Appendix 1: Washington Self Insurance and Comparative Analysis

This appendix contains a detailed review of the regulatory structures for self-insurance in Washington, Ohio, Oregon and Idaho. It will show major similarities and differences in regulation across the states. In addition, it will contain performance comparisons between self-insured firms and insured employers. This review illustrates some sophisticated and efficient regulatory techniques that may be of value in Washington.

1 Self-Insured Claim Processing Regulation in Washington

Self-insurance regulation in Washington has many features common to all states that permit self-insurance for workers' compensation.[1] There are also some features that are unique to Washington's system. As is typical in states with self-insurance, the workers' compensation administrative agency has regulatory authority over firms that wish to self-insure. To qualify initially as self-insurers, firms must meet stringent financial strength criteria in order to provide assurance that obligations for paying claims can be met over the long term.

Another typical function is agency monitoring of various aspects of claim processing to assure that standards for claim processing performance are met by self-insurers. As in all states, Washington self-insurers are obligated to pay the same benefits to injured workers as other insurers, for the same set of covered conditions and circumstances. Washington has a unique approach to payment of workers' compensation insurance premium. In almost all states the employer pays the full premium cost. In Washington half of the cost for the medical premium is paid by workers. This is not true for self insurance, where the entire risk is self-insured by the employer. This would seem to be a substantial disincentive to self-insure, on the order of 25% of claim costs, yet a typical portion of the Washington workers' compensation market uses self insurance. This seems to imply that self-insured employers believe that they can be substantially more cost-effective than L&I even with the hit in full payment of medical costs.

States vary in the degree of involvement that is permitted of firms that specialize in processing workers' compensation claims, known as third-party administrators (TPAs). These firms are permitted in Washington and in each of the comparator jurisdictions in the US, although not in British Columbia.[2] In Washington, about 92 percent of self-insured firms contract with a TPA to manage their workers' compensation claims.[3] The self-insured employer remains responsible for compliance with claims management in accordance with state laws.

In most states self-insurers are generally subject to the same regulatory standards for claim processing as other types of insurers. As there are only two states (Washington and Ohio) that use a state fund and self-insurance but do not permit private insurers, it is less meaningful to say what is typical in most states, but nevertheless some comparisons are useful. In many important ways, Ohio is the most comparable jurisdiction to Washington from the perspective of its insurance and self-insurance regulatory model. This document will highlight some features from Ohio, as well as provide some additional comparative context from Oregon and Idaho.

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[1] Two states, North Dakota and Wyoming, do not permit self-insurance, and coverage is provided only through a state fund. Ohio and Washington permit self-insurance; all other employers must insure through the state fund.

[2] In British Columbia, the workers' compensation government agency (WorkSafe BC) handles all claim administration activities on behalf of self-insurers.

[3] Source: 2014 Annual Report, Office of the Ombuds for Self-insured Workers

Some unusual features in the Washington system involve the necessity for Labor & Industries to perform certain claim processing functions instead of (or in addition to) the self-insurers or their TPAs. These functions include adjudication of compensability (both acceptance and denial), which must be done by L&I in all claims, though the self-insurer may recommend a decision. Another area with L&I involvement, where there is typically none in similar states, is claim closure.[4] Presumably, these functions have been placed within L&I because it is perceived as a neutral body that has less potential financial interest in the outcome. Nevertheless, these extra steps come at a cost in both time and staff effort. These added steps tend to slow down claim processing and in some cases may delay benefits. In other aspects of claim processing, timeliness of action by self-insurers is comparable to or better than L&I, although it should be recognized that self-insurers tend to be very large firms that enjoy economies of scale, and are able to dedicate staff to some processing functions that smaller employers (who must purchase L&I insurance) would have limited experience with.

For most claims decisions, all jurisdictions allow parties to appeal adverse decisions in some manner, although this mechanism typically involves delays, adversarial proceedings, attorneys and other frictional costs. The typical avenues of self-insurance claim-processing regulation attempt to minimize disputes through a combination of features which can involve monitoring processing through reporting of key events to the regulatory agency, feedback on processing performance statistics in relation to the industry as a whole, audit for accurate and timely processing performance, and sanctions when standards are not met.

For injured workers, most of whom have no experience with workers' compensation claims, information is a valuable commodity. Many states provide some form of free ombuds service to injured workers, typically from an independent or quasi-independent office that is empowered to provide advice to injured workers, resolve some disputes, and provide some degree of investigation and monitoring of system trends affecting injured workers. These offices differ across states in a variety of dimensions: statutory role, degree of funding and staffing, and means of interaction with various parties in the system to resolve disputes. In most cases these offices do not provide legal advice.[5] One relatively new program in the Washington system is the Office of the Ombuds for Self-Insured Injured Workers.[6] Unlike most similar state programs, this office assists only those injured workers whose employers are self-insured; the Washington program is funded by self-insured employers. The office was authorized by the 2007 legislature, and the Ombuds was first appointed on January 12, 2009. Thus the first full year of data on the office's operation was Fiscal Year 2010. As we might expect, there was an increase in workload over the initial years of the office, with counts of resolutions growing by 76 percent from FY2010 to FY2012. These counts have been roughly flat in FY2013 and FY2014.

The following tables summarize various aspects of the office's activity. In interpreting the information in the tables, it is important to note that the results are principally reflective of those cases where the worker contacted the office and an investigation was opened. The statistics do not fairly represent the full spectrum of claims in a year, only the ones contacting the Office of the Ombuds. Nevertheless some insight is provided by the trends observed.

[4] Under certain circumstances a self-insured employer in Washington may "self close" a claim. RCW 51.32.055(9) (allowing self-insured employers to order a claim closure under certain circumstances, including that the worker returns to pre-injury or equivalent work with the self-insured employer). We heard in some interviews that this self-closing procedure was little used because there was a 2-year review period, as opposed to the 60-day period if L&I ordered the closure. In file reviews we observed a fair number of self-insured "self" closures, so the practice may be more prevalent than indicated in interviews.

[5] At least two states are exceptions; Nevada and Texas have state-funded, attorney-staffed offices that can provide legal assistance to injured workers in some circumstances.

[6] The original term for this function was Ombudsman; later changed to Ombuds.

The first table summarizes complaints in which investigations were opened and completed. While this program is only six years old, the trend of initial caseload growth, followed by leveling off, indicates that the level of investigations is likely now consistent with the long-term level of activity in this function, provided that industry trends are stable. It is interesting to note that in each year, a majority of self-insurers were involved in zero investigations. The share of self-insured employers with zero investigations has varied between 54 and 66 percent. Of those with investigations, the majority of firms had 1 or 2 investigations, although in each year there were at least 5 firms with 10 or more investigations. Thus the activity for this office, particularly in the most recent years, is an indication of the frequency trend of claim processing issues that give rise to complaints by injured workers. It is important to note here that these counts do not indicate the complexity of the issues.[7]

Office Of The Ombuds Investigation Characteristics				
REPORT YEAR (FY)	Investigations Completed	Employers Involved	Count of Employers with Zero Investigations	Share of SI Employers with Zero Investigations
2010	289	123	243	66%
2011	400	128	233	65%
2012	508	166	196	54%
2013	505	158	202	56%
2014	486	136	221	62%

The second table summarizes the resolution types across the set of investigations completed in that year. One concern raised by the Ombuds in the most recent year was the falling share of complaints that could be resolved through direct contact with the self-insurer/TPA, which allows changes to treatment or benefits to be implemented promptly. Instead, a somewhat higher share of resolutions were by Department assistance (39% vs. 32% in 2013). At the same time, the share of claims determined to be adjudicated correctly rose from 29% to 38%, a new high. The Ombuds Office correctly cautions that this figure "should not be used to make general assumptions or interpretations as to the accuracy of self-insured claims adjudication as a whole."

Office of the Ombuds Resolution Profile by Fiscal Year, Number and % of Resolutions					
	2014	2013	2012	2011	2010
Claim Adjudicated Correctly	183	146	156	81	77
Resolved: SIE / TPA	65	111	108	106	92
Resolved: Dept. Assistance	190	162	153	164	78
Unable to Resolve	48	86	91	49	42
Totals	486	505	508	400	289
Claim Adjudicated Correctly	38%	29%	31%	20%	27%
Resolved: SIE / TPA	13%	22%	21%	27%	32%
Resolved: Dept. Assistance	39%	32%	30%	41%	27%
Unable to Resolve	10%	17%	18%	12%	15%
Totals	100%	100%	100%	100%	100%

Many investigations involve more than one claim issue; the table below details the major issues as a percentage of the total reported issues in that year. For the past three years the most frequent issue has been the payment

[7] Statistics are from Annual Reports of the Office of the Ombuds for Self-insured Workers, for Fiscal Years 2010-2014.

of time loss compensation. The Ombuds Office notes that the complexity of this computation often makes it difficult for workers to understand whether the time loss rate was calculated accurately.

The second most frequent issue involves medical treatment, most commonly a delay in authorization for some type of treatment. The Ombuds Office notes that there are no rules that require the self-insurer or its TPA to take action on a treatment request within a specified time.

Office of the Ombuds
Major Issues, by FY and % of Issues Reported

Report Year (FY)	Time loss/LEP	Medical treatment	Claim status	IME	Other	Incorrect Wages	Claim Closure	Med Bills
2010	29%	39%	n/a	6%	n/a	1%	3%	7%
2011	27%	33%	n/a	14%	8%	3%	5%	7%
2012	27%	24%	13%	11%	7%	4%	5%	7%
2013	25%	22%	17%	9%	14%	4%	4%	5%
2014	30%	15%	15%	14%	12%	6%	5%	3%

Notes Categories used are those defined in the 2014 Report of the Ombuds.
Multiple issues may be reported in a single claim.
Some issue categories were added in more recent years.

2 AUDIT REFORM

A substantial portion of the Ombuds Office Annual Report is dedicated to the discussion of recommendations for rule and regulation changes. Its 2014 report mentions prior recommendations for change, such as implementation of new regulations for determining when a self-insured employer has unreasonably delayed payment of medical bills. The most recent report discusses ongoing efforts at audit reform (audits had been suspended during process review). The new audit model envisions Tier 1 audits, currently focused on wage calculations, an important component of accurate time loss computation. The Ombuds recommends the addition of audit staff to extend this to accuracy and timely first payments to injured workers. Further recommendations include more comprehensive Tier 2 and 3 audits. If audit results demonstrate additional findings or deficiencies, the cost of the audit would be borne by the self-insurer rather than being paid by the sector as a whole. L&I appointed a task force to evaluate the self insurer audit program, and a year-long pilot for Tier 1 audits, focused on wage calculations, is planned for 2015. Tier 2 and Tier 3 (driven by results from performance-based audits), as well as issue-based (driven by data analysis of observed issues) and complaint-based (driven by stakeholder complaints) are reported to be underway.

In many important ways, Ohio is the most comparable jurisdiction to Washington from the perspective of its insurance and self-insurance regulatory model. A number of features have proven effective in regulating self-insurance in a system whose size is similar to Washington.

The Ohio state insurance fund, and self-insurance administrative agency is the Ohio Bureau of Workers' Compensation (BWC). The BWC monitors financial solvency, claim reserving practices, and payments of various assessments for dedicated funds and administration costs. Unlike the Washington system, BWC does not generally get involved in processing claims except in rare events; rather it monitors and audits for performance periodically, to ensure SI adherence to statutory requirements. The BWC also publishes a detailed claims

administration *Procedural Guide.*[8] Their audits consist of two levels of periodic audits on at least a 3-year cycle, with a third more comprehensive level if certain trigger deficiencies are found.

Recent changes to the Ohio audit process have allowed audits to proceed much more efficiently. BWC auditors get remote login access to SI claims systems, and thus have the ability to do audit work remotely as needed. According to BWC documents, since implementation of this new process, the number of audits increased by over 155% by the end of 2013. Per agency status reports, only about 3 to 4 percent of audited firms fail to receive a satisfactory rating. The BWC Self Insured director reported to the audit team that they had provided assistance and information to members of the L&I Self Insured audit reform task force.

3 Self-Insured Claim Processing Regulation in Ohio

The Self-Insured Department of the Ohio Bureau of Workers' Compensation (BWC) supports over 1,200 active employers that account for nearly 2 million Ohio employees (40% of all Ohio employees). The BWC Self-Insured Department describes its primary functions as:

1. Underwrite the self-insured authority for eligible employers including: the monitoring of self-insured status through a renewal process, managing securitization of letters of credits and bonds and the calculating/processing of semi-annual assessments.
2. Monitor and audit self insuring employers for proper administration of their workers' compensation programs including: ensuring the timely and accurate payment of benefits in accordance with the Ohio Revised Code and Ohio Administrative Code, verifying the proper reporting of yearly paid compensation totals, investigating and resolving complaints filed against self insuring employers, and developing and conducting training for prospective and existing SI employers.
3. Provide support for and work in conjunction with the BWC Claims Department to minimize costs against the Self-Insuring Employers Guaranty Fund (SIEGF) and Mandatory Surplus Fund related to defaulted employers. BWC Central Office takes on the responsibility of effectively administering a claim, including payments of compensation or benefits to the employees of the defaulted employer.[9]

Of about 1,200 active self-insurers, about 80 percent engage the services of third-party administrators (TPAs) to assist in claims administration. The BWC is the principal regulatory agency for self-insurance, and issues a detailed procedural guide for self-insurer claims administration.[10] Per BWC, the expectation is that self-insuring employers have proper controls in place to ensure compliance with the statutory requirements.[11]

[8] The Ohio Procedural Guide for Self-insured Claims Administration can be found at https://www.bwc.ohio.gov/downloads/blankpdf/SIClmsProcedureGuide.pdf. Washington publishes a similar guide, available at http://www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/Claims/Guidelines/Default.asp.

[9] Per Ohio BWC "2013 Self-Insured Department status report."

[10] The Ohio Procedural Guide for Self-insured Claims Administration can be found at https://www.bwc.ohio.gov/downloads/blankpdf/SIClmsProcedureGuide.pdf.

[11] OAC 4123-19-03(I) states that, by accepting the privilege of self-insurance, an employer acknowledges the ultimate responsibility for the administration of workers' compensation claims in accordance with the laws and rules that govern self-insurance. The employer must annually renew the privilege to pay compensation, etc., directly. Prior to renewal of the employer's privilege of self-insurance, BWC re-evaluates the employer's financial strength and administrative ability as described in OAC 4123-19-03. To renew its status as a self-insuring employer, the employer must establish it has fulfilled the minimal level of performance standards that an employer is required to meet before BWC grants permission to pay compensation and benefits directly, as provided in paragraph (K) of OAC 4123-19-03. The employer must have substantially resolved all outstanding complaints filed with BWC and that the employer has achieved a satisfactory rating in its most recent audit report.

The table below shows detail for the four most recent full years of SI Lost Time Claims.

Ohio Self-Insurer Claims Activity			
Calendar Year	Lost Time Claims Filed	Claims Disallowed/ Dismissed/ Disputed[12]	% Ultimately Denied (incl. appeals)
2010	12,190	952	7.8%
2011	11,447	956	8.4%
2012	10,091	892	8.8%
2013	8,361	748	8.9%

In its role of administrative agency, BWC monitors financial solvency, claim reserving practices, and payments of various assessments for dedicated funds and administration costs. BWC does not generally get involved in processing claims[13] except in rare events; rather it monitors and audits for performance periodically, to ensure SI adherence to statutory requirements. These audits consist of two levels of periodic audits on at least a 3-year cycle, and a third, more comprehensive level if various trigger deficiencies are found. The end notes of this document detail the audit levels as described in the *Guide*. As just discussed, Ohio recently implemented changes to its audit process, resulting in efficiency improvements; these changes have been well received. As shown in the table below,[14] only about 3 to 4 percent fail to receive a satisfactory rating.

Ohio Self-Insurer Audit Activity			
Year	Total Audits	Satisfactory Rating	Avg. Audits Per Month
2011	167	161 (96%)	13.91
2012	229	223 (97%)	19.08
2013	427	412 (96%)	35.58

SI processing performance is monitored for timely first payment; the Ohio standard is 21 days from knowledge of the claim. This is monitored in the audit process, and SIs also submit first reports of injury (FROIs) as claims data to BWC. SIs using TPAs are required to have an in-house claims manager in Ohio. SIs report all lost-time claims (7 or more days of time loss) to the BWC, as well as those with disputed issues, and categories of compensation paid.

There is an ombuds function within the BWC for information to injured workers on their claims. The office received 1,197 complaints in 2011 from injured workers or their representatives; 672 in 2012. Most complaints are received by phone, next most commonly by email. Note that these Ombuds statistics are not for SI claims only.[15]

[12] OAC 4121-3-13(A) defines a disputed issue as any issue that is disputed or disagreed between the injured worker and the self-insuring employer. A party to the claim must put BWC on notice that a dispute exists so that BWC can refer the issue to the IC for hearing. A Motion (C-86) may not be required for a referral to the IC.

[13] BWC Audit documents state: "Employers choose self-insurance, in large part, to have more control of their claims administration and to avoid the bureaucracy of state government. Our auditing/compliance efforts should align with this and not impede how an employer determines the best way to administer their SI program."

[14] Statistics taken from "Ohio BWC 2013 Self-Insured Department status report", provided 9/2014.

[15] Source: "2012 Annual Report for the Ombuds Office."

An average of approximately 300 worker complaints a year were received by the BWC SI section in 2011 through 2013. Complaints typically involve issues such as untimely payments; multiple valid complaints may trigger a Level 3 audit. Complaints that cannot be resolved by the BWC may go to another oversight body, the Self Insured Employers Evaluation Board (SIEBB). This is a rare occurrence; only 3 complaints were referred to SIEBB in each of 2012 and 2013; see table below.

Ohio Self-Insurer Claims Complaint Activity							
Year	**Total Complaints**	**Avg. Completion By SI Dept. (in days)**	**% Valid**	**% Invalid**	**% Dismissed/ Withdrawn**	**# Sent For Reconsideration**	**# Referred to SIEEB**
2011	314	25.04	35.9%	41.5%	22.6%	12	8
2012	293	25.13	34.3%	36.5%	29.2%	14	3
2013	259	23.09	33.5%	33.9%	32.6%	20	3

Per the *Procedural Guide*:

> "The [Self Insured Employers Evaluation Board] SIEBB consists of one member of the IC representing the public and serving as chairman. The governor also appoints one member of the Ohio Self-Insurers Association and one member of labor. BWC provides administrative support for the SIEEB.
>
> BWC refers all unresolved complaints or allegations of misconduct against a self-insuring employer to the SIEEB. At the injured worker's request, the SIEEB may elect to hear a complaint that BWC had dismissed.
>
> The SIEEB investigates allegations and issues a written determination. It may order the employer to take corrective action. If after a hearing it determines that an employer has failed to correct deficiencies or is otherwise in violation of the statute, the SIEEB will recommend BWC revoke the employer's self insurance privilege, or that BWC places the employer on probation. The SIEEB may also recommend a civil penalty, not to exceed $10,000, for each violation, payable into the self-insuring employers' surety bond fund."

Thus, there are several levels of scrutiny of SI claim processing. The final ones would come when there is a formal dispute. When there is a dispute that leads to adjudication, such as a dispute over compensability of a claim, the dispute goes to the system's judicial body, the Ohio Industrial Commission (IC). A party to a claim must notify BWC of the existence of the dispute; BWC then can refer the issue for a hearing at the IC. The dispute process is the same for BWC and SI claims when the dispute reaches the IC. There are several successive levels of appeal housed at the IC:

- District hearing officer;
- Staff hearing officer; and
- IC Commissioners.

Workers at these appeal levels are frequently represented by attorneys; fees are typically paid by a percentage of benefits received, although this varies by particulars of the case. The relatively low level of disputes indicates that parties generally perceive that processes for claims decisions are not systematically unfair.

The BWC self-insured auditing overview is included here:

Self-Insured Audits

Audit process

ORC 4123.35 and OAC 4123-19-10

BWC is required to audit self-insuring employers to ensure employers are administering programs according to the statutory requirements. The audit process consists of a three-tier program that focuses on the employer's knowledge and implementation of the administrative, reporting and claims-management requirements. The expectation is that self-insuring employers have proper controls in place to ensure compliance with the statutory requirements.

Level 1 assessment audit: BWC's self-insured underwriting unit primarily performs the Level 1 audit as part of an employer's yearly renewal. The data and information BWC audits are currently available via BWC systems or already provided by an employer as part of the program requirements.

Frequency: BWC's self-insured department targets completing a Level 1 audit on all active self-insuring employers on an annual basis. BWC may also perform a Level 1 audit if there is a change in the designated program administrator, or if there is a change from self administration to outsourcing functions to a third-party administrator.

Scope: The audit will include:

- Aggregate reserve reporting;
- *Report of Paid Compensation and Case Reserves* (SI-40) trends, including total lost-time claims, reductions and lifetime claims.

Level 2 compliance audit: Level 2 audits are a more comprehensive review of an employer's claim compliance and SI-40 reporting practice. BWC may schedule and conduct these audits on an as-needed basis based on the following triggers:

- Not in compliance of any area in a Level 1 audit;
- Unexplained significant variances on the SI-40 from one year to the next;
- Inability to provide material support for a reduction reported on previous SI 40s;
- High-risk self-insured employers;
- Concerns noted on prior Level 2 audits;
- Multiple valid complaints in a rolling 12-month period;
- More than four years since last audit.

Frequency: BWC's self-insured department targets completing a Level 2 audit on all active self insured employers every three to four years.

Scope: The audit will include:

- Accuracy of SI-40 reporting;
- Accuracy in calculating wages for TT and PP payments;
- Accuracy in PTD calculation;
- Timeliness of compensation payments;
- Number and type of complaints;
- Aggregate reserves.

Level 3 compliance audit: Level 3 audits review all aspects of an employer's claims administration and reporting practices. BWC may schedule these audits based on the following triggers:

- Any employer that is not-in-compliance in any area of the Level 2 audit;
- Four years or more elapsed since last Level 3 audit;
- Initial six-to-12 month audit for all new self-insured policies;
- Change in administrator requires completion of the online tutorial through the BWC and shortens the four-year timeline to 12 months from the point of turnover;
- Upon finding of a third valid self-insured complaint in any rolling 12-month period;
- Failure of an employer to demonstrate strong working knowledge and consistent practices will result in a repeat Level 3 audit in the following six months to one year.

Frequency: As needed

Scope: The audit will include:

- Timeliness of lost-time claim reporting to BWC;
- Timeliness of certifying claims;
- Timeliness of medical bill payments;
- Reasonableness of medical bill response;
- Timeliness of compensation payments;
- Accuracy of compensation payments;
- Timeliness of responding to treatment requests;
- Availability of claim file;
- Maintaining a complete claim file;
- Proper notification to injured worker on claims process.

Source: Ohio Bureau of Workers' Compensation, "Procedural Guide for Self-Insured Claims Administration," pp. 55-56 (June 2014) (available at https://www.bwc.ohio.gov/downloads/blankpdf/SIClmsProcedureGuide.pdf).

4 Oregon Self –Insurance Regulation

4.1 Safeguards for Claimants of Self-Insured Employers in Oregon

Insurers and self-insurers (SI) in Oregon have the same claim processing obligations, and workers have the same appeal rights regardless of the form of coverage. In the case of claim denial, claimant has 60 days to appeal the denial, and 180 days with good cause (rarely used, however). The denial letter must clearly state the appeal rights. There are free sources of advice available to workers, the Ombudsman for Injured Workers and the WCD Hotline. If the denial is based on an IME, there is a means to acquire a neutral medical opinion (Worker-requested medical exam, or WRME) paid by the insurer/SI. While possible, these are not frequently used. Upon receipt of additional evidence, the Insurer/SI could voluntarily accept the claim, though an assessed attorney fee would be possible if the worker was represented and the attorney was instrumental in the acceptance.

The insurer/SI has 60 days to accept or deny the claim. The clock for paying interim time loss begins 14 days from employer notice of claim, even if the claim has not been accepted, and if authorized by the attending physician, time loss continues until the denial is issued.

Percent of Disabling Claims Originally Denied			
CY of Claim Setup	SAIF Corp	Private Ins	Self-Ins
CY 2011	16.6%	12.7%	14.0%
CY 2012	14.8%	12.6%	13.1%
CY 2013	14.6%	12.3%	13.0%
Notes: Claims are shown by date set up on department Claims system, regardless of date of injury. Source: DCBS Report CC8025.			

4.2 Appeals of Denials

Appeals of compensability denials go first to the Hearings Division of the Oregon Workers' Compensation Board (WCB). An Administrative Law Judge hears the case and issues a written Opinion and Order. Another common mode of resolution is a negotiated settlement, called a Disputed Claim Settlement (DCS) in which a lump sum is paid in exchange for the denial remaining in force. Upon appeal of a denial, if the denial or a decision delay is found to be unreasonable, the insurer/SI is subject to a penalty of up to 25% of the benefits due, plus an assessed claimant attorney fee. The attorney fee is assessed whenever a represented worker successfully contests a denial at a hearing, regardless of the reasonability decision. The fee is based on a variety of factors, but assessed fees of over $5000 are common when denials are overturned. If either party disagrees with the ALJ decision, the next step in the appeal process would be to Board Review at WCB.

Appeal Rates of Disabling Claims Originally Denied			
CY of Claim Setup	SAIF Corp	Private Ins	Self-Ins
CY 2011	44.9%	45.4%	42.5%
CY 2012	41.6%	45.4%	41.1%
CY 2013	43.9%	40.3%	38.3%
Notes: Appealed claims may be litigated, settled, or withdrawn without a further decision. Appeal rates for 2013 are subject to further development. Source: DCBS Report CC8027.			

Statistics on results of appeals do not reliably separate out insurer type, and as described above, there are multiple types of resolutions that do not result in a decision on the merits. Of the minority of appeals that do get a decision on the merits through an ALJ Opinion & Order, just under half (44.1% in 2011, the last year published) of full denials are overturned. Among stipulated settlements, the more common mode of resolution, about one in six (16.0%) result in an overturned denial. Given that most denials are not appealed, and a minority of appeals result in overturning the denial, typically 80 to 90 percent of initial indemnity claim denials remain in force.

4.3 Claim Processing Monitoring and Enforcement.

Claim processing performance is monitored by the Workers' Compensation Division (WCD) for both insurers and self-insurers. This is done both through systematic reporting on each accepted indemnity claim and all denied claims, indemnity and medical only. Timeliness standards are 90% timeliness for both initial time-loss payment, and compensability decision. Penalties can be issued when insurers' quarterly performance falls beneath this standard. Additional penalties are possible for inaccurate timeliness reporting, in aggregate amounts up to $10,000 per quarter per reporting entity (both insurers and self-insurers).

In recent years overall timeliness performance on first payments has generally met or exceeded the 90% standard, varying between 90 and 92% timely between 2011 and 2013. Oregon classifies its insurers into 3

groups: SAIF Corporation, private insurers, and self-insurers. In general, SAIF has been most timely at over 94%, followed by self-insurers at about 91%; private insurers have been somewhat less timely at around 85%.

Insurer Performance Statistics on First Payment Timeliness			
CY of Create Date	SAIF Corp	Private Ins	Self-Ins
2011	94.6%	88.3%	91.2%
2012	94.6%	83.1%	90.7%
2013	94.4%	81.4%	90.4%
Source: DCBS report CC8095			

Audit functions also monitor claim processing performance in specific areas, and penalties may be assessed where performance deficiencies are found.

- Timely first payment and accurate reporting of timeliness
- Timely accept/deny and accurate reporting of timeliness
- Timely claim reporting (Form 1502 filing)
- Timely Notice of Closure, and accurate reporting of timeliness
- Timely permanent total disability and fatality payments
- Timely subsequent time loss payments
- Timely and accurate reimbursements to workers

Self-insurer regulation includes both annual audits and focused audits. In addition to claim processing, audits of self-insurers monitor financial performance to assure adequate reserving and funding. This assures both accurate assessment amounts (self-insurers pay administrative assessments on simulated premiums) and accurate SI security deposits. Where TPAs are used, the audit process verifies coverage relationships and responsibilities. Finally, audits also monitor the use of funds received from the Workers' Benefit Fund, which include return-to-work incentives.

5 SI Claim Management Regulation in Idaho

The Idaho Industrial Commission (IIC) regulates a system that covers approximately 602,000 Idaho employees[16] at over 55,000 employers. In 2013 there were 33,922 total claims reported system-wide. Idaho employers can obtain insurance through a state fund, private insurers, or self-insurance. There are 28 active self-insured employers (SI) that account for about 9 percent of claims (the precise share of employees is not available). This is a relatively small share of the state's market in self-insurance, likely reflecting the demographics of employers in the state.

The commission monitors claims through insurer reporting of claim processing activity at various points in the life of a claim. The Surety Claims Audit function performs periodic audits of the claims processing of insurers and self-insurers in the system. Three IIC staff are assigned to the audit function. The Audit Coordinator states that in a typical year, they audit roughly 50 firms in total, both insurers and self-insurers, a statistic that varies with the size of firms audited. The number of self-insurers among these varies, but is normally in the range of 10 to 20 percent of audits. Commission audit staff state that their goal is to randomly audit several carriers from each TPA once every two years.

[16] Per NASI annual publication, 2014, for 2012 coverage year.

The commission requires that claims be adjusted by adjusters based in Idaho, though permission may be granted to issue benefit checks from out of state. Most self-insurers engage the services of third-party administrators (TPAs) to assist in claims administration; adjusters at these firms must have an Idaho adjuster's license. The IIC issues a detailed list of its compliance criteria for insurer claims administration.[17] The IIC Surety Claims Audit Coordinator states that self-insured employers are treated the same as other insurers in expectations of compliance with the statutory requirements.

The table below shows detail of the most recent full year's data (CY 2013) for Idaho SI and compared to all employers.

Measure	Self-Insurers	All Other Insured
Employers Covered	28	54639
All Claims	3047	30875
Days to file first report with IIC (mean)	28	29
Days to file first report with IIC (median)	8	9
Time Loss claims closed (excl. LS & Fatal)	351	4632
Days from Disability to 1st Payment (mean)	16	31
Days from Disability to 1st Payment (median)	13	17
Litigated claims, as % of claims filed	0.59%	1.45%
Number of claims closed	465	6732
Denied claims as % of claims filed	6.4%	5.95

Source: IIC Special Surety Stat Sheet Revised 08/18/2014

In the IIC's role of administrative agency, the audit function is relatively comprehensive in terms of the facets of claim processing that are subject to audit. The IIC audits for 27 criteria which can qualify as a finding of non-compliance with an audit. (The criteria are attached below.) In some cases a single instance qualifies for a finding of non-compliance, while in the most common instances (timely indemnity and medical payments; timely reporting to the Commission) a tolerance of some percentage is allowed. There is no overall finding of in or out of compliance. Commission staff report that, given the number of criteria, it is rare that an audit occurs where all criteria are fully in compliance, and likewise it is rare that most criteria are out of compliance. Nevertheless, with clear and consistent criteria being used, they have noted improving compliance over the last three years.

Comparative performance feedback to insurers and self-insurers provides a corrective mechanism short of audit. Annual performance reports for each carrier compare individual firm performance to that of the industry as a whole. Commission staff report that this feedback often provides sufficient impetus to improve insurer performance prior to an audit. However, if auditors find a systematic problem, they may continue an audit in order to verify that performance has in fact returned to compliance.

Interestingly, Idaho does not have the authority to levy penalties for non-compliance. Nevertheless, IIC staff noted that there are methods of leverage that may be used to achieve compliance:

- A show-cause hearing process may be invoked;
- Firms may be required to issue payments from within Idaho (ability to pay from out of state is permissive, and often preferred by multi-state TPAs and carriers);

[17] The IIC criteria for non-compliance can be found at http://iic.idaho.gov/insurance/audit_criteria.pdf.

- Firms may be required to pay benefits on a weekly basis.

As can be seen in the table above, compared to the industry as a whole, performance metrics for Idaho self-insurers look quite strong. Most measures are either similar to the industry as a whole, or better for self-insurers as a group. In some cases this would not be surprising; for example, in making first payment the self-insurer knows immediately when an injury is reported or when disability begins. Other measures, such as share of litigated claims, have no natural process advantage for self-insurers, but here too the self-insurers have lower percentage of all claims litigated (0.59% vs. 1.45% at insurers) and a similar denial rate (6.4% vs. 5.9% at insurers). Thus it appears that the Idaho program successfully achieves acceptable to excellent performance by its own standards.

Unlike Ohio, Oregon, and Washington, Idaho does not have an ombudsman function, although there is a neutral information line that injured workers may use for information about insurers' claim processing obligations. The lack of a stand-alone ombudsman function may be understandable given the much smaller size of the Idaho system, which is less than a quarter the size of Washington's in terms of covered employment, and about one-eighth that of Ohio by the same measure.

The following chart summarizes salient features of these state systems.

Self-Insurance Regulatory Approaches, by Jurisdiction								
State	SI by any qualified large employer?	Compensability adjudicated by SI	TPA permitted	SI Market share of medical-NASI	Agency role monitoring/ regulation only	Graduated Audit	Ombudsman assistance function	Dispute tracking as part of regulation
WA	Y	N*	Y*	21%	N	?	Y*	?
OR	Y	Y	Y	19%	Y	Y	Y	Y
OH	Y	Y	Y	18%	Y	Y	Y	Y
ID	Y	Y	Y	3.6%	Y	N*	N*	Y
BC	N	N	N	2%*	N	N	Y*	N

Note: * indicates partial or qualified information.

IIC Criteria to qualify as a finding of non-compliance

	Audit issue	% or Number of Events to Qualify [if there has NOT been same finding within prior 24 months]	% or Number of Events to Qualify [if same finding within prior 24 months]
1	Out-of-state adjusting	1	1
2	Checks issued out-of-state without an approved Waiver	1	1
3	Lack of immediate access to claim files by in-state claims administrator	1	1
4	Non-prompt response to IC inquiries regarding claim status	1	1
5	Non-prompt indemnity payments [28 days for initial payment and 7 days for subsequent payments]	5%	3%
	(a) Non-prompt payment due to inadequate reserves	1	1
6	CoS not sent to claimant	5%	3%
7	Untimely notice to IC of changes in in-state claims administrator for a covered employer	1	1
8	Adjusting by unauthorized personnel [non-licensed TPA examiner inclusive of NCM]	1	1
9	FROIs not of record at IC	2%	1%
10	Insufficient in-state personnel to promptly adjust claims	1	1
11	Claims adjusting correspondence not sent from in-state office	1	1
12	Non-prompt adjusting	8%	6%
13	Untimely medical payments	15%	10%
14	EOB/EOR has no local contact info	1	1
15	Interim SoPs not on file at IC	1	1
16	Untimely notification of in-state signatories/adjusters	1	1
17	FROIs not sent to IC within 10 days of receipt by surety or claims administrator	5%	3%
18	CoS sent untimely to claimant	8%	5%
19	Initial payment copy not sent to IC	10%	5%
20	CoS not copied to IC	10%	5%
21	CoS incomplete [SSN, proper surety, etc]	10%	5%
22	SoPs filed with IC after 120 days	12%	10%
23	FROIs do not contain surety and/or in-state claims administrator or mandatory elements [SSN, etc]	10%	5%
24	Hard copy documents in claim file not properly date stamped	10%	5%
25	Claims administrator does not consistently classify and identify the correct surety on claims	1	1
26	In-State adjuster does not have sufficient authority to adjust claims	1	1
27	Failure to pay benefits in accordance with Statute and Rule	1	1

**Audit criteria are used as a guideline. Auditors reserve the right to issue a finding for any one individual non-compliance issue, or as may be required for short term re-audits.*

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