The Hidden Cost of Misplaced Incentives

Misplaced Financial Incentives in Workers' Compensation Undermine the Optimum Outcome for Injured Workers and Employers

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Abstract

Workers' compensation systems are undermined by misaligned financial incentives that produce predictable but unintended consequences for injured workers, employers, and the system itself. The problem is structural rather than personal. Participants respond rationally to the incentives placed before them, so reform requires changing the structure rather than exhorting the people working inside it.

This paper defines an Ideal Workers' Compensation System as the benchmark for evaluating any incentive. It sets out the axioms explaining how financial structures drive behavior, classifies the recurring forms of misalignment, and examines the biases that allow them to persist. It then supplies the Incentive Evaluation Framework, a method for testing proposed laws, regulations, payment methodologies, and business practices before adoption and revalidating them afterward. Its central question is whether an incentive working exactly as designed leaves the injured worker, the employer, and the system all better off.

Many of the most damaging structures are entirely lawful and consistent with professional norms. Those require redesign, not additional rules or appeals to ethics. Written for legislators, regulators, employers, payers, medical providers, and vendors, the paper is supported by five companion documents that supply the standard, the evidence, and a compendium of known misplaced incentives organized by functional responsibility.

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Introduction

Workers' Compensation was established to provide prompt, adequate, and consistent benefits to legitimately injured workers while protecting employers through a no-fault system. Legislators, regulators, and employers have largely pursued that intent in good faith.

What they have not always understood is that unintended consequences from the financial incentives in the system undermine the very goals the workers' compensation system is intended to achieve. The system loses its legitimacy when the unintended consequences of misplaced financial incentives drive up costs and impair the provision of benefits.

workers' compensation has accumulated decades of such unintended consequences. Benefits are paid, and claims are processed, yet the system consistently falls short of what an ideal system should deliver: injury prevention, quality care, adequate compensation, functional recovery, and durable return to work.

This paper was written to educate legislators, regulators, employers, third-party administrators (TPAs), insurance companies, medical providers, and industry vendors about this problem, to help them recognize where financial incentives have gone wrong, and to encourage everyone to return the system to its foundational goals.

The purpose of this paper is not to criticize the individuals or organizations that participate in the workers' compensation system. Most participants are attempting to fulfill their responsibilities within the financial, legal, and organizational structures that govern their work. The purpose of this paper is to examine those underlying structures, identify where they create unintended consequences, and provide a framework for redesigning incentives so the system more consistently achieves its intended objectives.

The Ideal System

The Ideal Workers' Compensation System establishes the standard against which every financial incentive and its unintended consequences should be evaluated. Without first defining what the system is intended to accomplish, it is impossible to determine whether a particular incentive moves the system toward its objectives or away from them.

Foundational Objectives of Workers' Compensation

- Prevent workplace injuries.
- Provide prompt, quality medical care.
- Return injured workers to productive employment.
- Provide adequate compensation during recovery and for permanent disability or impairment.
- Resolve claims efficiently and fairly in a cost-effective manner.

Appendix A, "The Ideal Workers' Compensation System," is a detailed explanation of the objectives of workers' compensation. It is the essential foundation of this entire paper.

Financial Incentives and Unintended Consequences

A financial incentive is any payment structure, benefit formula, fee schedule, or procedural rule that attaches a financial consequence to a specific behavior. Financial incentives can have unintended consequences, positive or negative, that may be financial, social, or personal, such as prolonged disability or loss of an occupation.

The axioms explain how financial incentives (and their unintended consequences) behave in the workers' compensation system. They describe how financial structures reliably produce behavior, regardless of intent.

1. **Every Financial Structure Creates Incentives.**
2. **Most Participants Respond Rationally to Incentives.**
3. **Systems Produce What They Reward.**
4. **Every Incentive Has Unintended Consequences.**
5. **Incentives Never Operate Alone.**
6. **Participants Adapt.**
7. **Some Misplaced Incentives Cannot Be Removed.**
8. **An Incentive Succeeds Only If It Improves the Overall Performance of the Workers' Compensation System.**
9. **Every Incentive Requires Revalidation.**
10. **Measured Objectives Displace Unmeasured Ones.**

These axioms are not theories or opinions. They describe the predictable behavior of financial incentive systems. Every misplaced financial incentive discussed in this paper can be understood as one or more of these axioms operating simultaneously.

Guiding Principle

Most professionals responding to misaligned financial incentives are not acting unethically. They are responding rationally to the financial structures in which they work.

Lasting reform, therefore, requires changing the incentive structure rather than expecting participants to consistently act against their own financial interests. Ethics, professionalism, and disclosure remain essential, but they cannot reliably overcome financial structures that reward different behaviors.

The axioms explain why misplaced financial incentives consistently produce unintended consequences. The next question is practical: what forms do those incentive structures take? Although the specific circumstances vary, most misplaced financial incentives arise through a limited number of recurring structural forms. Identifying those forms allows policymakers and practitioners to recognize them before they become embedded in the system.

Typology of Misplaced Financial Incentives

The following typology identifies the recurring structural mechanisms through which misplaced financial incentives influence behavior and produce unintended consequences within the workers' compensation system. The typology is intended as a practical framework for identifying existing misalignments, evaluating proposed reforms, and anticipating unintended consequences before they become embedded in the system. These are not mutually exclusive. Most significant system problems result from several operating simultaneously.

How Incentives Are Created

1. **Regulatory Misalignment.** Laws, regulations, or administrative requirements unintentionally encourage behavior that conflicts with the fundamental objectives of the workers' compensation system.

2. **Misaligned Performance Metrics.** Organizations optimize the outcomes they measure, even when those metrics do not reflect the system's intended objectives.

3. **Volume Over Value.** Compensation systems reward the quantity of services provided rather than the value or outcomes those services produce.

4. **Conflicting Financial Incentives.** Different participants are rewarded for decisions that benefit their own interests rather than the overall performance of the workers' compensation system.

How People Respond to Incentives

5. **Short-Term vs. Long-Term Incentives.** Immediate financial gains are rewarded even when they increase long-term costs, disability, or claim duration.

6. **Adversarial Incentives.** The financial structure rewards conflict, delay, or litigation instead of cooperation, recovery, and timely claim resolution.

How Organizations Respond to Incentives

7. **Organizational Silos.** Departments and organizations optimize their own performance measures, even when doing so harms the overall workers' compensation system.

8. **Cost Shifting.** Costs are shifted from one stakeholder to another rather than being reduced, creating the appearance of savings while increasing overall system costs.

9. **Risk Without Responsibility.** Organizations or individuals receive the benefits of decisions while transferring the associated risks or costs to others.

10. **Innovation Disincentives.** Financial or regulatory structures discourage investment in new approaches, technology, or practices that could improve outcomes.

How the System Ultimately Fails

11. **Information Asymmetry.** Unequal access to information distorts decision-making, weakens accountability, and creates opportunities for unintended consequences.

12. **Accountability Gaps.** Those making decisions often do not bear the financial or operational consequences of those decisions.

Appendix B, "The Typology of Misplaced Financial Incentives," develops each type in full and is available for the reader to reference.

Cognitive Biases and Unintended Consequences

Financial incentives do not operate in isolation. They operate within organizations led by intelligent, experienced professionals who are attempting to drive positive outcomes. Yet well-intentioned laws, regulations, payment systems, contracts, and business practices often produce unintended consequences.

One reason is that human decision-making is influenced by many predictable cognitive biases. These biases do not reflect dishonesty or incompetence. They are normal patterns of thinking that affect how individuals and organizations interpret information, evaluate success, and respond to complex systems.

These biases are numerous and intertwined. Understanding even a few of them helps explain why misplaced financial incentives are often overlooked even after their unintended consequences become apparent. Sometimes these biases even compound the negative effects of unintended consequences.

1. Confirmation Bias

Organizations naturally seek evidence that confirms existing beliefs while giving less attention to evidence that challenges them.

When a program appears successful based on a limited set of metrics, contradictory evidence may be dismissed as anecdotal or exceptional. As a result, incentive structures that no longer support the objectives of the workers' compensation system may continue long after their effectiveness has declined.

2. Status Quo Bias

Existing financial structures often become accepted simply because they have existed for many years.

Participants adapt to established systems and gradually come to believe that current practices are the best or only way to achieve the system's objectives. Long-standing incentive structures, therefore, receive less critical examination than newly proposed reforms.

3. Silo Thinking

Organizations frequently optimize the performance of individual departments rather than the workers' compensation system as a whole.

Claims administrators, medical providers, employers, regulators, attorneys, and vendors may each improve their own performance measures while unintentionally reducing the effectiveness of the overall system. Local optimization does not necessarily yield a global optimum.

4. Outcome Bias

Successful outcomes do not necessarily validate the incentive structure that produced them.

Experienced professionals often compensate for weaknesses in poorly designed systems through extraordinary effort and judgment. Their success can conceal structural problems until personnel change, technology evolves, or external conditions shift.

The absence of visible failure should never be mistaken for evidence that an incentive structure is properly aligned.

5. Incentive Blindness

Organizations often evaluate decisions based on their stated intentions rather than the behaviors they actually reward.

A policy intended to reduce costs may unintentionally discourage early treatment. A payment system intended to improve access may reward unnecessary utilization. A performance metric intended to improve efficiency may inadvertently encourage premature claim closure.

The critical question is never simply, "What was the intent?" The more important question is, "What behavior does this structure consistently reward?"

6. Attribution Bias

Poor outcomes are frequently attributed to individual participants rather than to the incentive structures within which they operate.

Workers' compensation has often responded to poor outcomes by imposing additional rules, education, oversight, or ethical requirements. While professionalism and accountability remain essential, most participants are responding rationally to the financial structures surrounding them.

Improving outcomes, therefore, requires redesigning incentive structures rather than assuming individuals will consistently act contrary to their own incentives.

Recognizing these cognitive biases does not eliminate unintended consequences. It does, however, improve our ability to identify them before they become embedded within the workers' compensation system.

If cognitive biases make it difficult to recognize misplaced incentives through intuition alone, then a structured decision-making process becomes essential. The Incentive Evaluation Framework is intended to provide that discipline.

Appendix C, "Cognitive and Organizational Biases," sets out the full set of biases, explains how each operates in workers' compensation, and is available for the reader to reference.

The Incentive Evaluation Framework

Every proposed law, regulation, payment methodology, administrative procedure, or business practice should be evaluated using the following framework before implementation. The purpose is not merely to identify financial incentives but to determine whether the proposed structure advances or undermines the foundational objectives of the workers' compensation system.

Each question flows directly from the Ideal Workers' Compensation System, the Axioms, and the Typology.

Step 1 — Does This Advance the Ideal Workers' Compensation System?

Start with destination, not mechanics. Ask whether the proposed structure advances the workers' compensation system's foundational objectives. Does it:

- Prevent workplace injuries?
- Improve quality and timeliness of medical care?
- Promote functional recovery?
- Encourage timely return to productive employment?
- Provide fair and adequate compensation?
- Improve the efficiency, fairness, and cost-effectiveness of the overall system?
- Reduce unnecessary disability, depression, family disruption, and other poor long-term outcomes?

If the answer is no, the proposal should be reconsidered before implementation.

Step 2 — What Behavior Does This Structure Reward?

Every incentive rewards some behavior. The critical question is not what the proposal intends to accomplish. The critical question is: **what behavior becomes more likely because of this structure?**

Examples include:

- More treatment
- Better treatment

- More litigation
- Earlier reporting
- Delayed reporting
- Faster recovery
- Greater disability
- Prevention
- Cooperation
- Cost shifting
- Administrative delay

Systems ultimately produce the behaviors they reward.

Step 3 — Which Type of Incentive Is Being Created?

Classify the mechanism using Typology. Does the proposal create or reinforce:

- Regulatory Misalignment?
- Misaligned Performance Metrics?
- Volume Over Value?
- Conflicting Financial Incentives?
- Short-Term vs. Long-Term Incentives?
- Adversarial Incentives?
- Organizational Silos?

- Cost Shifting?
- Risk Without Responsibility?
- Innovation Disincentives?
- Information Asymmetry?
- Accountability Gaps?

The most significant problems involve several types operating simultaneously. Classification helps anticipate recurring problems that have appeared elsewhere in the system.

Step 4 — How Will Rational Participants Respond?

Assume that participants are intelligent, experienced, and generally acting in good faith. Then ask: **How would a rational participant respond to this incentive?**

This question removes the discussion from the realm of morality. Professionals generally respond rationally to the structures within which they work. The objective is to predict behavior, not assign blame.

Step 5 — What Unintended Consequences Are Likely?

Every incentive produces consequences beyond those originally intended. Consider not only financial effects but also clinical, operational, organizational, and human consequences. Possible questions include:

- Will disability increase?

- Will recovery slow?
- Will depression become more common?
- Will return to work decline?
- Will litigation increase?
- Will costs merely shift elsewhere?
- Will communication improve or deteriorate?
- Will decision-making become more objective or more conflicted?
- Who bears the unintended burden?

The objective is to anticipate the second- and third-order consequences before they become embedded in the system.

Step 6 — How Will Success Be Measured and Revalidated?

No incentive should be considered permanent. Determine in advance:

- What outcomes will be measured?
- How often will they be reviewed?
- What unintended consequences will be monitored?
- Under what conditions will the incentive be modified or eliminated?

Systems evolve. Medical practice evolves. Technology evolves. Participant behavior evolves. Financial incentives must evolve as well.

The Central Question

Throughout this evaluation, one practical question should always be kept in mind: **if this incentive works exactly as designed, will the injured worker, the employer, and the workers' compensation system all be better off?**

If the answer is uncertain, additional analysis is required. If the answer is no, the incentive is misaligned regardless of how well-intended it may be.

> **Guiding Principle**
>
> Whenever financial inducement exceeds accountability, behavioral distortion becomes more likely.

Appendix E, "Compendium of Known Misplaced Financial Incentives," lists the known misplaced incentives by functional responsibility and is available for the reader to reference.

Redesigning the Incentives

The Appendix E typology and compendium describe the current system. Appendix A sets out the destination. Every misalignment documented in this paper can be measured against that standard.

Guiding Principle

The objective of reform is not to eliminate incentives. Incentives are the mechanism through which aligned systems produce good outcomes.

The objective is to align incentives with prevention, recovery, functional restoration, adequate financial resources during disability, and durable return to work.

Where a misplaced incentive lives determines who can repair it.

Some are written into statutes, regulations, or fee schedules. The presumption attached to a treating physician's opinion, the fee structure that ties injured worker attorney compensation to the size of the disability award, the schedule that converts impairment into money — these are creatures of law. No employer, carrier, or medical provider can change them unilaterally. Correcting them requires legislative or regulatory action, which takes years and lasts only as long as the coalition that produced it remains in power.

Others live in contracts, performance metrics, compensation plans, vendor agreements, and internal policy. An adjuster measured on claim closure rather than claim outcome. A caseload that makes early contact impossible. A vendor paid for each review performed rather than for each dispute resolved. None of these requires a statute. Parties created them as an agreement, and those parties can change them at the next renewal.

Confusing the two categories produces predictable waste. An operational misalignment treated as a legal problem waits for a legislature that was never needed. A legal misalignment treated as an operational problem produces task forces, contract language, and best-practice guidance that cannot reach the structure generating the behavior.

Before proposing reforms, identify who controls the structure. Read the compendium in Appendix E with that question in hand. For each entry, ask who wrote it, and the available remedy usually becomes obvious.

Conclusion

Misplaced incentives produce predictable reactions within a Newtonian system. Before enacting reform, policymakers must evaluate which behaviors are being rewarded and anticipate cascading effects. After implementation, outcomes must be monitored honestly and adjusted courageously. The destination is not abstract—Appendix A, *The Ideal Workers' Compensation System*, defines the design principles that a well-aligned system would embody. The present paper maps the structural obstacles between the current system and that goal.

The workers' compensation system has never lacked dedicated professionals. It has lacked a systematic method for identifying, evaluating, and redesigning the financial incentives that shape their decisions. That is the purpose of this paper. The goal is not to eliminate financial incentives, but to align them with the objectives the system was created to achieve. When

incentives reward prevention, recovery, timely return to work, fairness, and accountability, better outcomes become not merely possible but predictable.

Appendix A — The Ideal Workers' Compensation System

Design Principles for a Well-Aligned System

Purpose and Role in the Series

This paper defines what a workers' compensation system would look like if its financial incentives, benefit structures, procedural rules, and accountability mechanisms were fully aligned with its foundational objectives. It serves as the destination — the design standard against which the current system's misalignments can be measured.

Every workers' compensation system, regardless of jurisdiction, reflects a series of policy choices. Those choices determine how financial incentives are distributed among participants and, ultimately, the outcomes the system consistently produces. The principles described in this appendix represent the policy choices most likely to align those incentives with the fundamental objectives of workers' compensation.

The companion paper, *The Hidden Cost of Misplaced Incentives*, maps the structural obstacles between the current system and the principles described here. Appendix B sets the typology of misplaced financial incentives. Appendix C explains why cognitive biases make those incentives resistant to reform. Appendix E catalogs the known misplaced financial incentives operating in workers' compensation, organized by functional responsibility.

The principles in this paper represent an ideal within the existing workers' compensation framework — not an ideal in the absolute sense. A system designed from first principles might look quite different. Medical care for occupational injuries might be delivered entirely through group health plans, with workers' compensation serving only as a wage-replacement and disability-reimbursement system. Wage replacement itself might be better administered through a unified disability insurance structure. These are legitimate design alternatives that other countries have adopted in whole or in part. The principles described here do not foreclose those larger questions. They describe what the current system would look like if its financial incentives, benefit structures, procedural rules, and accountability mechanisms were fully aligned with its foundational objectives — the best version of what we have, rather than a defense of having it. Each reflects a design choice that could be made by a legislature, regulator, employer, or claims organization. Taken together, they describe a system that serves the two parties workers' compensation exists to serve — the injured worker and the employer — with all other participants aligned to support rather than supplant those primary interests.

The Foundational Objectives

An ideal workers' compensation system is designed to achieve five objectives, in order of priority:

1. Prevent workplace injuries.

2. Provide prompt, quality medical care.
3. Return injured workers to productive employment.
4. Provide adequate compensation during recovery and for permanent disability or impairment.
5. Resolve claims efficiently and fairly.

The two primary parties to workers' compensation are the injured worker and the employer. Regulators play a distinct role: they ensure the system remains aligned with its foundational objectives and that all participants are held accountable. All other participants serve the system in supporting roles. A well-aligned system recognizes these distinctions and structures its financial incentives accordingly.

Characteristics of an Ideal Workers' Compensation System

At the highest level, an ideal workers' compensation system:

- Encourages timely reporting.
- Encourages timely treatment.
- Uses objective medical evidence as the basis for decisions.
- Treats similarly situated workers consistently.
- Coordinates with adjacent benefit systems rather than shifting cost to them.
- Aligns incentives for every participant.
- Learns continuously.

The Twenty-Seven Design Principles

These principles describe what a well-aligned workers' compensation system does. Each principle identifies both the design requirement and the misalignment it is intended to prevent.

Objective 1 — Prevent Workplace Injuries

1. **Promotes high safety standards in the workplace by incentivizing and mandating shared responsibility between employers and employees.**

   Safety is a shared obligation. The system creates financial and regulatory signals that reward proactive injury prevention by both parties — rather than simply penalizing injuries after they occur. Chargeback programs, experience modification systems, and safety incentive structures should all be designed to meet this standard.

2. **Engages and mandates the worker's participation in safety programs, medical treatment, benefit processes, recovery, and return to work.**

   Injured worker engagement is both a right and a responsibility. The system should communicate clearly, in the worker's native language, what is expected at each stage. Passive participation in recovery is a predictable product of systems that do not actively engage workers — and it is expensive for all parties.

Objective 2 — Provide Prompt, Quality Medical Care

3. **Provides prompt, necessary, and appropriate medical care to enable maximum medical improvement and functional recovery.**

   The right care at the right time produces the best outcomes and the lowest total cost. More care is not always better care. Delays in authorization, volume-based payment structures, and over-reliance on passive treatment all undermine this principle. Medical decisions should be made by medical professionals using evidence-based criteria — not by administrative processes designed around cost containment.

4. **Applies evidence-based criteria to determine claim compensability, appropriate medical care, and impairment and disability conclusions. Supports all medically appropriate treatment evaluated against those standards.**

   Inconsistent compensability determinations, variable medical authorization standards, and subjective impairment rating practices all produce adversarial behavior by creating a financial incentive to contest every decision. Evidence-based medicine provides the standard against which the necessity of treatment, causation, and impairment should be measured. When clinical evidence is applied consistently, the value of adversarial medical opinion diminishes. Where it is not, competing medical opinions become a financial instrument rather than a clinical one. Clear criteria, consistently applied, reduce litigation by reducing the value of uncertainty as a strategic resource.

5. **Coordinates systematically with other benefit programs, including group health, mental health, LTD, STD, FEHA, ADA, and public and private disability and healthcare systems, to ensure comprehensive coverage and prevent cost-shifting between systems — not to reduce or offset benefits available to the injured worker.**

   Injured workers exist within a web of benefit programs. An ideal system coordinates proactively with all of them — both to ensure workers receive the full range of benefits available and to prevent the cost-shifting and venue arbitrage that payment differentials between systems otherwise produce. Pharmacy coordination between workers' compensation and group health to prevent adverse drug interactions is one concrete application of this principle.

6. **Keeps injured workers informed and engaged throughout the process, particularly regarding decisions, benefits, expectations, next steps, and**

timelines. Encourages timely, accurate, and clear communication among all stakeholders across all available platforms.

Injured workers who do not understand what is happening to their claim, why decisions were made, and what to expect next are more likely to hire attorneys, less likely to cooperate with medical treatment, and less likely to return to work. Proactive communication is not a courtesy. It is a cost management strategy. Nothing beats speaking in person to the injured worker in their native language to explain the workers' compensation system and the benefits available to them. Few organizations do so. Communication failures among the other participants produce the same results at the system scale: misunderstanding, mistrust, litigation, and elevated costs.

Objective 3 — Return Injured Workers to Productive Employment

7. **Encourages timely return to work through light duty, modified assignments, transitional programs, alternative roles, and permanent accommodations.**

   Return to work is the main predictor of long-term recovery outcomes. It reduces permanent disability, improves functional restoration, and reduces total claim cost. Every employer should provide light or modified work. Employers who offer degrading busywork or require resignation as a condition of settlement undermine recovery and invite litigation. Failure to return to work is an economic and social disaster for the injured worker — it also reduces life expectancy.

8. **Recognizes that employers with few workers have far less capacity to implement programs and processes than large employers, and applies proportionate requirements accordingly rather than holding all employers to a single standard.**

   Small employers face genuine capacity constraints in providing modified duty, managing claims, and funding extended disability. A well-designed system provides mechanisms — shared industry funds, state-managed return-to-work programs, proportionate regulatory requirements — rather than applying large-employer standards uniformly.

Objective 4 — Provide Adequate Compensation During Recovery and for Permanent Disability or Impairment

9. **Offers prompt, fair, fixed benefits within a no-fault system to legitimately injured workers, ensuring they are treated with the fairness and equity they deserve.**

   The no-fault bargain — employer immunity in exchange for guaranteed benefits — is the foundation of workers' compensation. Prompt, fair delivery of that bargain reduces adversarial behavior. Delay, denial, and contest of legitimate claims destroy the foundation and create conditions for litigation, attorney involvement, and elevated system costs.

10. **Provides clear, straightforward, and standardized benefit definitions easily applied to all instances with consistent outcomes.**

    Ambiguous benefit definitions create a financial incentive for dispute. Every term that can be argued is a term that will be argued. Standardized definitions with consistent application reduce the value of litigation as a benefit-maximization strategy.

11. **Supplies a sufficient financial safety net to allow injured employees to meet their essential financial obligations while temporarily disabled.**

    Temporary disability benefits that fall below essential financial needs create pressure to exaggerate injury, delay recovery, or pursue permanent disability ratings as the only available financial solution. The three-day waiting period, which costs minimum-wage workers a quarter of their monthly income, is a structural failure that produces predictable downstream costs.

12. **Compensates fairly for permanent body part loss or function, ideally using scientific, consistent, replicable national standards.**

    Permanent disability rating is the financial foundation of most disputed claims. Where ratings are subjective, inconsistent, or based on instruments not validated for workers' compensation use, the rating becomes a negotiating position rather than a clinical finding. Consistent, scientifically valid national standards remove the financial incentive to contest every impairment conclusion.

13. **Provides employers and co-workers with legal immunity via the exclusive remedy doctrine, with limited exceptions.**

    The exclusive remedy bargain is the structural foundation of the system. Where it is reliably enforced, employers and co-workers can focus on safety and recovery rather than litigation risk. Where it is routinely circumvented, the system's foundational incentive for employer participation — immunity from tort liability — is undermined.

14. **Ensures universal coverage of all workers. Regardless of the jurisdiction.**

    Independent contractor misclassification, PEO structures used to circumvent experience modification accountability, and other coverage avoidance mechanisms shift the cost of occupational injuries from employers to workers and public programs. Universal coverage closes these gaps and eliminates the financial incentive to misclassify workers to avoid coverage obligations.

Objective 5 — Resolve Claims Efficiently and Fairly

15. **Encourages and mandates prompt reporting of claims, timely determination of all disputes, prompt provision of benefits, and finalization of claims within a reasonable timeline.**

    Delay is one of the most reliable predictors of elevated claim cost. Every day between injury and first treatment, between evaluation and report production, and between hearing and decision degrades outcomes for injured workers and increases costs for

employers. Enforceable timelines are not optional features — they are core system design requirements.

16. **Promotes cooperation among participants whenever cooperation improves outcomes. Reserves adversarial processes for disputes that cannot reasonably be resolved through evidence-based collaboration.**

    Adversarial process is slow, expensive, and corrosive to recovery. It is also sometimes necessary. A well-designed system makes cooperation the default and litigation the exception by removing the financial reward for conflict through consistent criteria, accessible informal resolution, and fee structures that do not increase with the duration of the dispute. Where the structure pays more for fighting than for finishing, cooperation becomes an act of financial self-sacrifice, and few participants will sustain it.

17. **Provides non-judicial dispute resolution processes accessible to all parties without requiring legal representation for routine matters, reducing reliance on court litigation.**

    When dispute resolution requires legal representation to navigate effectively, the system creates financial incentive for legal involvement in claims that should not require it. Attorneys become structurally necessary for access rather than strategically chosen for complex disputes. An ideal system is navigable by injured workers without legal assistance for routine matters.

18. **Offers consistent benefits to all injured workers, regardless of whether they have legal representation.**

    If the presence of legal representation systematically increases benefit recovery, the system has created financial incentive for attorney involvement in every claim regardless of merit or complexity. Consistent benefit delivery regardless of representation removes this structural inducement.

19. **Identifies and eliminates fraud or abuse by any participant, permanently removing bad actors from the system.**

    Fraud is not a moral aberration — it is a structural consequence of insufficient accountability. Where enforcement is weak, penalties are minimal, and detection is unlikely, the financial logic of fraud is straightforward. An ideal system makes detection likely, consequences severe, and removal permanent.

System Design and Governance

20. **Respects and appreciates all constituents and service providers while focusing on serving the injured worker and the employer.**

    An ideal system treats every participant with professional respect while maintaining clarity about whose interests the system primarily serves. Service providers must be partners in delivering outcomes, not ends in themselves. This principle guards

against systems that become captured by the financial interests of their intermediaries.

21. **Aligns financial incentives to promote injury prevention, timely benefit provision, recovery, and return to work, recognizing that disincentives are not limited to penalties and incentives are not limited to direct financial rewards.**

    This is the central design principle of the series. Every financial structure in the system creates a behavioral signal. The question is not whether incentives exist — they always do — but whether they are aligned with the system's goals. Payment structures, benefit formulas, fee schedules, attorney compensation, administrative fees, and regulatory penalties are all incentive structures. Each should be designed to reward the behavior the system seeks and evaluated annually for unintended consequences.

22. **Supports employers' economic competitiveness in the global market.**

    Workers' compensation is a cost of doing business, and a system whose cost is out of line with comparable jurisdictions drives employment elsewhere. That harms the workers the system exists to protect. Cost control is not opposed to worker protection. A system that becomes unaffordable stops protecting anyone. The objective is not the lowest possible cost but the lowest cost consistent with prevention, prompt care, adequate benefits, and durable return to work.

23. **Defines specific, measurable goals and expectations for all participants, including timely decisions and communications by claims administrators, employers, medical professionals, and adjudicators.**

    Accountability requires measurement. Where performance expectations are vague or unenforceable, participants optimize for their own financial interests rather than system outcomes. Specific, measurable standards for every participant category — with consequences for non-performance — are the structural foundation of accountability.

24. **Collects and analyzes data necessary to evaluate cost trends and progress toward systemic goals, ensuring employers, employees, payers, and regulators are informed and confident in the system's transparency.**

    The workers' compensation industry lacks a comprehensive data dictionary or glossary. This impairs jurisdictional comparison, program effectiveness evaluation, and provider accountability — and will impair the quality of AI tools built on this data and their output. An ideal system establishes and enforces data standards, requires outcome reporting from all participant categories, and makes comparative performance data available to all stakeholders.

25. **Maintains effective administrative and adjudicatory oversight to ensure proper function and safeguard benefits in case of insolvency.**

Oversight without enforcement is theater. Self-insured employer qualification standards that are not enforced, TPA performance contracts without audit rights, carrier reserve adequacy requirements without examination, and provider credentialing systems that do not share disciplinary information across states all represent structural accountability failures. An ideal system maintains the resources, authority, and political will to enforce the standards it establishes.

26. **Protects whistleblowers.**

    Much of what is known about misplaced incentives comes from people inside the system who reported what they saw. Where retaliation is possible and protection is weak, the information the system most needs never surfaces. Whistleblower protection is an information-integrity mechanism rather than merely an employment right, and it is the practical precondition for the outcome reporting and oversight described elsewhere throughout these principles.

27. **Routinely reviews and adjusts its structure and mandates to ensure alignment with objectives and system effectiveness.**

    Every financial structure produces unintended consequences. An ideal system builds the review mechanism into its design — not as a response to crisis, but as a standard operating procedure. Annual review of incentive structures, benefit adequacy, enforcement effectiveness, and outcome data is how the system learns, adapts, and maintains alignment with its foundational objectives over time.

Relationship to Companion Documents

This appendix defines the destination. Appendix B classifies the structures that produce misalignment, Appendices C and D explain why they persist, and Appendix E catalogs the known instances against which this standard can be applied.

> *The objective of reform is not to eliminate incentives — incentives are the mechanism through which aligned systems produce good outcomes. The objective is to align incentives with prevention, recovery, functional restoration, adequate financial resources during disability, and durable return to work. This paper describes what that alignment looks like.*

Appendix B — Typology of Misplaced Financial Incentives

A Diagnostic Framework for Identifying Structural Misalignment

Purpose and Scope

This appendix provides a typology for identifying and analyzing misplaced financial incentives in workers' compensation systems. A typology is more than a list of examples. It is a classification system that identifies the recurring structural forms through which financial arrangements influence behavior and produce outcomes that deviate from the system's objectives.

The types are not mutually exclusive. The most significant problems involve more than one type of misalignment occurring simultaneously. A payment structure may simultaneously reward volume, encourage short-term decision-making, exploit information asymmetry, and avoid accountability. The types, therefore, should be used as overlapping diagnostic lenses rather than as isolated boxes.

The central question is the same throughout this framework: whose check gets bigger when this goes wrong? Ask it about any payment structure, benefit formula, or procedural rule, and the type it belongs to becomes visible.

This appendix is intended for legislators, regulators, employers, insurers, claims administrators, medical providers, attorneys, vendors, labor representatives, and others who design, operate, or evaluate workers' compensation systems. It can be applied to existing practices and proposed laws, regulations, contracts, payment systems, organizational metrics, and technology deployments.

How to Use the Typology

Each type is presented using the same structure: a definition, diagnostic signal, discussion, common examples, and implications.

The framework should be used before implementation to identify foreseeable misalignment and after implementation to identify unintended consequences. It should also be used during periodic revalidation because participants adapt, markets change, technology alters behavior, and incentives that once worked may later become counterproductive.

How Incentives Are Created: Regulatory Misalignment; Misaligned Performance Metrics; Volume Over Value; Conflicting Financial Incentives.

How People Respond: Short-Term vs. Long-Term Incentives; Adversarial Incentives.

How Organizations Respond: Organizational Silos; Cost Shifting; Risk Without Responsibility; Innovation Disincentives.

How the System Ultimately Fails: Information Asymmetry; Accountability Gaps.

How Incentives Are Created

Regulatory Misalignment

Definition. Laws, regulations, benefit formulas, fee schedules, administrative requirements, or enforcement structures that reward behavior inconsistent with the objectives of the workers' compensation system.

Diagnostic signal. Compliance with the rule produces behavior that is legally correct but operationally counterproductive.

Discussion

Regulation is necessary, but every regulatory structure also creates incentives. A rule designed to prevent abuse may generate delay, encourage defensive behavior, increase procedural activity, or shift attention away from recovery. Regulatory misalignment occurs when the behavior needed to follow the rule differs from the behavior needed to achieve the best overall outcome.

Common examples

- Deadlines or documentation requirements that increase procedural activity without improving decisions.
- Benefit or reimbursement rules that unintentionally reward greater disability or longer claim duration.
- Penalty structures that are either too weak to influence behavior or so severe that they encourage defensive overcorrection.

Implications

Regulatory proposals should be tested for the behavior they will reward, not merely the objective they are intended to advance. Existing regulations should be periodically reviewed for accumulated unintended consequences.

Misaligned Performance Metrics

Definition. Measures of success that reward activity, speed, savings, closure, or another limited indicator while failing to measure the outcomes that matter to the system as a whole.

Diagnostic signal. Participants improve the reported metric while recovery, service quality, fairness, or total system performance deteriorates.

Discussion

Organizations manage what they measure. When the selected metric is incomplete, participants adapt their behavior to improve the metric rather than the underlying outcome. The metric may be accurate yet misleading because it captures only one part of the system.

Common examples

- Measuring claim closure without measuring durable recovery or later reopening.
- Rewarding current-period medical savings without measuring disability duration or total claim cost.
- Evaluating claims staff primarily by caseload volume, diary compliance, or transaction speed.

Implications

Metrics should be balanced, outcome-focused, and tested periodically for gaming. No important performance measure should stand alone without countermeasures that reveal cost shifting or deterioration elsewhere.

Volume Over Value

Definition. Payment structures that reward the quantity of services, transactions, reports, procedures, or administrative activity rather than functional improvement or durable outcomes.

Diagnostic signal. Participant revenue increases when activity increases, regardless of whether the injured worker or the system improves.

Discussion

Volume-based payment is often easier to administer than outcome-based payment, but it predictably rewards more activity. The absence of a meaningful connection between payment and results is itself an incentive structure.

Common examples

- Fee-for-service medical payment across specialties.
- Hourly legal billing.
- Per-claim or per-transaction administrative and vendor fees.
- Medical-legal payment tied to report length or complexity.

Implications

Payment systems should reward appropriate service, quality, recovery, and durable outcomes where those outcomes can be fairly measured. At minimum, organizations should monitor whether increased activity is associated with improved results.

Conflicting Financial Incentives

Definition. Structures in which a participant's financial interest conflicts with the participant's professional, fiduciary, contractual, or system responsibility.

Diagnostic signal. The person or organization making a recommendation or decision benefits financially from a particular outcome, service, referral, or delay.

Discussion

Conflicting incentives do not require misconduct. Most people believe they can remain objective despite a financial interest. The structural concern is that the system repeatedly rewards one choice over another, creating predictable pressure on judgment.

Common examples

- Ownership interests in ancillary services or referral destinations.
- Compensation tied to the amount of disability, litigation, treatment, or settlement.
- Vendor arrangements that reward utilization while the purchaser bears the cost.

Implications

Conflicts should be disclosed, measured, and, where necessary, separated from decision authority. Organizations should not rely exclusively on personal integrity to neutralize a recurring structural conflict.

How People Respond

Short-Term vs. Long-Term Incentives

Definition. Financial or organizational pressures that reward immediate savings, visible results, or current-period performance while transferring costs or harm into the future.

Diagnostic signal. The decision-maker bears the cost of early action but does not receive credit for the later savings or improved outcome.

Discussion

Short-term incentives are powerful because budgets, performance reviews, contracts, and leadership tenure are often measured over short periods. Early investment in treatment, communication, prevention, staffing, or return-to-work support may be rejected even when it reduces total cost.

Common examples

- Delaying early intervention to protect a current budget.
- Reducing claims staffing and increasing caseloads to achieve immediate expense savings.
- Rejecting preventive or recovery investments because benefits will appear in a later fiscal period.

Implications

Evaluation should compare total expected system cost and outcome over an appropriate time horizon. Decision-makers should receive credit for investments that produce later savings and better recovery.

Adversarial Incentives

Definition. Compensation, procedural, or positional structures that reward conflict, delay, escalation, or strategic resistance rather than cooperation and timely resolution.

Diagnostic signal. Participant revenue or bargaining advantage increases as the dispute becomes longer, more complex, or more contentious.

Discussion

Workers' compensation necessarily includes disputed issues, but the system should not make conflict more rewarding than resolution. When delay and procedural activity create economic value, participants will rationally produce more of both.

Common examples

- Hourly legal billing combined with weak resolution timelines.
- Procedural rules that reward repeated appeals, continuances, or duplicative evaluation.
- Settlement strategies that create value from delay rather than accurate early decision-making.

Implications

The system should create greater value for accurate, timely resolution than for procedural expansion. Timelines, compensation methods, and accountability mechanisms should be evaluated together.

How Organizations Respond

Organizational Silos

Definition. Structures in which departments, vendors, or participants optimize their own budgets or performance measures while shifting cost, delay, or harm to another part of the organization or system.

Diagnostic signal. A decision improves one unit's results while worsening the total claim outcome or another unit's performance.

Discussion

Silos develop when responsibility, information, authority, and financial consequences are divided. Each unit may act rationally in pursuit of its own goals, yet the combined result is irrational for the organization.

Common examples

- Risk management, operations, human resources, legal, and finance use incompatible objectives.
- A claims department is reducing medical expenses while disability duration increases.
- Procurement is selecting the lowest-priced vendor while claims outcomes deteriorate.

Implications

Organizations should use shared outcome measures, cross-functional governance, and total-cost analysis. No department should be rewarded for savings that merely create greater costs elsewhere.

Cost Shifting

Definition. Structures that reward moving financial responsibility to another payer, benefit system, organization, department, or time period rather than preventing or reducing the underlying cost.

Diagnostic signal. A participant benefits when the same loss is classified, delayed, or transferred to a different source of payment.

Discussion

Cost shifting can make one program appear successful while total societal or organizational cost remains unchanged or increases. It is especially persistent where systems use different payment rates, eligibility standards, or reporting rules.

Common examples

- Shifting treatment between workers' compensation and group health.
- Transferring disability costs to Social Security, leave programs, or public benefits.
- Using classification or employment arrangements to avoid premium or coverage obligations.

Implications

Performance analysis should track cost across systems and over time. A reduction should not be treated as a true saving until the organization determines whether the cost was eliminated or merely transferred.

Risk Without Responsibility

Definition. Arrangements in which a participant controls decisions or creates risk but does not bear a meaningful share of the financial or operational consequences.

Diagnostic signal. Authority and economic consequence are separated, allowing one party to benefit from a decision while another absorbs the loss.

Discussion

Systems are more likely to produce responsible decisions when authority, information, and consequences are aligned. When they are separated, risk can be created without sufficient discipline.

Common examples

- Vendors recommend services while the payer bears all downstream costs.
- Decision-makers receiving upside compensation without exposure to adverse outcomes.
- Contract structures that transfer losses without transferring meaningful control or accountability.

Implications

Decision rights should be paired with measurable responsibility. Contracts should identify who controls the risk, who benefits, who pays when outcomes deteriorate, and how performance will be corrected.

Innovation Disincentives

Definition. Financial, regulatory, procurement, or organizational structures that make maintaining an ineffective status quo safer or more rewarding than adopting a demonstrably better approach.

Diagnostic signal. Participants bear the costs and risks of innovation while others receive the benefits, or failure is punished more severely than continued underperformance.

Discussion

Workers' compensation often retains outdated processes because budgets, contracts, approval structures, and professional habits reward continuity. Innovation may require current spending, shared data, workflow change, and acceptance of measured uncertainty.

Common examples

- Procurement rules that favor the lowest initial price over total value.
- Annual budgets that penalize pilot investments even when long-term savings are likely.
- Leadership structures that punish visible experimentation but tolerate invisible status-quo failure.

Implications

Organizations should create controlled pathways for piloting, measuring, and scaling improvement. Innovation should not be adopted merely because it is new, but the system should not structurally prevent evidence-based change.

How the System Ultimately Fails

Information Asymmetry

Definition. Conditions in which one participant possesses information that others need, or benefits from incomplete, delayed, distorted, inaccessible, or nonstandard information.

Diagnostic signal. The absence or unequal distribution of information allows behavior that complete and timely information would constrain.

Discussion

Accurate decisions require shared facts. Information asymmetry increases transaction costs, weakens accountability, encourages strategic behavior, and makes it difficult to distinguish actual improvement from reported improvement.

Common examples

- Selective reporting of medical, vendor, or outcome data.
- Incompatible data definitions and no industry data dictionary.
- Delayed injury reporting or incomplete transfer of claim information.
- Failure to share disciplinary, credentialing, or performance information.

Implications

Data standards, transparency, audit rights, and appropriate information-sharing should be treated as core system infrastructure. Measurement is unreliable when participants do not share common definitions or when data are incomplete.

Accountability Gaps

Definition. Weak, fragmented, delayed, or unclear oversight that allows participants to receive the benefit of misaligned behavior without a meaningful probability of correction or consequence.

Diagnostic signal. The expected benefit of noncompliance, poor performance, or cost shifting exceeds the expected cost of detection and correction.

Discussion

Accountability requires more than rules. It requires clear ownership, measurable expectations, timely information, audit authority, meaningful consequences, and a practical mechanism for correction. When any of these elements is missing, the incentive to comply weakens.

Common examples

- Penalties below the economic benefit of violation.
- Contracts without audit rights or enforceable performance standards.
- Oversight is divided among agencies or departments with no single owner.
- Poor performance that remains profitable because consequences are delayed or unlikely.

Implications

Every significant incentive structure should identify a named owner, measurable outcomes, review intervals, corrective authority, and consequences. Accountability should be designed into the system rather than added only after failure.

How the Types Compound One Another

The most damaging incentive structures rarely fit within only one type. They compound.

For example, a fee-for-service arrangement may reward volume over value. If the provider also controls referrals, the structure may create conflicting financial incentives. If the payer measures only unit price, misaligned performance metrics may conceal the increased volume. If the purchaser and claims department operate in silos, no one may measure the total effect. If data are incomplete, information asymmetry prevents detection. If the contract lacks audit rights, an accountability gap allows the structure to persist.

The diagnostic value of typology is identifying this interaction. Correcting only one component may leave the remaining incentives intact and produce little improvement.

Classifying a Structure

The Incentive Evaluation Framework in the main paper provides the method for evaluating a proposed or existing structure end-to-end. This appendix provides the classification step.

1. Determine what behavior creates financial or organizational advantage for each participant affected by the structure.
2. Classify the structure under every applicable type in this appendix. Most structures fall under more than one.
3. Identify where costs, risks, information, authority, and accountability are located, and where each of them moves once the structure is in place.

The third step is the most often skipped. A structure that appears to reduce cost has usually been relocated. The type it belongs to is easiest to see once the destination is named.

Relationship to the Companion Documents

The typology classifies structures. Appendix A supplies the standard against which they are measured, and Appendix E the catalog of known instances organized by functional responsibility.

Conclusion

The purpose of this typology is not to label participants or condemn financial incentives. Every complex system requires incentives, and many incentives produce valuable results.

The purpose is to make recurring patterns visible. Once a structure is classified, its likely behavioral effects become easier to anticipate, measure, and correct.

A well-designed workers' compensation system does not assume that good intentions will overcome misaligned incentives. It identifies what the system rewards, determines whether those rewards advance the desired outcomes, and redesigns structures that predictably produce something else.

Appendix C — Cognitive and Organizational Biases

Why Well-Intentioned People Defend Misaligned Systems

Purpose and Scope

The axioms in the main paper explain the principles that shape financial incentives. Appendix B classifies the recurring forms these misplaced incentives take. This appendix explains why those incentives persist long after they have been recognized.

Understanding the existence of a misplaced financial incentive is often not enough to correct it. Humans do not evaluate incentives objectively. We interpret them through cognitive biases that shape how we perceive information, explain our decisions, defend existing practices, and evaluate proposed reforms.

These biases do not indicate dishonesty or incompetence. They are normal features of human decision-making. They affect legislators, regulators, employers, insurers, physicians, attorneys, judges, claims professionals, and injured workers alike.

Recognizing these biases helps explain why systems that almost everyone agrees should improve often remain remarkably resistant to change.

Why Cognitive Biases Matter

Misplaced financial incentives influence behavior.

Cognitive biases make those behaviors feel reasonable.

Once a financial structure rewards a particular behavior, cognitive biases begin to reinforce that behavior by creating explanations that justify it, normalize it, and defend it against internal and external criticism.

Over time, these justifications become embedded within organizational culture. Eventually, the existing practice no longer feels like a choice. It just feels like things have always been done.

This interaction explains why reform efforts frequently encounter resistance even when the underlying problem is widely recognized.

The Incentive-Bias Reinforcement Cycle

Misplaced financial incentives and cognitive biases interact in a predictable sequence.

- **Step 1. The incentive creates the behavior.** A physician who owns an imaging facility orders more imaging.
- **Step 2. Bias blind spot justifies it.** "My ownership does not affect my clinical judgment."

- **Step 3. Confirmation bias entrenches it.** The cases where imaging revealed pathology are remembered. The cases where it changed nothing are not.
- **Step 4. Outcome bias makes it look inevitable.** "Of course, the study was necessary. Look what we found."
- **Step 5. Transmission spreads it.** Successes are shared with colleagues. Failures go unreported.
- **Step 6. The bandwagon effect normalizes it.** Other physicians adopt the practice because everyone does it.
- **Step 7. Status quo bias resists correction.** Changing the referral pattern now feels clinically and professionally dangerous.

By Step 3, the behavior has become self-validating. By Step 6, it has become a professional culture. By Step 7, reform feels like the aberration rather than the correction. The example is imaging, but the same sequence operates wherever a financial structure rewards a behavior often enough that the mind builds an explanation around it.

This cycle explains why identifying a misplaced financial incentive rarely produces immediate reform. By the time the incentive is recognized, it has often become psychologically and institutionally self-reinforcing.

Major Cognitive and Organizational Biases

Bias Blind Spot

Definition

The tendency to recognize bias in others while believing ourselves to be objective.

Discussion: The bias blind spot is perhaps the single most significant cognitive bias in workers' compensation because it allows intelligent and ethical professionals to sincerely believe that financial incentives do not influence their own decisions.

Workers' Compensation Examples

- Physician ownership of ancillary services.
- Expert witness selection.
- Organizational bonus structures.
- Attorney fee arrangements.

Implications

Reform cannot rely solely upon individual awareness because people rarely recognize their own bias.

Incentive Blindness

Definition

The tendency to evaluate a decision by the intention behind it rather than by the behavior it actually rewards.

Discussion

A bias blind spot conceals a participant's own interest. Incentive blindness conceals the structure itself. A policy is judged by what it was meant to accomplish, and the question of what behavior it makes profitable is never asked. Because the intention is usually sincere and often admirable, the structure survives review after review without anyone examining what it pays for.

Workers' Compensation Examples

- A cost containment program is evaluated on savings while it delays early treatment.
- A payment reform intended to improve access that rewards unnecessary utilization.
- An efficiency metric intended to speed resolution that encourages premature claim closure.
- A safety incentive intended to reduce injuries that reduces injury reporting.

Implications

The question is never simply what a structure was intended to accomplish. The question is what behavior it consistently rewards.

Confirmation Bias

Definition

The tendency to seek, or prefer, information that confirms existing beliefs while discounting contradictory evidence.

Discussion

Once participants adopt a preferred explanation, subsequent information is unconsciously filtered through that belief.

Workers' Compensation Examples

- Selective interpretation of medical evidence.
- Litigation strategies.
- Claims investigations.
- Regulatory decision-making.

Implications

Outcome measurement should challenge assumptions rather than simply reinforce them.

Anchoring Bias

Definition

The tendency to rely too heavily upon initial information when making later decisions.

Discussion

Early impressions often influence every decision that follows.

Workers' Compensation Examples

- Initial disability ratings.
- Reserve setting.
- Early compensability opinions.
- First medical impressions.

Implications

Organizations should periodically reassess important decisions using current evidence rather than relying upon initial assumptions.

Status Quo Bias

Definition

The tendency to prefer existing practices simply because they already exist.

Discussion

Long-standing systems often appear safer than new approaches, even when evidence favors change.

Workers' Compensation Examples

- Resistance to payment reform.
- Legacy administrative procedures.
- Outdated reporting systems.

Implications

Reform proposals should explain why maintaining the status quo also carries significant risk.

Availability Bias

Definition

The tendency to judge frequency or importance based upon memorable examples rather than representative data.

Discussion

Highly visible claims often influence policy more than objective evidence.

Workers' Compensation Examples

- Catastrophic claims.
- Fraud cases.
- Highly publicized verdicts.

Implications

Policy decisions should rely upon comprehensive data rather than isolated experiences.

Outcome Bias

Definition

The tendency to judge the quality of a decision by the result it happened to produce rather than by the soundness of the structure that produced it.

Discussion

Experienced professionals routinely compensate for weaknesses in poorly designed systems through extraordinary effort and judgment. Their success conceals the structural problem until personnel change, technology shifts, or external conditions move. A good result is then taken as evidence that the design is sound, and the design is left in place for the successor who lacks the same compensating skill.

Workers' Compensation Examples

- A claims unit whose results depend on one exceptional examiner.
- A program is judged successful because no failure has yet become visible.
- A settlement practice validated by a favorable result rather than by its reasoning.
- A vendor arrangement is retained because nothing has obviously gone wrong.

Implications

The absence of visible failure should never be mistaken for evidence that an incentive structure is properly aligned.

Loss Aversion

Definition

The tendency to fear losses more than we value equivalent gains.

Discussion

Organizations often resist reforms because they focus on what might be lost rather than what might be gained.

Workers' Compensation Examples

- Payment reform.
- Medical delivery redesign.
- Technology adoption.

Implications

Successful reform should clearly demonstrate the costs of maintaining the current system.

Sunk Cost Fallacy

Definition

The tendency to continue an unsuccessful course of action because substantial resources have already been invested.

Discussion

Past investments should not determine future decisions.

Workers' Compensation Examples

- Extended litigation.
- Long-running medical disputes.
- Legacy technology systems.

Implications

Future decisions should be based upon expected future outcomes rather than past expenditures.

Groupthink

Definition

The tendency of groups to suppress disagreement in favor of consensus.

Discussion

Organizations frequently reinforce existing practices because disagreement is uncomfortable.

Groupthink differs from the bandwagon effect. Bandwagon describes independent actors adopting a practice because others have already done so. Groupthink describes a group's suppression of dissent to preserve its consensus.

Workers' Compensation Examples

- Committee decisions.
- Executive leadership.
- Regulatory agencies.

Implications

Organizations should actively encourage respectful disagreement and independent review.

Silo Thinking

Definition

The tendency of a unit to optimize its own measured performance without regard to the performance of the system as a whole.

Discussion

Groupthink suppresses dissent within a unit. Silo thinking is narrower and more common: each unit performs well against its own measures while the total result deteriorates. Nobody behaves unreasonably. Every department is doing exactly what it was asked to do, and local optimization does not produce global optimization.

Workers' Compensation Examples

- Medical cost containment that increases indemnity duration.
- Underwriting results improved by measures that increase claim costs.
- Legal budgets are managed separately from the total claim outcome.
- Safety, claims, and human resources are measured against unrelated targets.

Implications

Any measure applied to a single unit should be tested against the total system cost and outcome before adoption.

Organizational Inertia

Definition

The tendency of organizations to resist structural change, even when opportunities for improvement are evident.

Discussion

Large institutions develop routines that become increasingly difficult to modify.

Workers' Compensation Examples

- Legacy claims processes.
- Regulatory structures.
- Administrative workflows.

Implications

Successful reform requires sustained leadership rather than isolated initiatives.

Diffusion of Responsibility

Definition

The tendency for accountability to disappear when responsibility is shared among many participants.

Discussion

Everyone assumes someone else is addressing the problem.

Workers' Compensation Examples

- Multi-party claims.
- Regulatory overlap.
- Vendor management.

Implications

Every major process should identify a clearly accountable owner.

Attribution Bias

Definition

The tendency to explain poor outcomes by the character or competence of individuals rather than by the structures within which they operate.

Discussion

When results disappoint, the intuitive response is to identify who is responsible. The structural response is to identify what the system rewarded. Workers' compensation has historically chosen the first, answering poor outcomes with additional rules, training, oversight, and ethical requirements. These answers assume participants are the problem. Most participants are responding rationally to the financial structures surrounding them.

Workers' Compensation Examples

- Poor claim outcomes attributed to examiner performance rather than caseload design.
- Utilization patterns attributed to individual physicians rather than to payment methodology.
- Litigation rates are attributed to attorney conduct rather than fee structure.
- Reporting failures attributed to worker behavior rather than to waiting periods and benefit formulas.

Implications

Improving outcomes requires redesigning incentive structures rather than assuming individuals will consistently act contrary to their own incentives.

Regulatory Capture

Definition

Regulators' tendency to gradually adopt the perspectives of the industries they regulate.

Discussion

Long-term relationships can unintentionally narrow perspectives and normalize the assumptions of the regulated community.

Workers' Compensation Examples

- Licensing.
- Credentialing.
- Rulemaking.

Implications

Independent review and diverse stakeholder participation strengthen oversight.

How Biases Reinforce the Typology

The cognitive and organizational biases described in this appendix reinforce every type of misplaced financial incentive identified in Appendix B. The following examples illustrate the relationship:

Regulatory Misalignment: Status quo bias, regulatory capture, anchoring, and conservatism bias can cause outdated rules to survive long after their original assumptions have changed.

Misaligned Performance Metrics: Salience bias and confirmation bias draw attention toward visible measures while obscuring important outcomes that are harder to quantify.

Volume Over Value: Anchoring, unit bias, and availability bias can normalize a standard quantity of services even when additional activity does not improve recovery.

Conflicting Financial Incentives: A bias blind spot and overconfidence lead participants to believe their financial interests do not influence professional judgment.

Short-Term vs. Long-Term Incentives: Loss aversion, hyperbolic discounting, and planning fallacy make immediate savings appear more valuable than larger future benefits.

Adversarial Incentives: Inter-group bias, reactance, fundamental attribution error, and sunk-cost commitment encourage escalation and make compromise feel like surrender.

Organizational Silos: Groupthink, tribal bias, and diffusion of responsibility encourage departments to optimize their own results while overlooking total system performance.

Cost Shifting: Loss aversion, the ostrich effect, and tragedy-of-the-commons reasoning encourage each participant to transfer costs outside its own area of accountability.

Risk Without Responsibility: Optimism bias and diffusion of responsibility allow decision-makers to accept risks others will bear whose consequences.

Innovation Disincentives: Status quo bias, ambiguity aversion, and loss aversion make established practices appear safer than promising alternatives.

Information Asymmetry: Availability bias, survivorship bias, and observer-expectancy effects cause incomplete information to reinforce existing beliefs.

Accountability Gaps: Bias blind spot, organizational inertia, and diffusion of responsibility allow known failures to persist without a clearly responsible decision-maker.

A Note on the Other Biases Named in This Appendix

The section above names biases that are not developed as full entries. They are defined briefly here so that the mapping can be read without reference to outside sources.

- **Ambiguity aversion**: preferring a known option to an uncertain one even when the uncertain option is likely to be better.

- **Bandwagon effect**: adopting a practice because others have adopted it.
- **Conservatism bias**: updating beliefs too slowly when new evidence arrives.
- **Fundamental attribution error**: explaining another person's behavior by their character while explaining our own by our circumstances.
- **Hyperbolic discounting**: valuing an immediate gain far above a larger gain that arrives later.
- **Inter-group bias**: favoring one's own group and discounting the motives of an opposing one.
- **Observer-expectancy effect**: recording or interpreting data in the direction the observer expects.
- **Optimism bias**: underestimating the likelihood of adverse outcomes.
- **Ostrich effect**: avoiding information that would require confronting an uncomfortable fact.
- **Planning fallacy**: underestimating how long something will take and what it will cost.
- **Reactance**: resisting a change because it is imposed, independent of its merits.
- **Salience bias**: giving weight to what is visible or vivid rather than to what matters most.
- **Survivorship bias**: drawing conclusions from the cases that remain visible while the failures have disappeared from the data.
- **Tragedy of the commons**: each participant optimizes its own position while a shared resource or shared cost pool deteriorates.
- **Tribal bias**: aligning judgment with the interests and beliefs of one's professional group.
- **Unit bias**: treating a customary quantity as the correct quantity.

Implications for Reform

Ethics alone cannot overcome structural incentives.

Education alone rarely changes behavior when the financial reward remains unchanged.

Disclosure alone seldom eliminates conflicts of interest because participants often sincerely believe the conflict does not influence them.

Meaningful reform requires redesigning the underlying financial structure while simultaneously recognizing the cognitive and organizational biases that will resist change.

Successful organizations make important outcomes visible, encourage independent review, periodically reassess existing practices, and build clear accountability directly into system design.

Designing Reform Around Bias

Make outcomes visible: Comparable outcome data reduces the influence of anecdote, selective attention, and survivorship bias.

Change the financial signal: Structural realignment is more reliable than asking participants to override their own financial interests through willpower or professional ethics.

Build in review cycles: Every incentive should be periodically reassessed because participant behavior, technology, markets, and unintended consequences change over time.

Assign responsibility: A named person or organization should be accountable for evaluating results and correcting misalignment.

Anticipate resistance: Resistance should be examined carefully, but it should not automatically be treated as evidence that reform is misguided. It may be the predictable response of an established system protecting itself.

Relationship to the Companion Documents

Biases explain why misaligned structures survive scrutiny. The structures themselves are classified in Appendix B and cataloged in Appendix E, and Appendix D describes the conflicts of interest that biases help conceal.

Conclusion

Misplaced financial incentives explain why systems produce behaviors that differ from their intended objectives.

Cognitive and organizational biases explain why intelligent, ethical, and well-intentioned people sincerely believe those behaviors are appropriate.

Neither incentives nor biases should be viewed as evidence of bad faith. Both are predictable characteristics of complex systems.

Designing a better workers' compensation system therefore requires addressing both the financial structures that influence behavior and the human psychology that resists change.

Only by understanding both can policymakers, regulators, employers, insurers, medical professionals, attorneys, and injured workers build a system that consistently achieves its foundational objectives.

Appendix D — Structural Conflicts of Interest

Why Legal, Ethical, and Financial Conflicts Are Not the Same

Purpose and Scope

The preceding appendices explain how financial incentives influence behavior, classify the recurring forms those incentives take, and describe the cognitive biases that allow misaligned systems to persist. This appendix addresses a related but frequently misunderstood point: not all conflicts of interest are the same.

Workers' compensation discussions often use the phrase "conflict of interest" without distinguishing among legal, ethical, and structural conflicts arising from financial incentives. The distinction matters because each requires a different remedy. Legal conflicts are addressed through statutes, regulations, licensing requirements, and professional discipline. Ethical conflicts are addressed through professional standards, organizational culture, and individual integrity. Structural conflicts are addressed only by redesigning the financial and organizational systems that create them.

Confusing these three categories has delayed or precluded meaningful reform for decades. Many of the most persistent problems in workers' compensation arise not from participants violating the law or professional ethics, but from a system that rewards behavior at odds with its stated objectives. Understanding the difference allows policymakers, regulators, employers, insurers, attorneys, physicians, and administrators to identify whether a problem requires enforcement, education, or structural redesign.

Why the Distinction Matters

Workers' compensation was designed to provide prompt medical care, fair income replacement, functional recovery, return to work, and efficient claim resolution. Most participants genuinely support those objectives. Yet many are compensated in ways that reward something else.

When that occurs, individuals face no legal violation and no ethical dilemma. They respond to the financial signals embedded within the system, and the result is predictable. The system gradually produces outcomes consistent with the incentives it creates rather than the objectives it proclaims.

Recognizing this shifts the discussion away from blaming individuals and toward improving system design.

Three Types of Conflict

Legal Conflicts of Interest

A legal conflict of interest exists when statutes, regulations, or professional rules prohibit a financial relationship or require its disclosure. Examples include:

- Prohibited self-referral

- Fee-splitting
- Undisclosed ownership interests
- Bribery and kickbacks
- Prohibited gifts
- Licensing violations

Legal conflicts are addressed through enforcement. When violations occur, regulators investigate, and sanctions may follow.

Ethical Conflicts of Interest

Ethical conflicts arise when professional responsibilities exceed minimum legal requirements. Examples include placing personal gain above client welfare, failing to disclose important information, abusing professional discretion, and exploiting vulnerable individuals.

Ethics depend on individual judgment. Professional organizations establish ethical standards precisely because not every questionable behavior violates the law, and most professionals attempt to meet those standards.

Structural Conflicts of Interest

Structural conflicts arise when financial or organizational incentives encourage behavior that differs from the objectives of the workers' compensation system. No law is broken. No ethical line is crossed. Participants respond rationally to the incentives surrounding them.

These conflicts are often invisible because they become accepted as normal business practice. They are also the most difficult to eliminate because removing one often requires changing statutes, contracts, payment methods, benefit structures, performance measures, and organizational incentives simultaneously.

	Legal Conflict	**Ethical Conflict**	**Structural Conflict**
Source	Law	Professional standards	Financial structure
Primary remedy	Enforcement	Ethics and professionalism	Redesign of the incentive

	Legal Conflict	Ethical Conflict	Structural Conflict
Typical consequence	Sanctions	Reputational or professional consequences	Predictably worse outcomes, with no one at fault
Can good people still be affected?	Sometimes	Yes	Always
Primary question	"Is it legal?"	"Is it right?"	"What behavior does this reward?"

Structural Conflicts Throughout Workers' Compensation

Structural conflicts appear throughout the system and affect nearly every participant. The following illustrates the principle rather than criticizing any profession.

Employers

Employers seek safe workplaces, productive employees, and predictable costs. Annual budgeting, experience modification, OSHA reporting, production schedules, and staffing shortages may nonetheless create pressures that discourage prompt reporting, modified duty, or early investment in prevention. The conflict is structural rather than personal.

Insurance Companies

Insurance companies seek accurate pricing, quality claims administration, and financial stability. Quarterly financial reporting, reserve practices, expense management, and competitive pressure may create incentives that emphasize short-term financial performance over long-term claim outcomes. A self-insured employer carries those same pressures directly. The issue is organizational design rather than bad faith.

Third Party Administrators

Third-party administrators are often compensated based on claim volume, administrative services, or contract renewal. Where revenue increases with claim duration or service volume, the structure deserves examination regardless of whether anyone intends a poorer outcome.

Claims Professionals

Claims professionals generally want injured workers to recover. Yet many are evaluated on files closed, diary compliance, indemnity savings, reserve reductions, and caseload size. Few

organizations measure long-term recovery, durable return to work, communication quality, or worker satisfaction with equal rigor. People optimize what they are measured against.

Medical Providers

Fee-for-service reimbursement rewards activity, and higher service volume generally produces higher revenue. This does not imply unnecessary treatment. It means the financial structure rewards services rather than outcomes. A physician may practice excellent medicine while responding to a payment system that encourages additional activity.

Injured Worker Attorneys

Attorneys for injured workers owe their clients zealous representation. Their compensation frequently depends on the permanent disability award or the settlement value. That creates an unavoidable structural tension: the worker benefits from recovery, while the fee structure often rewards disability. Neither observation questions professional integrity. It recognizes the financial signal embedded in the system.

Defense Attorneys

Defense counsel is often compensated hourly, and longer litigation generally produces more billable hours. Most attorneys remain committed to professional representation. The compensation structure still deserves examination wherever the financial signal differs from the outcome the system needs.

Vendors

Nearly every vendor is paid for activities such as transportation, interpretation, utilization review, bill review, pharmacy benefit management, medical record retrieval, surveillance, and nurse case management. Activity-based compensation is common across complex service industries. The question is whether those activities consistently improve recovery and system performance.

Regulators

Regulators are not immune. Political pressure, budget limitations, enforcement priorities, and institutional tradition all influence regulatory behavior. Each of these shifts with changes in personnel and leadership. Oversight systems require the same periodic evaluation as every other participant.

Why Ethics Alone Cannot Solve Structural Problems

Many reform efforts focus on ethics. Ethics matter. But ethics cannot reliably overcome financial structures, and expecting thousands of participants to repeatedly act against their own organizational incentives is unrealistic.

Well-designed systems reduce the need for extraordinary individual virtue. Poorly designed systems depend on it. That distinction explains why ethical education alone rarely produces sustained improvement.

Designing Better Structures

Reducing structural conflicts requires redesign rather than blame. Several principles consistently improve alignment.

- Financial rewards should support recovery rather than activity.
- Performance measures should emphasize outcomes rather than transactions.
- Authority should be paired with accountability.
- Information should be transparent.
- Outcome measurement should extend beyond immediate financial performance.
- Periodic review should identify emerging unintended consequences before they become institutionalized.

These principles recur throughout the companion papers because they are recurring characteristics of systems that work.

Relationship to the Companion Documents

Structural conflicts explain why good people produce poor outcomes. Appendix A supplies the standard, Appendix B the classification, and Appendix E the catalog of known conflicts.

Conclusion

Workers' compensation does not suffer primarily from a shortage of ethical people. It suffers from financial structures that reward behavior different from the behavior the system was created to achieve.

Legal conflicts require enforcement. Ethical conflicts require professional responsibility. Structural conflicts require redesign. Understanding the difference moves the discussion away from assigning blame and toward improving the systems within which good people work.

The objective is not to eliminate financial incentives. It is to ensure that every participant succeeds by helping the injured worker recover, return to productive employment, and receive the benefits workers' compensation promised.

Appendix E — Compendium of Known Misplaced Financial Incentives

Organized by Functional Responsibility

Purpose and How to Use This Compendium

This appendix serves as a companion reference to *The Hidden Cost of Misplaced Incentives*. It catalogs known financial incentive structures within the workers' compensation system that can influence participant behavior and lead to unintended consequences. Its purpose is to provide policymakers, regulators, employers, insurers, claims professionals, medical providers, attorneys, and other stakeholders with a practical reference for identifying where misplaced financial incentives exist within the system.

Unlike the main paper, which examines misplaced financial incentives through foundational principles, typologies, and evaluation methodologies, this compendium is organized by **functional responsibility**. Most participants view the workers' compensation system in terms of the responsibilities they manage rather than academic classifications. Organizing the material by functional responsibility allows readers to quickly identify the incentive structures that affect their own decisions while recognizing how those same structures influence the actions of others.

Many incentive structures appear under more than one functional area. This is intentional. A single statute, payment methodology, contractual provision, organizational policy, or administrative practice often influences multiple participants, each responding according to their own responsibilities and incentives. Entries are therefore included wherever a reader would reasonably expect to find them.

This compendium is intended for use whenever legislation, regulations, payment systems, contracts, organizational policies, administrative procedures, or operational practices are created, revised, or evaluated. Readers should first identify the functional responsibilities affected by the proposed change, then compare the proposal against the known incentive structures identified in this appendix. The **Typology of Misplaced Financial Incentives** presented in the main paper should then be used to classify the type of misalignment, and the **Incentive Evaluation Framework** should be applied to assess whether the proposed change is likely to improve or undermine the fundamental objectives of the workers' compensation system.

This appendix is intended to be a living reference document. As workers' compensation continues to evolve through legislative changes, medical advances, technological innovation, artificial intelligence, and new business models, additional misplaced financial incentives will inevitably emerge. Future editions should continue to identify, evaluate, and catalog these newly recognized incentive structures so that organizations can learn from prior experience and avoid recreating known unintended consequences.

1. Employers

Safety and Injury Prevention

- Safety incentive programs that reward low reported injury counts rather than actual injury reduction.
- Safety bonuses based solely on claim frequency.
- Annual budget cycles that penalize current-period safety investment.
- Cost shifting to employees.
- Experience modification manipulation.
- Under-reporting of payroll.
- Misclassification of employees.
- Independent contractor misclassification to avoid coverage obligations.

Injury Reporting

- Delayed reporting.
- Suppression of claims.
- Handling claims outside the workers' compensation system.
- Paying medical bills directly to avoid reporting.
- Failure to provide required claim forms.
- Failure to communicate reporting requirements.
- Charge-back program design that penalizes front-line managers for reported claims.
- OSHA recordability criteria that diverge from workers' compensation compensability.

Return to Work

- No modified duty program.
- Financial disincentives for accommodating injured workers.
- Lack of communication with treating physicians.
- Failure to provide job descriptions.
- Delayed return-to-work decisions.
- Programs that satisfy technical compliance without providing meaningful work.

2. Insurance Brokers

- The commission drives carrier selection primarily.
- Third-party administrator selection based on financial relationships.
- Large deductible program incentives.
- Retrospective rating incentives.
- Program marketing incentives.
- Renewal incentives.
- Absence of outcome-based broker performance measures.

3. Self-Insured Employers

- Internal budgeting pressures.
- Departmental cost shifting.
- Reserve suppression to protect current-year financial statements.
- Delayed settlements.

- Inadequate staffing.
- Executive compensation metrics.
- Qualification and security requirements that are inadequately enforced.

4. Insurance Companies

- Quarterly financial reporting pressures.
- Reserve management driven by period results.
- Short-term profitability incentives.
- Cost containment prioritized over recovery.
- Internal budget pressures.
- Ancillary company referrals.
- Settlement authority restrictions.
- Cost containment strategies that delay or deny early treatment.

5. Reinsurers, Excess Carriers, and Guarantee Funds

- Attachment points designed around accounting treatment rather than risk transfer.
- Reinsurance structures that discourage early resolution.
- Insolvency structures permitting under-reserved claims portfolios.
- Collateral requirements are disconnected from actual exposure.
- Guarantee fund distortions that transfer the cost of insolvency to solvent payers.

6. Professional Employer Organizations and Payroll Services

- Payroll allocation across entities.
- Multi-state reporting that concentrates exposure in lower-cost jurisdictions.
- Experience modification avoidance.
- Classification coding accuracy.
- Contractor classification.
- Payroll platforms that do not integrate workers' compensation classification codes.

7. Third Party Administrators

- Fee-per-file compensation.
- Revenue that increases with claim duration.
- Ownership of ancillary vendors.
- Low staffing ratios.
- Caseload-based incentives.
- Bill review profit centers.
- Pharmacy profit centers.
- Utilization review ownership.
- Performance guarantees emphasizing cost rather than outcomes.
- Contract structures without long-term outcome accountability.
- Undisclosed financial relationships with preferred provider networks.

8. Claims Administration

Claims Assignment

- Assignment by workload rather than expertise.

- Unequal caseloads.
- Geographic assignment practices.
- Automatic reassignment after litigation.

Reserving

- Under-reserving.
- Over-reserving.
- Calendar-year reserve management.
- Reserve manipulation.
- Reserve authority delays.

Settlement Philosophy

- Delay-until-trial philosophy.
- Lowball authority.
- Authority bottlenecks.
- Settlement measured by indemnity savings rather than total claim cost.
- Lifetime future medical favored over full closure.

Settlement Authority

- Authority limits that delay resolution.
- Multiple approval layers.
- Authority granted late in the litigation cycle.

Caseload Management

- Excessive caseloads.
- Diary management failures.
- Delayed investigations.
- Delayed compensability decisions.
- Delayed medical authorization.
- Poor communication.
- Selective use of medical reports.
- Failure to set expectations.

Examiner Metrics

- Performance metrics tied to short-term cost reduction.
- Pressure to close claims at minimal current cost.
- Activity measures rather than outcome measures.
- Absence of any measure of durable resolution.

9. Medical Management

Payment Structure

- Fee-for-service reimbursement across all specialties.
- No outcome-based payment for any provider type.
- Higher reimbursement for procedures than for clinical evaluation.
- Higher fees for complex procedures.
- Payment per physical therapy visit.

- Modality-based billing that favors passive treatment over active rehabilitation.
- Payment per chiropractic adjustment.
- Payment per surgical procedure.
- Payment for the volume of physician office visits.
- Injection procedure fees in pain management.
- Payment per nerve or muscle tested in electrodiagnostic studies.
- Payment for bilateral testing where only one side is symptomatic.
- Special procedure add-on fees of uncertain clinical utility.

Ownership and Self-Referral

- Employer-owned occupational clinics treating their own injured workers.
- Physician ownership of physical therapy facilities.
- Physician ownership of imaging facilities.
- Physician ownership of ambulatory surgical centers.
- Physician ownership of diagnostic testing facilities.
- Medical group ownership of pharmacies with mandatory dispensing.
- Physician dispensing.
- Employer-directed care to providers offering volume discounts.

Utilization Review and Networks

- Fee per review performed.
- Denial incentives.
- Delay incentives.
- Selective presentation of medical evidence.
- Managed care organization ownership of utilization review entities.
- Network volume-discount arrangements that obscure quality data.
- Absence of a payment differential for guideline-concordant care.
- Network outcome data not shared across payers.
- Absence of uniform outcome reporting requirements for providers.

Return to Work

- Treating physician reluctance to release to modified duty from liability concern.
- No payment differential for functional restoration.
- No financial consequences for restrictions more conservative than the findings support.

10. Medical-Legal

- AMA Guides used beyond their intended purpose.
- Payment by report volume.
- Supplemental report incentives.
- Permanent disability emphasis.
- Report complexity and length incentives.
- Referral relationships between evaluators and referring attorneys.
- Evaluator fees are higher for disability-supporting opinions.
- Failure to address all issues, generating further reports.
- Delayed evaluations.

- Delay between examination and report production.

11. Benefit Administration

These are the benefit structures themselves. Section 14 addresses the financial signals those structures send to the injured worker.

- Waiting period design.
- Temporary disability formulas.
- Permanent disability rating as the primary determinant of financial recovery.
- Lump-sum settlement calculation driven by the rating.
- Public safety officer temporary disability at full wages without tax deduction.
- Benefit coordination rules.
- Social Security Disability Insurance interaction.
- Medicare interaction and set-aside requirements.
- Structured settlement incentives.
- Vocational rehabilitation vendor payment per week of service rather than per placement.
- Nurse case management compensation is tied to duration.

12. Injured Worker Attorneys

- Percentage contingency fees tied to the permanent disability rating.
- Fees as a percentage of total monetary recovery.
- Delayed filing.
- Delayed settlement.
- Cumulative trauma pleading practices.
- Medical provider referral relationships.
- Deposition strategies that extend rather than resolve.
- Trial-delay incentives.
- No financial incentive to pursue return to work.

13. Defense Attorneys

- Hourly billing with no outcome accountability.
- Multiple depositions.
- Excessive discovery.
- Low settlement authority requests.
- Appeals without merit.
- Multiple court appearances.
- Inadequate settlement preparation.
- Failure to resolve liens.
- Absence of professionally trained negotiators.
- Multiple defense assignments to a single claim.
- Volume assignment agreements with carriers.
- No financial incentive for early resolution.

14. Injured Worker Incentive Structures

This section describes the financial structures that affect injured workers' decisions. It does not describe worker behavior. Workers, like every other participant, respond to the structures placed before them.

- Waiting period costs represent a substantial fraction of monthly income for lower-wage workers.
- Temporary disability rates that exceed normal take-home income.
- Return-to-work structures under which returning produces a net financial loss.
- Benefit coordination gaps between workers' compensation and other programs.
- Post-accident drug testing consequences that discourage reporting of legitimate injuries.
- Confidential settlement terms that limit what the worker may disclose.
- Access to care is limited by network, geography, or authorization delay.
- Transportation reimbursement that does not cover the actual cost of attending care.

15. Vendors

- Transportation: per-trip fees and mileage-based charges.
- Translation: per-hour and per-page fees and unnecessary interpreter usage.
- Copy services: per-page fees and duplicate requests.
- Medical record retrieval: volume-based billing.
- Court reporters: per-page transcript and appearance fees.
- Bill review: fee per bill processed, percentage-of-savings compensation, and down-coding incentives.
- Pharmacy benefit managers: spread pricing and rebate retention.
- Durable medical equipment: rental duration and per-item billing.
- Case management: duration-based compensation.
- Independent medical examination vendors: volume-based scheduling and panel composition.
- Artificial intelligence vendors: licensing tied to transaction volume and models trained on incomplete outcome data.

16. Fraud, Special Investigation Units, and Surveillance

- Investigation quotas.
- Surveillance quotas.
- Referral incentives.
- Fraud metrics measure activity, not recovery.
- Fee per investigation initiated.
- Hourly surveillance billing.
- Surveillance continued beyond reasonable need.
- Over-investigation.
- Under-investigation.

17. Subrogation

- Settlement before recovery.

- Carrier and employer conflicts.
- Credit allocation.
- Customer relationship conflicts.
- Excess carrier participation.
- Recovery expense allocation.

18. Claim Resolution

- Compromise and release versus stipulation incentives.
- Resignation is required as a condition of settlement.
- Structured settlements that inadequately fund future medical costs.
- Lifetime future medical stipulations as the default settlement structure.
- Lien resolution delays.
- Reopening incentives.
- Delayed settlement.
- Inadequate settlement authority.
- Calendar-year financial pressures.

19. Adjudicatory System

- No enforceable hearing timelines.
- Continuance incentives.
- Low appeal filing costs.
- No meaningful sanctions for frivolous appeals.
- Venue shopping.
- Calendar congestion.
- Administrative delay.
- Penalty provisions triggered by technical violations rather than substantive harm.

20. Regulators and Enforcement

- Low audit frequency.
- Penalties below the economic benefit of violation.
- Understaffed enforcement agencies.
- Slow license revocation.
- Limited fraud prosecution.
- Weak self-insurance oversight.
- Fragmented credentialing.
- Poor interstate coordination.
- Regulatory overlap.

21. Reporting and Analytics

- Rating bureau reporting.
- Division of Workers' Compensation reporting.
- Department of Industrial Relations reporting.
- Department of Insurance reporting.
- OSHA reporting.
- Medicare reporting.
- Internal reporting.

- Loss development reporting that obscures emerging trends from employers.
- Absence of data on cost shifting.
- Absence of mandatory outcome reporting for any participant.
- No comprehensive industry data dictionary or glossary.
- Coding practices.
- Data quality.

22. Cross-System Cost Shifting

- Workers' compensation and group health payment differentials.
- Medicare coordination failures that do not identify workers' compensation as the primary payer.
- Medicaid absorbing costs from inadequately funded settlements.
- Social Security Disability Insurance overlaps with permanent disability.
- Short-term and long-term disability insurance interaction.
- OSHA recordability divergence.
- Unemployment insurance interaction.
- Paid family leave interaction.
- Employer medical plan absorption of occupational injuries.
- Occupational versus non-occupational classification.
- Lack of integrated reporting across systems.

23. Compliance

- Labor Code compliance.
- Administrative regulation compliance.
- Licensing.
- Audits.
- Documentation incentives.
- Ethics requirements substituted for structural change.

24. Governance

- Executive incentives.
- Performance metrics that reward bad behavior.
- Organizational silos.
- Artificial intelligence governance failures.
- Lack of accountability.
- Weak quality assurance and audit.
- Absence of continuous improvement.

25. System Design

These misalignments arise from the system's structure rather than from any individual participant.

- Fragmented accountability.
- Silo budgeting.
- Conflicting statutory objectives.
- Fee-for-service payment models.

- Adversarial legal structures.
- Delayed dispute resolution.
- Regulatory overlap.
- Misaligned financial responsibility.
- Corporate merger reductions affecting claims and risk management functions.
- Underwriting cycles that reduce safety investment during soft markets.
- Statutes of limitation that expire before fraud patterns become visible.
- Confidential settlements that suppress system learning.
- Activity-based rather than outcome-based performance measures.
- Inadequate outcome measurement.

Relationship to the Companion Documents

This compendium is the reference list. The standard against which each entry should be judged is in Appendix A, the classification in Appendix B, and the reasons these structures persist in Appendices C and D.