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.

[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.

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[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]

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[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.*

Revised 2/26/14

Appendix 2: Contextual Analysis and Overview of Best Practices in Disability Management of Work-Related Disability

1 INTRODUCTION

Disability Management (DM) operates within a context of law, policy and practice determined by each jurisdiction. Its performance is mediated by the social, economic and demographic milieu within the state or province. Compensation systems that excel in DM are characterized by specific practices that facilitate early, safe, and durable return-to-work outcomes for injured workers. Local economic conditions and labor force demographics may also play a role in return-to-work outcomes. Other factors that can influence outcomes include financial incentives and disincentives enabled by law, policy and practice.

Data from the analysis of Washington State's workers' compensation system indicate a departure from outcomes noted in other jurisdictions for longer term temporary disability claims. Economic and demographic factors, legal entitlements, policy and practice may each play a role in accounting for this observed difference. One should consider how these contextual features influence the duration of disability in Washington.

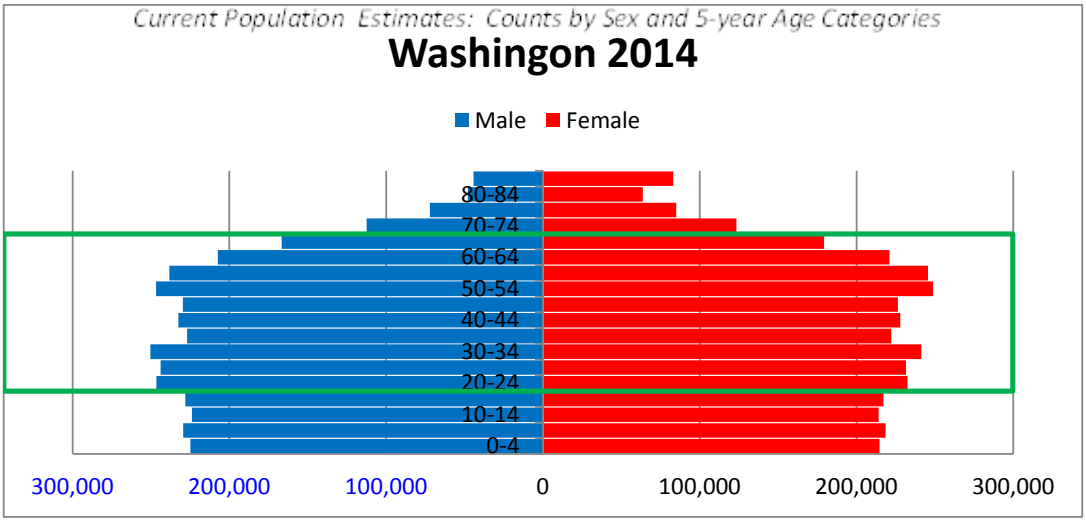
The purpose of this appendix is to establish the contextual similarities and differences between Washington State and two neighboring jurisdictions. If Washington's economic and demographic context is similar to its neighbours, factors influencing prolonged duration in Washington can justifiably be attributed to differences in law, policy and practice in the state. Finding that Washington had a significantly older demographic profile, or a relatively high unemployment profile, might explain why Washington experiences longer claim duration than its neighboring jurisdictions. In making these contextual comparisons we will not attempt to quantify exact causal relationships between the factors and disability duration. Rather, we will posit how each factor is logically related to greater or lesser disability.

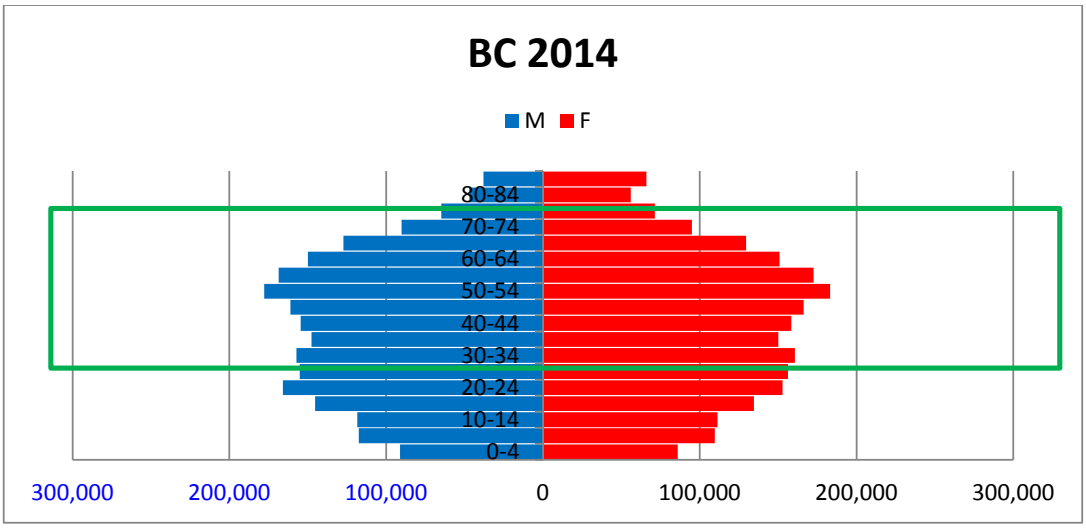
Also examined in this appendix is a comparison of administrative structure, policy and practice of governing claims management in Washington compared with Oregon and British Columbia. Differences in claims management would help explain comparatively high or low disability durations in Washington. If Washington State is broadly similar in structure, law and policy, then the search for the root causes of the difference would best be focused on practice and the general execution of the workers' compensation program. A brief examination of the law and policy relative to neighboring jurisdictions reveals some differences that may contribute to the observed differences.

After establishing contextual similarities and differences, this appendix seeks to explore the characteristics of an effective DM approaches to the issue of longer duration claims. These comments are not based solely on analysis of current practice in Washington State, but on the basis of experiences from other jurisdictions that may have application to L&I given the observed differences and particular concerns regarding longer duration claims.

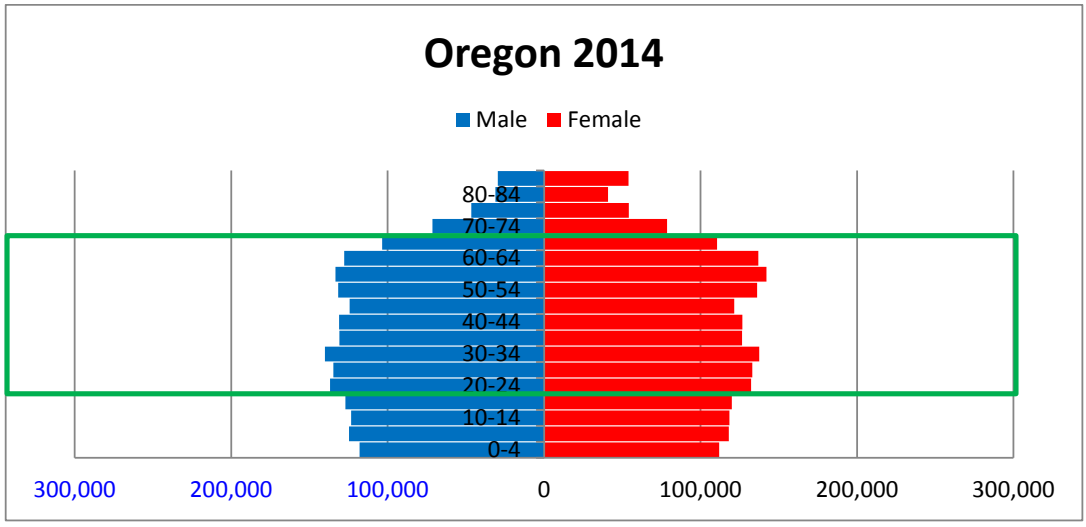
2 CONTEXTUAL ANALYSIS PART 1: DEMOGRAPHIC AND ECONOMIC ENVIRONMENT

2.1 DEMOGRAPHICS OF THE LABOR FORCE





Source: WorkComp Strategies



Source: WorkComp Strategies

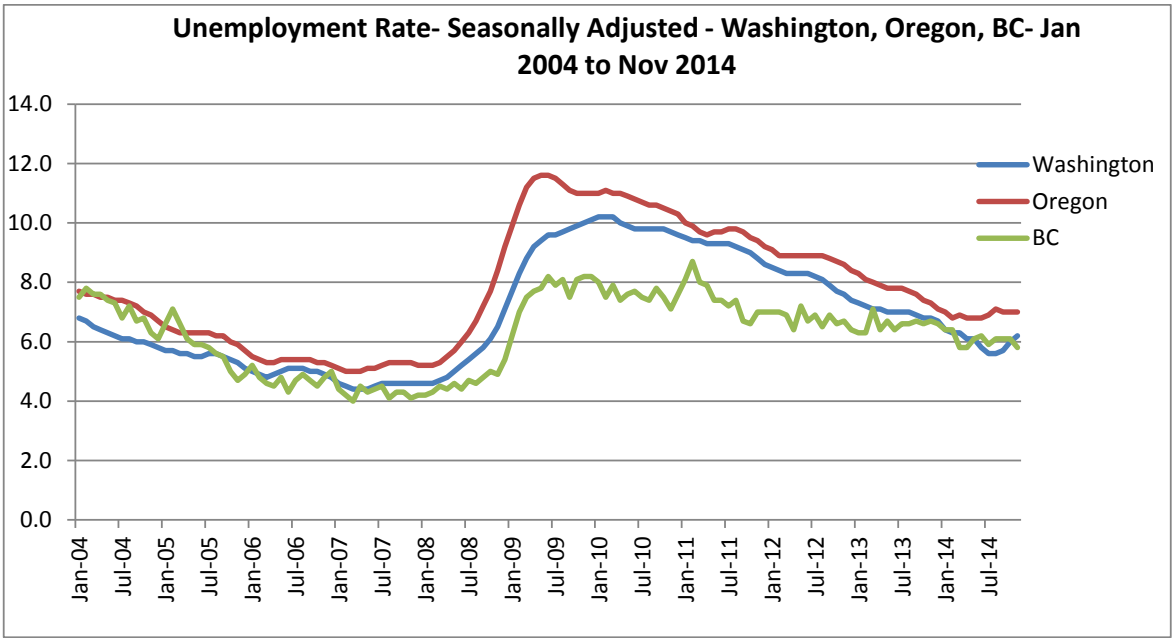
Age and gender are associated with different disability duration rates.[1] The demographic profiles of Washington, Oregon and British Columbia are broadly similar across the working age populations (boxed in green in the above population pyramids). (Source: US Census Bureau population projections and Statistics Canada data).

Workers' compensation does not operate on the whole population of working-age individuals but on the employed subset of that population. The participation rate is the number of labor force participants as a percentage of the population 15 years of age and over in Canada and 16 and over in the US. The BC participation rate is 63.6% as of November 2014 (Statistics Canada). Oregon has a participation rate of 61.4 percent in 2013 (State of Oregon Employment Department). Washington reports participation rates moderated during the recession and were at 65.6 in 2013 (Office of Financial Management 2014 Long-Term Economic and Labor Force Forecast). Thus, a relatively high percentage of the working age population are in the labor force.

Median age in Washington State was 37.4 (2013 Statista.com) while both BC and Oregon had higher median ages at 41.9 (2011 Stats Canada) and 39.1 (2013 Statista.com). Age is positively correlated with duration of recovery from injury. Average household size in all three jurisdictions was 2.5 (2011 various sources). As noted, Washington, Oregon and British Columbia have similar demographic distributions for the working-age population. The population of persons age 19 and younger in Washington State is indicative of a higher youth dependency ratio. This may have implications for family size and dependent care issues for injured workers in the working-age population, particularly in justifying differential compensation rates

Labor force participation rates and economic conditions vary moderately among the three jurisdictions, but close similarities in the economic conditions are evident in indicators such as the Unemployment Rate.

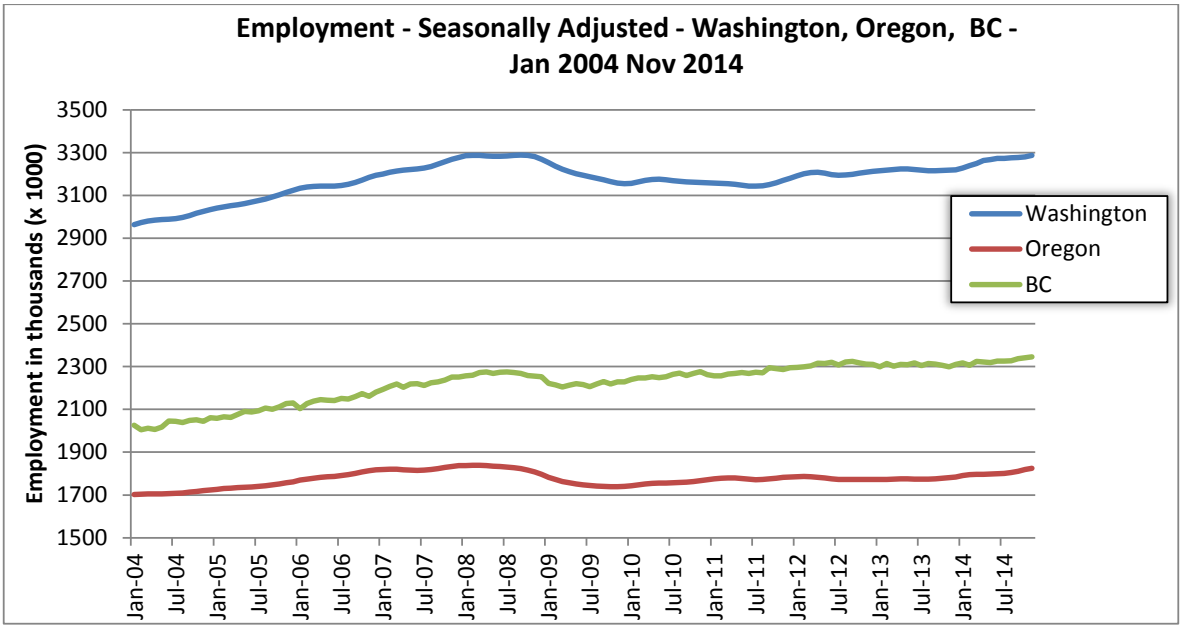
[1] For a general description of TTD duration differences see: Barry Lipton, John Robertson, and Katy Porter , Workers Compensation Temporary Total Disability Indemnity Benefit Duration—2013 Update, NCCI Research Brief, August 2013; for a statistical study of gender and age influences on TTD see: Frank Schmid, "Indemnity Benefit Duration, Maximum Weekly Benefits, and Claim Attributes," Casualty Actuarial Society E-Forum, , Winter 2011 Volume 2, available at: http://www.casact.org/pubs/forum/11wforumpt2/schmid.pdf.



Source: WorkComp Strategies

Although calculation methods differ (as evident in the "jagged" BC data line), the trends among these three jurisdictions are similar. The recession effects were felt earlier in Oregon and Washington than in BC and the magnitude of the recessionary impact on the US unemployment rates was more severe than in BC. By late 2014, however, the three jurisdictions had returned to unemployment rates prevalent in 2004.

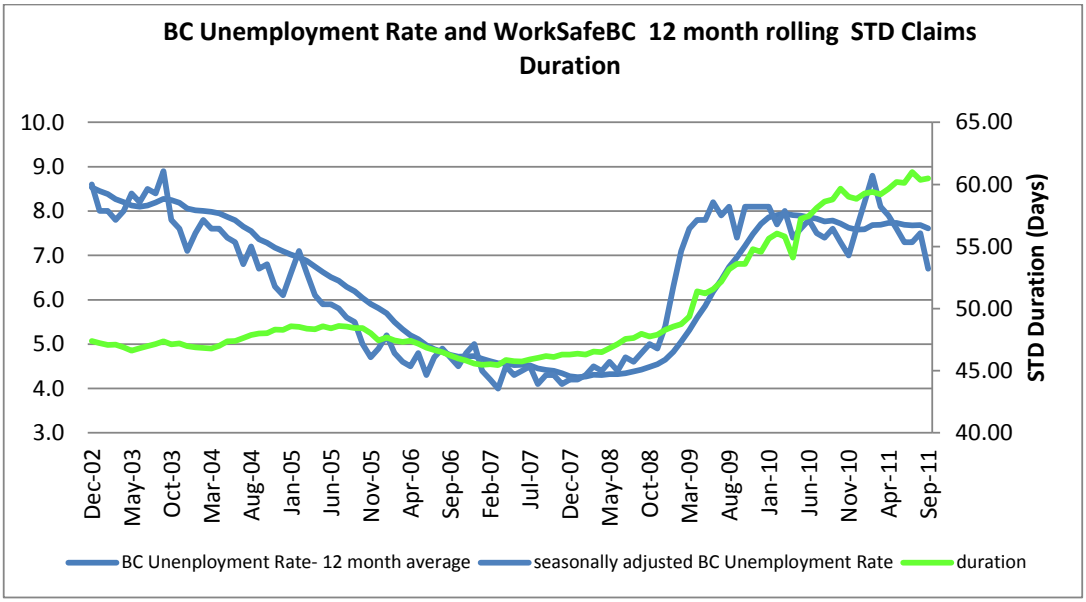
The recovery in terms of employment has been more rapid and vigorous in BC although Washington and Oregon have seen employment recover to near pre-recession levels.



Source: WorkComp Strategies

The above charts support the belief that the three jurisdictions have major demographic and economic conditions in common, as well as some differences. We do not detect any significant differences in these contextual factors that would explain why Washington State experiences a higher proportion of long-term disability cases.

The relationship between economic cycles and workers' compensation claims has been the subject of research.[2] Studies have also shown a high correlation between claim duration and rising unemployment. The BC example showed an increase in Claim Duration (days paid per claim) during the period of flattening and rising unemployment rates during the recent recession.



Source: WorkComp Strategies

The one-third increase in days paid per claim is significant. It is possible that the more severe impact of recession in Washington State may account for some of the longer-term claims' significantly longer duration but it is unlikely to account for all of that variation.

Employment and unemployment patterns in the three jurisdictions is broadly similar. Although direct comparisons are difficult because of definitional survey differences, the following table shows employment in each jurisdiction and the relative size (sorted on Washington data) of specific sectors in percentage terms.

[2] See for example: Institute for Work and Health, Issues Briefing http://www.iwh.on.ca/system/files/documents/iwh_briefing_business_cycles_2009.pdf.

BLS Data (preliminary, seasonally adjusted) in Thousands (000s)			Statistics Canada (Seasonally Adjusted) in Thousands (000s)	
Data Series	**Nov 2014**	**Nov 2014**	**Nov 2014**	
Labor Force Data	**Oregon**	**Wash**	**BC**	
Employment	1,825.1	3,287.0	2,346.0	Employment
Trade, Transportation, and Utilities	329.0	576.1	523.1	Trade, Transportation, Warehousing and Utilities
Government	298.1	551.9	114.6	Public Administration
Education & Health Services	254.8	449.8	457.6	Educational services, Health care and social assistance
Professional & Business Services	222.8	372.4	273.8	Professional, scientific, technical,business, building & other support services
Leisure & Hospitality	185.3	302.3	171.5	Accommodation and food services
Manufacturing	182.0	288.1	170.6	Manufacturing
Construction	75.8	161.3	192.2	Construction
Financial Activities	91.1	154.6	150.6	Finance, insurance, real estate and leasing
Other Services	62.5	114.5	103.2	Other Services
Information	32.9	110.0	116.3	Information, Culture and Recreation
Mining and Logging	8.0	6.4	50.0	Forestry, fishing, mining, quarrying, oil and gas
	Percentage of Employment by Sector			
	Oregon	Wash	BC	
Employment	100%	100.0%	100.0%	Employment
Trade, Transportation, and Utilities	18.0%	17.5%	22.3%	Trade, Transportation, Warehousing and Utilities
Government	16.3%	16.8%	4.9%	Public Administration
Education & Health Services	14.0%	13.7%	19.5%	Educational services, Health care and social assistance
Professional & Business Services	12.2%	11.3%	11.7%	Professional, scientific, technical,business, building & other support services
Leisure & Hospitality	10.2%	9.2%	7.3%	Accommodation and food services
Manufacturing	10.0%	8.8%	7.3%	Manufacturing
Construction	4.2%	4.9%	8.2%	Construction
Financial Activities	5.0%	4.7%	6.4%	Finance, insurance, real estate and leasing
Other Services	3.4%	3.5%	4.4%	Other Services
Information	1.8%	3.3%	5.0%	Information, Culture and Recreation
Mining and Logging	0.4%	0.2%	2.1%	Forestry, fishing, mining, quarrying, oil and gas
Employment accounted for by sectors noted	95.5%	93.9%	99.0%	

If high-risk (frequency and severity) sectors were disproportionately dominant in terms of employment in Washington State, this might be a source of extended-duration claims. The relative similarity suggests, at least in the general magnitude of sectors, the three jurisdictions have a similar mix of employment by sector. BC has a lower percentage of government (public administration) but this may be a definitional difference.

The three jurisdictions examined have broad similarities that allow for general comparisons. Observed differences in temporary claim duration seem not to be attributable to demographic or economic conditions. Differences in coverage and application of workers' compensation law are more likely to account for some of the variation in claim duration.

3 Contextual Analysis Part 2: Workers' Compensation Legislative and Administrative Environment

Washington State and its west coast neighbors have similarities in workers' compensation law and its administration.

Item	Washington	Oregon	British Columbia
Delivery of WC program	Exclusive State Fund under Labor & Industries (Department under Executive Branch)	Competitive State Fund and Private Insurers (SAIF and Liberty NorthWest have 90% of market)	Exclusive Canadian Board operating as WorkSafeBC at arm's length from government as a "statutory agency"

Item	Washington	Oregon	British Columbia
Association with OSHA function	State OSHA within Labor & Industries	No direct association at the operational level	Integrated OH&S function within WorkSafeBC
Self-insurance	Permitted with self-administration	Permitted with self-administration	Limited to historically permitted and contracted (Deposit Class employers) but no self-administration. All claims are adjudicated by WorkSafeBC
Income sources	Employer-paid premiums and Worker-paid premiums based on hours worked	Employer-paid premiums based on payroll and Worker and Employer contributions to Worker Benefit Fund based on hours worked	Employer-paid premiums and deposits (costs plus administration fees) from self-insured
Temporary Total Benefits	60% of worker's pre-injury monthly wage (plus 5% if married or in a state registered domestic partnership on DOI; 2% per dependent for up to 5-max is 75%	66 2/3% worker's pre-injury weekly wage	90% of net earnings (Essentially, "spendable" earnings: =.9*(Gross Earnings less (Fed Tax+ Prov Tax+Employment Insurance premiums + Canada Pension Plan[Social Security] contributions))
Waiting Period	3 days	3 days	0 (Temporary Disability Benefits payable from day following day of injury)
Retroactive Period	14 days	14 days	Not Applicable
Taxable status of Compensation	Not taxable	Not taxable	Not taxable
Maximum Duration of Temporary Disability	Duration of Temporary Disability	None	Duration of Temporary Disability
Employer required by WC or other statute to reinstate injured worker	No	Possibly under Home > 2013 ORS > Vol. 14 > Chapter 659A .043 (Unlawful Discrimination Against Injured Workers)	No
Vocational Rehabilitation Assistance	Limited- provided externally	Limited – provision through external providers registered with Dept. of C&BS WC Div. and through insurer-based Vocational Rehabilitation	Available to most long-term cases—provision primarily through internal Vocational Rehabilitation

Item	Washington	Oregon	British Columbia
		programs	Consultants
Access to and typical length of retraining	Restricted access but training up to the two-year cap is common	Restricted access.	Limited access based on disability and potential loss of earnings; emphasis on Training-on-the-Job and short-duration (13 week) courses.
Transition to Permanent total Disability	Temporary Disability continues until PD	Temporary Disability continues until PD	Income Continuity Benefits (not TD) may be paid and reimbursed from PD to termination of Temporary Disability
Duration of Total Permanent Disability	For life	For life	To age 65 or planned retirement or two years if after age 63
Basis of Permanent Partial Disability	Permanent partial disability benefits paid based on impairments listed in statute. Total permanent disability is based on incapacity from performing and obtaining gainful employment. Factors may include those personal to the worker, but unrelated to the work injury.	PPD based on scheduled impairments & work disability factors. Total permanent disability based on incapacity from regularly performing work at a gainful and suitable occupation. "Regularly performing" is the "ability of the worker to discharge the essential functions of the job," and "suitable" occupation is one that "the worker has the ability and the training or experience to perform, or an occupation that the worker is able to perform after rehabilitation." A "gainful" occupation is the lesser of (i) two-thirds of the worker's average weekly earnings; or (ii) federal poverty guidelines for a family of three. The worker is required to prove permanent and total disability, including that he/she made reasonable efforts to obtain employment. Benefits cease if there is RTW and post-injury earnings plus permanent and total benefit exceeds a worker's pre-injury wage	Functional Disability or, in exceptional cases, Loss of earnings (projected in the long run or deemed)

The general parameters of Washington State's workers' compensation statutes and arrangements are within the range of systems and statutes operating in its geographic area. Its structure as an exclusive state fund is similar to that of WorkSafeBC and the Canadian workers' compensation boards and commissions. Washington State and BC locate the lead agency for occupational health and safety with the lead agency for workers' compensation. Differences in insurance arrangements (exclusive state fund, competitive markets with state funds and private insurance markets) have not been associated with significant differences in claim duration or employer cost.

One key difference among the jurisdictions is the compensation rate for temporary disability. The compensation rate structure in Washington State is unique in its range from 60% to 75% of gross depending on the family composition of the claimant. This is very different from the 90% of net (spendable) income that applies in BC or the 66 2/3rds % that applies to temporary disability cases in Oregon.

Washington also differs from BC and Oregon in that it does not have a state (or provincial) income tax. The impact of this difference creates a gradient in the population of compensation recipients such that workers with larger families and earnings receive a greater percentage of spendable income while on compensation than compensation recipients in either BC or Oregon. Increasing compensation rates have been associated with increased claim duration Butler and Worrall[3], but the scholarly literature on this subject is complex and often contradictory.[4]. There are no data available on the breakdown of claimants by compensation rate structure or how the proportion of workers in each compensation rate category might differ between shorter and longer term claims.

The following table uses income levels from the Bureau of Labor Statistics (BLS) for May 2013 at the $10^{th,}$ 25^{th}, Median, and 75^{th} percentiles for various taxation categories as they would have been on May 31, 2013. Deductions for single and married status were calculated by the freely available Paycheckcity.com online application. The compensation rate for single claimants at 60% and married claimants at 65% are shown and the percent of spendable income represented by that calculation is highlighted. Alternative compensation rates from other jurisdictions are also simulated.

[3] Butler and Worrall, Claims Reporting and Risk Bearing Moral Hazard in Workers' Compensation, *Journal of Risk and Insurance*, 1991.

[4] See Ronald Ehrenburg, Workers' Compensation Wage and Risk of Injury (chapter 4) in John Burton, editor, New Perspectives in Workers' Compensation, 1988, found at: https://books.google.com/books?id=HBmgSLMT55EC&pg=PA77&lpg=PA77&dq=workers+compensation+higher+benefits+increasing+duration+of+disability&source=bl&ots=NqpqIzNwMo&sig=D_IKPL4U--kppg7TOm3d6iuQRCE&hl=en&sa=X&ei=DEA8VdDJJcayggT4tYCQBA&ved=0CDUQ6AEwAw#v=onepage&q=workers%20compensation%20higher%20benefits%20increasing%20duration%20of%20disability&f=false

Washington								
OCC_CODE	OCC_TITLE	OCC_GROU	TOT_EMP	A_PCT10	A_PCT25	A_MEDIAN	A_PCT75	A_PCT90
00-0000	All Occupa	total	2,827,200	20,550	26,920	40,910	66,120	97,080
Single								
	weekly			$ 395.19	$ 517.69	$ 786.73	$ 1,271.54	$ 1,866.92
	Fed			$ 44.35	$ 62.73	$ 107.81	$ 229.01	$ 381.92
	SS			$ 24.50	$ 32.10	$ 48.78	$ 78.84	$ 115.75
	Med			$ 5.73	$ 7.51	$ 11.10	$ 18.44	$ 27.07
	State			$ -	$ -	$ -	$ -	$ -
	WC/IN/SDI			$ 13.72	$ 13.72	$ 13.72	$ 13.72	$ 13.72
	Net/spendable			$ 306.89	$ 401.63	$ 605.32	$ 931.53	$ 1,328.46
	60% gross			$ 237.11	$ 310.61	$ 472.04	$ 762.92	$ 1,120.15
	66.67 gross			$ 263.46	$ 345.13	$ 524.49	$ 847.69	$ 1,244.61
	80% Net			$ 245.51	$ 321.30	$ 484.26	$ 745.22	$ 1,062.77
	90% Net			$ 276.20	$ 361.47	$ 544.79	$ 838.38	$ 1,195.61
	60% gross/spendable			77%	77%	78%	82%	84%
	66.67% gross/spendable			86%	86%	87%	91%	94%
	75% gross/spendable			97%	97%	97%	102%	105%
Married								
	weekly			$ 395.19	$ 517.69	$ 786.73	$ 1,271.54	$ 1,866.92
	Fed			$ 23.56	$ 32.65	$ 76.90	$ 149.63	$ 270.24
	SS			$ 24.50	$ 32.10	$ 48.78	$ 78.84	$ 115.75
	Med			$ 5.73	$ 7.51	$ 11.41	$ 18.44	$ 27.07
	State			$ -				$ -
	WC			$ 13.72	$ 13.72	$ 13.72	$ 13.72	$ 13.72
	Net/spendable			$ 327.68	$ 431.71	$ 635.92	$ 1,010.91	$ 1,440.14
	65% Gross			$ 256.87	$ 336.50	$ 511.37	$ 826.50	$ 1,213.50
	66.67 gross			$ 263.46	$ 345.13	$ 524.49	$ 847.69	$ 1,244.61
	80% Net			$ 262.14	$ 345.37	$ 508.74	$ 808.73	$ 1,152.11
	90% Net			$ 294.91	$ 388.54	$ 572.33	$ 909.82	$ 1,296.13
	65% gross/Spendable			78%	78%	80%	82%	84%
	66.67% gross/spendable			80%	80%	82%	84%	86%
	75% gross/spendable			90%	90%	93%	94%	97%

Source: computations by Terry Bogyo for WorkComp Strategies

BC's compensation rate is 90% of Net (spendable earnings). By this comparison, certain compensation rate classes will have higher compensation in Washington State. Larger families with median to higher incomes will likely receive a greater percentage of spendable earnings than single status claimants and those with lower incomes.

Oregon's compensation rate is 66 2/3rds percent of gross. Because of the state income tax, percentage of spendable income also varies. Using a similar methodology, the Oregon compensation rate as a percentage of spendable was calculated as follows:

OCC_CODE	OCC_TITLE	OCC_GROU	TOT_EMP	A_PCT10	A_PCT25	A_MEDIAN	A_PCT75
00-0000	All Occupa	total	1,640,300	19,500	24,020	35,850	55,980
Single							
	weekly			$ 375.00	$ 461.92	$ 689.42	$ 1,076.54
	Fed			$ 41.32	$ 54.36	$ 88.49	$ 180.26
	SS			$ 23.25	$ 28.64	$ 42.74	$ 66.75
	Med			$ 5.44	$ 6.70	$ 10.00	$ 15.61
	State			$ 26.00	$ 32.00	$ 50.00	$ 78.00
	WC			$ 0.64	$ 0.64	$ 0.64	$ 0.64
	Net/spendable			$ 278.35	$ 339.58	$ 497.55	$ 735.28
	66.67 gross			$ 250.00	$ 307.95	$ 459.61	$ 717.69
	80% Net			$ 222.68	$ 271.66	$ 398.04	$ 588.22
	90% Net			$ 250.52	$ 305.62	$ 447.80	$ 661.75
	66.67% gross/spendable			90%	91%	92%	98%
Married							
	weekly			$ 375.00	$ 461.92	$ 689.42	$ 1,076.54
	Fed			$ 21.54	$ 30.23	$ 62.31	$ 120.38
	SS			$ 23.25	$ 28.64	$ 42.74	$ 66.75
	Med			$ 5.44	$ 6.70	$ 10.00	$ 15.61
	State			$ 27.00	$ 34.00	$ 52.00	$ 78.00
	WC			$ 0.64	$ 0.64	$ 0.64	$ 0.64
	Net/spendable			$ 297.13	$ 361.71	$ 521.73	$ 795.16
	66.67 gross			$ 250.00	$ 307.95	$ 459.61	$ 717.69
	80% Net			$ 237.70	$ 289.37	$ 417.38	$ 636.13
	90% Net			$ 267.42	$ 325.54	$ 469.56	$ 715.64
	66.67% gross/spendable			84%	85%	88%	90%

Both Washington and Oregon have gradients in the calculated percentage of spendable earnings provided by the compensation rate. With the exception of some higher wage earners compensated at the 75% rate in Washington State, it is unlikely that differences in the rate of compensation among the three jurisdictions can account for the longer durations observed in Washington.

A central issue in the Washington system is the meaning of "employable." The statute and case law create a hurdle for L&I to declare that disability has ended at MMI and a claim can be closed (after PPD payment if applicable). Below is the governing statute in Washington:

RCW 51.32.090(3)(a) provides in pertinent part as follows: "As soon as recovery is so complete that the present earning power of the worker, at any kind of work, is restored to that existing at the time of the occurrence of the injury, the payments shall cease."

L&I has interpreted[5] this provision as follows:

[5] The excerpt was from the L&I Self-Insured Claims Adjudication Manual, pp. 52-53.

Once the payment of time-loss benefits has begun, the benefits must be continued until one of the following occurs:

- Released for Full Duty - When a worker is given a full release to the job of injury, time- loss benefits may be terminated. Note: If a worker is released for work on the same day they see their provider, time-loss is payable through the end of that day (i.e. worker has an appointment with their provider on January 17th, at the appointment the provider signs a release for work as of January 17th, the same day as their appointment, the worker is eligible for time-loss through the 17th).
- Found Employable – When a vocational assessment is conducted and a worker is determined to be employable, time-loss may be terminated after the determination of employability is made.
- Returns to Work – When a worker returns to work, they are not eligible for time-loss benefits. If the worker's earning capacity has decreased as a result of the injury or occupational disease they may be entitled to loss of earning power benefits until claim closure.

Case law interpretations of this standard include the following:

> A worker who has sustained a loss of earning power as the result of an industrial injury is entitled to loss of earning power compensation until the date on which the Department issues an order fixing the extent of his permanent partial disability. Thus, before temporary total or temporary partial disability compensation can be legally terminated on the basis that the worker's condition is fixed, the Department must first formally change the classification of the worker's disability from temporary to permanent. . . . Once the Department acted to classify [a] condition as fixed and permanent [as of a specific date] . . . loss of earning power compensation cannot be paid beyond that date." In Re: Weston, Claim No. J-506937 (Dec. 30, 1987).

The legal context for considering issues of employability dictates how Case Managers (CMs) must process claims. The following is a synopsis of how a claims supervisor characterizes the duties of a CM:

> If the doctor has not released the worker to the job of injury the CM has a responsibility to determine whether the worker can return to work before stopping time loss and closing the claim - it can be either the job of injury or a vocational evaluation to determine whether the worker has skills from prior employment that would make him/her able to work. If the injured worker is not rehired after injury (employer of injury or other) and if they do not have an unrestricted return to work from their doctor, then L&I must determine if they have "transferable job skills" that would enable them to find gainful employment.

This is a significant policy difference from most US states. Barth and Hunt in their 2010 report to L&I: "In many, if not most jurisdictions, MMI [Maximal Medical Improvement] alone is grounds for terminating temporary disability benefits." That said, the majority of workers' compensation cases return to work with their accident employers before MMI or a "medical plateau" is achieved. The determination of when MMI is reached is only significant in claims that have not returned to work before MMI is reached. The decision to terminate compensation then rests on the issue of "employability."

It is a matter of some disagreement between employers and labor advocates in Washington State as to whether the way "employability" is assessed in Washington is fair and reasonable. Some feel that

identifying that the person can get a common job making minimum wage (e.g., fast food, retail, delivery, customer service) satisfies the test. Others feel that employability must take into consideration the personal limitations of the worker that may have pre-existed the injury, e.g., prison record, substance abuse, extensive tattoos/body piercing. Below is the position of the State Labor Council:

> The problem is this: L&I adopted a standard in 1985 that defined "employability" or "able to work" as the ability to work at a job that pays at least the federal minimum wage. Since 1985, about 75,000 workers injured so severely that they could not return to their job of injury have been found "employable." Their benefits have been terminated and they have been left, in many cases, either unemployed or working at jobs with substantially less income than their wage at the time they were injured. They have received no vocational training, as they are ineligible once they are found "employable" at federal minimum wage. Workers who have spent years developing their skills are told they can be employed at a minimum wage job, regardless of what they were earning at the time they were injured. (State Labor Council, 2009, available as of Jan 2015 at http://www.wslc.org/legix/workcomp.htm)

A large WC law firm describes Washington law this way:

> This assessment is the gateway to retraining services, and the door is just barely ajar. Because of what is commonly called the “employability standard,” very few injured workers are provided the full benefit of vocational plan development and retraining services. If a worker is able to obtain and perform reasonable continuous gainful employment, paying at least minimum wage, they are “employable” and not eligible for further vocational services or retraining. This is a very low threshold for employability. An injured worker will only be found eligible for further vocational services if, in the sole discretion of the Director, vocational rehabilitation is both necessary and likely to enable the injured worker to become employable at gainful employment.

Source: Welch and Condon

BC traditionally has seen a little less than 5% of timeloss claims or about 3000 per year referred to Vocational Rehabilitation services (VRS) for assistance in return-to-work. Importantly, VRS is primarily an *internal* service of WorkSafeBC and referral may include counselling, an initial vocational assessment, and assistance in RTW. The referral generally takes place when it becomes clear RTW to the accident employer is unlikely. That determination is typically made no later than 12 weeks (3 months) and initial vocational assessments are typically completed within six months of the day of injury.

An internal referral using WorkSafeBC’s Case Management System (CMS) workflow tools is quick. Cases are usually seen within days and, because VR consultants have levels of expenditure authority, they can commence the VR plan immediately without additional approvals. This provides a shortened time-frame from identification to implementation of a Vocational Rehabilitation Plan.

It is instructive to compare the BC legislation regarding temporary disability to that of Washington State. There are two sections in the BC *Workers Compensation Act* (WCA) that cover Temporary Disability. Here they are:

> Temporary total disability

29 (1) Subject to sections 34 (1) and 35 (1), (4) and (5), if a temporary total disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment that equals 90% of the worker's average net earnings.

(2) The compensation awarded under this section must not be less than an amount equal to $374.56 per week, unless the worker's average earnings are less than that sum per week, in which case the worker must receive compensation in an amount equal to the worker's average earnings.

Temporary partial disability

30 (1) Subject to sections 34 (1) and 35 (1), (4) and (5), if a temporary partial disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment that equals 90% of the difference between

(a) the worker's average net earnings before the injury, and

(b) whichever of the following amounts the Board considers better represents the worker's loss of earnings:

(i) the average net earnings that the worker is earning after the injury;

(ii) the average net earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury.

(2) Where temporary partial disability results from the injury, the minimum compensation awarded under this section must be calculated in the same manner as prescribed by section 29 (2) for temporary total disability but to the extent only of the partial disability.

Despite the legislative language differences, the determination of “employability in British Columbia has similarities to Washington State.” “Employability Assessments” can be requested for cases of temporary disability (Section 30 WCA) as well as for cases of permanent disability (Section 23(3) WCA). With respect to temporary disability cases the *Rehabilitation Services and Claims Manual Volume II* (RSCM II) in policy C11-89 states:

> Documented objective evidence of what the worker is earning or is capable of earning is provided to the Board, who makes the decision on a worker’s entitlement under section 30.
>
> In determining section 30 benefits, the employment opportunity or opportunities should be available immediately or within the period under review (two weeks, one month) and there should be some certainty that workers would have these opportunities open to them should they choose to apply.

With respect to permanent disability cases, the same policy goes on to state:

> In exceptional cases, a worker's entitlement to a permanent partial disability award may be assessed under the method set out in section 23(3) of the Act. This method requires an employability assessment.

> The goal is to identify suitable occupations, along with estimated earnings, that maximize the worker's long-term earning capacity up to the pre-injury wage rate. In most cases, "long-term" refers to three to five years.
>
> The employability assessment process is conducted in light of all possible rehabilitation measures that may be of assistance and appropriate to the circumstances of each worker. The rehabilitation plan may form the basis for the employability assessment. A functional capacity evaluation may be used to assess the worker's capacity for work. This provides information on the worker's residual maximum functional capabilities, confirmation of identified alternative job options and plans for vocational reintegration.
>
> Labour market data in conjunction with the objective functional capacity information is used to create a residual vocational profile. A list of suitable occupations based on the profile is then produced. Consideration is then given to whether these occupations are reasonably available.

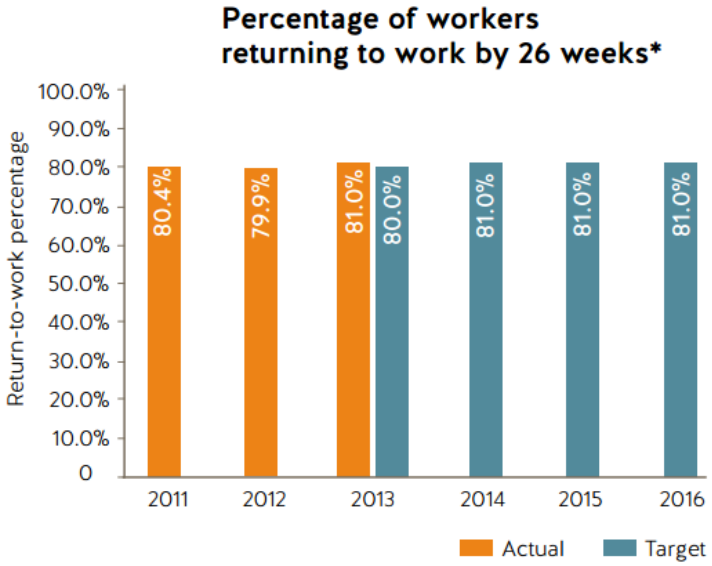
Significantly, WorkSafeBC vocational rehabilitation practices focus on direct placement, training on the job and brief retraining (typically under 13 weeks, occasionally up to 26 weeks and infrequently longer) to achieve RTW. The employability assessment is typically based on the assumption that these programs will be effective and the termination of temporary disability compensation with the commencement of any permanent disability compensation can be made at that time. (See WorkSafeBC Practice Directive#C11-3.)

It should be noted that permanent partial disability awards based on loss of earnings are only granted in cases that are "so exceptional" as to make the typical "disability award" inadequate. BC is a "disability" rather than "impairment" jurisdiction so the degree or percentage of disability is presumed to compensate for the assumed loss of earnings associated with the functional loss. The determination of "so exceptional" has been controversial in BC but has substantially reduced the number of cases that receive compensation under a loss of earnings. Permanent total compensation as it would apply in other jurisdictions is limited to very severe functional impairment such as total blindness, bilateral amputations, and quadriplegia. These cases are considered 100% disabled and granted Permanent Disability of 100% (the equivalent of what Washington State would term Permanent Total Disability) even if they return to work. In cases where the impact of the disability is so exceptional as to make RTW unlikely in the long run as determined by an employability assessment, the worker may receive what amounts to permanent total disability. Such cases may include, for example, Post-traumatic Stress disorders where the physical functional impairment may be lesser than the impact on employability.

These practice differences are significant and may influence the "expected value" of certain outcomes in BC and Washington state. The lower incidence of "Permanent total" disability cases in BC infers greater success in ameliorating the impact of a loss of function and achieving RTW either directly or through short-term training.

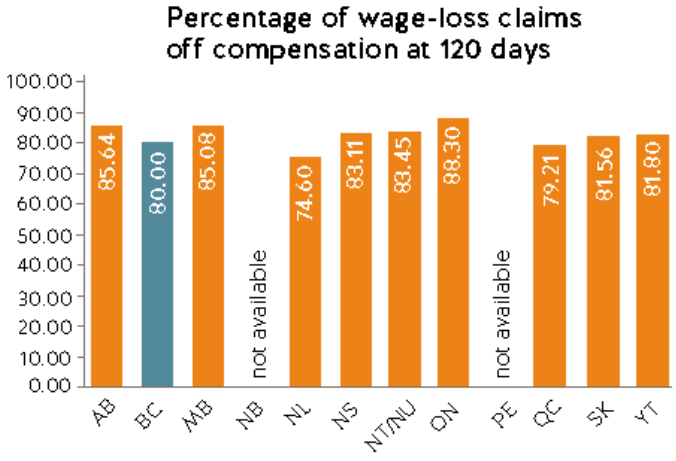
Public performance measures on return to work outcomes are not available for Oregon or Washington but WorkSafeBC has published a key performance measure/indicator on this outcome. The measure reflects the effectiveness of the Disability Management interventions and differs from measure of duration that depend solely on claim status (such as "claimant off benefits" or "claim terminated" regardless of reason). Publication of performance measurements have been shown to improve accountability and result in changes. WorkSafeBC publishes past performance and future targets in its Annual Report and Service Plan (AR&SP). The following chart is from the 2013 edition.

Key objective/performance indicator #2: Improve return-to-work outcomes



*Prior-year results have been updated as a result of continuous data refresh. Current-year results are based on a refined calculation methodology. In 2012, we tracked successful return-to-work by 26 weeks as a percentage of concluded wage-loss claims within the calendar year. For 2013, we refined this metric to track the percentage of concluded wage-loss claims within the calendar year, plus current-year wage-loss claims open more than 26 weeks.[25]

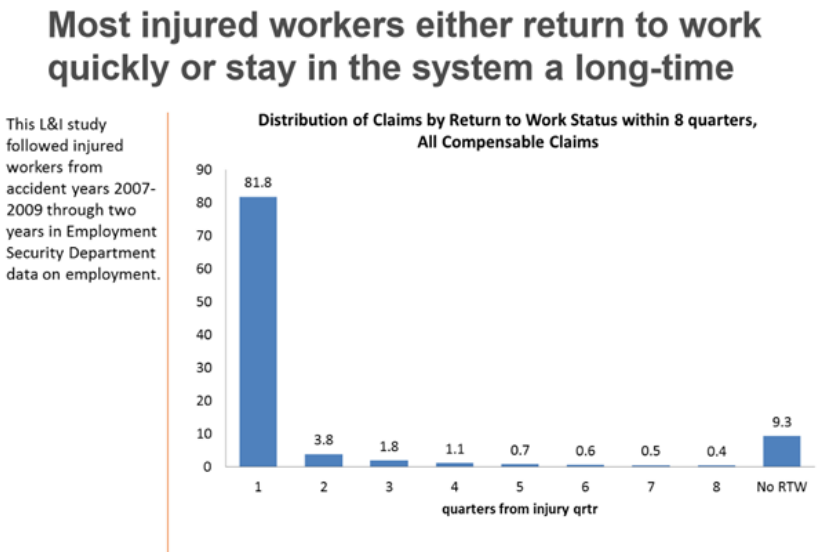
Data are published in Canada for other jurisdictions using 120 calendar days as a measure.



Source: AWCBC Key Statistical Measures 2012

https://apc.awcbc.org/KsmReporting/ReportReview/0?tempdatakey=ac996ebd-820e-4ef4-ac3c-caadf1d3c960

By the standard of these comparisons, Washington does a good job of getting the vast majority of injured workers back on the job quickly. Where the system departs from others is at the point where there are barriers to RTW particularly with the accident employer to the accident occupation.



Source: Kirsta Glenn presentation to WCAC

For the "failures" of the RTW system in the short term, WorkSafeBC refers cases to Vocational Rehabilitation Services, an internal program. The goal is to take the cases that have not returned to work through the regular process and return them to employment.

The stated goal as published in the 2013 Annual Report and Service Plan is:

> Improve return-to-work outcomes for workers in vocational rehabilitation (percentage of vocational rehabilitation clients who successfully return to work). The program receives approximately 3000 claims per year or about 5% of the claim volume. About 48% of cases return to work with new employers or enter self-employment with the assistance of the VR program.

Differences in the compensation for permanent disability are significant between BC and Washington. Previous work by Hunt, Harder, and others have highlighted these differences but it is important to note that both jurisdictions are faced with similar economic and workforce environments for these serious cases. One important difference is the introduction of an end date for permanent disability awards in BC. The "age 65" or planned retirement provision limits the size of the potential permanent disability award. This may have implications for the incentives that operate on the injured worker and may impact the effectiveness of disability management initiatives.

In Washington and BC compensation recipients receive an automatic cost of living increases. In BC, however, the rate is moderate and capped (cost of living= National CPI less 1% with a Cap of 4% and floor of 0%). As a result, some workers, particularly workers with little earning potential, receive from a

pension an income stream that exceeds or is comparable to their lifetime earning potential in Washington State.

Oregon appears to have some legislative requirements for the reinstatement of injured workers. Workers' compensation legislation in BC and Washington State do not contain specific requirements for mandatory reinstatement. Other legislation, collective agreements, and other regulations may, however, provide similar impetus for employers to accommodate injured workers. The *Americans with Disabilities Act* establishes obligations for covered employers to rehire injured workers with permanent disabilities.

All three jurisdictions can provide some rehabilitation services. WorkSafeBC appears to have the most direct involvement in the delivery of vocational rehabilitation services. Washington makes some use of state counselors, especially to facilitate early return to work. But all retraining plans would be written and implemented by private counselors.

Despite these differences, the statutory parameters of disability indemnification in the three jurisdictions are similar. A recent analysis of the temporary disability compensation recommendations of the 1972 National Commission on State Workmen's Compensation Laws found Oregon, Washington and BC to be in a group of states and provinces with the most compliance with the recommendations (Bogyo, *Does compliance with the National Commission's Temporary Disability Compensation Recommendations matter?*, www.*WorkersCompPerspectives.blogspot.com* , January 2015). This finding supports the general equivalency and therefore comparability of the compensation for temporary disability in these jurisdictions.

It is more likely that the root causes of the observed variation in long-term claim duration are a function of specific differences in the interpretation and application of law, policy and practice in the claims management of longer term claims than in the administrative structure of the insurance mechanism or the general level of compensation prescribed by statute.

4 DISABILITY MANAGEMENT: INITIATIVES THAT MAY ADDRESS LONGER DURATION CLAIMS

The United Nations specialized agency, the *International Labour Organization* (ILO), defines "Disability Management" (DM) as:

> A process in the workplace designed to facilitate the employment and reintegration of persons with a disability through a coordinated effort and taking into account individual needs, work environment, enterprise needs and legal responsibilities.

From the definition it is clear that DM is primarily a workplace issue. Disability Management fundamentals are focused on policies adopted by employers and the condition of the employer-employee relationship. Firms with fully developed DM programs in place have a complete range of programs, policies and services that support workers through the prevention of injury and disability, accommodation and support during recovery and active assistance in the return-to-work/stay-at-work stage. DM professionals such as certified Return-to-Work Coordinators are common in larger organizations. External resources used by successful firms include Certified Rehabilitation Counselor,

Certified Vocational Evaluation Specialist, Certified Work Adjustment Specialist, Certified Career Assessment Associate, Occupational Therapists and Vocational Rehabilitation Consultants.

Disability Management at the insurer level supports the DM fundamentals that should already be present in the organization's human resource policies. Disability and workers' compensation insurers may employ professionals such as Return-to-Work Nurse Advisors, Vocational Rehabilitation Consultants, Certified Rehabilitation Counselors and other internal and external resources to implement their DM programs.

Workers' compensation systems that integrate the DM model into their philosophy operate by providing, (among other things) the following:

- Setting expectations: Key messages relate to expected recovery paths and timelines, work as therapeutic, RTW as the usual and desired outcome [usually well before Maximal Medical Improvement].
- Ensuring [preferably direct but often indirect] three-point contact (worker, employer, treating physician)
- Supported contact between injured worker and accident employer: Often supported by specific legislation or rule concerning reinstatement following injury.
- Early identification and timely intervention: Key innovations involve use of data and predictive analytics to flag issues that indicate issues that my prevent RTW and the shortening of referral, review and approval stages of RTW and VR plans.
- Barrier identification and amelioration: Key innovations relate to regular and iterative identification of barriers and actions to overcome them.
- Early, safe and durable return to work support: Key innovations provide policy support of work as therapeutic. These include the use of graduated RTW, supernumerary and work-trial situations that are fully supported by wage-loss compensation equivalents or employer funding.
- Adoption [either explicitly or implicitly] of the ACOEM guidelines: Key innovations include adoption of the classification of absence from work as "Medically necessary", "Medically discretionary" and "Medically unnecessary".
- Providing special assistance to workers with co-morbidities or psycho-social overlays that restrict their employability.

Every jurisdiction selects strategies and initiatives to address the challenges specific to that jurisdiction. It is inappropriate to simply take a successful DM program from one jurisdiction and apply it to another with the expectation that it will deliver equivalent results. That said, the experiences of one jurisdiction may be an opportunity to examine the possible design and application of a similar program to address specific challenges.

One example of an effective program in the Oregon context is the "Preferred Worker" program. This program addresses a potential barrier to employment of an injured worker and provides an incentive to an employer to employ an injured worker. Washington has adopted and adapted this program. Oregon research and data support the effectiveness of this program. It is not clear that similar research and evaluation in WA has been carried out or that the impact of the program has been equally positive. In 2015 L&I proposed enhancements to the Preferred Worker Program, and as of April 2015 the Washington State Legislature approved the proposal. L&I reports that for the Stay at Work Program, actuarial estimates are that for every $1 spent on the program, $2.40 is saved in disability costs.

WorkSafeBC highlights the following programs and initiatives as being critical to achieving its targets for return to work (from 2012 and 2013 AR&SP):

- Providing dedicated return-to-work support for the construction sector — Under the Return-to-Work (RTW) to Construction program a construction RTW nurse contacts both the injured worker and employer to explore stay-at-work options upon registration, even before adjudication has taken place.
- Participation in industry groups — Made up of representatives from industry and WorkSafeBC, the Construction Claims Management Action committee is exploring and implementing innovative RTW programs for the construction industry. The committee's goal is to improve the industry's return-to-work outcomes.
- Facilitating RTW through dedicated teams embedded within health care — Teams work with authorities in the health care sector across B.C. to provide expertise and guidance in return-to-work practices and streamlined case management, facilitating earlier return to work.
- Delivering innovative RTW models — Return-to-Work Services was created to improve the customer experience and RTW outcomes for workers with musculoskeletal injury (MSI) claims. The team is staffed by nurses with clinical and return-to-work expertise. They have decision-making authority and ownership over claims related to MSI injuries. Since its establishment in 2012, RTW Services has achieved:
    - Faster return to work for those with MSI injuries, improving RTW by 1.7 days
    - $2.2 million reduction in wage-loss equivalency payments
    - 20 percent reduction in the volume of claims directed to case managers
- Delivering a series of clinical programs — RTW Services has delivered a series of clinical programs, customized to more quickly meet the individual needs of workers. This has helped to further reduce wait times for claim processing.
- Expanding return-to-work services — The role of WorkSafeBC nurses was expanded to enable them to more effectively facilitate return to work for injured workers. WorkSafeBC nurses (now return-to-work specialists) became claim owners, and decision makers for select claims, applying early-intervention methodology. Early results have yielded positive program outcomes.
- Delivering clinical programs — A series of programs, customized to more quickly meet the individual needs of workers, continued helping reduce wait times for claim processing.

Washington State relies mainly on external providers with professional internal staff (Vocational Services Specialists) who consult with claims managers and monitor or approve vocational rehabilitation plans. In addition to private counselors, Washington uses state employees in its Early Return to Work Program, and, since 2008, has also added state counselors located in various WorkSource office locations in the regional offices. Oregon insurers may engage their own VR staff but there is an established provider community of registered private providers in the state. Setting expectations and monitoring performance is essential. Washington has instituted key performance indicators for private counselors and encourages CMs to choose counselors based on measured performance.

The delivery of vocational rehabilitation in BC is primarily by WorkSafeBC employees (Vocational Rehabilitation Consultants or VRC). Key to the success of this program is the authority levels for expenditures and approval of plans initiated by these employees. Most typical cases can be referred to a VRC, receive and initial vocational assessment and have a vocational rehabilitation plan developed and implemented without reference to a superior for approval (although all cases are subject to clinical supervision internally). This process eliminates wait times for approvals and reviews. This is critical to achieving timely delivery of services. More complex, expensive and extensive vocational rehabilitation

plans are subject to progressively higher levels of review and approval. This process tends to put the emphasis on shorter duration, job oriented interventions including on-the-job training, short skills-based training programs and facilitated work trials (with wage-loss equivalent support).

Ontario's workers' compensation insurer, WSIB, had a model similar to the Washington system between 1999 and 2009. The Labour Market Re-entry Program was delivered by private vocational rehabilitation providers subject to approvals and oversight by WSIB staff. Lengthy referral times and approval times were identified as barriers to the effectiveness of the program. Despite legislative requirements in Ontario for mandatory reinstatement, long-duration claims without accident employer accommodation were often referred to this program and eventually underwent long training programs that did not result in a high proportion of successful return to work outcomes. WSIB has decided to conclude that program and bring the professional expertise into the WSIB to better support employers in returning their injured workers and to improve the efficiency of provision of VR services to those who can't.

Ontario has another feature in their plan that encourages accident employers to reinstate their injured workers. If an accident employer cannot provide an appropriate reinstatement, the cost of VR to provide the worker with an alternative is passed through as a surcharge to the accident employer.

A related no-fault compensation scheme is the Transport Accident Commission (TAC) in Victoria, Australia. It provides wage compensation on a no-fault basis to injury claimants from motor vehicle collisions. The TAC automated claims management system includes mandatory fields for client service representatives to specify at each contact the barriers to return-to-work and the actions being taken to overcome them. This is a unique innovation in Disability Management that may have application to other systems.

The conceptualization of impairment and disability has changed over time and this has had an impact on the way DM operates. The American College of Occupational & Environmental Medicine (ACOEM) published its guideline on work disability in its 2007 report *Preventing Needless Work Disability by Helping People Stay Employed*. That report contains the following table:

TABLE 4
When is a Disability Medically Required, Medically Discretionary, or Medically Unnecessary?

Medically Required	Medically Discretionary	Medically Unnecessary
Absence is medically required when: • Attendance is required at a place of care (hospital, physician's office, physical therapy) • Recovery (or quarantine) requires confinement to bed or home • Being in the workplace or traveling to work is medically contraindicated (poses a specific hazard to the public, coworkers, or to the worker personally, ie, risks damage to tissues or delays healing)	Medically discretionary disability is time away from work at the discretion of a patient or employer that is: • Associated with a diagnosable medical condition that may have created some functional impairment but left other functional abilities still intact. • Most commonly due to a patient's or employer's decision not to make the extra effort required to find a way for the patient to stay at work during illness or recovery	Medically unnecessary disability occurs whenever a person stays away from work because of non-medical issues such as: • The perception that a diagnosis alone (without demonstrable functional impairment) justifies work absence • Other problems that masquerade as medical issues, eg, job dissatisfaction, anger, fear, or other psychosocial factors • Poor information flow or inadequate communications • Administrative or procedural delay

Source: Cornerstones of disability prevention and management. *ACOEM Practice Guidelines*, 2nd ed. pp 80–82.

This paradigm is actively promoted by ACOEM and Dr. Jennifer Christian in particular. The classification is consistent with the medical literature that supports work as good for health and wellbeing, early return to work as effective therapy, and accommodation as an alternative to total disability.

In the UK, the National Health Service has adopted documentation that is implicitly consistent with this framework. Based on Dame Carol Black's, *Working for a Healthier Tomorrow*, (2008) the system adopted documentation reports that require physicians to be specific about the medical need for absence. The old "sick note" has been replace with new documentation called a "fit note." Early research following the April 2010 introduction of this program indicates it is working. One study by Shiels et al.[6] found:

- 1/3rd for mild to moderate mental health disorders
- 12% of patients had been given fit notes with a 'may be fit for work' assessment
- 22% of the individual fit notes issued were for a period of one week or less, 50% were for between one and four weeks, 24% for between one and three months and 4% for longer than three months
- The average length of a fit note episode was four weeks.

Disability management can be advanced by using skills and techniques shown to be successful in organizations worldwide. These can be internalized in a firm by given staff high level training in DM techniques. Other strategies such as the "Certificate of Recognition" (COR) program in place in some jurisdictions offer discounts and incentives on the premium side for organizations that implement and maintain certain prevention programs. Qualifying firms following independent audit receive reduced premiums. WorkSafeBC has a component of COR for "Injury Management and Return to Work". The program is currently under review while a new audit tool is created but the concept supports DM and follows a logic model that suggests costs associated with injuries will be lower in firms with effective RTW programs in place.

5 CONCLUSION

The contextual analysis suggests that Washington State is similar to its immediate neighbors to the north and south. In demographic and economic terms, these three jurisdictions have similar workforce-age populations, have experienced similar patterns of unemployment and are or have returned to pre-recession levels of employment. The general proportions of employment by sector are also similar.

From a law and policy perspective, all three jurisdictions provide substantially similar levels of compensation for temporary disability. The unique compensation rate structure in Washington State maybe more complex than in BC or Oregon but for most categories of earners, the percentage of spendable, non-taxable income provided for by legislation is in the 80-90% range. A more detailed segmentation of long duration claims by income replacement rate may determine the extent to which this may contribute to the observations noted.

The similarities across the three jurisdictions support the appropriateness of comparisons. Performance measurement and comparative analysis may isolate help isolate the specific differences in law, policy and practice that may underlay the differences in outcomes.

[6] Chris Shiels, Jim Hillage, Emma Pollard and Mark Gabbay, *An evaluation of the Statement of Fitness for Work (fit note): quantitative survey of fit notes*, Department of Work and Pensions (UK), June 2013, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207526/841summ.pdf

The observed pattern of long-duration claims requires greater analysis and action. The reasons for the observed difference in Washington State are not obviously based on a single clause within the statute or application of a specific policy or practice. Consequently, the solutions are unlikely to be found in a single change or set of legislative amendments. To address similar issues, other jurisdictions have implemented policies, programs and practices consistent with Disability Management to shorten duration, ameliorate the effects of impairments and achieve early, safe and durable return-to-work outcomes. These may provide Washington State a starting point for changes in practice, design of new progress and amendment to policy of law that would address both the human and financial cost of work-related injury, illness and disease.

Appendix 3: Research Methodology

This appendix reviews the major elements of the research methodology underlying the findings, observations, and recommendations regarding the performance audit of the claims management function of the Washington workers' compensation system. It proceeds in the following order:

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 claims data
7. Comparative data analysis of data from other jurisdictions

As we will note, these research tasks were interconnected and supported each other.

1 Stakeholder and Staff Interviews

The overall purpose of stakeholder interviews was to gain insights about the workings of the L&I claims process. We did not go into the interviews looking for problems or with preconceived notions about a reform agenda. Rather, we were looking for a balanced and objective assessment about the performance of the Washington system in general and suggestions about where the system could be improved. Where concerns or successes were indicated, we sought specific examples. A final motive for these interviews was to prepare for the claim file review and the survey of employers and injured workers, and to be alert to trends and patterns in the electronic data.

By design, the targets for our interviews were those stakeholders who have contact frequently 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. For example, a union representative is likely to hear about claims problems from members, rather than observe the vast majority of claims that are processed without friction. As another example, group Retro managers can be expected to defend the concept of Retro premium refunds against the criticism of organized labor.[1] These differing perspectives were why we interviewed a representative and balanced sample of experts, and remained aware of their potential biases.

In the process of documenting interviews, we generally included the following details:

- Date ranges for all the interviews
- Parties interviewed and titles and relevant job responsibilities
- Contact information for interviewees
- Where the interviews took place (phone or physical location)
- Approximate duration of the contact

[1] The Washington Labor Council has criticized several aspects of the retrospective rating program, particularly the uses of premium refunds by group managers; see their position on retrospective rating found March 14, 2014 at: http://www.wslc.org/legis/workcomp.htm.

In addition to this standard background we documented the responses to specific questions about the aspect of the claims process that are most familiar to the interviewed groups. For stakeholders outside of L&I, the questions for each group were premeditated to follow a pattern. However, some degree of customization of the list was necessary to follow the flow an interesting discussion, or to pick up on points heard in previous interviews.

1.1 L&I PERSONNEL

We completed extensive interviews with all the key staff in claims related functions of L&I. We also interviewed staff related to Human Resources and training. The process of contacting L&I staff was rather formal at first. All contacts were arranged through Rachel Aarts. During interviews, an additional staff member sat in the interview to record the conversation. Later in the process during subsequent contacts, the interviews become much less formal. By agreement, we simply copied Ms. Aarts in the question and answer process following initial contacts. Throughout the process Ms. Aarts was extremely attentive to our needs and consistently followed up on requests.

The process began with interviews of all the section managers within the Division of Insurance Services. The initial "kick off" meeting at L&I took place in December, with many high-level managers present, along with Joel Sacks, Director of the Department of Labor and Industries. JLARC staff attended the meeting as well. Additionally, we scheduled an interview with Vickie Kennedy early in the process. It was a general "get acquainted" meeting without significant substantive discussion. In late February, near the end of our interviews, we scheduled another meeting with Ms. Kennedy, which was much more substantive than the first. We covered the management initiatives launched in 2013, with a focus on the Return to Work Program. We also discussed the seemingly controversial topic of "side-bar" agreements to resolve claim issues. We had a follow up meeting with Director Sacks and L&I management in June 2014 to discuss progress and early discoveries. We did detailed interviews of staff in two "waves" of approximately 40 people total. We also conducted numerous follow up phone and in person interviews as needed with staff. We submitted written interview questions (approximately 100) seeking clarification and documentation of certain processes and procedures. The team received extensive training from L&I staff on the LINIIS and ORION claims systems and demos of the FileFast Early Claims Solution system and the SI SIEDRS and SICAM systems. We also worked with L&I Retro staff to conduct a scenario case study on rating and refund methods. In the course of our follow up with staff we obtained numerous reports and metrics used internally by L&I; these proved to be invaluable sources for the report. In November 2014 we interviewed Retro program staff to discuss detailed scenario modeling needed to research the premium and refund process. In March 2015, we conducted follow-up interviews with several staff members, including claim unit supervisors and several members of the management staff, concerning additional topics identified for follow up. We also conducted a follow-up discussion with Ms. Kennedy to provide an update concerning the audit.

1.2 BOARD OF INDUSTRIAL INSURANCE APPEALS (BIIA).

Interviews were conducted with the Board of Industrial Insurance Appeals (BIIA). Among other administrative law responsibilities, BIIA handles appeals to claim decisions by L&I and self-insured employers. We interviewed seven staff members, and all three Commissioners. We also interacted with staff numerous times on data questions.

1.3 RETROSPECTIVE ACCOUNT EMPLOYERS.

We interviewed public members of the Retro Advisory Committee, as well as the chair Tim Smolen from L&I. The interviews of the public members solicited both their individual perspectives on Retro, and also about the role of the Advisory Committee and the issues it has been addressing. All the public members of the Advisory Committee were associated with group plans, but the questions were mainly about how well the system serves retrospectively rated employers in general. We also interviewed three Retro employers.

1.4 ACCOUNT PLAN MANAGERS.

We interviewed three L&I policyholder service specialists who work with policyholders to answer questions about employer accounts, and sometimes help educate them on how they can lower their workers' compensation costs. The Account Managers are the primary contact for employers regarding their workers compensation account (including claim free discount questions).

1.5 ADMINISTRATORS FOR RETROSPECTIVE GROUP ACCOUNTS

We interviewed three group managers involved in administering Retro-rated groups. Group retro-rated insurance is in principle open to any employer in the state. The underwriting standards for group membership and plan design are left to the control of the group management. The interviewees were selected to include a range of groups by size and industry homogeneity. We also wanted to interview groups with both high-end service levels and groups with basic member services. In addition, two other group managers (one from a very large and one a small Retro plan) were interviewed. Their perspectives about Retro overall were similar to the members of the Advisory Committee. However, we found a diversity of organizational structures, rules, and management style among the Retro groups. The interview findings were reinforced by browsing the websites for most of the group programs.

1.6 RETROSPECTIVE GROUP EMPLOYERS

We interviewed a limited number of employers within the Retro groups. From other interviews with group managers, it appears that most group members give a great amount of deference to group managers on claims handling. The bottom line for the group members is cost. The group managers know that if they cannot consistently show premium refunds, and distribute them fairly, their group membership will decline.

1.7 NON-RETROSPECTIVE STATE FUND EMPLOYERS

We interviewed four state-fund insured, non-Retro employers. We interviewed both eastern and western Washington employers. This is probably the most diverse of the interest groups, and the most difficult to generalize about. They range in size and degree of injury hazard. We were told that approximately 80% of all fund employers had not had a LT claim in three years. Thus, the vast majority of fund employers have little knowledge of the claims process and little or no interaction with the claims staff. For this reason we need to be careful about over generalizing these three or even double that number. One SF employer hired an employer representative, to assist with workers' compensation issues. We discovered that some SF employers also hired Third Party Administrators to assist in managing their claims.

1.8 Self-Insured Employers.

We interviewed three individual self-insured employers. The self-insurance community in Washington employs about 30% of the Washington workforce. It is relatively diverse compared to other states. There are cases of small Washington only employers that probably would be considered too small for self-insurance in other states. There are a large number of public employers and health care organizations that are self-insured. In selecting the employers to interview we thought it desirable to begin with the Executive Director of the Washington Self-Insured Association (WSIA). In discussion with him and in consideration of the employers on the Board and Executive Committee of WSIA we conducted a formal interview of the WSIA president. We also had less formal conversations with other relevant individuals and recorded their feedback. We also attended a meeting of the Workers' Compensation Advisory Committee, which has self-insured members on its roster, and discussed workers' compensation issues with attendees and documented results. We had the opportunity to attend a WSIA meeting in Gig Harbor, WA. During that meeting we informally interviewed several self-insured employers and defense attorneys. There was turnover in the WSIA Executive Director position in 2014, and we conducted an interview with the new Director.

1.9 Educational Service Districts (ESDs)

ESDs are essentially "group self insurance," and operate like a self-insured employer. Hospitals are allowed to do the same. The audit team met with a group of ESD administrative personnel, and discussed the audit project and received general feedback. A second meeting with a focus group of ESD claims subject matter experts also was conducted, to receive more specific feedback on L&I claims management performance.

1.10 Union representatives

We spoke to a wide variety of labor leaders and conducted five interviews. These included the director of Project Help, an ombuds like service project, staffed through a bid process overseen by L&I, and currently managed by the WA State Labor Council. We also spoke to several staff and business managers at a Seattle union hall.

1.11 Workers' compensation bar

We formally interviewed three members of the bar, and attended a WSIA meeting and conducted several informal attorney interviews at the meeting. The interviews covered both worker and employer attorneys.

1.12 Third Party Administrators (TPA)

We interviewed five representative WA TPAs. It was clear to us that Third Party Administrators played a very important role in the claims process, not only for self-insured employers, but also for group and individual Retro employers. The people interviewed all had 12+ years of experience handling claims, most of this time in Washington, but they also offered some interesting comparisons with their experiences in Oregon. Their reaction to working with L&I had some common features, but a number of divergences as well.

1.13 Office of the Self-Insured Ombuds

We interviewed the long-serving ombuds appointed by the Governor to head the Office of the Ombuds for Injured Workers of Self-Insured Businesses. This interview helped identify documentation that provided insight into the SI claims function.

1.14 Non-Washington interviews

In the course of the performance audit, several state workers' compensation individuals not formally connected with Washington workers' compensation were interviewed, to gain insight into their respective systems. These included management from several states, including Ohio, Idaho, and Oregon. In addition, the audit team members themselves had in-depth working knowledge of the workers' compensation systems in several states, including British Columbia, Saskatchewan, Virginia, Wisconsin, California, and Tennessee, to name a few jurisdictions.

Our starting point in this learning process was to learn as much as necessary about the rules, procedures, and culture of L&I to complete this project. The L&I claims staff interviews were indispensable in the design of the file review methodology. In addition, these interviews cast light on some of the fundamental research questions in this engagement. We learned about operating procedures that showed differences in the consistency of treatment of various employers and injured workers. Additionally, we obtained valuable insights from stakeholders to the Washington system regarding the functions of L&I. We found a general level of harmony and respect of stakeholders toward L&I staff. We did discover concerns from stakeholders about certain L&I processes, e.g. some TPAs and employers expressed dis-satisfaction with the L&I Self-Insurance claim review process. Finally, we obtained comparative information needed to establish benchmarks and standards used in workers' compensation systems, to evaluate the Washington system.

2 Document Research and Review

A fundamental research methodology utilized throughout the performance audit involved review and research into existing documentation. During interviews we were provided documentation and information concerning L&I performance and other relevant subjects; this included, among other things, references to statutes, regulations, and policies. This was particularly true with respect to interviews of L&I personnel. Much information concerning Washington workers' compensation is publicly available, not only directly from L&I and the BIIA, but also from various stakeholders involved throughout Washington workers' compensation claims management process.

The audit team also was given access to the L&I information systems (LINIIS and ORION), as well as the "intranet" or web-based information system provided to L&I personnel. This internal network included access to reference material involved in claims management.

The audit team had frequent phone and email exchanges with L&I personnel, including numerous written follow up questions directed to L&I staff, which was a source of additional documentation and reference information.

3 REVIEW OF CLAIM FILES

3.1 PROCESS

The goals for the claim review were:

- ensuring that the project team is collecting the data that are needed to supplement the electronic data in order to have the data elements needed to answer the research questions (some questions could not be answered by claim data);
- ensuring that the project team reviews enough files and the right mix of files to answer the research questions that involve comparisons between self-insured, Retro and non-Retro employers; and
- ensuring that the project team reviews enough files so the results are credible.

The audit team consisted of the two lead investigators for the project (Bryant and Krohm) supported by two experienced claims adjusters. The team read background documents regarding the L&I claim system and processes. Additionally, interviews with non-L&I stakeholders were conducted and analyzed, to discover anomalous practices that would be useful to focus on in file review. Before commencing the actual file review the team had a period of training on maneuvering through and capturing data from the LINIIS and ORION claims systems. The cooperation of L&I staff in answering questions about what we were finding in the files was tremendously helpful.

For file-review data, we reviewed 264 State Fund (SF) files and 144 self-insured (SI) files. Note that in selecting the files, we did not distinguish between "allowed" and "denied" cases, and there were only a very small quantity of denied cases in the sample. We did a follow-up review of an additional set of denied SF and SI cases, to evaluate the quality of the adjudication decision in the "denied" context. We determined that 46 SF cases (50/50 Retro/non-Retro split) and 46 SI cases were a sufficient sample. For SI cases, it was clear that L&I review of the denial decision was not in-depth, at least from the record, and was essentially cursory in nature and reliant upon the TPA rationale. For SF cases, it was clear that CMs took basic steps to review the evidence of record in making their decision. For these reasons, due to lack of variance around a predominant pattern of findings, review was stopped at 46.

Our general approach in reviewing claim files involved: 1) a preliminary phase; 2) a comprehensive phase; and 3) a follow-up phase. The purpose of the preliminary phase was to test the validity of the methods for review. Following preliminary testing, the file review checklist was modified to accommodate identified issues and help ensure more thorough and accurate reviews.

Preliminary Phase. We sampled 40 claims for an initial review. It was essential that we learn the most efficient techniques for examining digital files, how to interpret terms and classifications correctly, and confirm the efficacy of the "checklist" to be used during review. We also tested our process for documenting findings on each file reviewed, and developed audit work-papers. After the preliminary review, we modified our checklist, and returned to L&I for one half-day of additional testing in the immediate lead-up to the comprehensive file review, for final confirmation of the efficacy of the checklist and preparation for training of the file-review team for maximal efficiency. During this entire phase we made maximum use of experts in the Quality Assurance Section to advise us on terminology, procedures and exceptions noted.

Comprehensive Phase. The focus of the comprehensive phase was on state-fund claims. The strategy on reviewing practices in self-insured claims, as well as results from comparing the electronic data between state-fund and self-insured claims, is discussed below. During the comprehensive review the team reviewed 264 State Fund files, testing for the items listed on the checklist. The rationale behind the sample size is provided below. The team utilized a checklist, which was based loosely on the L&I internal review standards, but modified to focus on measuring system performance at selected junctures in the claim process. During each day of reviews and in a debriefing at the end of the day the team shared questions and tried to coordinate our use of the checklist. We sampled 144 self-insured claims. The sampling methodology is described below.

It is important to emphasize that we studied a process. Individual errors or deviations became important only if we detected a widespread pattern of inconsistent claims handling. Minor, individual deviations from procedure that did not rise to the level of a consistent pattern of behavior, or that did not appear to affect the claim outcome were not noted as a cause for concern.

Follow Up Phase. This part of the analysis responded to issues that required more in-depth study. We examined denied claims primarily to determine the level of review afforded by the CM. The SI and SF process is quite different, but the legal standard for denial is the same between the two groups. We sampled 92 denied claims, 46 SI and 46 SF.

3.2 SAMPLING

For State Fund claims, we sampled 264 files with total medical costs > $5,000 with accident years between 2010 and 2013. We selected 264 as our sample size because it represents a sufficiently large sample to accomplish the statistical analyses if the characteristics of the data fall in the reasonably expected range from data collected in the file review. The required sample size depends on several factors: 1) the nature of the statistic being measure (e.g., population proportion, cardinal values, or ordinal values); 2) the characteristics of the statistic itself (e.g., mean and variance) and the actual difference, if any, being compared (e.g., between Retro and non-Retro); 3) the statistical confidence one wants to assign to any difference being the result of chanced sample variation (e.g., 90%, 95% confidence level); and, 4) the probability that if there is a real difference of a certain size, one will identify the difference. We made some reasonable range of predictions about the expected values and performed power calculations over the range to estimate the required sample size.

For our sample of 264, we pulled a 55/45 split of retro/non-Retro. When the underlying population is large, the sampling should use two equal size groups for statistical testing, e.g., a 50%/50% mix of Retro and non-Retro employers for maximum efficiency in statistical testing for difference between the groups.[2]

As for which files to include in the samples, we determined that selecting from those files where total medical costs exceed $5,000 was the best approach to ensure fair representation of the full range of CM decision making on the claims, e.g., responding to complex and prolonged treatment, permanent disability rating, use of independent medical exams, and the need for vocational services. The file-review team did preliminary testing of claims to determine the appropriate level that would provide a more

[2] Given that, then the smallest standard error is achieved by drawing samples of equivalent size. The size of the underlying population of each doesn't matter. Even if the actual population were, to use an extreme example, 95% Retro and 5% non-Retro, as long as the population is large relative to the sample size, you get a smaller standard error by having similar sample sizes.

complete view of claims management services in sampled claims. Based on distributions from 2011, claims with medical cost > $5,000 represented 19% of all state-fund allowed claims, and accounted for 80% of total dollars. Thus, we sampled from important claims accounting for the majority of dollars while excluding files with few "actions" on which to base an evaluation of performance.

It is important to note that these file samples were only part of the evidence for the aforementioned performance characteristics. We combined the file review results with results from our analysis of the L&I claims databases. This allowed for rigorous analysis using the larger and more complete electronic dataset, providing a view into outcomes of particular actions (or inactions). For example, the data analysis gave us measures of the frequency of vocational services and claim details which we could not have reliably calculated from the file reviews.

For many, but not all, of the required research questions, we relied on electronic data to test for differences in claims handling between self-insured and fund employers. However, some of the questions could only be answered from file reviews, e.g. evidence of potentially biased decision making.

For the file reviews, the unique aspects of self-insured claim handling was an important context for developing an appropriate methodology. There are no legal differences in handling claims between self-insured and State Fund employers. The law regarding timing, validity, and benefits must be followed. If non-compliant with the law, a particular self-insured decision may be protested, and if so the protest is filed with L&I, and possibly, appealed to the BIIA. Timing and legal compliance of these decisions is tracked within the L&I database, and consistency was tested through analysis of the electronic record. Important for our analysis, the initial allowance/denial decision must be formally issued by L&I. In those cases where an SI employer is recommending an "allowance" order, it is our understanding that very little L&I independent fact finding and review occurs, which is understandable because the SI employer, who by statute must have a claims-management function, is asserting review of the claim and recommending allowance. Denials, on the other hand, are a context that can be used to compare consistency between claims handling and decisions by SI and SF employers.

Additionally, SI employers make treatment decisions, provide vocational rehabilitation services, evaluate permanency (and can issue a PPD order, although we understand that this is relatively rare), and make recommendations regarding pensions. Allowance decisions of medical-only claims are not reviewed. Order dates are available in the electronic record, which were analyzed to determine variances between state-fund and self-insured practices.

4 CUSTOMER OPINION SURVEY

4.1 OVERVIEW

Many questions posed by the RFP sought information on perceptions of employers and workers which could only be answered by querying the parties directly. Divergence between processes and outcomes and the perceptions of processes and outcomes might suggest important points for L&I education and intervention. For example, L&I's internal targets for completing various processes may be out of sync with the perceptions of some stakeholders, e.g., the timeliness of resolving protests.

The complex nature of questions posed by JLARC and the desire to compare perceptions across several subgroups, particularly by employer 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.

We conducted opinion surveys of employers and injured workers, covering specific topics of interest to the audit team. The surveys (hereinafter called "Opinion Surveys") were conducted by phone as well as through online entry by some respondents.

For the survey, question format and wording were critical to success. We used focus groups to confirm the proper wording of the survey questions. For the focus groups we provided incentives to encourage participation. In addition to the focus groups we checked out understanding of the process with L&I experts to ensure the correct terminology for various situations, e.g., what is the best term for describing coverage provided by the State Fund, or the best term for an independent medical examination.

4.2 Managing the Survey

The survey contacts and recording of responses was managed by Q Market Research ("Q") as follows:

- Design, develop, and refine survey instruments
- Programming. The survey was programmed into Computer-assisted telephone interviewing (CATI) and an online tool. Q prepared a telephone instrument and an online survey instrument. The letter that was sent to the respondents explaining the reason for the survey offered him or her the option to complete the survey using the online survey tool. The CATI interview for the worker was also programmed into Spanish.
- Administration. The survey was again pre-tested on a sample and then finalized and administered. Interviewers were carefully trained, based on the lessons learned from the pre-testing activities.
- Finalizing the data. After data was collected, it is cleaned (coded and edited) and tabulated, and delivered to the research team for analysis.

4.3 Summary of Survey Responses Results

4.3.1 Employers

- Self-Insured (SI) Employers –Opinion Survey of risk manager staff/relevant HR person from employers; sample size = 165 actual responses (150 targeted)
- Insured employers, non-Retro rated (NR) –Opinion Survey of risk manager staff/relevant HR person from; sample size = 547 actual responses (450 targeted)
- Insured employers, Retro rated (R) –Opinion Survey of risk manager staff/relevant HR person from retro (including both group and individual retro) employers; sample = 697 actual responses (600 targeted)

4.3.2 Injured Workers

- Injured Workers (IW) for SI employers –Opinion Survey of IWs; sample size = 429 actual responses (425 targeted)
- IW for NR –Opinion Survey of IWs; sample size = 454 actual responses (425 targeted)
- IW for R – Opinion Survey of IWs; sample size = 658 actual responses (650 targeted)

4.4 Sampling Method

The first step in the sampling is matching employers between the three groups. This effort creates similar groups for comparing responses from self-insured employers to insured employers and, within

insured employers, similar groups of Retro and non-Retro employers. We used a propensity-score method, as described in Part 6 of this Appendix.

From the matched groups of employers, we then drew samples of employers for interviews.

From the matched groups of employers, we identified all claims meeting our selection criteria (date of injury within range and medical payments greater than $5,000). We then randomly sampled from among these claims at a rate that obtained sufficient samples to complete the target number of injured worker interviews for each group of employers. Injured workers were pulled for the sample regardless of whether they were represented by an attorney. Note: L&I injured worker surveys exclude attorney represented individuals, on the basis that they are prohibited, as a party, from making direct contact with such individuals; our project is not under these same constraints. If an individual responded to a call, "I can't discuss this with you on the advice of my attorney," we recorded the response as such. Also, we explained in introductory material that the information was anonymous and not part of any official record.

For the sample we drew claims from the years 2011 – 2013. The distribution of claims across the three injury years and the three groups of employers was carefully monitored so that the completed surveys match the targets within each subgroup. While we selected claims with total medical cost of $5,000 or greater, L&I surveys focus on claims with time-loss durations greater than 30 days. We determined, however, that selecting from those files where total medical costs exceed $5,000 is the best approach to include representative samples of the various required groups, as well as ensure large representation of other features of the claims process, e.g., vocational services and use of IMEs. Based on distributions from 2011, claims with medical cost > $5,000 represent 19% of all state-fund allowed claims, and account for 80% of total dollars. Thus, we sampled from important claims accounting for the majority of dollars while excluding files with few "actions" on which to base an evaluation of performance.

4.5 Results of Survey Contacts

Workers were mailed a letter explaining the purpose of the survey and asking them to fill out a survey on-line or contact the survey firm for an interview. Workers that did not respond received a follow-up postcard. If workers still did not respond, the survey firm called them. Up to 9 calls were made in an attempt to contact the worker.

Employers were also contacted by mail, explaining the survey and offering the call-in or on-line options. A follow-up postcard was sent. Finally, each employer not responding was called by Q Research. We also received assistance from the Washington Self-Insured Employer Association which sent an email request to members asking them to respond.

4.6 Comparisons with L&I Surveys

The methods that we used in the survey for the JLARC audit require different approaches to sampling employers and claims and conducting the survey than those used by L&I in conducting their customer opinion surveys, which are managed for L&I by Ipsos. Both approaches are well suited and appropriate for their specific purposes. But, the differing requirements necessitate differences in methods. First, the JLARC purpose is a bit different from the L&I-Ipsos objectives and consequently the surveys are designed differently, especially the sampling design. The primary focus in the L&I-Ipsos surveys is on how customers' perceptions change over time, specifically against the baseline at start. Our survey has a similar focus, but it adds a primary focus on whether different groups of employers or workers perceive

they are treated differently along the dimensions of self-insurance and, for insured employers, participation (or not) in Retro-rating plans.

The three statuses (self-insured, Retro-rated, or non-Retro rated) are characterized by different employer and worker characteristics. Since these characteristics are likely correlated with some of the issues at the heart of the performance audit, we needed to be sure we controlled for those characteristics, otherwise the comparisons among the groups would not be reliable. This makes the sampling more complex. The solution was propensity score matching. We end up with two pairs of matched samples for both the employer and worker surveys. We matched self-insured employers to insured employers (both Retro and non-Retro). Separately we matched within insured employers, Retro-rated to non-Retro rated. It is not correct to pool all insured employers in our sample and match them to self-insured, nor is it strictly correct to pool all the insured employers (workers) and compare the Retro to non-Retro rated employers (workers). The Retro and non-Retro insured employers in the sample matched to self-insured employers cannot, under the strictest interpretation, be used in the comparison between Retro and non-Retro employers (workers).

Second, self-insured employer claim data available for this study is not as complete as L&I's high quality data on State Fund claims. Consequently, we could not reliable use measures like time-loss and Kept-on-salary (KOS) when selecting the samples. The L&I-Ipsos survey approach uses time-loss and KOS as a set of criteria (which is correct for their sampling of State Fund employers). Our approach was to use the total medical cost as a selection criteria and set a threshold of medical cost that allowed us to focus on the 20% of cases that are more serious (80% of total cost). The resulting sample is quite similar but not identical to the L&I-Ipsos sample. We will have somewhat fewer small time-loss claims and slightly more large medical-only claims. This choice allows us to select very similar claims across all groups, especially when comparing self-insured and State Fund claims.

Third, the L&I-Ipsos approach excludes claims in which workers had attorney representation. We quite explicitly wanted to include represented claims since both workers and employers are more likely to have experienced challenges on these claims. It would also be more difficult to make reliable comparisons between, for example, self-insured claims and insured claims if the portion of attorney-represented claims differed based on whether the employer was self-insured or in the State Fund Because attorney representation is also correlated with the existence of protests, the potential problems of biasing the comparison could get worse as we examined claims with disputes. Whether or not disputes were handled consistently and equitably across the three employer types (self-insured, Retro, and non-Retro) was a high priority issue for JLARC. The L&I-Ipsos sample does not include attorney-represented workers in the surveys because of L&I concerns about potential *ex parte* communications.

The inclusion of attorney-represented claims could lead to differences in how worker perceptions compare between our results and those of L&I-Ipsos. Attorney representation is likely to be the result of more complex issues or disputes. Both of these characteristics are likely associated with more dissatisfaction with the claims process. Hence the JLARC audit, all else equal, will probably show lower customer satisfaction. This will apply to the worker survey, not the employer results. We do not believe the L&I-Ipsos sample excludes employers if one or more of an employer's time loss claims is represented.

Fourth, and quite important, we did not restrict our sample to claims that were "active" in the prior quarter. We include inactive and closed claims (including those that were denied) from all claims between 2010 and 2013 that met a certain severity level. Again, this is, in part, because it helps ensure that the samples are comparable between self-insured, Retro-rated, and non-Retro-rated workers and

employers. We take this different approach, also, because the basic differences in the purpose between the two surveys: the L&I-Ipsos method is focused on changes over time from a baseline. Our survey is focused on a certain period, not trends over time. Excluding inactive and closed claims would have made for highly skewed sampling from earlier years relative to later years. Readers should keep in mind that this choice can also affect the perceptions of the respondents, most importantly those of workers. Ipsos interviewed all workers very close to recent activity on their claim. Our survey interviewed some workers whose experience is further in the past, and the longer period of recall may affect their perceptions. The direction of any recall effect is not known. The most likely effect is to reduce more extreme views, both positive and negative. Trying to contact workers with inactive or closed claims is also more difficult, especially because the contact information may not be current.

Finally, our survey relies on "mixed methods." We allowed the workers and employers to choose to enter their survey responses on-line in an interactive environment or respond to a telephone interview. The mixed method approach has two advantages. First it can substantially reduce the cost of achieving sufficient samples. This was important in this instance because the scope of the audit, to compare across groups, required relatively large samples. Second, the mixed methods may help improve response rates among usually harder to reach populations.

4.7 RESPONSES

Response rates were calculated as follows:

$$\text{Response Rate} = \frac{\text{Completes}}{\left(\text{Completes}\right) + \left(\frac{\text{Completes}}{\text{Completes} + \text{Not Qualified}} \text{ X } \left(\text{Not Contacted} + \text{Refused}\right)\right)}$$

The following table summarizes the results.

	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%

5 BEST PRACTICES SURVEY

There is no universally recognized set of standards for handling workers' compensation claims. While certain practices are widely shared, workers' compensation systems exist in most states in a competitive business environment, and thus practices are proprietary to advancing particular business interests. Several of the questions involved in this performance audit of the Washington workers' compensation claims management function involved evaluating efficiency, as well as comparing results. To establish benchmarks that could be used to answer some of the questions required for the audit, we assembled a

"panel of experts" to participate in a survey. The survey asked general questions to the experts, who provided answers designed to address general claim management organization and performance. The panel did not address whether any particular Washington result conformed to "best practices"; rather, the panel was used to help derive a consensus benchmark that could be used to evaluate performance in general, including Washington performance.

The survey involved 14 respondents. All participants had lengthy careers in workers' compensation claims management. Experience included both front-line claim management experience, as well as supervisory experience. Most participants were involved in managing claims in the private, non-government context. The average professional experience for the respondents was 33 years, with extensive multi-state experience. The survey posed 25 questions about the claim management process, including:

- Number of Days for Lost Time Claims
  - In your opinion what time intervals would represent "best practice" goal for the claims adjuster (or nurse case manager) to make actual voice contact with the injured claimant? (0 = less than 1 business day to make actual contact; 21 = 21 or more business days to make actual contact)
  - In your opinion what time intervals would represent "best practice" goal for the claims adjuster (or nurse case manager) to make actual voice contact with the employer of injury? (0 = less than 1 business day to make actual contact; 21 = 21 or more business days to make actual contact)

- On average, how long (from the date of receipt of the accident report) does it take for an adjuster to communicate with the claimant that the claim is denied?

- How frequently would an adjuster (or nurse case manager) interact with an employer on strategies for returning the injured worker to the job within the physician's duty limitations? (For this question, assume that lost time payments are about to begin)

- % where IME needed re ability to return to work
  - As an estimate, in what percentage of lost-time claims, with disability over 60 days, is an IME needed by the adjuster to confirm or challenge the treating physician on the following issues. (0% = IME never needed; 50% = IME needed half of the time to confirm or challenge the treating physician; 100% = IME needed in every case on the particular issue)

- Generally speaking, how reliably can an adjuster predict, after 60 days of lost time, that a worker with a moderately severe injury (major sprain to a joint, tendon tear, etc.) will not likely return to work at the employer of injury ?

- Vocational evaluation (e.g. job skills assessment; ability to work)
  - What percentage of lost-time claims usually require the following:

- Vocational retraining plan
  - What percentage of lost-time claims usually require the following:

- Total number of open cases per front-line adjuster
  - In your opinion, based on average adjuster training and experience and assuming average case complexity, what would be a standard caseload per workers' compensation claims adjuster.

- Number of open lost-time cases per front-line adjuster
    - In your opinion, based on average adjuster training and experience and assuming average case complexity, what would be a standard caseload per workers' compensation claims adjuster.

There was a high degree of agreement of opinions expressed on most questions. The complete survey instrument is attached to Appendix 8.

6 DATA ANALYSIS OF L&I CLAIM DATA

6.1 INTRODUCTION

Our methods for conducting data analytics started first with becoming acquainted with the L&I data warehouse characteristics. We did this through review of the data dictionary and extensive interviews and questions with L&I research staff. After appropriate confidentiality agreements, we went through a formal data selection and transfer process. A significant dataset, covering claims with accidents between 1/1/10 and 12/31/13 was developed. We used an industry standard, open-sourced statistical software package, known as "R," to develop a database for inquiry.

From the onset of this study we recognized the challenge of obtaining, editing, and analyzing a very large and complex dataset constructed by L&I. The study could not have been completed without the full cooperation of L&I in supplying the correct data elements and assisting us in their interpretation. The cooperation in interpreting the data by L&I has been superb.

The data quality controls begin with correctly understanding the definitions of data elements and the way data are captured, edited, and recorded. This process begins with in-depth discussions with the L&I data warehouse managers. As described below, we conducted our own edit checks of data received from the L&I database to measure the conformance of records to data definitions and plausible values. Also described below is the process by which suspect data were evaluated for inclusion. In the case of anomalies, we consulted the appropriate authority within L&I for an explanation; following this we applied consistent standards for either reconstructing the record or excluding it from the analysis database, and documented these actions in case of later review.

There are significant distinctions that cut across several of the comparisons in the RFP between self-insured and state-fund handled claims. We discovered a large number of data elements on records of state fund claims that are not available for self-insured claims. This impacted cross-states comparisons to a certain extent, and in coordination with the Washington Self Insurer Association we sought inter-state data from TPA members with experience in states neighboring Washington; we were not successful in persuading TPAs to supply comparative data. We do believe that we were able to gain enough comparative data from other sources to conduct a solid analysis.

Through interviews we noted that the nature of the L&I review for self-insured claims differs from the state-fund context. This review process of TPA decisions is considered "oversight" and not original claims investigation. Reported exceptions include the denial process and the segregation process, and to some extent the closing process. The role played by L&I in these processes were described as more substantive than "simple" oversight; we note that these were "reported" exceptions because our observation, through file reviews, did not indicate a true difference in actual practice; in other words, we did not observe in the course of file reviews that L&I performed a review of these decisions that made a difference in the outcome.

Many of the characteristics analyzed in the context of legal decisions by L&I involve various aspects of timeliness. The RFP specified a number of these, which was driven by the difference between various dates available in the claim record. To prepare for this analysis, we first verified that these dates had the proper logical relationship (for example, date of bill payment is after date of bill receipt).

After this step, we computed lag times between relevant dates for each measure. In prepping for these queries, we found that some values fit the strict data definitions, but needed to be excluded as atypical, such as claims with long processing lags due to an initial denial decision being overturned for the first time after several levels of appeal. If extreme outlier values distorted results, we trimmed data that exceeded or fell below 3.5 standard deviations from the mean.

Lag times. A lag-time is the elapsed time between the conclusion of one event and the occurrence of a subsequent event. For lag time measures we looked at the distribution of time lag days for each group. This included various standard measures (means, percentiles, standard deviations). When data values were excluded as atypical, it was noted.

Proportions. Some of the legal-decision questions under analysis referred to statutory measures that specified a timeliness benchmark; we computed the proportion of cases that met the timeliness standard in addition to running measures of distribution. For many timeliness measures a reasonable goal was to maximize the share that conform to the standard, and thus resources were not devoted to improvement beyond meeting the standard. Thus it would be possible to view multiple aspects of the time to issue a particular decision, for example:

- Mean (average) time overall to issue the decision was 36 days;
- Median time was 26 days;
- 86% of claims measured met a timeliness standard of 30 days.

We established a “target” standard or standards, which was based on a number of factors, including statutory requirements, stated policies, and industry best practices. The target could also be a mean or median, and the proportional analysis would be based on what percentage of values is within certain ranges from that target, similar to a standard-deviation presentation. We were 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.

6.2 MATCHING

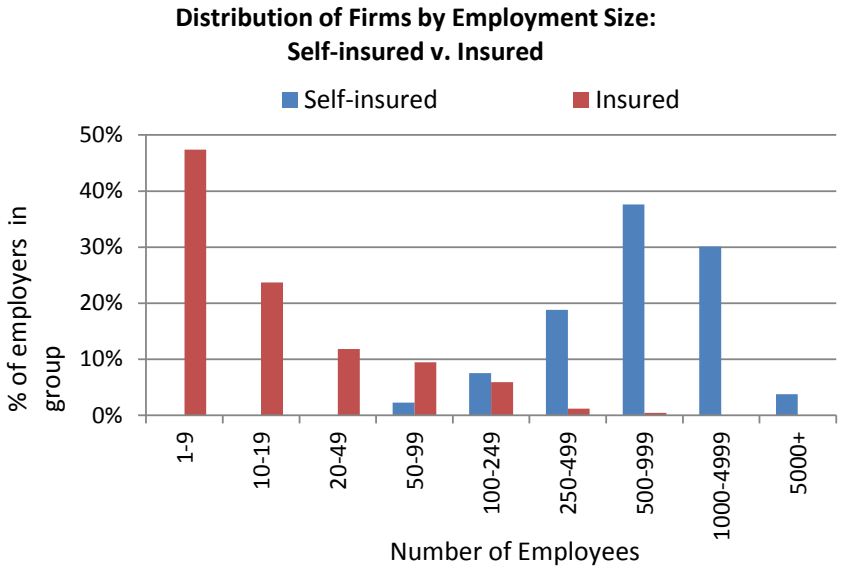
When an analysis requires comparison of measures, like opinions or performance, between two groups, it is important to control for factors that may lead to erroneous or unsupported conclusions. This audit aimed to compare various measures across different groups of employers in two pair-wise comparisons: self-Insured employers to Insured employers and Retro-rated (State Fund) employers to non-Retro-rated (State Fund) employers. Matching employer types was an important methodology challenge. JLARC's objective was to determine if L&I activities lead to actual differences in claims handling or employers' and workers' perceptions of claims handling. It was important for us to distinguish differences driven solely by, for example, employer differences, versus those driven by activities specific to L&I.

This challenge was present both with respect to data analysis in general, and also with respect to compiling a valid sample for conducting employer and worker perception surveys and analyzing results.

Our strategy involved first selecting employers and carefully matching the employers across the different dimensions to make the statistical analysis as accurate and precise as possible. The next step

involves sampling claims (and workers) from within the matched samples of employers. The impact of this two-stage approach is to create convincing, highly defensible inferences about the impact of different government processes (State Fund, L&I, and BIIA), independent of differences in the underlying employers and claimants. We describe this below.

Sampling employers. Regression techniques meant to control for differing characteristics when comparing outcomes between two or more groups can be improved on in many situations. Most importantly, when: 1) membership in one group over another involves some element of choice (here, whether to self-insure or choose a Retro program); or 2) the overlap between the two groups is limited (e.g., self-insured vs. insured and employer size), then standard regression approaches cannot be reliably used without likely creating biased results. This is shown visually below using the single dimension of firm size.



Source: WorkComp Strategies

In this example, we present a hypothetical distribution of firm size for self-insured and insured employers. Most employers are small, fewer than 50 employees. But virtually no firms smaller than 50 employees self-insure, in part because they do not meet minimum financial requirements. At the other extreme, virtually all firms larger than 1,000 employees self-insure (in our hypothetical example). If one uses standard regression techniques to control for characteristics, in this case firm size, the method extrapolates firm size beyond the ranges in which it is comparable between the two groups of employers. That is, the effect of firm size on a measure of interest, like time to return to work, may not matter for very large firms in the way it does for very small firms. Consequently, it is difficult to control for the effect of firm size when comparing very large and very small employers.

The state-of-the-art approach, propensity score matching, is to first match employers exploiting the unobserved process by which they make the decision to be members of one group over another. That approach uses logistic regression to model the probability that an employer will choose, for example, to self-insure, based on a range of available characteristics (size, industry, or injury experience, etc.). Indeed, the biggest methodological problem we face is matching employers for the comparison groups.

As one adds different dimensions (size, injury experience, industry, location, availability of re-insurance, state-specific factors such as the public nature of the filings, etc.), it quickly becomes complex, if not impossible, to judge which firm in one group is the best match to a firm in the second group. This is notwithstanding the perhaps very "personal" or individualistic part of decision to self-insure, including the degree to which the company is willing to assume risk.

We performed propensity score matching in some measures to address this issue. Using this technique, the regression coefficients from the logistic regressions can be combined into a single score, referred to as a propensity score, which is used to match employers. This method has been tested and proved to be more efficient and to produce better matches than other, formerly used approaches.[3] Some outliers in both groups (e.g., very small insured employers) may be excluded because no near matches can be found. We used this matching process as part of the first stage of comparison of measures across self-insured, Retro, and non-Retro employers.

We matched employers the following dimensions:

- Employer size (hours for insured employers and employees for self-insured)
- Experience rating (for insured employers) and pseudo-x-mod for self-insured[4]
- Primary class code (NAICS); we assigned a primary class code to self-insured employers if not available from claims data)
- Employer has exposure in more than one class code in year (Y/N) (imputed for self-insureds)
- ZIP Code (Several instate geographic regions and out-of-state headquarters)
- Multi-state employer (if we can determine this dimension)
- Primary NAICS Code (2-digit) (assigned by us)
- Years in business (<1, 1-2, 3-5, 6-10, 11+)

These data were readily available from our electronic database.

The next step in propensity score matching is selecting a method for choosing among all available matches in one group when matching to an employer in the second group. We chose the "best match" based on the closest propensity score. We also defined a range outside of which we would not match. That is, if no match is found within +/-X of the original employer's propensity score within the other pool, we dropped the original employer from the analyses. Since we are matching two groups of employers, rather than strictly a "treatment" and a "control" group, matching was done without replacement. Each of these choices requires some experience with the data to understand the distributions and the degree to which employer characteristics overlap. Consequently the precise choice was dependent on review of the electronic data available to us. These decisions were documented and explained in the interim review meetings with JLARC, including estimating impacts from the decisions.

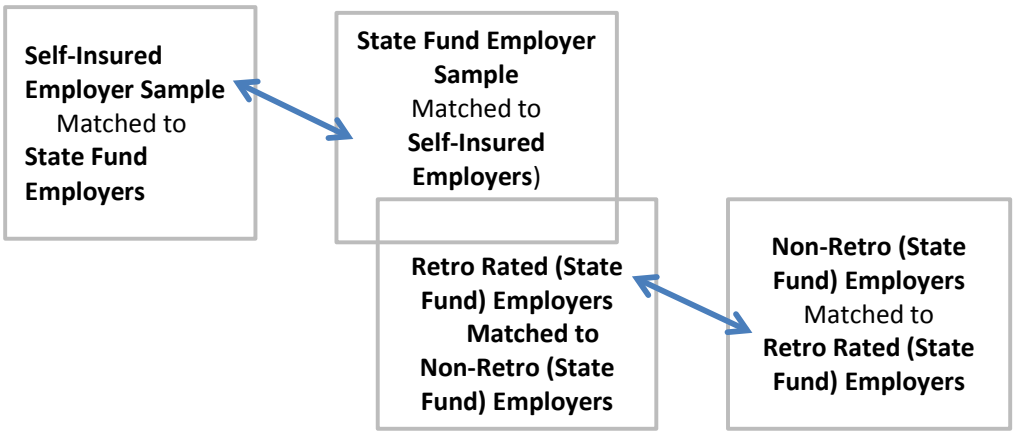
Note that the above discussion of matching applies equally to comparing self-insured and State Fund employers and Retro and non-Retro employers.

This process results in two sets of paired samples. The first pair of samples will have matched similar Insured and Self-insured employers based on the method described just above. The second pair of

[3] See, e.g., Heinrich, et al., "A Primer for Applying Propensity-Score Matching," Inter-American Development Bank (2010), and sources cited therein.

[4] The pseudo X-mod will be created by modeling the x-mod and frequency of injuries for insured employer by NAICS code and translating this to self-insured employers.

samples will match the Retro insured employers to the non-Retro insured employers. These two sets of paired samples are diagrammed in the figure below.



In the above diagram, two of the four samples, Insured employers (matched to Self-Insured Employers) and the Retro Rated Insured Employers (matched to the non-Retro Rated Insured Employers) overlap. That is, some employers may be in both samples. This does not pose any statistical problems, since the two pairs of samples are analyzed independently.

As indicated in the first diagram, there are some employers that will not match sufficiently closely to another group to be included in the analytic, matched samples. This is appropriate in this particular analysis because the interest of JLARC is to examine whether the different regimes (Self-insurance, Retro-rating participation, and non-Retro-rating participation) result in different outcomes for workers and employers because their employer status leads to differences in claims handling by L&I.

The stated objectives in the audit did not include, for example, analyzing specifically how small employers are treated relative to large employers or new employers relative to established employers. While our approach is not specifically designed for these types of distinctions, the approach used in our study does allow additional dimensions to be studies with confidence.

Sampling Claims and Workers. Matching employers using propensity scores should result in a very similar pool of claimants and claims. Ordinarily with propensity score matching other characteristics, beyond those matched on, will also be very close in terms of means and distributions. However, some dimensions of the claimants and claims may still differ in important ways that we feel might affect our inferences about the L&I's claims handling activities being studied.

By studying features within the claims process we can offer a much richer picture of differences in legal decisions than just the main distinctions between self-insurance, Retro employers, and traditional state fund employers. These sub-issues may help explain the gross differences we may find across groups.

The combination of propensity score matching and regression control is the best way to evaluate whether there are differences in important measures (e.g., consistency, fairness, timeliness, etc.) across the different groups of employers on legal decisions and protest handling. The data can be used to drill down and study what particular issues drove the protests or appeals, e.g., wage, PPD, or Pension. If differences are found, this approach will give, as near as possible, unbiased estimates of the size of any differences. As noted above, a solid measurement of the differences between groups has been accompanied by some explanation of the reasons for the differences and whether these causes are benign or need correction.

General Data Description. As indicated earlier, our dataset consisted of claims with dates of accident between 1/1/10 and 12/31/13. We used the calendar year approach as opposed to the development year approach because of the extremely long durations in Washington. For example, if we had measured all activity in a certain calendar year, we would be combining claims with many different years of activity. This would have made the dataset unworkably large. When development of a claim to maturity was needed for analysis (such as measuring ultimate durations of TTD), we were able to rely on L&I actuarial data. The L&I research and actuarial services teams were extraordinarily helpful.

Some general characteristics of the dataset: For all employer groups 2013 is likely to underrepresent the ultimate total of accepted claims; this is due to late reporting of claims and lengthy investigations for some claims. Note that SI data reporting can be delayed, which we expect resulted in lower claim counts for 2013, which were small relative to 2010-2012.

All reported claims by injury year

Measure	Number of claims
Total number of claims	569,262
Injury year 2010	144,037
Injury year 2011	142,127
Injury year 2012	144,482
Injury year 2013	138,616

All reported claims by injury year and medical only or timeloss

Year	No timeloss or medical	Medical only	Timeloss
Injury year 2010	13,564	98,769	31,681
Injury year 2011	14,133	97,236	30,705
Injury year 2012	13,583	100,977	29,716
Injury year 2013	10,643	88,808	25,458

Note that the total of these columns does not match the total above for all reported claims; some reported claims end up being excluded for various reasons, e.g., duplication, erroneously reported, etc.

Accepted claims by injury year and medical only or timeloss

Year	No timeloss or medical	Medical only	Timeloss
Injury year 2010	5,110	90,041	31,302

Injury year 2011	4,739	87,774	30,247
Injury year 2012	5,190	90,115	29,102
Injury year 2013	3,575	76,320	22,722

Note: 2013 results will increase as more claims are reported and investigations concluded.

Accepted claims by injury year and injury or illness

Year	Illness	Injury
Injury year 2010	5,288	121,170
Injury year 2011	5,174	117,598
Injury year 2012	4,840	119,625
Injury year 2013	3,470	106,937

Accepted claims by injury year

Year	Illness/Injury
Injury year 2010	126,458
Injury year 2011	122,772
Injury year 2012	124,465
Injury year 2013	110,407

Accepted claims by injury year and SF or SI

Year	SF		SI	
Injury year 2010	86,929	(69%)	39,529	(31%)
Injury year 2011	85,422	(70%)	37,350	(30%)
Injury year 2012	87,733	(70%)	36,732	(30%)
Injury year 2013	85,639	(78%)	24,768	(22%)

Note that many SI claims are reported long after they occur.

All SF claims by injury year and Retro or non-Retro

Year	non-Retro	Retro
Injury year 2010	55,870	43,117
Injury year 2011	56,391	41,378
Injury year 2012	58,545	42,672
Injury year 2013	52,433	37,430

BIIA data. In additional to published statistics by the BIIA data staff, we also received a large dataset from BIIA. This was in the form on an Excel spreadsheet. It contained data and a data definition lexicon of final orders from BIIA for the years 2012 and 2013. By using final orders some cases will have had dates of injury well prior to 2012; many cases decided in 2012 will have been filed in 2011 and even earlier. In addition, some appeals filed in 2012 and 2013 also were not included because they were not yet concluded. This was a cross section of decisions from 2012 and 2013 regardless of the date of injury or the date the appeal was filed. We also received reports developed by BIIA showing duration lags for key throughputs, such as time to decision. The dataset also included "issue" information, meaning those issues identified by the staff when the final order was issued. No opinion was given on whether any particular issue was more crucial to the case than others; rather all identified issues in a case were listed. BIIA data staff were very helpful in interpreting the data. We were able to use this issue information to gain insight into prevalence of certain issues. The data also included whether the appealing party was representing by counsel when filing the appeal. The data also included outcome information, including a flag by BIIA as to whether the particular order was a "reversal" or not. In this way the data provided a view into outcomes on appeal. The reversal information did not include partial reversals, however; i.e., if a claim was appealed on several issues, one of which was determined to merit reversal, then the entire claim was considered "reversed."

7 COMPARATIVE DATA ANALYSIS

The audit team conducted phone and in-person interviews with officials from other state workers' compensation programs. The audit team also collected data from several states. Some information was obtained through special records requests, but most was available on websites. We made personal requests for data from many states. States particularly helpful in providing information were North Dakota, British Columbia, Saskatchewan, Montana, Ohio, Oregon, and Idaho. We focused on the following key comparative data points:

- Denial Rate
- Time to initial Payment
- TTD Duration
- Time to Closure

We used WCRI and NCCI data to provide further comparisons; in some instances comparisons with up to 37 states was available. We conducted interviews with Idaho, Ohio, and Oregon self-insurance managers to gain comparative insight into their self-insurance programs.

Our targeted selection of jurisdictions was based on the following considerations:

- Proximity to Washington. Neighboring states are usually regarded as interesting comparisons by policy makers.
- Preference for monopolistic systems. The inclusion of BC, Saskatchewan, North Dakota, and Ohio was appropriate because of the shared insurance approach.
- Similarity in economy and size, as used to identify candidates for comparison shown in the Methodology Appendix to the RFP.
- Professional relationship with management in the jurisdiction. This refers to our ability to persuade an agency to perform custom analytics.
- Jurisdictions reported in the WCRI CompScope™ and the NCCI disability durations reports on selected measures.

Given these diverse selection criteria, we hesitate to call our selection "representative." There are two glaring problems with all comparisons of WC data across states. First, there are many factors that would explain persistent differences among states, e.g., disproportionately high employment in high-risk industries, the proportionate number of self-insured or high-deductible employers, or variations in causation standards and claim waiting periods. Even if there were a match on one important characteristic it would be very rare to find a match on multiple characteristics. For example, compared to Washington, the Oregon body of self-insureds includes fewer entities and fewer very large corporations, while British Columbia has a small number of self-insureds concentrated in a few large employers and a few industries. Neither is representative of Washington's situation. A second problem in comparisons is the different ways data are defined, collected, edited and reported by jurisdictions.

An additional 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. 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. Notwithstanding these methodological challenges, we did find a large number of meaningful measures of Washington's performance relative to other jurisdictions.

When performing comparisons of Washington workers' compensation program with other state programs, a major caveat is the unique treatment in Washington of self-insured employers. Specifically, Washington has two systems for controlling the process of claim adjudication: one for State Fund claims and one for self-insured claims. Many other states will report on regulation of claims activity as a whole – all claims, both insured and self-insured. For example, in the 2012 *Report on the Oregon Workers' Compensation System*,[5] the table on page 24 reports on the "Insurer claim acceptance and denial, median time lag days," but we confirmed that the data in that table includes "traditional" insured claims, self-insured claims, and state-fund (assigned risk pool) claims – in other words, all claims.[6] In our performance comparison (Chapter 5 of the report) we made adjustments to the Washington data to better compare it to other states, and disclosed major methodological differences in multistate comparisons.

In conducting our inquiry, the supplying states were asked to document any factors that might deviate from the stated request, e.g., first payment date is supplied voluntarily by a subset of self-insured, government self-insured are not counted in the data, or denials exclude certain types of denials (duplicate claims, out of state employment, etc.). The states were asked to cite any statutory standard or administrative goal for first payments, e.g., 80% of lost time claims paid within 14 days of date of injury. The response on this request for elaboration and documentation was generally poor.

Denial rates are seldom computed and published, by the insurance industry, self-insurers, research organizations, or government agencies.[7] Also, denial information must be carefully defined, since denial statistics may or may not include summary denials arising primarily outside of the claims management process (e.g., lack of employer coverage, claimant not an employee, duplicate claim, etc.).

In Washington, there was no need to contact self-insureds or their TPAs regarding the payment promptness and denial statistics. Both are available for the entire population of self-insureds via the electronic database. These data were tested and appear to be relatively sound. We combined the self-insured data with the Washington state fund data for analysis with other jurisdictions. Note that we did seek TPA data regarding the four comparative questions set forth above, in addition to the question of time to provider payment for initial treatment, for neighboring states to Washington (OR and ID). We worked on repeated requests with the Washington Self Insurer Association Executive Director, who was supportive of the request. Unfortunately, no TPAs were willing to supply the information. Fortunately, the above described methods resulted in sufficient comparative information.

[5] Available at http://www.cbs.state.or.us/external/imd/rasums/2362/11web/11_2362.pdf.

[6] Note that we have received data, based on a special request, from OR that is self-insured specific, thus simplifying (and improving) some comparisons considerably.

[7] Oregon is the shining exception; they publish denial statistics for insurance each year. Minnesota had a special project on denial rates in the early 1990s.

Appendix 4: Highlights from File Reviews

INTRODUCTION

In the review of claim files we covered a broad set of questions designed to cover several performance areas, and to answer specific questions set forth for this audit. The scope of the review and methodology are reviewed in Appendix 3: Methodology.

In the course of the review there were some recurrent performance themes, which we highlight here for analysis. The themes are as follows:

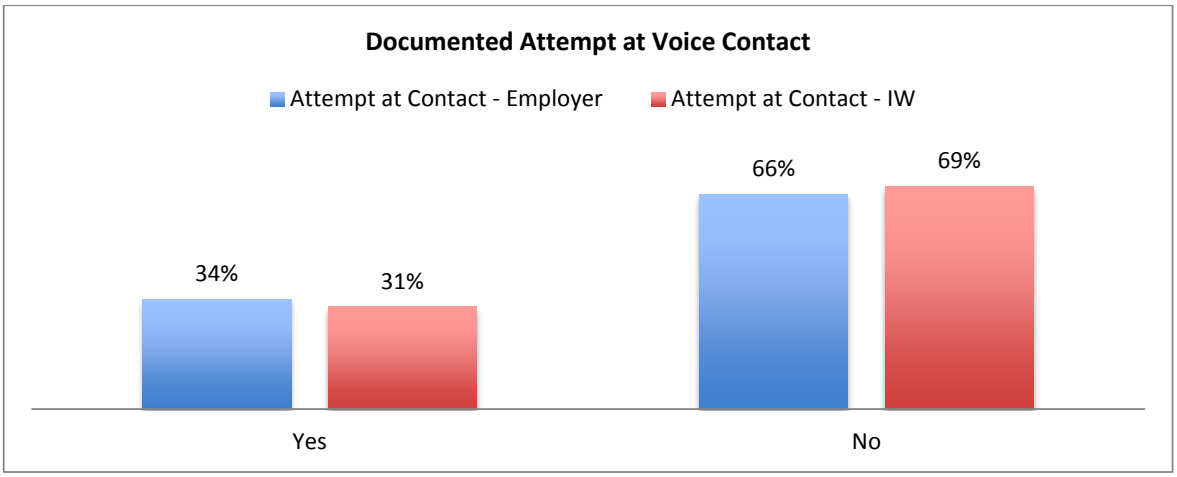
1. Voice contact
2. Allowance review
3. Denial review
4. Case management planning.

1 VOICE CONTACT

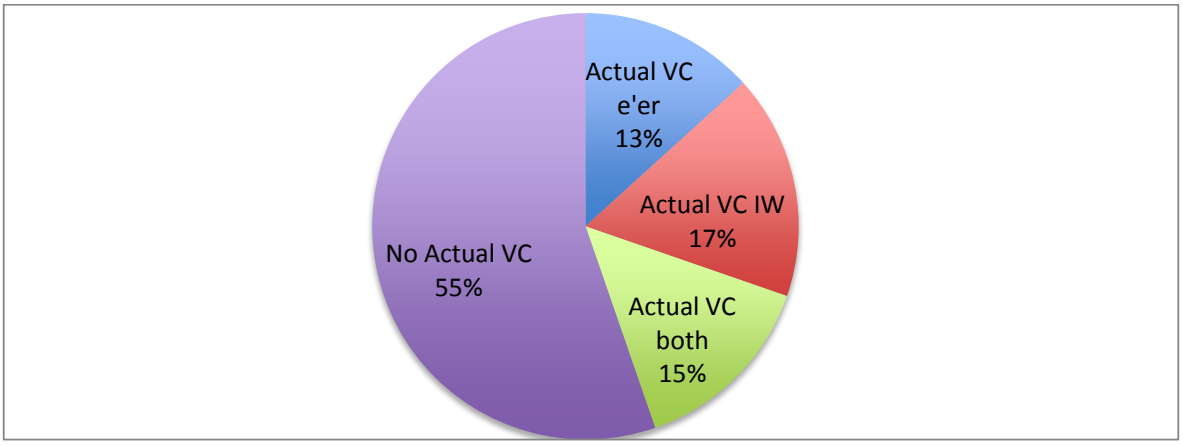
Here, we looked for actual and attempted voice contact within 30 days of claim receipt. (n=264; State Fund claims)

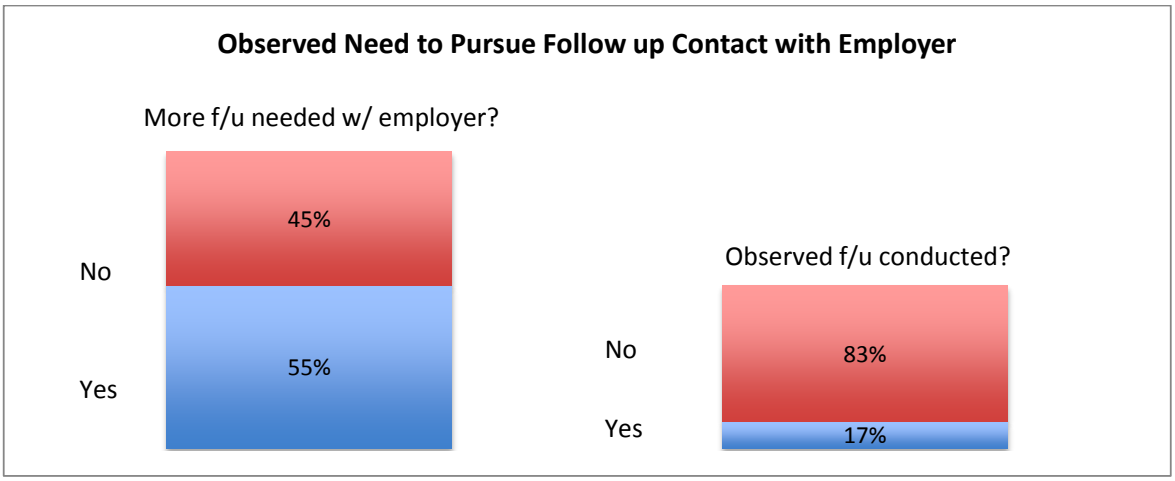
1.1 ACTUAL AND ATTEMPTED VOICE CONTACT

Only about a third of the files reviewed contained evidence of an attempt to contact the employer and the injured worker. The observation of whether follow up was needed was based on observed issues that present in the file for which follow up would help provide resolution. These included straightforward items, such as a stated desire for follow up, to what appeared to be an injury for which at least light-duty RTW would be appropriate, but there was no documented explanation of why light-duty RTW was not being pursued. In the opinion of the reviewers documentation of such follow up would have provided clarity and insight to managing the claim.



Voice Contact within 30 Days



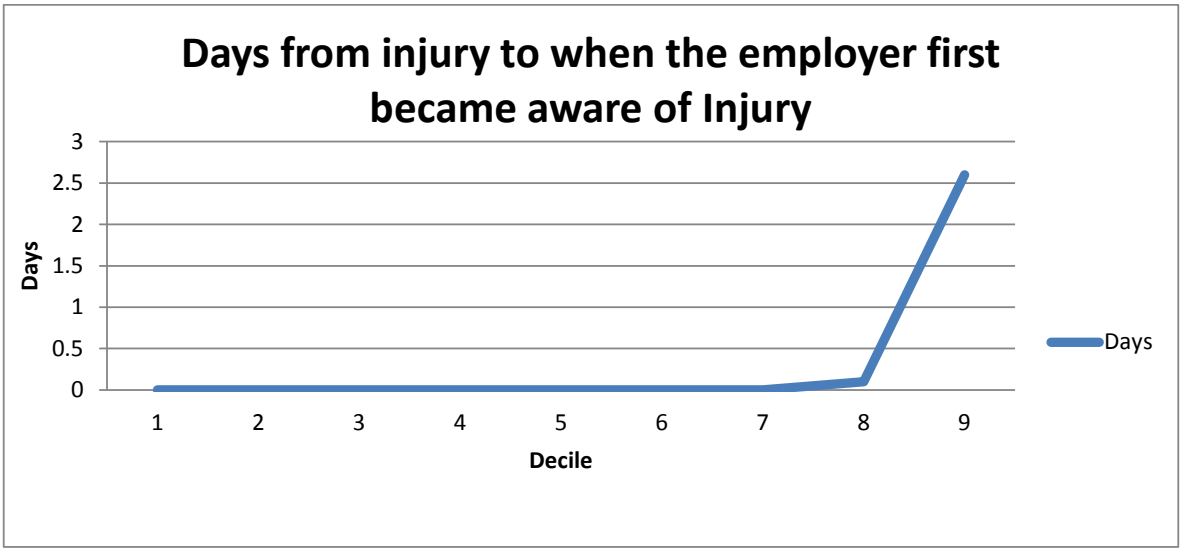


2 ALLOWANCE REVIEW

This covers various steps taken by the CM to verify that the reported injury was covered under the law and should be "allowed."

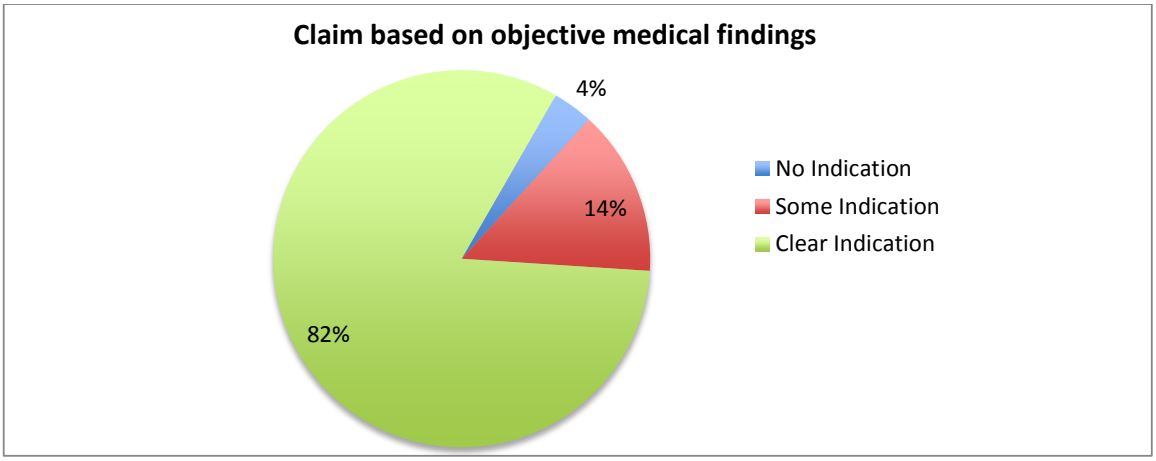
2.1 TIME FROM DATE OF INJURY TO APPARENT DATE OF EMPLOYER NOTICE

From injury to L&I receipt, median = 7 days; average = 18.8 days. Removing 2 x SD outliers, median = 7 days; average = 12.3 days. To process the risk class assignment, it takes an average of 0.7 days; median is same day (zero days) (n=262). The file reviewer identified the date that the employer was aware of the injury from the ROA or other documentation.

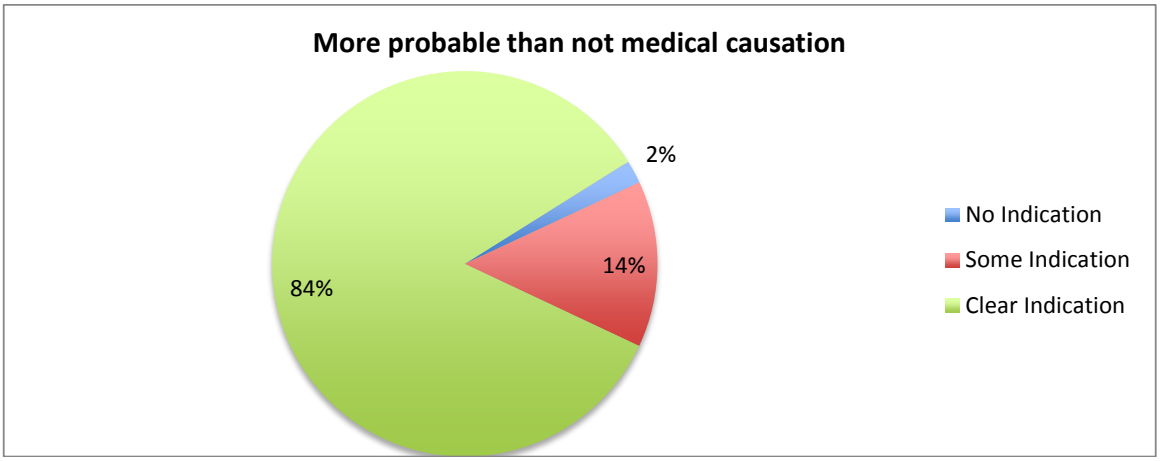


2.2 Review of Allowed Claims, State Fund (264 files reviewed)

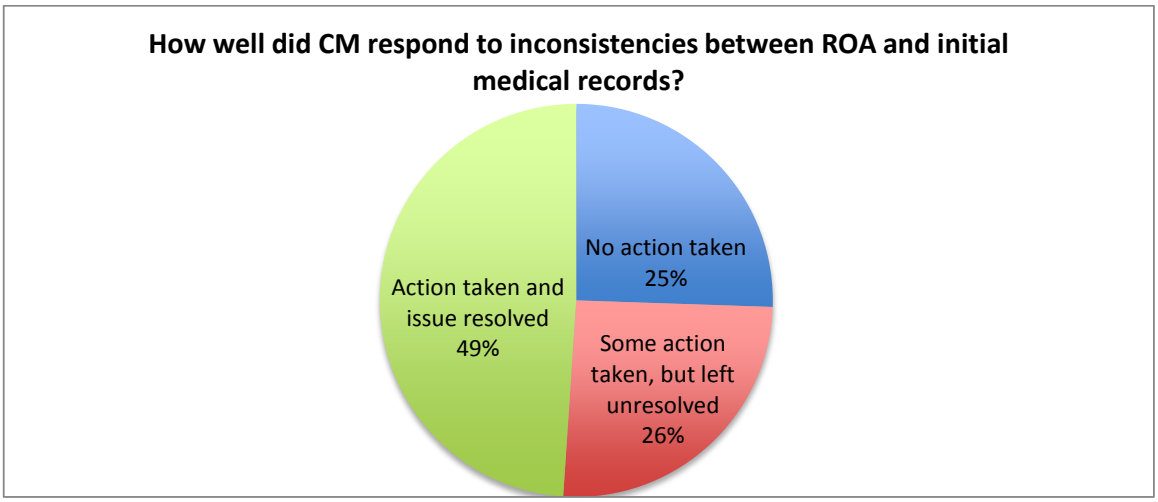
This review step examined the file to see if there were objective medical findings in the report of injury, or in follow up materials received by the CM. In 4% of the files there was no indication; in the remainder there were varying degrees of findings. Clear indication only meant that the doctor's statement was unambiguous and filled the necessary conditions, not that it was necessarily correct or thorough.



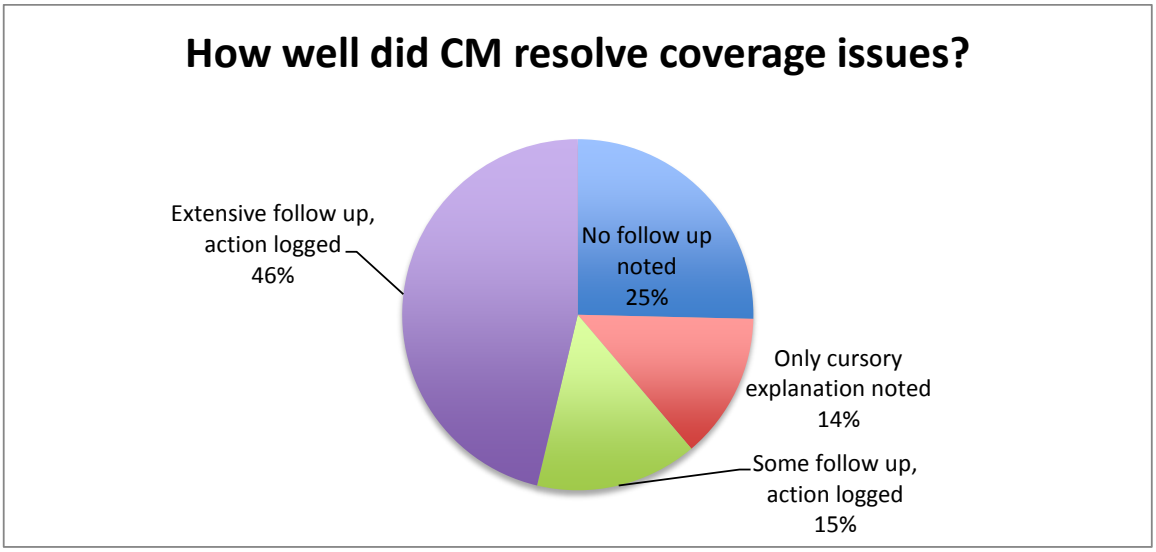
Another test for the validity of a claim is whether the treating physician opined that the injury was "more probably than not" related to work. In 2% of the files there was no such indication.



In 75% of the files the CM took varying degrees of action to resolve gaps or inconsistencies between the report of injury and other medical records. In a quarter of the cases the reviewers thought that there was no action taken to resolve an apparent inconsistency.



CM reaction of coverage problems and uncertainties was extremely varied. In 46% of the files there was extensive follow up shown. At the other extreme, in 25% of the files there was no follow up noted for issues that the review thought should have been pursued.

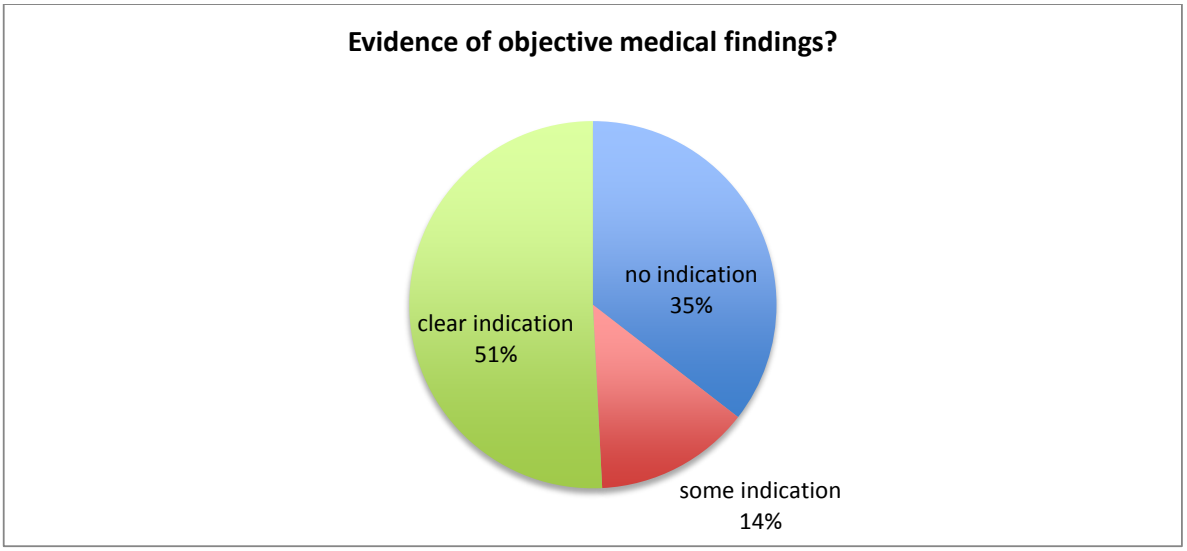


2.3 Review of Allowed Claims, Self Insured (144 files reviewed)

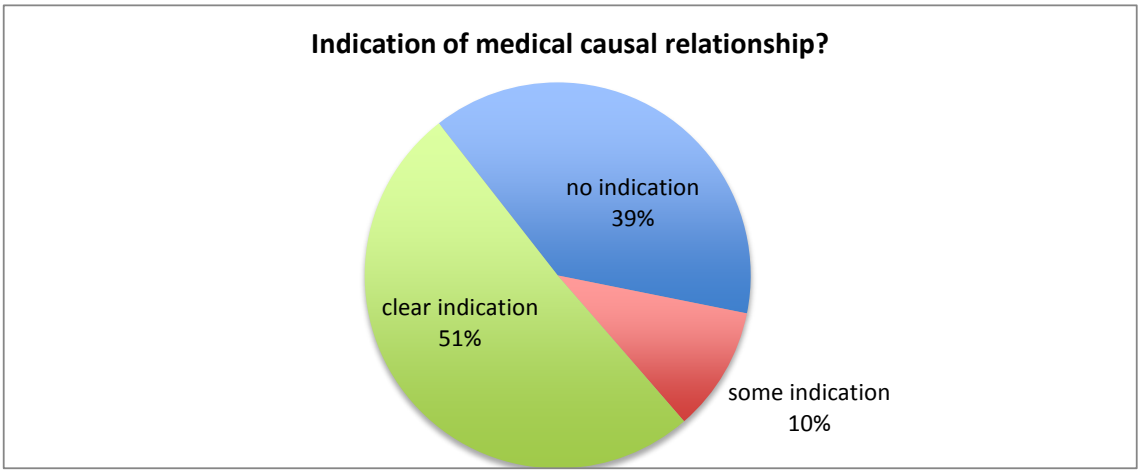
This review point explored the quality of the information provided by the physician on the first report of injury.

In nearly half the files there was some information missing that the reviewer thought was necessary to make a solid decision. Additionally, in nearly half the files reviewed there was no statement by the doctor that the injury was work related. This is a surprising breach in claim reporting.

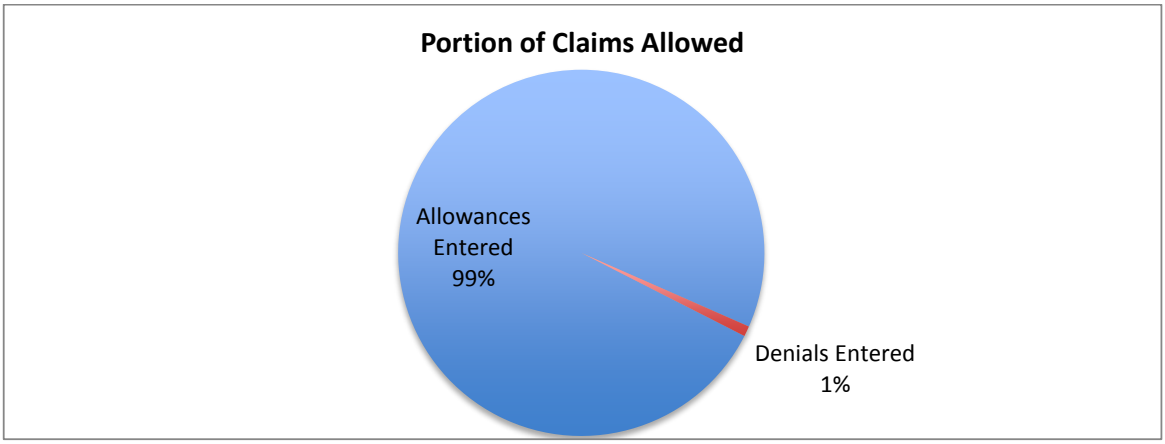
The first reports contained a wide range of statements by the doctor regarding the findings from the patient encounter. In just over a third of the files the reviewer saw no indication of any objective clinical evaluation of the injury.



In 39% of the self-insured files there was no indication shown of a medical causal relationship for the injury being claimed.



Despite what the reviewers saw as some rather clear gaps in the physician's report of injury, only 1% of the self-insured files reviewed were denied.



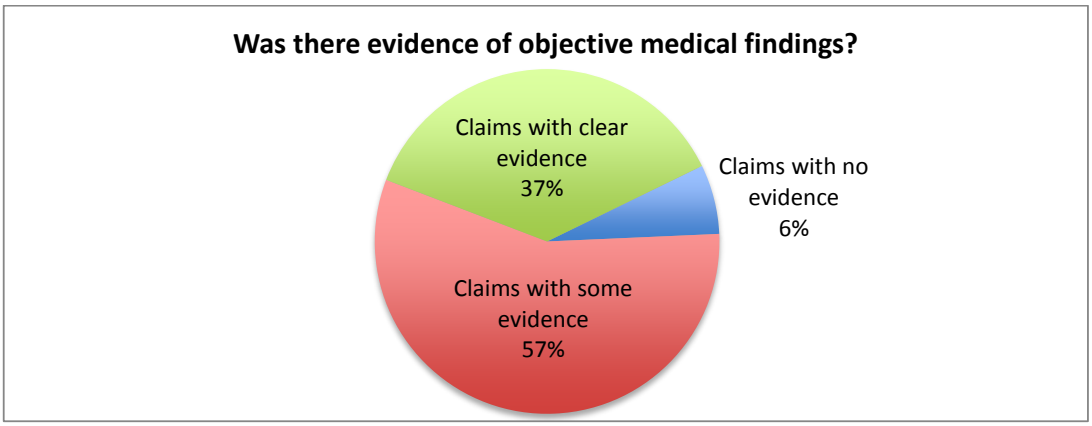
Note: In our reviewed files, there were 110 allowances entered by L&I, and 1 denial, which was later overturned. L&I sometimes enters an allowance, although the TPA does not specifically request it. In other cases, the TPA specifically requests allowance. In our review files, there were 72 specific TPA allowance requests, of which 66 were granted by L&I; the balance (72 – 66 = 6) were not yet acted upon by L&I.

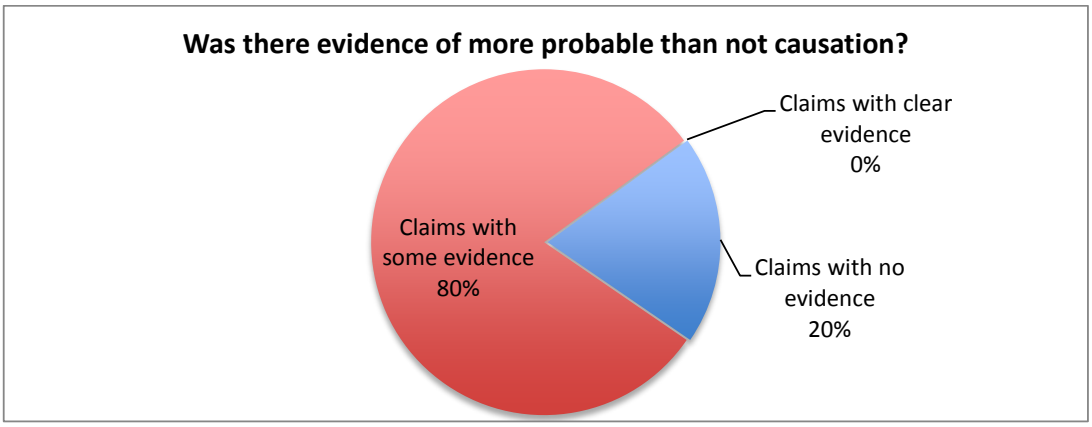
3 Review of Denials

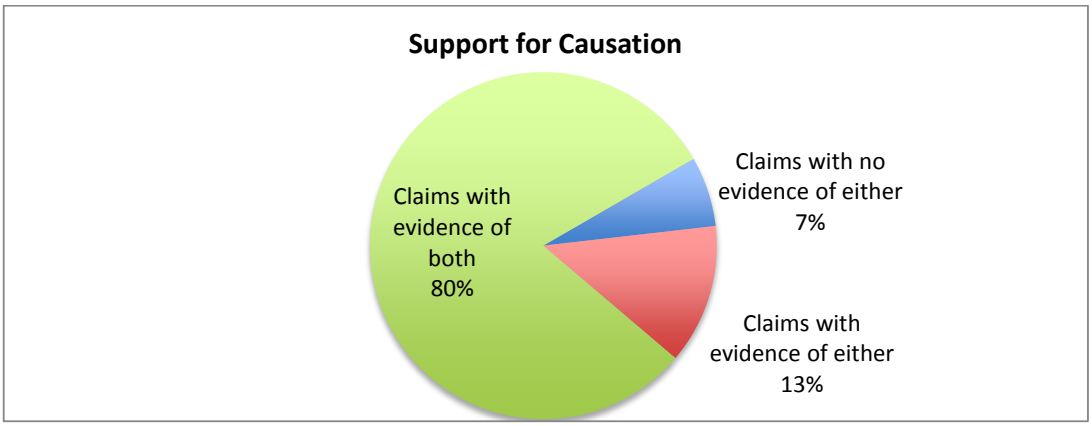
Here we looked at three aspects of the evidence presented to support denials by State Fund and self-insurance. Ninety two files were reviewed with an even split between State Fund and self-insurance.

3.1 STATE FUND

We looked for documented medical legal evidence important to addressing causation. The absence of such evidence does not mean that the claim should be denied; rather some degree of such evidence is likely present in most workers' compensation reported accidents. We calculated these results primarily for comparison purposes with self-insured files.

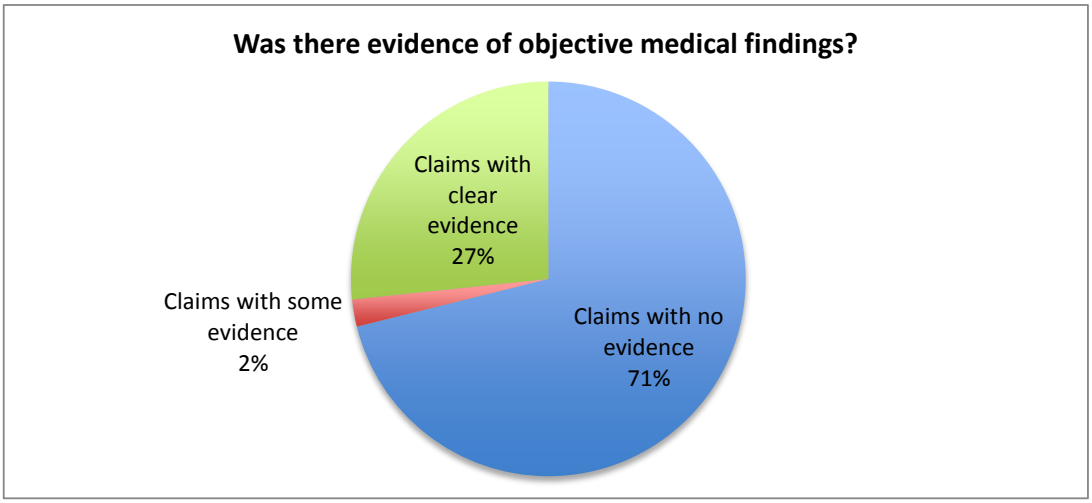


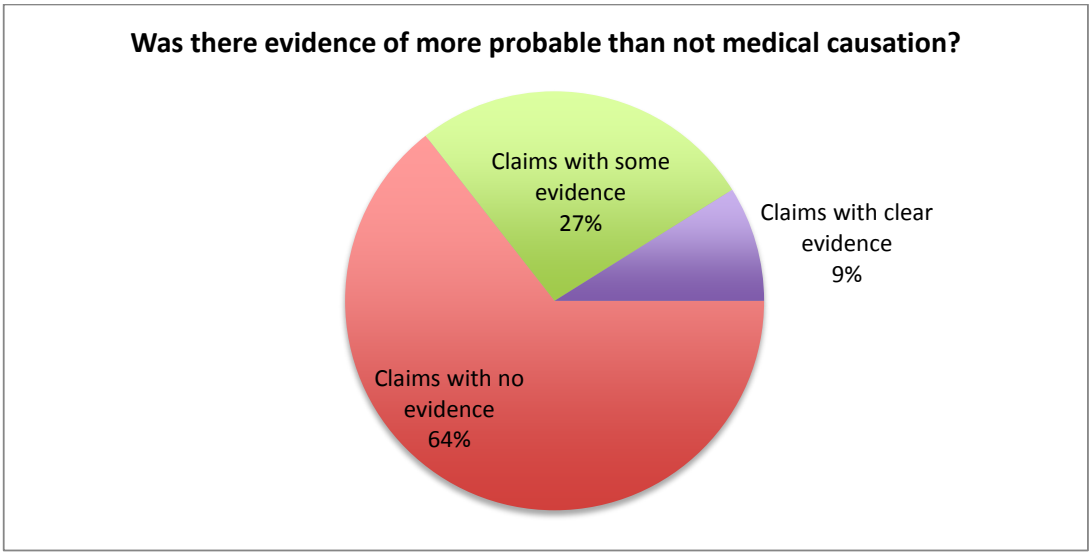


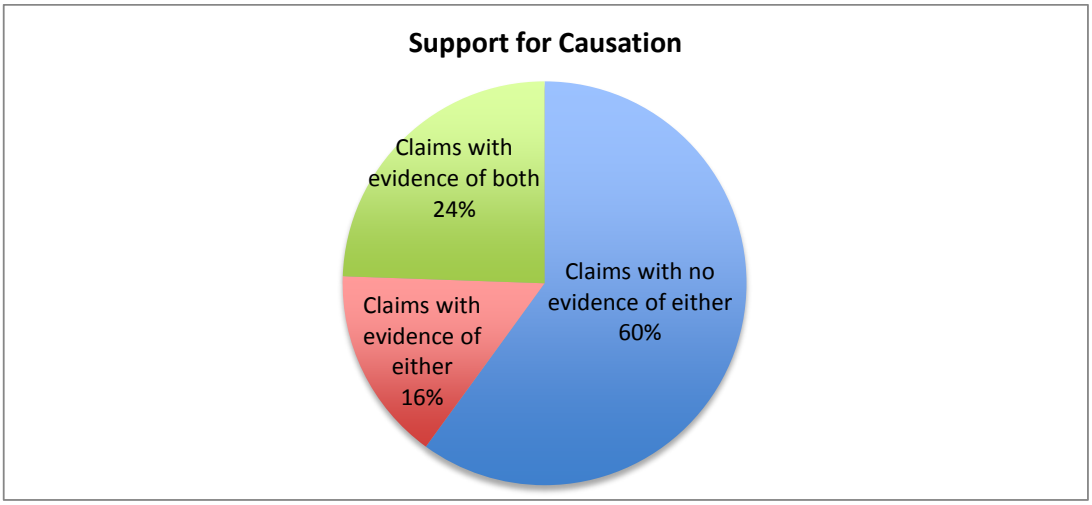


3.2 SELF INSURED

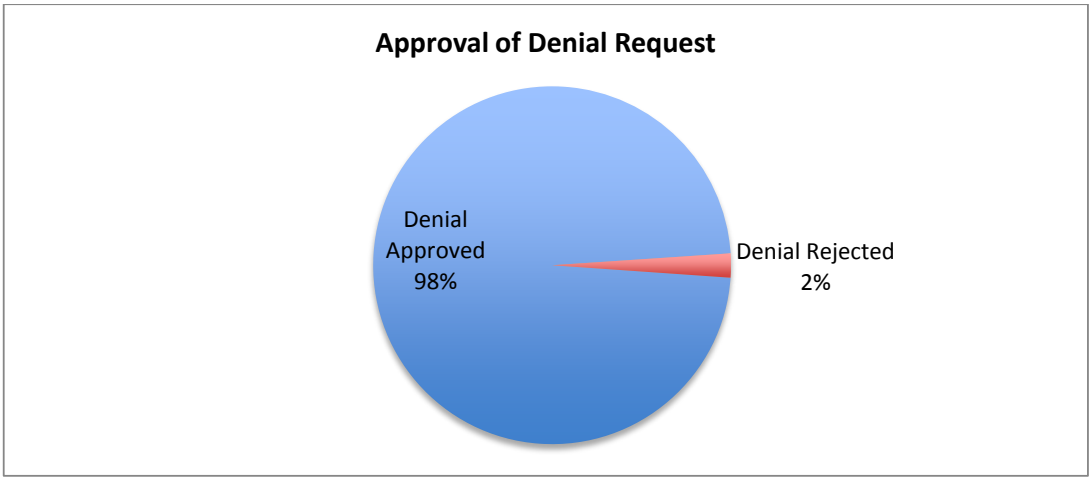
As for State Fund claims, we looked at the supporting evidence of record. The absence of evidence, e.g. objective medical findings, is not equivalent to proof that objective medical findings were missing, and thus the denial was appropriate. Rather, most reported injuries have some degree of evidence of medical causation. Solely for comparison with State Fund claims, we looked at the portion of self-insured claims where this evidence was present. We expected a similar portion of claims where there would be at least some supporting evidence of causation. What we found, however, was that there was far less documented evidence in self-insured claims. We believe that this is likely the result of simply not supplying the information to L&I, and provides at least some support for the conclusion that L&I is not conducting an in-depth review of denied claims.







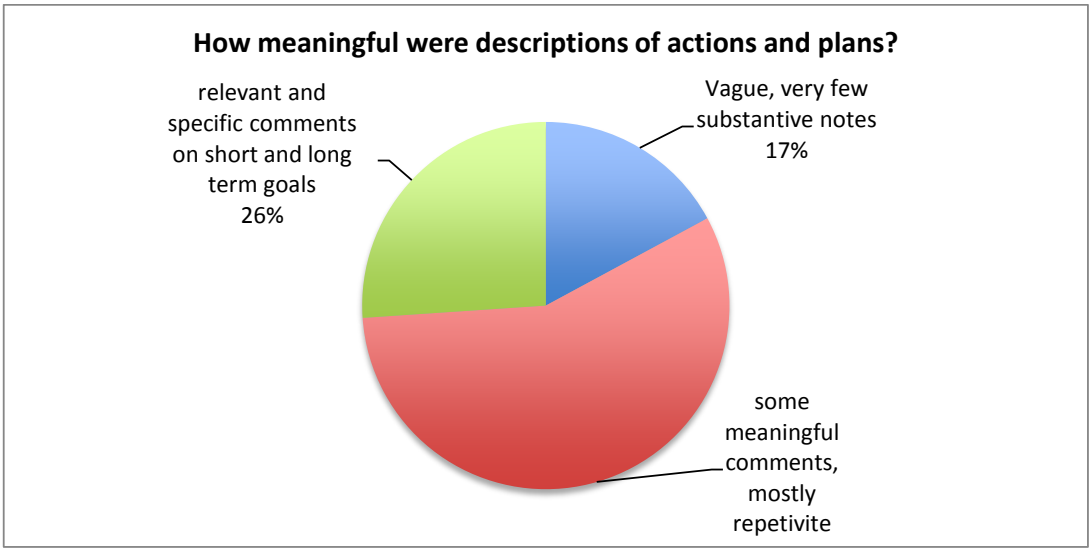
Importantly, only 2% of the denials recommended by the self-insurer were rejected by the L&I reviewer. This fraction may have gone down even further to the extent the self-insurer successfully protested the initial denial.



4 Case Management Planning

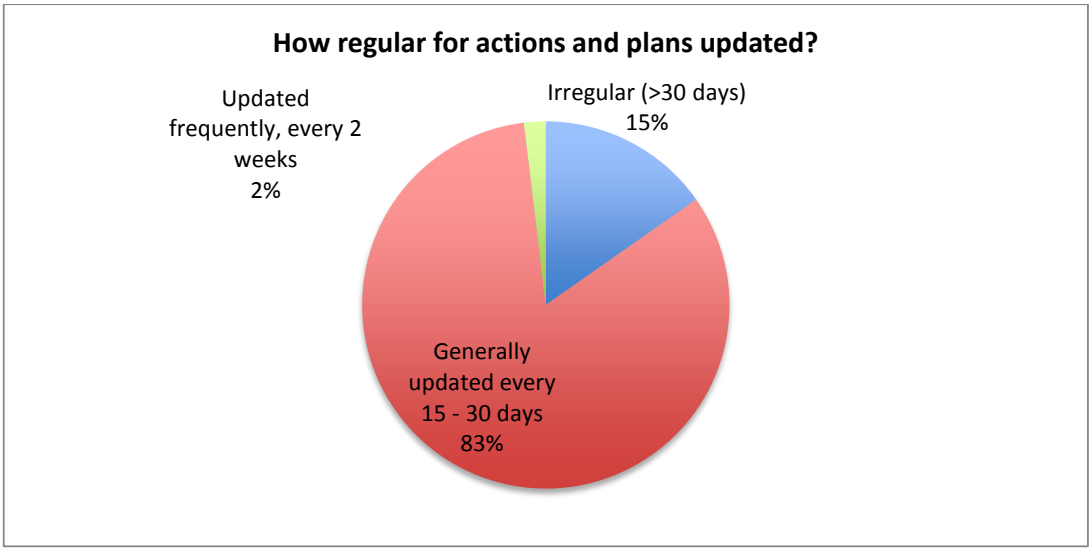
4.1 Documented Action Plans (257 statistically relevant files our of 264 reviewed)

This step of the file review rated the descriptions recorded in the actions and plans notations inserted in the file by the CM. It was rare to find more than a few words that hinted at potential problems, and there was very little documentation of potential solutions or plans to overcome or prevent problems. In some cases, in LINIIS single words were used to document actions or plans, such as: “opioids?” “close?” and in ORION, the detail and action field often were blank. Hence the degrees of documentation shown below are based on short and sometimes cryptic notes. L&I reports that recent system changes (March 2015) have increased the character space available in the information system for documentation to 650 characters in the Claim Details Action field and the Claim Details Plan field.



4.2 DOCUMENTED UPDATES (262 STATISTICALLY RELEVANT FILES OUT OF 264 REVIEWED)

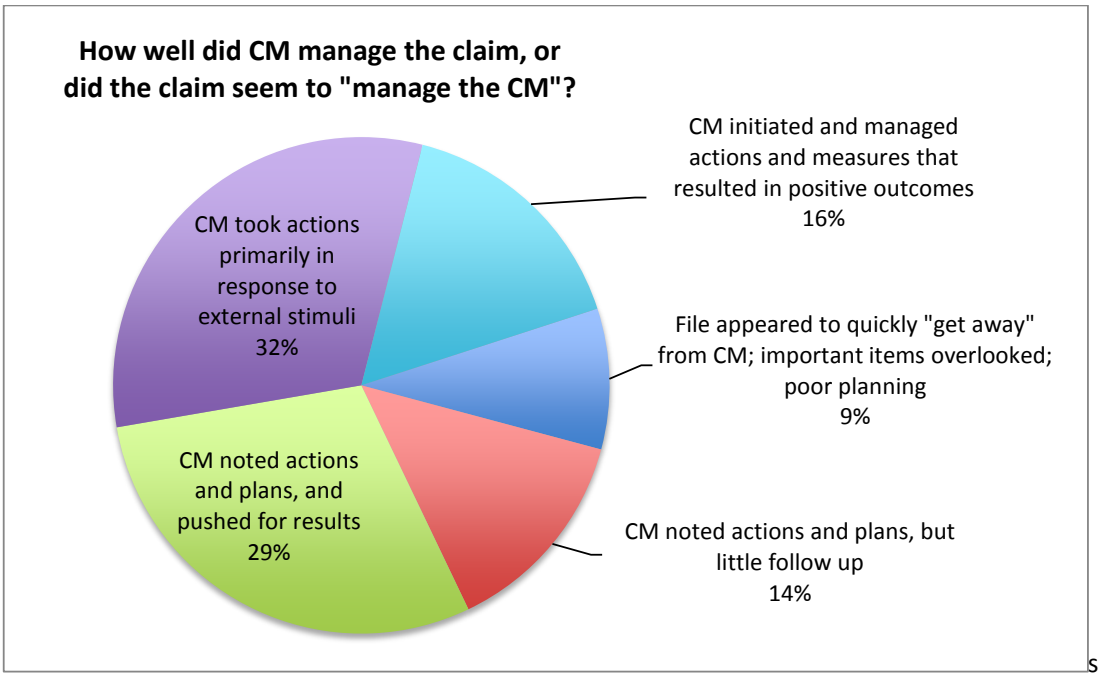
L&I claim management software demands that the files contain updates on the actions and plans periodically. We tended to see updates that were done every 2-4 weeks. Most of these were rather minor alterations of the previous actions and plans.



4.3 OVERALL DOCUMENTED PLANNING EFFECTIVENESS (262 STATISTICALLY RELEVANT FILES OUT OF 264 REVIEWED)

This critique is strictly based on what was recorded in the file. Ranked in order of the quality of file management: 16% of the files displayed a robust record of actions and planning by the CM that evidence proactive behavior to achieve positive results; 29% noted somewhat less proactive or actions

to move the file to a positive outcome; and in 32% of the files the reviewers saw CMs recording actions that were more passive reactions to the parties to the claim (claimant, doctor, employer, ERTW).



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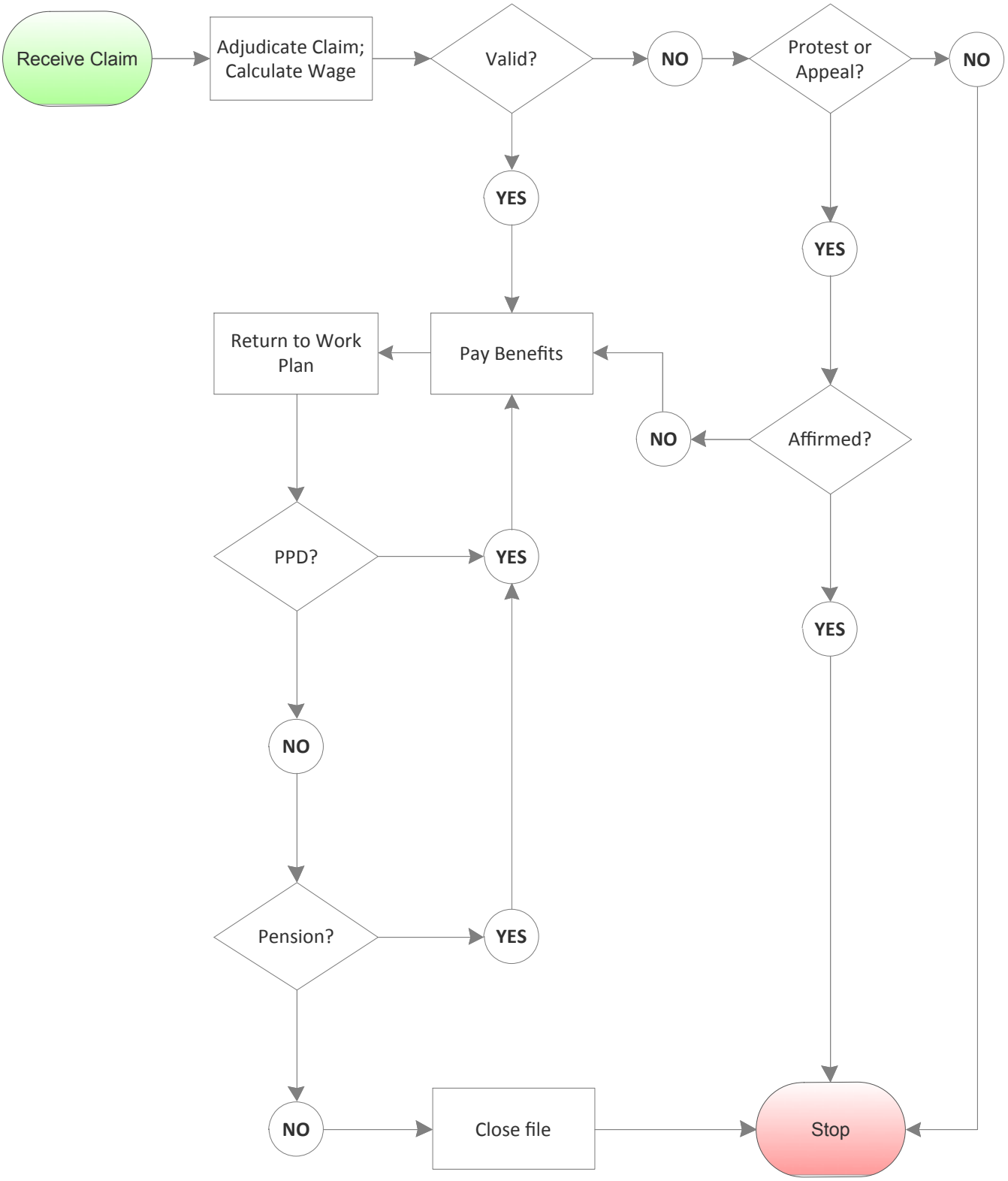
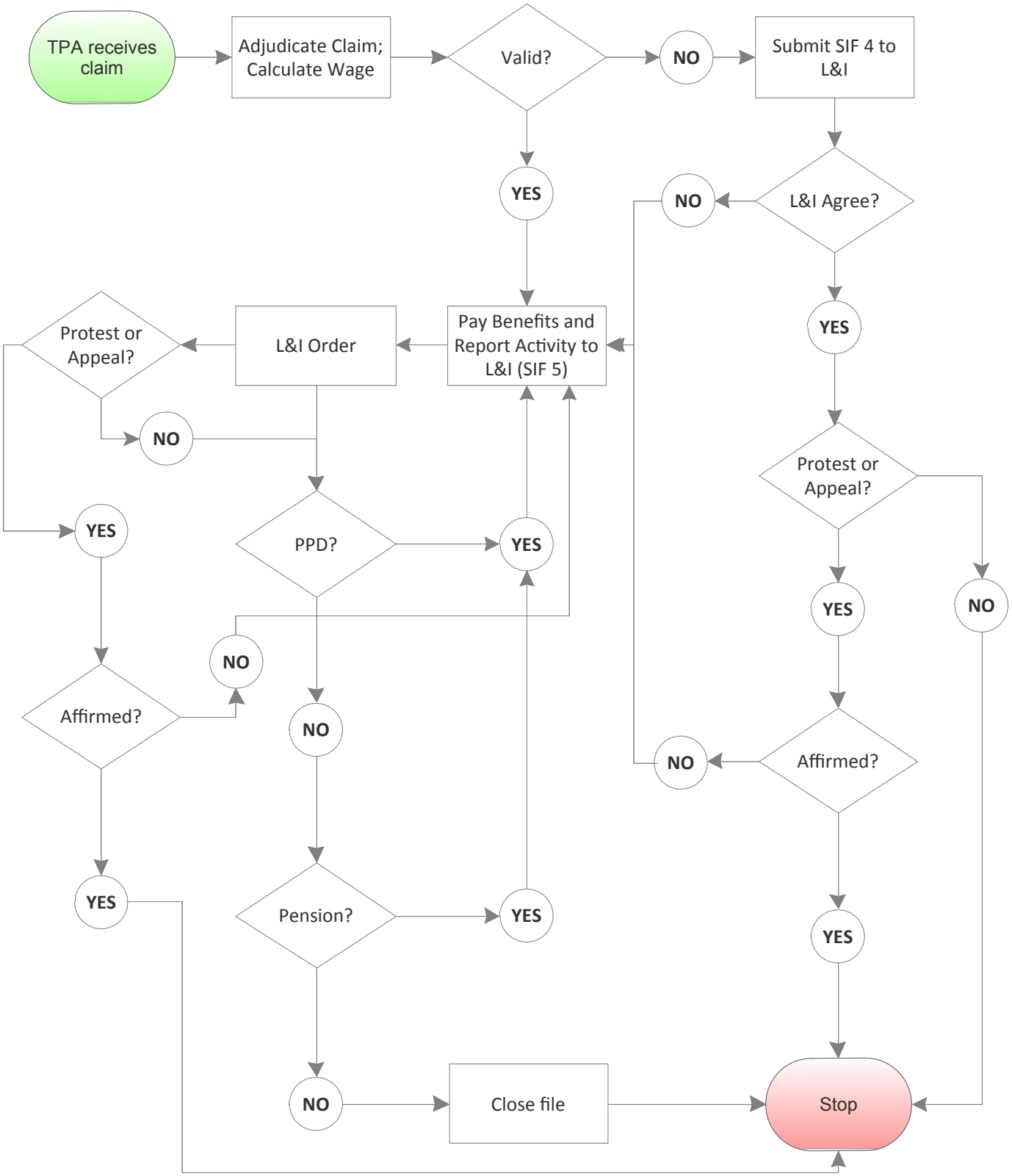
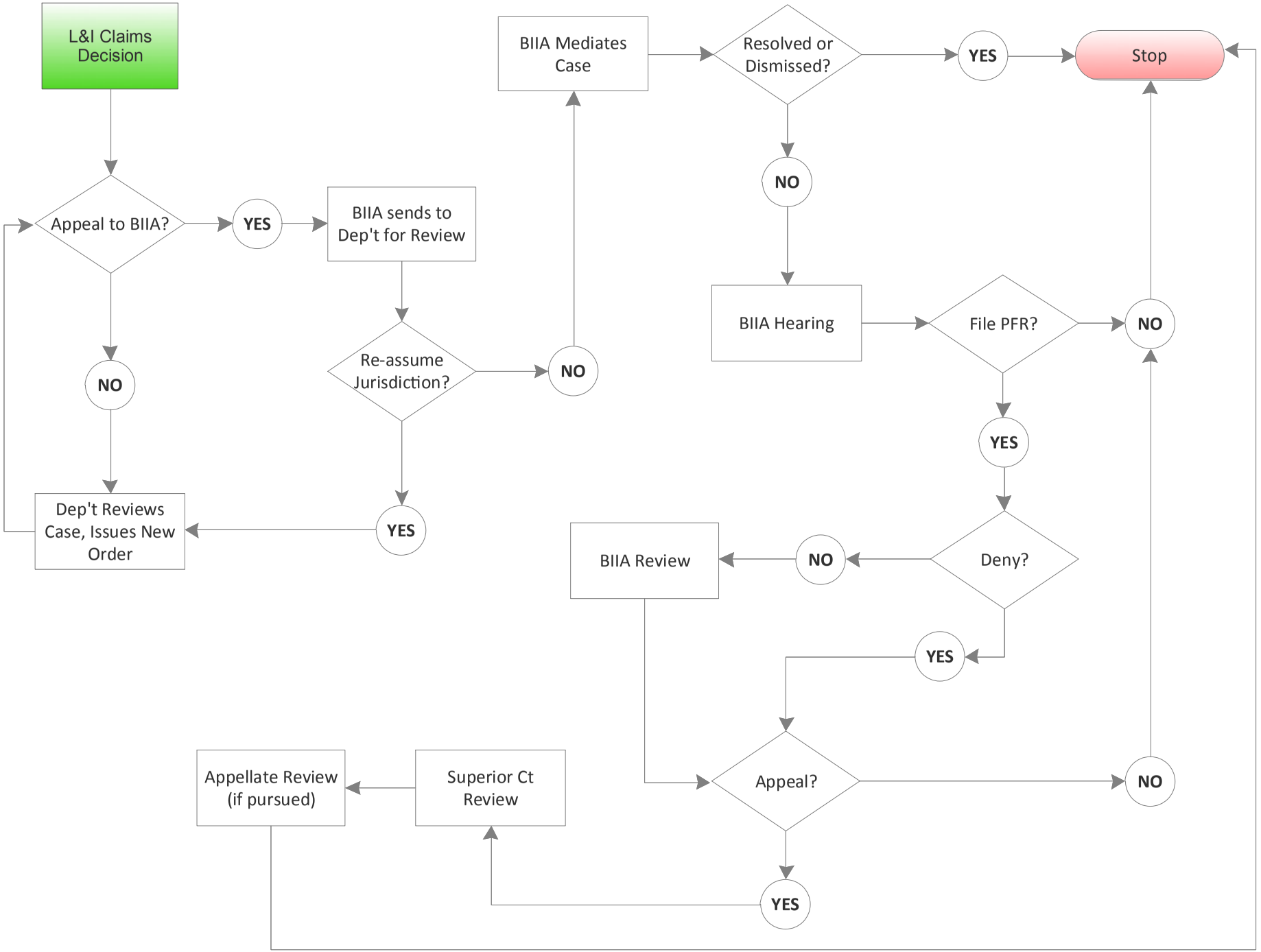
Appendix 5: Claims Management Flow Charts

The following three flow charts depict:

1. State Fund claims management
2. Self-insured claims management
3. Appeals (both State Fund and self-insured)


Receive Claim
Adjudicate Claim; Calculate Wage
Valid?
NO
Protest or Appeal?
NO
YES
YES
Return to Work Plan
Pay Benefits
NO
Affirmed?
PPD?
YES
YES
NO
Pension?
YES
NO
Close file
Stop


TPA receives claim
Adjudicate Claim; Calculate Wage
Valid?
NO
Submit SIF 4 to L&I
YES
L&I Agree?
NO
YES
Pay Benefits and Report Activity to L&I (SIF 5)
L&I Order
Protest or Appeal?
NO
YES
PPD?
YES
NO
Affirmed?
NO
YES
Pension?
YES
NO
Close file
Stop
Protest or Appeal?
YES
NO
Affirmed?
NO
YES
YES


L&I Claims Decision
Appeal to BIIA?
YES
BIIA sends to Dep't for Review
NO
Re-assume Jurisdiction?
NO
YES
Dep't Reviews Case, Issues New Order
BIIA Mediates Case
Resolved or Dismissed?
YES
Stop
NO
BIIA Hearing
File PFR?
NO
YES
Deny?
NO
BIIA Review
YES
Appeal?
NO
YES
Superior Ct Review
Appellate Review (if pursued)

Appendix 6: Survey of Washington Employers on Attitudes and Experience with L&I and Its Claims Handling

INTRODUCTION

Employer satisfaction with and confidence in L&I is critical to achieving the social policy objective of the legislation L&I is entrusted with administering. The strength and depth of positive perceptions influence L&I's success in its prevention programs, and stay at work /return-to-work (RTW) initiatives.

Strong organizational credibility and reputation take time to build but a sustained positive reputation particularly for fairness of process and decision-making can contribute to increased confidence that judgments on individual cases are sound. Weak organizational credibility on the same dimensions can increase doubt in the process and mistrust in the decisions made by the organization. If employer attitudes and experiences with L&I and its claims handling are low then the confidence and cooperation of this key stakeholder may be compromised.

To gain insight into the employer attitudes and experience, the audit team surveyed employers about their satisfaction with the L&I claims management process. The underlying logic model assessed multiple dimensions or "touch points" that contribute to overall experience. Experience is a function of the interactions and communications with claims managers, staff, and process essential to claims management and return-to-work.

1.1 SAMPLING STRATEGY

This survey is not based on a random sample of the entire population of Washington employers covered by workers' compensation. We sampled only employers with a history of multiple claims, to help ensure that representatives would have solid experience of interactions with L&I upon which to base responses. We did not include TPAs or employer representatives, but instead surveyed employer staff responsible for workers' compensation related decision and activities. During interviews we collected information from these stakeholders.

After selecting the sample, we mailed letters to the potential respondents, asking them to call to participate, or access a unique website. Each recipient was given a code that was unique to them, to input into the online tool or when calling, to prevent duplication. After the letters were mailed, we monitored participation rates, and followed up with postcards. The final participation results are in Exhibit A-1.

Exhibit A-1: Survey completion by employer type and survey tool

			Employer Type			Survey Tool	
	Call attempts	**Total completes**	State Fund: Retro	State Fund: Non-Retro	Self-Insured	Phone	Online
Employers	**8,545**	**1,409**	697	547	165	712	697

Results were compiled and validated, and the following report summarizes findings.

1.2 SEGMENTATION

One of the stated objectives of this audit was to study the opinions of employers about how their claims are handled by L&I. Consequently, for the survey of employers, we contacted the employers of injured workers directly. In many instances, employers delegate some responsibility for claims handling to a third party. Some employers, especially self-insured employers delegate the claims handling to a third party administrator (TPA). When claims are handled by a TPA, the employer is usually not involved in most claim decisions made by the TPA or L&I. The TPA will keep the employer informed, as necessary and may or may not communicate satisfaction or frustration with their interaction with L&I. Still other employers have Retro Group managers, as a service to group members, offering some degree of claims management assistance.

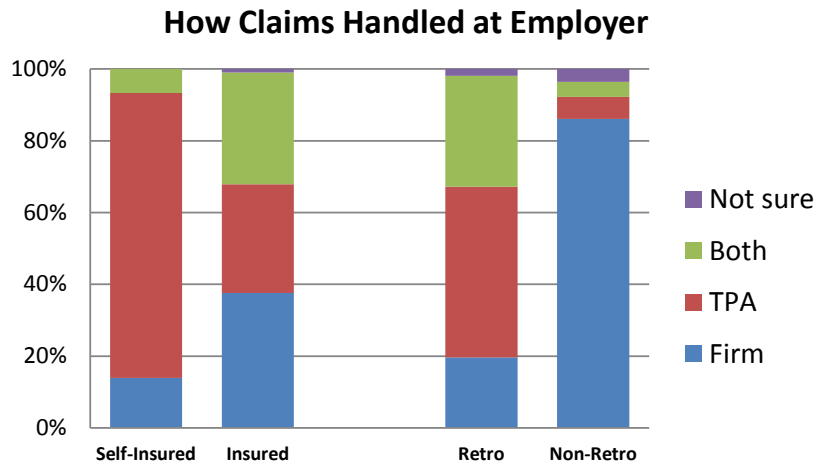
Key issues to keep in mind when interpreting the results of the survey is that when a TPA is an intermediary in the claim process, employers may less frequently interact with L&I and the composition of issues that lead to interaction between the employer and L&I may differ from the composition when employers handle their own claims. For example, an employer with a TPA is likely to be involved when the issue is occupational causation, but may not be involved when the issue is IME evaluations for permanent partial disability. A TPA likely handles nearly all medical treatment disputes and issues, but the employer is likely to be consulted directly with many return-to-work decisions, or at least to develop a return-to-work program that is applied by the TPA. Many employers are very active in managing workers' compensation issues, whereas others are not, and rely heavily on their TPA. This is variable by employer, and depends on the level of services provided by the TPA, as well as other factors particular to an individual employer.

The issue of who handles the claim is a bit more complex and important to our interpretation of results because JLARC is very interested in whether employers' opinions differ by insurance status (Self-insured, Retro-rated, and non-Retro). But, as can be seen below, employers within these groups have very different patterns as to who handles their claims. Self-insured employers primarily delegate claims handling to TPAs. Non-Retro employers overwhelmingly deal directly with L&I when required, without the benefit of an experienced intermediary. Retro-employers fall somewhere between these two groups in the extent to which they rely on employer representatives, which share some common features to the TPA model used at self-insured employers. In fact, in some cases the same TPA will serve self-insured employers as claims manager, and will also serve Retro groups as employer representative.

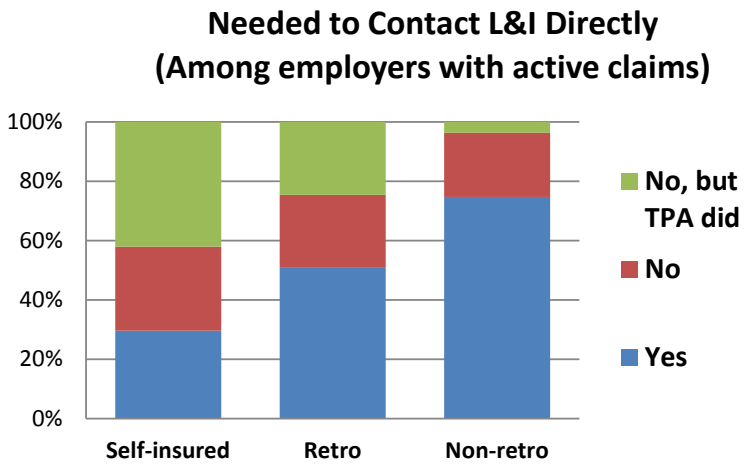
For many of the analyses we will break employers into four groups. The first group will be self-insured employers (seen as the far left column in the chart below). The second group is matched insured employers, selected because they match most closely to self-insured employers based on several characteristics (most importantly size). Both of the last two groups are insured, Retro-rated and non-Retro employers. They too are matched on characteristics to be as similar as possible. This division allows us to compare self-insured employers to insured employers while controlling for characteristics like size and industry that may affect the measures of interest. Similarly, we can compare Retro-rated insured employers to Non-Retro rated insured employers while controlling for important characteristics. This allows us to draw stronger inferences about how employers' interactions are or are not affected by their insurance status (Self-insured, Retro-rated, or non-Retro).

However, not all differences could be resolved by matching employers when selecting the samples. Most obviously, from the chart below, how claims are handled is a key characteristic that distinguishes these groups. Nearly all self-insured employers use TPAs and few non-Retro employers use TPAs. We did not have access to information on the claims handling process when we selected the samples so we could not match on this criterion. We had to ask this question about claims handling on the survey. Ultimately, we could use some other techniques to control for the use of TPAs to handle claims, most appropriately, regression adjustments. This would be done as a separate and later analysis.

Keep in mind, "claims handling" can be a very ambiguous term. There is a wide range of roles played by the employer. Self-insured employers that do not use a TPA will perform nearly all claim functions including paying disability benefits and medical bills. At the other end of the spectrum, L&I Claim Managers (CMs) handle the day-to-day claim transactions and non-retro rated insured employers may not pay much attention to the claim accept when a decision is required by L&I, like negotiating return-to-work options.



To further keep in mind is that the intervention of TPAs likely means an employer is less likely to interact with L&I. This can be seen in the chart below. Self-insured employers are, on average larger and have more claims. But they have less direct interaction with L&I, despite the greater number of claims, because they rely on TPAs. Retro employers, who often use employer representatives, are also less likely to have had contact with L&I about claims in the observation period, with all of the difference accounted for by intervention by employer representatives. Questions that ask employers specifically about their contact with L&I were only answered by those employers that had actual contact. Non-Retro employers were more likely to answer these questions because they rarely had TPAs intervening on their behalf. We will indicate when the pool of respondents is limited to those with actual contact with L&I.

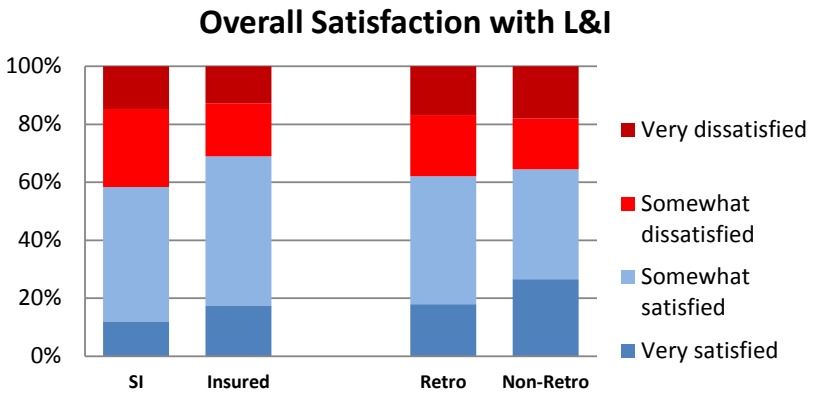


2 SUMMARY OF RESULTS

2.1 OVERALL SATISFACTION WITH L&I

First, we will summarize results of questions designed to address employer satisfaction with the L&I claims management function. Overall, almost 2/3rds of employers (64.3%) that answered the question were "Very satisfied" (19.4%) or "Satisfied" (44.9%) with their overall experience with L&I.

The level of satisfaction did not vary by the insurance status of the employer. In the chart below, we compare insured employers that were matched to Self-insured employers. Likewise, we also compare a separate group of Retro-rated employers that were matched to non-Retro-rated employers.

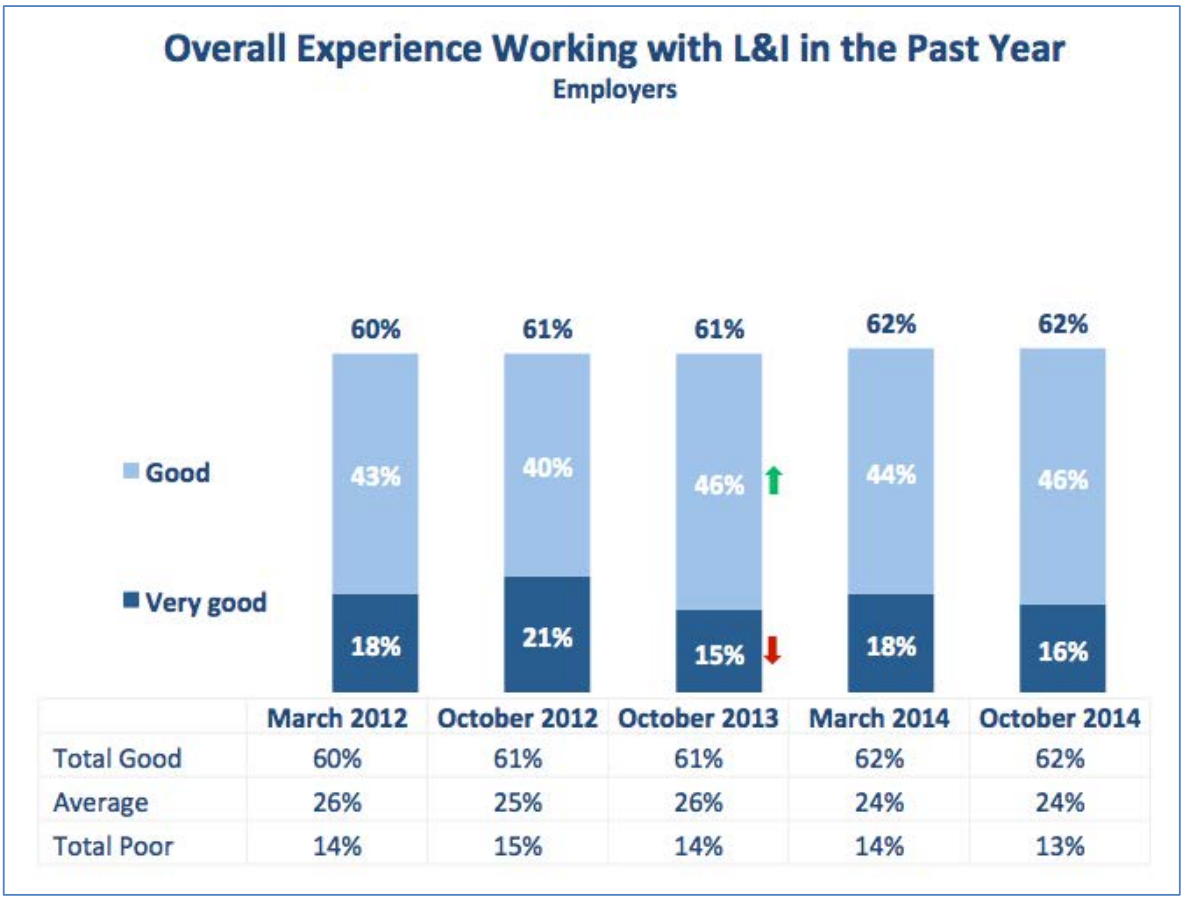


While the three insurance groups show a close similarity for the percentage of satisfied employers, there remains an important fraction of employers in all 4 groups that are "very dissatisfied," and a fairly

sharp difference between self-insured and non-Retro employers. Self-insured employers had the smallest percentage of “Very Satisfied” and “Very Dissatisfied,” seemingly showing a generally satisfactory relationship with L&I.

Interestingly, Self-insured employers that handled their own claims were substantially more frustrated with L&I (56.5% "Dissatisfied" or "Very dissatisfied") than when their claims were handled by a TPA (33.5%). Claims representatives perform fewer functions for Retro employers (e.g. they don’t make payments or hire IMEs or Voc Counselors), and the presence or absence of an employer representative did not affect Retro employers’ perceptions of L&I (31.6% dissatisfied or very dissatisfied when using a representative, 30.1% when not using a representative). Very few non-Retro-rated employers used employer representatives.

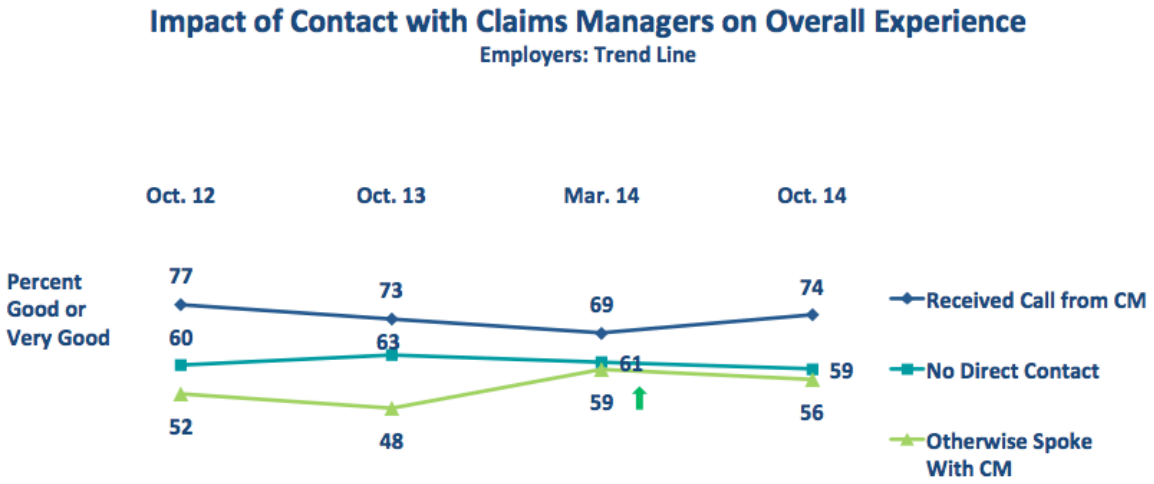
L&I also conducts employer surveys, and poses questions regarding overall perceptions of interactions with L&I. Our overall results (64% positive or very positive) are comparable with the results from recent surveys by L&I of employers (62% good or very good).



	March 2012	October 2012	October 2013	March 2014	October 2014
Total Good	60%	61%	61%	62%	62%
Average	26%	25%	26%	24%	24%
Total Poor	14%	15%	14%	14%	13%

Source: L&I Employer Survey, conducted by IPSOS (November 2014).

Perceptions of overall satisfaction where an interaction takes place are highly dependent on the rating of the interaction with claims managers and staff. Respondents who had direct contact with claims managers reported relatively high levels of overall experience satisfaction. Interaction with claims mangers and staff were very good/good in nearly 70% of responses.



Source: L&I Employer Survey, conducted by IPSOS (November 2014).

The survey supports the friendliness, helpfulness, and attentiveness (listening and understanding) of claims managers and staff. These measures also show a low proportion of employers rating claims managers low on these dimensions. The ratio of positive (very good, good) to negative (total poor) suggests staff are engaging employers and contributing to measures of overall positive satisfaction.

Dimensions where the ratio of positive to negative ratings is lowest are related to actions: resolving questions/concerns, suggesting RTW options. This may be a consequence of current policy and process constraints (although process was rated positively for more than 60% of respondents). For example, staff with no authority to make decisions may be courteous and attentive but rated poorly with respect to actions because of a lack of delegated authority or autonomy to make decisions or offer suggestions (or access to immediately available resources who can provide suggestions) for RTW options.

2.2 TIMELINESS

Next, we will summarize results of questions designed to address the issue of L&I's timeliness in performing its claims management function.

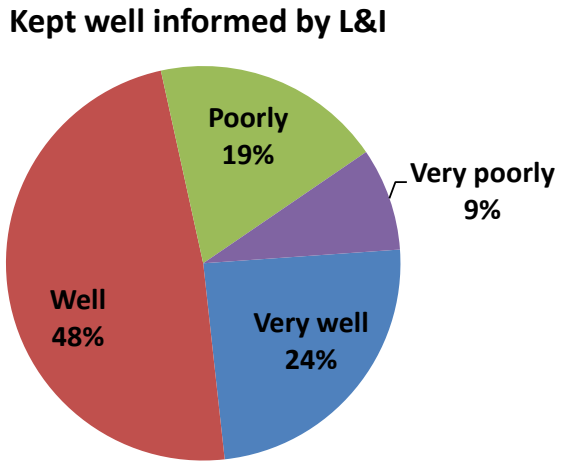
2.2.1 Kept informed in a timely manner

One of the key areas for this audit as the timeliness of L&I's interaction with employers. In this sense, we can treat timeliness as several different questions that dovetail:

- Does L&I keep employers informed about their claim(s)?
- Does this information come in timely enough that employers can make decisions and act on their claims?
- When employers have questions about claims, does L&I respond in a timely manner?

There are several other issues with timeliness as related to the dispute resolution process and medical-legal determinations, but we will deal with those in separate sections.

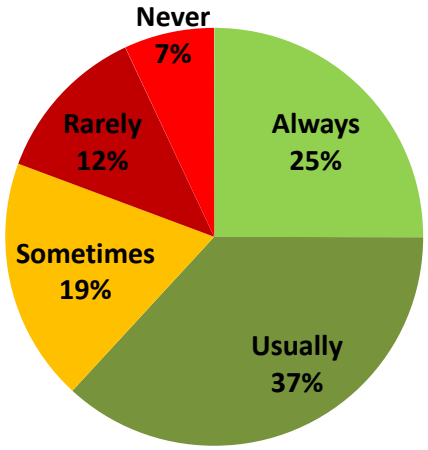
The response to the question about whether L&I kept employers sufficiently well informed about the progress of their claims received positive response, with 3/4s of employers satisfied with L&I's performance in this area.



2.3 Sufficiency of Time to Respond

A second question asked employers was if L&I's information on claims was sufficiently timely to allow them to respond to decisions on their claims. There are many decisions on occupational injury claims that are easier for employers to resolve when they are informed quickly about issues. Most importantly, timely claim reporting allows employers to investigate causation and comment to L&I on the Employer's Report of Accident, as well as decide whether to protest a particular L&I decision. In addition, during management of the claim employer issues arise where delay can result in less than optimal outcomes, specifically regarding timely return to work. Employers were quite positive about L&I keeping them informed. Almost 2/3rds of employers thought L&I always or usually kept them informed in a timely enough manner that they could take action on their claims. Given that there can be a large number of decisions made by CMs at various times in a claim, it should not be surprising that employers are not always satisfied at every point. Interestingly, larger employers with more claims were actually more likely to say L&I rarely or never kept them informed in a timely manner. This is a bit puzzling since larger employers have more frequent interaction with L&I.

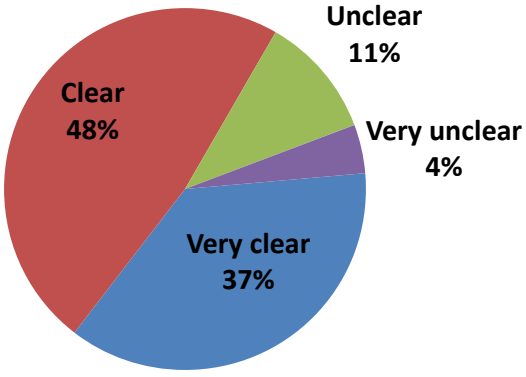
Informed Timely Enough for Employers to act on Claims?



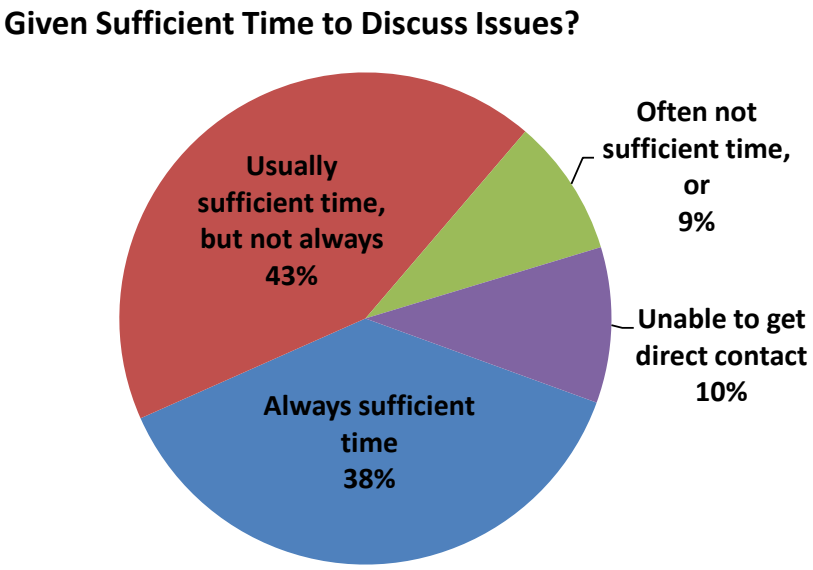
Only about half (55%) of employers felt they needed to contact L&I directly about their claims, even though, most employers had multiple claims. 50% of employers in the survey had more than 15 claims in the observation period. Consequently, only the subset of employers that needed to contact L&I were asked the questions about their direct interaction with the agency. Not surprisingly, the need to interact with L&I was partially determined by whether employers were represented by a third party. Among employers with a representative, despite being, on average, larger and having more claims, only 27.2% reported having to contact L&I directly concerning a claim. For employers that used both a representative and handled claims internally, 67.3% reported having to contact L&I directly. Three-quarters (75.1%) of employers handling their own claims reported contacting L&I directly.

When they contacted L&I, they responded that they were well informed about whom to contact. 85% of the time the contact was clear.

Who to Contact at L&I with a Question

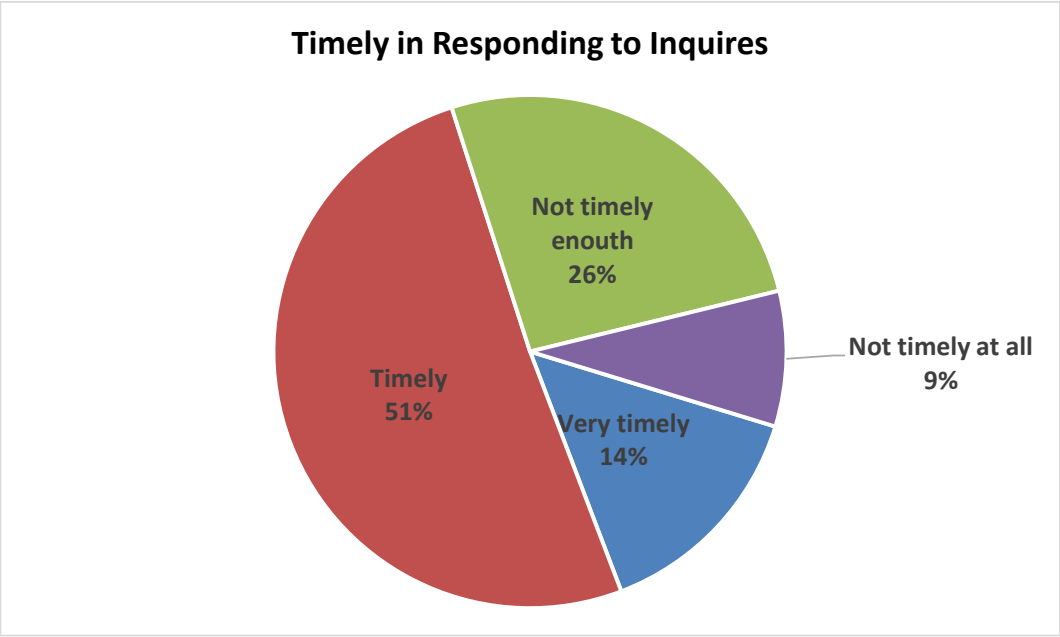


When employers did contact L&I, they were satisfied with the time they received to discuss issues about their claims. Again, more than 4/5ths of the time, they felt they got sufficient time.

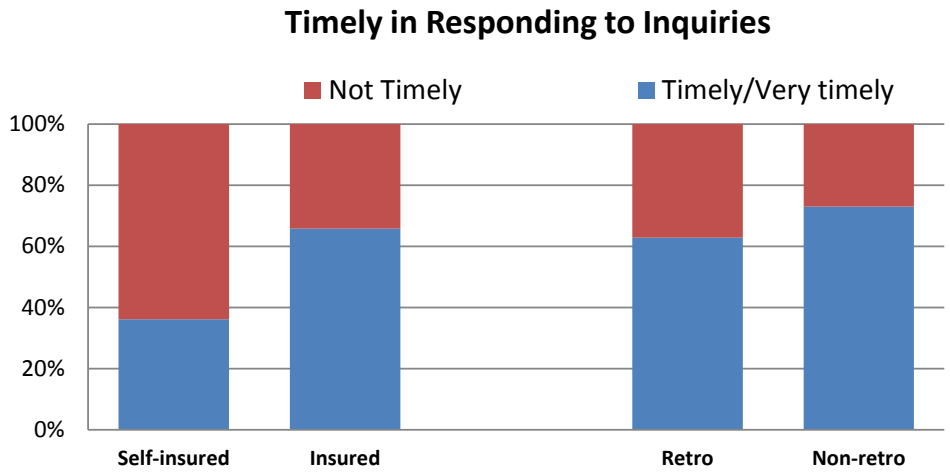


2.4 L&I's Timeliness in Responding

The employers differed from workers in having a stronger sense that L&I responded to them in a timely manner. Better than 2/3rds of employers felt that L&I was "Very timely" or "Usually timely." This contrasts with workers where the majority was frustrated with the response time of L&I. For example, 2/3rds of surveyed workers responded that their dispute was processed "very slowly" or "slowly."



The perception of L&I's timeliness did differ by employers' insurance status. Non-Retro employers had the most positive perception of L&I's responsiveness (73%). Self-insured employers were substantially less positive (36%). However, it is important to remember that a relatively small fraction (27%) of self-insured employers are included in this question because most often the contact with L&I, when needed, is through the TPA.



However, employers' perceptions did not differ by whether their claims had the involvement of a third party representative, the employer or both. The cause of this is not clear. The more positive perception of non-Retro employers may be due to efforts by L&I to assist smaller employers with less regular experience with claims or to Retro employer or TPA interest in more actively managing claims because of the impact on potential refunds or assessments. It is also possible that these employers have somewhat less rigid perceptions of what constitutes timely response.

2.5 Use of Online System

We also posed questions relating to the use of available online tools and systems. Nearly half of employers indicated they used the On-line system to keep track of their claims. Of these, a large majority (78.9%) found the online system to be "Easy" (56.1%) or "Very easy" (22.8%). Employers using an employer representative were less likely to have used the On-line System, but employers that both handled their own claims and used a representative reported being much more likely to use the On-line System. Insured employers were much more likely to use the On-line System than Self-insured employers, most likely because Self-insured employers most often use a TPA to handle claim decisions. Non-Retro employers were less likely than Retro employers to use the On-line system, even though Retro employers more often used a representative. (Note: in the table and discussion here, "Insured" employers are matched to "Self-insured" employers and constitute a different set of employers than those split into Retro and non-Retro, which are also matched. So the percentages will not match.)

Use of On-line Account System—by how claims are handled at firm

	All Employers	Firms	TPA	Both
Use On-line Account System	49.3%	48.3%	36.7%	75.8%
Easy/Very easy to use	78.9%	78.5%	75.3%	81.2%

Use of On-line Account System—by insurance status of employer

	Self-insured	Insured	Retro	Non-retro
Use On-line Account System	35.1%	72.6%	47.0%	31.5%
Easy/Very easy to use	69.8%	84.4%	73.7%	77.1%

Note: These responses are by the employer. Many employers use TPAs and, whereas the employer may not use the On-line system, it may be accessed by their TPA.

The large majority of employers find the On-line System easy to use. And this did not vary much by the different groups of employers split by insurance status or how they handled their claims. Even the smaller, non-retro employers with the fewest claims and probably the least experience with the On-line system found the system easy to use. Apparently the interface for employers is easy to navigate. Less than 5% of employers that used the On-line System reported they could not find the information they needed. The reaction to the On-line system by employers was far more positive than the reactions in the worker survey.

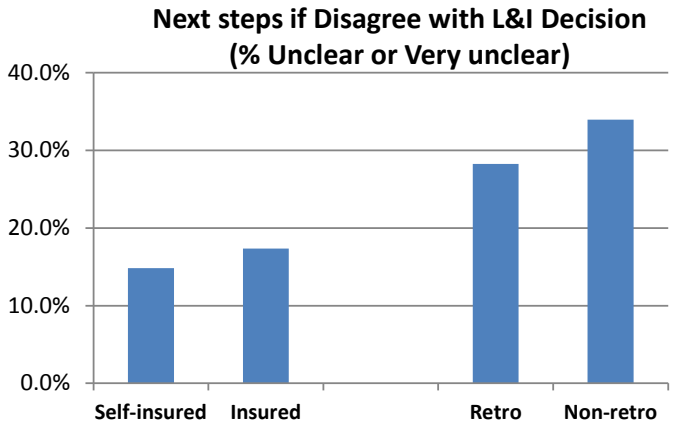
2.6 SATISFACTION WITH THE DISPUTE RESOLUTION PROCESS

One quality of a well-functioning dispute resolution system is that participants are clear on how to proceed if they disagree with a decision.

2.6.1 Understanding of the Process

Employers seem satisfied with the information they received from L&I about what to do if they disagreed with a decision on a claim or claims. Less than 1/4 (24%) of employers reported that the information was not sufficiently clear.

The satisfaction with understanding the next steps in disputes did differ by an employer's insurance status. But, that differentiation is more likely due to the size of the employers than the insurance status. Self-insured employers are larger and have more claims and, therefore, have more experience with claims related disputes, in terms of overall volume. Consequently, they are frequent actors in the dispute process and almost surely understand it better. When we match similar insured employers, as in the chart below, the employers understanding of the next steps presumably is similar. When we match retro employers who are similar to non-Retro employers, the retro employers are not so different from non-Retro. Non-Retro employers generally tend to be smaller than the average retro employer and have fewer claims and less experience with disputes. Matched Retro (to non-Retro) employers will be similar in the number of disputes, but some or most of them will also have a representative or internal expertise that may assist in understanding the process. The degree of confusion for the non-Retro employer is a concern, but the larger, more experienced employers appear generally comfortable



with what to do when disputing a decision.

2.6.2 Perceptions of Fairness

We asked three questions to get at the issue of fairness. We first asked two questions about the process:

- Did you have sufficient opportunity to present your case?
- Where you satisfied with the process?
  [Note: there are also a series of questions about the information and timeliness that we address in a separate section.]

Then we asked about the outcome:

- How satisfied where you with the decision?

One must keep in mind that the outcome can have a strong effect on the perception of fairness. However, in the case of employers, they may have multiple claims and interactions with the process. Consequently they may have several different outcomes and the perception shaped by all of them.

Overall Employer Responses on Issues Related to Fairness

	Yes	No
Sufficient information about how to proceed with protest	79.9%	20.1%

	Yes	No
Opportunity to present case(s)	70.0%	30.0%

	Very clear	Clear	Somewhat confusing	Very confusing
Explanation of Decision	7.9%	55.2%	25.5%	11.5%

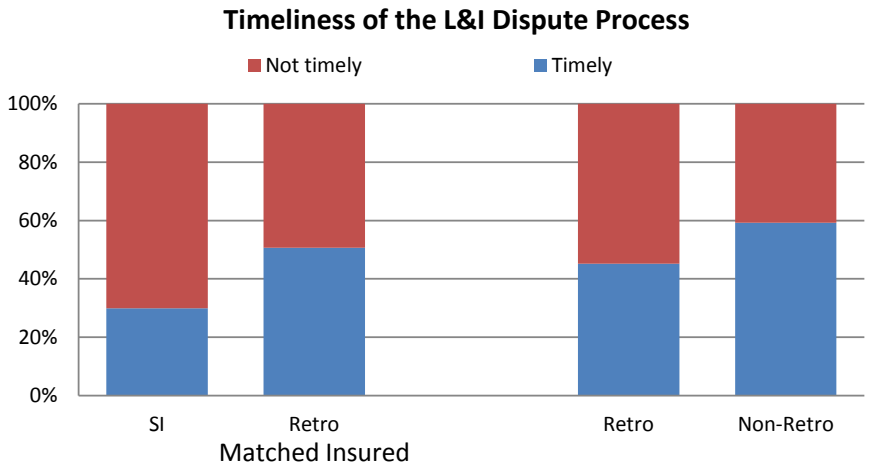
	Very timely	Timely	Not timely enough	Not timely at all
Timeliness in resolving dispute	4.7%	43.1%	31.4%	20.7%

Overall Rating?	Very satisfied	Somewhat satisfied	Somewhat dissatisfied	Very dissatisfied
Process	8.7%	40.1%	28.1%	23.2%
Decision(s)	8.7%	37.3%	26.4%	27.5%

Three areas of the process received generally satisfactory marks from employers: having sufficient information to proceed with protest, sufficient opportunity to present one's case, and the clarity of the decision. 60% to 80% of employers gave L&I high marks for these process areas. The fact that a fifth or more of the employers had a negative response should be of concern to L&I.

On the other hand, less than half (48.8%) of employers were satisfied with the overall process. There is one intervening issue that may at least partially explain this disconnect. A majority (52.1%) of employers thought the process was not timely. And the fraction of employers answering "Not timely at all" (20.7%) was much higher than the fraction answering "Very timely" (4.7%). The speed with which protests move through the system and get resolved may be an important factor in how employers perceive the overall process. Employers appear to understand the decisions made by L&I on claims, how to bring a protest if they disagree with a decision, and feel they have sufficient opportunity to present their side. But, the overall process still receives low marks. This may be because timeliness is such an important characteristic of a high quality process that it trumps employers' perceptions even when they feel the mechanics of the process were generally good.

Interestingly, the issue of timeliness is perceived differently by employers covered under different insurance arrangements. Self-insured employers are substantially and significantly less satisfied with the speed of the dispute resolution process than Retro and non-Retro employers. Non-Retro employers seem to be the most satisfied (almost twice as satisfied as SI employers) with the speed of dispute resolution.



Part of the explanation may be that SI employers have a lower percentage of claims with disputes resolved by L&I. However, as we discuss elsewhere, much of the L&I review of process for Self-insured employer decisions appears to be perfunctory. This may result in self-insured employers seeing the time required in the review process as just adding delays to the system, but no real value.

2.6.3 Appeals to BIIA

A substantial fraction of employers (82.5%) that had a least one protest resolved by L&I also had an appeal to BIIA. (Note that this does not imply a large fraction of appeals, an employer with a large number of claims and a substantial number of protests may only have one or two appeals to BIIA).

The level of satisfaction with this step in the dispute process was noticeably higher than with the process at L&I. Employers are getting sufficient information to pursue an appeal when they want to dispute an L&I order, or appeal an L&I decision that was protested. They also seem to be informed on how to respond when a worker files an appeal.

The satisfaction with the appeal process is higher and there is a shift in responses toward "Very satisfied" and away from "Very dissatisfied" when compared to the evaluations of the protest system. Still, 40% of the employers cited one of the two “dissatisfied” responses for process, and nearly 45% were dissatisfied to some degree with the decision. This high proportion of dissatisfied stakeholders is worth further exploration by L&I.

Employer Evaluation of BIIA Appeal Process (all employer types)

	Yes	No
Opportunity to present case(s)	79.5%	20.5%

	Very satisfied	Somewhat satisfied	Somewhat dissatisfied	Very dissatisfied
Process	12.9%	47.0%	24.5%	15.5%
Decision(s)	15.0%	40.2%	23.5%	21.3%

3 SUMMARY

Overall satisfaction with L&I was generally satisfactory. The ratings were roughly similar for all three insurance groups, though the percentage of very extreme ratings was highest for non-Retro and smallest for self-insured. Note that the sample of employers was selected to emphasize employers with experience with relatively complex claims, and hence the results are not necessarily applicable to the overall population of employers.

Employers were generally satisfied with the quality and timeliness of information received from L&I.

Employer responses differed from worker survey responses in several significant ways. Employer responses were generally more positive toward treatment by L&I. They were also more favorably disposed to information flows coming from L&I.

The responses of employers represented by a TPA or other agent often differed from non-represented employers, which had a more favorable view of overall treatment by L&I and the speed of protest resolution.

Employers overall gave much more favorable opinions about the appeal process than the protest process. The cause of this is multi-factorial, and could be the result of a relatively unfavorable regard for the quality or fairness of decisions by CMs in handling protests, in addition to other causes.

4 NOTES ON COMPARISONS

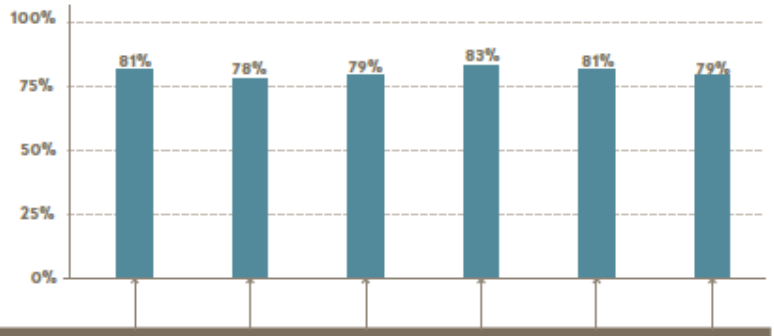
Direct comparison between L&I's employer survey results and those from other jurisdictions is problematic for several reasons. The first is that very few jurisdictions engage in such surveys and fewer still publish any results. Where results are published, the validity of such comparisons is questionable because results are often for composite measures and involve a particular sample mix of employers by industrial sector, size and insurance arrangements (which may or may not include self-insured, TPAs, Retro-groups, etc.). The uniqueness of exact questions and weightings used and other inherent differences including the time frames being evaluated--all of militate against direct comparisons as the basis for drawing strong inferences.

That said, L&I and WorkSafeBC have been asking similar questions with a similar general objective in jurisdictions that share similarities in industrial mix, economic conditions, organizational structure and legislation. At the aggregate level, comparison of trends and some of results may provide insight into the Washington Survey results. Keeping in mind the differences in legislation, policy and process and focusing on the relationship between perceived satisfaction and organizational reputation/credibility, some high level comparisons between WorkSafeBC and L&I may be worthy of note.

The following data reflect recent performance measurement results published by WorkSafeBC The two measures were obtained using a similar independent survey methodology and include the time frames

Employers' rating of their overall experience[1]

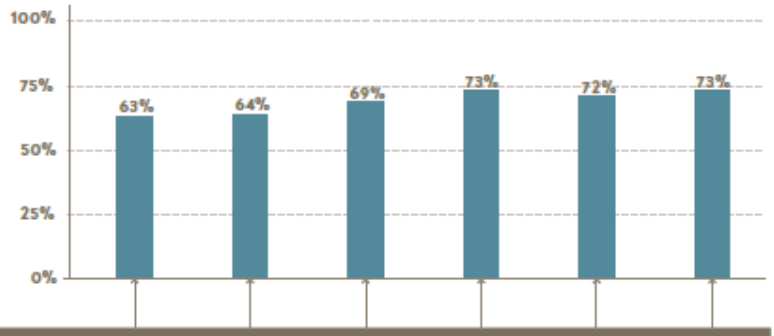
Employers who rated their overall experience with WorkSafeBC as very good or good.



	2008	2009	2010	2011	2012	2013
Very good/good	81%	78%	79%	83%	81%	79%
Average	15%	17%	18%	13%	15%	18%
Poor/very poor	4%	5%	3%	3%	4%	3%

Employers' rating of the claim process[1]

Employers who rated the claim process as very good or good.



	2008	2009	2010	2011	2012	2013
Very good/good	63%	64%	69%	73%	72%	73%
Average	30%	27%	24%	21%	21%	21%
Poor/very poor	8%	9%	7%	6%	6%	5%

1 Due to rounding, not all columns total 100 percent.

covered by the Washington State L&I Employer survey.

(source: WorkSafeBC, ***Statistics*** 2013, p. 97)

For Claim Process ratings, the levels of positive (Very good/good) noted for BC in the earlier years of the time frame presented coincide with the highest levels noted in the Washington State Employer Survey. If one disregards the cautions noted above and recalls that BC's economic and employment recovery occurred soon than Washington State's, the improving measures in BC may be associated with improvements in the economic environment. This may have positive portends for Washington.

While the levels achieved in BC are not drastically higher on the positive side, the low and relatively stable levels of negative ratings may also be of interest. Of particular note is the ratio of very good/good to poor/very poor for both claim process and overall experience. These ratios are significantly stronger in the WorkSafeBC case than those noted in the Washington State Employer Survey.

Further analysis may reveal components of processes or initiatives contributing to the higher positive and particularly lower negative results apparent in the BC data.

Appendix 7: Stakeholder Survey Results – Injured Worker Survey

1 INTRODUCTION

Over the summer of 2014 we sampled and surveyed injured workers over their satisfaction with the L&I claims management process. The sample included claims with > $5,000 in medical costs; this was done to be more certain about getting information about "serious" claims with more L&I interactions. Note that this methodology helps identify "serious" claims, but also potentially underestimates the good and efficient interactions of L&I with the more common but less costly claims. The sample did not exclude workers who had disputed claims with attorney representation, which is a standard exclusion in L&I surveys. We had L&I contact the applicants' bar to inform them that the survey was forthcoming, and explain the process.

After selecting the sample, we mailed letters to the potential respondents, asking them to call to participate, or access a unique website. Each recipient was given a code that was unique to them, to input into the online tool or when calling, to prevent duplication. After the letters were mailed, we monitored participation rates, and followed up with postcards. We also had the phone tool translated to Spanish, and had 135 respondents participate in Spanish.

The final participation results are as follows:

			Employer Type			Survey Tool		
	Call Attempts	Total Completes	State Fund: Retro	State Fund: Non-Retro	Self-Insured	Phone	Online	Spanish
Workers	11,274	1541	658	454	429	1140	401	135

Results were compiled and analyzed and the following report summarizes findings.

The worker survey results are not the only indicators available. The IPSOS Wave 4 September 2014 results from the L&I conducted worker survey of State Fund claims examined similar questions using a different methodology. The two surveys are not directly comparable. Taken together, however, they can provide a more complete picture of the factors supporting and detracting from the principal question: Are claim decisions made without favoritism or bias?

The inherent survey logic model of the IPSOS study suggests overall claim experience is moderated by behaviors such as listening to and understanding the concerns of others, caring for their well being, answering questions and being helpful and friendly. The JLARC study specifically addresses the perception of *respect* in contacts with L&I. Logically, the key factors that contribute to positive or negative overall claim experience will be consistent with the perception of respect. This approach is consistent with medical literature on patient care, which highlights listening, empathy, understanding, courtesy, and professional accountability as behaviors that demonstrate respect.

2 ARE CLAIM DECISIONS MADE WITHOUT FAVORITISM OR BIAS?

The first question to be addressed concerns L&I performance with respect to fairness. The audit design posed this question for consideration: Do workers believe the process and claims decisions made were fair?

Answering this question is really about answering a number of different questions. We'll group them here for simplicity. We'll also take this question in several subsections:

1. Overall claims process
2. When issue is protested or appealed
3. When claim is denied

2.1 OVERALL CLAIMS PROCESS

Satisfaction with the overall claims process is examined separately from the protest/appeal/denial process, which will be dealt with as separate processes and the outcomes measured within those specific groups of workers.

For overall satisfaction, we'll examine how workers felt about their interaction with L&I if they needed to interact. We'll also examine this separately for those that did and did not have an interaction through a protest, appeal or denial.

Q9_NEED_DIRECT_CONTACT_LNI

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NO	494	32.0	32.0	32.0
	Not sure	42	2.7	2.7	34.7
	REF	4	.3	.3	35.0
	YES	1003	65.0	65.0	100.0
	Total	1543	100.0	100.0	

Ignoring those workers that could not or would not answer, 33% had no need to contact L&I and can be considered satisfied with the claim process.

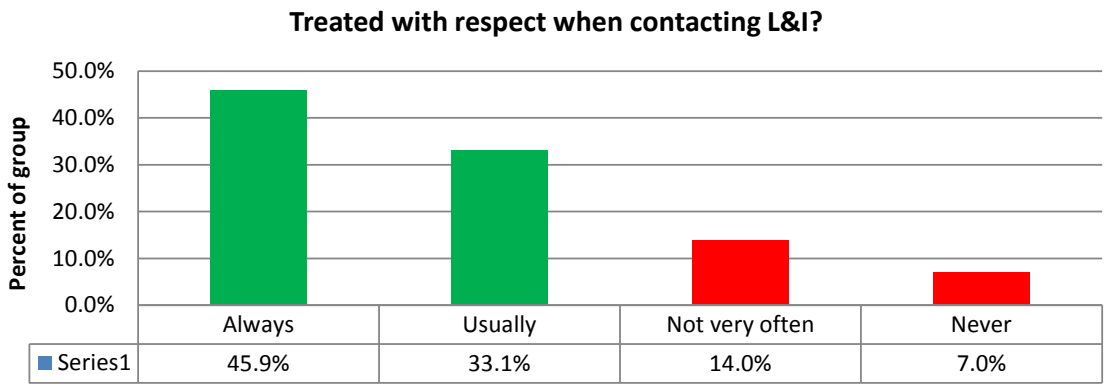
For the remaining 67% we examined their interaction using the following series of questions:

- treated with respect
- did need face-to-face
- sufficient face-to-face time

If the injured worker needed to contact L&I, we are interested how well that contact was handled.

2.1.1 Treatment with Respect

Question 12 asks, "When you contacted L&I, how often where you treated with respect?" [Note this question is only asked of the workers that indicated they needed to contact L&I]



Almost 4/5ths of workers were "Always" or "Usually" treated with respect. These numbers could be considered good, particularly the high portion answering "Always" (45.9%) and the low fraction answering "Never" (7.0%). But we suspect no organization will be satisfied if 1/5th of persons contacting them felt they were not treated respectfully.

Both a prior Gilmore survey (2009) for L&I and a recent North Dakota survey (2014) got somewhat more positive responses to similar questions about interactions with the agencies. The results are likely more similar to our survey results than the data indicate because our survey focused on more complex claims and included workers whose claims were denied and those with attorney representation.

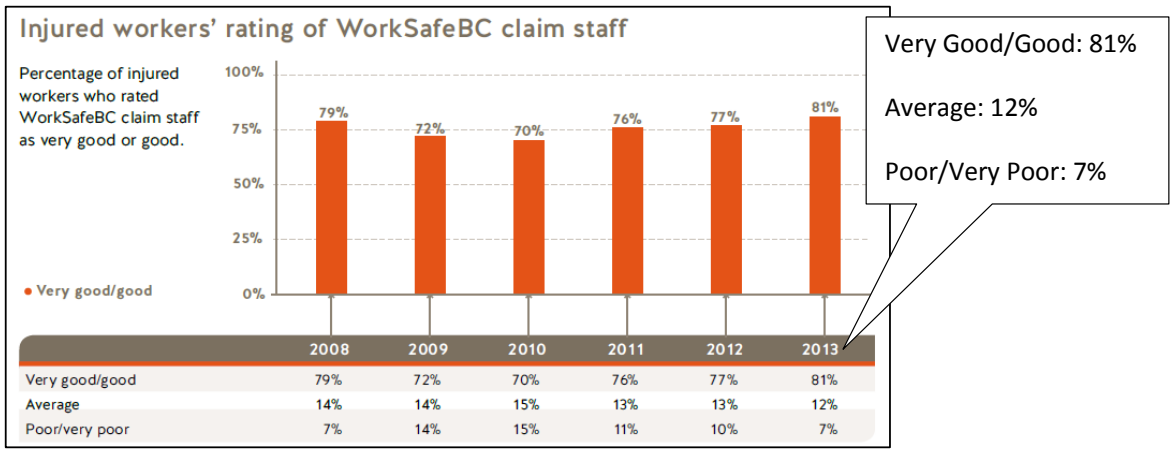
Results from similar question on Gilmore 2009:
88% Agreed/Strongly Agreed L&I was "courteous and professional"

North Dakota 2014:
92% said WSI staff "was polite"

It could be valuable to L&I to ask this question and follow-up specifically with the subset of claimants that were dissatisfied with the way they were treated. Finding exactly what made the experience poor would allow L&I to address issues in how workers perceive the interaction.

Note: The dissatisfaction with the way they were treated was not statistically different when evaluating those with protests, appeals or denied claims. There was a substantial level of dissatisfaction in each case.

WorkSafeBC results are consistent with these other studies although the question was different: From the 2013 Statistics document:



The recent IPSOS results show that direct contact with claims managers contributed to an overall assessment of good or very good for the overall claim experience (73%). Among those having direct contact with the claims managers, only 9% rated satisfaction with the overall experience as poor.

Assuming "being treated with respect" contributes to a positive assessment of the overall claim experience, it is likely that the reverse is also true. The apparent disconnect between the IPSOS survey and the JLARC survey suggests respondents to the latter may reflect a greater proportion of those dissatisfied with the overall experience.

On the positive side, the IPSOS study showed high ratings for claims managers for being helpful and friendly (76%), answering questions (72%), listing and understanding (68%), and carrying about [worker] well-being (64%).

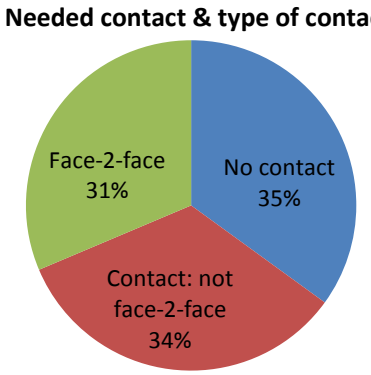
Also contributing to the assessment of an overall positive experience were contacts with claims office assistants. Although not decision makers, these claims personnel represent the spirit of the organization. The high scores for being helpful and friendly (83%) and answering questions or resolving concerns (71%) are consistent with respectful treatment. Claims office assistant categories, the very low percentages of survey respondents giving poor or very poor assessments of the categories mentioned (under 10%).

The JLARC survey and the IPSOS results may also reveal some common elements among respondents with lower assessments of overall satisfaction. As noted in earlier, the current survey found 21% of respondents reported they were seldom or never treated with respect in contacting L&I. This is surprisingly consistent with the percentage of respondents in the Ipsos findings who rated case managers poor or very poor in "carrying about your well-being."

2.1.2 Face-to-face contact with L&I

A specific issue we were asked to address in the audit was the interaction with L&I by workers that felt they needed direct, face-to-face contact with L&I.

This turns out to be an area where there are clear problems. We can think of the problem as two-fold: the number of workers that needed face-to-face discussion and the difficulty with getting the contact they felt they needed.

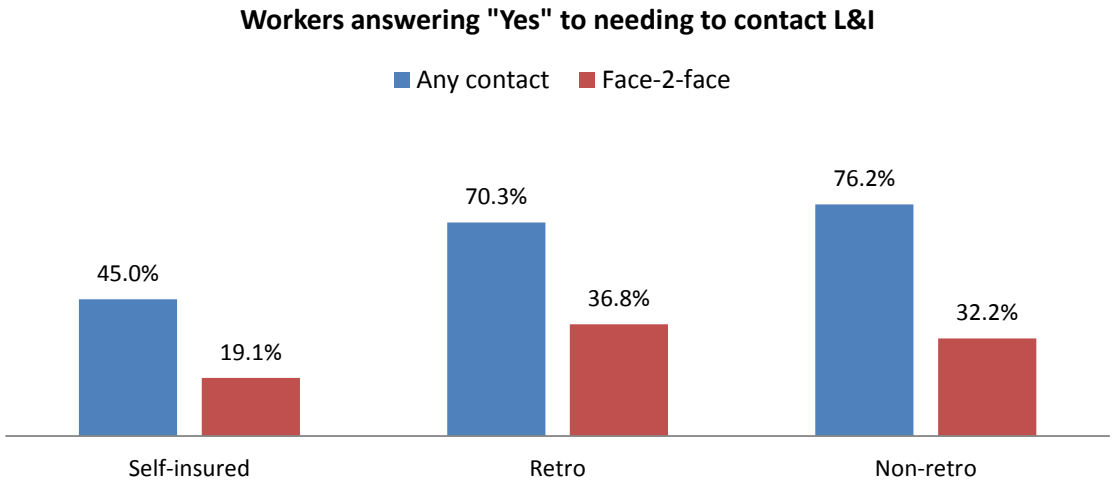


A surprisingly large fraction of workers reported a need for face-to-face contact with L&I. Nearly 1/3rd of all workers surveyed and nearly 1/2 of all workers that reported needing to contact L&I indicated a need for face-to-face contact. It is impossible to tell if this surprising result is due to the sample of respondents, or an unrealistic expectation in the general population.

What makes this unusual and difficult to compare is that L&I is relatively unique on offering this expectation. Consider other states where insurance is mainly delivered through private insurers or quasi-public state funds. In these states, the activities of the insurers are separate from the activities of adjudicating claim disputes. But while these processes are separated within L&I, the public perceives and even L&I talks as though the organization is a single entity delivering all these services.

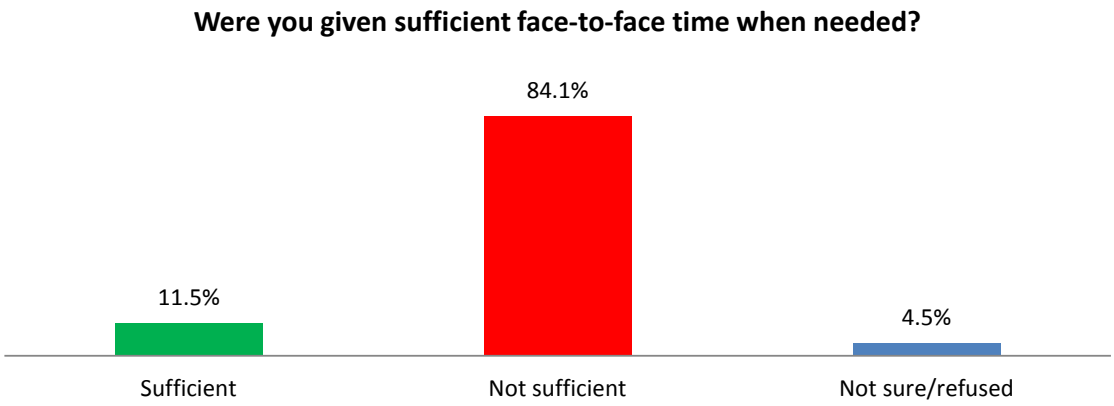
Insurers, both private and quasi-public, deliver their services at arm's length from claimants. We are not aware that insurers routinely have face-to-face contact with claimants outside judicial processes. Workers' compensation agencies do have contact on issues, but the majority of these contacts are handled by phone. There tends to be much more allowance for face-to-face meetings in mediation sessions and in vocational counseling.

Consequently, the expectation for face-to-face contact seems more an unrealistic expectation, like expecting a real human to answer the phone when you call a big corporate office. It may indicate that other, arguably more efficient forms of communication like phone, email and online, are not being as successfully utilized as the claimants might like.



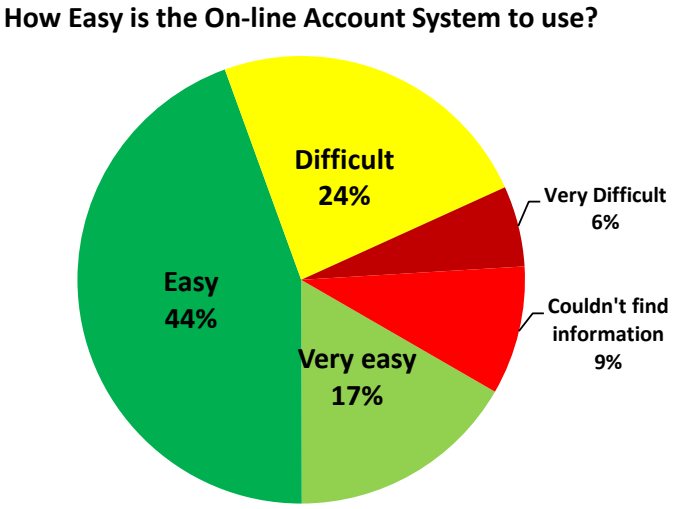
When we break down the workers by the insurance status of the employer we see confirmation for the contention that much of the frequency with which workers need to contact L&I is driven by L&I's dual role as insurer and adjudicator. Workers at self-insured employers, where the insurance function is handled by the employer (or its agent), are only about 60% as likely to need to contact L&I. Similarly, face-to-face contact is about 60% less often needed.

What is apparent is that when workers feel they need face-to-face contact with L&I, they are consistently dissatisfied with access to L&I. The chart below shows that the vast majority (84%) of workers that needed face-to-face contact felt they were given insufficient opportunity for this option.

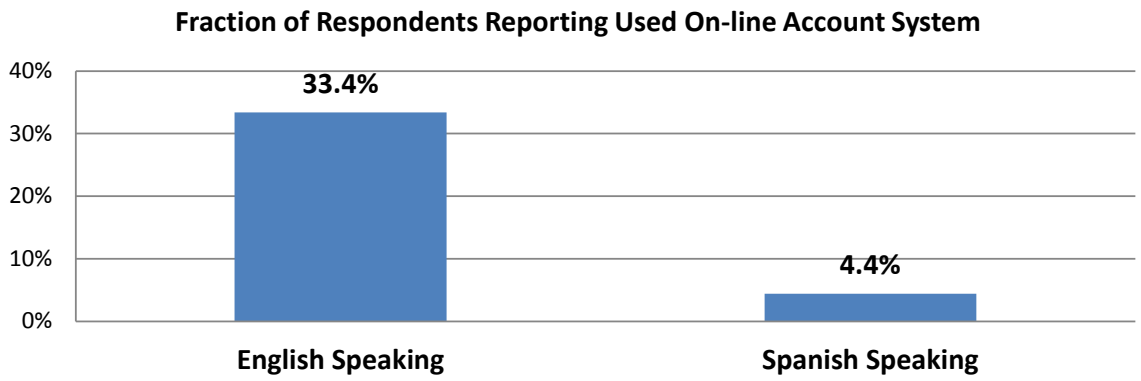


2.1.3 Online Services

The Claim and Account Center (CAC) is set up to let employers, workers, and other parties to a claim to track the all actions and documents recorded in the L&I claim file. One third of workers indicated that they used this system to track their claim. In focus groups, participants unanimously answered that the system was impossible to use and of no value. But this is inconsistent with the survey, where both employers and workers had a positive perception of how well the system worked. 60% of workers reported the system "very easy" or "easy" to use. While a substantial fraction of workers still find it difficult to use, the difference between the focus group (older claims) and the survey (relatively more recent claims) suggests that L&I is making substantial progress on improving the interface of the on-line system.



There was one area of possible concern about the On-line Account System. Spanish speaking workers rarely (4.4%) used the system to track their claims. There can be several reasons for this lack of use, for example, lack of access to computers and the Internet, or a lack of familiarity with the Internet. The most obvious barrier is that there is no non-English content available. Access barriers are discussed at greater length in Chapter 4: Communications.



This percentage of usage of online services is higher than in ND, where 54% reported being aware of online services, and about 26% reported using the services.

2.2 PROTESTS AND APPEALS

The workers' compensation system is meant to be a no fault system with simplified administration. Consequently, disputes should be relatively rare. When disputes arise, as they inevitably will, all parties to the dispute would like to see them resolved quickly and fairly.

We examined disputes as follows. First, how common are disputes? Second, are they disproportionately coming from one or more subsets of employers (Self-insured, Retro or Non-retro)? Third, when disputes arise, are they handled in a timely manner? Fourth, do the participants feel the process was fair?

2.2.1 Frequency

The number of claims with disputes on first glance seems high. Fully 1/3rd (32.7%) of claims in the survey had at least one dispute heard by L&I or BIIA. Over a quarter (27.9%) of sampled claims had an appeal of at least one decision by L&I. That decision could have been appealed by employer, provider or worker. By way of perspective, the 20,000 protests processed annually with L&I are approximately 15% of the total number of accepted claims.

There are several challenges with comparing our data with surveys done in other jurisdictions. First, we are focusing in this study on a subset of claims, those with medical costs > $5,000. We narrowed the sample in this way to identify important and serious claims, claims that represent the 20% most complex and expensive claims, generating 80% of the system costs. Most jurisdictions and studies, when they narrow the sample to more serious claims use claims with lost-time, usually lost-time greater than 7 days. We based our selection on medical cost because we did not have the ability within the survey sample to identify lost time claims among both insured and self-insured employers. Also, because Washington aggressively promotes the use of Kept-on-Salary (KOS) as a way of improving return to work, many claims that have lost time in other states could be medical only cases in Washington. In addition, KOS is thought to be more aggressively used by Retro employers than non-retro employers, and possibly more aggressively by Self-insured employers. Therefore, focusing on lost-time duration might make any comparisons across insurance status misleading. We chose the selection criterion based on medical cost as the most appropriate for making samples comparable across different employer groups in WA. But this does come at the expense of making cross jurisdiction comparisons somewhat more difficult.

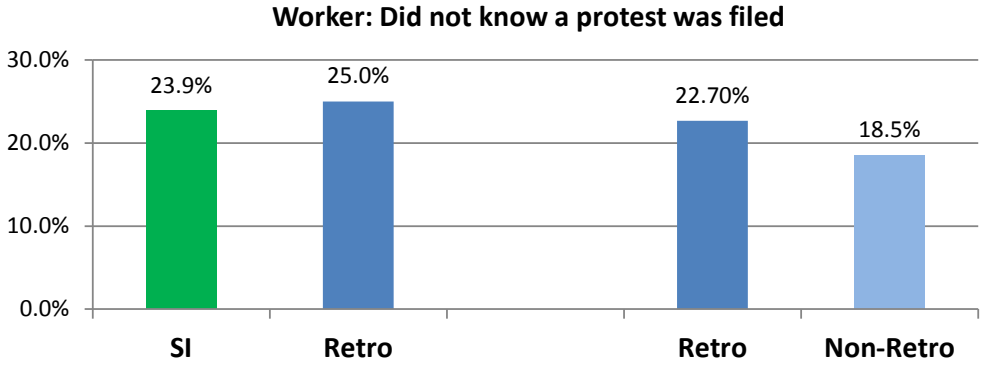
Distribution of Disputes among Workers Surveyed (excluding denied claims)	
Dispute category	
Percent of claims with at least one Protest and/or Appeal (431)	29.4%
Percent of claims with Protest (476)	27.4%
Percent of claims with a protest where decision by L&I was appealed to BIIA (133)	27.6%
Percent of claims where dispute when directly to BIIA (29)	2.0%
Percent of disputes going directly to BIIA (29)	6.8%
Note; this table excludes claims that were denied. A very high percentage of denied claims filed a protest.	

2.2.2 Worker perceptions of dispute process

Given this background on the frequency of protests and the party bringing the protest or appeal, we now turn to the workers perceptions of how this process worked. That is, was it clear, timely and fair?

2.2.2.1 Worker knowledge of protest

One area that was surprising was the fraction of times workers were unaware that a protest was filed on their claim. A little over 1/5th of the time (21.2%), workers did not know a protest had been filed. This was evenly split across the different types of insurance status.



We suspect that the protests where the employee is unaware are primarily protests filed by the employer, but may also include protests by providers (e.g. medical provider). There are other options, such as the worker could have forgotten or been confused. Workers represented by a lawyer that handled the protest may be less involved. But it does raise concerns about how informed L&I is keeping workers on potentially critical issues when the protest is raised by the employer. Since L&I is required to inform both employers and workers when a protest is filed (and file review found consistent adherence to the requirement), an important reason that workers were confused on whether protests were filed may lie in the difficulty workers have in understanding the letters sent by L&I. The filing of a protest may

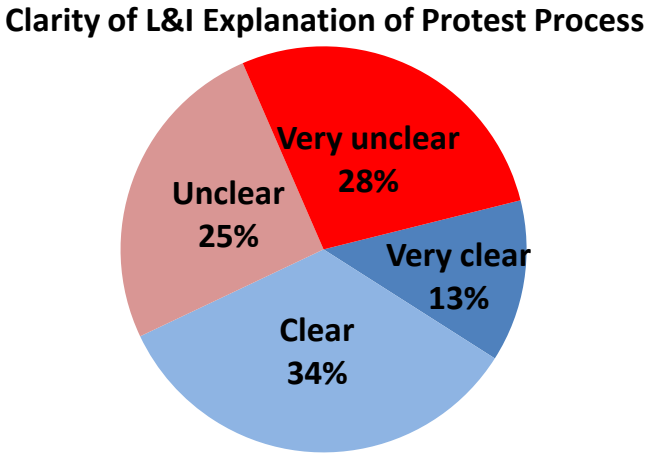
signal a need for L&I to communicate directly with the worker by phone to insure that the worker is fully informed on the issue in dispute.

In the survey, when workers answered that they were unaware of the protest process, we did not ask the subsequent questions about their perceptions of the materials and fairness.

2.2.2.2 Perception of timeliness and clarity of the decision and protest process

We asked workers how clearly L&I explained their decisions. Only about half of workers (48.5%) felt that L&I explained these clearly. A smaller fraction (41.3%) felt the explanations were unclear. And about 10% were unsure. The "unsure" answers may be because multiple important decisions may be made on a claim.

We asked, "How well did L&I explain your options when you disagreed with a decision on your claim." We asked this question of any worker where there was at least one protest filed by the worker or employer.[1] A very important fraction of worker, more than half (53.2%) reported that L&I's explanation was "Unclear" or "Very unclear."



This lack of clarity certainly is a cause of concern. The ability to pursue the dispute process is partly a product of understanding how to bring a case. We do not see in these data whether workers did not protest decisions because the process was too confusing. This might be an important problem if such a substantial fraction of workers find the dispute process so unclear. However, in defense of L&I, legal processes are almost complex. It is possible that L&I does at least as good a job as other jurisdictions, but the process is just inherently complex. One indication is that the level of education of the worker did not have any correlation to how well they did or did not understand the L&I explanations. This

[1] This question was supposed to be triggered by the source of the protest = worker, but it appears that the coding was such that it was triggered by any protest, either employer or worker. Consequently, there was a substantial fraction (30%) of workers that answered they did not know a protest was filed. We drop these workers from the denominator since the question of clarity of explanation is not appropriate. This is also why Q50, about how well L&I explained the process when the employer protested, is blank, because it would have been triggered by an indication of an employer protest, but this was not identified in the data given the survey callers.

suggests that the problem is not in the level of the written materials or oral explanations, but rather something basic to the process.

Across the insurance statuses (self-insured, Retro, non-Retro) there was no difference in the fraction of workers reporting they found the process "Unclear" or "Very unclear". The fraction reporting each category was virtually identical for claims from each group of employers. This indicates that L&I and SI adjusters are at least uniformly handling explanations of the workers' disputes, from the perception of the workers.

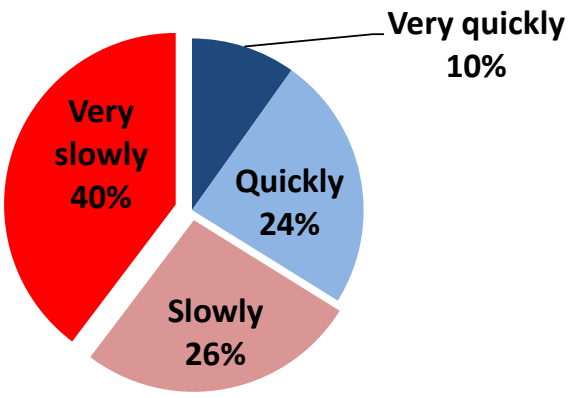
The written materials supplied by L&I to workers filing a protest appear to have been more useful than the overall clarity of the process as described just above. 60% of workers found the written materials "Somewhat" or "Very useful." Only a small portion (18%) did not find them useful at all.

We did not have detailed coding on the type of issue or issues in dispute. And this type of question is not very successful on surveys. But it is possible that certain types of disputes are more difficult for workers to understand and manage. It would be useful to go into more detail with L&I on the nature of the issues in dispute, but this is difficult because it is not well defined in the electronic data. If certain issues were especially problematic, special emphasis could be placed on redesigning these materials or extra attention and time focused on these workers in their interactions with L&I.

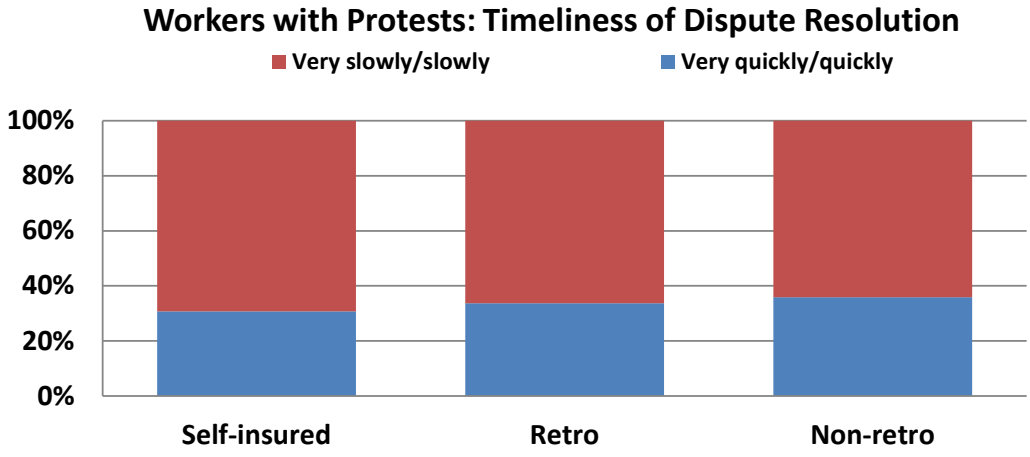
2.2.3 Timely resolution of protests

Workers' compensation dispute resolution is ideally a streamlined, administrative law system that can resolve disputes quickly. Unfortunately, this is not the perception of surveyed workers. Two-thirds of workers (66.2%) with a dispute felt that their dispute was resolve "Slowly" or "Very slowly," with "Very slowly" dominating these two answers.

Q51 L&I Resolved Protest in a Timely Manner



On this question, there was no difference in the responses across the different employer insurance statuses. For each group of employers, Self-insured, Retro-rated, and Non-retro, 2/3rds of workers were dissatisfied with the time required to resolve their disputes.



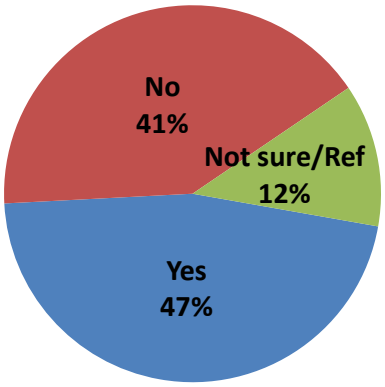
2.2.4 "Fairness" of protest

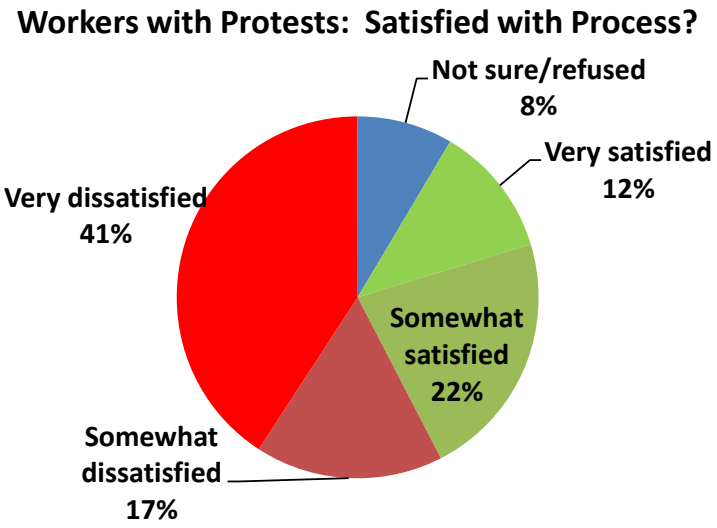
Fairness is a tricky concept to query workers about. The challenge is that "fairness" is a vague concept, or more precisely, it can be inexact, understood differently by different respondents, or both. In addition, the perception of fairness can be colored by the outcome of the dispute process.

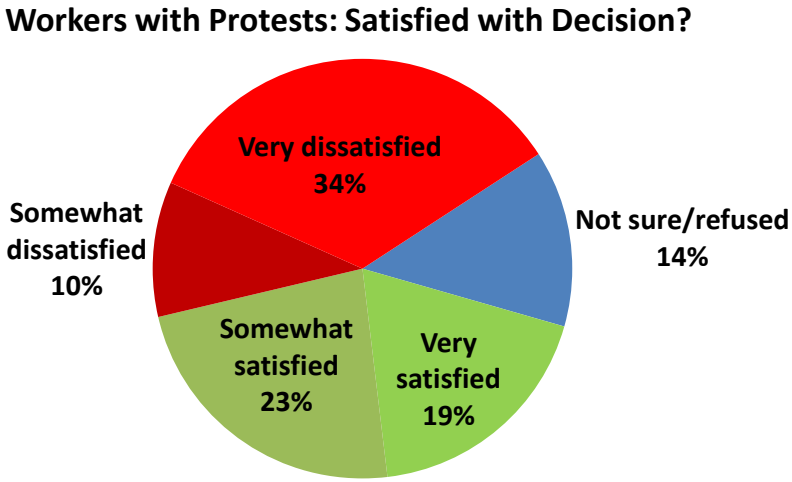
We get at the issue of fairness by asking a series of three questions.

- Did the workers feel they had sufficient opportunity to present their case?
- Were the workers satisfied with the process?
- Were the workers satisfied with the outcome?

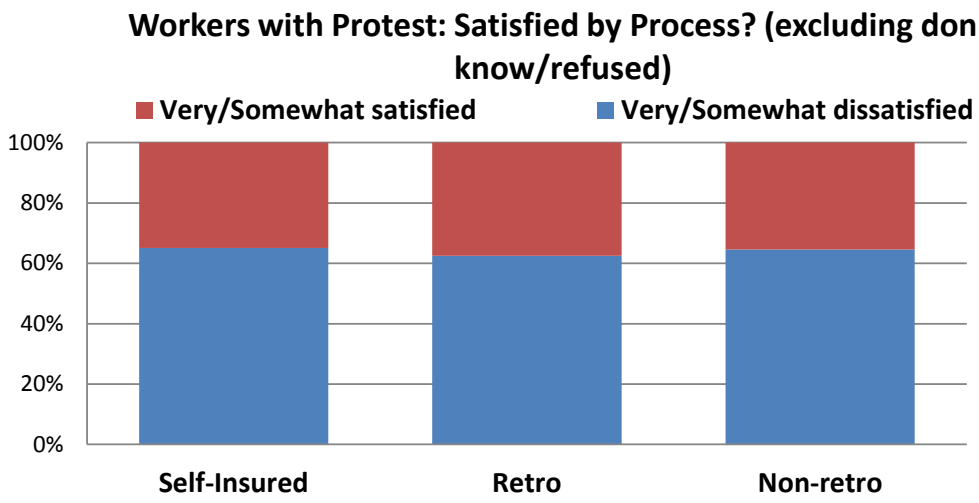
The concept of fairness should be considered in light of the answers to all three questions. Fortunately, the answers to the three questions are quite consistent. Note here that in most of these figures we include the fraction of workers answering "Don't know" or "Not sure". We do this here because unlike nearly all of the other questions, the fraction answering "Don't know" or "Not sure" is not trivial. This might be an indication of how difficult it is for workers to answer questions about the concepts.







A concern of set forth in the audit design was whether workers' perceptions of the process and the fairness of the process are similar across different employer, by employer insurance status. Differences or similarities in the workers' perceptions could indicate that L&I (or L&I interacting with the employers/TPAs) may be handling claims differently (if workers' perceptions differed) or consistently (workers' perceptions similar) depending on the employer's insurance status. Here we find that workers' perceptions are very similar across the different categories of employers (Self-insured, Retro, Non-retro). This should be reassuring to JLARC and policymakers more generally. Below we present one of the questions by insurance status. The answers to the other questions were very similarly distributed.



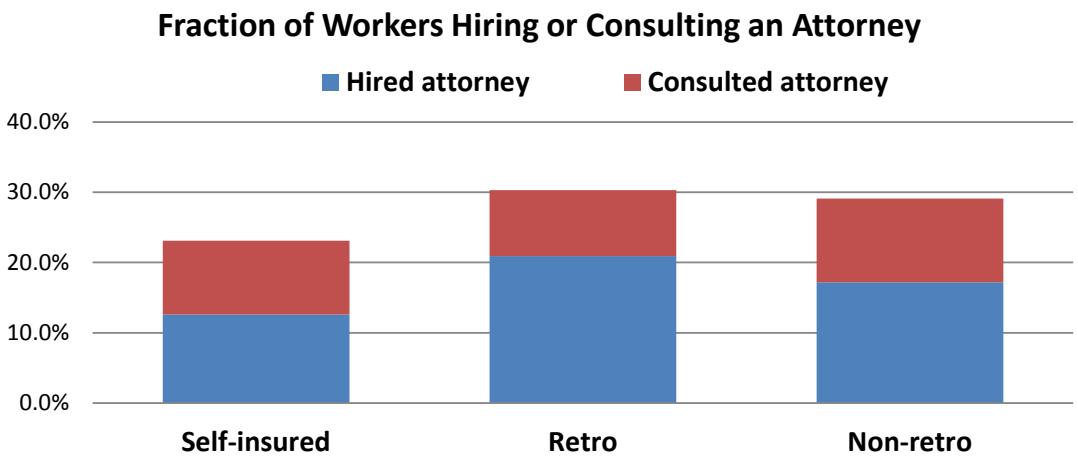
In the above chart we aggregate the satisfaction categories in to two groups. This is done to simplify the presentation. Also, when we limit the sample to just those workers that knew about a protest and split those workers into three groups, we are getting smaller cell sizes and, consequently, more variance in the statistics. When split this way, it is clear that the perceptions of workers about the dispute process were virtually identical and statistically indistinguishable by insurance category.

2.2.5 Attorney representation

Workers' compensation use administrative law to resolve disputes, which is intended to be more efficient and less formal that the regular court system. Attorney representation is often taken as an indication that the system is failing to limit disputes and to resolve disputes quickly and clearly when they occur. Administrative agencies often try to resolve disputes without attorney involvement through mediation or ombuds intervention. But, for some cases that come before administrative law judges, the injured worker with a dispute is encouraged to retain an attorney or get competent representation.

The survey respondents displayed a substantial fraction hiring attorneys. Approximately 17.5% of workers in the survey hired an attorney and an additional 10.9% consulted an attorney but did not ultimately hire one. This differed between insured and self-insured employers with about 12% of self-insured workers and 20% of insured workers hiring an attorney. For both groups, about 10% consulted but did not hire an attorney.[2]

[2] By way of perspective, WCRI, CompScope 2012 shows 1% as the median value of 16 states for the percentage of claims with >$500 in claimant legal expenses.



We asked an open-ended question about the why they hired or consulted with an attorney. The answers are hard to categorize exactly because the answers often indicated the frustration many workers felt that compelled them to visit an attorney. Text answers are hard to classify into strict criteria. Consequently, we will discuss the areas broadly without assigning exact percentages.

Several areas that stand out:

- **Confusion about the process.** Most commonly workers mentioned they consulted an attorney because they were confused about the claims process or the benefits they were entitled to. Closely related to confusion about the claims process, workers often mentioned consulting an attorney to clarify the extent of their rights to benefits.
- **Termination of indemnity benefits.** The termination of indemnity benefits seems to be a trigger for seeking an attorney. There may be confusion about how and why benefits end or transition to a different type of benefit. L&I might consider a proactive, direct contact with workers when benefits are going to end. To be efficient, these contacts might be limited to claims where the benefits have had durations greater than some threshold (e.g., 30 days) or some other claim characteristic or characteristics predict a higher probability of a dispute.
- **Medical treatment.** This is a very important trigger. It takes two forms, delays and denials. Many workers seeking an attorney indicated they were frustrated with the length of time it took to get approval for medical treatment. Another group sought an attorney after medical treatment was terminated and (in their perception) the claim closed. Ending medical treatment is not as easy a place to intervene, proactively, as the ending of a particular benefit. The ending of medical treatment tends to be much less precise. But, it might be important for claims managers to contact the worker directly when a decision is made to terminate medical treatment.
- **Additional body part**. There were a number of cases where the worker consulted an attorney because a 2nd body part was not allowed to be added to a claim. These appeared to be cases where the second body part was added after the claim had been open for some time. This might be another opportunity for the claims examiner to proactively contact the worker and explain why the additional body part is not being approved for treatment.
- **Denials.** Not surprisingly, a high fraction of workers who had their claim denied hired an attorney. Unlike workers that hire an attorney because of medical treatment issues, termination of benefits, or in hopes of speeding up the process, these workers are at risk of losing all, not just a fraction, of their benefits.

2.2.6 Impairment and IME

Methodological note: this section is designed to get the broad issues defined. The comparisons across SI, Retro & Non-retro are using the raw data, without the complete adjustment for matching. A full adjustment possibly would effect the comparison between SI & Retro and Retro and Non-retro. When the three groups are very similar in the statistics shown, matching adjustments are unlikely to matter. When there is a visible relationship, e.g., SI=>Retro=>Non-retro, differences may be reduced when we control more carefully for the matching.

Determining a worker's residual impairment after injury and any injury related permanent partial disability (PPD) indemnity payments is one of the most important and complex obligations of L&I. Measurement and indemnification of permanent disability is a complex process requiring training. Because of its complexity the mechanics of PPD determination will not be understood by the vast majority of workers. However, L&I has an obligation to assist workers in understanding their right to benefits. Not uncommonly, L&I's communication will involve explaining why they may not be eligible or eligible for a smaller benefit amount than expected.

We were interested in how well injured workers recovered from their injuries. When recovery leaves them with residual impairment we care about how well they understand the process and how they perceived the fairness of the determinations.

In addition, Washington handles the determination of PPD differently between insured employer and self-insured employers. For workers injured at insured employers, L&I assigns the Independent Medical Evaluator (IME) responsible for the determination of the existence and extent of impairment. These assignments are random, within certain limits. The random assignment is meant to protect both workers and employers by removing any monetary incentive for bias from the IMEs evaluation. Self-insured employers, on the other hand, have the ability to select IMEs of their choice.[3] Consequently, L&I needs to be sure that differences in the way IMEs are chosen does not result in differences in PPD benefits across workers.

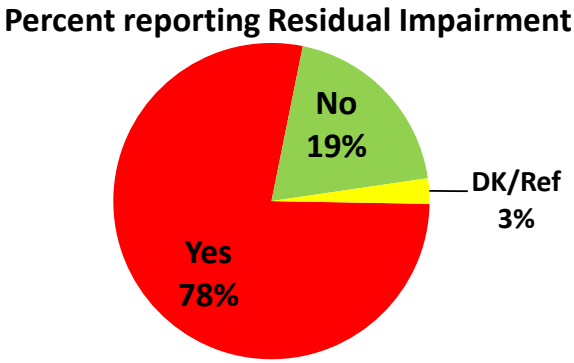
Hence, we should be interested in:

- How frequently workers feel they have residual impairment after recovery.
- When they perceive residual impairment, how severe is the impairment.
- When they perceive impairment, did they get evaluated for the impairment.
- What type of doctor did the evaluation (Primary physician or IME).
- How clearly was the process of determination explained to the worker.
- Did the worker feel the evaluation of impairment was fair.
- Did evaluation of impairment result in ratings and indemnity payments that were independent of the insurance status of workers' employers.

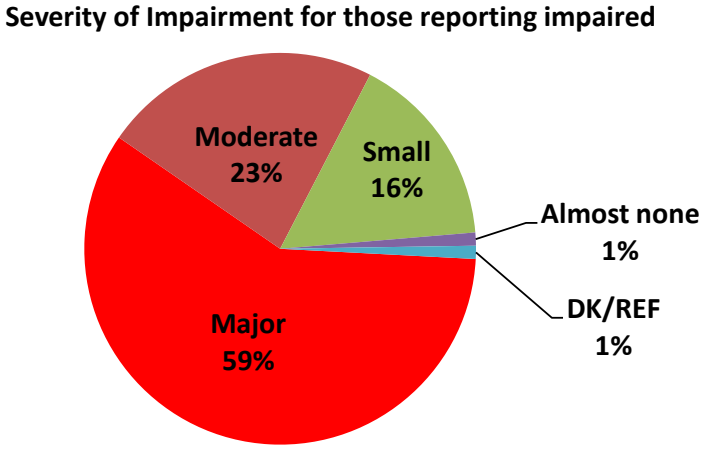
Some of these answers were surprising.

First, the number of workers reporting residual impairment, and especially “major” impairment was higher than anticipated. Almost 4/5ths of workers in the survey felt they had some residual impairment from their injury.

[3] RCW 51.36.070.

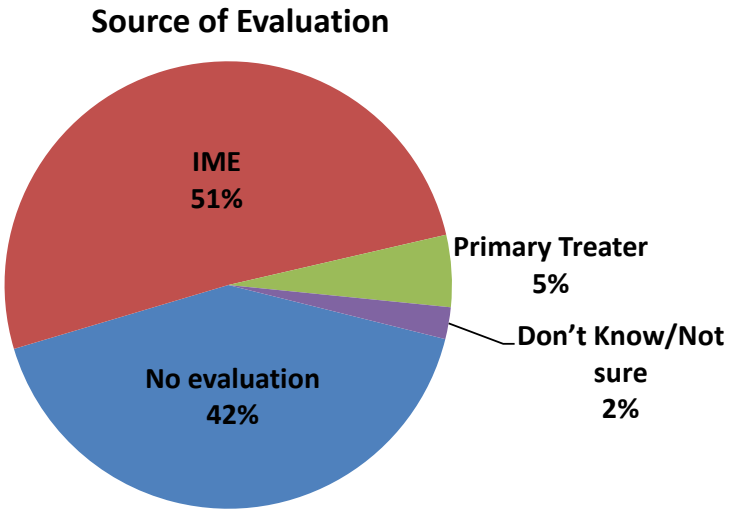


Among those that believed they had a residual impairment, 82% reported that the impairment was "Major, affecting their work or daily life almost every day" (59%) or "Moderate" (23%). That is, 2/3rds of workers in the sample felt that their injury resulted in residual impairment that had a moderate to major impact on their work and/or daily life. Though coming from a sample of injured workers with relatively severe injuries, these numbers are quite striking. The sample we drew is for the 20% of claims with the highest medical cost, which is about equivalent in other jurisdictions to claims with more than 7 days last time. After almost 2 years of recovery, a major fraction of surveyed workers still feel that the injury imposes an important limitation on their functioning.[4]



[4] The researchers had internal discussions about the meaning of the large fraction (64%) reporting "Major" or "Moderate" residual impairment. This fraction seems quite high relative to the portion of workers awarded PPD in other states. In California, a notably generous state, the rating bureau typically finds 45% to 50% of indemnity claims receive a PPD award. An 8-state comparison by WCRI (not including California) identified North Carolina as the highest state at 39% of claims with >7 days lost time receiving a PPD award. Two factors may be at work. First, we are asking workers perceptions of their residual impairment, not how the system evaluated them against a legal definition. Second, workers with greater residual impairment may have been more motivated to respond to the survey. It is common in workers' compensation surveys for workers with the least severe injuries to be underrepresented. It is impossible to say that either or both of these explanations are responsible for a substantially higher fraction of workers reporting Moderate to Major residual impairment.

Given the high proportion of respondents with perceived impairments, it is even more important that they receive evaluations for their impairment and that the process is clear and fair.

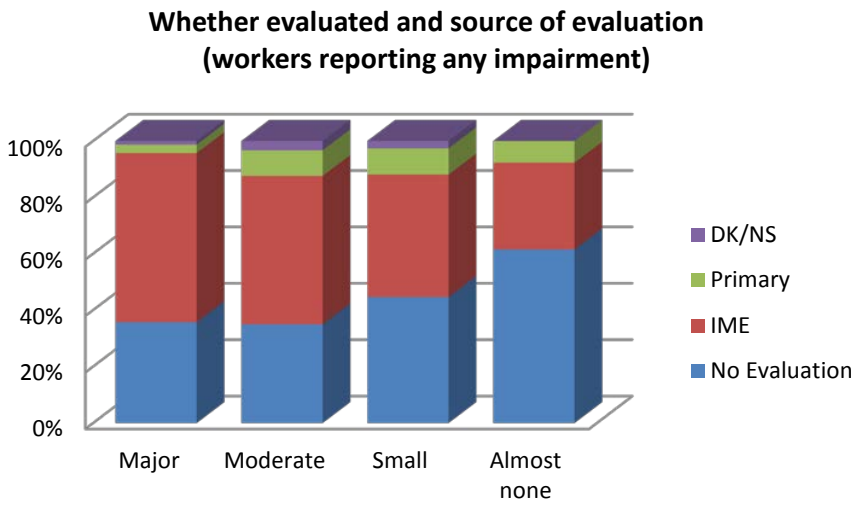


A substantial fraction of workers that report either "Major" or "Moderate" impairment had not received an evaluation by the time of the survey. We expect that some of these workers will be evaluated in the future. But it still appears that a substantial fraction of workers who feel that they have a significant impairment did not, and may not, receive an evaluation. Without an evaluation, they may not be eligible for PPD benefits. This may also indicate a mismatch between how workers perceive the severity of their residual impairment and what is compensible under law. In any case, it would be important to follow-up on claims of workers that have not had an evaluation but report significant impairments.

When evaluations are done, the vast majority are done by IMEs. Only a small fraction are done by the worker's primary treating physician and that fraction is even smaller when the impairment is more severe. Nearly all of the evaluations are being performed by doctors with special qualification for PPD measurement.[5] Providers are approved by L&I, after an application and review. They must be licensed to practice in:

- Medicine and surgery,
- Osteopathic medicine and surgery,
- Podiatric medicine and surgery,
- Chiropractic, or
- Dentistry.

[5] See WAC 296-23-317, which describes the qualifications to become an IME provider to "ensure that independent medical examinations are of the highest quality and propriety."

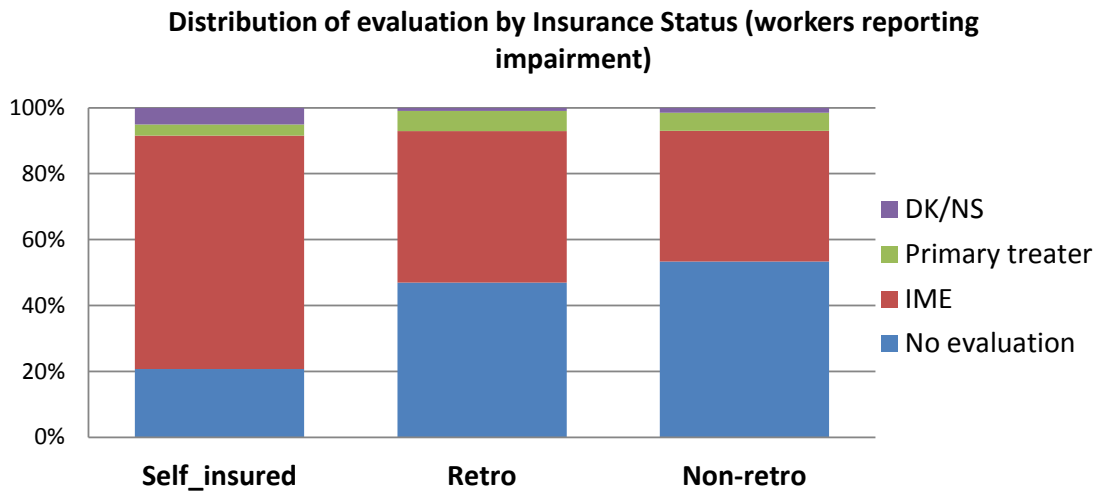


Interestingly, the fraction of workers reporting any impairment as well as the distribution of severity of impairments is identical across all three insurance statuses. Workers' injuries and the recovery of health after injury appear to be very similar, even when the employers have different insurance status and vary in size, claims handling by outside administrators, and internal human resources expertise.

On the other hand, the fraction of workers receiving an evaluation by the date of the survey is much higher at self-insured employers than at claims handled by L&I. Within the L&I insured, there are small differences between Retro and non-Retro employers, but these are not statistically significant.

This difference between Self-insured employer and insured employers can indicate at least three factors. First, self-insured employers' claims administrators may handle claims more quickly, moving up the timing of evaluations, so more are done prior to the survey. This would represent a timing issue, and as claims mature, the fraction receiving evaluations may be more comparable. One possibility is that because self-insured employer TPAs can select their choice of IMEs, they are able to do so much more quickly, all else equal, than L&I can arrange them for workers using L&I procedures. Also, IMEs may work harder to schedule appointments and complete evaluations quickly when future business depends on their reputation.

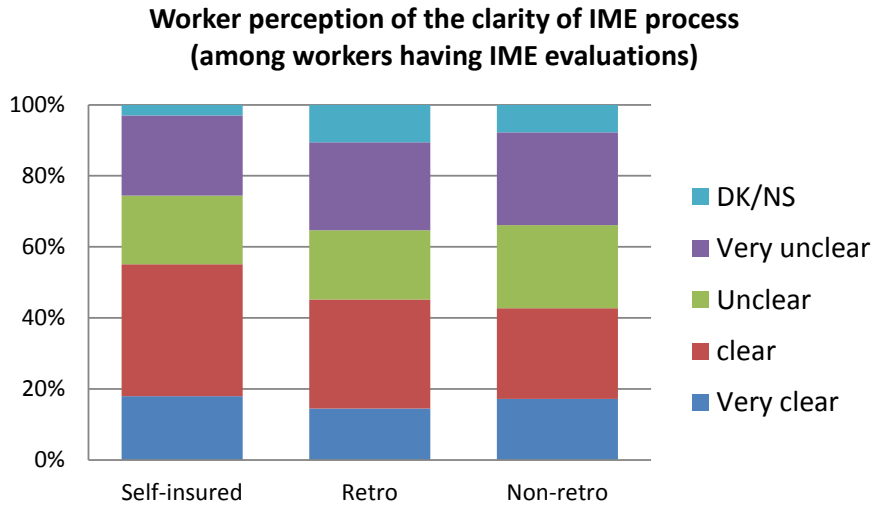
Second, Self-insured employers may pursue evaluations in a higher fraction of cases. This might be done to help resolve cases, handle return to work decisions or some other reason.



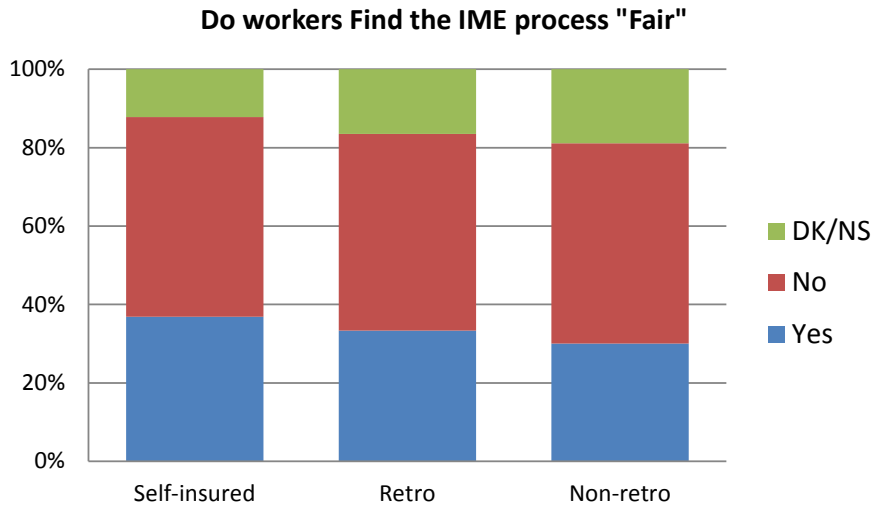
This also suggests directions for further research on the broader data on all claims available from the databases. Because the fraction of workers reporting any impairment and the distribution of severity among those reporting impairment is identical across all three insurance types, we should expect the PPD ratings and PPD indemnity should be very similar. We would hope that the ratings and indemnity would be very similar despite the greater control of the IME choice enjoyed by Self-insured employers. Across the large sample sizes in the full data sets, the measurement of PPD and indemnity should be very close given the very similar severity reported by workers.

2.2.7 Workers' perceptions on whether the IME process was clear and fair

It is important for injured workers to feel they understand the process and consider it fair. Both of these qualities share important roles in this process. In addition, it is important that workers across all types of employers (self-insured, retro and non-retro) share similar perceptions. We now examine these issues.



A substantial fraction of workers find the IME process “Unclear” or “Very unclear." This is likely unsatisfactory to L&I. The PPD determination and the IME process are arcane and can be confusing even to experienced participants. But, the clarity of the process is important for empowering workers.

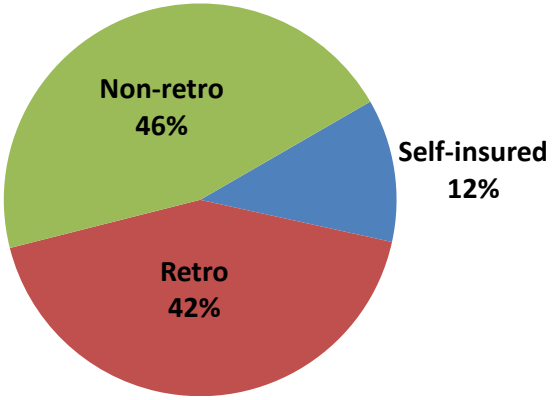


These numbers, again, are problematic. 2/3rds of workers reported they did not find the IME process fair or were unsure. Only 1/3rd reported it as fair. These high percentages may be driven by the lack of clarity in the process, as we observed just above. It might be also driven by the outcome of the IME evaluation, which could have been perceived by the worker as understating their injury. The numbers are equally poor for workers at all three types of employers by insurance status. The issue does not seem driven by the differences in the underlying claims handling between Self-insured TPAs or L&I, or based on Retro-group status. L&I and self-insured employer TPAs probably should make a stronger effort to understand why workers find the process so confusing and concentrate on improving those issues in written and personal communications. It might also be useful to consider how to manage workers’ expectations about eligibility for PPD indemnity and the size of awards. Often in legal processes, the only measures of outcomes participants are aware of are large settlements or awards that make the news. Consequently, participants can frequently over-estimate the expected settlement. Better upfront communication with participants can help. Communications could include information on the fraction of workers that receive benefits and the median award (average award, because a few large awards, will substantially overstate what a typical worker will receive).

2.3 DENIED CLAIMS

We used a stratified sampling strategy for accepted claims, stratifying by insurance type (self-insured, Retro, and non-Retro). For claims that were denied, we randomly sampled from among all claims where L&I denied the claim. The original sample gives us a close approximation of the fraction of denied claims that come from each type of insurance status:

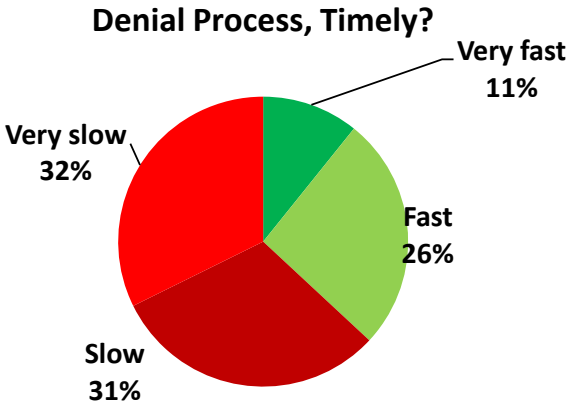
Distribution of Denied Claims by Employer's Insurance Status



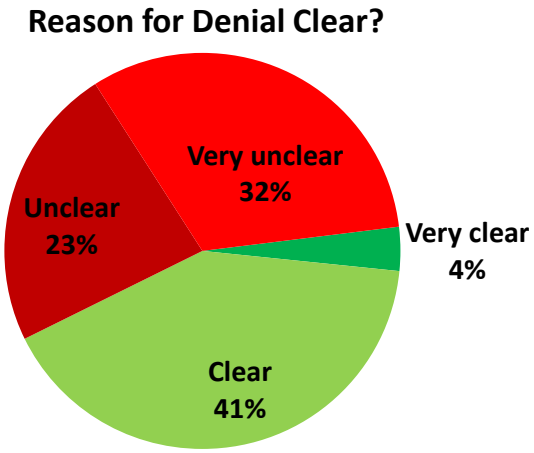
The respondents to the survey came more heavily from the Retro employer denied claims (62.7%) and Non-retro employer claims were under-represented (22.4%), while Self-insured respondents represented the approximate expected portion (14.9%).

67 workers with denied claims completed the survey. Nine workers expressed an understanding that their claims were accepted, despite the indication in the L&I data. We dropped these workers from the denied claim sample because the questions were not appropriate. A possible explanation is that these workers have multiple claims and one or more were accepted, while the reference claim was denied.

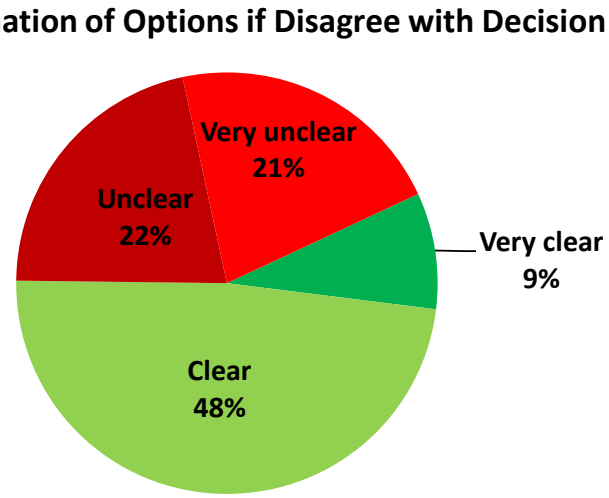
The response of denied claimants to the survey questions about the performance of L&I should be carefully considered. When respondents with accepted claims filed a protest, their perceptions of the quality & fairness of the process appear affected by their perception of the decision (outcome). For these accepted claimants, the decision might have limited their benefits in some way, but that limitation was partial. For denied claimants, L&I's decision to deny the claim means benefits are completely eliminated. Consequently, we might expect that their perceptions of the process could be much more heavily affected by L&I's decision to deny the claim. However, the perceptions of workers whose claims were denied appear similar to those involved in a protest on an accepted claim.



Timeliness of the denial process was consistent with the perceptions of workers filing protests on accepted claims. Timeliness of the legal process seems to be a concern, generally. But given that all of these workers lost this critical decision, it is surprisingly positive finding on L&I decision making that the perceptions about the occupational causation determination process were similar to other protests.



Workers' perceptions of the clarity of the reasons given for the denial decision, again, are very similar to the perceptions of workers involved in protests. Given that all of these workers "lost" this critical decision, we might have expected their perceptions to be substantially more negative than for disputes on other issues.



As described earlier, we were concerned that the outcome of a dispute would heavily influence the perception of the fairness of the dispute resolution process. Consequently, we chose a strategy of evaluating the fairness of the dispute process by examining the workers' (and employers') perceptions of parts of the process (e.g. timeliness, clarity of the decision and their understanding of what to do next if they disagree with the decision). This approach is well supported by the data presented above. For each of the areas examined above, workers who lost disputes about "allowance" had perceptions about

the components of the dispute resolution process that were very similar to those with other types of protests (where the worker prevailed an important fraction of the time). The outcome of the dispute had limited, if any, impact on the perception of the underlying components of the judicial process.

3 LOST TIME AND RETURN-TO-WORK

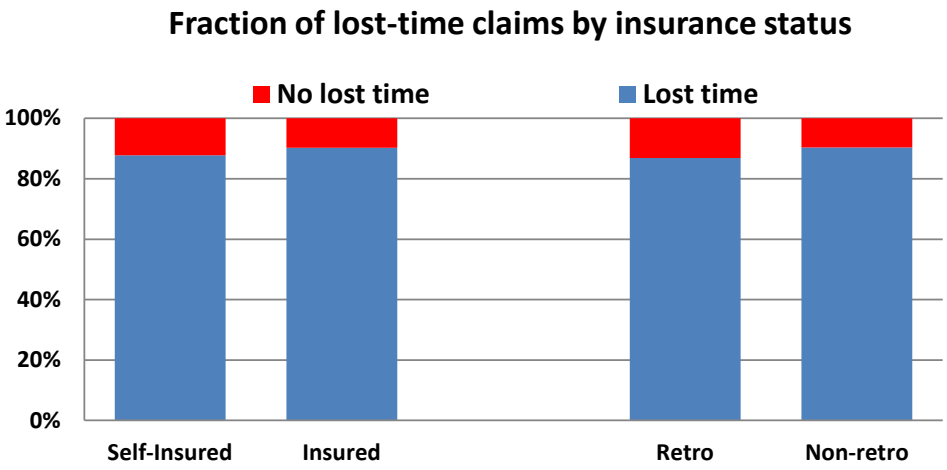
Next we address other perceptions of the claims management process. The sampling process for the survey was different than the typical approach for surveys of this type. Most surveys focus exclusively on workers with a minimum amount of lost time indemnity payments, usually greater than 7 days lost time. For several reasons, this was not appropriate for surveying for Washington. Most importantly, we were not able to obtain reliable lost time data for self-insured employers. Second, salary continuance, known as Kept-on-Salary (KOS) in Washington is thought to be common, potentially eliminating an important set of otherwise similar claimants and injuries from the sample. Third, the use of KOS was expected to differ by insurance status (SI, R, & NR) and this could bias our sampling. Consequently, we selected workers for the survey based on paid medical exceeding a $5000 threshold.

To identify all workers in the survey that experienced lost time greater than 3 days from those that had only medical costs, we used a three-step process. We included:

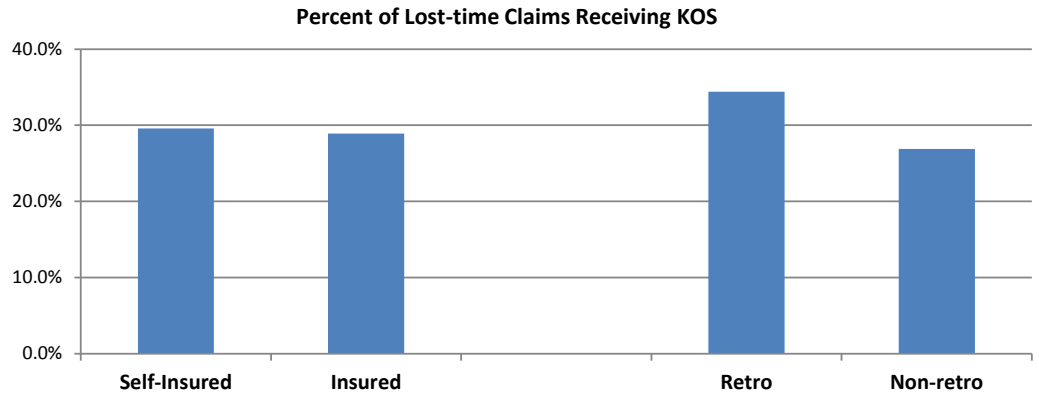
- All workers that had lost time reported by L&I (Fund employers only),
- Answered "Yes" to the question, "Did you miss 3 or more days of work due to your injury?" or
- Answered "Yes" to the question of whether their employer paid salary continuance.

Of the workers with accepted claims in the survey, 11.5% did not lose any time from work, despite having an injury or illness severe enough to generate very substantial medical treatment costs. The remaining 88.5% of accepted claims with lost-time will be the subset we use when examining return-to-work assistance. Thus, the responses are from injured workers with probably did not enjoy special income maintenance assistance (KOS) from their employers.ne strategy for improving stay at work/return to work is encouraging employers to pay salary continuance. Self-insured employers are thought to use KOS to help manage disability costs and total claim costs. Insured employers have an additional incentive in the form of minimizing their “experience rating,” which is a factor in setting premiums. Lost-time claims count against experience, but if an employer pays salary in lieu of temporary total disability, the indemnity portion of the claim does not count against a firm's experience rating. While all insured employers share this incentive, it is thought that Retro employers make more frequent use of KOS because Retro groups’ TPAs and administrators actively encouraging employers (sometimes as a condition of belonging to the group) to use KOS to keep firm and retro group costs down. Interviews with retro group administrators found that some Retro-rated groups make KOS a condition of participation in the group. Non-retro group employers may not be as knowledgeable about the potential savings from KOS. We examine how these assumptions play out in our survey results.

The fraction of claims with lost time is nearly identical across the different insurance statuses. Between 86.9% and 90.4% of claims in the sample had some lost time. There is no statistically significant variation by insurance status.



The fraction of claims receiving KOS is virtually identical across matched insured and self-insured employers, at about 30%. But the distribution is different within insured employers. Retro employers are more significantly more likely to use KOS, possibly reflecting the extra attention drawn to the advantage by retro-group administrators and explicit requirements to use KOS as a condition of membership in some groups. The percentages of KOS shown below are higher than the 18.4% of all State Fund LT claims shown by an L&I annual report to use KOS in 2013.



As an important consideration, and it has not been established definitively, but most observers think that KOS improves outcomes for workers as well as reducing costs for employers. Workers, by maintaining their attachment to the workplace, are thought to recover more quickly, experience less actual lost time, and have a higher probability of remaining with the at-injury employer. If true, all of these factors are also associated with greater future labor force participation and higher future earnings. Consequently, the lesson here may be that L&I should consider aggressively promoting KOS at Non-retro employers in the way Retro groups promote it for insured employers. Or, L&I could increase the incentives built into the experience rating system to increase the incentive for all insured employers, especially non-retro employers, to broaden the use of KOS. We will explore the Stay-at-Work (SAW) program usage in the employer section. SAW represents a variation on KOS, but with a substantial subsidy by L&I.

Appendix 8: Survey Instruments

1 EMPLOYER SURVEY

Preload:

- INSURED = 1 if insured, =0 if self insured
- RETRO = 1 if insured under retrospective rating program, = 0 if not in retro rated program
- MULTIPLE_CLAIMS = 1 if more than one active claim in reference period, = 0 otherwise
- LT_14 = 1 if at least one worker was off work for >14 days in reference period, = 0 otherwise
- IME = 1 if firm had at least one claim with an IME exam, = 0 otherwise
- SAW = 1 if firm had at least one claim receiving Stay-at-Work funding, = 0 otherwise.

Who we are:

Hello, I'm _____ of QMR, a research company. We are calling on behalf of a bi-partisan committee of the Washington Legislature that is overseeing the performance of the Department of Labor and Industries (L&I) and its workers' compensation claims management operations. You should have received a letter regarding this telephone interview.The Joint Legislative Audit and Review Committee (JLARC) is seeking employers' opinions to enhance its review.

This study is meant to review how well the Department of Labor and Industries is addressing the needs of employers who have workers' compensation claims. Your firm was randomly selected to be surveyed because you had at least one occupational injury claim of more than $5,000 between 2011 and 2013.

S1. This survey asks about your overall impressions of and satisfaction with L&I's handling of workers' compensation claims and does not ask about specific claims or technical issues. Would you be able to answer those questions for us?

Yes	1	[GO TO S3]
No	2	[ASK S2]

S2. ["NO" IN S1] Can you direct me to the person in the firm you think would be most familiar with workers' compensation claims and L&I?

S3. [WHEN SPEAKING WITH CORRECT PERSON] Is this a good time to speak with me?

Yes	1	[GO TO 1]
No	2	[SCHEDULE CALLBACK]

Some firms handle their own claims and work directly with the Department of Labor and Industries when there are any questions. Other firms contract with a third party administrator (TPA) to handle their workers' compensation claims and most issues with L&I.

1. Are workers' compensation claims handled by your firm or through a third party administrator?

Firm	1
TPA	2
Both (VOL.)	3

Focusing on all claims that were active during the period 2011 through 2013, I'd like to ask you some questions about how well L&I has responded to your needs and how well L&I handled your claims.

2. Thinking about the period between 2011 and 2013, how do you feel about your overall experience with the L&I claims process? Would you say you are:

Very satisfied	1	
Somewhat satisfied	2	
Somewhat dissatisfied	3	
Very dissatisfied	4	
Not sure (VOL.)	8	
Refused (VOL.)	9	

3. How satisfied are you with the process by which L&I determines whether to accept a worker's claim as occupationally related? Are you:

Very satisfied	1	
Somewhat satisfied	2	
Somewhat dissatisfied	3	
Very dissatisfied	4	
Not sure (VOL.)	8	
Refused (VOL.)	9	

4. How well did L&I clearly explain the decision[s] to accept or deny your [claim/claims]? Were the explanations generally:

Very clear	1	
Clear	2	
Unclear	3	
Very unclear	4	
Not sure (VOL.)	8	
Refused (VOL.)	9	

5. How well do you feel L&I kept you informed about status of your claim[s]? Would you say:

Very well	1	
Well	2	
Poorly	3	
Very poorly	4	
Not sure (VOL.)	8	
Refused (VOL.)	9	

6. Did **you** contact L&Idirectly, by phone, email or letterregarding [your claim/one or more of your claims] between 2011 and 2013?

Yes	1	
No	2	[SKIP TO 10]
No, but my TPA did (VOL.)	3	[SKIP TO 10]
Not sure (VOL.)	8	[SKIP TO 10]
Refused (VOL.)	9	[SKIP TO 10]

7. How clear was it who to contact when you needed to reachL&I about a claim? Was it:

Very clear	1
Clear	2
Unclear	3
Very unclear	4
Not sure (VOL.)	8
Refused (VOL.)	9

8. How do you feel about the length of time you were given to discuss the issue or issues when you needed to contact L&I? Would you say it was:

Always sufficient time	1
Usually sufficient time, but not always	2
Often not sufficient time, or	3
You were unable to get direct contact	4
Not sure (VOL.)	8
Refused (VOL.)	9

9. How timely was L&I in responding to your query or queries about your claim[s]? Was L&I:

Very timely	1
Timely	2
Not timely enough	3
Not timely at all	4
Not sure (VOL.)	8
Refused (VOL.)	9

10. [ASK EVERYONE] Have you ever used L&I's on-line Claims Account System (also known as ORCA) to track the progress of one or more of your claims?

Yes	1
No	2 [SKIP TO 12]
Not sure (VOL.)	8 [SKIP TO 12]
Refused (VOL.)	9 [SKIP TO 12]

11. [IF "YES" IN 10] When you used the Claims Account System to look at one of your L&I claims, how easy was it to find the information you needed? Would you say it was:

Very easy	1
Easy	2
Difficult	3
Very difficult, or	4
I couldn't find the information I needed	5
Not sure (VOL.)	8
Refused (VOL.)	9

12. [ASK EVERYONE] During the handling of your claim[s] did L&I contact you early enough and keep you well enough informed that you could make decisions about how to handle your claim(s)? Would you say you were kept informed:

All or nearly all the time	1
Usually	2
Only sometimes	3
Rarely	4
Never	5
Not sure (VOL.)	8
Refused (VOL.)	9

Both workers and employers can file protests with L&I about actions on claims. I'd like to ask you about your experience with L&I involving these protests. (I will call these protests "disputes").

13. Are you familiar with at least one claim that involved a dispute resolved by L&I?

Yes	1	
No	2	[SKIP TO 21]
Not sure (VOL.)	8	[SKIP TO 21]
Refused (VOL.)	9	[SKIP TO 21]

14. How would you rate L&I on the timeliness of resolving the dispute[s]? Would you say L&I was:

Very timely	1
Timely	2
Not timely enough	3
Not responsive at all	4
Not sure (VOL.)	8
Refused (VOL.)	9

15. Thinking of the decision[s] made in response to the protest[s], how did you feel about the explanation[s] L&I provided on the [decision/decisions]? [Was it/Werethey]

Very clear	1
Clear	2
Unclear	3
Very unclear	4
Not sure (VOL.)	8
Refused (VOL.)	9

16. How clearwas L&I about your options if you disagreed with adecision?

Very clear	1
Clear	2
Unclear	3
Very unclear	4
Didn't disagree with any decisions (VOL.)	5
Not sure (VOL.)	8
Refused (VOL.)	9

17. In thinking about the process used when you had a disagreement with L&I over [a claim/claims], did you believe you had sufficient information in order to present your arguments?

Yes	1
No	2
Not sure (VOL.)	8
Refused (VOL.)	9

18. And, in thinking about the process when you had a disagreement with L&Iover a claim decision or decisions,did you believe you had sufficient opportunity to present your arguments?

Yes	1
No	2
Not sure (VOL.)	8
Refused (VOL.)	9

19. How satisfied were you overall with the dispute process at L&I? Would you say you were:

Very satisfied	1
Somewhat satisfied	2
Somewhat dissatisfied	3
Very dissatisfied	4
Not sure (VOL.)	8
Refused (VOL.)	9

20. And how satisfied were you with the final decision[s] on the protest[s] at L&I? Were you generally :

Very satisfied	1
Somewhat satisfied	2
Somewhat dissatisfied	3
Very dissatisfied	4
Not sure (VOL.)	8
Refused (VOL.)	9

21. [ASK EVERYONE]Workers and employers can appeal a decision by L&I to the Board of Industrial Insurance Appeals, "The Board." We'd like to ask you about any appeals to the Board that involved your firm. If your firm had a claim involving an appeal, do you believe you had sufficient opportunity to present your arguments?

Yes	1	
No	2	
Did not have any appeals (VOL.)	3	[SKIP TO 24]
Not sure (VOL.)	8	[SKIP TO 24]
Refused (VOL.)	9	[SKIP TO 24]

22. How satisfied were you overall with the appeal process at the Board? Would you say you were:

Very satisfied	1
Somewhat satisfied	2
Somewhat dissatisfied	3
Very dissatisfied	4
Not sure (VOL.)	8
Refused (VOL.)	9

23. And how satisfied were you with the final decision[s] of the appeal[s] to the Board? Were you:

Very satisfied	1
Somewhat satisfied	2
Somewhat dissatisfied	3
Very dissatisfied	4
Not sure (VOL.)	8
Refused (VOL.)	9

24. [IF INSURED=1 – ALL OTHERS SKIP TO 32] When an occupational injury occurs that causes a worker to needtimeoff to recover, L&I should assist employers **and** workers in getting the worker back to work as soon as medically possible. Sometimes this involves modifying work to fit any work restrictions. For any claims active between 2011 and 2013, did L&I contact you offering assistance in getting an injured worker back to work?

Yes	1
No	2
My TPA would have handled that (VOL.)	3
Not sure (VOL.)	8
Refused	9

25. [IF INSURED=1 AND SAW=1 – ALL OTHERS SKIP TO 28] L&I has a program called "Stay at Work" that will pay part of an employee's wage and for many changes required for light dutyto keep an employee on the job while the worker recovers from a work injury. Our records indicate that for at least one of your claims you received Stay-at-workfunding from L&I, is that correct?

Yes	1	
No	2	[SKIP TO 30]

My TPA would have handled that (VOL.)	3	[SKIP TO 30]
Not sure (VOL.)	8	[SKIP TO 30]
Refused (VOL.)	9	[SKIP TO 30]

26. [IF "YES" IN 25 – ALL OTHERS IN SERIES SKIP TO 30] How would you describe the process of getting reimbursed by the Stay-at-Work program? Would you say it was:

Very easy	1	[SKIP TO 30]
Somewhat easy	2	[SKIP TO 30]
Somewhat difficult	3	
Very difficult	4	
Not sure (VOL.)	8	[SKIP TO 30]
Refused (VOL.)	9	[SKIP TO 30]

27. [IF "SOMEWHAT DIFFICULT" OR "VERY DIFFICULT IN 26 – ALL OTHERS IN SERIES SKIP TO 30] What makes it difficult to get reimbursed by the SAW program? (PROBE FOR SPECIFICS)

28. [IF INSURED=1 AND SAW=0 – ALL OTHERS SKIP TO 30]L&I has a program called "Stay at Work" (or "SAW") that will pay part of an employee's wage and for many changes to job duties while an employee recovers from a work injury. This program is meant to keep workers on the job during recovery. Are you aware of the Stay at Work program?

Yes	1	
No	2	[SKIP TO 30]
Not sure (VOL.)	8	[SKIP TO 30]
Refused (VOL.)	9	[SKIP TO 30]

29. [IF "YES" IN 28 – ALL OTHERS SKIP TO 30] How did you find out about the Stay at Work program?

L&I	1
TPA	2
Other (SPECIFY)	3
Not sure (VOL.)	8
Refused (VOL.)	9

30. [IF LT_14=1 – ALL OTHERS SKIP TO 32]When an injured worker is off work for more than two weeks, L&I often has a return-to-work specialist contact the employer and discuss ways to return the employee to work as soon as possible. Between 2011 and 2013, your firm had at least one claim where the worker was off work for more than two weeks. Did a Return to Work specialist from L&I contact you when your worker was out of work for more than two weeks? This specialist would be different than the claims manager usually handling claims.

Yes	1	
No	2	[SKIP TO 32]
Have never heard of an Early Return to Work specialist	3	[SKIP TO 32]
Not sure (VOL.)	8	[SKIP TO 32]

Refused (VOL.) 9 [SKIP TO 32]

31. How would you describe the assistance given by the L&IReturn-to-Work Specialist in getting the injured worker back to work?Would you say L&I's actions were:

Very helpful	1
Somewhat helpful	2
Not very helpful	3
Not helpful at all, or	4
I didn't receive any assistance (VOL.)	5
Not sure (VOL.)	8
Refused (VOL.)	9

32. [ASK EVERYONE] Overall and thinking about all of the claims you had between 2011 and 2013, how would you rate L&I's actions in terms of getting your injured worker[s] back to work as soon as possible? Would you say L&I's actions were:

Very helpful	1
Somewhat helpful	2
Not very helpful	3
Not helpful at all, or	4
I didn't receive any assistance (VOL.)	5
Not sure (VOL.)	8
Refused (VOL.)	9

33. How often did you offer to modify an injured workers job to enable him/her to come back to work sooner?

Most or all of the time	1
Often	2
Sometimes	3
Infrequently	4
Almost never or haven't had to yet	5
Not sure (VOL.)	8
Refused (VOL.)	9

34. Which of the following persons or agencies have assisted you with identifying appropriate modifications to enable the worker[s] to return? [CHECK ALL THAT APPLY]

Attending physician	1
TPA	2
Vocational Rehabilitation specialist	3
L&I specialist (other than the claims manager or Vocational Rehabilitation specialist)	4
Other (SPECIFY)	5
Not sure (VOL.)	8
Refused (VOL.)	9

35. Sometimes employers keep workers "on salary" while they are off work with an occupational disability. This can help workers return to work more quickly. Have you kept workers on salary (KOS) while they were temporarily off work for an injury? KOS means paying the employee the same wages and medical benefits.

Yes	1	
No	2	[SKIP TO 37]
Not sure (VOL.)	8	[SKIP TO 37]
Refused (VOL.)	9	[SKIP TO 37]

36. About how often do you keep injured workers on salary (KOS)?

Most or all of the time	1
Often	2
Sometimes	3
Infrequently	4
Never	5
Not sure (VOL.)	8
Refused (VOL.)	9

37. [IF INSURED=1 – ALL OTHERS SKIP TO 38] Has anyone from L&I ever talked to you about the advantages of keeping a worker on salary instead of temporary disability?

Yes	1
No	2
Not sure (VOL.)	8
Refused (VOL.)	9

38. [ASK EVERYONE] Overall, how would you rate the medical treatment that your injured worker[s] [has/have] received for their occupational conditions? Would you say it was:

Excellent	1
Pretty good	2
Fair	3
Poor	4
Very poor	5
Not sure (VOL.)	8
Refused (VOL.)	9

39. Do you feel your injured worker /injured workers, on average received too much medical treatment, about the right amount of medical treatment, or too little medical treatment?

Too much	1
About the right amount	2
Too little	3
Not sure (VOL.)	8
Refused (VOL.)	9

40. How would you rate the [worker's/workers'] attending physician[s] in terms of assisting in returning the worker to work as soon as medically appropriate? [Was the doctor/Were the doctors]:

Always helpful	1
Usually helpful	2
Not usually helpful	3
Not helpful at all	4
It varied (VOL.)	5
Not sure (VOL.)	8
Refused (VOL.)	9

41. How satisfied are you with the way L&I handles claim closures?

Very satisfied	1
Somewhat satisfied	2
Somewhat dissatisfied	3
Very dissatisfied	4
Not sure (VOL.)	8
Refused (VOL.)	9

42. [ASK IF IME=1OR INSURED=0 – ALL OTHERS SKIP TO 45] Your firm had at least one claim that involved an evaluation by an Independent Medical Examiner (IME). I would like to ask you about how well the IME process worked in resolving issues for your firm and its workers. Would you say the process was:

Very clear	1	
Clear	2	
Unclear	3	
Very unclear	4	
Did not have a claim with IME evaluation (VOL.)	5	[SKIP TO 45]
Not sure (VOL.)	8	[SKIP TO 45]
Refused (VOL.)	9	[SKIP TO 45]

43. Do you feel the IME process was completed in a timely manner? Would you say it was completed:

Very timely	1
Timely	2
Not timely enough	3
Not responsive at all	4
Not sure (VOL.)	8
Refused (VOL.)	9

44. Do you feel that the IME process resulted in fair evaluations?

Very fair	1
Generally fair	2
Generally unfair	3
Very unfair	4
Not sure (VOL.)	8
Refused (VOL.)	9

45. [ASK EVERYONE] Which of the following best describes your role within your firm?

Human resources	1
Workplace safety	2
Senior management	3
Other (SPECIFY)	4
Not sure (VOL.)	8
Refused (VOL.)	9

46. What is your exact job title? (PROBE FOR SPECIFICS)

Thank you for completing this survey. Your answers will help to improve the L&I process for all Washington employers.

2 WORKER SURVEY

Preload:
CLAIM DENIED = 1 if claim denied, = 0 otherwise.
IME = 1 if ever had an IME exam, = 0 otherwise
PPD = 1 if any PPD paid, = 0 otherwise
WORKER_PROTEST = 1 if any protest ever filed protest, = 0 otherwise.
AWA = 1 if worker ever had an "Ability to Work Assessment", = 0 otherwise
VR = 1 if worker had any VR services, = 0 otherwise.
Condition needs to be defined as "Injury" or "Illness"
ANY_LT = 1 if electronic record indicates any TD paid or KOS, = 0 otherwise.
BIIA = 1 if appeal filed with BIIA
Insured = 1 if employer insured through SF, = 0 if self-insured

INTERVIEWER INTRODUCTION: [WHEN SPEAKING WITH PERSON LISTED ON SAMPLE] Hello, this is NAME with QMR, a research company. We are calling on behalf of a bi-partisan committee of the Washington Legislature that is measuring the performance of the Department of Labor and Industries (L&I) and its workers' compensation claims management operations. You should have received a letter regarding this telephone interview. The Joint Legislative Audit and Review Committee (JLARC) is seeking injured workers' opinions to as a part of this review.

This study is meant to review how well the Department of Labor and Industries is addressing the needs of employees who have filed workers' compensation claims. You were randomly selected to be surveyed because you filed a claim with L&I between 2011 and 2013.

Your answers will be completely confidential. Your responses will be pooled with the answers of all other workers and only summary data will be reported. Your answers will not have any effect on your claim or eligibility for benefits.

Accept Deny section

1. According to the state of Washington's records, you filed a workers' compensation claim with the state for a work related injury or illness on [Date of injury]. Is that correct?

Yes	1	SKIP TO 3
No	2	[ASK 2]
Not sure (VOL.)	8	[ASK 2]
Refused (VOL.)	9	[ASK 2]

2. [IF NOT CORRECT] Is there another person in your household named [PERSON LISTED ON SAMPLE]?

Yes	1	[ASK TO SPEAK WITH CORRECT PERSON]
No	2	[THANK/TERMINATE]
Not sure (VOL.)	8	[THANK/TERMINATE]
Refused (VOL.)	9	[THANK/TERMINATE]

3. [IF CLAIM DENIED=1 – ALL OTHERS SKIP TO 4] The records indicate your claim was denied and you never received benefits for this injury or illness. Is that correct?

Yes	1	
No	2	[recode DENIED = 0]
Not sure (VOL.)	8	
Refused (VOL.)	9	

4. [ASK EVERYONE] How would you rate Labor & Industries' (L&I's) decision to [Accept/Deny] your claim? In terms of timeliness of the decision, was it:

Very fast	1
Fast	2
Slow	3
Very slow	4
Not sure (VOL.)	8
Refused (VOL.)	9

5. [IF CLAIM_DENIED =1– ALL OTHERS SKIP TO 9]How would you rate L&I's decision to deny your claim in terms of clearly describing the reasons for the denial? Was it:

Very clear	1
Clear	2
Unclear	3
Very unclear	4
Not sure (VOL.)	8
Refused (VOL.)	9

6. How would you rate L&I for clearly explaining your options if you disagreed with the decision to deny your claim? Was it

Very clear	1
Clear	2
Unclear	3
Very unclear	4
Not sure (VOL.)	8
Refused (VOL.)	9

[redacted] Question eliminated but number stays. [redacted]

[redacted] Question eliminated but number stays. [redacted]

[redacted]

9. [ASK EVERYONE] During your claim, did you need to contact L&I directly to get information about your claim, an explanation about your benefits or some other issue?

Yes	1	[ASK 10]
No	2	[SKIP TO 13]
Not sure (VOL.)	8	[SKIP TO 13]
Refused (VOL.)	9	[SKIP TO 13]

10. [IF "YES" IN 9 – ALL OTHERS SKIP TO 13] Did you ever feel you needed to have a face-to-face meeting with your claims manager or someone else at L&I?

Yes	1	[ASK 11]
No	2	[SKIP TO 12]
Not sure (VOL.)	8	[SKIP TO 12]
Refused (VOL.)	9	[SKIP TO 12]

11. Were you given sufficient opportunity to meet face-to-face with someone at L&I?

Yes	1
No	2
Not sure (VOL.)	8
Refused (VOL.)	9

12. [IF "YES" IN 9 – ALL OTHERS SKIP TO 13] When you contacted L&I, how often were you treated with respect? Would you say:

Always	1
Usually	2
Not very often	3
Never	4
Not sure (VOL.)	8
Refused (VOL.)	9

13. [ASK EVERYONE] Have you ever used L&I's Claims Account System to access information on your claim directly from the internet?

Yes	1	[ASK 14]
No	2	[SKIP TO 15]
Not sure (VOL.)	8	[SKIP TO 15]
Refused (VOL.)	9	[SKIP TO 15]

14. [IF "YES" IN 13 – ALL OTHERS SKIP TO 15] When you used the Claims Account System to access your claim, how easy was it to find the information you needed? Was it:

Very easy	1
Easy	2
Difficult	3
Very difficult	4
Couldn't find the information I needed	5
Not sure (VOL.)	8
Refused (VOL.)	9

15. [ALL DENIED=1 SKIP TO 21] We would like to ask you some questions about the medical treatment you received for your injury or illness. Thinking about the medical provider that handled most of your treatment for this injury or illness, was the provider:

Your usual provider?	1	[SKIP TO 17]
Chosen by you, but not your usual provider	2	[SKIP TO 17]
Selected for you by your employer?	3	[SKIP TO 17]
Selected for you by L&I?	4	[SKIP TO 17]
Chosen some other way?	5	[ASK 16]
Not sure (VOL.)	8	[SKIP TO 17]
Refused (VOL.)	9	[SKIP TO 17]

16. [IF "CHOSEN SOME OTHER WAY" IN Q15] How was the doctor selected? [PROBE FOR SPECIFICS]

Not sure (VOL.)	98
Refused (VOL.)	99

17. [ASK EVERYONE IN SERIES] How easy was it to find the doctor mostly responsible for treating your work related injury? Was it

Very easy	1
Somewhat easy	2
Somewhat difficult	3
Very difficult	4
Not sure (VOL.)	8
Refused (VOL.)	9

18. [ASK IF INSURED = 0 – ALL OTHERS SKIP TO 20]Did your employer make it clear how to obtain medical treatment for your injury or illness?

Very clear	1
Clear	2
Unclear	3
Very unclear	4
Not sure (VOL.)	8
Refused (VOL.)	9

19. Did you need to contact L&I for assistance obtaining medical care?

Yes	1
No	2
Not sure (VOL.)	8
Refused (VOL.)	9

20. [ASK EVERYONE] Overall, did you feel the medical treatment you received for your injury or illness was:

Excellent	1
Pretty good	2
Fair	3
Poor	4
Very poor	5
Not sure (VOL.)	8
Refused (VOL.)	9

21. [ASK IF ANY_LT=0; OR DENIED = 1– ALL OTHERS SKIP TO 23]Did you miss more than 3 days of work due to this injury or illness?

Yes	1	[ASK 22]
No	2	[SKIP TO 23]
Not sure (VOL.)	8	[SKIP TO 23]
Refused (VOL.)	9	[SKIP TO 23]

22. [IF "YES" IN 21 – ALL OTHERS IN SERIES SKIP TO 23] About how many weeks were you out of work because of this injury or illness?

___ Weeks	
Not sure (VOL.)	888
Refused (VOL.)	999

23. [ASK EVERYONE IN SERIES] Sometimes an employer will pay workers full salary for some of the time they are off work due to injury. This is called "Kept on Salary". Did your employer pay your full salary for at least part of the time you were off work due to your injury?

Yes	1	[ASK 24]
No	2	[SKIP TO 25]
Not sure (VOL.)	8	[SKIP TO 25]
Refused (VOL.)	9	[SKIP TO 25]

24. [IF "YES" IN 23 – ALL OTHERS IN SERIES SKIP TO 25] About how many **weeks** did your employer "keep you on full salary" when you were off work or unable to work full time?

____Weeks

Not sure (VOL.)	888
Refused (VOL.)	999

25. Have you returned to work since your injury or illness?

Yes	1	
No	2	[SKIP TO 30]
Not sure (VOL.)	8	[SKIP TO 30]
Refused (VOL.)	9	[SKIP TO 30]

26. When you first returned to work after your injury, did you return to the same employer or another employer?

The same employer	1	
Another employer	2	
Not sure (VOL.)	8	[SKIP TO 38]
Refused (VOL.)	9	[SKIP TO 38]

27. Did the employer make any modifications to your job to make it easier for you to return to work?

Yes	1	[ASK 28]
No	2	[if Q26 = 2, go to Q29, if Q26 = 1 go to Q38]
Not sure (VOL.)	8	[SKIP if Q26 = 2, go to Q29, if Q26 = 1 go to Q38]
Refused (VOL.)	9	[SKIP TO if Q26 = 2, go to Q29, if Q26 = 1 go to Q38]

28. [IF "YES" IN 27 – ALL OTHERS SKIP AS DIRECTED IN 27] Were these modifications to your usual job or a different job altogether?

Modifications to usual job	1	[Skip to Q38]
Different job altogether	2	[Skip to Q38]
Not sure (VOL.)	8	[Skip to Q38]
Refused (VOL.)	9	[Skip to Q38]

29. [IF "ANOTHER EMPLOYER" IN Q26– ALL OTHERS SKIP TO 38] Why didn't you return to the same employer? [DO NOT READ LIST; PROBE FOR SPECIFICS]

No job available when able to return to work	1	[Skip to Q38]
No job available that fit my work restrictions	2	[Skip to Q38]
Wanted to work for a different employer	3	[Skip to Q38]
No longer wanted to work for that employer	4	[Skip to Q38]
Wanted a different job (not because of my injury)	5	[Skip to Q38]
Wanted a different job because of the limitations caused by my injury	6	[Skip to Q38]
Other _____	7	[Skip to Q38]
Not sure (VOL.)	98	[Skip to Q38]
Refused (VOL.)	99	[Skip to Q38]

ALL SKIP TO Q38

30. [IF "NO" IN 25–] Why haven't you returned to work? Is it because of your injury or some other reason?

Injury	1	[SKIP TO 32]
Some other reason	2	[ASK 31]
Not sure (VOL.)	8	[SKIP TO 32]
Refused (VOL.)	9	[SKIP TO 32]

31. What is the reason you have not returned to work? [PROBE FOR SPECIFICS]

Not sure (VOL.)	98
Refused (VOL.)	99

32. Do you feel you could return today to the same job you had when you were injured?

Yes	1	[SKIP TO 36]
No	2	[ASK 33]
Not sure (VOL.)	8	[SKIP TO 34]
Refused (VOL.)	9	[SKIP TO 34]

33. [IF "NO" IN 32] Could you return to that job if it was modified?

Yes	1
No	2
Not sure (VOL.)	8
Refused (VOL.)	9

34. Do you feel there is another job with that employer you could do today if it was available?

Yes	1
No	2
Not sure (VOL.)	8
Refused (VOL.)	9

35. Has your employer ever discussed with you a modification to your job or an alternate job that would allow you to return to work?

Yes	1
No	2
Not sure (VOL.)	8
Refused (VOL.)	9

36. Can you think of any services or assistance would help you return to work in the near future?

Yes	1	[ASK 37]
No	2	[SKIP TO 38]
Not sure (VOL.)	8	[SKIP TO 38]
Refused (VOL.)	9	[SKIP TO 38]

37. What specific services would help you return to work in the near future?

Not sure (VOL.)	98
Refused (VOL.)	99

38. [ASK EVERYONE WITH CLAIM_DENIED=0AND (ANY_LT =1 OR Q21= YES)]Workers often receive assistance in making decisions about when to return-to-work as soon as possible and what temporary and permanent restrictions may be necessary to avoid re-injury. Did any of the following assist your efforts to return to work: [CHECK ALL THAT APPLY]

- Treating physician 1
- Claims manager 2
- L&I Early Return to work specialist 3
- Vocational rehabilitation specialist 4
- Your employer 5
- Other (specify)_____ 6
- Not sure (VOL.) 8
- Refused (VOL.) 9

PROGRAMMING NOTE: THE 38a-38c SERIES IS ASKED FOR EACH ENTITY ASSISTING IN THEIR EFFORTS TO RETURN TO WORK

38-1_a. Overall, how helpful was [38-1]

Very helpful	1
Somewhat helpful	2
Not very helpful	3
Not at all helpful	4
Not sure (VOL.)	8
Refused (VOL.)	9

38-1_b.Were the services of [38-1] given at the right time?

Yes, right time	1
No, I should have received the assistance sooner	2
No, I wasn't ready/I needed the assistance later when I was more fully recovered	3
Not sure (VOL.)	8
Refused (VOL.)	9

38-1c.How clearly did [38-1] explain what steps you would need to take to return to work? Would you say:

Very clearly	1
Somewhat clearly	2
Not very clearly	3
Not at all clearly	4
Not sure (VOL.)	8
Refused (VOL.)	9

38-2_a. Overall, how helpful was [38-2]

Very helpful	1
Somewhat helpful	2
Not very helpful	3
Not at all helpful	4
Not sure (VOL.)	8
Refused (VOL.)	9

38-2_b. Were the services of [38-2] given at the right time?

Yes, right time	1
No, I should have received the assistance sooner	2
No, I wasn't ready/I needed the assistance later when I was more fully recovered	3
Not sure (VOL.)	8
Refused (VOL.)	9

38-2c. How clearly did [38-2] explain what steps you would need to take to return to work? Would you say:

Very clearly	1
Somewhat clearly	2
Not very clearly	3
Not at all clearly	4
Not sure (VOL.)	8
Refused (VOL.)	9

38-3a. Overall, how helpful was [38-3]

Very helpful	1
Somewhat helpful	2
Not very helpful	3
Not at all helpful	4
Not sure (VOL.)	8
Refused (VOL.)	9

38-3_b. Were the services of [38-3] given at the right time?

Yes, right time	1
No, I should have received the assistance sooner	2
No, I wasn't ready/I needed the assistance later when I was more fully recovered	3
Not sure (VOL.)	8
Refused (VOL.)	9

38-3c. How clearly did [38-3] explain what steps you would need to take to return to work? Would you say:

Very clearly	1
Somewhat clearly	2
Not very clearly	3
Not at all clearly	4
Not sure (VOL.)	8
Refused (VOL.)	9

38-4_a. Overall, how helpful was [38-4]

Very helpful	1
Somewhat helpful	2
Not very helpful	3
Not at all helpful	4
Not sure (VOL.)	8
Refused (VOL.)	9

38-4_b. Were the services of [38-4] given at the right time?

Yes, right time	1
No, I should have received the assistance sooner	2
No, I wasn't ready/I needed the assistance later when I was more fully recovered	3
Not sure (VOL.)	8
Refused (VOL.)	9

38-4c. How clearly did [38-4] explain what steps you would need to take to return to work? Would you say:

Very clearly	1
Somewhat clearly	2
Not very clearly	3
Not at all clearly	4
Not sure (VOL.)	8
Refused (VOL.)	9

38-5_a. Overall, how helpful was [38-5]

Very helpful	1
Somewhat helpful	2
Not very helpful	3
Not at all helpful	4
Not sure (VOL.)	8
Refused (VOL.)	9

38-5_b. Were the services of [38-5] given at the right time?

Yes, right time	1
No, I should have received the assistance sooner	2
No, I wasn't ready/I needed the assistance later when I was more fully recovered	3
Not sure (VOL.)	8
Refused (VOL.)	9

38-5c. How clearly did [38-5] explain what steps you would need to take to return to work? Would you say:

Very clearly	1
Somewhat clearly	2
Not very clearly	3
Not at all clearly	4
Not sure (VOL.)	8
Refused (VOL.)	9

39. [ASK IF AWA=1; ALL OTHERS SKIP TO 41] You received an assessment of your ability to work. This assessment would have involved talking to a private counselor about your work history, education and specific skills. How would you rate the development of the Ability to Work Assessment in assisting your efforts to return to work? Was it

Very helpful	1
Somewhat helpful	2
Not very helpful	3
Not helpful at all	4
Not sure (VOL.)	8
Refused (VOL.)	9

40. [ASK IF VR=1 – ALL OTHERS SKIP TO TEXT BEFORE 41] Our records indicate that you have received the services of a Vocational Rehabilitation Counselor. How would you rate the help of the Vocational Rehabilitation counselor in assisting your efforts to return to work? Was it:

Very helpful	1
Somewhat helpful	2
Not very helpful	3
Not helpful at all	4
Not sure (VOL.)	8
Refused (VOL.)	9

TEXT TO READ TO EVERYONE:
Most injured workers recover fully from their injury. However some workers, even when they have recovered have some remaining permanent physical limitations that affect their work or daily life. An example of this may be your doctor telling you that you can no longer lift more than 25 pounds as a regular task.

41. Do you have any remaining impairment from your injury that affects your work or daily life? [IF NECESSARY: Impairments can be more difficulty lifting heavy objects or restrictions on sitting or standing for long periods.]

Yes	1	[ASK 42]
No	2	[SKIP TO 43]
Not sure (VOL.)	8	[SKIP TO 43]
Refused (VOL.)	9	[SKIP TO 43]

42. [IF "YES" IN 41– ALL OTHERS SKIP TO 43] How much does your remaining impairment affect your work or daily life? Would you say:

Almost no effect	1
Small effect (I only notice is occasionally)	2
Moderate effect	3
Major effect (It affects me nearly every day)	4
Not sure (VOL.)	8
Refused (VOL.)	9

43. [ASK IF INSURED=0 – ALL OTHERS SKIP TO 45] We would like to know if during your claim, the Claims Manager handling your case had you visit a specialist, called an Independent Medical Evaluator or IME, to resolve medical treatment questions or the level of permanent partial disability. This doctor would be different than your regular provider. Were you evaluated by an Independent Medical Evaluator?

Yes	1	[ASK 44]
No	2	[SKIP TO 47]
Not sure (VOL.)	8	[SKIP TO 47]
Refused (VOL.)	9	[SKIP TO 47]

44. [IF "YES" IN 43 – ALL OTHERS IN SERIES SKIP TO 47] How well did the Claims Manager handling your case explain the IME process to you? Would you say it was:

Very clear	1	[Go to 46]
Clear	2	[Go to 46]
Unclear	3	[Go to 46]
Very unclear	4	[Go to 46]
Not sure (VOL.)	8	[Go to 46]
Refused (VOL.)	9	[Go to 46]

45. [ASK IF INSURED = 1 AND IME=1 – ALL OTHERS SKIP TO 48] Our records indicate that you had an evaluation done by an Independent Medical Evaluator (IME) to resolve medical treatment questions or the level of permanent partial disability. How well did the Claims Manager handling your case explain the IME process to you? Would you say it was:

Very clear	1
Clear	2
Unclear	3
Very unclear	4
Not sure (VOL.)	8
Refused (VOL.)	9

46. Do you think you IME evaluation fairly reported the true extent of the physical effects of your injury?

Yes	1	[SKIP TO 48]
No	2	[SKIP TO 48]
Not sure (VOL.)	8	[SKIP TO 48]
Refused (VOL.)	9	[SKIP TO 48]

47. [ASK IF (INSURED = 1 AND PPD=1 **AND** IME=0) OR (INSURED = 0 AND PPD = 1 AND Q43 = "NO")] Sometimes your treating doctor will evaluate you for any permanent impairment. If so, the doctor would have given you a report, near the end of treatment, describing any permanent impairment. Did your doctor give you a report describing any permanent impairment?

Yes	1
No	2
Not sure (VOL.)	8
Refused (VOL.)	9

TEXT TO READ TO WORKER_PROTEST=1 – ALL OTHERS SKIP TO 56
Injured workers sometimes disagree with decisions made by the employer or L&I. When there is a disagreement, parties have the option to file a protest with L&I and request a resolution of the disagreement. Our records indicate that you or your employer filed a protestith L&I. We would like to ask you some question about how well that process worked.

48. [IF WORKER_PROTEST=1 – ALL OTHERS SKIP TO 56] How well did L&I explain your options when you or your employer disagreed with a decision made on your claim? Were the explanations generally::

Very clear	1
Clear	2
Unclear	3
Very unclear	4
Not sure (VOL.)	8
Refused (VOL.)	9

49. L&I supplies written information to explain your options when you disagree with an important decision about your claim. Did you find the written materials:

Very useful	1
Somewhat useful	2
Not very useful	3
Not useful at all	4
Not sure (VOL.)	8
Refused (VOL.)	9

[redacted]Question eliminated but number stays. [redacted]

51. How quickly did L&I resolve the disagreements?

Very quickly	1
Quickly	2
Slowly	3
Very slowly	4
Not sure (VOL.)	8
Refused (VOL.)	9

52. When L&I made a decision on a protest, did you feel they explained the decision and reasons for the decision in language that was clear and easy to understand?

Yes	1
No	2
Not sure (VOL.)	8
Refused (VOL.)	9

53. In thinking about the process used when there was a protest to L&I, did you believe you had sufficient opportunity to present your arguments?

Yes	1
No	2
Not sure (VOL.)	8
Refused (VOL.)	9

54. How satisfied were you overall with the protest process? Would you say you were:

Very satisfied	1
Somewhat satisfied	2
Somewhat dissatisfied	3
Very dissatisfied	4
Not sure (VOL.)	8
Refused (VOL.)	9

55. And how satisfied were you with the final decision of the protest? Were you:

Very satisfied	1
Somewhat satisfied	2
Somewhat dissatisfied	3
Very dissatisfied	4
Not sure (VOL.)	8
Refused (VOL.)	9

56. [ASK IF BIIA=1 – ALL OTHERS SKIP TO 59] Our records indicate that either you or your employer appealed a decision by L&I to the Board of Appeals. In thinking about the process used to appeal the decision to the Board of Appeals, did you believe you had sufficient opportunity to present your arguments?

Yes	1
No	2
Not sure (VOL.)	8
Refused (VOL.)	9

57. How satisfied were you overall with the appeal process? Would you say you were:

Very satisfied	1
Somewhat satisfied	2
Somewhat dissatisfied	3
Very dissatisfied	4
Not sure (VOL.)	8
Refused (VOL.)	9

58. And how satisfied were you with the final decision on the appeal? Were you:

Very satisfied	1
Somewhat satisfied	2
Somewhat dissatisfied	3
Very dissatisfied	4
Not sure (VOL.)	8
Refused (VOL.)	9

59. [ASK EVERYONE] Now we would like to ask you a few questions about you and the kind of work you did at the time you were injured.About how long had you done that same type of work you were doing when injured, including for other employers?

Less than 1 year	1
1 to 2 years	2
3 to 4 years	3
5 or more years	4
Not sure (VOL.)	8
Refused (VOL.)	9

60. About how many people worked for your employer at the location where you worked?

Less than 10	1
10 to 49	2
50 to 99	3
100 to 249	4
250 or more	5
Not sure (VOL.)	8
Refused (VOL.)	9

61. What was the highest level of education you achieved?

Less than high school	1
High school or GED	2
Some college	3
Associate Degree	4
Bachelor's Degree	5
Post-graduate degree	6
Not sure (VOL.)	8
Refused (VOL.)	9

62. How would you describe your health before you were injured

Excellent	1
Very good	2
Fair	3
Poor	4
Not sure (VOL.)	8
Refused (VOL.)	9

63. Do you have other health issues, besides your work injury or illness that made it more difficult for you to return to work due to your occupational condition?

Yes	1
No	2
Not sure (VOL.)	8
Refused (VOL.)	9

64. Did you hire an attorney to assist you with your workers' compensation claim?

Yes	1	[SKIP TO 66]
No	2	[ASK 65]
Not sure (VOL.)	8	[ASK 65]
Refused (VOL.)	9	[ASK 65]

65. Did you discuss your case with an attorney, but not ultimately hire one?

Yes	1	[ASK 66]
No	2	[SKIP TO CLOSING]
Not sure (VOL.)	8	[SKIP TO CLOSING]
Refused (VOL.)	9	[SKIP TO CLOSING]

66. What issue or issues caused you to speak with an attorney about your case? [PROBE FOR SPECIFICS]

Not sure (VOL.)	98
Refused (VOL.)	99

Thank you for completing this survey. Your answers will help to improve the L&I process for all Washington workers.

Workers' Compensation Claims Best Practices

Making Initial Contact

Page description:
These questions are designed to evaluate making initial contact in a claim. In answering the questions, assume that the accident report is complete. Assume also that the claims adjuster is presented with correct employer and claimant contact information. Please provide any comments in question 3.

1. In your opinion what time intervals would represent “best practice” goal for the claims adjuster (or nurse case manager) to make actual voice contact with the **injured claimant**? (0 = less than 1 business day to make actual contact; 21 = 21 or more business days to make actual contact)

Number of **Days** for Lost Time Claims	
Number of **Days** for Medical Only Claims	

2. In your opinion what time intervals would represent “best practice” goal for the claims adjuster (or nurse case manager) to make actual voice contact with the **employer of injury**? (0 = less than 1 business day to make actual contact; 21 = 21 or more business days to make actual contact)

Number of **Days** for Lost Time Claims	
Number of **Days** for Medical Only Claims	

3. Do you have any additional information or comments about initial contact?

Claims communications

Page description:
The following questions are designed to evaluate best practices regarding communications regarding various aspects of a claim.

4. What standard would be considered “best practice” for the adjuster to return most phone calls from the injured worker or employer of injury?

- ○ Within 4 hours
- ○ Within 1 business day
- ○ Within 2 business days
- ○ Within 3 business days
- ○ No firm limits should apply
- ○ Other *

5. On average, how many days have elapsed from the date of injury to the first report of injury being available to the adjuster? (1 = first report available within 1 day of injury; 10 = first report typically available 10 or more days after injury)

Number of **days**

6. Any comments or additional information regarding communications best practices?

Compensability decisions

Page description:
The following questions are designed to evaluate best practices regarding investigations and compensability.

7. On average, how long (from the date of receipt of the accident report) does it take for an adjuster to communicate with the claimant that the claim is **denied**?

- Less than 7 days
- Between 7 and 10 days
- Between 10 and 14 days
- Between 14 and 20 days
- Between 20 and 30 days
- Other *

8. On average, how long (from the date of receipt of the accident report) does it take for an adjuster to communicate with the claimant that the claim is **accepted**?

- Less than 7 days
- Between 7 and 10 days
- Between 10 and 14 days
- Between 14 and 20 days
- Between 20 and 30 days
- Not common practice to issue acceptance decision
- Other [ ] *

9. This question assesses the need for an adjuster to independently confirm the compensability of a claim, through witness statements, medical consults concerning causation, and the like, regardless of whether the employer raises a protest. With what regularity should the adjuster independently confirm compensability of the reported injury? For this question, assume that "independent confirmation" would involve inquiry beyond the accident report, such as phone calls, emails, statements, etc.

- Confirmation always required, 90% or more of lost-time claims
- Confirmation required 75% of the time
- Confirmation required 50% of the time
- Confirmation required only when the report of injury suggests a need
- Confirmation required only when the employer protests compensability
- Whether confirmation needed depends on the degree and quality of work-up of the injury that is provided to the adjuster
- Other [ ] *

10. Any additional information or comments regarding investigation and compensability?

Making Contact with the Treating Physician

Page description:
The following question is designed to evaluate how you would rate the effort a good claims adjuster (or in some cases an occupational nurse) should put into speaking to a treating physician about certain aspects of the claim.

11. How much effort should the adjuster take in making contact with the physician in the following circumstances:

	Should make utmost effort	Relatively high priority to make contact	Sometimes useful to make contact	Monitor and intervene only when necessary
When first medical report from treating physician is vague about the diagnosis, severity of injury, or whether further treatment is needed	Should make utmost effort	Relatively high priority to make contact	Sometimes useful to make contact	Monitor and intervene only when necessary
When first medical report from treating physician is vague, or open-ended, about restrictions or orders, without much explanation, e.g., "No work for X weeks"	Should make utmost effort	Relatively high priority to make contact	Sometimes useful to make contact	Monitor and intervene only when necessary
When ongoing physical medicine treatment is expected to exceed your guidelines, without documentation of functional improvement or pain relief	Should make utmost effort	Relatively high priority to make contact	Sometimes useful to make contact	Monitor and intervene only when necessary
When a prescription for opioids to manage pain is given for a common strain or sprain of a limb	Should make utmost effort	Relatively high priority to make contact	Sometimes useful to make contact	Monitor and intervene only when necessary
When, after initial treatment, the treating physician’s follow-up reports contain an expanded diagnosis of injury conditions, e.g., knee injury expanded to hip	Should make utmost effort	Relatively high priority to make contact	Sometimes useful to make contact	Monitor and intervene only when necessary
When treatment appears to deviate in the duration of treatment from treatment guidelines (official or internal)	Should make utmost effort	Relatively high priority to make contact	Sometimes useful to make contact	Monitor and intervene only when necessary

Getting help from occupational nurse or medical consultants

Page description:
The following questions are designed to evaluate the use of occupational nurses/medical consultants in managing claims.

12. How often would you expect a lost time claim to require review or consultation between the adjuster and a nurse/medical consultant? (0=consult never required; 50=consult required in 50% of cases; 100=consult always required)

Percentage of lost-time claims where nurse/medical consult required	

13. Given your answer to the previous question, what would you consider the optimal ratio of adjusters to nurse/medical consultants? (1 = 1 nurse consultant on staff for each adjuster; 5 = 1 nurse consultant for every 5 adjusters; 10 = 1 nurse consultant for every 10 or more adjusters)

Number of adjusters per nurse consultant	

14. Do you have any comments about the use of occupational nurse/medical consultants in handling claims?

Return to work

Page description:
The following questions are designed to evaluate strategies used by claims adjusters in returning an injured worker back to work.

15. How frequently would an adjuster (or nurse case manager) interact with an **employer** on strategies for returning the injured worker to the job within the physician's duty limitations? (For this question, assume that lost time payments are about to begin)

- Infrequently (less than 25% of lost-time claims involve such interactions with the employer)
- Sometime (between 25 and 50% of lost-time claims)
- Often (between 50 and 75% of lost-time claims)
- Very often (more than 75% of lost-time claims)

16. How important is it for non-compensable medical conditions that are encountered in physician reports to be expressly segregated from the claim?

- Very important segregate non-compensable medical conditions
- Somewhat important
- Limited value
- Not generally important to segregate non-compensable medical conditions
- Other [ ] *

17. As an estimate, in what percentage of lost-time claims, with disability over 60 days, is an IME needed by the adjuster to confirm or challenge the treating physician on the following issues. (0% = IME never needed; 50% = IME needed half of the time to confirm or challenge the treating physician; 100% = IME needed in every case on the particular issue)

% where IME needed re *ability to return to work*	
% where IME needed re *necessity of treatment*	
% where IME needed re *MMI/rating determination*	

18. Generally speaking, how reliably can an adjuster predict, after 60 days of lost time, that a worker with a moderately severe injury (major sprain to a joint, tendon tear, etc.) will not likely return to work at the employer of injury ?

- Low reliability; highly variable depending on the nature of the injury
- Moderate reliability; unless there are unusual claim characteristics
- Fairly good reliability
- Excellent reliability (nearly every case predicted)
- Other *

19. Do you have any comments or additional information regarding claim-manager involvement in return to work issues?

Vocational retraining and rehabilitation

Page description:
These questions are designed to evaluate best practices in the use of vocational services.

20. What percentage of lost-time claims usually require the following:

	Less than 5% of lost-time claims	Between 5 and 25% of lost-time claims	Between 25 and 50% of lost-time claims	Between 50 and 75% of lost-time claims	More than 75% of lost-time claims
Vocational evaluation (e.g. job skills assessment; ability to work)	○ Less than 5% of lost-time claims	○ Between 5 and 25% of lost-time claims	○ Between 25 and 50% of lost-time claims	○ Between 50 and 75% of lost-time claims	○ More than 75% of lost-time claims
Vocational retraining plan	○ Less than 5% of lost-time claims	○ Between 5 and 25% of lost-time claims	○ Between 25 and 50% of lost-time claims	○ Between 50 and 75% of lost-time claims	○ More than 75% of lost-time claims

21. In claims where the adjuster enlists vocational services (counseling or training), how many days from injury would you expect to begin these services?

- ○ Within 1 month of the injury
- ○ Between 1 and 3 months of the injury
- ○ Between 3 and 5 months of the injury
- ○ More than 5 months from the injury
- ○ Other [ ] *

22. Any comments or other information about the use of vocational services in handling claims?

Work Management

Page description:

23. What would you consider the optimal ratio of first level adjusters to supervisors? (1 = 1 supervisor per front-line adjuster; 5 = 1 supervisor for every 5 front-line adjusters; 15 = 1 supervisor for every 15 front-line adjusters)

Number of first-level adjusters per supervisor	

24. In your opinion, based on **average** adjuster training and experience and assuming average case complexity, what would be a standard caseload per workers' compensation claims adjuster.

Total **number** of open cases per front-line adjuster	
Number of open lost-time cases per front-line adjuster	
Number of open medical-only cases per front-line adjuster	

25. Any other information or comments about adjuster workload or supervision?

Background on your professional experience

Page description:

26. How many years of experience do you have with claims adjudication or supervision of the claim function for workers' compensation?

Years of w/c adjusting/claims supervision experience	

27. For the majority of your workers' compensation experience, in which of the regions below did you do the majority of your work?

- [ ] Northeastern US
- [ ] Middle Atlantic US
- [ ] Southeastern US
- [ ] Central US
- [ ] South Central US
- [ ] California
- [ ] Other Western US
- [ ] Canada
- [ ] Other _____ *

28. In what area is your **most recent** claims experience?

- ○ Private Insurance
- ○ TPA Claims
- ○ Audit
- ○ Other _____ *

29. Contact info (optional)

- ○ Name _____
- ○ Email Address _____
- ○ Phone Number _____

Injured Workers: Wave 4: September 2014

Tables and Charts

Methodology

Reported herein are the results of five waves of the Injured Workers survey. A total of 800 telephone interviews are conducted for the first two waves, followed by 910, 961, and 800 interviews conducted for the subsequent measures. Injured workers with the following types of claims are included in the sample:

- Allowed Wage Loss Claims that were active in the previous three months
- Claims 30 days or over, and
- Kept-on-Salary (KOS) claims that appear as medical-only are included.

Excluded from the research are injured workers with:

- Medical treatment-only claims
- Injured workers with legal representatives
- Injured Workers that reside outside of Washington State, and
- Respondents from previous waves of this survey that have been interviewed within the last 6 months.

The interviews were conducted from:

- Baseline: February 21 to March 8, 2012
- Wave 1: September 19 to October 5, 2012
- Wave 2: September 20 to October 12, 2013
- Wave 3: April 23 to May 2, 2014
- Wave 4: September 23 to October 7, 2014

The interviews are conducted in the respondent's choice of English or Spanish, and the proportion of Spanish interviews is controlled to correspond with the proportion of workers tagged as Spanish-speaking among L&I's injured worker customers.

The sample was selected in proportion to the distribution of claims by age over a two year period. The distribution used is that of claims opened between 2009 and 2011. This reflects the profile of claims opened during a two-year period, rather than all claims in the pipeline, which would result in a disproportionately high number of older claims.

Completion Rate

The final call dispositions for Wave 4 are as follows. The completion rate is high.

	Number	Percent
Completed Interviews	800	20%
Break-offs	28	1%
Disqualified	223	6%
Language Barrier	678	17%
Appointments	134	3%
Refusals	369	9%
Telephone Was Not Answered	1435	36%
Not in Service	317	8%
Total Sample Dialed	***3984***	***100%***

Margin of Error and Statistical Significance

Surveys based on random samples are subject to sampling error due to the fact that not everyone in the entire population was surveyed. The reliability of survey results is often reported as a range within which the actual result is expected to fall. This range is based on a specified level of probability, typically 95%.

Data based on the Wave 3 sample of 800 has a sampling error of ±3.5% at the 95% threshold. Thus, if a result of 50% is attained based on this sample, we can be sure, 95% of the time (or 19 times out of 20) that the result of a census would be between 46.5% and 53.5%.

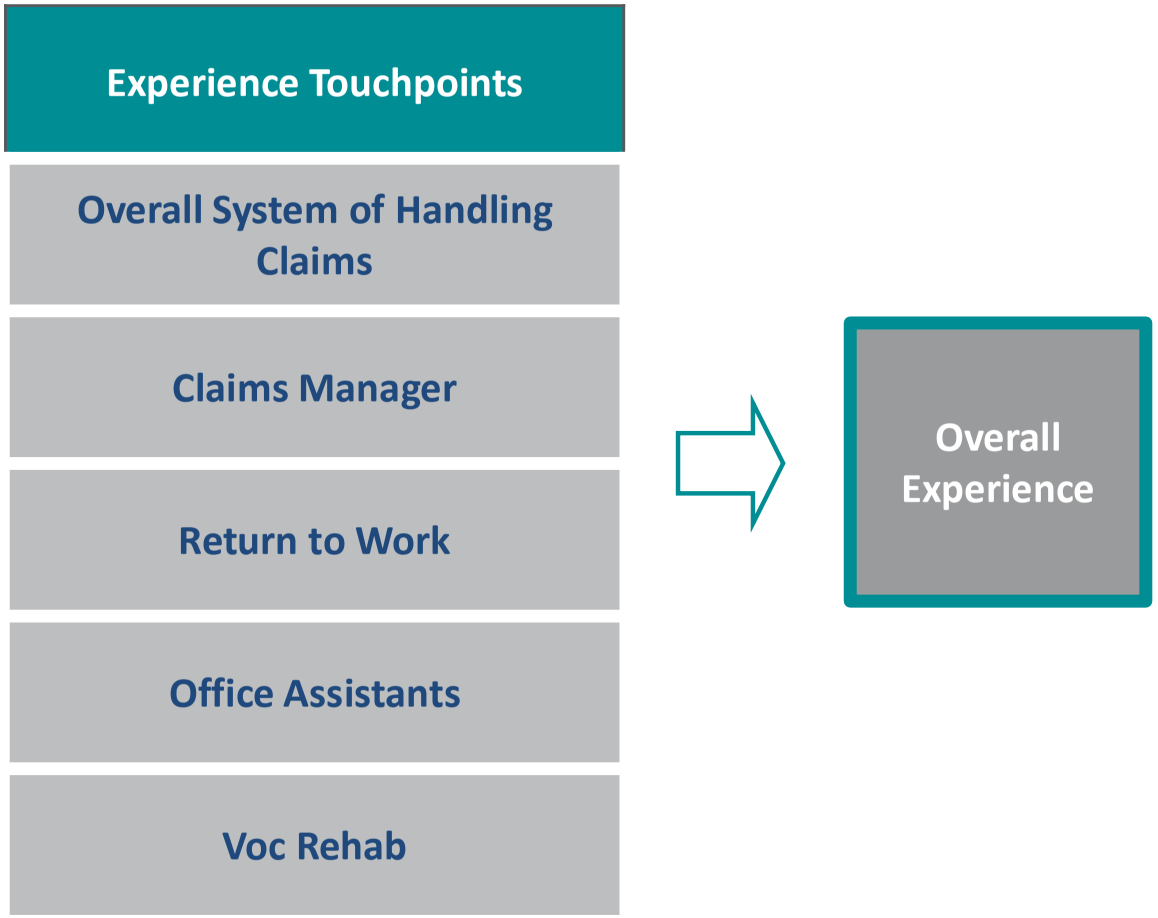
Data based on sub-groups is subject to greater margins of error. Examples of sub-groups and the associated margins of error are provided to follow.

	Sample Size	Margin of Error*
Wave 4 Total	800	±3.5%
Claims 30 to 180 days	300	±5.7%
Smaller groups of respondents (e.g.)	100	±9.8%
* For a result of 50% at the 95% confidence interval.		

Throughout this report, circles ◯ are used to denote sub-groups with scores that are statistically significantly higher than other sub-groups.
Arrows ⬆⬇ denote statistically significant changes from wave to wave.

Note that the percentages for rating scale questions are based on respondents who gave a rating.

Injured Worker Model



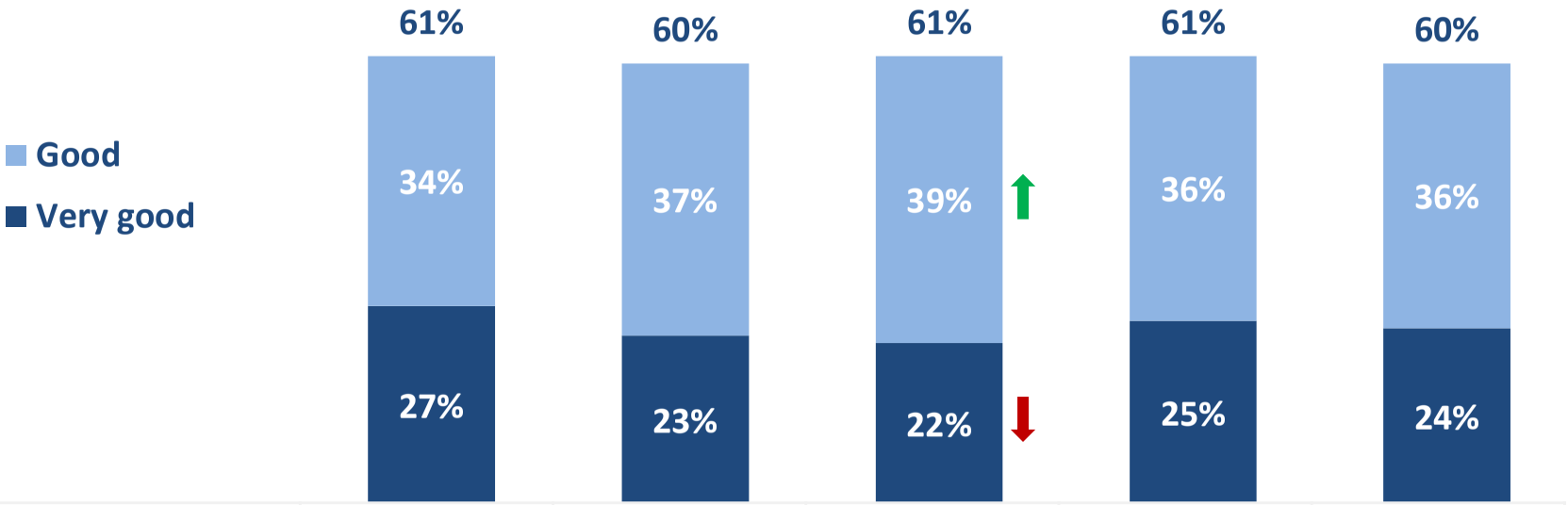
Injured Worker Model

Touchpoints	Drilldowns								
System of Handling Claims	Providing accurate information about your claim	Keeping you informed	How long it took to approve medical treatment	Having a clear, understandable claims process					
Claims Manager	Being helpful and friendly	Answering your questions	Listening to you and under-standing	Explaining reasons for decisions	Getting back to you in a timely manner	Caring about your well-being	Asking about concerns about RTW	Letting you know what would happen	Actively involving you in discussing next steps
Return to Work									
Office Assistants	Being helpful and friendly	Answering your questions or resolving your concerns							
Voc Rehab	Getting back to you in a timely manner	Listening to you and under-standing	Letting you know what would happen next for you	Caring about your well-being	Discussing the possible outcomes of the AWA				

= Top Priority = Secondary Priority

Waves 3 and 4 DA results.

Overall Experience Working with L&I
Workers



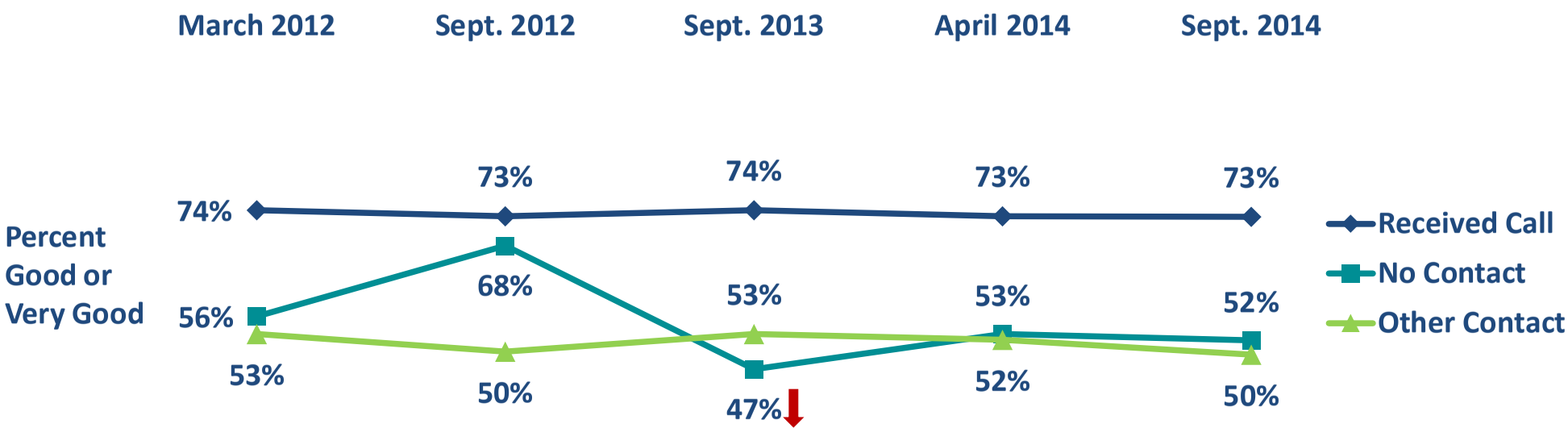
	March 2012	Sept. 2012	Sept. 2013	April 2014	Sept. 2014
Total Good	61%	60%	61%	61%	60%
Average	25%	25%	25%	26%	26%
Total Poor	14%	15%	14%	13%	14%
Number of Interviews	*(800)*	*(800)*	*(910)*	*(961)*	*(800)*

Q1a. Taking everything into account with this claim, how would you rate your overall experience of working with L&I?

Base: All respondents

Impact of Contact with Claims Manager on Overall Experience

Workers

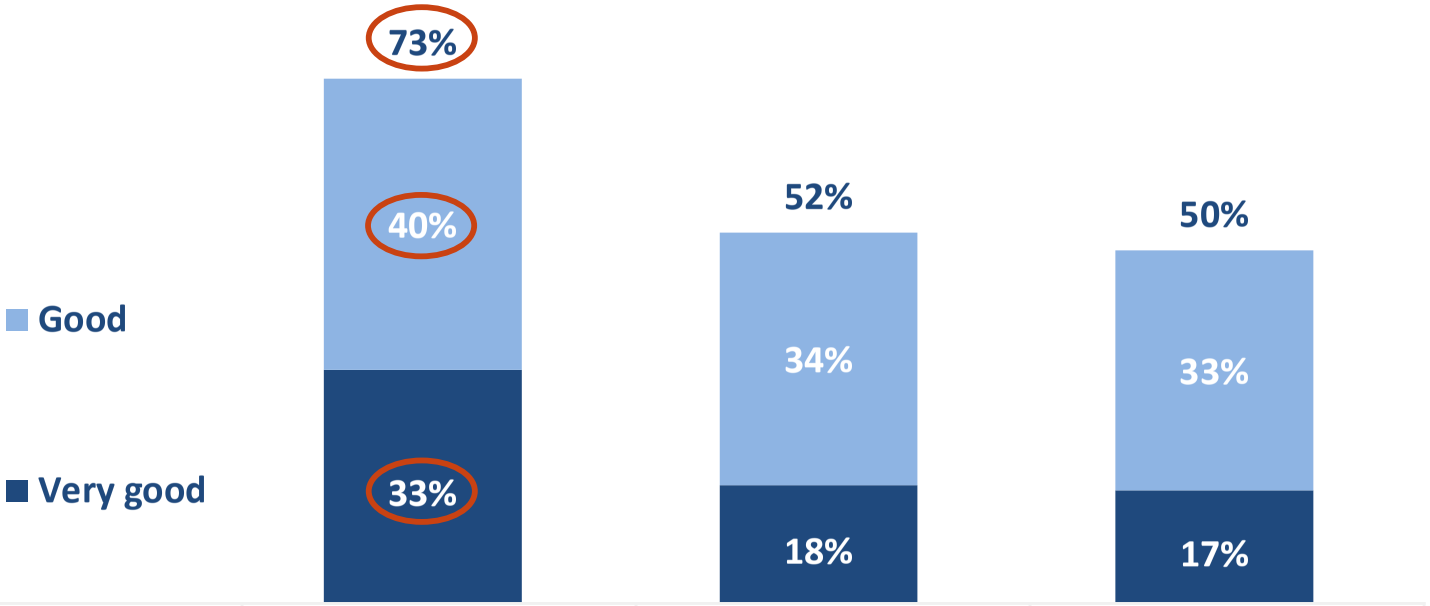


Q1a. Taking everything into account with this claim, how would you rate your overall experience of working with L&I?

Base: All respondents (n=800/800/910/961/800)

Impact of Contact with Claims Manager on Overall Experience

Workers: September 2014



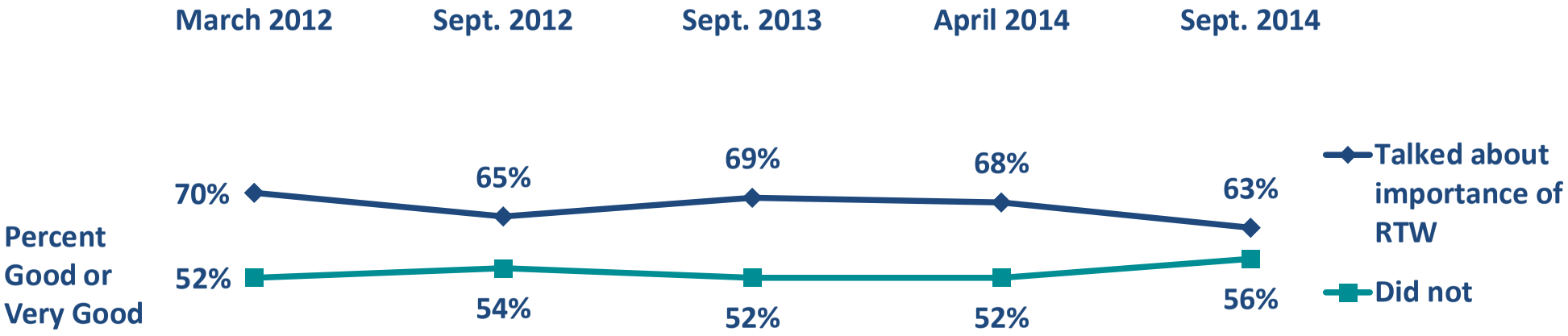
	Received Call from CM	No Direct Contact	Otherwise Spoke Directly
Total Good	73%	52%	50%
Average	18%	33%	31%
Total Poor	9%	15%	20%
Number of Interviews	*(354)*	*(108)*	*(331)*

Q1a. Taking everything into account with this claim, how would you rate your overall experience of working with L&I?

Base: All respondents (n=800)

Impact of Talking about RTW on Overall Experience

Workers

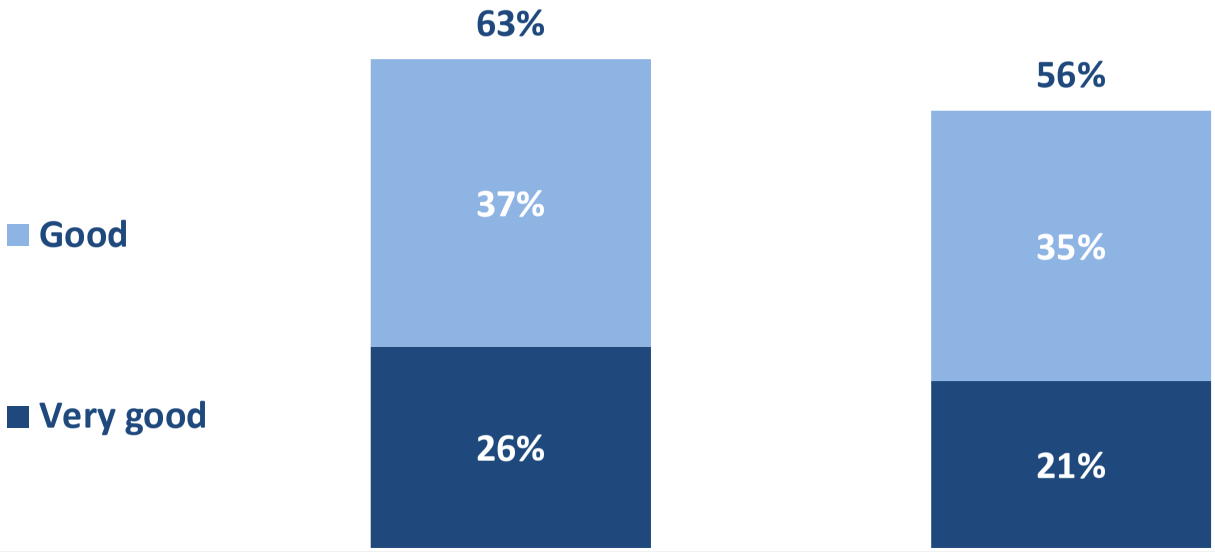


Q1a. Taking everything into account with this claim, how would you rate your overall experience of working with L&I?

Base: All respondents (n=800)

Impact of Talking about RTW On Overall Experience with L&I

Workers: September 2014



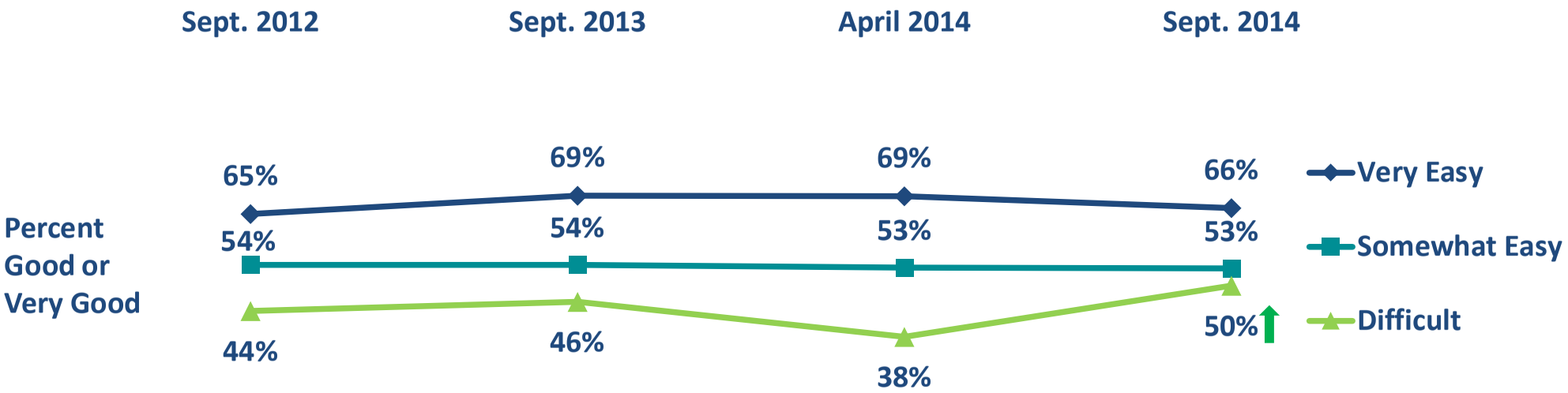
	L&I talked about importance of RTW as soon as medically possible	Did Not
Total Good	63%	56%
Average	25%	28%
Total Poor	13%	16%
Number of Interviews	*(329)*	*(350)*

Q1a. Taking everything into account with this claim, how would you rate your overall experience of working with L&I?

Base: All respondents

Impact of Ease of Finding a Medical Provider on Overall Experience

Workers

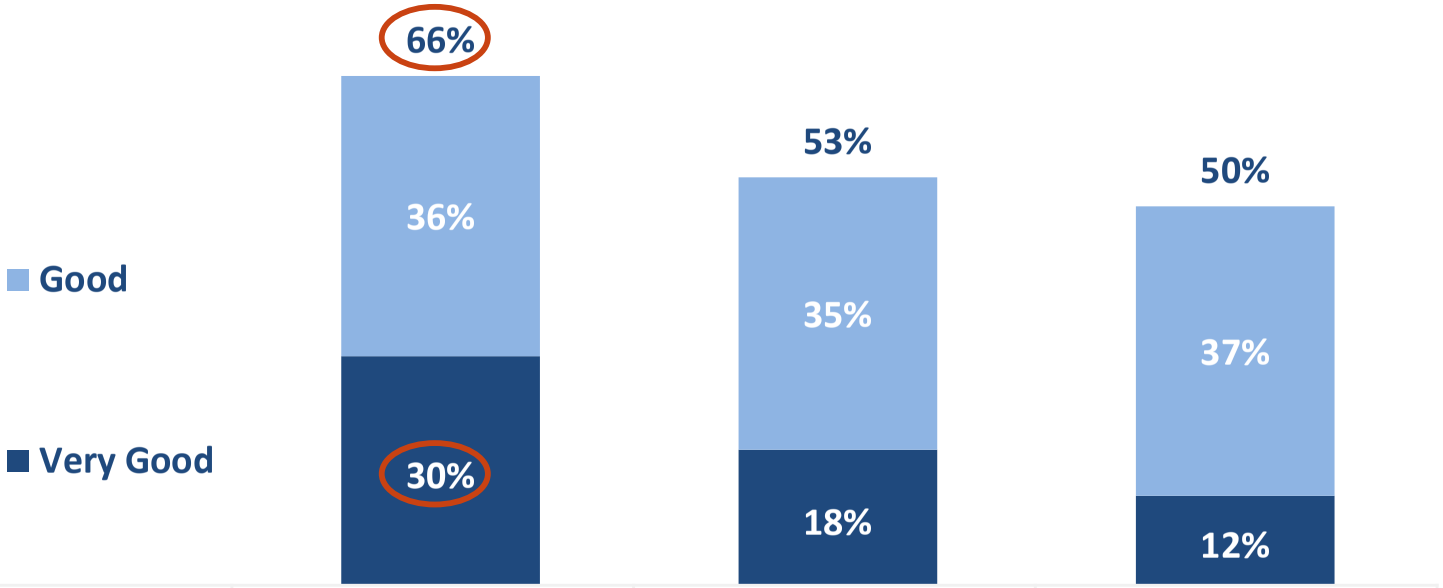


Q1a. Taking everything into account with this claim, how would you rate your overall experience of working with L&I?

Base: Injured workers who used a medical provider other than their regular doctor (n=592/652/676/546)

Impact of Ease of Finding a Medical Provider on Overall Experience

Workers: September 2014



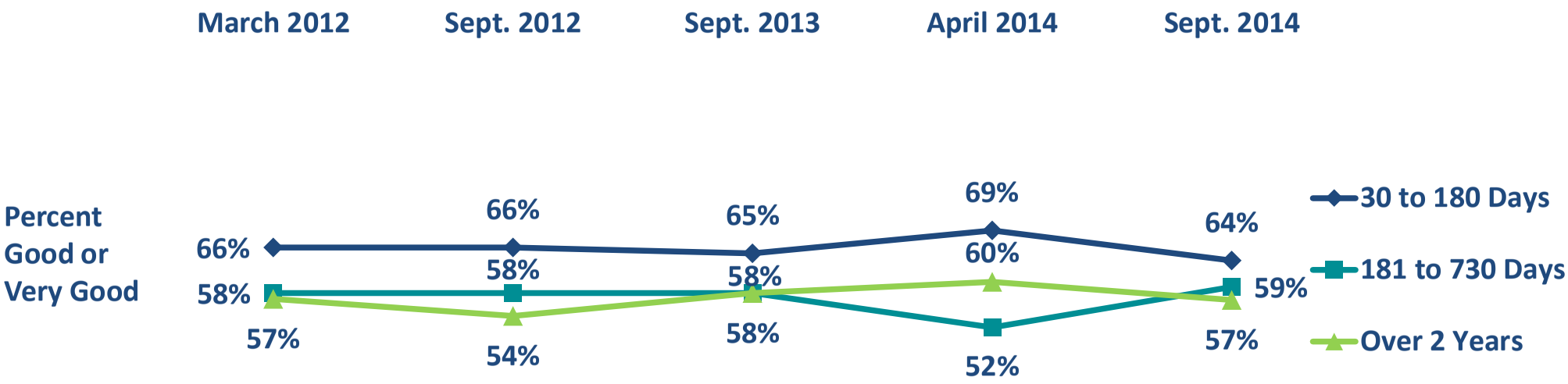
	Very Easy	Somewhat Easy	Difficult
Total Good	66%	53%	50%
Average	22%	33%	30%
Total Poor	12%	14%	21%
Number of Interviews	*(323)*	*(126)*	*(97)*

Q1a. Taking everything into account with this claim, how would you rate your overall experience of working with L&I?

Base: Injured workers who used a medical provider other than their regular doctor

Overall Experience by Age of Claim

Workers

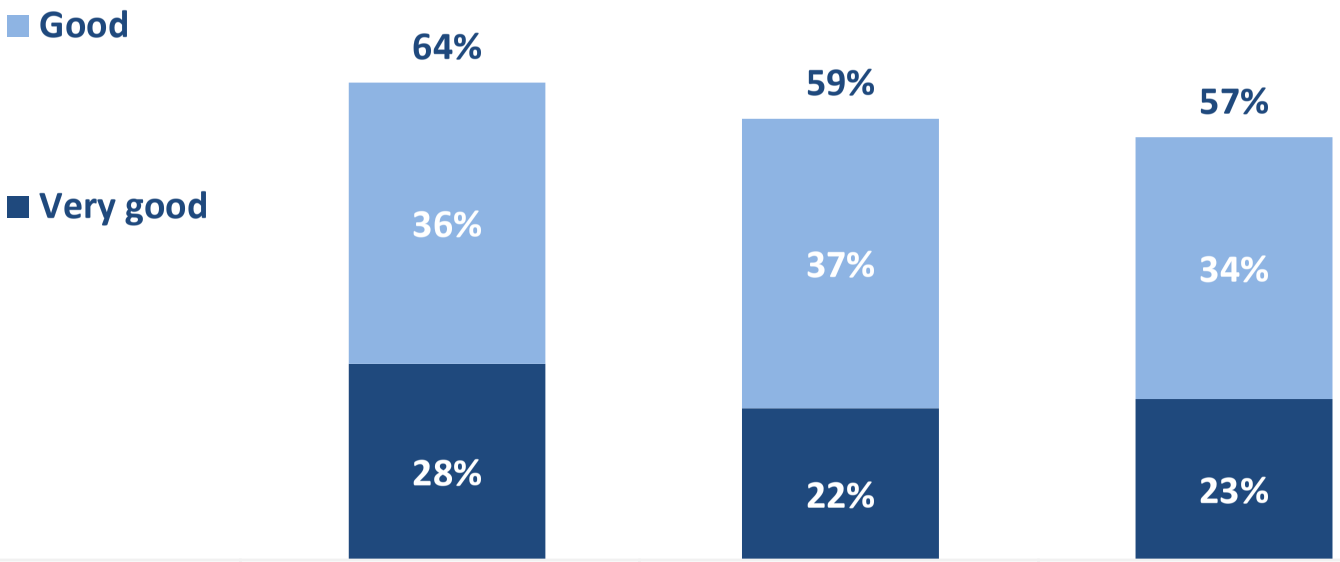


Q1a. Taking everything into account with this claim, how would you rate your overall experience of working with L&I?

Base: All respondents (n=800/800/910/961/800)

Overall Experience by Age of Claim

Workers: September 2014



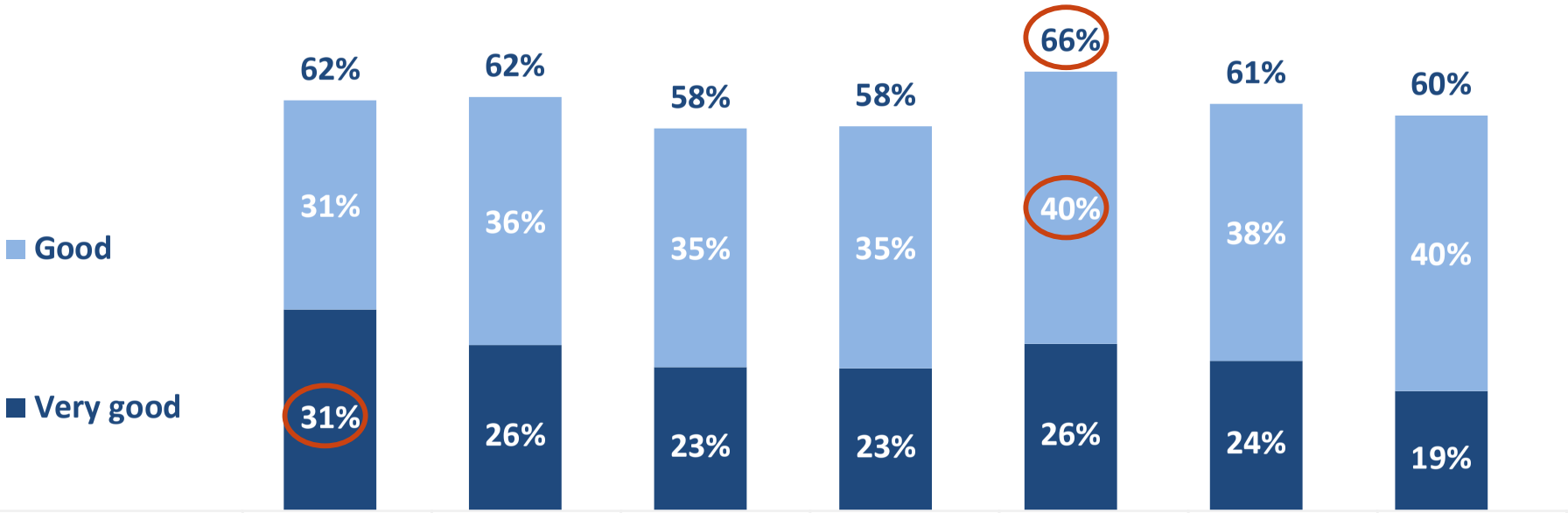
	30 to 180 Days	181 to 730 Days	Over 2 Years
Total Good	64%	59%	57%
Average	24%	27%	26%
Total Poor	13%	14%	17%
Number of Interviews	*(300)*	*(345)*	*(155)*

Q1a. Taking everything into account with this claim, how would you rate your overall experience of working with L&I?

Base: All respondents

Overall Experience by Delivery Service Area

Workers: April and September 2014 (Combined)



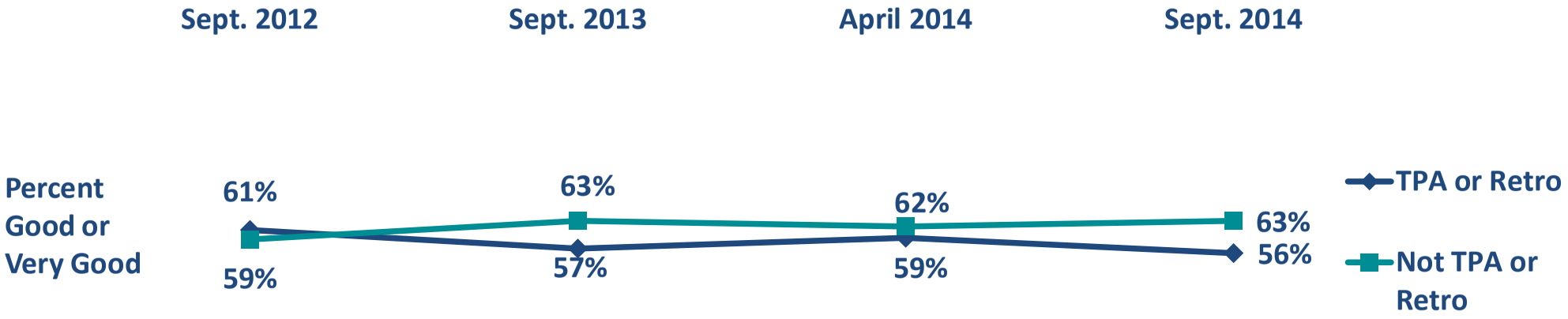
	DSA 1	DSA 2	DSA 3	DSA 4	DSA 6	DSA 7	DSAs 14 and 17
Total Good	62%	62%	58%	58%	66%	61%	60%
Average	25%	25%	28%	25%	22%	24%	32%
Total Poor	13%	13%	15%	18%	12%	14%	8%
Number of Interviews	*(211)*	*(233)*	*(298)*	*(213)*	*(293)*	*(183)*	*(134)*

Q1a. Taking everything into account with this claim, how would you rate your overall experience of working with L&I?

Base: All respondents

Overall Experience by Whether Employer is TPA or Retro

Workers

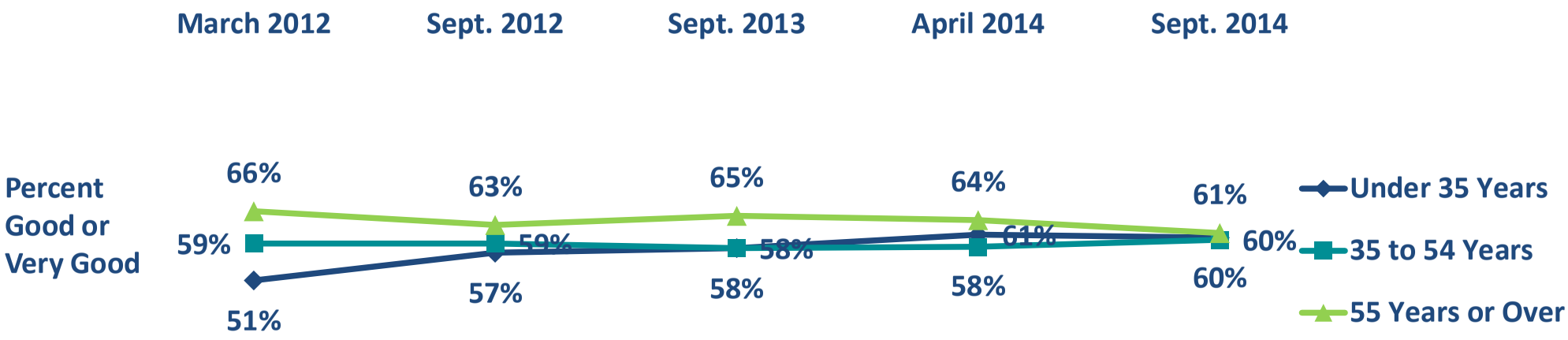


Q1a. Taking everything into account with this claim, how would you rate your overall experience of working with L&I?

Base: All respondents (n=800/910/961/800)

Overall Experience by Age of Worker

Workers

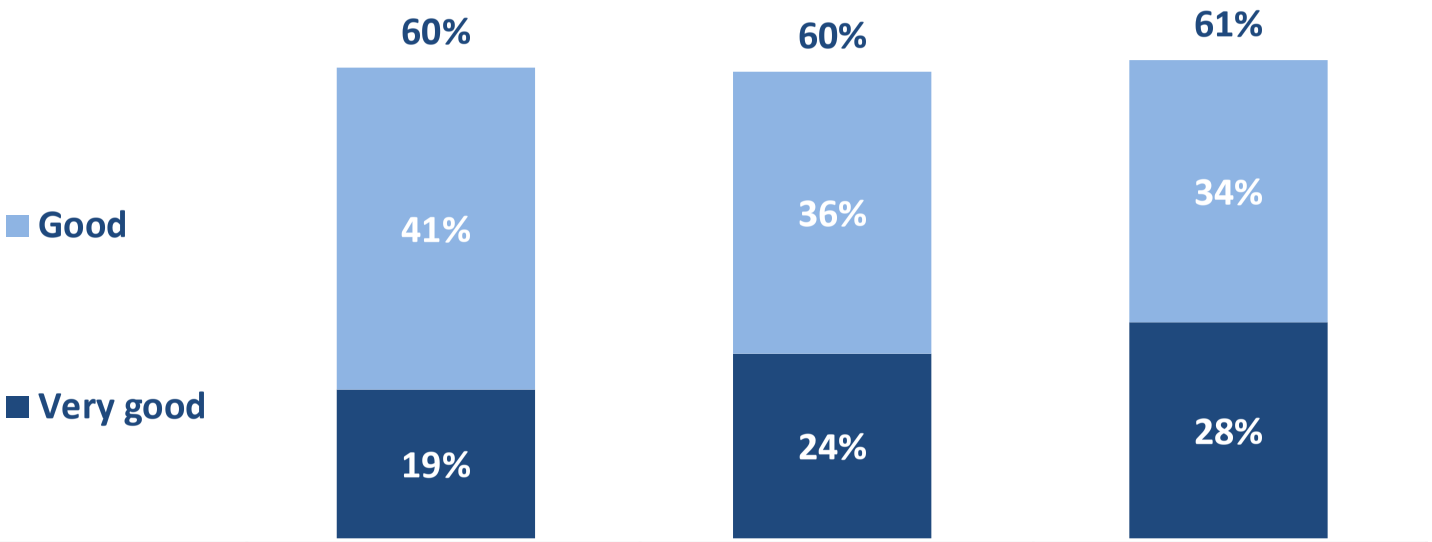


Q1a. Taking everything into account with this claim, how would you rate your overall experience of working with L&I?

Base: All respondents (n=800/800/910/961/800)

Overall Experience by Age of Worker

Workers: September 2014



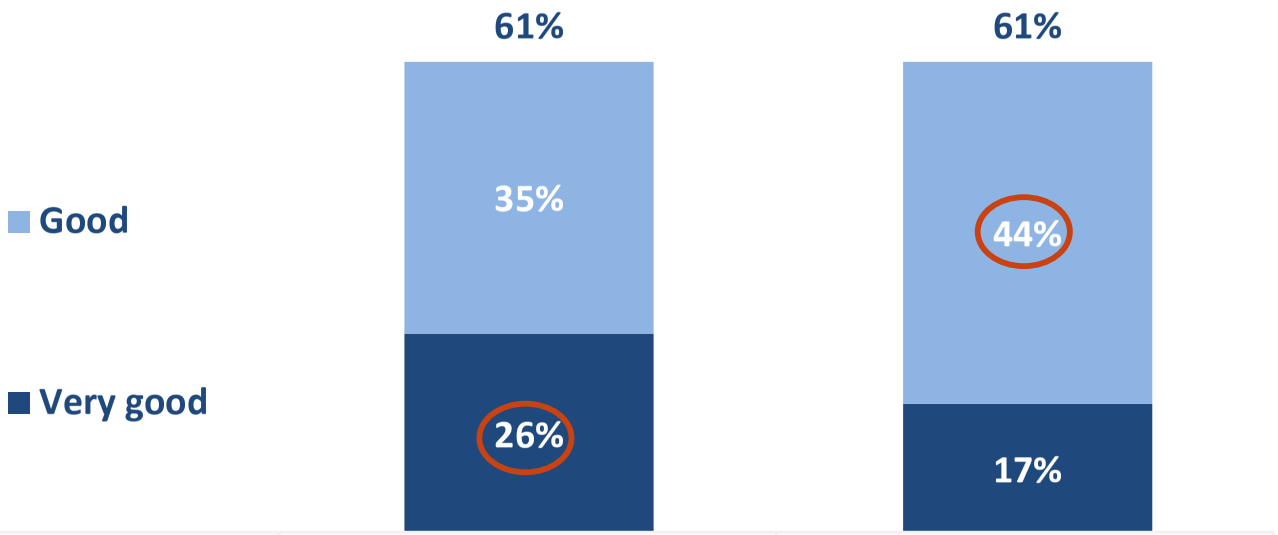
	Under 35 Years	35 to 54 Years	55 Years or Over
Total Good	60%	60%	61%
Average	27%	26%	26%
Total Poor	13%	15%	13%
Number of Interviews	*(136)*	*(388)*	*(274)*

Q1a. Taking everything into account with this claim, how would you rate your overall experience of working with L&I?

Base: All respondents

Overall Experience by Language of Claimant

Workers: April and September 2014 (Combined)



	English	Spanish
Total Good	61%	61%
Average	25%	34%
Total Poor	15%	6%
Number of Interviews	*(1569)*	*(192)*

Q1a. Taking everything into account with this claim, how would you rate your overall experience of working with L&I?

Base: All respondents

Top Positive Comments About Overall L&I Experience

Workers: September 2014

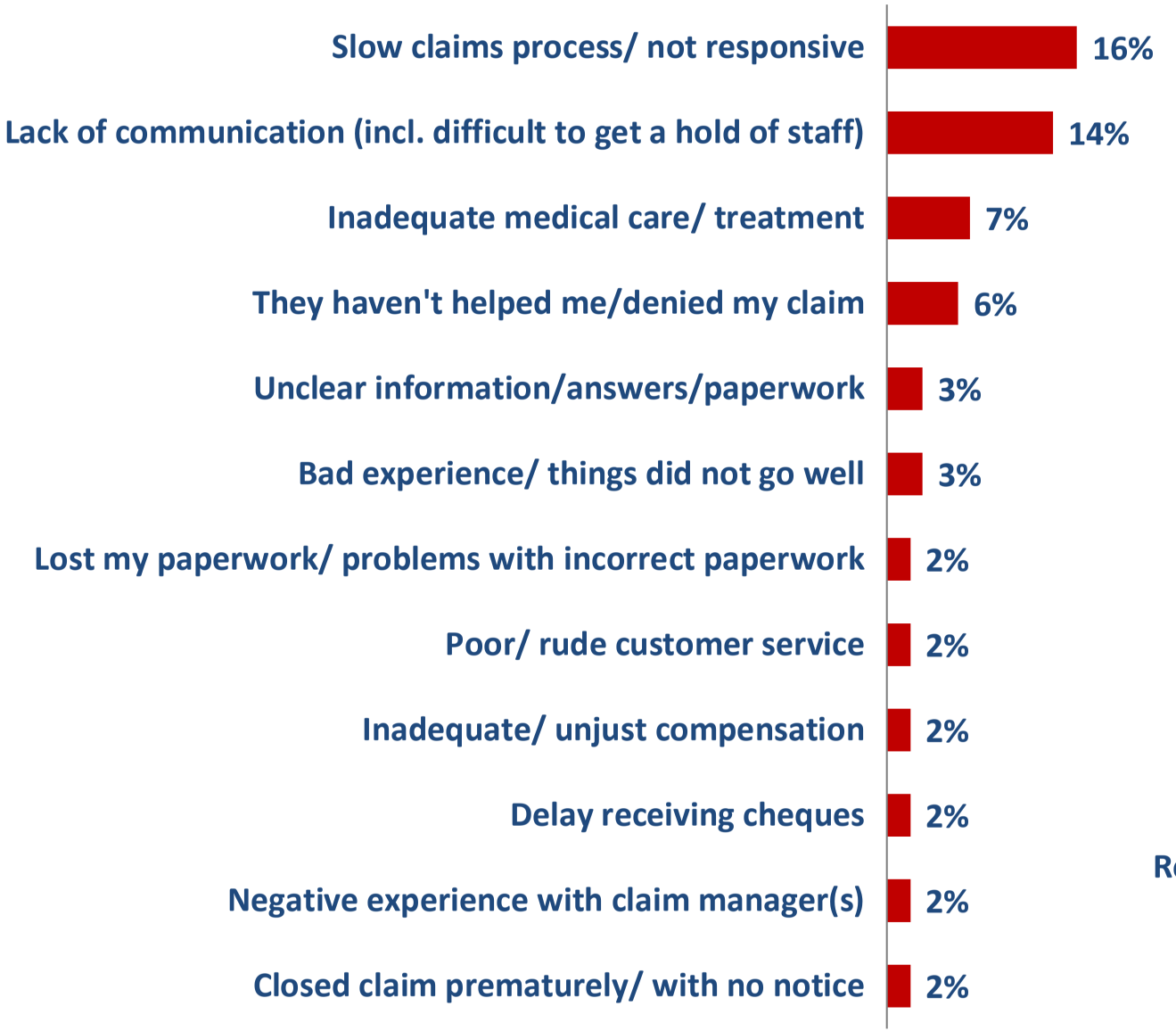
Responses <3% not shown.

Q1b. Why did you rate your overall experience with L&I as [INSERT Q1a RESPONSE]?

Base: All respondents (n=800)

Top Negative Comments About Overall L&I Experience

Workers: September 2014



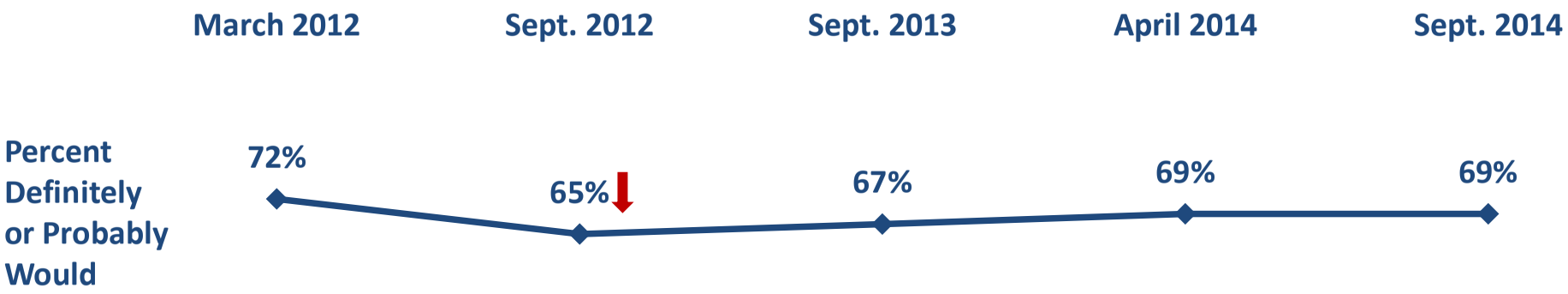
Responses <2% not shown.

Q1b. Why did you rate your overall experience with L&I as [INSERT Q1a RESPONSE]?

Base: All respondents (n=800)

Whether Would Speak Positively About L&I

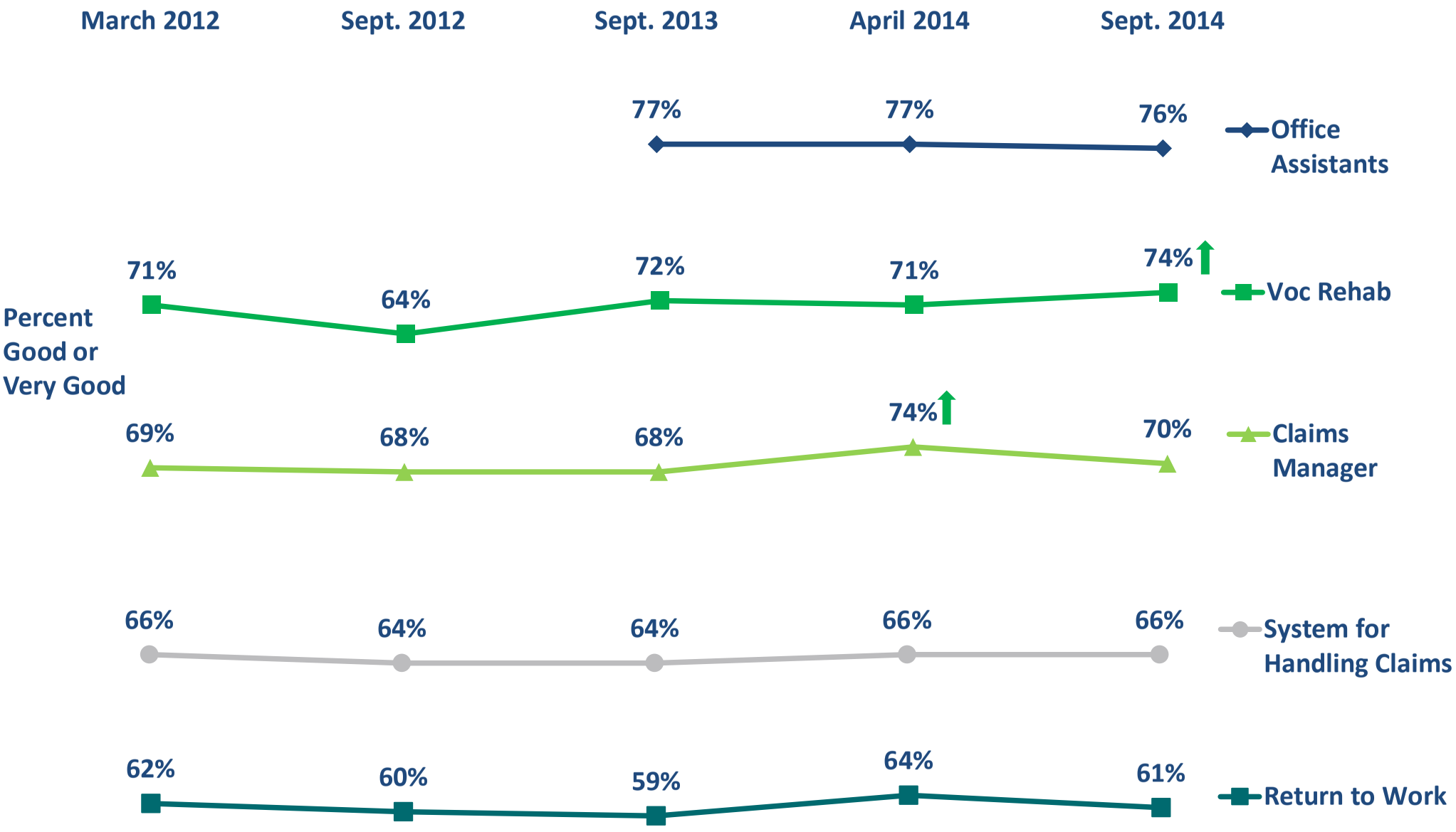
Workers



Q40. If you were speaking to a friend or co-worker about L&I, how likely is it that you would speak positively about the organization? Would you say you--

Base: All respondents (n=800/800/910/961/800)

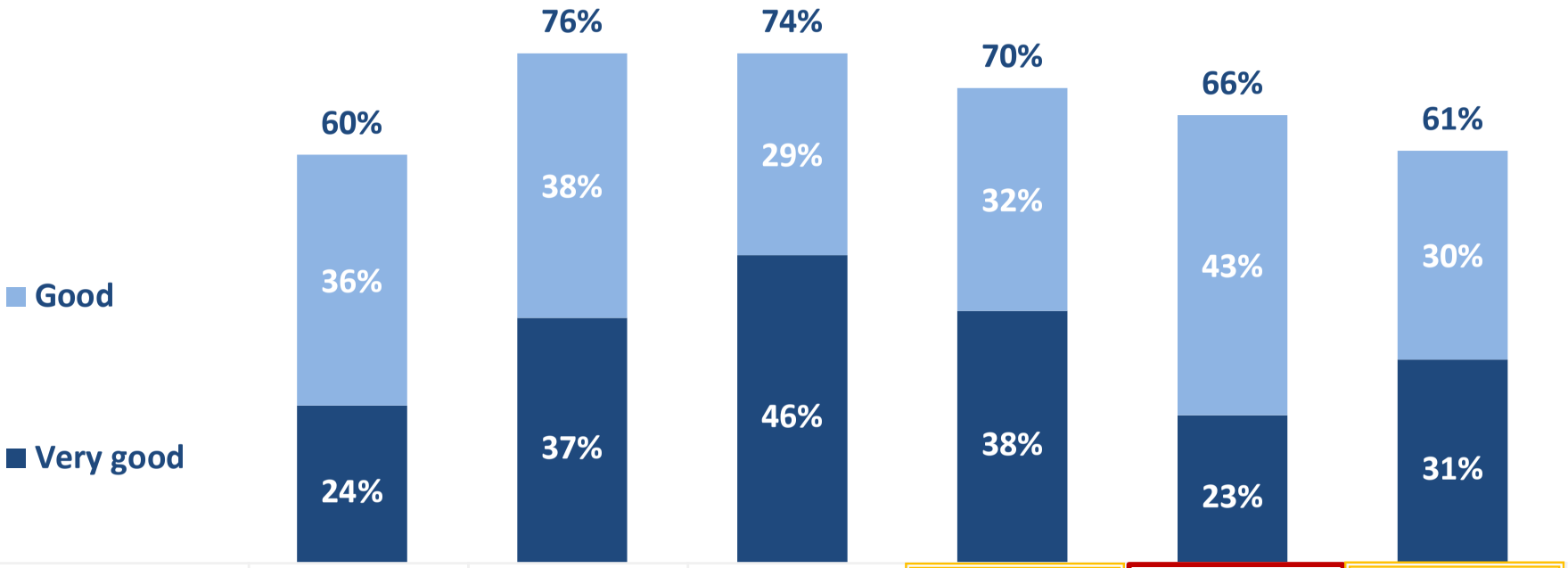
Overall Ratings on Touchpoints
Workers



Base: Respondents who provided a rating.

Overall Ratings on Touchpoints

Workers: September 2014

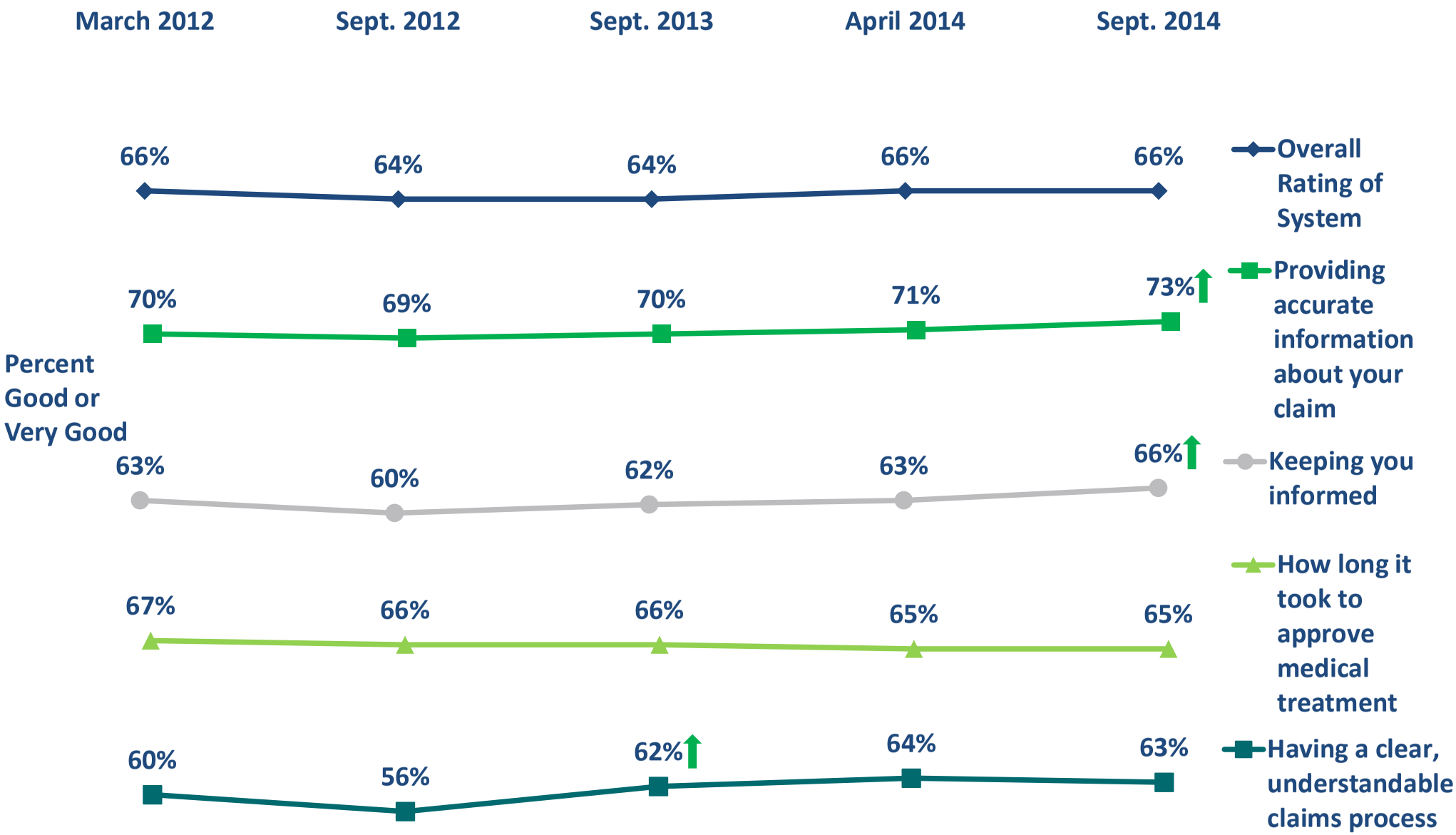


	Overall Experience	Office Assistants	Voc Rehab	Claims Manager	System for Handling Claims	Return to Work
Total Good	60%	76%	74%	70%	66%	61%
Average	26%	18%	13%	17%	21%	20%
Total Poor	14%	6%	13%	13%	13%	19%
Number of Interviews	*(800)*	*(497)*	*(288)*	*(737)*	*(781)*	*(671)*

= Top Priority = Secondary Priority

Base: Respondents who provided a rating.

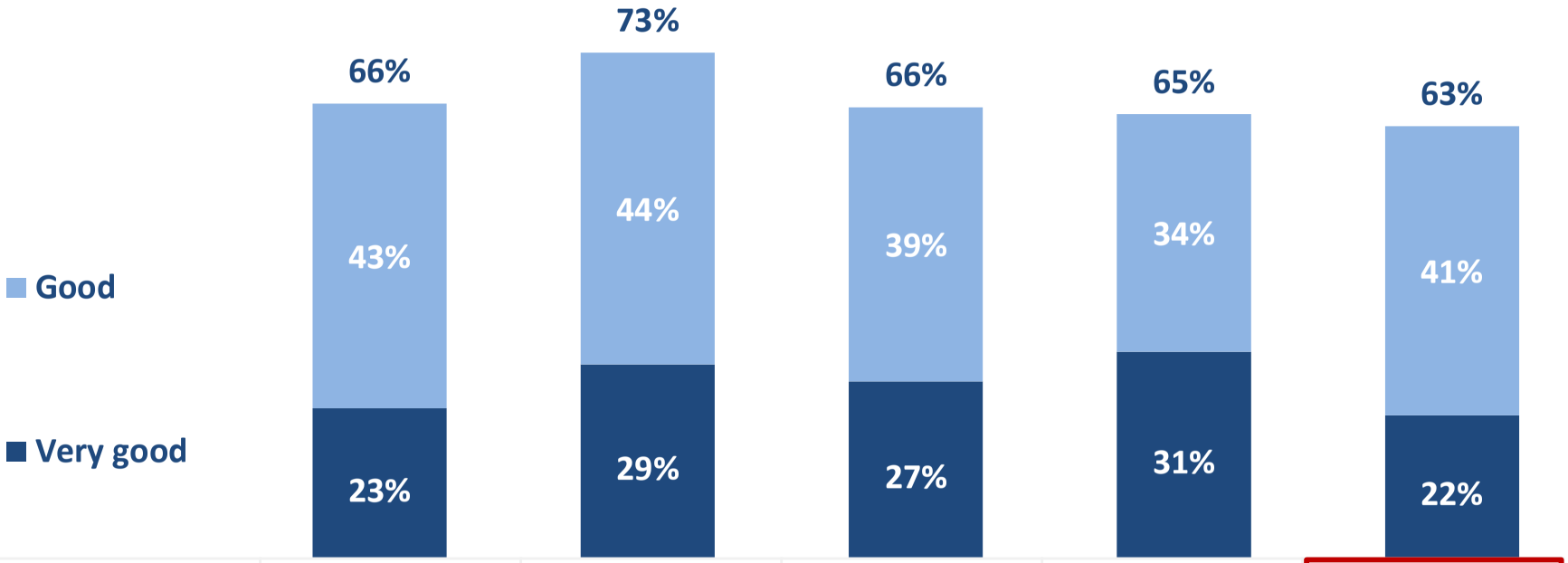
Claims System Drilldowns
Workers



Q6. How would you rate your overall experience with L&I's system for handling claims?
Q7. How would you rate L&I's system for handling claims when it comes to [INSERT ITEM]?
Base: Respondents who provided a rating for each drilldown.

Claims System Drilldowns

Workers: September 2014



	Overall Rating of System for Handling Claims	Providing accurate information about your claim	Keeping you informed	How long it took to approve medical treatment	Having a clear, understandable claims process
Total Good	66%	73%	66%	65%	63%
Average	21%	16%	19%	17%	22%
Total Poor	13%	10%	15%	18%	15%
Number of Interviews	*(781)*	*(773)*	*(773)*	*(755)*	*(767)*

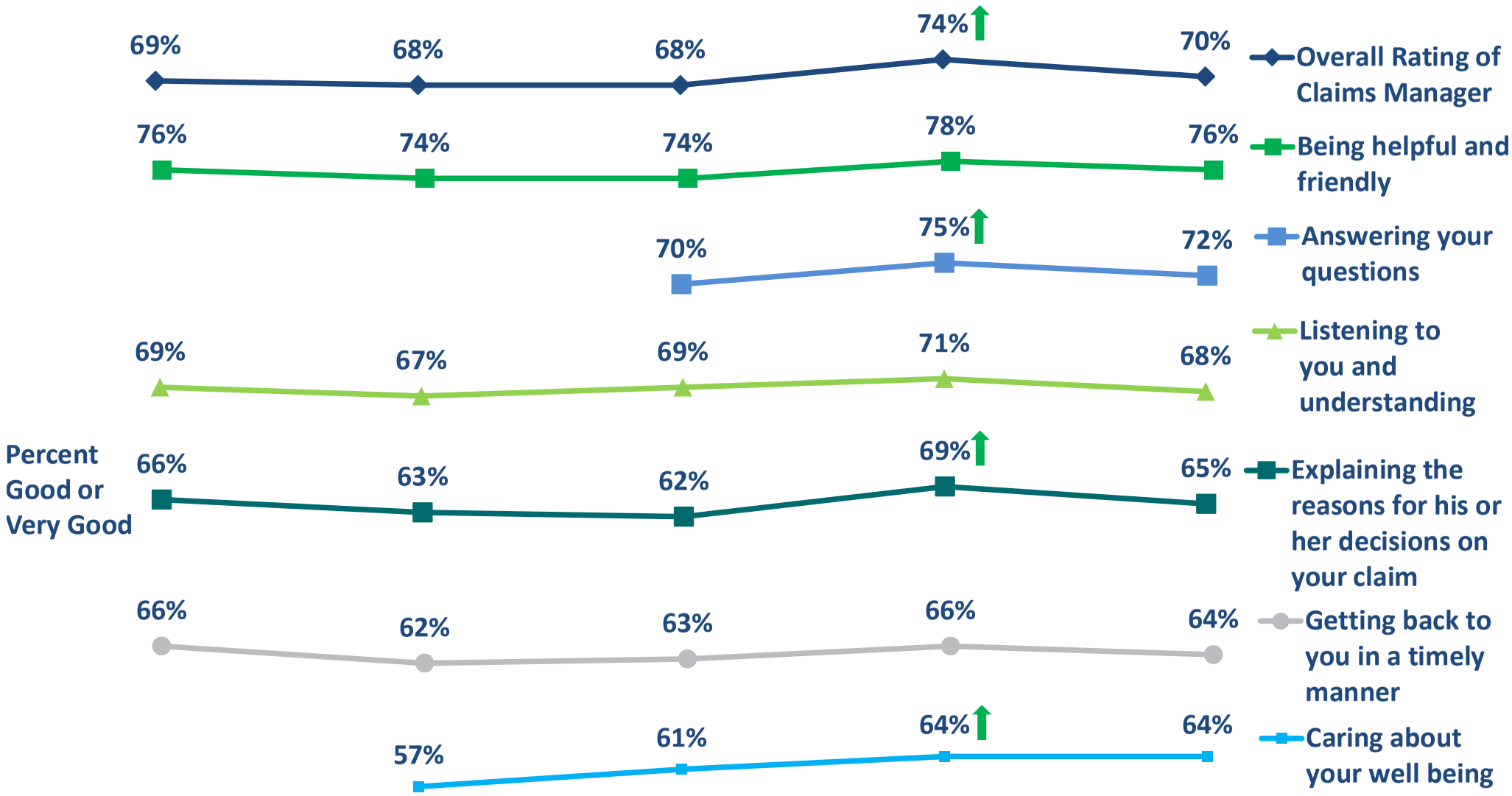
= Top Priority

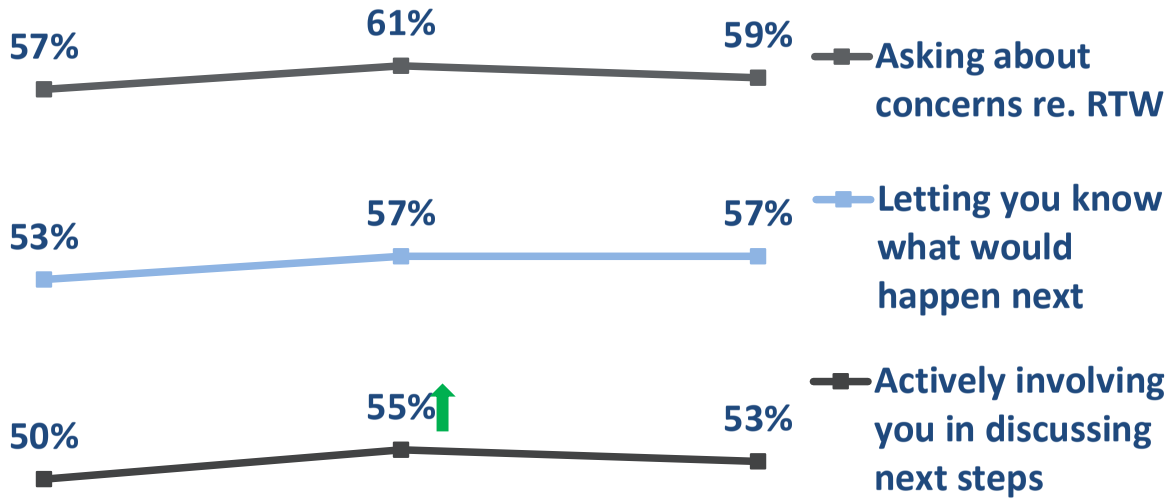
Q6. How would you rate your overall experience with L&I's system for handling claims?
Q7. How would you rate L&I's system for handling claims when it comes to [INSERT ITEM]?
Base: Respondents who provided a rating for each drilldown.

Ipsos Reid

Claims Manager Drilldowns

Workers





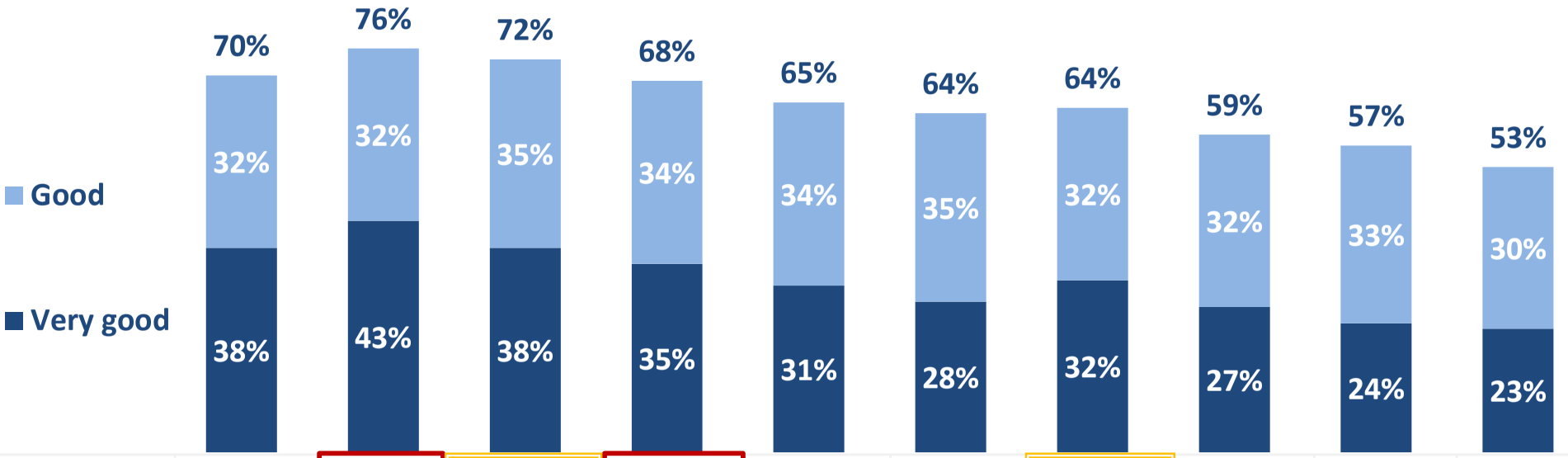
Q12. Your Claims Manager is the person that oversees the ongoing management of your claim. Overall, how would you rate your Claims Manager ?

Q13. How would you rate your (most recent) Claims Manager in terms of [INSERT ITEM]?

Base: Respondents who provided a rating.

Claims Manager Drilldowns

Workers: September 2014



	Overall Rating of Claims Manager	Being helpful and friendly	Answering your questions	Listening to you and under-standing	Explaining reasons for decisions	Getting back to you in a timely manner	Caring about your well-being	Asking about concerns about RTW	Letting you know what would happen	Actively involving you in discussing next steps
Total Good	70%	76%	72%	68%	65%	64%	64%	59%	57%	53%
Average	17%	15%	17%	17%	19%	20%	17%	17%	18%	19%
Total Poor	13%	9%	11%	15%	16%	16%	19%	24%	25%	28%
Number of Interviews	*(737)*	*(713)*	*(709)*	*(702)*	*(662)*	*(714)*	*(681)*	*(605)*	*(662)*	*(639)*

= Top Priority = Secondary Priority

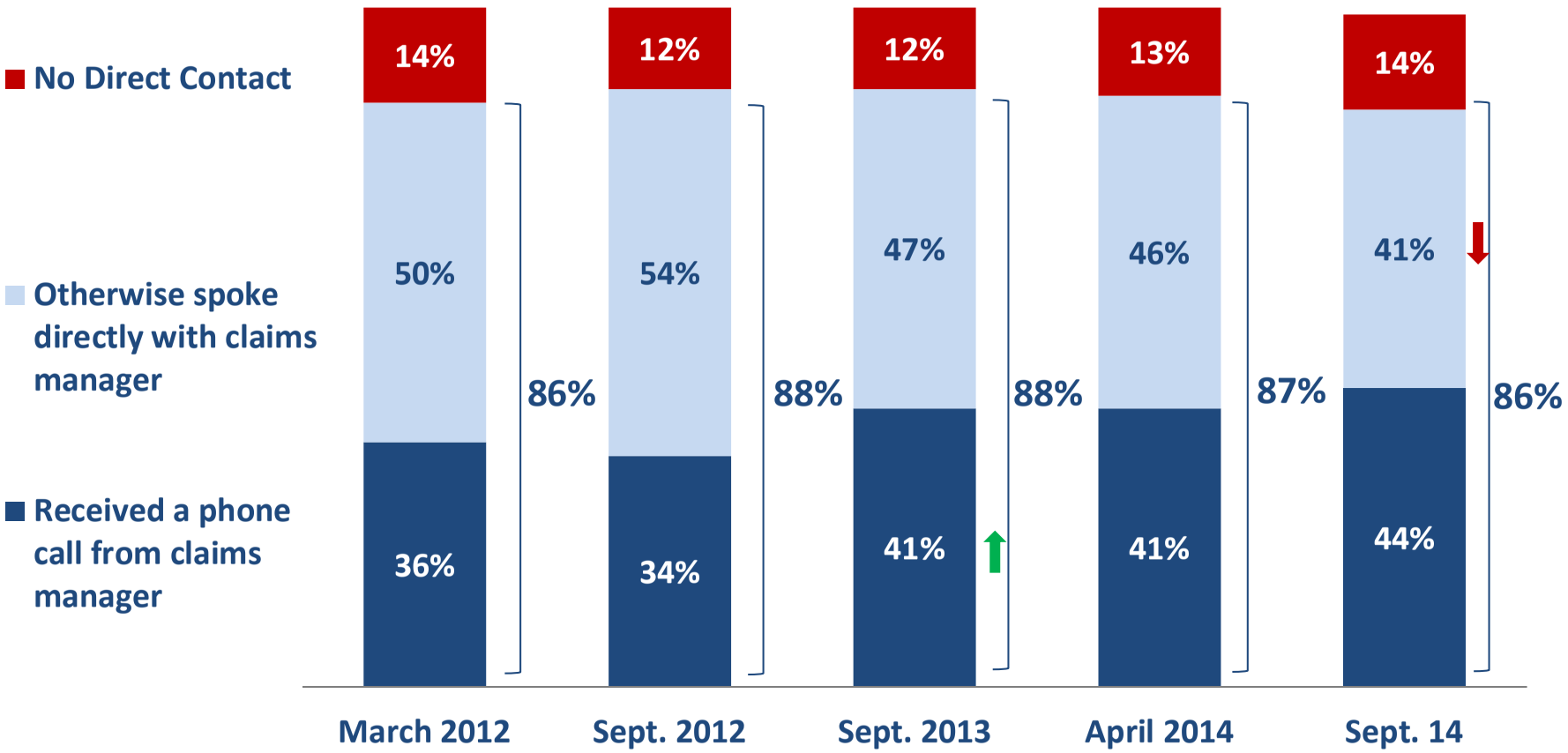
Q12. Your Claims Manager is the person that oversees the ongoing management of your claim. Overall, how would you rate your Claims Manager ?

Q13. How would you rate your (most recent) Claims Manager in terms of [INSERT ITEM]?

Base: Respondents who provided a rating.

Contact with Claims Manager

Workers: September 2014



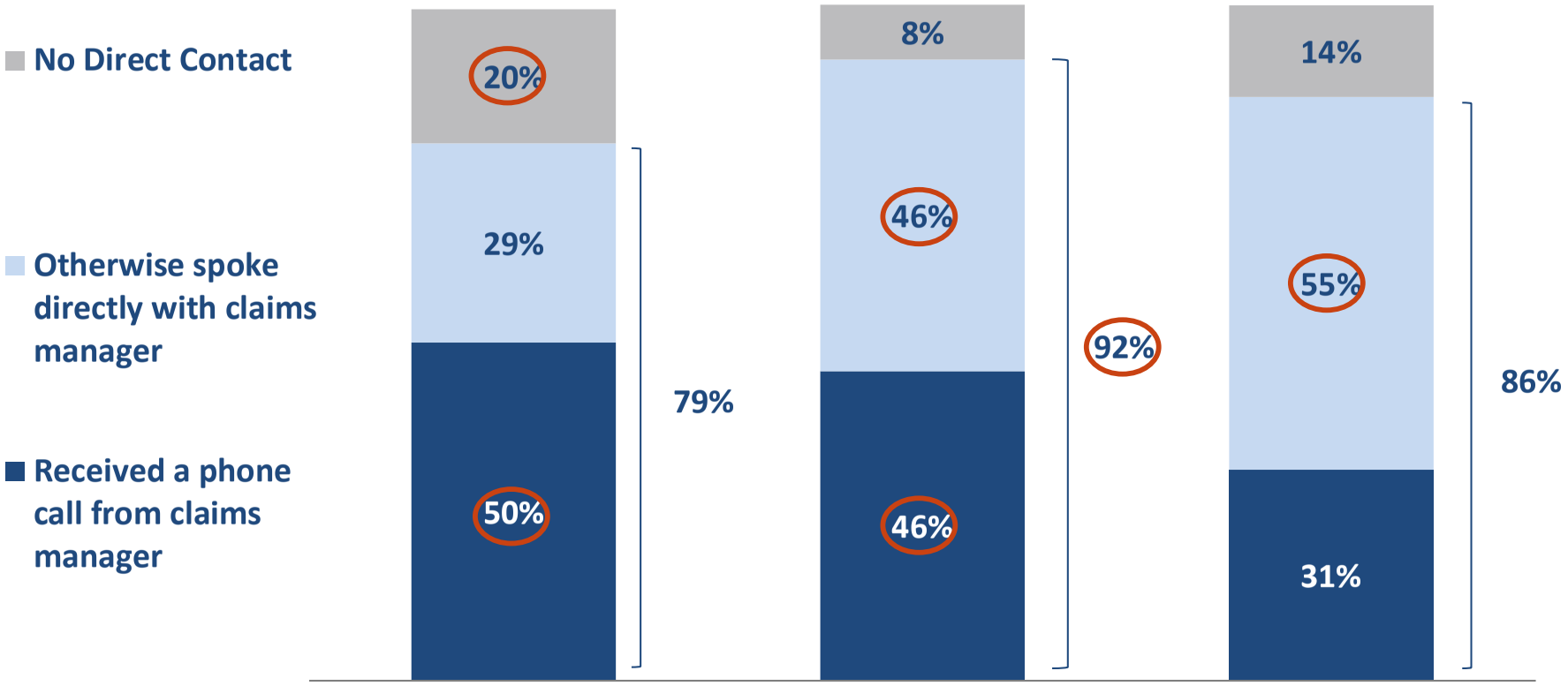
Q14. During this claim, did you receive a telephone call from (one of) your Claims Manager(s)? By this I mean a call that your claims manager initiated, not a response to you leaving a message or to you requesting a call

Q15. [IF NO] Have you spoken directly with (one of) your Claims Manager(s), either in person or over the phone?

Base: All respondents (n=800/800/910/961/800)

Contact with Claims Manager by Age of Claim

Workers: September 2014



No. of Interviews	*(300)*	*(345)*	*(155)*

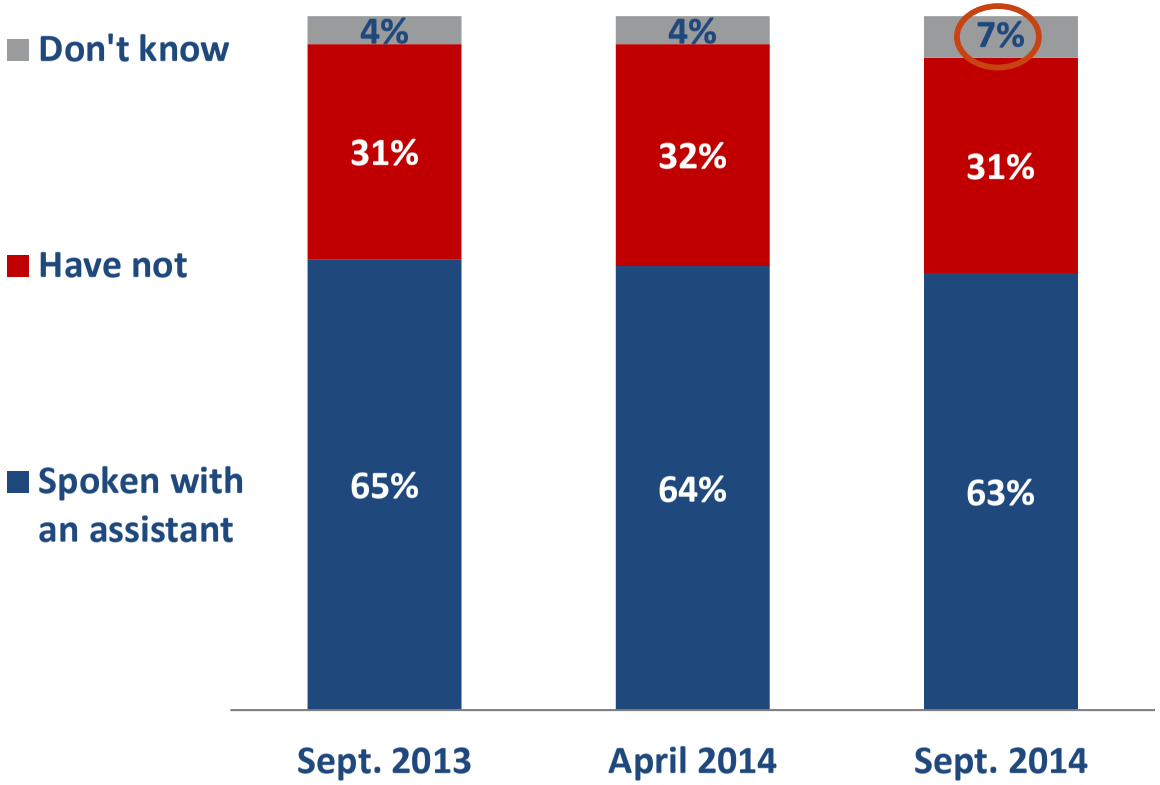
Q14. During this claim, did you receive a telephone call from (one of) your Claims Manager(s)? By this I mean a call that your claims manager initiated, not a response to you leaving a message or to you requesting a call

Q15. [IF NO] Have you spoken directly with (one of) your Claims Manager(s), either in person or over the phone?

Base: All respondents

Whether Spoken With An Office Assistant

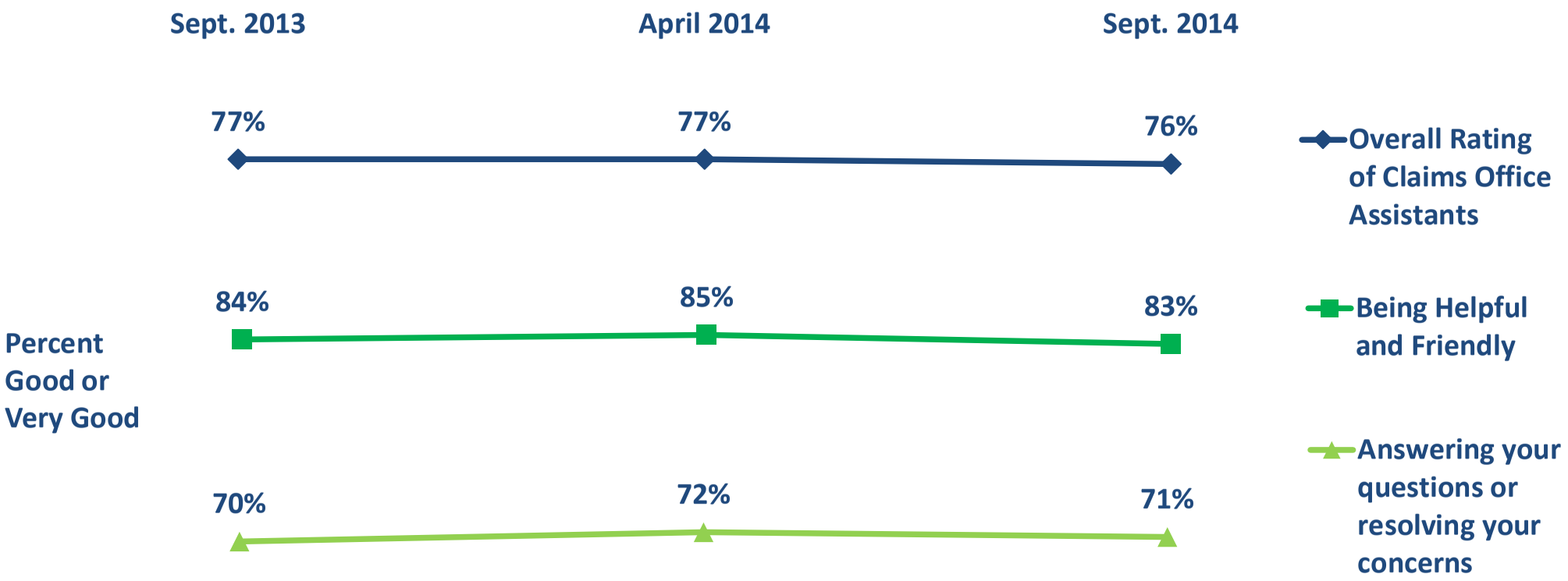
Workers: September 2014



Q16a. Have you spoken with an Office Assistant about your most recent claim?
Base: All respondents (n=910/961/800)

Claims Office Assistants Drilldowns

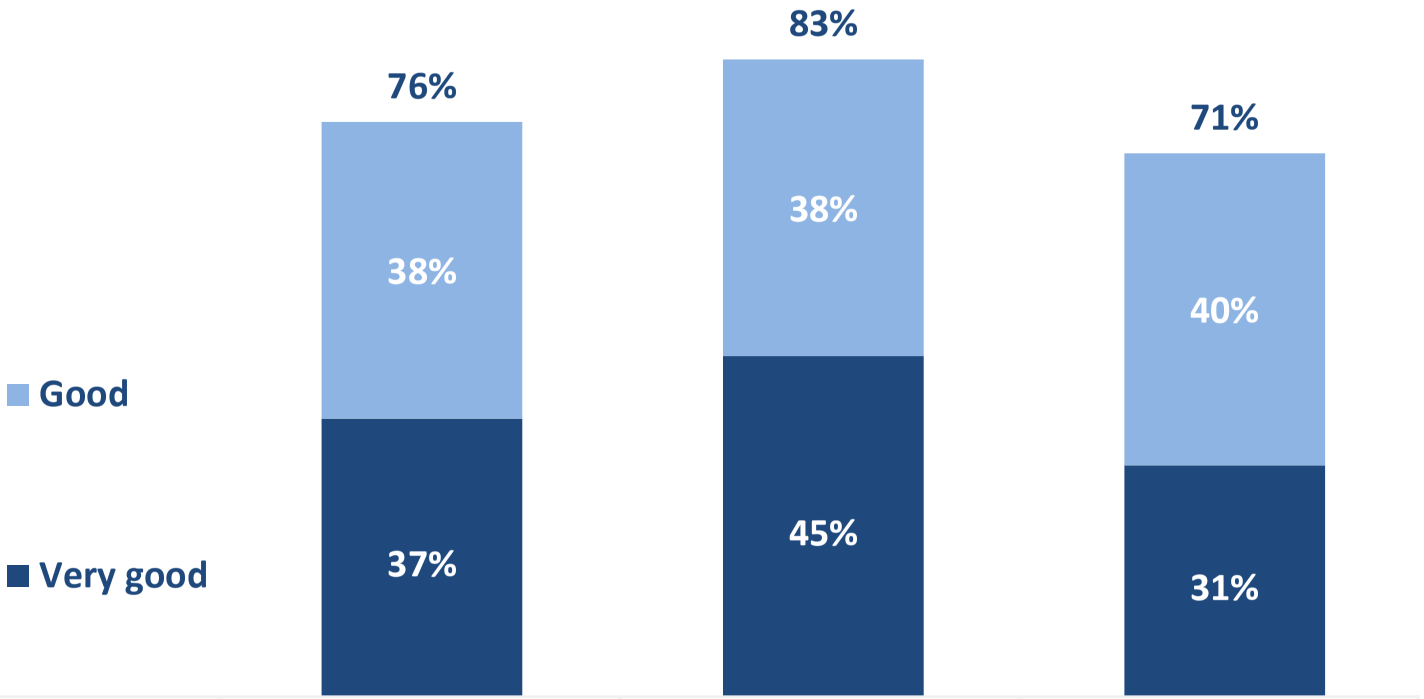
Workers



Q16b. Overall, how would you rate your experience with Claims Office Assistants?
Q16c. How would you rate your experience with Claims Office Assistants in terms of…
Base: Respondents who have spoken to an Office Assistant (n~500 per wave)

Claims Office Assistants

Workers: September 2014

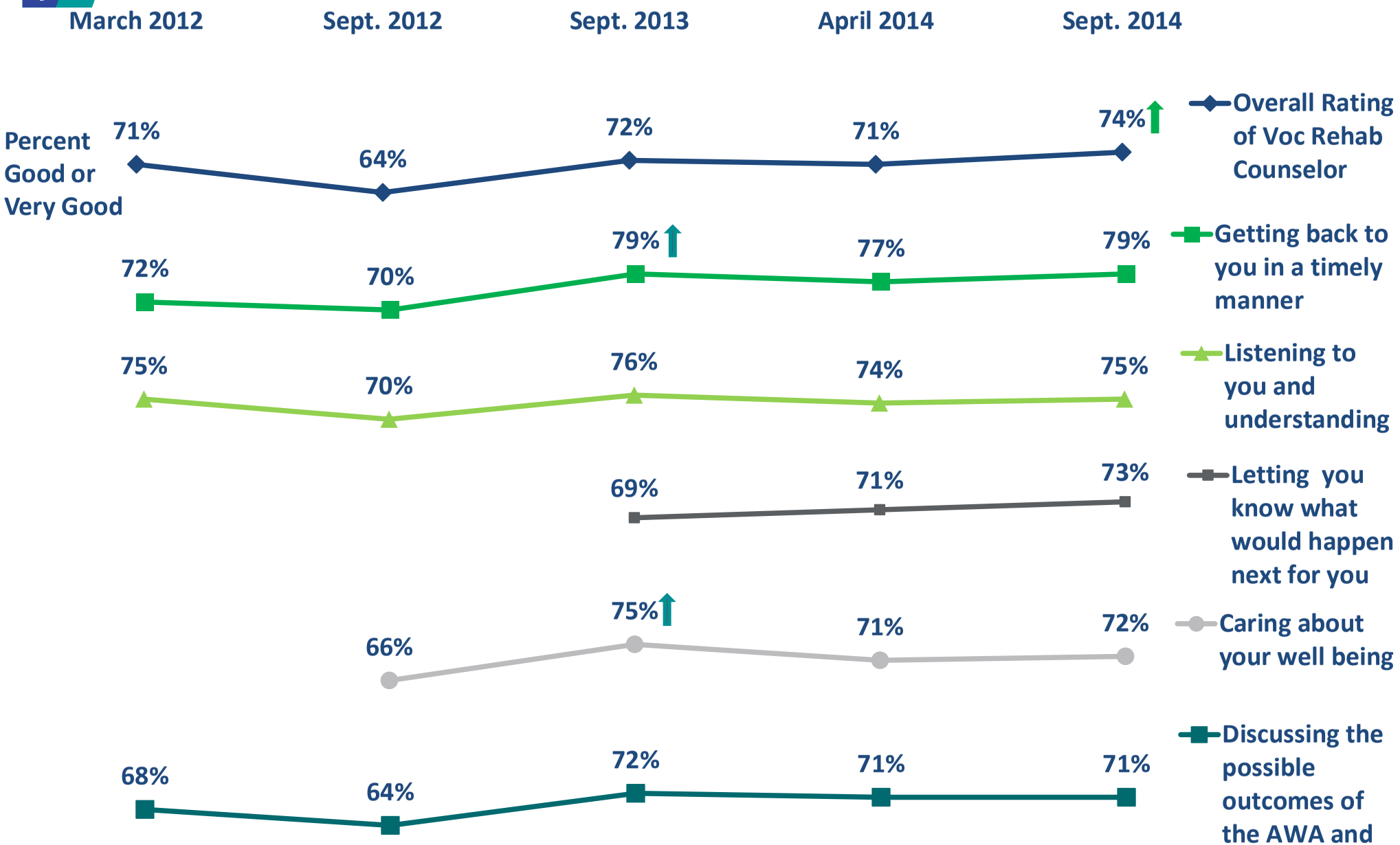


	Overall experience with Office Assistants	Being helpful and friendly	Answering your questions or resolving your concerns
Total Good	76%	83%	71%
Average	18%	14%	20%
Total Poor	6%	3%	9%
No. of Interviews	*(497)*	*(493)*	*(488)*

Q16b. Overall, how would you rate your experience with Claims Office Assistants?
Q16c. How would you rate your experience with Claims Office Assistants in terms of…
Base: Respondents who have spoken to an Office Assistant (n~500 per wave)

Voc Rehab Counselor Drilldowns

Workers



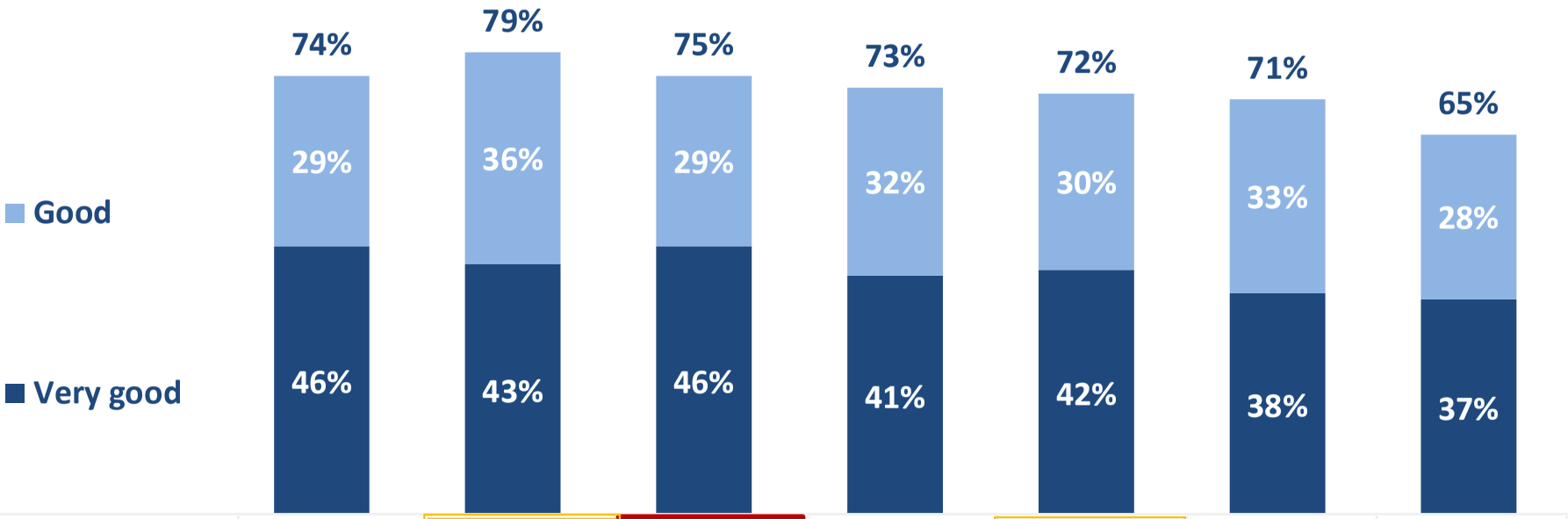
Q21. Overall, how would you rate your overall experience with your Voc Rehab counselor?

Q23. How would you rate your Voc Rehab counselor in terms of [INSERT ITEM]?

Base: Voc Rehab respondents who provided a rating (n~270 per wave); *AWA complete (n~240/wave)

Voc Rehab Counselor Drilldowns

Workers: September 2014



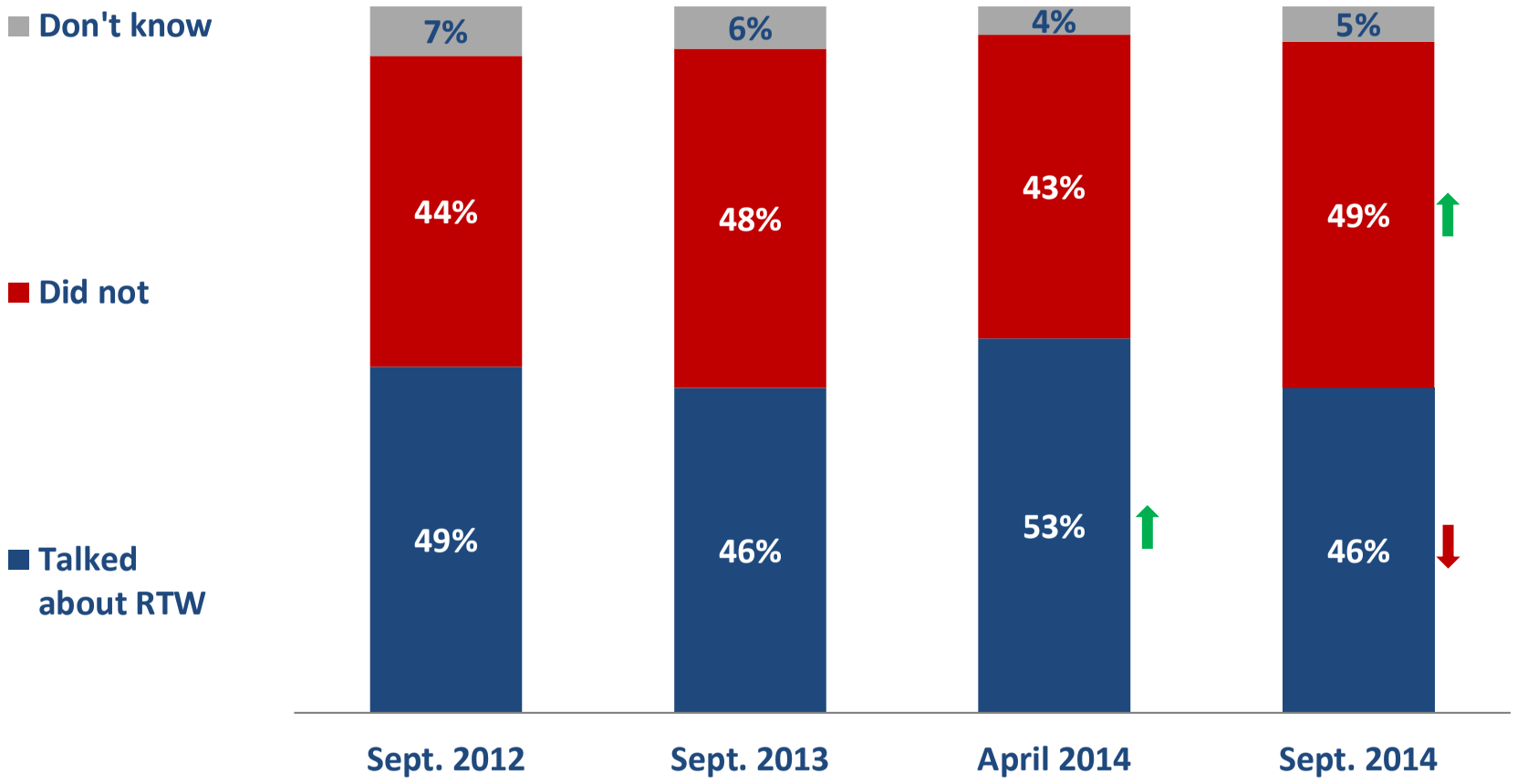
	Overall Rating of Voc Rehab Counselor	Getting back to you in a timely manner	Listening to you and under-standing	Letting you know what would happen next for you	Caring about your well being	Discussing the possible outcomes of the AWA and what it means to you*	Actively Involving you in selecting the job you would be trained in**
Total Good	74%	79%	75%	73%	72%	71%	65%
Average	13%	13%	14%	16%	15%	16%	21%
Total Poor	13%	7%	11%	12%	13%	13%	14%
Number of Interviews	*(288)*	*(277)*	*(284)*	*(269)*	*(277)*	*(245)*	*(43)*

= Top Priority = Secondary Priority

Q21. Overall, how would you rate your overall experience with your Voc Rehab counselor?
Q23. How would you rate your Voc Rehab counselor in terms of [INSERT ITEM]?
Base: Voc Rehab respondents who provided a rating;
* AWA complete; ** Voc Rehab retraining respondents

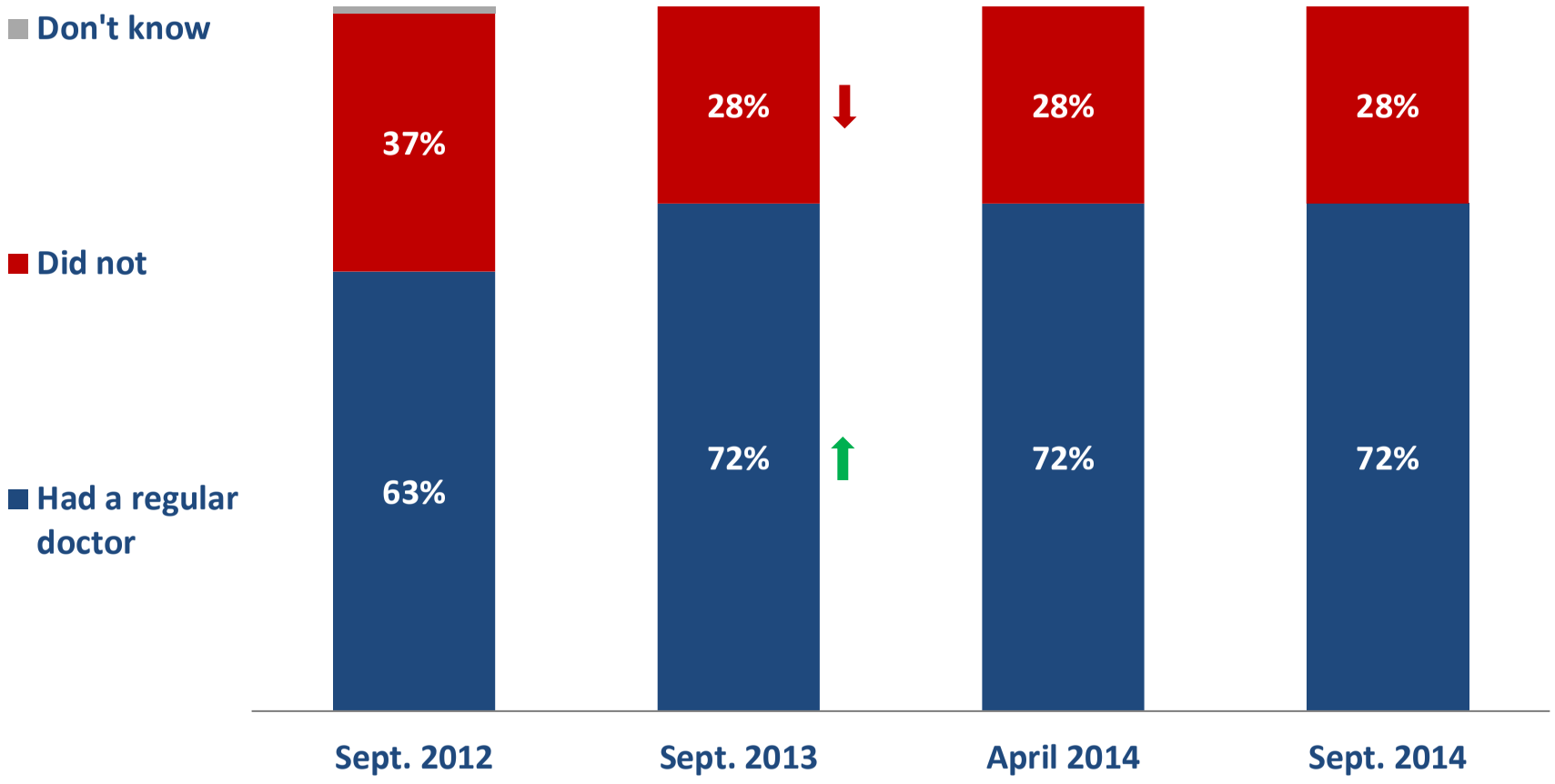
Whether Talked with L&I About Return to Work ASAP

Workers



Q35. Did anyone at L&I talk to you about the importance of returning to work as soon as medically possible?
Base: All respondents except those not expected to return to work (n=757/829/871/712)

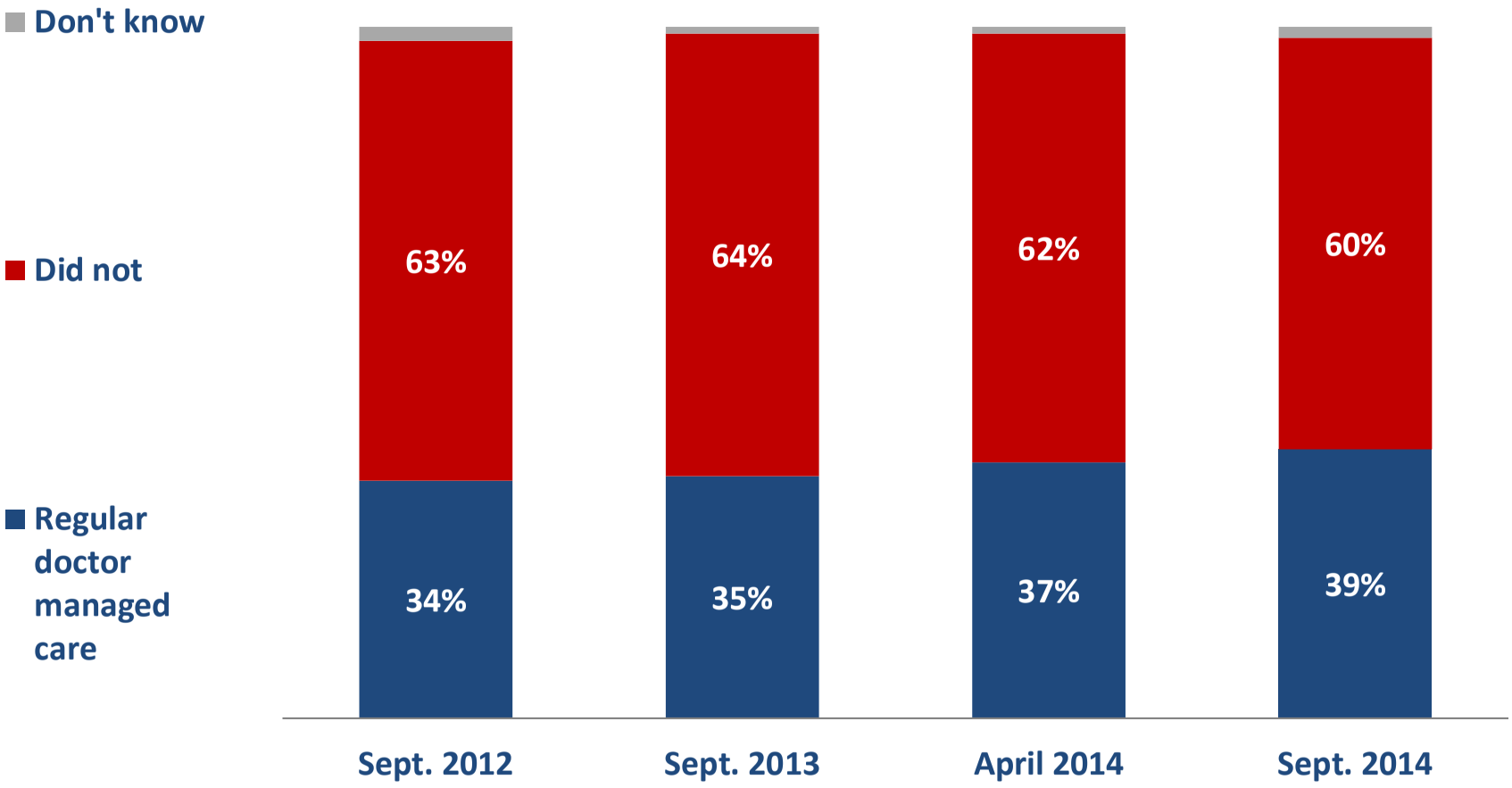
Whether Had a Regular Doctor or Medical Provider
Workers



Q23e Before the beginning of your most recent claim, did you have a regular doctor or medical provider?
Base: All respondents asked question (n=745/910/961/800)

Whether Regular Doctor Managed Care Throughout Treatment

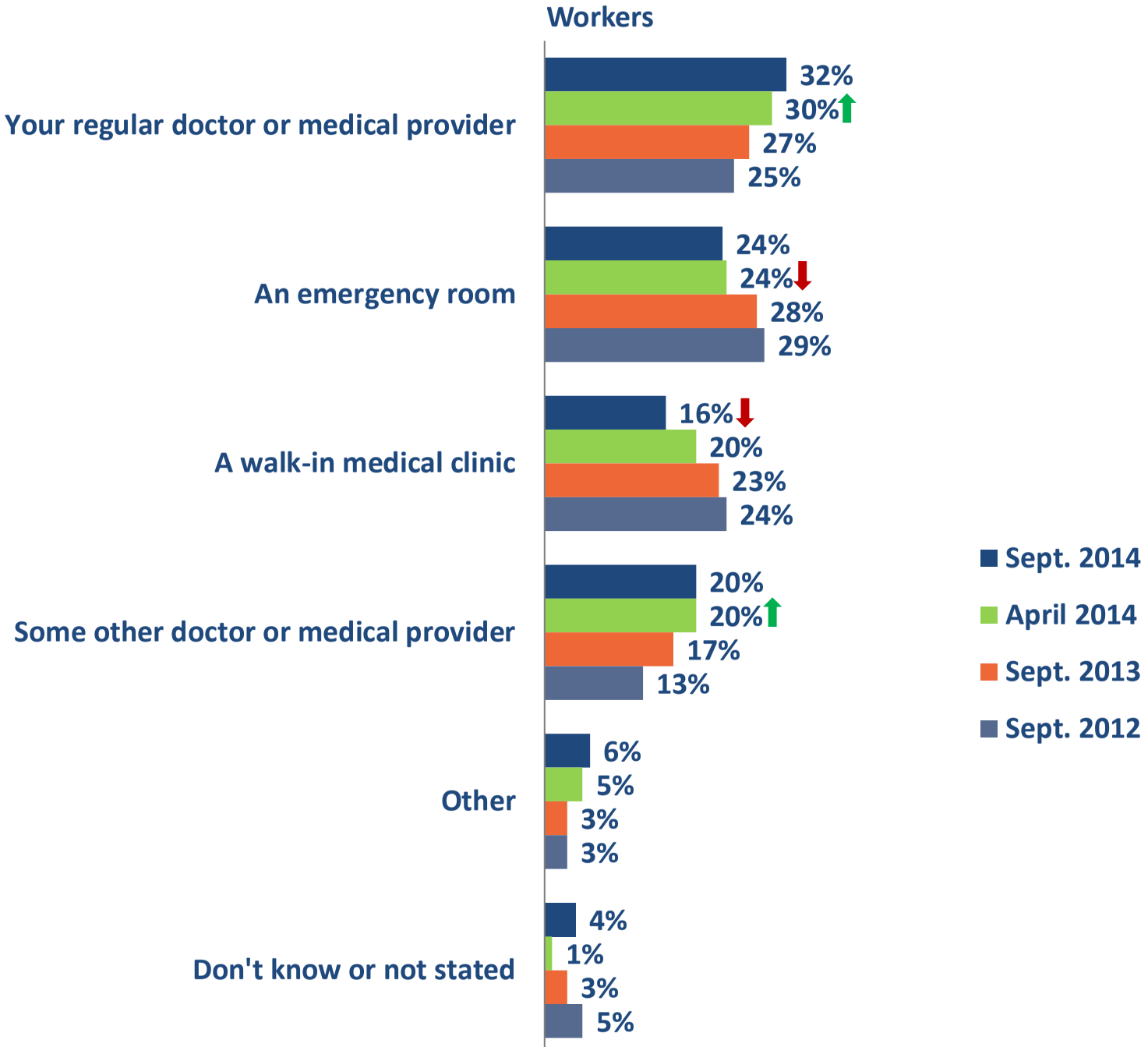
Workers



*23f. Did your regular doctor or medical provider manage your care **throughout the treatment** for your on-the-job injury or illness?*

Base: All respondents that have a regular doctor or medical provider (n=494/651/699/571)

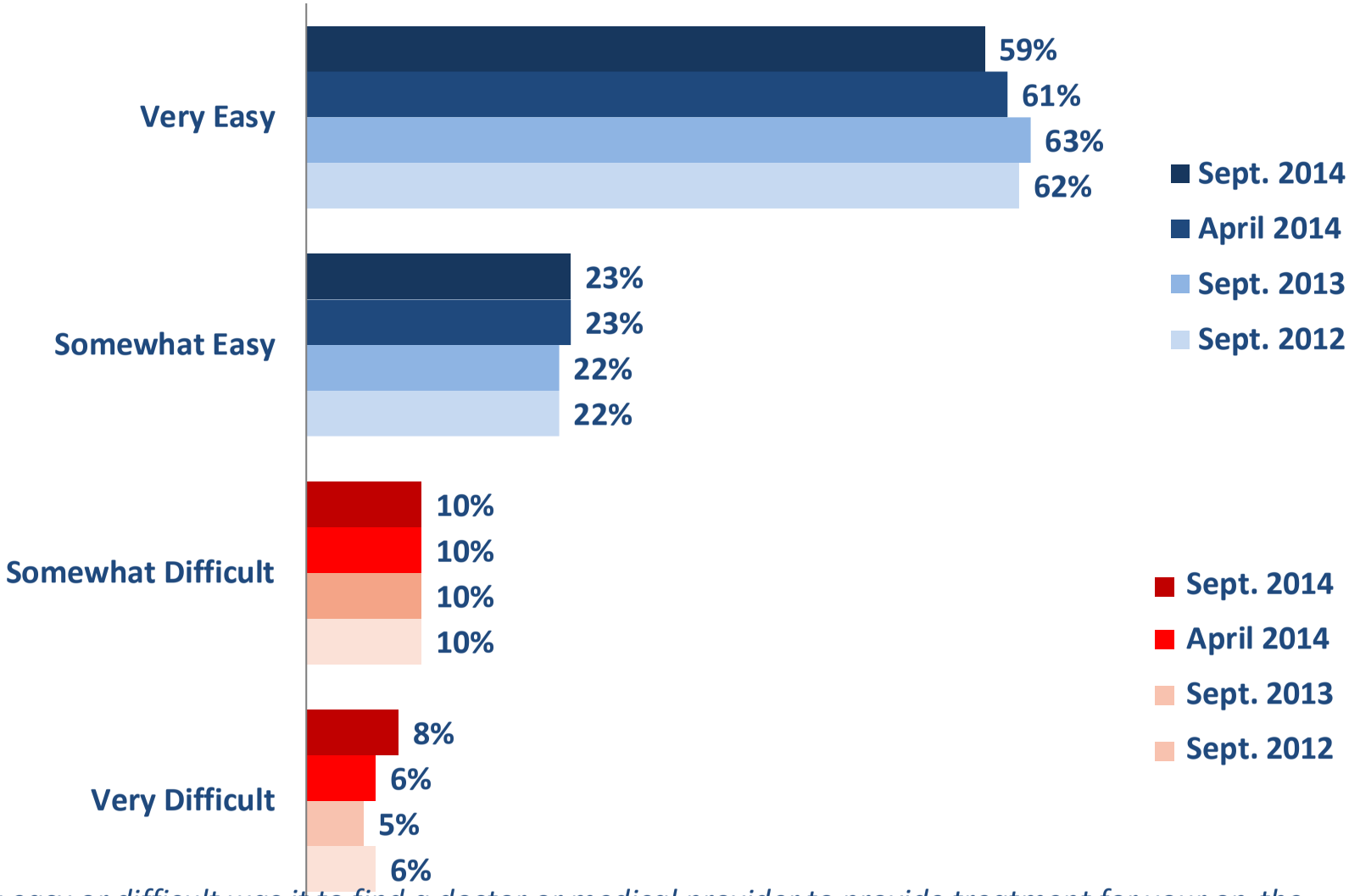
Provider of Initial Treatment



*Q23d Did you receive your **initial treatment** for your on-the-job injury or illness from…*
Base: All respondents (n=800/910/961/800)

Ease of Finding a Doctor or Medical Provider to Provide Treatment

Workers

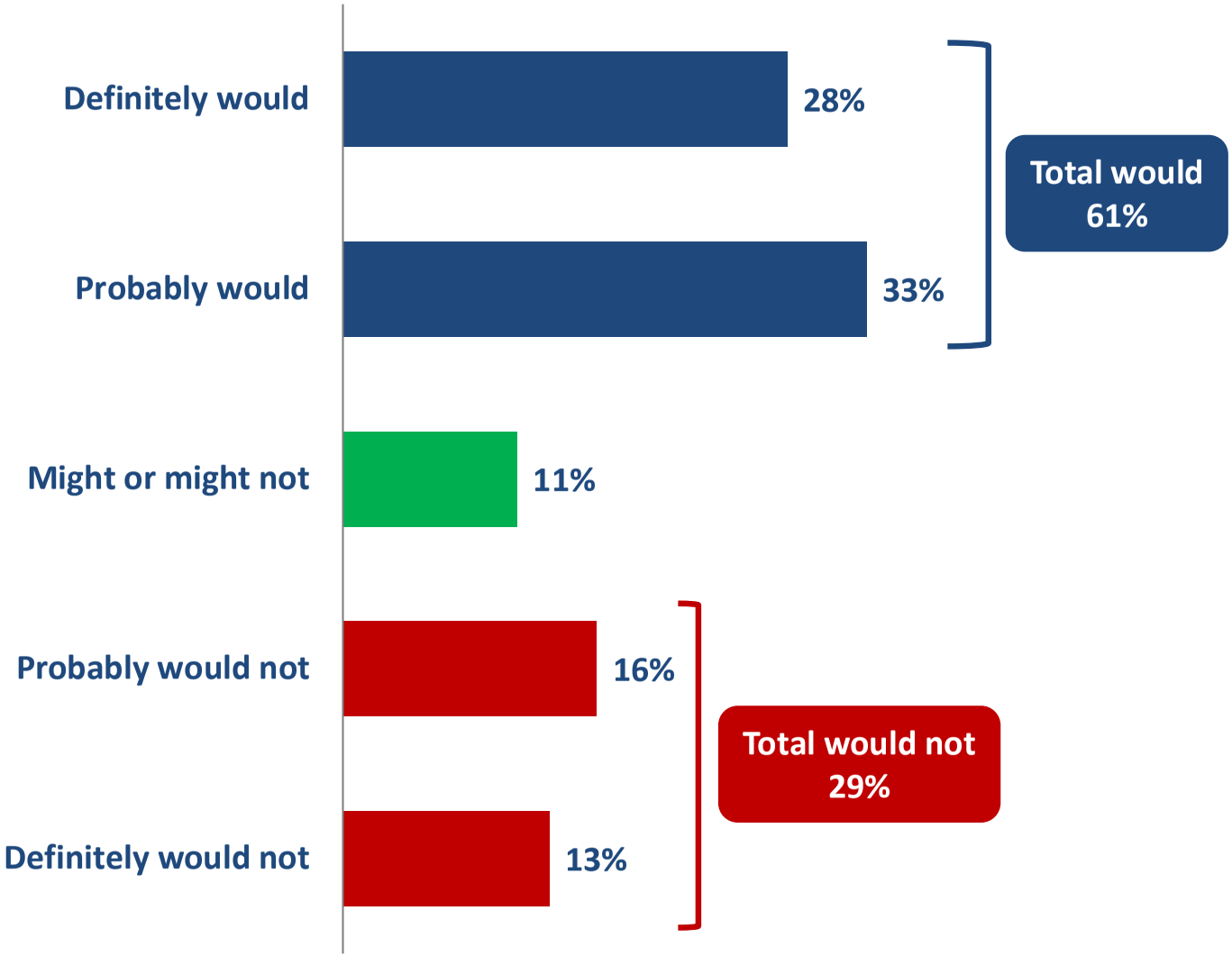


23g. How easy or difficult was it to find a doctor or medical provider to provide treatment for your on-the-job injury or illness?

Base: Respondents with no regular provider or regular provider did not provide treatment (n=592/652/676/546)

Whether Would Use Secure System for Documents and Email

Workers: September 2014

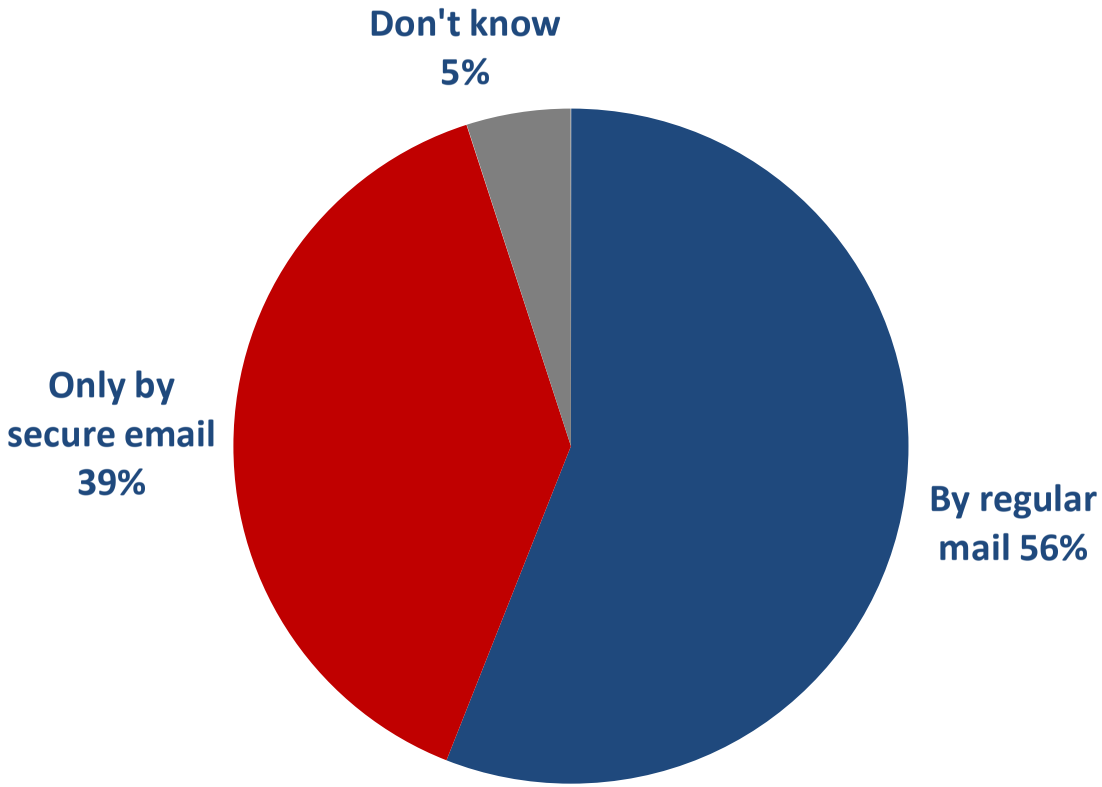


Q16d. If L&I had a system that allowed you to receive documents and communicate with your Claims Manager using secure email, how likely would you be to sign up for, and use this system?

Base: All respondents (n=800)

Mode to Receive Documents if Using Secure System

Workers: September 2014



Q16e. If you were using this system, would you want to receive your written claims documents by ...
Base: Respondents who definitely would, probably would or might or might not sign up for system (n=545)

Top Positive Comments About L&I Helping You Return to Work

Workers: September 2014

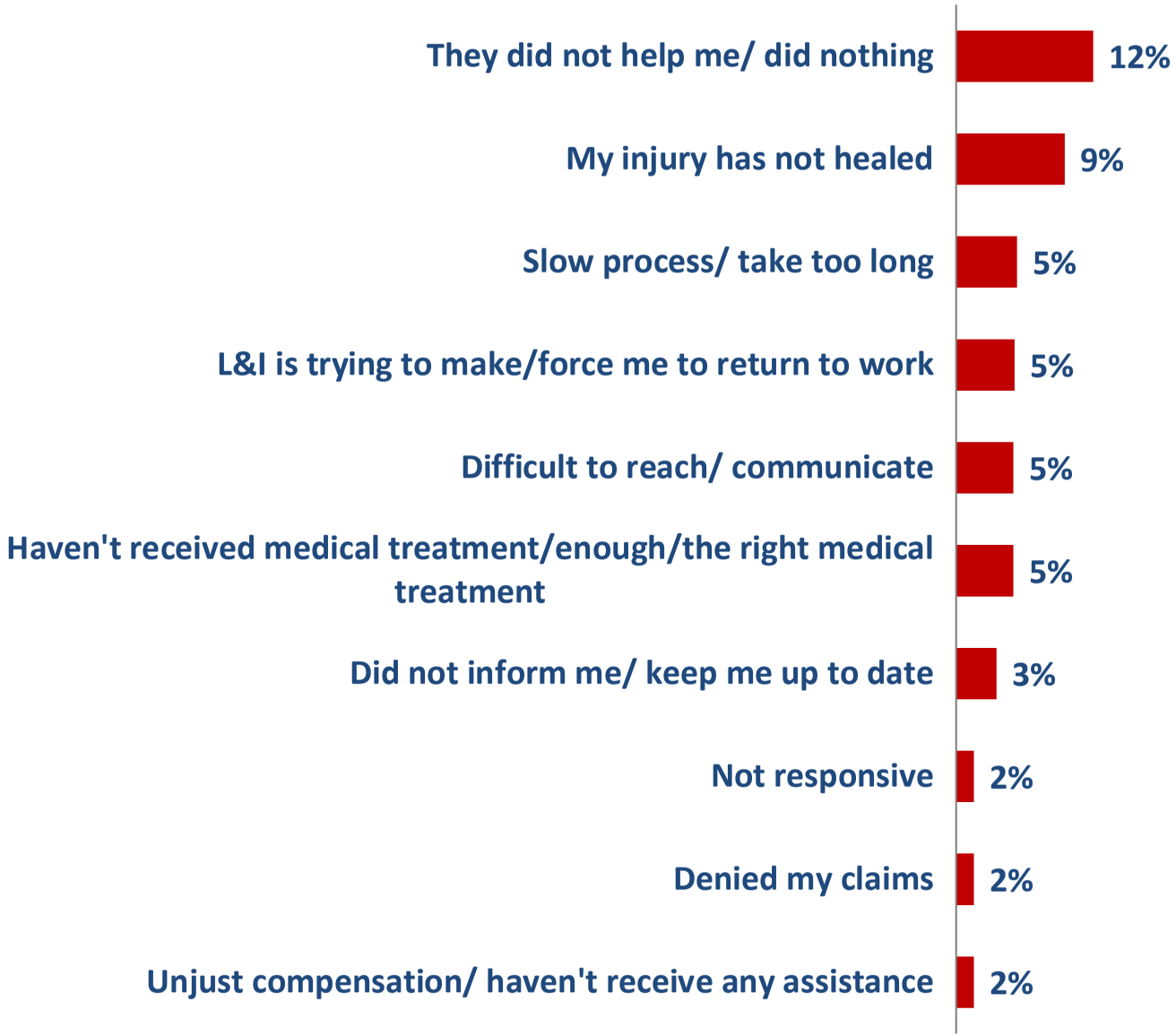
Responses <2% not shown.

Q32b. Why did you rate L&I as <Q32 RATING> for helping you return to work

Base: Respondents who provided a rating (n=671)

Top Negative Comments About L&I Helping You Return to Work

Workers: September 2014



Responses <2% not shown.

Q32b. Why did you rate L&I as <Q32 RATING> for helping you return to work

Base: Respondents who provided a rating (n=671)

	Percent of Injured Workers				
	March 2012	Sept. 2012	Sept. 2013	April 2014	Sept. 2014
Gender:					
Male	69%	73%	67%	68%	67%
Female	32%	27%	33%	32%	33%
Age:					
24 Years or Under	3%	6%	4%	3%	4%
25 to 34	9%	19%	15%	14%	14%
35 to 44	19%	21%	19%	21%	22%
45 to 54	28%	24%	26%	27%	26%
55 to 64	31%	24%	28%	27%	27%
65 or older	10%	6%	8%	8%	8%
Language:					
English	93%	91%	89%	89%	88%
Spanish	8%	10%	11%	11%	12%
Age of Claim:					
30 to 180 Days	38%	34%	38%	40%	38%
181 Days to 2 Years	43%	46%	41%	38%	43%
Over 2 Years	20%	20%	21%	22%	19%

	Percent of Injured Workers				
	March 2012	Sept. 2012	Sept. 2013	April 2014	Sept. 2014
Characteristics of Claims:					
Occupational Disease	10%	10%	10%	10%	10%
AWA (Ability to work assessment)	33%	34%	30%	37%	38%
Voc Rehab Retraining	6%	6%	5%	7%	6%
Stay at Work Program	-	3%	5%	6%	4%
Claim Re-Opened	5%	4%	6%	7%	8%
Protested or Appealed	4%	4%	15%	18%	20%
LEP (Lost Earning Potential)	7%	7%	11%	9%	9%
KOS (Keep on Salary)	4%	7%	5%	8%	6%
Claim Covered Under Elective Coverage	1%	1%	1%	1%	1%
Characteristics of Employers:					
Retro Group	35%	37%	30%	34%	32%
Use a TPA	26%	22%	19%	21%	21%

	Percent of Injured Workers				
	March 2012	Sept. 2012	Sept. 2013	April 2014	Sept. 2014
Employer Risk Industry:					
Agriculture	4%	4%	4%	4%	6%
Forest Products	5%	3%	3%	2%	3%
Miscellaneous Construction	6%	4%	4%	5%	7%
Building Construction	8%	9%	10%	9%	10%
Trades	6%	8%	8%	7%	8%
Food Processing and Manufacturing	2%	3%	3%	3%	4%
Metal and Machinery Manufacturing	3%	3%	2%	4%	3%
Miscellaneous Manufacturing	2%	2%	2%	2%	2%
Utilities and Communications	1%	1%	1%	1%	1%
Transportation and Warehousing	8%	9%	9%	11%	8%
Dealers and Wholesalers	4%	5%	4%	4%	3%
Stores	5%	6%	6%	6%	6%
Miscellaneous Services	19%	19%	19%	18%	19%
Health Care	4%	5%	5%	5%	4%
Misc. Professional and Clerical	5%	4%	6%	5%	5%
Schools	5%	4%	2%	3%	3%
Government	11%	9%	11%	10%	8%
Temporary Help	3%	2%	2%	2%	2%

Employers Customer Experience Survey

Wave 4: Tables and Charts

November 2014

Methodology

Reported herein are the results of the first five waves of the Employers BBCE survey. A total of around 600 to 680 telephone interviews were conducted for each wave.

The sample was selected from among employers with one or more allowed time loss claim(s) that was active in the past six months. Qualifying claims were 30 days or over.

Employers that use a third party administrator (TPA) or are part of a retro group were excluded from the sample since they often are not in direct contact with L&I, and because of the risk of calling the same TPA or Retro representative multiple times because they represent more than one employer.

The interviews were conducted from:

Baseline: March 15 to 28, 2012

Wave 1: October 10 to 19, 2012

Wave 2: October 23 to November 18, 2013

Wave 3: March 18 to 31, 2014

Wave 4: October 6 to November 3, 2014

The interviews are conducted in the respondent's choice of English or Spanish.

Minor weighting adjustments were applied to bring the sample into proportion with the universe of qualifying employers (excluding TPA and Retro) by employer size and participation in the Stay at Work program. The impact of the weighting is shown in the following table.

Number of FTEs:	Total Actual	Total Weighted
Less than 10	311	321
10 to 50	192	194
51 to 249	74	71
250 or more	24	14
Total	***601***	***601***

Completion Rate

The final call dispositions for Wave 4 are as follows. The completion rate is high.

	Number	Percent
Completed Interviews	601	21%
Break-offs	31	1%
Disqualified	182	7%
Language Barrier	36	1%
Appointments	158	6%
Refusals	481	17%
Telephone Was Not Answered	1,094	39%
Not in Service	215	8%
Total Sample Dialed	***2,800***	***100%***

Margin of Error and Statistical Significance

Surveys based on random samples are subject to sampling error due to the fact that not everyone in the entire population was surveyed. The reliability of survey results is often reported as a range within which the actual result is expected to fall. This range is based on a specified level of probability, typically 95%.

Data based on the Wave 4 sample of 601 has a sampling error of ±4.0% at the 95% threshold. Thus, if a result of 50% is attained based on this sample, we can be sure, 95% of the time (or 19 times out of 20) that the result of a census would be between 46% and 54%.

Data based on sub-groups is subject to greater margins of error. Examples of sub-groups and the associated margins of error are provided to follow.

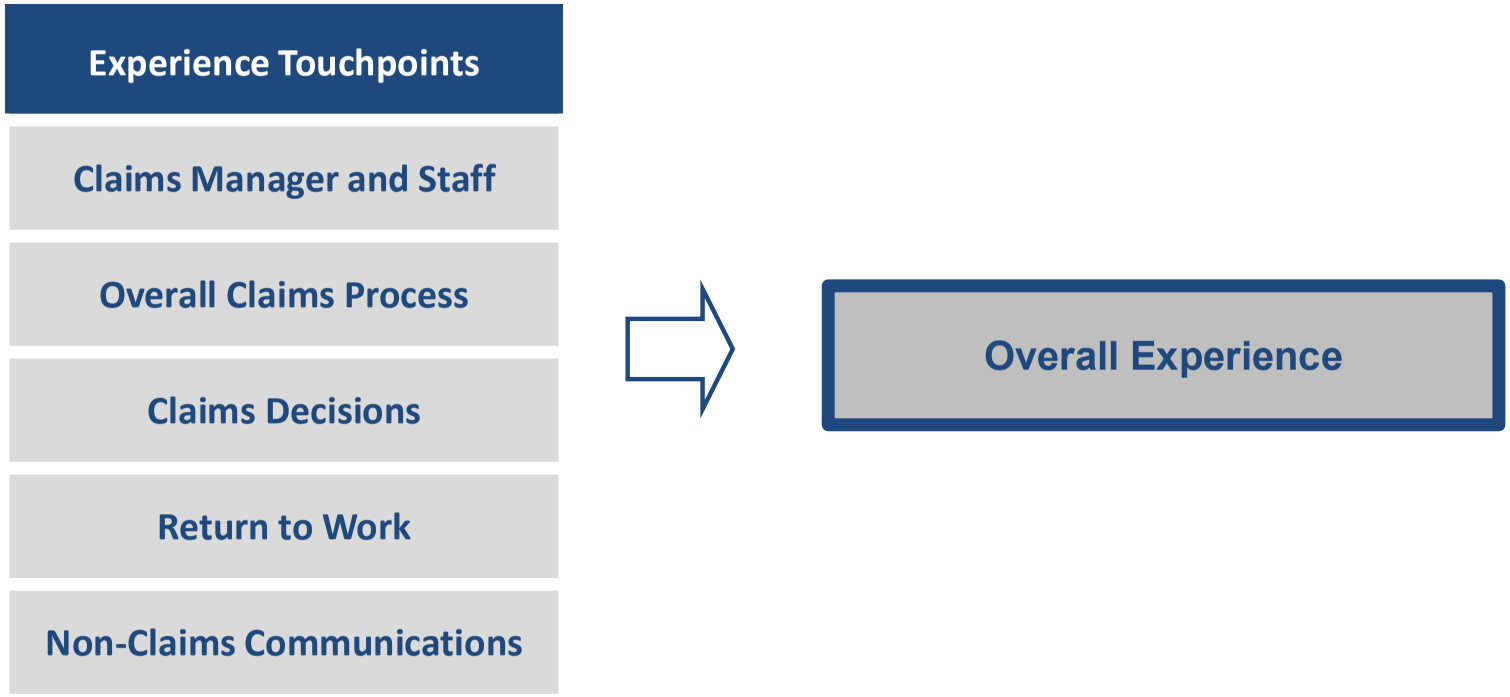
	Sample Size	Margin of Error*
Wave 4 Total	601	±4.0%
Employers who rated non-claims communication	400	±4.9%
Smaller groups of respondents (e.g.)	100	±9.8%

* For a result of 50% at the 95% confidence interval.

Throughout this report, circles ◯ are used to denote sub-groups with scores that are statistically significantly higher than other sub-groups.
Arrows ⬆⬇ denote statistically significant changes over time.

Note that the percentages for rating scale questions are based on respondents who gave a rating.

Employer Model



Employer Model

Touchpoints	Drilldowns					
Claims Manager and Staff	Being helpful and friendly	Listening to you and under-standing	Letting you know what actions to take	Returning calls and messages	Resolving your question or concern	Suggesting options for return to work
Overall Claims Process						
Claims Decisions	Taking care of your injured worker's needs	Timeliness of claims decisions	Taking into account your description of how the injury occurred	Clearly describing the reasons for the claims decisions	Fairness of the decision	
Return to Work	Fully involving your company in the RTW process	Working with you to get your injured worker back on the job	Ensuring your injured workers RTW at an appropriate pace			
Non-Claims Communications	Being helpful and friendly	Resolving your question or concern	Returning your calls and messages	Being available when you need to reach them		

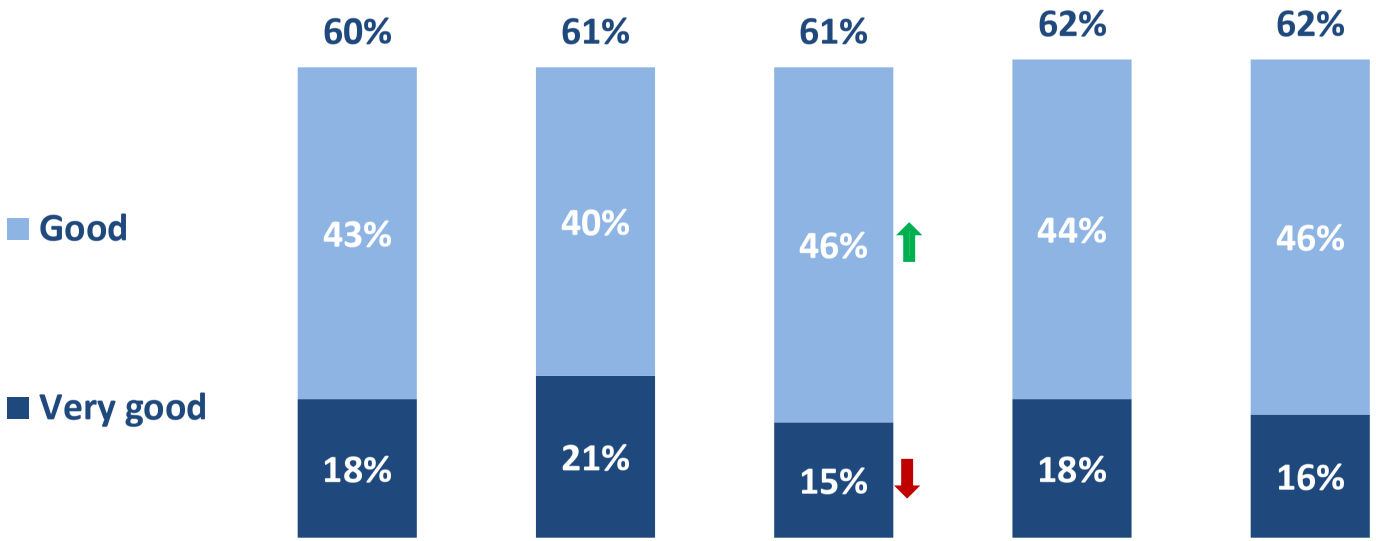
Waves 3 and 4 DA results.

= Top Priority = Secondary Priority

Overall Experience

Overall Experience Working with L&I in the Past Year

Employers



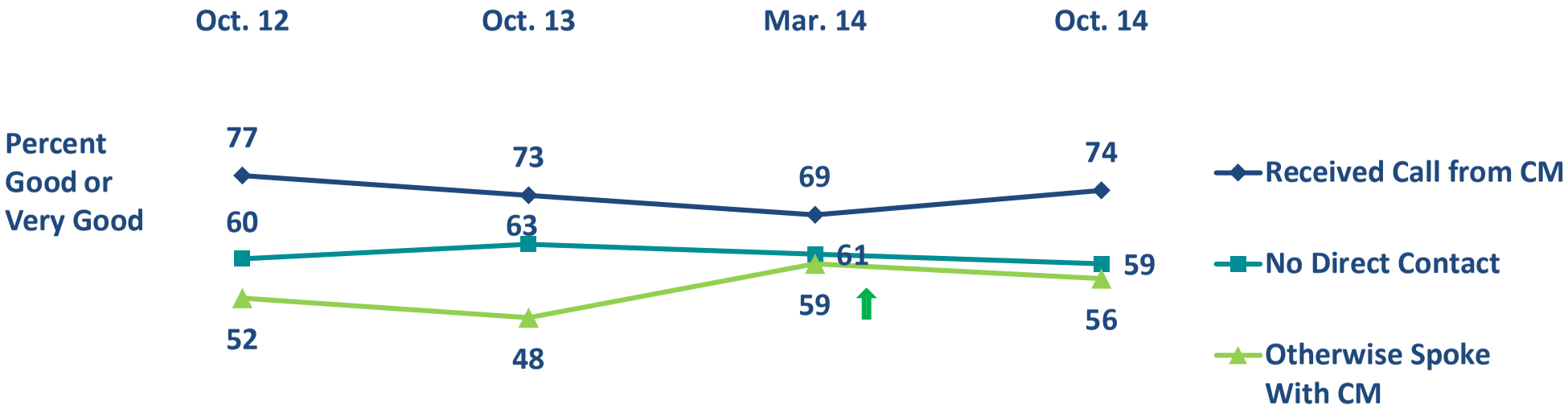
	March 2012	October 2012	October 2013	March 2014	October 2014
Total Good	60%	61%	61%	62%	62%
Average	26%	25%	26%	24%	24%
Total Poor	14%	15%	14%	14%	13%

*Q1. First, I would like to ask you a few general questions about your interactions with L&I **over the past year**. We will be using the scale of Very Good, Good, Average, Poor and Very Poor. Taking everything into account, how would you rate the overall experience of working with L&I…*

Base: All respondents (n~600 per wave)

Impact of Contact with Claims Managers on Overall Experience

Employers: Trend Line



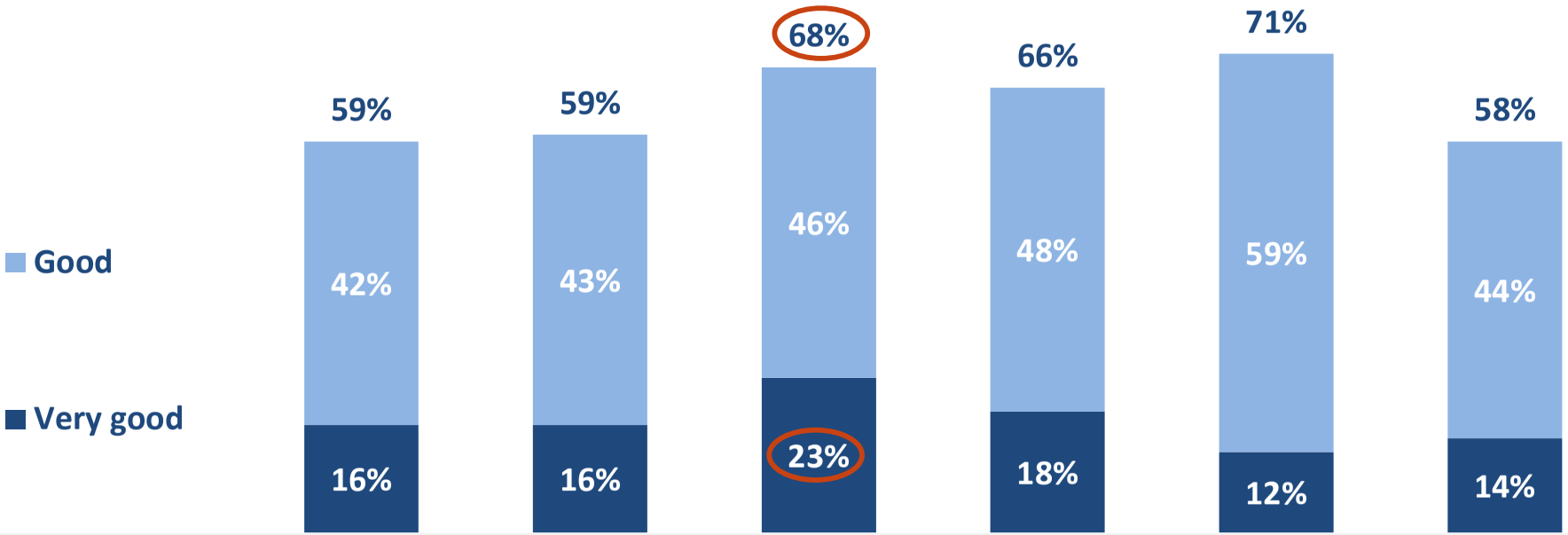
*Q1. First, I would like to ask you a few general questions about your interactions with L&I **over the past year**. We will be using the scale of Very Good, Good, Average, Poor and Very Poor. Taking everything into account, how would you rate the overall experience of working with L&I…*

Base: Employers who had a claim which started in the past year and received call (n=97/160/192/172); Had no direct contact (n=199/284/252/238); otherwise spoke with their CM (n=104/214/236/191)

Note: prior to March 2014, only employers who had a claim that started in the past year were asked the questions about contact with their Claims Manager

Overall Experience by Delivery Service Area

Employers: March and October 2014 (Combined)



	DSA 1	DSA 2	DSA 3	DSA 4	DSA 5*	DSA 6
Total Good	59%	59%	68%	66%	71%	58%
Average	26%	29%	21%	22%	16%	24%
Total Poor	15%	13%	10%	12%	13%	17%
Number of Interviews	*(184)*	*(198)*	*(203)*	*(172)*	*(26)*	*(245)*

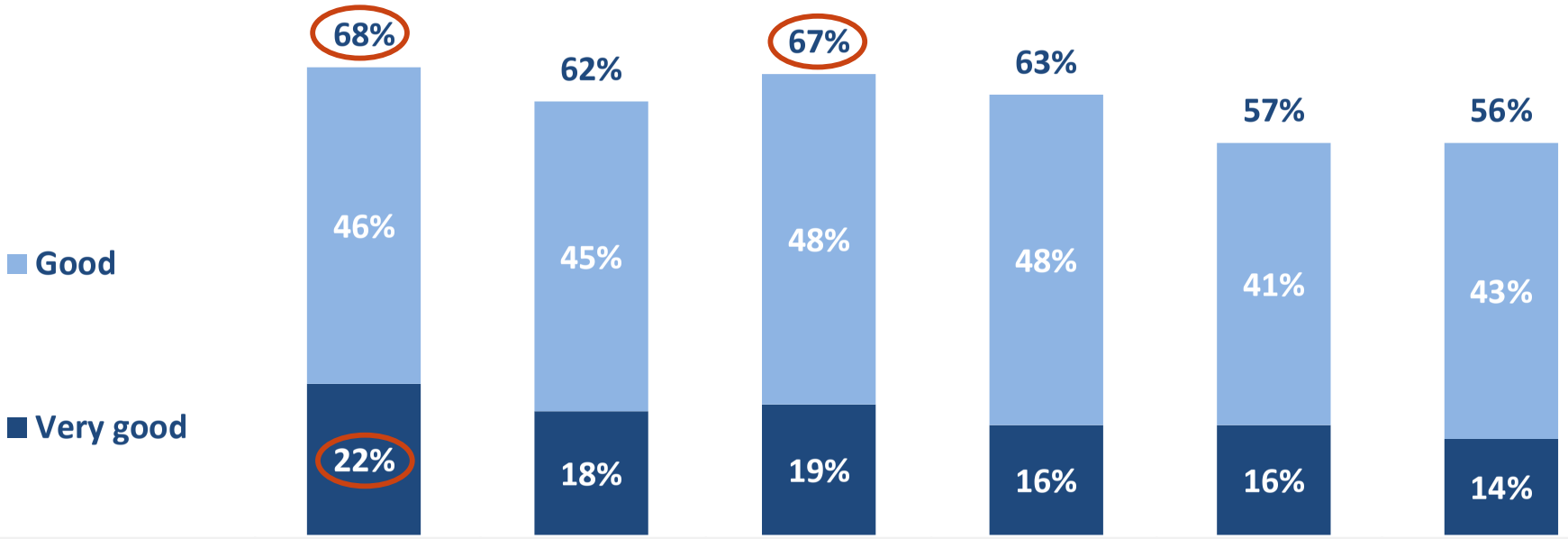
** Caution: small base*

*Q1. First, I would like to ask you a few general questions about your interactions with L&I **over the past year**. We will be using the scale of Very Good, Good, Average, Poor and Very Poor. Taking everything into account, how would you rate the overall experience of working with L&I…*

Base: All respondents

Overall Experience by Employer Services Team

Employers: March and October 2014 (Combined)



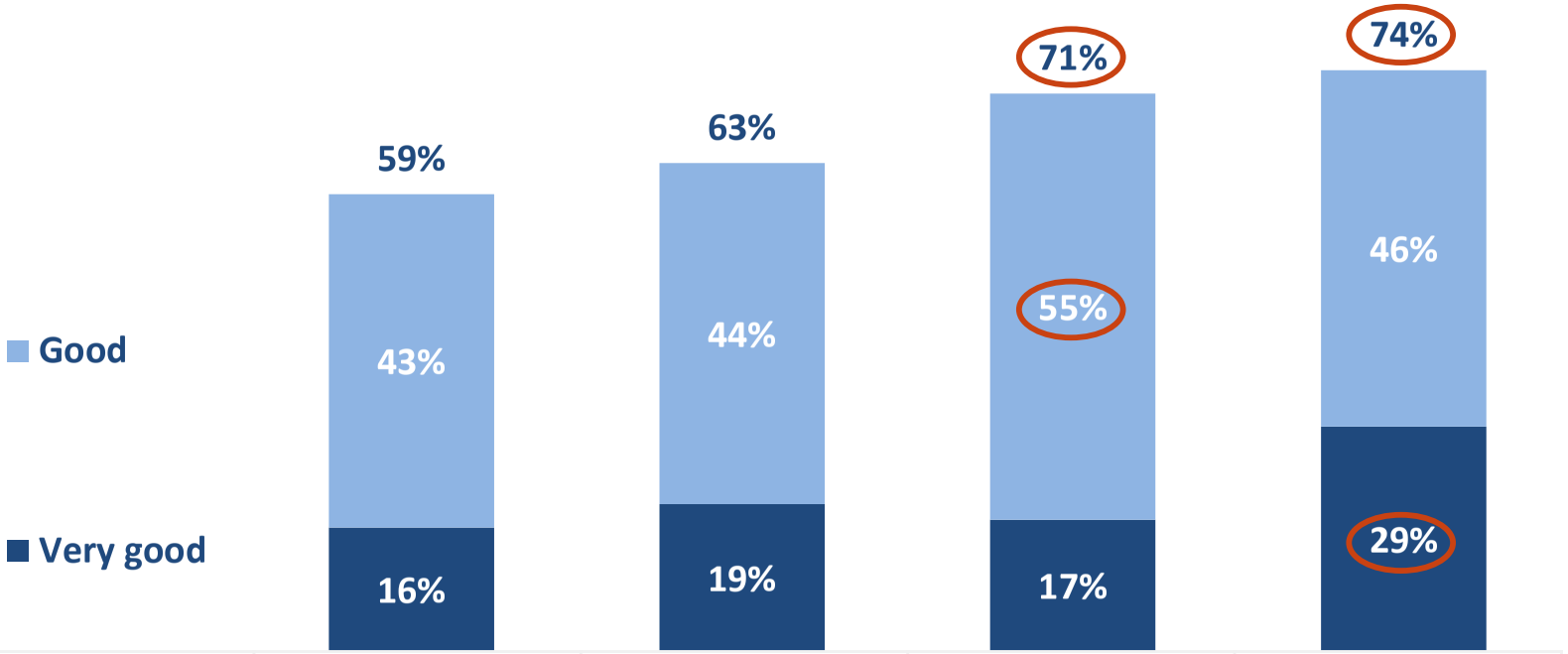
	Team 1	Team 2	Team 3	Team 4	Team 5	Specialist Team
Total Good	68%	62%	67%	63%	57%	56%
Average	22%	25%	21%	23%	28%	26%
Total Poor	10%	13%	13%	13%	15%	18%
Number of Interviews	*(222)*	*(252)*	*(202)*	*(165)*	*(214)*	*(221)*

*Q1. First, I would like to ask you a few general questions about your interactions with L&I **over the past year**. We will be using the scale of Very Good, Good, Average, Poor and Very Poor. Taking everything into account, how would you rate the overall experience of working with L&I…*

Base: All respondents

Overall Experience by Employer Size (FTEs)

Employers: March and October 2014 (Combined)



	Fewer than 10	10 to 50	51 to 249	250 or More*
Total Good	59%	63%	71%	74%
Average	25%	24%	24%	18%
Total Poor	16%	13%	5%	8%
Number of Interviews	*(659)*	*(418)*	*(155)*	*(49)*

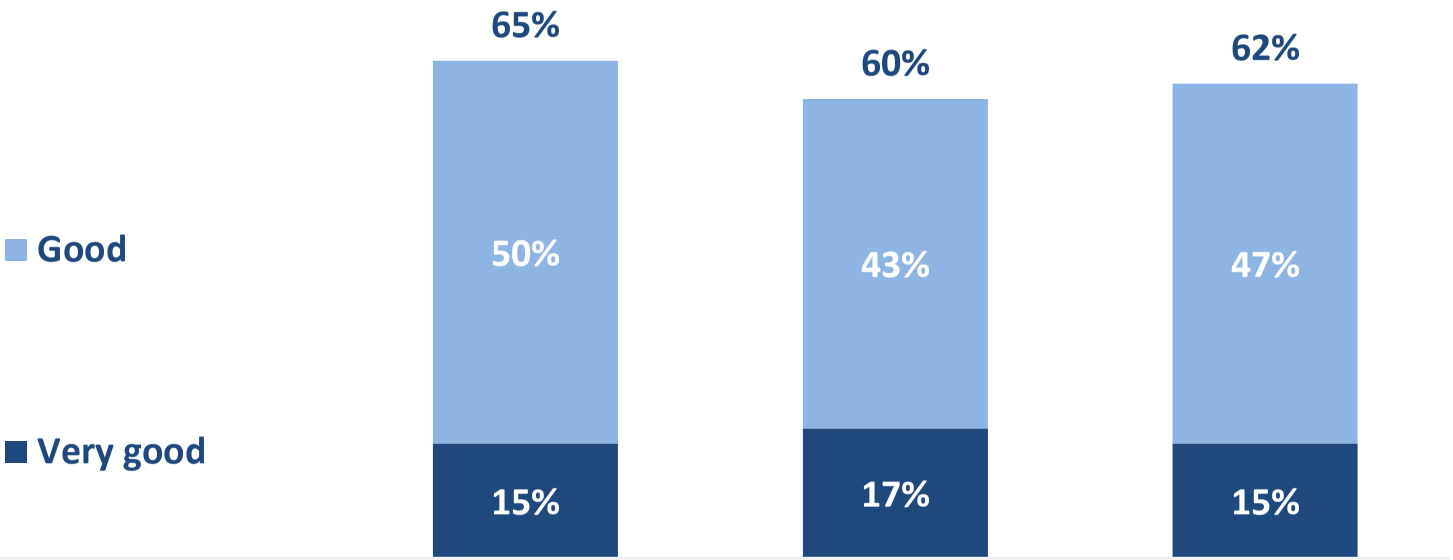
** Caution: Small base*

*Q1. First, I would like to ask you a few general questions about your interactions with L&I **over the past year**. We will be using the scale of Very Good, Good, Average, Poor and Very Poor. Taking everything into account, how would you rate the overall experience of working with L&I…*

Base: All respondents

Overall Experience by Number of Claims in Past Ten Years

Employers: October 2014



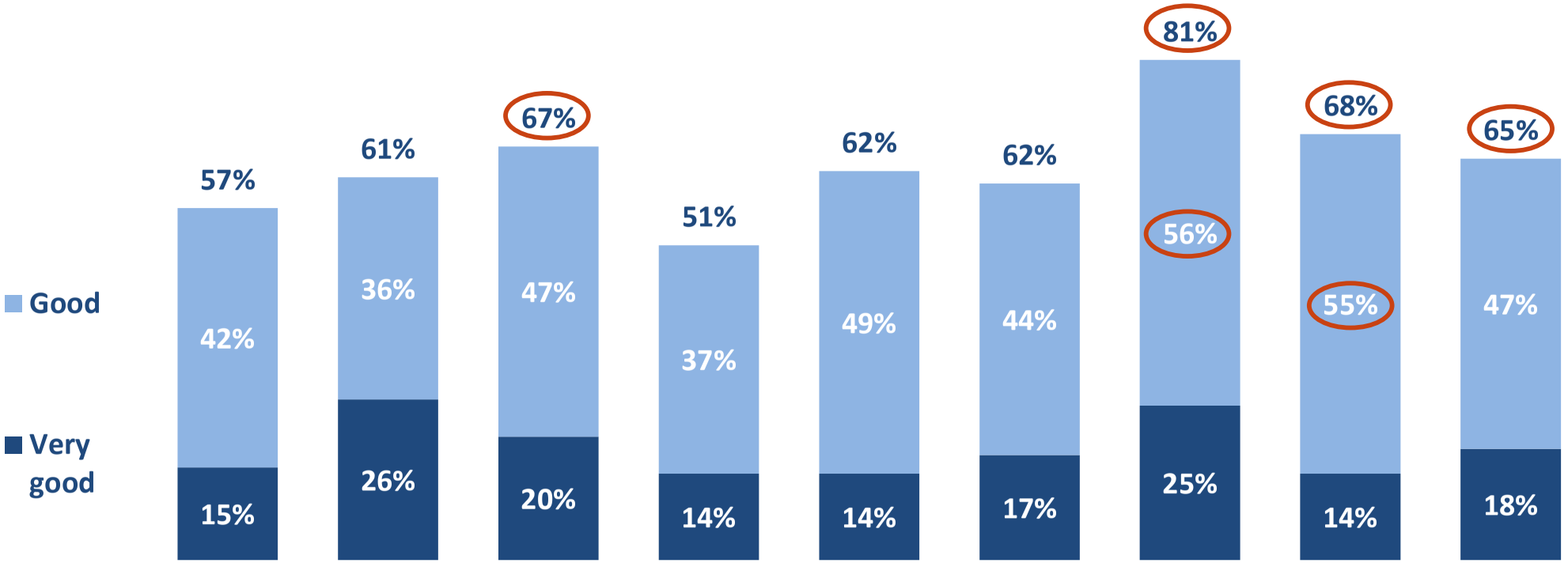
	1 or less	2 to 5	Over 5
Total Good	65%	60%	62%
Average	23%	24%	26%
Total Poor	11%	16%	12%
Number of Interviews	*(202)*	*(212)*	*(187)*

*Q1. First, I would like to ask you a few general questions about your interactions with L&I **over the past year**. We will be using the scale of Very Good, Good, Average, Poor and Very Poor. Taking everything into account, how would you rate the overall experience of working with L&I…*

Base: All respondents

Overall Experience by Risk Class

Employers: March and October 2014 (Combined)



	Building Construction/ Trades	Misc. Construction	Manu-facturing	Transpor-tation/ Warehouse	Wholesale / Retail	Misc. Service	Healthcare*	Government & School	Misc. Professional and Clerical
Total Good	57%	61%	67%	51%	62%	62%	81%	68%	65%
Average	27%	20%	24%	34%	24%	21%	12%	24%	23%
Total Poor	16%	18%	9%	15%	14%	17%	7%	8%	12%
No. of Interviews	*(206)*	*(63)*	*(98)*	*(92)*	*(123)*	*(294)*	*(48)*	*(76)*	*(136)*

** Caution: Small base*

*Q1. First, I would like to ask you a few general questions about your interactions with L&I **over the past year**. We will be using the scale of Very Good, Good, Average, Poor and Very Poor. Taking everything into account, how would you rate the overall experience of working with L&I…*

Base: All respondents

Top Positive Comments About Overall L&I Experience

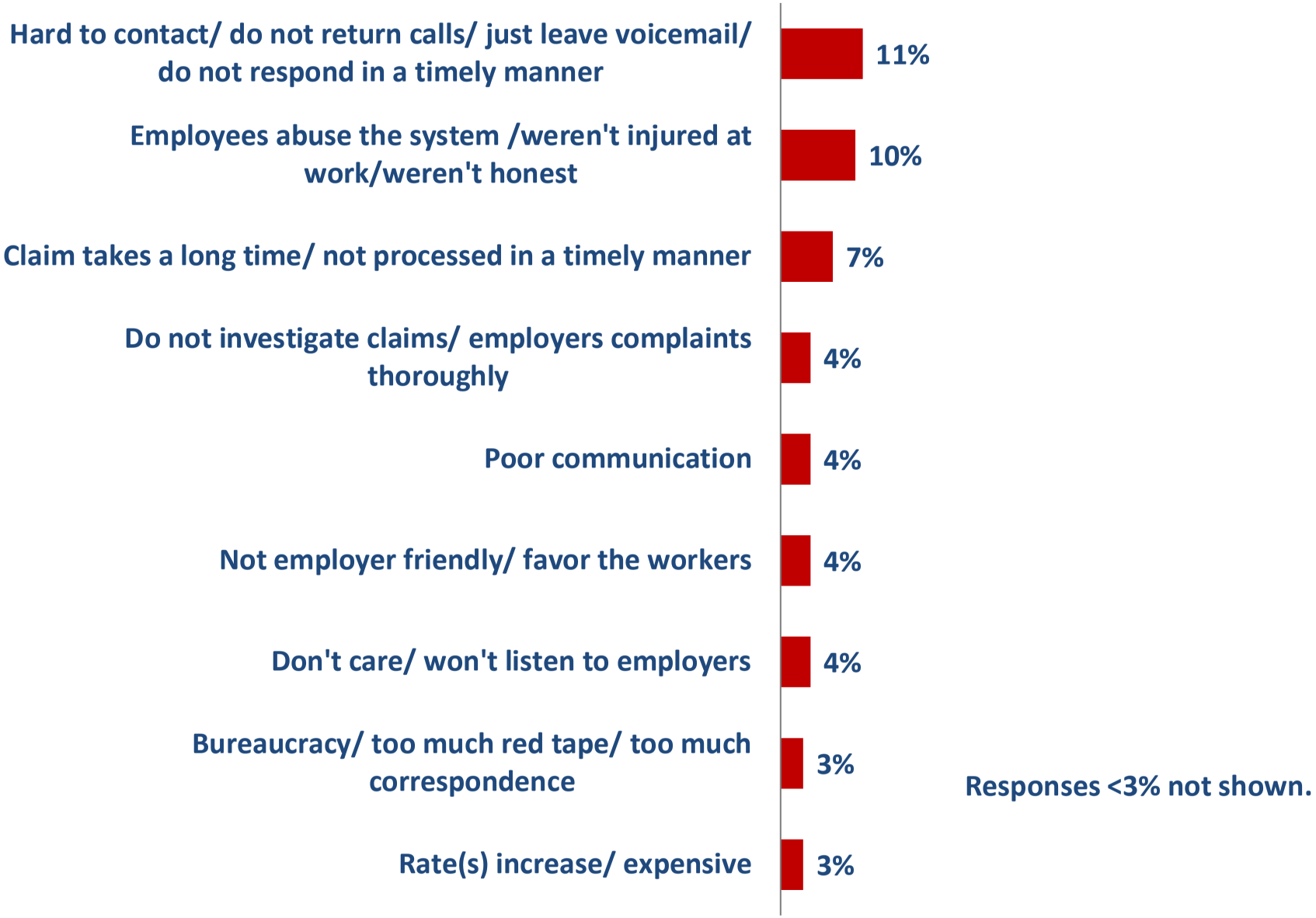
Employers: October 2014

Responses <3% not shown.

Q2. Why did you rate your overall experience with L&I as [INSERT Q1 RESPONSE]?
Base: All respondents (n=601)

Top Negative Comments About Overall L&I Experience

Employers: October 2014



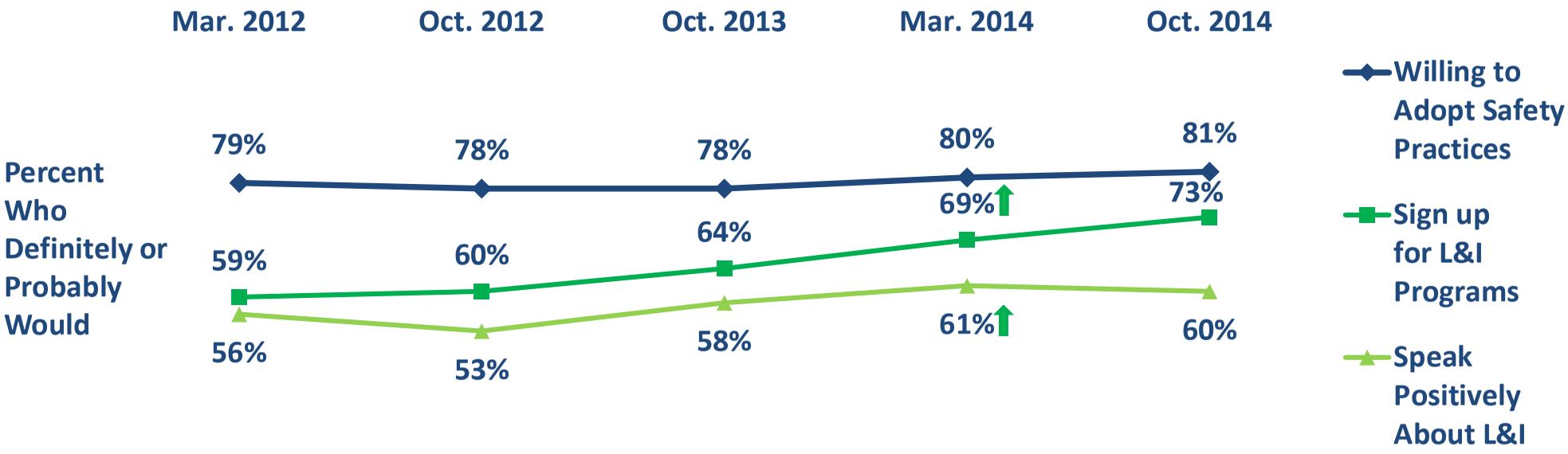
Q2. Why did you rate your overall experience with L&I as [INSERT Q1 RESPONSE]?

Base: All respondents (n=601)

Engagement

Engagement Measures

Employers: Trend Line



Q26. Using a scale of "definitely would, probably would, might or might not, probably would not, or definitely would not", what is the likelihood that you would…

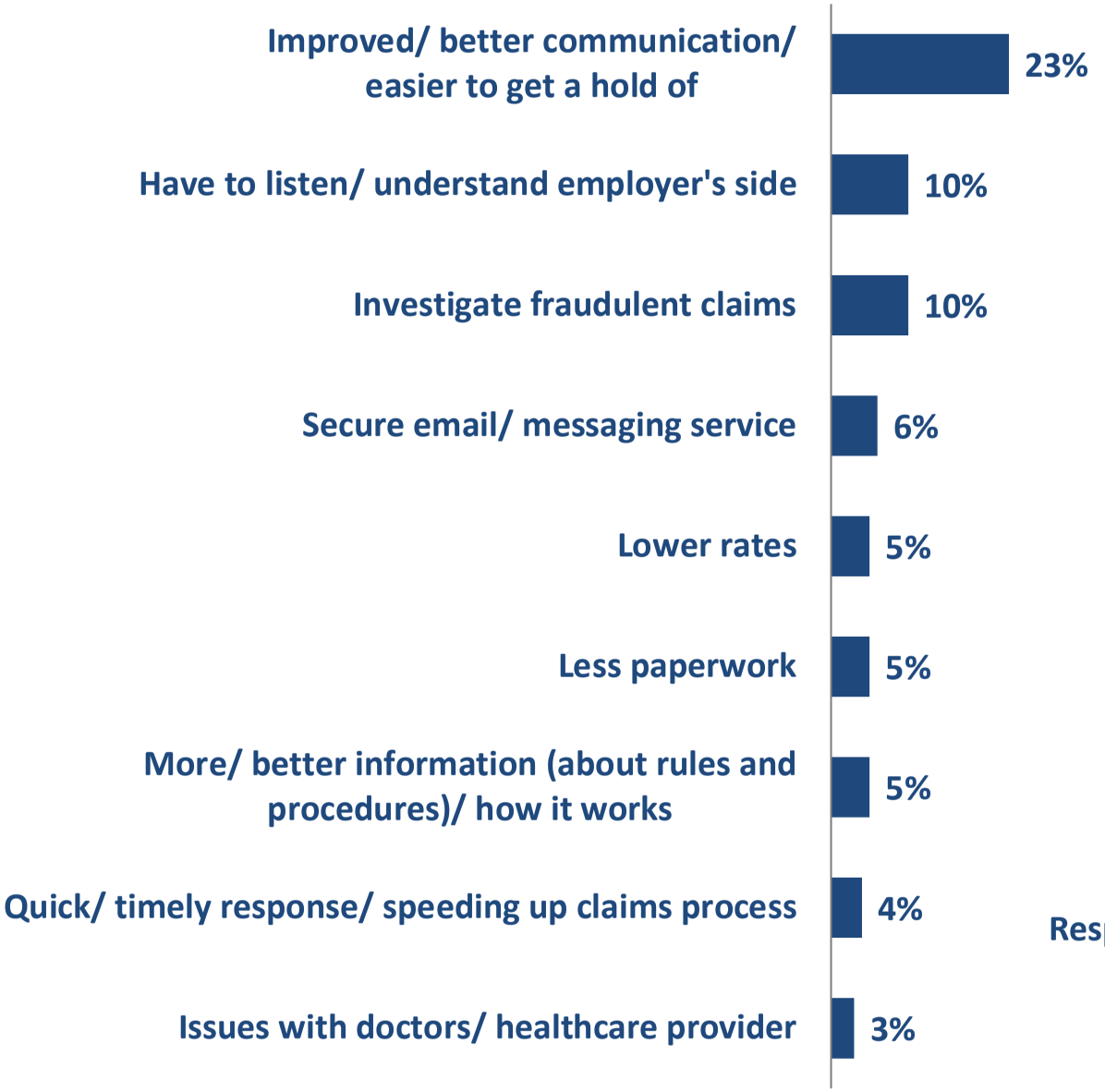
* *Note wording change. Baseline: Sign up for L&I recommended programs or services to help you improve workplace health and safety. Later waves: Sign up for L&I recommended programs or services to help you reduce workers' comp rates.*

Base: All respondents who provided a rating (n~600 per wave)

Easy to do Business With

Easy to Do Business with L&I

Employers: October 2014



Responses <3% not shown.

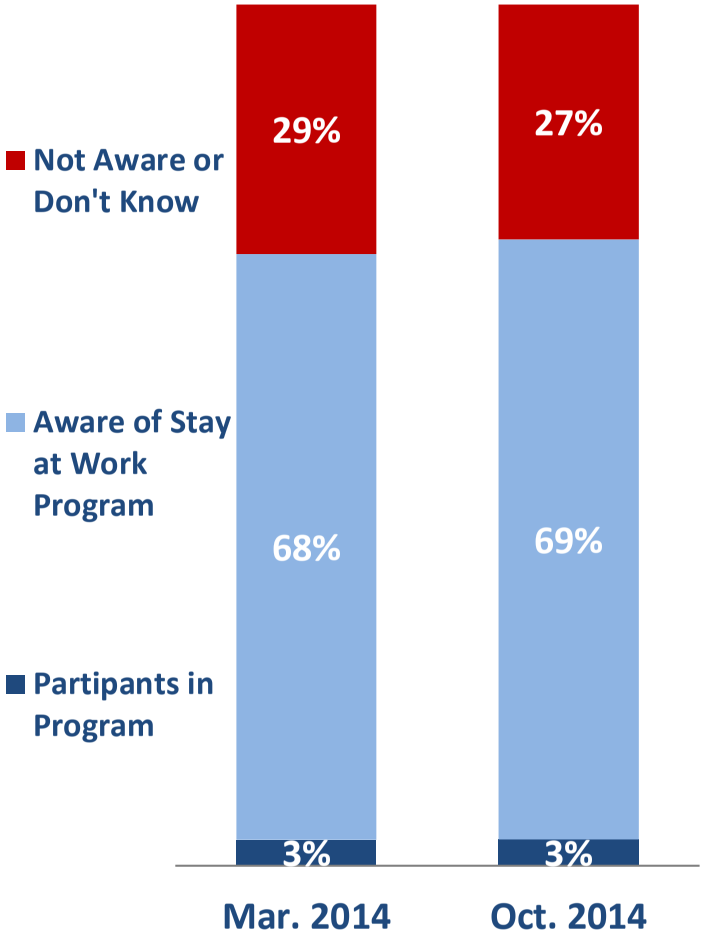
26b. If L&I were to do one thing that would make them **easier to do business with,** what do you think it would be?
Base: All respondents (n=601)

Stay at Work Program

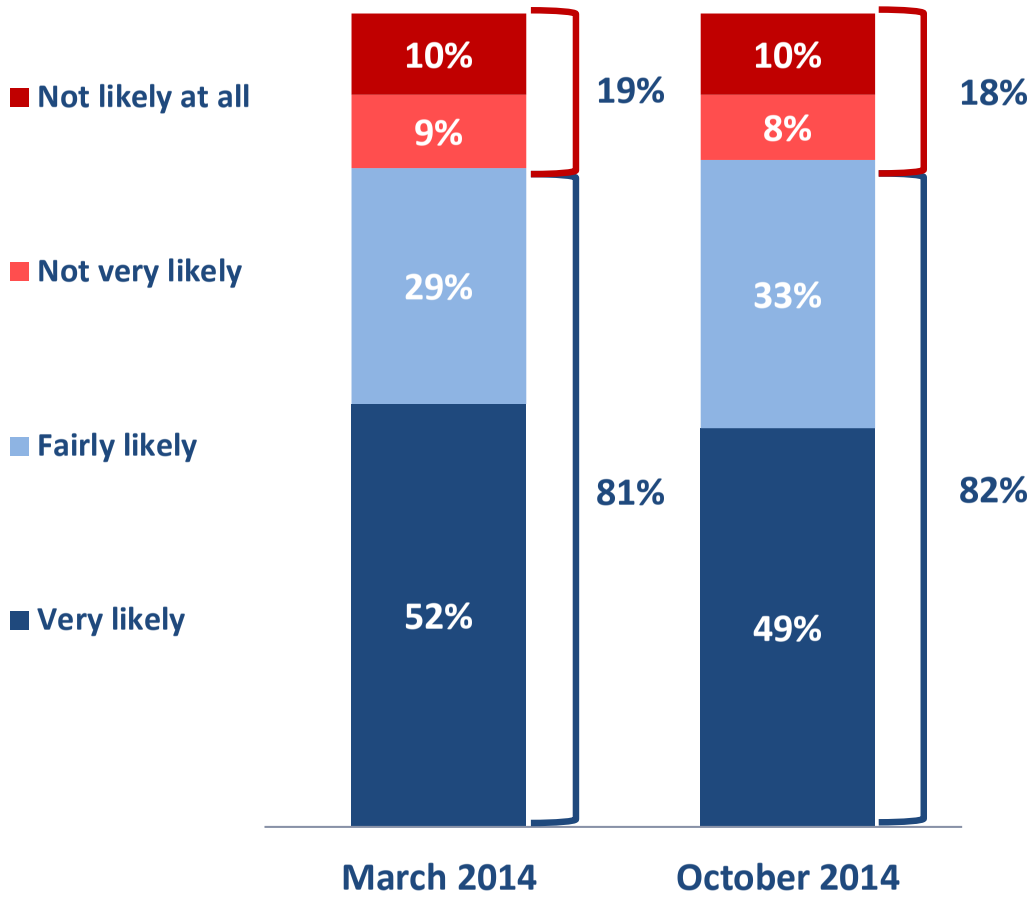
Awareness of the Stay at Work Program

Employers: October 2014

Participation in Stay at Work Program



Likelihood of Participating in Stay at Work Program



24f. L&I offers a Stay at Work Program, which reimburses employers for part of the cost of keeping an injured worker on light duty work while they recover. Have you heard or seen anything about the Stay at Work Program?

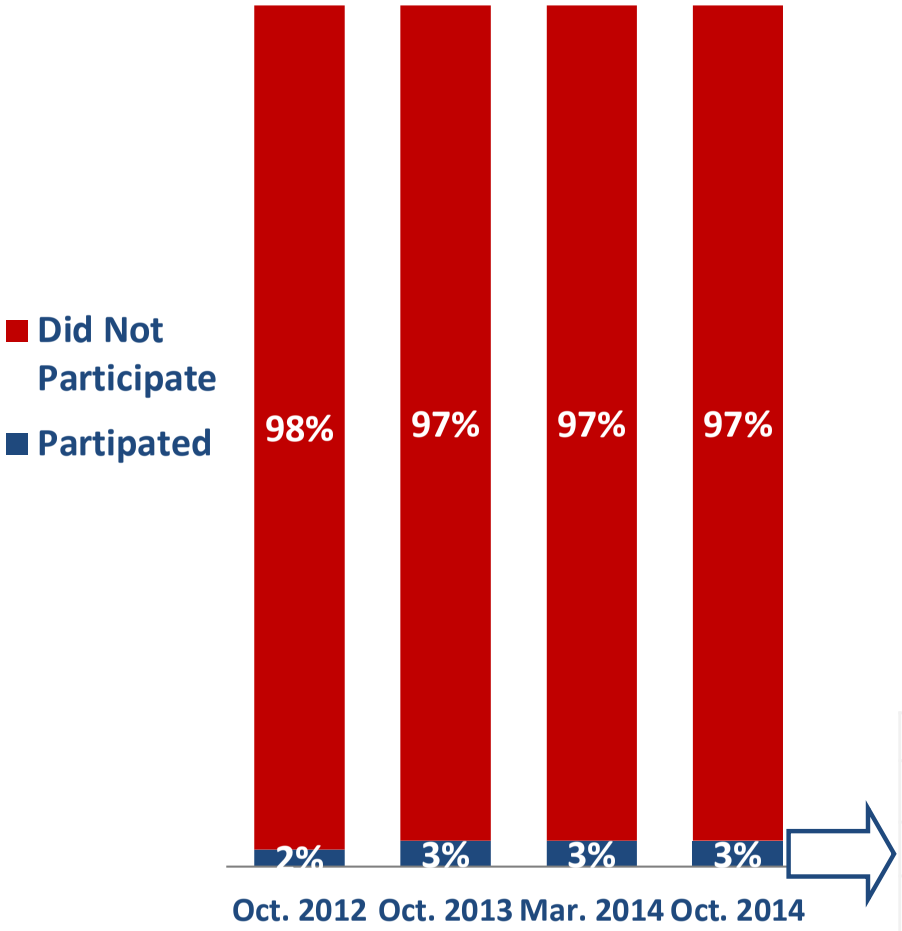
24g. This program would reimburse you for half of the injured worker's base wages and other expenses if the worker continues to be employed by you doing a light-duty job while they recover. The job must be approved by the worker's medical provider. How likely would you be to participate in this program if you were in this situation?

Base: All respondents (n=680/601); Stay at work non-participants who provided a rating of the program (n=598/512)

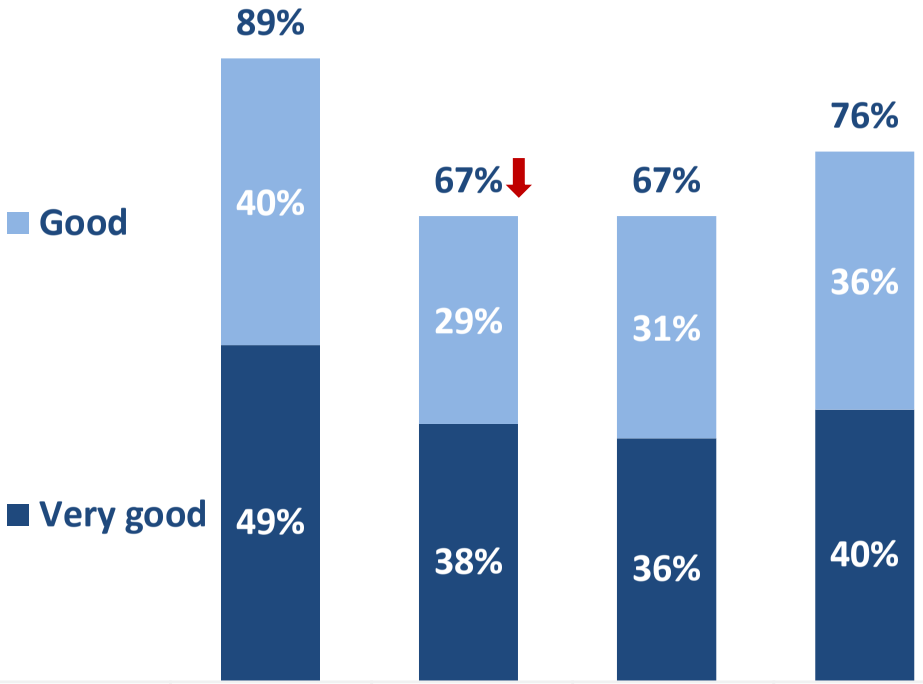
Stay at Work Program

Employers

Participation in Stay at Work Program



Overall Rating of Stay at Work Program



	Oct. 2012	Oct. 2013	Mar. 2014	Oct. 2014
Total Good	89%	67% ↓	67%	76%
Average	9%	12%	14%	16%
Total Poor	2%	21% ↑	19%	9%
Number of Interviews	*(35)**	*(59)*	*(47)**	*(57)*

** Caution: Small base*

24a. I understand that your organization participated in L&I's Stay at Work Program, which reimburses employers for part of the cost of keeping an injured worker on light duty work while they recover. Is that correct? IF YES:

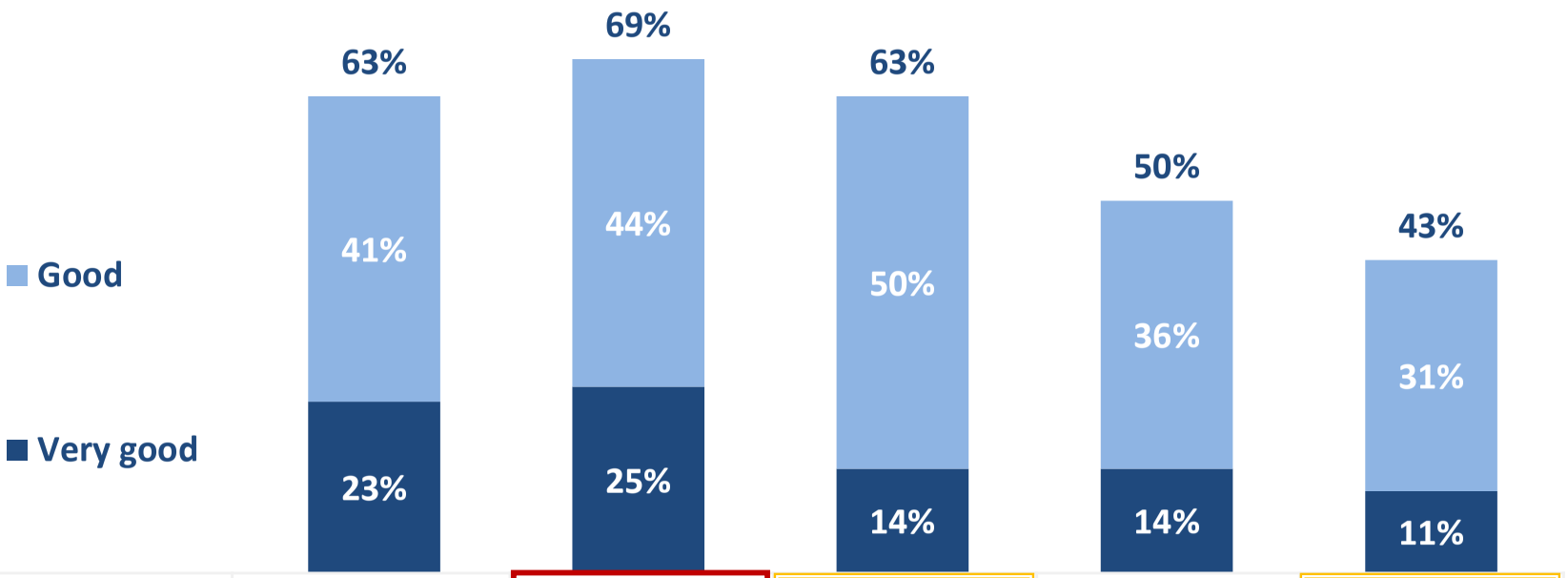
24b. Would you say that your overall experience with the Stay at Work Program was…

Base: All respondents (n=603/679/680/601); Stay at work participants

Touchpoints Summary

Overall Ratings on Touchpoints

Employers: October 2014



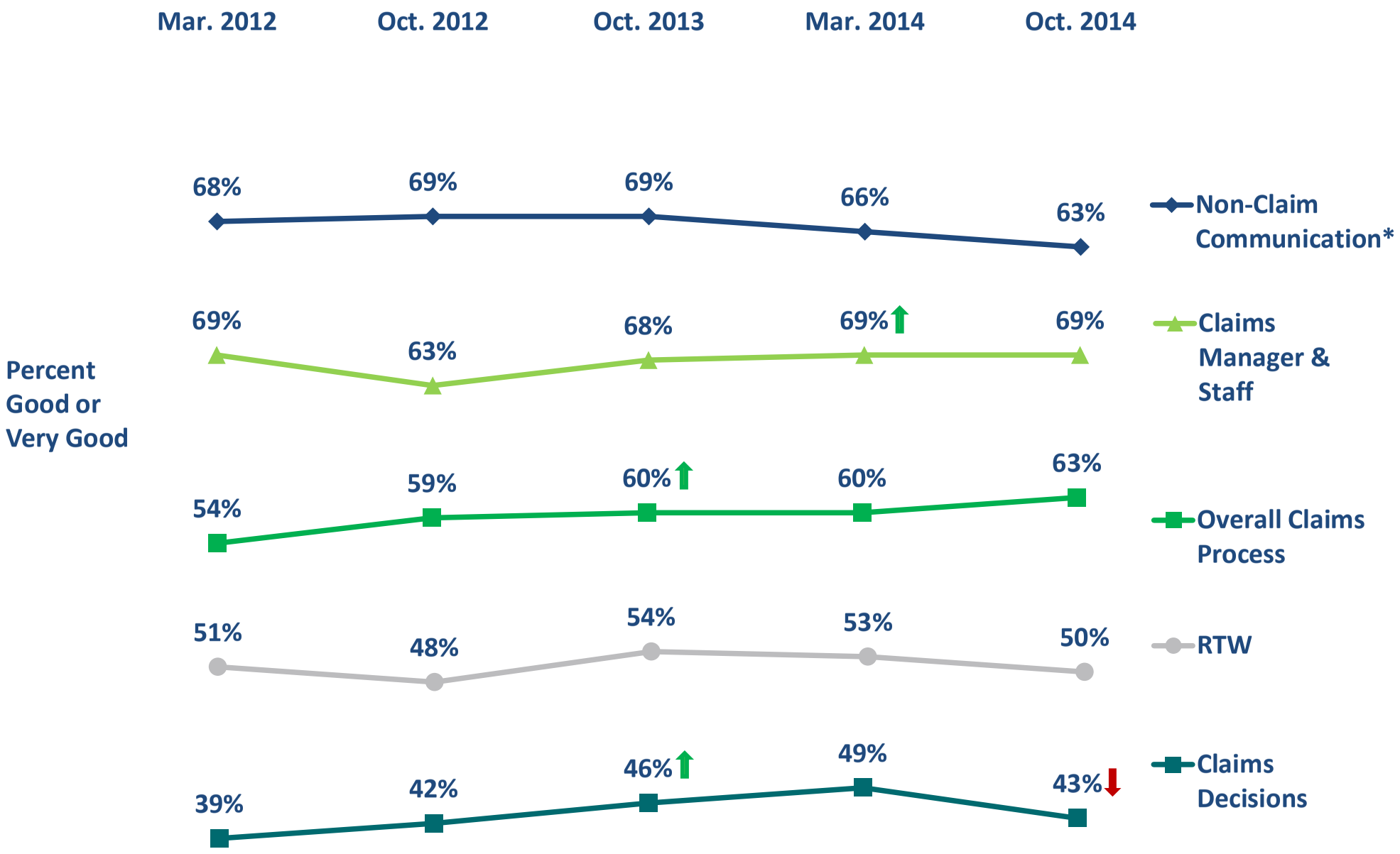
	Non-Claim Communication*	Claims Manager & Staff	Overall Claims Process	RTW	Claims Decisions
Total Good	63%	69%	63%	50%	43%
Average	28%	19%	25%	26%	29%
Total Poor	9%	12%	12%	24%	29%

= Top Priority = Secondary Priority

Base: All respondents (n~600 per wave)
* Respondents involved in non-claims communication (n~400 per wave)

Overall Ratings on Touchpoints

Employers: Trend Line

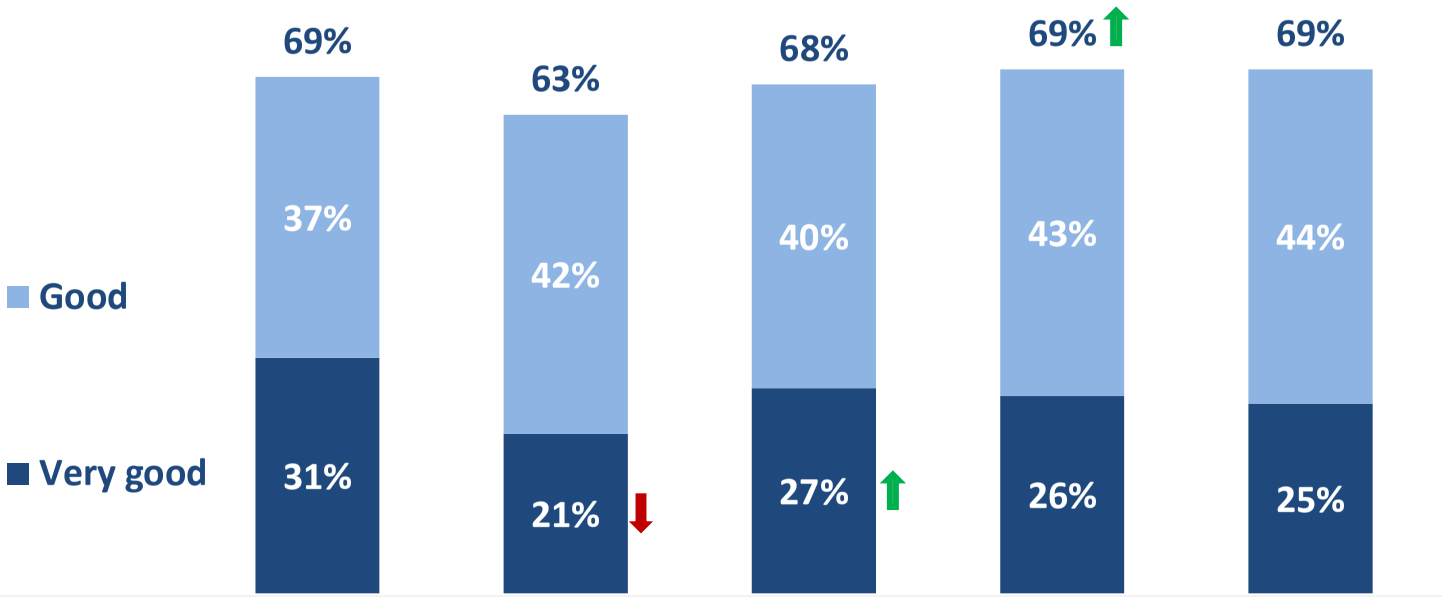


Base: All respondent s (n~600 per wave)
* Respondents involved in non-claims communication (n~400 per wave)

Claims Manager and Claims Staff

Overall Experience with Claims Managers and Staff

Employers



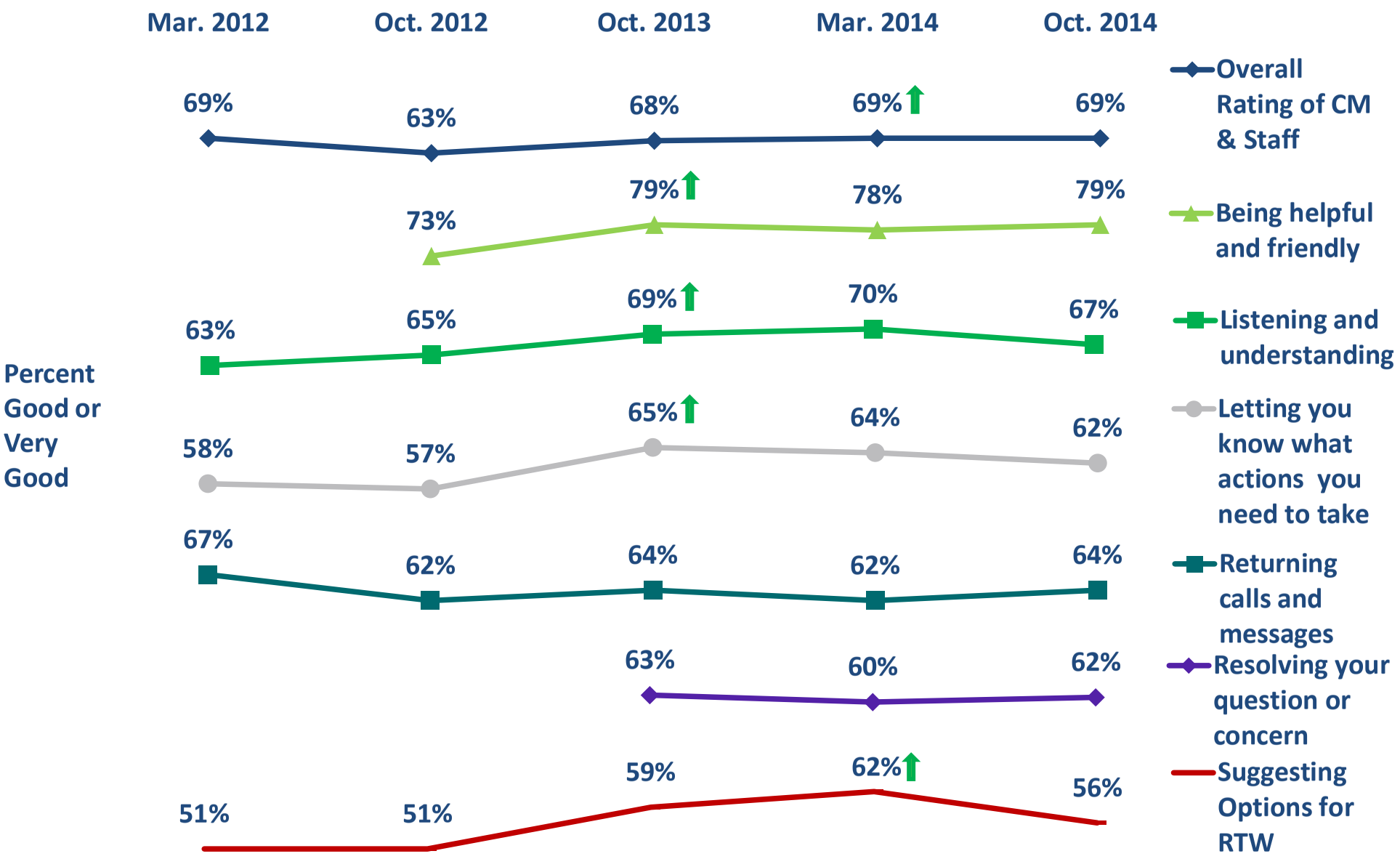
	March 2012	October 2012	October 2013	March 2014	October 2014
Total Good	69%	63%	68%	69% ↑	69%
Average	22%	22%	21%	21%	19%
Total Poor	10%	15% ↑	12%	10% ↓	12%

Q7. And, how would you rate the Claims Manager(s) and claims staff at L&I you worked with during the claims process?

Base: All respondents (n~600 per wave)

Claims Manager and Staff Drilldowns

Employers: Trend Line

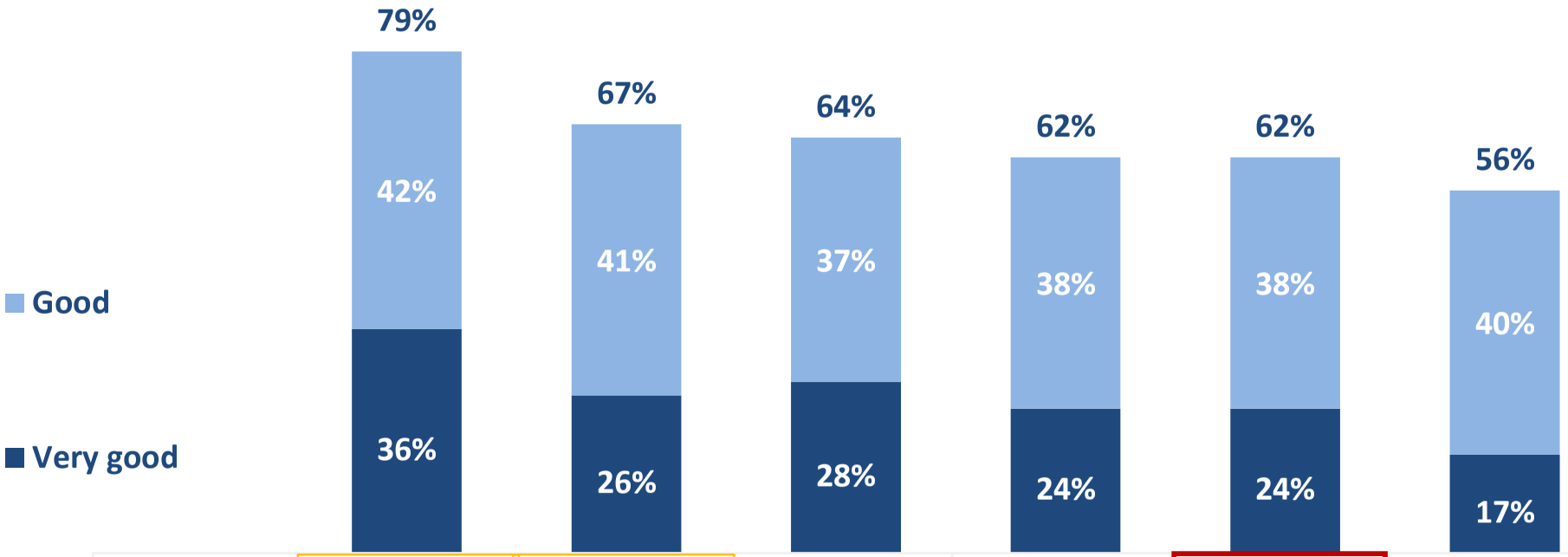


Q7. And, how would you rate the Claims Manager(s) and claims staff at L&I you worked with during the claims process? Q8. How would you rate the Claims Manager and claims staff in terms of…

Base: All respondents (n~600 per wave)

Claims Manager and Staff Drilldowns

Employers: October 2014



	Being helpful and friendly	Listening and understanding	Returning calls and messages	Letting you know actions to take	Resolving your question or concern	Suggesting options for RTW
Total Good	79%	67%	64%	62%	62%	56%
Average	15%	20%	21%	21%	18%	22%
Total Poor	7%	13%	15%	17%	20%	22%

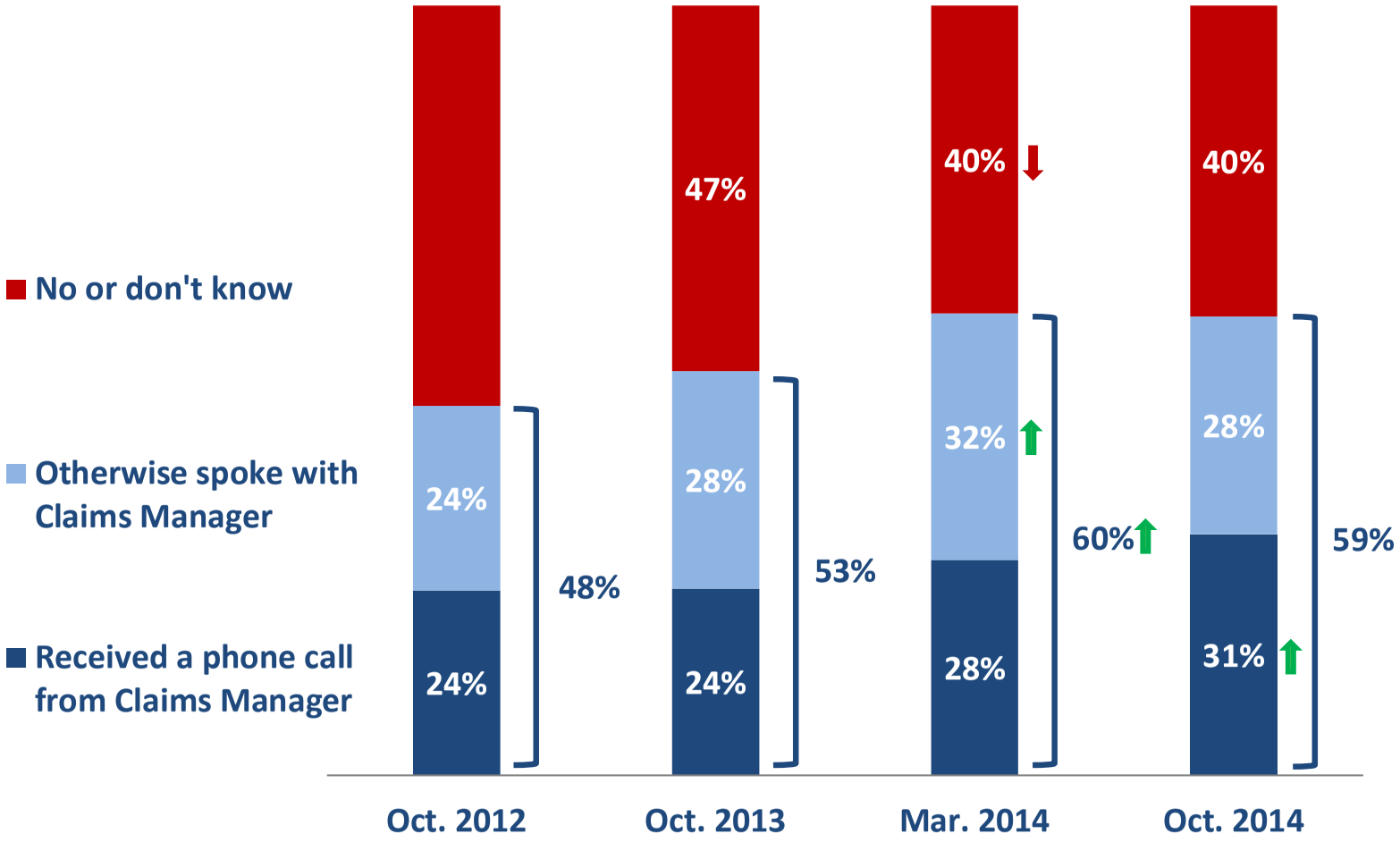
= Top Priority = Secondary Priority

Q8. How would you rate the Claims Manager and claims staff in terms of…

Base: All respondents (n~500 for each statement)

Contact with Claims Manager

Employers

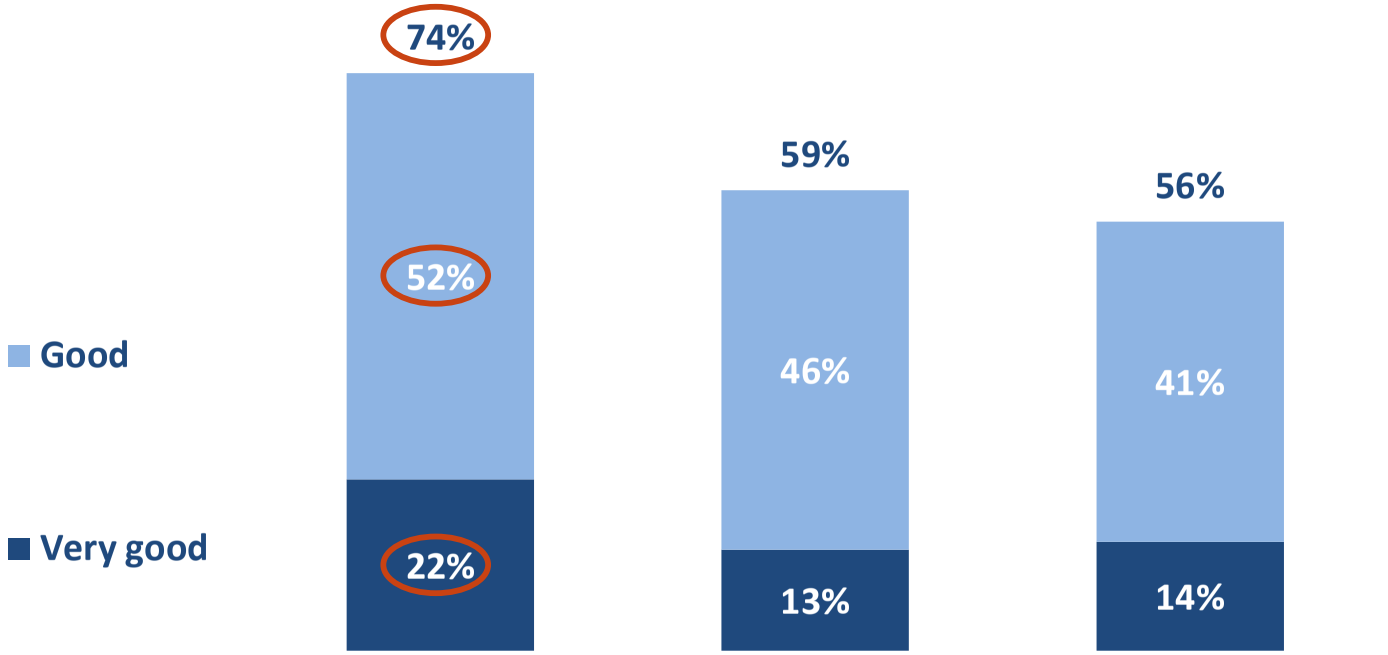


8b. Thinking now of the most recent claim, did you receive a call from the L&I Claims Manager early in the claims process? By this I mean a call that a Claims Manager initiated, not a response to you leaving a message or to you requesting a call. IF NO: 8c. Have you spoken directly with a Claims Manager, either in person or over the phone about this most recent claim?

Base: Employers who had a claim which started in the past year (n=417/524/542/471)

Impact of Contact with Claims Managers on Overall Experience

Employers: October 2014



	Received Call from CM	No Direct Contact	Otherwise Spoke with CM
Total Good	74%	59%	56%
Average	16%	28%	27%
Total Poor	10%	13%	17%
Number of Interviews	*(172)*	*(238)*	*(191)*

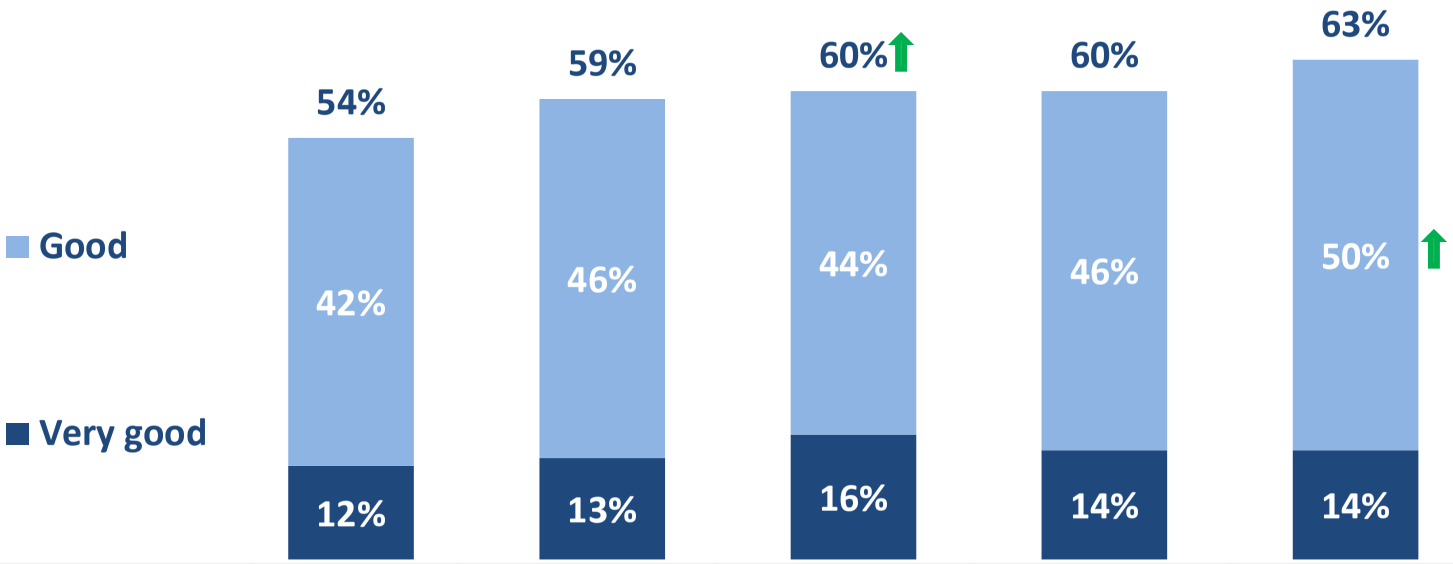
*Q1. First, I would like to ask you a few general questions about your interactions with L&I **over the past year**. We will be using the scale of Very Good, Good, Average, Poor and Very Poor. Taking everything into account, how would you rate the overall experience of working with L&I…*

Base: All respondents

Overall Claims Process

Experience with L&I's Overall Claims Process

Employers



	March 2012	October 2012	October 2013	March 2014	October 2014
Total Good	54%	59%	60%	60%	63%
Average	33%	28%	26%	29%	25%
Total Poor	13%	14%	14%	11%	12%

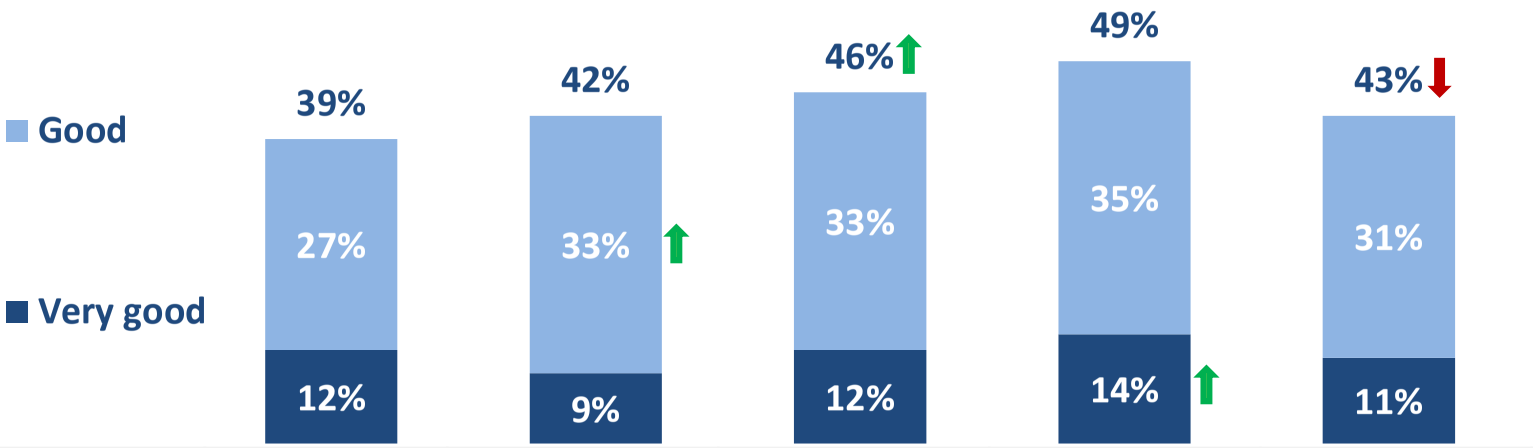
Q3. How would you rate the overall claims process including the forms you use to report an accident, the claims staff and the claim decisions?

Base: All respondents (n~600 per wave)

Claims Touchpoints: Claims Decisions

Overall Rating of L&I's Claims Decisions

Employers

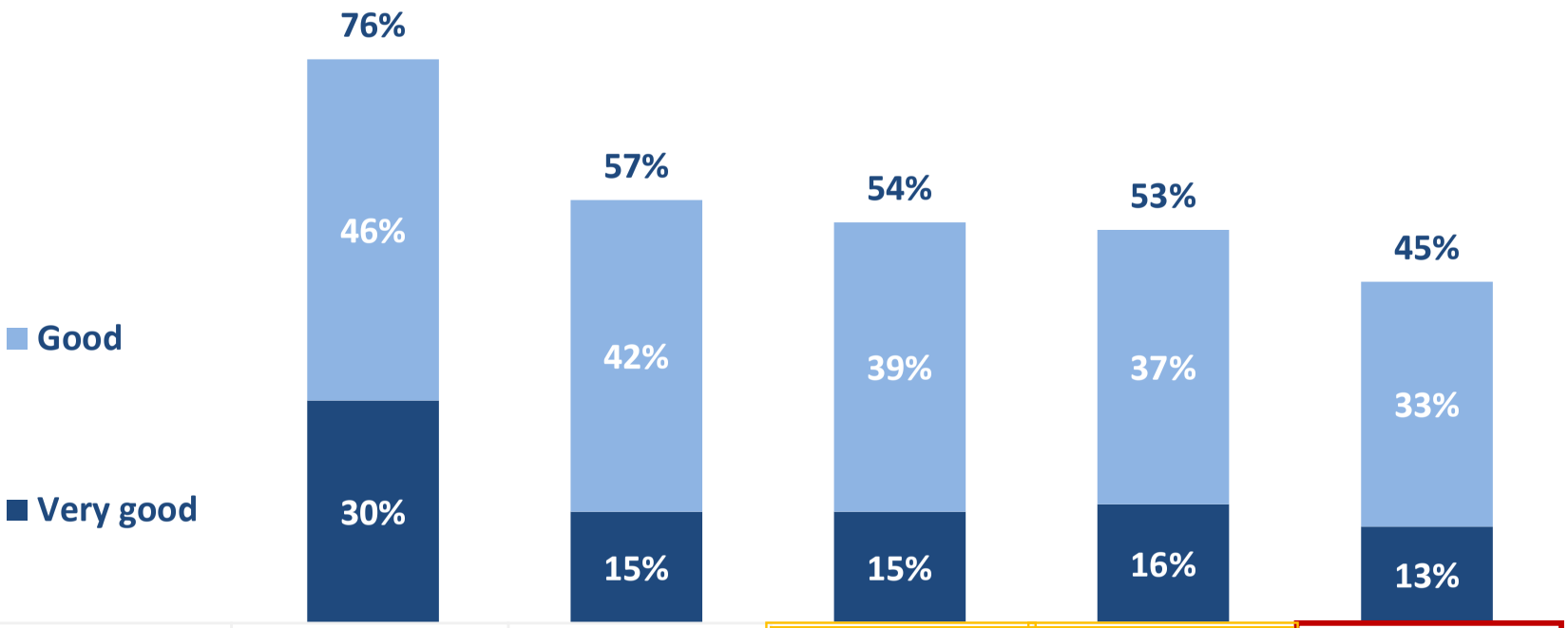


	March 2012	October 2012	October 2013	March 2014	October 2014
Total Good	39%	42%	46% ↑	49%	43%
Average	27%	31%	28%	24%	29%
Total Poor	34%	27% ↓	27%	28%	29%

Q12. Next, how would you rate L&I's claim decisions?
Base: All respondents (n~600 per wave)

Claims Decisions Drilldowns

Employers: October 2014



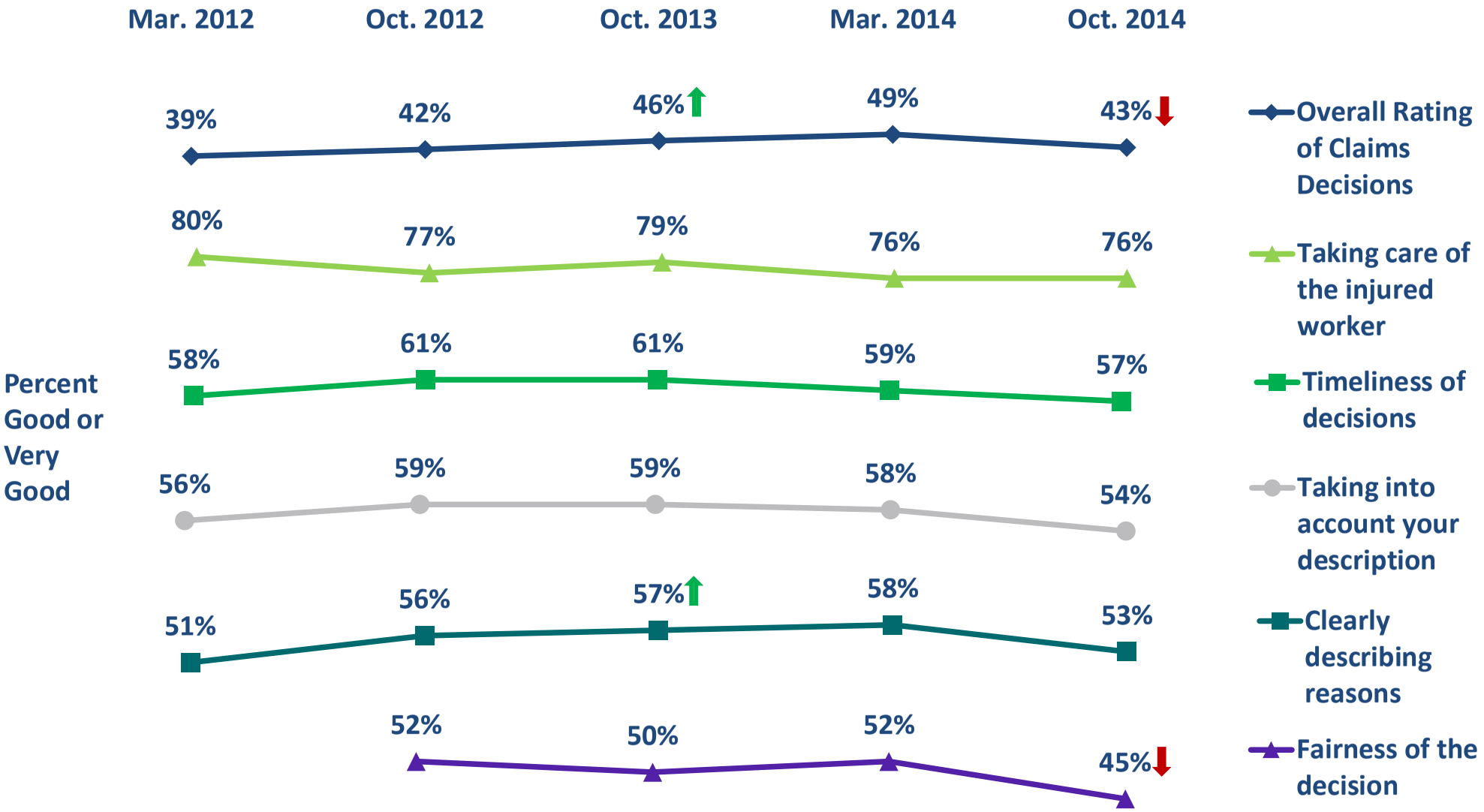
	Taking care of the injured worker's needs	Timeliness of decisions	Taking into account your description	Clearly describing reasons	Fairness of the decision
Total Good	76%	57%	54%	53%	45%
Average	14%	25%	23%	22%	27%
Total Poor	10%	18%	23%	25%	28%

= Top Priority = Secondary Priority

Q12. Next, how would you rate L&I's claim decisions?
Q13. And, how would you rate L&I's claim decisions in terms of [INSERT ITEM]
Base: All respondents (n=601)

Claims Decisions Drilldowns

Employers: Trend Line

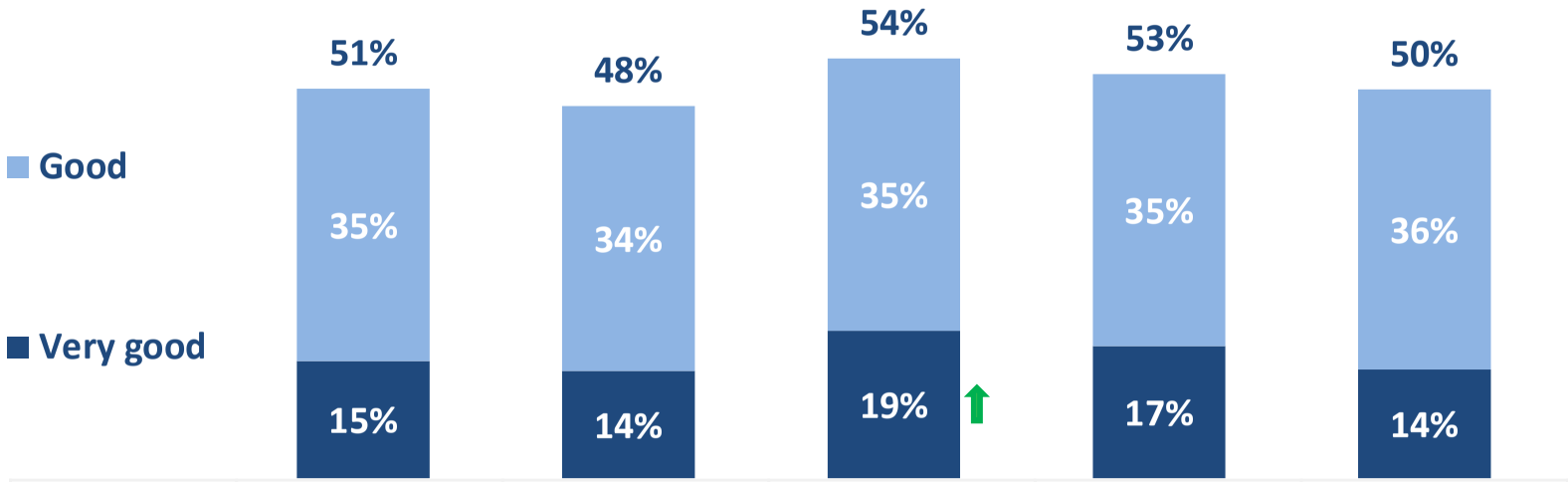


Q12. Next, how would you rate L&I's claim decisions?
Q13. And, how would you rate L&I's claim decisions in terms of [INSERT ITEM]
Base: All respondents (n~600 per wave)

Helping Injured Workers Return to Work

Overall Rating of Helping Injured Workers Return to Work

Employers

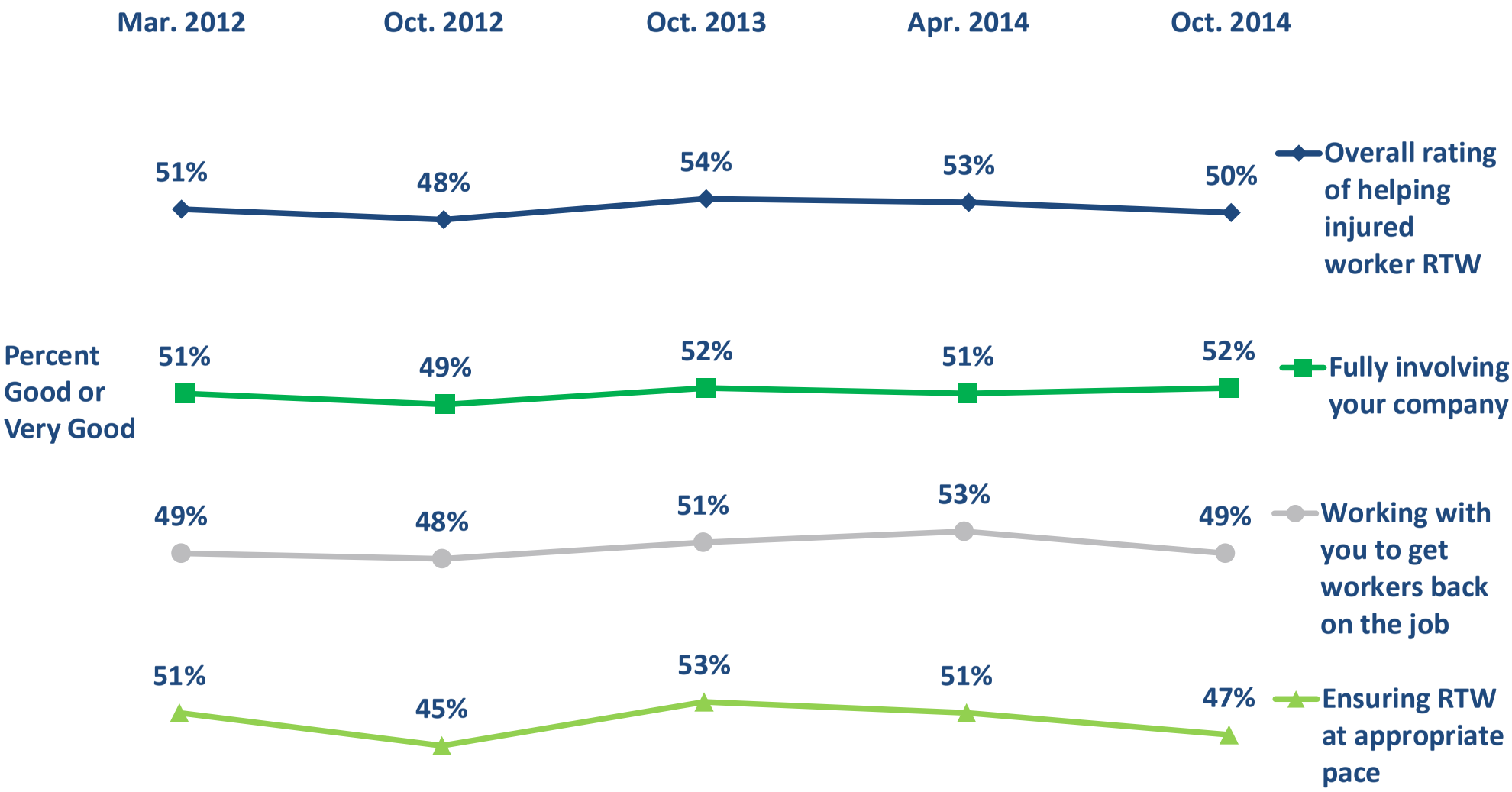


	March 2012	October 2012	October 2013	March 2014	October 2014
Total Good	51%	48%	54%	53%	50%
Average	22%	25%	20%	23%	26%
Total Poor	28%	27%	26%	25%	24%

Q14. Next, how would you rate L&I on helping your injured workers return to their job…
Base: All respondents (n~600 per wave)

Helping Injured Workers Return to Work Drilldowns

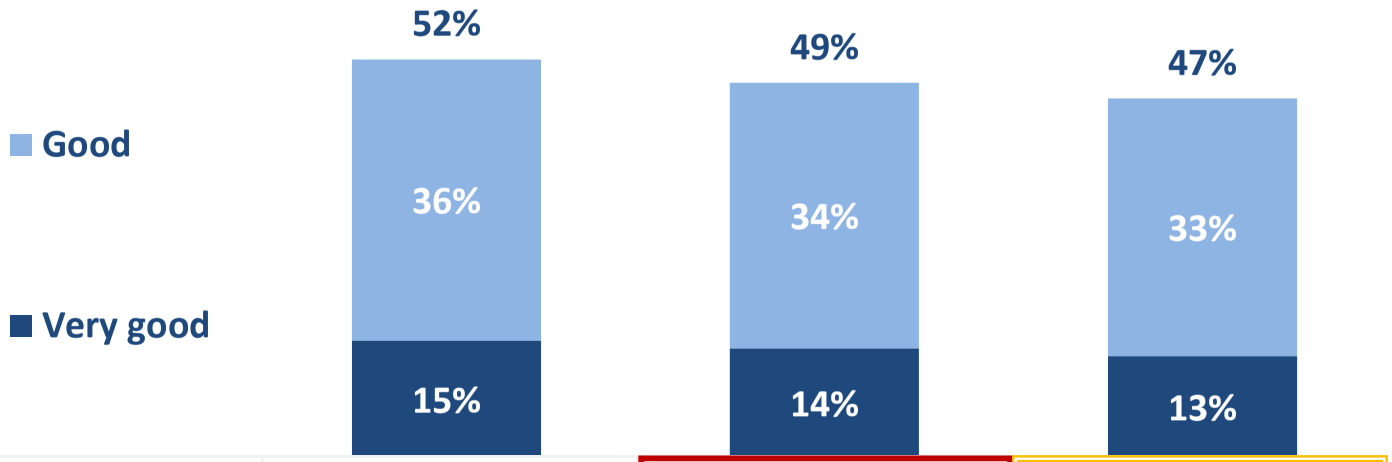
Employers: Trend Line



Q14. Next, how would you rate L&I on helping your injured workers return to their job…
Q16. How would you rate L&I in terms of [INSERT ITEM]?
Base: All respondents (n~600 per wave)

Helping Injured Workers Return to Work Drilldowns

Employers: October 2014



	Fully involving your company	Working with you to get workers back on the job	Ensuring RTW at appropriate pace
Total Good	52%	49%	47%
Average	23%	24%	26%
Total Poor	26%	28%	27%

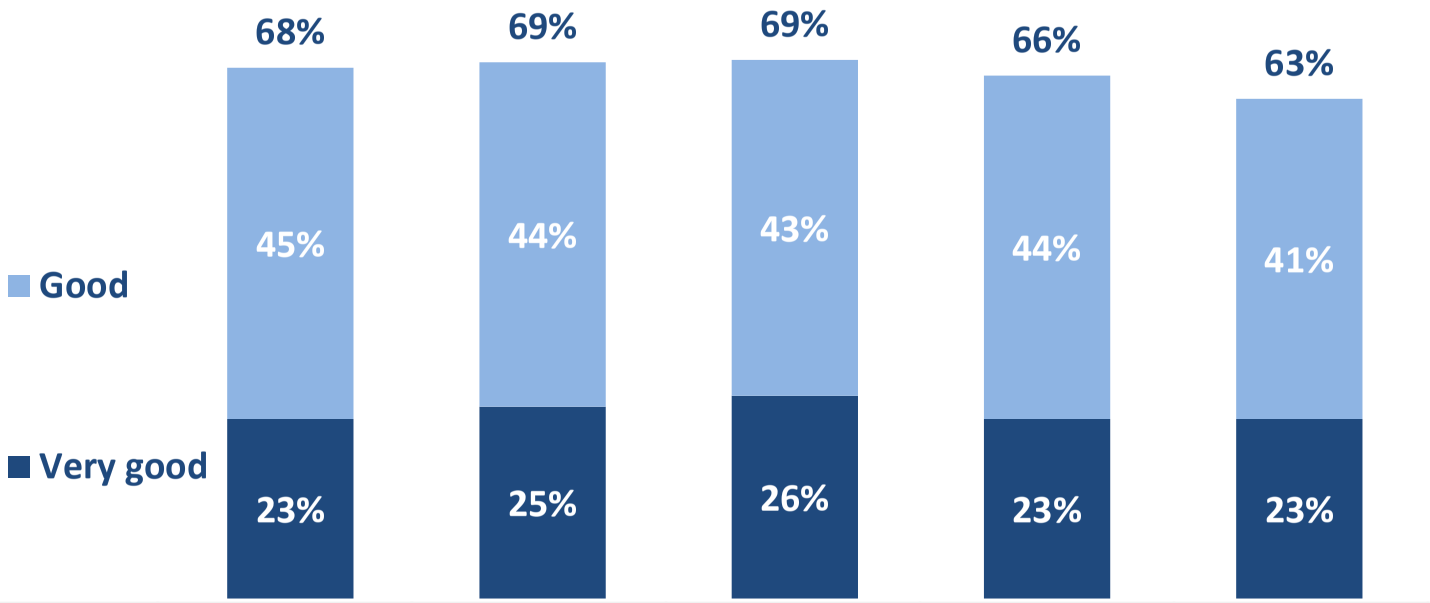
= Top Priority = Secondary Priority

Q16. How Would You Rate L&I In Terms Of…
Base All respondents

Non-Claims Communications

Overall Rating of Non-Claims Communication

Employers



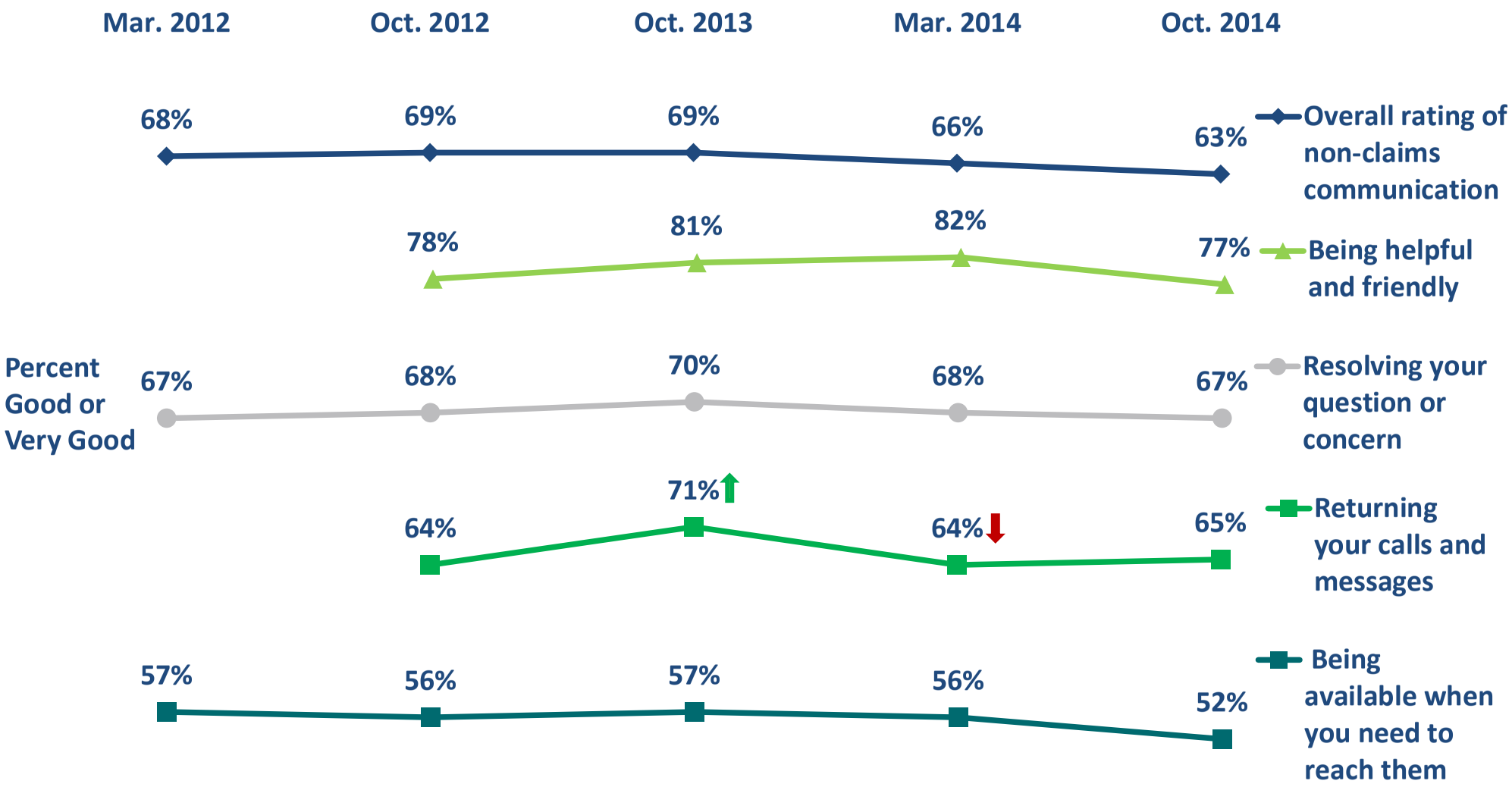
	March 2012	October 2012	October 2013	March 2014	October 2014
Total Good	68%	69%	69%	66%	63%
Average	26%	23%	24%	25%	28%
Total Poor	6%	8%	8%	8%	9%

Q19. Now I'd like to ask you about telephone calls and e-mail messages to L&I for reasons other than claims. How would you rate the overall service provided by L&I when responding to non-claim questions over the telephone or by e-mail. Would you say it is…

Base: Respondents involved in non-claims communication (n~400 per wave)

Non-Claims Communication Drilldowns

Employers: Trend Line

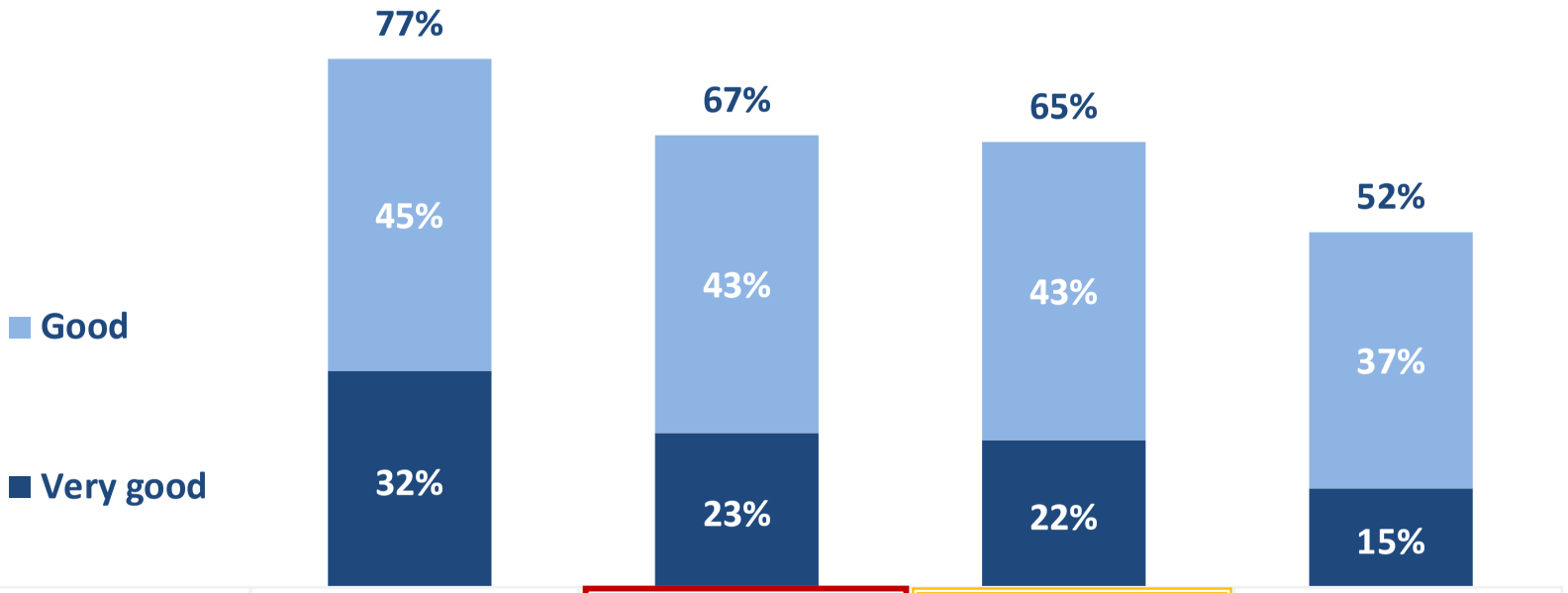


Q19. Now I'd like to ask you about telephone calls and e-mail messages to L&I for reasons other than claims. How would you rate the overall service provided by L&I when responding to non-claims questions over the telephone or by e-mail. Q20. And, how would you rate L&I when responding to non-claims question over the telephone or by email when it comes to [INSERT ITEM]

Base: Respondents involved in non-claims communication (n~400 per wave)

Non-Claims Communication Drilldowns

Employers: October 2014



	Being helpful and friendly	Resolving your question or concern	Returning your calls and messages	Being available when you need to reach them
Total Good	77%	67%	65%	52%
Average	18%	22%	22%	30%
Total Poor	5%	12%	13%	18%

= Top Priority = Secondary Priority

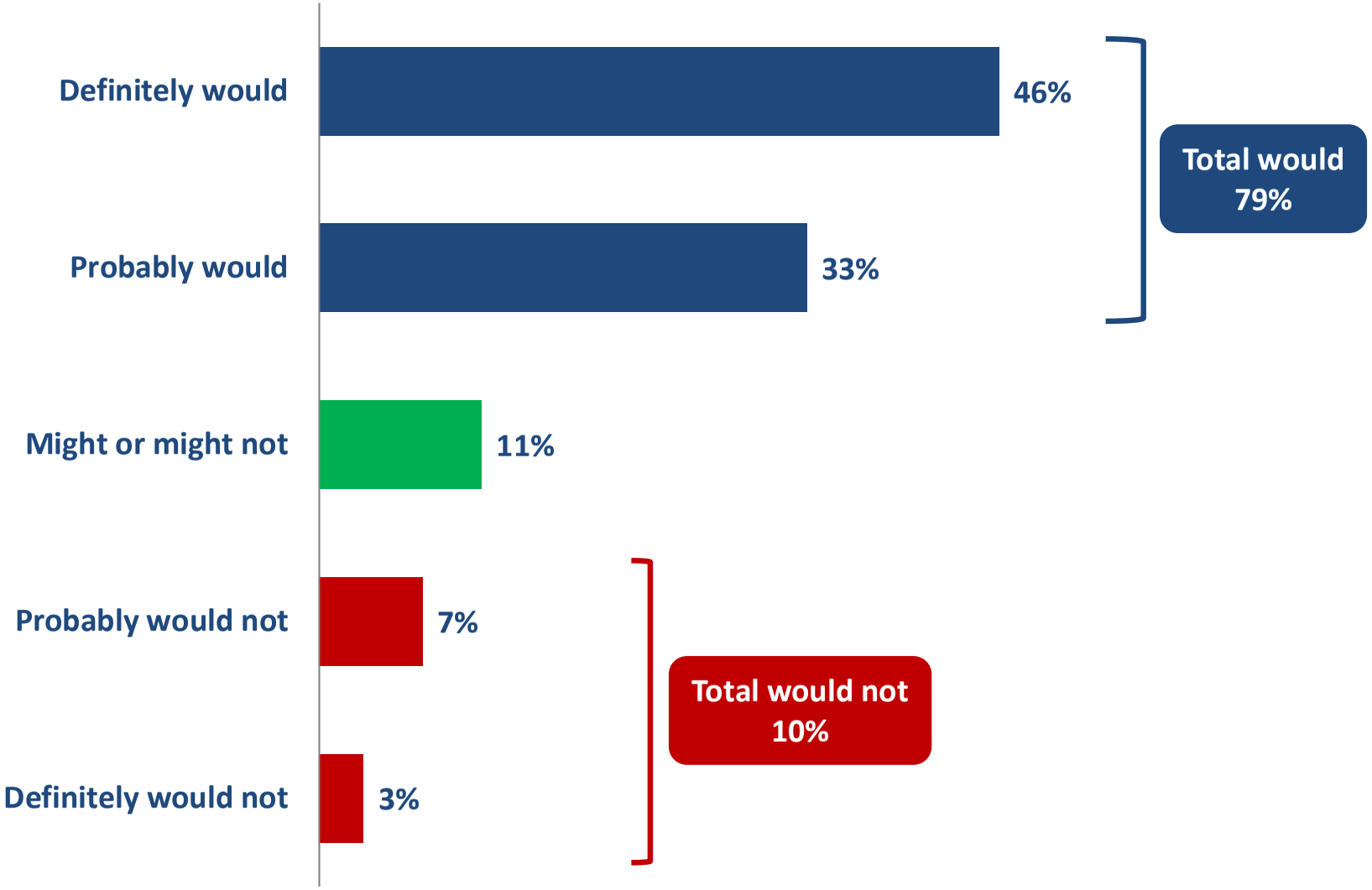
Q19. Now I'd like to ask you about telephone calls and e-mail messages to L&I for reasons other than claims. How would you rate the overall service provided by L&I when responding to non-claims questions over the telephone or by e-mail. Q20. And, how would you rate L&I when responding to non-claims question over the telephone or by email when it comes to [INSERT ITEM]

Base: Respondents involved in non-claims communication (n~400 per wave)

Communications Preferences

Whether Would Use Secure System for Documents and Email

Employers: October 2014

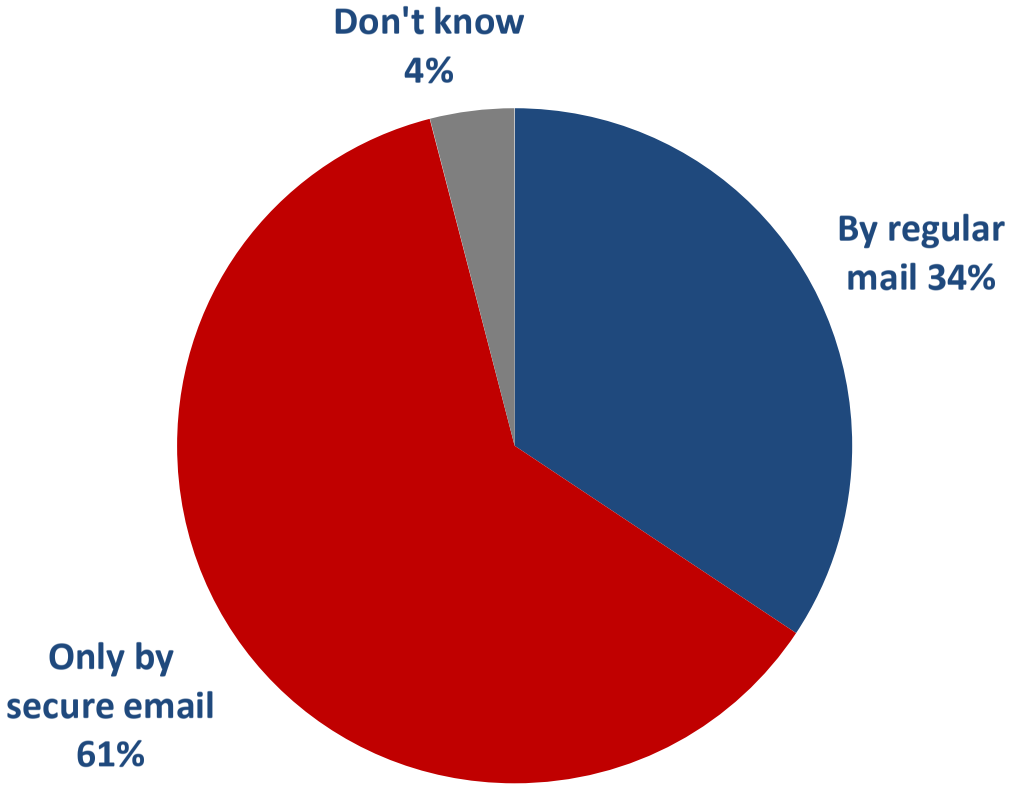


Q16e If L&I had a system that allowed you to receive documents and communicate with your claims manager using secure email, how likely would you be to sign up for, and use this system?

Base: All respondents (n-601)

Mode to Receive Documents if Using Secure System

Employers: October 2014



Q16f. If you were using this system, would you want to receive your written claims documents by ...
Base: Respondents who definitely would, probably would or might or might not sign up for system (n=538)

Employer Profiles

	Percent of Employers				
	March 2012 (600)	Oct. 2012 (603)	Oct. 2013 (679)	March 2014 (680)	Oct. 2014 (601)
Respondent's Role Within the Company*:					
Senior Management	n/a	23%	24%	26%	29%
Business Owner or Partner	n/a	45%	45%	44%	48%
Human Resources/ Risk Management	n/a	32%	31%	34%	31%
Workplace Safety	n/a	11%	11%	12%	15%
Other, None or Don't Know	n/a	4%	5%	4%	4%
* Multiple mentions. Note that answer categories were changed after the Baseline Wave.					
Number of Claims in Past Ten Years:					
One (includes 0)	30%	31%	31%	32%	34%
Two	14%	15%	16%	17%	16%
Three to Five	25%	23%	24%	23%	21%
Six to Ten	15%	15%	13%	13%	13%
Eleven to Fifty	12%	15%	15%	13%	14%
Over Fifty	2%	2%	2%	2%	2%

	Percent of Employers				
	March 2012 (600)	Oct. 2012 (603)	Oct. 2013 (679)	March 2014 (680)	Oct. 2014 (601)
Employer Size (FTEs):					
9 FTEs or Fewer	58%	55%	54%	55%	54%
10 to 50 FTEs	29%	30%	32%	31%	32%
51 to 249 FTEs	11%	12%	12%	12%	12%
250 FTEs or more	2%	2%	2%	2%	3%
Percent of Employers with Type of Claims:					
Occupational Disease	14%	15%	10%	13%	14%
Claims that Were Re-Opened	10%	10%	10%	9%	6%
Claims that Were Appealed	53%	54%	54%	47%	48%
Loss of Earning Power	4%	5%	6%	4%	6%
Kept on Salary	5%	5%	8%	8%	8%
Elective Coverage	1%	1%	2%	1%	2%
Ability to Work Assessments (AWAs)	61%	56%	50%	43%	48%
Voc Rehab Retraining	11%	13%	11%	9%	9%
Stay at Work Participant	-	2%	3%	3%	3%

	Percent of Employers			
	March and Oct. 2012 (1,203)	Oct. 2013 (679)	March 2014 (680)	Oct. 2014 (601)
Risk Class*:				
Agriculture	4%	6%	5%	6%
Forest Products	3%	3%	2%	3%
Miscellaneous Construction and Mining	4%	4%	5%	5%
Building Construction and Trades	18%	20%	15%	18%
Food Processing and Manufacturing	1%	1%	2%	2%
Metal and Machinery Manufacturing	5%	5%	4%	4%
Miscellaneous Manufacturing	2%	3%	2%	2%
Utilities and Communications	1%	-	1%	1%
Transportation and Warehousing	8%	7%	8%	7%
Dealers and Wholesalers	4%	2%	5%	4%
Stores	6%	6%	5%	6%
Temporary Help	1%	1%	1%	1%
Miscellaneous Services	20%	20%	24%	23%
Health Care	4%	6%	4%	4%
Misc. Professional and Clerical	11%	9%	11%	9%
Government and Schools	6%	6%	6%	5%

* Note: Risk Class is identified by the risk class in which the employer reported the greatest number of hours during the past six months.