

Workers' Compensation Advisory Committee (WCAC) Meeting
Labor and Industries, Tumwater, WA
Meeting Minutes
June 21, 2012

Business Representatives: Rick Anderson, Washington Farm Bureau - Sakuma Brothers; Rebecca Forrester, Group Health; Nancy Dicus, Vigilant; and Kris Tefft, Association of Washington Business

Labor Representatives: Rebecca Johnson, Washington State Labor Council; Cody Arledge, Washington State Building and Construction Trades Council; and Karen Gude, United Food and Commercial Workers 1439

Labor and Industries: Judy Schurke, Director; Beth Dupre, Assistant Director for Insurance Services (Chair); and Vickie Kennedy, Chief Policy Advisor

Board of Industrial Insurance Appeals: Dave Threedy

Recorder: Sharon Avery

Court Reporter: Milton Vance

Guests: Tammie Hetrick, Greg Kabacy, Dave Kaplan, Tom Kwieciak, Scott Dilley, Viona Latschaw, Paulette Avalos, Jerry Bonagofsky, Stephanie Hoffman, Todd Gendrau, Veronica Shakotko, Larry Stevens, Jan Gee, Donna Egeland, Kim Hoff, and Brian Bishop

L&I Staff: Mike Ratko, Rachel Aarts, Sharon Elias, Bill Smith, Dustin Dailey, Leah Hole-Curry, Janet Peterson, Kirsta Glenn, Rena Shawver, Debra Tollefson, Megan Soria, Rob Cotton, and Tim Smolen

Opening Comments and Safety Message

The meeting began with introductions of the committee members and audience. Director Schurke announced Sofia Aragon, Washington State Nurses Association, as a new labor member to the committee. Ms. Aragon will join the committee at the next meeting.

The minutes from the April 9, 2012 quarterly meeting were approved.

Follow-up on previous assignments from April 9, 2012:

Assigned To:	Follow Up Request	Action
Vickie Kennedy	<u>Pay During Appeal:</u> The department is analyzing claims and data to determine whether the self-insured overpayment reimbursement fund, established as part of the 2007 legislation requiring the payment of benefits during an appeal, will likely be used and when. The data will be used as part of a report to the legislature along with the WCAC's	The department will provide the information to the WCAC at a future meeting.

	<p>recommendations for the fund.</p> <p>A question was asked about whether the department had seen any appeals related to the Second Injury Fund experience rating.</p>	<p>Legal Services and the Self-Insurance Programs reviewed their records and were not able to identify any appeals on that issue.</p>
Vickie Kennedy and Kirsta Glenn	<p><u>Second Injury Fund</u>: RDS is analyzing any impacts the experience rating of the Second Injury Fund for self-insured employers may have had on pension trends or worker outcomes.</p>	<p>RDS has gathered the data and is working with other department managers including Natalee Fillinger, Self-Insurance Program Manager, to draft a report to submit to the committee and the legislature.</p>
Sharon Avery	<p>A request was made for the list of stakeholder contacts provided to Upjohn for the Occupational Disease Study.</p>	<p>Completed</p>
Janet Peterson	<p>A follow up meeting to be scheduled to discuss the WCAC Health Care subcommittee's next steps and direction.</p> <p>A request was made for a diagram to provide a visual of all health care committees and how they interact. (WCAC, WCAC-HC, COHE, Provider Network Advisory Group)</p>	<p>A meeting has been scheduled for July 20, 2012 following the Special WCAC meeting in Tukwila.</p> <p>The diagram was forwarded to committee members.</p>

Ms. Dupre presented a safety video from the Safety and Health Assessment & Research for Prevention (SHARP) program from www.keeptruckingsafe.org.

Board of Industrial Insurance Appeals (BIIA) Update: Dave Threedy

The presentation was reviewed. These are projected numbers of where the BIIA expects to be at the end of the month.

- *Total Appeals Filed and Granted*: Projected for June 2012, there will be 3,754 total appeals filed and 2,023 appeals granted in the quarter.
- *Department Reassumption Rate by Quarter*: The reassumption rate is projected to be about 28.3 percent.
- *Average Proposed Decision and Order (PD&O) Time-Lag by Quarter for Hearing Judges*: The goal is 30 days for hearing judges to issue their Proposed Decision and Orders. For June, it is projected at 33 days; this is staying fairly constant.
- *D&O Time-Lag by Quarter*: This is the time it takes for the review judges to draft a Decision and Order and for the three BIIA members to review, make changes, and sign off. It is projected at 38 days for judges and 19 days for BIIA members—both of these are decreasing.
- *Quarterly Average Weeks to Completion*: The BIIA's goal is to keep this around 34 weeks. The average weeks to completion is projected at 31.8 weeks.
- *Structured Settlements*: Mr. Threedy provided updated information not noted on the presentation slide. Twenty-two claim resolution structured settlement agreements were filed (five were re-files of rejected agreements). Eleven of these were rejected, 10 approved and one is pending.

A question was asked to clarify the settlement process for unrepresented workers; are the conferences held with mediation judges? Mr. Threedy answered there are mediation review judges as well as hearing judges doing the conferences. The judges are working from the Seattle and Olympia offices.

Questions were asked if there are any trends with the increase in appeals filed and if there are any trends on why the BIIA is rejecting the structured settlement agreements. Mr. Threedy advised there are no trends at this point. However, most the agreements that were rejected were because they clearly did not meet the statutory requirements. For example, the periodic payment plan that is required in the statute either was not present or did not conform to the limitations.

The BIIA is interviewing for additional Industrial Insurance Appeals Judge positions—two positions will become vacant due to retirements and one is currently vacant. Two of these judges will be for hearings and one may be a mediation judge.

The BIIA's Seattle office will move to a new location on Second Avenue in the Bay Vista building by early October.

Financial Update: Sharon Elias

Ms. Dupre presented Sharon Elias with a Certificate of Achievement for Excellence in Financial Reporting. This is the highest form of recognition in the area of governmental accounting and financial reporting and is given out by the Government Finance Officers Association of the United States and Canada. Ms. Dupre acknowledged Ms. Elias and her team for an exceptional job.

Sharon Elias, Chief Accounting Officer, presented a financial update.

Insurance Operation Highlights

- Premiums earned have increased as a result of an increase in hours reported, an increase in the number of accounts, and changes in the premium rate.
- Retrospective Rating Adjustments liability increased largely due to the observed changes in the relative performance between retro-participating and non-participating policies.
- Benefit liabilities increased due to discount accretion, development on prior accident year liabilities, and the change in discount rate.

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Insurance Operation Highlights cont.

- The Stay at Work program that was implemented as a result of HB2123 began issuing reimbursements in January 2012. Through the period ending March 31, 2012, the total paid to employers was \$1.4 million.
- The Benefit (Loss) Ratio increased during the second and third quarters of the fiscal year as a result of changes in the benefit liability.

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Ms. Elias reviewed the **Insurance Operations Highlights** on slides 14 and 15.

Results of Insurance Operation (in thousands)

	Cumulative from 7/1/2011 to 3/31/2012	Fiscal Year Ending 6/30/2011	Fiscal Year Ending 6/30/2010	Fiscal Year Ending 6/30/2009
Insurance Operation				
A Premiums earned	1,073,383	1,429,530	1,250,433	1,360,533
Deductions				
B Benefits (losses) incurred	1,499,112	1,601,225	2,135,874	2,348,838
C Claim administrative expenses incurred (LAE)	142,389	159,641	152,309	185,980
D All other insurance expenses	51,439	84,379	71,375	132,490
E Total Insurance expenses	1,692,940	1,845,245	2,359,558	2,667,308
F Net insurance operation gains (losses)	(619,557)	(415,715)	(1,109,125)	(1,306,775)
G Benefit (Loss) Ratio (B/A)	139.7%	112.0%	170.8%	172.6%
H Claim Administration Liability (LAE) Ratio	13.3%	11.2%	12.2%	13.7%
I Other insurance expense Ratio (D/A)	4.8%	5.9%	5.7%	9.7%
J Combined Ratio (G+H+I)	157.7%	129.1%	188.7%	196.0%
K Net insurance operation gain (loss) Ratio	-57.7%	-29.1%	-88.7%	-96.0%

*Does not include self insurance or non-insurance expenses.



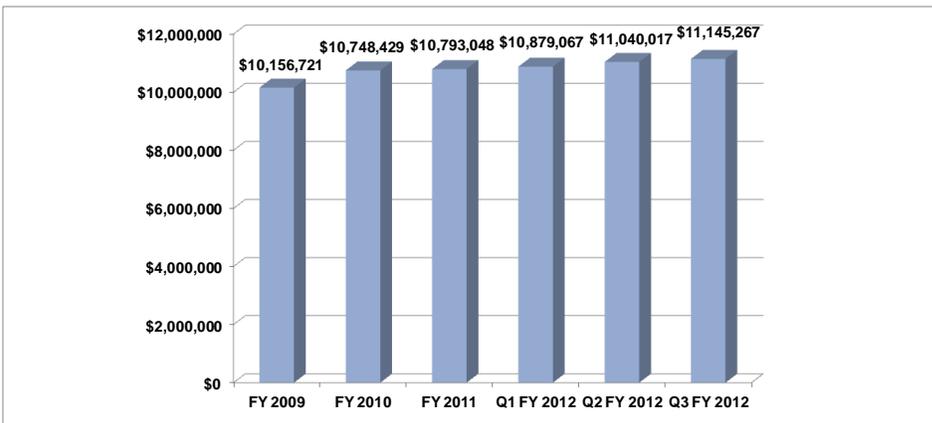
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Slide 16 compares the cumulative results of the insurance operation for three quarters, 7/1/2011-3/31/2012, to past fiscal years.

- **Premium Earned: \$1.073 billion**
 - o There are three different components in premiums earned. The first is standard premium that is received and collected; another is premiums receivable; and the last is changes in retrospective liabilities.
 - o The number of reported hours and accounts has increased compared to previous years. The major driver of changes in premiums earned in a quarter is the change in covered hours.
- **Benefits Incurred: \$1.4 billion**
- **Claims Administrative Expenses Incurred: \$142 million**
- **All Other Insurance Expenses: \$51 million** (this includes managing policies and BIIA expenditures, but does not include self-insurance payments to the department or non-insurance expenditures).
- **Benefit (Loss) Ratio:** This is the biggest portion of our financial insurance operation. The benefit loss ratio is at 139.7 percent. This means for every dollar we collect, we are spending a dollar and thirty-nine cents for benefits.
 - o There are two components of benefits loss; one is benefits paid and the other is changes in the benefit liability. Benefits paid increased less than 1 percent compared to the same period in the prior fiscal year. The overall change in benefit liability is 3.3 percent compared to June 30, 2011. This is also 23 percent of benefits incurred, so any change in benefit liability makes a significant difference.
 - o Compared to the same period in the prior year (7/1-3/31):
 - o Accident account benefits paid \$470.2 million, decreased by \$0.5 million
 - o Medical Aid account benefits paid \$408.7 million, decreased by \$10 million. This reflects continued cost containment efforts.

- Pension Reserve account benefits paid \$268 million, increased by \$12.5 million as a result of new pensions; in addition, new pension benefit amounts are higher than those for existing pensions.
- *Claim Administration Liability (LAE) Ratio*: This has remained constant throughout the years and is at 13.3 percent.
- *Other Insurance Expense Ratio*: This is lower than in the past and is at 4.8 percent.
- *Combined Ratio*: The overall combined ratio is 157.7 percent. This means for every dollar we collect, we are spending a dollar and fifty-seven cents. We rely heavily on investment income to offset our expenditures.

Benefit Liabilities (in thousands)



Benefit Liabilities:

The overall change in benefit liabilities is 3.3 percent.

This is an increase of \$352 million as of June 30, 2011 to \$11.14 billion.

Fiscal Year to Date Change in Benefit Liabilities As of March 31, 2012

(in thousands)

	Accident Account	Medical Aid Account	Pension Reserve Account	Totals
Benefit Liability as of June 30, 2011	\$ 4,139,876	\$ 3,265,484	\$ 3,387,688	\$ 10,793,048
New Benefits incurred since June 30, 2011	575,969	482,386	4,608	1,062,963
Development on prior liabilities as of March 31, 2012:				
Discount accretion	72,010	58,197	157,155	287,362
Other development on prior liabilities	(3,731)	43,489	247	40,005
Change in discount rate	73,300	2,827	-	76,127
Claim payments	(470,176)	(408,725)	(267,991)	(1,146,892)
Establishing state fund pension awards	(149,784)	-	149,784	-
Establishing SI 2nd Injury pension awards	-	-	32,654	32,654
Change in Benefit Liability	97,588	178,174	76,457	352,219
Benefit Liability as of March 31, 2012	\$ 4,237,464	\$ 3,443,658	\$ 3,464,145	\$ 11,145,267



The chart above explains the changes in benefit liabilities:

- The Accident account benefit liability increased \$97.5 million.
- The Medical Aid account increased \$178.1 million.
- The Pension Reserve account increased \$76.4 million.
- \$352 million reflects the total changes in benefit liability as a result of discount accretion, prior liability changes and changes in the discount rate.

Ms. Elias noted that in December she reported that the non-pension discount rate was changed from 2.5 to 2 percent.

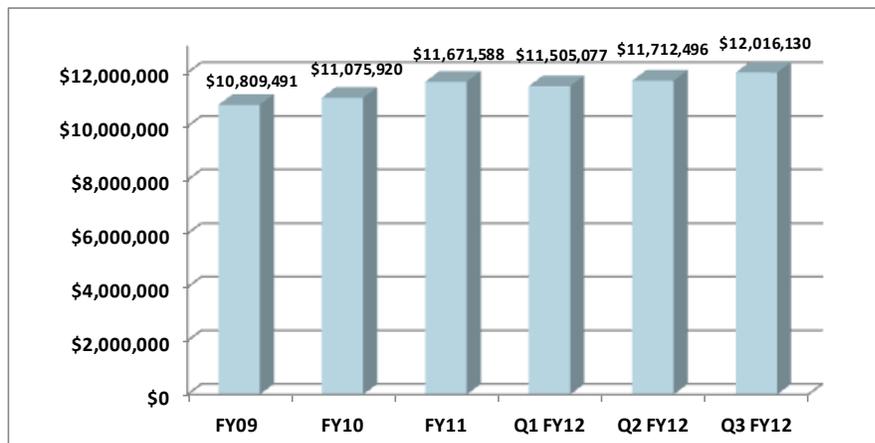
Investment Highlights

- Overall, investments have increased \$344.5 million as compared to June 30, 2011 as a result of favorable market conditions.
- The most significant increase was \$275.1 million in fixed income.
- Unrealized gains are significantly lower than where they had been at March 31, 2011.

Ms. Elias reviewed the **Investment Highlights** on slide 23.

Total Investments

(in thousands)



Securities Lending Collateral not included

Total Investments:

The change was from \$11,712,496 million to \$12,016,130 million, a \$345 million increase.

Investment Income equals income coming from interest payments, dividends, and capital gains collected upon the sale of investments (dollars in thousands)

	Cumulative from 7/1/2011 to 3/31/2012	Fiscal Year Ending 6/30/2011	Fiscal Year Ending 6/30/2010	Fiscal Year Ending 6/30/2009
Investment Income				
L Net investment income earned	365,618	491,654	486,996	517,863
M Net realized capital gains	28,584	68,768	17,725	(41,466)
N Net investment gain (loss)	394,202	560,422	504,721	476,397
O Investment Income Ratio (N/A)	36.9%	39.2%	40.4%	35.0%

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Slide 25 explains investment income and investment income ratio. We have an investment ratio of 36.9 percent for the current year to date, similar to years past.

Investment Yield equals the annual rate of return on investments expressed as a percentage (dollars in thousands)

	July 1, 2011 through March 31, 2012	Fiscal Year Ended June 30, 2011	Fiscal Year Ended June 30, 2010	Fiscal Year Ended June 30, 2009	Fiscal Year Ended June 30, 2008	Fiscal Year Ended June 30, 2007	Fiscal Year Ended June 30, 2006
Investment Income	365,618	491,654	486,996	517,863	537,559	529,987	499,810
Net Realized Gain (Loss)							
Fixed Income	29,942	45,634	17,643	(34,280)	143,541	110,742	28,530
Equity	(1,358)	23,134	82	(7,186)	203,603	108,336	46,043
Total Realized Gain (loss)	28,584	68,768	17,725	(41,466)	347,144	219,078	74,573
Unrealized Gain (Loss)							
Equities	15,716	370,867	149,875	(350,312)	(473,712)	252,129	149,153
TIPS	12,510	46,077	29,192	(11,337)	44,947	20,267	
Total Unrealized Gain (Loss)	28,226	416,944	179,067	(361,649)	(428,765)	272,396	149,153
Total Invested Assets	12,016,130	11,671,588	11,075,920	10,809,491	11,003,478	10,989,850	10,087,317
Investment Yields							
Investment Income/Average Invested Assets	3.1%	4.3%	4.5%	4.7%	4.9%	5.0%	
Realized Gain (Loss)/Average Invested Assets	0.2%	0.6%	0.2%	-0.4%	3.2%	2.1%	
Unrealized gain (Loss)/Total Invested Assets	0.2%	3.7%	1.6%	-3.3%	-3.9%	2.6%	
Total	3.6%	8.6%	6.2%	1.1%	4.1%	9.7%	

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Slide 26 explains the investment yield. The investment yield equals the annual rate of return on investment. Unrealized gain and equities and TIPS are significant to our investment yields. Equity investments are highly susceptible to change due to market conditions, and therefore can be unpredictable.

Net Income (loss) equals what remains after subtracting all the costs from revenues
(dollars in thousands)

	Cumulative from 7/1/11 to 3/31/2012	Fiscal Year Ending 6/30/2011	Fiscal Year Ending 6/30/2010	Fiscal Year Ending 6/30/2009
F Net insurance operation gains (losses)	(619,557)	(415,715)	(1,109,125)	(1,306,775)
N Net investment gain (loss)	394,202	560,422	504,721	476,397
Other Income				
P Fines, penalties, and interest	35,757	52,626	43,040	54,614
Q Self insurance and non-insurance revenue over expenditures	15,763	10,970	21,121	26,633
Total other income	51,520	63,596	64,161	81,247
R Net income	(173,835)	208,303	(540,243)	(749,131)
S Operating Ratio (J - O)	121.0%	89.9%	148.3%	161.0%

Slide 27 explains the net income (loss) is what remains after subtracting all the costs from revenues. Other income includes fines, penalties, and interest charged. The second component is self-insurance contributions and non-insurance revenue over expenditures.

Overall the operating ratio is 121 percent.

Contingency Reserve Highlights

The following impacted contingency reserve unfavorably, which resulted in an overall decrease of \$157.8 million:

- Although investments improved in the 3rd quarter, the overall year-to-date returns were less than expected.
- Adverse development in prior accident year liabilities and change in discount rate.
- Current fiscal year operating loss.

Ms. Elias reviewed the **Contingency Reserve Highlights** on slide 28.

Change in Contingency Reserve (dollars in millions)

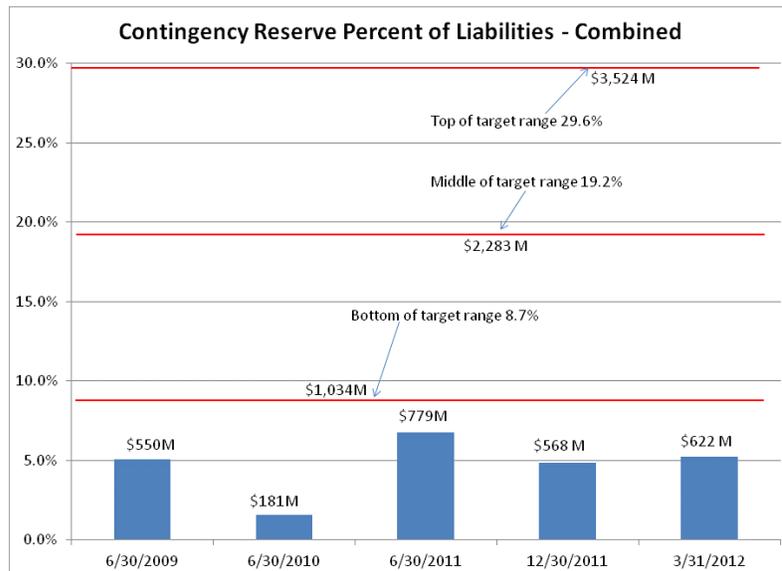
Contingency Reserve, July 1, 2011	\$ 779.4
<u>Unexpected Investment Results</u>	
Equities: Unrealized Gains (Losses)	15.7
TIPS: Unrealized Gains	12.5
Equities: Realized Gains (Losses)	(1.4)
Fixed Income: Realized Gains	29.9
Sub-total Gains (Losses)	<u>56.7</u>
Less Expected Gains	<u>(79.7)</u>
Sub-total	(23.0)
Insurance Operations Results	
Prior Year Loss Unfavorable	(40.0)
Change in Discount Rate	(76.1)
Current Fiscal Year Income (Loss)	<u>(18.7)</u>
Sub-total	(134.8)
Change to Contingency Reserve	(157.8)
Contingency Reserve, March 31, 2012	<u>\$ 621.6</u>

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Change in Contingency Reserve:

- As of July 1, 2011, the contingency reserve balance was \$779.4 million.
- Unexpected Investment Results: The investment loss in unrealized and realized gains was \$23 million.
- Insurance Operations Results: Results were unfavorable by \$134.8 million.
- The contingency reserve decreased by \$157.8 million to \$621.6 million.



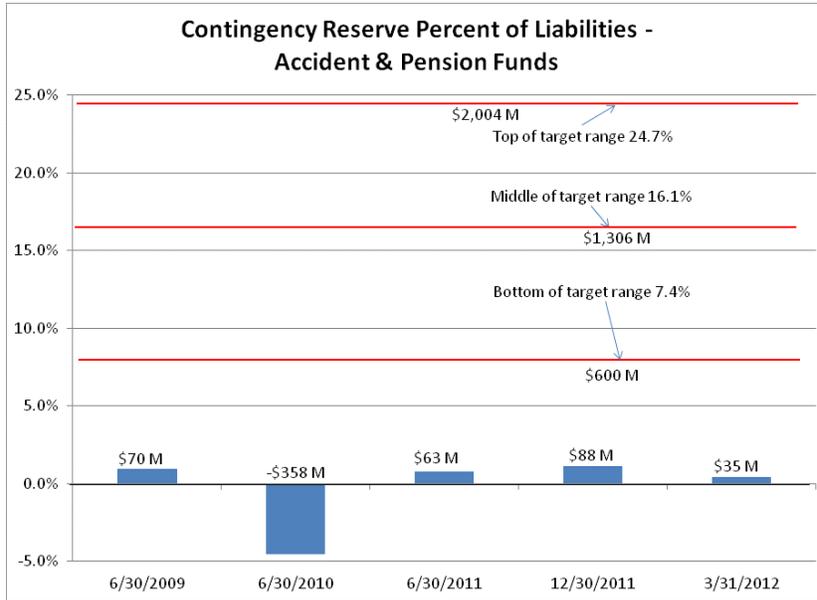
* Securities Lending Collateral not included in liabilities

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This chart explains the combined contingency reserve balance in relation to the draft contingency reserve policy.

Currently the contingency reserve is at \$622 million, below the bottom of the target range.

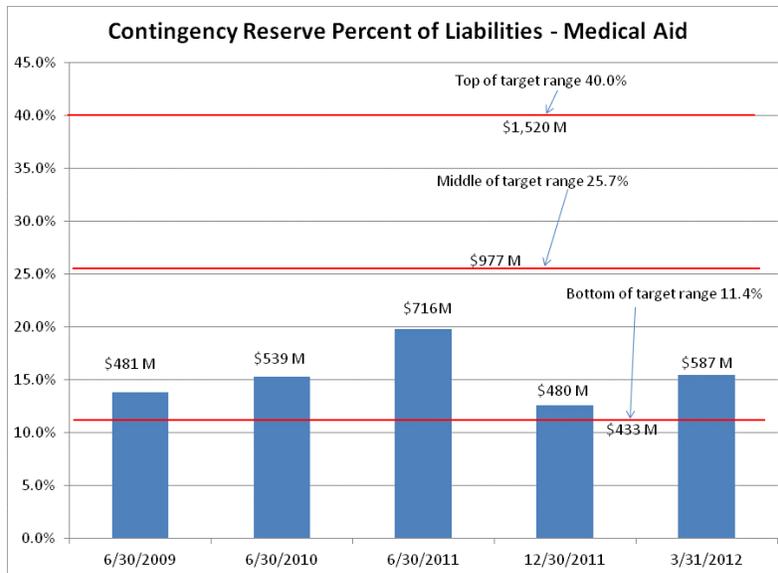


* Securities Lending Collateral not included in liabilities



The contingency reserve for the Accident and Pension Funds was \$35 million, below the bottom of the target range.

The Accident Fund had a positive reserve balance of \$57 million, but the Pension Reserve had a negative contingency reserve balance of \$22.5 million.



* Securities Lending Collateral not included in liabilities



The contingency reserve for the Medical Aid Fund is at \$587 million, above the lower target.

Reform Updates: Status and Performance

Washington Stay at Work: Bill Smith

Bill Smith, Stay at Work Program Manager, presented an update on the Washington Stay at Work (WSAW) program. As a reminder, the WSAW program provides a financial incentive for employers to bring their injured workers quickly and safely back to light duty or transitional work. Eligible employers can be reimbursed for 50 percent of the base wages paid to injured workers and other costs such as clothing, tools or additional training.

Mr. Smith provided updated statistics and highlights.

- There are 1,539 claims that have participated in the program so far.
- As of June 20, 2012 \$3.3 million in reimbursements have been reinvested in keeping workers on the job.
- There are currently 568 employers participating in the program. The top three industries that have received payments at this point are health care, construction and manufacturing.
- As of the end of May 2012, the injured workers demographics are:
 - Male: 707
 - Female: 514
 - Average age for both genders is 41 years old
 - Sprains, strains, tears and fractures top the list of injuries
 - According to medical disability resources, a back strain injury is 35 percent likely to recover within a month, 85 percent within three months, and 95 percent within six months. With 66 work days of available reimbursement for a worker to be on the job, or three months of productivity, 85 percent of workers should be able to return to work.
- We are at 40,000 days of light duty reimbursements (not on time-loss).
- The average number of days per claim that is received is 29 days.

Operational Program Measures:

- The program is averaging 334 claims reimbursements processed each month.
- 98 percent of all applications are processed accurately.
- The program is currently not able to meet its goal to process applications within four to seven days from receipt. The current average is fifteen days. To improve the timeliness, the program has implemented overtime and has additional assistance from five adjudicators (the program has three adjudicators).

Looking ahead:

- There is online training available for employers on the web site that walks them through the application process.
- The program is working on an on-line application form to be available in November that will allow employers to fill out requests on-line.
- The program continues with outreach and target marketing efforts by working with the department's communications office and meeting with employers to present them with the information about the program.

A comment was made that members of a Retro program had delivery people, from the grocery industry, that are paid base plus commission. The claims have been rejected because the program does not cover commission. This may be a problem for many industries that might want to modify the law because base wage plus commission is fairly common. Mr. Smith advised that the law is currently written as the base wage excluding commission, but will look into the concern.

It was asked that Mr. Smith talk about the program's targets for reimbursements every quarter. Mr. Smith advised that the program's goal is to process 1,000 applications per quarter, and this target is being met with outreach efforts. The outreach program is targeting work with the top 100 claims/premium companies and with Retro groups as well as farm groups in Eastern Washington.

A question was asked how much premium has or will be collected. Ms. Kennedy confirmed that \$6 million was collected for the first quarter and \$24 million is expected over the year.

Structured Settlement: Dustin Dailey

Dustin Dailey, Structured Settlement Program Manager, continued with an update for the Structured Settlement Program. As a reminder, structured settlement agreements provide a new option for resolving the non-medical portion of industrial insurance claims.

The program is fully operational and able to intake applications, negotiate, follow through the process and make payments. The program is having success with the BIIA's approval; the one State Fund settlement agreement that was not approved was quickly readjusted and approved the second time.

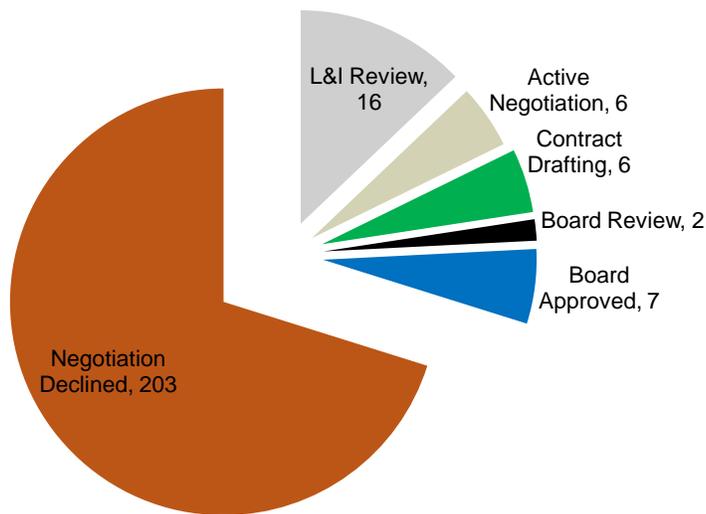
Mr. Dailey provided examples of settlements that have been approved and how they helped the injured workers:

- Assisted worker to receive dental care that he could not afford (dental unrelated to claim).
- Assisted worker to relocate and retire to extended family's home town.
- Allowed workers to avoid the cost and uncertainty of litigation for a much quicker resolution.

A total of 240 State Fund applications have been received; the application source is predominantly from injured workers (218) versus employers (22). 49 of those workers are represented by legal counsel, while 191 are pro se.

Recent Status Highlights

State Fund Settlement Request Status



Washington State Department of
Labor & Industries

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This chart shows the current status of all application requests that have come in.

Some workers speak to staff in the unit and get a clear understanding of their options, and they decide that settlement is not the best option for them.

At any given time, the program is reviewing 10 to 20 applications. These are full claim file reviews. Staff are determining whether to proceed to negotiation. We have six in active negotiations, six being drafted for contracts, two at the BIIA, and seven have been BIIA approved. We currently have four that are in payment status.

Looking Ahead: The program is working on 'Phase 3' of implementation, a Case Management System. The system will organize the department's available information and maintain privacy for the sensitive information workers are sharing; the system should have the ability to gather information but only allow the settlement unit to view it.

The first release is scheduled for September 2012. This will auto populate analysis forms with the department's information. Currently, staff spend about 45 minutes on every settlement request to review current systems and enter data manually.

Settlement Contract Refinements: Though there are no standard templates for the contracts, the program has identified some areas to focus on including:

- Identify all the workers' compensation claims covered by a settlement. Some workers have several past claims. The unit identifies all claims and presents them in the contract so the BIIA has a full picture of the worker.
- List all medical conditions including medical conditions not related to the claim. This makes it clear what conditions are and are not part of the settlement and should prevent issues with Medicare.
- Account for all department and OSE liens and debts.
- Detailed payment schedule that meets the statutory requirements.
- Prohibit worker from assigning payments as these will always go directly to the worker.

- Confirms worker's right to reopen the claim for medical benefits only.
- Ability to work; there are no limits on the worker's ability to work; we are encouraging workers to go back into the workforce, if appropriate.
- Attorney's fees; it is clear that 15 percent is the maximum a worker's attorney can charge.
- Affect on claimant's beneficiaries; if the worker passes away during the payment stream of the periodic payments, we are generating a form that the worker can use to designate a beneficiary. We also will not settle future claims; survivor claims are not part of a settlement agreement.

A question was asked when the program is identifying all workers' compensation claims, including past claims, does this close the worker's ability to file a new claim if the injury is exacerbated? Mr. Dailey clarified that we are including all past claims, but not automatically settling all of them—the settlement is for the open claim or claims under review. Other claims are not affected, unless clearly stated in the contract.

Another question was asked if the program discusses with workers their rights once a settlement is complete. Mr. Dailey explained when the department settles with an unrepresented worker, part of the process is to meet with them face to face and talk about how the settlement may impact their claim in the future. An Assistant Attorney General also meets with unrepresented workers to review the contract and ensure they understand the language. For represented workers, we rely on the worker's counsel to make the same assurances to the worker.

A question was raised seeking clarification of the worker's ability to designate a beneficiary and how settlement affects spousal and other survivor's rights. Mr. Dailey provided an example of a worker with an asbestos claim. If we were to settle with the worker and they passed away due to the effects of the asbestosis, any survivor benefits arising from the claim are not included in the settlement agreement. We would pay the survivor's pension to the surviving spouse. The statute does not allow us to settle future claims from a beneficiary.

A question was asked if the program can provide the average age of the claims and the average settlement amounts. Mr. Dailey advised because the program is new, there is not an adequate population of settled claims to begin reporting meaningful averages. But based on incoming information, the claims vary from two to 10 years old. The average settlement amount is considered confidential claim data.

A question was asked if there is a breakdown of applications filed by legal counsel versus pro se applicants that show the applications that were accepted and currently going through the negotiation process. Mr. Dailey does not have this break down.

A concern was raised regarding the example of a worker settling their claim for the ability to pay for dental care; they felt the goal of structured settlements and workers' compensation was for workers to have the ability to pay for everyday living expenses. Mr. Dailey agreed and clarified—we are looking beyond the worker's immediate needs and into the long range future. Retirement benefits and Social Security are considered in settlement requests to ensure that when the settlement is paid out, the worker is able to pay for everyday expenses. When the program focuses on providing cash up-front, it is to satisfy debts or needs that if unaddressed would interfere with everyday expenses in the future.

A question was asked regarding the time frames from when a person files an application to the time it actually receives BIIA approval. Mr. Dailey advised it is about three to four months from the date of application to the date of first payment (this includes the 30 day revocation period after the BIIA approves.)

A question was asked regarding liens and debts. Is the program recovering claim overpayments that have been previously waived or deemed unrecoverable or overpayments on other claims? Mr. Dailey answered that recovery is for current overpayment balances.

Mr. Dailey was asked to provide more details regarding preauthorized reopening as part of settlements. This comes specifically out of the legislation that allows the program to waive requirements to file a reopening application as part of a settlement; for example, if there is current information where a doctor advises a specific medical procedure to be done 10 or 15 years in the future, these can be preauthorized.

Medical Provider Network: Leah Hole-Curry and Janet Peterson

Leah Hole-Curry, Medical Administrator, provided an update for the Medical Provider Network. A brochure was handed out to the committee. As a reminder, the mandate is to establish a Medical Provider Network to ensure effective health care treatment and access to quality providers. Starting January 2013, injured workers must see network providers for ongoing care. This is new business for the department and is about a two-year process. We are in the last six months of implementation.

Some recent highlights include:

- The department has launched the provider application website (www.JoinTheNetwork.Lni.wa.gov) to begin intake of applications.
- We have completed recruitment mailings to all current department providers to advise them of the new requirement and to encourage them to apply.
- We have a delegation process. If a provider organization has a credentialing process and can demonstrate their process is substantially similar to the department's, we can delegate some tasks and expedite the process. There are 30 organizations identified that may qualify. We currently have 10 agreements signed with major medical groups that already have credentialing in place. We currently have 2,400 applications for individual providers. In total, there are approximately 7,000 providers the department has heard from.
- Completed installation of new credentialing database software.
- Conducted training on software and new business processes.

Looking Ahead: Here is what to expect in the next six months prior to start:

- We will continue our provider recruitment. It will become more targeted for geographic locations by type and specialty.
- Establish a credentialing committee to review applications with clinical issues.
- Launch Network Provider Directory in October.
- Monitor network adequacy.
- Notify injured workers of changes in October and December. Workers will be notified in December if their attending doctor has not applied to be a network provider and will be provided with the provider directory to find a new physician.
- Transition of care for injured workers who lose their attending provider.

A question was asked regarding current issues with workers who “doctor shop” for providers who are generous with prescribing opioids. How will the department credential these providers? Ms. Hole-Curry answered the enrollment and certification process is a review of the minimum requirements in the statute and rules. However, we currently have a provider quality process at the department to review a provider for

quality of care issues. Ms. Peterson committed to providing details of the process to the committee. It is on the website and includes a list of phone numbers to contact for different types of complaints.

<http://www.lni.wa.gov/ClaimsIns/FraudComp/Complaints/AboutProvider/default.asp>

It was asked what the plan for transitional care for workers who may lose their attending physician was. Ms. Hole-Curry advised there is a current process to find another attending provider for workers whose provider has retired, moved, or has had their provider number terminated. The department is also investigating additional resources to assist if needed during provider network implementation.

It was asked what percent of the current provider base does 7,000 providers (accepted applications/delegation) represent. Ms. Hole-Curry answered the current data shows there are 8,600 providers with open claims. The department's focus for network establishment is to ensure geographic access similar to a baseline measured by the percent of workers that have access to at least five attending physicians within 15 miles.

Centers of Occupational Health and Education (COHE) Expansion: Janet Peterson

Janet Peterson, Program Manager for Health Services Analysis, continued the presentation with a reminder that the COHE Expansion's goal is to promote and incentivize use of occupational health best practices for providers. Tools to achieve this include expanding geographic access to the COHEs, identifying best practices throughout the life of claims, and identifying "top tier" network practices.

Some recent status highlights include:

- Completed feasibility study and market research for an Occupational Health Management System. We learned we should look at potential integration with electronic medical records which we currently have limited access to. We conducted market research and issued a Request for Information and received 14 responses; we held eight two-hour demonstrations.
- Solicited input and developed mock up of revised "scorecards" for COHE providers. We began issuing some in the fall and received mixed reviews on this being a useful tool for providers. We developed a new revised version and received positive feedback.
- Initiated preliminary pilots of new best practices: Functional Recovery Questionnaire and Activity Coaching. The Functional Recovery Questionnaire is a short list of questions that can be used quickly to identify patients that are high risk of disability and target those for more intensive interventions. The Activity Coaching trains some physical therapists to work with patients to set personal goals for increased physical and work activity.
- Began discussions with the Provider Network Advisory Group on criteria for "top tier" providers. The next meeting is scheduled for July 2012.
- Self-Insured COHE Pilot underway June 1st (through agreement between King County and the Renton COHE). This is in the implementation phase.

In addition to the provider score cards, the operational performance measures include:

- Compared to non-COHE claims, average time-loss days for COHE claims are slightly lower at six months, and three to five days lower at 18 months. This is up-to-date data and is being monitored on a quarterly basis.
- Actuarial estimates for Accident Year 2010: Ultimate costs of claims initiated by COHE providers are around 14 percent lower than other claims (excluding Harborview COHE claims). This is disability costs and medical costs combined.

- For fourth quarter 2011, 37.5 percent of COHE providers were “low adopters” of best practices. It is important for the provider score cards to be successful because there are differences among COHE providers in terms of their adoption of best practices. We want to ensure we provide feedback to these providers.

Looking Ahead: The department will be working on the following:

- Issue Request for Proposal (RFP) and select vendor for Occupational Health Management System and have them aboard by November 2012. We are currently finalizing the system’s business requirements to explain to potential vendors. The RFP should be released the first week of July.
- Expand pilots on Functional Recovery Questionnaire and Activity Coaching. The number of referrals for both of these pilots has been small; we are working on more communication and increasing the impact.
- Begin new pilot on surgical best practices by October 2012. The plan is to roll this out to surgeons in July. It includes best practices with hand-offs between primary care and surgery, preparing expectations prior to surgery, and the hand-off back to the primary care providers.
- Issue RFP for new COHE sponsors in early 2013, and expand to six COHEs by July 2013.

A question was asked if referrals are made for the Functional Recovery Questionnaire by claim managers. Ms. Peterson answered the issue is having providers use the questionnaire within the first four weeks of the claim. We want to work with the providers on how to identify the appropriate claims. The questionnaires are not requested by the claim managers. The Occupational Health Management System will be helpful for these referrals.

A question was asked what the average time-loss duration is currently and if this can be reported as an average or median for future meetings.

The Recession, The Construction Industry, and the Impact on Workers’ Compensation: Kirsta Glenn

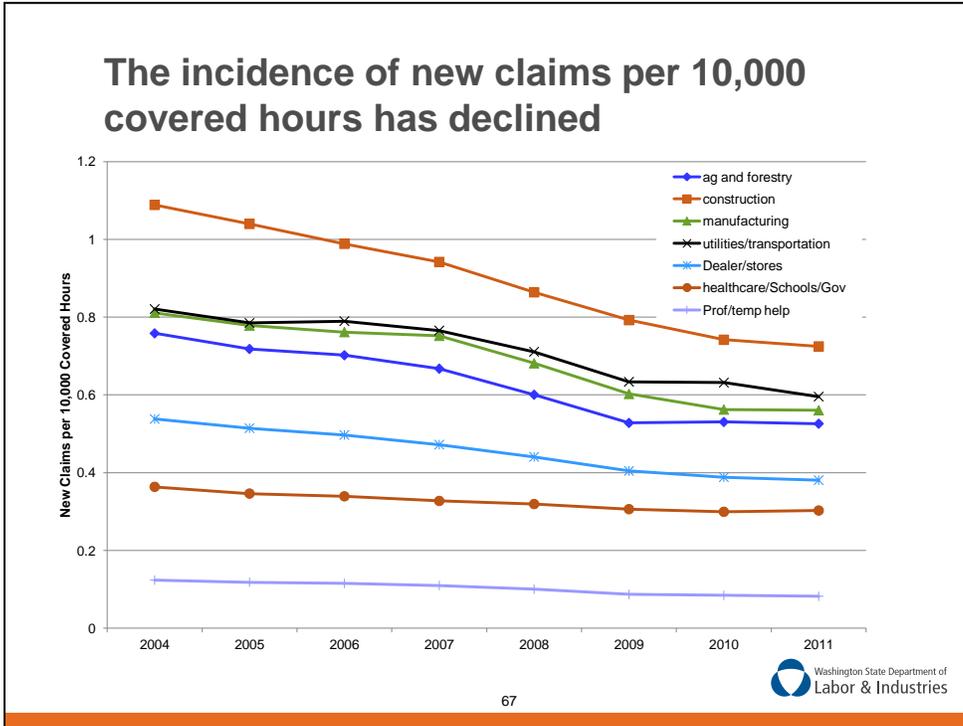
Kirsta Glenn, Research and Data Services Program Manager, presented an economic update and how it relates to the workers’ compensation system.

The construction industry is an important industry in workers’ compensation and has been impacted relatively severely by the recession. Ms. Glenn examined data that helps show the magnitude of the recessionary impact versus other factors of the system on claims from the construction industry.

Change in construction employment has been dramatic. In the boom from 2002 to 2007, total employment grew by 9 percent and construction employment grew by 31 percent. The bust was the peak to the trough. Total employment declined by 6.8 percent with a loss of 201,500 jobs. Construction employment declined by 36 percent, and that represented a loss of 75,000 jobs. The economy is not back where it was before the end of the recession, however employment is increasing. Construction employment is still 34 percent off of its peak; a third of construction jobs was lost and has not come back. This has an unprecedented impact on workers compensation.

Construction’s importance to workers’ compensation system: In 2007 (before the recession), construction comprised 9.5 percent of covered hours and 30 percent of premium. In 2011, it was 6.5 percent of covered hours and 20 percent of premium. In 2007, construction represented 22 percent of new claims coming into the system, now only 15.4 percent of new claims come from the construction industry. Claims from the

construction industry represent a consistent 26 percent of active time-loss claims. This is due to older construction claims that are still in the system.



The incidence of new claims per 10,000 covered hours has declined. This is positive news. Incidence declined dramatically over the recession; there was a long-term decline due to improved safety, and to a change in the industry mix toward more services and more professional business services. There has also been a short-term decline in the incidence of injuries likely due to newer, less experienced, workers being laid off first. Since the end of the recession, the decline in incidence is beginning to level off. The construction industry behaved relatively like the other industries.

But the average duration of time-loss claims has risen more in construction than other risk classes



Source: L&I actuarial services



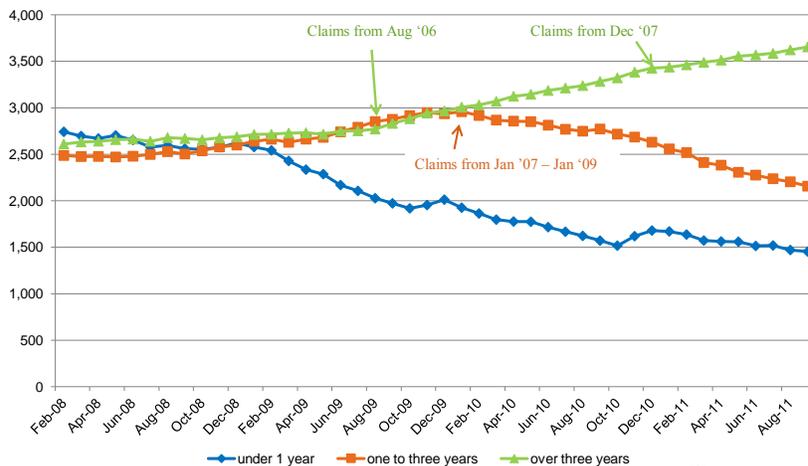
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But the average duration of time-loss claims has risen more in construction than other risk classes. This data is broken down into three risk classes for construction: building construction, miscellaneous construction, and trades (i.e. carpentry, electricians, plumbers). These classes are compared to miscellaneous services for other risk classes. Ms. Glenn compared the time-loss index for 2007 (red) to 2011 (blue); the increase in time-loss duration for miscellaneous services was 21 percent. The increase in each of the three construction sectors is around 40 percent. This is almost twice the increase in duration in miscellaneous services.

A question was asked if less use of kept on salary would affect the time-loss duration index and Mr. Vasek answered it would.

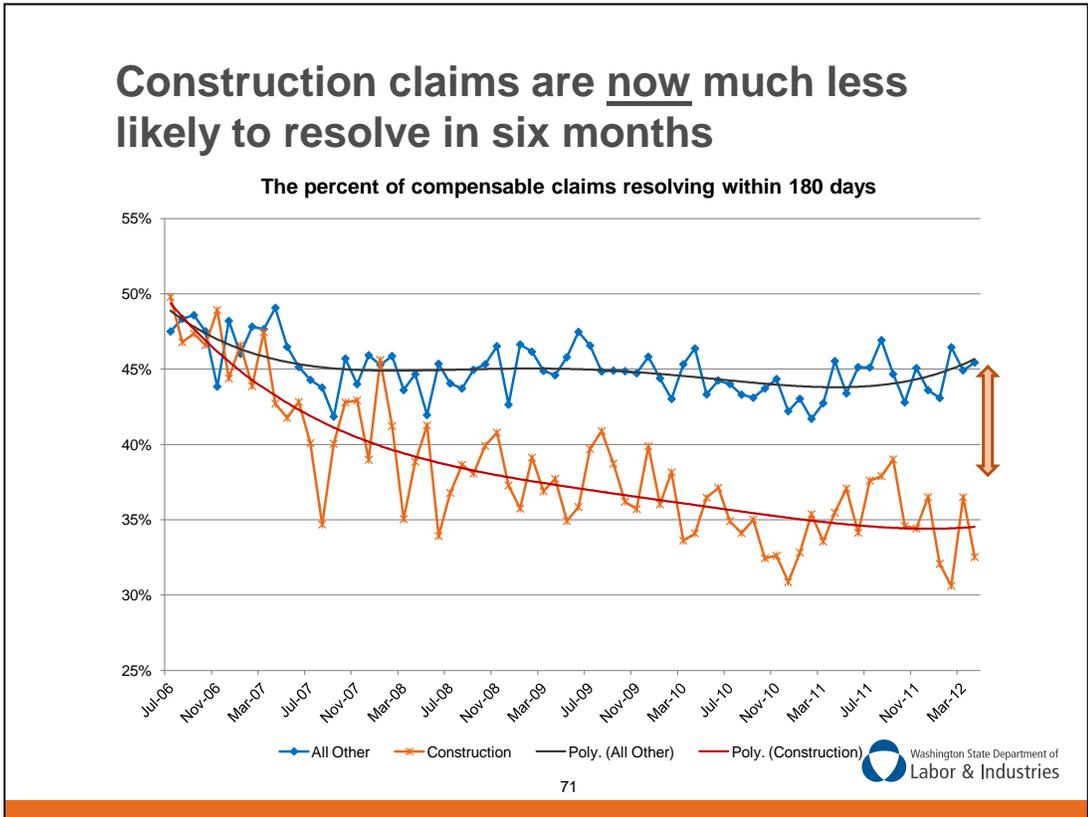
Older construction claims continue to grow, even as fewer new construction claims enter system

The number of construction claims by age group.



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Older construction claims continue to grow, even as fewer new construction claims enter system. In this graph, the blue line represents the younger construction claims, under a year old. At the start of the recession, the number of new claims coming from the construction industry declined. Construction claims between two and three years old continued to increase until the end of 2009 and then began to decline. The number of construction claims over three years old continues to increase in our system. There is now a higher concentration among older construction claims and a lower concentration among younger construction claims.



Construction claims are now much less likely to resolve in six months. This is an important agency metric of early claim behavior. If the claim can be resolved and the worker is back to work within six months, that is seen as a prevention of long-term disability.

Among claims from other industries, on average 45 percent resolve within six months. For construction, the average is lower at 35 percent resolving in six months. The dramatic decline in the rate at which construction claims are resolved is a clear indication of the impact of the recession on our system.



Long-term construction claims have also experienced a disproportionately large impact from the recession.

	% closed at 2 yrs	% closed at 3 yrs	% retraining	% still open 2012	Ave Incurred cost
Claims received in 2005 and still active one year later:					
All other (7,421)	58%	76%	11%	6%	\$318,484
Construction (2,271)	52%	69%	21%	10%	\$464,071
Claims received in 2008 and still active one year later:					
All other (6,947)	52%	70%	8%	20%	\$236,812
Construction (2,427)	40%	57%	21%	31%	\$297,995

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Department of Labor & Industries

Long-term construction claims have also experienced a disproportionately large impact from the recession. This table was corrected from the initial presentation. The labels for all other and construction claims have been switched. Construction claims tend to be more severe than average and pass through the system more slowly. They also have a higher incurred cost. We have seen a greater impact from the recession on construction claims than other claims.

The financial implications. There are two forces that work in opposite directions. The construction risk class is positively impacted by the decline in incidence, while there is negative impact from the slower resolution rate. Other risk classes are not affected by changes in construction, because their rates are set independently.

The average duration of time-loss claims is affected by the lower concentration of new construction claims and the higher concentration of construction claims among older claims. The average time-loss duration is not affected by the fall in the incidence rate.

Actuarial analysis of the impact of the change in industry mix on the average duration of younger claims. An actuarial analysis has been completed to determine the causes of an improvement seen in the resolution of young claims. The average duration of time-loss claims that are less than 24 months from injury date has declined. About one third of this decline is attributed to the change in industry mix toward less hazardous industries and about two thirds of the decline is due to other factors such as our implementation of new lean claims management techniques for the first six months of a claim, early return-to-work services and the effects of the Stay at Work Program.

What does the future hold? Construction is expected to make a comeback

Historical and forecasted growth –
source Economic and Revenue Forecast Council (May Update)

Year	Total Employment	Construction Employment
2006	3.0%	8.7%
2007	2.6%	7.9%
2008	0.9%	-3.6%
2009	-4.6%	-20.4%
2010	-1.3%	-11.6%
2011	1.4%	-2.4%
2012	1.7%	1.1%
2013	2.0%	3.9%
2014	1.8%	7.2%
2015	1.7%	6.6%



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What does the future hold?
Construction is expected to make a comeback.

Total employment is expected to grow about 2 percent per year. Construction employment is expected to grow 6 to 7 percent per year by 2014 and 2015.

We are expecting to see a large influx of new claims from the construction industry once the recovery is underway.

In conclusion, the increase in construction hours will cause an increase in construction claims and an increase in return-to-work possibilities. The other improvements seen in early claim resolution, not due to industry mix, will help us in all risk classes. The recovery is likely to have a fairly limited impact on older claims because the workers have lost their connection with their employer of injury and have been in the system a long time.

Medical Trend and Medical Management: Leah Hole-Curry and Janet Peterson

Leah Hole-Curry, Medical Administrator, began with an update on the department's medical cost trend.

Focus for this update:

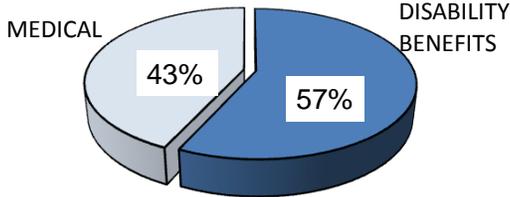
- *L&I's annual medical inflation rate is around 3.2 percent, outperforming national rates and the Governor's statewide goal of 4 percent.* The department is a recognized national leader in managing health cost drivers (price, utilization and benefits) while improving health care outcomes.
- *L&I's most significant target for cost control, overall claim cost, requires getting injured workers back to work through fast access to appropriate, quality medical care.* This differs from traditional health care insurers. Traditional medical insurers, such as Medicare or employer health benefits, provide comprehensive coverage, while we pay the medical component only when someone has a work-related illness or injury.
- *L&I is fully engaged in our journey to excellence by improving medical delivery to reduce overall costs. This includes national firsts: adoption of best-in-class strategies; collaboration with WA agencies and health care community; and major statutory changes.* The department has been a national first in terms of some of our statutory changes as well as best-in-class strategies such as the opioid guidelines and COHE projects. These were validated through research to demonstrate actual change in value, and now they are being implemented as standard practice.
- *L&I has additional opportunities to reduce medical costs.* We are on track to launch the new Medical Provider Network in January 2013, and to increase evidence based pre-authorization for several conditions/treatments.

L&I's Medical Costs as Compared to the Average National Worker's Comp Program

Medical Losses as a % of Total Losses

Washington State Fund*

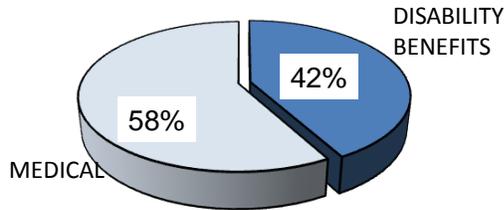
Accident Year 2009



L&I's medical costs are 26% less than the average workers' compensation program in the US

National Average**

Accident Year 2009



*Discounted as of 12/31/11, excluding Supplemental Pension Fund
 **Source: NCCI 2010 Annual Issues Symposium Presentation

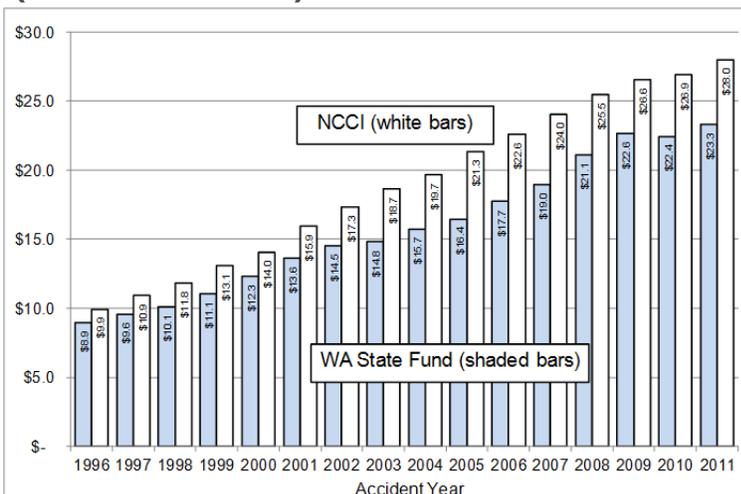


This slide is from NCCI and compares L&I's medical costs to the average national workers' comp program.

The national average for a workers' compensation program's overall costs is 42 percent for disability benefits and 58 percent for medical. At L&I, we are 57 percent disability benefits and 42 percent for medical.

L&I's medical costs are 26 percent less than the average workers' compensation program in the US.

Comparison with NCCI: Medical Costs per Compensable Claim (in \$ thousands)



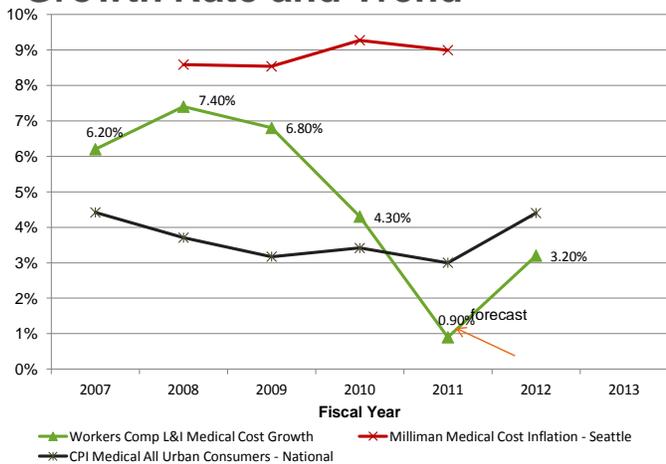
WA State Fund Discounted Medical Aid Fund losses as of 3/31/2012, excluding Stay at Work Program.
 *NCCI Data as of 12/31/11 for 2011, as of 12/31/2010 for 1996-2011, undiscouted, developed to ultimate.
 **Source: <https://www.ncci.com/Documents/AIS-2012-SOL-Presentation.pdf>



Medical Costs per Compensable Claim: Nationwide, medical costs are increasing year after year.

From 1996 to 2011, the State Fund in Washington has outperformed the national average in terms of medical costs per claim.

Comparison to Industry-wide Medical Cost Growth Rate and Trend



L&I has had a **decline** in health care trend since 2008 and a near zero growth in 2010/2011.

L&I cost dip due to the short-term impact of reimbursement policies - including prior review of high cost radiology, reduced pharmacy fees and reimbursement for some services.

L&I growth rate outperforms comparable health care growth trends, both national health care cost trends (2007 – 2012) as well as the Seattle growth trend (2011 and 2012)

Notes: Both the Milliman estimate of cost inflation and the medical CPI are calculated on a calendar year basis. Milliman Medical Index: "measures the total cost of healthcare for a typical family of four covered by a Preferred Provider Plan" CPI Medical All Urban Consumers approximates consumer out-of-pocket spending on medical goods & services (including employee HC premiums)

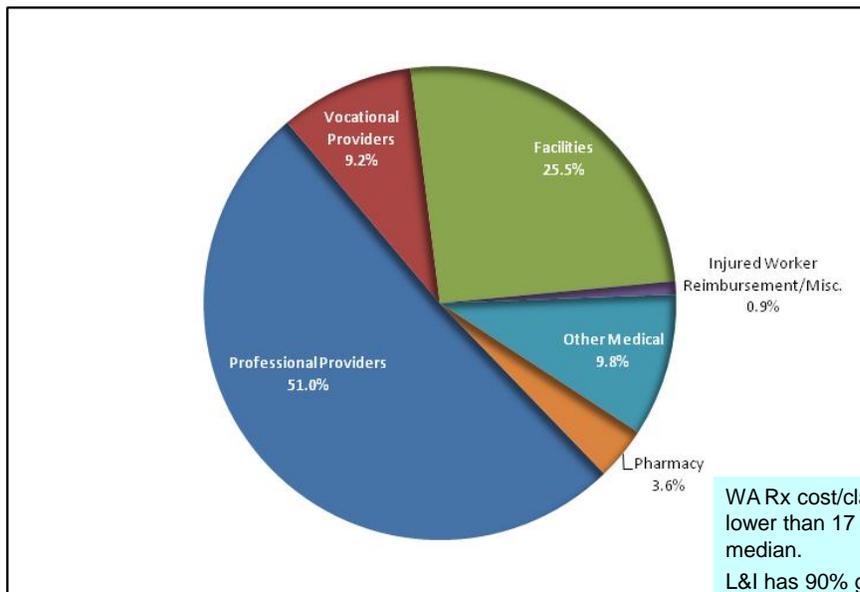


Comparison to Industry-wide Medical Cost Growth Rate and Trend:
This chart graphs medical inflation. L&I was at a higher rate than the Medical CPI from 2007 to 2010, but has dipped and stayed below the trend since.

The cost dip around 2011 is due to changes in reimbursement rates for prescriptions, and starting an evidence-based prior authorization process for high cost radiology.

Janet Peterson, Program Manager for Health Services Analysis, continued the presentation.

Total CY 2011 Medical Aid Benefit Costs



WARx cost/claim is 40% lower than 17 state median.
L&I has 90% generic rate.



For calendar year 2011, the department spent approximately \$600 million on Medical Aid Fund benefits. The majority of the dollars went into payments to *professional providers* (51 percent). The next largest category is *facilities* (25.5 percent). This includes inpatient hospital as well as outpatient hospitals (including emergency room facilities), ambulatory surgery centers and nursing homes. The next category is *other medical* (9.8 percent) which includes home health durable medical equipment, interpreters and other costs associated with medical visits. *Vocational providers* (9.2 percent) are also paid out of the Medical Aid Fund.

Pharmacy is highlighted because of our total Medical Aid Fund, 3.6 percent is to pharmacies for prescriptions. This is significantly lower than other workers' compensation insurers due to the fees that we pay, and clinically-based initiatives such as the state-preferred drug list. Jayme Mai, Pharmacy Manager with the department, has been recognized for her achievements in this area. When looking at other states, pharmacy payments are typically at 6 to 8 percent of total workers' compensation medical costs.

Lastly, *injured worker reimbursement/misc.* (.9 percent) includes primarily workers' travel as well as some other miscellaneous costs.

L&I Continues to Drive Down its Health Care Cost Trend

Top 4 Initiatives

Strategic Cost Driver	Current Efforts	Initiatives for Improvement	Other State Initiatives Underway
1. Lack of coordination of care and low adoption of known best practices	COHE Pilot demonstrated 20% reduction (1in5claims); COHEs piloting additional best practices	Expand COHEs to ensure access to 50% of the state by 2013 and 100% in 2015; adopt successful best practices	Medical home pilots in Medicaid; PSHA community reporting
2. Over-prescription of opioids which increased deaths, disability and delays return to work	Coordinated development of agency guidelines; dosing thresholds; Provider feedback reports; DOH rules	Update opioid guidelines to address additional scenarios; new tools for tapering and pain management	Prescription Monitoring Program
3. Providers who deliver poor quality care	Weak legal authority to remove providers; Share quality of care complaints with DOH and other agencies	New Medical Provider Network – clear legal criteria to deny network enrollment and remove provider for risk of harm	State programs use managed care networks, credentialing standards in place; some use closed networks
4. Unnecessary treatments and surgeries (e.g. back surgery)	Utilization review for some procedures based on treatment guidelines; Health technology assessment decisions	Network provider requires compliance with treatment guidelines; Expand utilization review program to include more treatments;	HTA; PDP; IIMAC; IICAC; Advanced Imaging; Bree Collaborative; Agency Medical Director coordination; provider feedback reports

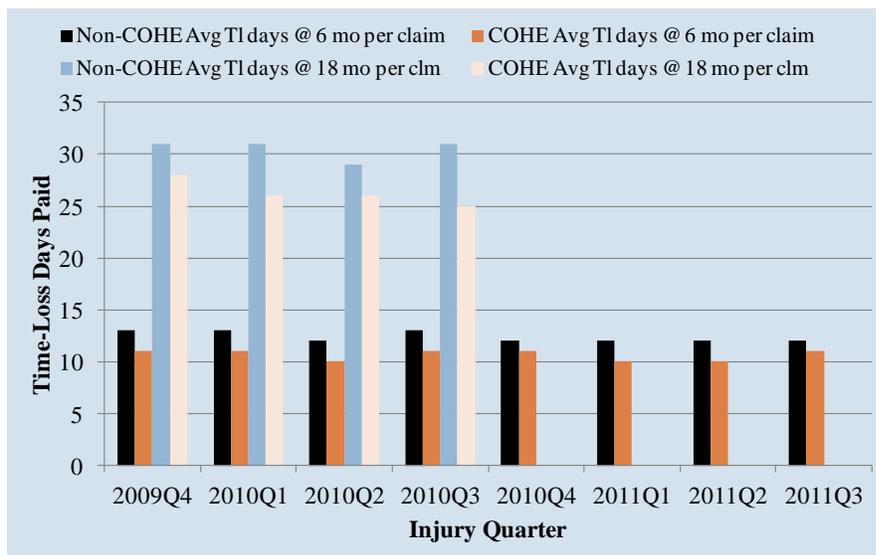
Ms. Peterson reviewed the top four cost drivers and initiatives to address them.

The issue of poor quality of care has a large impact on medical costs. The Medical Provider Network will help address this by establishing rules and standards for providers who treat injured workers, and will help control costs.

A question was asked if the department has processed the 7,500 applicants for the Medical Provider Network and what is the percentage of requests that have been rejected. Ms. Peterson answered we are not at that point yet where we have actual figures on denied applications. We are in the process of setting up a credentialing committee to review clinical issues and for final input on those decisions. We are recruiting physicians to participate through our Industrial Insurance Medical Advisory Committee and Industrial Insurance Chiropractic Advisory Committee. Once we have results, the department will report back to the WCAC.

Coordination of Care: L&I Out front with COHE

Results; Lower Time Loss Days Paid, Average @ 6 and 18 Months

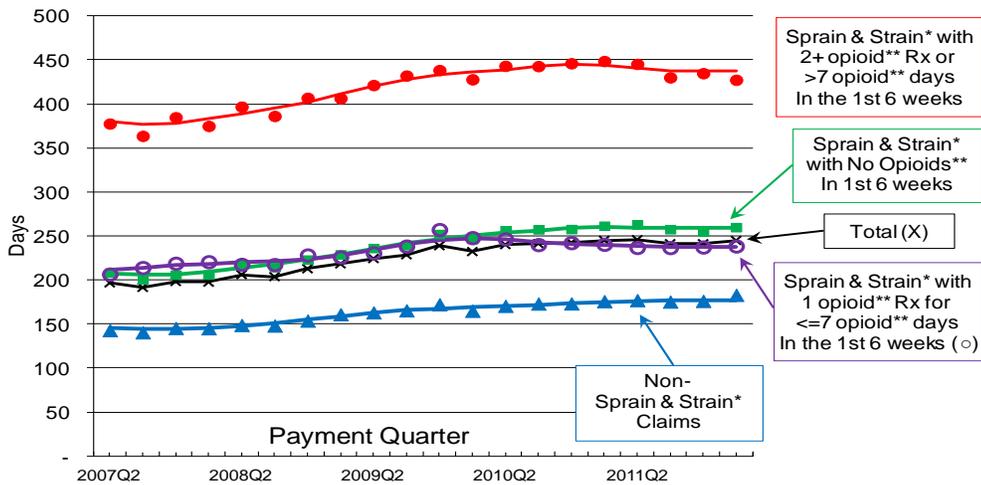


Coordination of Care: L&I Out Front with COHE: This chart compares the average number of time-loss days paid on claims at six months, then again at 18 months. At six months, there is two-day difference between the average number of time-loss days paid for non-COHE versus COHE claims (this includes both compensable claims and medical only claims). The average non-COHE claims is 12 to 13 days while COHE claims are 10 to 11 days, a difference of around 20 percent. When comparing 18 month claims, the difference is also around 10 to 20 percent.

A request was made to see the data with just time-loss claims.

Impact of Opioid Rx in the 1st six weeks of the claim

Timeloss Duration Truncated at 7 Years



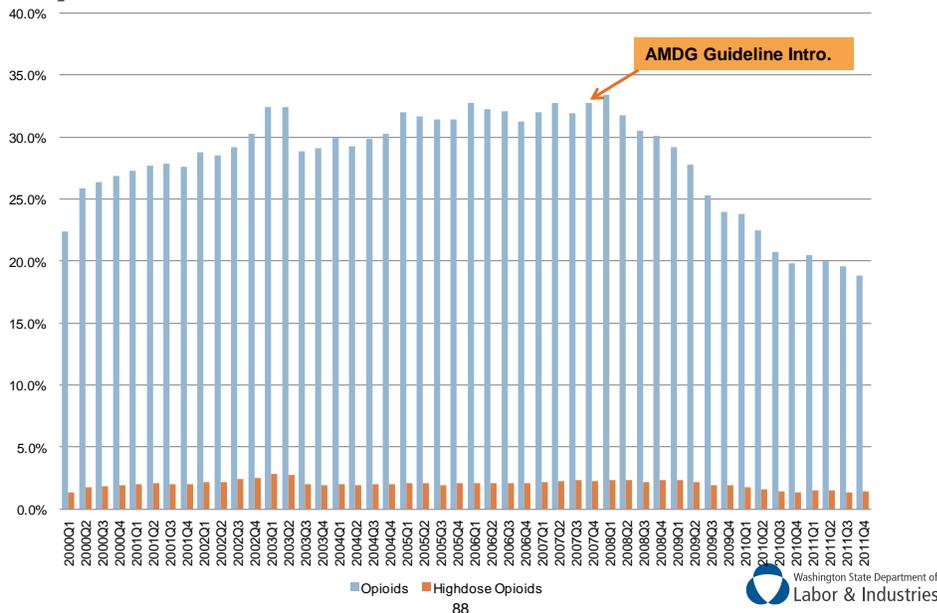
* Sprain & Strain Claims have 1 or more allowed diagnosis in the ICD-9 range 840.0 - 848.9
 **Drugs in therapeutic classes H3A, H3N, H3X, and H3U



Impact of Opioid Prescriptions in the first six weeks of the claim: The red line represents sprain and strain claims that in the first six weeks had at least two opioid prescriptions or a prescription that was for more than seven days. There is a dramatic difference in the pattern of disability. These have almost twice as much time-loss when compared to claims with no opioid prescriptions in the first six weeks and the ones with one prescription that was no more than seven days.

A comment was made that there is the possibility of more opioids or longer opioids prescribed for injuries that are more significant. Ms. Peterson agreed, but added this data is consistent with the national research showing early use of opioids is related to disability.

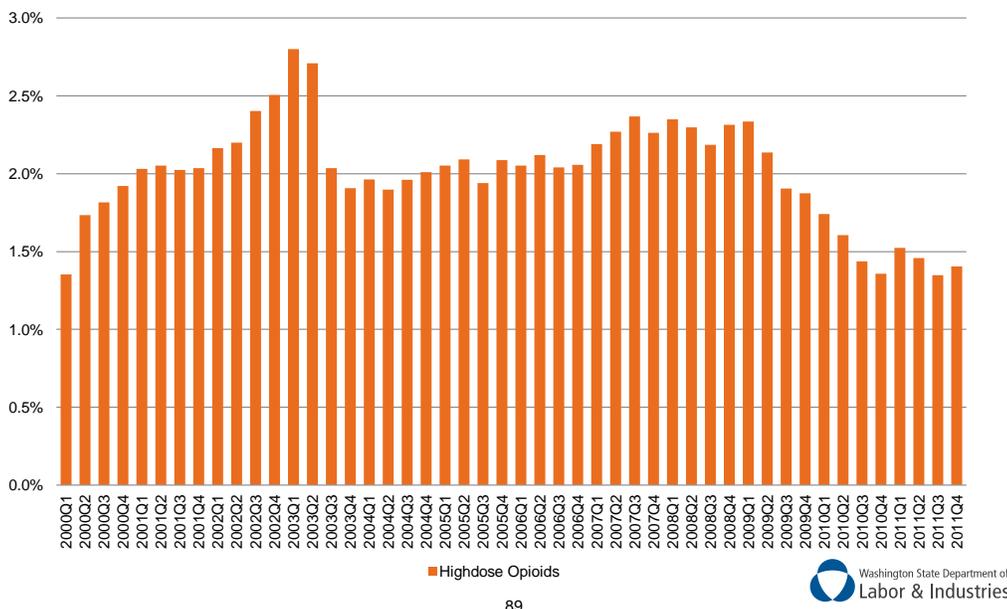
Percent of Time-loss Claimants on Opioids 2000-2011



Percent of Time-loss Claimants on Opioids 2000-2011:

This data is based on payment dates, not by accident year. There has been a decrease in the past few years in the percentage of time-loss claims where we are seeing payments for opioids.

Percent of Time-loss Claimants on High Dose Opioids 2000-2011



Percent of Time-loss Claimants on High Dose Opioids 2000-2011:

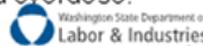
Based on the agency Medical Director's guidelines, opioids with more than 120 morphine-equivalent dosage are considered high dose and should be referred for a consult. There is a slight decline in these high dose claims.

L&I Leads in Evidence Based Medicine

L&I is a leader in evidence based health policy: Using good, unbiased science to ensure workers receive high quality health care that is safe and works.

Example Outcomes

1. Evidence based criteria for advanced imaging review. Resulted in a \$2M annual savings. Partnered with OneHealthPort for a on-line exchange and "gold cards" for institutions.
 - L&I implemented HTA decisions that limit harm and expense on unproven care and avoid about \$2.8M annually for items like Interthecal pain pumps; Vagal Nerve stimulators; and Discography.
 - IIMAC and IICAC evidence based decisions that reduce unnecessary and harmful care and avoidance of up to \$18M, through Coverage Guidelines and Policies on Electrodiagnostic Testing, Carpal Tunnel Syndrome, and others.
 - AMDG Opioid Dosing Guideline: Groundbreaking work to reduce disability and unintentional deaths related to high dose and overdose.



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Ms. Peterson concluded the presentation with the review of slide titled L&I Leads in Evidence Based Medicine.

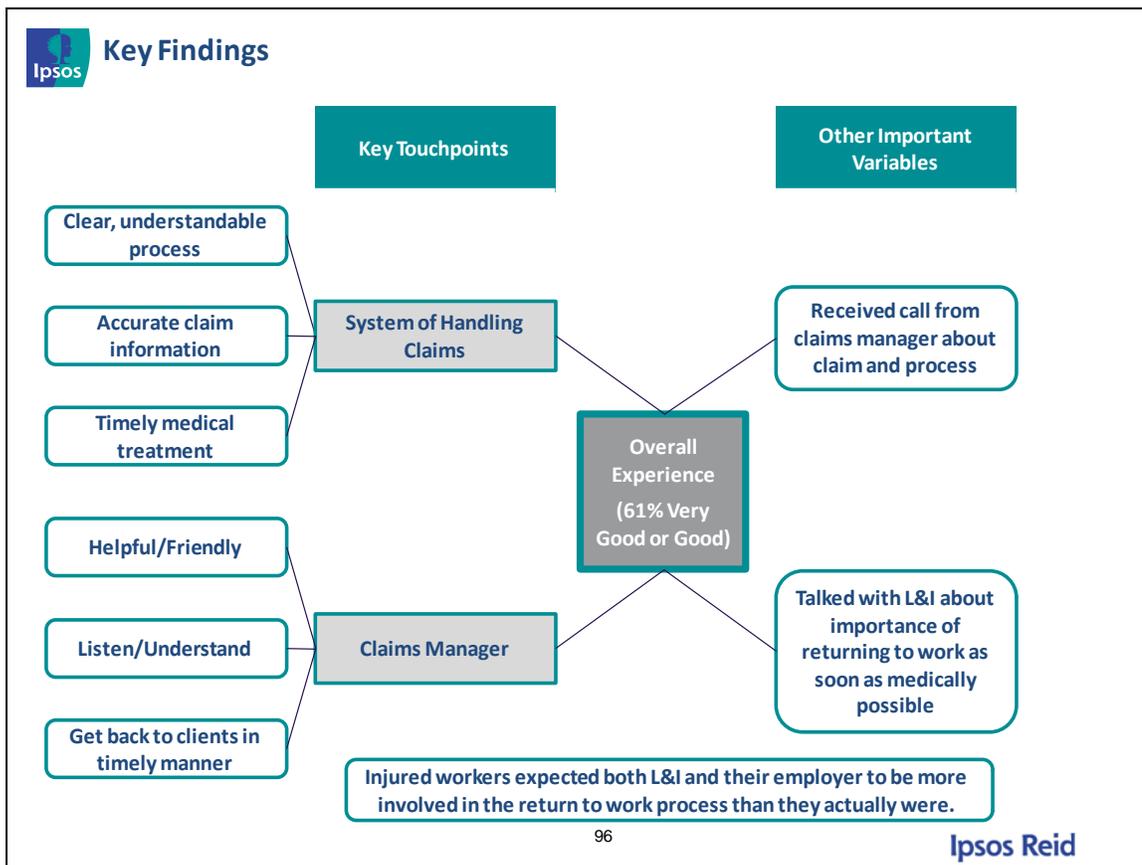
Building a Better Customer Experience: Ron Langley and Kyle Braid, Ipsos Reid

Director Schurke introduced the presentation. This is an agency-wide effort, modeled after British Columbia's efforts. Building a Better Customer Experience (BBCE) will help us understand our customers' definition of value of services they receive, whether an employer, contractor or injured worker, from the department. Surveys have been conducted for DOSH Contractor Compliance and Insurance Services Claims Administration. Additional surveys will be completed in the fall. Ron Langley is the department's Customer Experience Manager.

Mr. Langley added that the department has reached the first milestone where the baseline surveys are completed from injured workers and employers in the workers' compensation system. Mr. Langley introduced Kyle Braid, Project Manager from Ipsos Reid.

Mr. Braid began with a background review of the project.

For the injured worker survey, 800 interviews were conducted in February and March 2012. The sample primarily included time-loss claims thirty days and older. Medical only claims, claims for workers represented by an attorney and out of state claims were excluded. Interviews were conducted in both English and Spanish.



Key Findings: At the start of the survey, workers were asked how they rate their overall experience working on their claim with the department: 61 percent (six out of ten) rated the overall experience as very good or good. The key drivers of their overall experience included *System of Handling Claims* and *Claims Manager*. Other variables included: *Received call from claims manager about claim and process* and *Talked with L&I about importance of returning to work as soon as medically possible*. Among injured workers who stated their claims manager called them first, there is a much higher likelihood that the overall experience was positive.

Overall experience:

- 61 percent of workers rated it a good experience, 25 percent rated it an average experience and 14 percent had a poor experience.
- One of the initial findings was the shorter term claims, 30 to 180 days, had slightly higher ratings than older claims.
- There was not a significant difference in overall experience by size of employer.
- The top positive comment was “No problems/ It was a smooth process.” Other comments included: “Prompt service/quick call back”, “Helpful staff”, “Knowledgeable/able to answer questions” and “Good communication”.
- The top negative comment was “Slow claims process/Not responsive”. Other comments included; “Lack of communication/Hard to contact”, “Inadequate/unfair compensation”, and “Bureaucratic system”.
- 37 percent of injured workers stated they had a prior time-loss experience with the department. When asked to compare their previous experience with their current, 35 percent said their experienced improved, 40 percent noted no change and 24 percent said it had worsened.

Touch points:

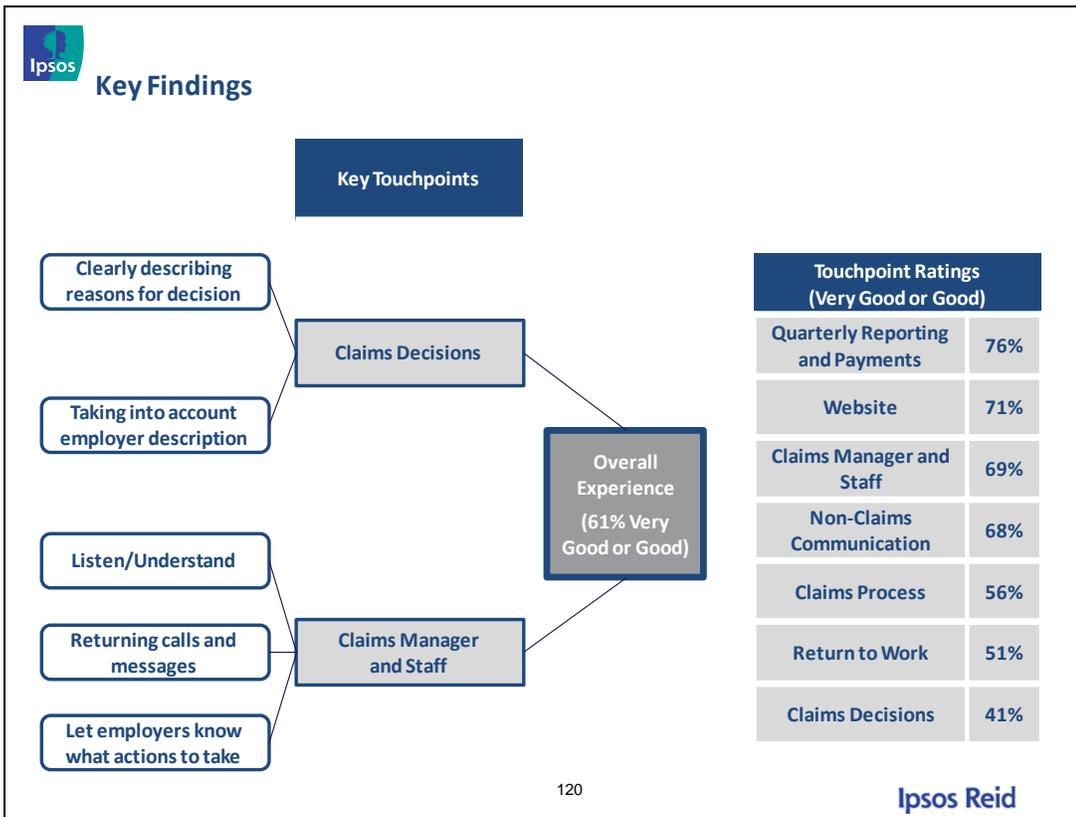
The overall ratings were positive; it was noted that “people” were rated higher than “process”.

Elements with Most Impact on Overall Experience:

In addition to the key touch points, several attributes were identified.

- Claims Handling:
 - Top Priority: Having a clear, understandable claims process
 - Secondary Priority: Providing you with accurate information about your claims
 - Secondary Priority: How long it took to approve medical treatment
- Claims Manager:
 - Top Priority: Being helpful and friendly
 - Secondary Priority: Listening to you and understanding
 - Secondary Priority: Getting back to you in a timely manner
- Contact with Claims Manager:
 - 86 percent of workers have spoken directly with their claim managers. Thirty-six percent of them received a phone call from the claim manager first to discuss their claim and the claim process.
- Talking with L&I about Return to Work:
 - 43 percent of workers said they spoke to someone about return to work; 53 percent said no one discussed this with them and 5 percent did not know.
- Expected and Actual Involvement in Return to Work: When asked how involved groups are expected by workers to be involved in the return-to-work process, the following expectations and what workers felt were actual were noted:
 - L&I: Expected (84 percent) Actual (66 percent)
 - Yourself: Expected (98 percent) Actual (96 percent)
 - Your Doctor: Expected (95 percent) Actual (90 percent)
 - Your employer: Expected (75 percent) Actual (56 percent)

Mr. Braid continued with the employer portion of the survey. Six hundred interviews were conducted with employers in March 2012. The sample included employers with one or more allowed time-loss claim(s) that were active in the last six months. Qualifying claims were 30 days or older. The sample did not include employers using third party administrators or who were Retro participants.



Key Findings: 61 percent of employers noted an overall experience of very good or good. The two key drivers are *Claims Decisions* and *Claims Manager and Staff*. Claims decisions are correlated with their overall experience. The attributes included: clearly describing reasons for decisions and taking into account employer description. For claim managers and staff, the attributes were: listen/understand, returning calls and messages and let employers know what actions to take.

A question was asked about the results for the department versus results of British Columbia. Mr. Braid replied on the employer side, the ratings are higher for B.C., but noted the “Claims Decision” is rated lowest in B.C. as well.

Overall experience:

- 61 percent of employers rated a good experience, 27 percent rated an average experience and 12 percent had a poor experience.
- Smaller employers reported higher incidences of poor experience than large employers.
- The top positive comment was “Do their job well/ no problems or complaints.” Other comments included; “Knowledgeable/answers my questions”, “Responsive/Timely Responses”, “Keep me informed/up-to-date” and “Helpful/Cooperative”.
- The top negative comment was “Employees abuse the system (including fraud)”. Other comments included; “Do not investigate claims/employers complaints thoroughly”, “Hard to contact/do not return class/just leave voicemails”, and “Not employer friendly/favor the workers”.

Overall ratings on touch points:

Quarterly reports and payments, website and claim managers and staff were rated high while return-to-work and claims decisions were rated lower.

In addition to the key touch points, several attributes were identified.

- Claims Decisions: Overall, four out of 10 rated it good or very good; three out of 10 rated it an average score; three out of 10 rated poor. This is considered a very good score. Employers believe the department is taking care of their injured workers' needs.
 - Top Priority: Clearly describing reasons for decisions
 - Secondary Priority: Taking into account your description of how the injury occurred
- Claims Manager:
 - Top Priority: Listening and understanding
 - Secondary Priority: Returning calls and messages
 - Secondary Priority: Letting you know what actions to take
- Helping Injured Workers Return to Work:
 - Top Priority: Ensuring RTW at an appropriate pace
 - Secondary Priority: Working with you to get the worker back on the job
- Quarterly Reporting and Payments:
 - Top Priority: Ease of reporting hours and paying premiums
 - Secondary Priority: Statements and forms being easy to understand
- Non-claims communication:
 - Top Priority: Resolving your question or concern
 - Secondary Priority: Being courteous

A question was asked if employer satisfaction with claims have increased at WorkSafe BC and if changes have been implemented to encourage this. Mr. Braid answered the numbers for the employer side has gone up substantially; about 10 years ago, 50 percent reported to be satisfied with services, it is now eight out of 10 employers who report to be happy with services provided. On the injured worker side, there has been some growth, but not as strong as the employers.

Next Meeting: Beth Dupre

The next WCAC Quarterly meeting is scheduled for September 17, 2012, from 9:00 a.m.-12:00 p.m. at the Tumwater office.

Meeting adjourned.

Assignments from 6/21/12 meeting:

Assigned To:	Follow Up Request
Vickie Kennedy	<p><u>Pay During Appeal:</u> The department is analyzing claims and data to determine whether the self-insured overpayment reimbursement fund, established as part of the 2007 legislation requiring the payment of benefits during an appeal, will likely be used and when. The data will be used as part of a report to the legislature along with the WCAC's recommendations for the fund.</p> <p>The department will provide the information to the WCAC at a future meeting.</p>
Bill Smith Vickie Kennedy	A comment was made that members in their retro program had delivery people, from the grocery industry, that are paid base wage plus commission. The WSAW claims have been rejected because the program does not cover commission. This may be a problem

	for many industries that might want modifications to the law because base wage plus commission is fairly common. Mr. Smith will look into the concern.
Janet Peterson Sharon Avery	A question was asked regarding current issues with workers who “doctor shop” for providers who are generous with prescribing opioids. How will the department credential these providers? Ms. Hole-Curry answered the enrollment and certification process is a review of the minimum requirements in the statute and rules. However, we currently have a provider quality process at the department to review a provider for quality of care issues. Ms. Peterson committed to providing details of the process to the committee. It is on the website and includes a list of phone numbers to contact for different types of complaints. http://www.lni.wa.gov/ClaimsIns/FraudComp/Complaints/AboutProvider/default.asp
Janet Peterson	A question was asked if the department has processed the 7,500 applicants for the Provider Network and what is the percentage of requests that have been rejected. Ms. Peterson answered we are not at that point yet, we are in the process of setting up a credentialing committee so we have clinical reviews on those decisions. We are recruiting physicians to participate with our Industrial Insurance Medical Advisory Committee and Industrial Insurance Chiropractic Advisory Committee. Once we have results on this measure, the department will report back to the WCAC.
Janet Peterson	<u>Coordination of Care: L&I Out front with COHE:</u> A question was asked to verify that this data includes treatment only claims as well as time-loss claims. Ms. Peterson confirmed the data includes all claims and is an average of both. A request was made to see the data with just time-loss claims.