Summary of Methodology

OVERVIEW

As outlined in the Introduction, the audit design involved specific questions aimed at addressing the focus areas outlined in the 2011 Washington workers' compensation reform legislation. The audit team utilized seven core research methods to address these focus areas:

1. Stakeholder and staff interviews
2. Documentation research and review
3. Review of claim files
4. Customer opinion survey
5. Best practices survey of panel of claims management experts
6. Data analysis of L&I claim data
7. Comparative data analysis of data from other jurisdictions

For the data-oriented methods (items 3, 4, 6, and 7), the general timeframe under study was 2010 – 2013. These methods are described in additional detail in Appendix 3, but we provide a brief introduction here.

1 STAKEHOLDER AND STAFF INTERVIEWS

The overall purpose of the stakeholder interviews was to gain insights about the workings of the L&I claims process. The scope of the interviews included representatives from the following groups:

- L&I personnel – management, supervisors, and front-line claim managers
- Employers and employer group managers involved in L&I's Retrospective rating program (Retro)
- L&I Retro personnel
- Non-Retro state fund employers
- Self-insured employers and TPAs
- Union representatives
- Attorneys
- Self-Insured Ombuds and Project Help management

By design, those interviewed were stakeholders who have contact with L&I through various phases and conditions of the claim process. They have much valuable information about how the process is working to advance their particular constituency's needs. Not surprisingly, the stakeholders contacted had different views of L&I because their underlying vested interests and range of experiences are different. These differing perspectives are why interviews were directed at a representative and balanced sample of experts. The team also interviewed Project Help representatives and the Self-Insurance Ombuds. Project Help is a cooperative effort between L&I and the Washington State Labor Council (AFL-CIO), designed to provide one-on-one counseling to help navigate the claims process. Project HELP provides assistance with both self-insured and state fund claims. The Self-Insurance Ombuds is a department within L&I, but managed independently from the Insurance Services Division, which is responsible for the claims management function. The Ombuds is appointed by the Governor.

2 DOCUMENTATION RESEARCH AND REVIEW

During interviews we were provided documentation and information concerning L&I performance and other relevant subjects. This was particularly true with respect to interviews of L&I personnel. The audit team also was given access to the L&I information system, which included access not only to case files, but also to reference information available to L&I personnel. Numerous written follow up questions were addressed by L&I staff, and documentation provided.

3 REVIEW OF CLAIM FILES

The audit team performed on-site review of actual claim files to analyze claim management performance and perform many of the tests required in the audit design, including testing for fairness and bias. The team utilized several approaches to reviewing files to ensure broad coverage. The audit team consisted of the two lead investigators for the project supported by two experienced claims adjusters. The audit team was trained on maneuvering through and capturing data from L&I's LINIIS and ORION information systems. LINIIS is a mainframe system that functions as the core information system used in claims management. ORION is a web-based system that displays basic claim history and actions and also stores images. There is some integration between LINIIS and ORION. L&I staff were available to answer questions as review progressed.

The review involved 500 claims, with samples from State Fund and self-insured claims. The State Fund samples included groupings of claims involving Retro and Non Retro employers. After a preliminary review of a small sample of claims, designed to validate the method and the checklist to be utilized, the team modified the checklist, and returned to L&I for additional testing in the immediate lead-up to the comprehensive file review, to finalize the checklist and prepare for training of the file-review team for maximal efficiency. The checklist that was utilized, as well as the rationale behind the sample size, is discussed in detail in Appendix 3.

It is important to note that the self-insured claim management process differs from the State Fund process in several key respects. The general difference is that third-party administrators (TPAs) are engaged by most self-insured employers to fulfill their claim management responsibilities; for State Fund claims, L&I handles this responsibility directly, within the Claims Management Section of its Insurance Services Division. For the self-insured claims, TPAs or employers themselves will apply Washington law to specific claim-related decisions, and then submit the decision for approval to the L&I Self Insurance Unit. The impact of this distinction on the file-selection and review methodology is that for self-insured claims, the audit team must rely on the documentation submitted by the TPA to analyze the rationale for the denial decision. Each TPA will use a separate information system, and utilize proprietary methods designed, for marketplace competitiveness, to ensure compliance and efficiency.

We sampled claims with total medical costs greater than $5,000. The team determined that selecting from those files for which total medical costs exceeded $5,000 was the best approach to including representative samples of the various required groups, as well as ensuring fair representation of other

factors, like "kept on salary," utilization of File Fast, and complex, medical-only claims.[1] Further description of the Claim File sampling and review methodology is provided in Appendix 3.

4 CUSTOMER OPINION SURVEY

Many questions in the audit sought information on perceptions of employers and workers, which were addressed by querying the parties directly through telephone and online surveys. The complex nature of questions posed by JLARC and the desire to compare perceptions across several subgroups, particularly by insurance status (self-insured, retro, non-retro), required surveying multiple groups and attaining sufficiently large samples of completed interviews to reveal statistically valid differences, if any, between the several groups. Survey strategies and sample size decisions were designed and calculated to reliably identify differences if they are meaningful.

For the surveys, question format and wording were critical to success. To confirm the survey questions, the team utilized "focus groups" of workers and employers. For the sample used in the survey, the dates were as follows: dates of injury equally distributed among 2011, 2012, and 2013. The distribution of claims across the three injury years and the three groups of employers were carefully monitored so that the completed surveys match the targets within each subgroup. The team selected claims with total medical cost of $5,000 or greater, for the same reasons outlined above in the description of the file-review methodology. Questions were worded, as far as practicable, to track the wording used by L&I in its prior surveys and to survey questions used in other jurisdictions to allow for comparisons.

The team surveyed injured workers and employers, using telephone and online-entry methods. Letters were mailed to the sample in advance of active outgoing calls, encouraging recipients to call or log-on and complete the survey. Letters were followed-up with post-card reminders. Callers were able to complete the survey in English or Spanish. The survey took about 15 minutes on average to complete. There were approximately 20,000 call attempts.

Exhibit M-1: Survey completion and other disposition

	Workers	Employers
Completed interviews	1,541	1,409
Refusal and mid-terminations--respondents who ended the interview before completion regardless of qualification	328	271
Respondents who do not meet the screening criteria and those respondents who would have qualified but their quota group was full	12	122
Applies to all final dispositions that do not fit any other category. For example, answering machine, wrong number, etc.	2,290	1,262
Response rate	37.2%	49.9%

Source: WorkComp Strategies

[1] "Kept on Salary" is a program that encourages employers to keep disabled employees on regular salary during periods of temporary disability, as opposed to processing a claim for temporary disability benefits. The goal of the program is to minimize financial disruption to the worker and minimize premium impacts from claims. The File Fast program is an initiative to encourage prompt, thorough reporting of workplace injuries. A "medical only" claim is one in which an injury results in medical treatment, but there is no work disability. Medical only claims are often minor in nature.

Exhibit M-2 shows the distribution of completed worker and employer responses by employer type (i.e., Retro, Non-Retro, and Self-Insured), as well as by survey instrument. The exhibit also notes that 135 of the worker responses were completed in Spanish.

Exhibit M-2: Survey completion by employer type and survey tool

	Employer Type				Survey Tool			
	State Fund: Retro	State Fund: Non-Retro	Self-Insured	**Total**	Phone	Online	**Total**	Spanish
Workers	658	454	429	**1,541**	1140	401	**1,541**	135
Employers	697	547	165	**1,409**	712	697	**1,409**	

Source: WorkComp Strategies

The completion rates met or exceeded the minimum levels that were considered necessary to establish a statistically valid sample.

5 BEST PRACTICES SURVEY

While certain practices are familiar, there is not an established set of standards for handling workers' compensation claims. To establish a benchmark for testing some of the inquiries involved in the audit, we assembled a "panel of experts" to participate in a survey, pursuant to which the participants answered general questions relating to claim management organization and performance. This panel was very helpful for informing "best practice" standards utilized for workers' compensation claims.

There were 14 respondents, all of whom had varied and lengthy careers in workers' compensation claims management; most experience was in private, non-government industry. The average professional experience for the respondents was 33 years. The survey posed 25 questions about the claim management process, including contacting parties to the claim, case workloads, investigations, allowances, denials, medical management, and vocational rehabilitation services. The survey instrument is attached to Appendix 3.

6 DATA ANALYSIS

Many of the characteristics that were analyzed in the context of claim decisions by L&I involved various aspects of timeliness. The audit design specified a number of these, which were driven by the difference between various dates available in the claim record. Where dates were in electronic files, we tested date relationships with a logic-based statistical software program. Other dates were manually collected during file reviews. The L&I database is large and complex; we were frequently assisted in better understanding the data by experts with the L&I Research and Data Services team.

6.1 LAG TIME MEASURES

For lag time measures the team looked at the distribution of lag days for each group under analysis. This included various standard measures (e.g., means, percentiles, standard deviations).

6.2 PROPORTIONS VERSUS BENCHMARKS

Some of the legal-decision questions under analysis referred to statutory measures that specified a timeliness benchmark; in such cases, the team computed the proportion of cases that met the timeliness standard and ran measures of distribution. Sometimes there was not a statutory standard, but instead the audit was designed to analyze results as compared with "best practices" or those standards that, based on the experience of the audit team, were expected. The team was flexible in utilizing those standards that are most "resonant" with stakeholders, determined through review of L&I law and policy as well as acceptable norms.

In analyzing results, the team utilized a propensity-score approach to test for differences in findings in the file review between "matched" employers (i.e., employers that are statistically comparable). The propensity scoring technique allowed for statistically robust tests of differences between the review scores between Retro/Non Retro and Self-insured/State Fund claims. The data-analytic methods are discussed in additional detail in Appendix 3.

7 COMPARATIVE DATA ANALYSIS OF DATA FROM OTHER JURISDICTIONS

For comparative analytics from other states, the team relied primarily on publicly available materials. Additionally, in terms of inter-jurisdictional experience the composition of the audit team was broad, which afforded insight into various programs across the US and Canada. The team also interviewed officials from other state workers' compensation programs, and received program information from these and other sources. One constraint in terms of inter-jurisdictional comparisons involves the unique aspects of workers' compensation programs in the US and Canada. Each jurisdiction has an individualized set of laws and regulations, resulting in difficulties in drawing strict comparisons. Moreover, Washington uses an exclusive state-fund model, meaning that, except for those employers who are self-insured, all workers' compensation insurance must be purchased from the Washington State Fund. There are many procedural and legal differences that complicate particular comparisons of jurisdictions, e.g., number of permanent total disability claims or percentage of denied claims. Thus, in structuring data comparisons consideration of these differences was essential to reaching valid results. Notwithstanding these methodological challenges, we did find a large number of meaningful measures of Washington's performance relative to other jurisdictions.