2017 WORKERS' COMPENSATION BENCHMARKING STUDY

CLAIMS MANAGEMENT OPERATIONAL STUDY

Quantifying 3-Year Progress, Expanding Claims Differentiators

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Rising Medical Solutions

RISING

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Preface

About the Study

The Workers' Compensation Benchmarking Study is a national research program that examines the complex forces impacting 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 focusing 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 serving payers of medical claims in the workers' compensation, auto, liability, and group health markets. Rising spearheaded 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, Denise Zoe Algire, MBA, RN, COHN-S/CM, FAAOHN

Denise Zoe Algire is the Director of Risk Initiatives & National Medical Director for Albertsons Companies. She is a nationally recognized expert in managed care and integrated disability management. She is board certified in occupational and environmental health and is a fellow of the American Association of Occupational & Environmental Health Nurses. Bringing more than 20 years of industry experience, her expertise includes claim operations, medical management, enterprise risk management, and healthcare practice management.

Study Advisory Council

Essential to the study program and research is its Advisory Council, comprised of 18 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.

Among those distinguished advisors we thank for their time and commitment are:

- Denise Zoe Algire | Director of Risk Initiatives & National Medical Director | **Albertsons Companies**
- Raymond Jacobsen | Senior Managing Director | **AON Benfield**
- Marcos Iglesias, MD | Senior Vice President, Chief Medical Officer | **Broadspire**
- Rich Cangiolosi | Vice President, Western Region | **Cannon Cochran Management Services, Inc. (CCMSI)**
- Pamela Highsmith-Johnson, RN, BSN, CCM | Director of Case Management | **CNA Insurance**
- Cathy Vines | Director, Healthcare Cost Containment Strategy | **CopperPoint Mutual Insurance**
- Daniel T. Holden | Manager, Corporate Risk & Insurance | **Daimler Trucks North America LLC**
- Kelly Kuri | Claims Manager | **Frank Winston Crum Insurance**
- Scott Emery | Senior Director, Claims | **Markel**
- Trecia Sigle | Associate Vice President, Workers' Compensation Claims | **Nationwide Insurance**
- Tom Stark | Technical Director, Workers' Compensation | **Nationwide Insurance**
- Tom McCauley | Owner & Consultant | **Networks by Design**
- David Price | President | **POMCO Risk Management**
- Laura Crowe | Risk Management Director | **Presbyterian Healthcare Services**
- Darrell Brown | Chief Claims Officer | **Sedgwick**
- John Smolk | Principal Manager, Workers' Compensation | **Southern California Edison**
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- Stephen Sullivan | Managing Editor, WorkCompWire.com
- William Wilt, FCAS, CFA | President, Assured Research
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- California Self-Insurers Association (CSIA)
- Colorado Self Insurers Association (CSIA)
- Florida Association of Self Insureds (FASI)
- Illinois Self-Insurers Association (ISIA)
- International Association of Industrial Accident Boards & Commissions (IAIABC)
- Iowa Self-Insurers Association (ISIA)
- National Council of Self-Insurers (NCSI)
- New York Claims Association (NYCA)
- New York Self-Insurers Association (NYSIA)
- New Jersey Self Insurers' Association (NJSIA)
- Oregon Workers' Compensation Association (OWCA)
- Texas Self-Insurance Association (TSIA)
- Washington Self-Insurers Association (WSIA)
- West Virginia Workers' Compensation Association (WVWCA)
- Wisconsin Chapter, Public Risk Management Association (PRIMA)

Introduction

Now in its fifth year, the 2017 Workers' Compensation Benchmarking Study continues its potent method of validating *how* and *what* higher performing claims organizations are doing differently than their lower performing peers. Reprising its 2014 survey questions, the study not only further specifies the high performer's profile on an expanded set of successful behaviors, but it also quantifies the industry's overall progress in the past three years.

With 572 claims leader participants, the 2017 study keeps pace with the industry as it strives to do ever better in managing claims, including its contemplation of an advocacy-based claims model for engaging injured workers.

However, determining which opportunities and challenges to address, often with limited resources, continues to be a persistent and widespread issue for claims organizations. Which practices will have the most positive impact and ROI? Is there concrete data proving these practices move the needle? Are there emergent areas that are becoming the new industry norms?

To answer these questions, the 2017 study advances the industry's collective intelligence – with more than 1,700 claims leader insights over a five-year period – to provide a maturing benchmark tool and point payers toward those differentiating practices yielding the best claim results.

Have claims practices improved in the past 3 years?

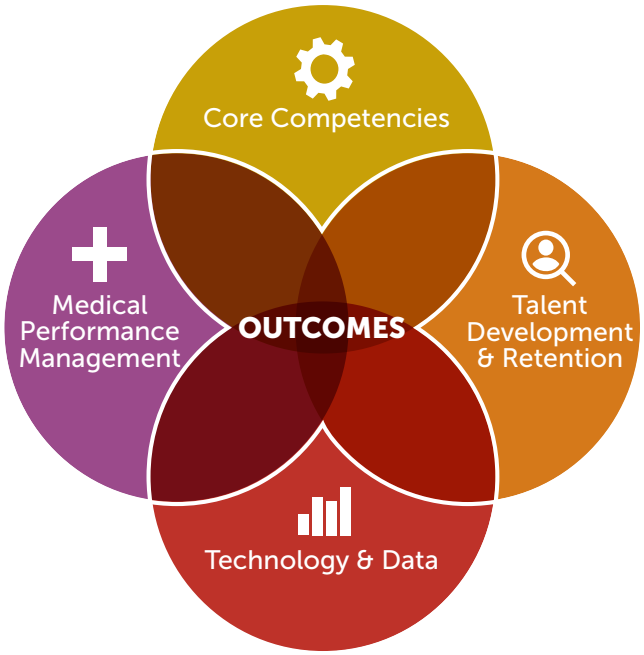
Have emergent areas become new industry norms?

2017 data quantifies industry advancement & validates an expanded set of high performance practices.

High performance data validating the extent of industry advancement in claims best practices

By exploring the below key areas, the 2017 study clearly identifies the prevalence and methods that are generating better claim outcomes in workers' compensation:

4 Major Drivers of Claim Outcomes



Executive Summary

The workers' compensation industry provides benefits to an estimated 135.6 million U.S. workers, with over $61 billion in paid benefits annually – costing employers over $94 billion.[1] Managing these claims is increasingly complex and challenging.

Since 2013, the Workers' Compensation Benchmarking Study has surveyed more than 1,700 claims leaders on their top operational priorities, challenges, and opportunities, as well as their strategies for improving claim outcomes. Building on prior research, the 2017 study reprises the 2014 survey questions to quantify the industry's progress in the past three years. Additionally, it continues to build a convincing profile of successful claims organizations by adding an expanded set of differentiating practices. These operational best practices were identified among **higher performing organizations, defined as those payers with a claims closure ratio of 101 percent or greater** – a common industry benchmark used as an overall indicator of operational performance. Claims closure ratio can be impacted by rapid premium growth, acquisitions, jurisdictional mix, and book of business / claim-type mix.

This year, for the first time, the study report includes a visual key for readers to quickly identify data trends from prior study reports as well as *what* practices are identified as *high performance differentiators*, with varying degrees of distinction amongst peer organizations.

Data Trend:

- Increase
- Decrease
- Consistent
- Mixed Results
- New Question / No Trend

Level of Differentiation between High Performers & Lower Performers:

- Modest
- Moderate
- Major

The 2017 survey's 572 responses demonstrate what drives success for a diverse group of claims leaders. The respondents include large carriers, third party administrators, employers, governmental entities, as well as risk pools and state funds / mutual funds.

The results reflect the following data trends, as well as key operational differentiators of higher performing organizations:

1. **Closure ratio performance declines.** Claims closure ratio is a common industry benchmark used as an overall indicator of operational performance. The 2017 results indicate an overall decline in performance from the 2014 study, with more than 50 percent of participants reporting growing claims inventories.

2. **Core competencies are intrinsically linked to claim outcomes.** Core competencies – the collective skills, abilities, and expertise required to manage claims – are the framework *ultimately responsible* for driving performance and claim outcomes, yet are still an attention-challenged area for the industry. Higher performing organizations are much more likely to align key performance indicators (KPIs) and best practices within core competencies than their lower performing peers.

3. **Medical cost escalation, the new normal in modern workers' compensation.** With total medical spend averaging more than 50 percent of overall workers' compensation claim costs nationally, and over 60 percent in many jurisdictions,[2] it's no surprise survey participants continue to rank medical management as *the number one factor most critical to claim outcomes*. This trend will continue with future medical costs projected to experience six-and-a-half percent growth in both 2017 and 2018.[3] This new normal has claims leaders on high alert for opportunities to impact medical performance management and outcomes, with demonstrated higher performance for those capitalizing on these opportunities.

4. **Predictive technologies on the rise in driving best practices.** Claims are affected by a number of complex factors. Utilizing decision support tools, such as predictive models and workflow automation, allows organizations to quickly access claims with a probability to incur high claim costs, litigation, and other key drivers of claim outcomes. The 2017 results show use of predictive modeling is increasing industrywide, and organizations that leverage decision support systems and numerous data sources report notably better claim outcomes.

Cont'd

5 **Drop in quality assurance and audit programs despite higher performance impact.** Two important tools claims organizations utilize to ensure compliance with best practices and client service agreements are quality assurance and audit programs. Higher performing organizations are much more likely to have an audit and/or quality assurance program in place.

6 **Investment in training and development declines, while a claims talent crisis looms.** With many industry professionals approaching retirement, claims organizations face an unprecedented talent shortage. These converging forces underscore the critical need to invest in training new talent and to shore up investment in existing staff to ensure tenure. The 2017 results show a decline in training budgets, as well as training programs for new hires and senior-level claims staff, compared to the 2014 study findings. Higher performing organizations have higher budget allocation for training and development and are more likely to invest in both new hire and senior-level staff development and training.

7 **Advocacy-based claims models, a key talent strategy in workers' compensation.** An area of evolution in the workers' compensation industry is advocacy-based claims models, described as an employee-centric customer service claims model that focuses on employee engagement during the injury recovery process. The goal of the approach is to remove adversarial obstacles, make access to benefits simple, build trust, and hold organizations accountable to metrics that go beyond cost containment. Higher performing organizations are more likely to use advocacy-based strategies as a key talent strategy, as well as to improve claim outcomes.

8 **Systems integration still limited.** To operate in an increasingly complex environment, claims systems must be agile, integrating with multiple systems, and must extend beyond an organization's four walls. Research by the Katie School of Insurance and Financial Services reports the inability of legacy systems to work with new technology and the costs associated with integration are the most significant barriers to implementing technology changes and innovation in workers' compensation.[4] Similar to the 2014 study, the 2017 survey results show true systems integration is limited, with many reporting a web-link or manual copy-and-paste of information as "integrated." Higher performing organizations are much more likely to have integrated systems across multiple programs.

9 **Use of provider quality and outcome measures remains rare in workers' compensation.** Measuring provider outcomes is necessary to improve the quality of care to patients. According to the New England Journal of Medicine, patients receive the proper diagnosis and care only 55 percent of the time, with wide variations in quality, access, and outcomes.[5] Quality and outcome measures can be used to improve patient safety, appropriate use of resources, and overall health outcomes. The 2017 results indicate only one-third of organizations measure provider performance and outcomes, a modest improvement from the 2014 study. Higher performing organizations demonstrate more frequent use of these measures.

10 **Pharmacy continues to be a top priority.** Industry leaders continue to rank pharmacy spending as one of their top issues. Driving this concern are several macroeconomic factors, including growing costs of specialty drugs, cost inflation of generic drugs, and the ongoing prevalence of opioids as well as concomitant drug therapy (i.e. other classes of medications with a sedating effect). Recent WCRI research reveals a decrease in the frequency of opioids prescribed to injured workers, however, higher utilization in older claims and dangerous combination therapy was also identified.[6] The 2017 results reflect an overall decline in pharmacy as a percentage of medical spend from the 2014 study.

[1] 2017 National Academy of Social Insurance: Workers' Compensation Benefits, Coverage, and Costs. Available: https://www.nasi.org/sites/default/files/research/NASI_Workers%20Comp%20Report%202017_web.pdf

[2] Medical Price Index for Workers Compensation NCCI 2017. Available: https://www.ncci.com/Articles/Documents/II_MPI-WC-Study.pdf

[3] Medical Cost Trends Behind the Numbers 2018. PwC Health Research Institute. Available: https://www.pwc.com/us/en/health-industries/health-research-institute/behind-the-numbers.html

[4] Jones, James R. and Williams, Michael R. "The Effect of Technology and Automation on Workers' Compensation Claims Practices." Katie School of Insurance & Financial Services (2004).

[5] Elizabeth McGlynn, Stephen Asch, John Adams, et al., The Quality of Care Delivered to Adults in the United States, The New England Journal of Medicine 348, no. 26 (June 2003): 2,641. Available: http://www.nejm.org/doi/full/10.1056/NEJMsa022615

[6] WCRI Interstate Variations in Use of Opioids, 4th Edition. Vennela Thumula, Dongchun Wang, and Te-Chun Liu. June 2017. WC-17-28. Available: https://www.wcrinet.org/reports/interstate-variations-in-use-of-opioids-4th-edition

Methodology

The 2017 study focus was guided by facilitated think-tank sessions with the Principal Researcher and the Advisory Council Members. The Study Report is based on the survey results of **572** respondents, including managers, directors, vice presidents, and executive-level claims leadership from every major type of workers' compensation payer organization.

The research was conducted using a confidential, online survey tool. The survey tool structure and questionnaire were developed by the Principal Researcher. 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 survey included a total of 73 partially categorized and closed-ended questions, including demographic, dichotomous, rank order scaling, Likert scale, multiple choice, constant sum, and random order question sets in order to reduce response bias.

Survey invitations were directed to leaders who oversee claim operations and sent through direct email invitations, as well as various industry channels. All direct email invitations included an opt-out link, allowing recipients to remove themselves from study communications. The results are presented in average responses of the entire group of participants, no individual or organization who participated in the study is identified.

The survey was open for a total of 44 days from June 1, 2017 through July 14, 2017. Participants were allowed to exit the survey at any point during the questionnaire and were given the option to receive a copy of the Study Report in exchange for completing the survey.

Responses Received

- **572** completed responses
- **14** excluded responses *(participants who did not meet the survey target audience were excluded from the study results)*
- **584** incomplete responses, where the survey was started but not completed *(incomplete responses were excluded from the study results)*
- Average response time to complete the survey was **21** minutes

The Principal Researcher completed the data validation and analysis, as well as authored this Study Report.

Survey Participant Demographics

About the Survey Participants

The study targeted workers' compensation leaders who oversee claim operations. The study includes 572 participants representing workers' compensation claims professionals, with managers representing the largest respondent population followed by director, vice president, and C-suite executives (see Figure 1). The survey responses include participation across industry sectors, with self-insured employers representing the greatest participation by organizational type, followed by insurance companies and insured employers (see Table 1). The 2017 study response rate represents a 42 percent increase from the 2014 study.

Figure 1 Survey Question: *Role / Level of Responsibility*
[572 Responses]

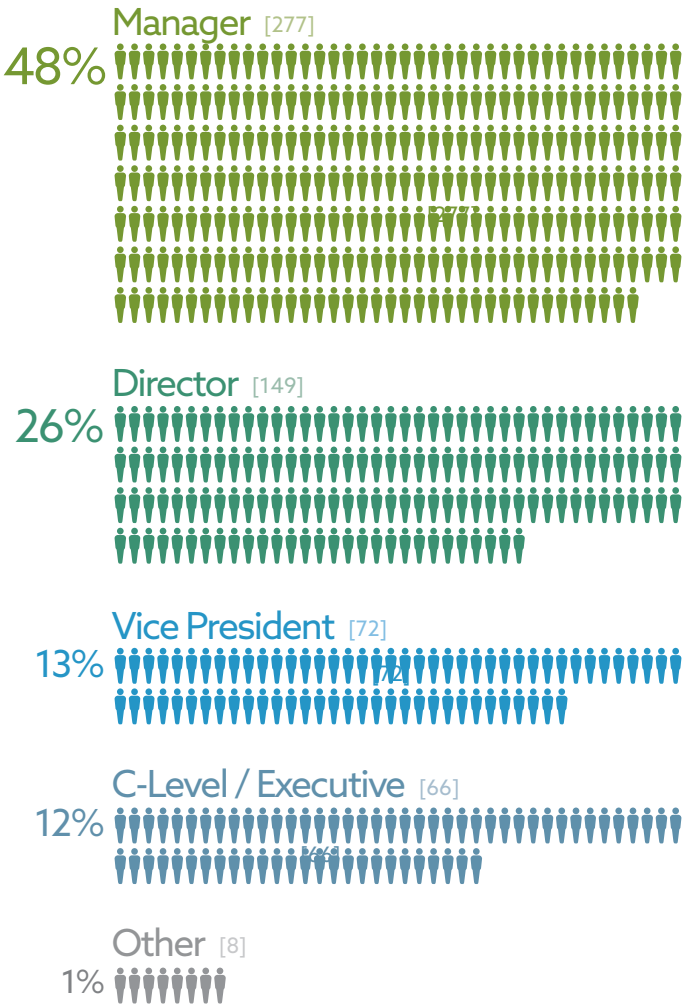


Table 1 Survey Question: *Organization Type*
[572 Responses]

	2017		2014	
Answer	count	%	count	%
Self-Insured Employer	169	30%	95	24%
Insurance Company	109	19%	92	23%
Insured Employer	94	16%	63	16%
Third Party Administrator	80	14%	78	19%
Governmental Entity	55	10%	29	7%
Risk Pool	26	4%	22	5%
Other	22	4%	14	3%
State Fund / Mutual Fund	13	2%	7	2%
Reinsurance or Excess Insurance Company	4	1%	4	1%

Participants include a broad representation of small, midsize, and large organizations. Organization size was measured by total annual premium and total annual claims dollars paid (see Table 2), as well as employee headcount. The 2017 survey included some additional answer options to further stratify small to midsize organizations' results. The 2017 study shows an increase in large organization participation, with nearly a 40 percent increase in the number of respondents compared to the 2014 study.

Table 2 Survey Question: *Organizational Size – Total Annual Premium & Total Annual Claims Dollars Paid*
[572 Responses]

	Total Annual Premium		Total Annual Claims Dollars Paid	
Answer	count	%	count	%
< $25M	176	31%	213	37%
> $25M to $100M	51	9%	87	15%
> $100M to $350M	48	8%	62	11%
> $350M to $750M	24	4%	29	5%
> $750M	60	11%	70	12%
Unknown	103	18%	111	20%
Not Applicable	110	19%	-	-

See **Appendix A** for all results related to "Survey Participant Demographics"

Participant Geographic Focus

Most survey participants are located in their organizations' corporate headquarters, as shown in Figure 2. Organizations with regionally-based workers' compensation business have modestly greater representation, with 53 percent of participants reporting claim operations in one or more regions and 47 percent reporting workers' compensation business nationwide (see Figure 3).

Organizations often examine the trends and differences in loss costs across jurisdictions when considering program effectiveness. Payers should proceed with caution as many forces can drive differences in the same mix of business and job type, including: benefit rates, propensity for litigation, medical fee schedules, treatment guidelines, and regulatory changes.[1]

Figure 2 Survey Question: *Corporate Headquarters or Regional Office Location*
[572 Responses]

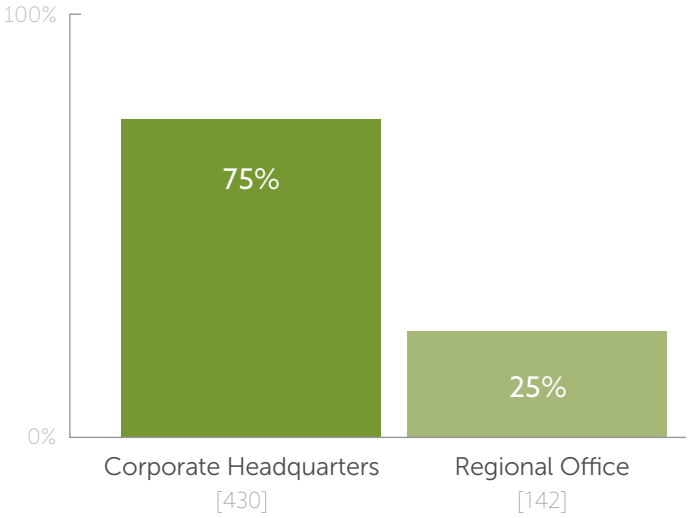
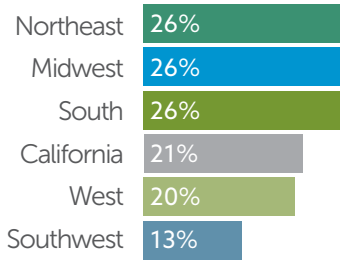


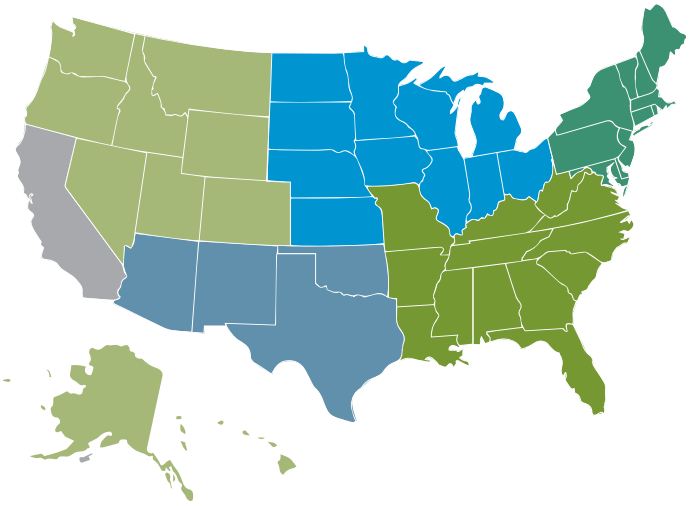
Figure 3 Survey Questions:

Geographic Focus - National or Regional in Scope
[572 Responses]

Indicate the Regions your company currently manages workers' compensation claims. Select all that apply.
(Conditional question for participants who answered "Yes" to Regional in Scope)
[304 Responses]

Geographic Focus:
National in Scope 47% [268]
Regional in Scope 53% [304]





Note: Participants could select more than one region

Method of Claims Management

The 2017 study finds 50 percent of participants report their claims are managed by a third party administrator (TPA), as shown in Table 3, up from 45 percent in the 2014 study.

Table 3 Survey Question: *My organization's workers' compensation claims are predominately managed by a(n):* [572 Responses]

Answer	count	%
Third Party Administrator	287	50%
Insurance Company / State Fund / Mutual Fund	171	30%
Self-Insured / Self-Administered	114	20%

Claim Caseloads down from 2014

The industry has long struggled to define an optimal caseload number for claims examiners. A specific benchmark does not exist. However, several recently interviewed claims leaders indicate that, depending on the jurisdiction, caseloads between 100 to 120 are optimal to achieve desired outcomes.[2] Many factors, including litigation, regional differences, and regulatory requirements impact the caseload a claims examiner can effectively manage. Caseload numbers alone do not represent the entire story. According to Property Casualty 360, "We must look beyond the numbers and consider case complexity."[3] Unmanageable caseloads can lead to incomplete investigations, missing diary dates, lack of follow through on action plans, overpayments and, ultimately, higher claims leakage. This puts the claims examiner at higher risk for bad faith claims allegations and the employer at higher risk for poor claim outcomes.

In addition to examiner experience level and case complexity, other important considerations are the level of administrative support claims examiners have, the efficiency and number of systems and/or client special instructions staff access to manage claims, and the settlement autonomy / authority granted to claims examiners. Additional considerations include Medical Only to Indemnity Claims ratio, as well as the Future Medical Claims to Active Indemnity Claims ratio. Study results reflect an overall caseload reduction compared to 2014 results, with 60 percent of respondents reporting 125 or less Lost Time (i.e. Indemnity Claims) caseloads and nine percent reporting Lost Time caseloads greater than 150 (see Table 4).

The 2017 results indicate organizations with Lost Time caseloads of 125 or less demonstrate more favorable claims closure ratios.

Table 4 Survey Question: *What is your organization's average Lost Time caseload per Lost Time Claims Examiner?* [572 Responses]

	2017		2014	
Answer (# of cases)	count	%	count	%
< 80	153	27%	95	24%
80 to 100	82	14%	40	10%
100 to 125	109	19%	55	14%
125 to 150	111	20%	102	25%
150 to 175	25	4%	23	6%
175 to 200	10	2%	12	3%
200 to 225	8	1%	3	1%
225 to 250	1	< 1%	3	1%
250 to 275	1	< 1%	1	< 1%
275 to 300	1	< 1%	-	-
> 300	4	1%	2	< 1%
Unknown	67	12%	68	16%

Closure Ratio performance declines

Claims closure ratio is a common industry benchmark used as an overall indicator of operational performance. It is defined as the number of claims closed, divided by the number of claims received during a specified timeframe. The goal is to achieve a 100 percent or greater closure ratio (i.e. 1.0). This ensures organizations maintain stable claim inventories. A closure ratio *less than* 100 percent (1.0) means claim inventory is growing, and a ratio *greater than* 100 percent (1.0) means inventory is declining. Claims closure ratio can be impacted by rapid premium growth, acquisitions, jurisdictional mix, and book of business / claim-type mix.

In a mature, stable workers' compensation program, claims should be closing at a rate of at least one-to-one. Nationwide, the overall workers' compensation claims frequency is declining;[4] therefore, one would expect closure ratio results to reflect this national trend. However, some jurisdictions do not allow future medical care to be settled, which impacts closing ratios and claims severity.

Survey participants were asked to report their overall claims closure ratio for calendar year 2016. Study results show that 24 percent of respondents have an average closure ratio of 101 percent or greater, and more than half, 58 percent, report an average closure ratio of less than 100 percent, up from 37 percent reported in 2014. These results indicate an overall decline in performance from the 2014 study, with more than 50 percent of participants reporting growing claims inventories (see Table 5). The closure ratio stratified by organizational type reflects that insurance companies, TPAs, and state fund / mutual funds report the most favorable outcomes with 38 percent reporting a closure ratio of 101 percent or greater (see survey question 11 in Appendix A).

Table 5 Survey Question: *Claims Resolution - What is your overall claims closure ratio for calendar year 2016?* [572 Responses]

	2017		2014	
Answer	count	%	count	%
≤ 50%	26	5%	12	3%
51 to 60%	30	5%	8	2%
61 to 70%	33	6%	13	3%
71 to 80%	49	9%	17	4%
81 to 90%	58	10%	34	8%
91 to 100%	134	23%	67	17%
≥ 101	137	24%	97	24%
Unknown	105	18%	156	39%

Appendix A Index – Survey Participant Demographics

For more information on the survey participants' demographic data, please refer to the below tables and figures in **Appendix A**.

[1] A Cautionary Tale: The Danger of Comparing Average Loss Costs Across State Lines. NCCI 2017. Available: https://ncci.wistia.com/medias/hn3oehmtre

[2] Cap TPA Adjuster Caseloads to Improve Service, Outcomes. 2010. Available: http://www.businessinsurance.com/article/99999999/NEWS080101/399999969

[3] 6 Factors Impacting the Claims Caseload. Property Casualty 360, May 28, 2013. Available: http://www.propertycasualty360.com/2013/05/28/6-factors-impacting-the-claims-caseload?page=2&slreturn=1508701289

[4] NCCI 2017 State of The Line Guide. Available: https://www.ncci.com/Articles/Documents/II_AIS2017-SOL-Guide.pdf

Operational Challenge

Prioritizing Core Competencies

Core competencies critical to claim outcomes

Managing workers' compensation claims continues to be increasingly complex, with several converging forces influencing the work environment, including everchanging federal and state regulations, the growing incidence of opioid addiction, the aging workforce, and chronic health conditions. This mounting complexity underscores the importance of focusing resources on what matters most. Core competencies – the collective skills, abilities, and expertise required to manage claims effectively – are the framework *ultimately responsible* for driving performance and claim outcomes.

This area of the report explores *what* organizations consider core competencies, *how* resources are allocated to those core competencies, and *how* best practices and outcomes are defined and measured.

Prioritizing core competencies most critical to claim outcomes

The 2017 results reflect a continued, consistent industry view of priorities. Similar to 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. Moreover, participants prioritize all 10 core competencies the same as 2014 rankings (see Table 6).

Top 3 Core Competencies Ranked Most Critical to Claim Outcomes

1. Medical Management
2. Disability / RTW Management
3. Compensability Investigations

Medical Management continues #1 ranking

With NCCI reporting total medical spend is averaging more than 50 percent of overall workers' compensation claim costs nationally and approaching 20 percent of the U.S. gross domestic product,[1] it's no surprise survey participants continue ranking medical management as the number one factor most critical to claim outcomes. This trend will likely continue as medical costs are projected to increase with a six-and-a-half percent growth anticipated in 2017 and 2018, according to a study from PwC's Health Research Institute.[2] Additionally, medical cost growth continues to outpace general price inflation, with the consumer price index (CPI) trending at just one percent growth over the past year with no expectation to change in the near term, according to the Bureau of Labor Statistics.[3]

Key Considerations:

What do organizations consider their core competencies?

How do organizations define best practices within core competencies?

How do organizations measure effective claims management?

Do organizations utilize risk / reward strategies to drive best practices and achieve outcomes?

Icon Key

Data Trend:

- Increase
- Decrease
- Consistent
- Mixed Results
- New Questions / No Trend

Level of Differentiation between High Performers & Lower Performers:

- Modest
- Moderate
- Major

See **Appendix B** for all results related to "Prioritizing Core Competencies"

As medical care costs continue to dominate total claim costs, study results show an industry *focus* on the operational area most impacting overall claim costs. Next, organizations need to center attention on *how* to hedge these escalating costs, including a thorough examination of medical quality, utilization, and costs. Given the intense industry and national focus on improving health care, the need for clinical expertise in claims organizations as well as claims professionals' knowledge in medical management is essential. The 2017 study results show higher performing organizations are more likely to have medical management programs in place. Examples include, nurse / claims triage, nurse case management, and utilization review.

Disability / RTW Management and Compensability Investigations continue #2 and # 3 rankings

Disability and RTW management also remain highly critical to claim outcomes. Many industry studies support the benefits of early RTW for both the employee and employer. In claims where an employee is losing time from work, it is in the best interest of all stakeholders to return the employee to work in some capacity as soon as possible. According to the Department of Labor, strategies to keep employees at work reduce workers' compensation costs, improve productivity, and save human capital costs associated with talent recruitment.[4] In a national RTW policy study at Syracuse University, employers with a formal RTW program were associated with shorter disability durations and lower medical costs.[5] The 2017 study results support these findings with higher performing organizations more likely to have RTW services in place.

The importance of compensability investigations on claim outcomes, including claim settlement and resolution, cannot be overestimated. The potential downstream impact, if this competency is not effectively executed, is significant. As soon as an injury or illness is reported, organizations should investigate it immediately. This timeliness directly affects outcomes. Most claims are compensable, but not all of them are. To be compensable, an injury must arise out of and in the course of employment. If an employee is injured due to a workplace hazard, an immediate investigation can prevent other injuries. If corrective action is not taken, employers may face regulatory fines, sanctions, and other lawsuits.

Table 6 Survey Question: *Please rank in the order of highest priority the core competencies most critical to claim outcomes, with 1 being the "highest priority" and 10 being the "lower priority."*

[572 responses]

Answer	Overall Rank	Mean
Medical Management	1	3.06
Disability / RTW Management	2	3.08
Compensability Investigations	3	3.65
Claim Resolution	4	4.28
Case Reserving	5	5.65
Litigation Management	6	5.99
Oversight Governance / Supervisory Oversight	7	6.47
Bill Review	8	7.03
Fraud & Abuse Detection	9	7.23
Vocational Rehabilitation	10	8.56

Measuring best practices within core competencies

Many organizations use metrics to measure operational performance; however, the emphasis tends to be on quantitative measures as opposed to qualitative or outcome-based measures of performance. A key study focus is benchmarking how organizations structure performance measures to expand on standard metrics. Of the benchmarking study's 572 responses, 71 percent report measuring best practices within core competencies, down from 75 percent in the 2014 study, indicating an opportunity for the industry. The results indicate higher performing organizations are much more likely to measure best practices within core competencies than lower performing peers (see Table 7).

Table 7 Survey Question: *Does your organization measure best practices / performance within core competencies?* [572 responses]

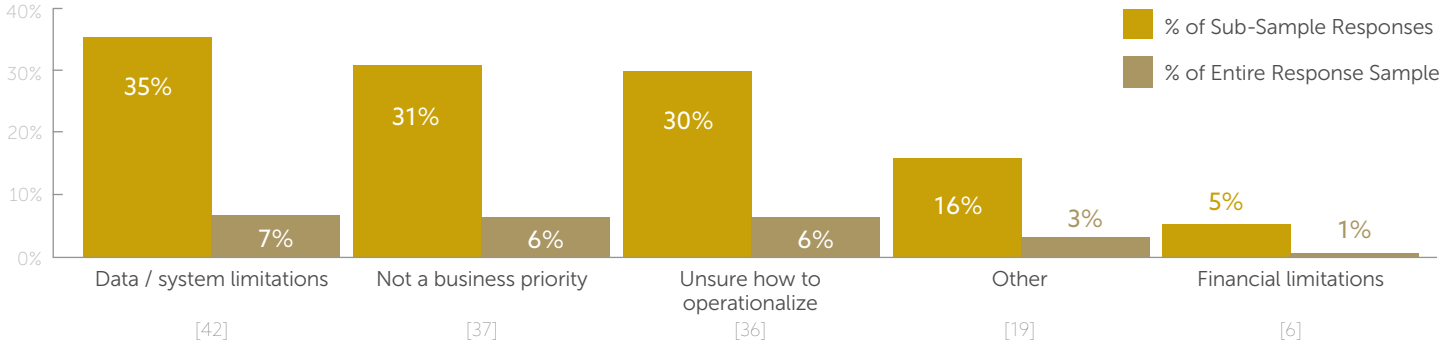
Responses Segmented by Claims Closure Ratio

Answer	count	≤ 50%	51% to 60%	61 % to 70%	71% to 80%	81% to 90%	91% to 100%	≥ 101%
Yes	404	4%	4%	5%	7%	9%	26%	31%
No	121	6%	7%	9%	12%	16%	20%	7%
Unknown	47	9%	6%	2%	11%	4%	11%	8%

There are several factors that may influence an organization's ability to measure best practices. The 2017 study examines the limitations for organizations that report not measuring best practices and performance within core competencies. The primary reasons are: data / system limitations, unsure how to operationalize and, startlingly, measuring best practices is not a business priority in 31 percent of the sub-sample (see Figure 4). This is a call to action for lower performing organizations. Claim costs represent approximately 80 percent of most claims organizations' expenses. With decreased budgets and scrutiny of operational expenses, this requires claims organizations to take a close look at what claim activities and best practices drive optimal outcomes. According to TechRepublic, "lean times often present opportunities for analyzing, fine-tuning, and improving business processes. Financial survival may in fact depend on such improvements."[6]

> *"Lean times often present opportunities for analyzing, fine-tuning, and improving business processes. Financial survival may in fact depend on such improvements."*
>
> – TechRepublic[6]

Figure 4 Survey Question: *What are the primary limitations / reasons for not measuring best practices / performance within core competencies? (Conditional Question for respondents who answered "No" in Table 7)* [121 responses]



Note: Participants were able to select more than one answer for this question

Aligning best practices and key performance indicators, a business imperative

The 2017 results indicate that, of the participants that measure best practices, 71 percent measure performance in the top three areas ranked most critical to claim outcomes, up from 58 percent in the 2014 study. Additionally, higher performing organizations are more likely to measure performance real-time in these top three areas, as well as other key performance metrics.

For companies seeking to become high-performance organizations, aligning metrics and desired outcomes is often the first step. Additionally, organizations should align metrics with key performance indicator (KPI) statistics that reliably reveal cause and effect. To identify cause and effect, the Harvard Business Review reports metrics should be *persistent* (i.e. resulting in consistent outcomes of a given action over time) and *predictive* (i.e. a causal relationship between the action the statistic measures and the desired outcome).[7]

Measuring Best Practices in the Top 3 Core Competencies Ranked Most Critical to Claim Outcomes

- Medical Management
  74% measure best practices
- Disability / RTW Management
  77% measure best practices
- Compensability Investigations
  61% measure best practices

Table 8 Survey Question: *Please indicate, on average, how often your organization measures best practices / performance within core competencies for each area. (Conditional Question for respondents who answered "Yes" in Table 7)*

[404 responses]

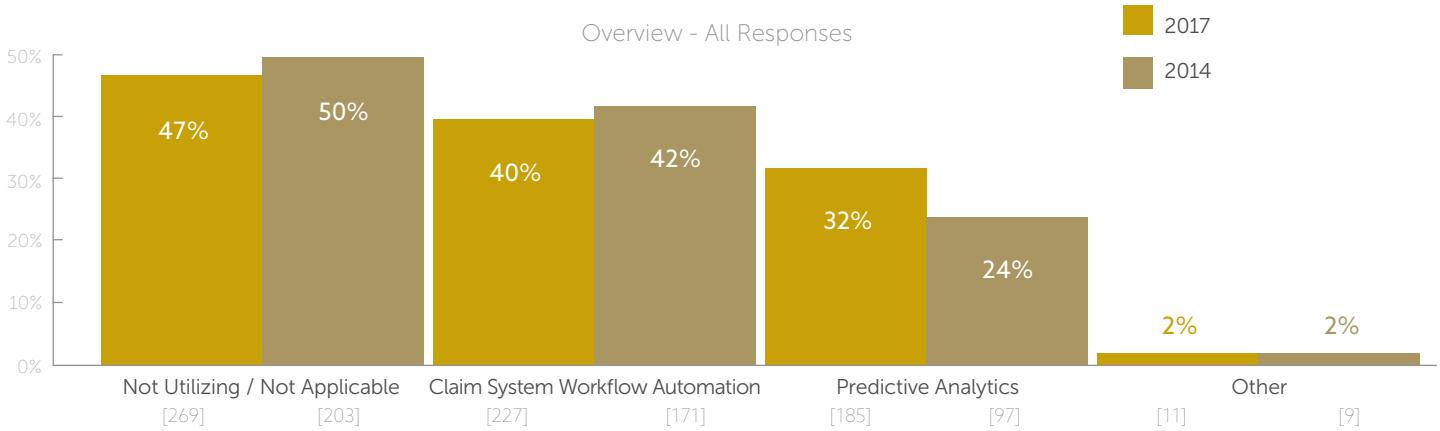
Answer	count	Real-Time / Daily	Weekly	Monthly	Semi-Monthly	Quarterly	Biannually	Annually
Disability / RTW Management	312	30%	12%	31%	1%	16%	4%	6%
Claim Resolution	310	18%	5%	45%	2%	18%	4%	8%
Medical Management	300	26%	10%	36%	1%	17%	4%	7%
Case Reserving	299	24%	6%	36%	1%	22%	3%	8%
Litigation Management	256	14%	4%	36%	3%	27%	6%	10%
Compensability Investigations	246	29%	7%	33%	2%	18%	5%	7%
Bill Review	218	23%	11%	36%	2%	17%	3%	9%
Oversight Governance / Supervisory Oversight	208	22%	7%	32%	3%	20%	6%	10%
Fraud & Abuse Detection	130	22%	7%	28%	3%	25%	6%	9%
Vocational Rehabilitation	66	12%	8%	38%	5%	21%	6%	11%

Using systems to drive best practices

To remain competitive, organizations often use tools such as workflow automation and predictive modeling to ensure consistency in execution and to drive desired outcomes. Workers' compensation claims are affected by numerous indicators, including jurisdictional differences, injured worker demographics, socioeconomic factors, employment, medical conditions, as well as current and prior injuries. These various factors, coupled with claim and medical transaction data, are the baseline for predictive modeling tools. Predictive technologies have become increasingly important as a key decision support tool in the management of workers' compensation claim costs. Using predictive models allows organizations to quickly identify and access claims with a probability to incur high claim costs, litigation, and other key drivers of claim outcomes.

The 2017 study results demonstrate 40 percent of organizations are utilizing systems such as workflow automation to manage best practices, slightly down from 42 percent in 2014. While even less, 32 percent, are currently utilizing advanced analytics such as predictive modeling; however, the 2017 results do reflect an eight percent improvement over the 2014 study (see Figure 5).

Figure 5 Survey Question: *Does your organization utilize any of the following systems to direct or manage tasks within best practices?* [572 responses]



Note: Participants were able to select more than one answer for this question

With the growing cost and complexity of claims, utilizing tools to identify high risk cases as early as possible is a clear competitive advantage. A cross-tabulation of the data shows organizations that utilize systems to drive best practices report notably better claim outcomes (see Table 9).

Table 9 Survey Question: *Does your organization utilize any of the following systems to direct or manage tasks within best practices?* [572 responses]

Responses Segmented by Claims Closure Ratio

Answer	count	≤ 50%	51% to 60%	61 % to 70%	71% to 80%	81% to 90%	91% to 100%	≥ 101%
Not Utilizing / Not Applicable	269	6%	7%	3%	12%	12%	20%	15%
Claim System Workflow Automation	227	3%	3%	8%	5%	8%	26%	33%
Predictive Analytics	185	3%	3%	7%	4%	10%	26%	35%
Other	11	9%	-	9%	9%	9%	27%	27%

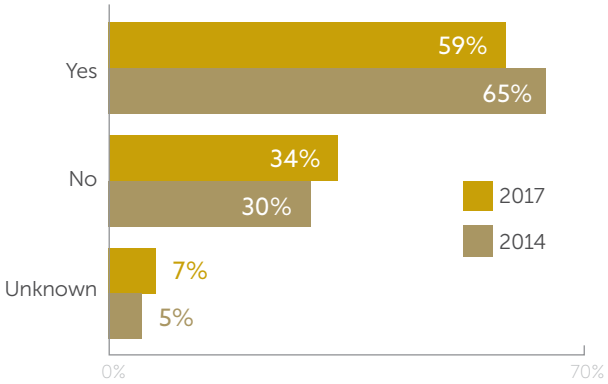
Note: Participants were able to select more than one answer for this question

Driving outcomes through quality assurance and audit programs

Two important tools claims organizations use to ensure compliance with best practices and client service agreements are quality assurance and audit programs. Depending on the organization, audit programs are managed either internally or externally by consultants and/or brokers. The 2017 study results show only 59 percent of participants have an audit or quality assurance program in place, down from 65 percent in 2014 (see Figure 6). Higher performing organizations are considerably more likely to have an audit and/or quality assurance program in place (see Table 10).

Figure 6 & Table 10 Survey Question: *Does your organization use an audit or quality assurance program focused on claim outcomes for operational performance?* [572 responses]

Overview – All Responses



Responses Segmented by Claims Closure Ratio

Answer	count	≤ 50%	51% to 60%	61 % to 70%	71% to 80%	81% to 90%	91% to 100%	≥ 101%
Yes	338	4%	4%	6%	8%	9%	24%	31%
No	194	5%	7%	7%	11%	12%	25%	16%
Unknown	40	8%	3%	-	5%	8%	15%	13%

Balancing risk / reward strategies to empower best practices and achieve outcomes

Rewarding good outcomes and penalizing poor performance is a seemingly commonsense approach to achieving results. So why aren't more organizations taking advantage of this strategy? In many industries, incentives and penalties play an important role in service contracts. However, using the same approach with internal staff has some limitations, not the least of which is understanding how to influence human behavior effectively. Organizations face challenges such as collective bargaining agreements (i.e. labor union contracts), company culture, and human resource practices. Many times, organizations do not know how to operationalize such metrics. Risk / reward systems should align KPIs with desired outcomes and motivate employees to work harder to achieve desired outcomes.

Similar to the 2014 study, less than 50 percent of participants in the 2017 survey report using risk / reward strategies. The results show organizations are much more likely to use risk / reward incentives with staff compared to vendor partners, representing a considerable opportunity for claims organizations. With the outsourcing of many key claim activities, harnessing well-defined service level expectations and associated incentives / penalties with vendor partners is more critical than ever. The 2017 results show that higher performing organizations are more likely to harness risk / reward strategies with staff, as well as with vendor partners.

Survey Question: *Does your organization utilize incentives for staff or vendor partners to achieve best practices / performance measures?* [572 responses]

- **48%** report using incentives for **staff**
- **31%** report using incentives for **vendor partners**

Survey Question: *Does your organization utilize penalties for staff or vendor partners when best practices / performance measures are not met?* [572 responses]

- **47%** report using penalties for **staff**
- **41%** report using penalties for **vendor partners**

Appendix B Index – Prioritizing Core Competencies

For more information on all survey question results and additional benchmark analyses related to this focus area, please refer to the below tables and figures in **Appendix B**.

B-1: Ranking of Core Competencies Most Critical to Claim Outcomes

B-2: Use of Best Practices / Performance Measures within Core Competencies
Segmented by Claims Closure Ratio

B-2.1: Measurement Areas for Best Practices / Performance within Core Competencies

B-2.2: Measurement Frequency for Best Practices / Performance within Core Competencies

B-2.3: Primary Reasons for Not Measuring Best Practices / Performance within Core Competencies

B-3: Systems Used to Direct or Manage Tasks within Best Practices
Segmented by Organization Type
Segmented by Claims Closure Ratio

B-4: Use of an Audit or Quality Assurance Program Focused on Claim Outcomes
Segmented by Claims Closure Ratio

B-5: Use of Staff Incentives to Achieve Best Practices / Performance Measures
Segmented by Claims Closure Ratio

B-6: Use of Staff Penalties When Best Practices / Performance Measures Aren't Met
Segmented by Claims Closure Ratio

B-7: Use of Vendor Partner Incentives to Achieve Best Practices / Performance Measures
Segmented by Claims Closure Ratio

B-8: Use of Vendor Partner Penalties When Best Practices / Performance Measures Aren't Met
Segmented by Claims Closure Ratio

[1] Medical Price Index for Workers' Compensation NCCI 2017. Available: https://www.ncci.com/Articles/Documents/II_MPI-WC-Study.pdf

[2] Medical Cost Trends Behind the Numbers 2018. PwC Health Research Institute. Available: https://www.pwc.com/us/en/health-industries/health-research-institute/behind-the-numbers.html

[3] BLS Economic News Release Consumer Price Index Summary. Oct 2017. Available: https://www.bls.gov/news.release/cpi.nr0.htm

[4] Assessing the Costs and Benefits of Return-to-Work Programs. Mathematica Policy Research 2015. Available: https://www.dol.gov/odep/topics/pdf/RTW_Costs-Benefits_2015-03.pdf

[5] Corporate Return to Work Policies and Practices: A National Study. Syracuse University, Burton Blatt Institute, 2012. Available: http://bbi.syr.edu/projects/Return_To_Work/docs/RTW_study_final_report.pdf

[6] 10 Best Practices for Business Process Measurement. TechRepublic. 2009. Available: http://www.techrepublic.com/blog/10-things/10-best-practices-for-business-process-measurement/

[7] The True Measures of Success. Harvard Business Review. 2012. Available: https://hbr.org/2012/10/the-true-measures-of-success

Operational Challenge

Talent Development & Retention

Training and development budgets decline, while claims talent crisis looms

With many industry professionals approaching retirement, claims organizations are facing an unprecedented talent shortage. The converging forces of the aging U.S. population and retirement of Baby Boomers creates an even *greater* exposure for the industry. In the last 10 years, the number of workers 55 or older increased 45 percent across all industries; however, in property casualty insurance, this percentage increased by 74 percent and is expected to continue at an alarming rate according to McKinsey & Company.[1] The talent crisis, coupled with a declining investment in training and development in the past three years, could leave the industry with a bleak future.

This area of the study provides an opportunity for organizations to benchmark *how* industry peers invest in talent development and retention.

The survey results indicate that most claims organizations include staff development in their strategic goals, as shown in Figure 7. However, there continues to be a disconnect, with only 54 percent reporting that they have a training and development group (see Figure 8), and even fewer reporting that they invest in training for new hires and senior-level claims staff.

Figure 7

Survey Question:

Is staff development included in your organizational / departmental strategic goals?

[572 responses]

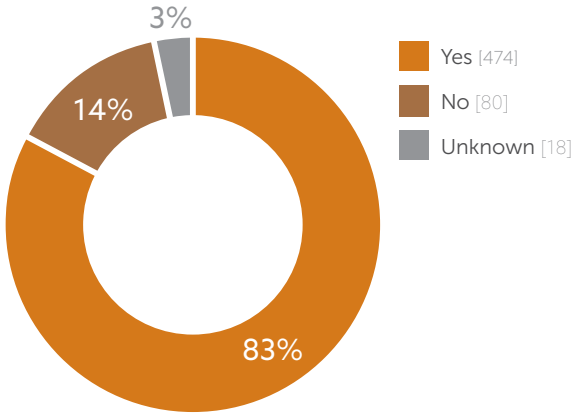
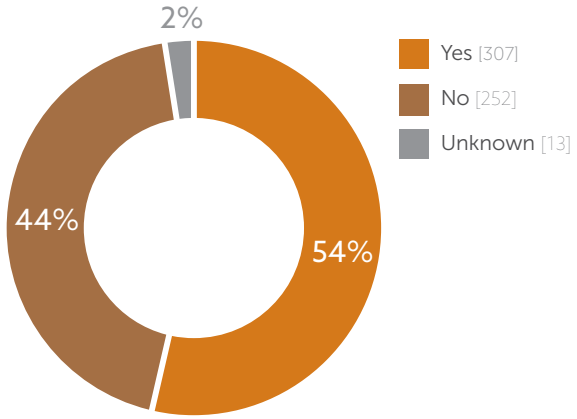


Figure 8

Survey Question:

Does your organization have a dedicated training and development group?

[572 responses]



Key Considerations:

What is the industry doing to attract and retain claims talent?

What is the financial investment in training and development in peer organizations?

Do organizations include staff development in their strategic goals?

Is training customized based on skill level to ensure ongoing development for tenured staff?

How do organizations tackle the challenge of knowledge transfer from senior-level staff to less experienced staff members?

Is investment in talent development linked to performance indicators?

Icon Key

Data Trend:

- Increase
- Decrease
- Consistent
- Mixed Results
- New Questions / No Trend

Level of Differentiation between High Performers & Lower Performers:

- Modest
- Moderate
- Major

See **Appendix C** for all results related to "Talent Development & Retention"

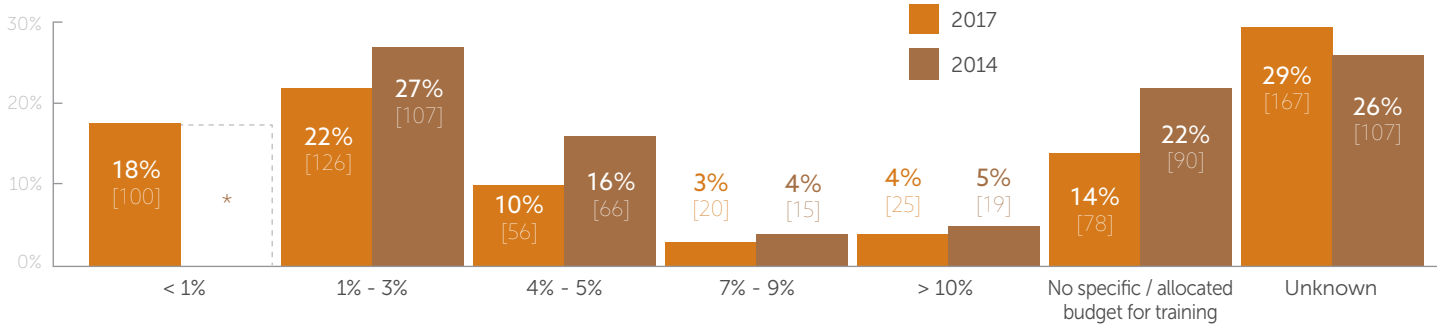
Investing in talent development has proven rewards

Many claims leaders identify talent recruitment, retention, and development as one of their key challenges. However, building a strong business case for investing in training programs can be difficult. Intuitively, most industry leaders know there is a positive return-on-investment (ROI) for investing in human capital, but measuring the quantitative impact poses challenges. It requires collaboration with internal and external resources, including human resources, recruitment, finance, and external competitive intelligence data. According to Deloitte, top organizations allocate more money to talent development than other companies and they reap the benefits by financially outperforming their peers with profit growth three times that of their competitors.[2] There are other advantages to investing in human capital, including employee resilience and retention. According to an industry study examining property casualty insurance employees, the driving forces that contribute to employee retention are management support, satisfaction, empowerment, and work environment.[3]

> *"Top organizations allocate more money to talent development and outperform their peers with three times the profit growth."*
>
> – Deloitte[2]

The results reflect a decline in training budgets, with 40 percent of respondents reporting three percent or less of their annual budget is dedicated to staff development and training compared to 27 percent in the 2014 study (see Figure 9). The 2017 study results also reflect higher performing organizations invest more in staff development and training.

Figure 9 Survey Question: *What percentage of your annual budget is dedicated to staff development and training?* [572 responses]



Percentage of Annual Budget Dedicated to Staff Development / Training

* Note: Answer option of "less than 1%" was not an answer option in the 2014 survey

New hire training, high expectations for declining investment

The survey results reflect only 38 percent of participants provide training for new hire claims staff with no experience or minimal experience (see Figure 10). Even more alarming, 33 percent of participants assign claims to inexperienced hires within six weeks or less.

Organizations that have a training program for new hires report, on average, 40 hours or less of training (see Figure 11), a decline from the 2014 study. Although 2017 results demonstrate a decline in this training investment, participant expectations for employee commitment have increased. For an average of 40 hours or less of new hire training, claims leaders expect three to four years of employment to justify the ROI (see Figure 12).

Organizations who invest more time in their new hire training program report better outcomes, with more favorable claims closure ratios. They also report a higher level of confidence that training prepares new claims staff to do their jobs well.

Figure 10 Survey Question: *Does your organization have a formal training program for new hire claims staff with little to no experience?*

[572 responses]

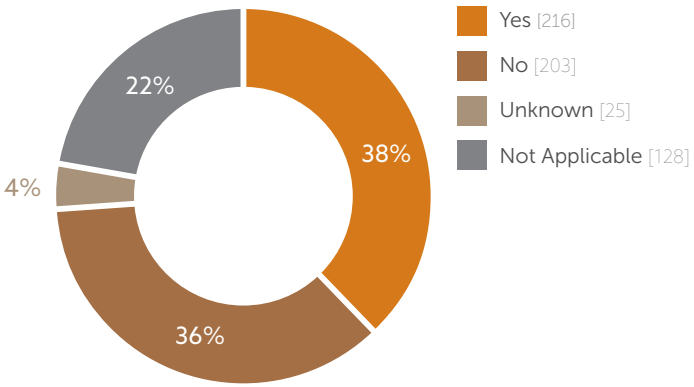


Figure 11 Survey Question: *Considering your new hire claims staff training program, how many hours of formal / classroom training are dedicated to the program? (Conditional Question for those who answered "Yes" in Figure 10)*

[216 responses]

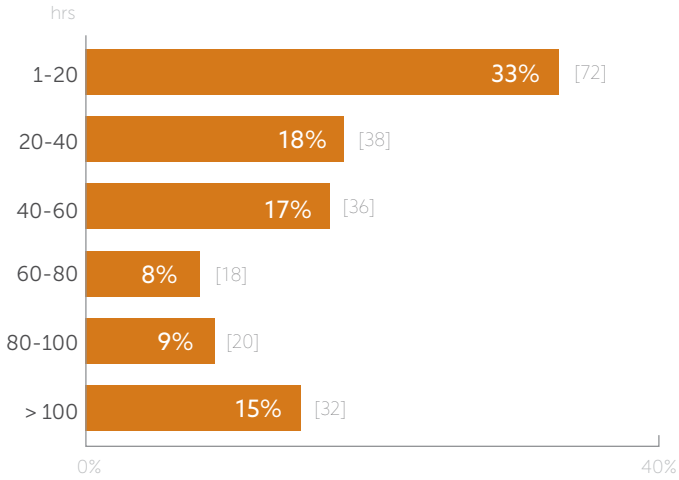


Figure 12 Survey Question: *What do you consider a reasonable ROI for training provided to new hire claims staff? (Conditional Question for those who answered "Yes" in Figure 10)*

[216 responses]

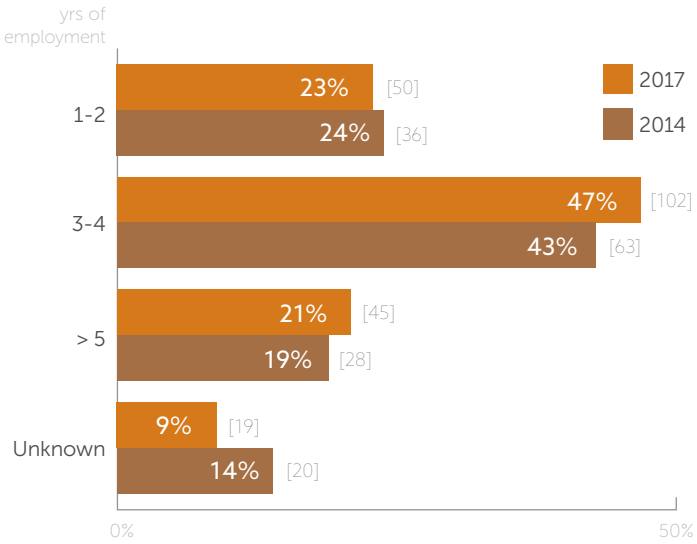
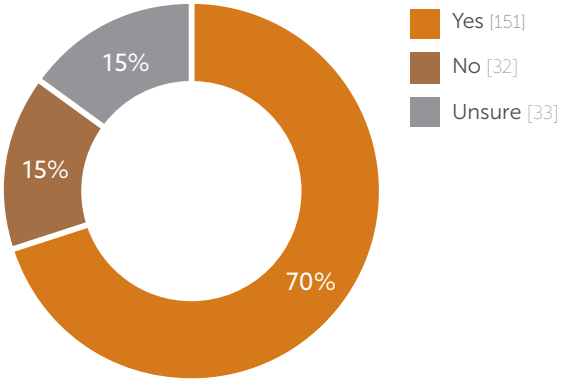


Figure 13 Survey Question: *Overall, do you believe completion of the new hire training program prepares new claims staff to carry a case load? (Conditional Question for those who answered "Yes" in Figure 10)*

[216 responses]

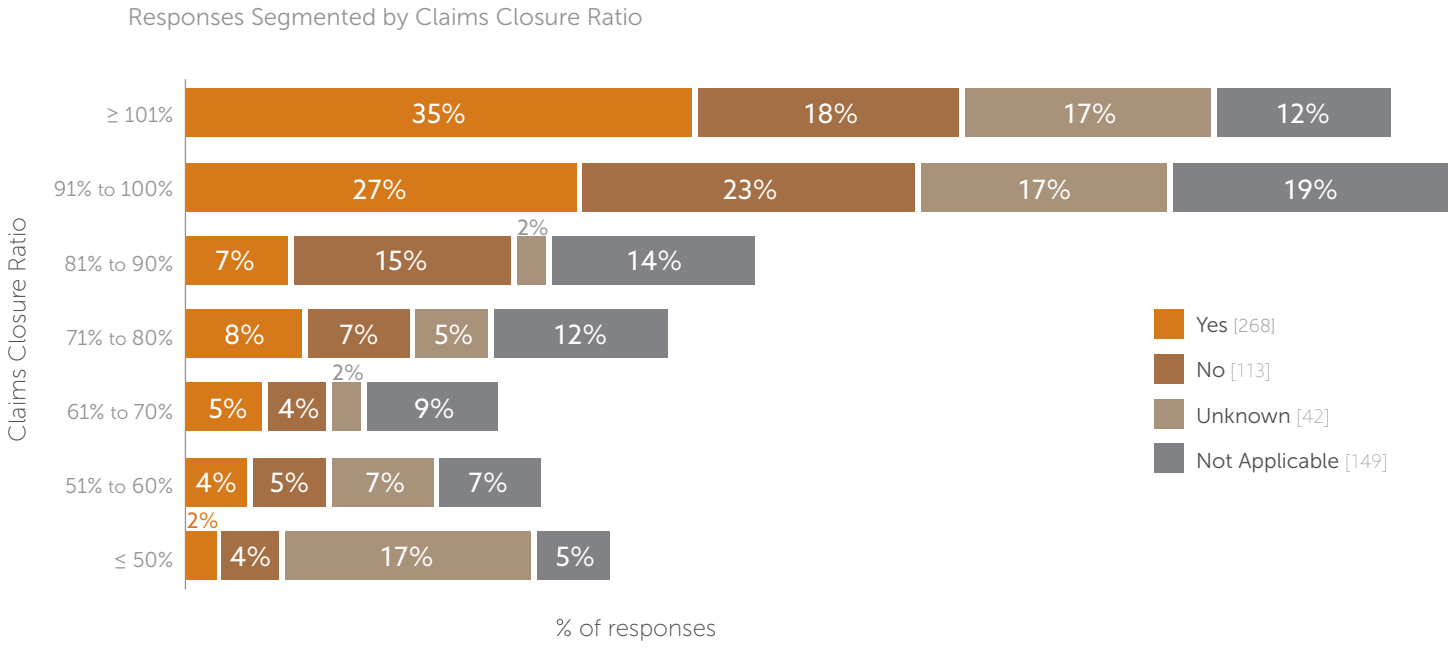


Investing in senior-level claims staff

In a recent Deloitte study, learning and development was identified as one of the insurance industry's most critical talent challenges. Meeting the demand for new and rapidly changing skills needs, due primarily to increasing claim complexity and industry innovation, underscores this need.[4] Although the industry recognizes the value of talent development, only 47 percent of study participants provide training for senior-level claims staff, down from 51 percent in 2014. To provide greater insight into the primary reasons organizations do not provide senior-level claims staff training, the 2017 study includes an additional question to identify these driving factors. The results show 35 percent indicate no perceived need for training and nearly 20 percent indicate staff are too busy managing claims to participate in training. This is a recipe for, at minimum, talent stagnation and, more alarmingly, a talent exodus – neither are desirable for the industry. To remain competitive, organizations need to balance business needs and invest in continued training and development of senior-level claims staff.

The results indicate higher performing organizations are more likely to provide training for senior-level claims staff (see Figure 14), and provide training more frequently.

Figure 14 Survey Question: *Does your organization provide technical training and development programs for senior-level claims adjusters?* [572 responses]



Employee benefits and formal career path programs

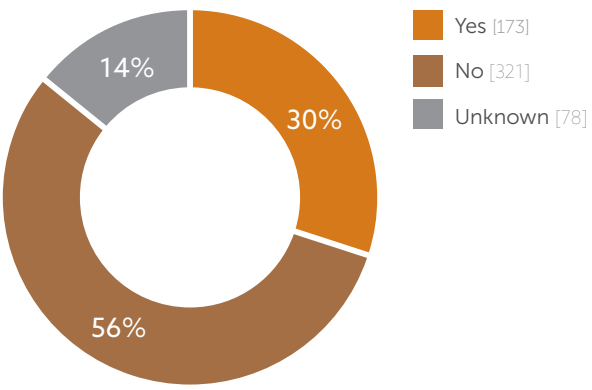
In addition to new hire and senior-level claims staff training, the study examined what other talent retention strategies organizations use. The 2017 results show organizations are investing more in employee benefit strategies than the 2014 study, with the largest increase in options more likely to be valued by employees, like working from home and bonus / profit sharing. However, similar to 2014, only 30 percent offer a formal career path with growth opportunities for claims staff, representing a competitive advantage for those that do.

Table 11 Survey Question: *Other than salary and standard benefits, what staff retention benefits / programs are in place for non-management staff? Select all that apply.* [572 responses]

	2017		2014	
Answer	count	%	count	%
No initiatives currently in place / Not Applicable	81	14%	94	23%
Wellness programs	336	59%	195	48%
Tuition reimbursement	328	57%	199	49%
Professional conference fee reimbursement	297	52%	192	48%
Professional membership dues reimbursement	254	44%	184	46%
Bonus / Profit sharing	243	42%	118	29%
Work from home option	236	41%	102	25%
Time for staff to participate in community outreach programs	215	38%	122	30%
Recognition / rewards for industry designations (i.e., AIC, CPCU, CRM)	209	37%	126	31%
Flextime for exercise during the workday	165	29%	84	21%
Onsite exercise programs	163	28%	100	25%
Four day work-week or other alternative scheduling arrangement	147	26%	79	20%
Gym memberships	116	20%	66	16%
Stock options	43	8%	26	6%
Other	31	5%	4	1%

Note: Participants were able to select more than one answer for this question

Figure 15 Survey Question: *Does your organization offer a formal career path program with growth opportunities for claims staff?* [572 responses]



Knowledge transfer, critical to long-term organizational success

Many organizations have limited resources or are in a constant state of flux with expanding claim inventories. This environment typically results in a greater focus on essential operations and less on talent strategy and succession planning. Deloitte outlines that, to address the most critical talent gaps created by an imminent mass talent loss, leading organizations are harnessing peer-based, informal learning to supplement traditional, formal learning to ensure knowledge transfer.[5]

The 2017 results indicate 62 percent of organizations have formal processes in place to ensure ongoing and effective knowledge transfer from senior-level staff to less experienced staff, up from 55 percent in the 2014 study. Given the significant hurdle the industry is facing with an aging demographic and limited talent pool, this represents a critical opportunity for organizations to formalize mentoring programs and succession planning.

Table 12 Survey Question: *Are formal processes in place to ensure knowledge transfer from senior-level staff to new / less experienced staff? Select all that apply.* [572 responses]

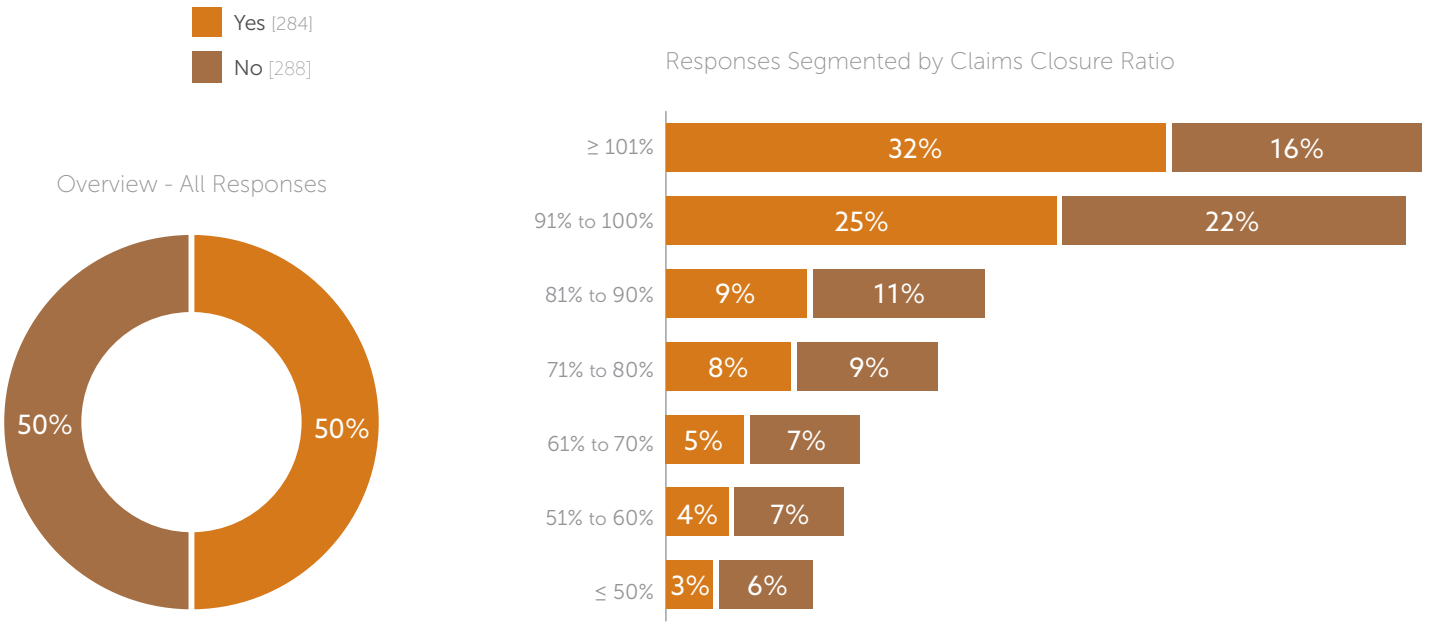
	2017		2014	
Answer	count	%	count	%
No Processes in Place / Not Applicable	218	38%	180	45%
Oversight governance / supervisory oversight	182	32%	148	37%
Cross-training program	169	30%	100	25%
Regular multidisciplinary strategy / staffing sessions	157	27%	93	23%
Other	32	6%	1	< 1%

Note: Participants were able to select more than one answer for this question

Advocacy-based claims models, a key talent strategy in workers' compensation

An area of interest to the workers' compensation industry is advocacy-based claims models, described as an employee-centric customer service claims model that focuses on employee engagement during the injury recovery process. Such models remove adversarial obstacles, make access to benefits simple, build trust, and hold the organization accountable to metrics that go beyond cost containment. The study initially examined the use of advocacy-based claims models in its 2016 survey. To garner a better understanding of the industry's socialization of advocacy-based models, the 2017 study asked if participants knew what an advocacy-based claims model is. This survey question was presented independently of other questions to reduce bias. As shown in Figure 16, 50 percent of participants report knowledge of advocacy-based claims models. Self-insured employers, as well as higher performing organizations, are more likely to be familiar with the model (see Figure 17).

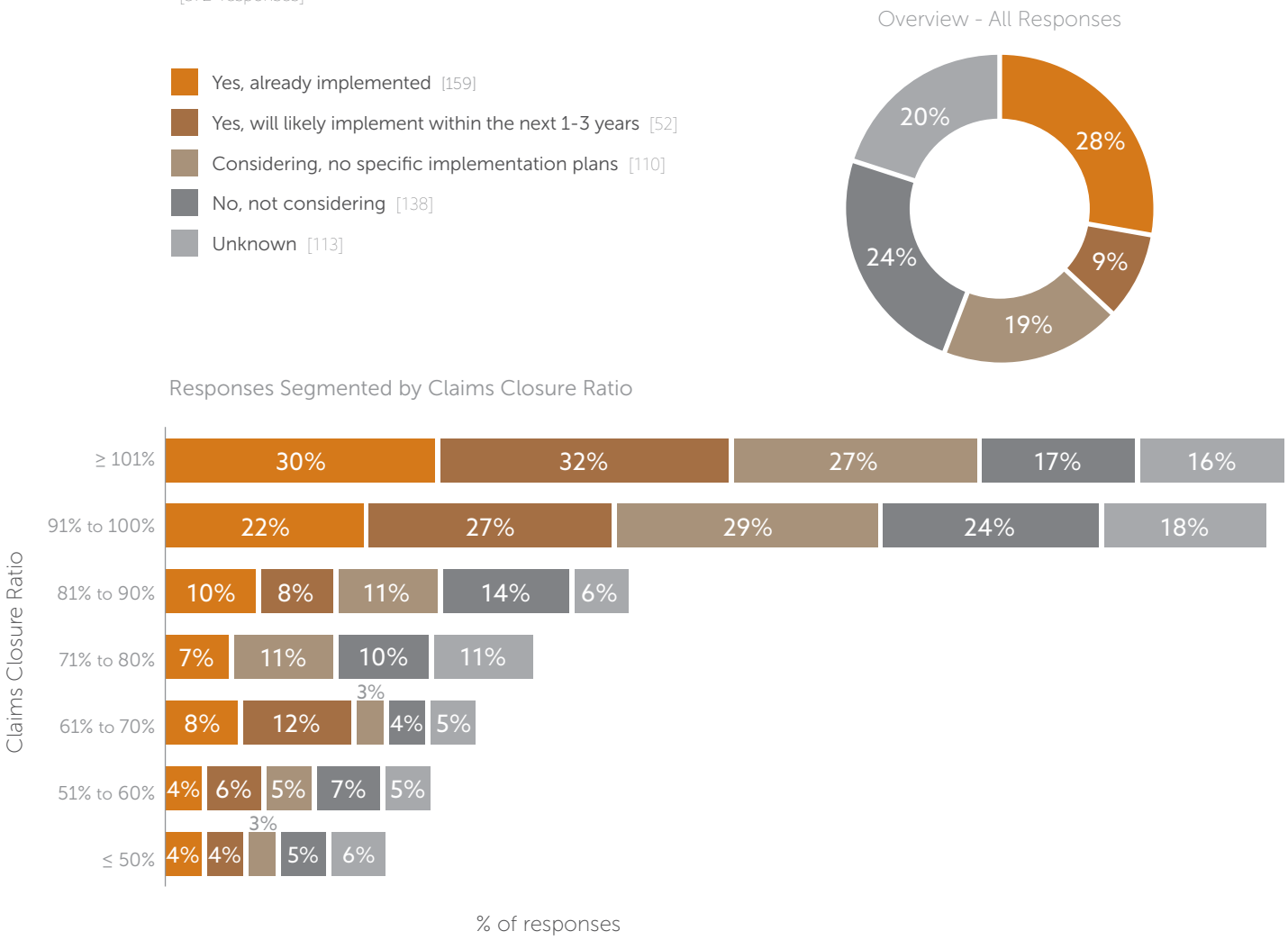
Figures 16 & 17 Survey Question: *Do you know what an advocacy-based claims model is?* [572 responses]



Industry use of advocacy models

The results reveal 28 percent of participants have already implemented an advocacy model (see Figure 18), a slight decline from the 2016 study results of 31 percent. Additionally, self-insured employers, as well as higher performing claims organizations, are more likely to have implemented an advocacy-based claims model or are considering implementation. Lower performing peer organizations are more likely to report they are not considering an advocacy-based claims model (see Figure 19).

Figures 18 & 19 Survey Question: *Has your organization considered implementing / adopting an advocacy-based claims model?* [572 responses]



Key characteristics and metrics for advocacy models

For organizations that report implementing an advocacy-based claims model, the 2017 study examines what specific strategies are implemented and how claims leaders measure the impact of the advocacy program. Given the critical importance of injured worker communication, it's no surprise that organizations are more likely to start there (see Table 13), looking at when and how they communicate with injured workers, as well as the tone and degree of empathy conveyed. The most common metrics used to measure the advocacy model's effectiveness is claim costs and duration, followed by injured worker satisfaction and litigation rate (see Table 14). Higher performing organizations are more likely to implement multiple initiatives and utilize more metrics to identify program results.

Table 13 Survey Question: *What advocacy-based claims model initiatives have you implemented? Select all that apply. (Conditional Question for those who answered "Yes" in Figure 18)* [159 responses]

Answer	count	% of Sub-Sample Responses	% of Entire Response Sample
Revamped employee / injured worker communications	102	64%	18%
Emphasis on workers' compensation as a benefit delivery system (vs. a claims adjudication system)	98	62%	17%
Focused claims adjuster training on empathy and/or other "soft skills"	90	57%	16%
Dedicated employee / injured worker advocates, available in addition to the claims examiner	82	52%	14%
Cultural shift within your organization supporting an advocacy model, including executive-level buy in	81	51%	14%
Other	16	10%	3%

Note: Participants were able to select more than one answer for this question

Table 14 Survey Question: *What measures are you using to determine the effectiveness of your claims advocacy model? Select all that apply. (Conditional Question for those who answered "Yes" in Figure 18)* [159 responses]

Answer	count	% of Sub-Sample Responses	% of Entire Response Sample
Claim costs	108	68%	19%
Claim duration	108	68%	19%
Injured worker satisfaction	99	62%	17%
Litigation rate	98	62%	17%
Claims talent employee retention	47	30%	8%
Speed / Number of days to reach a decision vs. statutory requirements	40	25%	7%
Other	17	11%	3%

Note: Participants were able to select more than one answer for this question

Advocacy approaches and soft skills training, impact on talent

The 2017 results show participants believe an advocacy-based claims model will positively impact claims talent development and retention strategies. The results indicate 20 percent believe an advocacy model will *greatly* impact, and 58 percent believe it will *somewhat* impact talent strategies. Participants rank employee engagement as the greatest potential impact on claims talent retention (see Table 15). According to the Society for Human Resource Management (SHRM), job satisfaction and employee engagement are the primary predictors of employee retention and should be considered key ingredients to human capital strategies.[6]

Employee Engagement Ranked #1 Claims Talent Development & Retention Strategy

Table 15 Survey Question: *Considering an advocacy-based claims model, how could it most impact claims talent development and retention strategies? Please rank in the order of greatest potential impact, with 1 being the "greatest impact" and 5 being the "lower impact."* [572 responses]

Answer	Overall Rank	Mean
Employee engagement	1	2.39
Connect claims talent strategy to organizational mission / customer service model and employee service model	2	2.90
Transform the image of the claims profession, from "adjuster" to "advocate"	3	2.97
Elevate the social factors, meaningful work of claims professionals	4	3.33
Improve organizational reputation / social image	5	3.42

Study results indicate that only 55 percent of organizations provide soft skills training for frontline claims professionals (see Table 16), down from 65 percent in 2016. Active listening, with training provided by just 34 percent of organizations, is a structured form of listening that improves overall understanding. It forces attentiveness, minimizes defensiveness, and focuses on the speaker; so rather than planning a next question, it forces the listener to reflect on the speaker's comments. It can be mastered; however, it requires practice and commitment according to the Harvard Business Review.[7] Training on empathy – an essential skill when dealing with people who are injured – is provided by only 22 percent of organizations. Interpersonal skills are, by far, one of the most critical competencies required of claims staff to be effective in their role. Higher performing organizations are more likely to invest in soft skills training and abilities.

Table 16 Survey Question: *Does your organization include any of the following skills and abilities testing / training for frontline claims professionals? Select all that apply.* [572 responses]

Answer	count	%
Customer service skills	248	43%
Communication skills	242	42%
Active listening skills	194	34%
Critical thinking	181	32%
Empathy	126	22%
Aptitude testing*	81	14%
None / Not Applicable	260	45%

Note: Participants were able to select more than one answer for this question

* test designed to determine a person's ability in a particular skill or field of knowledge

Appendix C Index – Talent Development & Retention

For more information on all survey question results and additional benchmark analyses related to this focus area, please refer to the below tables and figures in **Appendix C**.

C-16: Ranking of Areas that Advocacy-Based Models Could Most Impact Talent Development and Retention Strategies

C-17: Provision of Soft Skills Testing / Training to Frontline Claims Professionals
Segmented by Organization Type
Segmented by Claims Closure Ratio

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[1] Building a Talent Magnet: How the Property and Casualty Industry Can Solve Its People Needs, McKinsey & Company 2010. Available: http://www.aamga.org/files/hr/BuildingaTalentMagnet.pdf

[2] The New Best Practices of a High-Impact Learning Organization. Bersin by Deloitte. 2012. Available: http://blog.bersin.com/the-new-best-practices-of-a-high-impact-learning-organization/

[3] Retention of Property Casualty Insurance Company Employees; Cross Sectional Empirical Industry Study. Mary B. Lavoie. Wilmington University 2017. Available: https://search.proquest.com/openview/cd0a83c2236d6640ff874577cb2b7c69/1?pq-origsite=gscholar&cbl=18750&diss=y

[4] Human Capital Trends in The Insurance Industry. Deloitte 2016. Available: https://www2.deloitte.com/content/dam/Deloitte/us/Documents/strategy/us-cons-human-capital-trends-in-the-insurance-industry.pdf

[5] Human Capital Trends in The Insurance Industry. Deloitte 2016. Available: https://www2.deloitte.com/content/dam/Deloitte/us/Documents/strategy/us-cons-human-capital-trends-in-the-insurance-industry.pdf

[6] 2016 Employee Job Satisfaction and Engagement: Revitalizing a Changing Workforce. SHRM. Available: https://www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/pages/job-satisfaction-and-engagement-report-revitalizing-changing-workforce.aspx

[7] What Great Listeners Actually Do. Harvard Business Review. Zenger and Folkman 2016. Available: https://hbr.org/2016/07/what-great-listeners-actually-do

Operational Challenge

Impact of Technology & Data

Claims management basics, prime target for innovation

Technology continues to be a key differentiator in workers' compensation claims management. Unrelenting medical and indemnity costs and increased focus on elevating service delivery has created an ideal environment for innovation. Organizations are turning to technology to improve claim operations and to become more customer and injured worker centric.

In a recent research brief, insurance and technology research firm Novarica addressed the top innovations in workers' compensation.[1] Novarica indicates that workers' compensation is being transformed by technology, from pre-loss use of wearables and the Internet of Things, to post-loss use of drones. Primarily though, the industry is focused on improving the "nuts and bolts" of claims management through leveraging business intelligence and proactive analytics to determine which claims are likely to result in larger costs. Key initiatives include using mobile apps to improve loss control and communicate more real-time with injured workers, as well as using business intelligence and analytics.

This area of the study focuses on *how* organizations use technology to enhance operations and impact claim outcomes.

Technology budgets and predictive modeling capabilities, key to innovation

The 2017 results indicate information technology (IT) budgets decreased since the 2014 study, with 33 percent of participants reporting that three percent or less of their budget is allocated to workers' compensation IT (see Table 17).

Table 17 Survey Question: *What percentage of your organization's annual budget is spent on IT systems for workers' compensation programs?* [572 responses]

	2017		2014	
Answer	count	%	count	%
< 1%	128	22%	*	*
1 - 3%	60	11%	97	24%
4 - 6%	39	7%	22	5%
7 - 9%	24	4%	28	7%
10 - 12%	26	5%	22	5%
13 - 15%	15	3%	9	3%
≥ 16%	28	5%	24	6%
Unknown	252	43%	202	50%

* NOTE: Answer option of "less than 1%" was not an answer option in the 2014 survey

Key Considerations:

How do organizations utilize data to impact / manage operations?

What strategies are used to ensure data integrity?

What key systems are integrated with claim systems?

How do organizations balance process with strategy metrics?

How are advanced analytics such as predictive modeling used to enhance operations?

Are metrics helping or hindering operational effectiveness?

How can organizations use technology to drive high performance?

Icon Key

Data Trend:

- Increase
- Decrease
- Consistent
- Mixed Results
- New Questions / No Trend

Level of Differentiation between High Performers & Lower Performers:

- Modest
- Moderate
- Major

See **Appendix D** for all results related to "Impact of Technology & Data"

Similar to the 2014 study, organizations with greater workers' compensation IT budgets are more likely to have systems in place such as workflow automation and predictive analytics (see Table 18). Higher performing organizations are more likely to have larger budget allocation (see Table 19). Additionally, 2017 results indicate more organizations are harnessing predictive modeling overall.

Tables 18 & 19 Survey Question: *What percentage of your organization's annual budget is spent on IT systems for workers' compensation programs?* [572 responses]

Responses Segmented by Organizations' Use of Systems to Drive Best Practices

Answer (% of budget)	count	Claim System Workflow Automation	Predictive Analytics	Other	No / Not Applicable
< 1%	128	23%	19%	1%	67%
1 - 3%	60	37%	30%	3%	43%
4 - 6%	39	49%	36%	3%	38%
7 - 9%	24	71%	42%	13%	21%
10 - 12%	26	73%	46%	-	27%
13 - 15%	15	40%	47%	-	33%
≥ 16%	28	68%	39%	4%	21%
Unknown	252	38%	35%	1%	47%

Note: Participants were able to select more than one answer for this question

Responses Segmented by Claims Closure Ratio

Answer (% of budget)	count	≤50%	51% to 60%	61% to 70%	71% to 80%	81% to 90%	91% to 100%	≥101%
< 1%	128	7%	7%	5%	15%	13%	25%	14%
1 - 3%	60	3%	8%	12%	10%	5%	28%	18%
4 - 6%	39	3%	5%	3%	8%	15%	31%	23%
7 - 9%	24	4%	-	4%	8%	13%	33%	38%
10 - 12%	26	8%	-	8%	12%	4%	35%	31%
13 - 15%	15	-	13%	7%	-	27%	33%	13%
≥ 16%	28	11%	4%	7%	-	21%	21%	18%
Unknown	252	3%	4%	5%	6%	7%	18%	30%

Systems integration still limited

Many workers' compensation programs are hampered by legacy systems that lack necessary capabilities, resulting in inefficient operations. Legacy systems generally lack integration capabilities and are not able to take on disparate data from other systems. To operate in an increasingly complex environment, claims systems must be agile, integrating with multiple systems, and must extend beyond an organization's four walls. A research study published by the Katie School of Insurance and Financial Services reports that the inability of legacy systems to work with new technology and the costs associated with integration are the most significant barriers to implementing technology change and innovation in workers' compensation.[2]

Similar to the 2014 study, the 2017 results show true systems integration is limited, with many reporting a web-link or manual copy-and-paste of information as "integrated." Participants were asked to identify which systems are integrated and the functional nature of that integration with their claims system. The results indicate a modest increase, nine percent, in predictive modeling systems integration (see Table 20). Bill review and nurse case management are more likely to be integrated real-time, as shown in Table 21. Higher performing organizations are much more likely to have integrated systems across multiple programs.

Table 20 Survey Question: *Do any of the following systems or programs integrate with your claims system? Check all that apply.*
[572 responses]

	2017		2014	
Answer	count	%	count	%
No Systems Integration / Not Applicable	177	31%	132	33%
Bill Review	275	48%	202	50%
Nurse Case Management	223	39%	163	40%
Pharmacy Benefit Manager or Pharmacy Point of Service System	198	35%	140	35%
Utilization Review	179	31%	124	31%
Provider Networks	130	23%	77	19%
Safety / Loss Control	129	23%	85	21%
Predictive Modeling	128	22%	53	13%
Legal	124	22%	68	17%
Evidence-Based Medicine Guidelines	85	15%	52	13%
Fraud & Abuse Detection Systems	85	15%	62	15%
Imaging or Imaging Service Providers (i.e. MRI, CT, X-Ray)	78	14%	71	18%
Provider or Hospital Electronic Health Records	50	9%	35	9%

Note: Participants were able to select more than one answer for this question

Table 21 Survey Question: *Indicate how each selected system or program integrates with your claims system. (Conditional Question for respondents who selected a system(s) or program(s) in Table 20)* [395 responses]

Answer	Count	The system contains a web link to the claims system	Staff manually copies and pastes data into the claims system	Data populates the claims system through a scheduled file upload / flat file transfer	Data populates the claims system in real-time	Health Level 7 (HL7) integration	Other
Bill Review	275	12%	6%	52%	24%	2%	4%
Nurse Case Management	223	16%	20%	21%	32%	1%	10%
Pharmacy Benefit Manager or Pharmacy Point of Service System	198	21%	8%	48%	17%	2%	4%
Utilization Review	179	17%	14%	35%	25%	-	9%
Provider Networks	130	31%	14%	19%	22%	3%	11%
Safety / Loss Control	129	15%	23%	29%	17%	-	16%
Predictive Modeling	128	12%	6%	41%	29%	2%	10%
Legal	124	18%	27%	22%	17%	-	16%
Evidence-Based Medicine Guidelines	85	34%	16%	13%	25%	2%	10%
Fraud & Abuse Detection Systems	85	20%	13%	20%	31%	-	16%
Imaging or Imaging Service Providers (i.e. MRI, CT, X-Ray)	78	21%	19%	24%	23%	1%	12%
Provider or Hospital Electronic Health Records	50	20%	16%	30%	14%	4%	16%

Improving claims examiner efficiency, critical to outcomes

Claim outcomes are significantly impacted by activities that occur at the outset of the claim. Therefore, it is imperative for organizations to consider leveraging technology to enhance foundational claim activities. Managing claims efficiently at the earliest, most critical point following an injury can favorably impact outcomes. According to Advisen, some organizations are utilizing automated tools to improve decision making and enhance communication among claim stakeholders to ensure the injured worker gets the most appropriate level of care as soon as possible, and that each step of the process is effectively managed to maximize outcomes. "More efficient claims management not only results in lower costs to insurers and employers, it also can lead to much greater satisfaction by injured workers."[3]

Taking a closer look at industry initiatives, the study examined what organizations are doing to improve claims examiner efficiency. The results reflect a modest decline from 2014 in most areas, indicating an opportunity for the industry (see Table 22). Higher performing organizations report increased investment in IT resources to integrate systems, as well as implementing workflow automation, as key strategies.

> *"More efficient claims management not only results in lower costs to insurers and employers, it also can lead to much greater satisfaction by injured workers."*
>
> – Advisen[3]

Table 22 Survey Question: *What initiatives / strategies is your organization undertaking to streamline / improve claims adjuster efficiency? Select all that apply.* [572 responses]

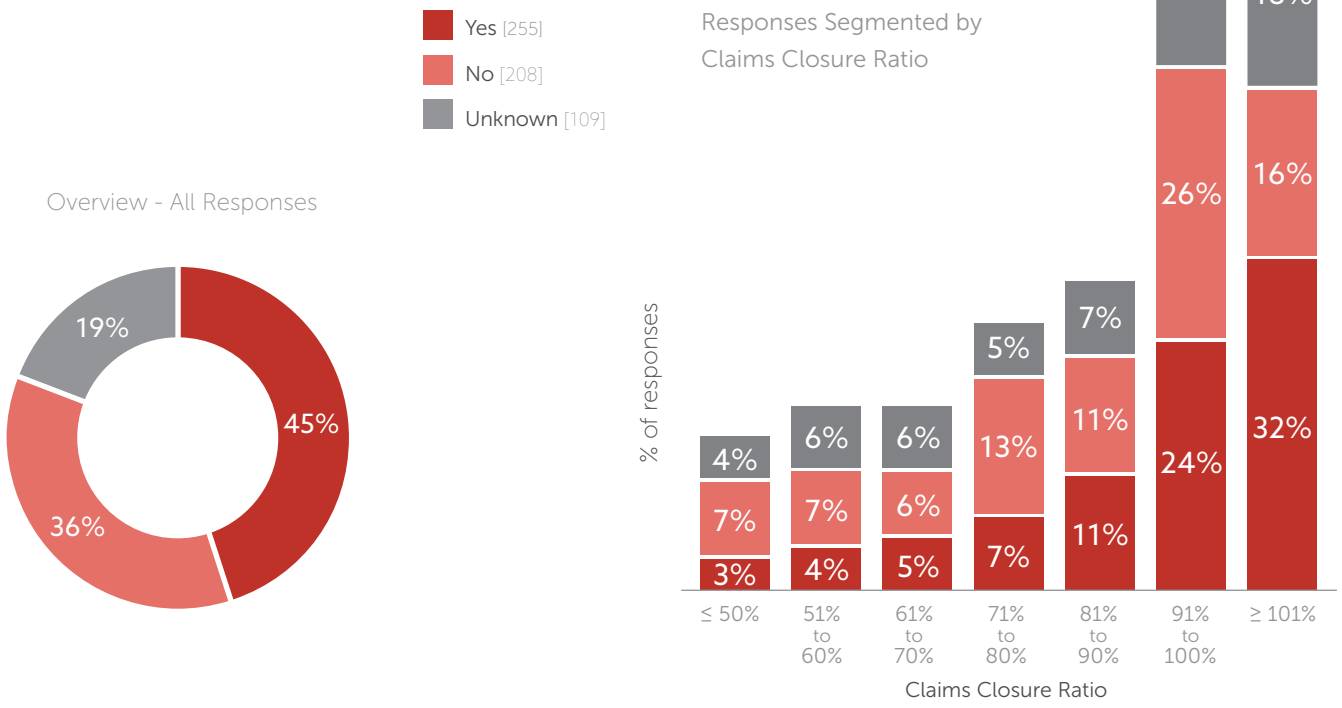
	2017		2014	
Answer	count	%	count	%
No Initiatives / Not Applicable	183	32%	122	30%
Increased investment in IT resources to integrate systems	260	45%	196	49%
Workflow Automation	260	45%	192	48%
Administrative Support / Offload Admin Tasks	214	37%	149	37%
Added Hardware / Tools (i.e. additional computer monitors, mobile devices)	132	23%	130	32%
Increased Specialization	74	13%	42	10%
Other	10	2%	12	3%

Big data aspirations and analytics

"Big Data" is a term that simply describes the large volume of data – both structured and unstructured – that inundates businesses on a daily basis. Big data is three dimensional, consisting of what is called the "3-Vs" – increasing volume (amount of data), velocity (speed of data in and out), and variety (range of data types and sources).[4] The *amount* of data is not what's most important; it's what organizations *do* with the data that matters. Big data can be analyzed for insights that lead to better decisions and strategic initiatives. According to Willis Towers Watson, big data aspirations are on the rise in the industry, with use in many key business functions expected to more than double in the next two years. Key growth areas include using big data for management decisions to support loss control and claims management.[5] Using big data is a ripe opportunity for workers' compensation claims organizations, which are inundated by the 3-Vs. So, what are the challenges? Primarily staff, people with the capabilities to undertake such an initiative, as well as lingering legacy systems that do not capture the level of data needed. Organizations should strategically assess their options and partner with external resources if they lack the skill and expertise in-house.

Organizations limited by legacy systems could consider utilizing a data warehouse to aggregate and produce meaningful data intelligence. The 2017 results indicate 45 percent of participants are using a data warehouse to integrate systems (see Figure 20), a slight increase from the 2014 study. Additionally, higher performing organizations are much more likely to use a data warehouse, as shown in Figure 21.

Figures 20 & 21 Survey Question: *Does your organization use a data warehouse to consolidate or integrate systems for reporting purposes?* [572 Responses]



Using outcome-based measures to manage operational performance

Performance measurement is generally defined as regular measurement of outcomes and results which generate reliable data on the effectiveness and efficiency of programs. The core characteristics of a well-designed performance measurement system should include collecting and analyzing both *quantitative* (closed-ended) and *qualitative* (open-ended) data. Performance measurement systems must be able to correlate cause and effect by providing an appropriate balance of quantitative *and* qualitative activity-based metrics, which represent the means to achieve desired goals or objectives (i.e. outcomes).

Less than 50 percent of organizations report using outcome-based measures to manage performance, a slight improvement from the 2014 study, as shown in Figure 22. Participants were asked to report what outcome measures they use, with an improvement in several areas including the use of evidence-based medicine to determine claim outcomes (see Table 23). Higher performing organizations are considerably more likely to utilize outcome measures and source multiple metrics (see Figure 23).

Figure 22 Survey Question: *Does your organization use outcome-based data / metrics to manage operational performance?* [572 Responses]

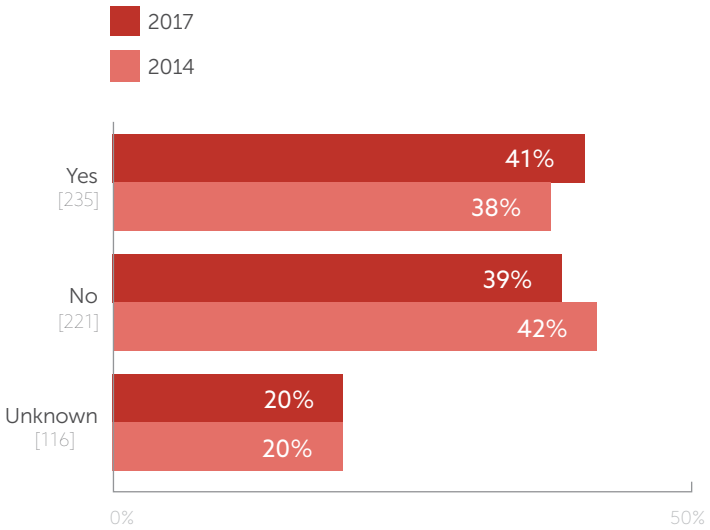


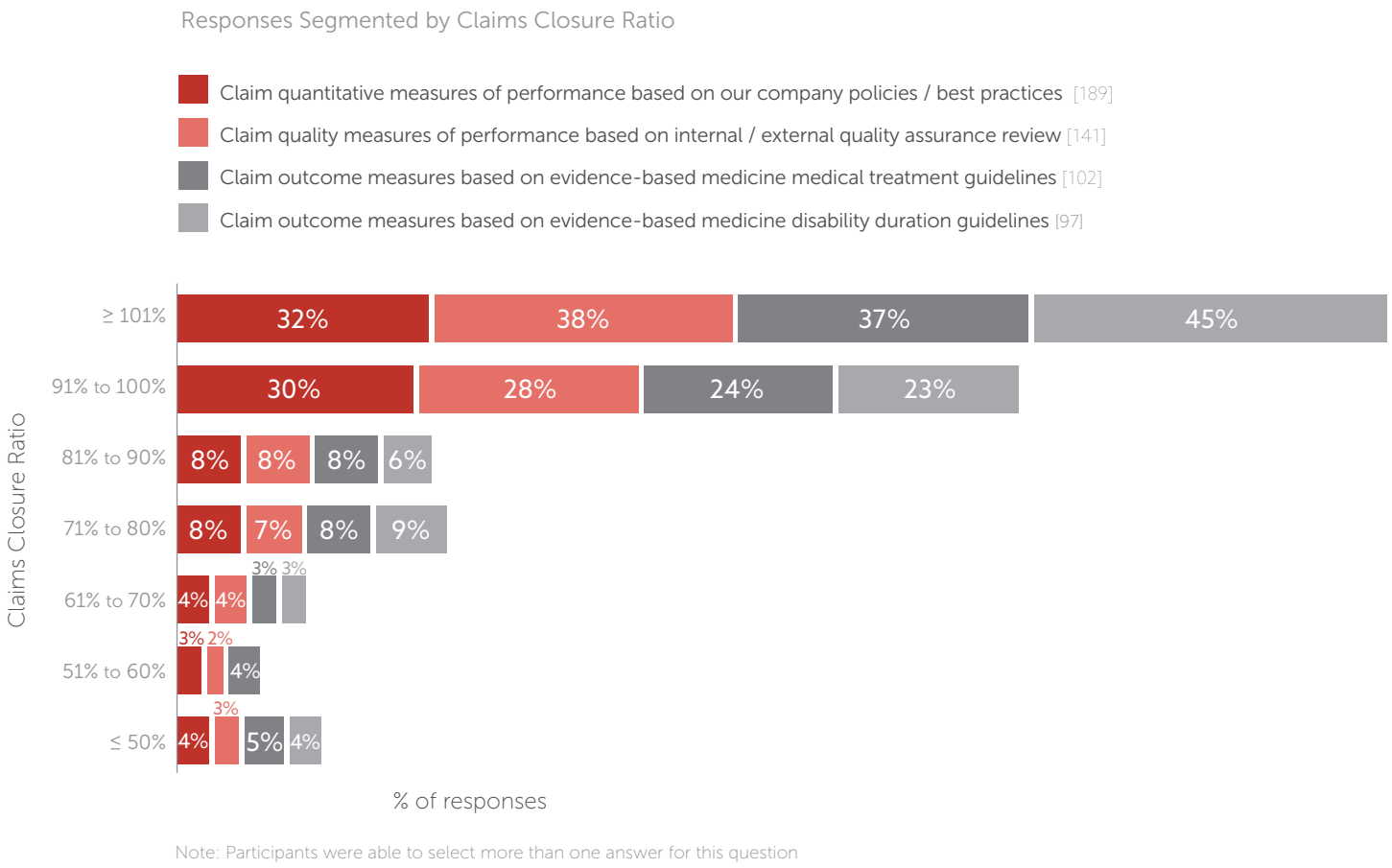
Table 23 Survey Question: *What outcome-based systems or data do you utilize to manage operational performance? Select all that apply. (Conditional Question for those who answered "Yes" in Figure 22)* [235 Responses]

Overview - All Responses

	2017			2014	
Answer	count	% of Sub-Sample Responses	% of Entire Response Sample	count	% of Entire Response Sample
Claim quantitative measures of performance based on our company policies / best practices	189	80%	33%	123	30%
Claim quality measures of performance based on internal / external quality assurance review	141	60%	25%	104	26%
Claim outcome measures based on evidence-based medicine medical treatment guidelines	102	43%	18%	47	12%
Claim outcome measures based on evidence-based medicine disability duration guidelines	97	41%	17%	46	11%
Other	2	1%	< 1%	2	< 1%

Note: Participants were able to select more than one answer for this question

Figure 23 Survey Question: *What outcome-based systems or data do you utilize to manage operational performance? Select all that apply. (Conditional Question for those who answered "Yes" in Figure 22)* [235 Responses]



Note: Participants were able to select more than one answer for this question

Appendix D Index – Impact of Technology & Data

For more information on all survey question results and additional benchmark analyses related to this focus area, please refer to the below tables and figures in **Appendix D**.

[1] Novarica Business and Technology Trends, Workers' Compensation. Oct 2017. Available: https://novarica.com/company-info/

[2] Jones, James R. and Williams, Michael R. "The Effect of Technology and Automation on Workers' Compensation Claims Practices." Katie School of Insurance & Financial Services (2004).

[3] Innovation vs. Inertia and Regulation: Gaining a Competitive Advantage in Workers' Compensation. Advisen, 2011. Available: https://www.advisenltd.com/2011/06/01/innovation-vs-inertia-regulation-gaining-competitive-advantage-workers-compensation/

[4] Wikipedia. Available: https://en.wikipedia.org/wiki/Big_data

[5] P&C Insurers' Big Data Aspirations for Advanced Predictive Analytics. Willis Towers Watson 2015. Available: https://www.towerswatson.com/en-US/Insights/Newsletters/Americas/americas-insights/2016/pc-insurers-big-data-aspirations-for-advanced-predictive-analytics

Operational Challenge

Medical Performance Management

Medical cost escalation, the new normal

Several recent NCCI and PwC reports illustrate what has become the normal state of modern workers' compensation. Medical spending is averaging more than 50 percent of overall workers' compensation claim costs nationally and is over 60 percent in many jurisdictions.[1] This trend will continue with future medical costs projected to increase year-over-year with six-and-a-half percent growth anticipated in 2017 and 2018.[2,3] This trend has been developing for well over a decade. According to NCCI research, the average medical cost per lost time claim has increased in each of the last 20 years, more than tripling since 1995.[4]

There are many macroeconomic factors contributing to the escalating cost of medical care; however, key drivers are medical inflation, the aging workforce, obesity, the national opioid crisis, and overall increased utilization of medical resources. This *new normal* has industry leaders rethinking traditional medical performance management strategies.

This area of the study focuses on *what* medical management strategies claims organizations are using and *how* they measure medical performance and outcomes.

Using provider quality and outcome measures to drive performance

Quality health care is defined by the Institute of Medicine as care that is "safe, effective, patient-centered, timely, efficient, and equitable."[5] Measuring provider outcomes is a necessary step to improving the quality of care to patients. However, according to a New England Journal of Medicine article, patients receive the proper diagnosis and care only 55 percent of the time, with wide variations in quality, access, and outcomes.[6] Research consistently shows chronic misuse of health care services. Quality and outcome measures can be used to improve patient safety, appropriate use of resources, and overall health outcomes.

Quality and outcome measures that can be applied in workers' compensation are: treatment within evidence-based medicine guidelines, benchmarking return-to-work outcomes, administrative measures (i.e. timely report submissions), coordination of care, and patient satisfaction. According to Oliver Wyman, organizations that utilize these performance strategies are building the foundation not only for value-based medicine models in workers' compensation, but also for a partnership with employers and health care providers to improve the health and productivity of the U.S. workforce.[7]

Key Considerations:

Are organizations utilizing medical management outcome measures?

How is provider quality measured?

With the prevalence of outsourcing medical management to vendor partners, how do organizations measure outcomes and ROI?

Is the industry utilizing risk / reward contracting strategies with providers or vendor partners?

Icon Key

Data Trend:

- Increase
- Decrease
- Consistent
- Mixed Results
- New Questions / No Trend

Level of Differentiation between High Performers & Lower Performers:

- Modest
- Moderate
- Major

See **Appendix E** for all results related to "Medical Performance Management"

Use of provider quality and outcomes still rare in workers' compensation

The 2017 study shows only 34 percent of organizations measure provider performance and outcomes, a modest improvement from the 2014 study, as shown in Figure 24. Of the organizations that measure provider performance, less than half share the results with providers (see Figure 25), an important feature to drive change. The survey identified primary factors affecting the limited use of provider performance and outcome measures. Respondents' most significant issues are data and systems limitations, as well as uncertainty about how to operationalize provider performance measures, representing an opportunity to better leverage technology and/or vendor partners that offer provider outcome measurement solutions. Surprisingly, 27 percent of sub-sample respondents report that measuring provider performance and outcomes is not a business priority (see Table 24). Higher performing organizations demonstrate more frequent use of provider performance and outcome measures.

Figure 24 Survey Question: *Does your organization use measures to gauge medical provider outcomes / performance?*
[572 Responses]

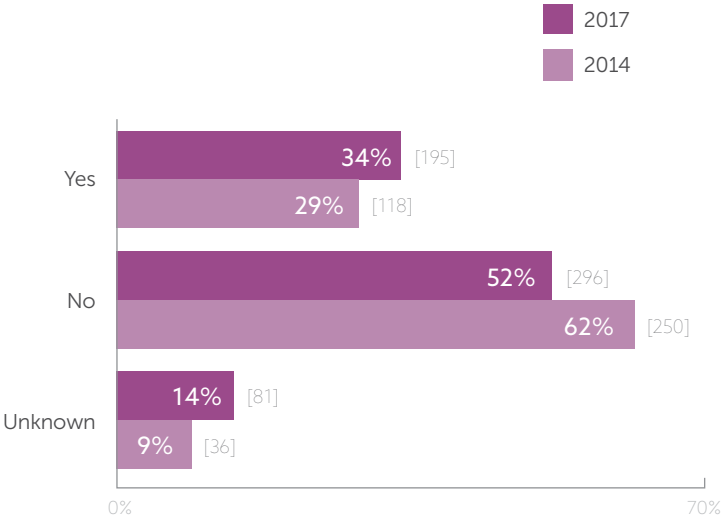


Figure 25 Survey Question: *Are the outcomes / performance measure results shared with providers? (Conditional question for those who answered "Yes" in Figure 24)*
[195 Responses]

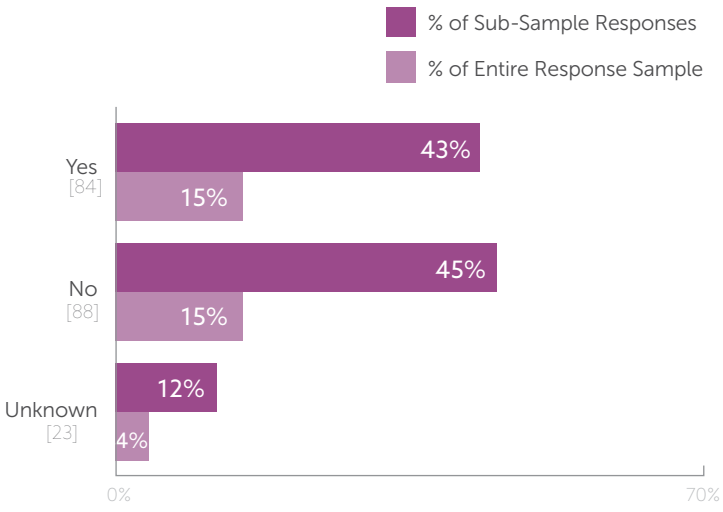


Table 24 Survey Question: *What are the primary limitations / reasons for not using provider outcomes / performance measures? Select all that apply. (Conditional question for those who answered "No" in Figure 24)*
[296 Responses]

Answer	count	% of Sub-Sample Responses	% of Entire Response Sample
Data / System Limitations	121	41%	21%
Unsure How to Operationalize	94	32%	16%
Not a Business Priority	79	27%	14%
Other	59	20%	10%
Financial Limitations	43	15%	8%
Litigation Concerns	24	8%	4%

Note: Participants were able to select more than one answer for this question

The 2017 results indicate 65 percent of participants leverage provider performance measures, such as return-to-work and treatment within evidence-based guidelines, a moderate improvement from the 2014 study (see Table 25). Additionally, 56 percent report using more common measures, such as average medical spending and disability days (see Table 26). Of concern, only 27 percent report measuring provider narcotic utilization, a figure inconsistent with the great emphasis now placed on curbing opioid misuse and abuse.

These findings suggest a modest improvement in the use of provider performance measures from the 2014 study; however, a significant opportunity exists to better leverage these tools in driving improved quality and outcomes. Higher performing organizations are more likely to utilize provider performance measures and to leverage more metrics, as shown in Figure 26.

Table 25 Survey Question: *Are you using any of the following data points to measure provider outcomes / performance?*
[572 Responses]

	2017		2014	
Answer	count	%	count	%
No, none currently in place / Not Applicable	199	35%	174	43%
Total Claim Costs	297	52%	187	46%
RTW Outcomes	288	50%	167	41%
Treatment within Evidence-Based Guidelines	162	28%	91	23%
Quality & Timely Submission of Reports	142	25%	101	25%
Efficiency Measures, Average Number of Evaluation & Management (E&M) Visits per Claim by Diagnosis Code	79	14%	25	6%
NCQA Cost of Care Measures	22	4%	11	3%
AHRQ Clinical Quality / Appropriate Care Measures	18	3%	10	2%
Other	3	1%	12	3%

Note: Participants were able to select more than one answer for this question

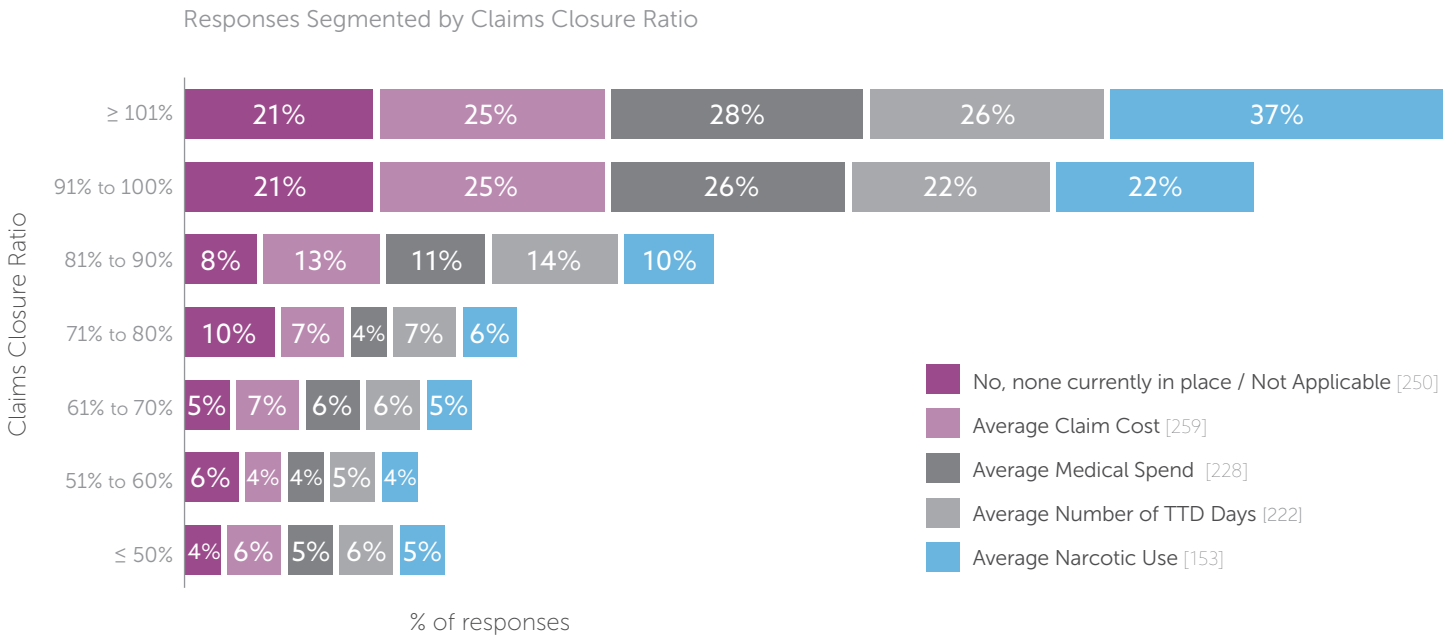
Table 26 Survey Question: *Are you using any of the following measures to gauge overall provider performance?*
[572 Responses]

Overview - All Responses

	2017		2014	
Answer	count	%	count	%
No, none currently in place / Not Applicable	250	44%	202	50%
Average Claim Costs	259	45%	164	41%
Average Medical Spend	228	40%	152	38%
Average Number of TTD Days	222	39%	126	31%
Average Narcotic Use	153	27%	85	21%

Note: Participants were able to select more than one answer for this question

Figure 26 Survey Question: *Are you using any of the following measures to gauge overall provider performance?* [572 Responses]



Note: Participants were able to select more than one answer for this question

Medical management programs most critical to claim outcomes

The challenge of managing medical severity and disability durations in workers' compensation has been a catalyst for integrating medical management programs and resources within traditional claims models. The strategic use of clinical resources from the outset of the claim has become an industry standard – from 24-hour nurse triage models, to embedding nurses within claims teams working hand and glove with their claims partners, to the use of physician advisors. For many organizations with limited internal resources, clinical resources and medical management programs are often provided by vendor partners.

The 2017 study examined the medical management programs considered most critical to claim outcomes (see Table 27), as well as which programs are insourced or outsourced to vendor partners (see Table 28).

Given the industry's intense focus on medical costs and disability management, it's no surprise the three medical management programs ranked most critical to claim outcomes are nurse case management, return-to-work services, and nurse / claims triage. These are the same top three rankings in the 2014 study.

Top 3 Medical Management Programs Ranked Most Critical to Claim Outcomes

1. Nurse Case Management
2. Return-to-Work Services
3. Nurse / Claims Triage

Table 27 Survey Question: *Please rank in the order of impact the programs you believe are most critical to claim outcomes, with 1 having the "greatest impact" and 10 having the "least impact."*
[572 Responses]

Answer	Overall Rank	Mean
Nurse Case Management	1	3.49
Return-to-Work Services	2	3.90
Nurse / Claims Triage	3	4.17
Pharmacy Benefit Manager / Network	4	5.38
Utilization Review	5	5.73
Physician Case Management	6	5.75
Bill Review	7	5.86
Company Developed / Owned Provider Network	8	6.65
Peer Review	9	6.96
Outsourced / Leased Provider Network	10	7.11

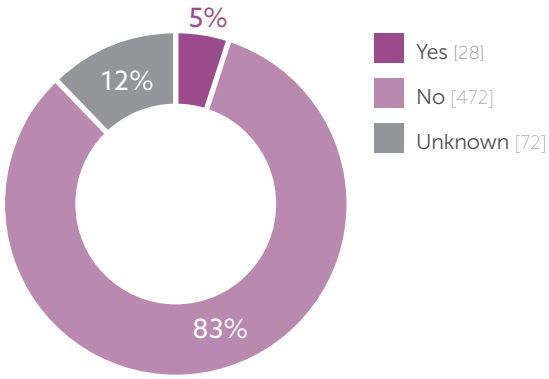
Table 28 Survey Question: *Indicate if any of the following medical management programs are currently in place and if they are insourced or outsourced.*
[572 Responses]

Answer	Not Applicable	Insourced	Outsourced	Combination Insourced & Outsourced	Unknown
Nurse Case Management	6%	22%	51%	20%	1%
Bill Review	6%	20%	64%	8%	2%
Pharmacy Benefit Manager / Network	9%	7%	75%	5%	4%
Utilization Review	11%	18%	56%	11%	4%
Return-to-Work Services	16%	43%	18%	20%	3%
Nurse / Claims Triage	19%	25%	41%	12%	3%
Peer Review	19%	14%	56%	7%	4%
Physician Case Management	33%	11%	39%	9%	8%
Outsourced / Leased Provider Network	34%	4%	45%	7%	10%
Company Developed / Owned Provider Network	38%	16%	31%	8%	7%

Using risk / reward strategies with medical providers and vendor partners still rare

The intense focus on medical inflation and improving the quality of care in workers' compensation has stimulated stakeholders – including state regulators, health care providers, payers, employers, and labor groups – to develop proposals for significant changes in the payment and delivery of medical care to injured workers. Industry considerations include value-based payment, or similar pay for quality initiatives, as opposed to traditional fee-for-service models. Value-based models can include pay-for-performance, risk / reward contract strategies, bundled payments, and/or outcomes-based payment models. According to PwC, cost is not the only factor driving the development of new approaches to health care delivery in workers' compensation. Workers' demands for improved care and employers' efforts to harness quality providers are equally important.[8]

Figure 27 Survey Question: *Does your organization use risk / reward-based contracting with medical providers?*
[572 Responses]



Similar to the 2014 study, 2017 results show a small number of organizations are leveraging risk / reward strategies with medical providers (see Figure 27), indicating a clear advantage for those who do. Of the strategies implemented, organizations are more likely to use patient channeling and pay-for-performance strategies, with a slight increase in adoption of these initiatives from the 2014 study (see Table 29).

Table 29 Survey Question: *What risk / reward strategies are used with medical providers? Select all that apply. (Conditional question for those who answered "Yes" in Figure 27)*
[28 Responses]

	2017			2014	
Answer	count	% of Sub-Sample Responses	% of Entire Response Sample	count	% of Entire Response Sample
Referral or Patient Channeling	17	61%	3%	7	2%
Pay for Performance / Higher Reimbursement Rate	15	54%	3%	6	1%
Fast Track Payments	11	39%	2%	6	1%
Decreased / No Utilization Review	10	36%	2%	7	2%
Limited Bill Review	8	29%	1%	3	1%
Other	-	-	-	3	1%

Note: Participants were able to select more than one answer for this question

The industry has clearly identified medical management as a top priority throughout the 2017 study, as well as in other well-respected industry research. As more claims departments outsource medical management functions to vendor partners, there is a growing need to leverage risk / reward performance strategies.

The 2017 results indicate only 24 percent of respondents use risk / reward strategies with medical management vendor partners; the same results as the 2014 study (see Figure 28). A small increase in the use of service level agreements (SLAs) is noted, a step in the right direction to incentivize quality and performance with vendor partners. Considering the prevalence of medical management outsourcing, with nine of the 10 programs surveyed being predominantly outsourced (see Table 28), there is a significant industry opportunity to improve program effectiveness by implementing performance strategies with vendor partners. Higher performing organizations are more likely to leverage risk / reward strategies with vendor partners.

Figure 28 Survey Question: *Do you use performance strategies to incentivize or hold medical management vendor partners accountable?*
[572 Responses]

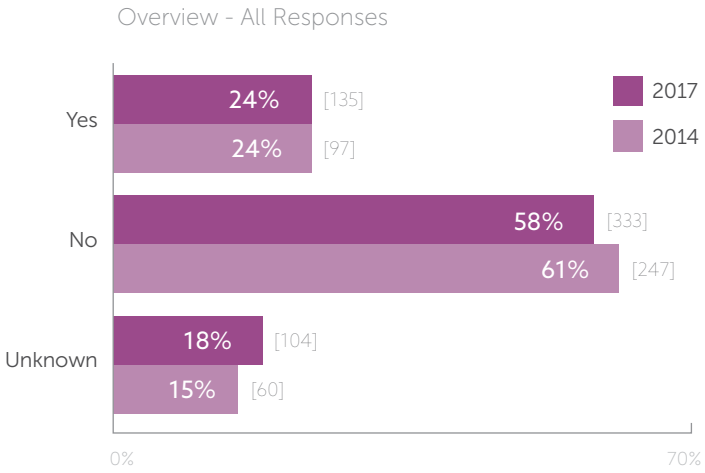


Table 30 Survey Question: *What performance strategies are used to incentivize or hold medical management vendor partners accountable? Select all that apply. (Conditional question for those who answered "Yes" in Figure 28)*
[135 Responses]

	2017			2014	
Answer	count	% of Sub-Sample Responses	% of Entire Response Sample	count	% of Entire Response Sample
Service Level Agreement (SLA) with Performance Standards & Financial Commitments	86	64%	15%	54	13%
Increased Volume Based on Performance	53	39%	9%	54	13%
Decreased Volume Based on Performance	42	31%	7%	38	9%
Fast-Track Payments	37	27%	6%	17	4%
Limited Bill Review	20	15%	3%	13	3%
Decreased UR Requirements	18	13%	3%	12	3%
Pay-for-Performance Measures	15	11%	3%	13	3%
Other	3	2%	1%	-	-

Note: Participants were able to select more than one answer for this question

Claims leaders consistently identify top medical cost drivers

Knowing your organization's top medical cost drivers is imperative to effectively manage and implement meaningful programs. Depending on the mix of industries and injuries, some organizations may experience different utilization of medical services. According to NCCI, provider and hospital payments account for 80 percent of medical costs.[9] Changes in payments for these services can have a significant impact on organizational expenditures. Participants rank medical providers as the top 2017 cost driver, followed closely by in-patient / hospital and pharmacy costs, the same three priorities were identified in the 2014 study.

Top 3 Ranked Medical Cost Drivers

1. Medical Provider / Physicians
2. In-Patient / Hospital
3. Pharmacy

Table 31 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."*
[572 Responses]

Answer	Overall Rank	Mean
Medical Provider / Physicians	1	3.04
In-Patient / Hospital	2	3.53
Pharmacy	3	3.88
Physical / Occupational Therapy Services	4	4.30
Ambulatory Surgery Centers / Out-Patient Surgery Centers	5	4.39
Diagnostics (i.e. MRI, CT, X-Ray)	6	4.82
Durable Medical Equipment	7	7.25
Medical Cost Containment Services	8	7.45
Home Health Care	9	7.85
Medical Transportation	10	8.51

Pharmacy continues to be top of mind

Claims leaders continue to rank pharmacy spending as one of their top issues. Driving this concern are several macroeconomic factors, including growing costs of specialty drugs, cost inflation of generic drugs, and the ongoing prevalence of opioids as well as concomitant drug therapy (i.e. other classes of medications with a sedating effect). Recent WCRI research revealed decreases in the frequency of opioids prescribed to injured workers, however, higher utilization in older claims and dangerous combination therapy was also identified.[10]

Concurrent use of opioids and benzodiazepines is associated with adverse patient outcomes, as well as increased workers' compensation costs. The combination therapy was involved in an alarming 31 percent of opioid overdose deaths in 2014. The CDC guidelines recommend providers avoid prescribing opioids and benzodiazepines combination therapy due to the risk of potentially fatal overdoses.[11] According to WCRI, despite these concerns, opioids and benzodiazepines were prescribed within one week of each other in a significant number of claims. Additionally, and even more alarming, the "Holy Trinity" of opioids, benzodiazepines, and muscle relaxants were frequently used concurrently by injured workers in all states studied.[12]

The 2017 results show an overall decline in pharmacy as a percentage of medical spending from the 2014 study. This is consistent with industry research which indicates that the influence of recent legislative initiatives, including state formularies and use of prescription drug monitoring programs (PDMPs), has impacted pharmacy utilization. Additionally, clinical programs – such as designated pharmacy nurses who collaborate closely with pharmacy-benefit management programs to ensure injured worker safety and appropriate prescription use within evidence-based medicine guidelines – has impacted outcomes and overall pharmacy spending among workers' compensation payers. However, there is still much to be done to rein in the opioid epidemic and combination therapy among injured workers, as well as nationally across the health care delivery system.

Table 32 Survey Question: *What percentage of your overall medical spend is attributable to pharmacy?*
[572 Responses]

Answer	count	%
1 - 5%	79	14%
6 - 10%	103	18%
11 - 15%	72	13%
16 - 20%	49	9%
21 - 25%	48	8%
26 - 30%	23	4%
≥ 31%	33	6%
Not Applicable / Unknown	165	28%

Appendix E Index – Medical Performance Management

For more information on all survey question results and additional benchmark analyses related to this focus area, please refer to the below tables and figures in **Appendix E**.

[1] Medical Price Index for Workers' Compensation NCCI 2017. Available: https://www.ncci.com/Articles/Documents/II_MPI-WC-Study.pdf

[2] NCCI State of The Line Guide 2017. Available: https://www.ncci.com/Articles/Documents/II_AIS2017-SOL-Guide.pdf

[3] Medical Cost Trends Behind the Numbers 2018. PwC Health Research Institute. Available: https://www.pwc.com/us/en/health-industries/health-research-institute/behind-the-numbers.html

[4] NCCI 2015 State of The Line – Analysis of Workers' Compensation Results. Available: https://www.ncci.com/Articles/Documents/II_AIS-2015-SOTL-Article.pdf

[5] Agency for Healthcare Research and Quality The Institute of Medicine's Health Care Quality Initiative. Available: https://www.ahrq.gov/professionals/quality-patient-safety/talkingquality/resources/initiatives/imqi.html

[6] Elizabeth McGlynn, Stephen Asch, John Adams, et al., The Quality of Care Delivered to Adults in the United States, The New England Journal of Medicine 348, no. 26 (June 2003): 2,641. Available: http://www.nejm.org/doi/full/10.1056/NEJMsa022615

[7] Oliver Wyman, "Bringing Value-Based Healthcare to Workers' Compensation." Jan 2014. Available at: http://www.oliverwyman.com/insights/publications/2014/jan/bringing-value-based-healthcare-to-workers-compensation.html#.VDKqiPm4yHN

[8] High-Performance Health Networks: A Methodical Approach Creates a Right to Win. PwC Strategy. 2015. Available: https://www.strategyand.pwc.com/reports/high-performance-health-networks

[9] NCCI Workers' Compensation 2016 Issues Report Fall Edition. Available: https://www.ncci.com/Articles/Pages/II_IssuesReport.aspx

[10] WCRI Interstate Variations in Use of Opioids, 4th Edition. Vennela Thumula, Dongchun Wang, and Te-Chun Liu. June 2017. WC-17-28. Available: https://www.wcrinet.org/reports/interstate-variations-in-use-of-opioids-4th-edition

[11] CDC Guidelines for Prescribing Opioids for Chronic Pain. Available: https://www.cdc.gov/drugoverdose/prescribing/guideline.html

[12] WCRI Spotlight June 2017: Concomitant Use of Opioids and Benzodiazepines, Other Central Nervous Depressants. http://www.wcrinet.org/images/uploads/files/Opioidspotlight.rev4_.pdf

Conclusion

Since its inception, the Workers' Compensation Benchmarking Study has conducted research for, *and with*, claims leaders to provide organizations with a means for evaluating strategic aspects of their claim operations alongside industry peers.

From its initial identification of widespread claims challenges / opportunities in **2013** and **2014**, to the **2015** Study's "solutions roadmap" for future advancement, to identifying *how* and *what* high performing claims organizations are doing differently than lower performing peers in **2016**, the annual Report continually reveals the cumulative intelligence of the workers' compensation claims community.

Reprising its 2014 survey questions, the 2017 Study not only further specifies the high performer's profile on an expanded set of successful behaviors, it also benchmarks the industry's overall progress in the past three years. The 2017 Study also continues its exploration of the emerging claims advocacy approach to engaging injured workers.

The 2017 Report is the fifth Workers' Compensation Benchmarking Study directed and published by Rising Medical Solutions. To learn more or to access the study's online Resource Center, visit: www.risingms.com.

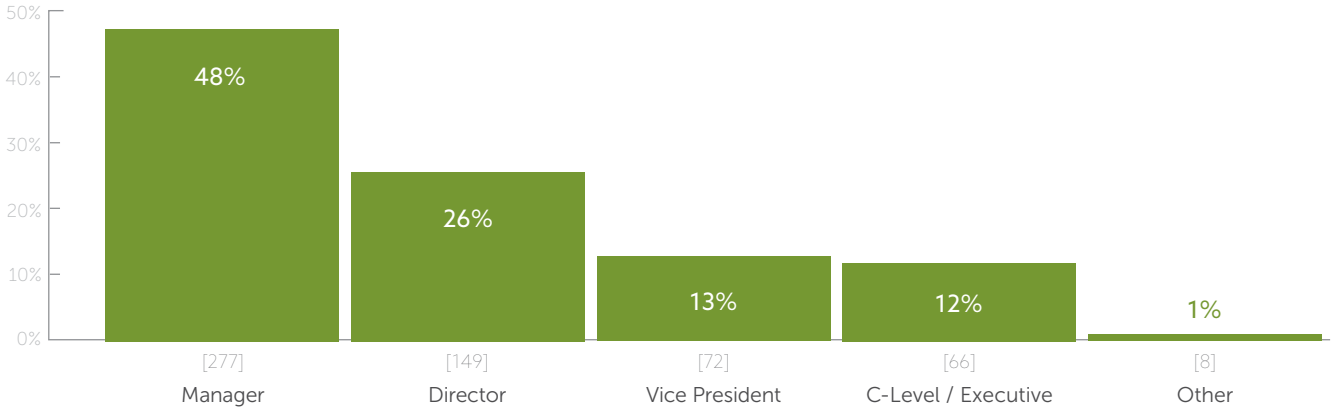
Contact

We welcome your reaction to the 2017 Workers' Compensation Benchmarking Study. Please let us know if you find the study useful, have questions about the research, or would like to participate in future studies by contacting Rachel Fikes, VP & Study Program Director, at Rising Medical Solutions: wcbenchmark@risingms.com.

Appendix A - Survey Participant Demographics

1 Role / Level of Responsibility:

[572 responses]



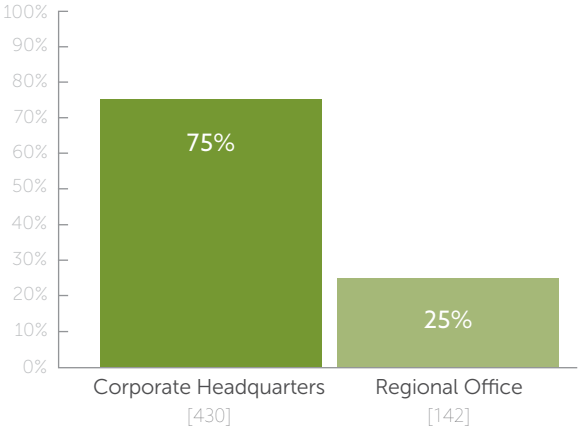
2 Organization Type:

[572 responses]

Answer	count	%
Self-Insured Employer	169	30%
Insurance Company	109	19%
Insured Employer	94	16%
Third Party Administrator	80	14%
Governmental Entity	55	10%
Risk Pool	26	4%
Other	22	4%
State Fund / Mutual Fund	13	2%
Reinsurance or Excess Insurance Company	4	1%

3 Location:

[572 responses]



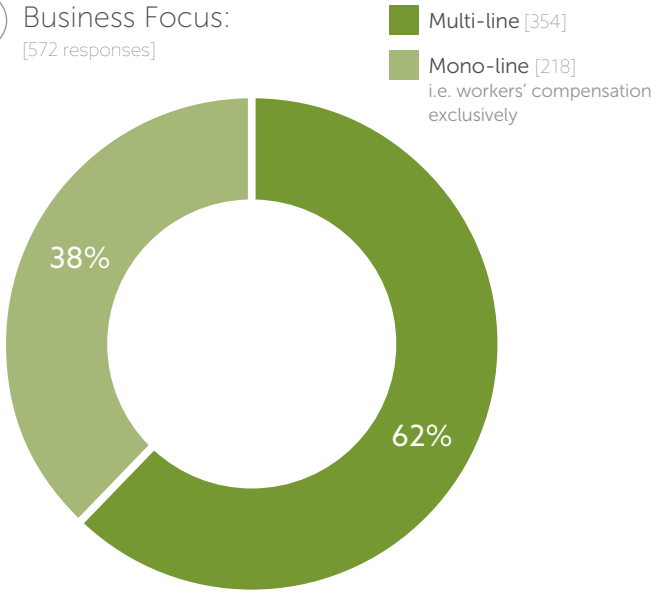
4 My organization's workers' compensation claims are predominately managed by a(n):

[572 responses]

Answer	count	%
Third Party Administrator	287	50%
Insurance Company / State Fund / Mutual Fund	171	30%
Self-Insured / Self-Administered	114	20%

5 Business Focus:

[572 responses]



6 Geographic Focus:

[572 responses]

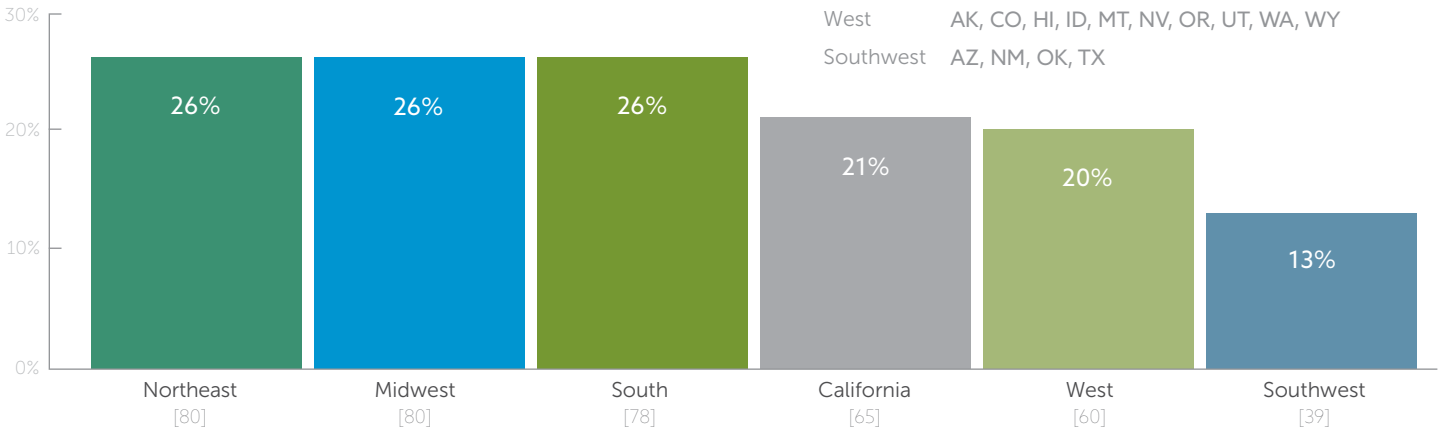
Answer	count	%
Regional in Scope	304	53%
National in Scope	268	47%

Conditional Question for those who selected "Regional in Scope" in Question 6

6.1 Indicate the Regions where your company currently manages workers' compensation claims. Select all that apply.

[304 responses]

Northeast	CT, DC, ME, MA, NH, RI, VT, DE, MD, NJ, NY, PA
Midwest	IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, SD, WI
South	AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, VA, WV
California	CA
West	AK, CO, HI, ID, MT, NV, OR, UT, WA, WY
Southwest	AZ, NM, OK, TX



Note: Participants were able to select more than one answer for this question

7 Organizational Size - Total Annual Claims Dollars Paid: (if unknown, select "Unknown")

[572 responses]

Overview - All Responses

Answer	count	%
< $25 Million	213	37%
> $25 Million to $100 Million	87	15%
> $100 Million to $350 Million	62	11%
> $350 Million to $750 Million	29	5%
> $750 Million	70	12%
Unknown	111	20%

Responses Segmented by Organization Type

Answer	Insurance Company	Reinsurance or Excess Insurance Company	Third Party Administrator	Self-Insured Employer	Insured Employer	Risk Pool	State Fund / Mutual Fund	Gov't Entity	Other
respondent # by organization type	109	4	80	169	94	26	13	55	22
< $25 Million	9%	-	18%	49%	56%	58%	8%	66%	9%
>$25 Million to $100 Million	13%	25%	21%	12%	12%	27%	46%	16%	5%
> $100 Million to $350 Million	27%	-	15%	6%	7%	4%	8%	2%	5%
> $350 Million to $750 Million	11%	25%	5%	5%	-	-	-	5%	-
> $750 Million	19%	-	14%	11%	12%	4%	15%	5%	14%
Unknown	21%	50%	27%	17%	13%	7%	23%	6%	67%

8 Organization Size - Total Annual Premium: (if not applicable or unknown, select "Not Applicable" or "Unknown")

[572 responses]

Overview - All Responses

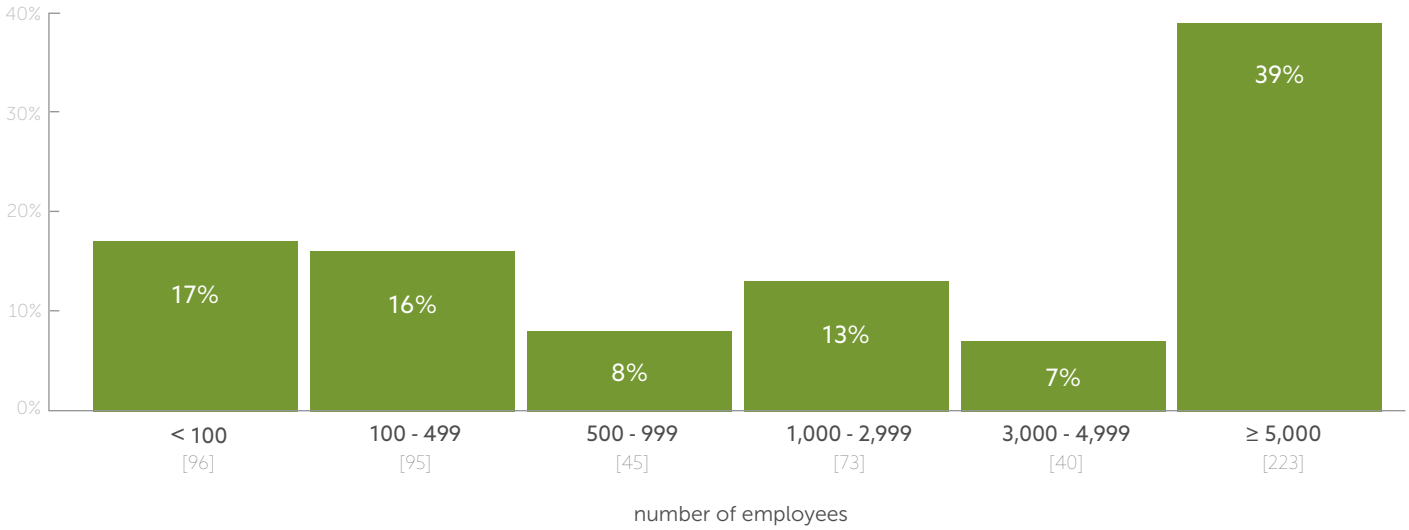
Answer	count	%
< $25 Million	176	31%
> $25 Million to $100 Million	51	9%
> $100 Million to $350 Million	48	8%
> $350 Million to $750 Million	24	4%
> $750 Million	60	11%
Unknown	103	18%
Not Applicable	110	19%

Responses Segmented by Organization Type

Answer	Insurance Company	Reinsurance or Excess Insurance Company	Third Party Administrator	Self-Insured Employer	Insured Employer	Risk Pool	State Fund / Mutual Fund	Gov't Entity	Other
respondent # by organization type	109	4	80	169	94	26	13	55	22
< $25 Million	8%	-	24%	33%	55%	31%	8%	53%	9%
> $25 Million to $100 Million	11%	-	5%	6%	7%	35%	23%	7%	9%
> $100 Million to $350 Million	21%	25%	5%	4%	5%	12%	31%	-	5%
> $350 Million to $750 Million	16%	-	4%	1%	2%	-	-	-	-
> $750 Million	31%	25%	4%	7%	3%	-	15%	2%	23%
Unknown	8%	50%	28%	19%	20%	14%	15%	13%	22%
Not Applicable	5%	-	30%	30%	8%	8%	8%	25%	32%

9 Organization Size - Total Employee Headcount:

[572 responses]



10 What is your organization's average Lost Time caseload per Lost Time Claims Examiner? (if unknown, select "Unknown")

[572 responses]

Overview - All Responses

	2017		2014	
Answer (# of cases)	count	%	count	%
< 80	153	27%	95	24%
80 to 100	82	14%	40	10%
100 to 125	109	19%	55	14%
125 to 150	111	20%	102	25%
150 to 175	25	4%	23	6%
175 to 200	10	2%	12	3%
200 to 225	8	1%	3	1%
225 to 250	1	< 1%	3	1%
250 to 275	1	< 1%	1	< 1%
275 to 300	1	< 1%	-	-
> 300	4	1%	2	< 1%
Unknown	67	12%	68	16%

[10 cont'd] What is your organization's average Lost Time caseload per Lost Time Claims Examiner? (if unknown, select "Unknown")

Responses Segmented by Organization Type

Answer (# of cases)	Insurance Company	Reinsurance or Excess Insurance Company	Third Party Administrator	Self-Insured Employer	Insured Employer	Risk Pool	State Fund / Mutual Fund	Gov't Entity	Other
respondent # by organization type	109	4	80	169	94	26	13	55	22
< 80	13%	-	11%	33%	43%	15%	15%	47%	9%
80 to 100	26%	-	18%	11%	10%	15%	23%	9%	-
100 to 125	29%	-	13%	21%	13%	42%	31%	5%	5%
125 to 150	19%	-	43%	17%	14%	15%	-	13%	18%
150 to 175	4%	-	9%	5%	2%	-	15%	4%	-
175 to 200	2%	25%	1%	2%	1%	-	-	4%	-
200 to 225	-	-	1%	1%	2%	-	8%	2%	5%
225 to 250	-	25%	-	-	-	-	-	-	-
250 to 275	-	-	-	-	1%	-	-	-	-
275 to 300	-	-	-	-	-	-	-	2%	-
> 300	1%	25%	1%	-	1%	-	-	-	-
Unknown	6%	25%	3%	10%	13%	13%	8%	14%	63%

Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer (# of cases)	count	≤ 50%	51% to 60%	61 % to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥ 151%	Unknown
< 80	153	5%	8%	8%	13%	13%	27%	11%	1%	-	-	-	1%	13%
80 to 100	82	5%	9%	11%	9%	9%	17%	21%	5%	1%	-	-	1%	12%
100 to 125	109	1%	2%	6%	8%	12%	21%	28%	8%	-	-	1%	-	13%
125 to 150	111	6%	4%	2%	5%	7%	32%	29%	6%	2%	-	-	-	7%
150 to 175	25	8%	8%	8%	4%	8%	28%	20%	4%	-	-	-	-	12%
175 to 200	10	-	-	-	20%	-	30%	10%	20%	-	-	-	-	20%
200 to 225	8	13%	-	13%	13%	25%	-	12%	12%	-	-	-	-	12%
225 to 250	1	-	-	-	-	-	-	-	-	-	-	-	-	100%
250 to 275	1	-	-	-	-	-	-	-	-	-	-	-	-	100%
275 to 300	1	100%	-	-	-	-	-	-	-	-	-	-	-	-
> 300	4	-	-	-	25%	-	50%	25%	-	-	-	-	-	-
Unknown	67	3%	4%	2%	3%	9%	10%	2%	-	-	-	-	-	67%

11 Claims Resolution - What is your overall claims closure ratio for calendar year 2016? (Claims closure ratio is defined as the number of claims closed divided by the number of claims received during a calendar year period.) (if unknown, select "Unknown") [572 responses]

Overview - All Responses

	2017		2014	
Answer	count	%	count	%
≤ 50%	26	5%	12	3%
51 to 60%	30	5%	8	2%
61 to 70%	33	6%	13	3%
71 to 80%	49	9%	17	4%
81 to 90%	58	10%	34	8%
91 to 100%	134	23%	67	17%
101 to 110%	106	19%	72	18%
111 to 120%	25	4%	15	4%
121 to 130%	3	1%	2	< 1%
131 to 140%	-	-	2	< 1%
141 to 150%	1	< 1%	-	-
≥ 151%	2	< 1%	6	2%
Unknown	105	18%	156	39%

Responses Segmented by Organization Type

Answer	Insurance Company	Reinsurance or Excess Insurance Company	Third Party Administrator	Self-Insured Employer	Insured Employer	Risk Pool	State Fund / Mutual Fund	Gov't Entity	Other
respondent # by organization type	109	4	80	169	94	26	13	55	22
≤ 50%	2%	-	3%	4%	7%	3%	-	13%	5%
51 to 60%	3%	-	-	8%	9%	8%	-	5%	5%
61 to 70%	5%	-	5%	5%	9%	8%	15%	4%	5%
71 to 80%	3%	25%	9%	10%	16%	8%	8%	7%	-
81 to 90%	6%	-	11%	10%	14%	8%	8%	11%	14%
91 to 100%	29%	-	25%	24%	21%	31%	8%	20%	5%
101 to 110%	27%	25%	33%	17%	6%	19%	38%	9%	-
111 to 120%	9%	-	5%	4%	1%	4%	-	5%	-
121 to 130%	1%	-	-	< 1%	-	4%	-	-	-
131 to 140%	-	-	-	-	-	-	-	-	-
141 to 150%	-	-	-	< 1%	-	-	-	-	-
≥ 151%	1%	-	-	-	-	-	-	2%	-
Unknown	14%	50%	9%	18%	17%	7%	23%	24%	66%

Appendix B - Prioritizing Core Competencies

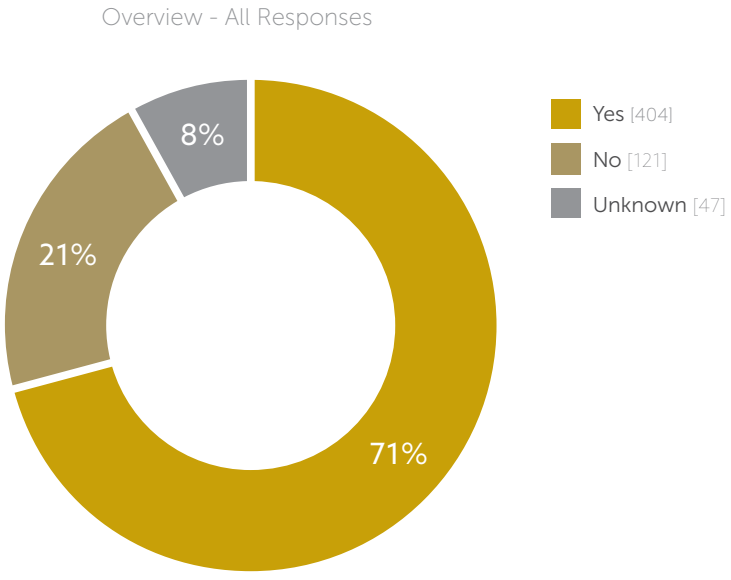
1 Please rank in the order of highest priority the core competencies most critical to claim outcomes, with 1 being the "highest priority" and 10 being the "lower priority."

[572 responses]

Answer	Overall Rank	Mean
Medical Management	1	3.06
Disability / RTW Management	2	3.08
Compensability Investigations	3	3.65
Claim Resolution	4	4.28
Case Reserving	5	5.65
Litigation Management	6	5.99
Oversight Governance / Supervisory Oversight	7	6.47
Bill Review	8	7.03
Fraud & Abuse Detection	9	7.23
Vocational Rehabilitation	10	8.56

2 Does your organization measure best practices / performance within core competencies?

[572 responses]



[2 cont'd] Does your organization measure best practices / performance within core competencies?

Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer	count	≤ 50%	51% to 60%	61 % to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥ 151%	Unknown
Yes	404	4%	4%	5%	7%	9%	26%	24%	5%	1%	-	-	1%	14%
No	121	6%	7%	9%	12%	16%	20%	5%	2%	-	-	-	-	23%
Unknown	47	9%	6%	2%	11%	4%	11%	4%	2%	-	-	2%	-	49%

Conditional Question for those who answered "Yes" in Question 2

2.1 Considering the following core compentencies, please indicate in which areas your organization measures best pratices / performance. Select all that apply.
[404 responses]

Answer	count	% of Sub-Sample Responses	% of Entire Response Sample
Disability / RTW Management	312	77%	55%
Claim Resolution	310	77%	54%
Medical Management	300	74%	52%
Case Reserving	299	74%	52%
Litigation Management	256	63%	45%
Compensability Investigations	246	61%	43%
Bill Review	218	54%	38%
Oversight Governance / Supervisory Oversight	208	51%	36%
Fraud & Abuse Detection	130	32%	23%
Vocational Rehabilitation	66	16%	12%

Note: Participants were able to select more than one answer for this question

Conditional Question for those who answered "Yes" in Question 2, and then segmented by their response in Question 2.1

2.2 Indicate, on average, how often your organization measures best practices / performance within core competencies for each area.

[404 responses]

Answer	count	Real-Time / Daily	Weekly	Monthly	Semi-Monthly	Quarterly	Biannually	Annually
Disability / RTW Management	312	30%	12%	31%	1%	16%	4%	6%
Claim Resolution	310	18%	5%	45%	2%	18%	4%	8%
Medical Management	300	26%	10%	36%	1%	17%	4%	7%
Case Reserving	299	24%	6%	36%	1%	22%	3%	8%
Litigation Management	256	14%	4%	36%	3%	27%	6%	10%
Compensability Investigations	246	29%	7%	33%	2%	18%	5%	7%
Bill Review	218	23%	11%	36%	2%	17%	3%	9%
Oversight Governance / Supervisory Oversight	208	22%	7%	32%	3%	20%	6%	10%
Fraud & Abuse Detection	130	22%	7%	28%	3%	25%	6%	9%
Vocational Rehabilitation	66	12%	8%	38%	5%	21%	6%	11%

Conditional Question for those who answered "No" in Question 2

2.3 What are the primary limitations / reasons for not measuring best practices / performance within core competencies? Select all that apply.

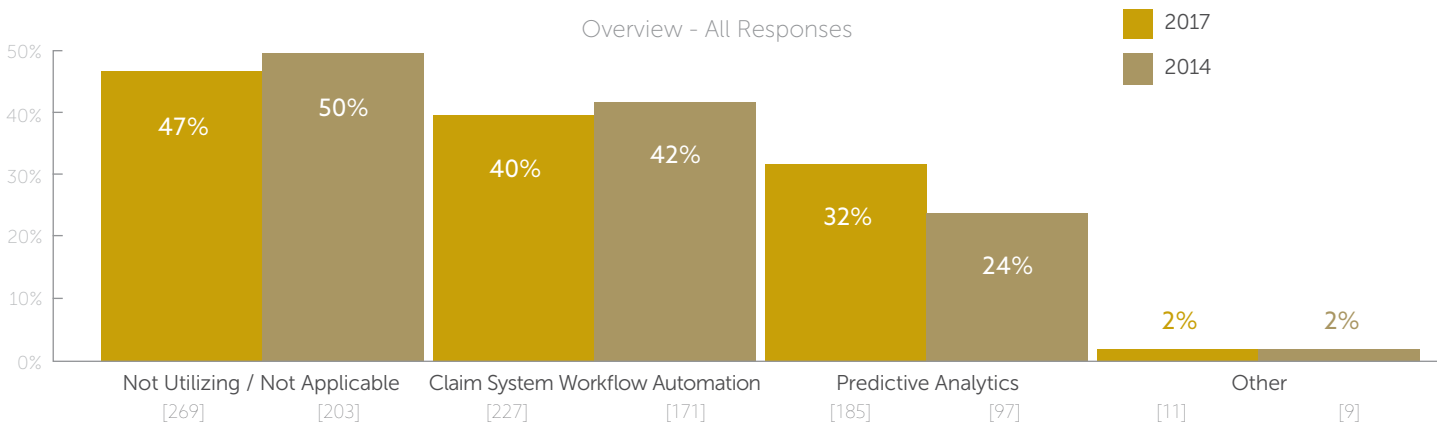
[121 responses]

Answer	count	% of Sub-Sample Responses	% of Entire Response Sample
Data / system limitations	42	35%	7%
Not a business priority	37	31%	6%
Unsure how to operationalize	36	30%	6%
Other	19	16%	3%
Financial limitations	6	5%	1%

Note: Participants were able to select more than one answer for this question

3 Does your organization utilize any of the following systems to direct or manage tasks within best practices? Select all that apply. (If no, select "Not Applicable")

[572 responses]



Note: Participants were able to select more than one answer for this question

Responses Segmented by Organization Type

Answer	Insurance Company	Reinsurance or Excess Insurance Company	Third Party Administrator	Self-Insured Employer	Insured Employer	Risk Pool	State Fund / Mutual Fund	Gov't Entity	Other
respondent # by organization type	109	4	80	169	94	26	13	55	22
Not Utilizing / Not Applicable	32%	25%	31%	55%	57%	23%	31%	67%	64%
Claim System Workflow Automation	50%	75%	61%	30%	27%	73%	46%	27%	18%
Predictive Analytics	50%	50%	39%	27%	28%	35%	38%	9%	32%
Other	1%	-	1%	3%	1%	8%	-	-	5%

Note: Participants were able to select more than one answer for this question

Responses Segmented by Claims Closure Ratio / Claims Resolution

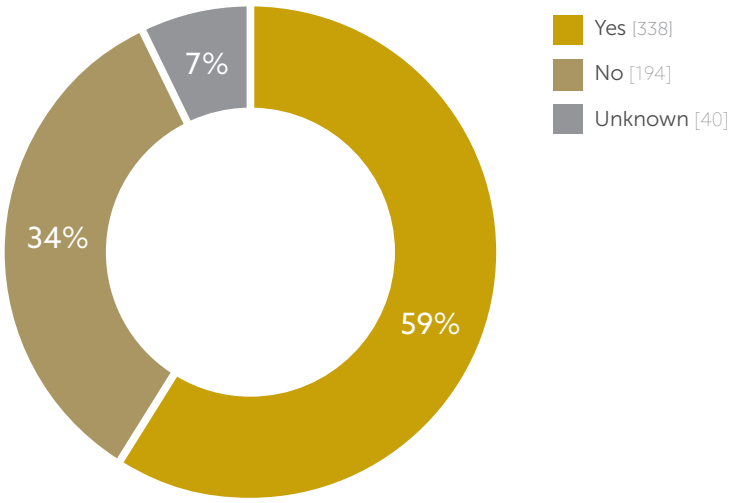
Answer	count	≤ 50%	51% to 60%	61 % to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥ 151%	Unknown
Not Utilizing / Not Applicable	269	6%	7%	3%	12%	12%	20%	13%	2%	-	-	-	-	25%
Claim System Workflow Automation	227	3%	3%	8%	5%	8%	26%	27%	6%	-	-	-	-	14%
Predictive Analytics	185	3%	3%	7%	4%	10%	26%	24%	8%	1%	-	1%	1%	12%
Other	11	9%	-	9%	9%	9%	27%	27%	-	-	-	-	-	10%

Note: Participants were able to select more than one answer for this question

4 Does your organization use an audit or quality assurance program focused on claim outcomes for operational performance?

[572 responses]

Overview - All Responses

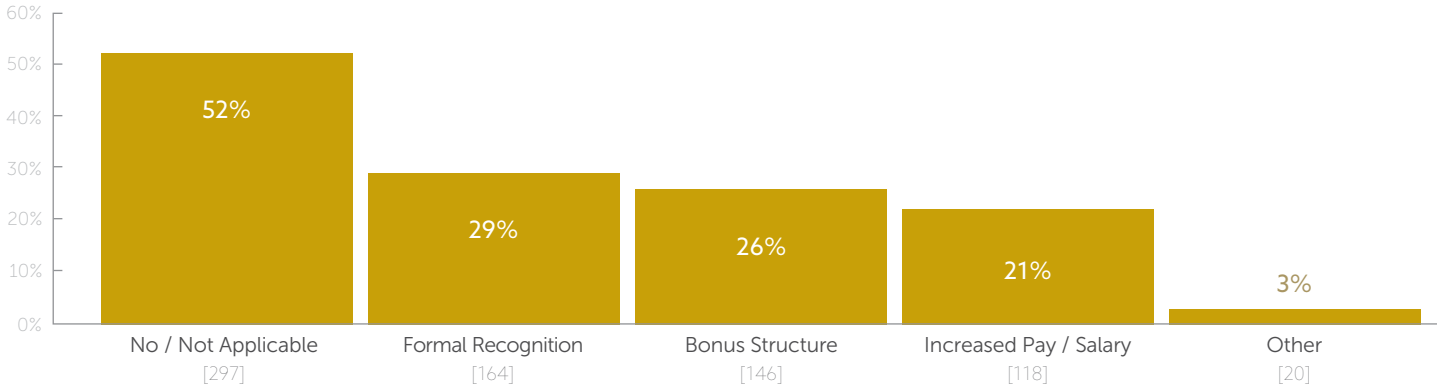


Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer	count	≤ 50%	51% to 60%	61 % to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥ 151%	Unknown
Yes	338	4%	4%	6%	8%	9%	24%	24%	5%	1%	-	-	1%	14%
No	194	5%	7%	7%	11%	12%	25%	11%	4%	1%	-	-	-	17%
Unknown	40	8%	3%	-	5%	8%	15%	10%	3%	-	-	-	-	48%

5 Does your organization utilize incentives for staff to achieve best practices / performance measures? Select all that apply. (If no, select "Not Applicable") [572 responses]

Overview - All Responses



Note: Participants were able to select more than one answer for this question

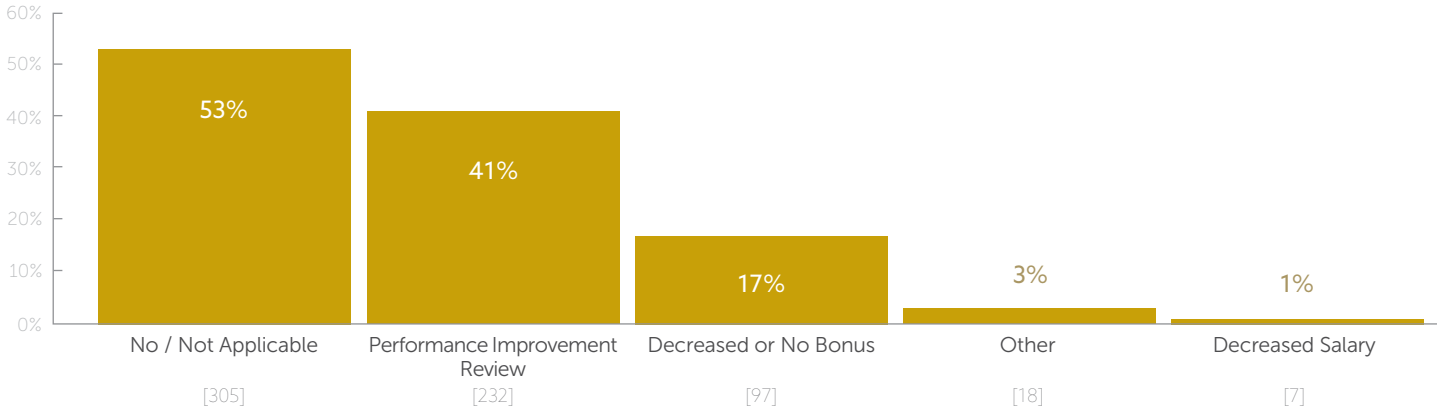
Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer	≤ 50%	51% to 60%	61 % to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥ 151%	Unknown
count	26	30	33	49	58	134	106	25	3	0	1	2	105
No / Not Applicable	73%	63%	73%	53%	57%	40%	33%	48%	67%	-	100%	50%	68%
Formal Recognition	12%	17%	12%	33%	31%	32%	40%	48%	-	-	-	50%	19%
Bonus Structure	12%	20%	15%	24%	22%	28%	40%	24%	33%	-	-	50%	19%
Increased Pay / Salary	-	-	6%	18%	10%	23%	43%	24%	33%	-	-	50%	15%
Other	8%	3%	-	4%	2%	5%	4%	8%	-	-	-	-	1%

Note: Participants were able to select more than one answer for this question

6 Does your organization utilize penalties for staff when best practices / performance measures are not met? Select all that apply. (If no, select "Not Applicable") [572 responses]

Overview - All Responses



Note: Participants were able to select more than one answer for this question

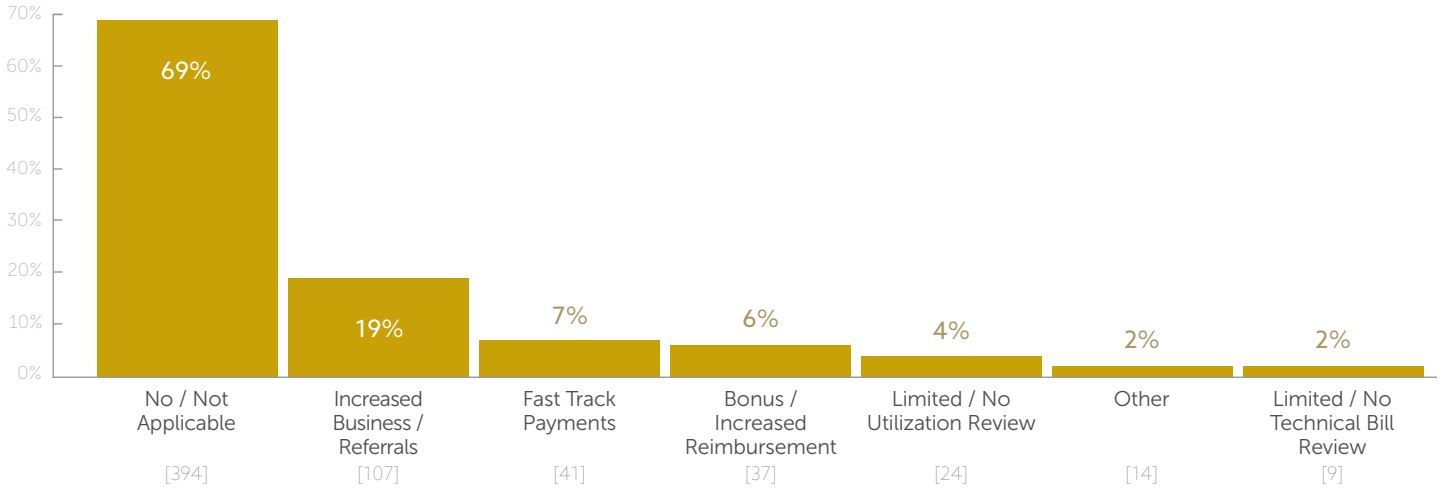
Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer	≤ 50%	51% to 60%	61 % to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥ 151%	Unknown
count	26	30	33	49	58	134	106	25	3	0	1	2	105
No / Not Applicable	65%	67%	73%	55%	64%	45%	36%	44%	33%	-	100%	-	66%
Performance Improvement Review	23%	23%	24%	37%	29%	49%	60%	56%	67%	-	-	100%	27%
Decreased or No Bonus	12%	13%	9%	12%	12%	18%	29%	16%	33%	-	-	50%	12%
Other	12%	-	-	4%	2%	4%	3%	4%	-	-	-	-	3%
Decreased Salary	4%	-	-	2%	-	-	4%	4%	-	-	-	-	-

Note: Participants were able to select more than one answer for this question

7 Does your organization utilize incentives for vendor partners to achieve best practices / performance measures? Select all that apply. (If no, select "Not Applicable") [572 responses]

Overview - All Responses



Note: Participants were able to select more than one answer for this question

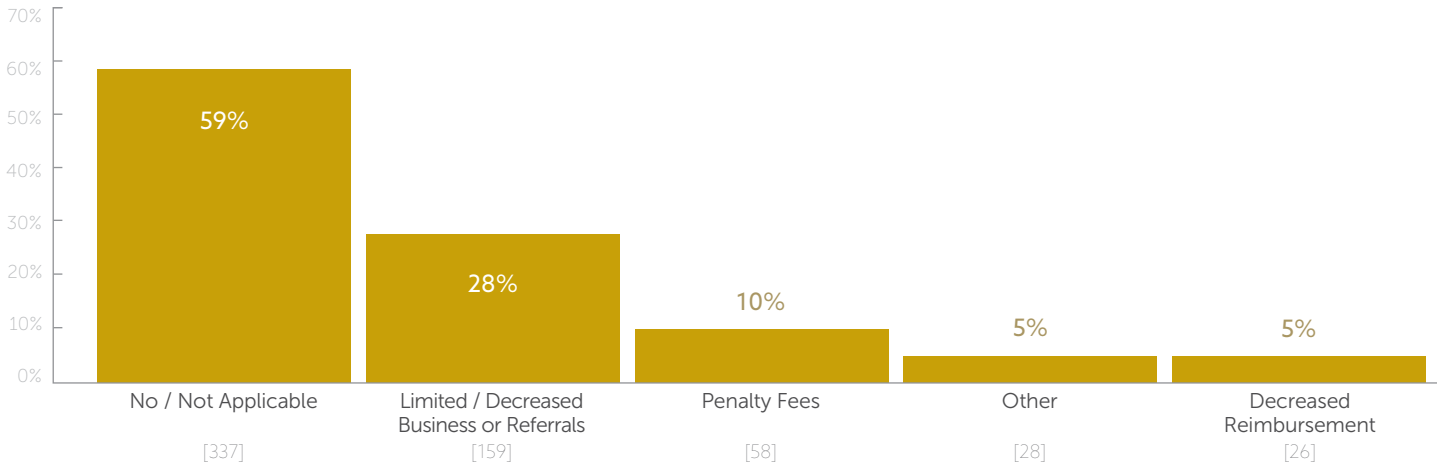
Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer	≤ 50%	51% to 60%	61 % to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥ 151%	Unknown
count	26	30	33	49	58	134	106	25	3	0	1	2	105
No / Not Applicable	81%	80%	73%	76%	78%	65%	55%	56%	67%	-	100%	50%	76%
Increased Business / Referrals	12%	7%	18%	12%	9%	22%	32%	24%	33%	-	-	50%	13%
Fast Track Payments	-	7%	3%	14%	3%	7%	14%	8%	-	-	-	-	3%
Bonus / Increased Reimbursement	-	-	-	2%	9%	5%	14%	8%	-	-	-	-	7%
Limited / No Utilization Review	12%	7%	3%	2%	-	4%	7%	8%	-	-	-	-	2%
Other	-	-	6%	4%	3%	4%	1%	4%	-	-	-	-	1%
Limited / No Technical Bill Review	4%	-	-	4%	2%	1%	3%	-	-	-	-	-	1%

Note: Participants were able to select more than one answer for this question

8 Does your organization utilize penalties for vendor partners when best practices / performance measures are not met? Select all that apply. (If no, select "Not Applicable") [572 responses]

Overview - All Responses



Note: Participants were able to select more than one answer for this question

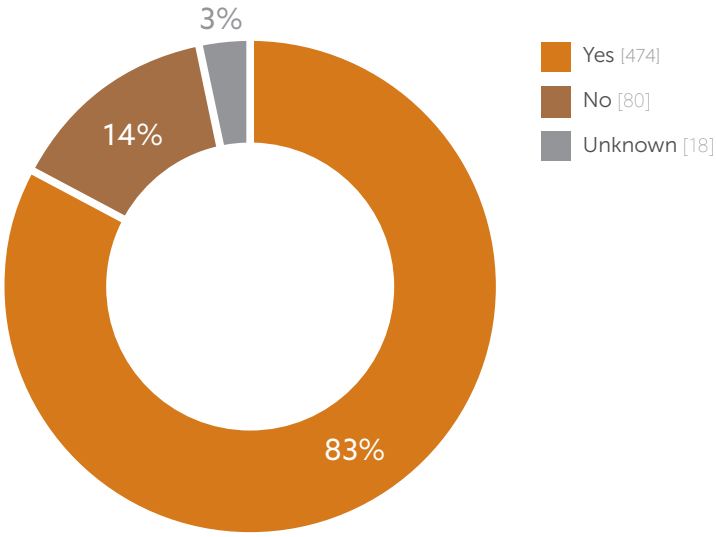
Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer	≤ 50%	51% to 60%	61 % to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥ 151%	Unknown
count	26	30	33	49	58	134	106	25	3	0	1	2	105
No / Not Applicable	69%	73%	70%	69%	62%	57%	44%	52%	33%	-	-	-	64%
Limited / Decreased Business or Referrals	15%	17%	24%	20%	17%	31%	44%	32%	67%	-	-	50%	22%
Penalty Fees	15%	3%	3%	4%	10%	8%	15%	24%	-	-	100%	50%	9%
Other	8%	7%	6%	4%	7%	4%	5%	4%	-	-	-	-	5%
Decreased Reimbursement	8%	3%	-	2%	7%	6%	7%	-	-	-	-	-	3%

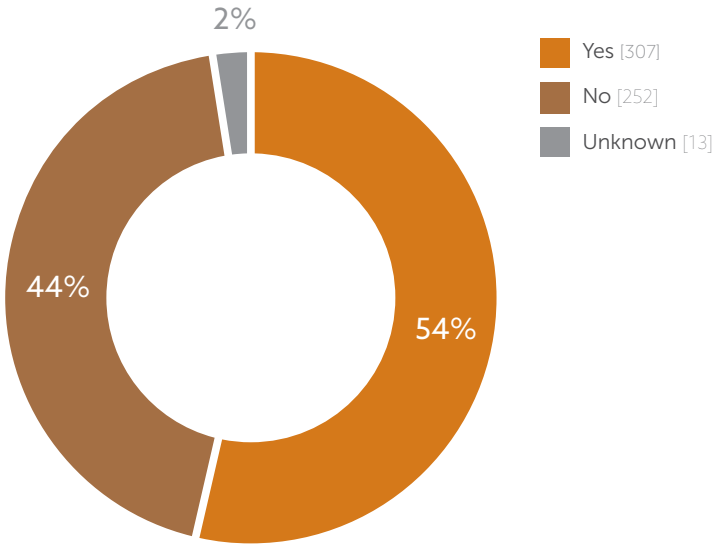
Note: Participants were able to select more than one answer for this question

Appendix C - Talent Development & Retention

1 Is staff development included in your organizational / departmental strategic goals?
[572 responses]



2 Does your organization have a dedicated training and development group?
[572 responses]



[2 cont'd] Does your organization have a dedicated training and development group?

Responses Segmented by Organization Type

Answer	Insurance Company	Reinsurance or Excess Insurance Company	Third Party Administrator	Self-Insured Employer	Insured Employer	Risk Pool	State Fund / Mutual Fund	Gov't Entity	Other
respondent # by organization type	109	4	80	169	94	26	13	55	22
Yes	61%	25%	49%	52%	49%	38%	85%	60%	59%
No	37%	75%	51%	46%	47%	62%	15%	40%	27%
Unknown	2%	-	-	2%	4%	-	-	-	14%

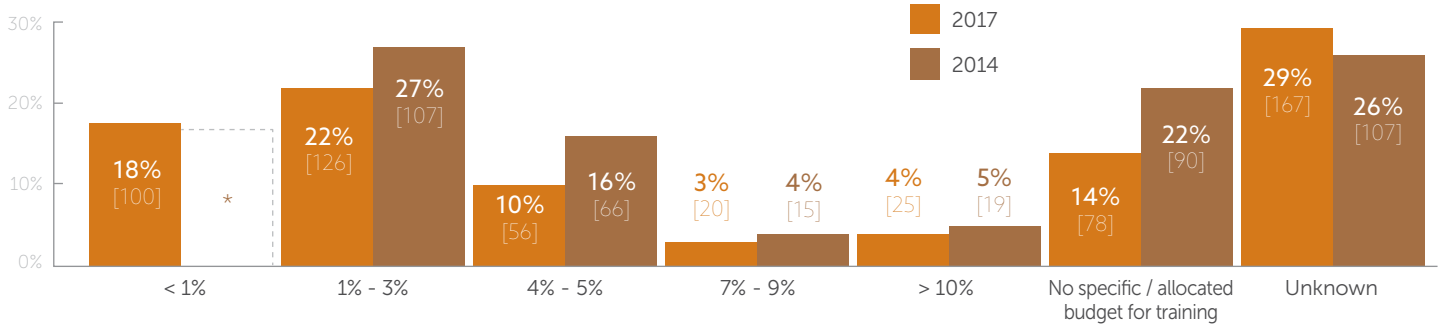
Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer	count	≤50%	51% to 60%	61% to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥151%	Unknown
Yes	307	4%	6%	7%	10%	9%	19%	20%	5%	-	-	-	1%	19%
No	252	5%	5%	4%	6%	11%	29%	17%	4%	1%	-	-	-	18%
Unknown	13	8%	-	-	15%	8%	15%	8%	-	-	-	-	-	46%

3 What percentage of your annual budget is dedicated to staff development and training?

[572 responses]

Overview - All Responses



Percentage of Annual Budget Dedicated to Staff Development / Training

*Note: Answer option of "less than 1%" was not an answer option in the 2014 survey

[3 cont'd] What percentage of your annual budget is dedicated to staff development and training?

Responses Segmented by Organization Type

Answer	Insurance Company	Reinsurance or Excess Insurance Company	Third Party Administrator	Self-Insured Employer	Insured Employer	Risk Pool	State Fund / Mutual Fund	Gov't Entity	Other
respondent # by organization type	109	4	80	169	94	26	13	55	22
< 1%	14%	-	16%	21%	12%	12%	15%	35%	9%
1 - 3%	17%	25%	26%	21%	19%	27%	31%	29%	23%
4 - 5%	15%	25%	9%	7%	11%	8%	-	7%	18%
7 - 9%	5%	-	4%	3%	4%	8%	8%	-	-
> 10%	3%	-	6%	2%	6%	4%	-	9%	9%
No specific / allocated budget for training	13%	-	15%	13%	22%	23%	8%	4%	-
Unknown	33%	50%	24%	33%	26%	18%	38%	16%	41%

4 How many years of experience, on average, does a claims examiner need to become an expert in workers' comp claims adjusting?

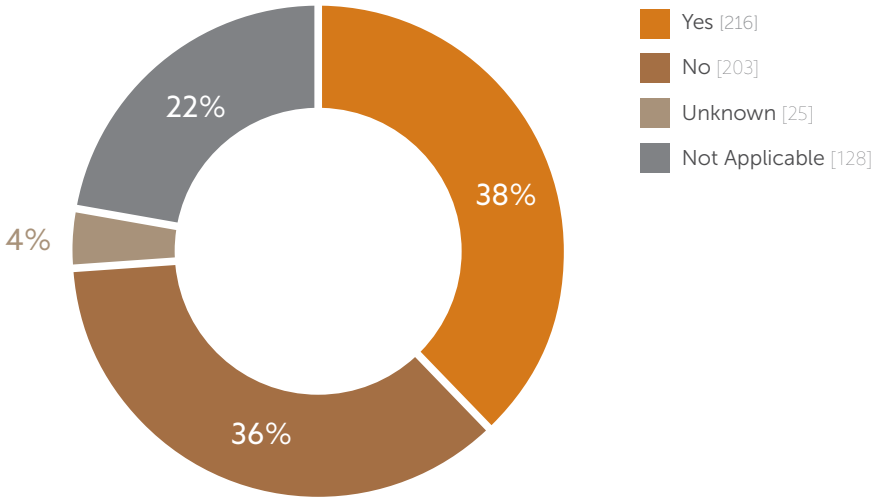
[572 responses]

Answer	count	%
Less than 1 Year	5	1%
1 - 2 Years	19	3%
2 - 3 Years	63	11%
3 - 4 Years	78	14%
4 - 5 Years	148	26%
5 - 6 Years	117	20%
6 - 7 Years	26	5%
7 - 8 Years	20	3%
> 8 Years	96	17%

5 Does your organization have a formal training program for new hire claims staff with no experience to minimal experience?

[572 responses]

Overview - All Responses

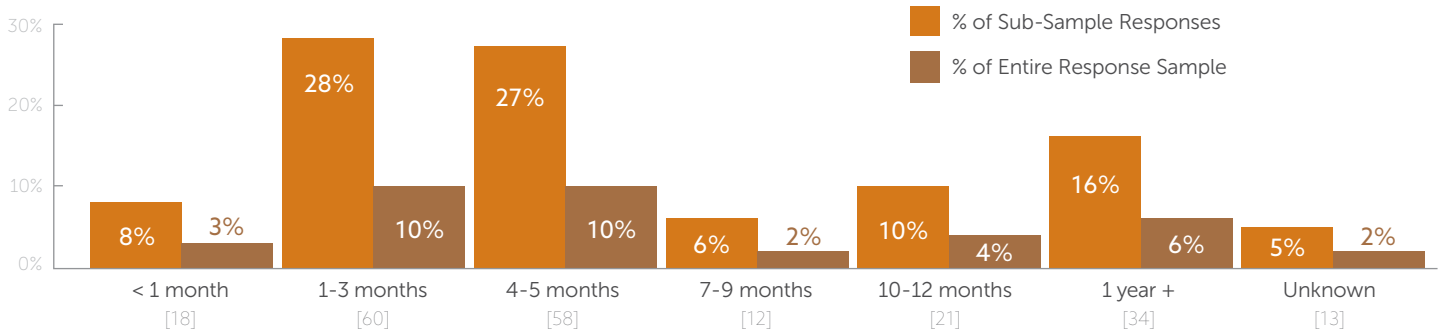


Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer	count	≤50%	51% to 60%	61% to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥151%	Unknown
Yes	216	5%	5%	4%	5%	8%	22%	27%	7%	-	-	-	1%	16%
No	203	2%	6%	5%	8%	12%	29%	16%	1%	1%	-	-	-	20%
Unknown	25	12%	8%	4%	8%	4%	12%	8%	-	-	-	-	-	44%
Not Applicable	128	5%	5%	10%	16%	11%	20%	11%	5%	1%	-	1%	-	15%

Conditional Question for those who answered "Yes" in Question 5

5.1 What is the length of the training program for new hire claims staff with no experience to minimal experience? [216 responses]



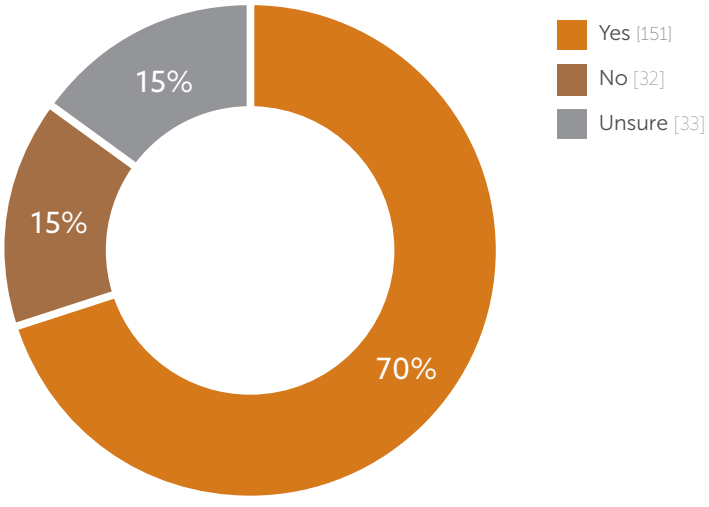
Conditional Question for those who answered "Yes" in Question 5

5.2 Considering your new hire claims staff training program, how many hours of formal / classroom training are dedicated to the program? [216 responses]

Answer	count	% of Sub-Sample Responses	% of Entire Response Sample
1 to 20 hours	72	33%	13%
20 to 40 hours	38	18%	7%
40 to 60 hours	36	17%	6%
60 to 80 hours	18	8%	3%
80 to 100 hours	20	9%	3%
> 100 hours	32	15%	6%

Conditional Question for those who answered "Yes" in Question 5

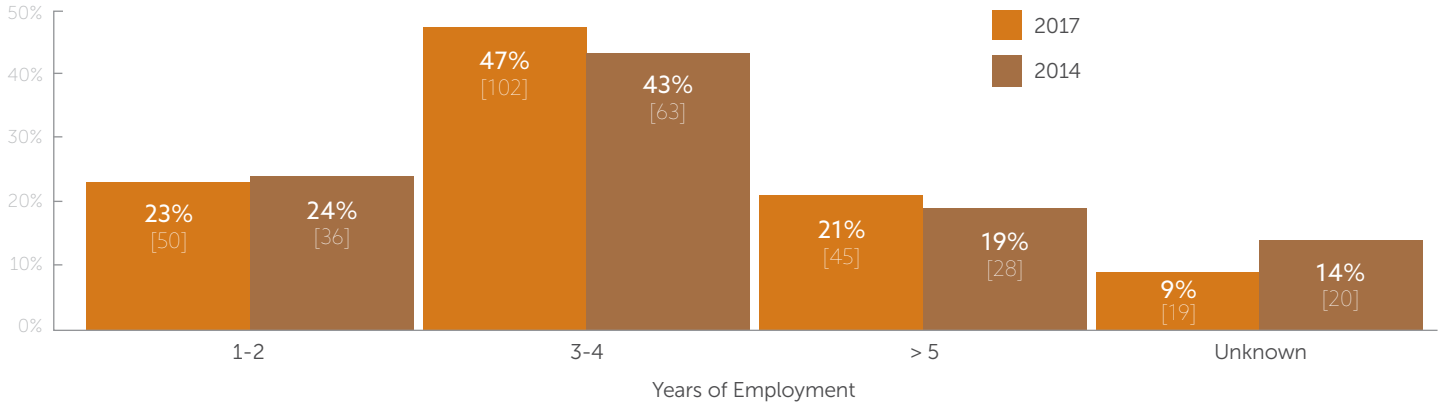
5.3 Overall, do you believe completion of the new hire training program prepares new claims staff to carry a caseload? [216 responses]



Conditional Question for those who answered "Yes" in Question 5

5.4 What do you consider a reasonable ROI for training provided to new hire claims staff?

[216 responses]



6 When do you assign claims to new hire claims staff with no experience to minimal experience?

[572 responses]

Overview - All Responses

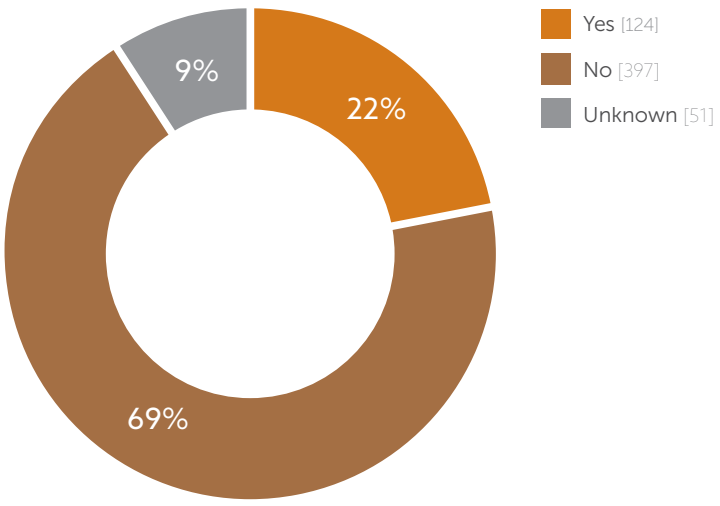
Answer	count	%
Within two weeks of date of hire	58	10%
Four to six weeks after date of hire	128	23%
Three months after date of hire	71	13%
Four months after date of hire	10	2%
Five months after date of hire	2	< 1%
Six months or more after date of hire	41	7%
Unknown	39	7%
Not Applicable	223	38%

[6 cont'd] When do you assign claims to new hire claims staff with no experience to minimal experience?

Reponses Segmented by Hours of Formal / Classroom Training for New Hires

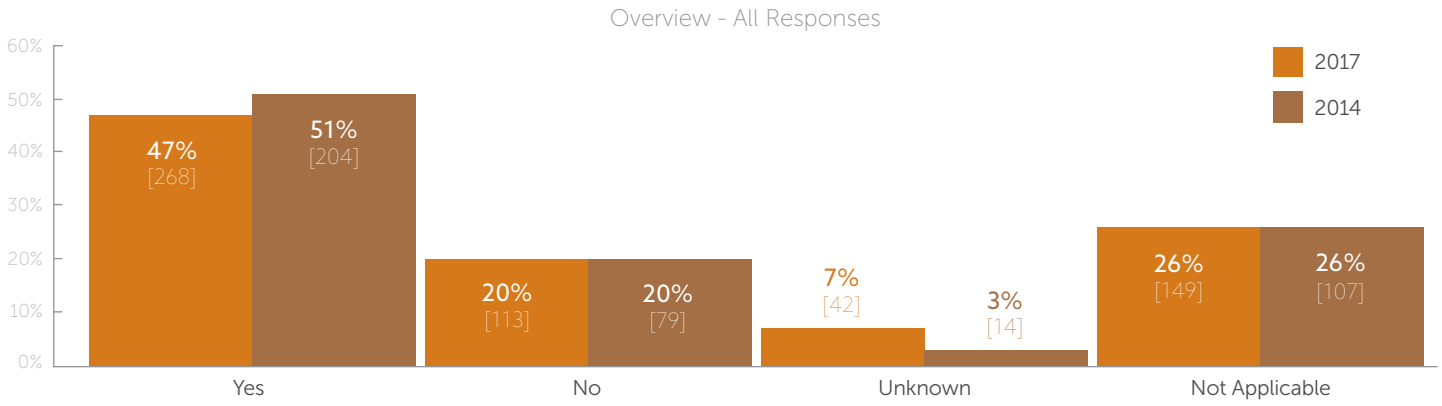
Answer	Hours					
	1 to 20	20 to 40	40 to 60	60 to 80	80 to 100	> 100
respondent # by hours of training for new hires	72	38	36	18	20	32
Within two weeks of date of hire	13%	5%	14%	6%	10%	6%
Four to six weeks after date of hire	46%	50%	44%	33%	45%	22%
Three months after date of hire	21%	24%	19%	28%	20%	34%
Four months after date of hire	-	3%	3%	-	10%	6%
Five months after date of hire	-	3%	-	-	5%	-
Six months or more after date of hire	10%	11%	3%	17%	10%	16%
Unknown	3%	4%	9%	16%	-	7%
Not Applicable	7%	-	8%	-	-	9%

7 Does your organization collaborate with colleges or universities to conduct training, either through custom training programs or degree programs?
[572 responses]



8 Does your organization provide skills training and development programs for senior-level claims adjusters?

[572 responses]



Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer	count	≤50%	51% to 60%	61% to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥151%	Unknown
Yes	268	2%	4%	5%	8%	7%	27%	28%	6%	-	-	-	1%	12%
No	113	4%	5%	4%	7%	15%	23%	13%	4%	1%	-	-	-	24%
Unknown	42	17%	7%	2%	5%	2%	17%	10%	2%	-	-	-	-	38%
Not Applicable	149	5%	7%	9%	12%	14%	19%	8%	2%	1%	-	1%	-	22%

Conditional Question for those who answered "Yes" in Question 8

8.1 On average, how often do senior-level claims adjusters participate in skills training and development?

[268 responses]

Answer	count	% of Sub-Sample Responses	% of Entire Response Sample
Less than once per year	16	6%	3%
Monthly	49	18%	9%
Quarterly	108	40%	19%
Twice a year	56	21%	10%
Annually	39	15%	7%

Conditional Question for those who answered "No" in Question 8

8.2 What is the primary reason / limitation for not providing skills training and development programs for senior-level claims adjusters? [113 responses]

Answer	count	% of Sub-Sample Responses	% of Entire Response Sample
Not a perceived need	40	35%	7%
Other	32	28%	6%
Time constraints / too busy managing claims	22	20%	4%
Budget limitations	19	17%	3%

9 Are formal processes in place to ensure knowledge transfer from senior-level staff to new / less experienced staff? Select all that apply. (If no, select "Not Applicable")
[572 responses]

	2017		2014	
Answer	count	%	count	%
No Processes in Place / Not Applicable	218	38%	180	45%
Oversight governance / supervisory oversight	182	32%	148	37%
Cross-training program	169	30%	100	25%
Regular multidisciplinary strategy / staffing sessions	157	27%	93	23%
Other	32	6%	1	< 1%

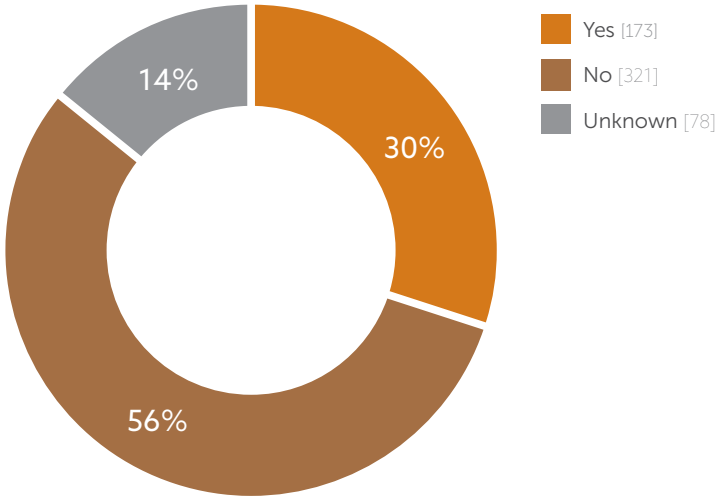
Note: Participants were able to select more than one answer for this question

10 Other than salary and standard benefits, what staff retention benefits / programs are in place for non-management staff? Select all that apply. (If none, select "Not Applicable")
[572 responses]

	2017		2014	
Answer	count	%	count	%
No initiatives currently in place / Not Applicable	81	14%	94	23%
Wellness programs	336	59%	195	48%
Tuition reimbursement	328	57%	199	49%
Professional conference fee reimbursement	297	52%	192	48%
Professional membership dues reimbursement	254	44%	184	46%
Bonus / Profit sharing	243	42%	118	29%
Work from home option	236	41%	102	25%
Time for staff to participate in community outreach programs	215	38%	122	30%
Recognition / rewards for industry designations (i.e., AIC, CPCU, CRM)	209	37%	126	31%
Flextime for exercise during the workday	165	29%	84	21%
Onsite exercise programs	163	28%	100	25%
Four day work-week or other alternative scheduling arrangement	147	26%	79	20%
Gym memberships	116	20%	66	16%
Stock options	43	8%	26	6%
Other	31	5%	4	1%

Note: Participants were able to select more than one answer for this question

11 Does your organization offer a formal career path program with growth opportunities for claims staff?
[572 responses]



12 What is your organization's attrition / turnover rate at the claims adjuster level in the last 12 months? (If not applicable or unknown, please select "Not Applicable / Unknown")

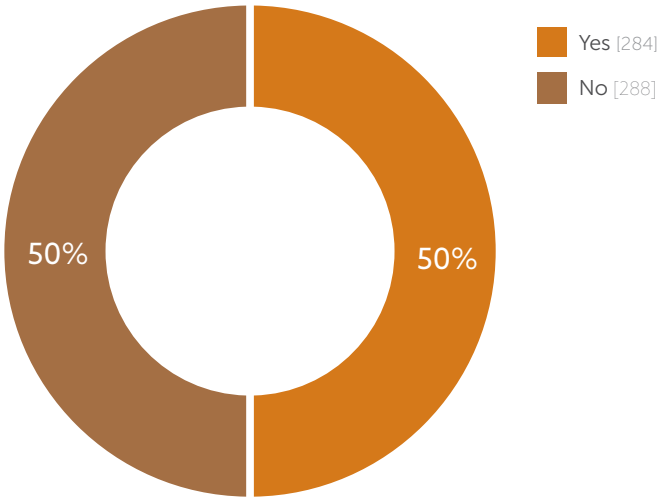
[572 responses]

	2017		2014	
Answer	count	%	count	%
< 10%	278	49%	122	30%
> 10 to 20%	68	12%	46	11%
> 20 to 30%	25	4%	10	2%
> 30 to 40%	7	1%	6	2%
> 40 to 50%	4	1%	2	1%
> 50%	4	1%	7	2%
Not Applicable / Unknown	186	32%	211	52%

13 Do you know what an advocacy-based claims model is?

[572 responses]

Overview - All Responses



Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer	count	≤50%	51% to 60%	61% to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥151%	Unknown
Yes	284	3%	4%	5%	8%	9%	25%	25%	6%	-	-	-	1%	14%
No	288	6%	7%	7%	9%	11%	22%	12%	3%	1%	-	-	-	22%

14 Has your organization considered implementing / adopting an advocacy-based claims model?

[572 responses]

Overview - All Responses

Answer	count	%
Yes, already implemented	159	28%
Yes, will likely implement within the next 1-3 years	52	9%
Considering, no specific implementation plans	110	19%
No, not considering	138	24%
Unknown	113	20%

Responses Segmented by Organization Type

Answer	count	Insurance Company	Reinsurance or Excess Insurance Company	Third Party Administrator	Self-Insured Employer	Insured Employer	Risk Pool	State Fund / Mutual Fund	Governmental Entity	Other
Yes, already implemented	159	20%	-	23%	30%	14%	3%	2%	6%	2%
Yes, will likely implement within the next 1-3 years	52	17%	-	10%	40%	19%	4%	-	10%	-
Considering, no specific implementation plans	110	25%	-	12%	26%	18%	6%	3%	9%	1%
No, not considering	138	20%	3%	14%	24%	15%	5%	3%	13%	3%
Unknown	113	12%	-	6%	35%	19%	4%	3%	12%	9%

Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer	count	≤50%	51% to 60%	61% to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥151%	Unknown
Yes, already implemented	159	4%	4%	8%	7%	10%	22%	23%	5%	1%	-	-	1%	15%
Yes, will likely implement within the next 1-3 years	52	4%	6%	12%	-	8%	27%	25%	12%	-	-	-	-	6%
Considering, no specific implementation plans	110	3%	5%	3%	11%	11%	29%	23%	2%	-	-	1%	1%	11%
No, not considering	138	5%	7%	4%	10%	14%	24%	12%	4%	1%	-	-	-	19%
Unknown	113	6%	5%	5%	11%	6%	18%	12%	4%	-	-	-	-	33%

Conditional Question for those who answered "Yes" in Question 14

14.1 What advocacy-based claims model initiatives have you implemented? Select all that apply.

[159 responses]

Overview - All Responses

Answer	count	% of Sub-Sample Responses	% of Entire Response Sample
Revamped employee / injured worker communications	102	64%	18%
Emphasis on workers' compensation as a benefit delivery system (vs. a claims adjudication system)	98	62%	17%
Focused claims adjuster training on empathy and/or other "soft skills"	90	57%	16%
Dedicated employee / injured worker advocates, available in addition to the claims examiner	82	52%	14%
Cultural shift within your organization supporting an advocacy model, including executive-level buy in	81	51%	14%
Other	16	10%	3%

Note: Participants were able to select more than one answer for this question

Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer	count	≤50%	51% to 60%	61% to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥151%	Unknown
Revamped employee / injured worker communications	102	6%	4%	6%	7%	9%	19%	28%	5%	1%	-	-	1%	14%
Emphasis on workers' compensation as a benefit delivery system (vs. a claims adjudication system)	98	4%	2%	8%	6%	8%	21%	29%	4%	1%	-	-	1%	16%
Focused claims adjuster training on empathy and/or other "soft skills"	90	4%	1%	8%	6%	10%	21%	32%	7%	1%	-	-	1%	9%
Dedicated employee / injured worker advocates, available in addition to the claims examiner	82	7%	5%	10%	6%	11%	24%	18%	4%	-	-	-	-	15%
Cultural shift within your organization supporting an advocacy model, including executive-level buy in	81	4%	2%	9%	6%	9%	26%	27%	6%	1%	-	-	1%	9%
Other	16	6%	-	-	6%	13%	13%	25%	6%	6%	-	-	-	25%

Note: Participants were able to select more than one answer for this question

Conditional Question for those who answered "Yes" in Question 14

14.2 What measures are you using to determine the effectiveness of your claims advocacy model? Select all that apply.
[159 responses]

Overview - All Responses

Answer	count	% of Sub-Sample Responses	% of Entire Response Sample
Claim costs	108	68%	19%
Claim duration	108	68%	19%
Injured worker satisfaction	99	62%	17%
Litigation rate	98	62%	17%
Claims talent employee retention	47	30%	8%
Speed / Number of days to reach a decision vs. statutory requirements	40	25%	7%
Other	17	11%	3%

Note: Participants were able to select more than one answer for this question

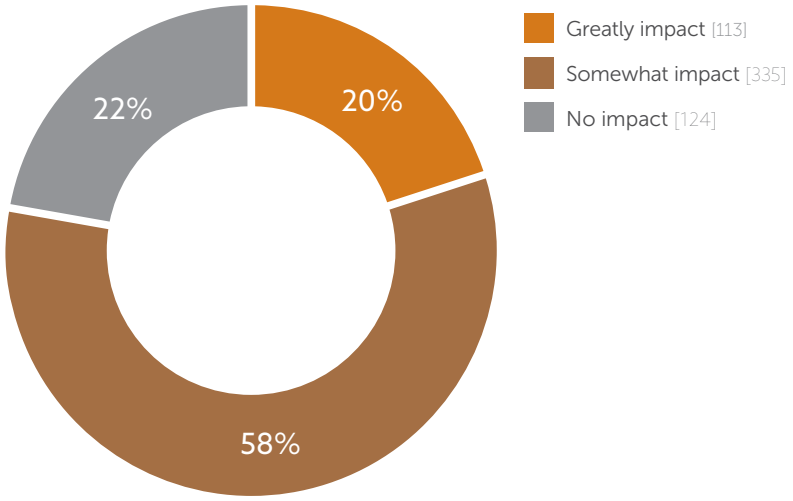
Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer	count	≤50%	51% to 60%	61% to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥151%	Unknown
Claim costs	108	5%	5%	9%	10%	8%	19%	24%	6%	-	-	-	1%	13%
Claim duration	108	5%	2%	6%	6%	9%	23%	27%	6%	-	-	-	1%	15%
Injured worker satisfaction	99	7%	4%	8%	8%	10%	22%	23%	6%	1%	-	-	-	11%
Litigation rate	98	6%	2%	9%	5%	7%	22%	28%	7%	1%	-	-	1%	12%
Claims talent employee retention	47	6%	2%	2%	11%	11%	30%	23%	9%	-	-	-	2%	4%
Speed / Number of days to reach a decision vs. statutory requirements	40	5%	5%	8%	10%	8%	25%	15%	5%	3%	-	-	3%	13%
Other	17	6%	-	6%	6%	12%	41%	12%	-	-	-	-	-	17%

Note: Participants were able to select more than one answer for this question

15 In your opinion, will an advocacy-based claims model impact claims talent development and retention strategies?

[572 responses]



16 Considering an advocacy-based claims model, how could it most impact claims talent development and retention strategies? Please rank in the order of greatest potential impact, with 1 being the "greatest impact" and 5 being the "lower impact." [572 responses]

Answer	Overall Rank	Mean
Employee engagement	1	2.39
Connect claims talent strategy to organizational mission / customer service model and employee service model	2	2.90
Transform the image of the claims profession, from "adjuster" to "advocate"	3	2.97
Elevate the social factors, meaningful work of claims professionals	4	3.33
Improve organizational reputation / social image	5	3.42

17 Does your organization include any of the following skills and abilities testing / training for frontline claims professionals? Select all that apply. (If no, select "None / Not Applicable")

[572 responses]

Overview - All Responses

Answer	count	%
Customer service skills	248	43%
Communication skills	242	42%
Active listening skills	194	34%
Critical thinking	181	32%
Empathy	126	22%
Aptitude testing*	81	14%
None / Not Applicable	260	45%

Note: Participants were able to select more than one answer for this question

* test designed to determine a person's ability in a particular skill or field of knowledge

[17 cont'd] Does your organization include any of the following skills and abilities testing / training for frontline claims professionals? Select all that apply. (If no, select "None / Not Applicable")

Responses Segmented by Organization Type

Answer	Insurance Company	Reinsurance or Excess Insurance Company	Third Party Administrator	Self-Insured Employer	Insured Employer	Risk Pool	State Fund / Mutual Fund	Gov't Entity	Other
respondent # by organization type	109	4	80	169	94	26	13	55	22
Customer service skills	61%	25%	61%	34%	23%	50%	69%	33%	50%
Communication skills	50%	75%	58%	39%	30%	38%	54%	33%	41%
Active listening skills	46%	50%	51%	28%	22%	31%	31%	24%	32%
Critical thinking	45%	75%	38%	30%	16%	23%	54%	20%	41%
Empathy	27%	-	33%	18%	16%	23%	38%	20%	18%
Aptitude testing	20%	25%	24%	7%	9%	12%	31%	16%	14%
None / Not Applicable	29%	-	28%	56%	62%	46%	8%	56%	45%

Note: Participants were able to select more than one answer for this question

Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer	count	≤50%	51% to 60%	61% to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥151%	Unknown
Customer service skills	248	4%	4%	6%	8%	9%	22%	23%	6%	-	-	-	1%	17%
Communication skills	242	6%	4%	7%	8%	9%	23%	20%	5%	-	-	-	1%	17%
Active listening skills	194	6%	6%	6%	8%	10%	22%	19%	5%	1%	-	-	1%	16%
Critical thinking	181	6%	3%	6%	9%	9%	24%	18%	7%	1%	-	-	1%	16%
Empathy	126	6%	3%	6%	6%	11%	28%	20%	5%	-	-	-	1%	14%
Aptitude testing	81	4%	2%	5%	12%	7%	25%	15%	9%	-	-	-	1%	20%
None / Not Applicable	260	4%	7%	5%	8%	10%	24%	16%	3%	1%	-	-	-	22%

Note: Participants were able to select more than one answer for this question

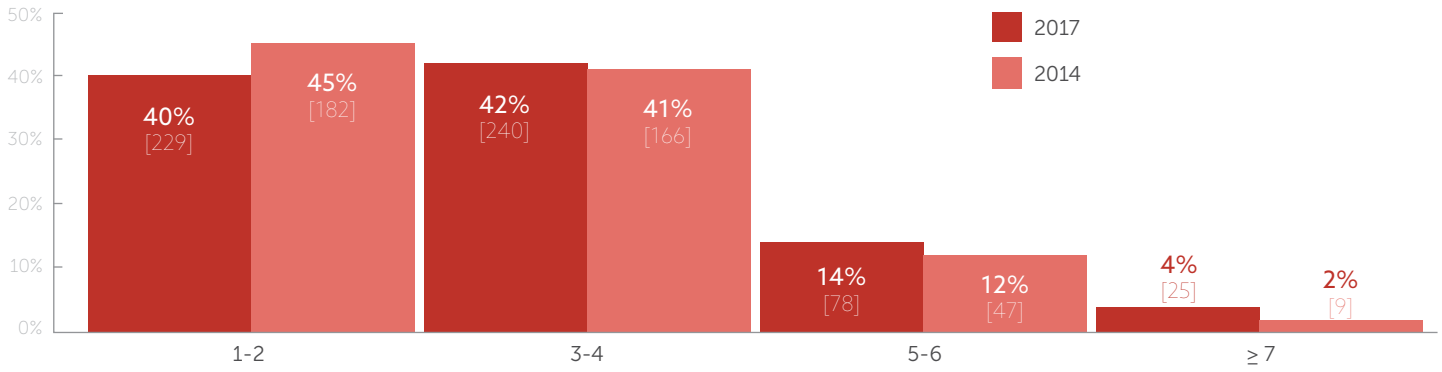
Appendix D - Impact of Technology & Data

1 What percentage of your organization's annual budget is spent on IT systems for workers' compensation programs?
[572 responses]

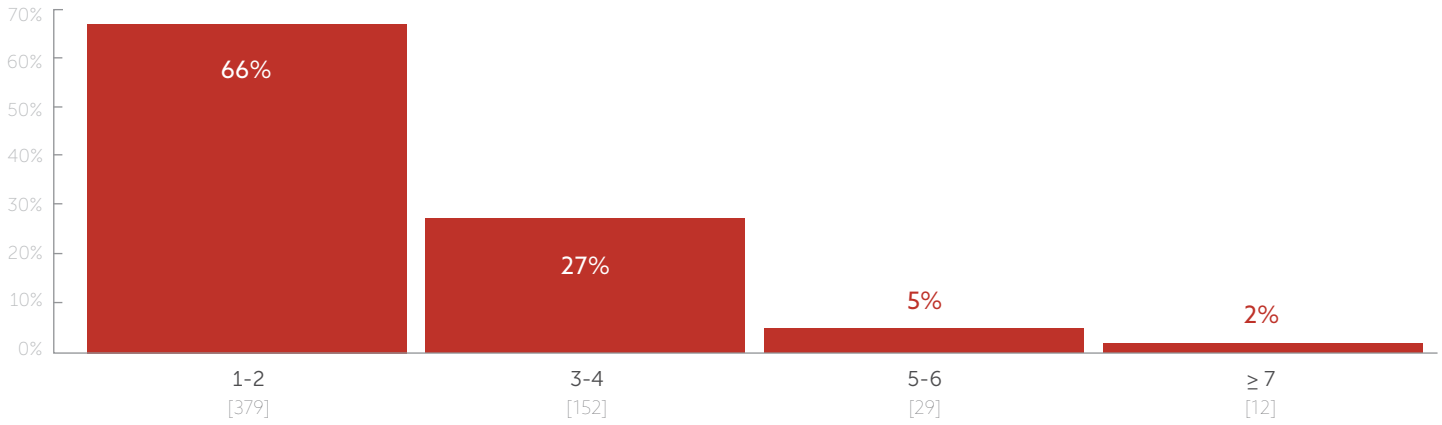
	2017		2014	
Answer	count	%	count	%
< 1%	128	22%	*	*
1 - 3%	60	11%	97	24%
4 - 6%	39	7%	22	5%
7 - 9%	24	4%	28	7%
10 - 12%	26	5%	22	5%
13 - 15%	15	3%	9	3%
≥ 16%	28	5%	24	6%
Unknown	252	43%	202	50%

* NOTE: Answer option of "less than 1%" was not an answer option in the 2014 survey

2 Including internal and external programs / systems, how many systems do your claims adjusters utilize in the daily management of claims? (i.e. claims system, UR, legal, bill review, payment systems, web portals)
[572 responses]



3 How many systems do you consider efficient for a claims adjuster to utilize in the daily management of claims?
[572 responses]



4 What initiatives / strategies is your organization undertaking to streamline / improve claims adjuster efficiency? Select all that apply. (If none, select "Not Applicable")

[572 responses]

Overview - All Responses

Answer	2017 count	2017 %	2014 count	2014 %
No Intiatives / Not Applicable	183	32%	122	30%
Increased investment in IT resources to integrate systems	260	45%	196	49%
Workflow Automation	260	45%	192	48%
Administrative Support / Offload Admin Tasks	214	37%	149	37%
Added Hardware / Tools (i.e. additional computer monitors, mobile devices)	132	23%	130	32%
Increased Specialization	74	13%	42	10%
Other	10	2%	12	3%

Note: Participants were able to select more than one answer for this question

Responses Segmented by Organization Type

Answer	Insurance Company	Reinsurance or Excess Insurance Company	Third Party Administrator	Self-Insured Employer	Insured Employer	Risk Pool	State Fund / Mutual Fund	Gov't Entity	Other
respondent # by organization type	109	4	80	169	94	26	13	55	22
No Initiatives / Not Applicable	10%	-	8%	44%	56%	35%	8%	40%	32%
Increased investment in IT resources to integrate systems	66%	75%	76%	34%	19%	58%	69%	31%	36%
Workflow Automation	68%	75%	76%	34%	18%	54%	62%	35%	27%
Administrative Support / Offload Admin Tasks	50%	-	61%	27%	27%	42%	54%	29%	23%
Added Hardware / Tools (i.e. additional computer monitors, mobile devices)	32%	25%	40%	17%	9%	46%	31%	16%	14%
Increased Specialization	21%	25%	18%	9%	12%	4%	15%	7%	9%
Other	3%	-	3%	2%	1%	-	8%	-	-

Note: Participants were able to select more than one answer for this question

[4 cont'd] What initiatives / strategies is your organization undertaking to streamline / improve claims adjuster efficiency? Select all that apply. (If none, select "Not Applicable")

Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer	count	≤50%	51% to 60%	61% to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥151%	Unknown
No Initiatives / Not Applicable	183	8%	5%	6%	11%	12%	21%	8%	4%	1%	-	1%	-	23%
Increased investment in IT resources to integrate systems	260	2%	4%	3%	7%	9%	28%	24%	5%	-	-	-	-	18%
Workflow Automation	260	2%	4%	6%	7%	8%	27%	28%	4%	-	-	-	1%	13%
Administrative Support / Offload Admin Tasks	214	4%	6%	8%	7%	9%	22%	26%	4%	1%	-	-	-	13%
Added Hardware / Tools (i.e. additional computer monitors, mobile devices)	132	3%	2%	5%	11%	5%	27%	28%	5%	2%	-	-	1%	11%
Increased Specialization	74	4%	1%	11%	7%	4%	26%	27%	7%	1%	-	-	-	12%
Other	10	10%	-	-	-	10%	10%	50%	10%	-	-	-	-	10%

Note: Participants were able to select more than one answer for this question

5 Do any of the following systems or programs integrate with your claims system? Select all that apply. (If no systems are integrated, select "Not Applicable")

[572 responses]

Overview - All Responses

Answer	2017 count	2017 %	2014 count	2014 %
No Systems Integration / Not Applicable	177	31%	132	33%
Bill Review	275	48%	202	50%
Nurse Case Management	223	39%	163	40%
Pharmacy Benefit Manager or Pharmacy Point of Service System	198	35%	140	35%
Utilization Review	179	31%	124	31%
Provider Networks	130	23%	77	19%
Safety / Loss Control	129	23%	85	21%
Predictive Modeling	128	22%	53	13%
Legal	124	22%	68	17%
Evidence-Based Medicine Guidelines	85	15%	52	13%
Fraud & Abuse Detection Systems	85	15%	62	15%
Imaging or Imaging Service Providers (i.e. MRI, CT, X-Ray)	78	14%	71	18%
Provider or Hospital Electronic Health Records	50	9%	35	9%

Note: Participants were able to select more than one answer for this question

[5 cont'd] Do any of the following systems or programs integrate with your claims system? Select all that apply. (If no systems are integrated, select "Not Applicable")

Responses Segmented by Organization Type

Answer	Insurance Company	Reinsurance or Excess Insurance Company	Third Party Administrator	Self-Insured Employer	Insured Employer	Risk Pool	State Fund / Mutual Fund	Gov't Entity	Other
respondent # by organization type	109	4	80	169	94	26	13	55	22
No Systems Integration / Not Applicable	19%	-	8%	40%	43%	15%	8%	45%	55%
Bill Review	56%	25%	78%	43%	31%	65%	46%	40%	23%
Nurse Case Management	43%	50%	64%	35%	31%	50%	46%	20%	23%
Pharmacy Benefit Manager or Pharmacy Point of Service System	49%	25%	53%	30%	15%	65%	38%	22%	14%
Utilization Review	31%	25%	49%	24%	28%	58%	54%	22%	18%
Provider Networks	23%	25%	40%	17%	22%	27%	23%	16%	18%
Safety / Loss Control	14%	-	16%	26%	28%	42%	23%	31%	-
Predictive Modeling	32%	50%	40%	15%	13%	31%	31%	7%	27%
Legal	36%	50%	16%	15%	19%	23%	31%	22%	18%
Evidence-Based Medicine Guidelines	18%	25%	21%	14%	9%	12%	31%	7%	18%
Fraud & Abuse Detection Systems	27%	-	25%	7%	13%	12%	15%	11%	5%
Imaging or Imaging Service Providers (i.e., MRI, CT, X-Ray)	18%	50%	21%	14%	10%	12%	23%	2%	-
Provider or Hospital Electronic Health Records	10%	-	8%	9%	11%	12%	-	7%	-

Note: Participants were able to select more than one answer for this question

[5 cont'd] Do any of the following systems or programs integrate with your claims system? Select all that apply. (If no systems are integrated, select "Not Applicable")

Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer	count	≤50%	51% to 60%	61% to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥151%	Unknown
No Systems Integration / Not Applicable	177	7%	5%	3%	12%	10%	21%	8%	5%	1%	-	1%	-	27%
Bill Review	275	3%	6%	5%	6%	10%	25%	27%	5%	1%	-	-	1%	11%
Nurse Case Management	223	4%	7%	6%	4%	11%	22%	26%	5%	1%	-	-	-	14%
Pharmacy Benefit Manager or Pharmacy Point of Service System	198	4%	7%	5%	7%	10%	22%	29%	5%	-	-	-	1%	10%
Utilization Review	179	4%	5%	6%	7%	9%	22%	26%	6%	1%	-	-	-	14%
Provider Networks	130	5%	7%	5%	8%	12%	23%	18%	7%	-	-	-	1%	14%
Safety / Loss Control	129	6%	10%	10%	10%	13%	16%	17%	3%	-	-	-	1%	14%
Predictive Modeling	128	5%	2%	6%	5%	13%	27%	26%	5%	-	-	-	-	11%
Legal	124	6%	6%	7%	8%	12%	24%	15%	5%	1%	-	-	1%	15%
Evidence-Based Medicine Guidelines	85	4%	8%	5%	11%	7%	19%	27%	5%	-	-	-	1%	13%
Fraud & Abuse Detection Systems	85	4%	5%	5%	8%	12%	26%	22%	5%	-	-	-	-	13%
Imaging or Imaging Service Providers (i.e. MRI, CT, X-Ray)	78	5%	8%	4%	9%	9%	28%	21%	8%	-	-	-	-	8%
Provider or Hospital Electronic Health Records	50	2%	8%	8%	10%	16%	22%	22%	2%	-	-	-	-	10%

Note: Participants were able to select more than one answer for this question

Conditional Question for those who selected a system(s) or program(s) in Question 5

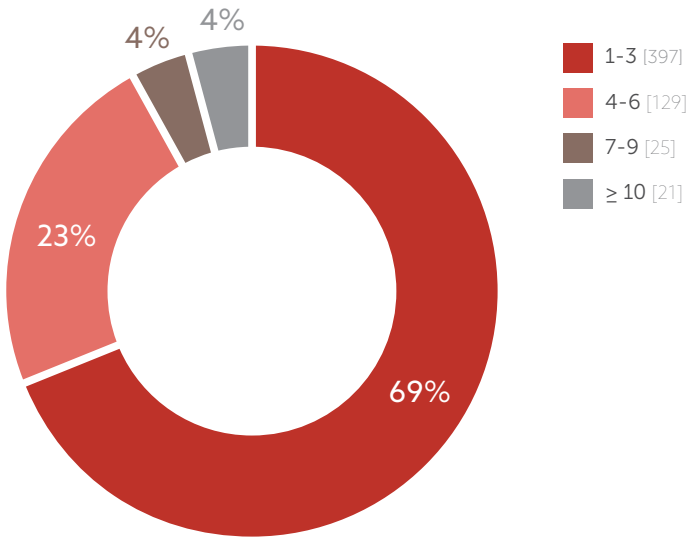
5.1 Indicate how each selected system or program integrates with your claims system.

[395 responses]

Answer	count	The system contains a web link to the claims system	Staff manually copies and pastes data into the claims system	Data populates the claims system through a scheduled file upload / flat file transfer	Data populates the claims system in real-time	Health Level 7 (HL7) integration	Other
Bill Review	275	12%	6%	52%	24%	2%	4%
Nurse Case Management	223	16%	20%	21%	32%	1%	10%
Pharmacy Benefit Manager or Pharmacy Point of Service System	198	21%	8%	48%	17%	2%	4%
Utilization Review	179	17%	14%	35%	25%	-	9%
Provider Networks	130	31%	14%	19%	22%	3%	11%
Safety / Loss Control	129	15%	23%	29%	17%	-	16%
Predictive Modeling	128	12%	6%	41%	29%	2%	10%
Legal	124	18%	27%	22%	17%	-	16%
Evidence-Based Medicine Guidelines	85	34%	16%	13%	25%	2%	10%
Fraud & Abuse Detection Systems	85	20%	13%	20%	31%	-	16%
Imaging or Imaging Service Providers (i.e. MRI, CT, X-Ray)	78	21%	19%	24%	23%	1%	12%
Provider or Hospital Electronic Health Records	50	20%	16%	30%	14%	4%	16%

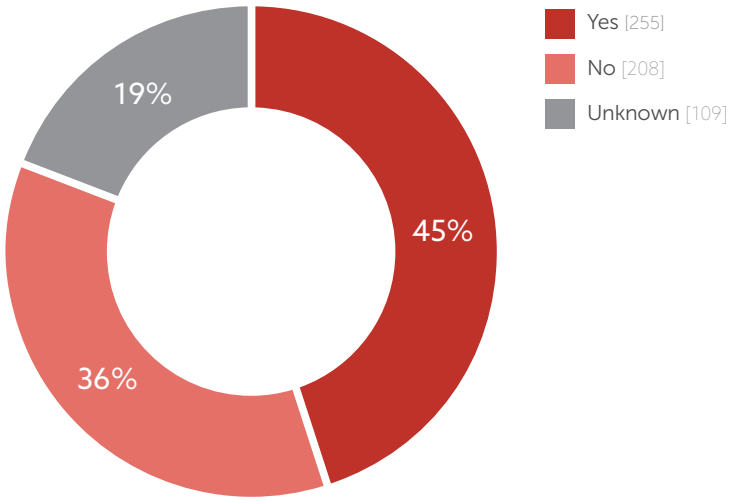
6 How many different systems do you receive data / metrics reports from?

[572 responses]



7 Does your organization use a data warehouse to consolidate or integrate systems for reporting purposes?

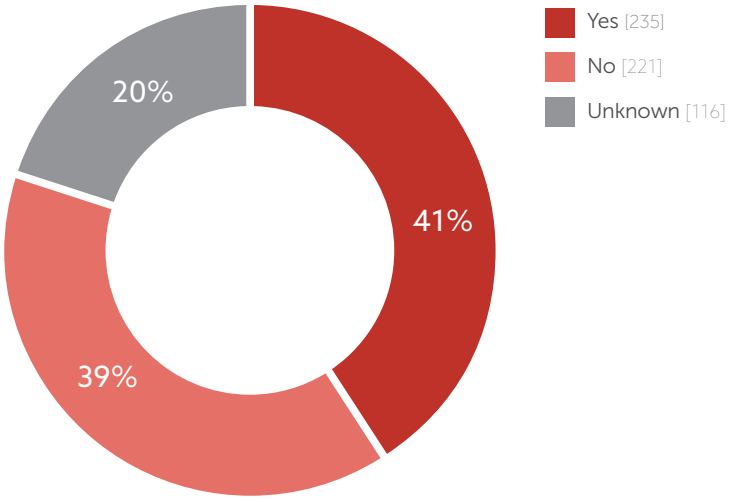
[572 responses]



8 Does your company use outcome-based data / metrics to manage operational performance?

[572 responses]

Overview - All Responses



Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer	count	≤50%	51% to 60%	61% to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥151%	Unknown
Yes	235	4%	4%	5%	9%	8%	30%	24%	6%	-	-	-	1%	9%
No	221	6%	6%	7%	9%	12%	22%	16%	3%	-	-	-	-	19%
Unknown	116	3%	6%	5%	9%	10%	13%	12%	5%	1%	-	-	-	36%

Conditional Question for those who answered "Yes" in Question 8

8.1 What outcome-based systems or data do you utilize to manage operational performance? Select all that apply.

[235 responses]

Overview - All Responses

Answer	2017 count	2017 % of Sub-Sample Responses	2017 % of Entire Response Sample	2014 count	2014 % of Entire Response Sample
Claim quantitative measures of performance based on our company policies / best practices	189	80%	33%	123	30%
Claim quality measures of performance based on internal / external quality assurance review	141	60%	25%	104	26%
Claim outcome measures based on evidence-based medicine medical treatment guidelines	102	43%	18%	47	12%
Claim outcome measures based on evidence-based medicine disability duration guidelines	97	41%	17%	46	11%
Other	2	1%	< 1%	2	< 1%

Note: Participants were able to select more than one answer for this question

Responses Segmented by Organization Type

Answer	Insurance Company	Reinsurance or Excess Insurance Company	Third Party Administrator	Self-Insured Employer	Insured Employer	Risk Pool	State Fund / Mutual Fund	Gov't Entity	Other
respondent # by organization type	109	4	80	169	94	26	13	55	22
Claim quantitative measures of performance based on our company policies / best practices	84%	67%	87%	72%	81%	100%	100%	93%	55%
Claim quality measures of performance based on internal / external quality assurance review	74%	100%	82%	51%	45%	63%	50%	40%	45%
Claim outcome measures based on evidence-based medicine medical treatment guidelines	46%	-	51%	40%	48%	38%	-	33%	45%
Claim outcome measures based on evidence-based medicine disability duration guidelines	42%	-	62%	40%	29%	38%	-	33%	55%
Other	-	-	-	2%	2%	-	-	-	-

Note: Participants were able to select more than one answer for this question

[8.1 cont'd] What outcome-based systems or data do you utilize to manage operational performance? Select all that apply.

Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer	count	≤50%	51% to 60%	61% to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥151%	Unknown
Claim quantitative measures of performance based on our company policies / best practices	189	4%	3%	4%	8%	8%	30%	25%	6%	-	-	-	1%	11%
Claim quality measures of performance based on internal / external quality assurance review	141	3%	2%	4%	7%	8%	28%	29%	7%	1%	-	-	1%	10%
Claim outcome measures based on evidenced-based medicine medical treatment guidelines	102	5%	4%	3%	8%	8%	24%	29%	8%	-	-	-	-	11%
Claim outcome measures based on evidenced-based medicine disability duration guidelines	97	4%	-	3%	9%	6%	23%	34%	9%	-	-	1%	1%	10%
Other	2	-	-	-	50%	-	50%	-	-	-	-	-	-	-

Note: Participants were able to select more than one answer for this question

Conditional Question for those who answered "Yes" in Question 8

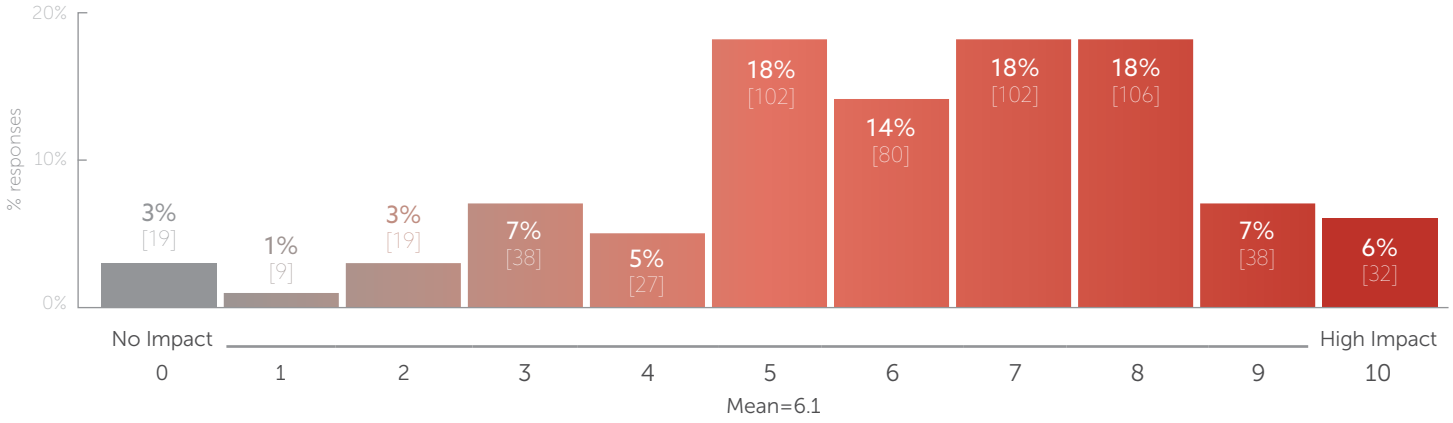
8.2 Your outcome-based data / metrics are segmented or measured by which of the following? Select all that apply. [235 responses]

Answer	count	% of Sub-Sample Responses	% of Entire Response Sample
Claims Adjuster	148	63%	26%
Office / Operation	126	54%	22%
Jurisdiction	116	49%	20%
Frontline Supervisor	79	34%	14%
Nurse Case Manager	71	30%	12%
Medical Provider	68	29%	12%
Vendor Service Provider	62	26%	11%
Other	16	7%	3%

Note: Participants were able to select more than one answer for this question

9 In your opinion, what is the impact of your organization's overall metrics on claim performance / outcomes? (with a rating of 0 being "no impact" and a rating of 10 being "high impact")

[572 responses]

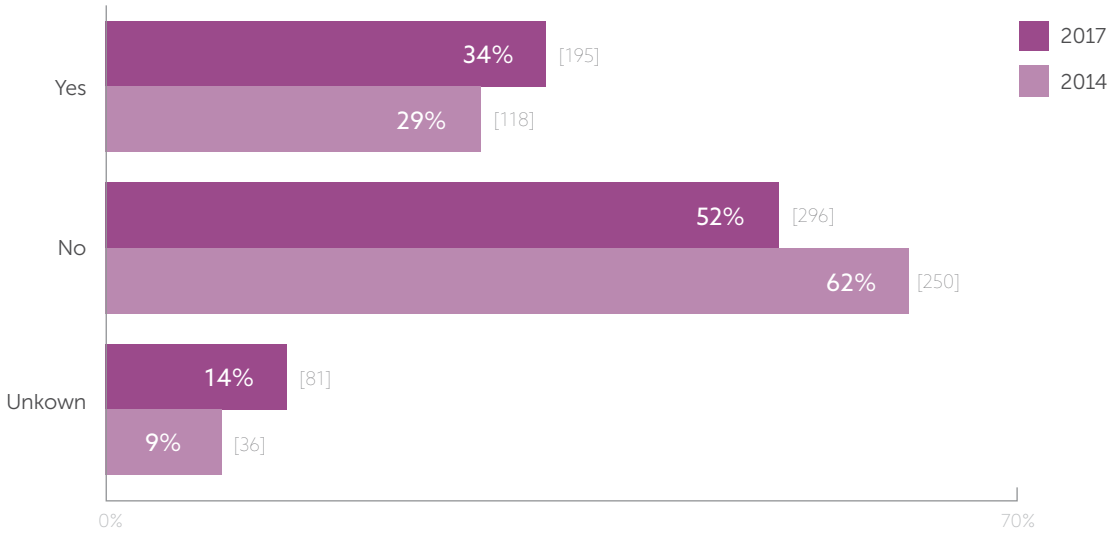


Appendix E - Medical Performance Management

1 Does your organization use measures to gauge medical provider outcomes / performance?

[572 responses]

Overview - All Responses



Responses Segmented by Claims Closure Ratio / Claims Resolution

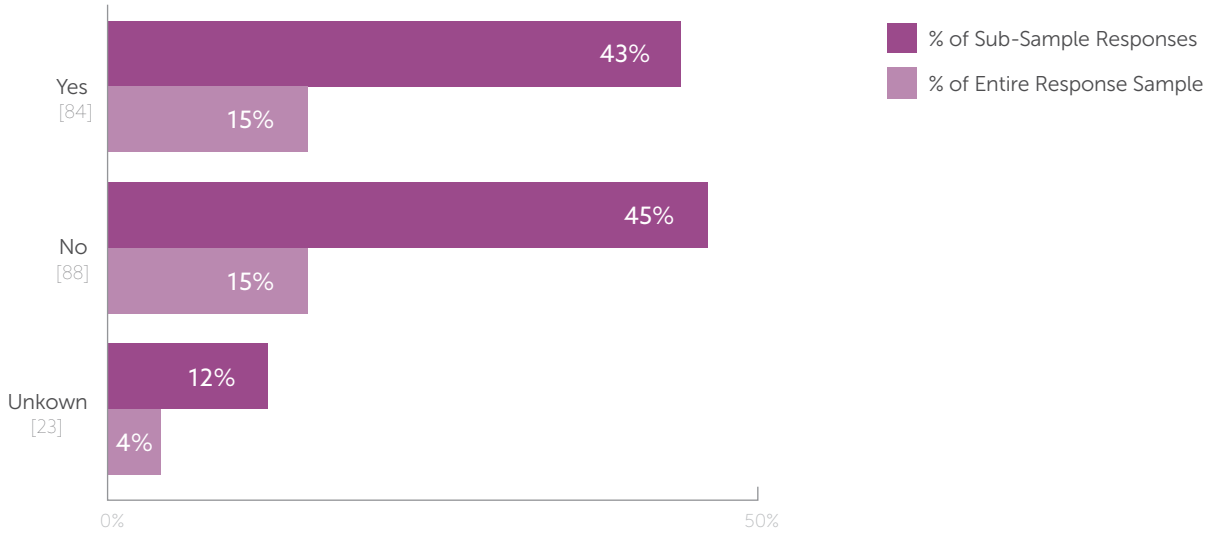
Answer	count	≤50%	51% to 60%	61% to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥151%	Unknown
Yes	195	5%	5%	5%	9%	11%	21%	23%	7%	-	-	1%	1%	12%
No	296	4%	6%	6%	8%	10%	27%	18%	3%	1%	-	-	-	17%
Unknown	81	5%	4%	5%	10%	7%	15%	11%	4%	1%	-	-	-	38%

Conditional Question for those who answered "Yes" in Question 1

1.1 Are the outcomes / performance measure results shared with providers?

[195 responses]

Overview - All Responses



Conditional Question for those who answered "No" in Question 1

1.2 What are the primary limitations / reasons for not using provider outcomes / performance measures? Select all that apply.

[296 responses]

Answer	count	% of Sub-Sample Responses	% of Entire Response Sample
Data / System Limitations	121	41%	21%
Unsure How to Operationalize	94	32%	16%
Not a Business Priority	79	27%	14%
Other	59	20%	10%
Financial Limitations	43	15%	8%
Litigation Concerns	24	8%	4%

Note: Participants were able to select more than one answer for this question

2 Are you using any of the following data points to measure provider outcomes / performance? Select all that apply. (If no, select "Not Applicable")

[572 responses]

Answer	2017 count	2017 %	2014 count	2014 %
No, none currently in place / Not Applicable	199	35%	174	43%
Total Claim Costs	297	52%	187	46%
RTW Outcomes	288	50%	167	41%
Treatment within Evidence-Based Guidelines	162	28%	91	23%
Quality & Timely Submission of Reports	142	25%	101	25%
Efficiency Measures, Average Number of Evaluation & Management (E&M) Visits per Claim by Diagnosis Code	79	14%	25	6%
NCQA Cost of Care Measures	22	4%	11	3%
AHRQ Clinical Quality / Appropriate Care Measures	18	3%	10	2%
Other	3	1%	12	3%

Note: Participants were able to select more than one answer for this question

3 Are you using any of the following measures to gauge overall provider performance? Select all that apply. (If no, select "Not Applicable")

[572 responses]

Overview - All Responses

Answer	2017 count	2017 %	2014 count	2014 %
No, none currently in place / Not Applicable	250	44%	202	50%
Average Claim Costs	259	45%	164	41%
Average Medical Spend	228	40%	152	38%
Average Number of TTD Days	222	39%	126	31%
Average Narcotic Use	153	27%	85	21%

Note: Participants were able to select more than one answer for this question

[3 cont'd] Are you using any of the following measures to gauge overall provider performance? Select all that apply. (If no, select "Not Applicable")

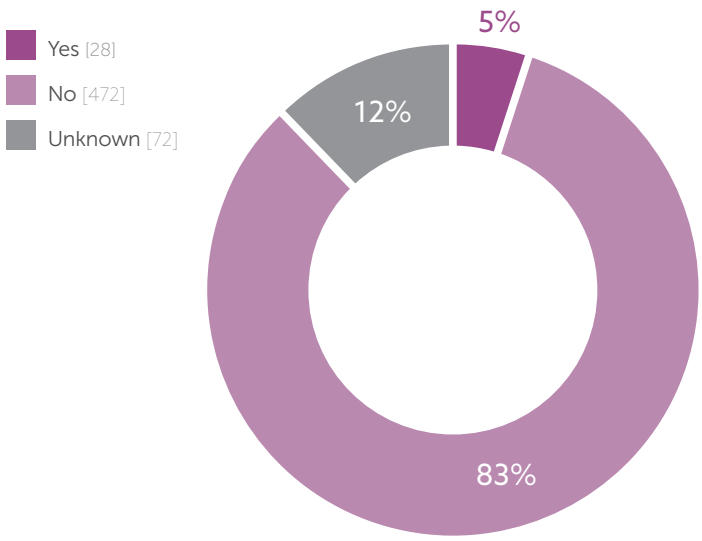
Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer	count	≤50%	51% to 60%	61% to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥151%	Unknown
No, none currently in place / Not Applicable	250	4%	6%	5%	10%	8%	21%	17%	4%	-	-	-	-	25%
Average Claim Costs	259	6%	4%	7%	7%	13%	25%	20%	5%	-	-	-	-	13%
Average Medical Spend	228	5%	4%	6%	4%	11%	26%	23%	5%	-	-	-	-	16%
Average Number of TTD Days	222	6%	5%	6%	7%	14%	22%	21%	5%	-	-	-	-	14%
Average Narcotic Use	153	5%	4%	5%	6%	10%	22%	26%	8%	1%	-	1%	1%	11%

Note: Participants were able to select more than one answer for this question

4 Does your organization use risk / reward-based contracting with medical providers?

[572 responses]



Conditional Question for those who answered "Yes" in Question 4

4.1 What risk / reward strategies are used with medical providers? Select all that apply.
[28 responses]

	2017			2014	
Answer	count	% of Sub-Sample Responses	% of Entire Response Sample	count	% of Entire Response Sample
Referral or Patient Channeling	17	61%	3%	7	2%
Pay for Performance / Higher Reimbursement Rate	15	54%	3%	6	1%
Fast Track Payments	11	39%	2%	6	1%
Decreased / No Utilization Review	10	36%	2%	7	2%
Limited Bill Review	8	29%	1%	3	1%
Other	-	-	-	3	1%

Note: Participants were able to select more than one answer for this question

5 Indicate if any of the following medical management programs are currently in place and if they are insourced or outsourced. (If not currently in place, select "Not Applicable")
[572 responses]

Answer	Not Applicable	Insourced	Outsourced	Combination Insourced & Outsourced	Unknown
Nurse Case Management	6%	22%	51%	20%	1%
Bill Review	6%	20%	64%	8%	2%
Pharmacy Benefit Manager / Network	9%	7%	75%	5%	4%
Utilization Review	11%	18%	56%	11%	4%
Return-to-Work Services	16%	43%	18%	20%	3%
Nurse / Claims Triage	19%	25%	41%	12%	3%
Peer Review	19%	14%	56%	7%	4%
Physician Case Management	33%	11%	39%	9%	8%
Outsourced / Leased Provider Network	34%	4%	45%	7%	10%
Company Developed / Owned Provider Network	38%	16%	31%	8%	7%

6 Please rank in the order of impact the medical management programs you believe are most critical to claim outcomes, with 1 having the "greatest impact" and 10 having the "least impact."
[572 responses]

Answer	Overall Rank	Mean
Nurse Case Management	1	3.49
Return-to-Work Services	2	3.90
Nurse / Claims Triage	3	4.17
Pharmacy Benefit Manager / Network	4	5.38
Utilization Review	5	5.73
Physician Case Management	6	5.75
Bill Review	7	5.86
Company Developed / Owned Provider Network	8	6.65
Peer Review	9	6.96
Outsourced / Leased Provider Network	10	7.11

7 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."
[572 responses]

Answer	Overall Rank	Mean
Medical Provider / Physicians	1	3.04
In-Patient / Hospital	2	3.53
Pharmacy	3	3.88
Physical / Occupational Therapy Services	4	4.30
Ambulatory Surgery Centers / Out-Patient Surgery Centers	5	4.39
Diagnostics (i.e. MRI, CT, X-Ray)	6	4.82
Durable Medical Equipment	7	7.25
Medical Cost Containment Services	8	7.45
Home Health Care	9	7.85
Medical Transportation	10	8.51

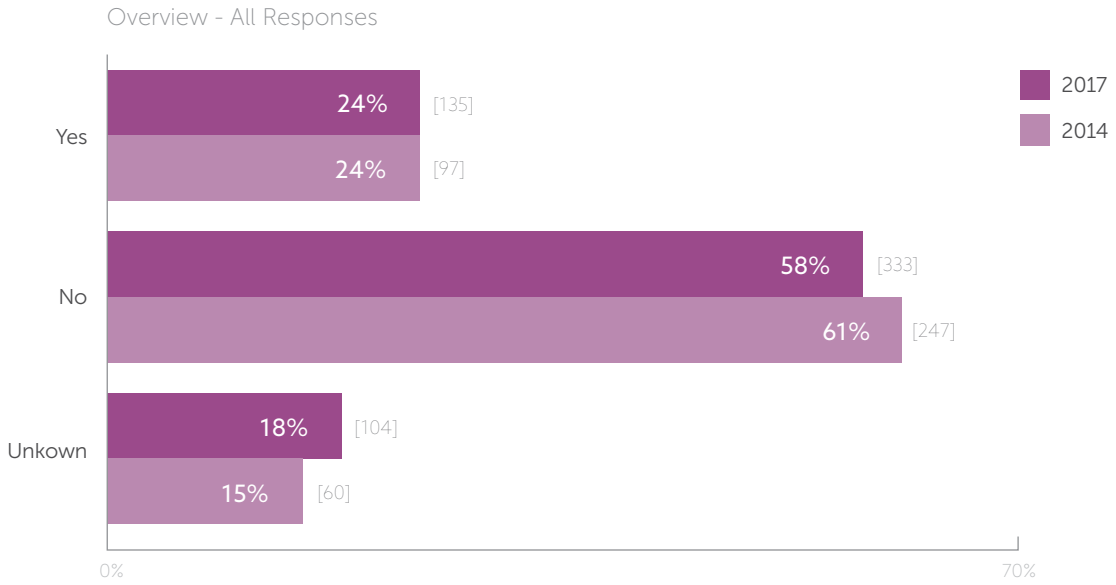
8 What percentage of your overall medical spend is attributable to pharmacy? (If not applicable or unknown, select "Not Applicable / Unknown")

[572 responses]

Answer	count	%
1 - 5%	79	14%
6 - 10%	103	18%
11 - 15%	72	13%
16 - 20%	49	9%
21 - 25%	48	8%
26 - 30%	23	4%
≥ 31%	33	6%
Not Applicable / Unknown	165	28%

9 Does your organization use performance strategies to incentivize or hold medical management vendor partners accountable?

[572 responses]



Responses Segmented by Claims Closure Ratio / Claims Resolution

Answer	count	≤50%	51% to 60%	61% to 70%	71% to 80%	81% to 90%	91% to 100%	101% to 110%	111% to 120%	121% to 130%	131% to 140%	141% to 150%	≥151%	Unknown
Yes	135	6%	5%	3%	7%	8%	21%	30%	7%	-	-	-	1%	12%
No	333	4%	6%	7%	10%	11%	27%	15%	4%	-	-	-	-	16%
Unknown	104	5%	4%	6%	8%	9%	14%	15%	4%	2%	-	-	-	33%

Conditional Question for those who answered "Yes" in Question 9

9.1 What performance strategies are used to incentivize or hold medical management vendor partners accountable? Select all that apply.
[135 responses]

Answer	count	% of Sub-Sample Responses	% of Entire Response Sample
Service Level Agreement (SLA) with Performance Standards & Financial Commitments	86	64%	15%
Increased Volume Based on Performance	53	39%	9%
Decreased Volume Based on Performance	42	31%	7%
Fast-Track Payments	37	27%	6%
Limited Bill Review	20	15%	3%
Decreased UR Requirements	18	13%	3%
Pay-for-Performance Measures	15	11%	3%
Other	3	2%	1%

Note: Participants were able to select more than one answer for this question

2017 WORKERS' COMPENSATION BENCHMARKING STUDY

CLAIMS MANAGEMENT OPERATIONAL STUDY

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