

**Workers' Compensation Advisory Committee (WCAC) Meeting
Labor and Industries, Tumwater, WA
Meeting Notes
April 9, 2015**

Business Representatives: Mike Roozen, Farm Bureau; Kris Tefft, Washington Self-Insurers Associations; Nancy Dicus, Vigilant; and Bob Battles, Association of Washington Business

Labor Representatives: Joe Kendo, Washington State Labor Council; Karen Gude, United Food Commercial Workers 1439; and Neil Hartman, Washington State Building Trades

Labor and Industries: Joel Sacks, Director and Vickie Kennedy, Assistant Director for Insurance Services

BIIA: Dave Thredy, Board of Industrial Insurance Appeals

Absent: Sheri Sundstrom, Hoffman Construction; Karen Bowman, Washington State Nurses Association; and Lee Newgent, Washington State Building Trades

Court Reporter: Milton Vance

Recorder: Sharon Avery

Guests: Terry Peterson, Brian Ducey, Patrick Koenig, Lloyd Brooks, Viona Latschaw, Kim McIssac, Janice Camp, Regine Neiders, Alan Paja, and Neil Hartman

L&I Staff: Brenda Heilman, Karen Jost, Debra Hatzialexiou, Julie Black, Ron Burford, Dave Overby, Jeff DeVere, Rob Cotton, Mike Ratko, and Rachel Aarts

Welcome & General Updates: Joel Sacks and Vickie Kennedy

The meeting began with introductions of the committee members and audience. Jeff DeVere, Deputy Assistant Director for Insurance Services, was introduced to the committee.

Ms. Kennedy provided a brief overview of agency request legislative proposals related to Insurance Services. The first workers' compensation bill incorporates two significant changes: the recommendations of the Vocational Rehabilitation Subcommittee for elements of the 2007 pilot improvements and enhancements to the Preferred Worker Program. Both the House and Senate versions have passed their respective chambers.

The bill that would allow the department to utilize additional Stay at Work resources and one-time Self-Insured Program investments by accessing non-appropriated funds without waiting for the legislative budget process is in the House Rules Committee.

Director Sacks shared information from the Senate and House budgets. From the workers' compensation perspective, the House and Governor's budgets are similar. There were four packages requested in the Governor's budget that were not in the Senate's budget. The packages include:

- Special Investigations Unit (underground economy)
- Additional resources to reduce long-term disability- primarily through improved quality of medical treatment
- Chemical Safety Team
- Prevailing Wage Program improvements

If the legislation passes to allow expenditures for one-time self-insurance projects (mentioned earlier), we will be able to build the Self-Insurance Risk-Analysis System (SIRAS), required for full implementation of the audit reforms, without a state budget appropriation.

There were two provisos in the Senate budget that were not in the House budget. One would require the department to conduct a pilot with five Retro groups regarding Independent Medical Exam (IME) scheduling and the second would preclude the department from spending money to bring staff together for meetings if contingency reserve target goals are not met.

Another proviso in the Senate budget would require the Board to work with the department on a study of superior court and appellate court outcomes from decisions of the Board.

A question was asked what the implications are for the overall audit reform project if the bill for SIRAS is not passed. Ms. Kennedy advised the department started a tier pilot. We are updating existing laptop systems used for auditing with existing funds. The most problematic area would be the technology to connect to a national database.

Ms. Kennedy summarized rules under development. The first concerned the annual review of the Medical Aid fee schedule. Overall, the proposal results in about a 2 percent increase in the fee schedule effective July 1, 2015.

Pension Discount Rate and Morality Table: The contingency reserve has been reduced for the one-time cost of the updated mortality tables along with the first .1 percent reduction in the discount rate, from 6.5 to 6.4. The rules became effective April 1, 2015, although technology changes were not completed to input these into the pension system. They will be in the system before the annual experting that evaluates all of the existing pension liabilities. This will correct the system for new pensions beginning April 1st, along with the existing pensions.

The changes were not completed because of other programming needs involving the payment system. The Supreme Court, in the *Crabb* case, indicated that the freeze on cost-of-living increases effective July 1, 2011, as part of the workers' compensation reforms, did not apply to workers who were entitled to the maximum benefit level. The department is working on the adjustments in the payment system and anticipates it to be in place before this year's cost-of-living increase.

A CR 101 has been filed concerning travel expense reimbursement for injured workers who are in active vocational retraining plans. Under the current process, a worker will not get reimbursed for the first fifteen miles one direction for travel, however this may not be consistent with our statutory authority for workers' compensation retraining. The department is proposing language allowing travel reimbursement from the first mile as it was before the current limitation was adopted.

Lastly, in the workers' compensation reform bill from 2011, the department is required to report on the outcomes of the structured settlement legislation. A RFP will be issued at the end of the month to enlist a researcher to conduct this work. The department would like one representative from the labor and business community to help evaluate the RFP responses at the beginning of June.

The department shared a safety message focused on a nationwide stand-down for construction focusing on falls.

Industrial Insurance (State) Fund Financial Overview: Rob Cotton

Rob Cotton, Workers' Compensation Accounting Supervisor, presented a financial update for fiscal year 2015-second quarter.

Committee members should have received the annual financial reports electronically on December 15, 2014. The reports and 10 year history are also available on the department's website at: <http://www.lni.wa.gov/ClaimsIns/Insurance/Learn/StateFund/Reports>.

The department received clean audit opinions on all of our audits for fiscal year 2014. The department also received our fifth Certificate of Achievement for Excellence in Financial Reporting from the Governmental Finance Officers Association (GROA). Director Sacks expressed his appreciation to staff.

Mr. Cotton provided a financial highlights overview for July 2014-December 2014:

- Overall, the performance of the state fund during second quarter of fiscal year 2015 is positive.
- The contingency reserve balance increased \$63 million, from \$950 million to \$1,013 million from July 1, 2014 through December 31, 2014 due to:
 - Premiums collected greater than new liabilities;
 - Investment income increased; and
 - Prior year's benefit liabilities decreased (favorable).
- Other significant changes included the investment unrealized losses increased \$15 million due to the stock market and the accounting adjustments unrelated to operations or investments increased \$14 million.

State Fund Results:

- Insurance Operations:
 - Premiums Earned (we took in): \$917 million
 - Total Expenses Incurred (we spent): \$1,113 million
- Premiums Earned:
 - Net premium earned increased by \$262 million mainly due to an increase in the number of hours reported by employers and the premium rate increase in the Medical Aid Account which was effective January 1, 2014.
- Net Benefits Incurred:
 - Benefits incurred increased from \$119 million compared to last year.
- Investment Income:
 - Total investment income was \$262 million mainly due to interest generated from our bond investments.
- Investments grew \$299 million during the first two quarters and ended at \$13.7 billion, impacted by reinvesting our net income and increasing our portfolios.
- Other Revenues and Expenses:
 - The net for other revenues and expenses was \$26 million.
- Results of Operations:
 - We have a net positive of \$92 million.
- Contingency Reserve:
 - As of December 31, 2014, the contingency reserve balance was \$1,013 million. This is below the WCAC target of \$1,873 million (14 percent of liabilities based on the agreed-upon ten year plan).
 - The contingency reserve for the Accident and Pension Funds was \$305 million.
 - The contingency reserve for the Medical Aid Fund was \$ 708 million.

- Key Financial Ratios:
 - The operating ratio is 94.4 percent.

A question was asked regarding the disparity in percentages between the Accident and Pension and Medical Aid targets and if these are incorporated into rate-setting. Director Sacks answered that the Medical Aid Fund is not at the ultimate target and still needs to grow. Secondly, due to the asset allocation balance, more money is in stocks in the Medical Aid Fund. The State Investment Board consults the department on asset allocations. The actuaries take this into account during the rate-setting process.

Another question was asked about the overall investment return this year. Director Sacks reviewed slide 26 and it was confirmed by Bill Vasek, Senior Actuary, that if you compare the investment income against the total invested assets, it is about 4 to 5 percent.

Self Insurance Risk Analysis System (SIRAS): Vickie Kennedy

Ms. Kennedy provided a brief overview of the Self-Insurance program and the Self-Insurance Audit's oversight role. The audit reform efforts were in response to dissatisfaction of all parties in the system; workers, self-insured employers, and the department. The need for Self-Insured Audit Reform included:

- Insufficient data to identify areas of non-compliance;
- Dissatisfaction with next-on-the-list audit selection;
- Redundant and duplicate reporting systems required for employers; and
- Lack of a process for audit response to complaints that may indicate a pattern.

To address the issues, a work group of business and labor stakeholders and the department met to modernize the auditing process developed a new approach that includes the Self-Insurance Risk Analysis System (SIRAS). Through this system, we will have information to help prioritize audits, and it will also allow us to be responsive with both issue-based and complaint-based audits.

For employers that are multi-state, it is difficult to compare their compliance in Washington with how they are doing in other states. The budget package is expected to address this issue for self-insurers interested in utilizing a nationwide reporting system.

The new audit process is a tiered system. The department is piloting Tier 1 in 2015, without additional staff resources; the department hopes to reach out to all 360 self-insured employers annually rather than conducting a full-scope audit for each employer every five years.

The stakeholder advisory group identified the calculation of wages as the first element for Tier 1 audit. We are now conducting audits using judgmental sampling of claims which supports reviews focused on common errors, including variable schedules, overtime, bonuses, and multiple rates of pay. Often, the most common patterns occur in the construction, temporary worker, farm labor, custodians, and nursing industries. Judgmental sampling allows for fewer claims to be reviewed while having more impact on overall compliance.

The best performing self-insurers will go through Tier 1. Tier 2 will be a smaller population based on performance from Tier 1, while Tier 3 will focus on employers with the lowest compliance rates. The stakeholder group is still working on the design for Tier 2, however, timeliness of benefit payments is an area they are focused on. Tier 3 would be the full-scope audit similar to what we have today.

Based on the data, the department may also look at specific issues for issue-based audits, and be able to gather data analytics and patterns to be more responsive to particular problems in the system.

Ms. Kennedy concluded with the timeline and next steps. The committee representatives will continue to work on defining Tiers 2 and 3 and anticipate developing rules and responsibilities for a permanent advisory group. Starting July 2015, with the budget package, we will start developing the system needs for gathering data for input into SIRAS.

A question was asked how worker complaints are addressed. Ms. Kennedy answered we currently address a worker's complaint on a claim-specific issue, but the data is not used to drive an audit. Under the new model, worker complaints would be incorporated in the system and the data could be used to consider whether an audit is indicated.

Director Sacks introduced Donna Egeland as the new Ombudsman for Self-Insured Injured Workers. In her new role, Ms. Egeland commented that she is reviewing existing processes designed to ensure injured workers receive benefits they are entitled to, and how we can expedite processes and work with the community to solve problems. She is mandated by the legislature to produce a report once a year with a series of independent recommendations. Ms. Kennedy added the ombudsman has the ability to investigate individual referrals on specific claims.

Insurance Services Performance Metrics Dashboard: Vickie Kennedy

Ms. Kennedy reminded the committee that we will be reporting the Insurance Services Performance Metric dashboard on a quarterly basis. Ms. Kennedy reviewed the dashboard for the overall indicator and focus areas. The overall indicator for long-term disability is red because it remains flat and we are not likely to meet our June 2015 goal.

As a reminder, the overall indicator for the agency goal of helping injured workers heal and return to work is to decrease the number of long-term disability (LTD) claims.

The three key focus areas are:

- Create a culture of return to work;
- Reduce the development of preventable disability; and
- Collaborate with stakeholders to reduce system delays.

Creating a culture that promotes Return to Work: There are two operational initiatives for this focus area. The first is targeting return-to-work services on high risk claims, progress is measured by the change in the percentage of claims on day 40 after claim receipt who are still on time-loss at 6-12 months. This effort focuses on delivering services on these claims through department field staff who engage with workers and the employers of injury, along with providers, to return the worker to work.

Claims are identified by a "return-to-work score". These claims meet certain criteria that indicate the worker may be at high risk for long-term disability. Risk factors include working for small employers, back injuries, and opioid use in the first few weeks of a claim. Claim managers receive a report when a claim is on time-loss at the 40th day and has these risk factors. This will trigger staffing and likely a referral to the field staff.

Early indicators from the pilot units have been positive and we are beginning to roll the approach out to each of the claims units.

Secondly, we are working to speed the vocational process by looking at how we can use vocational providers differently early on in the claim. Working with an employer and worker at 90 days into a claim is much different than working with the parties later or after multiple referrals. The department believes working with the worker and the employer of injury and looking at other options is critical to maintaining return-to-work

motivation and identifying barriers early on in the claim. The target is 10 percent and we are at 9.6 percent of claims with first AWA referrals within 90 days.

Help injured workers heal and reduce preventable disability: There are two measures in this focus area. The first is the percent of initiated claims seeing a COHE provider. Our goal by end of June 2015 is 50 percent and we are currently at 43 percent. The second measure is the percent of claims with opioid use six to twelve weeks from injury. These claims are much more likely to turn into long-term disability.

Two guidelines have been implemented since July 2013, to give providers the tools they need to minimize the number of workers that are on long-term opioids. Based on billing data, the number has been stable with overall usage reduced from 5 percent to 1 percent, about an 80 percent reduction.

Collaborate with stakeholders to reduce system delays: Two efforts in this focus area include reducing the median time-loss days to first Ability to Work Assessments (AWA) referrals. A target has not been established, but the measure of days has gone down from 249 day (CY 2013) to 177 days in the fourth quarter of 2014. Secondly, the department is working with external vocational community on new approaches for Vocational Rehabilitation Counselors.

Provider Survey Results & Outreach Efforts: Karen Jost

Karen Jost, Program Manager for Health Services Analysis, provided an update from the 2014 provider survey results and outreach efforts.

Psychologists were added as a provider type to survey in 2012 due to challenges in access and services related to mental health.

The 2014 survey was sent to 9,700 providers who billed the department within the last 18 months and we received an 11.6 percent response rate. There were six areas of focus for this survey including satisfaction, trust, willingness to treat, role in return-to-work, comparing L&I to other payers, and awareness of L&I resources.

Overall, 65 percent of providers had a very satisfied or somewhat satisfied experience treating patients with L&I claims.

Generally, providers trust the department more than they are satisfied with us. Psychologists, psychiatrists, and orthopedic and neurologic surgeons were most dissatisfied. There are projects underway to review and update policies related to processing claims with mental and behavioral health needs. A project manager has been hired who will work with stakeholders to gather data and determine what can be done to improve processes surrounding mental health services. Orthopedic and neurologic surgeons are more challenging to address because they are not traditional attending providers and they struggle with the department asking them questions on a claim that they do not have expertise on, especially regarding return to work and causation; their expertise is in conducting the surgeries. The department is working on a best practices program to look at transition of care in surgery cases to ensure workers are getting transitions to and from surgeons in a timely manner. Another effort since 2006 incentivizes orthopedic and neurologic surgeons to adopt best practices of seeing a worker in a timely manner and completing the surgery quickly once it has been authorized, documenting the return to work plan and the rehabilitation plan using the activity prescription form.

We learned that most providers are willing to treat L&I patients.

A new question asked how much of a role should providers play in helping patients return to work. 77 percent of providers felt they have a significant role in return to work.

Compared to other payers regarding bill payment process, once a claim is accepted, bills get paid quickly and accurately. Providers expressed appreciation for being able to bill electronically. Areas where we struggle include the bill payment process of sending payments and remittance advices through Department of Enterprise Systems as part of a statewide initiative. The remittances do not contain information providers need to reconcile their accounts. A few providers commented the department pays slower than other payers. We currently pay on a two week billing cycle, but it is possible to explore in the future whether we can pay more frequently.

Claim managers, the provider hotline, quick fee schedule look-up, Claim and Account Center and interactive voice response all were seen as very useful resources for providers.

A question was asked if any of the resources help providers calculate the PPD rating. Available resources include the medical examiners handbook and staff in the Office of the Medical Director that can assist with questions.

There are a number of process improvements underway to address issues with authorizations, documentation, and leveraging technology. Regarding issues with authorizations, a new request for authorization form has been designed that is a priority work item for the claim manager so it can be responded to in a timely manner. This form has been very useful for the providers that are utilizing it. The department has also streamlined utilization review for surgeons in consistent compliance with the treatment guidelines.

We are developing an occupational health management system, an electronic platform, for COHEs and health services coordinators to be able to exchange medical information with claim managers. Another challenge we have is for providers to be able to access our systems electronically. We are working on creating one portal for them to access the tools they need. There are ongoing Lean projects with the credentialing team and the provider hotline.

The Health Services Analysis program is providing support and outreach efforts for providers with billing workshops, and assistance from two provider account representatives. We work with self-insured employers to provide a Self-Insurance Colloquium twice a year to share information about best practices

Ms. Jost addressed a question regarding complaints about providers who are not responding to requests for information. There is a project underway to establish a process where we can systematically compile information and target outreach efforts to those providers who are struggling.

A concern was raised about employers' frustrations in treatment delays, specifically authorizations for MRI. Ms. Jost advised MRIs require utilization review which takes one to two days. The department reduced costs by \$30 million last year because MRIs were previously being approved when they were not consistent with medical treatment guidelines.

Logger Safety Initiative: Vickie Kennedy

Ms. Kennedy provided an update on the Logger Safety Initiative (LSI). The safety initiative is a partnership of contract loggers, private land owners, the Department of Natural Resources and Labor and Industries. The goal is to reduce the frequency and severity of injuries and fatalities in manual logging and increase the proper reporting of hours and premiums. The LSI, through the taskforce, established requirements for training, performance, and supervision that go above and beyond existing DOSH rules. For those participating, they must undergo a technical premium audit, comply with reporting requirements by notifying the department of new logging sites, implement LSI safety standards and undergo a DOSH comprehensive consultation, and pass a performance-based independent third-party audit to verify compliance with LSI safety standards.

As of April 3, 2015, a total of 107 logging companies and nine forestry landowners were participating in LSI. Of that, 86 companies received full certification by addressing all of the requirements and are receiving 20 percent reduction from their base premium rate.

The hours are increasing in 5001 classification, which we attribute, in part, to the work of this initiative and the requirements about premium reporting.

214 audits have been conducted and 71,000 hours, or about 35 FTEs, have been recovered in the system.

Comparing 2014 activity to prior years, the number of DOSH consultation occurring on logging job sites tripled.

The initiative received partial funding in the last biennial budget, but also required us to recover part of the costs from the forest products industry. Our recovery was directed to be \$420,000 of the cost, so we have estimated the need to collect \$210,000 in 2015 and \$210,000 in 2016. A budget request has been submitted to permanently fund the additional consultation staff along with the third party safety audit contract.

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

Dave Thredy provided the quarterly update from the BIIA.

- Total Appeals Filed:
 - 3,537
- Decision & Order Time-Lag by Quarter: This is how many days it takes the Board members to process a Decision and Order after a Petition for Review has been granted; this is at an average of 29 days.
- Quarterly Average Weeks to Completion: The goal is to keep this measure at less than 32 weeks; it is currently at 29.7weeks.
- Caseload at End of the Quarter: There were 5,495 appeals at the end of the quarter.
- Percentage of Final Orders Appealed to Superior Court- Quarterly: 3.9 percent

Closing Comments:

September minutes were adopted.

Meeting Adjourned.