FINEOS

Workers' Compensation: How to Reduce Case Administration Costs by 15%

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FINEOS Corporation Limited
Pembroke House,
8-10 Lower Pembroke Street
Dublin 2, Ireland

Telephone: + 353 1 639 9700
Fax: + 353 1 639 9701
Email: info@FINEOS.com

Title: [Workers' Compensation: How to Reduce Case Administration Costs by 15%]

3

Table of contents

4

Abstract

Workers' compensation is big business. According to the National Safety Council, the cost of work injuries in 2003 to *Fortune 500* companies was the equivalent of 15 cents of every dollar of pre-tax corporate profits. This white paper examines the key issues affecting providers of workers' comp, including insurers, state regulators, provincial boards and self-insured administrators. The paper provides an overview of workers' comp systems; the history and role of workers' comp programs; the factors contributing to premium increases; and the burden of rising rates and inefficient systems. It concludes with an examination of where effective case management and software can be used to automate key business processes and reduce case administration costs by as much as 15%.

5

Introduction

Workers' compensation, it doesn't interest you? Well, it should – it affects nearly all of us. Indeed, it's estimated that 90-97% of the American workforce is covered by a workers' compensation program. No doubting, it is a massive social program.

And boy is it one pain in the neck (or should that be back?) for employers in terms of premium rates paid and lost productivity. In 2002 alone, nearly 1 million US workers took time off because of work-related disorders of the lower back and upper extremities, either to receive medical care or for recuperation[1].

The genesis of workers' comp goes back to Germany in the 1880s. The scheme was subsequently adopted and modified in England before, ultimately, being adopted by state law in the United States, beginning in Wisconsin, in 1911. By 1949, all states had enacted similar legislation. In Canada, Ontario led the way with legislation passed in 1914.

Essentially, workers' comp is a covenant between workers and employers. At its inception, workers gave up their constitutional right to sue their employers for on-the-job injuries and occupational diseases in exchange for fast and efficient wage-loss replacement, reasonable and necessary medical and rehabilitative care and, when a return to complete medical-functional status was not possible, disability awards to compensate for lost future earnings.

Ah, a noble enterprise. Yes, there's a bit of that. But it's really in place for sound economic reasons. Without it, the entire US economy – and economies across the globe, which have their own variations of the scheme – would be mired in interminable litigation battles, ludicrous expenses and diminished productivity.

[1] Institute of Medicine of the National Academies, 'Musculoskeletal Disorders and the Workplace: Low Back and Upper Extremities', 2004.

6

The three insurance models

Workers' comp uses the same basic model as other lines of insurance, i.e. groups exposed to similar types of risk spread the risk and costs among themselves. Premiums are collected to offset payouts in the event of an accident or illness.

In the United States, each state has its own specific set of laws and manages its own workers' comp system. States employ different insurance models, and three distinct types exist in the US: a fully private model, a fully public model, and a "hybrid" model in which private insurers and a publicly run program operate in the same state.
The fully private and hybrid models are the most common. Forty-five states use one of the two, meaning that employers in these states have many insurers from which to choose. Twenty-six of these 45 states have totally private systems in which private insurers compete against each other for business.

The remaining 19 of the 45 states use the "hybrid" in which the state operates a program that competes with private carriers. The outstanding five states use the totally public model. In addition, bigger corporations across the country are self-insured.

Meanwhile, in Canada, all workers' comp insurance is provided through workers' compensation boards, which have complete jurisdictional powers, based on government legislation to provide and administer workers' comp in their respective provinces.

Which system is best?

Intriguingly (or perhaps infuriatingly), the most comprehensive academic survey done on workers' comp comes to a dead-end when asked which system is best. Three national experts in workers' comp, Terry Thomason, Timothy Schmidle and John Burton, Jr.[2], noted that a recurrent theme of their study was that programs are complex and achieving the defined objectives is inherently "counter-productive: achieving one objective often interferes with reaching one or more of the remaining goals."

This is especially true for the interplay of cost and benefits, for instance, because any increase in benefits must be supported and paid for by a proportional increase in costs to employers and workers.

Furthermore, the authors of that study concluded that it is "likely that no empirical study will ever surmount all of these problems and completely dispose of the issue once and for all." All that can be hoped for is that plan administrators try to improve in three areas: efficiency; choice for employers; and service for injured workers.

[2] Washington Policy Center, 'Reforming Washington's Workers' Compensation System', 2005.

7

Issues and trends

Nonetheless, there are a host of fascinating macro trends and issues impacting on market performance of workers' comp plans, which drive performance and future policy decisions. Record low interest rates are a prime example, as insurers, across every line of business, often rely on investment returns for profitability.

Perhaps it is disingenuous to single out investment returns as a problem area in comparison to, say, diagnosing specific system issues such as pricing or IT performance. Is it not? In most incidences, the unparalleled investment earnings of the 1990s merely masked underlying financial weaknesses in the workers' comp system.

In reality, at performance level, there are really four key issues to contend with. These are as follows.

8

1. Rising medical costs

One of the most acute problems lies with rising medical costs. At the state level, the vast majority of states show an increase in total medical benefits each year from 1998-2002, with 20 states showing double-digit percent increases between 2001 and 2002. For 13 of these states, the growth in medical benefits drove the overall increase in total benefits between 2001 and 2002. For example[3]:

- California medical benefits rose by 26.3%, while cash payments to workers rose 9.7%
- Delaware medical benefits rose by 23.7%, while cash benefits to workers rose 9.2%
- Iowa medical benefits rose by 18.3 percent, while cash benefits to workers fell by 0.8%
- South Carolina medical benefits rose by 24.1%, while cash benefits to workers rose by 6.0%
- West Virginia medical benefits rose by 27.6%, while cash benefits to workers rose by 12.2%

The same is true in Canada. While accident frequency has been steadily declining (63% from 1985 to 1995), medical costs have been increasing. Healthcare costs in Ontario increased by 50% from 1998 to 2001, leading to a projected 7.4% premium increase in 2003. Fascinating stuff. This trend suggests that increases in total benefits paid in some constituencies are driven by medical care *much more* than cash payments to workers, increased injury rates or benefit payouts.

Effectively, rising medical costs are the result of four factors:

1. A broader definition of "workplace injury"
2. An increased number of medical visits made per claimant. Although, the frequency of claims has fallen almost 40% since 1990 (and 27% since 1997)[4], the number of medical visits per claim has increased steadily
3. Rising prescription drug costs. In 2001, for example, the cost of prescription drugs rose 15.7% over 2000[5]
4. Increasing medical treatment costs. The medical costs of workers' comp claims have grown much more rapidly than medical costs in general, as measured by the medical Consumer Price Index (CPI). Indeed, and this is an amazing fact, for the period 1995-2002, the medical costs of workers' comp claims have increased 82%, while medical costs in general as measured by the CPI have increased just 36%[6]

That's the diagnosis. Unfortunately, few cures have been offered up to resolve the current medical cost crisis.

[3] National Academy of Social Insurance, 'Workers' Compensation: Benefits, Coverage, and Costs, 2003', 2004.
[4] Marsh Risk Consulting, 'Controlling the Cost of Workers' Compensation', 2005.
[5] Klingel, Stephan J. 'Workers' Compensation Market Snapshot: A Host of Critical Issues Affect Market Results', 2004.
[6] ib id.

2. Fraud and inappropriate claims

Workers' comp plans have evolved into incredibly complex operations. No surprise that, in such a set-up, there is room for problems. Indeed, analysts agree that as many as 25% of all filings may have some element of impropriety. Two areas stand out. The first is human error. Schemes are rife with misunderstandings, misidentification of workers' occupations and honest mistakes.

The second problem is more galling. Workers' comp laws create irrational incentives: the longer a worker is out of work, the more likely he or she is to get a cash award. Every workers' comp jurisdiction has a waiting period – typically three or seven days – before a claimant is entitled to wage-replacement benefits. By extending an absence, a worker becomes entitled to indemnification for lost wages – often on a retroactive basis to day one of the claim. In addition, for many workers the "tax free" status of wage replacement payouts represents an actual increase in available funds.

The problem is compounded by the growing role of healthcare providers in the workers' comp equation. Traditionally, workers' comp used to be an arrangement between employer and worker. Now healthcare providers are in the mix. With access to medical services – and human nature being human nature – the longer workers are out of work the more likely they are to perceive the need to avail themselves of these insured services. At the same time, health care providers are more likely to extend the number and type of treatment modalities when a workers' comp plan guarantees them payment. This extended treatment period can actually make it harder to get back into the discipline of a 40-hour week once the "disability" has cleared up. In strict cost terms, the problem doesn't lie in the amount charged per visit, rather the number of visits.

The problem is getting out of hand. In fact, the National Insurance Crime Bureau calculates that workers' comp fraud alone costs insurers $5 billion each year. This, in turn, is billed back to employers in the form of a whopping $6.5 billion of premium[7]. There are three specific areas where change is needed:

1. Definitions of compensable injuries and occupational diseases must be written more tightly
2. A higher degree of proof should be required for subjective conditions such as stress that are susceptible to legal manipulation, patient exaggeration, mistakes in causation, abuse or fraud
3. Intelligent controls are needed on the number of medical visits per claim, particularly to physical therapists and chiropractors

[7] Long, S., 'Controlling the Cost of Workers' Compensation', May 2004.

3. Terrorism

Conceived in order to promote stability in the marketplace, the Terrorism Risk Insurance Act (TRIA) expires at the end of 2005; unless, of course, Congress extends its lifespan. The date looms large, as workers' comp insurers will be forced to weigh carefully the heightened risk of writing business in a post-TRIA world.

At present, TRIA guarantees that in the case of a terrorist attack causing more than $5 million in damages, the government will cover 90% of terrorism-related losses after insurers pay a deductible equal to a percentage of their net premiums from the previous year. Insurers pick up the other 10% of claims. Total losses for the industry are capped at $15 billion, while government losses end at $100 billion.

Arguments for extending TRIA are certainly compelling; not least of which is the fact that traditional underwriting rules are redundant in attempting to spread risk appropriately, as it is impossible to accurately predict the frequency or severity of terrorism loss. There is no one to re-insure in such a situation. But, history tells us that wonderfully sound arguments often fail to make it into legislation. Time will tell.

4. Frequency and indemnity

What is wrong with the world? Over the past three years, workers' comp costs in the USA have increased by an average of 50%. Yet, spurred by the U.S. Occupational Safety and Health Administration, the frequency of workplace fatalities has decreased by 60% while workplace injuries have dropped, as mentioned, by almost 40% since 1990. The figures don't add up. In Canada, a similar pattern emerges with the frequency of injuries dropping by 63% between 1985 and 1995.

Every employer understands the bottom line though. Escalating costs are threatening the very existence of businesses across the United States. Today, employers pay almost twice as much in workers' comp costs than they contribute to Medicare. Indeed, if current trends continue, by 2010 employers will contribute more to workers' comp than to Social Security[8].

In state-funded schemes[9], this situation is exacerbated by the fact that every workers' comp dollar is more valuable than a regular wage dollar because state benefits are not subject to federal income, Social Security and Medicare taxes. The anomaly of a workplace that is safer yet costing the employer more in workers' comp costs is the result of claims severity, i.e. the total cost of claims, including medical, indemnity, and expenses.

[8] Marsh Risk Consulting, 'Workers' Comp Claims Severity – The Major Cost Driver', 2004.
[9] Washington Policy Center, 'Reforming Washington's Workers' Compensation System' 2005.

This is not to advocate recklessness in the workplace. (Funnily, workers are doing a good enough job of that without any encouragement. According to a recent Gallup poll, 50% of workers circumvent safety procedures.) It is merely to suggest that savvy employers should place as much emphasis on managing, as they do on preventing, claims.

Key claims management objectives

Effective claims management is the one area in which scheme administrators can make an immediate and measurable[10] impact on the system's performance. With claims management, the problems are easily identifiable and, more importantly, are easily corrected.

Once an injury occurs, the primary objective of a good claims management system is to engage "three-party contact" among employer, attending physician and injured party with a view to speedily and safely returning that worker to work. At a micro level, it's proven that slow turnaround times lead to needless cost. At present, most systems are hugely inefficient.

For example, in research carried out on the Washington's workers' comp system, auditors found that the claims-initiation process requires claims to be passed through an unusually high number of departments and that it takes "more than six days to accomplish what is just 90 minutes of actual work[11]". The same is true in Canada where a new claim can take as long as 12 days just to reach the claim adjudicator.

So, once you drill down, what are the objectives of a good claims management system? Logically, there are primary and secondary ones. These are as follows:

Primary

1. Implement a **best-practice case management** model informed by performance and trend analysis
   - Improve data capture
   - Improve communications, i.e. make information available as quickly as possible
   - Introduce intelligent workflow (e.g. status reporting, service levels, auto-generation of follow-up tasks)
   - Reduce paper flow
2. Intervene intelligently with **proactive recovery and rehabilitation** processes in order to improve return-to-work rates for injured workers
3. **Relationship management**, i.e. engage more effectively with providers and other stakeholders
4. Identify and **manage fraud** indicators
5. Reduce **IT maintenance** costs

[10] For example, any workers' comp system can have metrics around the following:
- Claim duration
- Return to Work – Rate
- Return to Work – Durability
- Benefits paid to workers as a proportion of total claims costs
- Total notional premium as a percentage of total gross remuneration
- Average recommended premium rate

[11] Washington Policy Center, 'Reforming Washington's Workers' Compensation System', 2005.

Secondary

1. Reduce **annual reserves**
2. Reduce **administration costs**
3. Improve **staff productivity**
    - Free staff from menial work and enable them to focus on their chosen area of expertise
    - Enable staff to increase their workloads due to reduced case handling times
    - Decrease staff turnover, which results in increased productivity and reduced hiring and training costs
4. Increase flexibility by introducing easier mechanisms for **process change**

Technology – the key enabler

Technology provides the enabler to deliver on these goals. With intelligent process automation, insurers can hardcode consistent policies for reporting claims, incident investigations and medical referrals.

Good technology ensures that employers are prompted to initiate clear, consistent and regular communication with the injured worker. It also provides the bedrock for the effective communications with medical providers that are critical to successful outcomes for injured workers. It supports an intelligent case/claim decision model to reduce “red tape” and ensure injured workers receive the care and benefits they require in a timely fashion.

A successful IT system also helps to orchestrate the bulk of the time-consuming, error-prone processes tied up with workers’ comp claims. It helps insurers to provide fast, effective service, and can enable internal business users to:

- Carry out fast and cost-effective modifications
- Change business decision logic quickly without the requirement to recode the basic support application structure
- Adopt a migration strategy from existing, outmoded systems that minimizes business impact and risk
- Engage total supply chain electronically via a thin client solution
- Install a robust, but flexible, solution that meets the ever-changing needs of the business
- Improve the quality of data submitted by insurers
- Capitalize on claimant-centric systems, as antiquated systems tend to only record claims

15

Where FINEOS can help

Overview

FINEOS has built up a client roster of claims management customers in North America, AsiaPac and Europe. These include corporations such as Aetna, Assurant, and the Principal Financial Group as well as New Zealand's Accident Compensation Corporation (ACC).

Its claims management system has been proven to deliver measurable business benefits, including the following:

- Reduced calls from call centre to claims department by 70%
- Claims' cycle times cut by 40%
- Reduction in postage by 40%
- Reduction in outgoing phone calls by 28%
- Improved service levels by 25%
- Saving in staff training by 25%
- Improvement in administration of work processes by 20%
- Reduced administration processing time by 15%
- Claims' administration costs cut by 10-15%
- Expenses each year reduced by 10%
- Reduction in short-term disability (STD) claims reaching long-term disability (LTD) claims by 2%
- Reduction in annual reserves through tighter claims management processes by 1%

The expertise it has built up in the claims management sphere means that it can address the key objectives of an effective workers' comp claims management system in the following ways.

16

1. Best-practice case management

Unlike process- or payment-driven providers, FINEOS provides a holistic case management solution. Across the organization, whether it's litigation or rehabilitation, it will ensure stated guidelines are met, helping to screen claims and allocate them into their appropriate streams, as pre-ordained.

The system's case management functionality is designed to enable clients to manage their business by case-sensitive activities and triggers rather than complex process designs. It is perhaps the defining feature of the system.

Indeed, speaking at an industry conference in Australia in 2004, Gerard McCreevey, General Manager, ACC, suggested that FINEOS has the "best case management of any product in the world". And ACC should know. The corporation evaluated 53 different systems before choosing a vendor to spearhead its $90 million workers' comp project.

Highly configurable, it provides each business user with an optimized view of their cases, incorporating a complete view of all relevant-party communication, task, process and document relationship information.

All of the information captured as a result of claimant or stakeholder activity is recorded and allocated to an assigned case number. This gives users a single view of each case file, allowing them to inquire on all aspects of case data, irrespective of how many people or processes are involved. The claimant-centric data structure allows the case manager to quickly and easily review any past claims for relevance in resolving the current claim or to assist in assigning costs.

Users can browse through all cases and drilldown to a particular case to view its owner, status, related contacts, tasks, documents (incoming and outgoing) and contracts. This improves the speed and precision at which staff can service claims.

In addition, claims are settled quicker and cheaper through application of standardized best practices, as claims handlers no longer have to make all their own judgments for a case because previously settled matching cases are easy to find on the FINEOS system.

It also enables users to effectively manage and control all interactions with a party. This element of control is crucial. By incorporating best practice – whether they are derived from in-house or industry sources – organizations can measure and improve the claims process.

As Berend-Jan de Leeuw, Manager, Bodily Injury Claims Department, Aviva testifies: "The FINEOS system gives us best practice. With better information, we are able to handle cases earlier, cheaper – and with better standards. That's the most important benefit with FINEOS."

Workflow automation

An integral part of the FINEOS case management functionality is its intelligent workflow automation mechanisms for routing of tasks, auto-generation of follow-up tasks, service level agreements, status reporting, automatic updates, screen and validation management.

Work can be allocated by automatically routing tasks to predefined work queues and flagging priority items. It manages what work needs to be carried out by each department and/or individual and highlights when tasks have gone past their target dates.

Intelligent task generation ensures tasks are seamlessly distributed to the pre-defined work-queues of the appropriate person or department. This powerful feature guarantees that time-critical tasks are turned around efficiently as in the instance of a workplace fatality. As Berend-Jan de Leeuw, Manager, Bodily Injury Claims Department, Aviva, bears testament: “The FINEOS system has integrated workflow management, which is very important for us as it enables us to gain more control of our claims handling process.”

Process change

The ability to rapidly implement process change – for example, in response to fraud issues, regulatory change or customer demand – is also a key component of the system. As part of the product, the FINEOS Process Composer allows existing or potential business processes to be defined in the system in a graphical format, providing tremendous flexibility.

As Craig Doering, Director of Information Systems, Workability Division, Broadspire, explains: “The strength lies in the flexibility of the FINEOS application. Our ability to provide good customer service is enhanced because the technology we have allows us to have different processes for different groups.

“Before we started using FINEOS, whenever a customer wanted a different workflow, a different process, we would have to hard-code that into our system. If you had 20 customers, you almost had 20 different systems because each customer had unique, hard-coded pieces in that system. With the FINEOS Process Composer, a super-user can go in there and make those changes in a matter of minutes.”

Data capture

With the flexibility afforded by the FINEOS Process Composer, data capture processes are also improved as a result. As Doering explains, “It helps us facilitate the gathering of better data. We’ve configured FINEOS to reflect our episode/event extension methodology.”

Additional data can be captured and filtered into processes seamlessly, which helps to avoid time-consuming human intervention as well as helping to circumnavigate opportunities for error or fraud.

This helps to inform better return-to-work processes as well. For example, information such as a worker's previous employments, training that a worker had previously undergone, etc. is readily apparent, as all data capture is electronic, comprehensive, and claimant centric. In addition, paper flow is vastly improved with the scanning, imaging, indexing, auto-generation and customization of claim-related correspondence.

2. Proactive recovery and rehabilitation

With its sophisticated workflow automation, FINEOS can orchestrate timelines for the recovery and rehabilitation plan of each individual case based on best practices. It automatically identifies key milestones so that staff and interested stakeholders can make timely interventions over the lifespan of a claim.

Case information is available from a central source. When required, the system will also pull appropriate intelligence from third-party sources. For example, it can integrate with the medical disability advisor (MDA) for figures and data, which helps with the provision of consistent duration guidelines.

Moreover, the system's process automation accurately manages the return-to-work process for claims. It intelligently drives key processes, automatically creating, triggering and monitoring tasks according to prescribed practices.

Ultimately, it helps clients to be more proactive in getting claimants back to work. As Mike DeSimone, VP Product Development, Workability Division, Broadspire explains: "The FINEOS tools help us in our ability to get somebody back to work sooner. We focus on productivity and getting people back to work and the tools that we have and the systems that we use help us get people back to work in a safe, effective way."

3. Relationship management

The system draws on the key tenets of effective customer relationship management (CRM), helping to orchestrate all parties in the claims process. It provides secure, web-based portals for each interested third party, including workers, employers and the range of providers, e.g. medical doctors, rehab, registered nurses, etc. Having all parties informed and engaged leads to speedy, effective claim resolution.

Karen Kelly, Project Manager, Assurant Employee Benefits felt the inherent CRM philosophy was an important driver in their decision to implement FINEOS: “The FINEOS proposal closely aligned with our core ideology and business practices – creating and maintaining a long-term relationship with our customers. Utilizing FINEOS’s CRM element as a relationship manager appealed to us.”

By providing appropriate, real-time access to claim file information stakeholders are able to engage more effectively. They can trigger tasks – from employer verifications to the flow of medical data – and view information as required. If necessary, they can also filter information into the electronic claim file system via intelligently generated electronic forms. This ability to scan, index and image documents removes paper headaches and cuts administration costs.

More importantly, the provision of role-specific portals vastly speeds up the claims process, as stakeholders can carry out activities – from medical to indemnity and legal ones – concurrently. It also helps to reduce service costs, as information is more transparent.

According to Richard Caffrey, Canada Life: “We initially experienced a 70% reduction in calls from our front office to our claims department, which would have been queries about what’s happening on a file or what’s outstanding, and so on. I have no doubt that the quality of service has improved significantly as a result.”

4. Fraud management

The single source for claim information also feeds into effective fraud detection practices, as it is easier to identify and manage fraud indicators. With access to consolidated information, claims handlers can draw up individual claimant information instantly and more readily spot anomalies – as suggested by industry standards or best practice – across cases.

Expert claims handlers can slice and dice their information to identify fraud patterns. For example, this could be providers' behavior around injury codes, specific over treatment for injury codes (by matching up to treatment codes) or even identifying the number of claims a particular claimant might have (which the system could automatically alert on submission of a claim). This reduces the work an individual claims handler would have in trawling through various systems for instances of fraud. The system can also automatically refer cases to fraud units.

Privacy and security

Whenever personal medical records are being stored or shared, concerns regarding privacy and security arise. HIPAA was introduced into the US in 1996 to reduce administrative costs in the healthcare industry by requiring the use of standardized electronic data transmission, including unique identifiers, and diagnostic and treatment code sets. In Canada, PIPEDA legislation dealing specifically with the privacy of personal information was implemented in 2004.

FINEOS can easily integrate the required code tables, identifiers and other requirements necessary to conform to both HIPPA and PIPEDA. Security within the FINEOS system and related database is flexible and can be configured to meet your organization's security needs regardless of jurisdiction.

Reporting

A quick search on the internet will show that most current reports include data and trends that were several years out of date at the time the report was prepared, putting decision makers in a lag rather than a lead position. With FINEOS, you have the ability to data mine a knowledge-rich environment in a timely and efficient manner.

5. IT maintenance – a single platform

FINEOS provides a single platform across the front office for claims. Having a single system speeds up turnaround times for cases as the amount of time claims handlers spend navigating around numerous systems for reporting, registering, reserving and paying cases is reduced.

Also, having a single claims management system means that claims experts no longer waste valuable time doing administration instead of adjudication. In addition, training costs are reduced, as staff no longer have to learn so many systems. IT maintenance costs are reduced considerably as well.