cases.

Claims Involving Non-Complying Employers

The workmen’s compensation law covered every employee in the service of any person, firm, or private corporation employing three or more workmen or operatives regularly in the same business or in or about the same establishment under any contract of hire, but not including any person whose employment was casual and not in the usual course of
Trade, business, profession or occupation of his employer.\(^2\) The only election given to such an employer was to qualify to become a self-insurer or to participate in the state insurance fund through the payment of premiums.

The act spelled out in considerable detail the rights of such an employee when the employer filed to comply with the workmen's compensation law.\(^3\) The employee had the choice of proceeding against his employer by civil action or filing an application with the Industrial Commission for compensation. The commission heard and determined such an application in the same manner as any other claim, and made such an award as it would have if the employer had been covered. The employer was required to pay the award or to furnish a bond guaranteeing its payment.

If the employer failed to make the payment or furnish the bond within ten days after notification of the award, the award then constituted a liquidated claim for damages against the employer in the amount so ascertained. The commission then certified the claim to the Attorney General who proceeded to file a civil action against the employer in the name of the state for the collection of the award. In such an action it was sufficient for the claimant-plaintiff to set forth a copy of the record of the proceedings.

\(^2\) Sections 1465-60 and 1465-61 G. C.; 4123.01 R. C.

\(^3\) Section 1465-74 G. C.; 4123.75 R. C.
of the commission, which constituted *prima facie* evidence of the facts of the record. As soon as the issues were made in the suit, it was placed at the head of the trial docket.

The amount recovered in such a suit was paid into the state insurance fund. The amount of a final judgment against the non-complying employer was paid to the employee from the commission's surplus fund, and if the state was able to recover from the employer it was paid to the commission and credited to that fund. However, in no case was any payment made by the commission from the surplus fund until after a final judgment had been secured against the employer. Thus there could be considerable delay before any payment was made to the employee.
### APPENDIX B

### TABLE XI
WORK TIME IN OPENING AND SORTING MAIL IN THE FILE ROOM

<table>
<thead>
<tr>
<th>1954</th>
<th>HIGH</th>
<th>LOW</th>
<th>MEAN AVERAGE</th>
<th>MEDIAN AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan.</td>
<td>1 hr. 10 min.</td>
<td>30 min.</td>
<td>51.75 min.</td>
<td>57.5 min.</td>
</tr>
<tr>
<td>Feb.</td>
<td>45 min.</td>
<td>35 &quot;</td>
<td>40.28 &quot;</td>
<td>40 &quot;</td>
</tr>
<tr>
<td>March</td>
<td>1 hr. 15 &quot;</td>
<td>25 &quot;</td>
<td>37.61 &quot;</td>
<td>35 &quot;</td>
</tr>
<tr>
<td>April</td>
<td>45 &quot;</td>
<td>25 &quot;</td>
<td>34.55 &quot;</td>
<td>32.5 &quot;</td>
</tr>
<tr>
<td>May</td>
<td>40 &quot;</td>
<td>20 &quot;</td>
<td>32.50 &quot;</td>
<td>35 &quot;</td>
</tr>
<tr>
<td>June</td>
<td>45 &quot;</td>
<td>25 &quot;</td>
<td>35.00 &quot;</td>
<td>35 &quot;</td>
</tr>
<tr>
<td>SIX MONTHS</td>
<td>1 hr. 15 min.</td>
<td>20 min.</td>
<td>38.44 min.</td>
<td>35 min.</td>
</tr>
</tbody>
</table>

### TABLE XII
SORTING NEW CLAIMS BY THE INDEX UNIT

<table>
<thead>
<tr>
<th>1954</th>
<th>HIGH</th>
<th>LOW</th>
<th>MEAN AVERAGE</th>
<th>MEDIAN AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan.</td>
<td>1 hr. 50 min.</td>
<td>30 min.</td>
<td>54.58 min.</td>
<td>52.5 min.</td>
</tr>
<tr>
<td>Feb.</td>
<td>1 &quot; 20 &quot;</td>
<td>20 &quot;</td>
<td>50.91 &quot;</td>
<td>50 &quot;</td>
</tr>
<tr>
<td>March</td>
<td>1 &quot; 25 &quot;</td>
<td>20 &quot;</td>
<td>39.42 &quot;</td>
<td>37.5 &quot;</td>
</tr>
<tr>
<td>April</td>
<td>1 &quot; 00 &quot;</td>
<td>20 &quot;</td>
<td>33.46 &quot;</td>
<td>30 &quot;</td>
</tr>
<tr>
<td>May</td>
<td>50 &quot;</td>
<td>15 &quot;</td>
<td>30.43 &quot;</td>
<td>30 &quot;</td>
</tr>
<tr>
<td>June</td>
<td>50 &quot;</td>
<td>15 &quot;</td>
<td>32.69 &quot;</td>
<td>32.5 &quot;</td>
</tr>
<tr>
<td>SIX MONTHS</td>
<td>1 hr. 50 min.</td>
<td>15 min.</td>
<td>39.96 min.</td>
<td>35 min.</td>
</tr>
</tbody>
</table>
TABLE XIII
TRANSPORTATION BETWEEN THE CLAIMS AND ACTUARIAL SECTIONS AFTER WORK WAS COMPLETED BY THE INDEX UNIT

<table>
<thead>
<tr>
<th>1954</th>
<th>HIGH</th>
<th>LOW</th>
<th>MEAN AVERAGE</th>
<th>MEDIAN AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan.</td>
<td>20 min.</td>
<td>00 min.</td>
<td>7.17 min.</td>
<td>7.5 min.</td>
</tr>
<tr>
<td>Feb.</td>
<td>30 &quot;</td>
<td>00 &quot;</td>
<td>10.22 &quot;</td>
<td>10. &quot;</td>
</tr>
<tr>
<td>March</td>
<td>2 hr. 20 &quot;</td>
<td>00 &quot;</td>
<td>16.67 &quot;</td>
<td>5 &quot;</td>
</tr>
<tr>
<td>April</td>
<td>30 &quot;</td>
<td>00 &quot;</td>
<td>7.50 &quot;</td>
<td>5 &quot;</td>
</tr>
<tr>
<td>May</td>
<td>40 &quot;</td>
<td>00 &quot;</td>
<td>16.00 &quot;</td>
<td>10 &quot;</td>
</tr>
<tr>
<td>June</td>
<td>50 &quot;</td>
<td>00 &quot;</td>
<td>12.37 &quot;</td>
<td>12.5 &quot;</td>
</tr>
<tr>
<td>SIX MONTHS</td>
<td>2 hr. 20 min.</td>
<td>00 min.</td>
<td>11.68 min.</td>
<td>10 min.</td>
</tr>
</tbody>
</table>

Because of the mechanical equipment available, figures on the control sheet showing the claims as leaving one unit and arriving at the next at the same time were accepted. Where such figures were given when work had to be done on the C-l's, the zero time was ruled out as being impossible and the calculations were made without any data for that date.

TABLE XIV
WORK TIME INVOLVED IN THE ACTUARIAL SECTION

<table>
<thead>
<tr>
<th>1954</th>
<th>HIGH</th>
<th>LOW</th>
<th>MEAN AVERAGE</th>
<th>MEDIAN AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan.</td>
<td>2 hr. 00 min.</td>
<td>50 min.</td>
<td>1 hr. 20.40 min.</td>
<td>1 hr. 00 min.</td>
</tr>
<tr>
<td>Feb.</td>
<td>2 &quot; 00 &quot;</td>
<td>50 &quot;</td>
<td>1 hr. 11.59 &quot;</td>
<td>1 hr. 00 &quot;</td>
</tr>
<tr>
<td>March</td>
<td>2 &quot; 45 &quot;</td>
<td>30 &quot;</td>
<td>1 hr. 20.38 &quot;</td>
<td>1 hr. 20 &quot;</td>
</tr>
<tr>
<td>April</td>
<td>3 &quot; 00 &quot;</td>
<td>50 &quot;</td>
<td>1 hr. 28.75 &quot;</td>
<td>1 hr. 27.5 &quot;</td>
</tr>
<tr>
<td>May</td>
<td>3 &quot; 00 &quot;</td>
<td>00 &quot;</td>
<td>1 hr. 29.20 &quot;</td>
<td>1 hr. 30 &quot;</td>
</tr>
<tr>
<td>June</td>
<td>1 &quot; 45 &quot;</td>
<td>00 &quot;</td>
<td>1 hr. 22.50 &quot;</td>
<td>1 hr. 20 &quot;</td>
</tr>
<tr>
<td>SIX MONTHS</td>
<td>3 &quot; 00 &quot;</td>
<td>30 min.</td>
<td>1 hr. 20.58 min.</td>
<td>1 hr. 17.5 min.</td>
</tr>
</tbody>
</table>
In connection with the preceding table, because of ambiguities on the control sheets for March 13, April 22 and 29, June 15 and 16, no figures for those dates were included in the calculation of the mean averages.

### TABLE XV
CHECKING OF COVERAGE BY THE ACCOUNTS SECTION (FIRST TIME)

<table>
<thead>
<tr>
<th></th>
<th>1954</th>
<th>HIGH</th>
<th>LOW</th>
<th>MEAN AVERAGE</th>
<th>MEDIAN AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan.</td>
<td></td>
<td>2 hr. 45 min.</td>
<td>30 min.</td>
<td>1 hr. 30.22 min.</td>
<td>1 hr. 30 min.</td>
</tr>
<tr>
<td>Feb.</td>
<td></td>
<td>3 &quot; 00 &quot;</td>
<td>45 &quot;</td>
<td>1 hr. 46.14 &quot;</td>
<td>1 hr. 50 &quot;</td>
</tr>
<tr>
<td>March</td>
<td></td>
<td>2 &quot; 30 &quot;</td>
<td>15 &quot;</td>
<td>1 hr. 06.40 &quot;</td>
<td>1 hr. 00 &quot;</td>
</tr>
<tr>
<td>April</td>
<td></td>
<td>2 &quot; 15 &quot;</td>
<td>15 &quot;</td>
<td>1 hr. 15.00 &quot;</td>
<td>1 hr. 15 &quot;</td>
</tr>
<tr>
<td>May</td>
<td></td>
<td>4 &quot; 00 &quot;</td>
<td>15 &quot;</td>
<td>1 hr. 30.60 &quot;</td>
<td>1 hr. 30 &quot;</td>
</tr>
<tr>
<td>June</td>
<td></td>
<td>2 &quot; 45 &quot;</td>
<td>15 &quot;</td>
<td>1 hr. 38.48 &quot;</td>
<td>1 hr. 45 &quot;</td>
</tr>
<tr>
<td>SIX MONTHS</td>
<td>4 hr. 00 min.</td>
<td>15 min.</td>
<td>1 hr. 27.50 min.</td>
<td>1 hr. 30 min.</td>
<td></td>
</tr>
</tbody>
</table>

### TABLE XVI
TOTAL TIME CONSUMED IN THE ACTUARIAL AND ACCOUNTS SECTIONS INCLUDING TRANSPORTATION TIME FROM AND BACK TO THE CLAIMS SECTION

<table>
<thead>
<tr>
<th></th>
<th>1954</th>
<th>HIGH</th>
<th>LOW</th>
<th>MEAN AVERAGE</th>
<th>MEDIAN AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan.</td>
<td></td>
<td>4 hr. 45 min.</td>
<td>1 hr. 05 min.</td>
<td>2 hr. 40.00 min.</td>
<td>2 hr. 30 min.</td>
</tr>
<tr>
<td>Feb.</td>
<td></td>
<td>4 &quot; 10 &quot;</td>
<td>2 hr. 00 &quot;</td>
<td>3 hr. 07.95 &quot;</td>
<td>2 hr. 57.5 &quot;</td>
</tr>
<tr>
<td>March</td>
<td></td>
<td>4 &quot; 35 &quot;</td>
<td>1 hr. 35 &quot;</td>
<td>2 hr. 43.15 &quot;</td>
<td>2 hr. 30 &quot;</td>
</tr>
<tr>
<td>April</td>
<td></td>
<td>4 &quot; 05 &quot;</td>
<td>1 hr. 30 &quot;</td>
<td>2 hr. 44.81 &quot;</td>
<td>2 hr. 45 &quot;</td>
</tr>
<tr>
<td>May</td>
<td></td>
<td>6 &quot; 10 &quot;</td>
<td>2 hr. 05 &quot;</td>
<td>3 hr. 13.00 &quot;</td>
<td>3 hr. 05 &quot;</td>
</tr>
<tr>
<td>June</td>
<td></td>
<td>4 &quot; 05 &quot;</td>
<td>1 hr. 15 &quot;</td>
<td>3 hr. 07.50 &quot;</td>
<td>3 hr. 15 &quot;</td>
</tr>
<tr>
<td>SIX MONTHS</td>
<td>6 hr. 10 min.</td>
<td>1 hr.</td>
<td>2 hr. 55.66 min.</td>
<td>2 hr. 55 min.</td>
<td></td>
</tr>
</tbody>
</table>
According to the preceding Table, the high in May occurred on May 7th. On this particular control sheet, there were internal indications that an error had been made in recording the time the group left the accounts section and reached the index section, for the time consumed in the next successive step on this group was unusually short, just as the period listed here was unusually long. The next longest period, both for May and for the whole six months, was 4 hours, 30 minutes.

TABLE XVII

ASSIGNING CLAIM NUMBERS AND DOCKETING CLAIMS (WORK TIME)

<table>
<thead>
<tr>
<th>1954</th>
<th>HIGH</th>
<th>LOW</th>
<th>MEAN AVERAGE</th>
<th>MEDIAN AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan.</td>
<td>10 hr. 10 min.</td>
<td>3 hr. 45 min.</td>
<td>6 hr. 33.56 min.</td>
<td>6 hr. 30 min.</td>
</tr>
<tr>
<td>Feb.</td>
<td>7 &quot; 20 &quot;</td>
<td>5 hr. 15 &quot;</td>
<td>6 hr. 24.72 &quot;</td>
<td>6 hr. 30 &quot;</td>
</tr>
<tr>
<td>March</td>
<td>8 &quot; 15 &quot;</td>
<td>5 hr. 40 &quot;</td>
<td>6 hr. 55.55 &quot;</td>
<td>6 hr. 50 &quot;</td>
</tr>
<tr>
<td>April</td>
<td>8 &quot; 15 &quot;</td>
<td>5 hr. 30 &quot;</td>
<td>6 hr. 45.38 &quot;</td>
<td>6 hr. 52.5 &quot;</td>
</tr>
<tr>
<td>May</td>
<td>10 &quot; 30 &quot;</td>
<td>2 hr. 50 &quot;</td>
<td>6 hr. 39.20 &quot;</td>
<td>6 hr. 45 &quot;</td>
</tr>
<tr>
<td>June</td>
<td>8 &quot; 00 &quot;</td>
<td>5 hr. 15 &quot;</td>
<td>6 hr. 44.42 &quot;</td>
<td>6 hr. 45 &quot;</td>
</tr>
<tr>
<td>SIX MONTHS</td>
<td>10 hr. 30 min.</td>
<td>2 hr. 50 min.</td>
<td>6 hr. 41.05 min.</td>
<td>6 hr. 45 min.</td>
</tr>
</tbody>
</table>

The shortest elapsed time was on May 7th, as noted above. The next shortest time for May was 4 hours, 45 minutes, and the shortest time for the six month period was 3 hours, 45 minutes.
### TABLE XVIII

**Delays and Overlapping in Transferring Claims from the Docketing Clerk to the Clerks Who Send Acknowledgments**

<table>
<thead>
<tr>
<th></th>
<th>1954</th>
<th></th>
<th></th>
<th>Mean Average</th>
<th>Median Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HIGH</td>
<td>LOW</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan.</td>
<td>+2 hr. 30 min</td>
<td>-3 hr. 10 min</td>
<td>-34.50 min</td>
<td>-57.5 min</td>
<td></td>
</tr>
<tr>
<td>Feb.</td>
<td>+2 hr. 35 min</td>
<td>-2 hr. 15 min</td>
<td>-35.45 min</td>
<td>-55 min</td>
<td></td>
</tr>
<tr>
<td>March</td>
<td>+4 hr. 15 min</td>
<td>-2 hr. 20 min</td>
<td>-14.44 min</td>
<td>-1 hr.</td>
<td></td>
</tr>
<tr>
<td>April</td>
<td>+3 hr. 00 min</td>
<td>-2 hr. 15 min</td>
<td>-17.20 min</td>
<td>-40 min</td>
<td></td>
</tr>
<tr>
<td>May</td>
<td>+4 hr. 35 min</td>
<td>-2 hr. 25 min</td>
<td>-14.00 min</td>
<td>+10 min</td>
<td></td>
</tr>
<tr>
<td>June</td>
<td>+6 hr. 25 min</td>
<td>-1 hr. 55 min</td>
<td>+11.80 min</td>
<td>+12.5 min</td>
<td></td>
</tr>
<tr>
<td>SIX MONTHS</td>
<td>+6 hr. 25 min</td>
<td>-3 hr. 15 min</td>
<td>-16.44 min</td>
<td>-55 min</td>
<td></td>
</tr>
</tbody>
</table>

In the above table, the symbol + was used to indicate situations where the control sheet showed that there was a delay from the time the docketing clerk finished with the claim and the typists began, and the symbol - was used when it was indicated that there was an overlapping.

### TABLE XIX

**Work Time in the Index Unit Sending Acknowledgments**

<table>
<thead>
<tr>
<th></th>
<th>1954</th>
<th></th>
<th></th>
<th>Mean Average</th>
<th>Median Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HIGH</td>
<td>LOW</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan.</td>
<td>6 hr. 30 min</td>
<td>1 hr. 50 min</td>
<td>4 hr. 40.24 min</td>
<td>4 hr. 50 min</td>
<td></td>
</tr>
<tr>
<td>Feb.</td>
<td>6 &quot; 45 &quot;</td>
<td>3 hr. 00 &quot;</td>
<td>5 hr. 13.41 &quot;</td>
<td>5 hr. 30 &quot;</td>
<td></td>
</tr>
<tr>
<td>March</td>
<td>6 &quot; 35 &quot;</td>
<td>1 hr. 30 &quot;</td>
<td>5 hr. 11.30 &quot;</td>
<td>6 hr. 00 &quot;</td>
<td></td>
</tr>
<tr>
<td>April</td>
<td>6 &quot; 45 &quot;</td>
<td>1 hr. 55 &quot;</td>
<td>5 hr. 05.00 &quot;</td>
<td>5 hr. 30 &quot;</td>
<td></td>
</tr>
<tr>
<td>May</td>
<td>10 &quot; 37 &quot;</td>
<td>1 hr. 30 &quot;</td>
<td>4 hr. 54.24 &quot;</td>
<td>4 hr. 30 &quot;</td>
<td></td>
</tr>
<tr>
<td>June</td>
<td>7 &quot; 45 &quot;</td>
<td>1 hr. 30 &quot;</td>
<td>4 hr. 40.77 &quot;</td>
<td>4 hr. 27.5 &quot;</td>
<td></td>
</tr>
<tr>
<td>SIX MONTHS</td>
<td>10 hr. 37 min</td>
<td>1 hr. 30 min</td>
<td>4 hr. 57.17 min</td>
<td>5 hr. 15 min</td>
<td></td>
</tr>
</tbody>
</table>
TABLE XX

TOTAL TIME SPENT IN THE INDEX UNIT
FOR DOCKETING AND CORRESPONDENCE TO ACKNOWLEDGE CLAIMS

<table>
<thead>
<tr>
<th></th>
<th>1954</th>
<th>HIGH</th>
<th>LOW</th>
<th>MEAN AVERAGE</th>
<th>MEDIAN AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan.</td>
<td>12</td>
<td>12 hr. 30 min.</td>
<td>9 hr. 30 min.</td>
<td>10 hr.</td>
<td>10 hr.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>30 min.</td>
<td>43.80 min.</td>
<td>45 min.</td>
</tr>
<tr>
<td>Feb.</td>
<td>13</td>
<td>10 hr. 10 min.</td>
<td>10 hr. 00 min.</td>
<td>11 hr.</td>
<td>10 hr.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>30 min.</td>
<td>05.00 min.</td>
<td>45 min.</td>
</tr>
<tr>
<td>March</td>
<td>14</td>
<td>10 hr. 00 min.</td>
<td>8 hr. 00 min.</td>
<td>11 hr.</td>
<td>11 hr.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>50 min.</td>
<td>52.41 min.</td>
<td>45 min.</td>
</tr>
<tr>
<td>April</td>
<td>14</td>
<td>7 hr. 35 min.</td>
<td>8 hr. 00 min.</td>
<td>11 hr.</td>
<td>11 hr.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>30 min.</td>
<td>35.85 min.</td>
<td>37.5 min.</td>
</tr>
<tr>
<td>May</td>
<td>15</td>
<td>7 hr. 30 min.</td>
<td>9 hr. 30 min.</td>
<td>11 hr.</td>
<td>11 hr.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>22 min.</td>
<td>17.44 min.</td>
<td>15 min.</td>
</tr>
<tr>
<td>June</td>
<td>15</td>
<td>7 hr. 35 min.</td>
<td>9 hr. 30 min.</td>
<td>11 hr.</td>
<td>11 hr.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>00 min.</td>
<td>36.54 min.</td>
<td>15 min.</td>
</tr>
<tr>
<td>SIX MONTHS</td>
<td>15 hr. 22 min.</td>
<td>7 hr. 35 min.</td>
<td>11 hr.</td>
<td>11 hr.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>22.76 min.</td>
<td>15 min.</td>
<td></td>
</tr>
</tbody>
</table>

In most cases the figures in the table above do not include transportation time from the accounts section or to the safety and hygiene section. However, in fourteen instances it was necessary to include the transportation time to the safety and hygiene section because the clerks in the index unit had failed to mark on the control sheet the time they finished with the claims. Thus it was necessary to rely upon the time they arrived at the next section for a definite figure. Thus the mean average time is distorted and enlarged.

Coding of the Claims Statistically by the Safety and Hygiene Section

In all except the fourteen instances mentioned above, it was possible to measure the time which elapsed between the time the work was finished in the index unit, the claims were transported to the safety and hygiene section and work begun on them there.
TABLE XXI
TRANSPORTATION TIME
FROM INDEX UNIT TO SAFETY AND HYGIENE SECTION

<table>
<thead>
<tr>
<th>1954</th>
<th>HIGH</th>
<th>LOW</th>
<th>MEAN AVERAGE</th>
<th>MEDIAN AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>40 min.</td>
<td>05 min.</td>
<td>13.89 min.</td>
<td>15 min.</td>
</tr>
<tr>
<td>Jan.</td>
<td>1 hr. 20 min.</td>
<td>00 min.</td>
<td>16.25 min.</td>
<td>10 min.</td>
</tr>
<tr>
<td>Feb.</td>
<td>40 min.</td>
<td>05 min.</td>
<td>12.50 min.</td>
<td>10 min.</td>
</tr>
<tr>
<td>March</td>
<td>1 hr. 50 min.</td>
<td>00 min.</td>
<td>17.80 min.</td>
<td>15 min.</td>
</tr>
<tr>
<td>April</td>
<td>45 min.</td>
<td>00 min.</td>
<td>9.13 min.</td>
<td>8 min.</td>
</tr>
<tr>
<td>May</td>
<td>2 hr. 00 min.</td>
<td>00 min.</td>
<td>15.00 min.</td>
<td>10 min.</td>
</tr>
<tr>
<td>SIX MONTHS</td>
<td>2 hr. 00 min.</td>
<td>00 min.</td>
<td>14.04 min.</td>
<td>10 min.</td>
</tr>
</tbody>
</table>

TABLE XXII
WORK TIME IN SAFETY AND HYGIENE SECTION

<table>
<thead>
<tr>
<th>1954</th>
<th>HIGH</th>
<th>LOW</th>
<th>MEAN AVERAGE</th>
<th>MEDIAN AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6 hr. 00 min.</td>
<td>2 hr. 05 min.</td>
<td>3 hr. 55.80 min.</td>
<td>4 hr. 00 min.</td>
</tr>
<tr>
<td>Jan.</td>
<td>4 hr. 35 min.</td>
<td>1 hr. 30 min.</td>
<td>3 hr. 20.45 min.</td>
<td>3 hr. 35 min.</td>
</tr>
<tr>
<td>Feb.</td>
<td>5 hr. 00 min.</td>
<td>1 hr. 25 min.</td>
<td>3 hr. 38.70 min.</td>
<td>3 hr. 40 min.</td>
</tr>
<tr>
<td>March</td>
<td>5 hr. 30 min.</td>
<td>2 hr. 35 min.</td>
<td>3 hr. 52.88 min.</td>
<td>3 hr. 42.5 min.</td>
</tr>
<tr>
<td>April</td>
<td>6 hr. 05 min.</td>
<td>2 hr. 20 min.</td>
<td>3 hr. 48.75 min.</td>
<td>3 hr. 42.5 min.</td>
</tr>
<tr>
<td>May</td>
<td>4 hr. 45 min.</td>
<td>1 hr. 20 min.</td>
<td>3 hr. 22.31 min.</td>
<td>3 hr. 25 min.</td>
</tr>
<tr>
<td>June</td>
<td>6 hr. 05 min.</td>
<td>1 hr. 3 hr.</td>
<td>3 hr. 40.10 min.</td>
<td>3 hr. 40 min.</td>
</tr>
<tr>
<td>SIX MONTHS</td>
<td>6 hr. 05 min.</td>
<td>20 min.</td>
<td>40.10 min.</td>
<td>40 min.</td>
</tr>
</tbody>
</table>
### TABLE XXIII

**TRAVEL TIME BETWEEN THE SAFETY AND HYGIENE SECTION AND THE FILE ROOM IN THE CLAIMS SECTION**

<table>
<thead>
<tr>
<th>1954</th>
<th>HIGH</th>
<th>LOW</th>
<th>MEAN AVERAGE</th>
<th>MEDIAN AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan.</td>
<td>1 hr. 05 min.</td>
<td>05 min.</td>
<td>29.42 min.</td>
<td>20 min.</td>
</tr>
<tr>
<td>Feb.</td>
<td>2 &quot; 15 &quot;</td>
<td>05 &quot;</td>
<td>44.00 &quot;</td>
<td>35 &quot;</td>
</tr>
<tr>
<td>March</td>
<td>1 &quot; 00 &quot;</td>
<td>05 &quot;</td>
<td>27.12 &quot;</td>
<td>25 &quot;</td>
</tr>
<tr>
<td>April</td>
<td>5 &quot; 20 &quot;</td>
<td>00 &quot;</td>
<td>45.62 &quot;</td>
<td>27.5 &quot;</td>
</tr>
<tr>
<td>May</td>
<td>1 &quot; 05 &quot;</td>
<td>00 &quot;</td>
<td>25.00 &quot;</td>
<td>20 &quot;</td>
</tr>
<tr>
<td>June</td>
<td>1 &quot; 10 &quot;</td>
<td>05 &quot;</td>
<td>23.60 &quot;</td>
<td>15 &quot;</td>
</tr>
<tr>
<td>SIX MONTHS</td>
<td>5 hr. 20 min.</td>
<td>00 min.</td>
<td>32.13 min.</td>
<td>20 min.</td>
</tr>
</tbody>
</table>

The high figure of 5 hours 20 minutes for the transportation of the claims from one section to another seems unreasonably high, although no explanation is apparent from the face of the control sheets. The next highest figure was 2 hours 35 minutes, which also occurred in April. It will be noted that the mean average and the median average time both are higher for this step than they were for any of the other steps involving transportation.

### TABLE XXIV

**WORK TIME IN PLACING CLAIMS IN FILE FOLDERS**

<table>
<thead>
<tr>
<th>1954</th>
<th>HIGH</th>
<th>LOW</th>
<th>MEAN AVERAGE</th>
<th>MEDIAN AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan.</td>
<td>1 hr. 20 min.</td>
<td>04 min.</td>
<td>28.60 min.</td>
<td>25 min.</td>
</tr>
<tr>
<td>Feb.</td>
<td>1 &quot; 10 &quot;</td>
<td>10 &quot;</td>
<td>29.82 &quot;</td>
<td>30 &quot;</td>
</tr>
<tr>
<td>March</td>
<td>50 &quot;</td>
<td>05 &quot;</td>
<td>23.70 &quot;</td>
<td>25 &quot;</td>
</tr>
<tr>
<td>April</td>
<td>1 &quot; 00 &quot;</td>
<td>10 &quot;</td>
<td>22.38 &quot;</td>
<td>20 &quot;</td>
</tr>
<tr>
<td>May</td>
<td>1 &quot; 15 &quot;</td>
<td>05 &quot;</td>
<td>22.40 &quot;</td>
<td>20 &quot;</td>
</tr>
<tr>
<td>June</td>
<td>1 &quot; 25 &quot;</td>
<td>05 &quot;</td>
<td>24.42 &quot;</td>
<td>20 &quot;</td>
</tr>
<tr>
<td>SIX MONTHS</td>
<td>1 hr. 25 min.</td>
<td>04 min.</td>
<td>25.09 min.</td>
<td>25 min.</td>
</tr>
</tbody>
</table>
With reference to the preceding Table, the mean average for the various steps were added together for each of the six months and for the total of the six months. As a cross check against this the elapsed time for each control sheet was calculated from the time the work started each morning at 8:00 o’clock in the file room until the processing was finished and the claims were in individual folders and ready to be sent to the examining unit. Consistently the total obtained from adding the mean average time of the various steps was greater than the elapsed time obtained by calculating from 8:00 a.m. of the arrival date until the time the placing of the claims in their folders was completed.

### TABLE XXV

**VARIATION OF TIME CONSUMED BY DIFFERENT METHODS OF CALCULATION**

<table>
<thead>
<tr>
<th>Year</th>
<th>MEAN AVERAGE TIME WHEN SEPARATE STEPS WERE ADDED:</th>
<th>MEAN AVERAGE TIME WHEN USING ONLY FIRST AND LAST TIME FIGURE:</th>
<th>EXCESS OF FIRST AMOUNT OVER THE SECOND:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1954</td>
<td>Jan. 20 hr. 21.84 min. 20 hr. 23.63 min. 23.60 min.</td>
<td>20 hr. 00.24 min. 20 hr. 23.63 min. 21.60 min.</td>
<td>10.97 min.</td>
</tr>
<tr>
<td></td>
<td>Feb. 20 &quot; 34.60 &quot; 20 &quot; 23.63 &quot; 10.97 &quot;</td>
<td>20 &quot; 34.61 &quot; 20 &quot; 25.74 &quot; 8.87 &quot;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>March 20 &quot; 34.61 &quot; 20 &quot; 25.74 &quot; 8.87 &quot;</td>
<td>20 &quot; 45.35 &quot; 20 &quot; 36.23 &quot; 9.12 &quot;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>April 20 &quot; 45.35 &quot; 20 &quot; 36.23 &quot; 9.12 &quot;</td>
<td>20 &quot; 18.65 &quot; 20 &quot; 00.20 &quot; 18.45 &quot;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>May 20 &quot; 18.65 &quot; 20 &quot; 00.20 &quot; 18.45 &quot;</td>
<td>20 &quot; 17.06 &quot; 20 &quot; 09.09 &quot; 7.97 &quot;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>June 20 &quot; 17.06 &quot; 20 &quot; 09.09 &quot; 7.97 &quot;</td>
<td>20 hr. 28.18 min. 20 hr. 16.01 min. 12.27 min.</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX C

REAPPLICATIONS FOR ADDITIONAL OR MODIFIED AWARDS

After the first award upon the merits of a claim has been made, the claimant may have rights for further benefits which require the initiation of further applications by the claimant. These fit no definite pattern. Some of them can be disposed of primarily by the legal reviewers while others require the setting of an oral hearing in most or all cases.

In terms of the total workload of the commission, all except the application for a determination of permanent-partial disability involved only a small proportion of the special and oral hearings held. Nevertheless, each of the reapplications generally required more time than a new lost-time claim in their processing.

It is difficult to determine the extent to which the various rights which have led to a reapplication will be affected by the 1955 reorganization of the administration of workmen’s compensation. In most cases the right will remain and the administrator will have to devise procedures for processing them. Whether it will be done in the regional offices or primarily in the central office in Colum-
bus remains to be seen. Many of them involve a higher level of discretion than has been given to the claims examiners in the past. Some of the 1955 changes are designed to limit and discourage the number of applications for a determination of permanent-partial disability and the court appeal of these applications has been limited.

Applications for Determination of Percentage of Permanent-Partial Disability

Section 80 of the workmen’s compensation act\(^1\) dealt with all types of permanent-partial disability. The different subsections of section 80 showed several philosophies and techniques. Section 80a made little distinction as to whether the partial disability was permanent or temporary. Its benefits were based upon economic impairment as reflected in a smaller wage the claimant was able to earn after an injury. The commission checked his wage before and after the accident and awarded him two-thirds of the difference up to the weekly maximum ($32.50 in 1954). The writer participated only indirectly in the 1954 field study of permanent-partial disabilities. Where such indirect information is used, the Legislative Service Commission Study will be cited for documentation.

Subsection 80c contained a specific schedule of injuries dealing principally with amputations of members of

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\(^1\) 1465-80 G.C., 4123.57 R.C.
the body or ankylosis which rendered the member useless. In addition it contained provisions for the loss of sight of one eye or the loss of hearing of one or both ears. The schedule detailed what payments were to be for the loss of a specific finger, a hand, etc., so that usually there was involved only a medical question of the anatomical loss suffered by the claimant. Most schedule awards under subsection 80c were adjudicated by the claims examiners or legal reviewers, without notice or hearing, based upon the medical information in the files, but subject to an application for reconsideration by the full commission by either the claimant or the employer. If compensation was completely denied the claimant also had the right to request a rehearing.\(^2\)

This subsection is based upon concepts of indemnity to the claimant for his injury since the award under subsection 80c is in addition to payments of compensation for total-ttemporary disability made during the healing period. Even if the claimant had lost no time from work his entitlement under the schedule was not affected.

Section 80b was enacted to cover injuries which tended to affect the body as a whole rather than some specific member, such as permanent injuries to the back or head.

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\(^2\) Interview, Peter Pencheff, attorney examiner, claims section, who was in charge of processing applications for awards under section 80b, August 15, 1954.
This provision was adopted in 1941. There was a requirement that a determination of the extent of the permanent disability could not be made for a minimum of forty weeks after the claimant was able to return to work. This waiting period was designed to give time for maximum recovery from the injury. Under section 80b the claimant received an award in terms of a percentage of disability to the body as a whole. This percentage was applied to a period of two hundred fifty weeks to determine the number of weeks for which compensation should be paid. The weekly payments were at the same rate as those for total-temporary disability.

During the period immediately after injury claims involving a potential permanent disability were handled in a manner similar to any other total-temporary or medical-only claim. Until the summer of 1954, the procedure followed was to make a record on each claim where there was a potential permanent injury. When forty weeks had expired after the indicated date of ability to return to work, a notice was sent to the claimant by one of the five legal reviewers in the claims section. This was a form letter outlining his rights and enclosing a copy of the form upon which he could apply for a determination of the extent of any permanent-partial disability. Between half and three-

3 House Bill 558, 119 Ohio Laws 565.
quarters of the claimants receiving the letter and application form returned the completed application. In approximately half of the cases where the form was completed and returned, the claimant had engaged an attorney or lay representative to represent him. On about August 1, 1954, this practice of notifying the claimant of his rights under section 80b after forty weeks was discontinued.  

When an application for a determination under section 80b was made the file was checked to see that the proper time had elapsed, and a notice was sent to the employer of the application. If it had, the file was forwarded to the medical section where an examination of the claimant was arranged. The medical examination for the commission was conducted by one of the staff physicians or by an outside specialist if needed. In all cases a determination under section 80b was made at an informal oral hearing after notice before a board of claims or a deputy commissioner in Columbus. During 1953, there were 8,558 applications for a determination of percentage of permanent-partial disability disposed of by the commission. An award of additional benefits was made in approximately eighty-five percent of these cases.

4 Interview, Thompson, op. cit. (September 1, 1954)
5 Interview, Pencheff, op. cit.
6 Percentage based upon Annual Claims Report, 1953, op. cit.
During the summer of 1954, a study of six hundred fifty applications under section 80b was made by the Ohio Legislative Service Commission. This sample was approximately ten per cent of the estimated 6,500 such awards made between July 22, 1953 and July 21, 1954. The study showed considerable time elapsing between the time of the application and the date a decision was made. There was a mean average of 140.6 days in state-fund cases and 262.4 days in self-insurer cases, or a mean average of 177.2 days for all cases. It was found that delays of three to four months in scheduling an examination of the claimant by the commission's doctors were frequent. There was a time lapse of from one to five months between the report of the commission's doctor and the preparation of the legal reviewer's recommendation. The study further indicated that the amounts of compensation awarded in state-fund cases totalled 52.0% more than the award in cases involving self-insurers. An award is, of course, affected by the type of injury involved. When the cases in the sample were analyzed according to types, such as back injuries, head injuries, etc., the amount of the award in state-fund claims still was found to be consistently higher.7

The sample in the 1954 study showed that there was

7 Ohio Legislative Service Commission, op. cit., Part II, pp. 1-2. (See page 358 for documentation.)
a concentration of these claims in the hands of comparatively few lawyers. The record of one such specialist, who handled 14.6% of the cases in the sample, was that he obtained 94.3% higher permanent-partial compensation awards for his clients (before the deduction of his fee) than the claimants received who had no representation. In all cases where an attorney represented the claimant, the award was fifty per cent or more larger than that of an unrepresented claimant. Attorney's fees were estimated as ranging from twenty to twenty-five per cent of the award. The effectiveness of the attorneys no doubt had a bearing on the fact that there was representation of the claimant in approximately three-fourths of the permanent-partial claims.  

The 1955 session of the General Assembly considered again the problems involved in permanent-partial injuries. Sections 80a and 80c were left virtually the same, except for changing the maximum weekly payment from $32.20 to $40.25. However, several changes were made in section 80b, which gives awards based on a percentage of permanent disability rather than on economic impairment:

(B) The determination of the employee's permanent physical disability shall be based upon that pathological condition of the employee resulting from the injury and causing permanent physical impairment evidenced by medical or clinical findings reasonably demonstrable but if such findings are based solely upon

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8 Ibid., pp. 4-6.
the testimony of the claimant without corroboration by objective medical findings the commission shall cause a medical advisory board to determine whether the employee is physically disabled and the determination of the medical advisory board including its determination if any of the percentage of permanent physical disability of the employee shall be binding upon the commission . . . In the event compensation is computed for the purpose of paying fees for services rendered in the prosecution of a claim the commission shall, after hearing, fix the amount of such fees.9

In many of the claims there had been involved injuries which had produced complaints which were not readily "evidenced by medical or clinical findings reasonably demonstrable". This was especially true with head and back injuries. Employer groups had tended to look upon such situations as an opportunity for abuse of the section. Under the new amendment, such cases must be referred to a medical advisory board for a determination of whether there is any disability and, if there is any, its amount. This determination of the advisory board is binding upon the commission and may not be appealed to the courts. Thus this type of decision will be taken out of the hands of a hearing officer and given to medical experts. In all other types of situations, the opinions of the medical advisory boards are not binding on the commission or the regional boards of review.

9 Amended Substitute House Bill 700, 101st General Assembly, 4123.57 R. C.
Application to Modify a Previous Award

Where a party in interest wished to have the previous classification of a claim changed, the case could be initiated by the filing of an Application to Modify Previous Award (Form C-85). Such a proceeding affected the category of disability previously determined rather than the duration of the award. In case a claimant who had been receiving temporary-partial payments under section 80a became incapacitated for continuing light work he could use this method to obtain a determination of his right to have his classification changed to total-temporary and the disability payments changed accordingly. An application to modify a previous award was relatively rare.

Application for Additional Award Beyond the Date of Last Payment

In cases where there had been a break in the period of disability and medical treatment and in which the claimant at a later time again became disabled or required medical attention as a result of the same injury, it was necessary to use a special application for additional compensation in order to reopen the claim. Such applications were referred to the attorney examiners in the legal section. They might secure an investigation if it seemed to be indicated. On the basis of the information in the file they disposed of the more obvious cases of entitlement without an
oral hearing.¹⁰

**Cases Where the Right to Continue Receiving Compensation Was in Issue**

In some cases after an award of compensation had been made and payments had begun there might be a question raised either by the commission or by the employer of the claimant's right to continue receiving benefits under the original award. The employer sometimes felt that one of his employee-claimants was malingering or concealing his recovery or that the physician was prolonging the treatment. In some cases the commission itself might feel that recovery in a particular case was unduly slow. In cases where the issue centered on a medical question the commission might require the claimant to submit to its staff or by outside specialists.¹¹ Approximately half of such cases were disposed of by the legal reviewers without a hearing after notice.¹²

**Lump Sum Payments and Lump Sum Settlements**

The act provides that "the Industrial Commission, under special circumstances, and when the same is deemed advisable, may commute payments of compensation or benefits

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¹⁰ Interview, Thompson, *op. cit.* (August 17, 1954).
¹¹ *Loc. cit.*
¹² Based upon statistics in Annual Claims Report, 1953, *op. cit.*
to one or more lump sum payments.\textsuperscript{13} Where only a portion of
the potential payments is awarded, it is referred to as a
lump sum "payment". This is usually asked for where the
claimant needs a larger amount than he gets in weekly pay-
ments for some specific purpose, such as paying fees or
making a large purchase which will be to the benefit of the
claimant, as where a widow-claimant wishes to pay off the
mortgage on the home. Where all the potential payments are
awarded and the full rights of the claimant exhausted, it
is referred to as a lump sum "settlement". Since 1951,
final settlements can be made only by the commission itself
sitting \textit{en banc}.\textsuperscript{14}

By custom, the commission referred applications for
a lump sum settlement to four of the attorney examiners in
the legal section, who heard these applications on a part-
time basis in addition to their other work of reviewing
files and rendering legal opinions. These hearings were in-
formal with all the parties involved sitting around the
table. They were held in the morning, and at the end of a
hearing the parties were notified that the recommendation
of the hearing officer would be presented to the full com-
mission at 4:00 p.m. on the same day. If the parties were
present at that hour, they came to the hearing table and the

\textsuperscript{13} 1465-87 G. C., 4123.64 R. C.
\textsuperscript{14} 1465-87a G. C., 4123.65 R. C.
commissioners read the recommendation to the parties. Oral arguments were permitted at this time, but no new evidence might be presented. The commission made its decision at once and announced it to the parties present. Official notices of the decision were later sent to the parties in interest. The decision of the commission on granting lump sum payments or a lump sum settlement was final and not subject to a rehearing or a direct appeal to the courts. It has been the policy of the commission never to grant a lump sum settlement in a permanent-total disability claim.\textsuperscript{15} Under the 1955 legislation the Industrial Commission retained the sole right to decide upon applications for a lump sum award but the administrator may make recommendations on the subject to the commission.\textsuperscript{16}

Applications for Extra Benefits Because of Specific Safety Violations by Employer

A claimant can file for additional benefits in those cases where the injury has been caused by the employer's failure to observe some specific safety regulation or statute. This involves an extra award assessed against the employer by way of penalty. As a result it necessitates a separate hearing on the question of the penalty award

\textsuperscript{15} Interview, Brock, \textit{op. cit.}

\textsuperscript{16} 4121.121(J) R. C.
after a special investigation of the safety aspect of the case by an inspector in the safety and hygiene section. By custom, all hearings on safety violation applications were heard by the assistant supervisor of the legal section. After the hearing the hearing officer consulted orally with the members of the commission and received their decision. Notice of this decision was sent in writing to the parties in interest.\textsuperscript{17}

Applications for a Rehearing Under Section 90 of the Act

Section 90 of the workmen's compensation act permitted a rehearing only when the commission had denied compensation to the claimant upon one of eight grounds listed in the act. In cases where an award had been granted, but the claimant was dissatisfied with the amount, no basis for an application for a rehearing was furnished. However, this could be obtained collaterally by applying for an additional award. If the additional award were refused, it became the grounds for an application for a rehearing.\textsuperscript{18}

Other Types of Additional Hearings

Under the sections of the act relating to occupational disease, the claimant who had been denied compensa-

\textsuperscript{17} Interview, Brock, op. cit.

\textsuperscript{18} Interview, Homer H. Hickling, Supervisor, Legal Section, August 6, 1954.
tion benefits for an occupational disease had certain rights
to apply for a hearing before a silicosis referee or a medi­
cal board of review, or both. Most of these applications
for the new medical hearing were passed upon by the legal
reviewers with a small percentage being reconsidered by the
commission at an oral hearing.

In cases where a separate hearing before a medical
board of review was given before a board of doctors, the
legal section would furnish an attorney examiner to preside
over the hearing. He merely passed upon the admissibility
of evidence and did not enter into the decision of the medi­
cal issues involved.19

19 Loc. cit.
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SELECTED BIBLIOGRAPHY

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I, William Elbert Biggs, was born in Crystal Springs, Mississippi, December 4, 1915. I received my secondary education in the public schools of that city and of Louisville, Kentucky. My undergraduate training was obtained at the University of Louisville, from which I received the degrees of Bachelor of Arts in 1938, Bachelor of Law in 1940, and Master of Arts in 1949. I practiced law in Louisville, Kentucky from 1940 until 1948, excluding the period of World War II. A portion of this practice consisted of adjusting and defending workmen’s compensation claims for private insurance companies. While in residence at Ohio State University I acted in the capacity of a teaching graduate assistant in 1949-50, and assistant in 1950-51 in the Department of Political Science. I was an instructor in the Department of Government and Politics at the University of Maryland during the fall semester, 1951. From spring 1952 through 1954-55 I was an assistant professor in the Department of Government and Public Administration at The American University, and since fall 1955 I have been an associate professor.