



2015 WORKERS' COMPENSATION BENCHMARKING STUDY

CLAIMS MANAGEMENT
OPERATIONAL STUDY

INSIGHTS REPORT

Study Director & Publisher:
Rising Medical Solutions

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Preface

About the Study

The Workers' Compensation Benchmarking Study is a national research program examining the complex forces that impact claims management in workers' compensation today. The study's mission is to advocate for the advancement of claims management by providing both quantitative and qualitative research that allows organizations to evaluate priorities, hurdles, and strategies amongst their peers. Conceived by Rising Medical Solutions (Rising), the study's impetus evolved from various conversations Rising had with industry executives about the gap in available research that focuses on how claims organizations address daily operational challenges.

Today, the ongoing study program is a collaboration of workers' compensation leaders who represent diverse perspectives and share a commitment to providing meaningful information about claims management trends and best opportunities for advancement. Recognizing the need for an unbiased approach, the study is guided by an independent Principal Researcher and an Advisory Council of industry experts whose involvement is critical to maintaining a framework that produces impartial and compelling research.

About the Study Director & Publisher

Rising Medical Solutions

Rising is a national medical cost containment and care management company that serves payers of medical claims in the workers' compensation, auto, liability, and group health markets. Rising spearheads the study idea and leads the logistical, project management, industry outreach, and publication aspects of the effort. For study inquiries, please contact VP & Study Program Director Rachel Fikes at wcbenchmark@risingms.com.

About the Principal Researcher & Study Report Author

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Study Advisory Council / Research Participants

Essential to the study program and research is its Advisory Council, comprised of nearly twenty workers' compensation executives who represent national and regional carriers, employers, third party administrators, brokerages, and industry consultancies.

Since 2013, their varied perspectives have guided the study's continued efforts to examine some of the most significant operational challenges facing claims organizations today. From the formation of research strategies to the interpretation of results, the Council has provided critical expertise throughout this endeavor.

In 2015, members of the Council both participated in think-tank sessions as well as this year's qualitative, focus group research. Among those distinguished advisors we thank for their time and commitment are:

- **Gale Vogler** | Director, Managed Care | **Acuity Insurance**
- **Raymond Jacobsen** | Senior Managing Director | **AON Benfield**
- **Leann Farlander** | Cost Containment Director | **Athens Administrators**
- **Fred Boothe** | Vice President of Claims Services | **BrickStreet Insurance**
- **Rich Cangioli** | Vice President, Western Region | **Cannon Cochran Management Services, Inc.(CCMSI)**
- **Cathy Vines** | Director, Healthcare Cost Containment Strategy | **CopperPoint Mutual Insurance**
- **James Masingill** | Vice President, Claim Operations | **Markel FirstComp Insurance**
- **Barbara Spain** | Senior Counsel, Workforce Management Practice Group | **McDonald's Corporation**
- **Tom Stark** | Technical Director, Workers' Compensation | **Nationwide Insurance**
- **Tom McCauley** | Owner & Consultant | **Networks by Design**
- **David Price** | Vice President, Risk Management | **POMCO Group**
- **Laura Crowe** | Risk Management Director | **Presbyterian Healthcare Services**
- **Mark Walls** | Vice President, Communications & Strategic Analysis | **Safety National**
- **John Smolk** | Principal Manager, Workers' Compensation | **Southern California Edison**
- **Joe McLaughlin** | Senior Vice President, Sales & Marketing | **TRISTAR Insurance Group**
- **Kyle Cato** | Workers' Compensation & Safety Manager | **Williams-Sonoma, Inc.**
- **Tim Mondon** | Senior Vice President, Bill Review | **Zenith Insurance**
- **Kelly Kuri** | Team Manager, Workers' Compensation | **Zurich North America**
- **Peter McCarron** | Senior Vice President, Workers' Compensation Claims | **Zurich North America**

Invited Research Participants & Acknowledgments

In addition to our Advisory Council members, this year's focus group research captured the insights, guidance, and experiences of a broader group of Industry Executives. The depth of their perspectives was vital to the study's qualitative research endeavors. Our many thanks to these individuals for contributing their considerable expertise towards advancing claims management in the industry.

- **Anne Marie Collins** | Principal | **AON Benfield Inpoint**
- **Adele Pollard, RN, MS, LRC, CCM** | Vice President | **Case Management Associates**
- **Pamela Highsmith-Johnson, RN, BSN, CCM** | Director, Case Management | **CNA**
- **Srivatsan Sridharan** | Senior Vice President, Workers' Compensation Product Management | **Gallagher Bassett**
- **Melissa Dunn** | Vice President & Managing Director | **Helmsman Management Services**
- **James Moore** | President | **J&L Risk Management Consultants**
- **Alan Turnipseed** | Senior Vice President & Managing Consultant | **Marsh Risk Consulting**
- **Annette Sanchez** | Senior Vice President & Managing Consultant | **Marsh Risk Consulting**
- **Mary Zmuda** | Director - Safety, Sustainability, Health & Environment | **MillerCoors, LLC**
- **Jim King** | Workers' Compensation Director, P&C Claims | **Nationwide Insurance**
- **Peter Rousmaniere** | Risk Management Consultant & Writer
- **Tim Stanger** | Vice President of Claims | **Safety National**
- **Debra Drake** | Director, Medical Cost Containment | **San Francisco Reinsurance Company / Allianz Resolution Management (ARM)**
- **Kimberly George** | Senior Vice President, Corporate Development, M&A, and Healthcare | **Sedgwick**
- **Barry Bloom** | Principal | **The bdb Group**
- **James Bowers** | Workers' Compensation Claims Process Leader | **Westfield Insurance**
- **Rob Gelb** | Managing Vice President | **York Risk Services**
- **Davidson Pattiz** | Chief Operating Officer & Executive Vice President | **Zenith Insurance**

We would also like to acknowledge the industry leaders and organizations that provided further counsel during the Study Report review, as well as those who have heightened the industry's awareness of the study research. Thank you for your invaluable support:

- **Joan Collier** | Editor-in-Chief, Workers' Compensation, a Claims & Litigation Management (CLM) Alliance publication
- **Dan Reynolds** | Editor-in-Chief, Risk & Insurance
- **Stephen Sullivan** | Managing Editor, WorkCompWire.com
- **Robert Wilson** | President & CEO, WorkersCompensation.com
- **William Wilt, FCAS, CFA** | President, Assured Research
- **William Zachry** | Group Vice President, Risk Management, Albertsons Safeway, Inc.

Introduction

Since its inception, the Workers' Compensation Benchmarking Study's national survey of claims leaders has provided the industry with quantitative research on claims operational challenges. This year brings a new approach to the study program – utilizing qualitative research – to take the peer data a step further from quantifying industry challenges to roadmapping industry solutions.

The decision, made with the study's expert Advisory Council, was based on resounding feedback from claims professionals who have asked exactly *how* to overcome the widely-faced challenges identified in the [2013](#) and [2014](#) studies.

Now in its third year, the Workers' Compensation Benchmarking Study builds upon the 662 claims leaders who have described, via online surveys, the current state of claims management on 70-plus data points. In 2015, 40 Industry Executives participated in qualitative research and have related these survey results to their strategic visions for future advancement.

Central to this year's qualitative effort was a survey of these Executives about the industry challenges they felt were most critical to examine during the 2015 research exercise. Below are the top issues they ranked as most pressing in the study's four key areas of claims management (see Appendix A for full survey results).

Industry Issues Ranked Most Critical for 2015 Qualitative Research



Prioritizing Core Competencies

- What strategies can we employ to operationalize qualitative and outcome-based measures?
- What are the benefits of using technologies such as workflow automation and predictive modeling to drive claim best practices?
- How do we effectively leverage risk/reward strategies with vendor partners?
- What strategies can organizations undertake to align claim best practices, internal processes, and systems throughout the organization?



Impact of Technology & Data

- How can data help to better manage claims, measure best practices, and achieve improved outcomes?
- Data analytics are a big concern/opportunity, how can claim operations use analytics strategically?
- What advanced technologies are used to communicate with key stakeholders throughout the claim cycle (e.g., workers, physicians, employers)? How are they implemented, addressing security/privacy issues?
- Are claims organizations leveraging predictive modeling? How is the information used effectively?



Talent Development & Retention

- How can we develop formalized programs that ensure knowledge transfer from senior-level claims staff to less experienced staff?
- How do we ensure recruitment, retention, and development of claims talent is a key business strategy?
- With a significant focus on technology, how can claim operations attract the tech-savvy Millennial generation?
- What should a new hire claims training program look like?



Medical Performance Management

- How do we define and measure provider outcomes?
- Both the 2013 and 2014 studies identified nurse case management, return-to-work services, and nurse/claims triage as most critical to claim outcomes. How/when are these resources utilized? Is there outcomes data to support ROI/impact?
- How can we better manage/mitigate the impact of pharmacy on overall medical costs and MSA allocations?
- How can we leverage value-based payment models in workers' compensation?

Methodology

The study's 2015 approach was formulated through facilitated think-tank sessions with the Principal Researcher and the Advisory Council Members. The Study Report is based on the qualitative research conducted through focus groups and interviews with 40 Industry Executives including directors, vice presidents and executive-level leadership from every major type of workers' compensation payer organization.

The study used focus groups to yield in-depth qualitative data on experiences, perspectives, insights and opinions, as well as potential solutions related to claims operational challenges. The use of focus groups increases candor, probe, and the thinking behind participants' opinions and can generate data that would be inaccessible without the interaction of group participants.

The study convened three focus groups of Industry Executive participants. Participants were selected by direct invitation from the Advisory Council Members and study architects. The participants were grouped to ensure an equitable distribution of industry roles including insurance carrier, brokerage, third party administrator (TPA), employer, and industry consultant.

Prior to convening the focus group meetings, Industry Executives participated in a confidential 32-question online survey to prioritize claims challenges and opportunities most critical to discuss. The survey tool structure and questions were developed by the Principal Researcher, formalized as problem statements identified from the 2013 and 2014 studies as well as priorities identified by the Advisory Council Members during think-tank sessions. The survey questions were organized across the study's four indexes – Prioritizing Core Competencies; Talent Development & Retention; Impact of Technology & Data; and Medical Performance Management.

The focus groups were led by subject-matter expert moderators utilizing a consistent discussion framework tool. Focus group content was organized across the study's indexes, with each group discussing three of the four indexes. All three groups examined Medical Performance Management, as well as two of the remaining indexes – Prioritizing Core Competencies; Talent Development & Retention; Impact of Technology & Data. Focus group participants discussed their experiences, perspectives, insights and opinions, as well as possible solutions regarding different efforts related to the problem statements.

The Principal Researcher completed the qualitative data validation and analysis, and authored this Study Report. The Report is based on the interpretation and compilation of the qualitative research. Each study participant's views are not necessarily reflected in every conclusion.

Executive Summary

The workers' compensation industry is facing a number of complex operational challenges that organizations must overcome to remain competitive, including the rapidly shrinking talent pool, emerging technologies, and operationalizing performance measures — all while improving efficiencies, reducing costs, and providing high levels of service.

The fundamental question the 2015 study undertakes is *how* organizations turn the challenges identified in the 2013 and 2014 surveys into action. This Report summarizes the greatest impact opportunities and most potent strategies that payers may consider over the next two to three years. These actionable strategies were identified by Industry Executives through qualitative research and are based on their collective experiences, perspectives, insights, and opinions.

Now three years into the study, four central themes have emerged that are deeply rooted in the industry's human capital and outcomes management:

- 1 **A shift in focus –from principally process-focused performance to outcome-based performance.** Industry Executives say that any significant advance in claims is tied to success in outcomes. Performance in claims organizations, however, is largely governed by compliance and tactical business requirements. To move from principally process-focused measures to operationalizing outcome-based measures, organizations should begin with the end in mind and reverse engineer performance measures to identify what claim activities have the greatest impact on the desired outcome.
- 2 **Recognition of claims talent as a key business differentiator.** Organizations rely heavily on claims talent to minimize risk and loss exposure as well as maintain operational efficiencies. However, the considerable impact of claims talent on business profitability is rarely translated into a significant investment in claims human capital. To transform talent management strategies will require organizations to reposition the image of claims from a cost center to a key business driver.
- 3 **Claim outcomes, changing the future with data.** Technology and managing multiple data sources remain major factors for improving the claims process and outcomes. Quickly becoming a best practice, predictive modeling is used to detect claims severity, fraud, litigation, and to improve ultimate outcomes. Industry Executives report many organizations are using predictive modeling in an effort to predict and change the future of claims development.
- 4 **The evolving landscape requires a new approach to provider reimbursement models.** Medical benefits represent nearly 60 percent of total claim costs for most workers' compensation organizations and are predicted to reach 70 percent by 2018.¹ These concerns have organizations rethinking traditional medical management strategies. Industry Executives agree value-based payment models are a viable option for the workers' compensation industry to cut costs, improve efficiency, and achieve overall better treatment outcomes for injured workers.

¹ Robert Hartwig, Insurance Information Institute available at:

<http://www.iii.org/Presentations/Making-Sense-of-Now-and-Forecasting-the-Future-The-Economys-Impact-on-Workers-Compensation.html>

As successful outcomes management increasingly becomes the most effective measure of claims excellence, Industry Executives recommend a holistic approach towards industry solutions. Strategies that will have the greatest impact will involve multiple drivers:

 **Core Competencies [1]**
Building a strong foundation by mastering and measuring things that matter.

 **Talent Development & Retention [2]**
Enhancing organizational results by investing in claims management talent development.

 **Technology & Data [3]**
Changing the future of claims by effectively leveraging predictive modeling and workflow automation to enhance individual judgment and organizational focus.

 **Medical Performance Management [4]**
Leveraging the changing landscape through medical management strategies focused on healthcare quality and outcomes.

4 Major Drivers of Claim Outcomes





Operational Challenge

Prioritizing Core Competencies

Building a strong foundation

A well-built organization starts with a strong foundation, and core competencies are analogous to that strong foundation in workers' compensation claims management. According to the Harvard Business Review, a core competency is a unique characteristic or capability that provides a competitive advantage, delivers value to customers, and contributes to continued organizational growth.² During the 2015 study's qualitative research exercise, Industry Executives discussed key issues impacting claim core competencies, namely how to: employ outcome-based measures, utilize technology to drive claim best practices, and leverage risk/reward strategies.

The 2014 study participants rank medical management, disability/return-to-work (RTW) management, and compensability investigations as the top three capabilities most critical to claim outcomes (see Table 1).

Research conducted by Bersin & Associates on the role of core competencies and performance revealed that high-performing organizations focus on both "organizational capabilities" and "individual capabilities" to drive leadership and management skills such as *quality*, *initiative*, and *communication*. Lower-performing organizations focus primarily on individual, tactical, and job-specific capabilities.³

Table 1 Rank in order of highest priority the core competencies most critical to claim outcomes, with 1 being the "highest priority" and 10 being the "lower priority."

Answer	Overall Rank	Mean
Medical Management	1	3.14
Disability/RTW Management	2	3.21
Compensability Investigations	3	3.47
Claim Resolution	4	4.37
Case Reserving	5	5.54
Litigation Management	6	6.30
Oversight Governance/Supervisory Oversight	7	6.31
Bill Review	8	6.91
Fraud & Abuse Detection	9	7.18
Vocational Rehabilitation	10	8.58

Source: 2014 Workers' Compensation Benchmarking Study Report

² Harvard Business Review "The Core Competence of the Corporation" C.K. Prahalad, G. Hamel; May-June 1990

³ <http://www.successfactors.com/static/docs/Bersin-Competency-Report.pdf>

Top 4 Issues Ranked by Industry Executives in 2015 Study:

- 1 What strategies can we employ to operationalize qualitative and outcome-based measures? And how do we tackle system limitations that may challenge an organization's ability to implement such measures?
- 2 What are the benefits of using technologies such as workflow automation and predictive modeling to drive claim best practices? How/where do organizations start?
- 3 Many organizations outsource key claim and medical management functions. How do we effectively leverage risk/reward strategies with vendor partners?
- 4 What strategies can organizations undertake to align claim best practices, internal processes, and systems throughout the organization?

When we think of core competencies in workers' compensation claims, the industry tends to focus on job-specific technical proficiencies and tactical process execution; for example, timely AOE/COE investigations, litigation management, and accuracy of case reserving. Appropriately so, claims management relies on the successful execution of many interdependent core competencies, all of which can influence the ultimate claim costs and outcomes. However, payers should consider broader organizational capabilities as a means to improve claim operation effectiveness and overall business results.

Communication, an often underappreciated competency

In workers' compensation claim operations, one could argue that communication is an "individual" as well as an "organizational capability." According to the Industry Executives that participated in the 2015 study, communication is a critical competency that is vital to the mastery of all other competencies but is often difficult to evaluate qualitatively. For example, effective communication is much broader than the traditional best practice concept of completing "three-point contacts;" however, the industry tends to focus on process metrics related to this task because they are easier to quantify.

Communication impacts every phase of the claim life cycle from initial investigation, to medical and disability management, to claim resolution. Communication also spans across systems, departmental silos, and organizational boundaries. For example, organizations that understand the importance of how systems integration impacts individual performance as well as business unit alignment (e.g., underwriting and claims, safety and post-loss AOE/COE investigations) can significantly improve their organizational results.

Using technology to drive claim best practices

The nature of workers' compensation claims management has changed from predominantly indemnity-focused to healthcare-focused, requiring claims professionals to expertly navigate a minefield of medical complexities

including multiple comorbidities. This shift significantly increases the issues that claims professionals must manage on a daily basis – which results in the need for an expanded tool set of core claim competencies. One Industry Executive describes the role of today's claims professional as akin to the infamous character Neo from the movie *The Matrix*, constantly dodging claim "bullets" left and right with their complex problem-solving and data-backed decisions.



To be successful in this demanding environment, organizations should leverage decision support tools like workflow automation, predictive modeling, and business process management to improve strategic claim decisions and operational efficiency. With real-time analytics, claims professionals are armed to respond dynamically to complex claims issues as they arise.

As critical as technology is to maximizing claims effectiveness, this is an opportunity area where the industry can make great progress. The 2013 and 2014 study results reflect that less than half of organizations are utilizing workflow automation to manage best practices and about one quarter are utilizing advanced analytics such as predictive modeling.

Operationalizing qualitative and outcome-based measures

Industry Executives focused on how to optimally integrate claim core competencies and performance metrics across systems, vendor partners, and business units such as triage/intake, underwriting, and claims. Major obstacles, identified as opportunities by some, include: the disconnect between core competencies, business processes, and key performance metrics, as well as the lack of consistency in data definitions.

For example, three commonly used claim outcome measures – average claim cost, claim duration, and open/closure ratio – are not consistently defined across the industry. This can impact an organization's ability to effectively use benchmark data to develop performance metrics. Another concern echoed by most is how to limit the distraction of too many metrics and focus on what truly drives outcomes.

Performance in claim organizations is largely governed by compliance and business requirements. To move from principally process-focused measures to outcome-based measures requires assessment of the causal effect between claim activities and desired outcomes. The identification of the desired outcome alone is insufficient. Thought must be given to the activities (levers) that drive the desired outcomes. For example, one Industry Executive described a specific operational performance target of "average disability durations at or below the 50th percentile of the Official Disability Guidelines' RTW benchmark." To achieve the desired outcome, the organization

identified the leading and lagging indicators by correlating what claim activities had the greatest impact on achieving the desired outcome.

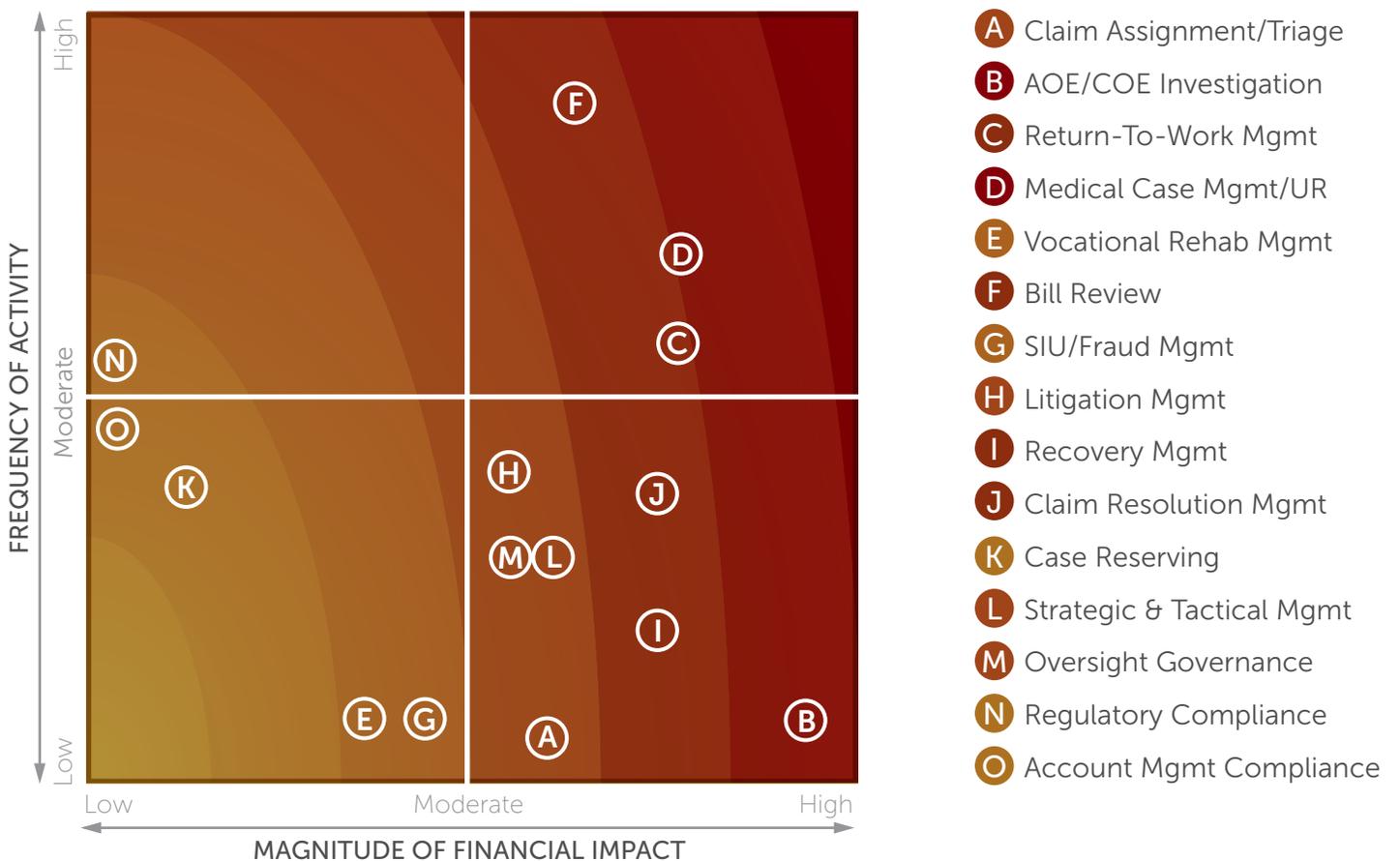


Begin with the end in mind

To operationalize outcome-based measures, organizations should begin with the end in mind and reverse engineer performance measures. Start with the ultimate goals and desired outcomes, then ensure an appropriate balance between quantitative and qualitative claim and medical activity-based metrics to drive the desired cause and effect. For example, a quantitative measure might be the identification of modified work availability before lost time occurs and the time lag in identifying modified duty availability to actual return-to-work. Qualitative measures might be the evaluation of *effective* communication with key stakeholders, or appropriate instructions/management of specialized return-to-work resources.

Alan Turnipseed, SVP & Managing Consultant with Marsh Risk Consulting, indicates this can be achieved by creating a "hot map" of the key impact points of claim and medical activities and processes across the claim life cycle. This approach will help an organization assess the financial opportunity associated with each identified impact point, as well as prioritize next steps into an actionable strategic plan/roadmap. This practice ensures that metrics developed by an organization are focused on the key claim and/or medical activities offering the greatest potential return on investment to drive desired outcomes. For example, AOE/COE investigations typically occur early in the claim cycle, with a low frequency. However, the potential financial impact associated with the AOE/COE investigation process can be significant. Other examples include: return-to-work management activities occur moderately throughout the claim cycle and have a high potential financial impact; whereas regulatory compliance activities occur moderately throughout the claim cycle but can have a relatively low financial impact depending on the jurisdiction.

Figure 1 Claim Activity Hot Map - Conceptual Model



NOTE: The above claim activity hot map graphic is a conceptual model depicting the frequency and financial impact potential of claim activity categories. There are multiple sub-activities within each category.

When considering desired outcomes and performance measurements, organizations must evaluate the downstream impact on existing policies and procedures, business processes, and information technology capabilities. Industry Executives report that claim systems often capture disparate data or lack the ability to effectively measure qualitative activities captured in free-form text notes. The most effective performance measurement systems employ quantitative (data-driven) metrics, as well as time-intensive qualitative evaluations gleaned through internal peer review processes and/or external auditing.

Greatest Impact Opportunities - Key Strategies for Implementing Claim Outcome Measures

- 1 Begin with the end in mind.** Start with the desired outcomes and reverse engineer the performance model to identify activities that will drive the desired outcome.
- 2 Utilize Stay-At-Work/Return-To-Work outcomes to benchmark claims.** Benchmarks can be based on the Official Disability Guidelines (ODG)⁴ and MDGuidelines⁵ published disability durations. Some organizations report utilizing RTW metrics from the date of injury to RTW, as well as from RTW to claim resolution settlement.
- 3 Ensure medical treatment per episode of care is within published Evidenced Based Medicine Guidelines (EBM)** (e.g., American College of Occupational & Environmental Medicine⁶, ODG⁴). This can be automated by incorporating EBM into claim or bill review systems by diagnosis codes.
- 4 Mitigate the effect of added injury/body parts.** Track the degree of added body parts to accepted claims by provider, attorney, as well as claims professional. Evaluate the results against execution of claim core competencies.
- 5 Monitor claim litigation rate.** Track the degree of litigation by provider and attorney, as well as execution of core competencies such as ongoing effective communication with key stakeholders, appropriate and timely completion of utilization review and/or approval of medical treatment requests.
- 6 Benchmark claim resolution/closure ratio with equitable jurisdictional measures.** Claims resolution/closure ratio is a common industry benchmark used as an overall indicator of operational performance and is defined as the number of claims closed divided by the number of claims received. The goal is to achieve a 100 percent or greater closing ratio. This allows organizations to ensure that stable claim inventories are maintained. Jurisdictional limitations on settling future medical absolutely impact the ability to close claims. Organizations should consider this when establishing or comparing benchmark results to ensure equitable measures.

⁴ <http://www.worklossdata.com/return-to-work-guidelines.html>

⁵ <https://www.mdguidelines.com/>

⁶ <https://www.acoem.org/apg-i.aspx>



Operational Challenge

Talent Development & Retention

Talent, the next big claims crisis

One of the biggest risks organizations are faced with now and in the near term is the mass exodus of experienced claims talent. This crisis is about to become much worse due to two emerging trends: the retirement of Baby Boomers and the growing skills gap. The confluence of these forces has dramatically changed how organizations view talent management. During the 2015 study's qualitative research exercise, Industry Executives targeted the following issues as most critical to talent development and retention: prioritizing talent management as a key business strategy, implementing contingency planning and knowledge transfer programs, and attracting the Millennial generation.

Talent management strategies that focus primarily on recruitment and secondarily on development will fall gravely short. The workers' compensation industry's investment in talent is upside-down. Most organizations invest 70 percent more on recruitment than they do on training and development. According to a Talent Management Study completed by Deloitte, organizations should focus on building their talent strategies around the things that matter most to employees — their *development, deployment, and connection* to others.⁷



The 2014 study results reflect that less than 50 percent of participants have a formal training and development program, and even less invest in training for new hires as well as senior-level claims staff. The 2013 study revealed similar results.

⁷ <http://www.griffithfoundation.org/uploads/Deloitte-on-Ins-Talent-Crisis.pdf>

⁸ <http://www.inc.com/brian-evje/want-hr-to-matter-start-with-the-ceo.html>

Top 4 Issues Ranked by Industry Executives in 2015 Study:

- 1 Business continuity and contingency planning are standard business practices. How can we take a similar approach to develop formal knowledge transfer programs to ensure knowledge transfer from senior-level claims staff to less experienced staff?
- 2 How do we ensure recruitment, retention, and development of claims talent is a key business strategy?
- 3 With a significant focus on technology, how can claim operations attract the tech-savvy Millennial generation?
- 4 What should a new hire claims training program look like? If organizations don't have a formal training and development program, where do you start? What options are available internally and externally?

Industry's Investment in Talent Development Could Be The Problem....

Ideal State	Current Claims Organization Investment
<p>In-depth training for new talent, including opportunities for career mobility and advancement for ambitious professionals.</p>	<p>36% conduct formal training for new claims examiners, with little to no experience</p> <p>40 hours or less is the average classroom training for new claims examiners</p> <p>3-4 years of employment is the average ROI considered reasonable for the new hire training provided (or 1 year for every 10 hours of training)</p> <p>31% have recognition/rewards for designations (e.g., AIC, CPCU, CRM)</p> <p>29% have formal career paths with growth opportunities</p>
<p>Cultivation of future leaders, including ongoing training and formalized succession planning.</p>	<p>51% conduct senior-level claims examiner training</p> <p>13% provide monthly technical training, and 87% provide less frequent to no technical training for senior-level claims examiners</p> <p>20% collaborate with colleges or universities to conduct custom training or degree programs</p>

Source: 2014 Workers' Compensation Benchmarking Study Report

Claims management talent, a key business differentiator

Workers' compensation organizations rely heavily on claim operations to maintain high customer satisfaction, engage injured workers, and minimize risk and loss exposure – all while maintaining operational efficiencies. Considering the volume of complex issues claims professionals juggle on a daily basis, this is no easy feat. The 2015 Industry Executives advise that more organizations should include customer service skills and aptitude testing with a greater focus on emotional intelligence, resilience, and empathy in their talent recruitment strategy.

Based on a study conducted by McKinsey, the industry faces three major challenges to attracting talent: "poor reputation, limited understanding among high school and college students of the industry's career opportunities, and a diminishing pool of trained talent."⁹ Industry Executives who participated in the 2015 research

indicate that their talent strategies are expanding to include proactive university recruitment campaigns as well as educational outreach to business and financial programs about opportunities in claims management.

A wake-up call for talent management strategy

Industry Executives suggest we focus on claims as a purposeful profession, elevating the social factors of the profession by "rebranding" the claims adjuster as an advocate. Today's workers want a seat at the table, and to be part of something bigger than profit-making; they want to work for organizations with a greater mission. In a Deloitte survey of Millennials, 60 percent report a "sense of purpose," as part of the reason they chose to work for their current employers. Millennials are just as interested in how a business develops its people and how it contributes to society as they are in its products and profits.¹⁰

⁹ <http://www.aamga.org/files/hr/BuildingaTalentMagnet.pdf>

¹⁰ <http://www2.deloitte.com/content/dam/Deloitte/global/Documents/About-Deloitte/gx-wef-2015-millennial-survey-executivesummary.pdf>

Rebranding the role alone will not be enough. True change will require organizations to move beyond performance metrics which focus primarily on cost containment to those based on clinical quality and patient functional outcomes—discussed at length in this Report.

These challenges will not be addressed overnight. Industry Executives highlight the following initiatives and talent management strategies.

Greatest Impact Opportunities –Key Talent Management Strategies:

- 1 **Transform the image of the claims profession, including elevating its social factors.** Immediate steps could include key internal and external messaging, including public relations, job descriptions, and web/social media communications. Longer-term strategies include collaborating with industry groups and professional associations to collectively rebrand the profession.
- 2 **Engage in national and local education initiatives.** Collaborate with HR and university programs to establish a claims apprenticeship program, or graduate and leadership programs.
- 3 **Restructure talent management strategies, with more emphasis and investment in developing talent.** These efforts must go beyond the traditional classroom setting. Consider utilizing formal and informal mentoring relationships, grand-rounds/group problem-solving and strategy presentations, as well as individual development and advancement goals.
- 4 **Develop individualized short-term and long-term training and development plans for employees.** Incorporate business needs, as well as personal growth goals with feedback from employees.
- 5 **Provide an accelerated career path for the progression of high achievers.** The career path should clearly outline the professional and educational goals needed for advancement.
- 6 **Consider implementing flexible work arrangements.** Benchmark internal options to those offered in other comparable sectors.

Knowledge transfer, mission critical for business continuity

Knowledge transfer is often an afterthought, and the importance is not recognized until resources are walking out the door. Many organizations have limited resources or are in a constant state of flux with expanding claim inventories, which relegates talent strategy and succession planning to the backburner.

Dan Holden, Manager of Corporate Risk & Insurance for Daimler Trucks North America, recommends that organizations should approach the talent deficit holistically by combining “effective knowledge transfer practices, knowledge recovery initiatives, strong knowledge management technologies, and more effective Human Resource practices” enterprise-wide.¹¹

¹¹ Holden, Dan. (2014) “The Aging Workforce & Succession Plans.” Available at: <http://insurancethoughtleadership.com/the-aging-workforce-and-succession-planning/>

The 2014 study results indicate that 55 percent of organizations have formal knowledge transfer programs in place and 2 percent have mentoring. Given the industry's significant hurdles with the aging demographic and a limited talent pool, this topic was discussed in detail by Industry Executives during the focus group sessions.



The key to effective knowledge transfer begins with an assessment of vulnerabilities. Organizations should know the demographic profile of their workforce by department, jurisdiction, and function. The assessment of vulnerabilities should consider what positions/employees have specific experience and knowledge that others do not and if the knowledge can be transferred through processes, procedures, and/or written documentation.

Greatest Impact Opportunities – Key Strategies for Knowledge Transfer Programs:

- 1 **Diagram what knowledge should and can be transferred.**
- 2 **Document any checklists, templates, and formats used for documents or standard operating procedures.**
- 3 **Develop formal mentoring programs.**
- 4 **Create opportunities for younger employees to work and learn from those with experience.**
- 5 **Utilize retirees as trainers and coaches.**
- 6 **Formalize content management repositories.**
- 7 **Consider the different ways that people learn** (e.g., online, face-to-face, video) and how to best train auditory, visual, or kinesthetic learners. Break up training into smaller sessions and utilize active participatory training to avoid simply talking at/lecturing to adult learners.

¹² Deloitte. 2014 Property and Casualty Insurance Industry Outlook, "Innovation Leading the Way."(2014.) <http://www.deloitte.com>



Operational Challenge

Impact of Technology & Data

Changing the future with data

Most claims professionals can recall claims that went awry. Perhaps they had an opportunity to intervene or settle early on. They can't predict the future... but looking back, these cases *seemed* relatively benign at their onset.

Technology and managing multiple data sources remain major factors for improving the claims process and outcomes. Predictive modeling uses applications and techniques to build, test, refine, and apply algorithms in an effort to predict the future, in order to *change* the future. During the 2015 study's qualitative research exercise, Industry Executives addressed key issues impacting claims technology and data, namely how to utilize data to drive best practices and how to leverage predictive modeling to improve claim outcomes.

Quickly becoming a best practice, Industry Executives discuss how predictive modeling is used to detect claims severity, fraud, or litigation, and to improve the overall claims process. It is not a magic bullet and does not replace the industry knowledge of seasoned claims professionals. Rather it is seen as an adjunct – a tool to enhance individual and organizational performance. Tom Stark, Technical Director of Workers' Compensation for Nationwide Insurance says, "A good 20-year supervisor can eyeball a claim and can tell if something is off. But now organizations need to bottle that wisdom, institutionalize it, and effectively harness the expertise that only a seasoned examiner has. Sharing and applying this knowledge on a broader, more cost-effective basis is what analytics and predictive modeling means to me."

Controlling workers' compensation claim costs and improving outcomes for injured workers are the driving purpose behind predictive modeling. Claims leaders are all too familiar with the 80/20 rule, in that roughly 80 percent of claim costs result from 20 percent of the inventory. If you could identify "creeping" catastrophic claims at day one, what would you do differently? Predictive modeling aims to identify those seemingly standard claims that start simple and develop into significant catastrophic losses.

Providing data-driven support to claims decision makers



Top 4 Issues Ranked by Industry Executives in 2015 Study:

- 1 How can data help to better manage claims, measure best practices, and achieve improved outcomes?
- 2 Data analytics are a big concern/opportunity, how can claim operations use analytics strategically?
- 3 Communication is important throughout the claim cycle. What advanced technologies are used to communicate with key stakeholders (e.g., workers, physicians, employers)? How are they implemented, addressing security/privacy issues?
- 4 Predictive modeling is frequently used on the underwriting side. Are organizations leveraging this technology on the claim operations side? How is the information used effectively?

How industry leaders are deploying predictive modeling

Predictive modeling is not new to workers' compensation. It's frequently used on the underwriting side to improve accuracy and price. However, there is a considerable disconnect between underwriting and claim operations data mining. On the claims side, workers' compensation predictive modeling often uses a severity model at First Notice of Loss (FNOL) as well as non-traditional data elements (e.g., social media, socio-economic factors such as unemployment data, DUIs, criminal history in the work or employee residence geographic areas) to add insight and potential exposure detection early in the claim. These models often include over 100 variables from multiple sources.¹³

Industry Executives report using a variety of predictive models, including a "**Litigation Model**" which targets claims with the propensity for litigation. Litigated claims incur, on average, seven times greater claim costs overall. One large national insurance carrier Industry Executive shares that claims identified as high litigation risks in his organization are fast tracked to a face-to-face interaction with a field claims professional. Often times injured workers seek an attorney due to uncertainty or unfamiliarity with the complex system of workers' compensation. "We have found that face-to-face communication dispels that uncertainty," he explained.

Other models used by Industry Executives include:

1) Severity Model

Utilizes red-yellow-green light visual cues in a claim system to quickly assess claim severity. The model is tied to workflow automation to fast track red light claims for evaluation and strategy, which facilitates timely risk identification and engagement of specialty resources.

2) Laser Model

Utilizes data mining and word recognition in the accident description and claim file documents to drive claim management activities throughout the claim lifecycle, including special investigations (SIU), subrogation, apportionment and clinical resource intervention.

3) Early Intervention Risk Scoring Model

Utilizes a questionnaire to identify injured workers at risk for delayed recovery. Screening is completed at two weeks post injury on all medical-only and lost time claims. The tool identifies psychosocial risk factors that often result in protracted recovery and needless disability. High-risk claims are assigned to clinical resources and engaged in Cognitive Behavioral Therapy (CBT) to enhance coping skills and resilience.

Limitations of predictive modeling and metrics

Industry Executives indicate that one of the biggest operational limitations is data reliability. Predictive models will not work without sufficient, reliable data. Bad data leads to erroneous predictions and wasted resources. Organizations need to ensure that the data produced through metrics and analytics is meaningful, otherwise it may actually hinder operations. It's the law of diminishing returns; and if you have too many data points or too many triggers, the information will have little value. According to Mark Walls, VP of Communications & Strategic Analysis with Safety National, it's also critical that modeling is a continual, iterative process. "Generally models don't run frequently enough to change the trajectory of the claim."

¹³ <http://www.contingenciesonline.com/contingenciesonline/201205?pg=37#pg37>

Greatest Impact Opportunities - Key Strategies for Implementing Data Analytics and Predictive Modeling:

- 1 Use actuarial modeling to drive outcomes, with continuous modeling throughout the claim.** This is not a "one and done" solution, models need to continually evaluate risks.
- 2 Ensure that predictive modeling is built and implemented using your own historical claims data.** Many actuarial predictive models are built using multiple data sources using multivariate analysis. It takes a large data set to build a reliable model. The model should be tested and refined with organizational claims data to improve reliability.
- 3 Connect analytics with workflow push activities that are triggered by data points in the claim.** This should automatically push resource activities for next steps in claim management (e.g., engaging a nurse, SIU, litigation management).
- 4 Keep data relevant.** The key is to determine the "so what?" How will you use the data to impact claim operations? Outline the desired goals and how the data will be used, including actionable workflows. If it doesn't drive the daily management of claims, stop and rethink the purpose.



Operational Challenge

Medical Performance Management

Workers' compensation changing landscape

Healthcare costs are a serious issue affecting businesses today. Although group health costs garner much attention, workers' compensation medical costs are a significant concern for employers. According to the National Council on Compensation Insurance (NCCI) 2015 State of The Line report, the average medical cost per lost time claim has increased in each of the last 20 years, more than tripling since 1995.¹⁴ Medical benefits represent nearly 60 percent of total claim costs for most workers' compensation organizations.¹⁵ Future predictions are even more concerning, with the Insurance Research Institute projecting medical to reach 70 percent of total claim costs by 2018.¹⁶ These concerns have the workers' compensation industry rethinking traditional medical management strategies.

During the 2015 study's qualitative research exercise, Industry Executives examined key issues impacting medical performance management, namely how to: measure provider outcomes, utilize value-based payment models, and address the effect of pharmacy on overall medical costs.

Value-based payment models, a viable option for workers' compensation

The cost of healthcare has led claims organizations to rethink how care is delivered and how providers are paid. Traditional fee-for-service models will continue to decline as we transition towards a value-driven healthcare system that rewards high quality and cost effective patient care. Across the country, health plans and healthcare providers are adopting value-based healthcare models.

Value-Based Payment (VBP) is a strategy used to promote the quality and value of healthcare services. The goal of VBP programs is to shift from the traditional volume-based fee-for-service payments, to payments that are tied to outcomes. Industry Executives highlight the following model options for workers' compensation.

Top 4 Issues Ranked by Industry Executives in 2015 Study:

- 1 How do we define and measure provider outcomes?
- 2 Both the 2013 and 2014 studies identified nurse case management, return-to-work services, and nurse/claims triage as most critical to claim outcomes. How/when are these resources utilized? Is there outcomes data to support ROI/impact?
- 3 The impact of pharmacy on overall medical costs and MSA allocations, including narcotic pain medicines and physician dispensing, is a concern. How can we better manage/mitigate this risk?
- 4 Traditional provider payment strategies in workers' compensation are based on a fee-for-service model with discount methodology. How can we leverage value-based payment models?

¹⁴ <https://www.ncci.com/documents/AIS-2015-SOTL-Article.pdf>

¹⁵ NCCI, State of the Workers Compensation Line, May 2009, slide 36, available at: <https://www.ncci.com/Documents/AIS-09-SOL-Complete.pdf>

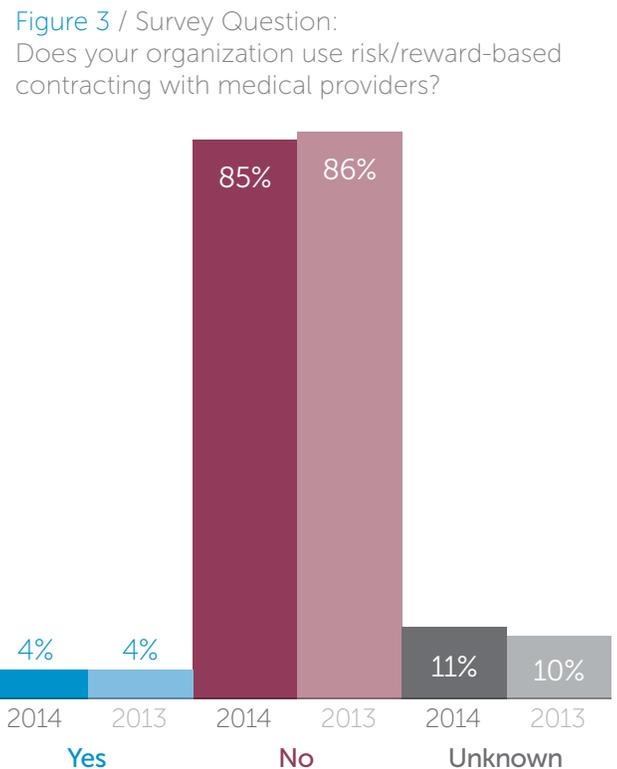
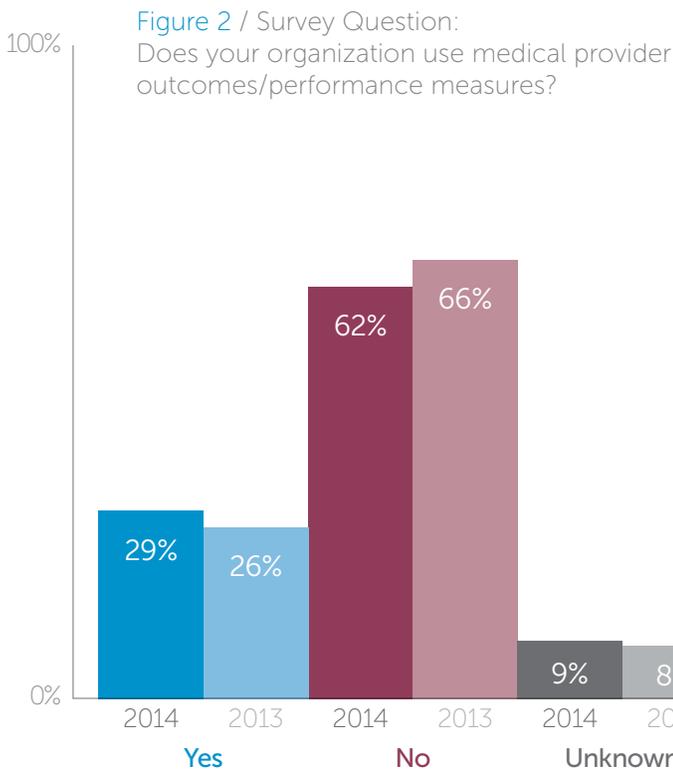
¹⁶ Robert Hartwig, Insurance Information Institute available at:

<http://www.iii.org/Presentations/Making-Sense-of-Now-and-Forecasting-the-Future-The-Economys-Impact-on-Workers-Compensation.html>

Greatest Impact Opportunities - Key Strategies for Value-Based Payment Models:

- 1 **Pay-for-performance programs.** Consider payment models that reward providers for improvements in healthcare quality metrics and patient outcomes. For example, payment incentives for improved function and return-to-work at or below the fiftieth percentile of disability duration benchmarks for a population of claims.
- 2 **All-inclusive case rates and bundled payments that reduce avoidable complications.** Payers can consider bundled contracts with providers for particular episodes of care, such as knee replacements, spine surgeries, and shoulder arthroscopies.
- 3 **Accountable Care Organization (ACO) models** involve healthcare organizations characterized by a care delivery model that ties provider reimbursements to both quality metrics and a reduction of the total cost of care for an assigned population of patients. In workers' compensation, the population of patients could include, for example, a payer population of claims, employer group, or risk pool. In some cases insurers can contract with an existing ACO and the ACO becomes the plan's network.

Although this new VBP approach is certainly impacting other areas of the healthcare system, workers' compensation is still transitioning towards embracing the value-based payment concept. The 2014 study results reflect a small number, 29 percent, of industry participants measure provider performance and outcomes and 5 percent use risk/reward contracting strategies with medical providers. The 2013 study shows similar results. Many large networks are still operating with contracts and terms that are twenty years old, which undoubtedly have not changed to reflect the new environment.



Source: 2013 & 2014 Workers' Compensation Benchmarking Study Report

According to a report by Oliver Wyman, contrary to the prevailing thought among many payers, workers' compensation would greatly benefit from value-based healthcare as a way to cut costs, improve efficiency, and achieve overall better treatment outcomes.¹⁷

Unlike the traditional healthcare model, which pays providers according to fee-for-service, a value based model compensates providers based on measurable outcomes. This reduces medical costs and leads to better overall care for patients. The Oliver Wyman report suggests three reasons why value-based healthcare can address the following issues in workers' compensation today:

1) Payment based on volume rather than quality

Fee-for-service models drive up the number of services delivered, and regulatory efforts to address this have been largely unsuccessful.

2) Micromanagement of care

The inherent delays due to prior authorization requirements for medical treatment can result in many unintended consequences, including delayed care, strained provider relations, and increased litigation.

3) State-by-state regulation

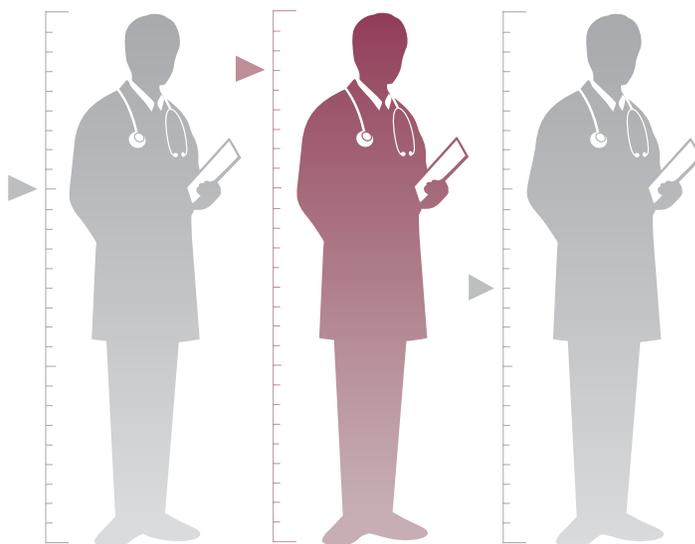
State-specific reimbursement methodologies result in widely varied provider payments across the US, and direction of care restrictions can actually lead uninformed patients to inadequate, low quality care.

Using provider outcome measures

Measuring provider outcomes is essential to assessing the quality of care and defining who is best able to treat injured workers. Historically, workers' compensation providers were selected based on

a fee schedule discount methodology. Providers willing to treat workers' compensation patients and accept a discount from the fee schedule were included in provider networks. However, with rising medical costs and poor clinical outcomes, more organizations are utilizing quality and outcome models to guide provider selection and make certain employees receive the best possible care.

One of the clearly misguided perceptions is that more care is better care. Many studies have indicated that the counter is true. According to the Agency for Healthcare Research & Quality, patients receive the proper diagnosis and care only 55 percent of the time, with wide variations in healthcare quality, access, and outcomes.¹⁸ Consequently, outcome measures that rely largely on billing data diagnosis codes are frequently incorrect or incomplete.



To drive the industry forward, Industry Executives highlight the following outcome measures to aid claims organizations in selecting quality providers and to achieve the best possible health and functional outcomes for injured workers.

¹⁷ <http://www.oliverwyman.com/insights/publications/2014/jan/bringing-value-based-healthcare-to-workers-compensation.html>

¹⁸ <http://www.qualitymeasures.ahrq.gov/>

Greatest Impact Opportunities - Key Strategies for Provider Outcome Measures:

- 1 **RTW Outcomes** utilize total lost time days compared to the Official Disability Guidelines (ODG)¹⁹ or MDGuidelines²⁰ Disability Durations. Both include national data on an average person's return-to-work timeframes based on their given diagnosis.
- 2 **Clinical Quality** measures provider quality by adherence to evidence-based treatment guidelines (EBM). Outcome measures can be embedded in claims and billing software systems. Some organizations embed EBM directly into their claims system as a decision support tool for reserves, return-to-work benchmarks, and for provider and employer communication regarding return-to-work best practices. Additionally, some organizations embed EBM Guidelines as a clinical decision support tool within utilization review, medical case management, and bill review systems. With utilization review and bill review systems, treatment can be flagged by correlating diagnosis codes and treatment codes outside of EBM.
- 3 **Agency for Healthcare Research & Quality (AHRQ) Clinical Quality and Appropriate Care Measures.**²¹ Measures quality based on EBM for a specific clinical condition. Organizations should consider clinical quality as a measure of provider and hospital performance. Clinical quality measures require qualitative review of data and supporting documents, such as bill review and operative reports. Quality cannot be determined by bill review data alone. AHRQ publishes quality measures by disease or clinical topic, with an average of 25 metrics depending on the condition.

Organizations could start by selecting a few metrics for the most common surgeries in their claims population. For example, utilizing one of AHRQ's surgical care improvement metrics (the number of surgery patients who received appropriate venous thromboembolism (VTE) prophylaxis)²² could validate that not only was a surgery appropriate per EBM guidelines, but also the proper clinical standards of care were followed. Despite the evidence that VTE is one of the most common postoperative complications and prophylaxis is the most effective strategy to reduce morbidity and mortality, it is often underused. According to Heit et al. (2000), surgery was associated with over a twentyfold increase in the odds of being diagnosed with VTE.²³

One organization that has implemented clinical quality measures for a specific provider specialty is the State of Washington Department of Labor & Industries through the Orthopedic and Neurological Surgeon Quality Project.²⁴
- 4 **Administrative Efficiency** assesses the quality of documentation and timely submission of reports within jurisdictional requirements by the medical provider and the effect of litigation on both clinical quality and efficiencies.
- 5 **Zero Never Events** or serious reportable events, as defined by the National Quality Forum,²⁵ should be incorporated into ongoing provider credentialing and monitoring. These events include, for example, a surgery performed on the wrong body part, death, or disability resulting from a medication error.
- 6 **Risk of Harm.** Harm is defined as intended or unintended physical or psychiatric injury resulting from, or contributed to, by healthcare services that then require additional monitoring, treatment or hospitalization, or that worsens the condition(s), increases disability, or causes death. Risk of harm events, such as increased chronic or prolonged pain, delayed recovery, or decreased function, should be incorporated into provider performance tracking.^{26 27 28}

¹⁹ <http://www.worklossdata.com/return-to-work-guidelines.html>

²⁰ <https://www.mdguidelines.com/>

²¹ <http://www.qualitymeasures.ahrq.gov/about/glossary.aspx>

²² <http://www.qualitymeasures.ahrq.gov/content.aspx?id=49154>

²³ Heit JA, Silverstein MD, Mohr DN, Petterson TM, O'Fallon WM, Melton LJ 3rd. Risk factors for deep vein thrombosis and pulmonary embolism: a population-based case-control study. *Arch Intern Med.* 2000 Mar 27;160(6):809-15.

²⁴ <http://www.lni.wa.gov/ClaimsIns/Providers/ProjResearchComm/OrthoNeuro/QualInd.asp>

²⁵ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2814808/table/T1/>

²⁶ http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/advances-in-patient-safety-2/vol1/advances-west_102.pdf

²⁷ <http://www.ahrq.gov/research/findings/nhqrdr/nhqr13/chap4.html>

²⁸ <http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-01030>

Partner with providers

Partnering with providers will go a long way towards improving overall network quality as well as ensuring sustained access to care during the looming provider shortage. In fact, the industry is already seeing provider access issues that are impacting injured workers. A study conducted by the University of Washington School of Public Health to evaluate the quality and access to care for injured workers in California, indicates that almost half (47 percent) experienced access to care issues which had a significant impact on disability.²⁹

Kimberly George, SVP Corporate Development, M&A, and Healthcare at Sedgwick states, "Networks are here, they are important, but we need to truly partner with physicians. The networks keep contracting to doorbells versus getting inside and forming relationships with the physicians themselves."

Organizations should consider inviting network providers to participate in developing and evaluating quality and outcome measures. This is a strategy that many health plans have used for years, often inviting physicians from various specialty groups to participate in quality committees. This creates more of a partnership and gives payers a provider voice in the community. Case studies of three organizations participating in the Institute for Healthcare Improvement's Triple Aim initiative certainly support that partnering with providers pays off. The results indicate that partnering with providers on outcomes both improved the quality of care while lowering costs.³⁰

Several provider professional associations have supported outcome measures important to workers' compensation. For example, outcomes based on successful return-to-work are supported by the

American Academy of Orthopedic Surgeons, the American Medical Association, the American College of Occupational and Environmental Medicine, as well as the California Orthopedic Association.³¹

Table 2 / Survey Question:

Considering the Medical Cost Drivers impacting your organization's medical spend, rank in order of greatest total dollars spent, with 1 being the "highest cost driver" and 10 being the "lower cost driver."

Answer	Overall Rank	Mean
Medical Provider/Physicians	1	2.87
In-Patient/Hospital	2	3.58
Pharmacy	3	4.00
Physical/Occupational Therapy Services	4	4.13
Diagnostics (e.g., MRI, CT, X-Ray)	5	4.60
Ambulatory Surgery Centers/ Out-Patient Surgery Centers	6	4.67
Medical Cost Containment Services	7	7.24
Durable Medical Equipment	8	7.36
Home Health Care	9	8.12
Medical Transportation	10	8.44

Source: 2014 Workers' Compensation Benchmarking Study Report

Drug spend - a leading cost driver in workers' compensation medical

The rising cost of pharmacy-related claims expense is undoubtedly a contributing factor to overall claim severity. Annual drug spending in workers' compensation ranges from 10 to 14 percent of medical costs depending on the source used, or between four billion to six billion dollars annually.³² According to the CompPharma LLC 10th Annual Survey of Prescription Drug Management in Workers' Compensation, it continues to be a top concern for claims organizations.³³

²⁹ <http://governor.nh.gov/commissions-task-forces/workers-comp/documents/wcc-california.pdf>

³⁰ D. McCarthy and S. Klein, The Triple Aim Journey: Improving Population Health and Patients' Experience of Care, While Reducing Costs, The Commonwealth Fund, July 2010.

³¹ <http://www.aaos.org/news/aaosnow/aug13/advocacy3.asp>

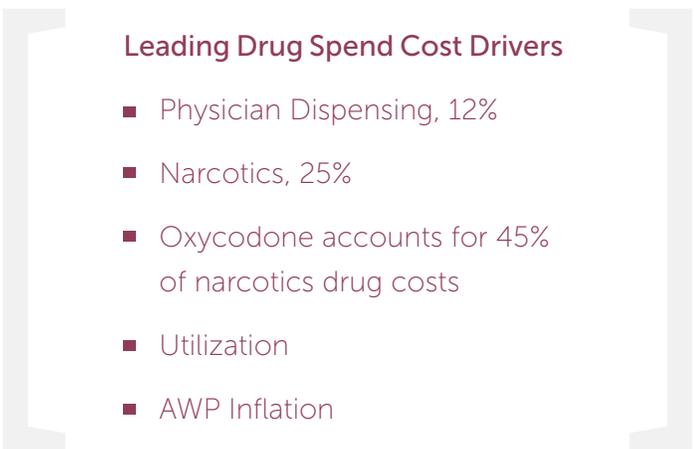
³² <http://comp-pharma.com/CompPharmaPayerSurvey2014Public.pdf>

³³ <http://comp-pharma.com/CompPharmaPayerSurvey2014Public.pdf>

The 2014 study echoes similar concern with participants reporting that pharmacy is one of the top three medical cost drivers and represents, on average, 22 percent of their overall medical spend.

Physician dispensing tied to higher costs, poor outcomes

Physician dispensing is also a topic of national debate, with the practice increasing in almost every state. According to the most recent NCCI Drug Study, physician dispensing accounts for 12 percent of overall pharmacy spend.³⁴



Source: Helios 2015 Workers' Compensation Drug Trends Report

This practice is associated with higher costs and more lost time than pharmacy-dispensed medications in workers' compensation claims. A study in the Journal of Occupational and Environmental Medicine reveals a negative impact on workers' compensation claims when physicians dispense narcotic drugs to injured workers within the first 90 days of injury.³⁵ The study's major findings indicate that the number of prescriptions per claim, medical treatments, and indemnity costs were all significantly higher in claims where a pharmaceutical was dispensed by the physician within 90 days of injury compared to claims without physician dispensing. These differences

persisted when controlling for age, sex, attorney involvement, and injury complexity.

Medications dispensed by physicians are typically purchased by repackaging companies that split bulk shipments from drug manufacturers into smaller packages to sell at a higher unit price. When a drug is repackaged, it is assigned a new national drug code (NDC) and a new average wholesale price (AWP), typically increasing the cost by an average of 250 percent. These higher costs are passed onto workers' compensation payers as AWP forms the basis of most state pharmacy fee schedules.

AWP inflation drives increased pharmacy spend nationally

Claims organizations are also experiencing an increased pharmacy spend largely due to AWP inflation for generic medications. AWP inflation for generics has increased by more than ten-fold, moving from 0.7 percent in 2013 to 10 percent in 2014, according to the Helios 2015 Workers' Compensation Drug Trends Report.³⁶ This is consistent with the anticipated acceleration in prescription drug costs highlighted in the National Health Expenditure Projections for 2013–2023 from The Office of the Actuary of the Centers for Medicare and Medicaid Services (CMS). The report projects a drug spending growth of over 6 percent in 2014 and 2015.³⁷



Source: Helios 2015 Workers' Compensation Drug Trends Report

³⁴ https://www.ncci.com/documents/Prescription_Drugs-2013.pdf

³⁵ White JA, Tao X, Artuso RD, Bilinski C, Rademacher J, Bernacki EJ. "Effect of physician-dispensed medication on workers' compensation claim outcomes in the state of Illinois." J Occup Environ Med. 2014 May;56(5):459-64.

³⁶ <http://www.helioscomp.com/docs/default-source/Drug-Trend-Report-Files/dtr-2015-33015-single.pdf?sfvrsn=2>

³⁷ CMS The Office of the Actuary. National Health Expenditure Projections 2013–2023.

Greatest Impact Opportunities - Key Strategies for Tackling Pharmacy Spend:

- 1 Implement point-of-sale medication management** through Pharmacy Benefit Management (PBM) partners, starting with the first-fill. This will ensure prescriptions are clinically appropriate, and mitigate rising AWP inflation and third-party billing.
- 2 Develop a Pharmacy Benefit Network (PBN)**, where jurisdictions allow, to control out of network claims, physician dispensing, and third-party billing.
- 3 Limit physician dispensing through contracts or Letters of Agreement with network providers.** Ensure provider notifications include a formal notice that physician dispensing is not authorized and will not be reimbursed. Close the bill review loop, with rules/edits that stop reimbursement of physician dispensing for formal adjudication review.
- 4 Develop formal clinical management and oversight**, and engage multidisciplinary clinical resources as part of the claims team, including pharmacists.
- 5 Implement proactive provider outreach and education programs** to ensure prescribed medications are necessary, are not duplicative, and do not present potentially harmful interaction effects.
- 6 Develop an injury-specific workers' compensation formulary supported by Evidence-Based Medicine.** Organizations must tie their formulary to EBM to ensure clinical appropriateness. A drug's presence on a formulary doesn't indicate that it's appropriate for all injuries.
- 7 Conduct intensive case management for opioid utilization at first-fill**, including provider communication and patient education. The greatest opportunity to eliminate opioid misuse, abuse, and addiction is at first-fill.

Conclusion

Some 5,000 insurer, TPA, and employer-based professionals fill claims leadership positions in workers' compensation operations nationwide. They think as much about the future as they do day-to-day operations. To date, approximately 700 of these leaders have shared their insights through quantitative surveys and qualitative interviews conducted by the Workers' Compensation Benchmarking Study in 2013, 2014, and now 2015.

This year, the study's new approach – conducting focus group research – drew upon the experiences, perspectives, insights, and opinions of 40 Industry Executives as they related the prior years' 662 survey responses to their strategic visions for future advancement. This resulting Insights Report synthesizes the past three years' research into an incisive, "solutions roadmap" for claims leadership going forward.

Through this multi-year study, the 2015 qualitative efforts uncover a somewhat uncompromising, and surprisingly aligned vision from participants – a vision where process improvement and compliance is no longer the dominant force, but where claims organizations are creators of value through successful outcomes management.

The 2015 Report is the third Workers' Compensation Benchmarking Study published by Rising Medical Solutions. To learn more or to access the study's online Resource Center, go to: www.risingms.com

Contact

We welcome your reaction to the 2015 Workers' Compensation Benchmarking Study. Please let us know if you find the study useful, have questions, or would like to participate in future studies by contacting Rachel Fikes, VP & Study Program Director, at Rising Medical Solutions: wcbenchmark@risingms.com.

Appendices

Introduction

Prior to convening the focus group meetings, Industry Executives were asked to participate in a confidential 32-question online survey to prioritize claims challenges and opportunities most critical to discuss during the research exercise. The survey questions were formalized as problem statements identified from the 2013 and 2014 study reports, as well as priorities identified by the study Advisory Council Members during think-tank sessions. The survey questions were organized across the study's four indexes, and participants were asked to rank each question 1-3, with 1 being the lowest priority and 3 being the highest priority for discussion during the focus group sessions. Appendices A – D include the complete survey results:

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Appendix A

Prioritizing Core Competencies

Survey Question: Give each of the following questions/topics a ranking of 1 to 3 for possible discussion during the focus group exercise.

Discussion Topic	1 Lowest Priority <i>(if we had time)</i>	2 Somewhat a Priority <i>(interesting)</i>	3 Highest Priority <i>(most compelling)</i>	Average Value
What strategies can we employ to operationalize qualitative and outcome based measures? And how do we tackle system limitations that may challenge an organization's ability to implement such measures?	0%	40%	60%	2.60
What are the benefits of using technologies such as workflow automation and predictive modeling to drive claim best practices? How/where do organizations start?	13%	40%	47%	2.33
Many organizations outsource key claim and medical management functions. How do we effectively leverage risk/reward strategies with vendor partners?	16%	37%	47%	2.30
What strategies can organizations undertake to align claim best practices, internal processes, and systems throughout the organization?	13%	47%	40%	2.27
Are claims leaders using performance measurement systems to identify operational risks and opportunities to drive business success, if so how?	10%	60%	30%	2.20
How can organizations link claims core competencies and best practices to performance measures?	23%	37%	40%	2.17
How can claims leaders incorporate best practices with business strategy?	23%	40%	37%	2.13
Is there value in utilizing incentives and penalties to achieve claims best practices for internal staff and vendor partners?	40%	43%	17%	1.77

Appendix B

Talent Development & Retention

Survey Question: Give each of the following questions/topics a ranking of 1 to 3 for possible discussion during the focus group exercise.

Discussion Topic	1 Lowest Priority <i>(if we had time)</i>	2 Somewhat a Priority <i>(interesting)</i>	3 Highest Priority <i>(most compelling)</i>	Average Value
Business continuity and contingency planning are standard business practices. How can we take a similar approach to develop formal knowledge transfer programs to ensure knowledge transfer from senior-level claims staff to less experienced staff?	17%	50%	33%	2.17
How do we ensure recruitment, retention, and development of claims talent is a key business strategy?	17%	53%	30%	2.13
With a significant focus on technology, how can claim operations attract the tech-savvy Millennial generation?	20%	57%	23%	2.03
What should a new hire claims training program look like? If organizations don't have a formal training and development program, where do you start? What options are available internally and externally?	37%	23%	40%	2.03
Does the C-suite see the claims examiner role as critical to business success? Why or why not? Does this impact talent recruitment and retention?	37%	33%	30%	1.93
What alternative recruitment strategies have worked/not worked for claims operations? For example, partnering with universities or creating internship programs for new college graduates.	40%	40%	20%	1.80

Appendix C

Impact of Technology & Data

Survey Question: Give each of the following questions/topics a ranking of 1 to 3 for possible discussion during the focus group exercise.

Discussion Topic	1 Lowest Priority <i>(if we had time)</i>	2 Somewhat a Priority <i>(interesting)</i>	3 Highest Priority <i>(most compelling)</i>	Average Value
How can data help to better manage claims, measure best practices, and achieve improved outcomes?	4%	43%	53%	2.50
Data analytics are a big concern/opportunity, how can claim operations use analytics strategically?	6%	47%	47%	2.40
Communication is important throughout the claim cycle. What advanced technologies are used to communicate with key stakeholders (e.g., workers, physicians, employers)? How are they implemented, addressing security/privacy issues?	17%	30%	53%	2.37
Predictive modeling is frequently used on the underwriting side. Are organizations leveraging this technology on the claims operations side? How is the information used effectively?	10%	50%	40%	2.30
How are claim operations using business intelligence and analytics through the use of data warehousing?	10%	53%	37%	2.27
How can we use technology to improve claims examiner efficiency?	17%	40%	43%	2.27
What scalable options are organizations using to address legacy claims system limitations and integration with other systems?	17%	43%	40%	2.23

Appendix D

Medical Performance Management

Survey Question: Give each of the following questions/topics a ranking of 1 to 3 for possible discussion during the focus group exercise.

Discussion Topic	1 Lowest Priority <i>(if we had time)</i>	2 Somewhat a Priority <i>(interesting)</i>	3 Highest Priority <i>(most compelling)</i>	Average Value
How do we define and measure provider outcomes?	10%	27%	63%	2.53
Both the 2013 and 2014 studies identified nurse case management, return-to-work services, and nurse/claims triage as most critical to claim outcomes. How/when are these resources utilized? Is there outcomes data to support ROI/impact?	20%	10%	70%	2.50
The impact of pharmacy on overall medical costs and MSA allocations, including narcotic pain medicines and physician dispensing, is a concern. How can we better manage/mitigate this risk?	10%	33%	57%	2.47
Traditional provider payment strategies in workers' compensation are based on a fee-for-service model with discount methodology. How can we leverage value-based payment models?	20%	30%	50%	2.30
Medical severity due to macroeconomic factors, such as the aging workforce, obesity, diabetes and hypertension, has a significant impact on claims. What resources/strategies are we using to identify, predict, and/or manage these issues?	13%	47%	40%	2.27
Diminishing access to providers is an ongoing concern nationally, as well as for the workers' comp industry. What strategies can we undertake to mitigate this?	13%	67%	20%	2.07
Is risk/reward-contracting with medical providers an option in workers' comp? What are strategies for implementation?	27%	50%	23%	1.97

Medical Performance Management (cont'd)

Survey Question: Give each of the following questions/topics a ranking of 1 to 3 for possible discussion during the focus group exercise.

Discussion Topic	1 Lowest Priority <i>(if we had time)</i>	2 Somewhat a Priority <i>(interesting)</i>	3 Highest Priority <i>(most compelling)</i>	Average Value
The undercurrent of mistrust across stakeholders in workers' comp makes partnering with providers a challenge. How can we create meaningful partnerships with providers?	37%	37%	26%	1.90
The 2014 study reflects that some organizations are experiencing an impact on claims as a result of the ACA. What impact are we seeing, how do we address the risk/opportunity?	27%	60%	13%	1.87
Telehealth/virtual provider visits are a possible solution to the provider shortage. Is anyone using this now, if so how was it implemented?	33%	50%	17%	1.83



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