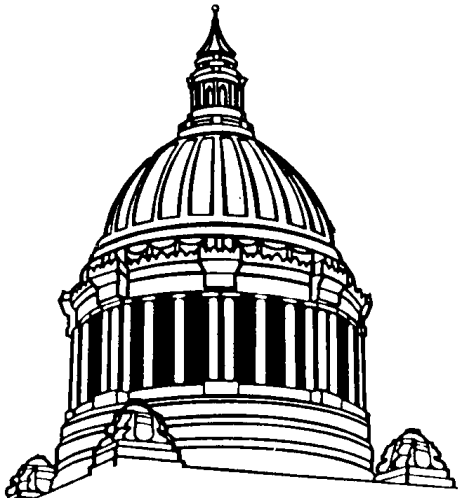

State of Washington
Joint Legislative Audit and Review Committee

Worker's Compensation System Performance Audit

Report 98-9

Prepared by Edward M. Welch for the Joint Legislative Audit and Review Committee.

December 11, 1998

Upon request, this document is available in alternative formats for persons with disabilities.

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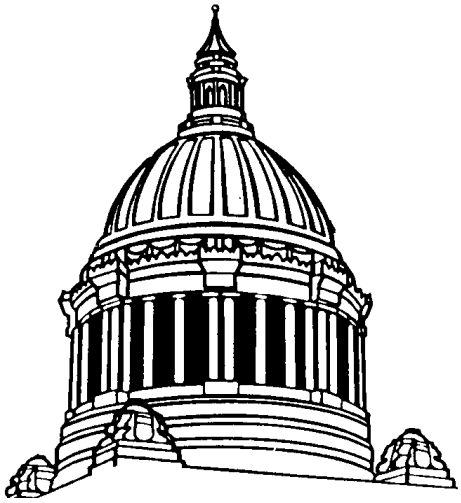
The Joint Legislative Audit and Review Committee

Established by Chapter 44.28 RCW, the Joint Legislative Audit and Review Committee (formerly the Legislative Budget Committee) provides oversight of state funded programs and activities. As a joint, bipartisan legislative committee, membership consists of eight senators and eight representatives equally divided between the two major political parties.

Under the direction of the Legislative Auditor, committee staff conduct performance audits, program evaluations, sunset reviews, and other types of policy and fiscal studies. Study reports typically focus on the efficiency and effectiveness of agency operations, impact of state programs, and compliance with legislative intent. As appropriate, recommendations to correct identified problem areas are included. The Legislative Auditor also has responsibility for facilitating implementation of effective performance measurement throughout state government.

The JLARC generally meets on a monthly basis during the interim between legislative sessions. It adopts study reports, recommends action to the legislature and the executive branch, sponsors legislation, and reviews the status of implementing recommendations.



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Appendices

Due to the volume and length of the material referenced, appendices to this report are not available electronically. Copies may be obtained upon request from Barb Neff or Curt Rogers at (360) 786-5171, 506 16th Avenue SE, PO Box 40910, Olympia, WA 98501-2323.

PERFORMANCE AUDIT OF THE WASHINGTON STATE WORKERS' COMPENSATION SYSTEM

Summary

EXECUTIVE SUMMARY

This is the report of a performance audit of the Washington State Workers' Compensation System conducted under a contract with the Joint Legislative Audit and Review Committee (JLARC) by Edward M. Welch of Michigan State University with the assistance of numerous subcontractors. The results of the audit consist of this final report and 21 appendices. Our formal conclusions and recommendations are contained in the report.

System Overview

In Appendix A we present an overview of the Washington State Workers' Compensation System. We summarize in this report some ways in which Washington is unique or unusual (Chapter 2). It is one of only six states in which workers' compensation insurance is only available from a state-operated fund. This has substantial effects throughout the system. Self-insurance is also an alternative, but it is only available to large employers and certain public entities. Employers insured through the state fund have an option of being insured through a retrospective rating plan. This option is most often used by groups of medium to small size employers.

Washington is unique in several ways

Washington is also unique in that it uses hours worked instead of payroll amounts as the basis for insurance premiums and it charges workers for part of the cost of the system. These factors shift the cost to a certain degree, but do not otherwise impact the system. Washington is also unique or unusual in the way claims

are reported, the way claims are managed, and the formal procedures used to close claims.

Workers' compensation is the exclusive remedy workers have against their employers for workplace injuries. They do not have to prove fault in order to receive benefits, and they cannot sue their employer even if it was at fault. We found that, in general, the laws in Washington were in line with other jurisdictions in this regard.

Benefits and Costs

Relatively high benefits and low costs

The broadest measures available of the success of a workers' compensation system are the benefits it pays and the costs it charges. By these measures, Washington is doing quite well. As can be seen from Figures A and B, Washington pays benefits that are higher than average and charges costs that are lower than average. Washington is above the 75th percentile in benefits paid and below the 25th percentile in costs charged (Chapter 3).

Figure A
Average Benefit, 1998

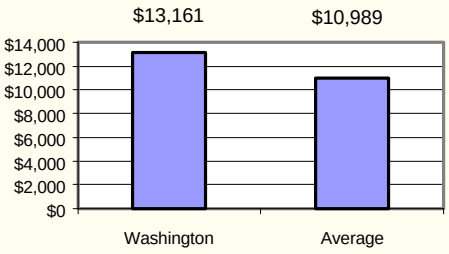
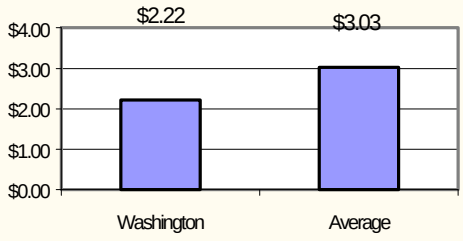


Figure B
Average Premium Rate, 1995



Although the Washington system appears to be doing quite well by these objective measures, there is room for improvement.

Worker Outcomes

We measured the rates at which injured employees returned to work in Washington (Chapter 4). Seventy-five percent of injured workers are back to the job within about three months but a significant number, even among those who receive only short-term benefits, had not returned to work three-and-a-half years

after their injury. In measures of return to work, there were few differences between retrospectively-rated employers and other employers insured by the fund. Workers employed by self-insured employers returned to work faster and received less in time-loss benefits. When we looked at longer term measures of return to work, however, there were few significant differences between self-insured employers and employers insured by the fund.

We also looked at the amount of wages lost by workers as a result of their injuries. We found that in all categories of disability a small but significant number of workers continued to suffer a wage loss for long periods of time. To a substantial extent, this wage loss is not replaced by their workers' compensation benefits. The benefits paid to workers did not coincide well with the extent of their wage loss. This was especially true for workers who received an award for permanent partial disability. Workers who had low permanent partial ratings suffered a more serious unreplaced wage loss than those with higher ratings.

A significant portion of injured workers do not return to work or have a long term wage loss.

A substantial portion (between 12 and 38 percent) of the workers we surveyed reported that they wound up depleting their savings, losing a home, car, or other significant assets, and relying on Aid to Families with Dependent Children (AFDC) or other similar programs. Workers also expressed serious concerns that they might lose their job or suffer other adverse consequences as a result of filing a workers' compensation claim.

Customer Satisfaction

We conducted a survey of injured workers (Chapter 5). We found that generally workers were divided into two camps, those who had a good experience with the system and those who had a bad experience. Very few were neutral. Between 20 and 40 percent of the injured workers we talked to felt that the system participants they dealt with did not behave ethically, did not consider their point of view, did not base decisions on accurate information, did not provide them with explanations for their actions, and did not treat them with dignity and respect. It should be noted that the response rate to our survey was quite low. It is very likely that we talked to the people who are most dissatisfied with the system. However, even if these findings represent only a small portion of

the workers involved in the system, they deserve serious attention.

Many employers express considerable dissatisfaction with the system

We met with employers in focus groups and in other meetings. The employers we met with expressed great dissatisfaction with the present system, especially with the service they received from the Department of Labor and Industries (L&I). They complained about delays, inadequate communication, inconsistency in decisions and policies, and in general, the service they received. Our findings differ from some surveys that have been conducted by the department. They do not necessarily result in a finding that the department is operating badly. They do, however, clearly point to areas in which there is room for improvement.

Financial Outcomes

In Chapter 6, we illustrate the ways in which the financial outcomes of the Washington Fund differ from those of the private insurance industry. In general, the fund delivers a larger percentage of its income in benefits to injured workers.

In recent years, the fund has built up an excess surplus which it has returned to policyholders through lower rates (and, very recently, through an announced dividend). In this respect, the operations of the fund are very similar to what we have seen in recent years in private insurance.

Operational Analysis

Our operational analysis of the system constituted the largest chapter in our audit (Chapter 7). We found that, in general, the system was very formal and legalistic. It does a reasonably good job of detecting and prosecuting fraud, but there was room for much improvement in the prevention of fraudulent and troublesome claims.

The system could be improved if those functions which are typically performed by an insurance company were separated from other functions within the department. There was also a need for more direct accountability to workers and employers who are the customers of the system. We recommend a change in the organization of the system to address these problems.

Within the claims area, too often the goal of claims management was a finding of employability and a formal closure of the claim rather than a successful return to work of the injured worker.

Payments in Washington are very slow to begin

Workers in Washington experience a substantial delay between the time an injury occurs and the time they receive their first payment. Washington does not even regularly measure the pay lag in this manner. (It measures instead the delay from the time the department receives a report.) The delay in payment causes obvious problems for workers and also delays the active management of the claim by the department and the involvement of the employer.

As mentioned above, we found a great deal of dissatisfaction with the claims system by both employers and workers. There was also little involvement in the management of claims by insured employers. Most private insurers throughout the country have found that they can improve their results if the employers are actively involved early in the claim.

In Washington, claims involving insured employers are ordinarily reported by the worker to a doctor who then reports to the department. This is unusual, if not unique. It results in delayed payment to the worker and less involvement by the employer. All other jurisdictions that we know of use a system in which the worker reports the injury to the employer and it reports to the department. We recommend that Washington change to such a system.

We found numerous ways in which the approach of the department deviated from what we consider to be the best practices for managing workers' compensation claims.

- Claims handlers were organized into units of up to 20 people without close assistance or supervision from a manager experienced in handling workers' compensation claims.
- In most cases, an employer deals with a different claims manager for each of its claims.

- Prompt personal contact with the worker, the employer, and the treating doctor is delayed, if it takes place at all.
- Individual claims handlers do not set the reserves on their claims. The setting of reserves by claims adjusters results in accurate, timely reserves and helps the adjusters make decisions about the handling of files and monitor their development.
- Washington claims managers almost never visit the workplaces that are involved in the claims they manage.

Proposed changes in claims management

Washington uses a formal system for the closing of cases. It requires a great deal of time from claims managers and the use of many independent medical examinations. We suggest that it could be replaced by a much simpler system.

Washington oversees self-insured employers more closely than most states

We heard complaints that the state fund does not manage claims properly and is inconsistent in the claims decisions it makes. We also heard complaints that self-insurers are held to different standards than the state fund. We recommend that the department create a compliance unit which would monitor the performance of the state fund and self-insured employers.

We noted that the department does very little to regulate attorney fees, the use of refunds paid to retro groups, and third party administrators. We do not recommend regulation in these areas, but we do recommend that the department provide information about these areas to the workers and employers involved.

In Washington, as in many states, most of the very large employers are self-insured. Our return to work and wage loss studies showed that employees of these firms return to work more quickly and receive less in time-loss benefits than other workers. On longer term measures of return to work and wage loss, however, there were few differences. The department oversees and regulates the operation of self-insured employers to a greater extent than almost any other state. If a compliance unit and an office of mediators or ombudsmen described in the report can be

implemented successfully, we recommend that this oversight be relaxed.

We reviewed the department's use of resources. Its ratio of loss adjustment expense to losses is smaller than for private insurers. (It is spending less than private insurers.) We found some evidence that, to a small extent, insurance funds are supporting other activities of the department. In the claims area, we recommend a complete reorganization of the way resources are used. Given that reorganization and other changes we recommend, there should be enough claims managers to handle the caseload.

Resources appear to be sufficient although they should be reorganized

Dispute Resolution

The dispute resolution process both at the Board of Industrial Insurance Appeals (BIIA) and within the department is complex and formal (Chapter 8). It includes protest and reassumptions rarely used in other jurisdictions. These add an unnecessary layer to the system. We recommend that the department adopt a policy of dealing with these in an expedited fashion.

We also felt that the system could be improved if there was an office of mediators or ombudsmen who could assist workers and small employers. While there will always be some disputes that need attorneys, judges, and formal litigation, other jurisdictions have found that there are many problems which can be resolved quickly and informally if such assistance is made available.

In the area of dispute resolution, we looked in detail at the operation of the Board of Industrial Insurance Appeals. Although parties were often dissatisfied with the outcome in individual cases, we found fewer complaints about the board than about the department. We suggest numerous ways to improve the dispute resolution process. Some of these involve the board and some the department, as discussed above.

Washington is only one of a handful of states that allows superior court review

Washington is one of only a handful of jurisdictions that allows the appeal of workers' compensation claims to superior court where there can be a trial by jury. This adds another step to the process but also does much more. Because courts of general jurisdiction are very formal in their evidentiary and procedural

rules, the presence of this ultimate alternative adds a formality to everything that happens in this system. We recommend that this alternative be eliminated.

Vocational Rehabilitation

Washington has a low standard of employability

We also looked at the use of vocational rehabilitation in Washington (Chapter 9). Under the present system, there is a great deal of emphasis on closing claims by finding that the worker is employable. The system could be improved if the emphasis instead were shifted to the actual return to work of injured individuals.

Washington workers can be denied eligibility for vocational rehabilitation if it is shown that they are employable at a job which pays the federal minimum wage. This denies vocational rehabilitation to many individuals who, as a result of their injury, are not able to return to employment that is equivalent to the work they were doing at the time they were injured. The time and amount of resources which are made available to Washington injured workers for retraining is relatively low. We recommend changes in these areas.

We also recommend steps designed to increase the professionalism in vocational rehabilitation in Washington and specific steps for improvement in the performance-based system for referrals to private vocational rehabilitation counselors.

Efforts to Promote Workplace Safety

We conducted an evaluation of the safety and prevention activities of the department (Chapter 10). The best way for an employer to improve its workers' compensation experience is to prevent injuries. This will have much more impact on individual employers than any activities by the department or any changes in the law. While individual employers and workers have the ultimate responsibility for preventing injuries, the department has a responsibility to assist them. In many ways the department was doing a good job of this, but we have suggested opportunities for improvement.

Actuarial Analysis

Another substantial part of our audit involved an actuarial analysis of the state insurance fund. This involved very technical issues which are discussed in detail in the appendices and are summarized in Chapter 11. The actuaries examined the ways premium rates are set and retrospective rating dividends calculated. They found ways in which these calculations resulted in inequities among the various classifications of work and between retro and non-retro rated employers. In general, they found that the system of calculation results in lower premiums for retro rated employers at the expense of other insured employers.

Rate system calculations result in lower premiums for retro employers at the expense of the other injured employers

They found that the methods used for calculating overall premium rates and measuring reserves were adequate. They agreed with other members of the audit team that case reserves should be set by individual claims adjusters. They found that the contingency reserve maintained by the Washington State Fund was high in comparison to similar reserves maintained by the private insurance industry. In the past, the department has reduced the contingency reserve by charging reduced premiums to future policyholders. The actuaries felt it would be more equitable to return these reserves as dividends to the people who paid premiums in the past. (Since the completion of this audit, the department has announced that it will pay a dividend to past policyholders.)

Change Process

The recommendations we have made are not designed to alter the system to the advantage of either workers or employers. They are instead intended to improve the efficiency of the system for all concerned.

Implementation of these changes will require that the department and all of the parties involved in this system break away from their traditional and sometimes comfortable ways of doing things. For the most part, however, they are not new ideas. Instead, as discussed in the report, they are in nearly every case approaches that have been used in a large number of other states or by private insurance companies. They can be done in Washington.

Most of our recommendations will help both the worker and employers

Perhaps the most important thing needed is an increased spirit of cooperation between labor and management. There will always be some differences concerning workers' compensation. There are, however, many changes which result in better service to both workers and employers. We encourage the business and labor communities to cooperate in implementing such changes.

RECOMMENDATIONS

Summary

Recommendation 1

The department should consider the possibility of having a board that would oversee its activities that are related to insurance services.

Legislation Required:	Yes
Fiscal Impact:	There would be small costs associated with providing a staff and holding meetings for the board. The board members would be paid travel expenses and nominal honoraria.
Completion Date:	The department already shares much information with the Workers' Compensation Advisory Committee. It could begin immediately expanding the role of that committee. Full implementation should occur in a year.

Recommendation 2

The department should adopt an alternative system for the reporting of injuries under which the worker would report to the employer and the employer would report to the department. An educational effort should be launched to promote this method of reporting.

Legislation Required:	The department believes yes, but as discussed in the report, we question this.
Fiscal Impact:	This should simplify the process involved in opening claims and thus reduce the cost to the department. There would be start-up costs in educating workers and employers about the new approach. Through better claims management, this should result in reduced losses.
Completion Date:	This would require six months of planning followed by one year of implementation.

Recommendation 3

The claims functions should be organized into units that include five to seven claims adjusters, clerical support, and a claims supervisor.

Legislation Required:	No
Fiscal Impact:	It will require a rearrangement, but no net change in resources. Through better claims management, this should result in reduced losses.
Completion Date:	This could be started in a few units within four months. It would require an additional year for full implementation.

Recommendation 4

To the greatest extent possible, employers should be assigned to an individual claims adjuster.

Legislation Required:	No
Fiscal Impact:	It will require a rearrangement, but no net change in resources.
Completion Date:	This could be started in a few units within four months. It would require an additional year for full implementation.

Recommendation 5

Claims management duties should be changed as follows:

- There should be a personal contact with the three key parties involved in a claim as soon as possible and no later than 48 hours after a report is received.
- All new claims should be reviewed by a claims supervisor within three days after the report is received.
- The people handling claims should set reserves on those claims.
- The people handling claims should be required occasionally to visit the workplaces involved.
- Claims adjusters should have sufficient support for clerical and investigative tasks.

Legislation Required:	No
Fiscal Impact:	There will be some training and other costs involved in the transition to the new system. Concerning on-going costs, there will be an increase in costs related to workplace visits and investigations. Through better claims management, this should result in reduced losses.
Completion Date:	Implementation of parts of this could begin immediately. It will take 18 month to implement fully.

Recommendation 6

The measurement of claims management performance should be changed to emphasize prompt payment, three-party contact, and successful return to work.

Legislation Required:	No
Fiscal Impact:	None Through better claims management, this should result in reduced losses.
Completion Date:	Six months

Recommendation 7

There should be less reliance on the formal claim closure process.

Legislation Required:	Yes
Fiscal Impact:	There will be some small transitional costs. In the long run it should result in a substantial reduction of costs to the department and reduced losses.
Completion Date:	Two years

Recommendation 8

There should be a compliance unit within the department which monitors the operation of the insurance services division and self-insured employers.

Legislation Required:	No
Fiscal Impact:	There will be a cost to the creation of the unit and costs associated with the ongoing operation of the unit.
Completion Date:	It could be partially implemented without legislation in six months. Complete implementation will take another year.

Recommendation 9

The department should offer some form of ongoing refresher training for all individuals who are managing claims.

Legislation Required:	No
Fiscal Impact:	There will be small ongoing costs for this training.
Completion Date:	Two months

Recommendation 10

Once the department has in place a compliance unit and a system of ombudsmen or mediators, the current oversight of the claims processes of self-insured employers should end.

Legislation Required:	Yes
Fiscal Impact:	This will result in an ongoing reduction of costs for the department.
Completion Date:	Two years

Recommendation 11

When the department begins sending monthly checks through an attorney or when it sends any lump-sum payment through an attorney, it should notify the claimant of the rate or the amount of the payment or payments sent to the attorney and the statutory limit on attorney fees.

Legislation Required:	No
Fiscal Impact:	There will be a small cost associated with mailing this information to workers.
Completion Date:	Nine months

Recommendation 12

When the department sends dividends to a retro group, it should notify the member employers of the amount of the dividend and the basis for its calculation.

Legislation Required:	No
Fiscal Impact:	There will be a small cost with calculating this information and mailing it to employers.
Completion Date:	Nine months

Recommendation 13

The department should collect and publish information about the performance of third-party administrators to the extent it becomes available through audits and otherwise.

Legislation Required:	No
Fiscal Impact:	There will be start-up costs to create a system for calculating this data. There will be some ongoing costs for its continued calculation and publication.
Completion Date:	Nine months

Recommendation 14

The department should develop a system of allocating indirect costs among its funding sources and publish financial statements which clearly indicate where its funds come from and how they are spent.

Legislation Required:	No
Fiscal Impact:	There will be small ongoing costs associated with the preparation and publication of these reports. It is possible that when these reports are published, it will become apparent that insurance funds are subsidizing other operations. If that happens, it may result in a shift of costs from insurance funds to general tax funds.
Completion Date:	Six months

Recommendation 15

The department should create a system of mediators or ombudsmen to provide assistance to workers and employers.

Legislation Required:	No
Fiscal Impact:	There will be a training cost associated with the creation of this unit and there will be ongoing costs associated with its staffing and with publicizing the availability of this function. These costs will be offset by the savings from resolving disputed cases in a less formal manner.
Completion Date:	Six months

Recommendation 16

The department should adopt a policy that all protests and reassumptions are resolved within 30 days.

Legislation Required:	No
Fiscal Impact:	This will result in substantial savings to the department.
Completion Date:	Three months

Recommendation 17

Superior court review of decisions by the Board of Industrial Insurance Appeals should be eliminated.

Legislation Required:	Yes
Fiscal Impact:	This will result in direct savings to the department from the cases which are no longer appealed. It will result in other savings through less formal procedures in all claims.
Completion Date:	Two years

Recommendation 18

The primary goal of vocational rehabilitation as formally stated and as observed in practice should be successful return to work of the injured worker.

Legislation Required:	Full implementation will require legislation. Partial implementation can be effected without legislation.
Fiscal Impact:	This will not result in any increased cost to the department. It will require more resources in some cases, but this should be offset by a reduction in litigation and re-openings.
Completion Date:	Partial implementation can begin in four months; full implementation will require an additional year.

Recommendation 19

The standard for employability as it relates to vocational rehabilitation benefits should be some portion of wages at the time of injury rather than the federal minimum wage.

Legislation Required:	Yes
Fiscal Impact:	This will result in increased costs and some additional staffing to the department and increased losses through an increase in the number of workers who are eligible for vocational rehabilitation benefits.
Completion Date:	Eighteen months

Recommendation 20

Increase the current monetary and time limitations on retraining.

Legislation Required:	Yes
Fiscal Impact:	This will result in increased costs and some additional staffing to the department and in an increase in losses because of the increase in benefits to workers. This will result in increased costs to employers.
Completion Date:	Eighteen months

Recommendation 21

There should be an increased professionalism with regard to vocational rehabilitation within the department, specifically:

- The department should move towards requiring higher standards of private sector rehabilitation providers.
- There should be better availability of qualified, professional rehabilitation counselors to assist and advise claims managers within the department.
- There should be more effective training of claims managers and vocational rehabilitation providers concerning best practice methods for achieving the department's hierarchy of return to work objectives, including the appropriate goals for and effective use of vocational rehabilitation services.
- The sections within the department charged with evaluating, contracting and managing, and setting policy for vocational rehabilitation should include

managerial leadership by individuals who are qualified and experienced vocational rehabilitation professionals.

Legislation Required:	No
Fiscal Impact:	There will be direct costs to the department in implementing the changes involved. In the long run, it may also increase the vocational rehabilitation costs to the extent that more qualified professionals will expect higher compensation.
Completion Date:	Partial implementation could begin in four months. This will require an additional year for full implementation.

Recommendation 22

With regard to a performance-based referral system:

- Performance standards of quality and effectiveness in vocational rehabilitation practice should be adequately defined to determine the appropriate indicators to be used and how best to measure them.

- Measures of satisfaction should include and focus primarily on injured workers and employers.

- The evaluation mechanism should include a minimally acceptable threshold for referral.

- The full range of the provider's activity in serving state fund cases should be considered in evaluating performance.

- All of the parties involved should be assured that once the evaluation is established, it would be used in making referrals. This assurance should be accomplished by formalizing and announcing the procedures that will be used to accomplish it.

Legislation Required:	No
Fiscal Impact:	No change. The department is already in the process of doing this.
Completion Date:	One year

Recommendation 23

We recommend a series of changes in the departments safety related activities that are designed to:

- Expand emphasis on the prevention and control of musculoskeletal disorders.
- Develop methods for more closely integrating service involving hazard identification and control, with service aimed at controlling workers' compensation losses.
- Improve the customer-focused orientation of service content and delivery.
- Improve service communications and recordkeeping.
- Provide more detailed information to employers about the availability of specific services.
- Improve responsiveness and timeliness of service delivery.
- Better coordinate services between various consulting entities and eliminate redundancy.

Legislation Required:	No
Fiscal Impact:	There will be a cost to implementing the changes. In the long run, the overall costs should be about the same. This will result in fewer injuries and reduced losses.
Completion Date:	Implementation should begin within four months and will require an additional year for implementation.

Recommendation 24

We recommend that the department produce (either through its own actuaries or through an outside independent consulting company) a well-documented, exhaustive actuarial rate filing report detailing all assumptions and methods used. It should be similar to reports that are submitted to regulatory authorities by a licensed insurance company in states that use a "prior approval" rate filing procedure.

Legislation Required:	No
Fiscal Impact:	There will be an annual cost for the preparation of this report.
Completion Date:	One year

Recommendation 25

Adopt a plan by which excess premiums are returned as dividends to prior contributors–both employers and employees–that generated the excess premiums, rather than to future policy holders/contributors as reduced rates.

Legislation Required:	No
Fiscal Impact:	No increased cost.
Completion Date:	Already implemented by the department.

Recommendation 26

Adopt changes in the rate setting process that are discussed in detail in Appendices P and Q and which are designed to minimize cross subsidies.

Legislation Required:	No
Fiscal Impact:	There will be a cost in having actuaries review the rate setting process. Once the review is completed, there should not be continuing costs.
Completion Date:	Begin within three months, complete within one year.

Recommendation 27

As explained in Appendix R, the department should adopt adjustments to its retrospective rating plan which are designed to make its application more balanced actuarially.

Legislation Required:	No
Fiscal Impact:	There will be a cost to having actuaries make the necessary adjustments. Once the adjustments are made, there should be no increased cost in maintaining the system.
Completion Date:	Begin within three months, complete within one year.

Recommendation 28

The department should establish underwriting guidelines to avoid adverse selection by employers in retrospective rating plans.

Legislation Required:	No
Fiscal Impact:	There will be some costs involved in creating the guidelines and in enforcing them on a continuing basis.
Completion Date:	Begin within three months, complete within one year.

Recommendation 29

As explained in Appendix R, the department should institute a dividend plan that applies to both retrospectively rated and non-retrospectively rated employers. A properly designed dividend plan would eliminate the need for the performance adjustment factor, or a loss conversion factor of less than 1.0, and would also provide an appropriate mechanism to release excess reserves equitably.

Legislation Required:	No
Fiscal Impact:	There will be a cost in developing the plan. Once it is implemented, however, there should be no increased ongoing cost.
Completion Date:	Begin immediately, complete within one year.

Recommendation 30

We recommend that the department produce (either through its own actuaries or through an outside independent consulting company) a well documented, exhaustive actuarial reserve report detailing the assumptions and methods used. Such a report should be similar to those that are submitted to regulatory authorities by private insurance companies.

Legislation Required:	No
Fiscal Impact:	There would be an annual cost in producing the report.
Completion Date:	One year

Recommendation 31

Case reserves, particularly in lost-time claims, should be set as early as possible by the claims adjusters responsible for handling each individual claim.

Legislation Required:	No
Fiscal Impact:	It will require a rearrangement, but no net change in resources.
Completion Date:	Implementation could begin immediately, but it will take 18 months to fully implement.

Recommendation 32

As discussed in Appendix U, we recommend adjustments that are designed to more equitably distribute costs between retro and non-retro employers.

Legislation Required:	No
Fiscal Impact:	There will be a cost to making the adjustments to the current system. Once the adjustments are made, however, there should be no increase in ongoing costs.
Completion Date:	Begin in some units within three months, fully implement across the department in 18 months.

FISCAL NOTE

In the recommendations above, we comment on the fiscal impact of the recommendations. With the exception of Recommendation 14, these recommendations will not have any impact on general tax funds. Instead, the impact will fall on insurance premiums that are collected from employers and workers and/or assessments on employers.

In some recommendations, we comment on an effect this will have on "losses". By this we mean benefits paid to injured workers and medical providers. Where we indicate there will be a savings, we believe it will come through (1) earlier but appropriate return to work, (2) less delay in the closing of cases, and (3) the denial of benefits in a small number of cases that are inappropriately paid under the present system. Some of the recommendations will result in an increase in losses through an increase in benefits to workers.

If all the recommendations are adopted, there should be a net overall reduction in losses, which will more than compensate for the increased administrative costs.

SUMMARY OF RECOMMENDATIONS

Items the department should begin working on immediately:

Recommendation 3: Organization of claims functions

Recommendation 4: Employers assigned to adjuster

Recommendation 5: Claims management duties

Recommendation 6: Measurement of claims management performance

Recommendation 9: Refresher training

Recommendation 14: Allocating indirect costs and publishing financial statements

Recommendation 16: Protests and reassumptions resolved in 30 days

Recommendation 18: Goal of vocational rehabilitation

Recommendation 21: Increased professionalism with regard to vocational rehabilitation

Recommendation 22: Performance-based referral system

Recommendation 23: Safety related activities

Recommendation 24: Rate filing report

Recommendation 25: Pay dividends

Recommendation 30: Reserve report

Recommendation 31: Claims managers set case reserves

Items the department can do with a little more time:

Recommendation 11: Notification regarding attorney fees

Recommendation 12: Notification of retro group dividends

Recommendation 13: Publish information about third-party administrators

Recommendation 26: Changes in rate setting process

Recommendation 27: Changes to retrospective rating plan

Recommendation 28: Underwriting guidelines for retrospective rating plan

Recommendation 29: Institute new dividend plan

Recommendation 32: Adjust cost distribution between retro and nonretro employers

New units that will need to be created:

Recommendation 8: Compliance unit

Recommendation 15: Mediators or ombudsmen

Items that will require significant legislative or regulatory action:

Recommendation 1:	Board governing insurance activities
Recommendation 2:	Employer reporting of injuries
Recommendation 7:	Claim closure process
Recommendation 10:	Oversight of the claims processes of self-insured employers
Recommendation 17:	Superior court review eliminated
Recommendation 19:	The standard for employability for vocational rehabilitation
Recommendation 20:	Increase the current monetary and time limitations on retraining

INTRODUCTION

Chapter One

THE AUDIT

This is a report of a performance audit of the Washington State Workers' Compensation System. The audit was conducted under a contract between Edward M. Welch of Michigan State University and the Joint Legislative Audit and Review Committee (JLARC). Various subcontractors conducted parts of the audit.

This audit has been conducted in accordance with government auditing standards as published by the Comptroller General of the United States. Our findings are supported by sufficient, competent, and relevant evidence. The basis for our findings and comments is indicated in this report or in the attached appendices. To the greatest extent possible, we have based our findings and comments on objective evidence documented in this report or a supporting appendix or work paper. As we indicated in our proposal, there are some areas in workers' compensation where objective evidence is not available. When we have relied on the judgment and experience of members of the audit team, we have so indicated.

ORGANIZATION OF THIS REPORT

There were several major components of this audit. The results of each are described in detail in one or more appendices to this report. In the body of the report, we have summarized and integrated the results of those components and have stated our specific recommendations concerning the Washington State Workers' Compensation System.

The findings, conclusions, and recommendations found in this report represent the consensus of the audit team. The appendices serve various purposes. In most cases, they contain a more detailed description of the analysis we conducted and of the basis for our findings. In some cases, they expand and provide more detail on the recommendations we have offered. In a few cases, such as Appendix I, Insurance Viewpoint, they provide a particular point of view on one or more issues.

The various chapters of the report and supporting appendices are as follows:

Outline of the report

1 Introduction

2 System Overview
- A Overview of System
- B Exclusive Remedy

3 Benefits and Costs
- C Benefit Study
- D Cost Study

4 Worker Outcomes
- E Return to Work Study
- F Wage Loss Study

5 Customer Satisfaction
- G Workers' Survey
- H Employer Focus Groups

6 Financial Outcomes

7 Operational Analysis
- I Insurance Viewpoint

8 Dispute Resolution

9 Vocational Rehabilitation
- J Vocational Rehabilitation Audit Final Report
- K Summary Report of VR Survey Results

- L Qualitative Study of the VR Program and Its Impacts
- M Comparison of State Fund VR to Self-Insured and Other WC Systems

10 Efforts to Promote Workplace Safety
- N Safety Study

11 Actuarial Analysis
- O Exposure Base and Unique Classification (E1)
- P Rate Setting Practices (E3)
- Q Evaluation of the Degree of Cross Subsidies in the Rating System (E4)
- R Comparison of Retrospective Rating Plan Design (E5)
- S Reserve Report (E6)
- T Case Reserve Report (E7)
- U Performance of the Retrospective Rating Plan (E8)

Chapters 2 through 6 contain descriptive and analytical information as well as many findings. Our formal recommendations are found in Chapters 7 through 11.

THE AUDIT TEAM

Below we list the members of the audit team. We describe very briefly their background and indicate the portions of the audit in which they were primarily involved. It should be noted that there was considerable overlap, and in many cases team members contributed to many parts of the audit.

Jeff E. Biddle, Department of Economics, Michigan State University; Return to Work and Wage Loss Studies.

Phillip Bork, JD, Consultant; Former Member and Chair, Washington Board of Industrial Insurance Appeals; President and Executive Director, International Association of Industrial Acts and Boards and Commissions; Dispute Resolution.

John F. Burton, Jr., Ph.D., Dean, School of Management and Labor Relations, Rutgers University; Chair, National Commission on State Workmen's Compensation Laws, 1972; Chair, Steering

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Company; Past President, Workers' Compensation Claims Association of Oregon; Dispute Resolution and Operational Analysis.

Srinivasa Ramanujam, MAAA, FCAS, FCIA, ARM, ARe, CPCU; Actuary, Insurance Industry Consultants; Actuarial Study

Karen Roberts, Ph.D., School of Labor and Industrial Relations, Michigan State University; Workers' Survey.

Daryl C. Royal, Attorney; Exclusive Remedy.

J. Frances Saroki, MA, Graduate Assistant, Office of Rehabilitation and Disability Studies, Michigan State University; Vocational Rehabilitation Study.

Terry L. Thomason, Ph.D., Faculty of Management, McGill University; Benefit and Cost Studies.

Ervin Vahratian, Consultant; Formerly Director and Deputy Director, Michigan Bureau Disability Compensation; Dispute Resolution.

Edward M. Welch, JD, School of Labor and Industrial Relations, Michigan State University; Director, Michigan Bureau of Disability Compensation, 1985-1990; Principal Investigator and Director of the Audit, Prepared the Final Report, Operational Analysis, and Self-Insurance Study.

Donna B. Winthrop, Consultant, Alternative Resource Center; Workers' Survey and Employer Focus Groups.

AGENCY RESPONSES

We have shared the report with the Office of Financial Management (OFM), the Department of Labor and Industries, and the Board of Industrial Insurance Appeals, and provided them an opportunity to submit written comments. We received written comments from the Department of Labor and Industries and the Board of Industrial Insurance Appeals. Their response, as well as the auditor's comments to their response, are provided in Chapter 13.

ACKNOWLEDGEMENTS

A crucial issue for an audit is the extent of cooperation from the department being audited. The cooperation of the Department of Labor and Industries (and the Board of Insurance Industrial Appeals) has been excellent. They have accommodated us and provided assistance in virtually every way we requested. For this, we must first express appreciation to Gary Moore, Director, Department of Labor and Industries, and Doug Connell, Assistant Director, Insurance Services Division. We are also especially grateful to Catherine McDonald who acted as the coordinator for this project. She was immensely helpful in every respect. We also express our appreciation to her assistant, Dawn Deck. Many other people within the department were of great assistance to us. It would be impossible to list them all here. Two people, however, were especially helpful in obtaining data. They were William Vasek, FCAS, Ph.D., and Carl F. Wolfhagen.

At the Board of Industrial Insurance Appeals, board members, Frank E. Fennerty, Jr., Judy Schurke, S. Frederick Feller, and Thomas E. Egan, as well as numerous staff members at the board, were very helpful in providing information.

People who helped

We are also greatly appreciative of the cooperation and assistance we received from the Joint Legislative Audit and Review Committee through Larry Brubaker. Larry not only insisted that we meet the highest possible standards in preparing our audit, he also assisted us in achieving those standards.

We received assistance from literally hundreds of people in the state of Washington. We hesitate to list them because we know we will inevitably neglect someone who was especially helpful. However, a few people stand out and must be mentioned. From the outset, we were greatly assisted by Robby Stern of the Washington State Labor Council and Clifford Finch of the Association of Washington Businesses. They provided an entrée for us to the labor and business communities. Margie Weinburg was especially helpful in providing contacts within the self-insurance community and Betty Rehberg was helpful in contacting employer retro groups. Michael Temple assisted us in contacting trial lawyers.

The members of our Technical Review Advisory Committee were also especially helpful. They included: Abdul-Aleem Ahmed, IAM & AW Lodge 751; Larry Bellinger, The Boeing Company; Joanne Collier, TOC Management Services; Doug Connell, Department of Labor and Industries; Steven E. George, Hop Growers of Washington; Bill Johnson, US Marine; Jeffrey Johnson, Washington State Labor Council; Wayne Lieb, Attorney; Catherine McDonald, Department of Labor and Industries; Terry Peterson, Comprehensive Risk Management; Teri Rideout, Attorney; Don Scoville, Puget Sound Educational Service District; Rick Slagle, Attorney; Robby Stern, Washington State Labor Council; Mike Welch, Attorney; Roger Yockey, UFCW Local 1105; and Kelli Zimmerman, Washington Contract Loggers Association.

This project also would not have been possible without the cooperation of several officials at Michigan State University. We wish to express our appreciation to Kenneth Corey, Dean, College of Social Science; Michael Moore, Director, School of Labor and Industrial Relations; Theodore Curry, Associate Director, Human Resource Education and Training Center; and Fred Salas, Office of Contract and Grant Administration.

Thomas M. Sykes
Legislative Auditor

On December 11, 1998, this report was approved by the Joint Legislative Audit and Review Committee and its distribution authorized.

Representative Cathy McMorris
Chair

SYSTEM OVERVIEW

Chapter Two

INTRODUCTION

In this chapter, we provide a broad overview of the Washington State Workers' Compensation System. We will begin with a very broad overview of what workers' compensation is and how it works. It will be followed by a chapter that highlights the ways in which Washington's system differs from most other jurisdictions. This will be followed by discussions of the exclusive remedy, insurance alternatives, and the responsibility of employers. Many of the issues that are discussed very broadly here are reviewed in more detail in other chapters of the report.

WORKERS' COMPENSATION IN GENERAL

What is workers' compensation?

Workers' compensation is the system by which society compensates individuals who suffer illness or injuries related to their employment. Prior to its creation in the second decade of this century, injured workers could only receive compensation from their employers if they could establish that the employer was in some way negligent or at fault. If they could establish this, they received whatever benefits a jury would give them, including compensation for pain and suffering and loss of enjoyment of life.

The workers' compensation system was a trade-off. Employees receive benefits for a work related injury regardless of who was a fault. They are, however, only entitled to limited, specified damages. They receive certain indemnity benefits to compensate them for their wage loss, medical benefits, and certain vocational rehabilitation benefits but nothing else. Workers' compensation is

their exclusive remedy. They are not allowed to sue their employers for personal injuries.

To be compensable, it is not ordinarily required that the work be the "cause" of the injury. It is usually enough if the work aggravates or contributes to the condition.

In general, workers receive temporary total or time-loss benefits during a healing period or until their medical condition has stabilized. If they suffer from a permanent impairment that renders them unlikely to ever return to work, they are generally awarded life-long benefits for a permanent and total disability. In Washington, this is called a pension. Workers who suffer a permanent impairment that does not totally disable them receive a permanent partial disability award. This is usually measured in terms of the extent of the physical impairment.

The weekly compensation rate is usually set as a percentage of the worker's income subject to some maximum limit. The rate most frequently used is 66 2/3 percent of the worker's average weekly wage. The most frequent maximum benefit rate is an amount equal to the average wage earned by all employees in the state.

The medical benefits provided under workers' compensation involve no deductibles or co-pays. In general, they cover all the treatment that is needed for the work related injury.

In all states, there is some state agency that supervises the workers' compensation system. It keeps records of the benefits paid, provides information to workers and employers, grants approval for self-insurance, and resolves disputes that arise concerning workers' compensation benefits. This latter function often takes up the greatest part of the agency's time.

All states require that employers provide some security for workers' compensation. This can take three forms: private insurance, a state sponsored insurance company, and self-insurance.

THE WASHINGTON SYSTEM

Appendix A, Overview of the Washington State Workers' Compensation System, provides a more extensive summary of the most important aspects of the Washington system. To the extent possible, it also compares the Washington system to the workers' compensation systems found in other jurisdictions in the United States. We will highlight here a few areas in which the Washington system differs substantially from that found in most other states.

Washington is one of only six states that use an exclusive state fund to provide workers' compensation insurance to employers.[1] This is a pervasive feature of the Washington system. Its effect on the system is discussed throughout this report, especially in Chapter 7, Operational Analysis. We also comment on this issue below under the section "The 'Three-Way' Issue."

Washington bases premiums on hours worked rather than payroll and has a unique listing of job classifications that are used in calculating premiums. These issues are discussed in Chapter 11, Actuarial Analysis. They appear to have some effects on the system, but the effects do not appear to be very great.

How Washington is unusual or unique

In Washington, employees of employers who are insured through the state fund (but not self-insured employers) pay, through a payroll deduction, one-half of the premium for the fund which covers medical benefits provided under workers' compensation. Although no data was provided, we understand that a few employers do not enforce this requirement. It should be noted that vocational rehabilitation, as well as medical expenses, are paid out of this fund. This of course shifts costs to some extent. One might also expect that, as a result of this, workers would be more sensitive to the cost of workers' compensation or organized labor would take some positions which were different because its members pay part of the cost. We were unable, however, to point to any significant way in which the system appears to operate differently because of this provision.

[1] The other jurisdictions with exclusive state funds are Nevada, North Dakota, Ohio, West Virginia, and Wyoming. Nevada is scheduled to allow private insurance beginning in 1999.

In Washington, it is ordinary practice for employees of insured employers to report their injury through their doctor. This is very unusual, if not unique. In most jurisdictions, workers report an injury to their employer and the employer either directly, or through its insurer, reports to the state agency. As discussed in Chapter 7, we feel this approach has a significant impact on the Washington system and recommend that it be changed.

There are several aspects of the claims-handling procedure that are different in Washington, including the very formal way cases are closed. In many jurisdictions, insurers or self-insured employers close their claim files and remove the reserves on a case without having any formal action from the state. There are a number of unique or unusual aspects of the way vocational rehabilitation is handled in Washington. These are discussed in Chapter 9 of this report.

Problem areas

Washington is one of a handful of states that allows an appeal of factual issues to the superior court where there can be a trial by jury. This is discussed in more detail in Chapter 8. We recommend that it be changed.

We would also draw attention to the ways in which Washington calculates the benefit rate for temporary and seasonal employees. There is a great deal of controversy over this issue. This is not unique to Washington. We find it in other jurisdictions as well. We would point out, however, that it is a cause of difficulty in a great many cases. If the parties involved in workers' compensation in Washington could work together to clarify and perhaps simplify this calculation, it would contribute significantly to a reduction in problems that are seen in the system.

Finally we would draw attention certain interrelated concepts and procedures in the Washington system. These have to do with:

- The concept of “employability”
- The criteria for stopping time-loss benefits
- The eligibility criteria for vocational rehabilitation

- The criteria for closing a claim
- The effect of closing a claim

These are crucial concepts that are used every day, but we found considerable confusion concerning them. For example, it is widely assumed that the closing of a case terminates a worker's right to further medical care. The department has pointed out to us that this is not the case. This is discussed further in Chapters 3, 7, and 11.

EXCLUSIVE REMEDY

When a worker can and cannot sue the employer

The Request for Proposals (RFP) raised specific concerns about the exclusive remedy provision of Washington's law. Under workers' compensation systems, workers receive benefits without regard to fault. In return, employers are protected from civil actions filed by workers. In other words, workers' compensation is the "exclusive remedy" that workers have against their employers. In Washington and elsewhere, employers are concerned about the possible erosion of their protection under the exclusive remedy principle. Daryl C. Royal researched the legal standing of the exclusive remedy in Washington and compared it to national trends. His findings are found in Appendix B. We will summarize them here.

The Washington exclusive remedy provision appears to be a fairly typical one, which tracks the majority view in this country in most respects. Washington has adopted an intentional tort exception slightly looser than the common statute, permitting an action to proceed even if there was not a specific intent to injure. However, the standard is still a stringent one that requires that an injury be certain to occur before it will come into play. This is a stricter standard than the "substantial certainty" standard adopted by some states breaking from the majority. As a result, Washington employers are likely to have an average exposure to civil suits for work-related injuries.

THE "THREE-WAY" ISSUE

As mentioned above, Washington is one of only six states in which there is an exclusive state fund. In other jurisdictions, employers

are able to buy insurance from private insurance companies. In about 20 states, they have a choice of buying insurance from private insurance companies or a competitive state-operated fund. In Washington, the term "three-way" refers to an option under which employers could be self-insured, purchase insurance from private insurance companies, or purchase insurance from a state fund.

Traditionally and at present in Washington, employers believe that a system that at least allows competition from private insurers is superior and will result in greater efficiency. Organized labor generally believes that such as system will be inferior in numerous respects and that it is improper to allow an insurance company to profit from the sufferings of injured workers.

A state fund versus private insurance

When the RFP for this audit was published, we and other bidders asked if the desire to move to a three-way system was the main reason behind the audit. We were told both formally and informally that there was no hidden agenda and no single overriding issue, that we were to deal with the specific questions raised in the RFP. If those questions lead to some comment or recommendation about private insurance then, of course, we should discuss it.

Somewhat surprisingly, the topic did not come up very often in our discussions with employers. At meeting after meeting, we would ask, "What are the most important changes you would like to see us recommend?" Rarely, if ever, did an employer representative say "Recommend a three-way system." It seems clear, however, that this comes from their view of the political realities rather than a lack of desire to have such a system.

We do not offer a recommendation on this issue. We would, however, offer a few thoughts for the parties to consider in this regard.

To the business community, we would point that the objective evidence described in Chapter 3 shows that the Washington system is operating quite efficiently at the present time. It is able to provide relatively high benefits at relatively low costs. This appears to be at least in part due to the fact that there are certain

economies involved in an exclusive state fund (no taxes, insurance profits, or marketing expenses). In the operational analysis in Chapter 7, we also point out several other ways in which the Washington State Fund takes advantage of its special position. While there is a conventional wisdom among businesses that private competition will lead to more efficiency, there are clearly some advantages to the present system. Privatization would involve the surrender of some of these advantages and may disturb the present balance that allows for relatively low costs.

To organized labor and the people in the department who wish to preserve the status quo, we would point out that the single best way to avoid privatization is to have the state fund do an exceptionally good job. As we discuss in various parts of this report, the Washington State Fund appears to be doing well as measured by certain objective standards. As we also point out, however, there are many ways in which the participants, both employers and workers, are dissatisfied with the operation of the state fund. We make a number of specific recommendations for improvements in this regard. It seems clear to us that the best way to avoid privatization would be to implement these and other measures designed to improve the operation of the Washington system.

THE RESPONSIBILITY OF EMPLOYERS

This audit concentrates on the operation of the Washington Department of Labor and Industries. We note many areas in which improvements can be made. We feel, however, that we must also point out that employers play a crucial role in workers' compensation. In 1986, some of the members of this audit team took part in the study of the intra-state differences in workers' compensation experiences within Michigan.[2] We found that the differences in the workers' compensation experiences of employers within Michigan were greater than the differences in the workers' compensation experiences of employers among other states. At that time, the difference between Michigan and its

[2] "Employer Factors Related to Workers' Compensation Claims and Disability Management," *Rehabilitation Counseling Bulletin*, Rochelle V. Habeck, Michael J. Leahy, H. Allan Hunt, Fong Chan, and Edward M. Welch, March, 1991, pages 210-242.

neighbor Indiana was 2 to 1. The costs in Michigan were twice those in Indiana. The difference between Indiana and Maine, at that time the lowest and highest cost states, were 6 to 1. Maine's costs were six times those in Indiana. Within Michigan, however, the differences were 10 to 1. The study looked at 5,000 employers in 29 different industries. Within each industry group, the worst employers had ten times as many claims as the best.

This was followed up by a survey of the best and worst employers in certain groups. The study concluded that the differences were attributable to three factors:

- Safety
- Disability Management
- Corporate Culture

Employers have much control over their own experience

Those companies that had effective safety programs in which everyone was involved tended to have fewer injuries. Companies that had return to work and other disability management programs also tended to fall in the group with fewer injuries. Finally, companies that had what was called an open corporate culture also tended to have fewer claims.

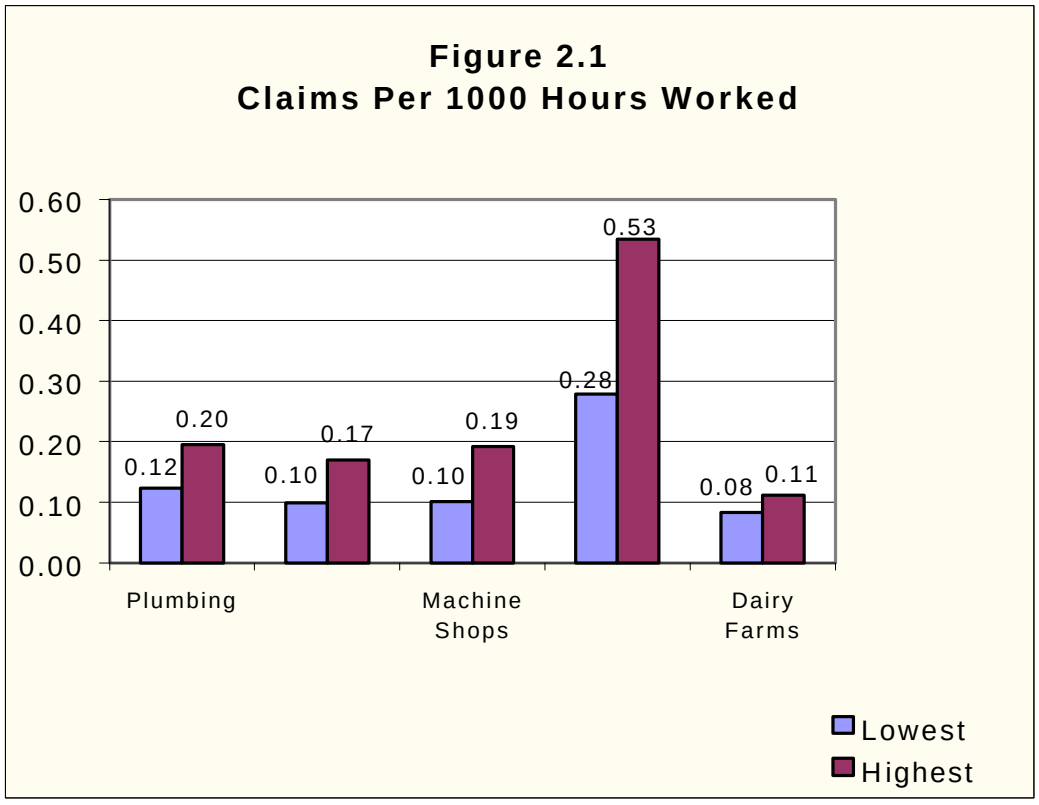
We asked the department to take a quick look at some of the differences among employers within Washington. Figure 2.1 shows the number of claims per 1,000 hours worked for five different classifications. Within each classification, we have broken employers down in to quintiles based on their experience modification factors. Thus Figure 2.1 shows the number of claims for the best and the worst employers within each classification.

As we would expect, there are big differences among classifications. Logging is much more dangerous work than dairy farming. We would emphasize, however, that there are also big differences within each classification. The best plumbing companies had 0.12 claims per 1,000 hours worked while the worst had 0.20. This is true in all classifications. This is significant because these are businesses which are competing with one another. All of the businesses reported here are insured through the Washington State Accident Fund. All are receiving approximately the same services from the fund. Yet some are doing much better than others. Previous studies indicate that this

is probably based on their attention to safety, their return to work efforts, and their relationship with their employees.

Employers have a great deal of control over their own workers' compensation experience. We recommend here changes which will improve the services provided by the department. In the long run, however, employers are mistaken if they blame all of their workers' compensation experiences on the state law or the state agency. Some Washington employers are doing much better than others even though they are all subject to the same laws and are insured through the same fund. Washington employers who hope to improve their workers' compensation experience will have to do some of the work themselves.

Figure 2.1
Claims Per 1000 Hours Worked



BENEFITS AND COST

Chapter Three

INTRODUCTION

The broadest measures of a state's workers' compensation system are the benefits it pays to injured workers and the costs it charges. There is no agreement as to the right level of benefits or the appropriate amount of costs. Accordingly evaluations of these issues are usually done by making comparisons among jurisdictions. As part of our audit, John F. Burton, Jr. of the School of Management and Labor Relations at Rutgers University, and Terry L. Thomason of the Faculty of Management, McGill University, conducted such a study. The results are reported in Appendices C and D. They are summarized here.

BENEFITS

Appendix C contains a comparison of the level of benefits provided by the workers' compensation statute in Washington with statutory benefits provided in the other 49 states and the District of Columbia. (The appendix also includes calculations for a Model Worker's Compensation Act). As explained in detail in the appendix, the analysis involves an examination of each type of benefit (temporary total, permanent partial, survivor's, etc.) in each jurisdiction. For each type of benefit, we first examined the value or amount of the benefit that is paid on a weekly basis. We next looked at the average duration, how long the benefit is paid. Finally, we examined the frequency, or number of cases, in which each particular type of benefit is paid. In addition, we examined other factors such as whether there are offsets (such as social security) to each of the types of benefits. The tables in Appendix C

summarize our findings for all of the jurisdictions on each of these issues.

We have then combined the values for each type of benefit and arrived at an estimate of the overall average benefit level for each jurisdiction and for all the jurisdictions considered. As can be seen from Figure 3.1, the benefits in Washington are substantially (about 20 percent) above the average.

Washington has relatively high benefits

Figure 3.1
Per Claim Cash Benefits, 1998

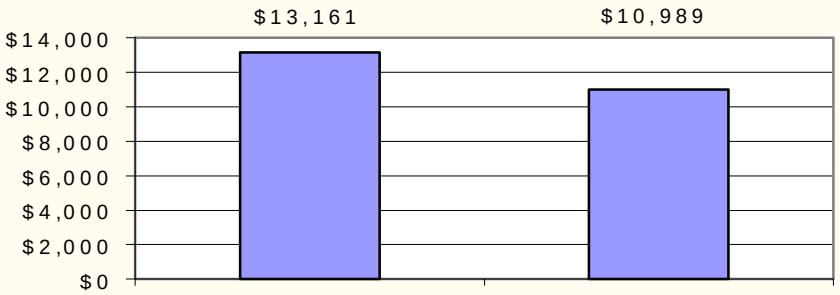
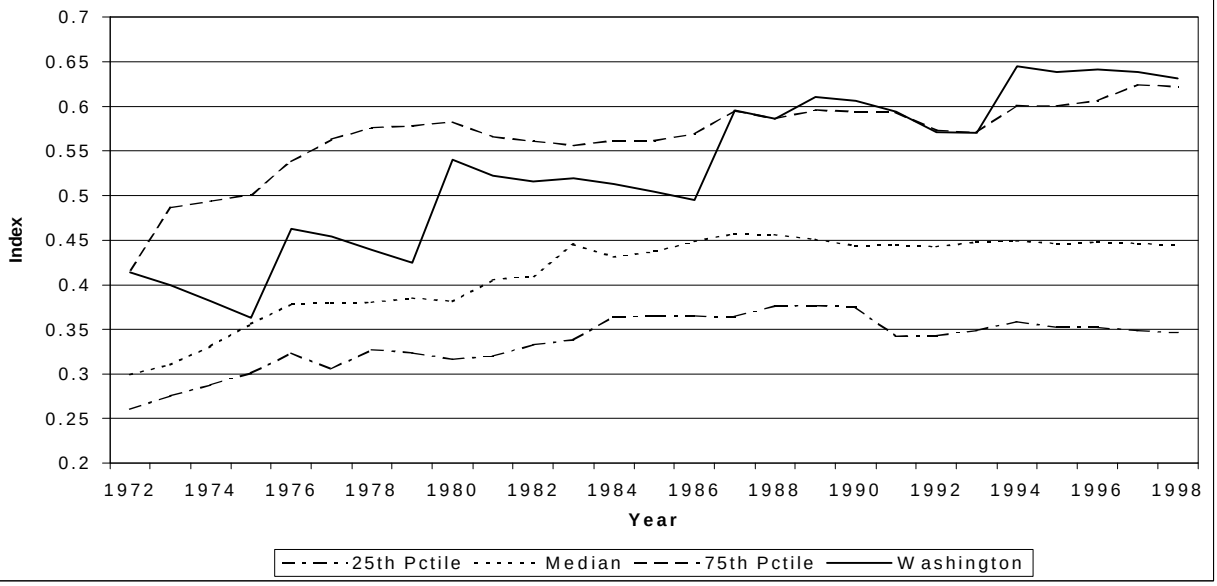


Figure 3.2 provides more details. The solid line represents the Washington benefit level. The top broken line represents the 75th percentile (75 percent of the jurisdictions were below this level). The middle line represents the mean level and the bottom line the 25th percent level. As can be seen, Washington has been above average for as long as data have been available. Since the mid 1980s, it has generally been above the 75th percentile. In other words, it is offering a benefit level that is higher than that offered in 75 percent of the jurisdictions reviewed.

Figure 3.2
Cash Benefits -- All Claims, 1972-98



PREMIUM COSTS

To estimate costs, we examined insurance premium levels. This approach unfortunately excludes self-insured employers. This, however, is unavoidable. Washington collects considerable information about the benefits paid by self-insured employers. As discussed in Chapter 7, most other states do not monitor their self-insureds nearly as closely. Throughout the country, self-insured employers tend to feel that information about their workers' compensation costs is proprietary and they are often reluctant to make it public. Even where, as in Washington, detailed information about self-insured claims is maintained, information about the total cost of managing these claims is not available to nearly the same degree as it is for insured employers. Accordingly, given the data that is available, an examination of insurance premium costs is the best way to make comparisons across jurisdictions.

Even for insurance costs, data is not available from all the states. We include here data from 47 states,[1] the District of Columbia, and two Canadian provinces: British Columbia and Ontario.

It would be possible to make a comparison using the overall average of the premiums charged in all job classifications. This would not be appropriate, however, since most of the work performed (and premiums charged) fall into a much smaller sample of the job classifications that are used. We looked at the work in 71 job classifications (24 manufacturing, 13 contracting, and 29 other classes). This accounts for about 74 percent of the national payroll covered by workers' compensation. In addition, we weighted these classes according to the national payroll distribution. This adjusts for the fact that some states might have a high percentage of workers in logging or construction, while another state would have a high percentage of workers performing clerical duties. The procedure produces workers' compensation cost measures for comparable employers in each state.

Our analysis of premium levels began with the published or "manual premium." To arrive at the premium actually paid, however, numerous adjustments were made to this. Today most states allow competitive pricing. This means that insurance company A might charge one premium for work in a certain classification, while insurance company B will charge a different premium which is lower or higher. In many states there are dozens, even hundreds, of insurers writing workers' compensation insurance. In addition to the differences in manual rates, the rate actually paid is affected by a variety of other factors, including experience modification adjustments, premium discounts, retrospective rating adjustments, scheduled credits, deviations, and dividends. As explained in Appendix B, we have attempted to take all of these factors into consideration for each jurisdiction in arriving at our final estimate.

We report data for 1985 through 1995. The Department of Labor and Industries provided us with Washington data through 1998 (with the exception of 1996, which was unavailable), but current

[1] The states excluded are Nevada, North Dakota, and Wyoming.

data was not available from enough other jurisdictions to extend the comparison beyond 1995.

Washington's system of calculating rates is unique in two ways. It uses hours worked rather than dollars of payroll as the basis for the calculations, and it uses a unique set of job classifications. The RFP raised certain issues about the extent to which these create difficulties in making comparisons with other jurisdictions. There is no doubt that they make such comparisons somewhat more difficult. The department, however, was able to provide us with conversion factors that appear to be a reasonable approach to making adjustments for comparison of the Washington system to other jurisdictions. The difficulties involved in requiring these conversions must be evaluated in comparison to the other difficulties involved in this process. In this context, the Washington problems do not seem so serious when compared with the difficulties of evaluating the average cost of a state that allows competitive pricing. In those jurisdictions, there are likely to be at least 200 carriers, each charging a different rate for each different classification and each writing a different percentage of the market in each classification. In Washington, on the other hand, there is a single insurer which charges one rate for each classification. From our point of view as someone making comparisons, the difficulties involved in the Washington conversions are no more challenging than the difficulties we find in other jurisdictions.

Washington has relative low premium costs

The results of our analysis are summarized in Figures 3.3 and 3.4. Figure 3.3 shows the adjusted manual premium or the average cost of per hundred dollars of payroll for 1995. By this measure, Washington's average costs were about 27 percent below the national average.

Figure 3.3
Adjusted Manual Rate, 1995

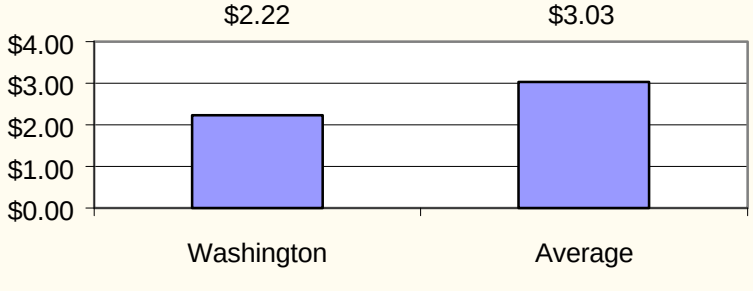
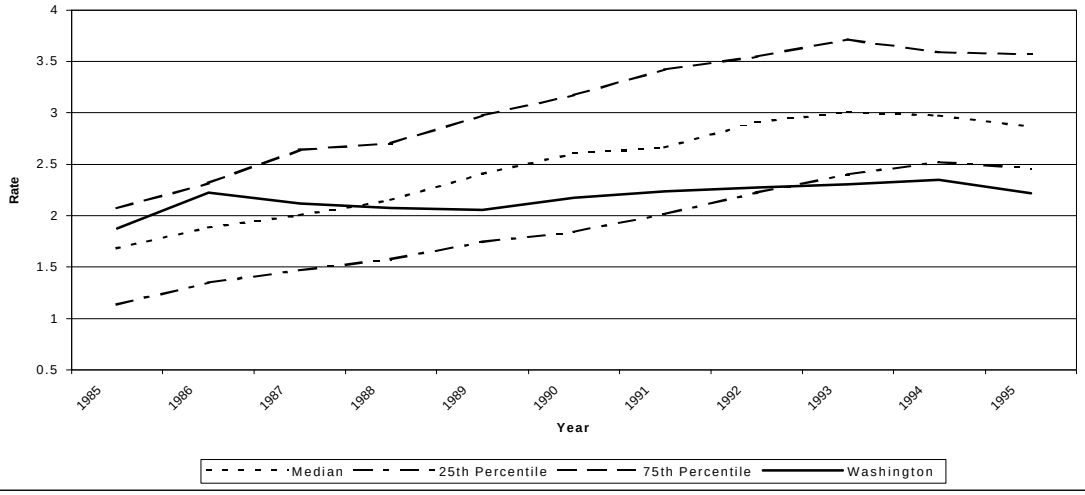


Figure 3.4 shows Washington's relative position over an 11-year period. As with Figure 3.2, it compares Washington's standing with the 75th percentile, the median, and 25th percentile of all jurisdictions in the study. As can be seen in the mid-1980s, Washington's costs were above average. While the average national costs rose substantially through the early 90s and have decreased slightly since then, Washington's costs have remained relatively stable. As a result, Washington fell below the average in about 1988 and dropped below the 25th percentile in 1993. As discussed Appendix D, we found similar results when we examined the cost per employee per week, as compared to the cost per hundred dollars of payroll. Although we report data only through 1995, since then costs in general have gone down in Washington and across the country.

Figure 3.4
Adjusted Manual Rates, 1975-95



When considering costs, it must be remembered that Washington is the only state in which workers make a significant contribution to premium costs. Workers are charged 50 percent of the medical aid premium for state fund insured employers. The figures reported here are for the total workers' compensation insurance premium, including the part paid by workers. The amount paid by employers is actually less than this and thus the position of

Washington employers relative to employers in other jurisdictions is even better than described above.[2]

EFFICIENCY

Washington's system appears to be unusually efficient

By the measures we have described above, Washington appears to be a state that has relatively high benefits and relatively low costs. There are many possible explanations for this, which we were not able to examine in this study. As explained in Appendix D, however, we were able to conduct a regression analysis which attempts to examine the extent to which various external factors may account for the differences. We were able to control for factors such as the benefit level, injury frequency, medical expenses, the amount of employment that is covered under the law, and the degree to which work is unionized. When compared to other states, Washington still has relatively low insurance costs after considering all of these factors. Accordingly, it would appear that there is something very significant about the structure of the Washington State Workers' Compensation System and/or the way it manages claims that results in the relatively low insurance premium costs.

We did not specifically measure the effect of the following factors, but there are specific aspects of Washington's exclusive state fund which may, to at least some degree, account for the ability to provide relatively high benefits at a relatively low insurance premium rate. Unlike private insurance companies in other jurisdictions, the state fund pays no taxes[3] and does not take money out of the fund as profits. In addition, the exclusive state fund does not incur marketing expenses. In other jurisdictions, it

[2] Most economists consider the question of who nominally pays the premium is unimportant because workers pay most of the cost of workers' compensation in the long run through reduced wages. They point to studies which show that when workers' compensation costs go up, wages go down proportionately. See for example: Moore, Michael J., and Viscusi, W. Kipp, *Compensation Mechanisms for Job Risks* (Princeton: Princeton University Press, 1990). To whatever extent this may be the case, however, it is probably not as important in the short run to employers or workers as an increase in the insurance premium bill or a larger deduction from the paycheck resulting from higher benefit payments.

[3] Of course, the payment of taxes by private insurers generates income for the state in another form and, to at least some extent, reduces the burden on all other taxpayers.

is typical that up to 9 percent of the premium goes to insurance agents and brokers.[4]

SUMMARY

We have conducted an analysis of the relative benefit levels and insurance premium costs in Washington and 52 other North American jurisdictions. To the extent data is available, we have adjusted for as many factors as possible. We have looked at the type of benefits offered, the amount of each individual type of benefit, and the frequency with which each type of benefit is provided. We have looked at the insurance premiums published in manual rates and adjusted these for a variety of factors in order to estimate the premium rates actually charged to employers.

High benefits and low costs

The results of our analysis suggest that Washington is in a very good position. It is a state with relatively high benefits and relatively low premium costs. It is in the top 25 percent in benefits offered and the bottom 25 percent in costs charged. To the extent our analysis allows us to evaluate the question, it appears that these are largely the result of the structure of the Washington system and the way in which it manages claims.

These findings have important implications for any potential changes in the Washington system. Throughout the rest of this report, we recommend a number of changes. For the most part, they are relatively minor changes, which would not result in a major shift in the structure of the system. We would caution the people of Washington concerning any significant structural change. Any such change could potentially have an adverse effect on what appears to be a very desirable balance that is currently found in the system.

[4] "Where Does the Money Go?" *On Workers' Compensation*, Jan/Feb 1997, page 20.

WORKER OUTCOMES

Chapter Four

INTRODUCTION

This chapter describes the outcomes experienced by workers as a result of a workplace injury. It is broken into three sections. The first examines return to work; the second, wage loss; and the third, other outcomes.

RETURN TO WORK

Introduction

How quickly and to what extent do individuals return to work?

The RFP asked in numerous places for information about the return to work of injured employees in Washington. As part of our audit, Jeff E. Biddle of the Department of Economics at Michigan State University conducted an extensive study evaluating this issue. It is reported in detail in Appendix E. We will provide here a summary of the most important points.

Our study was based on data provided to us by the Department of Labor and Industries and the Employment Security Department. Our study focused on individuals injured from July of 1993 through June of 1994. We excluded cases involving fatalities and pensions.

Basic Findings

At the most basic level, we found that 25 percent of the people who received payments for loss work time for their injuries returned to work within 11 days, 50 percent within 35 days, and 75 percent within 96.

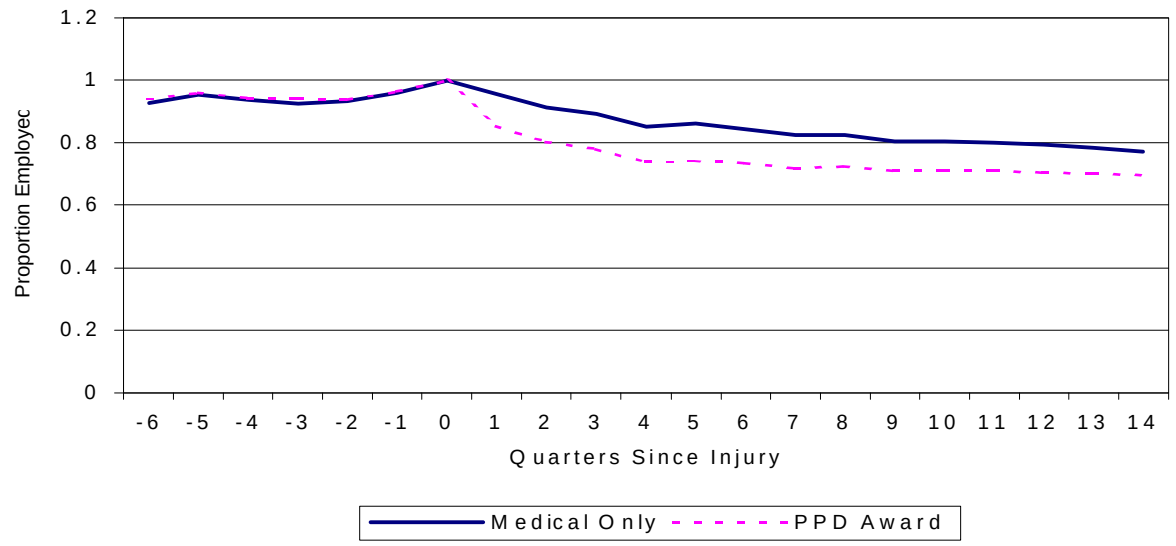
The time to the first day on which an individual returns to work is an imperfect measure of successful return to work. Some workers may return to work for one or two days and then have another long period of unemployment. Individuals also leave work for reasons not related to an injury, some retire, others may move out of the state of Washington, or leave work for other reasons. Some workers may have found jobs in uncovered employment. In the discussion below, we measure employment by whether earnings were reported to the Employment Security Department.

Comparison with a control group

We wanted to determine the degree to which the post-injury unemployment was caused by the injury. The best way to do this would be to compare the post-injury employment experiences of the injured workers to those of a sample of workers who were not injured. During the time frame allowed for the audit, we were not able to construct such a sample. We did, however, have available data for individuals involved in medical only cases, that is, individuals who reported having an injury but did not receive any time-loss or permanent partial disability (PPD) benefits. We used these individuals as our control group. This is, of course, not as good a control group as individuals who suffered no injury at all. To the extent it biases the results, however, it leads to an underestimate of the detrimental effects of injury.

The use of the medical only control group is illustrated by Figure 4.1. The solid line shows the portion of workers in the control group with Employment Security earnings reports for each of the listed quarters. The broken line shows the percentage for individuals who received a permanent partial disability award. By definition, 100 percent of both groups were working in the quarter of injury. For the quarters before the injury, there is a close parallel between workers in the control group and the permanent partial disability claimants. This confirms that we are comparing comparable groups of workers. As expected even for workers in the medical only group, there is a decline in employment (that is, in the percentage with Employment Security earnings reports) following the injury. There is, however, a greater decline in employment for workers who suffer an injury. The difference between the two levels of employment represents our estimate of the unemployment attributable to the injury.

Figure 4.1: Illustration of Excess Nonemployment



In Table 4.1, we use this approach to estimate the percentage of workers who are unemployed as a result of their injury. The table shows the difference in the percentage of workers with earnings between workers in each injury category and those in our control group of medical only cases.[1] Thus, there was little difference for workers with minor injuries. For workers with a permanent partial disability, however, the employment rate during the first quarter after the quarter of injury was 11 percentage points lower than for workers in the control group. At 14 quarters after the injury, the difference was 7 percentage points.

The biggest differences occur for those individuals who were off more than 180 days. What is perhaps more significant is among workers with moderate injuries (15-60 days), a significant portion (between 2 and 4 percent) were unemployed as a result of their injury even 3.5 years following their injury.

Even among workers with relatively minor injuries a significant portion were still off work 2.5 years after the injury

[1] Workers in the first five categories include individuals who receive lost time benefits for the period indicated but who did not receive any permanent partial award. The last category includes all workers who received an award of permanent partial disability benefits. Most of the workers in this last category also received time-loss benefits for some period.

Table 4.1 Lack of Employment Attributable to Injury			
Injury Category	One Quarter After Injury	Eight Quarters After Injury	Fourteen Quarters After Injury
14 or Fewer Days	0%	1%	0%
15-30 Days	2%	3%	2%
31-60 Days	4%	6%	4%
61-180 Days	15%	9%	9%
More than 180 Days	40%	37%	30%
PPD Award	11%	9%	7%

Perhaps the best measure of a successful return to work is the degree to which an individual can return and achieve earnings equivalent to those he or she received prior to the injury. To measure this, we looked at the percentage of workers who were earning 80 percent or more of their pre-injury wages at various times following the injury. Once again, the most meaningful figure comes from comparing the earning experiences of injured workers to those in our control group. Table 4.2 shows the percent of workers who fail to attain their pre-injury earnings as a result of their injury. Thus for workers in the least severe category (14 or fewer days of lost time), the percentage who were not earning at least 80 percent of their pre-injury wage 14 quarters following the injury was one point higher than for workers in the control group. For workers who missed from 61 to180 days, the difference was 12 percentage points, and for workers with a permanent partial disability, 10 percentage points.

Table 4.2 Percent of Workers Failing to Attain Pre-Injury Earnings Levels as a Result of Injury		
	8 Quarters After Injury	14 Quarters After Injury
14 or Fewer Days	3%	1%
15-30 Days	6%	4%
31-60 Days	7%	8%
61-180 Days	14%	12%
More than 180 Days	35%	33%
Permanent Partial Disability	12%	10%

State Fund, Retro Groups, and Self-Insured Employers

We examined the differences in the various measures of return to work among employees of employers insured by the Accident Fund who were not part of a retro program, those who were a part of retro programs, and self-insured employers. At first glance, it would appear that retro employers do somewhat better than fund employers and that self-insured employers do significantly better. Table 4.3 shows the average time to first return to work for retro and self-insured employers as compared to state fund employers. It separates small cases with less than 30 days of lost time from larger cases involving more than 30 days of lost time. In the latter category, employees of retro employers appear to return to work 13 days faster than those of state fund employers and employees of self-insured employers return to work 22 days faster.

Self-insured and retro employers get their people back to work sooner

Table 4.3
Comparison of Average Time to First Return to Work

	Cases with 30 or Fewer Days	Cases With More than 30 Days
Retro Groups vs. Fund	0.3 Days Shorter	13.6 Days Shorter
Self-Insured Firms vs. Fund	1.2 Days Shorter	22.4 Days Shorter

Table 4.4 illustrates some other comparisons. There were relatively small differences between fund, retro, and self-insured employers in the portion receiving PPD benefits and in the mean of PPD payment. However, there were very large differences in the average number of days for which lost time benefits were paid. Fund employers averaged about 115 days, retro plan employers averaged 97 days, and self-insured employers averaged only about 59 days.

Table 4.4 Insurance Status Comparisons			
	Fund Insured	Retro Plan	Self-Insured
Proportion Receiving Permanent Partial Disability Payments	0.24	0.23	0.22
Mean Payment for PPD Claim	$8,231.83	$8,372.88	$7,423.28
Average Number of Compensation Days (For Claims with Time Loss Payments)	114.93	97.4	58.9

In the long run, there is not much difference among employer types

It is unfair, however, to make a judgement based on these raw figures. There are significant differences among employers in the various insurance groups and the types of workers they employ. These include differences in the age, gender, skill levels, and pre-injury employment experiences of their workers, the industry in which the work was performed, and the location of the firm. In order to make a fair comparison, these sorts of factors must be taken into consideration.[2] As explained in Appendix E, we conducted a multi-variate analysis, using statistical techniques designed to show what the outcomes would be if we could make all of these factors comparable across the three groups of employers.

The results of the multi-variate analysis show that there is very little difference in the long-term return to work experiences among fund employers, retro employers, and self-insured employers.[3] Indeed, when we control for all these factors, there were no significant differences in long-term measures of return to work between those injured while working for employers under a retro plan and those injured while working for other employers insured by the fund.

[2] Size of the employer is also another significant factor. In the data we had, however, we were not able to control for this. To the extent that this is an important factor, our findings tend to overestimate the other differences.

[3] There is one category, workers with more than 180 days of time loss, that showed some differences we were not able to explain. Only a relatively small percentage of the workers involved fall in this category, and some of the observed differences may be attributable to the fact that we do not yet know the ultimate outcome of some of those cases.

There were also very few differences between the long-term return to work outcomes of those injured while working at a self insured firm and those injured while working for employers insured by the fund. The only significant differences were in the category of workers who received PPD benefits. For those workers, the data suggest that employees of self-insured companies tended in the long run to do *worse* than employees of fund insured employers. When we looked at the percentage of people working and the percentage of workers earning 80 percent of their pre-injury wages in the 14th quarter after injury, the results were between 3.5 and 5.5 percentage points worse for employees of self-insured employers.

Thus, it would appear that self-insured employers achieve an earlier return to work and pay fewer days in time loss benefits but do not do any better in long-term measures of return to work. Indeed, long-term outcomes for their employees with PPD injuries are worse.

Comparison to Other States

It is extremely difficult to make comparisons across states for several reasons. Studies similar to this have only been conducted in a handful of states: Wisconsin, Florida, Texas, and California. Even where the studies exist, the comparisons are difficult because the studies were not always conducted in the same manner. They were not conducted at the same time and the economic and labor market characteristics of each state differ significantly. Appendix E includes a detailed discussion of these issues and makes comparisons where possible. In summary, it can be said that in none of the states examined did injured workers seem to be having significantly better return to work experiences than workers injured in Washington. In some cases, the return to work experiences of injured workers in other states were significantly worse than those observed in Washington.

WAGE LOSS

Introduction

To a large extent, the goal of a worker's compensation system is to replace some portion of the wages that are lost by workers because of an employment related disability. We have examined the extent to which the Washington system does this by looking at the pre- and post-injury earnings of a sample on injured workers. This part of the audit was performed by Jeff E. Biddle of the Department of Economics at Michigan State University.

The sample of workers used in this wage loss study was the same as that used in the return to work study that is discussed above. That is, we focused on workers injured between July of 1993 and June of 1994. We obtained data concerning them from the

Department of Labor and Industries, as well as earnings data from the Employment Security Department. We did not look at fatal injuries or workers who received a pension. As discussed in the Appendix E, we excluded a few other workers for statistical reasons. What follows is a summary of a more detailed report found in Appendix F.

Wage loss due to injury

The simplest way to measure earnings loss due to injury would be to compare the wages an individual earns after an injury to those he or she was earning prior to the injury. There are a couple of important deficiencies in such an approach. First, most workers tend to have wages that increase over time, even when adjusted for inflation. Second, a certain percentage of workers have reduced wages, or leave the workforce completely for reasons that are not related to an injury. Some workers retire. Others choose to stay home for personal reasons.

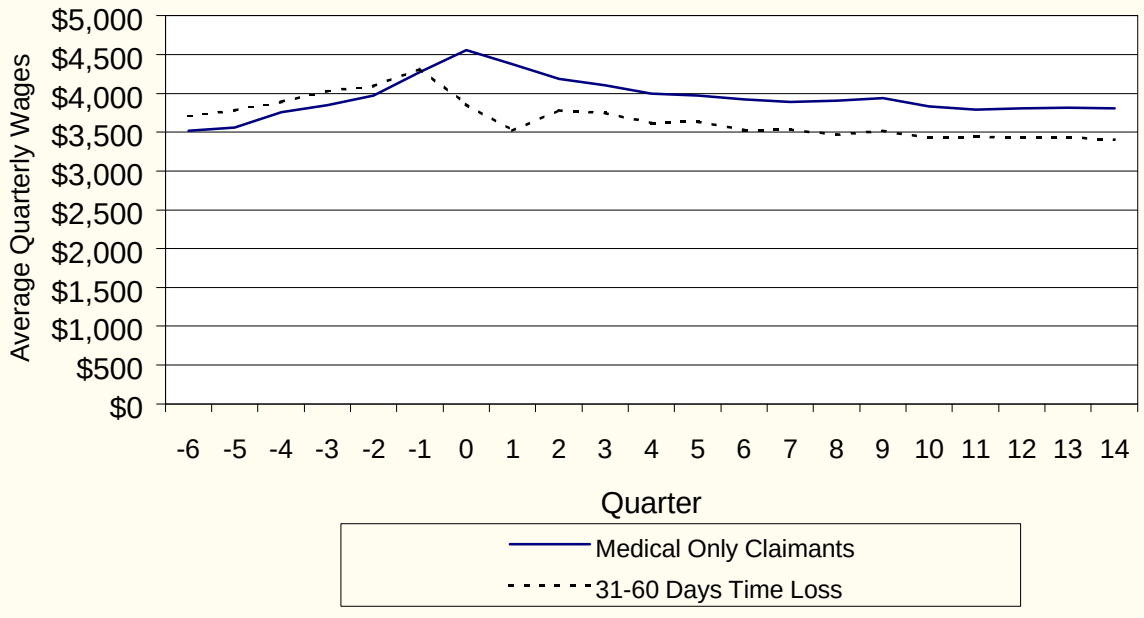
In this wage loss study as in the return to work study discussed above, we accounted for these factors by comparing the wages of injured workers with the wages of a control group of workers who experienced a medical only claim.

It should be noted that since workers' compensation benefits are not subject to income tax, one dollar in workers' compensation benefits is more valuable to a worker than one dollar in wages. In

Appendix F, we report estimates of both before and after tax wage loss. In this report we will emphasize after tax figures.

As indicated above, we have defined wage loss to mean wage loss resulting from the injury as measured by the difference between the wages earned after injury by injured workers and the wages earned over the same period by workers in the "medical only" control group. This can be illustrated by Figure 4.2.[4] The solid line shows the earnings for workers in the control group. The broken line shows earnings for workers who suffered an injury and received time-loss benefits for between 31 and 60 days. The figures on the vertical axis indicate the amount of earnings. The figures on the horizontal axis indicate quarters, measured as quarters before and after the quarter of injury.

Figure 4.2
Estimating Lost Wages Using a Control Group



[4] Figure 4.2 shows data for women. As discussed in Appendix F, we found similar results for men.

Prior to the injury, the earnings for both groups of workers were quite similar, although not identical. This confirms that the control group is a fairly good match for our purposes. Following the injury, the earnings for both groups slope slightly downward, which reflects the fact that some members of both groups leave the Washington labor force over time for a variety of reasons not related to an injury.

It is also to be expected that the earnings of injured workers drop significantly below those of the control group in the one or two quarters following the injury. This is illustrated by the drop in the broken line. What is perhaps somewhat surprising is that during the period studied (14 quarters or 3.5 years) the average earnings of the injured workers as a group do not rise again to equal those of the control group. The sample of injured workers in this figure includes those who received time-loss benefits for between 31 and 60 days and who do not receive any permanent partial award. These are what the system assumes to be relatively minor claims. Yet injury related wage loss persists for this group even 3.5 years after the injury.

Wage Loss and Replacement Rates

Table 4.5 illustrates the after tax wage loss for men with various categories of injuries.[5] As we would expect, on average, workers with a longer duration of time loss have more severe wage losses.

Table 4.5
After Tax 3.5 Year Wage Loss & Replacement Rate

Injury Category	Loss	Rate
14 or Fewer Days	$2,410	0.11
15-30 Days	$4,117	0.23
31-60 Days	$6,870	0.27
61-180 Days	$9,869	0.46
More than 180 Days	$27,127	0.91
PPD Award	$13,051	1.21

[5] Tables 4.5 and 4.6 show result for men only; women were analyzed separately. The patterns of wage loss and replacement rates across injury categories were the same for men and women. Results for women are reported in Appendix F.

Table 4.5 also reports a "replacement rate". Workers' compensation benefits are designed to replace the wages lost as a result of the injury. We have estimated the replacement rate by dividing the average amount of benefits paid to workers in an injury category by the average estimated wage loss for workers in that category. As in other areas, we have controlled for inflation and Appendix F, we report both before and after tax replacement rates. In this summary, we will focus on the after tax replacement rates.

Workers compensation benefits do not replace all of the wages lost

The figures in Table 4.5 show the average wage loss and replacement rates taken over all of the individuals in each injury category. A further analysis showed that there was actually a relatively small number of individuals in each category who experienced a low replacement rate. This indicates that the positive average wage losses and low replacement rates listed in Table 4.5 are not attributable to the fact that most workers suffer a mild or moderate unreplaced wage loss, but rather to the fact that there are a few workers who suffer a very significant unreplaced wage loss.

In general then, it would appear that there is a small but significant number of workers in all categories for whom worker's compensation benefits fall far short of replacing the wage loss they suffer as a result of their injury. It would also appear that this unreplaced wage loss persists for at least 3.5 years following the injury.

Differences Among Categories

The replacement rates for permanent partial claims are somewhat deceiving because the workers' compensation payments include the entire permanent partial award which is intended to compensate the worker for a lifelong permanent disability. The wage loss figures, however, represent the wage loss during the 3.5 post-injury years for which we have data. To explore this matter further, we have made a rough estimate of what the wage loss would be if projected for ten additional future years. In doing this, we have assumed that the loss for the additional ten years would be approximately the same as the loss for the last year for which we have data. Table 4.6 looks at these values after dividing permanent partial disabilities into five

quintiles based on the size of the permanent partial disability award.

Inconsistencies in replacement rates for permanent partial disability

As Table 4.6 illustrates, the replacement rate increases with the severity of the injury, as measured by the size of the award. Thus people with the least severe injuries receive workers' compensation benefits that replace only 11 percent of their wage loss, while people with the most severe have 63 percent of their wage loss replaced. In one sense, this should not be surprising. In most states, the rate of benefits for permanent partial disabilities is based on the impairment rating and the worker's pre-injury wages. In Washington, by statutory definition, the workers' pre-injury wages do not affect the total benefit received. Nevertheless, we suspect that most participants in the Washington system will be surprised that there is such a substantial difference in the replacement rate and by the fact that it is the least severe injuries that are undercompensated.

Table 4.6
Estimated Longer-Term Wage Losses and Replacement Rates for PPD Injuries

Quintile	Wage Loss	Replacement Rate
Lowest	$38,775	0.11
Second	$36,309	0.24
Third	$42,598	0.33
Fourth	$42,287	0.38
Highest	$43,212	0.63

As discussed in Appendix F, a study similar to this done in California found very similar results. This was quite surprising there because the conventional wisdom had been that the California system overcompensated less severe injuries and undercompensated more severe injuries. Similar studies have not been conducted in any other states but it may be that this is an unintentional feature of all workers' compensation systems. It is interesting to note that an Ontario study which examined not wage loss but people's perceptions of the non-economic aspects of

work-related injuries found that the *AMA Guides* tended to undercompensate less severe injuries.[6]

As discussed earlier, it would appear that the lower average replacement rates in the less severe injury categories are to a large extent attributable to the fact that a few individuals suffer very severe wage loss. We conducted a regression analysis of a variety of factors to identify workers who were more likely to suffer a very severe wage loss. The results reveal that younger workers and low income workers are particularly at risk for suffering serious wage loss as a result of injury.

Workers employed by self-insured employers, when compared to those employed at state fund employers, are slightly less likely to suffer a wage loss and after adjusting for all factors their replacement rates are higher. Employees of retro plan employers, when compared to employees of state fund employers, are noticeably more likely to have a large wage loss and their replacement rates tend to be lower.

Comparisons With Other States

It is very difficult to make comparisons among the states for several reasons. Very few states have conducted studies such as this. When they have been conducted, different methodologies have been used, and the studies have been conducted at different periods of time. In addition, there are great differences among the states in factors such the type of work performed which might influence the outcome more than the nature of the workers' compensation system. Studies of wage losses have been done using data from Florida and California, and they suggest that PPD claimants in those states have larger wage losses and lower replacement rates than Washington PPD claimants.

OTHER OUTCOMES

As discussed more fully in Appendix G and Chapter 5, we conducted a survey of injured workers. As part of that survey we asked a series of questions about the financial impact that the

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[6] Sandra Sinclair and John F. Burton, Jr., "Measuring Non-Economic Loss," *Workers' Compensation Monitor*, July/August 1994, Vol. 7 No. 4, pp 1-14.

Other impacts on workers

injury had on the worker, the worker's family, and about their perceptions of the attitudes others had about their situation. As shown in Table 4.7, about 38 percent of the workers indicated that they depleted their savings as a result of the injury and 15 percent indicated that even after depleting their savings they could not make ends meet. Twenty-eight percent were required to use leave or vacation days for some of the time they missed from work. Almost 13 percent lost their home, car, or some other asset as a result of the injury and 14 percent applied for AFDC, food stamps or some other similar program.

Table 4.7
Financial Impact, Percent Experiencing

Depleted savings	38.2%
Cannot make ends meet	15.6%
Used sick leave or vacation days	28.0%
Lost home, car, or other significant asset	12.8%
Had to rely on AFDC, food stamps, etc.	14.3%

As shown in Table 4.8, a very significant percentage of injured workers fear retaliation and perceive an adverse attitude towards workers' compensation claimants. This, of course, is not evidence that these things actually happen, but of workers' perceptions of the situation.

Table 4.8
Perception of Attitudes, Agree or Strongly Agree

Risk loss of job	43.8%
Risk losing promotion and other opportunities	41.3%
Co-workers will think you are faking or exaggerating	26.4%
Supervisor will think you are faking or exaggerating	31.5%
People out there ready to take my job	39.2%
Will be discriminated against or harassed	41.8%
Health care providers would rather not treat	28.2%

As noted in Appendix G and Chapter 5, the response rate from our survey was relatively low. It is very likely that our responses included individuals who had the worst outcomes in their cases. Nevertheless, these results would suggest that there are a

significant number of workers who suffer severe adverse impacts as a result of their work related injuries.

CUSTOMER SATISFACTION

Chapter Five

INTRODUCTION

In this chapter, we review measures of satisfaction of workers and employers, the two primary customers of the department. As explained below, the response rate for both of these measures was somewhat lower than we would have liked. The results, however, do coincide with the views we received in informal discussions with system participants. Accordingly, while these results cannot be cited as proof that the department is doing badly, they point to areas in which there is room for improvement.

WORKER SURVEY

Introduction

We conducted a telephone survey of injured workers in order to learn about their experiences with the workers' compensation system. The design, analysis, and report of this part of the audit were conducted by Karen Roberts of the School of Labor and Industrial Relations of Michigan State University. The actual survey itself was conducted by Marketing Resource Group, Inc. of Lansing, Michigan, under the direction of Paul King. The results of the survey are discussed in detail in Appendix G. We will summarize here the findings related to customer satisfaction. Other results from the survey are reported in Chapter 4.

The sampling frame consisted of all non-fatal claims with final closure dates during the first two quarters of 1997. The sample was further broken down into sub-groups to ensure that we had representation of individuals who 1) filed an appeal to the Board

of Industrial Insurance Appeals, 2) received permanent partial disability awards, 3) had claims that were open for less than six months, and 4) all other cases.

The overall response rate was 14.7 percent. If we exclude from the denominator individuals who could not be reached for various reasons, this increases to 36.3 percent. This was somewhat disappointing. Appendix G discusses various reasons and implications of this. There is certainly the possibility that individuals who were most dissatisfied with the system were more willing to talk about it on the telephone. Accordingly, the results reported here may be biased towards the workers who are most dissatisfied with the system.

Some workers were satisfied, others were dissatisfied, few were neutral

Overall Satisfaction

Figure 5.1 summarizes some of the measures of overall satisfaction with the system. Perhaps the most striking aspect of this figure is what we would call its bimodal distribution. There were very few people who were in the middle, neither satisfied nor dissatisfied. Instead, most people were either satisfied or dissatisfied. This pattern persisted throughout the survey. In almost every category, we found a bimodal distribution such as this. People either liked the system and its various participants or they disliked it. Very few were neutral.

Figure 5.1
Overall Satisfaction

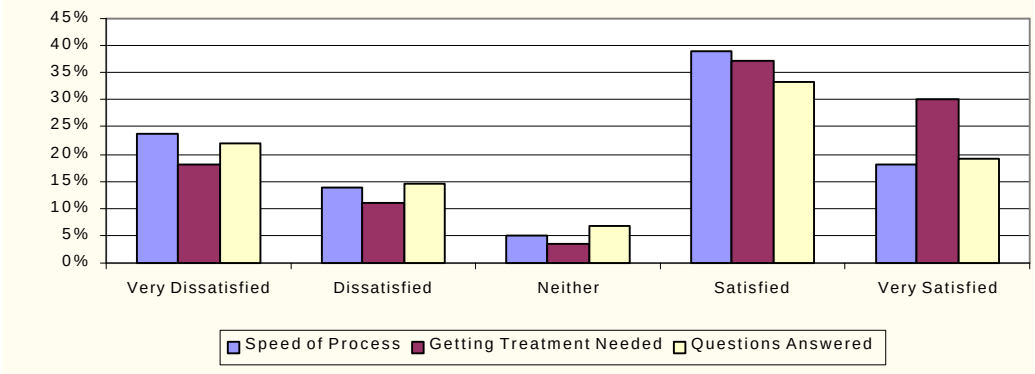


Figure 5.1 shows the results on three measures of overall satisfaction: the speed with which a compensation claim was processed, getting the treatment a claimant needed for this injury, and the ability of the claims management staff to answer questions a claimant had about his/her claim. In each of these categories, more people were satisfied than dissatisfied. But in each, there were a very substantial number of people who were unhappy with the performance of the system.

Specific Participants

We asked injured workers a set of questions about four important participants in the workers' compensation system: claims managers, independent medical examiners, BIIA adjudicators, and vocational rehabilitation providers.

Figure 5.2 summarizes the responses with regard to five questions that were asked concerning these people:

- Behaved in ways that you considered to be ethical;
- Considered your viewpoint when making decisions;
- Treated you with dignity and respect;
- Used information for decisions that was accurate;
- Provided you explanations regarding his or her decisions.

Figure 5.2
Percent of Workers Who Disagreed or Strongly Disagreed

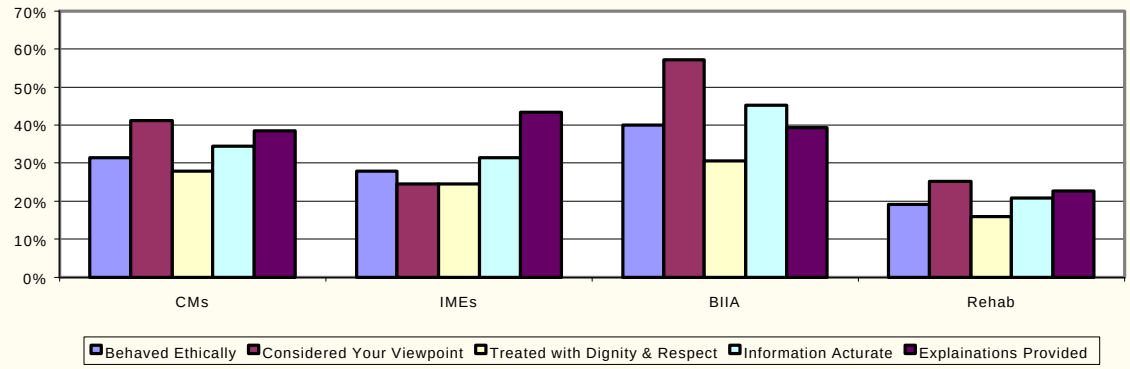


Figure 5.2 shows the total percent of workers who were either disagreed or strongly disagreed with these statements for the listed system participants. Workers were most often satisfied with vocational rehabilitation providers and least satisfied with BIIA. This latter finding should be viewed with some caution because the sample of cases involving the BIIA was relatively small and because we can assume that by nature, these were more troublesome cases.

Some workers expressed considerable distrust

These results raise some serious concerns. For example, 23 percent of the workers strongly disagreed with the idea that their claims manager behaved ethically, 30 percent strongly disagreed that the claims manager treated the worker with dignity and respect, almost 20 percent strongly disagreed that the claims manager had accurate information for the decision he or she was making, and 26 percent strongly disagreed that they were provided with information about the decisions made. There were similar findings with respect to Independent Medical Examinations (IME) and board adjudicators.

At the same time, there was a substantial percentage (often more than half) of workers who agreed with these statements and felt that the system participants were doing their jobs well. Nevertheless, the substantial percentage that disagreed should raise some concerns.

Regression Analysis

We conducted a regression analysis to analyze the interrelationships between answers to questions given in the survey and other data about the workers which we obtained from L&I. These results are reported in Appendix G. Among other things, we found that younger workers were more likely to incur additional debt. (This coincides with the findings of lower wage replacement rates for younger workers in our wage loss study.) There was evidence of some gender bias. As we might expect, cases that involved an appeal to the board were more likely to result in a negative view of the system. Somewhat surprisingly, workers with permanent partial disability awards were more likely to have a positive view of the system. The seriousness of the injury appeared to increase dissatisfaction, but the duration of

the disability did not. There was no significant difference between employees of self-insured companies and companies insured by L&I, except that employees of L&I insured companies were more likely to experience a negative effect on their income.

EMPLOYER FOCUS GROUPS

Introduction

Employer focus groups were conducted in June 1998. This portion of the audit was conducted by Bruce Hayden of A.W. Wesley and Co. and Donna B. Winthrop of Alternative Resource Center. More details concerning the focus group are found in Appendix H.

Participants in the focus groups were drawn from a sample constructed by the department. They were designed to ensure representation from three employer types: self-insured employers, retro employers, and other state fund employers. To be included, an employer must have had at least one lost-time injury since January of 1996. From the employers selected, we invited representation by a person knowledgeable about the daily operations of workers' compensation and the ongoing related concerns of the employer.

Of 491 written invitations, 44 persons confirmed attendance and 35 people attended. Thirteen people were no shows and five people who had not responded attended. This was somewhat disappointing and may have resulted in a bias in favor of individuals who were most dissatisfied with the system.

The focus groups were held in Seattle and Spokane the week of June 15, 1998. Ten focus group sessions were conducted–eight in Seattle and two in Spokane. Each session was scheduled for two hours. Separate sessions were held for the three employer groups in Seattle, while the sessions in Spokane were a mix of all employer groups. The sessions ranged in size from one to seven participants. One of the groups in Spokane included only agricultural employers.

Job titles of participants included owner, top executive, controller, accountant, human resources manager, employee health manager, safety officer, workers' compensation manager, and

benefits coordinator. Participant level of experience ranged from six months on the job to more than twenty years of handling claims and managing workers' compensation.

Several firms were seasonal employers, others were multi state employers, and two-thirds of the employing firms were unionized. Size ranged from ten employees to more than 5,000 employees, with more than half employing less than 400 employees.

Findings

Detailed participant responses are found in the Appendix H. Common themes developed across the sessions regarding the Washington workers' compensation system, specifically:

The employers we talked to expressed considerable dissatisfaction

- Delays in delivery of service to injured workers and in responding to employer concerns;
- Inadequate communication between L&I and employers;
- All believe the system favors the employee and is biased against the employer;
- Difficult, impossible, to get an "inappropriate" decision corrected;
- "Docs have all the power"–most would prefer employer choice of initial physician;
- Eighty to ninety percent of their claims are simple and routine;
- Ten to twenty percent of their claims take 80 percent of their time because of an inconsistent and untimely process;
- Lack of consistency in application of policy by L&I and the Washington Industrial Safety and Health Acts (WISHA);
- Inconsistent daily practices and decisions among claims managers and vocational rehabilitation counselors;

- Lack of opportunity for the state fund employers, retro and non-retro, to affect the claims process including determination of claim validity, use of independent medical examiners, and vocational rehabilitation services;

- L&I claim managers make decisions in the absence of employer information or do not give weight to employer evidence;

- A majority of the self-insured and retro group employers expressed fear of reprisal if they complained about a particular claims manager, compliance officer, or trial judge;

- The retro plan employers value the claims and safety services provided by their retro associations. The Third-Party Administrators (TPAs) provide claims management services and act as a liaison with L&I while the association provides prevention services that often replace WISHA services. Retro employers want to have the same claims management controls they see the self-insured employers as having;

- The self-insured employers want increased control over the entire claims management process and decrease L&I's oversight of claims management;

- They want the state fund to be held to the same standards as L&I applies to them. They want more control and less redundant oversight from L&I.

The overall impression from the focus groups is that employers are not satisfied with the current approaches used by L&I to fulfill its mission of providing services to injured workers. Employers perceive the system as inefficient even though most of the claims have an effective outcome, that is workers are provided necessary treatment and have little or no loss time. Employers want a voice in claim management decisions, fact-based decision making, consistent practices, timely actions, freedom from reprisal, and for the self-insured employers, reduced oversight.

A recent survey of employers conducted at the request of the department[1] found a much higher level of satisfaction among employers. It is difficult to explain the differences between that survey and our results. It may be that our low response rate tended to emphasize the views of employers who were dissatisfied. It may be that people felt freer to express their views when they were in small groups meeting face to face with outside investigators whose study was sponsored by the legislature and who guaranteed anonymity.

It should also be pointed out that in general employers are not usually happy with their experiences with workers' compensation. There is no national norm of employer satisfaction. But, if there were, we expect it would be fairly low. Even when the system is working well, having an injured employee is generally not a good experience for employers.

Room for improvement

We do not conclude from these findings that the Washington system is necessarily bad or below average. Indeed, as indicated elsewhere in this report, the objective evaluations of the Washington system indicate that it is doing relatively well. Nevertheless, we do believe that these findings show that there is a substantial need for improvement in the Washington system and point to specific areas in which improvements can be made. Specific recommendations concerning these are discussed elsewhere in this report.

[1] The Gilmore Research Group. 1998. Customer Satisfaction Study, prepared for State of Washington, Department of Labor and Industries, Seattle, WA. April.

FINANCIAL OUTCOMES

Chapter Six

OVERALL PERFORMANCE

Insurance companies use certain ratios as indicators of their financial operation. Various aspects of their operation are described as a percentage of premiums. These are reported in Table 6.1 and illustrated graphically in Figures 6.1 – 6.3.

Table 6.1
Financial Results

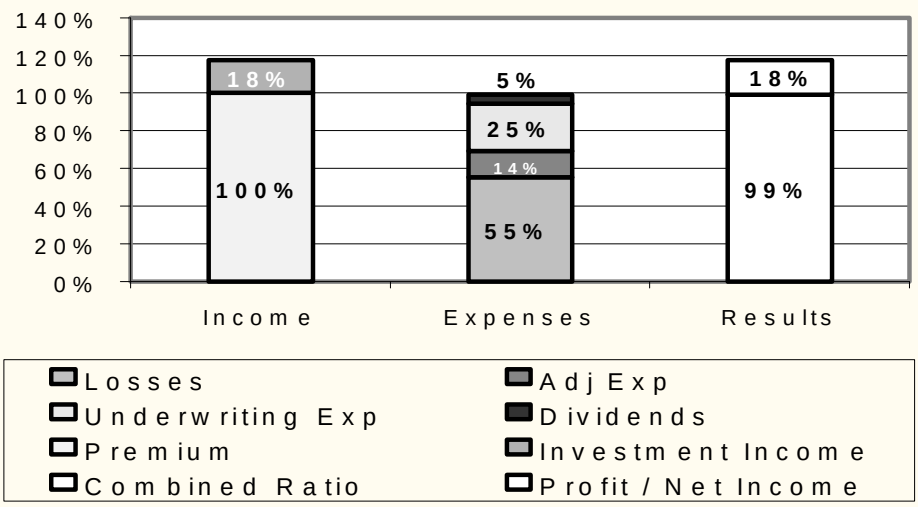
	Private Insurance			Wasington Fund					
	1996			1996			1997		
	Inc.	Exp.	Results	Inc.	Exp.	Results	Inc.	Exp.	Results
	A	B	C	D	E	F	G	H	I
Premium	100%			100%			100%		
Investment Income	18%			59%			78%		
Losses		55%			118%			161%	
Adj Exp		14%			11%			14%	
Underwriting Exp		25%			5%			7%	
Dividends		5%							
Combined Ratio			99%			138%			185%
Profit / Net Income			18%			23%			-4%

Columns A-C in Table 6.1 and Figure 6.1 report the operation of the private workers' compensation industry for the United States in 1996 (the last year for which full data is available) as reported by the National Council on Compensation Insurance. Column A represents income. Since everything is measured as a percent of premium, premium by definition equals 100 percent. There was also investment income that was equal to about 18 percent of the premium.

Column B reports where the money went. An amount equal to about 55 percent of the premium went to losses, that is payments to injured workers and healthcare providers. An amount equal to about 14 percent of the premium went to loss adjustment expense. This includes claims adjusters, attorneys, independent medical examinations, etc. About 25 percent went to underwriting and other expenses. This includes marketing and commissions to insurance agents. Private insurers paid dividends equal to about 5 percent of the premium.

Private insurance results. 1996

Figure 6.1
Private Insurance, 1996

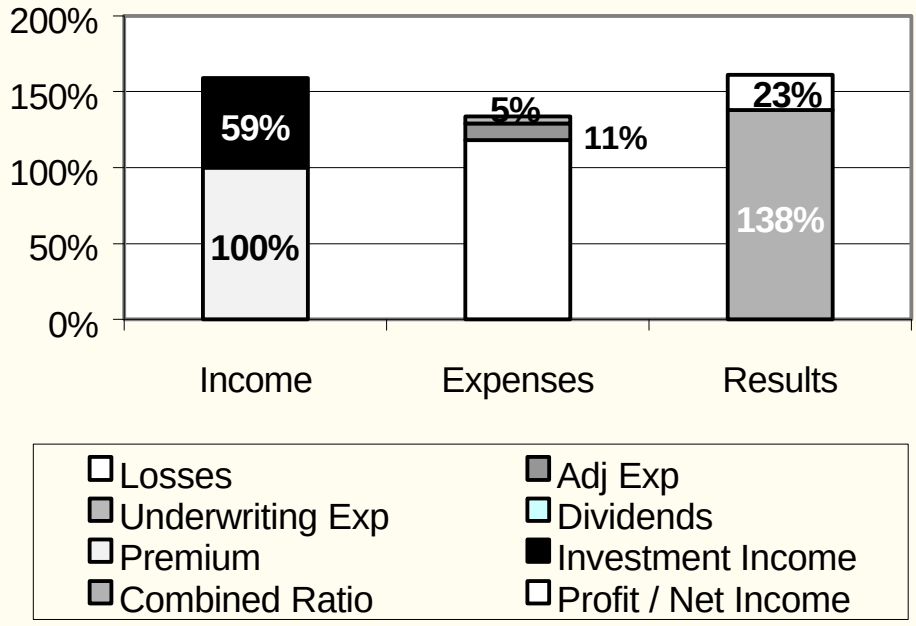


Column C represents two measures of results. The combined ratio is a figure frequently used by insurers to summarize their performance. It shows all of the expenses as a percent of premium. For 1996, this was 99 percent. This does not mean that they had a profit of only 1 percent. The combined ratio does not consider investment income. When this is considered, they had a profit of about 18 percent.

Columns D-E and Figure 6.2 show similar results for the Washington State Accident Fund for the 1996 fiscal year. First, we notice that investment income was much higher as compared to premium. This results from two factors. As discussed in Chapter 3 of this report, premiums in Washington are relatively

low. The state fund also has a rather large contingency reserve and it is doing very well with its investments. It is aided substantially in its investment success by the fact that it is not taxed as private insurance companies are.

Figure 6.2
Washington Fund, FY 1996

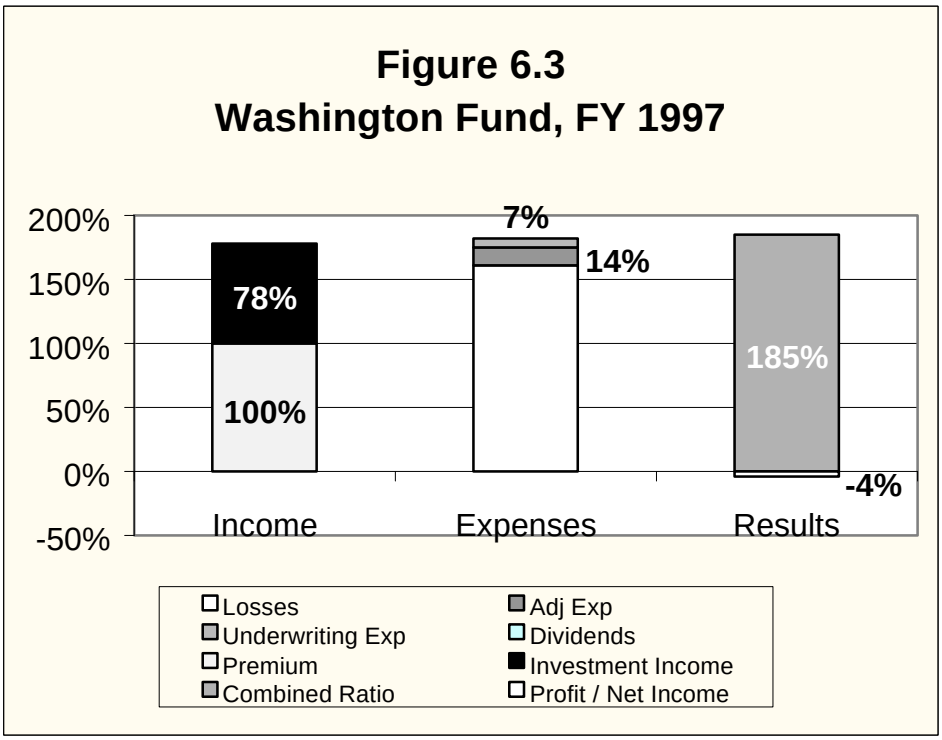


State funds results, 1996

We also note that losses represent a much larger percent of premium. This results from the fact that premiums are relatively low and from the fact that other expenses are low. This allows a higher percentage of the premium dollar to be paid in benefits to workers and healthcare providers. Loss adjustment expense is somewhat lower and underwriting and other expenses are substantially lower than private insurers. As a result, both the combined ratio and the net income are higher.

Columns G-I and Figure 6.3 show the same results for Washington for the 1997 fiscal year. The differences here are largely accounted for by a decision by the fund to reduce its contingency reserve through a reduction in premiums. Premium income was thus substantially lower and other factors measured as a percent of premium were higher. For the 1997 fiscal year, the fund actually had a net operating loss. This result was expected since the fund intended to reduce its contingency reserve.

State fund results, 1997



CONTINGENCY RESERVE

This topic is discussed in more detail in the actuarial analysis, Chapter 11. We will, however, offer a few general comments here from a non-actuarial point of view.

Workers' compensation premiums are necessarily based on an estimate of what the losses will be for the period to be covered by the premiums. It has turned out that in Washington and all across the country, the premiums charged in the early 1990s were higher than they needed to be. This has resulted in a large excess surplus or contingency reserve.

Estimating the extent of the excess is very difficult. The last few years have seen drops in losses (benefits paid) in Washington and all across the country. This followed several years of dramatic increases. No one is entirely sure why the losses are going down and as a result, no one can be entirely sure they will continue to go down. The increased surplus has also resulted from the fact that the Washington State Fund and private insurers across the country have benefited from the very favorable stock market. The future of this trend is of course also difficult to predict.

One way to estimate the appropriateness of surplus in Washington would be to compare it with the surplus held by private insurers. As discussed in the actuarial analysis, by this measure, the surplus in Washington seems high.

Returning part of the surplus to policy holders

During the last couple of years, the department has taken steps to reduce the contingency reserve. This was appropriate. Until very recently, the fund has sought to reduce the contingency reserve by reducing the premium rates it charges. There is a problem with this approach. It provides a benefit to future policyholders from a surplus that was created by past policyholders. Since these two groups are never identical, some unfairness will result.

Another approach is to pay dividends to past policyholders. This approach is more actuarially sound. Between the time this audit was completed and the time this report was published, the fund announced that it will, in fact, pay a dividend to past policyholders.

In Washington there is still one problem involved. Washington is the only state in which employees contribute to the insurance premium. The employees of insured employers pay 50 percent of the costs of the Medical Aid Fund. The recent dividend will be paid entirely through the Accident Fund. Thus employers will receive a refund for part of their contribution but workers will not. Most economists would argue that this is not a problem because in the long run workers' compensation costs are reflected in changes in wages. This is, however, not the same as getting a refund.

It would, of course, be extremely difficult to provide a dividend to employers and expect them to find the workers who contributed to the fund at various times in the past and pass the dividend back to them. This problem is unique to Washington and there are no models to follow from other states. One possibility would be to provide a dividend from the Medical Aid Fund as a credit against future payments. This would not give the benefit to exactly the same workers who paid the premiums but it would at least give workers some benefit from the dividend.

OPERATIONAL ANALYSIS

Chapter Seven

INTRODUCTION

This chapter presents a summary of an operational analysis of the Washington Department of Labor and Industries. It is supplemented by Appendix I: Insurance View Point. This part of the audit was conducted primarily by Bruce Hayden and Deena Lindstedt. Ken Gipson and Ed Welch also played significant roles. Ed Welch integrated the various findings into this summary and formalized the recommendations.

There are numerous functions within the department that are not related or are only indirectly related to workers' compensation. We have not analyzed those operations. In Chapter 8 we discuss dispute resolution. This includes some topics that are closely related to the discussion here.

In conducting this analysis, we looked at data that is regularly published by the department, obtained various special reports for our use, conducted an audit of individual claims files, met with and observed numerous employees in the department, and interviewed representatives of business, labor, and other interests. We also relied on information from other parts of the audit and on the knowledge and experience of the members of the audit team.

THE DEPARTMENT

Formality and Legalism

This is difficult to quantify but it appears to us that everything in the Washington State Workers' Compensation System is more formal, more legalistic, more process oriented than we see in private insurers. The people who manage claims are technically classified as "adjudicators." The claims-closing process is the best example of this but many other claims actions can only be accomplished through formal orders. To some extent this formality is required by law and/or results from the fact that the department is a state agency rather than a private insurer. Nevertheless, we see it as a hindrance to more efficient operation.

Their may be more formality than is necessary

There are many initiatives within the department that attempt to be customer oriented. As indicated elsewhere, however, the customers still complain about the lack of service.[1] It may be that the people at L&I could be more responsive to the needs of their customers if they were allowed, to some extent, to break out from the formal rules and procedures that are imposed upon them. The closing of claims is an important example of this. We will discuss it in more detail later.

Data and Reporting

The department publishes numerous reports including a monthly management report, a quarterly report, and annual financial statements. As discussed in the chapters below dealing with claims management, there are a few simple statistics that are thought to be important in many other jurisdictions that are not used in Washington. The department also does not prepare the sort of filings that are used in other jurisdictions to justify premium rates. Our actuarial analysis suggests that they should. See Chapter 11.

Our discussions with individuals within the department lead us to believe that there is much data which is collected and published routinely but which is never or rarely used. Perhaps it

[1] We saw this in our workers' survey, employer focus groups, meetings with interest groups, and in just about every meeting we had with employers.

served a specific purpose when it was created, but often that purpose is no longer important or has been forgotten.

The quarterly report measures a number of important things and would be helpful to someone who has an intimate knowledge of the Washington system. It reports everything on a quarterly basis, however. This is good for showing trends but most people would like to have annual figures. Furthermore, it reports virtually no numbers. It contains graphs that represent the numbers but in very few instances, does it supply the numbers behind the graphs.

We offer this example to illustrate our point. As discussed elsewhere, we looked at the question of the appropriate caseload for claims managers. Section 11G of the Quarterly Report deals with this issue. We did not find it very helpful. First of all, it provides graphs but no numbers. There is no breakout for medical only claims. This is a distinct class that most people would want to look at separately. It groups together claims scheduled for closing and closed claims with a reopening pending. The former category is not important in measuring caseload but the later category is very important. The other published source of information concerning this was the Monthly Management Report. It, however, reports on cases opened and closed, not pending, and it categorizes cases differently than the Quarterly Report. We found no way to make comparisons between the two sets of data. We did eventually receive the data we requested from the department but even then we could not track it back to the published reports.

On a rather routine basis the department collects and publishes a huge amount of data. The department would be better off if it concentrated on fewer data items and reported them in ways that would be easier to understand and also included the data itself. Below we make specific recommendations for performance measures with regard to the claims handling process.

Use of Technology

The availability of data is perhaps the most striking aspect of the use of technology in Washington. As mentioned earlier, the WCRI has conducted a series of administrative inventories of a number

of jurisdictions. Washington is one of the few states in which they describe a good data system. The WCRI and everyone else that analyzes the workers' compensation system in any jurisdiction usually winds up with a conclusion that insufficient data is collected and that the data that is collected is poorly maintained and not readily available for analysis. Washington is clearly a leader in this regard. Of course, this results not only from the fact that it does a good job of managing and collecting the data but also from the fact that it is an exclusive state fund.

Washington has an advanced imaging system

Washington has a very advanced imaging system. By the use of this system, paper documents that come to the department are converted to electronic images that appear on a computer screen. This eliminates, to a very large extent, the need for physical paper files for each claim. This has many advantages. Perhaps the most important has to do with the physical storage of paper files. It is possible that without the imaging system, the department would be buried under tons of paper that it would be required to store and maintain. The imaging system also makes each claim file available to anyone who has a computer connected to the system and the proper password. This is much more efficient than the use of paper files which must be passed from person to person physically and which can only be in the hands of one person at a time.

There are, however, drawbacks to this system. Computer screens can be hard to read. It is also much more difficult to navigate through a file on a computer. Claims handlers and especially supervisors and auditors are accustomed to picking up a file and flipping through it in a chronological order. Most experienced claim handlers find this to be the most appropriate way to get a quick picture of what is happening in a file, as well as an evaluation of the person managing the claim. That is not possible on a computer screen. Instead, one must review one document, return to a menu, retrieve the next document, and then review it. Computer systems can also become slow. If there are many people accessing the same server, there can be delays each time a new screen is requested.

All things considered, however, the department probably had no choice but to move to an imaging system. Given this choice, it is important that the department maintain hardware that is

efficient enough to allow users prompt access to the documents they need.

Certain files are "auto-adjudicated." Auto-adjudication is applied primarily to new medical-only claims as they are run through the system. They are screened by the computer system and, based on the diagnostic code and other information, they can be paid without any human intervention. They are assigned to claim managers, but they are not prompted for review. There are also other medical bills that are screened entirely by the automatic system and not reviewed by claims managers. This goes too far.

Automation should be used wherever possible to assist claims handlers in making decisions about claims, especially those that are quite routine. At the same time, the human element is important. All new claims should be reviewed at least briefly by a claims adjuster before they are referred to auto-adjudication. This will allow the adjuster to identify the small percentage that need further attention. In ongoing claims, it may not be necessary for the claims handler to specifically approve each medical bill, but the management of the entire claim will be better if the claims manager is aware of what medical bills are being paid. Also, there may be circumstances under which there is an over-utilization of medical services, which is not triggered in the computer system but would be noticed by a claims person.

Fraud

Fraud is an emotional issue for workers' compensation. The media and the popular press frequently run stories about disabled workers who are caught in some compromising situation. One of the basic problems has to do with what we mean by "fraud." For some people, a fraudulent claim is one in which you think you should get benefits, and I think you should not. This definition is not acceptable. When speaking of worker fraud, we believe there are two types of cases. There is what we call outright fraud, cases in which a worker deliberately and intentionally lies. Cases in which a worker is telling his or her employer and the department that he or she has no income when in fact the individual is actually working. The media often quotes numbers concerning this type of fraud. There are, however, absolutely no carefully constructed studies that document the amount of such fraud.

There is another category that we call difficult cases. We would not necessarily call these claims fraudulent, but many observers of the system see them in that way. These are cases in which a worker complains of symptoms and disability that exceed anything that can be readily explained by examining physicians. This is indeed a very common problem in workers' compensation. We submit, however, that it is a very different situation from an individual who intentionally lies.

It is our view that L&I does a very good job of dealing with fraud in the formal sense. We believe, however, that there is room for improvement in an informal arena. Put differently, Washington seems to do an adequate job of catching fraud but it could do a great deal more to prevent it.

Washington has a special unit to investigate fraudulent claims

Washington has a special unit to investigate fraudulent claims. It receives reports from anonymous tips, employers, department employees, vocational rehabilitation counselors, and others. It investigates these, takes administrative action in most of them, and refers some of them for prosecution. It boasts that it has a "100 percent conviction rate when pursing criminal prosecution of worker fraud." It goes on to point out that this represents eight cases. This approach and the outcomes in Washington are very similar to what we see in other jurisdictions.[2]

We were very impressed by the way the department uses its position as a state agency to allow a match of its records with records from other state agencies in an effort to identify individuals who are inappropriately receiving workers' compensation and wages at the same time. This is a possibility only because the department is a state agency. We were pleased to see it taking advantage of this situation.

Similarly, the department uses its standing as a state agency to obtain information from other sources in order to catch and deter employer payroll fraud. In this area, Washington seemed to be doing at least as well, perhaps better, than private insurers in most jurisdictions.

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[2] See "Workers' Compensation System Abuse Claimant Activity, Fiscal Year 1997," Oregon Department of Consumer and Business Services, August 1998 and *Fraud in the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation, January 1998.

The real key to avoiding fraud is active claims management. This means that claims adjusters identify those cases that deserve special attention. Some companies have checklists that they give to adjusters. In other cases, experienced adjusters can "just get a feeling for a case." We hasten to add that these are not necessarily individuals who should be denied benefits or harassed in any way, but they are cases that clearly need more attention. We believe that the changes we have recommended for the ways in which claims are managed would allow substantial improvement in this regard. We would also suggest that claims adjusters be provided with the option of simply and quickly obtaining activities checks or surveillance in appropriate cases.

In summary, Washington appears to be doing about as well as other jurisdictions with its special fraud unit. It appears to be doing better than most in matching its records with other sources. There is, however, considerable room for improvement in avoiding fraud through better case management.

Regionalization

In the mid-1990s, there was a reorganization of the department that resulted in the assignment of a number of functions to regional offices. That appears to have created considerable turmoil in the department and while there may have been some advantages, few people either inside or outside of the department describe it as a positive move. When the current director was appointed, he apparently stopped any further moves towards regionalization but did not attempt to undo the changes that had recently been made.

In the sections below concerning claims management, we make a number of recommendations concerning the organization of how claims are managed. We feel that it would best at this time if those changes were made without any further move towards regionalization. However, in the long-run after those changes are initiated, the department and its customers may find that it could accomplish its mission more effectively if the people managing claims were closer to the businesses of the employers and the homes of the workers they serve. Down the road, some assignment of claims managers to regional offices may appear to

be a natural step. We would encourage the department to consider that at the appropriate time. We would suggest, however, that the reporting requirements be different than presently in place in regional offices. The people in a regional office managing claims should report to the claims management director in the home office, not to a regional administrator who reports to a deputy director for field services.

Management of Insurance Services

There are several aspects of the management of insurance services provided by the department which are troublesome:

There are several aspects of the organization of insurance services that are troublesome

- In recent memory, whenever a new governor is elected there is a new director of the department. Often the director has no experience in the area of workers' compensation.

- Most of the activities of the department related to workers' compensation come under the Insurance Services Division. Traditionally, this has been headed by a deputy director. The individual currently holding the job, however, has only been given the position of assistant director. This is somewhat surprising since the activities in this area constitute, by far, the majority of the activities of the department.

- In examining the budget of the department, it was very difficult for us to make an evaluation of exactly which services were being funded with workers' compensation premiums and which services should be funded by those premiums.

- The department funds a substantial amount of research. We applaud it for doing that, but there does not appear to be much public discussion of this research agenda or its value to workers and employers who are ultimately paying for it.

- As indicated below, there appears to be considerable dissatisfaction on the part of employers and workers with the present operation of this system.

- Finally, numerous business representatives raised the question, "To whom is the department ultimately accountable?" The answer, of course, is the governor or legislature. In some way, however, the department should be more directly accountable to the workers and employers it serves.

Private insurers have a board of directors, which is ultimately accountable for their operations. Since the department is a state agency, a board cannot take ultimate responsibility. But it could assume much of the responsibility for the operation of the insurance services provided by the department, and it could ensure that the customers of the system have more direct control over its operation. The exclusive state funds in West Virginia and Ohio have a council and a board, respectively. They have somewhat less power than the board we recommend below, but considerably more power than the present Washington Workers' Compensation Advisory Committee. Canadian jurisdictions have boards that operate very much like boards of directors in the private sector.

Recommendation 1

The department should consider the possibility of having a board that would oversee its activities that are related to insurance services.

Such a board would include equal representatives of employers, workers, and the public. One of the public representatives would be the director of the department. The appointment process would be designed to insure that the appointees were truly representative of their constituencies regardless of the political status of elected officials. In order to encourage continuity and some independence, they would serve for overlapping fixed terms of at least four years.

This board would, in turn, hire the director of the Insurance Services Division. The director would enter into an employment contract with the board, and report to the board.

Such a reorganization would result in more continuity of management and help improve customer satisfaction.

These management changes would require legislative action. In the meantime, the present Workers' Compensation Advisory Committee could be used to greater extent to assist with the management of the Insurance Services Division.

CLAIMS MANAGEMENT

Introduction

In the following subsections will discuss various aspects of the claims management process within the department. We will highlight certain important findings and offer specific recommendations.

Goal

Return to work should be the goal of claims management

In many ways the goal of the management of a workers' compensation claim in Washington appears to be a finding that the worker is "employable" and closure of the claim. Later in this report, we discuss more specifically the goal of return to work with respect to vocational rehabilitation. We would point out here, however, that return to work should be the goal of the claims process as well. Certainly, some claims managers that we talked to indicated an understanding that the real goal should be a successful return to work of the injured employee. Our view of the overall process, however, is that the return to work goal is not given sufficient emphasis. This is discussed in our vocational rehabilitation report, but it is also of importance here. We believe the system could be improved if there was more emphasis on return to work rather than a finding of employability or formal closure of the claim. Return to work, of course, does not simply mean the first day an individual returns to the job but a successful long-term return to employment.

Lack of Satisfaction

As we talked to people in Washington, one of our most striking findings was the widespread dissatisfaction with the current workers' compensation operations with the department, especially by employers. The interest groups we met with expressed great dissatisfaction with the way the department

operates. They complained about inconsistencies in the decisions that are made and the ways cases are handled: they complained about failure to return phone calls and, in general, they complained about the way the department handles claims.

As discussed in Chapter 5, we also met with employer representatives in focus groups for which the participants were randomly selected and in which we guaranteed confidentiality. These groups expressed very much the same concerns as did the interest groups. In addition, members of these groups expressed a fear of retaliation. They indicated a concern that if they complain about the behavior of a claims manager, the individual claims manager could retaliate by treating them badly in some future claim. (We also heard comments that if a worker complained too much to his or her claims manager, that worker's file was "put on the bottom of the stack.") We did not uncover any evidence that these things actually happen. If they happened frequently, there would probably be some such evidence. It is clear, however, that people believe these things happen. Furthermore, the present organization of claims management functions is not the best approach for preventing such occurrences. The reorganization of claims management resources that we discuss below would reduce the likelihood that retaliation could occur.

Labor unions and trial lawyers had some complaints about the operation of the department but, in general, were not as critical as employer groups. Our survey of injured workers indicated that some injured workers are pleased and satisfied with their treatment but a substantial number are quite dissatisfied.

This does not prove that the department is performing badly. We had a rather low response rate for both the focus groups and workers' survey. It is quite possible that the people who took part were those who were most dissatisfied with the system. Interest groups have their own agenda and, for a variety of reasons, it is likely that they might be inclined to emphasize the negative.

Furthermore, workers' compensation is an area in which all the participants are typically dissatisfied. Employers generally find workers' compensation claims to be frustrating and for workers an injury is, at best, an unpleasant experience. There are no national norms for dissatisfaction with the workers' compensation

system. We would certainly guess, however, that in the average or perhaps in every state, the "normal" level of satisfaction would be on the negative side.

However, the dissatisfaction we found points clearly to ways in which the department can improve. We presume that the ultimate goal of the state of Washington in requesting this audit is not lay blame but to improve the workers' compensation system. Accordingly, we do not assert that the expressions of dissatisfaction prove poor performance by the department. We do argue strongly that they point to ways in which the department could dramatically improve both the satisfaction of its customers and its objective performance.

The department is taking steps to deal with customer dissatisfaction

At present, the department lists customer satisfaction as one of its primary goals. We assume that at least in part they sense the same dissatisfaction which we have found. They are taking some steps to deal with this situation. In the following sections and elsewhere in this report, we list numerous suggestions which are designed to improve the operation of the Washington State Workers' Compensation System. We believe that these improvements will in turn lead to much more satisfaction on the part of employers and workers.

Long-Term Disability (LTD) Pilot Projects

The department has pilot projects underway in Yakima and Everett that are designed to test ways to reduce long-term disability. We found these to be very promising. So far the objective data from these studies do not document much in terms of better claims results. They do, however, show a substantial improvement in customer satisfaction. It may be too early to expect significant changes in claims results. As we noted earlier, our objective measures of performance of the Washington system are quite good. It is in customer satisfaction that the department is lacking most. That makes the results of these pilots especially significant.

This brief mention of the LTD pilots perhaps underestimates their importance. We do not elaborate on them because they are being carefully studied and reported upon by the department. They also represent experiments rather than the current primary

practice of the department. They do, however, incorporate to varying extents some of the recommendations we make here. They are evidence that even before this audit, the department was, on its own, investigating its procedures and examining new ways to operate.

Employer Involvement

Many of the employers and interest groups we talked to complained that employers are not involved in the management of claims. Employers are not made active partners in managing the claim and accomplishing a return to work with the injured worker. Our experience teaches that this is an important issue. The employer's assistance in returning the injured employee to work is critically important.[3] Outcomes for employers and workers are better when the employer is a partner in the claim process.

The observations of the claims handling process, by Deena Lindstedt and Bruce Hayden, suggests to us that employers in Washington are much less involved than in other jurisdictions. This is a result of a variety of policies and practices that could be changed. We will discuss these below. To be sure, some of the claims managers we talked to indicated an understanding of the

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[3] Butler, R. J., Johnson, W. G., & Baldwin, M. L. (1994). Measuring success in managing work-disability: Why return to work doesn't work. *Industrial and Labor Relations Review*, March 28, 1994; Hunt, A. H., & Habeck, R. V. (1993). *The Michigan Disability Prevention Study*. Kalamazoo, MI: W.E. Upjohn Institute for Employment Research; Johnson, W. G. (1983). *Work Disincentives of Benefits in Workers' Compensation Insurance.* Ithaca: Cornell University ILR Press, pp. 138-153; Johnson, W. G., & Ondrich (1990). The duration of post-injury absences from work. *Review of Economics and Statistics, 72*(4), 578-586; *The Research Review*, Texas Workers' Compensation Center, (August 1995); Habeck, R. V., Leahy, M. J., Hunt, H. A., Chan, F., & Welch, E. M. (1991). Employer Factors Related to Workers' Compensation Claims and Disability Management. *Rehabilitation Counseling Bulletin*, 34(3), 210-225; King, C. T., Pavone, J., & Marshall, S. R. (1993). *Return-to-work Patterns and Programs for Injured Workers Covered by Texas Workers' Compensation Insurance.* Center for the Study of Human Resources; Gottlieb, A., Vandergoot, D., & Lutsky, L. (1991). The role of the rehabilitation professional in corporate disability management. *Journal of Rehabilitation*, 23-28; Taylor, M., Hintzman-Egan, D., & Farrell, G. (1994). *Back to Work: A Rehabilitation Study*. Minneapolis, Minnesota: Northwestern National Life.

importance of employer involvement. It would appear that in the long-term disability pilot projects, employers are more involved. Nevertheless, our view is that overall the structure of the Washington system for managing claims does not generate sufficient employer involvement.

Delayed Payments

One frequently used measure of system performance is the amount of time that elapses between an injury and the first payment of time-loss benefits to a worker. Most jurisdictions measure this from the date of injury to the date the check is mailed. In most jurisdictions, the goal is to have a substantial portion of payments made within two weeks. This is sometimes measured as 14 and sometimes measured as 15 days.

Washington is very slow in beginning the payment of benefits

Table 7.1 shows the percentage of cases in which the first payment was made within two weeks for four jurisdictions for which data was available. The record in Washington is poor. The department reports to us that only about 13 percent of injured workers receive their first check within 15 days. Wisconsin and Oregon have set a goal of paying 80 percent of the workers within two weeks and, as the table shows, are exceeding that goal.

Table 7.1
Percent of First Payments in Two Weeks

WA	OR	WI	MI
13%	88%	82%	49%

Washington does not even regularly measure delay between injury and payment. Instead, it measures the delay from the time a claim is reported until it is paid.[4] If one looks only at internal performance, it can be argued that this is an appropriate measure, but this is not what really matters to injured workers or employers. Private insurers all across the country have taken

[4] The Washington statute requires measurement in this format but does not prohibit the department from publishing other measures as well. The payment data is measured differently for self-insured employers. They claim that as a result, they are held to a higher standard. Our discussion here applies primarily to cases in which the employer is insured through the state fund. Issues involving self-insured employers are discussed elsewhere.

upon themselves the responsibility to educate and assist their insured employers concerning early reporting and prompt payment of claims.

The most obvious problem with the delayed payment is that workers go without income for a period of time. There are many other problems as well. The carrier cannot begin to manage the claim, and the employer may not be involved in the return to work. There is a widespread belief in workers' compensation circles that delay in the first payment leads to longer, more costly claims and to more litigation.[5]

It has been pointed out to us that the 13 percent figure for Washington includes some cases that are originally reported as medical only. It should also be noted that Oregon measures the delay from report to the employer and Wisconsin measures the delay from the last day worked. As a result of these factors, the differences may be less extreme than the figures cited above suggest. It should also be noted that it is our opinion that this delay does not result from poor performance by employees of the department, it rather results from a system feature, doctor reporting, which is discussed below.

Although the figures may be somewhat less dramatic than we originally reported, we remain convinced that this is a very serious weakness in the Washington system and strongly recommend that it should be remedied.

Claim Reporting

One of the most significant causes for delayed payments and the lack of employer involvement is the manner in which claims are reported in Washington. It is the custom for an injured worker of an insured employer to go to a physician who in turn reports the injury to the department. This is a highly unusual, if not unique, approach.[6] In other states, a worker who suffers an injury reports

One of the most significant causes of delay is the manner in which claims are reported

[5] "Prompt Reporting Pays Off," Welch, Elizabeth G., *On Workers' Compensation*. September 1994. p. 160.

[6] We do not know any other jurisdiction that uses this approach. We have been told that there may be a couple of other states that do so, but no one has been able to identify them to us.

the injury to his or her employer, and the employer reports it to the insurer or the state agency.

The department takes the position that this reporting procedure is required by law. We find this difficult to reconcile with the Washington Industrial Insurance Laws that provide:

> Whenever any accident occurs to any worker it shall be the duty of such worker or someone in his or her behalf to forthwith report such accident to his or her employer, superintendent or foreman or forewoman in charge of the work, and of the employer to at once report such accident and the injury resulting therefrom to the department. (RCW 51.28.010)

To be sure the following section of the law provides for assistance to workers by physicians. It would appear to us, however, that the statute itself contemplates the reporting of injuries by workers through their employer.

The first and most obvious advantage of employer reporting is that it speeds the first payment of benefits. Employers can frequently report an injury to the state even before or while the worker is seeing the physician. Physician reporting creates paperwork for physicians which results in delays. When a report comes to the state agency from a physician, efforts must be made to verify who the correct employer is. When an employer reports an injury, it can be presumed that it is the correct employer.

Employer reporting would speed payment and help get the employer involved in claims management

Employer reporting also gets the employer involved in managing the claim from the very beginning. The employer who knows what is going on is much more likely to assist with claims management and return to work.

Washington should adopt a system under which most claims are reported by the worker to his or her employer and then by the employer to the department. We recognize that there are instances in which workers are reluctant to report injuries to employers. For this reason, we would recommend that Washington retain the option of reporting through physicians, at least until employer reporting has been tested on a widespread

basis. We would also recommend consideration of an option under which a worker could report an injury directly to the department.

Recommendation 2

The department should adopt an alternative system for the reporting of injuries under which the worker would report to the employer and the employer would report to the department. An educational effort should be launched to promote this method of reporting.

As indicated by the language quoted above, we do not believe that this would require a statutory change. It would appear to us that Industrial Insurance Laws already provide for this type of reporting. Instead it would require an effort by the department to educate employers and workers. Indeed, we would recommend that the department launch an intensive educational effort to inform workers and employers about the importance of prompt reporting.

As soon as a report of injury is received from an employer, the department should begin the process of opening the claim, obtaining information from the physician, and eventually beginning payment. We would suggest that the department should at least allow reporting by fax, and we would note that there are a great many insurance companies that allow telephone reporting by their insured employers.

Organization and Assignment of Claims Units

In private insurance companies, third party administrators, and self administered self-insured employers, it is the practice for a claims supervisor to oversee a unit of between five and eight claims adjusters.[7] In Washington, a unit supervisor might be supervising 17–21people, most of whom are claims managers. A

[7] Washington uses the term "claims manager" to refer to individuals with differing levels of expertise and experience manage claims of various levels of complexity. A more typical, though somewhat old-fashioned term, is claims adjuster. Claims manager, more typically, refers to individuals who supervise claims adjusters. For clarity's sake, we will use the terms claims adjuster and claims supervisor in this discussion.

person can become a unit supervisor in Washington without any prior experience in workers' compensation.

Smaller claims units would be more effective

In most other jurisdictions, the claims supervisor is actively involved in the management of claims. He or she is a mentor or coach, but also has responsibility for the outcome of the claims. There may be some functions which claims adjusters cannot perform without the approval of their supervisor. Washington has had coaching and mentoring systems in the past, and a new one has recently been implemented. The use of supervisors is a better approach, however, because the supervisor is held accountable for the people in his or her unit and for the outcome of the claims.[8]

Closer supervision by individuals who are actually involved in the management of claims should help insure better consistency in claims decisions that are made, and greatly reduce the possibility that retaliation could occur. One of the duties of the supervisor would be to insist that the claims adjusters focus on the successful return to work of the individual worker and the satisfaction of the insured employer. We will suggest below that individual claims managers be given responsibility for setting and maintaining reserves on cases. In this regard, they will often need the assistance of a more experienced claims person. We think that this can be best provided by a supervisor who has experience in managing claims and who has a more manageable number of claims handlers to supervise.

Recommendation 3

The claims functions should be organized into units that include five to seven claims adjusters, clerical support, and a claims supervisor.

In Washington, an employer rarely gets the same claims adjuster for two claims in a row. It is the widespread practice in the insurance industry that employers are assigned to an adjuster or team of adjusters. This practice allows claims adjusters to become more familiar with the situation of individual employers, allows

[8] We do not claim to be experts on the Washington State classification system. It would appear, however, that people who are now classified as Claims Adjudicators 4 or 5 could probably perform as claims supervisors.

the claims adjuster to establish a working relationship with the employer, and results in more accountability by the claims adjuster.

At present, claims involving litigation and claims involving pensions are handled by a separate unit. This has several disadvantages. It involves another new person with which the worker and the employer must deal and something is always lost when a case is passed from one adjuster to another. It is a better approach if a single individual, or at least a single claims unit, has complete responsibility for a case from beginning to end. We believe that if claim units are organized as we describe here and assistance is available from a claims supervisor, these claims could be handled within the individual claims unit.

Employers should be assigned to an individual claims adjuster

The Washington system would be improved if, to the greatest extent possible, all the claims for an individual employer were handled by the same adjuster. It may also be desirable to have units organized by industry or geographically.

Recommendation 4

To the greatest extent possible, employers should be assigned to an individual claims adjuster.

Claims Management Functions

We suggest several changes in the duties assigned to the people who handle claims. These would bring Washington more in line with the way these functions are ordinarily handled by private insurers.

It has become a widespread, generally accepted best practice in the workers' compensation insurance industry that within 48 hours of a report of injury, the claims adjuster should make a "three-party contact." This means that the claims adjuster speaks on the phone with the injured worker and a representative of the employer and either speaks by phone or receives a written report from the treating physician. The system in Washington tends to put great emphasis on formal written documents. Often, however, it is a personal contact that speeds recovery and facilitates return to work. Men and women who are injured on the job are often

frightened and bewildered; they are in pain; they are worried about their injury; they are worried about their income; and they are worried about their employment future. Someone should talk to them. It is the best practice to make a personal contact with every injured worker who it appears will have a time-loss case.

Some employers accommodate workers and bring them back to work very promptly. They put them in jobs that are clearly within their limitations and gradually ease them back to full duty. As noted above, in the last several years, it has almost become axiomatic across the country that this is one of the most important ways in which an employer can control costs and reduce the suffering of workers at the same time. It is the best practice among private insures to begin talking to employers about this approach immediately following the injury. This should happen in Washington.

Personal contacts with the worker and the employer are also essential in dealing with fraudulent and difficult cases. A personal contact with the employer can provide the claims adjuster with information about the individual involved and the circumstances of the claim. A personal contact with the worker is an opportunity for the claims adjuster to make a judgment about the nature of the claim and individual involved. In potentially fraudulent cases, the personal contact will let the worker know that someone is involved and in control of the situation. This presence may deter some workers from knowingly pursuing false claims. Finally, a reassuring conversation with an injured worker will, in some cases, calm the fears and worries of the individual and prevent small claims from becoming big ones.

Prompt, direct, personal involvement in claims management will improve results

The first few days of a claim are of critical importance. It is the point at which a decision is made about the compensability of the claim. It is also a point at which a judgment can be made about potential problems in a claim, the degree to which the claim will need special attention, and the assignment of the claim to an appropriate adjuster. It is the best practice in the insurance industry to have all new claims reviewed by experienced expert claims specialists within the first few days.[9] In the context we

[9] This practice is followed by the following insurance companies and third-party administrators: Accident Fund Company of Michigan, Fremont Compensation Insurance Groups, Zurich Insurance Group, CNA, and ALEXIS.

describe here, all new cases should be reviewed by the claims supervisor within three days of the date they are opened.

Claims adjusters should be required to set reserves on files. A reserve is the claims adjuster's estimate of what the ultimate total costs of the case will be. In Washington, this is only done by people in a special unit and only done seven or eight months after the claim is opened. As discussed in other parts of this report including the actuarial report, the setting of reserves focuses the attention of the claims adjuster on the long-term prospects for the case. It also results in more accountability of the claims adjuster for the file. We recognize that considerable training and experience is necessary to set reserves. Accordingly, we suggest that this recommendation be adopted gradually as training can be accomplished and experience gained. At least at first, claims adjusters should have the assistance of their supervisors in setting reserves.

Claims adjusters should be required to occasionally visit the workplaces of the employers that are assigned to them. Not all claims adjusters will ever be able to visit the workplaces for all their employers. If a claims adjuster is handling claims for a large number of small employers, then visiting the work site of a small sample is the most that can be expected. If, however, a claims adjuster has an assignment of a large employer with numerous injuries, the claims adjuster ought to go to the work site and look at the work that is done and see how it is performed. We would suggest that claims adjusters spend at least six days a year in the field visiting workplaces.

Claims adjusters should also have clerical support for some of their tasks. This should be used to free up their time for making personal contacts with the parties involved. We would prefer to see claims adjusters making these contacts rather than having them delegated to customer service representatives or other individuals. Adjusters should also have input from specialists in the area of vocational rehabilitation. This is discussed more thoroughly in other parts of this report.

Where necessary (perhaps 3 to 5 percent of the claims), a claims manager should be able to request an investigation. By this we mean that a representative of the department would visit the

workplace, the injury location, the worker, and/or the employer, conduct interviews, and take written statements. Such an investigation should be able to be accomplished within ten days after a request in most cases and should be accomplished within one or two days in extremely unusual cases. We would suggest that, ideally, the claims adjuster personally conduct the investigation described above. We recognize that under the present arrangement this would be nearly impossible, as discussed above. In the long run, it may be desirable to open claims offices at locations across the state.

In order to accomplish the above, we make the following recommendation concerning claims management functions.

Recommendation 5

Claims management duties should be changed as follows:

- *There should be a personal contact with the three key parties involved in a claim as soon as possible and no later than 48 hours after a report is received.*
- *All new claims should be reviewed by a claims supervisor within three days after the report is received.*
- *The people handling claims should set reserves on those claims.*
- *The people handling claims should be required occasionally to visit the workplaces involved.*
- *Claims adjusters should have sufficient support for clerical and investigative tasks.*

Measurement of Claims Operations

We have mentioned above several areas that we believe are of importance in improving the management of claims handling, and included recommendations designed for improvement in these areas. In addition, we believe that further improvement can be achieved if these areas are included and highlighted in the performance measures of claims operations. There should be a change in the way individual claims adjusters, claims units, and

the department itself are measured and evaluated. Three criteria should be given special importance (though these would perhaps not be the only criteria used). They are:

The focus should be on prompt payment, early three party contact, and return to work

1. The percentage of cases in which first payment is made within 14 days of the date of injury.
2. The percentage of cases in which three party contact is made within 48 hours from the receipt of the claim.
3. The percentage of cases in which an injured worker successfully returns to work within various time frames.

Recommendation 6

The measurement of claims management performance should be changed to emphasize prompt payment, three-party contact, and successful return to work.

Claim Closure

The claim closure process is overly formal

Washington has a very formal procedure under which claims are closed (and in some cases reopened). A formal order is issued. This requires considerable time by claims managers. It also often requires the use of an IME. This can result in considerable delay between the time a case is ready to be closed and the time the file is actually closed. We are told there is also a substantial backlog of cases in the category "waiting to be closed." During this time, the status of the injured worker is uncertain and case reserves remain charged against the insured employer.

Most states do not have a formal procedure by which the state agency closes a claim. There is no formal catalog or listing of such procedures. However, we have reviewed the WCRI administrative inventories of 15 states.[10] In 12 of these states, the inventories do not even mention any formal system for closing claims.[11] This does not mean that the insurance companies keep their files open

[10] Georgia, New York, Wisconsin, North Carolina, Colorado, Pennsylvania, Illinois, California, Connecticut, Missouri, Texas, Minnesota, Michigan, Oregon, and Oklahoma.

[11] A formal procedure was mentioned in New York, Oregon, and Oklahoma.

or keep a reserve on cases indefinitely. Instead carriers close their file and remove the reserve without an official order from the state agency. They do this when, in their judgment, it appears unlikely that there will be any further expenses.

This would require a substantial adjustment for all the participants in the Washington system. It might, however, save a great deal of time, money, effort, and frustration. We wonder if the time and resources spent to formally close a case exceed the value that is obtained from this approach. (Many system participants we spoke to assumed that the primary value in the formal closing procedure was an assurance that further medical and time-loss benefits could not be paid. We were told by the department that this is not correct.)

Recommendation 7

There should be less reliance on the formal claim closure process.

Compliance Unit

A compliance unit should monitor the state fund and self-insured employers alike

As discussed elsewhere, many workers have expressed concern about the behavior of claims managers they have had to deal with. Employers complain of a lack of consistency in decisions that were made and the way claims were handled. Self-insureds felt that they were held to different standards than claims managers within the department. The suggestions we have made for reorganizing the management of claims should alleviate many of these problems. However, there should be some unit that is charged with the responsibility of insuring compliance by all parties with the legal standards required by the law and regulations and with the department's standards for providing satisfactory service. Such a unit could also respond to and investigate complaints from workers and employers. The later function might reduce the need for formal litigation in some circumstances.

A few states, such as Oregon, have a compliance unit which monitors the claims operations of self-insured employers, the state fund, and insurance companies. These are considered by

many experts to be highly successful.[12] Such a unit could set and monitor standards such as the percentage of cases in which the first payment is made within 15 days, accuracy in calculating the benefit rate, and the percent of cases which become disputed. It could also investigate allegations of improper handling of cases. It would not be the goal of this unit to resolve a dispute in an individual case but rather to look for patterns and practices of abuse by claims handlers.

Such a unit would monitor the operation of both self-insured employers and the state fund. It could eventually replace many of the functions of the current self-insurance unit. For the state fund the compliance reviews could be used in evaluating the performance of claims units, claims supervisors, or individual claims adjusters. The unit could publicize the results for the department and for self-insured employers.

Recommendation 8

There should be a compliance unit within the department which monitors the operation of the insurance services division and self-insured employers.

Training and Consistency

Workers' compensation cases often involve very complex issues. They also involve workers who are at a difficult time in their life and employers who are upset that a claim has been filed. This creates a very stressful situation for the people who must manage these claims. The department is also a very large organization and some inconsistency is almost inevitable unless steps are taken to avoid it. On way to deal with all of these problems is through a system of ongoing training and dialogue among the workers involved.

Training can improve consistency

The department has an extensive training program for new claims managers but very little in terms of on-going training and support. The department could benefit from a system in which claims handlers met several times a year for refresher training or updates. These should be arranged so that the classes include

[12] See, for example, *Workers' Compensation in Oregon*, Duncan S. Ballantyne and James S. Dunleavy, Workers' Compensation Research Institute, 1995.

claims managers from multiple units across the department. This would result in an exchange of information which would improve consistency. Managing claims of injured workers is a very difficult job. The people who do it need support and networking. These training sessions would provide that. We are told that in the past the department held round table discussions which functioned in this manner. Something of this sort should be resumed.

Recommendation 9

The department should offer some form of ongoing refresher training for all individuals who are managing claims.

INDEPENDENT MEDICAL EXAMINATIONS

Changes in claims management should reduce reliance on IMEs

Everyone complained about Independent Medical Examinations (IME). Labor representatives complained that they were used too often and too soon. Employers complained that they were not used quickly enough. Self-insurers complained that they were too costly and were required too often. In this regard, it would appear that Washington is suffering from a problem that is commonplace in workers' compensation across the country. Throughout the 1990s, many states have struggled with workers' compensation reform. In almost every case, one of the goals was to find a better way to do medical evaluations. While the states have experimented with a variety of alternatives, no one seems to have resolved the problem.[13]

The Washington Workers' Compensation Advisory Council is considering the creation of medical centers of excellence. The proposal is still in its formative stages, but we understand that these would be medical centers which would conduct evaluations and treat injured workers. They would also be models for other

[13] This can be seen in a review of the administrative inventories of state workers' compensation programs published by the Workers' Compensation Research Institute. A couple of the alternatives that seem promising are agreed upon medical examinations where both parties agree to be bound by an examination that they choose together and state-appointed panels. Neither of these approaches, however, appears to have been completely successful.

practitioners. This sounds to us like a promising alternative and we would encourage its development.

Here again, we believe that the recommendations we have made for claims management will reduce some of the need for IMEs. If the claims adjuster can be continually communicating with the worker, the employer, and the doctor's office, a substantial number of cases can be resolved without the need for reliance on IMEs. As discussed elsewhere, that the need for IMEs is to some extent generated by what we see as an excessive formality in the Washington system. Efforts to reduce this formality may also alleviate the reliance on formal independent examinations. The recommendations we have made for case closures will also reduce the need for IMEs.

SELF-INSURANCE

Introduction

This chapter looks at issues related to workers' compensation self-insurance in the state of Washington. It is based upon extensive interviews with self-insured employers, with the Self-Insurance Division of the Department of Labor and Industries, with labor representatives, a review of records and reports from the department, and the knowledge and experience of the auditors concerning self-insurance programs in other jurisdictions. This part of the audit was conducted primarily by Ed Welch and Ken Gipson.

There are no published materials which catalog, in any significant detail, the ways in which the various jurisdictions approve or monitor self-insurance. As part of our audit, Gary Calkins, who recently retired as Funds Administrator in Michigan, researched and prepared a working paper that provided information concerning the regulation of self-insurance in California, Ohio, and Oregon. Calkins and Welch also provided information about the system in Michigan.

Financial Monitoring

One of the most important functions of a state regulator with regard to workers' compensation self-insurance is to insure that the employer has sufficient financial resources to pay claims as they come due. Washington, like most states, has a guarantee fund (called the Self-Insurers' Insolvency Trust). This fund pays benefits to injured workers in the event a self-insured employer becomes insolvent. The trust is financed by assessments on all self-insured employers. While this fund protects workers from an ultimate loss, the proper regulation of self-insurance should minimize the need to resort to this fund and thus the need to assess self-insured employers for its support.

To protect against insolvencies, the regulator should scrutinize the financial status of employers before approving self-insured status and continually monitor the financial status of the employers they approve. In addition, regulators ordinarily require various forms of surety such as excess insurance, bonds, and letters of credit. It can happen that an employer will go into bankruptcy and become insolvent, but there will be no loss to workers or other self-insured employers because the sureties are sufficient to pay the claims.

In our view, Washington is doing a good job of monitoring the solvency of self-insured employers. Since the self-insurance program began in the early 1970s, there have been only 25 insolvencies (there are four other companies in questionable status). In all but five of these cases, there has been sufficient surety to pay all the claims. This compares to 40 insolvencies in California, 50 in Ohio, and 17 in Oregon. We would not recommend any changes.

Auditing

Approximately every three years, the department audits each self-insured employer. This consists primarily of a very detailed audit of a sample of about 70 claims files. It also includes an onsite review and a safety review. (The safety review is conducted by individuals who are trained primarily in claims management. It would seem that this could more effectively be carried out by

those people within the Department of Labor and Industries who are specially trained in safety.) No employer has ever lost its self-insurance status as a result of an audit, but a few have been put on what amounts to a probationary status, and it is apparently quite common for penalties to be issued as a result of these audits.

Washington appears to be doing a good job of monitoring the solvency of self-insurers

Self-insured employers have numerous complaints about the audits. They complain especially about what they see as inconsistencies. Actions that are approved by the department while they are managing claims are sometimes the subject of penalties during an audit. This frequently centers on topics such as the rate at which benefits should be paid, and the opening and closing of claims. The frequency and nature of the audits conducted in Washington appear comparable to what takes place in California, Ohio, and Oregon. By contrast, in Michigan, the state agency only examines the financial status of self-insured employers. It does not audit their claim files or safety performance on any regular basis.

Claims Oversight

We were unable to indentify any other state that plays such an active role in the management of self-insured claims

In Washington, the department takes a very active role in monitoring the management of claims involving self-insured employers. For example, a self-insured employer cannot reopen a case without approval of the department. (The department scrutinizes these to be sure that a reopening is not used when opening a new claim would be the more appropriate action.) The statute has recently been changed to allow self-insured employers to close claims under more circumstances, but there are still many actions that require approval of the department.

The Board of Industrial Insurance Appeals will only hear appeals of a formal order issued by the department. Accordingly, if a worker disagrees with an action taken by a self-insured employer, the worker must first protest the action to the department. We were told that when such a protest is received, it is a common practice for the department to request copies of the entire claim file and to review not only the decision that was protested but entire handling of the claim.

Self-insured employers tell us that sometimes they seek help or advice from the department in the management of claims and find this helpful. In general, however, they would like to be allowed more independence in managing claims. They feel that they can do as good a job as the people in the department and that the department review results in redundancy. Labor representatives expressed to us concern that self-insured employers are already overly aggressive in the management of claims and that if the scrutiny of the department is removed they will deny more claims and close others more quickly.

We were unable to identify any other state in which the state agency plays such an active role in the management of self-insured claims. Indeed in many states, self-insured employers are given complete discretion to manage their own files. In these jurisdictions, the state agency only intervenes when there is a dispute between a worker and a self-insured employer.

Different Treatment

Self-insured employers told us that they are held to different standards, treated differently, and have different outcomes than the state fund and state-fund employers. They point out that because of the way the amount of delay is measured, they are measured by a standard that requires the commencement of payments earlier than the standard applied to the state fund. (Some department officials argue that technically the standard is the same. This may or may not be the case, but it seemed apparent to us that practically speaking, self-insurers are held to a higher standard.) Self-insurers are required to report on vocational rehabilitation whenever a claim exceeds 90 days and the fund is not. Employees of self-insured employers do not contribute to the Medical Aid Fund whereas employees of an employer insured through the state fund pay half of the costs of the Medical Aid Fund.

Finally, self-insured employers claim that they do a better job of returning injured individuals to work. As discussed in our return to work and wage loss studies, it appears to us that employees of self-insured firms do have a faster first return to work and do receive less in time-loss benefits than employees of fund-insured firms. In this regard, it must be remembered, however, that self-

insured firms are on average much larger than fund-insured firms. This gives them an inherent advantage in light duty and return to work efforts. Moreover, we found that when we looked at long-term measures of consistent employment and wage loss, employees of self-insured firms did no better than employees of insured firms and in some categories, did not do as well.

Comments and Recommendations

In other portions of this report, we make recommendations concerning how claims are reported and opened, how claims are closed, and vocational rehabilitation. In each case, we intend those recommendations to be applied equally to cases involving the state fund and self-insured employers. We feel that these will resolve many of the concerns raised by self-insured employers concerning these specific issues and also concerning the monitoring and auditing functions of the department as they relate to these issues. For example, many of the complaints concerning monitoring involve both when and how cases are closed. If, as we suggest, Washington adopted a less formal system for closing cases, the need for review and approval of case closures by the department would be reduced.

Self-insured employers feel that it is unfair that their employees are not required to contribute to the Medical Aid Fund. Those of us who are outsiders find it difficult to view the situation in this way. We are more struck by the fact that Washington is virtually the only state in which employees contribute to the cost of workers' compensation in any way. What we find unusual is the fact that employees of fund employers are required to contribute to medical costs.

Regulation could eventually be relaxed

Self-insured employers would like to be able to manage their cases without interference by the department. Such a change would require legislative approval and it appears to us that at the moment, labor would oppose such a move. Thus, in order to achieve this change, a better atmosphere of trust must be created between self-insured employers, their workers, and the department. We held one meeting in which representatives from all three groups took part. They did not reach agreement on much, but they did share their views. We felt that, to at least some degree, they came away understanding better the problems

and concerns of the other parties. We would urge these three groups to attempt to work together in the future, to listen to one another, and to build an atmosphere of trust.

We have recommended elsewhere an increased availability of ombudsmen/mediators and a compliance unit that would monitor the operations of the fund and self-insured employers. Once these alternatives are in place and working effectively, we would recommend that self-insured employers be allowed to handle their own claims without interference by the department. Under this scenario, workers would have several protections available. One, they could ask the assistance of an ombudsmen/mediator who would attempt to achieve a voluntary resolution of any difference between the worker and the self-insured employer. Two, they could file a formal appeal to the Board of Industrial Insurance Appeals. (We would not require them to protest through the department.) Three, they could complain to the compliance unit. The compliance unit would not resolve their individual dispute but would use the information received in a continual process of monitoring the performance of the self-insured employer. We believe that this situation would result in sufficient overall monitoring of self-insureds and provide individual workers with appropriate relief when they were treated unfairly.

Recommendation 10

Once the department has in place a compliance unit and a system of ombudsmen or mediators, the current oversight of the claims processes of self-insured employers should end.

It should be noted that this recommendation is intended to change the way claims are managed, it is not intended to change appeal procedures or how a case is protested, appealed, or brought before the Board of Industrial Insurance Appeals.

REGULATION OF OUTSIDE PARTIES

Introduction

There are numerous outside providers that have impact on the workers' compensation system. We noticed three areas in which the department provides very little regulation or oversight in each area. We do not recommend additional regulation by the department, but we do recommend that the department provide information about these issues to the individuals who are most affected by them. This provision of information will allow the individuals to make better judgments concerning the providers with which they are dealing.

Attorneys

In general, the regulation of attorneys in Washington and other states is governed by the bar association and the courts. There is, however, one area that is the responsibility of the department. RCW 51.52.120 provides a maximum attorney fee of "30 percent of the increase in the reward secured by the attorney's services." It provides that the director of the department has primary responsibility for enforcing this and that the board has such responsibility in cases involving appeals.

In Washington, it is common when a worker is represented by an attorney to have the worker's monthly checks mailed to the attorney's office. Sometimes this occurs even in cases in which there is no formal dispute. This is unusual. In most states, attorneys charge fees based on a lump-sum payment of past-due benefits and receive their fees in a single payment. In many states, this occurs when a compromise and release has been completed. The Washington law, however, does not allow for such settlements. The statutory standard of "30 percent of the increase in the award secured by the attorney's services" is subject to interpretation in individual cases and indeed could be subject to abuse in circumstances in which the monthly checks were sent to the attorney.

Workers should be notified of payments to their attorneys

At the present time, the department and the board are available to intervene in disputes concerning attorney fees, but they do not take any active role in regulating the fees charged. We received some suggestions that the department should scrutinize or regulate the fees actually charged by attorneys. We did not, however, find any specific evidence of abuse by attorneys and, indeed, we did not hear widespread complaints or suspicions concerning such abuse. Accordingly, we would not recommend such regulation. There is, however, another alternative. We feel that the department has a duty to inform claimants of the legal standard. Accordingly, we recommend that the department adopt a policy of providing claimants with information about the limits on attorney fees and of reminding them of these limits at appropriate points.

Recommendation 11

When the department begins sending monthly checks through an attorney, or when it sends any lump-sum payment through an attorney, it should notify the claimant of the rate or the amount of the payment or payments sent to the attorney and the statutory limit on attorney fees.

Retro Groups

Groups of retro employers sponsored by an association have become a very important part of the Washington system. In numerous ways, the department oversees the operation of these groups. There is one respect, however, in which the department takes a completely hands-off approach.

Members should be notified of payment of dividends to retro groups

Large sums of money are returned to these groups as dividends. These are based on the losses of the retro group as compared to the losses of other similar employers. The department does not monitor in any way the extent to which these dividends are refunded to the members who paid the premiums as opposed to being used for other purposes of the associations sponsoring the group.

The retro groups in Washington are in many ways similar to self-insurance groups found in other jurisdictions. In many such jurisdictions, the state agency would monitor very closely the

percentage of dividends that are returned to the members. They would limit the portion that is used for administrative fees and for other purposes of the association. We do not recommend that the department regulate or even monitor how the dividends are used at this point. We do recommend, however, that the department provide information to the member employers about the dividends that are returned.

Recommendation 12

When the department sends dividends to a retro group, it should notify the member employers of the amount of the dividend and the basis for its calculation.

Third-Party Administrators (TPAs)

Self-insured employers frequently hire companies that specialize in the management of workers' compensation claims to act as TPAs and assist in the management of their operation. This is true in Washington and across the country. In Washington, TPAs often also assist retro groups and individual employers in the management of their claims. It can be argued that since these employers are fully insured by the Accident Fund, they should not need the assistance of TPAs. While that might be true in theory, it is clear to us that under the present system in Washington, TPAs play a very important role for insured as well as self-insured funds.

The department does not attempt in any way to evaluate or regulate TPAs even though they play a key role in this system. In some states, the state agency does regulate TPAs. In many states, as in Washington, they do not. It is felt that this is a function that can be handled by the marketplace. If TPAs do not perform well, then employers will not hire them. We believe this approach could be enhanced by providing more information.

The department very carefully audits the performance of self-insured employers. This must generate considerable data concerning the TPAs that service these employers. At this point, we do not advocate the regulation or licensing of TPAs. We would suggest, however, that the department at least publish

information about the operation of TPAs, which become available during audits.

Recommendation13

The department should collect and publish information about the performance of third-party administrators to the extent it becomes available through audits and otherwise.

ALLOCATION OF RESOURCES

Non-Insurance Activities

The Department of Labor and Industries is responsible for a number of areas that are not related to workers' compensation. These include such things as the compensation of crime victims, plumbing certificates, and electrical inspections. Clearly these functions are not properly part of a workers' compensation system. The Washington Industrial Safety and Health Act (WISHA) is also administered through the department. It could be argued that the consulting portion of the WISHA function is properly within the workers' compensation system. However, the regulatory function probably is not. Some of the people we talked to raised questions concerning the extent to which workers' compensation insurance premiums were financing other activities.

This is a performance not a financial audit, but we attempted to look at this issue. We found it very difficult to analyze in detail the financial arrangements within the department. We would suggest that a more detailed financial audit would be in order.

There is a document called Allotment and Expenditure Status Report by Division which represents the department's budget. There is also a series of financial statements representing the activities of the Industrial Insurance Fund. It is not possible, however, to track between these two documents. There is a document the describes how funds from the self-insurance administrative assessment are spent. In some areas, such as the self-insurance division, there is a clear relationship to the department budget. In others, such as WISHA, there is no apparent relationship.

The available documents do not provide sufficient information about funding sources. For example, the budget document indicates that WISHA receives 75 percent of its funding from the Accident Fund and 15 percent from the Medical Aid Fund. We knew, however, that there were substantial federal funds for OSHA activities, and we had another document which indicated that in 1997 $1.2 million from the self-insurance administrative assessment went to WISHA. We were told by the department that these amounts are included in the Accident Fund and Medical Aid Fund accounts. We have no reason to doubt this statement, but a document that purports to list funding sources should not include federal grants under items that appear to be insurance premiums.

The available documents do not provide sufficient information about funding sources

We were provided with a report that showed a finer breakdown of expenditures within the budget. In some areas this was helpful. In others, it was not. We could not tell, for example, how much of the WISHA budget goes to enforcement as opposed to consultation.

We understand that the department provides about $4.5 million per year to support research and training at the University of Washington. We did not find this reflected in the budget document. (The document showing expenditures from the self-insurance administrative assessment did include about $1.2 million for University of Washington environmental research.)

The department does not have any formal system for allocating overhead expense (the director's office, information services, the building in Tumwater, etc.) among the various functions and funding sources within the department. To at least this extent insurance premiums collected from insured employers in Washington are supporting other activities of the department.

Recommendation 14

The department should develop a system of allocating indirect costs among its funding sources and publish financial statements which clearly indicate where its funds come from and how they are spent.

Self-Insurance

Table 7.2
Expenditures Self-Insurance Administrative Assessment FY 1997

	Amount	Percent of Total
Self-Insurance General Administration	$4,262,196.00	100.0%
Asst. Attorney General	$630,774.43	5.5%
Board of Appeals	$2,949,178.01	27.8%
U of W Environmental Research	$1,212,945.31	29.5%
Safety Division	$1,216,174.21	8.7%
Vocational Dispute Resolution	$136,476.75	23.7%

Table 7.2 shows the expenditures from the Self-Insurance Administrative Fund for fiscal year 1997. (This is based on a document provided by the department. As discussed above, it is not possible to track from this to the department's budget document.) It shows the dollars spent in each area and the percentage this represents of the total funds spent in the area. This would indicate that self-insurers are paying about 5 percent of the department's attorney general costs, 28 percent of the board costs, and 24 percent of the costs of vocational dispute resolution. While we have no exact way of measuring, these figures seem reasonable.

It also indicates that self-insurers pay 8.7 percent of the costs of the "Safety Division." We assume this refers to WISHA. However, the 8.7 percent figure does not seem to match the WISHA budget and, as discussed above, the published documents do not show how much of WISHA funds are spent on compliance as opposed to consultation. The self-insurance assessment also contributes about $1.2 million a year to environmental research by the University of Washington. This is certainly something that benefits all employers in the state. Whether there should be a contribution under this fund is a policy issue.

The self-insurance assessment pays all of the cost of the self-insurance section of the department. This seems appropriate. As mentioned above, there is no system for allocating overhead costs within the department. The expenditure report for the self-insurance administrative assessment indicates that it does not bear any of the burden of expenses such as information services, administration, or building maintenance. To this extent, self-

insured employers appear to be bearing less than their reasonable share of the cost of the operation of the department.

Insurance Industry Comparison

The insurance industry uses certain ratios to measure its performance. These are discussed more generally in Chapter 6. Here we will look at the ratio involving certain expenses. Table 7.3 summarizes data concerning the Washington State Fund and information provided by the National Council on Compensation Insurance (NCCI). The NCCI data summarizes the overall performance of all private workers' compensation carriers in the United States.[14]

Table 7.3
Expense Ratios

	NCCI		Washington	
	1996	1997	FY 96	FY 97
Adjustment Expense / Premium	13.8%	14.0%	11.0%	14.0%
Underwriting & Other Exp. / Premium	25.1%	26.0%	9.0%	10.0%
Adjustment Expense / Losses	25%	24%	9%	9%

The first line shows loss adjustment expense as a percentage of premium. In 1996, the dollars that the private insurance industry spent on loss adjustment expense equaled about 13.8 percent of the premium they collected. (Loss adjustment expense includes items such as claims managers, independent medical examinations, and attorney fees.) Washington State Fund expenditures measured by this ratio varied more than NCCI figures but were within about the same range.

By insurance industry standards, the department may not be spending enough on claims management

Underwriting and other expenses include marketing and other costs. Here the expenses of the Washington State Fund are dramatically lower. This is primarily because the fund does not have any competition. It has underwriting expenses that are devoted to collecting premium and assuring that companies are classified appropriately, but it does not need to compete with other entities for its business. Underwriting expenses also

[14] *1998 Workers' Compensation Issues Report*, NCCI, Ballantyne, April 1998. Numbers for 1997 are estimates.

includes payments made to brokers and agents. In many jurisdictions, this can be as much as 9 percent of the premium.

Some would argue that it is more appropriate to measure loss adjustment expense as a percent of losses rather than premiums. The last row in Table 3.2 shows these figures. In other words, in 1996, NCCI companies spent an amount on loss adjustment expense that was equal to 25 percent of the dollars they paid out in losses (benefits to workers and medical providers). Here again, Washington's costs appear to be relatively small. There are several possible explanations for this. The claims adjusters employed by the state fund may be paid lower salaries than similar people in private industry. The state fund uses as attorneys employees of the attorney general's office. Many (though certainly not all) private insurers use independent law firms. It may be that the fund is operating more efficiently than private industry in a number of ways including, perhaps, the use of technology.

It is possible that the fund is not spending enough money on claims adjustment. In other parts of this report we make recommendations that may result in the need for additional resources. These figures would suggest that some increase in the resources devoted to claims adjustment might be appropriate.

Claims Management Resources

As discussed in Section 7, we believe that claims management resources are not now allocated in the most efficient way. We make numerous suggestions for the rearrangement of those resources. We address here the question of will there be enough claims managers within the department to handle the flow of claims under the arrangement we propose.

There is a conventional wisdom that the appropriate case load for workers' compensation claims adjuster is about 150 active cases.[15] It is the experience of the audit team that this ideal is not always realized. Nevertheless, we feel that in general a caseload of between 150 and 175 files is a reasonable goal.

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[15] *Employers Guide to Workers' Compensation*. Edward M. Welch, Bureau of National Affairs (Washington, 1994) p. 367.

We carefully reviewed the situation in Washington and believe that the same standard should apply. We would assign time-loss cases among Level 2 and 3 claims managers. (A supervisor would allocate them based on the difficulty of the case, and the experience and expertise of the individuals.) A Level 2 or 3 claims manager should be able to very comfortably handle 150 cases, and 175 would not be unreasonable. However, anything over 175 claims will necessarily result in a decrease in services. Similarly, a caseload of at least 200 medical-only claims would be a reasonable assignment for a Level 1 claims adjuster.

There appears to be enough resources to manage claims under the reorganization we suggest

The data which was made available to us suggests that at present the department is within the 150 to 175 case range for what we would call active time-loss cases. (We would define this more broadly than the department and include provisional claims, claims not yet allowed, claims with protests pending, and claims pending a reopening.)

Under the reorganization, we propose additional resources will be freed up for mainstream case management. We propose that work now performed by the pension, case reserve, retrospective rating, and legal services units be incorporated into the regular claims units. The change in the claim reporting procedure, we propose, would also result in a reduction in the workload of the employer services division. (If an employer reports an injury, there would be no need for the resources that are now expended identifying the proper employer.) These changes would free up additional resources that could be assigned to the claims units.

Thus, there should be enough Level 2 and 3 claims managers in the department to achieve a case load of between 150 and 175 time-loss cases that need active management and enough Level 1 claims managers to achieve a case load of about 200 medical only cases.

The supervisors of the claims units we propose can be drawn from current unit managers and Level 4 and 5 claims managers. The compliance unit can eventually be staffed by the people now in the self-insurance unit. An office of mediators or ombudsman would require additional people.

DISPUTE RESOLUTION

Chapter Eight

OVERVIEW

There is a basic assumption that workers' compensation should be simple and avoid litigation. No system has been successful in achieving that. When we deal with issues such as what caused a disease or how disabled an individual is, there will inevitably be disputes. We will always need judges and lawyers to help us resolve these disputes. We feel that, in general, a system functions better if the use of a formal dispute resolution is narrowed to those cases involving more serious disputes and if minor disagreements can be resolved early and simply or avoided by other means.

One striking feature about the Washington State Workers' Compensation System is the multiple levels of dispute resolution. In Washington, a decision about a claim could go through all of the following steps:

- Protest to the department
- Appeal to the board
- Reassumption by the department
- Appeal to the board
- Mediation hearing before the Board
- Administrative hearing before the board
- Review by full board

Washington has more levels of appeal than most jurisdictions

- Superior court trial
- Appeal to appellate courts

It would probably be unusual to have both a protest and a reassumption in the same case, but all of the other steps could very likely occur.

In contrast, most other jurisdictions would have a far simpler procedure.

- Mediation hearing
- Administrative hearing
- Review by board
- Appeal to appellate courts

The extra levels present in Washington necessarily take up more time and more resources. There is no evidence that they produce better outcomes.

DISPUTE PREVENTION AND EARLY INTERVENTION

Claims Management

In all workers' compensation systems, a great deal of effort is devoted to the formal procedures for resolving disputes. It is often much more important to the overall functioning of the system to have claims management policies and procedures which avoid disputes. Many of the recommendations discussed in the operational analysis portion of this report should lead to a reduction in the number of disputed claims.

Mediators/Ombudsmen

In recent years, a great many states have found that they can improve the operation of their system by having available individuals who are known as ombudsmen, mediators, or

consultants.[1] These are generally people who a worker (or small business owner) can call when he or she feels that their case is not going the way they think it should. In some cases, all that is necessary is for the mediator to explain the law. In many cases, the mediator will contact an insurer or self-insured employer and attempt to resolve the situation. These mediators find that often the problem is simply a lack of communication that they are able to facilitate. In some slightly more serious disputes, the mediator will make serial calls to the various parties or sometimes schedule a meeting in his or her office. In these situations, the person will actually attempt to mediate a resolution of the problem.

Finally, the mediators must acknowledge that there some cases which cannot be solved in this manner. In these cases, it is most appropriate to tell the party that the matter can only be resolved through the formal dispute resolution procedure and to provide appropriate information about how to initiate this process.

In Washington, the department has an 800 number, but it does not seem to function in this manner. Washington also has Project Help. The two individuals in this project seem to function in the manner described above and do so effectively. Their resources, however, appear to be limited, and they do not appear to be receiving the widespread publicity that mediators receive in other states. There is some controversy over how well Project Help is managed. We did not investigate that issue. It would appear to us that there are some political considerations since Project Help operates under a contract with the State Labor Council.

Workers (and small employers) need a place they can go for help

We believe that Washington could benefit by a system of mediators or ombudsmen. To be effective, it should have resources, including an 800 number, and have sufficient staff to answer the phones personally and to act promptly on matters that are brought to its attention. It should also receive widespread publicity. It will only work if workers and employers know it is there and know how to contact it.

[1] The Workers' Compensation Research Institute reports that 32 states now have a function similar to this, *Dispute Prevention and Resolution in Workers' Compensation: A National Inventory, 1997-98*, Duncan S. Ballantyne, Workers' Compensation Research Institute, 1998.

In most jurisdictions, the mediator is part of the state agency. He or she is seen as a neutral because the disputes are generally between the worker and an employer or private insurance company. In Washington, the dispute will often involve the Department of Labor and Industries. Accordingly, to be effective, such an office must at least be outside of the Industrial Insurance Division of the department. We would suggest that it report directly to the department director, or that it, perhaps, be a function of the Board of Industrial Insurance Appeals. We do not recommend that this office be opened as a replacement for Project Help. Indeed, it would probably be beneficial to have multiple alternatives for obtaining such assistance.

Recommendation 15

The department should create a system of mediators or ombudsmen to provide assistance to workers and employers.

It is, of course, inevitable that this mediation office will serve workers much more often than it serves employers. Is it appropriate for employers' premium dollars be used to finance such an office? In most other jurisdictions, employers have not seen this as a problem. Instead, they believe that the early and simple resolution (or complete avoidance) of disputes benefits everyone involved in the system. (Put more bluntly, they think that if these cases can be resolved without the workers going to attorneys, they will be better off in the long run.)

Should the trial bar object to the state attempting to usurp its arena in representing injured workers? Realistically, mediators are not going to resolve the big disputes. They are going to settle the small ones. In an area that involves the cause of disability or a question of how much pain a man or woman is experiencing, there will always be situations in which the parties need formal legal representation. It is our belief that a system is best served if the small cases can be resolved quickly and informally, and the formal dispute resolution procedures can be directed towards the more difficult cases.

Protests and Reassumptions

At present if a party is dissatisfied with an order issued by the department, it may either file a protest or an appeal. A protest results in a review by the department. If the party files an appeal, the case goes to the Board of Industrial Insurance Appeals, but the department then has the option to reassume the case and review it. In theory, the protest and reassumption options allow for a speedy, informal reassessment of actions taken and avoid the need for formal dispute resolution in a substantial number of cases. It is our view that it is not working that way in Washington. The department was not able to supply us with data concerning what happens in protests or reassumptions. It is not clear how many of them eventually result in an appeal to the board, how many of them result in a resolution of the issue, or how many of them result in a reversal of the original action. It is clear, however, that at least in the cases in which there is an eventual appeal, a reassumption greatly delays the process of moving the file forward.

Our file audits and discussions with parties lead us to a concern that these options may lead to a more casual attitude towards the issuing of orders. Orders should only be issued when absolutely necessary. The claims managers should first of all attempt to resolve any issues in an informal way. Secondly, when an order is issued, it should be done with great care and consideration. It would appear that there may be some claims managers who issue an order with less than the necessary amount of care thinking, "Well, if the aggrieved party doesn't like it, he or she can protest," or "Well, if I messed up, we can fix it through a reassumption."

Presently claims are delayed and resources wasted by the way protests and reassumptions are handled

The department should adopt a policy that all protests and reassumptions are resolved within 30 days. Officially the department now has 90 days to deal with reassumptions and can extend this period for an additional 90 days. We suggest that the official situation eventually be changed, but we would point out that a shorter time frame is always within the discretion of the department. It could simply become the department's policy to resolve all of these within a shorter period than officially allowed.

We suggest that the process of reviewing reassumptions and protests should *not* be a process of redoing the decision. Instead it

should be a process of looking to see whether the decision was made properly. In other words, a senior claims adjuster should review the file, examine the material that is currently in the file, and decide whether the original order was proper or not. If it was proper, it should be affirmed and if it was not, it should be withdrawn. The goal should be to have the original claims adjuster act more carefully in issuing orders and to move on to the board those cases in which there is a genuine dispute.

The biggest delay in reviewing these claims comes when an additional independent medical examination is necessary. We suggest that new IMEs should not be used as part of the process of reviewing protests or reassumptions. The order should be reviewed based on the material that was available at the time it was made. The emphasis should be on doing things right in the first place, not on providing a second chance to correct errors. If this approach is taken, then it should be possible to conduct these reviews within a 30-day period.

Recommendation 16

The department should adopt a policy that all protests and reassumptions are resolved within 30 days.

BOARD OF INDUSTRIAL INSURANCE APPEALS

Description

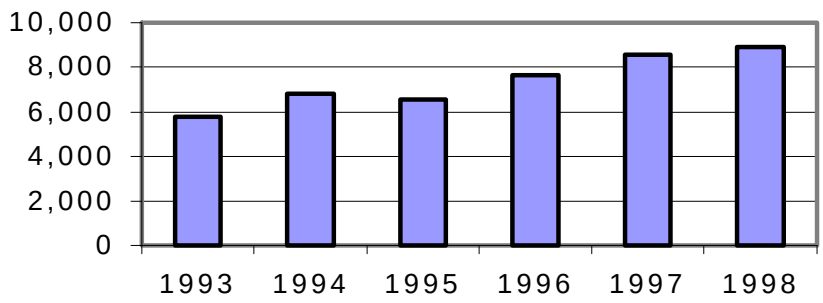
In addition to cases involving workers' compensation claims, the board also hears appeals concerning safety citations, the compensation of crime victims, and a few other issues. These, however, represent a small portion of the board's caseload and were not a focus of our audit. In the workers' compensation area, in addition to appeals concerning benefits for claimants, the board hears appeals concerning the premiums charged to employers. In the analysis below we have focused only on claims dealing with benefits for workers.

The following data is based on information provided to us by the Board of Industrial Insurance Appeals. The information is based

on averages for one fiscal year. These are necessarily rough estimates because the actions on a given case could be spread over more than one year. Nevertheless, we believe that they provide a fair estimate of board activities.

During fiscal year 1998, the board received 8,917 appeals. This is a modest increase over 1997 and a very substantial increase over the past five years. See Figure 8.1. In all the interviews we conducted, no one was able to offer a persuasive explanation for the increase in appeals.

Figure 8.1
Total Appeals Recieved



Appeals are increasing

In 1998, the board issued 8,741 final orders of all types. This is a substantial increase over 1997 and part of an increasing trend. Table 8.1 summarizes the nature of these actions. The first column describes each action as a percentage of all final orders. The second column shows the actions as a percentage of final orders excluding those in which an appeal was either reassumed or denied. The third column focuses only on actions actually taken by the board, cases in which it either denied review or issued a decision and an order.

Table 8.1
Final Orders as Percentage of:

	All Final Orders	Final Orders after Grant of Appeal	Board Actions
Reassumed Appeals	24%		
Denied Appeals	12%		
Settlements (Order on Agreement of Parties)	22%	34%	
Dismissals	26%	40%	
PDOs Adopted	11%	16%	
Petitions for Review Denied	4%	6%	60%
Board Decisions and Orders	2%	4%	40%

Of the applications that were received, appeals were granted in 64 percent of the cases. In 24 percent, the case was reassumed by the department; and in 12 percent, the appeal was denied on jurisdictional grounds. Appeals in cases involving self-insured employers were much more likely to be granted (81 percent) as compared to appeals in state fund cases (58 percent). These results have been fairly consistent over the last five years.

Settlements involve cases in which an order is issued based on an agreement by the parties. They represented 34 percent of the outcomes in cases in which an appeal had been granted; 99 percent of the time they represented some modification of the order originally issued by the department.

In 1998, Industrial Appeals Judges issued 1,458 proposed decisions and orders. This is an increase over recent years but a lower number than the amount issued in 1993. Thirty-seven percent of these proposed decisions and orders were appealed to the full board. This is a drop from recent years where the number has varied from 41 to 47 percent. The remaining proposed decisions and orders that became final represent 16 percent of the decisions in cases in which an appeal was granted.

The remaining 520 orders represent actions taken by the board itself. This is a decrease over prior years. Of these actions, 60 percent represented cases in which the board denied review and 40 percent represented cases in which the board actually issued a decision or order. This is the highest percentage of decisions or orders in the last five years. Previously it had ranged between 29 and 37 percent.

In 1998, 300 cases were appealed to the superior court. This is an increase over 1997 but a decrease over prior years. It represents 58 percent of all appealable actions. The percentages remain fairly constant over recent years. There was a higher percentage of appeals in cases involving self-insurers (63 percent) as compared to cases involving the state fund (54 percent).

The superior courts issued decisions in 280 cases during 1998. A significant portion of these cases (perhaps 25 percent) are resolved through settlements, but the courts do not provide data concerning these. In the remaining cases, the courts affirmed the board 68 percent of the time and reversed it in 32 percent of the cases.

Analysis

In general the parties we spoke with were relatively happy with the operation of the board. Parties sometimes express dissatisfaction with decisions in particular cases but that is almost unavoidable in workers' compensation. The only consistent complaint we heard about appeals was the delay in moving files from the department to the board.

Superior court review adds another layer and increases formality at all levels

As discussed above the last few years have seen an increasing number of appeals and, as a result, the board is falling somewhat behind. No one offered a good explanation for the increase nor do we find one. We believe, however, that the suggestions we make elsewhere may result in a reduced number of disputes and thus a lesser load for the board.

Washington is among a very few states that allow an appeal to the superior court. This extra step results in further delay and an additional expenditure of resources. In addition, the presence of this option results in an increased formality in all the proceedings before it. Because every case can potentially be appealed to superior court, every step must be taken in a manner that meets the evidentiary and procedural standards of the civil courts. The elimination of superior court review should lessen the formality and complexity of the hearing processes that now seem necessary in Washington.

Recommendation 17

Superior court review of decisions by the Board of Industrial Insurance Appeals should be eliminated.

VOCATIONAL REHABILITATION

Chapter Nine

INTRODUCTION

As part of our audit, we conducted an evaluation of the vocational rehabilitation services within the Washington Workers' Compensation System. This part of the audit was performed by Rochelle V. Habeck, Michael J. Leahy, and J. Frances Saroki, of the Office of Rehabilitation and Disability Studies, Michigan State University.

The vocational rehabilitation audit was broken down into three components. We conducted a survey of three groups of people involved in vocational rehabilitation in Washington, contract managers who manage contracts providing vocational rehabilitation services to the department, individual private vocational rehabilitation counselors, and vocational rehabilitation counselors in the field staff of the department. The results of these surveys are reported in more detail in Appendix K, Summary Report of Vocational Rehabilitation Survey Results. We also conducted a comparative analysis of vocational rehabilitation services provided by the department through the state fund to those services provided by self-insured employers in Washington and to vocational rehabilitation services provided in six jurisdictions: California, Michigan, Minnesota, Oregon, Wisconsin, and British Columbia. The results of that study are reported in Appendix M, Comparison of State Fund Vocational Rehabilitation to Self-Insured and Other WC Systems. The third component of the study was a qualitative analysis of the Washington Vocational Rehabilitation Program and its impacts. The results of this are reported in Appendix L, Qualitative Study of the Vocational Rehabilitation Program and Its Impacts. The

latter two components of the study were based upon: a) documents related to vocational rehabilitation provided by L&I; b) data provided by L&I staff in response to specific requests; c) data obtained in response to vocational rehabilitation-related questions developed for other portions of the audit that were collected from injured workers, employers, and claims audit and wage analysis data; d) reports and publications about comparable jurisdictions and best practices in workers' compensation rehabilitation; e) survey data obtained from contract managers and individual vocational rehabilitation counselors (VRCs) from contracted firms and from L&I field VSCs; and f) interview data obtained from more than 30 interviews conducted in person and by telephone and mail follow-up with the major participants in vocational rehabilitation within Washington state's system of workers' compensation.

This section of the final report summarizes our major findings and lists the formal recommendations that we propose. Appendix J, Vocational Rehabilitation Final Audit Report, contains a more detailed synthesis and evaluation of our audit. Readers with particular interest in vocational rehabilitation issues are encouraged to examine that document. In response to the issues raised in the RFP, this section will begin with a comparison of the state fund and self-insurers in Washington; move next to a comparison with other jurisdictions; follow this with an audit of the efficiency and effectiveness of Washington's system; discuss the clarity, logic, and understanding of the vocational rehabilitation program in Washington; and finally conclude with specific recommendations for improvements.

COMPARISON OF THE STATE FUND WITH SELF-INSURERS IN WASHINGTON

Although both the state fund and self-insurance systems operate under the same workers' compensation statutes and case law, they have developed different processes and reportedly have different costs and outcomes. Our review of these two systems within Washington State confirms this overall finding.

It should be noted that there are a number of differences between state fund and self-insured employers that are beyond the control

of the workers' compensation system. For example, the state fund covers small, medium, and large employers, while the self-insurance system covers large employers, who typically have a diversity of work available and have greater financial flexibility to keep positions open and create light duty jobs. Most self-insured employers have active return to work and risk management programs in place, whereas many state fund employers do not (up to 50% of state fund claims come from employers without this capacity).

There are a number of differences between state fund and self-insured employers

Within the workers' compensation system, there are a number of differences between the way workers' compensation is handled by the state fund and self-insured employers. Self-insured employers have a 90 day trigger time (90 days of continuous time-loss) in which they must address vocational status. The state fund has no such requirements. Self-insured employers can deliver direct placement, training and other vocational services to injured workers even before the determination of eligibility is completed. These are options are not available through the state fund. Further, self-insured employers are not restricted in relation to training costs, whereas the state fund is limited in the time and money it can offer for training. As a result, self-insurers can provide greater resources if all parties agree with the vocational goal and plan.

Thus, although the department imposes a 90 day trigger time on self-insured employers, in virtually all other regards, the self-insurance system is more flexible and is able to provide an array of resources at the beginning of the process. The state fund system is more conservative, structured, and follows a strict, linear pathway in the delivery of services.

The differences in approach, combined with distinctions related to the employers who use these systems, have produced very different outcomes. The self-insurance system performs significantly better than the state fund system by closing more cases with an actual return to work outcome and fewer cases in which the outcome is a finding that the worker is either employable or unable to return to work and thus no longer entitled to vocational rehabilitation services. The timeliness of referrals and service utilization suggests that generally more attention is focused within the self-insurance system at an earlier

point in the age of a case. There also appears to be more use of job modification and other intervention techniques designed for accommodating jobs at the workplace in order to facilitate return to work for injured workers. While the employer-related factors obviously play an important role to this success rate, the processes employed and the flexibility available in the approach used by self-insured employers are compelling and deserve specific attention as systems with the state fund are modified to achieve better outcomes.

COMPARISON OF STATE FUND AND OTHER STATE SYSTEMS

In Appendix M, we identified some of the important variables and themes of other jurisdictions and compared them to Washington State. Specifically we discussed the goals of the vocational rehabilitation program, costs and utilization, timeliness of referrals and service provision, range and level of benefits provided, outcomes, quality control, and qualified providers. We compared the Washington system to California, Michigan, Minnesota, Oregon, Wisconsin, and British Columbia.

As discussed below in Chapter 9 there is some conflict concerning the goal of vocational rehabilitation in Washington. It is generally accepted, however, that the statutory goal is a finding of employability. Of the five jurisdictions reviewed on this issue only California appeared similar to Washington on this dimension. The remaining jurisdictions (British Columbia, Michigan, Minnesota, and Oregon) all clearly have return to work as the goal of vocational rehabilitation services.

The comparison of costs and utilization rates among the jurisdictions selected indicates that total vocational rehabilitation costs for Washington are higher than any of the jurisdictions except for California. Washington also has the highest reported utilization rate for vocational rehabilitation services and the lowest cost per case reported. See Table 9.1. However, although total costs were reported, the elements used in calculating costs were not specified or necessarily comparable among these jurisdictions. Caution should be used in interpreting this finding.

In relation to timeliness of referrals and service provision, Michigan, Minnesota, and Oregon are somewhat more timely in making referrals and in providing services than Washington.

Table 9.1
VR Costs and Utilization Rates

System	VR Costs ($)	Cost/Case ($)	Utilization (%)
Washington	43 million	2,835	26.0
California	236 million	7,642	15.6
British Columbia	39 million	n/a	14.0
Michigan	n/a	3,281	2.6
Minnesota	13.6 million	5,710	5.0
Oregon	13.5 million	6,687	12.0
Wisconsin	n/a	7,835	1.0

In comparison with the other jurisdictions reviewed, Washington State is consistent with the general range and level of vocational rehabilitation benefits provided with two very notable exceptions. The first of these limitations is the lack of attention to placement services and other specific interventions directed at facilitating the attainment of employment for those clients who are not hired by their employer of injury. The second limitation relates to the self-imposed limits on time and financial support for retraining.

In return to work outcomes following the provision of vocational rehabilitation services, Washington was found to rank last among those jurisdictions in this analysis who have reported this data.[1] Table 9.2 summarizes the results, which are discussed in more detail on pages 15 and 16 in Appendix J.

Washington has a relatively low return to work rate

Table 9.2
Return to Work Rate

Washington	31%
British Columbia	50%
Michigan	42%
Minnesota	70%
Oregon	91%

Finally, although most jurisdictions in this review have developed systems to set standards and monitor services provided by external, private providers, our review of the processes in the

[1] Data were not available for California and Wisconsin.

various jurisdictions, which is described in detail in Appendix M, indicates that the Washington State Fund exercises the greatest control of all the jurisdictions in relation to case decisions and processes. The standards and eligibility criteria related to the certification of private providers in Washington were similar in some respects to other jurisdictions, but Washington relies more heavily on nonprofessionals (bachelor's level personnel and interns) than the other jurisdictions reviewed.

THE EFFICIENCY AND EFFECTIVENESS OF WASHINGTON'S SYSTEM FOR PROVIDING VOCATIONAL REHABILITATION SERVICES THROUGH PRIVATE FIRMS

Introduction

The sources of data obtained provided extensive information and insight into the performance of the department in regard to its vocational functions, its use of vocational rehabilitation services and resources, and their relationship to the outcomes achieved from the costs invested. We examined the functioning of various units within the department that deal with the use and oversight of private sector rehabilitation services. A current vocational policy initiative that is underway, which is designed to reexamine the provision of vocational rehabilitation services in Washington, was also reviewed.

We will discuss here a number of issues related to the use of private sector rehabilitation services. It is the judgment of the auditors, however, that these should not be considered in isolation. A number of other topics that are discussed in this chapter and throughout the report have an impact on the efficiency and effectiveness of these services. In particular, the approach taken by department to claims management and the way in which claims managers are trained and evaluated impact when and how they refer cases to private sector providers. Further, the level of vocational rehabilitation benefits restricts the options available to providers and the goals of vocational rehabilitation as provided in the statute and regulations and as

interpreted by the department influence the services that providers deliver. Accordingly, in evaluating the provision of private sector vocational rehabilitation services, the context of the system must be kept in mind. Relying on current procedures of the department to achieve effectiveness and efficiency in its approach to the use of purchased vocational rehabilitation services is limited. The use of purchased vocational rehabilitation services needs to be more fully and effectively integrated in the organization's approach to return to work.

Evaluation of Private Sector Rehabilitation Services

There is some controversy concerning the criteria used to monitor the quality and effectiveness of private sector rehabilitation services. According to the Vocational Services Handbook, RCW 51.32.095(4) requires that the department establish criteria to monitor the quality and effectiveness of rehabilitation services provided by the individuals and organizations used, and that the state fund shall make referrals for vocational rehabilitation based on the performance criteria (p. B-3). In February 1997, the State Auditor's report documented that the department was not in compliance with this requirement. In June 1998, the department announced the implementation of the Vocational Purchasing and Referral Project in three service locations (Everett, Vancouver, and the Tri-Cities), using the Performance-Based Referral formula described above.

This means that the department is now using vocational performance data in three specific service delivery locations within the state to provide some information about provider firm performance to claims managers, which suggests to us that the department is in the initial stages of coming into compliance with the RCW.[2] However, according to our understanding of the requirement and the system in place, achieving compliance with the rule will require further development. There are two major limitations to the proposed approach: the questionable validity of the final ratings as reflecting the quality and effectiveness of the services provided by the organizations used; and the lack of

[2] It should be noted that when the survey or focus group comments about the performance-based referral process were made, the process had not been implemented in the test units and the data comparisons with four volunteer firms had not been completed.

certainty that the state fund will make referrals on the basis of the performance criteria, since there has been no demonstration of this capacity to date.

After talking to numerous parties in the Washington system and reviewing this situation we found:

(a) The performance standards of quality and effectiveness in vocational rehabilitation practice have not been adequately specified to determine the appropriate indicators to be used and how best to measure them.

(b) Satisfaction data, as an indicator of quality, do not incorporate and use data from injured workers and employers as the primary customers of vocational rehabilitation services. The items used to construct the satisfaction measures should better represent components related to quality than the current survey proposed for use with the claims managers. These data should be incorporated into the overall rating. As currently proposed by the department, the claims manager survey form will emphasize efficiency and be reported separately from the performance data ratings. This process is unlikely to result in referrals based on effectiveness and quality as defined in best practice.

Problems with the system of evaluating private sector providers

(c) Without a defined criterion or minimally acceptable threshold for indicating that providers meet the established standards for quality and effectiveness, the currently proposed rating system may distort the evaluation of the true performance of provider firms.

(d) The full range of the provider's activity in serving state fund cases is not considered in evaluating performance. The department indicates that 70 percent of outcomes are accounted for in the two closing criteria included. However, a comprehensive approach would allow the department more opportunity to assure that providers meet performance standards relative to the wide variety of case situations of referral and reduce the impact of evaluation factors that may inappropriately impact case management practices.

(e) The procedures for enforcing the utilization of the evaluation data by the state fund in making referrals have not been adequately delineated. Although the department reports that an evaluation of the referral process is planned as part of the evaluation of the performance rating system, a systematic and proactive procedure is needed as part of the front-end of this process. One part of the requirement is to establish the process for using performance data. An equally important part is assuring that referrals are made on the basis of the data.

Qualifications of Rehabilitation Providers

Washington relies more heavily on less qualified providers

The level of professional qualifications of providers of vocational rehabilitation services is relatively low. For example, as discussed in Appendix M, in Minnesota, the standards and criteria for eligibility as a Qualified Rehabilitation Consultant (QRC) include national certification (e.g., Certified Rehabilitation Counselor (CRC), Certified Disability Management Specialist (CDMS), Certified Case Manager (CCM)). These credentials are also used in Michigan; however, there the firm (based on the education and experience of its providers) is approved as opposed to individual practitioners. Oregon's standards are also equivalent to Minnesota and Michigan in relation to education and experience. They stipulate that full certification requires a master's degree in vocational rehabilitation and six months of experience, or a master's degree in a related field and one year of experience in performing vocational evaluations or developing individualized return to work plans, or a bachelor's degree and two years of such experience. In Wisconsin, since all referrals are handled by the Division of Vocational Rehabilitation, the personnel who provide services to workers' compensation cases are also at the master's degree level in rehabilitation counseling or closely related field.

By comparison, Washington's system, although similar to the above in relation to many of the higher level eligibility categories (combinations of different degrees, specific course work, and experience), relies much more heavily on individuals with a bachelor's level of education and on interns who meet minimum educational eligibility standards and do not meet the experience requirements.

THE CLARITY, LOGIC AND UNDERSTANDING OF THE VOCATIONAL REHABILITATION PROGRAM

The RFP asks whether the vocational rehabilitation system in Washington workers' compensation is clear, logical, and well understood. Our audit findings suggest that the content of the law is viewed to be somewhat clear and understandable, but that there is less clarity in the department's interpretations about its purpose and that there is inconsistency in its administration at the case level. Different interpretations among the key players have led to confusion about the program, variation in its implementation, and misunderstandings about the program and the actions of the parties.

Table 9.3 summarizes the responses from Appendix K to the question: "Given your understanding of Workers' Compensation law and rules (RCW, WAC), and how L&I currently implements these policies and procedures, what do you believe is the primary emphasis in using vocational rehabilitation services?" There were substantial differences in the responses of contract managers, private sector rehabilitation counselors, and L&I rehabilitation counselors. There were also substantial differences within each group.

Table 9.3
Primary Purpose in Using VR

	Contract Manager	Rehabilitation Counselors	L&I VR Counselors
Employability	39%	59%	29%
Claim Closure	39%	27%	14%
Return to Work	14%	14%	50%
Other	8%	0%	7%

In the qualitative interviews we conducted of system participants, which are reported in Appendix L, we also found considerable confusion concerning the purpose in using vocational rehabilitation in the views expressed. In general, when we talked in-depth to the participants, representing business and labor groups, providers, and representatives of the department, there

was agreement that the better outcome for the injured worker is to be back working than to be determined "employable" but to be unemployed. This sentiment that return to work is the appropriate employment goal of a workers' compensation program is reflected in the purpose as stated in the act, which is to reduce "to a minimum the suffering and economic loss arising from injuries and/or deaths occurring in the course of employment.[3]"

Thus, many system participants interviewed discussed the apparent conflict between the desirable goal of a return to work and what they perceive to be the statutory goal of a finding of employability. Participants explained that the statutory goal of vocational rehabilitation is construed to mean a finding of employability which results in the termination of vocational rehabilitation benefits (and other benefits as well). Further, participants also explained that it is widely accepted that a person is considered employable if it can be inferred from the vocational/educational history that he or she is hypothetically able to perform work that pays at least the federal minimum wage, regardless of whether the individual actually returns to such work. The statutory basis for this widespread interpretation is not entirely clear.

The provisions of the industrial insurance laws relating to vocational rehabilitation begin by providing:

> One of the primary purposes of this title is to enable the injured worker to become employable at gainful employment.[4]

There is a lack of clarity in Washington's system of vocational rehabilitation

It is not clear to us that this means the legislature intended vocational rehabilitation to stop when a worker was found employable but not employed. The next section of the statute[5] provides a list of priorities under vocational rehabilitation. Here the first priority is "return to the previous job with the same employer." Indeed, all of the priorities listed involve return to work or job placement.

[3] RCW 51.12.010
[4] RCW 51.32.095(1)
[5] RCW 51.32.095(2)

Whatever the original intent of the legislature, our surveys and qualitative discussions with system participants indicate that there is confusion concerning what is in fact the policy goal and what should be the goal.

Employment Level

We also found a lack of clarity concerning the level of potential employment that constitutes employability. It is the generally agreed among the parties in Washington that the level of employment at which entitlement to vocational rehabilitation services ceases is any reasonably attainable employment which pays at least the federal minimum wage. The source of this assumption is not clear. The formal regulations published by the department provide:

> (a) "Employable" means having the skills and training that are commonly and currently necessary in the labor market to be gainfully employed on a reasonably continuous basis when considering the worker's: age, education, experience, and physical and mental capabilities due to the industrial injury or subsequent reopening.
>
> (b) "Gainful employment" means any occupation, not to exclude self-employment, which allows a worker to be compensated with wages or other earnings considering RCW 51.12.010.[6]

RCW 51.12.010 provides:

> There is a hazard in all employment and it is the purpose of this title to embrace all employments, which are within the legislative jurisdiction of the state.
>
> This title shall be liberally construed for the purpose of reducing to a minimum the suffering and economic loss arising from injuries and/or death occurring in the course of employment.

[6] WAC 296-18A-420

Thus we have a very specific employment level standard at the federal minimum wage which is widely accepted as the intended criterion of the law, but which is not found in the statute or the published regulations of the department. Further, this standard is viewed by most of the parties as troublesome in several ways.

For example, labor representatives complain bitterly about this standard because it is so low. They argued that a skilled aircraft or construction worker should not be denied vocational rehabilitation services when he or she is unable to return to his or her former occupation simply because there are jobs he or she could perform at a fast food restaurant. Many employers argued that the low standard forces workers to return to their former jobs even when they are unable to safely perform the work in order to protect their families financial security. This in turn too often results in new injuries, future reopenings, or additional medical claims. Other parties elaborated on the ways the standard compromises the medical and vocational rehabilitation process, as detailed in Appendix L.

CONCLUSIONS

Goal

As discussed above, we found confusion among the parties in Washington in using what is the ultimate goal concerning vocational rehabilitation services. The statute itself is subject to differing interpretations. While there was confusion concerning the meaning of the statute and department policies, we found a broad consensus supporting the idea that in appropriate cases, the proper goal of vocational rehabilitation should be an actual return to work, and a negative view of the current standard. Certainly, there may be some cases in which the termination of services without a successful employment outcome is appropriate. This, however, should not be the ultimate goal or predominant outcome of vocational rehabilitation service utilization.

The goal of vocational rehabilitation should be to return to work

Recommendation 18

The primary goal of vocational rehabilitation as formally stated and as observed in practice should be successful return to work of the injured worker.

We hasten to add, that we do *not* mean that every injured worker should be entitled to vocational rehabilitation. We agree that it should be reserved for cases in which it is "both necessary and likely" to help the individual return to work. Furthermore, we agree very strongly with the priorities listed in the statute, which indicate that return to work with the same employer should be the first priority in every case. We believe, however, that if some of the resources that are now devoted to determining whether an individual is employable were instead directed toward services that assist people to return to work, the outcomes could be better for many workers and result in greater value in the return on investment for employers.

Employment Level

As indicated above, we found that there was a generally accepted belief about the level of employment that constitutes the standard for employability, but that there was a lack of support for this specific standard in the statute or published regulations. We agree with the system participants who take the position that the standard as applied is too low. We believe that the standard of employability as applied to vocational rehabilitation should be changed.

Recommendation 19

The standard for employability as it relates to vocational rehabilitation benefits should be some portion of wages at the time of injury rather than the federal minimum wage.

The text of Recommendation 19 was changed to clarify its intent. In interpreting the implications of the Recommendation 19 above, readers should keep in mind our statement following Recommendation 18 in which we emphasize that we do not mean that every injured worker should receive vocational rehabilitation benefits and our discussions above concerning lack of clarity, logic, and understanding of the legal aspects of the vocational rehabilitation program.

As we understand the current system in Washington, if a worker is formally determined to be employable at the federal minimum

wage, then benefits will terminate. This standard is too low. This automatic termination of further benefits should only occur if a worker is found to be employable at the wages he or she was receiving at the time of injury.

We recognize the need for further criteria for determining which claimants should be referred for vocational rehabilitation and encourage its development. To some extent, however, this must always be done on an individual basis guided by the best practices of the rehabilitation counseling profession. There is also a need to determine what benefits a worker should receive when he or she does not return to work, but is not eligible for vocational rehabilitation, and when a case is referred for vocational rehabilitation, but his or her final wage is not equivalent (at some specified proportion) to the previous wage or vocational rehabilitation does not result in placement at all.

Monetary and Time Limitations

The dollar and time limits now placed on vocational rehabilitation services provided by the state fund are too low to accomplish successful rehabilitation in many cases. In response to our survey (see Appendix K), both contract managers and private rehabilitation counselors rated the low monetary and time limits as both the number one significant barrier to successful rehabilitation and the number one suggestion for improvement in the system. As explained in Appendix M, the limits in Washington were the lowest among the jurisdictions studied. As explained in Appendix J**,** the benefit level has not been changed since it was established in 1982. According to providers, there are many cases in which it would be appropriate and prudent to exceed these limits.

Recommendation 20

Increase the current monetary and time limitations on retraining.

Professionalism

The efficiency and effectiveness of vocational rehabilitation could be addressed in part by raising the level of professionalism of

There is a need for greater professionalism

providers of services. For example, as pointed out earlier, the professional standards for providers of purchased vocational rehabilitation services are lower in Washington than in other jurisdictions we observed. Further, the availability of professional rehabilitation counselors to assist claims managers has been cut in half by a recent reorganization. Finally, vocational rehabilitation professionals no longer manage the vocational functions and initiatives of the department.

Recommendation 21

There should be an increased professionalism with regard to vocational rehabilitation within the department, specifically:

- *The department should move towards requiring higher standards of private sector rehabilitation providers.*
- *There should be better availability of qualified, professional rehabilitation counselors to assist and advise claims managers within the department.*
- *There should be more effective training of claims managers and vocational rehabilitation providers concerning best practice methods for achieving the department's hierarchy of return to work objectives, including the appropriate goals for and effective use of vocational rehabilitation services.*
- *The sections within the department charged with evaluating, contracting and managing, and setting policy for vocational rehabilitation should include managerial leadership by individuals who are qualified and experienced vocational rehabilitation professionals.*

Performance-Based Referral System

As discussed above, the department has experienced difficulties in implementing a performance-based referral system for private sector rehabilitation services. In response to this deficiencies discussed above, we would suggest the following recommendation.

Recommendation 22

With regard to a performance-based referral system:

- *Performance standards of quality and effectiveness in vocational rehabilitation practice should be adequately defined to determine the appropriate indicators to be used and how best to measure them.*
- *Measures of satisfaction should include and focus primarily on injured workers and employers.*
- *The evaluation mechanism should include a minimally acceptable threshold for referral.*
- *The full range of the provider's activity in serving state fund cases should be considered in evaluating performance.*
- *All of the parties involved should be assured that once the evaluation is established, it would be used in making referrals. This assurance should be accomplished by formalizing and announcing the procedures that will be used to accomplish it.*

Claims Management

Better claims management is also very important

As discussed above, employment and vocational rehabilitation outcomes are greatly effected by the ways in which claims are managed, as well as by the provision of vocational rehabilitation services. Accordingly, we would reiterate here the importance of the recommendations in the operational analysis chapter of this report. All of those recommendations that are designed to allow claims managers to function more effectively and in closer and more effective interactions with the injured worker and the employer can help achieve successful vocational rehabilitation. The inclusion of return to work as one of the primary criterion for the evaluation of insurance services is especially important in this regard. A reduction in reliance on the formal claims closing process could also reduce the demand on rehabilitation counselors to perform functions unrelated to return to work.

Other Suggestions

Appendix J contains numerous other observations and suggestions that could improve the vocational rehabilitation parts of the Washington Workers' Compensation System. We encourage those with a particular interest in this topic to review the ideas listed there.

EFFORTS TO PROMOTE WORKPLACE SAFETY

Chapter Ten

INTRODUCTION

As part of our audit, we conducted an analysis of the safety and loss prevention activities of the Department of Labor and Industries (L&I). This portion of the audit was conducted by Allard E. Dembe of the University of Massachusetts Medical School. A complete discussion of this part of the study is found in Appendix N. We will summarize the findings here.

The techniques used in conducting this analysis are described in detail in the appendix. Findings are based on interviews with key L&I officials, regional L&I management and supervisors, and L&I safety and loss control field consultants; discussions with employer associations, state advisory committees, and business and labor interest groups; conversations with representatives of retro groups and self-insurance groups; direct surveys and telephone interviews with 119 Washington employers; review of L&I accident prevention data and literature, analysis of safety and loss control records selected from approximately 50 employer files maintained by L&I; and contact with officials in other states, federal agencies, and insurance trade associations to collect comparative information.

FINDINGS

Washington State's approach to providing safety and loss control services is distinctive because it places Occupational Safety and Health Administration (OSHA) compliance, safety consultation,

and workers' compensation loss control services under one administrative division. Because Washington has an exclusive workers' compensation fund, employers cannot use the loss prevention services provided by commercial insurers and brokers, as done in other states. Consequently, L&I has an especially high level of responsibility for providing high-quality services that are responsive to employer needs and effective in containing workers' compensation losses.

The recent campaign to establish a focused WISHA program targeting high-risk employers for enforcement actions, and coordinating consulting and risk management services with the targeting effort, holds promise for producing a positive impact at employer locations most likely to experience serious injuries and illnesses. The WISHA division's programs are being carried out by a staff of well-trained, competent, and dedicated safety professionals who are committed to their mission and conscientious in carrying out their duties.

Close linkages between enforcement and consultation can cause problems

While this approach has many strengths, it also has some weaknesses. The close linkage between enforcement and consultation frightens away some employers who might otherwise like help, but who want to avoid code inspections. More important, because the consulting service is closely aligned with code enforcement, it does not devote sufficient attention to hazards for which there are no codes, including back pain from manual materials handling, which is a leading contributor to workers' compensation loss. This approach also diminishes attention given to administrative aspects of workers' compensation loss control, including claims management, medical management, return-to-work programs, and coordination between workers' compensation insurance and safety program efforts.

The relatively rigid distinctions existing within L&I separating the consulting functions performed by safety consultants, health consultants, risk management specialists, and therapist consultants leads to artificial distinctions that are perplexing to many employers, who see these as closely related aspects of a single problem. It also creates an extensive system of hand-offs and referrals that contributes to a relatively low level of service productivity by WISHA consultants.

About half of the 119 employers surveyed in this audit indicated that they do not use L&I safety consulting services because they do not feel it is needed, they receive service from other sources, they are unaware of what services are available, or they fear reprisal from WISHA compliance. Employers who do receive service (the other half of those surveyed) generally feel that it is beneficial and helps to contain workers' compensation losses, and that the technical and communications skills of L&I's consultants is very good.

The incidence rate of occupational injuries and illnesses in Washington is significantly worse than most other states, and has been worse for many years. As indicated in Tables 1 and 2 of Appendix N, data from the US Bureau of Labor Statistics indicate that nonfatal occupational injury and illness rates per 100 full time workers in 1996 were 39 percent higher in Washington than the national average for total cases and 15 percent higher for lost workday cases. As illustrated in Table 1 of Appendix N, this persists across all major industry groups. This indicates that further improvement in the state's loss control and safety efforts is still needed.

The incidence rate in Washington is worse than most other states

SUMMARY

Appendix N explains in detail a series of changes to the various safety programs of L&I.

Recommendation 23

We recommend a series of changes in the department's safety related activities that are designed to:

(a) Expand emphasis on the prevention and control of musculoskeletal disorders.

(b) Develop methods for more closely integrating service involving hazard identification and control with service aimed at controlling workers' compensation losses.

(c) Improve the customer-focused orientation of service content and delivery.

(d) Improve service communications and recordkeeping.

(e) Provide more detailed information to employers about the availability of specific services.

(f) Improve responsiveness and timeliness of service delivery.

(g) Better coordinate services between various consulting entities and eliminate redundancy.

The current management of WISHA recognizes many of these needs and has taken appropriate steps to begin addressing some of them. For example, planning has already begun to strengthen service delivery in the area of controlling musculoskeletal disorders. But the continuing high incidence rates of injuries and accidents in Washington compared to other states indicates that additional measures are still needed to improve the scope and effectiveness of loss prevention services.

ACTUARIAL REPORT

Chapter Eleven

INTRODUCTION

The RFP raised many questions requiring an actuarial judgement. Our actuarial study was conducted by Insurance Industry Consultants, Inc. of Atlanta. Sri Ramanujam, MAAA, FCAS, FCIA, ARM, ARe, CPCU was the lead actuary. The reports of this analysis are found in Appendices O through U. They are organized to coincide with specific sections of the RFP. An unavoidable problem with this mode of organizing the report is the repetition of some analysis and recommendations already presented in another chapter.

- E1 Exposure Base and Unique Classification
- E3 Rate Setting Practices
- E4 Evaluation of The Degree of Cross Subsidies in the Rating System
- E5 Comparison of Retrospective Rating Plan Design
- E6 Reserve Report
- E7 Case Reserve Report
- E8 Performance of the Retrospective Rating Plan

The issues concerning cost comparisons raised in section E (2) are discussed separately in Chapter 2 of this report dealing with Benefits and Costs. The issues concerning benefits raised in sections E (9) and E (10) are discussed in Chapters 2 and 3 of this report dealing with Benefits and Costs and the Overall System Structure.

In this chapter we summarize the actuarial findings.

EXPOSURE BASE AND UNIQUE CLASSIFICATION (E1)

In any workers' compensation system, the amount of premium charged must be based to at least some degree on the exposure as a matter of pricing equity. All other states use payroll for this purpose. (There are a few exceptions for a small number of classifications.). The dollars of payroll are multiplied by the rate per $100 of payroll to calculate the premium charged.

Washington is unique in using hours worked to set premium

Washington uses hours worked instead of payroll. There are advantages and disadvantages to both approaches. The value of each approach is a matter of opinion as to effectiveness. It is a trade off in regard to accuracy vs. convenience. Because Washington is the only state that uses hours worked, it is more difficult to make comparisons with other states.

Since different types of work involve different hazards of injuries, workers compensation premiums are also based on the type of work performed by the employees. This is based on a system of job classifications. A large number of states use a classification system that is published by the National Council on Compensation Insurance (NCCI). Washington uses its own unique classification system. The use of a unique classification system prevents direct comparisons with other states. In this regard, however, it should be noted that Washington is not the only state with a unique classification system. About half of the workers' compensation premium nationwide comes from states using their own classification. Two examples are California and New York but there is an overhead cost to maintaining a unique classification system. In Appendix O, we offer some further suggestions concerning the use of the present systems.

RATE SETTING PRACTICES (E3)

In 1998, rates were reduced by five percent overall. This was accomplished by reducing L&I's contingency reserve over a three-year period to reach its contingency reserve goal. This goal is 10 percent of its liabilities. We have no problem with this approach of using "surplus" to reduce rates, except that this rate benefit accrues to the benefit of future policy holders, when in fact this

"surplus" was built up by past policy holders. For example, it will be a rare coincidence that the number of employers and the composition, and distribution of employers within classes of employment, will remain the same during each year of operation of the fund. This will thus result in some cross subsidies among policyholders.

In making calculations for projecting losses in future years, the department makes a distinction of serious and non-serious cases by picking a threshold value that results in half the claim costs being serious. While this method may be simple and expedient, this method has, in our opinion, no statistical foundation. Thus we cannot comment with certainty at this time that rates are equitably distributed across all class codes.

In addition to this, there are two other cross-subsidy issues that arise from the methodology historically used. These have to do with the way retrospective refunds are handled in determining manual rates: 1) As discussed in Appendix P, they may result in inequities across classes when there are classes that have different relative experiences in the Accident Fund versus the Medical Aid Fund; and 2) when classes have a different proportion of employers that are retrospectively rated.

There are some cross-subsidies between classifications

In our opinion, case reserving practices and methodologies do not impact significantly on the overall rate level indication computed. This approach is quite different from standard industry practices. This means that the methodologies used to examine overall rate level indications by L&I do not take into account individual case reserves set up by the department. See also Chapter 11 below dealing with case reserves.

In jurisdictions where there is not an exclusive state fund, the National Council on Compensation Insurance (NCCI) or a state rating bureau files an actuarial report detailing all of the assumptions and methods used in setting rates. Since Washington has an exclusive state fund for the provision of workers' compensation insurance, there is no statutory or regulatory requirement that such a rate filing be made. Even though there is no regulatory requirement for such a filing, its preparation would provide in a standardized format an explanation to the public of the rationale behind the rating

structure adopted by the fund and would allow easier comparisons with other jurisdictions.

Recommendation 24

We recommend that the department produce (either through its own actuaries or through an outside independent consulting company) a well-documented, exhaustive actuarial rate filing report detailing all assumptions and methods used. It should be similar to reports that are submitted to regulatory authorities by a licensed insurance company in states that use a "prior approval" rate filing procedure.

EVALUATION OF THE DEGREE OF CROSS SUBSIDIES IN THE RATING SYSTEM (E4)

One way to evaluate the size of the surplus in relation to premium in Washington, is to compare this to the same ratio for the insurance industry. The contingency reserve policy holder surplus now held by the Washington Fund, measured as a percent of premium, is high in comparison to the surplus held by the insurance industry (119% vs. 74%). The size of the contingency reserve indicates that collected premiums have been too high relative to the insurance industry. The practice of reducing the contingency reserve by lowering future rates creates a subsidy of future policy holders by previous ones. This is in addition to the classification cross subsidies discussed in Chapter 11 above.

Our analysis shows that over the rating years from 1989 through 1995, the net-loss ratio (the ratio of losses or benefits paid out divided by the premiums collected) is higher for retro employers than for other employers by about 5.6 percent. This means that, when compared to losses, the premiums are lower for retro employers than for others. This results in a subsidy of the retro employers by non-retro employers.

The Washington experience rating plan and retrospective rating plans charge higher premiums to employers with greater losses.

These two rating plans are designed to do this, for premiums to vary with losses. This direct cost relationship creates an incentive for employers to reduce the incidence of worker injuries. As explained here and in the appendix, there are some cross subsidies in the Washington rating system. To the extent that they exist, they tend to reduce the incentive for employers to control losses as their influences interfere with this direct cost relationship and reduce the economic impact.

In a perfectly refined system, cross subsidies will not exist. In the competitive environment found in other states there is an economic incentive to identify and eliminate subsidies. In a state with an exclusive state fund such as Washington, there is a tradeoff between administrative convenience (and cost) and actuarial equity.

The refunds to retrospectively rated employers are based on their experience in both the accident fund and the medical aid fund but the refunds are funded through a charge to the Accident Fund Rate in manual rate making. This creates cross subsidies between classifications whose relative Accident Fund and Medical Aid Fund rates differ.

As a result of the way rates are calculated a cross subsidy exists between classifications that have consistently high participation in retrospective rating and those that do not. The classifications with low participation in retrospective rating subsidize those with a high participation because they pay for a higher proportionate share of the anticipated retrospective premium refunds.

As discussed in the appendix, there are several aspects of the experience rating plan that create the possibility of cross subsidies between classifications. These are related to the size of the experience modification factor and the amount of premium paid by employers.

Self-insured employers utilize the second injury fund much more than state fund employers, because of economic incentives. It should be noted, however, that the Second Injury Fund for self-insured employers is separate from a similar function available to insured employers. Accordingly, this does not result in any cross subsidies.

Recommendation 25

Adopt a plan by which excess premiums are returned as dividends to prior contributors–both employers and employees–that generated the excess premiums, rather than to future policy holders/contributors as reduced rates.

Recommendation 26

Adopt changes in the rate setting process that are discussed in detail in Appendices P and Q and which are designed to minimize cross subsidies.

COMPARISON OF RETROSPECTIVE RATING PLAN DESIGN (E5)

Retro employers have been paying relatively lower premiums than non retro employers

Retrospective rating plans are plans under which the premiums charged to an employer are retrospectively adjusted based on the loss experience of the employer. We compared the retrospective rating plan used in Washington with that used in general by the private insurance industry (as reported by NCCI) and that used in Ohio, another exclusive state fund jurisdiction.

The Washington plan uses a Performance Adjustment Factor in the calculation of refunds. The intended goal of this factor is to make the incurred loss ratios of retrospectively rated employers as a group equal to those of other employers. In other words, the ratio of benefits paid out to premiums collected should overall be approximately the same for both groups. As the performance adjustment factor has been applied, however, it has significantly and consistently resulted in a higher (loss) ratio for employers in a retrospective rating plan. In other words, retro employers have been paying relatively lower premiums than other non-retro employers.

The Washington plan allows employers to select at their sole discretion the retrospective rating plan option. When private insurers operate plans such as these, however, there is an underwriting function which assures that the plans do not become populated by only the best (or the worst) employers in an industry. There is no such function in Washington.

The loss conversion factors used in Washington in calculating the retrospective premium are significantly less than 1.000. This results in a lower adjustment of premiums based on past losses and thus reduces the incentive for loss control. In private insurance they are usually equal to or greater than 1.00.

The final retrospective premium is calculated earlier in Washington than it is in other jurisdictions. This means that the amount of the retrospective premium is based to a larger degree on a less accurate estimate of what the eventual losses will be. Because the final premium adjustments are made too soon, they are less likely to be accurate.

In Washington State, employers can enroll as a member of a retro association thereby having their retrospective premiums based on the experience of the entire group. In other states, members of groups will still have their premiums calculated individually.

In Washington, it is assumed that employers with a retrospective rating plan will implement safety and loss control programs. In other jurisdictions, underwriters take a more active role in assuring that this is done.

Recommendation 27

As explained in Appendix R, the department should adopt adjustments to its retrospective rating plan which are designed to make its application more balanced actuarially.

Recommendation 28

The department should establish underwriting guidelines to avoid adverse selection by employers in retrospective rating plans.

Recommendation 29

As explained in Appendix R, the department should institute a dividend plan that applies to both retrospectively rated and non-retrospectively rated employers. A properly designed dividend plan would eliminate the need for the performance adjustment factor, or a loss conversion factor

of less than 1.0, and would also provide an appropriate mechanism to release excess reserves equitably.

RESERVE REPORT (E6)

Reserves and reserving methodologies are consistent with those approved by professional actuarial bodies

This section deals with the overall reserves maintained by the department. By that we mean the department's estimated value of the outstanding claim liabilities as of a specified date. (The following section deals with case reserves.) In our opinion, the reserves and reserving methodologies used by the department are consistent with those approved by professional actuarial bodies. However, we found the data maintained by the department was not sufficiently documented to allow for an easy review of their reserve estimate by a third party.

To ensure accountability and allow comparisons with other jurisdictions, the procedures adopted to estimate actuarial reserves should be well documented.

Recommendation 30

We recommend that the department produce (either through its own actuaries or through an outside independent consulting company) a well documented, exhaustive actuarial reserve report detailing the assumptions and methods used. Such a report should be similar to those that are submitted to regulatory authorities by private insurance companies.

CASE RESERVE REPORT (E7)

Case reserves refer to an estimate of what the future costs (losses) will be in an individual case. For private insurers across the country, it is customary for these reserves to be set by individual claims handlers (sometimes in consultation with a supervisor) who are managing the case. In Washington, reserves are set by a special reserving unit within the department. Claims management and adjusting are handled by the Claims Administration Unit independently from the Reserving Unit.

A test of the appropriateness of reserving practices is the consistency over a period of time. Ideally, such tests should be carried out on reserving data carried on a report year basis, but such data was not available from L&I. Therefore, as a substitute the actuaries examined case reserve data on an accident year basis. Observed incremental loss development factors in Washington are erratic and change with annual updates of the latest loss data. As explained in the Appendix W, in some ways the case reserves in Washington appear less consistent than we would expect given the large number of claims involved. The setting of reserves can affect experience rating.

Case reserving also has implications beyond experience rating. It can be of assistance in managing the individual claims. For example, it can help in making decisions about the use of surveillance, legal assistance, rehabilitation or medical care. It is also helpful to loss prevention and loss control efforts. Managing reserves provides the claims handler with a target. Identifying the economic value of a claim at an early date helps to determine the proper course of action early in the claim. The accuracy of reserves can also be enhanced if reserves are monitored and adjusted on a regular basis as developments occur in a claim.

The discussion above refers to the consistency of reserves over a period of time. There is also a question of consistency across the units and individual claims managers. If, as we recommend here and elsewhere, reserves are set by individual case managers, there will need to be some audit function to insure consistency across the department. A unit, which performs this function, could be much smaller than the present case reserve unit.

These issues are also discussed in Chapter 7 dealing with the management of claims.

Recommendation 31

Case reserves, particularly in lost time claims, should be set as early as possible by the claims adjusters responsible for handling each individual claim.

PERFORMANCE OF THE RETROSPECTIVE RATING PLAN (E8)

Costs are going down for retro employers relative to other employers as a result of the way premiums are calculated

As indicated in Chapter 11 above, it would appear that the retrospective rating plan, as applied, results in premiums that are relatively lower for employers with retrospective rating plans than for other employers.

As indicated in Chapter 11 above, it would also appear that the retrospective rating plan does not create incentives for loss prevention to the greatest extent possible.

There is an assumption behind retrospective rating plans that they will result in better safety and loss control efforts which will in turn result in lower losses for the participants in these plans. The data we examined does not support the assumption that this is happening in Washington. Instead, costs are going down for retrospective rating plan employers relative to other employers as a result of the way premiums are calculated.

Recommendation 32

As discussed in Appendix U, we recommend adjustments that are designed to more equitably distribute costs between retro and non-retro employers.

THE CHANGE PROCESS - BREAKING AWAY

Chapter Twelve

In conclusion, we would offer a few words concerning the implementation of the changes we recommend. Many of these changes will require a willingness to break away from past practices. We expect that there will be some resistance to some of the recommendations we offer, simply because they involve a change in the way things are done. We encourage all the parties to work together to recognize the difficulties that are involved in making such changes, but to resist the temptation to maintain the status quo simply because change is difficult. Everything we recommend is based on successful practices in other jurisdictions. To accomplish significant improvement the parties must be willing to do things differently. In the long run, we believe these changes will result in better service to employers and workers and more meaningful, responsible jobs for the employees of the department.

Successful implementation will require cooperation between the department, labor, and management

We would encourage Washington to consider the use of outside help in the implementation of the change process. Because many of the recommendations require a breaking away from past practices it may be necessary to have the viewpoint and encouragement of someone from outside this system. Such a person or team could facilitate the changes and could attempt to mediate differences which arose between various interest groups. It might also be appropriate to use an outside party to conduct a review of the change process one and/or two years after it begins.

Finally and most important, the successful implementation of these changes will require cooperation between labor and management. It is typical that workers' compensation is a

partisan issue. Interest groups use it as a touchstone for the loyalty of elected officials. Every issue is evaluated as to how it will ultimately help one cause or one political party. While it is impossible to quantify, we felt that there was even more of this in Washington than we see in other states. We hope the parties will try to avoid this in reviewing these recommendations. There will always be differences over workers compensation issues but there are many potential improvements to the Washington Workers' Compensation System that will benefit both workers and employers. They can best be implemented by a cooperative effort of all the parities.

We suggest that the various interest groups review these recommendations and decide which ones they can all support (all of them we hope). We would then suggest the creation of a board or committee to oversee the implementation of these changes. Such a committee could take a form similar to the board we discuss in Chapter 8 or it could be based on the current Workers' Compensation Advisory Committee. Whatever its format, its goal should be to emphasize areas of mutual concern and encourage cooperation while at the same time insisting that the changes be accomplished.

At present, Washington has a workers' compensation system that is very good in many respects. There are, however, many ways in which the system could be substantially improved. Implementing these improvements will require a lot of hard work and a willingness to accept new ideas. That will in turn require the support of a group of leaders in the Washington workers' compensation community who are willing to work together for the benefit of the system as a whole.

AGENCY RESPONSES

Chapter Thirteen

- **Department of Labor and Industries Response To Preliminary Report**
- **Board of Industrial Insurance Appeals' Response To Preliminary Report**
- **Auditor's Comments**

To link to this appendix, click here.

AUDITORS COMMENTS

We have received the response from the department and the board to our preliminary report. We are very pleased that they indicate openness to change and a willingness to accept many of our recommendations. We hope that after further consideration and consultation with the representatives of workers and employers, the department may be open to even more of the changes we have suggested.

Recommendation 1: The department should consider the possibility of having a board that would oversee its activities that are related to insurance services.

Agency Position: Non-Concur.

Auditor's Comments: Recommendation 1 only indicated that the department should "consider the possibility" of having a board. We are disappointed that the department rejects even this possibility. We would hope that the department would at least consider the possibility of expanding the role of its current advisory committee.

Recommendation 3: The claims functions should be organized into units that include five to seven claims adjusters, clerical support, and a claims supervisor.

Recommendation 4: To the greatest extent possible, employers should be assigned to an individual claims adjuster.

Agency Position: 3) Non concur, and 4) partially concur.

Auditor's Comments: The current initiatives undertaken by the department are good and will improve service. They are, however, different from the suggestions we make here. We recognize that there may be some costs in implementing these but we would encourage the department to at least try them out on a small scale before rejecting the ideas completely.

Recommendation 5E: Claims adjusters should have sufficient support for clerical and investigative tasks.

Agency Position: Concur.

Auditor's Comments: The department would probably need some additional staff to implement this. It is very difficult to estimate the exact amount.

Recommendation 7: There should be less reliance on the formal claim closure process.

Agency Position: Partially concur.

Auditor's Comments: We are pleased that the department is willing to undertake a review of the claims closure process. We would suggest that this begin with a dialogue that includes the department, the attorney general's office, and representatives of workers and employers. The aim of the dialogue should be to define exactly what is meant by "closing a claim," what is the statutory basis for this, and what are the benefits of it? We would suggest that the dialogue carefully distinguish between assumptions that are based on repeated practices of the department and legal principles that are based upon statutory or case law.

Recommendation 8: There should be a compliance unit within the department which monitors the operation of the insurance services division and self-insured employers.

Agency Position: Partially concur.

Auditor's Comments: There are certainly similarities between a quality assurance unit and a compliance unit. There are, however, also many differences. For example, strengthening the quality assurance unit will not deal with the problem (or at least perceived problem) that the fund is held to different standards than self-insured employers.

Recommendation 10: Once the department has in place a compliance unit and a system of ombudsmen or mediators, the current oversight of the claims processes of self-insured employers should end.

Agency Position: Non-concur.

Auditor's Comments: We recognize that this is a sensitive and difficult issue. We believe, however, that the proposals we have made in this recommendation and Recommendation 8 and 15 (compliance unit and ombudsmen) would protect the interests of injured workers while allowing self-insured employers to manage claims in a more appropriate manner.

Recommendation 13: The department should collect and publish information about the performance of third-party administrators to the extent it becomes available through audits and otherwise.

Agency Position: Non-concur.

Auditor's Comments: We are not recommending that the department exercise regulatory authority over third-party administrators. We recognize that there may be some difficulties in implementing this. To a certain extent, however, the department must have available information about the performance of third-party administrators. To the extent it does, it should make this information available to the public.

Recommendation 15: The department should create a system of mediators or ombudsmen to provide assistance to workers and employers.

Agency Position: Non-concur.

Auditor's Comments: The initiatives launched by the department are good. They will solve some problems. We believe, however, that injured workers and small employers should have a place to go outside of the claims management division where they can get information and advice. They should not have to write a letter to the director's office. Instead, there should be an 800 number that is broadly advertised.

In states where benefits are paid by private insurers, workers can turn to a state agency for this type of assistance. A weakness of an exclusive state fund is that there is no separation of parties between the insurer and the state agency. This weakness could be remedied by an office of ombudsmen.

Recommendation 16: The department should adopt a policy that all protests and reassumptions are resolved within 30 days.

Agency Position: Partially concur.

Auditor's Comments: We are pleased that the department is willing to explore this issue. We are very disappointed; however, that it is not willing to set for itself a goal that is any better than that already allowed by the statute.

Recommendation 17: Superior court review of decisions by the Board of Industrial Insurance Appeals should be eliminated.

Agency Position: Non-concur.

Auditor's Comments: The board has pointed out that while this recommendation would result in the elimination of appeals to superior court, it might also result in an increased number of appeals to the board. In that case, the board points out that it would need additional resources. We agree that if the number of appeals increased, the board should be granted additional resources.

It is possible to interpret some of the comments from the board and the department to mean that the number of appeals are held down under the present system because it is formal and complicated and that it would be bad to reduce the formality and complexity because more individuals would exercise their right to appeal. We presume that is not the position the board or the department intends to take. We would certainly reject that approach.

Recommendation 18: The primary goal of vocational rehabilitation as formally stated and as observed in practice should be successful return to work of the injured worker.

Agency Position: Non-concur.

Auditor's Comments: We are glad that the department is open to evaluating these issues. However, we are disappointed that it will not at least agree that return to work ought to be the primary goal of vocational rehabilitation. We recognize that this cannot be achieved in every case and that not everyone is an appropriate candidate for these services. It nevertheless ought to be "the primary goal."

Recommendation 19: The standard for employability should be wages at the time of injury, not the federal minimum wage. (Note: In the proposed final report, recommendation 19 was revised to clarify its intent.)

Agency Position: Non-concur.

Auditor's Comments: As we understand the current system in Washington, if a worker is formally determined to be employable at the federal minimum wage, then benefits will terminate. This standard is to too low. This automatic termination of further benefits should only occur if a worker is found to be employable at the wages that he or she was receiving at the time of injury.

We recognize the need for further criteria for determining which claimants should be referred for vocational rehabilitation and encourage its development. To some extent, however, this must always be done on an individual basis guided by the best practices of the rehabilitation counseling profession. There is also a need to determine what benefits a worker should receive when he or she does not return to work but is not eligible for VR, and when a case is referred for VR but his or her final wage is not equivalent (at some specified proportion) to the previous wage or VR does not result in placement at all.

We agree that negotiations with the various parties are an appropriate and probably necessary way to work out these issues.

Recommendation 24: We recommend that the department produce (either through its own actuaries or through an outside independent consulting company) a well-documented, exhaustive actuarial rate filing report detailing all assumptions and methods used. It should be similar to reports that are submitted to regulatory authorities by a licensed insurance company in states that use a "prior approval" rate filing procedure.

Agency Position: Non-concur.

Auditor's Comments: Our understanding is that the full complement of a rate report (as indicated in the recommendation) is not routinely packaged as such. The department had, at our request, put together a rate filing report for our audit. We did not mean to imply that required documentation could not be produced. The gist of our recommendation is that such package be prepared whenever rates are developed. We see this as expedient and responsive to stakeholder interest, and others who review the department rate recommendations. Reference to a prior approval setting is to offer a type of standard as an example.

Recommendation 25: Adopt a plan by which excess premiums are returned as dividends to prior contributors—both employers and employees—that generated the excess premiums, rather than to future policyholders/contributors as reduced rates.

Agency Position: Partially concur.

Auditor's Comments: We recognize that achieving equity is difficult in general and may be impractical in the case of the employee premium payers. However, since the department receives the individual employee's contribution to the Medical Aid Fund from their employers, the department could return the dividend to that employer for distribution to its employees. One way is to credit each dividend to premiums receivable and due from these employers so that they remit a net premium. Employees may be noticed of such dividend via poster in the employer's office.

Recommendation 26a: (No. 1 Appendix P) Adjust Accident and Medical Aid Funds premium rates the same percentage as for Retro.

Agency Position: Non-concur.

Auditor's Comments: The refund calculation is determined by using the combined experience of the Accident Fund and Medical Aid Fund. The refund is equal to the Standard Premium minus the Retrospective premium. Therefore the Medical Aid Fund does contribute to the size of the refund, even though paid from the Accident Fund. For example, in deriving the combined Retro premium, the Medical Fund losses will either increase or decrease the Retro premium. Except for the special case where the Accident Fund and Medical Fund premium and losses are identical, the Retro refund will be smaller if Medical Fund losses are higher than the Accident Fund and vice versa.

Recommendation 26b: (No. 2 Appendix P) Eliminate the adjustment for Retro refunds in the determination of classification rates.

Agency Position: Non-concur.

Auditor's Comments: We do not see the economic necessity of building back in the Retro refunds, as this ensures subsequent Retro refunds in the future, other things equal. In other words, by adding the Retro refund cost to the experience rate, there should be a similar refund next year. Assuming your retrospective rating plans are actuarially balanced, there is no need to adjust rates for the actual/anticipated refunds, since by definition, Retrospective plans would yield on the whole the appropriate premium, i.e., equivalent to the non-Retro premium. However, if a refund is the purpose, we have no problem.

Recommendation 26e: (No. 4 Appendix Q) Incorporate an adjustment for the impact of experience rating by classification into a classification rate-making system.

Agency Position: Non-concur.

Auditor's Comments: We disagree. In rate making, the overall rate indication implicitly corrects for the off-balance created by the experience rating plan by using Standard Premium as a benchmark, i.e., the manual premium multiplied by the experience modification factor. This is equivalent to first performing the analysis on the manual basis, then adjusting the result for the (overall rate) off-balance produced by the experience rating plan. This is accomplished by dividing the manual loss ratio by the average experience modification factor.

What we have proposed is a refinement of this process to a classification level. Classification rates are currently produced on the manual (rate) basis which assume the ratio of standard to manual premium is the same for each and every classification. Our analysis showed that there are significant and consistent differences in this ratio by classification. Some classifications produced rates by this process that are consistently excessive or inadequate. This consistency suggests a systemic bias and other factors are not being equitably distributed to the classification rate. In essence, we suggest reducing the overall off-balance calculation experience rating to the classification level.

Recommendation 27: As explained in Appendix R, the department should adopt adjustments to its retrospective rating plan. These adjustments are designed to make the application more balanced actuarially.

Agency Position: Non-concur.

Auditor's Comments: The Retrospective Rating plans do not incorporate the latest or current expense figures in their formulation, therefore, they are not actuarially balanced as to the cost difference between prior and current expense figures.

The statement that the 5.6 percent calculation included the entire premium and loss figures for firms that were only partially enrolled in Retro plans, is apparently incorrect based on our discussions with the department, they said this situation only applies to partially enrolled accounts that had a subaccount retrospectively rated but not the balance of the account. In addition, we understood this was an infrequent occurrence and not material dollar wise. As regards including the interest payments in the retro return, the department rate making process included these interest payments treated as a retro return in computing the Accident Fund rates. Therefore, it is appropriate to include it in this analysis.

If the Retro program consistently has a net return-refund, this implies the standard rating method consistently charges too much for these employers.

Recommendation 29: As explained in Appendix R, the department should institute a dividend plan that applies to both retrospectively rated and non-retrospectively rated employers. A properly designed dividend plan would eliminate the need for the performance adjustment factor, or a loss conversion factor of less than 1.0, and also would provide an appropriate mechanism to release excess reserves equitably.

Agency Position: Non-concur.

Auditor's Comments: We did not mean to imply in our recommendation that the Retro program should be replaced by a universal dividend program. Rather we recommend a dividend program that applies to both Retro and non-Retro employers where standard pricing mechanisms consistently generated too much premium. For example, a non-Retro employer that implements loss control measures will receive some benefit (dividend) if his program is effective in controlling costs. Under the current system, the non-Retro rated employer must either become retrospectively rated or wait until his loss data are included in the experience period used for his experience rating modification.

Recommendation 32: As discussed in Appendix U, we recommend adjustments that are designed to more equitably distribute costs between Retro and non-Retro employers.

Agency Response: Non-concur.

Auditor's Comments: As explained for Recommendation 27, we offer the same response here. The Retrospective Rating plans do not incorporate the latest or current expense figures in their formulation, therefore, they are not actuarially balanced as to the cost difference between prior and current expense figures.

The statement that the 5.6 percent calculation included the entire premium and loss figures for firms that were only partially enrolled in Retro plans, is apparently incorrect based on our discussions with the department, they said this situation only applies to partially enrolled accounts that had a subaccount retrospectively rated but not the balance of the account. In addition, we understood this was an infrequent occurrence and not material dollar wise. As regards including the interest payments in the retro return, the department rate making process included these interest payments treated as a retro return in computing the Accident Fund rates. Therefore, it is appropriate to include it in this analysis.

If the Retro program consistently has a net return-refund, this implies the standard rating method consistently charges too much for these employers.