

**Audit Committee**

**Wednesday, December 16, 2008, 2:00 p.m.**

**William Green Building**

30 West Spring Street, 2<sup>nd</sup> Floor (Mezzanine)

Columbus, Ohio 43215

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Members Present: Kenneth Haffey, Chair  
Robert Smith, Vice Chair  
James Harris  
William Lhota  
Jim Matesich

Members Absent: None

Other Directors Present: David Caldwell, Alison Falls, James Hummel,  
Thomas Pitts, and Larry Price

**CALL TO ORDER**

Mr. Haffey called the meeting to order at 2 p.m. and the roll call was taken.

**MINUTES OF NOVEMBER 20, 2008**

Mr. Matesich requested that page 3, ¶5 be clarified to read, "Bureau management has agreed to develop a beginning-to-end settlement process . . . ."

Mr. Lhota moved that the minutes of November 20, 2008, be approved as amended. Mr. Matesich seconded and the amended minutes were approved by a unanimous roll call vote.

**DISCUSSION ITEMS**

**ANNUAL DISASTER RECOVERY/BUSINESS CONTINUITY PLAN**

Thomas Croyle, Chief Information Officer, presented the annual report on the BWC disaster recovery/business continuity plan. He described the BWC systems, disaster recovery plan (DRP) costs, DRP planning, and incidents from the past twelve months.

BWC has eight mission-critical applications, including V3 (claims management), WCIS (risk management), and rates and payments. Ancillary applications include email. All applications are supported on one mainframe.

BWC has a contract with IBM to move operations to its New York Data Center in the event of an incident. BWC personnel would work out of the Plain City Command Center during recovery. OIT also works with other state agencies. MailGard provides remote printing services for correspondence and checks. BWC expects recovery within forty-eight hours of an incident.

The DRP is tested twice per year at the Plain City Command Center. Any incident will incur \$25,000 in costs to IBM, \$10,000 to MailGard, and \$38,900 in travel expense for fifteen BWC personnel. Annual costs are \$353,700 for the new, three-year contract with IBM. The old contract with SunGard was \$547,000. The contract with MailGard is \$65,862.

BWC held a test on December 6 and 7. OIT was able to get all mission-critical systems restored. However, the restoration took longer than expected due to unforeseen problems. BWC is currently undertaking a post-mortem.

Mr. Hummel asked whether the costs for the test were in the annual contract or were in an incident fee. Mr. Croyle replied the costs were in the contract.

In one of two recovery incidents during the twelve-month reporting period, BWC was conducting a scheduled shut-down and a fuse failed. The second was a transformer fire on Chestnut Street on November 14. There was no direct effect on BWC because of back-up generators. However, the fire required evacuation and terminating the emergency power.

Mr. Caldwell asked what the cause of the fuse failure was. Mr. Croyle stated that the exact cause was unknown, but it may be because of use of recycled parts by the manufacturer.

Mr. Lhota asked who owns the transformer. Mr. Croyle reported that it belongs to AEP.

Mr. Price requested that copies of the December test post-mortem be distributed to the Workers' Compensation Board when available.

## **OPEN DISCUSSION WITH CHIEF INTERNAL AUDITOR**

Caren Murdock, Chief of Internal Audit, provided a report on several ongoing projects.

The Internal Audit Division (IAD) is working with Joe Bell, Chief Audit Executive, Office of Budget and Management (OBM), on the transition of the department to the OBM. OBM will be absorbing BWC IAD and one other agency in July 2009. Mr. Bell will report to the Workers' Compensation Board in March 2009.

Ms. Falls asked why OBM was only absorbing the Internal Audit departments of two agencies. Ms. Murdock replied that was because only two agencies were identified as doing formal internal audit work and would permit a smooth transition to OBM. Ms. Ryan added that current budget constraints have required a modification to the original OBM implementation plan which will result in a slower transfer of staff.

Mr. Smith asked what some of the other issues are. Ms. Murdock replied that the fold-in must accommodate human resources and collective bargaining issues, among others.

Mr. Smith asked if Ms. Murdock would be overseeing only BWC. Ms. Murdock replied she may be overseeing one other agency.

Mr. Hummel asked what the other agency in the OBM transition was. Ms. Murdock replied it was the Department of Public Safety.

Mr. Lhota asked where the IAD would be physically located. Ms. Murdock replied that IAD would be located in the William Green building.

Ms. Murdock reported that IAD has eight ongoing projects. Of which, three projects are expected to be completed and included in the February Quarterly Executive Summary. She further reported that there are two new hires to start in January: an internal auditor 3 and the investments auditor.

Mr. Haffey reported that he speaks with Caren Murdock and Don Berno, Board Liaison, once per week on IAD staffing and project issues.

## **LITIGATION UPDATE**

Mr. Haffey reported that there would be no litigation update for this month.

## **NEW BUSINESS/ACTION ITEMS**

### **ANNUAL REPORT**

Ann Shannon, BWC Legal Counsel, presented the BWC Annual Report to the Audit Committee for review and approval. Ohio Revised Code § 4121.12(F)(3) requires BWC to make an annual report. BWC is also responsible for several other reports, including new ones required by Am. Sub. H.B. 100. BWC has decided to combine them all in one document. After the Audit Committee accepts the Annual Report, it will be submitted to the Workers' Compensation Board for approval.

Several departments are responsible for the report and Communications is responsible for compiling and publication. Among the combined reports are the external audit, the actuarial audit, the safety and hygiene report, and the Industrial Commission report. The Annual Report is primarily available on a CD-ROM, but can be printed if requested. Ms. Ryan added that publishing as a CD-ROM saves printing costs of .19 per copy.

Mr. Smith asked about the missing pages in the hard copy distributed to the Workers' Compensation Board. Keary McCarthy, Chief of Communications, replied that some pages were intentionally left blank and that some pagination is wrong in the printing. He stated that he would research the problems and provide better copies to the Workers' Compensation Board. Mr. Berno added that Ms. Shannon and he had checked the report on December 16 and all reports required by the Ohio Revised Code were included.

Mr. Haffey moved that the Audit Committee of the Workers' Compensation Board of Directors refer the BWC Annual Report to the Board of Directors for review and approval. Mr. Lhota seconded and the motion was approved by unanimous roll-call vote.

### **SUBSTITUTION/CHANGE OF CHAIRMANSHIP**

Mr. Haffey left the meeting for another commitment. Mr. Smith assumed the chair for the balance of the meeting.

### **RULES FOR FIRST READING: BWC 50/50 PROGRAM, OHIO ADMINISTRATIVE CODE RULE 4123-17-14.2**

Ms. Valentino recommended amendment of Ohio Administrative Code Rule 4123-17-14.2 to change the deadline for payment of the second installment of the premium for the second half payroll period of 2008 and later years. Over 17,000 employers use the program, which is a 60% increase over 2005. The average payment is \$20,000 for each employer. The amendment extends the deadline of the second payment to June 1.

Mr. Smith commented that the change will save staff time to process late payments.

Mr. Lhota moved that the Audit Committee suspend its practice of conducting a first and second reading of proposed Administrative Code Rules pursuant to the Governance Guidelines in order to recommend immediately that the Bureau of Workers' Compensation Board of Directors approve the Administrator's recommendation to amend Rule 4123-17-14.2 of the Administrative Code Rule, "Bureau Fifty-Fifty Program." The motion consents to the Administrator amending Rule 4123-17-14.2 as presented here today. Mr. Matesich seconded the motion.

Mr. Price asked if this amendment is a temporary or permanent change to payment dates. Ms. Valentino replied that BWC will evaluate the effectiveness of the change on collections and employer financial relief and the effect of adoption on new and different employer programs.

The motion was approved by a vote of four ayes and no nays.

**RULE REVIEW—SECOND READING: INTERSTATE JURISDICTION, OHIO ADMINISTRATIVE CODE RULES 4123-17-14, 4123-17-17, & 4123-17-23**

Tina Kielmeyer, Chief of Customer Services, and Michael Glass, Director of Underwriting and Premium Audit, recommended amendment of three Ohio Administrative Code Rules as required by recent legislation, Am. Sub. S.B. 334 and Am. Sub. H.B. 562. The amendments eliminate duplicate payroll reporting. BWC has been discussing reciprocal agreements with other states. So far, all responses are negative because the agreements are prohibited by the laws of these states. Accordingly, BWC has informed them that the entire payroll of employers doing business in Ohio will be reportable. New York has responded that it is amenable to a change in its law. Ohio already has an agreement with West Virginia. The rules as presented today are identical to those presented in November with the exception of adding "out-of-state" to Rule 4123-17-23(C), as suggested by Mr. Pitts.

Mr. Lhota asked what the stake-holders reaction was. Ms. Kielmeyer replied the stakeholders have been very positive. It was the stakeholders who sponsored the legislation.

Mr. Lhota moved that the Audit Committee recommend that the Bureau of Workers' Compensation Board of Directors approve the Administrator's recommendation to amend Rules 4123-17-14, 4123-17-17, and 4123-17-23 of the Administrative Code. These rules make changes relating to interstate jurisdiction to implement Senate Bill 334 and House Bill 562. The motion

consents to the Administrator amending rules 4123-17-14, 4123-17-17, and 412-17-23 as presented here today. Mr. Matesich seconded and the motion was approved by a roll call vote of four ayes and no nays.

**RULE REVIEW—SECOND READING: AMBULATORY SURGERY CENTER FEE SCHEDULE, OHIO ADMINISTRATIVE CODE RULES 4123-6-37.3**

Freddie Johnson, Director of Managed Care Services, and Anne Casto, Casto Consultants, recommended adoption of Ohio Administrative Code Rule 4123-6-37.3 regarding a fee schedule for Ambulatory Surgery Centers (ASC). The rule is based on provisions of the Ohio Revised Code and the *Ohio Hospital Association* case. If approved today, and then by the Board, the timeline for implementation is April 1, 2009. The rule and proposed fees reflect 3 recommendations being made:

- Adoption of Medicare’s new ASC methodology and 2009 transitional rates; projected to increase reimbursement by \$1.7 million or 23% from 2007 reimbursements;
- Expansion of the scope of services for which ASCs can receive reimbursements; expanded a little over 400 new services;
- Modification of selected billing protocols and practices; thus enhancing service billing and practice efficiencies.

Mr Johnson indicated that while BWC was able to answer questions from the Audit Committee at the November meeting, BWC wanted to provide some additional insights on the cost-benefit of adopting or not adopting the proposed fee schedule.

Ms. Casto reported that failure to adopt the proposed fee schedule could result in additional cost to the bureau due to procedure migration. Cost benefit figures were presented based on migration from the ASC setting to the hospital outpatient setting at the five, ten, fifteen and twenty percent levels. Additional cost projections ranged from \$1.2 million to \$5 million. The breakeven point for BWC is between five and ten percent migration. The provider recommends the facility for the procedure. If the BWC reimbursement for an out-patient procedure is deemed too low, the ASC may decline the admission and the provider will then perform the procedure at a hospital outpatient setting. Cost-benefit analysis was also performed for the expanded scope of services. For 127 procedures using a 12% migration estimate, the savings to the bureau would be \$53,000.

Mr. Matesich moved that the Audit Committee recommend that the Bureau Workers' Compensation Board of Directors approve the Administrator’s recommendation to adopt Rule 4123-6-37.3 of the Administrative Code, “Payment of Ambulatory Surgical Center Services.” The motion consents to

the Administrator adopting Rule 4123-6-37.3 as presented here today. Mr. Lhota seconded and the motion was approved by a roll call vote of four ayes and no nays.

**UPDATE ON PROVIDER FEE SCHEDULE RULE, OHIO ADMINISTRATIVE CODE RULE 4123-6-37.1**

Robert Coury, Chief, Medical Services and Compliance, provided an update on approval of the provider fee rule, Ohio Administrative Code Rule 4123-6-37.1. The Workers' Compensation Board approved the rule at its September 26 meeting and it was filed in October with the Joint Committee on Agency Rule Review (JCARR). BWC held its first public hearing on November 18, where the Ohio Association of Rehabilitation Facilities (OARF) contended that the fee schedule is based on the wrong section of the Ohio Revised Code and uses the wrong methodology. The BWC Legal Department disagrees. However JCARR seemed amendable to the contentions of OARF, so BWC pulled the rule and will remove the part of the schedule pertaining to rehabilitation.

The original time-line was to implement the schedule in February 2009. The removal of the rehabilitation portion will delay the implementation by fifteen to thirty days. The rehabilitation fee portion is under review and BWC may have to request amendment of the Ohio Revised Code because of anachronistic statutes drafted to empower BWC to operate rehabilitation centers in Cleveland and Columbus. An alternative is to enact a rehabilitation fee schedule under the rehabilitation statutes.

**ADJOURNMENT**

Mr. Lhota moved to adjourn, Mr. Smith seconded, and the meeting was adjourned.

Prepared by: Larry Rhodebeck, Staff Counsel  
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December 22, 2008



**TO:** BWC Board of Directors

**FROM:** Tina Kielmeyer, Chief, Customer Services Division

**SUBJECT:** BWC Lump Sum Settlement Program Update

**DATE:** January 12, 2009

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As you are aware, BWC's lump sum settlement program has recently undergone an internal audit and a comprehensive review by an insurance consulting firm.

Both the audit and independent consulting review yielded many valuable recommendations to improve the internal controls and overall performance of our lump sum settlement program.

A team of BWC settlement experts is being convened to immediately evaluate, prioritize and implement much needed settlement program enhancements.

The team's five major objectives are:

1. To clearly define and communicate our guiding philosophy and objectives for settlements - each settlement needs to answer the question, *is this an appropriate resolution strategy for all stakeholders?*
2. To establish settlement eligibility guidelines that are consistent with our guiding philosophy and objectives - in order to deliver fair and equitable claims outcomes we need to objectively evaluate each case and avoid adverse selection.
3. To develop and implement a comprehensive settlement evaluation process – better defined eligibility will enable improved evaluation utilizing objective tools and resources.
4. To implement a rigorous governance and interactive control program – an improved control structure will be implemented that incorporates detailed evaluation documentation, regular claims committees or roundtables, ongoing qualitative audits, appropriate claims settlement authority hierarchy and performance metrics.
5. To effectively utilize and align our internal resources to efficiently operate our settlement program – clearly establish a claims owner and a consistent operating structure throughout the organization.

While we are evaluating our settlement program and making necessary changes, we have decided to not resume fast track settlements at this time. This information has been communicated internally and externally.

Additionally, BWC will work closely with our stakeholder community to solicit input and communicate program changes as needed.

While settlements represent just one component of BWC's claim resolution strategy, management and staff recognize the critical importance of ensuring robust controls and performance.

Please let me know if I can be of further assistance.

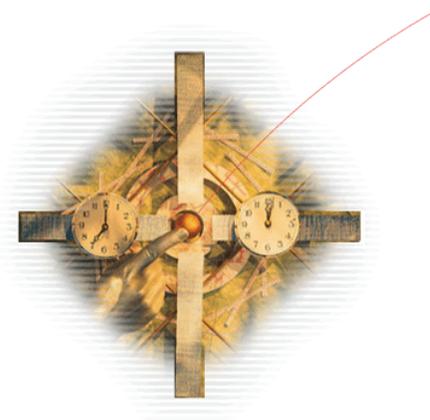
# Lump Sum Settlement Project

## Final Report

Presented by

Patricia A. Drago and Fred G. Marziano

December 17, 2008



**Insurance Perspectives + Solutions**

208 2<sup>nd</sup> Avenue, Belmar, NJ 07719  
732-681-2947 [www.inperspectives.com](http://www.inperspectives.com)

### *Executive Summary*

Ohio BWC launched a Pursuit of Settlement initiative in 2006 which resulted in a dramatic increase in the volume of Lump Sum Settlements [LSS]. LSS costs increased from \$141 million in 2005 to \$242 million in 2007. The 2008 forecast reflects costs closer to \$300 million. Given the scale and impact of lump sum settlements, the Ohio BWC chartered the LSS Project to review current practices and controls, analyze industry best practices, and make recommendations to improve Ohio BWC's claims settlement process. Our observations and findings led to a number of recommendations in five key areas:

- Claims settlement philosophy and strategy
- Claim eligibility for lump sum settlement
- Claim evaluation
- Interactive controls and governance considerations
- Effective alignment and utilization of resources

### *Philosophy*

The past few years have seen a swing from one extreme to another; from a fairly rigid, one-settlement-number-take-it-or-leave-it negotiating style to an almost consuming focus on flexibility and ease of doing business. Underpinning the new approach was a belief that the LSS tool should be used to resolve as many claims as possible in order to shorten the long claims tail and to eliminate the uncertainties associated with future liabilities and potential problem claims. Field staff responsible for executing the LSS initiative had varying interpretations of this initiative and associated performance expectations, which increased the execution risk.

Lump sum settlement is an important tool in the resolution of workers compensation claims. Our recommendations are an effort to return Ohio BWC to best practices and the basics of proper claim handling: to settle the right claims for the right value at the right time under the right circumstances. An effective LSS is appropriate to the individual claim, practical, economically reasonable, and beneficial. Each claim is different. Claims professionals must use critical thinking and analysis to understand the factors involved to determine whether LSS makes sense in that particular case.

### *Eligibility Criteria and Considerations*

There is currently no organized perspective on what constitutes a claim eligible for LSS. In a departure from general industry practice, an overwhelming majority of candidates for LSS are initiated externally, usually by outside counsel representing the injured worker.

Ohio BWC is accountable to achieve optimal claims outcomes while balancing the needs of all stakeholders. To consistently deliver fair and equitable claims outcomes, and to avoid the risk of adverse selection, Ohio BWC should develop a point of view on LSS eligibility. As with claims handling in general, the eligibility determination is a case-by-case assessment. Our recommendations offer a more disciplined approach accompanied by examples of claims that generally fit eligibility or ineligibility criteria. Ongoing discussion, claim committee insight and experience will help to further refine an organized perspective that, once institutionalized, will drive more consistent selection of appropriate candidates for LSS.

### *Claim Evaluation*

Ohio BWC would benefit from a comprehensive set of evaluation guidelines that includes the use of objective tools and resources. Currently, claims evaluations are based primarily on individual skills and experience. While these are not without value, a predominantly subjective approach to evaluation is subject to the risk of human bias due to anchoring, overconfidence and perpetuation of outdated assumptions.

Our recommendations seek to restore a more rigorous and disciplined evaluation based on the facts and circumstances unique to each claim. This includes more consistent reliance on concrete tools and professional resources that will counterbalance subjective risks and lead to evaluations that are more objective, credible and defensible.

### *Interactive Controls and Governance Considerations*

Ohio BWC does not have adequate controls in place for LSS. There are no objective mechanisms to verify that LSS outcomes are generally reasonable and appropriate. It is certainly possible that LSS activity to date will reap future benefits; but the reverse is also a possibility. The problem is that the ultimate impact is unknown.

Our recommendations address an improved control structure that centers on the following components: detailed evaluation documentation; regular claims committees; ongoing qualitative audits; claim settlement authority; and monitoring metrics.

The first two components, a detailed evaluation form and settlement committees, were discontinued when the current LSS initiative was launched. We are recommending they be updated and restored. The development and implementation of an objective, comprehensive LSS audit is a critical need. File audit is the primary measure of claims professionals' performance, and provides the agency with critical information on overall performance gaps and trends. The authority split between Claims and Legal has led to issues with accountability and performance management. It is recommended that, once a claims "owner" of LSS is identified, all settlement authority be returned to the claims function. Current metrics around settlement volume and turnaround time should be supplemented with a robust set of metrics and actuarial diagnostics that will monitor financial trends and impact. Since most of these control mechanisms are interactive, they also serve the dual purpose of supporting and improving quality execution.

### *Effective Alignment and Utilization of Resources*

Industry best practices suggest that Claims is accountable for control and execution of all aspects of its performance. Staff attorneys partner with claims as advisors, offering guidance, interpretation and advice, as well as manage outside litigation. Ownership of the LSS program should reside in Claims once all structure and staffing issues are resolved.

Dedicated LSS claims resources are dispersed throughout 16 Service Offices. And while the Law Department has a designated “owner” for LSS; there is no counterpart in Claims. Many of the issues surfaced in this project may be traced back to the fact that there is no claims “owner” for the LSS initiative. This gap may help to explain why Ohio BWC ended up creating a hybrid authority structure. The scale and impact of LSS warrant a centralized reporting structure to a single, accountable, seasoned claims leader. To further improve execution, we recommend the regionalization of LSS claim resources to create a more nimble, consistent and responsive aggregate capability.

Adequate, mandatory training is needed to assure the continuous development of higher level skills critical to the successful pursuit of lump sum settlements. The new WC Certification program is an excellent start, but is voluntary and has had limited reach to date. The starting point is the development of a core skills inventory and assessment tool for the LSS CSS position. This would identify performance expectations and, when combined with audit results, would provide an objective basis for performance management and candidate selection criteria, leading to continuous upgrades in quality of staff. It would also enable targeted training and effective investment of training dollars. Given the volume and dollars associated with LSS, we urge Ohio BWC to give evaluation and negotiation training a high priority.

### *Conclusion*

By addressing these five key components, OHIO BWC will make significant strides in managing and controlling the utilization and impact of lump sum settlements.

### **Project Scope and Objectives:**

- Review current Lump Sum Settlement process, including:
  - Determination of eligibility
  - Calculation of settlement amount
  - Review and approval of claim settlements
- Analyze industry Best Practices via survey
- Recommendations to improve current claims settlement process
- Final report, to include:
  - Results of review
  - Summary of Best Practices
  - Recommendations for improvement

### **Resources:**

Resources used during this project included:

- Documents and custom MIS reports posted to SharePoint database under LSS Project
- Ohio BWC web site
- Interviews with assigned LSS Project Team members
- Discussions with Administrator, COO and Audit Committee Chair
- Interviews with additional staff in Actuarial, Finance, Employer Services, Regional Management and Service Office Management
- Site visit to Dayton Service Office and discussion with Dayton LSS team
- External insurance industry survey on Best Practices:
  - 12 active insurers [one via its primary TPA; two via ex-executives]
  - 5 insurers with run-off operations
  - 5 State Funds
  - 1 consulting expert/auditing firm with extensive WC executive experience and current WC insurer clients

**Guiding Considerations**

The key objective is to handle each claim based on the individual merits of that claim to:

- Drive the best outcomes individually and at an aggregate level
- Appropriately and effectively balance the best interests of all stakeholders: employee, employer, Ohio BWC and the State of Ohio to:
  - Achieve fair and equitable settlements
  - Managing fiscal accountability
  - Support the Ohio BWC mission
- From this starting point, influencing or overriding operational, financial or external considerations may be applied to meet additional needs

Not within the scope of this project is a specific claim audit or file review to assess reasonableness of settlement amount or effectiveness of claim negotiations.

All analysis and recommendations are offered as business and operational advice and should not be construed as legal advice. Advice with regard to legal issues and/or implications should be obtained from your legal counsel to ensure that the unique aspects of your specific jurisdiction are addressed.

**Ohio BWC Mission:**

“Protect injured workers and employers from loss as a result of workplace accidents, and to enhance the general health and well-being of Ohioans and the Ohio economy” to achieve:

- Stable costs
- Better services
- Safer workplaces
- Accurate rates

**Claims Mission and Purpose:**

Support Ohio BWC mission through the delivery of “adequate, prompt, equitable benefits to injured workers and dependents; and appropriate medical care and rehabilitation with the goal of earliest possible return to work and restoration of injured worker.”

- Fair and equitable claims handling
- Stable and consistent technical execution
- Appropriate resolution of claims based on fundamental best practices
- Fiduciary and moral responsibility to achieve optimal claims outcomes while balancing the needs and interests of all stakeholders

### Claims Settlement [LSS] Philosophy and Strategy

**Observations:** Ohio BWC does not have a documented guiding philosophy and strategy for Lump Sum Settlements. [Also noted by Internal Audit - Recommendation #1]

#### **Recommendation # 1: Proposed Philosophy and Strategy**

LSS is a key tool to resolve appropriate claims fairly and equitably for all stakeholders. When developing the claims resolution strategy on each claim, the CSS should consider whether LSS is an option. LSS should not be used if the following tests cannot be met:

- Injured worker – Is it appropriate? Does it make sense?
- Employer – Is it appropriate? Is it reasonable and practical?
- Ohio BWC – Is it appropriate? Does it discharge OHIO BWC's purpose and responsibility? Is it economically reasonable and beneficial?

Operating guidance:

- Settle the right claims for the right value at the right time under the right circumstances
- Implement a program, process, procedures and systemic controls that maximize the probability of this outcome

Why use LSS?

- Potential benefits to injured worker [IW] of a fair and equitable settlement:
  - Address legitimate financial need
  - “Healing” process often comes with LSS: no longer “dependent” on WC, IW is free to get on with his life, even go back to work, start a new chapter
  - May close psychological/emotional issues
- Potential benefits to Employer of a fair and equitable settlement:
  - Accelerates closure and certainty of claims cost
  - Lowers ultimate claim costs
  - Should contribute to lower rates in the long run
- Effective LSS are beneficial to BWC in its role as fund fiduciary:
  - Lowers ultimate benefit and administrative operating costs which leads to improvements in competitive rates
  - Accelerates certainty of ultimate liabilities in a significant claims population, benefitting actuarial analysis and reserve adequacy pick
  - Shortened tail benefits management of investment portfolio durations
  - Removes risk of escalating and unpredictable medical inflation
  - Removes “moral hazard” claims from the WC system

## **Eligibility Criteria and Considerations**

**Observations:** Ohio BWC has not developed an Agency philosophy and accompanying guidance for determining the types of claims generally eligible or ineligible for LSS.

### **Recommendation # 2: LSS Eligibility Criteria**

Ohio BWC should develop its philosophy and guidance on how to assess claim eligibility for LSS. For each claim, when developing the claims resolution strategy, the claims professional should conduct a thorough analysis of the following factors and circumstances specific to that claim to determine whether LSS is an appropriate option:

- Nature of injury, injured worker recovery progress and co-morbidity conditions
- Injured workers behavior, motivation and attitude toward recovery and rehab; are they capable of caring for themselves properly?
- Return to Work prospects
- Education and other socioeconomic factors
- Prospect of significant future medical
- Prospect of claim deterioration if claim continues in WC system
- Risks to injured worker and other stakeholders if removed from WC system

Recommendations 2.a, 2.b and 2.c which follow offer more specific recommendations on claim types generally eligible or ineligible for LSS.

## **Recommendation # 2.a: Claim Types Eligible for LSS**

This is a list of suggested claim types with characteristics that generally lend themselves to LSS resolution based on industry best practices. This should be intended for use as a guideline and not as an ironclad set of rules, since individual factors and circumstances will vary from case to case. It is recommended that Ohio BWC use this list as a starting point for discussion of desired agency philosophy in determining eligibility for LSS. In each case, Ohio BWC should also develop general guidance on appropriate discount below NPV for LSS consideration.

Development of guidance that supports OHIO BWC's philosophy will enable Claims to flag exception claims for Claims Committee or Executive Staffing review. It will also enable Claims to implement qualitative authority guidelines.

- Claim is stable and predictable. Claimant MMI, in general good health, and potentially capable of some work. Future medical, if any, is routine and predictable. Ideal point in time is pre-event [PPD/PTD]. Heart or diabetes comorbidity may be considered depending on claimant age. A "rated age" should be obtained in such cases.
- PTD or probable PTD with condition stabilized and no likely RTW; medical predictable and calculated into life care plan developed with input by medical professional.
- Difficult, prolonged claims that won't improve with time, provided injured worker has reached MMI.
- Maintenance claims that won't benefit from further medical management or case management efforts.
- Back, knee and hip claims, and other lingering soft tissue injuries that risk deterioration and RSD if maintained in the WC system. Ideal point in time is at 2-3 years post-injury.
- Claimant with recovery hampered by psychosocial or emotional issues that are likely to resolve with LSS and claim closure.
- Widow/widower lifetime benefits where claimant has alternate means of ongoing support; otherwise, consider LSS to address special financial needs. Widow's LSS evaluation should include appropriate discount relative to age, children, length of marriage and length of widowhood.
- Claims with significant disputed issues where prospects for successful litigation outcome are 50/50 or less should be evaluated for a sharp compromise resolution.

- Irrespective of the above, the factors and circumstances in Recommendation #2 should always be considered on all claims to ensure that LSS is appropriate in that particular claim.

### **Recommendation # 2.b: Claim Types Ineligible for LSS**

This is a list of suggested claim types with characteristics that generally do not lend themselves to LSS resolution based on industry best practices. This is a starting point for Ohio BWC discussion and determination of ineligible claims. This should be intended for use as a guideline and not as an ironclad set of rules, since individual factors and circumstances will vary from case to case. Individual claim circumstances may warrant that an exception be made to permit consideration of LSS. Such exceptions should be flagged for escalation to the Claims Committee or Executive Staffing, as determined by Ohio BWC authority controls.

It is important to keep in mind that eligibility determination is separate and distinct from authority to approve recommended settlement range.

- Catastrophic injuries, including, but not limited to, spinal cord injuries such as quadriplegia and paraplegia, brain injuries, serious burns
- Claims that are volatile, not medically stable, or in acute care stage. These should be managed to stability and MMI before considering LSS.
- Claims with significant and/or multiple co-morbidities
- LSS for dependent children is generally discouraged.
- Injured worker still working for employer.
- Frivolous or nuisance claims with limited medical, RTW and *de minimus* permanency
- Claims where injured worker is incapacitated.
- Claims with suspected fraud or where medical treatment is abused to drive up claim costs

### **Recommendation # 2.c: Claims Requiring Case-by-Case Consideration**

We recommend that the first two categories be evaluated for LSS consideration using the criteria outlined in Recommendation #2 and approved by Claims Committee or Executive Staffing, as required. Claims that fall within the third group may be handled through the normal authority hierarchy. We recommend that Ohio BWC not require higher-level approval of individual claims disallowed by the LSS CSS.

- Claimants with significant drug dependency, especially with off-label use, or unrelated alcohol or drug addictions.
- Claims with significant future medical, whether or not MSA involved.
- Unusual Settlements
  - Sole proprietor, partnership with no arm's length relationship
  - Self-insured DWRF
  - Great Deference request
  - Respiratory OD claims
  - Claims with index hits
  - Future DWRF payment claims
  - Rehab claims where Ohio BWC acts as the employer
  - Overpayment waiver requests
  - VSSR [Ohio BWC is settling]
  - Partial settlements
  - Claims with parallel SI claims
  - Claims requiring reconstruction
  - Any other extraordinary circumstances

### Evaluation of LSS Settlement Range

**Observations:** A comprehensive set of evaluation guidelines that includes the use of objective tools and resources is lacking. There is insufficient clarity around qualitative standards and performance expectations. Ohio BWC withdrew an existing LSS operational manual when the LSS initiative was implemented in 2006. There is a set of evaluation guidelines within an unreferenced document entitled “Lump Sum Settlement Policy”. There does not appear to be broad awareness of this document, nor is the document clearly marked as a policies and procedures manual. This was also noted by Internal Audit in their Recommendation # 2.

Each claim should be evaluated based on the facts and circumstances of that claim. Evaluation sets the stage for effective negotiations and a positive outcome. A quality evaluation range derives from a rigorous and comprehensive assessment of each relevant claim component or factor, including a probability assessment of each component/factor. Industry best practices reflect an increasing use of objective tools and resources to determine and support LSS values, and to counterbalance potential human biases. It is important to be aware of overconfidence bias, the human tendency to anchor on recent or outlier cases, and the risk of perpetuating outdated assumptions in order to avoid evaluations outside a reasonable range.

**Recommendation # 3:** Ohio BWC should refine current guidance and develop and document a comprehensive guide to claim evaluation that incorporates a consistent approach and the disciplined use of an objective set of evaluation tools. [“Ohio BWC Best Practices Guidelines for Evaluation of Liability”]

**Recommendation # 3.a:** Ohio BWC should identify and/or create a set of objective tools and resources [evaluation “toolkit”] to assist the LSS CSS and Attorneys in the development of credible and defensible medical and life expectancy projections and overall evaluation range on each LSS claim.

- **3.a.1.** Identify claim thresholds for required use of a Nurse/MCO professional to assist in developing projected medical cost and probability of future treatment.
- **3.a.2.** Set claim thresholds for required use of certified Life Care Plan specialists to assist in developing projected medical care cost and probability of future treatment in more complex claims. Develop approved panel of Certified Life Care professionals [this would be a constructive tool even where LSS is not an issue, to help manage medical and understand medical exposure].

- **3.a.3.** Set claim criteria and identify qualified, credentialed specialists to provide IMEs/rated age on appropriate claims involving older claimants and/or co-morbidity conditions, or higher-value claims. Certain life companies also offer this service. Consider doing away with the Medical Checklist.
- **3.a.4.** Identify appropriate specialists to estimate permanency restriction based on AMA Impairment Guidelines to establish agency-wide consistency and objectivity.
- **3.a.5.** Vocational rehabilitation: Develop panel of voc rehab specialists. An employability study should be done where claim is pre-PTD and valued over \$100,000. We would encourage Claims to work this into front-end claims handling so that the information is available earlier in the claim life cycle and before LSS application. [Refer also to Internal Audit Recommendation # 8.]
- **3.a.6.** Formalize use of Disability Duration Guidelines from outset of claim handling as per recommendations of Dr. Christian in 2005 report.
- **3.a.7.** Discuss with Pharmacy Benefit Manager [PBM] the development of a tool that tracks the timing of generic availability of name drugs.

**Recommendation # 3.b:** Ohio BWC should update its comprehensive list of components and special considerations useful to the evaluation of a claim for LSS. This should include the use of objective tools and resources. The list below incorporates and supplements prior Ohio BWC guidance and may be used as a starting point. Objective tools and resources are identified by **bold type**:

- Identification of Subrogation potential
- Identification of companion claims
- Identification of support liens
- Identification of overpayments
- Identification of other applicable funds or contributors
- Index for SI and Third Party claims
- Determine future medical; break out by hospital, skilled care, pharmacy and unskilled care. Estimate probability and cost of treatment using a **nurse/MCO** on small to moderate-size claims; obtain a **Life Care Plan** from a certified medical resource on larger, more complex claims.
- On pharmacy, check with **PBM** for timing of generic availability
- Identify and assess medical-legal issues
- Determine future indemnity: TT, PPD [schedule or %], PTD [pre-or-post]. Consider RTW, MMI, I.C. historical cut-off dates.
  - Consult **Disability Duration Guidelines** to establish benchmark for primary injury code and occupation category
  - For PPD, use **medical resource** to estimate permanency restriction based on **AMA Impairment Guidelines**
  - Obtain a **Voc Rehab** review where RTW appears possible

- Determine life expectancy. If any co-morbidity and/or older IW, or younger IW and significant co-morbidity, obtain a **Rated Age via IME or certified specialist**. Consider establishing a claim value threshold for use of this tool.
- Ensure that timeline on projected medical aligns with adjusted life expectancy.
- Evaluate DWRF/VSSR
- Evaluate wage loss and living maintenance wage loss [must be in rehab]
- Evaluate dependent benefits [see special considerations]
- Establish settlement range
- Present evaluation to Claims Committee or Executive Staffing as required
- Secure necessary authority
- Develop negotiation strategy
- Special Evaluation Considerations:
  - Age: over 65, MSA is an issue; prescriptions could be a major component. Given increasing life expectancies, and voc rehab as unlikely, an IME/Rated Age would be helpful in establishing a realistic settlement range.
  - Widow: actuarial studies have found the following factors to greatly influence remarriage probability: age, children, length of marriage, and length of widowhood [remarriage probability decreases significantly after five years]. NPV discount is considered on a younger widow with no children by half of industry survey respondents, with discount ranging from 5 – 50%. Fewer discounts are taken on middle aged dependents, and little to no discount is normally taken on older widows or those widowed more than 10 years.
  - Unrepresented workers are not an issue for any survey respondent.
    - A judge or hearing officer has to approve LSS
    - Claimant is encouraged to have an attorney review
    - Half of survey respondents will pay \$450-700 for “friendly counsel” to review proposed settlement
    - Many are likely to offer a number close to or above the middle of evaluation range
    - All are careful to offer a clear explanation of obligations and end result

### Governance and Interactive Controls for Lump Sum Settlements

**Observations:** Ohio BWC does not have adequate controls in place for LSS. This was also noted by Internal Audit in Recommendations # 4 and 13. An increased focus on a higher volume of LSS is consistent with recent industry trends. However, Ohio BWC has no mechanisms to verify that LSS are generally reasonable and appropriate. It is possible that settlement activity to date will reap future benefits; but the reverse is also a possibility. An improved control structure centered on the following components will greatly assist in this determination:

- Claim evaluation documentation
- Claims Committees
- Qualitative audits
- Claim settlement authority
- Monitoring metrics

When the LSS initiative was implemented, Ohio BWC discarded several important tools that serve the dual role of interactive quality management and governance control:

- Detailed **Settlement Evaluation Worksheets**
- **Settlement Committees** are no longer held
- **Authority** approval previously rested with the same hierarchy that had accountability for performance management. The Claims hierarchy is now completely removed from the authority structure.

The new Verification **Worksheets** are not sufficiently detailed and do not foster a rigorous, disciplined approach to evaluation. The old Settlement Form is better, but led to one number instead of a range, often leading to a more rigid, take-it-or-leave-it “negotiating” approach.

**Settlement Committees** were felt to be cumbersome and bureaucratic. Scheduling was challenging. Participation by needed resources was sporadic and unreliable. Nearly 100% of survey respondents use a committee mechanism, and all believe that this approach improves consistency and quality of claim evaluations. The committees also serve the additional purpose of training newer associates and calibrating the organization’s evaluation thought process.

Existing **audit** activity reflects an insufficient focus on quality of evaluation, effectiveness of negotiation and reasonableness of outcome:

- Claims audits [IMS] are focused on compliance and timeliness, and do not incorporate an assessment of performance against qualitative standards
- Legal audits, when completed, touch on the quality of handling. However,
  - The audit sample is not statistically adequate/credible
  - The audits are high-level and not sufficiently detailed
  - The audit findings are not formally shared or aggregated
  - Audit findings are not trended at individual, office or agency level to identify best practices and performance gaps
  - Done effectively, self-auditing is valuable; but it needs to be complemented by an independent, objective audit to satisfy governance/control considerations.
- Internal Audit does not have the technical resources to evaluate claims handling quality

Ohio BWC's authority structure is unusual. Survey respondents confirm that in nearly all industry organizations, the claim function has a hierarchical authority structure. Legal's authority is delegated from Claims and not direct. Contingent authority is not used. At Ohio BWC, only the LSS CSS has any settlement authority, with Settlement Attorneys having all settlement authority over LSS CSS. Contingent authority is no longer an issue – it has now been discontinued.

Ohio BWC does not have appropriate **metrics** in place to monitor LSS. The key metrics used are volume of settlement, turnaround time and comparison of LSS outcome to MIRA II reserve.

**Recommendation # 4.a:** Ohio BWC should reintroduce an updated **Evaluation Worksheet** to achieve consistent, detailed, component-based documentation of LSS evaluation, including analysis and rationale. Look at combining the data fields on the discontinued LSS Evaluation Form, Settlement-At-A-Glance, the current Verification Worksheet, and the new pilot Verification Worksheet into one new detailed form that rolls up to a settlement range. Leverage the claims system to pre-populate data fields wherever possible. To the extent the I.C. requires a “simpler” form, the new form could be designed to also produce an “abstract” with a subset of the information sufficient to satisfy the I.C.'s needs.

**Recommendation # 4.b:** Reinstated a **Claims Committee** [formerly Settlement Committee] mechanism at the field level to provide broader perspective, critical thinking and analysis, input of relevant resources, calibration of evaluation skills, and training. We recommend that Ohio BWC continue the new Executive Staffing mechanism on claims over \$200,000. Determine which claims should be presented at Claims Committee based on dollar amount and qualitative criteria. Committee sessions should be regularly scheduled with mandatory participation by required resources. Performance Agreements should be amended to include this performance expectation.

**Recommendation # 4.c:** We recommend that, as soon as practicable, Ohio BWC develop and implement an LSS **claim quality and performance audit program** [Q&P] that assesses the following:

1. Was LSS properly considered in this claim?
2. Thoroughness and quality of evaluation
  - a. Were appropriate claim components and factors considered and included? [thoroughness]
  - b. Where relevant, were appropriate objective resources used?
  - c. Were projections and estimates supported?
  - d. Were calculations accurate?
  - e. Were analysis and rationale clear?
  - f. Was evaluation properly documented?
  - g. Overall quality of evaluation
3. Negotiation
  - a. Was a negotiation strategy developed?
  - b. Was negotiation strategy adequately documented?
  - c. Overall effectiveness of negotiations
4. Economic reasonableness of outcome
5. Did turnaround time meet requirements?

We recommend the following audit process:

- An initial audit should be conducted of a statistically credible, random, representative sample of closed LSS claims to:
  - Establish a baseline of performance
  - Identify best practices and performance gaps
  - Assess economic impact
- Once a performance baseline is established, specific targets and performance expectations may be established for LSS CSS and Attorneys, with subsequent audit results used to measure performance progress and identify trends.
- We recommend that Fast Track claims be included using an appropriate subset of audit criteria, but adding ICD9 coding accuracy.
- Subsequent audits would be scheduled at appropriate intervals depending on prior audit results and/or significant changes in LSS activity or trends.
- Audits should be conducted by an objective resource outside of the Legal and LSS functions. Alternative options are:
  - Small, dedicated internal team
  - Ad hoc internal resources assembled as needed
  - Add seasoned claims technical resources to Internal Audit team
  - Outsource to external WC specialist

**Recommendation # 4.d:** We do not recommend any immediate changes to the current LSS **authority** structure between Legal and Claims. Once Ohio BWC has determined its organizational plans, and, provided that a claims “owner” is in place for LSS, we recommend that Ohio BWC restore a hierarchical settlement authority structure within the Claims function.

**Recommendation # 4.d.1:** We recommend that Ohio BWC consider evolving toward an **authority** program that vests varying settlement authority levels [within a range] in LSS CSS reps commensurate with skill and performance. Once LSS audits and performance standards are in place, Ohio BWC can build objective information that will assist in customizing LSS CSS authority.

**Recommendation # 4.e:** We recommend that Ohio BWC develop and implement a set of key measures, monitoring reports and actuarial diagnostics to manage the success of LSS. We have also identified several areas where data mining and analysis would be beneficial. We recommend the following array of tools as a starting point:

**Quality Monitoring:**

- The primary measure for the LSS CSS should be quality as defined in the new Q&P audits to be developed. Audits should be conducted on a continuous basis throughout the year, with 25 files per LSS CSS as a minimum target. Once a baseline performance level is established, short-term objectives should be set by individual and in the aggregate for improvement in each of the five primary audit components. We recommend that a long-term goal be set to reach and sustain an aggregate performance level that exceeds 85-90% achievement of performance standards across all components.
- Fast Track quality monitoring is addressed in that section of our report.

**Operational Measures:**

These apply to all LSS, including Fast Track. It would be beneficial to produce These reports with and without Fast Track data, as well as reports based exclusively on Fast Track activity.

- Monitor overall claim activity trends by tracking New, Reactivated, Deactivated and Ending Inventory in the aggregate and by Claim Type: Medical Only, Temporary Total, Permanent Partial, Permanent Total and Death. [See Data exhibit 5a/5c\* as an example; and note that PPD inventory is ticking upward since 2006 despite increase in LSS activity, suggesting further investigation.]
- Monitor LSS activity trends at Agency, Region, Service Office, and individual LSS CSS levels by tracking New Applications, Approved, Disallowed, Withdrawn and Ending counts.
- Monitor and benchmark LSS Approval Rates [%] at Agency, Region, Service Office and individual LSS CSS levels.
- Monitor LSS volume and injury year impact by tracking Calendar Year Settlement counts by Injury Year. [See Datum exhibit 1.1\*, Claim Level, as an example.]

- Monitor LSS Paid activity by tracking LSS counts and Average Paid by Value Ranges. [See Datum 2\* and Datum 3\*, as examples; note that, except for the smallest and largest Value Ranges, Average Paid is remarkably consistent from 2003-2008, while LSS Counts have migrated upward in the under-\$10,000 ranges. LSS over \$100,000 have increased in Count and Average Paid, suggesting further investigation.]

### **Actuarial Diagnostics:**

The focus here is to determine at the earliest possible time whether observed LSS activity represents an acceleration or deterioration of expected development, along with the projected ultimate reserve impact. Workers Compensation is a long-tail line where conclusive determinations in the early years of a strategic initiative should not be expected. However, diagnostics and analysis may provide data on early directional trends to test assumptions, build confidence in the initiative, and/or provide objective reasons to slow or change aspects of the program.

To develop meaningful diagnostics, Ohio BWC will need to utilize paid and incurred methods, as well as settlement ratios. We understand the latter two have not been used historically, and that this will present a challenge. We recommend that an actuarial working team be chartered to develop a small set of methods and tools to analyze LSS activity and trends, with the following actuarial diagnostics as a conceptual starting point:

- Using pre-2006 data and development factors, develop expected ultimate total incurred and expected settlement rate triangles for all relevant injury years. Then load in post-2005 data [LSS initiative years] for a comparative actuarial analysis.
- Using pre-2006 data and development factors, develop expected ultimate average paid and expected settlement rate triangles by injury year. Then compare to current actual paid plus incurred by injury year, and actual settlement rates to identify any divergence from expected not explained by settlement rate changes. [Data would need to be normalized for medical inflation, frequency changes, and any changes in SIC mix.]

### **Data Capture, Mining and Analysis:**

During the course of this project, we identified a number of issues that present opportunities for further analysis. These are highlighted here as suggestions for future consideration:

- For LSS involving PPD, consider tracking % restriction by body part [average and range], differentiating I.C. award versus LSS CSS determination pre-award versus AMA Impairment Guideline.
- Consider capturing injured worker status information post-LSS [RTW, remarriage, death, re-injury].
- Track I.C. \$0 PPD awards as a % of total
- Investigate the characteristics of claims where the LSS is the first indemnity payment to the injured worker. [More than 1 in 5 LSS claims since 2002 according to Datum exhibit 15\*]

- Investigate the drivers behind reactivation of claims previously closed by LSS. [see Datum exhibit 13a\*]
- Investigate the frequency of new injury claims by workers who previously received an LSS.
- Investigate Fast Track settlements on claims inactive for more than one year.
- Investigate the % of claims with a PPD award that also receive one or more successive PPD awards.
- As a member of NCCI, explore the availability of benchmarking data on key metrics.

\*Data/Datum exhibits refer to spreadsheets in attached Excel Workbook titled BWC.MIS.1.V3

## **Fast Track Pilot Program**

**Observations:** The basic concept of Fast Track [FT], to reduce PPDs and achieve earlier closure on smaller claims, has potential merit. No comparable industry practice surfaced, but survey feedback indicates increased attention to resolution of smaller claims to preclude subsequent volatility and deterioration. The Ohio BWC FT program overemphasizes efficiency and speed without a balancing consideration for “time to do a good job” and obtain a reasonable and appropriate outcome. LSS at \$10,000 or less accounted for nearly \$100,000,000 in the 12 months ending April 30, 2008. CSS need more than a “couple of minutes” to check for companion claims, subrogation, child support liens, and overpayments, and to ensure they have a grasp of prior events and issues on the claim. Currently, there are no limits on claim amounts previously paid or total incurred. There are no limits on length of inactive status prior to Fast Track request. There is also some question of reliability of ICD9 coding relied upon to negotiate Fast Track claims.

**Recommendation # 5:** We believe that there is merit in extending the Fast Track [FT] pilot for another year. To assure consistent quality results while maintaining a focus on efficient resolution, we recommend the following limitations and controls:

- Claims with companion files should not be eligible for FT
- Set a limit on the size of claims eligible for FT
- Claims inactive for greater than 1 year should not be eligible for FT
- Consider denying FT settlements for frivolous or nuisance claims
- Decide whether “avoided administrative expense” is a good trade-off
- Single-call resolution is a reasonable goal for a pilot, but we recommend that to enable quality handling, you not set a time limit on the calls.
- FT CSS performance standards should require verification of ICD9 code accuracy, companion claims, liens, subrogation and overpayments

**Recommendation # 5.a:** Explore whether AMA Impairment Guidelines would provide more objective information to the FT CSS in evaluating probable PPD % restriction, and how they could be most effectively used.

**Recommendation # 5.b:** Consider instituting a control to flag Active files 60 days before PPD eligibility. Review flagged files to determine suitability for an FT settlement. If suitable, claimant or claimant's attorney may be notified that the claim is FT-eligible.

**Recommendation # 5.c:** Create a V-3 system Fast Track indicator. Currently, Legal is capturing FT settlements on separate weekly spreadsheets that are not aggregated. A system indicator would eliminate manual recordkeeping and provide more robust tracking and performance metrics.

**Recommendation # 5.d:** Create a V-3 PPD data field to capture % restriction with a companion indicator to capture whether the % is an FT CSS determination or the result of an I.C. award.

**Recommendation # 5.e:** Fast Track results should be measured quarterly using Q&P results; % allowed versus % disallowed; and average paid trends.

## Claims Structure

**Observations:** LSS are handled by LSS CSS who are dispersed throughout the Service Offices [S.O.] reporting to local management. The Law Department has a designated “owner” for LSS. There is no counterpart in Claims who “owns” LSS. In fact, there is no direct, day-to-day “owner” focused exclusively on the Claims function in general. We believe the absence of this “owner” hampers the organization’s ability to define claims strategy, develop systemic claims initiatives and objectives, identify claims issues and opportunities, motivate execution, and foster continuous improvement. A clearly identified “owner” would be accountable for overall claims performance and controls.

Currently claims are assigned based on geography. To leverage existing skills and capabilities, Ohio BWC is considering a different structural approach – assignment based on skill level and case complexity. We encourage continued progress toward a structure that permits alignment of case complexity with skill level. This is especially important for complex cases. Although this is outside project scope, we believe that continued progress in this direction would have a beneficial impact on LSS outcomes.

There is a significant inventory of older claims that may not fit the definition of complex claims. The dedicated LSS CSS team could take ownership of this inventory backlog over time, focusing their efforts on proactive resolution of these claims. Ohio BWC may also consider a point in time when appropriate claims from the complex claim team should be handed off to the LSS CSS. The challenge resides in the transition where Ohio BWC would have to carefully manage the volume of incoming LSS apps.

**Recommendation # 6.a:** We recommend that Ohio BWC define “complex cases” and consider specializing and regionalizing complex case teams in several locations. With appropriate workloads, CSS with this experience and skill level are capable of handling their files ‘cradle-to-grave’, including any LSS where appropriate. In such cases, their in depth knowledge of the claim, rapport with the claimant and attorney, and understanding of the claim nuances would enable positive LSS results. Such an approach would also support the goal to increase the instances where Ohio BWC initiates the LSS.

**Recommendation # 6.b:** We recommend regionalization of the LSS CSS and creation of a centralized reporting structure. An “aggregate capability” for LSS CSS would provide more consistency, resource flexibility and backup. It would also facilitate recruitment of an experienced, technically expert manager/director accountable for the LSS division.

**Recommendation # 6.c:** Whether or not the LSS CSS reporting structure is centralized, we recommend the recruitment of a senior technical claims resource who would serve as a subject matter expert for Claims generally and “owner” of the LSS process. If the LSS CSS reporting structure were not to be centralized under this individual, a dotted-line reporting relationship should be implemented. This is a common and effective industry practice which frees up local management to focus on administrative issues, while still assuring quality oversight at the individual claim level.

**Recommendation # 6.d:** We recommend that Ohio BWC give serious thought to the recruitment of a chief claims executive.

## **Roles and Responsibilities**

**Observations:** Who should 'own' the LSS program? General industry practice holds the Claims function accountable for control and execution of all aspects of its performance. Staff attorneys partner with claims staff as advisors, offering guidance, interpretation and advice, as well as manage outside litigation. Here, again, Ohio BWC has evolved to an unusual approach out of necessity. Whether this remains the same or the accountability and authority reverts back to Claims depends on the structural direction Ohio BWC decides to take. Should a senior claims technical manager/expert be recruited and given ownership of the LSS program and process, this will set the stage to have authority and accountability shift back to Claims.

**Recommendation # 7:** We recommend that ownership of the LSS program reside in Claims once structure and staffing issues are resolved.

## **Skills Assessment, Training and Performance**

**Observations:** We agree with Internal Audit's Recommendation # 7 that LSS CSS are not receiving adequate, ongoing training in evaluation and negotiation. The new Ohio WC Certification program is an excellent start in addressing core training needs, but it is voluntary and has had limited reach to date.

We note that there is only one Position Description [PD] for the CSS position. This does not enable differentiation of the higher skill levels required to perform certain job duties such as LSS.

**Recommendation # 8.a:** We recommend that Ohio BWC develop a core skills inventory and assessment tool for the LSS CSS position. This inventory would serve as a foundation for performance expectations. A periodic skills assessment, combined with ongoing audit results, would provide an objective basis for individual performance management and candidate selection criteria, leading to continuous upgrades in quality of staff. Aggregate trending would identify skill gaps across the organization and enable targeted and effective investment of training dollars in areas of need.

**Recommendation # 8.b:** We recommend that core skills training be made mandatory for new LSS CSS and experienced LSS CSS with skill gaps identified by a formal skills assessment or Q&P audit results.

**Recommendation # 8.c:** We recommend that Ohio BWC identify alternative resources to deliver ongoing training in evaluation and negotiation skills, and weigh the benefits of self-developed training against the time it would take to create and deliver these modules. Given the volume and dollars associated with LSS and the current aggregate assessment of skill gaps, we recommend that this be given a high priority.

**Recommendation # 8.d:** We recommend that Ohio BWC consider expanding the CSS position descriptions to allow for differentiation in proficiency levels. We believe that this would better reflect the higher skill level required in complex claims and LSS, as well as provide staff with additional incentive to meet and exceed performance expectations, and to pursue training and development opportunities.

**Recommendation #8.e:** We recommend that Ohio BWC develop performance standards and expectations for all LSS CSS against which they will be measured, based on components outlined in the new Q&P audit and the current CSS compliance audits. These performance standards should also be incorporated into the S.O. Performance Agreement [or Division Performance Agreement, if LSS CSS reporting is centralized] at a summary level to ensure organizational alignment.

## **Additional Considerations**

### **Structured Settlements:**

There may be situations where a structured settlement or annuity may be desirable and useful in achieving an LSS. This may apply to the medical or indemnity components, and is frequently utilized in larger MSAs [\$25,000 is a commonly noted threshold]. The majority of respondents manages and controls the structured settlement process by:

- Vetting and developing a panel of approved structured settlement brokers
- Implementing controls to ensure that only financially stable life companies are used to provide annuities
- Assigning contingent liability of annuities to financially sound third parties
- Maintaining adequate and accurate records of all structured settlements in a secure, centralized location or database

**Recommendation # 9:** We recommend that Ohio BWC thoroughly investigate and verify its authority to use structured settlements or annuities as part of an LSS. If structured settlements or annuities will be used, even if only in a small number of cases, we recommend, we recommend that Ohio BWC manage and control the process through its own approved vendor panel.

## **Additional Considerations**

### **Medicare Set-Asides [MSA]:**

There may be situations where LSS is a desired outcome notwithstanding significant projected medical costs. Depending on the injured worker's status relative to Medicare eligibility, and the timing of that eligibility, the approval of CMS [Center for Medicare and Medicaid Services] may be required.

- Most survey respondents actively manage the CMS notification, negotiation and approval process, either directly or through a vendor, when MSA criteria are triggered by a proposed LSS.
- Many survey respondents set up structured annuities for larger MSAs, but most give the injured worker the option of self-administering smaller amounts. In LSS with a very large medical allocation, the workers compensation provider may set up a medical trust managed by a professional administrator, although most try to avoid this ongoing expense. Some respondents will consider the use of a reversionary trust, but this has significantly decreased.
- A number of respondents are re-thinking whether LSS is the right claim resolution when an MSA is involved because the CMS process has become cumbersome, complex and contentious. Also, CMS involvement often significantly increases the value of the claim. Some respondents find that use of a medical professional to negotiate with CMS is a good investment.
- New Medicare Secondary Payer reporting requirements that apply to workers compensation plans are going into effect July 1, 2009.  
See <http://www.jjcelderlaw.com/MMSEAMSABull.htm>
- We understand that Ohio BWC is preparing a 'white paper' on this issue that is due shortly.

**BWC Survey – Lump Sum Settlement Best Practices in Workers Comp**

1. General philosophy and objectives of LSS as a tool in resolving WC claims
2. Use of specific claim criteria to identify appropriate claims for LSS?
3. Use of specific criteria for claims that should not be candidates for LSS?
4. Discuss philosophy or guidelines re: specific types of claims, if not covered above:
  - a. Widow/widower and relevance of age/remarriage probability
  - b. Unrepresented injured worker
  - c. Acute care ongoing
  - d. Medical stabilized, but significant future medical estimated
5. Are partial lump sum settlements permitted or encouraged?
6. How the organization allocates resources to handle LSS
  - a. Job level/skill required
  - b. Dedicated staff vs. front-line claims professional
  - c. Dispersed vs. centralized or regionalized handling?
  - d. Involvement of Law Department?
7. How is authority handled? Use of Claims Committees/roundtables?
8. Any co-morbidity guidelines in addition to PTD Life expectancy tables and NPV impacts?
9. How are evaluations documented?
10. Philosophy on use of annuities or structured settlements in WC LSS?
11. Audits – how are LSS evaluations [reasonableness] handled? Standalone, or part of general claim audit process?
  - a. Audit team structure – how staffed and whether dedicated?
12. Metrics – what types of metrics work best [case specific/actuarial diagnostic triangles/etc]?
13. Open discussion

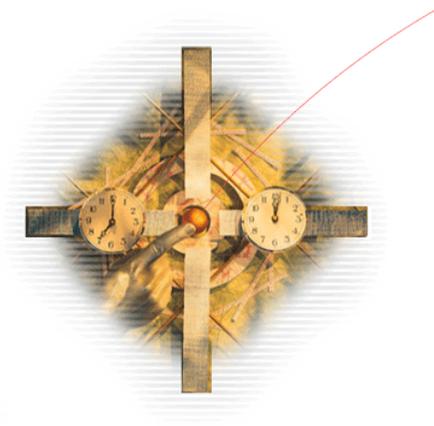
# Lump Sum Settlement Project

## Industry Survey

Presented by

Patricia A. Drago and Fred G. Marziano

December 22, 2008



**Insurance Perspectives + Solutions**

208 2<sup>nd</sup> Avenue, Belmar, NJ 07719  
732-681-2947 [www.inperspectives.com](http://www.inperspectives.com)

*Industry Survey*  
*Lump Sum Settlement Practices in Workers Compensation*  
November 24 – December 8, 2008

*Survey Scope*

A 2008 industry survey of Workers Compensation Lump Sum Settlement [LSS] practices was conducted by Insurance Perspectives + Solutions on behalf of the Ohio Bureau of Workers Compensation. The survey involved a high-level discussion of conceptual approach, philosophy and best practices regarding LSS. Each survey averaged 30-40 minutes. The following survey topics were used to guide discussion:

1. General philosophy and objectives of LSS as a tool in resolving WC claims.
2. Attitude toward partial lump sum settlements.
3. Use of specific claim criteria to identify appropriate claims for LSS.
4. Use of specific criteria for claims that should not be candidates for LSS.
5. Special considerations for death claims and unrepresented claimants.
6. Consideration of co-morbidity s. guidelines.
7. Other evaluation considerations and documentation.
8. Philosophy on use of annuities or structured settlements in WC LSS.
9. Medicare Set-Aside considerations.
10. Resource considerations in handling LSS.
11. Authority structure and use of settlement committees or round-tables.
12. Audit structure and approach.
13. Metrics and controls.

## *Survey Participants*

There were twenty-four survey participants, representing more than 20% of domestic net workers compensation premiums, including the following respondent groups:

- Twelve active P&C insurers: nine direct, one via its primary TPA, and two via recently departed executives
- Five insurers with run-off operations
- Five State Funds
- One TPA
- One consulting expert/auditing firm with extensive WC experience and current WC insurer clients

## *Survey Results*

### **Highlights**

Several key considerations permeated survey discussions. The majority of participants indicated an increased emphasis on the use of LSS in the past several years to cap unpredictable future liabilities and manage the long tail generally associated with workers compensation claims. Medical cost escalation and inflation were cited by nearly everyone as catalysts for increased LSS activity. No respondent reported a “black box” or “rule book” to identify candidates for LSS; the approach generally used is a claim-by-claim judgment call based on the analysis of claim-specific factors.

An underlying theme in discussions with a majority of respondents was a stated concern with fairness to all parties, especially the injured worker, combined with a good economic result.

Claims where the injured worker has reached maximum medical improvement [MMI], with medical treatment costs deemed stable and predictable, are most commonly selected for LSS consideration. More than half selected claims that are not likely to benefit from further case management, yet have a high risk of deterioration over time. LSS is also used to address injured worker needs when the available benefits structure proves inadequate. A minority of respondents believe that there is a “right number” on every claim, including “nuisance” claims.

Respondents are disinclined to use LSS in claims where the injured worker is still employed by the insured. In catastrophic injury claims, LSS is less frequently used; those that do consider LSS approach these claims with great caution. Claims that combine advanced age and major co-morbidities are frequently excluded from LSS; the minority that uses LSS in these situations usually obtains a rated age and negotiates a significant discount from net present value. In claims with significant projected medical, the increasing involvement of the Center for Medicare Services [CMS] in the determination

of Medicare Set-Aside [MSA] amounts appears to have a growing chilling effect on decision to use LSS.

Most survey respondents reported a significant increase in the use of medical and other resources in the evaluation of LSS claims. Objective resources most frequently cited were independent medical exams [IME] or medical opinions to obtain a rated age; life care plans, AMA Impairment Guidelines, disability duration guidelines and use of actuaries to validate net present value and discounts on larger claims.

## **1. General Philosophy and Objectives of LSS**

The past few years have witnessed a major increase in emphasis on the use of LSS by the great majority of survey participants. This trend is expected to continue. The primary catalyst cited is the unpredictability and volatility of future medical costs compounded by WC medical inflation rates that substantially exceed normal CPI medical inflation. Embedded in future medical costs are the impacts of medical advances, an aging population, and increased longevity. LSS is seen as a tool to achieve certainty of claim outcome and cap long-term tail liabilities. As phrased by a number of participants, “The best claim is a closed claim”.

Participants generally seek the earliest opportunity to consider LSS in a particular claim, ideally when they still have control of the claim, with the time frame ranging from two to five years from the date of injury. Citing balance sheet considerations, most of the respondents with run-off operations, a small minority of insurers, and two of the state funds have instituted a very aggressive push to close claims via LSS. Only one participant cited a slowdown in LSS due to cash flow management considerations.

The great majority of respondents are focused on two key objectives in all LSS: fairness to all parties, especially the injured worker, and a good economic result that delivers a better outcome than the ultimate estimated exposure.

There is no “black box” or “rule book” used to identify candidates for LSS. The majority of respondents have general guidelines that require ongoing determination and assessment of a claim resolution strategy and plan of action for every lost time claim. As part of the claim analysis, LSS is to be considered as a way to bring the claim to final closure. Survey responses such as, “It is not a canned approach”, “There are so many soft issues to evaluate”, and “Claims aren’t widgets” describe the general consensus. The following is a composite view of claim-specific factors cited by survey respondents:

- Nature of injury, injured worker’s recovery progress and co-morbidity conditions.
- Injured worker’s behavior, motivation and attitude toward recovery and rehab; are they capable of caring for themselves properly?
- Return to Work prospects.
- Education and other socioeconomic factors.

- Prospect of significant future medical.
- Prospect of claim deterioration if claim continues in WC system.
- Risks to injured worker and/or other stakeholders if claim is settled and injured worker no longer has access to the workers comp system.

While virtually all claims are considered for LSS, the majority of survey participants discourage the use of LSS to close nuisance claims. A small minority actively encourage settlement of nuisance claims to preempt any risk of an “event”.

A number of respondents cited two areas of caution:

- The risk of adverse selection needs to be carefully managed.
- LSS should not be pursued unless the talent exists to do it professionally and effectively.

## **2. Partial Settlements**

Several states do not permit settlement of the workers compensation medical component. In these states, respondents may consider settlement of the indemnity component where it makes sense based on claim-specific factors. In states where full settlement of all claim components is permitted, nearly all survey respondents discouraged the use of partial LSS absent unusual circumstances or a significant financial benefit. The major concern cited is the loss of control and leverage over the medical component when only the indemnity piece is settled. Only one state fund has achieved positive results with medical treatment usually winding down once the indemnity component is settled.

Respondents cited the following examples of exceptions to the general attitude against partial settlements:

- Settlement of non-skilled, attendant care provided by a family member.
- Settlement of home renovations where the benefit structure available will not be adequate to provide for needed alterations.
- Settlement of disputed issues.

## **3. Claim Criteria to Identify Appropriate Claims for LSS**

The balance between fairness of outcome and the economic benefits of LSS is an overarching consideration for nearly all participants. “Will this settlement help the injured worker?” “What is my future risk on this claim?” “How will settlement achieve a better financial outcome?”

“Stable and predictable” claims are considered for LSS by all survey respondents. At the opposite end of the spectrum, a majority of respondents use LSS on claims that have reached a plateau, yet continue to be difficult and prolonged. “Claims don’t get better

with time.” If we can no longer add value, why keep it open?” Many consider resolving emotional and/or psych overlay claims with a settlement. “LSS can free the injured worker from emotional turmoil and dependency on the system; they can get on with their lives.” Key to resolution is an understanding of the issues in a particular claim to ensure that LSS will achieve the right result for everyone. “LSS should only be pursued at the right point in a claim.”

Although they find these more difficult, a minority in each participant group will consider catastrophic injuries for LSS, provided all acute care issues are resolved, and provided that the injured worker is doing the right thing in medically caring for him/herself. In these situations, a life care plan is developed by a certified medical professional, and a “special needs trust” is established.

Responses were mixed on the use of LSS in claims that involved co-morbid conditions. Most respondents are more willing to consider claimants with diabetes and heart conditions, using a rated age to determine an appropriate discount. Responses were evenly divided on whether to settle claims involving older workers [over 65-70] with no real prospects for return to work [RTW], or who were looking to retire. Respondents who use LSS in these claims cited increasing longevity and pharmaceutical use as key considerations. Such claims are likely to settle for a significant discount supported by an IME and/or rated age determination.

A small minority of survey participants believe that every claim has a settlement value, including “throwaway” nuisance claims.

The following claim circumstances were cited most frequently across all respondent groups as good candidates for settlement:

- Injured worker has reached MMI, medical treatment is stable with routine future care and costs are predictable; claimant is capable of some work.
- Claims that would fit the above with an emotional or psychological overlay.
- Subjective injuries involving the back, knee and/or hip, especially where deterioration into RSD is a probable risk.
- Maintenance cases that won’t get any better, or that become difficult and prolonged.
- Claims where it is in the claimant’s best interests to opt out of the workers compensation system.
- Claims where the statutory benefit structure falls short of meeting claimant’s needs.
- Death claims.
- Disputed claims based on probability of success.

#### **4. Claim Criteria to Identify Claims Ineligible for LSS**

Nearly all respondents will exclude a claim from LSS consideration if the claimant is incapacitated or still works for the insured employer. A majority do not generally settle nuisance claims.

The great majority of respondents do not consider LSS a viable tool in claims involving acute, volatile or deteriorating medical, or where there are medical complications or too many unknown issues. Instead, resources are invested in case management efforts to resolve issues and stabilize the injured worker's medical condition. Working with the claimant and medical providers to achieve MMI is taken seriously.

Catastrophic injury and/or major co-morbidities that are volatile or life-threatening will rule out LSS for a minority of respondents. Others will use a life care plan, IME and rated age to achieve an appropriate settlement.

A significant minority of respondents are re-thinking the use of LSS in claims with significant projected medical costs where a Medicare Set-Aside is required. The involvement of CMS tends to escalate the medical cost estimate and allocation, often making a realistic settlement impractical.

Several respondents raised concerns about using LSS in claims involving abuse of medical treatment to drive up costs, or where outright fraud is suspected.

#### **5. Special Considerations for Eligible Claims**

The majority of survey participants will consider LSS for dependents' benefits in death claims. Annuities are frequently used to pay out periodic lump sums during college years for minor dependents. A small minority of those who settle widow/widower claims does not consider remarriage probability or apply any discount to net present value. For the majority, the amount of discount to net present value varies from 5% to 75%, depending on the widow's age, whether there are children, the length of the marriage, and the length of widowhood. For example, most would apply a steep discount in the case of a young widow with no children. On the other hand, discounts are nominal or nonexistent for older widows or after 8-10 years of widowhood.

Respondents unanimously agreed that settlement with an unrepresented claimant is appropriate. "Public policy suggests that we should not treat an unrepresented claimant any differently." In every case, a court or industrial commission would have to review and approve a settlement for fairness. Respondents take care to communicate plainly and clearly to ensure that the injured worker understands his or her obligations and the end result. Many will begin negotiations from a higher point in their evaluation range to assure fairness. If there is any discomfort, or in more complex cases, the claimant is

advised to seek counsel. Nearly half of respondents will offer to pay a flat fee to retain “friendly counsel” to review the final LSS terms, especially in higher-value settlements.

## **6. Additional Considerations on Co-Morbidity**

Survey participants were in general agreement about the need to “look at the whole picture” and “understand the injured worker’s condition holistically.” There are no specific guidelines on how to consider the impact of co-morbidities on claim eligibility and evaluation for one third of the participants; these rely on the claims professional’s skill and experience to make this judgment. For the majority of participants, claim practices are embedded that include the disciplined use of objective medical tools such as certified professionals, IMEs and/or medical experts to determine a rated age, especially in larger, more complex claims, or where an MSA may be involved. Many of these set some threshold, making the use of these tools discretionary in lower-valued claims.

Several respondents have a medical director on staff trained in occupational health and medicine, enabling a consistent approach to determination of rated age. Others retain a specific medical expert to ensure this consistency. These two groups comprise just over half of respondents. The remainder outsource to annuity insurers and/or IMEs using outside medical experts.

Once the impact of co-morbidities on the claim evaluation is accounted for, a number of participants cited the need to consider the overall impact on claim eligibility for LSS. “Knowing what we know about this injured worker, would putting money into their hands produce a better long-term outcome?” “Can this claimant properly care for himself?”

## **7. Other Evaluation Considerations and Documentation**

Respondents were generally consistent in their claims philosophy: set the stage for effective negotiations and a positive outcome by evaluating each claim based on the facts and circumstances of that individual claim. A quality evaluation range derives from a rigorous and comprehensive assessment of each relevant claim component or factor, including a probability assessment of each component/factor. “We need evidence that the projected medical treatment is likely to happen, and not merely possible.” Discussions with the great majority of respondents point to the increased use of objective tools and resources to determine and support LSS values, and to counterbalance potential human biases.

The following is a composite view of tools, resources and techniques cited by survey participants and used to mitigate the risk of “voodoo economics” in LSS evaluations:

- Tap the knowledge of medical experts to develop a credible view of projected medical treatment and costs.

- Use life care plans prepared by a certified professional in more serious claims.
- Obtain a rated age in claims involving catastrophic injury, complications, co-morbidities and/or older claimants; align life expectancy and projected medical.
- Leverage standard reference tools, such as AMA Impairment and Disability Duration guidelines.
- Use Pharmacy Benefit Manager [PBM] resources to determine the availability of generic substitutes.
- In pain management claims involving pharmaceutical abuse, assign for a drug utilization review.
- Identify all possible benefit contributors.
- Use actuarial resources to assist with and/or validate net present value and additional discounts.

Survey discussions also surfaced a few ideas from respondents:

- One respondent is partnering with their PBM to look at name brand drugs coming off patent during the next five years and the availability of generic substitutes, working this information into LSS evaluations.
- The same respondent is developing a pilot to investigate diagnostic films, citing the findings in a recent national study on the frequency of diagnostic errors. The pilot project involves a reevaluation of diagnostic films in target cases where surgery is projected.
- Several respondents have created proprietary tools to model the evaluation of claim components and net present value.

Nearly all survey participants require a detailed, component-based worksheet documenting the analysis and evaluation of workers compensation claims. Evaluations are generally done throughout the life of the claim and updated periodically. When a claim is selected for settlement, the evaluation must also include “a clear outline of the issues, mitigation factors, risk factors and legal unknowns” and the claim professional’s settlement rationale. Many respondents use a “short-form” version of the evaluation worksheet on smaller claims.

## **8. Use of Structures/Annuities**

The majority of respondents view structured settlements or annuities as desirable and useful tools in resolving a claim provided “you are getting the right value, it makes economic sense... and it works for the injured worker”. Just under a third use structures extensively. Respondents find these tools especially helpful for future medical costs in catastrophic injury and other large claims; \$25,000 is a commonly noted threshold. “It is the right way to go.” “It pushes more attention to the injured worker managing their medical costs.” “It is one tool in the broader settlement goal discussion.”

The trend toward greater use of structured settlements for the medical component is partly in response to the challenges associated with Medicare Set-Asides. A small number of respondents consider setting up a “special needs” medical trust. Discussions reflected a trend away from the use of a reversionary feature in such trusts.

Survey respondents were less enthusiastic about the use of structures in smaller claims, or to resolve the indemnity component. “If you are simply replacing a stream of income at net present value, it doesn’t make any sense.” “It needs to serve a purpose; to accomplish something more than you would get without it.” One indemnity example often cited is the use of structures in death claims to provide periodic lump sums throughout a dependent’s college years.

The majority of respondents manages and controls the structured settlement process by:

- Vetting and developing a panel of approved structured settlement brokers, usually brokers specializing in workers compensation claims.
- Implementing controls to ensure that only financially stable life companies are used to provide annuities.
- Assigning contingent liability of annuities to financially sound third parties.
- Maintaining adequate and accurate records of all structured settlements in a secure, centralized location or database.

## **9. Medicare Set-Aside [MSA] Considerations**

The majority of survey respondents expressed significant concerns about the escalation of medical costs when CMS is involved in determining the allocation for an MSA. A few utilize a nurse or other resource with medical credentials to negotiate the allocation with CMS, finding that this leads to a more accurate and consistent result. One insurer now has an MSA-certified nurse on staff piloting smaller cases. Several respondents use Medicare counsel to negotiate. The majority relies on an MSA vendor for negotiations, although concern was expressed about the lack of consistency among MSA vendors. A small handful of respondents are seriously re-thinking whether to use LSS at all when an MSA is involved.

What comes through clearly in the discussions is that, “if you don’t negotiate, you are leaving money on the table unnecessarily”. “You need to look at the CMS medical allocation critically, especially with regard to conditional payments and elective surgeries.” “Get an exam and rated age to ensure that medical is not over-allocated.” When using MSA vendors, “it is important to send accurate records and check the MSA vendor’s work to ensure that items are not arbitrarily added”.

With few exceptions, negotiations are handled by the respondent, or a medical specialist or vendor on their behalf; it is unusual for negotiations to be delegated to the injured worker’s counsel. In smaller, less complicated claims, the injured worker is frequently

offered the option to self-administer the medical component; \$25,000 was cited by several respondents as an appropriate threshold. In larger, more complex claims, or where the claimant is incapacitated, the benefits provider will likely utilize a structure or trust to ensure that the dollars are available when needed. In determining whether to use a structure or a trust, the costs of a trust administrator are taken into consideration. The use of trusts, which have ongoing administrative costs, appears to be diminishing; a few respondents will not select a trust unless they are able to negotiate a one-time sum for administrator fees.

## **10. Resource Considerations in Handling Lump Sum Settlements**

The survey included a discussion of claims structure supporting LSS activity. The great majority of Run-off insurers and State Funds favored end-to-end handling by the assigned line claims professional. Active insurers were evenly divided among centralized and/or dedicated specialists, end-to-end handling, and a hybrid of the two. In the end-to-end model, insurers also relied on home office oversight, with reporting triggers based on qualitative criteria as well as dollar thresholds. In the centralized models, adjusters were often assigned more complex claims to handle generally, and not solely for the purpose of LSS. Within the hybrid models were two variations: in the first, claim complexity determined claim assignments; and, in the second, a dedicated resolution team handled run-off claims, while line adjusters handled claims end-to-end arising from the active book of business. The following determining factors were cited by respondents to support their given structure:

- The structure “depends on the stability and quality of staff”.
- The line claims professional may not have the most objective perspective.
- The original adjuster “knows the case best and will have better insights into claim nuances and intangibles”.
- The original adjuster likely has a “better rapport with the injured worker and his/her counsel”.
- “Higher skills are required for more complex claims.”
- A dedicated team managing acute care drives a better result.
- The second opinion of a dedicated, specialized team has advantages.
- With a dedicated team, you risk losing ground in training replacements.

The survey also included a discussion on the role of in-house legal staff in settlements. Respondents were consistent in their replies that claims is accountable for handling LSS, while legal staff provided guidance and interpretation. In many situations, legal staff manages outside firms on litigated claims, raises red flags where appropriate, and, when requested, negotiates an LSS based on authority delegated by claims.

## **11. Authority Structure**

With one minor exception, all respondents reported that settlement authority resides entirely within the claims function. In one situation, in-house legal staff has limited authority to settle claims where they are managing outside firms on litigated files.

Authority is generally hierarchical within the claims structure. Authority levels are established to not only ensure appropriate evaluations, but also to ensure that appropriate resources are utilized in determining the LSS evaluation. Active insurers rely on home office oversight and consultations on more complex and higher-valued claims. Reporting triggers are based on both qualitative criteria and dollar thresholds.

“Round-table” discussions are nearly universal on disputed, catastrophic, complex and unusual claims. They are generally utilized early on in the development of a claim and not solely for LSS. “Round-tables are a good investment of time and resources”. They “help to train and calibrate evaluation skills” and “enhance critical thinking and analysis”. They “help to push challenging claims into active resolution”.

## **12. Audit Structure and Approach**

More than half of survey respondents have a separate, dedicated claim audit team. Audits generally focus on end-to-end claims handling, and do not focus solely on LSS handling. As part of the normal audit process, the following LSS components are reviewed: appropriate selection, quality of evaluation, effectiveness of negotiation, and reasonableness of outcome. A small number of respondents periodically include field “guest auditors” as a training and development tool. Those with dedicated audit teams cite the following benefits:

- Stability and consistency in application of standards.
- Calibration of evaluations.
- More reliable systemic trending.
- Dissemination of best practices.
- Available support for corrective action plans.

About half of respondents with dedicated audit teams have also implemented self-audits at the front-line level. Self-audit results are validated by dedicated teams during formal audits. One respondent has added clinical staff to the dedicated audit team to “raise our game level”, create a “holistic and robust approach to measuring quality” and to “bring more objectivity to the audit process”.

Those respondents who do not have a separate, dedicated audit team described the following approaches:

- Self-audits supplemented by periodic external audits to validate results.

- Self audit at six months to review quality, compliance and best practices, plus an audit by an external vendor twice each year to review best practices and obtain an assessment of global trends, including evaluation and negotiation of LSS claims.
- Bi-annual audits by an external specialist focused on a different specific issue each time.
- Unit managers cross-audit each others' teams, supplemented periodically by an external audit that reviews the quality of evaluations, effectiveness of negotiations and reasonableness of outcomes.

### **13. Metrics Discussion**

Survey participants are consistent in their belief that quality assurance audits are the primary measure for effective LSS execution [and claims handling in general]. A comprehensive audit implemented and conducted throughout the year will “provide a credible baseline and help measure performance progress” at the organization and individual levels.

Most respondents have moved away from volume as a measure of success. Several do produce a monthly scorecard that measures and trends LSS activity, average paid, but the quality assurance audit remains the primary measurement tool.

**Board of Directors**  
**Ohio Bureau of Workers' Compensation**  
**Audit Committee**  
**January 22, 2009**  
**External Audit Management Letter Comments – Status Update**

**Breakdown of Comments Received:**

- **Significant Deficiency (1)**
  - Managed Care Organization (MCO) SAS 70 Reviews
- **Material Weakness**
  - None
- **Other Matters for Consideration (12)**
  - Claim Payments (2)
  - Issue, Maintain, and Service Policies (3)
  - General (2)
  - Financial Reporting Department (2)
  - Net Assets (1)
  - ORC Compliance (1)
  - Fixed Assets (1)

**Comment Status**

- **Significant Deficiency**
  - Managed Care Organization (MCO) SAS 70 Reviews - In Progress
- **Other Matters for Consideration**
  - Claim Payments - Resolved
  - Issue, Maintain, and Service Policies
    - Resolved – 2
    - In Process – 1 (Targeted resolution June 30, 2009)
  - General – Resolved
  - Financial Reporting Department – Resolved
  - Net Assets -
    - Pending – 1 (Requires legislative change proposed in 2010-11 budget)
  - ORC Compliance -
    - Pending – 1 (Resolution dependent on IT and Business Staff availability)

**Board of Directors**  
**Ohio Bureau of Workers' Compensation**  
**Audit Committee**  
**January 22, 2009**  
**External Audit Management Letter Comments – Status Update**

- Fixed Assets -
  - In Progress – 1 (Targeted resolution date June 30, 2009)

# 12-Month Audit Committee Calendar

Date	January	Notes
1/22/2009	1. Quarterly Litigation Update (Executive Session)	
	2. External audit outstanding comments	
Date	February	
2/19/2009	1. Internal Audit QES Review	
Date	March	
3/19/2009	1. Inspector General Annual Report	
Date	April	
4/29/2009	1. Discussion of external audit	
	2. Quarterly Litigation Update	
Date	May	
5/28/2009	1. Internal Audit QES Review	
	2. FY10 Administrative Budget -(1st reading)	
Date	June	
6/18/2009	1. FY2010 Audit Plan	
	2. FY2010 Financial Projections - (1st reading)	
	3. FY2010 Admin Budget (2 <sup>nd</sup> reading)	
Date	July	
7/30/2009	1. External audit update	
	2. FY2010 Financial projections (2nd reading)	
	3. Quarterly Litigation Update	
Date	August	
8/27/2009	1. Internal Audit QES Review	

# 12-Month Audit Committee Calendar

Date	September	Notes
9/24/2009	1. External Audit Update	
	2. IG Semi-Annual Update	
Date	October	
10/29/2009	1. Operation Review Report	
	2. Charter Review	
	3. Quarterly Litigation Update	
Date	November	
11/19/2009	1. External Auditor Retention Letter	
	2. Annual Financials MD&A Review	
	3. Internal Audit QES Review	
	4. Comprehensive Report	
	5. Approve Committee Charter Changes	
Date	December	
		1/14/2009 9:52:56 AM