REPORT TO THE VERMONT GENERAL ASSEMBLY

Study and Recommendations Relating

To Workers' Compensation

Adjuster Performance Standards

By:

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& Health Care Administration

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TABLE OF CONTENTS

EXECUTIVE SUMMARY 2

INTRODUCTION 5

METHODOLOGY 9

FINDINGS 13

I. PERFORMANCE STANDARDS AND COMPLIANCE PROGRAMS IN OTHER STATES 13

A. Maine's Compliance Monitoring Program 14

B. Wisconsin's Compliance Monitoring Program 19

C. Minnesota's Compliance Monitoring Program 23

D. Colorado's Compliance Monitoring Program 25

E. Florida's Compliance Monitoring Program 27

F. Oregon's Compliance Monitoring Program 29

G. Summary of State Program Characteristics 31

II. IDENTIFYING POTENTIAL PROBLEMS IN VERMONT'S CLAIMS ADJUSTING PROCESS 32

A. Survey Respondents 32

B. Survey Results 33

III. SOLUTIONS 34

A. Immediate Steps for Improvement 34

1. *Eliminate the Compensation Agreement and replace it with a Memorandum of Payment* 34

2. *Implement ten day requirement for adjuster response to inquiries in Labor & Industry Rule 1-46* 36

3. *Do not implement individual adjuster caseloads maximums* 37

B. Implement Pilot Study 39

C. Study Areas for Further Enhancement 41

RECOMMENDATIONS 44

Recommendation 1: Eliminate the need for the injured worker's signature on the forms that document the benefits to be paid. 44

Recommendation 2: Implement mandatory ten-day response time for adjusters to respond to inquiries. 45

Recommendation 3: Refrain from imposing caseload maximums. 46

Recommendation 4: Undertake a pilot program to monitor adjusting entity performance relating to three verifiable events during the claims process. 46

Recommendation 5: Investigate ways in which the claims adjusting process can be streamlined. 48

APPENDIX A 50

APPENDIX B 52

EXECUTIVE SUMMARY

Pursuant to Act 132, H. 632, Sections 2(1)(A) & (B), the Vermont Legislature directed the Vermont Department of Banking, Insurance, Securities and Health Care Administration ("BISHCA") to issue a report to the General Assembly which included findings and proposals regarding whether additional regulation of the insurance industry should be enacted, including:

(A) Higher performance standards for adjusting workers' compensation[1] claims.

(B) Implementing caseload maximums for workers' compensation adjusters.[2]

BISHCA commissioned Phyllis Severance-Phillips, a consultant in the workers' compensation field, to help develop the findings and produce this report. Ms. Severance-Phillips's background is contained in Appendix A, along with a detailed description of the services she provided.

BISHCA assigned Charles Piasecki, Insurance Division Market Conduct Chief, to oversee the study. Mr. Piasecki's background is included in Appendix A. Rebecca Heintz, staff attorney for the Insurance Division, assisted in the preparation of this report.

BISHCA also worked with the Vermont Department of Labor & Industry ("Labor & Industry") throughout the study in order to obtain vital information about the workers' compensation claims system that it directly regulates.

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[1] The legislation was drafted broadly enough to arguably incorporate adjusters handling any type of claim. However, legislative testimony and the placement of the legislation in H. 632 indicates that the study was intended to examine workers' compensation claims adjusting only.

[2] Act 132, H. 632 also directed BISCHA to study rate stabilization techniques in workers' compensation programs. This issue is addressed in a separate study.

The conclusions contained in this report are BISHCA's conclusions.

Our study resulted in a number of recommendations that have the potential to improve the workers' compensation process. We have discussed these recommendations with Labor & Industry. Labor & Industry will need to conduct a resource allocation analysis before implementing the recommendations contained herein.

We have recommended Labor & Industry as the appropriate department to undertake a pilot program and a study. The pilot program involves analysis of workers' compensation claims data, which is presently reported to Labor & Industry. Pursuant to Title 21 and related regulations, Labor & Industry directly regulates the workers' compensation claims process and would be the agency to implement changes that the pilot program or study may indicate are appropriate.

The following are our recommendations based on the study's findings:

1. Eliminate the need for the injured worker's signature on the Compensation Agreement. Replace the existing form with a memorandum of coverage that requires the adjuster to sign a proof of service statement.

2. Institute a mandatory ten day response time for workers' compensation adjusters to respond to inquiries.

3. Do not impose an individual adjuster caseload maximum.

4. Undertake a one year pilot program to monitor the timeliness of claims acceptance or denial, first indemnity payments and termination of benefits in order to establish a baseline understanding of the present workers' compensation claims process and identify potential means of defining or enhancing adjuster entity compliance.

5. Convene a study committee of adjusters and medical providers under the direction of the Department of Labor and Industry to investigate additional ways in which the claims handling process can be streamlined, paying particular attention to ways in which to

facilitate the medical treatment provider community's participation in the claims process.

INTRODUCTION

Vermont's workers' compensation program provides medical and wage replacement benefits for employees who are injured on the job. Workers' compensation benefits are provided on a no-fault basis, meaning that there is no reduction in the amount paid to an injured worker because of his or her own negligence. By the same token, workers' compensation benefits are an injured worker's exclusive remedy against the employer in the event of a work-related injury, meaning that in most circumstances an injured worker cannot sue his or her employer in tort even if the injury was caused by the employer's negligence.

The workers' compensation system is regulated both by the Department of Labor & Industry ("Labor & Industry") and the Department of Banking, Insurance, Securities and Health Care Administration ("BISHCA"). Pursuant to Chapter 9 of Title 21, Labor & Industry regulates the claims activities specific to workers' compensation claims. Labor & Industry creates the specific rules that companies and adjusters must follow when administering a workers' compensation claim. Also, the agency is responsible for resolving disputes relating to workers' compensation claims. In addition, it develops and conducts the continuing education required for workers' compensation adjusters. Under Title 8, BISHCA regulates the licensing of workers' compensation insurance carriers and workers' compensation adjusters. BISHCA also reviews workers' compensation premium rate filings and has the authority to perform market conduct examinations or investigations of insurance companies and adjusters.

With minor exceptions, Vermont law requires any employer with at least one employee to either purchase workers' compensation insurance to cover its obligation to

pay benefits or to be granted approval[3] to self-insure its obligation. Workers' compensation claims must be administered only by licensed workers' compensation adjusters. The licensing process has three components:

1. An examination requirement, whereby applicants must pass a written licensing test specific to workers' compensation adjusting to obtain a license;

2. An experience component, whereby newly licensed workers' compensation adjusters must be supervised by more experienced workers' compensation adjusters; and

3. A continuing education requirement, whereby adjusters must attend an annual educational conference in order to maintain their license.

The requirement that all workers' compensation adjusters be properly licensed, supervised and receive continuing education as to the specifics of Vermont's workers' compensation program underscores the critical role adjusters play in the system. Vermont's injured workers depend on having their workers' compensation claims handled efficiently and appropriately in order to obtain medical treatment and return to work in a timely fashion. In turn, Vermont's employers, and their insurers, must have workers' compensation claims effectively and affordably administered.

The adjuster stands in the middle of these stakeholder groups. He or she is responsible for defining benefits in every claim, and for doing so promptly, cost-effectively and in accordance with Vermont law. The number of steps needed to completely resolve a workers' compensation claim can vary depending on the type of claim. However, an involved workers' compensation claim can require as many as fifty-

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[3] Depending on the type of entity seeking approval, Labor & Industry or BISHCA has the authority to grant approval for self-insured entities.

four separate steps be completed prior to closing the claim. The questionnaire included in Appendix B lists the steps involved in the workers' compensation adjusting process.

The adjusting process works as it should in most cases. That is, injury claims are reported promptly, thoroughly investigated and either accepted or denied consistent with the law and in a timely manner. Injured workers receive the medical treatment they require in order to return to work as quickly as possible. Employers receive the feedback they need to plan for each employee's safe return to the work site. Claim costs – both financial and human – are minimized.

Unfortunately, however, the process does not run smoothly in all cases. Claims administration may be hampered because the employer failed to timely report the injury, or because the adjuster did not receive relevant medical reports, or because the necessary medical evaluations cannot be scheduled promptly. In addition, adjusters with unreasonably high caseloads may overlook important details bearing on a claimant's right to benefits, or may fail to deliver benefits owed in a timely fashion. Finally, the burden imposed by administrative processes – forms to be filed, documentation to be reviewed, actions to be approved or rejected, disputes to be resolved – may add further delays to claims administration.

Faced with testimony from Vermont's workers' compensation community, the Vermont Legislature considered a number of proposed reforms to the system in its 2003 session. In the 2004 legislative session, in response to concerns raised as to the quality of the workers' compensation claims adjusting process, the Legislature mandated that BISHCA study the efficacy of enacting regulations to require "higher performance standards for adjusting claims" and/or "implementing caseload maximums for

adjusters."[4] Given the pivotal role adjusters play in the system, it is appropriate to consider ways in which their performance might be enhanced to ensure the highest level of quality possible.

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[4] Act No. 132, enacted May 26, 2004.

METHODOLOGY

Pursuant to Act No. 132, H. 632, Section 2(1)(A) (eff. May 26, 2004), the Legislature directed BISHCA to make findings and proposals regarding: 1) additional regulation pertaining to higher performance standards for adjusting workers' compensation claims; and 2) caseload maximums for workers' compensation adjusters.

The workers' compensation claims system is highly regulated. However, performance standards specific to adjusters' claims handling practices are minimal. Claims must be administered in accordance with the law pertaining to benefits, but present regulation does not address workers' compensation claims adjusting specifically in any great detail.[5]

We decided to examine other states' programs that have been implemented to monitor and improve workers' compensation claims performance. There is both danger and reward in such a comparative review. Given the intricacies of each state's workers' compensation law and administration system, there is danger in importing some small aspect of another state's system and attempting to impose it on Vermont's workers' compensation program, which may differ in important but subtle respects. Nonetheless, some aspects of the adjusting process do not differ significantly from state to state and we felt that examining other states' approaches and experiences would be instructive.

In examining the Vermont system specifically, we determined that the first objective in studying the usefulness of higher performance standards was to identify

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[5] Under Department of Labor & Industry Rule 1-46, various specific timelines and required forms for claims processing and dispute resolution exist. Further, claims must be adjusted in accordance with the Insurance Trade Practices Act, Chapter 129 of Title 8. However, the Insurance Trade Practices Act is broadly worded and does not contain specific timelines or performance standards for workers' compensation claims adjusting.

specific problems that existed or may exist under the present regulatory structure. Our initial investigation uncovered many anecdotal cases in which either the employer or the employee did not feel that the adjusters were satisfactorily performing their obligations. However, we were not able to uncover any clear evidence of systemic problems.

In investigating the specific claims giving rise to the complaints, we determined that where adjusters were criticized, contributing factors that were out of the adjuster's control existed in most circumstances. For example, an adjuster's failure to give prompt approval for a medical procedure recommended by the injured worker's treating physician may be driven most often not by the adjuster's inattention, as the injured worker might perceive, but by the physician's failure to forward the relevant medical records in a timely manner. Similarly, the failure to file the forms necessary for administrative review by Labor & Industry may result from a claimants' unwillingness to sign them, not adjusters' burdensome caseloads.

Consequently, we decided to break the adjusting process into individual steps in order to identify where specific problems, or bottlenecks, might exist. Once any problems were identified, we could then determine if implementing adjuster performance standards would be helpful. To that end, we developed a chart identifying the discrete steps of the workers' compensation claim adjusting process.[6]

We then provided a variety of stakeholder groups with the opportunity to comment on the perceived problems that currently exist in Vermont's workers' compensation claims

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[6] This chart is attached at Appendix B.

process and ways in which these problems, or bottlenecks, might be alleviated. Among those polled were:

- Workers' compensation claims department managers from the 14 largest writers of workers' compensation in Vermont;
- A representative sampling of both claimant and defense attorneys;
- Licensed workers' compensation adjusters;
- The Vermont Claims Association (a professional association of claims adjusters);
- The Vermont Insurance Agents Association; and
- The Vermont Department of Labor & Industry.[7]

These stakeholder groups represent the constituents who are the everyday users of Vermont's workers' compensation program. Adjusters understand the intricacies of how the program is designed to work. Attorneys know the devastating consequences when the program fails. Agents know how burdensome the cost is to employers. All groups are equally invested in improving the system so that it remains healthy, effective and affordable.

Respondents were asked to rate the "bottleneck potential" of every step included on the chart (Appendix B) and to suggest changes that might alleviate problems at that step. Many respondents also made general comments and recommendations. In addition, a number of adjusters attending Labor & Industry's annual conference participated in a brainstorming session to identify both perceived deficiencies in Vermont's workers' compensation system and best practices in other states. This information was invaluable.

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[7] In addition to the above groups, the National Council of Compensation Insurers (NCCI) and the Property and Casualty Insurance Association of America (PCIAA) had opportunity to comment, but declined.

We also interviewed adjusters, insurance company managers and other state regulators regarding the efficacy of caseload maximums for adjusters.

FINDINGS

I. PERFORMANCE STANDARDS AND COMPLIANCE PROGRAMS IN OTHER STATES

Efforts in other states to review performance standards of the workers' compensation adjusting process is typically accomplished by either conducting retrospective file reviews or by monitoring self-reports of carrier performance against a variety of defined standards. Some states focus compliance programs on penalties or fines as a means of encouraging appropriate compliance; others publicize adjusting entity[8] compliance results as a means of encouraging better conduct.

In 2001, the International Association of Industrial Accident Boards and Commissions (IAIABC), an association of the state agencies responsible for administering workers' compensation programs, embarked on a study of the compliance monitoring efforts currently being undertaken throughout the country to measure adjusting entity performance. The IAIABC did not issue a formal report, but the study group did identify as noteworthy the compliance monitoring and benchmarking efforts of Maine, Wisconsin, Colorado and Oregon. The ultimate goal of each of these state's programs is to improve outcomes by maintaining a workers' compensation systems in which injuries are promptly reported and appropriately adjusted in a cost-effective manner. However, each state envisions a different path to achieving this goal.

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[8] Typically, the adjuster who handles an injured worker's claim is an employee of the insurance carrier that provides workers' compensation insurance to the employer. A self-insured employer, however, may either hire its own adjuster or retain the services of a third-party administrator to handle its employees' claims. The term "adjusting entity" encompasses all three of these possibilities.

This report examines the performance monitoring programs currently in force in six states – Maine, Wisconsin, Minnesota, Colorado, Florida and Oregon.[9] The states selected represent a sampling of different types of monitoring systems (retrospective audit versus self-reported benchmarking), different enforcement mechanisms (penalties and fines versus corrective action planning and/or publicity), different geographic locations and varying market and constituent sizes. Clearly the list is not exhaustive, but the similarities and differences among the states studied represent a reasonable sampling of the various potential approaches.

A. Maine's Compliance Monitoring Program

Established in 1997, Maine's workers' compensation compliance monitoring and benchmarking program is a model of a self-reporting system that has achieved measurable results at a fairly low cost. The Maine Workers' Compensation Board administers the program. Its goals are:

(1) To provide timely and reliable data to policy makers;

(2) To monitor and audit form filings and payment performance; and

(3) To identify carriers, self-insured employers and third-party administrators who are not complying with identified minimum standards (i.e. benchmarks).

The philosophy underlying Maine's program is that "what gets measured gets done." The program's focus is on achieving better compliance by monitoring performance in specific areas and publicizing each adjusting entity's resulting "score." Rather than relying on administrative fines and penalties to punish specific failures in

[9] Information about these systems was collected from individual state regulators in the different states. For this reason, information was easier to obtain in some states than others. As such, the overview below necessarily contains more detail for certain states.

individual claims, the program seeks to encourage best practices by publicly comparing each adjusting entity's performance and inviting its consumers (identified primarily as employers and their insurance agents) to do likewise.

The key components of Maine's system are:

- **Objectively verifiable benchmarks, focusing on initial claim activity.**

The Maine program monitors four events, all of which occur within the first three weeks of a workers' compensation injury. These are:

1. Timely filing of First Report of Injury;
2. Timely payment of first indemnity benefit;
3. Timely filing of Memorandum of Payment;[10] and
4. Timely filing of Notice of Controversy.[11]

Maine has defined an aggregate performance benchmark for each event, against which each adjusting entity is measured. For example, the benchmark for timely payment of the first indemnity benefit is 80% compliance, meaning that an entity that has made a timely first payment in at least 80% of its claims is deemed to have met the standard. The benchmark for timely filing of the Memorandum of Payment is 75%, meaning that an entity that fails to make timely filings in at least 75% of its claims fails the standard.

The benchmark for each event is intended to represents a reasonable expectation of quality performance, and takes into account the unexpected occurrences that occasionally arise to affect timeliness in an individual claim. Together, the standards set

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[10] This is the form filed with the state to document the carrier's initial payment and identify anticipated claim issues.
[11] This is the form used to deny all or part of a claim for benefits.

a minimum level of acceptable performance that is realistic and attainable. At the same time, they leave ample room for motivated performers to demonstrate excellence by achieving even better results.

Monitoring the timeliness of the benchmarked events is simple – a matter of counting days. In that respect, the focus is less on the "quality" of adjusting than on the "quantity" of timely filed forms. The theory, however, is that these four events represent a measurable indicator of appropriate claims adjuster activity and, if done timely and accurately, at least the injured worker's claim moves along expeditiously.

- **Compliance monitoring based primarily on self-reporting rather than auditing.** Particularly with respect to the timely payment of benefits, the Maine program relies primarily on adjusting entities' self-reporting rather than administrative audits or retrospective claims reviews. This allows the program to run with a minimal staff and budget.[12] The obvious trade-off, however, is that the results may be less reliable than if they were based on retrospective administrative audits rather than self-reported compliance.

- **Compliance results reported publicly and broken down across various carrier groups.** The Maine Workers' Compensation Board publishes both quarterly and annual reports detailing the results of its compliance monitoring. The reports are available to the public and are posted on the Board's website.

Significantly, the reports detail all compliance monitoring results individually for every entity monitored, be it an insurance carrier, a self-insured employer or a third-party

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[12] The Board's Office of Monitoring, Audit and Enforcement has an annual budget of approximately $538,000. Approximately one-half of that is allocated to the Office's compliance monitoring efforts.

administrator.[13] The results are also collated for comparative purposes across the various groups doing business in Maine – in-state versus out-of-state carriers, for example, or standard carriers versus third-party administrators. This allows members of the public to access data as to how any individual company or coverage option group has performed in comparison with its competitors. For example, an insurance producer seeking workers' compensation coverage for a client can learn whether Carrier A is better than Carrier B when it comes to timely payment of benefits or a self-insured employer can determine which third-party administrator seeking to handle its claims has come under increased scrutiny recently for deficient performance.

Providing the data to the public in this manner allows the Maine program to encourage a higher level of compliance by relying on market forces such as competition, comparative analysis and the power of an informed consumer to encourage better performance.

- **Corrective Action Plans imposed on poor performers.** Rather than imposing fines and penalties on performers that do not meet minimum standards, Maine encourages better performance by developing a Corrective Action Plan for the deficient performer suggesting ways in which claims adjusting issues can be addressed and remedied. These plans often include training to address specific deficiencies, more frequent administrative monitoring, and documented deadlines for meeting interim improvement goals.

Entities subject to Corrective Action Plans are publicly identified in both quarterly and annual reports. An entity that fails to adhere to the elements of its

[13] The timeliness of the First Report of Injury is reported only in the aggregate, not by individual entity.

Corrective Action Plan may be subjected to fines and penalties for violations of Maine laws relating to unfair claims practices.

- **High compliance performers recognized.** In keeping with its philosophy that competition and comparative analysis will encourage better performance, the Maine program specifically recognizes high compliance performers in its public compliance report. To qualify as a high performer, an entity must have met or exceeded the benchmark standard in all categories monitored. The top three entities in each group – standard carriers, self-insured employers and third-party administrators – receive special notice and recognition in the Annual Compliance Report.

- **Focus on entity performance, not individual adjuster activity.** Although all of the benchmarks monitored in the Maine program measure the timeliness of activities typically conducted by adjusters, the Maine program focuses on the compliance of the entity providing claims adjusting services, not its adjuster-employees. Thus, there are no performance benchmarks relating to individual adjuster caseloads, no Corrective Action Plans targeting individual adjuster activity, and no special recognition for high performing individuals.

The reasons for maintaining the focus of compliance monitoring on the entity rather than the adjuster include:

- High turnover among adjusters makes it difficult to monitor their performance consistently;
- Differences among entities as to support staffing ratios, case management assistance, supervisory responsibilities and other claims management functions make it difficult to identify benchmarks that can be applied rationally to all adjusters;
- An adjuster's caseload handling ability is profoundly affected by individual characteristics such as training, education, experience and

general work habits. Imposing arbitrary caseload maximums or other product goals on all adjusters without considering these factors could hinder an entity's ability to manage its claims adjusting process cost-effectively and efficiently;

- Imposing fines and penalties on individual adjusters would raise difficult collection issues, and might punish them unfairly for management decisions beyond their control;
- Targeting individual adjusters for compliance monitoring could involve the Workers' Compensation Board in inefficient micro-managing of the entity's staffing, hiring and general business decisions.

Although the individual adjuster plays a key role in an entity's ability to maintain high compliance and meet acceptable performance standards, the Maine program recognizes that from both an enforcement and public scrutiny standpoint, the focus must be on the adjusting entity, not the individual.

In summary, the Maine compliance monitoring program encourages high quality claims adjusting by directing public scrutiny towards benchmarked performance indicators, identifying both the good performers and the deficient ones. It assists poor performers by developing individualized action plans to encourage improvement and publicly recognizes high achievers for exceptional performance.

According to state regulators there, Maine has seen a noticeable improvement in timely filing of the first report of injury and timely payment of benefits.[14]

B. Wisconsin's Compliance Monitoring Program

Wisconsin's compliance monitoring program is similar in many respects to Maine's. The program's stated goal is to "promote excellence in claims handling

[14] Maine law requires the first report of injury be filed within seven days of accident. In the first year of the compliance (1997), 36.7% of these reports were filed on time. In 2004, compliance was at 82.4%. Maine law requires benefits be paid within fourteen days. In 1997, 59.4% of benefits were paid on time. In 2004, 85.6% of benefits were paid on time.

practices" and "provide insurers and the general public with information" as to the various adjusting entities' claims handling performance. The information gathered through compliance monitoring is used to focus education and training efforts, improve performance, and ensure compliance with Wisconsin's workers' compensation statutes and rules.

Wisconsin's program has been in effect since 1998. Its key components are:

- **Objectively verifiable benchmarks.** As with the Maine compliance monitoring program, Wisconsin's program monitors the timeliness of payments and various filings with the state. The list of actions monitored, however, is far more extensive than those tracked in Maine. Among the items monitored are:

  - Timely filing of First Report of Injury;
  - Timely payment of first indemnity benefit;
  - Timely filing of first Supplemental Report;
  - Timely filing of Final Payment Report;
  - Timely filing of Final Medical Report;
  - Accuracy of average weekly wage and compensation rate calculation; and
  - Timeliness of response to claims correspondence.

The Wisconsin program monitors events that occur throughout the claim process. All of the monitored events are objectively verifiable and easily calculated.

As with the Maine program, Wisconsin has established benchmarks whereby compliance in the monitored categories is determined by reference to an aggregate benchmark rather than by the individual claim. Thus, an adjusting entity that makes

timely payment of the first indemnity benefit for 80% of its claims is deemed to be in compliance, notwithstanding that it made late payments 20% of the time.

The Wisconsin program also relies on automatically issued fines, which are monitored, to assess and encourage compliance. A forfeiture (i.e. penalty) automatically issues in an individual claim if the adjusting entity fails to comply with a reporting requirement, for example, by failing to timely file a Final Medical Report. The due date for each filing is programmed into the state's computer system based on the date of the triggering event and a fine (usually $100) automatically issues whenever the due date is missed. In addition to issuing the penalty, the Wisconsin program also monitors the ratio of claims received to forfeitures issued. The forfeiture benchmark is 97%, meaning that an adjusting entity that has been issued forfeitures and penalties in no more than 3% of its claims is deemed to have met the standard.

- **Compliance monitoring based primarily on self-reporting rather than auditing.** As is the case in Maine, Wisconsin's compliance monitoring efforts rely primarily on the adjusting entity's self-report rather than administrative audits or individual claim reviews conducted by the state. However, the timeliness of most of the monitored events is measured from an independently documented, objectively verifiable point – the date of injury or the date of release to work, for example.

- **Compliance results reported publicly.** The Wisconsin Workers' Compensation Division publishes its "Claims Handling Performance Indicator Report" quarterly and annually. The report details all compliance monitoring results individually by adjusting entity, grouped according to claim volume (large, medium or small). Best performers are listed first.

- **Poor performers targeted for further administrative scrutiny.** Like Maine, the Wisconsin program relies primarily on increased scrutiny, training and education to improve deficient claims handling. An adjusting entity that fails to meet the benchmark for a monitored event receives a warning letter notifying it of the deficiency. Corrective action planning often occurs at this stage. In the event of consistent non-compliance, an adjusting entity may be subject to fines, and in extreme circumstances may be referred to the Insurance Commission for action against its licensure.

- **Focus on entity performance, not adjuster activity.** For the same reasons that the Maine program focuses on adjusting entity performance rather than adjuster activity, Wisconsin's compliance monitoring efforts target the adjusting entity itself rather than its adjuster-employees.

However, data is available to adjusting entities on individual adjuster performance. Thus, if an adjusting entity so chooses, it can access the claims detail from which its performance was determined by entering an assigned identification number and password. In this way, an entity can identify the adjuster responsible for specific deficiencies in individual claims, and take the steps it chooses – further training, additional supervision, diminished caseload responsibility – to improve performance. Much like Maine's program, Wisconsin's compliance monitoring efforts are geared towards defining acceptable benchmarks for adjusting entities' performance, publicizing the results and inviting consumers to choose the best performers. Unlike Maine, Wisconsin also uses monetary penalties and administrative review to further encourage entity compliance. By monitoring a variety of claims handling events throughout the life of the claim, the program allows the Workers' Compensation Division to target its

education and training efforts on areas where the most deficiencies are noted. In theory, by doing so, claims adjusting techniques are improved throughout the system.

C. Minnesota's Compliance Monitoring Program

Like Maine and Wisconsin, Minnesota's monitoring efforts focus primarily on objectively verifiable events that are easy to quantify as the key measures of both the employer's and the adjusting entity's compliance with the workers' compensation laws. Unlike Maine and Wisconsin, however, Minnesota has not defined specific compliance benchmarks by which performance is judged. The penalty for poor performance, furthermore, is not simply adverse publicity but also a series of routinely imposed fines.

The key components of Minnesota's program are:

- **Objectively verifiable compliance measures.** As noted, Minnesota's program monitors objectively verifiable events in order to monitor compliance, such as prompt payment of first benefit payment and prompt denial of benefits.

- **Fines and penalties used to encourage compliance.** Minnesota's workers' compensation statute allows for the assessment of fines and penalties against employers and insurance carriers for a wide variety of violations, including failing to file required reports in a timely manner, denying benefits without notice, and failing to pay benefits in a timely manner. The state routinely assesses these penalties, although it is not automatic as it is in Wisconsin.

Interestingly, Minnesota's statute subjects not only employers and adjusters to potential penalties, but also vocational rehabilitation and health care providers are subject to monetary sanctions for certain workers' compensation activities, such as failing to provide services in accordance with a certified managed care plan, failing to follow

certain workers' compensation rules, or failing to comport with professional conduct standards.

Once assessed, the penalties collected are paid to one of three recipients, depending on the nature of the violation. Most penalties are paid to the Assigned Risk Safety Account, a program that awards grants and loans to employers to improve the safety of their workplaces. Some penalties are paid to the Special Compensation Fund to assist in financing the entire workers' compensation system. Finally, when a penalty is assessed for failing to make a timely benefit payment, the fine is paid directly to the injured worker.

In the fiscal year ending June 30, 2003, Minnesota assessed more than $4 million in fines and penalties for workers' compensation penalties, and collected nearly $2 million.[15] The most frequent violations were for late first payment of indemnity benefits, late First Reports of Injury and late claim denials, which together accounted for 75% of all assessed violations.[16]

- **Some compliance information publicly reported.** The Minnesota Department of Labor & Industry publishes an annual "Prompt First Action Report" that details every adjusting entity's record as to prompt first payments or claim denials. The report indicates the number of claims handled by each entity and the percentage that were either paid or denied within the statutory time frame for doing so. As in Maine and Wisconsin, determining whether the first payment was timely is based primarily on the

[15] The difference between the amount assessed and the amount collected is due to: (1) penalties that are settled or withdrawn after assessment; (2) penalties that are challenged, which may delay their collection; and (3) penalties that are paid to injured workers, which are included in the "assessed" calculation, but not in the "collected" calculation.

adjusting entity's self-report as to when the payment issued and calculating whether the payment was made within the mandated timeline.

Further, the Department of Labor & Industry publishes an annual report detailing the number and types of penalties assessed and collected. However, this report provides only summary data and does not identify individual entities.

- **Focus on entity performance, not adjuster activity.** As is the case in both Maine and Wisconsin, Minnesota directs its compliance monitoring and enforcement efforts towards the adjusting entity rather than the individual adjuster. It does not track individual adjuster caseloads, and does not levy fines against individual adjusters.

To summarize, Minnesota's compliance monitoring and enforcement program places a heavier emphasis on fines and penalties than it does on publicity as the means to encouraging better performance. The focus may be working – the number of penalties assessed has decreased steadily in the past three years across most violation categories. However, the number of injury claims reported also has declined during this period.

D. Colorado's Compliance Monitoring Program

Colorado's compliance monitoring program differs considerably from Maine, Wisconsin and Minnesota.

The key components of Colorado's program[17] are:

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[16] By far the most costly violation, however, was for failure to insure, which accounted for only 13% of the number of violations found, but for more than half of the total amount assessed.
[17] Because of the highly confidential nature of the Colorado program, it was not as easy to obtain information from state regulators about this program. The level of detail in this section of the report reflects that difficulty.

- **State audits and reviews exclusive means of monitoring.** Colorado relies exclusively on on-site audits and retrospective reviews as a means of ensuring appropriate claims handling practices. Due to staffing and budgetary constraints, generally only the adjusting entities with the greatest market share are audited. Even the larger adjusting entities are scrutinized only once every few years; annual reviews are too costly and time-consuming to undertake.

- **Audit results are not public.** Audit results are entirely confidential. The state does not reveal the identity of the adjusting entities audited, the type and extent of specific deficiencies found or the remedial actions taken.

- **Focus on remediation, but fines are available.** For the most part, audit recommendations focus on education and training as the means to improving claims handling practices. Colorado statutes do not provide for any automatic penalties, but administrative sanctions can be recommended for ongoing or egregious violations.

- **Focus on adjusting entity performance, but may include individual adjuster analysis.** Colorado reviews adjusting entity performance and individual claims compliance. Audit results do not assess adjuster caseload, but audit recommendations may suggest that an adjusting entity consider reduced caseloads as a means of addressing specific deficiencies.

As compliance monitoring and enforcement data is not publicly distributed, it is impossible to gauge the impact Colorado's program has had on improving claims handling practices overall.

E. Florida's Compliance Monitoring Program

Florida employs a combination of both self-reported monitoring and retrospective audits to enforce compliance with its workers' compensation laws and encourage effective claims handling procedures. The Florida Division of Workers' Compensation has assumed a more active regulatory role in recent years, and has increasingly emphasized fines and penalties as the means to improving the claims adjusting process. This represents a significant shift in philosophy from Florida's past view of the regulator as a "process partner" in the adjusting scheme. It also has required the state to make a major capital investment in data storage, analysis and retrieval systems in order to implement the new program.

The key components of Florida's compliance monitoring and enforcement system are:

- **Extensive penalties for untimely payment and reporting.** Recent legislative reforms established clear and concise time frames for making payments to both injured workers and medical treatment providers. Reforms also established time frames for reporting information, including both claims and medical data, to the state. All such data must be reported electronically and the state requires strict compliance Florida has invested heavily in electronic data collection, retrieval and analysis systems, which allows it to, among other things, automatically impose fines whenever a late payment is made or a late report is filed.

In addition, the Florida program has established a performance benchmark requiring that 95% of an adjusting entity's payments to both injured workers and medical providers must be timely. If the standard is not met, further penalties can be assessed.

- **Audits are used to monitor timeliness and quality of adjusting.** In addition to automated monitoring of entity reported data, Florida conducts approximately 45 audits annually. Each audit involves a large sampling of claim files and a thorough inspection of benefit entitlement issues, timely and accurate payments and appropriate reporting. Thus, Florida's program looks beyond the timely adjusting of claims, but also looks at the quality of the claims adjusting.

- **Only summary data published.** Florida publishes some compliance data regarding penalties assessed against each adjusting entity, but data is provided in a summary format only. Florida does not publish any information identifying the specific violations giving rise to these fines.

- **Focus on entity performance, not adjuster activity.** As with the other states studied, Florida focuses its compliance monitoring and enforcement efforts on the adjusting entity, not the individual adjuster. Audit recommendations may include staffing and caseload considerations in certain situations, but there are no generally mandated standards or maximums.

Florida's Department of Workers' Compensation believes that its expanded insurer compliance efforts have resulted in significantly improved performance by the adjusting entities that do business in Florida. Certainly its shift in focus from "process partner" to "penalty assessor" has generated a huge increase in the number of penalties assessed and fines collected.[18] There has been documented improvement in the timeliness of both payments and reports, an indication that adjusting entities are mindful

[18] Florida reports that the number of files reviewed during audit increased by more than 400% from FY 2003 to FY 2004 (from 2,366 to 13,792), and the value of penalties assessed for late reporting and/or payment increased by more than 100% (from approximately $900,000 to more than $1.8 million).

of the financial burden imposed by Florida's punitive enforcement philosophy and are becoming increasingly adept at compliance as a result.

F. Oregon's Compliance Monitoring Program

Unlike Maine, Wisconsin or Minnesota, Oregon primarily uses retrospective audits to encourage compliance with its workers' compensation laws. It employs a three-year audit cycle, which means that every adjusting entity can anticipate a thorough review of its adjusting practices at least once every three years. However, in order to maintain this schedule, the sample size of claims audited is relatively small.

The key components of Oregon's system are:

- **Primary focus on timely and accurate payments.** The principal goal of Oregon's compliance audit program is to ensure that injured workers' benefits are calculated correctly and paid timely. The secondary focus is verifying that adjusting entities are submitting timely and accurate data to the Workers' Compensation Division.

- **Penalties assessed for failure to achieve performance benchmarks.** Like Maine and Wisconsin, Oregon has defined benchmarks by which compliance is measured. The benchmark for acceptable performance in most of the audited categories is 80%, meaning that an adjusting entity that complies with the applicable timeliness standard in at least 80% of the claims audited is deemed to have "passed" in that category. If the 80% standard is not met, a penalty is assessed, the amount of which is dependent on the number and type of violations discovered.

- **Stricter standard for accurate reporting of timely first payment.** As is the case in Maine and Wisconsin, an important focal point of Oregon's compliance monitoring program is to ensure that an injured worker's first benefit payment is timely.

In order to encourage accurate self-reporting in this area, Oregon imposes both a strict performance standard and a heavy penalty for failing to accurately report first benefit payments. Performance benchmarks are not applied in this category. Rather, if an audit reveals that a first payment was reported as having been timely made, when in fact it was not, the adjusting entity must pay a fine.

- **Audit results are not public.** The audit report, number and type of violations found, and penalties imposed are all confidential.

- **Focus on entity performance, not individual adjuster activity.** As in the other states studied, Oregon's compliance efforts focus on the adjusting entity's performance, rather than the individual adjusters. Audit report recommendations may include staffing and/or caseload considerations, or suggestions for increased education and training efforts, but individual adjusters are not singled out or otherwise identified.

As is the case in Colorado, the fact that Oregon does not publish any specific data as to its compliance audit results makes it difficult to assess the impact its program has had on the claims adjusting process. Anecdotally, the same adjusting entities seem to fall below the benchmarked standard in the same categories year after year. Unlike Florida, the penalties imposed in Oregon for failure to demonstrate acceptable adjusting practices consistently are neither widespread nor severe. Conceivably the adjusting entities have decided that the penalties are not significant enough to warrant changing the way they staff their offices, train their adjusters or handle their claims.

G. Summary of State Program Characteristics

To summarize, the compliance monitoring and enforcement efforts in other states share many characteristics, including:

- All focus primarily on timeliness as the most efficient measure of adjusting entity compliance.

- All focus on adjusting entity performance rather than individual adjuster activity.

- None have imposed adjuster caseload maximums as a means of ensuring better performance.

The following comparisons also are instructive:

- Three of the states studied – Maine, Wisconsin and Oregon – use benchmarks rather than individual claim data as the primary indicator of acceptable adjusting performance. Two states – Minnesota and Colorado – use individual claim data. Only one state – Florida – uses a combination of both individual claim data and defined benchmarks to evaluate performance.

- Three states – Maine, Wisconsin and Minnesota – publish the results of their compliance monitoring and enforcement efforts specifically by adjusting entity. Colorado and Oregon do not publish the results of their compliance audits at all, either individually or in summary fashion. Florida publishes summary data as to the amount of penalties assessed and collected, but does not identify the specific entities which have been penalized.

- Maine, Wisconsin and Colorado focus compliance efforts on achieving better results through education, training and corrective action planning. In contrast, Minnesota, Florida and Oregon focus on fines and penalties as the primary means to encourage improved adjusting practices.

Unfortunately, except for some limited exceptions, very little data is available to assess how effective any of these states' compliance monitoring and enforcement efforts have been at improving adjusting practices overall. Further, an adjusting entity's performance is a function of many variables, such as market share, geographic location, injury trends, and corporate philosophy. Finally, the different states' programs vary so

widely that it is impossible to calculate the impact of any one compliance program factor on performance as a whole or compare the efficacy of the various approaches.

However, it appears that both Maine and Minnesota are achieving better compliance with their workers' compensation programs, but whether this is as a result of their monitoring efforts or not is impossible to establish. Florida has realized a significant increase in revenues attributable to the number of fines and penalties it now assesses. Again, whether this will translate into better adjusting practices overall remains to be seen.

II. IDENTIFYING POTENTIAL PROBLEMS IN VERMONT'S CLAIMS ADJUSTING PROCESS

A. Survey Respondents

As noted above, we created a survey chart (attached as Appendix B) in which we asked various stakeholders to identify potential problem areas, i.e. bottlenecks, in the claims adjusting process. Respondents were also given the opportunity to make general comments and recommendations about the claims process.

We received surveys from insurance companies, lawyers, individual adjusters and independent insurance producers. We sent surveys to the top 14 insurance companies writing workers' compensation coverage in Vermont. This group represents 90% of the workers' compensation business written in Vermont for the year 2002. We received a completed survey from each company.

We sent surveys to fourteen lawyers who specialize in workers' compensation. Half normally represent the claimant and half normally represent the insurance companies. All of these lawyers responded either by completing the survey or answering questions over the phone.

Workers' compensation licensed adjusters were mailed surveys and they also were presented with surveys at a continuing education seminar in September of 2004. We received ten completed surveys from this group. In addition, approximately twenty licensed adjusters participated in a two-hour discussion group at the Labor & Industry sponsored continuing education program held in September of 2004.

Finally, we received two completed surveys from independent insurance producers who specialize in workers' compensation.

B. Survey Results

The bottlenecks identified varied somewhat, depending on the stakeholder group responding. Some processes in the claims process, however, consistently received ratings indicating a high risk of a bottleneck and/or were repeatedly noted in the comments section of the survey. These included:

- Establishing and maintaining contact with the injured worker's treatment provider(s);
- Obtaining relevant medical records, particularly those relating to prior injuries;
- Clarifying the injured worker's current work capacity; and
- Scheduling independent medical evaluations.

However, to a large extent, these are matters most often outside an adjuster's control. Adjusters and attorneys alike experience significant delays in their attempts to get treatment providers to address issues that are relevant legally, but not medically – causation issues relating to compensability, for example. Often it is difficult to retain a treatment provider's attention during the give-and-take process of identifying suitable

modified-duty work, which impacts not only the injured worker's ongoing entitlement to benefits, but also the vocational rehabilitation process.

Adjusters noted the following bottleneck, in addition to the ones listed above:

- Obtaining the injured worker's signature and the Department of Labor & Industry's approval on the agreements pursuant to which benefits are paid.

Attorneys noted the following bottlenecks:

- Receiving responses from adjusters;
- Scheduling delays by the Department of Labor & Industry for both informal conferences and formal hearings; and
- Paying benefits in a timely manner.

Finally, the scarcity of doctors who are trained and willing to perform independent medical evaluations contributes to scheduling delays that affect all aspects of the claim and frustrate all of the stakeholders involved in it.

III. SOLUTIONS

A. Immediate Steps for Improvement

As hoped, responses to the survey did help identify a few bottlenecks in the claims process which appear to be easily rectified.

1. *Eliminate the Compensation Agreement and replace with a Memorandum of Payment*

The Compensation Agreement is the form which identifies the indemnity benefits for an injured worker with either a temporary or permanent disability. Under present procedures, benefits cannot be paid until both the adjuster and the injured worker sign the Compensation Agreement form and it is submitted to Labor & Industry.

Many stakeholders commented that injured workers might be reluctant to sign the form because they are unfamiliar with its function or legal significance, even when there is no disagreement about the benefits due to the injured worker. Without the claimant's signature, benefits cannot begin to be paid and the claims adjusting process is slowed considerably.

What is important is that the injured worker receives timely and comprehensible notice of an adjuster's determination as to what benefits are due, in what amounts and at what times. Provided that the injured worker has adequate time to dispute or otherwise respond to an adjuster's determination in this regard, it is not necessary that he or she actually sign the form before it can become valid and enforceable.

We recommend eliminating the Compensation Agreement and the signature requirement and replacing it with a document which notifies the injured worker of the adjusters' determination and gives the worker a specific period of time in which to contest that determination.

In Maine, for example, the adjuster is required to circulate a "Memorandum of Payment" form to the injured worker, the employer and the Department of Labor & Industry within 17 days of receiving notice of a work-related injury. The Memorandum of Payment documents the claim's status, the type of payment to be made and the basis for the adjuster's calculation. The form also documents the date on which the first indemnity payment was issued, which allows Maine to track the timeliness of this event.

We recommend Vermont adopt a similar procedure. Rather than circulating a "Compensation Agreement" requiring the injured worker's signature, the adjuster should circulate a "Memorandum of Payment" instead. The Memorandum should document the

adjuster's intentions as to paying or denying benefits as well as the calculation as to when and in what amount they are due. Upon receipt of this Memorandum, the injured worker should be given a specific amount of time to contest the adjuster's determination, by notifying the interested parties accordingly, or accept them by taking no action at all. For its part, Labor & Industry can review the Memorandum in the same way that it now reviews the Compensation Agreement and either accept it or reject it as necessary.

Revamping the process in this way also will give Labor & Industry the data it needs to monitor the timeliness of an adjuster's first indemnity payment to an injured worker.

2. *Incorporate ten-day requirement for adjuster response to inquiries in Labor & Industry Rule 1-46*

As noted above, attorneys complained that adjuster responsiveness to inquiries was a problem. The workers' compensation regulations do not impose specific responsiveness obligations on workers' compensation adjusters. However, such adjusters are subject to the Insurance Trade Practices Act, Chapter 129 of Title 8. However, as noted above, the Insurance Trade Practices Act contains primarily broad standards, requiring that claims be affirmed or denied within a "reasonable time" and requiring adjusters to "act reasonably promptly" in response to communications. *See* 8 V.S.A. § 4724(9). Nonetheless, adjusters for claims other than workers' compensation claims are further subject to, in most instances, the Insurance Division's Regulation 79-2.[19] Regulation 79-2 requires that adjusters in claims (other than workers' compensation claims) respond to inquiries from claimants within ten days. We recommend this relatively simple and not overly onerous standard be incorporated into the Labor &

Industry rules pertaining to workers' compensation claims. We note, however, that we don't recommend this response timeline requirement be limited to claimant inquiries as it is under BISHCA Regulation 79-2. We received comments about the timeliness of adjuster responses from several stakeholder groups.

3. *Do not implement individual adjuster caseload maximums*

Act 132, H. 632, Section 2(1)(B) instructed BISHCA to study the efficacy of "implementing caseload maximums for adjusters." For the following reasons, we concluded that implementing caseload maximums for workers' compensation adjusters is not the most effective way of improving adjuster performance.

The stakeholders polled in our study and the state administrators who provided information about their state systems offered valuable insight as to whether statutorily imposed caseload maximums might be a means of improving adjuster performance and achieving better compliance. All agree that an unreasonably heavy caseload inhibits an adjuster's ability to meet performance standards. However, the general consensus is that managing individual adjuster caseloads and general performance is best addressed through each adjusting entity's internal structure and the decisions it makes with respect to hiring, training and staffing its claims handling operation.

The adjusters who attended the brainstorming session at the Department of Labor & Industry's annual conference voiced strong opinions as to whether the state should involve itself in setting caseload maximums. Among their insights:

- An adjuster's ability to handle a certain caseload depends on a wide variety of factors relating to the individual (experience, education, training, work habits),

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[19] Workers' compensation adjusters are exempt from Regulation 79-2.

the type of claims involved (medical-only, routine indemnity, catastrophic loss) and other job-related responsibilities (marketing, clerical, supervisory). A seasoned, well-trained adjuster with good organizational skills is likely to be able to handle a larger caseload than a poorly trained adjuster with only minimal experience. A caseload composed primarily of small medical-only and routine indemnity claims takes far less time to manage than one composed of more complicated indemnity claims and catastrophic losses. An adjuster whose sole responsibility is to adjust claims can devote more time to the task than one who also must make marketing calls, supervise other employees and handle clerical functions.

Rather than imposing some arbitrary maximum by statute, each of these factors must be considered in determining what an appropriate caseload is for any individual adjuster. Further, it would be extremely difficult to efficiently attempt to address all of these factors through complex legislation without also creating numerous unanticipated administrative inefficiencies which could defeat the goal of the maximums. Focusing on adjuster entity performance, rather than caseload, appears to be more efficient.

- Most adjusters handle claims in a number of different states, and their claim volume in any one state varies widely from year to year. If an individual's Vermont caseload was limited artificially by statute, it is likely that the adjuster would simply assume responsibility for a larger volume of claims in other states instead. Although they may handle fewer Vermont claims, they could continue to handle the same number of claims overall.

- It would be difficult for the state to calculate an adjuster's caseload accurately, particularly with respect to medical-only claims, which tend to open and close

quickly and often are outsourced for their primary function, that of medical bill review and payment.

In addition administrators from the other states we contacted noted the following:

- Enforcing adjuster caseload maximums would require more comprehensive auditing of individual claims, an expensive and time-consuming process.
- Imposing caseload maximums without regard to a particular adjusting entity's hiring, training and staffing practices likely would result in increased inefficiencies rather than better performance overall.

One individual interviewed described how a company could circumvent the intent of implementing caseload maximums for adjusters. He described a company that had adjusters with low caseloads. This company would appear to be the ideal model except for the fact that the company's adjusters were responsible for various marketing functions as well as adjusting functions. As such, the company's adjusters' workload was just as demanding for the individual, despite the low caseloads.

None of the states studied have imposed adjuster caseload maximums by statute. All have opted instead for outcome-based performance measures, leaving it to the adjusting entities themselves to determine how best to hire, train and staff their operations in order to achieve the mandated standards. We have concluded, consistent with other states, that improving workers' compensation adjuster performance is most efficiently achieved through focusing on performance objectives, rather than caseload maximums.

B. Implement Pilot Study

The majority of state programs which we reviewed focused on objectively verifiable events rather than more subjective quality measures. Obviously, it is less

resource intensive for the state to focus compliance efforts on objectively verifiable events. Further, by focusing performance objectives on concrete measurable standards, adjusting entities and other stakeholders have clear direction from the state as to what is expected of them during the claims adjusting process.

Taking into account the entire claims process in Vermont and input we received on that process from the various stakeholders, the identified problem areas and other states' experiences, we identified three activities which we felt were the critical activities in the claims process that might be improved by further monitoring or regulation:

1. Accepting or denying the claim in a timely manner;
2. Paying benefits on accepted claims in a timely manner; and
3. Terminating benefits on resolved claims in a timely manner.

These claims activities can be measured based on objective criteria. As such, they can be assessed with reasonable certainty relying on data reported by the adjusting entities themselves and could be monitored by the State in a relatively cost effective fashion. Further, the events noted span the life of the claim and are thus likely to protect stakeholders in a more comprehensive manner than focusing on only the beginning of the claim.

Although we were able to identify three areas that may be improved through monitoring or more specific regulation, at this time whether adjusting entities in Vermont are achieving these three events in a timely manner is unknown. Such events are not specifically monitored on a systems-wide basis. Thus, we felt it was premature to recommend specific objectives or regulations.

We believe that additional study is needed to determine how adjusting entities are presently meeting these three obligations. At this time, we do not know how timely the adjusting entities within the state are accomplishing each of these objectives. As such, we are recommending that the Department of Labor & Industry conduct a pilot program to study when these events are occurring. After establishing how long each of these events typically takes, the State can determine whether claims are being handled in a timely manner and whether or not additional time constraints should be imposed.

Further, once a baseline has been determined, benchmarks can be established to define acceptable compliance. We believe a benchmark can be a useful tool to encourage compliance because it allows for a certain amount of error (an inevitable part of the adjusting process) while still requiring a pre-established reasonable level of compliance.

Another benefit of conducting the pilot project is that Labor & Industry can assess its data collection and data monitoring experience. After conclusion of the pilot study, Labor & Industry should be able to make meaningful recommendations about the costs and benefits associated with greater monitoring of adjuster entity activity.

C. Study Areas for Further Enhancement

The pilot program recommended above focuses on three discrete areas in the claims process which may potentially be improved through objectively verifiable standards, the setting of benchmarks and increased monitoring. However, various other steps in the claims handling process were identified by survey respondents which need additional review. As such, we believe a study of these remaining areas of concern should be undertaken.

Because Labor & Industry has historically regulated the workers' compensation claims process and is intimately involved with the process already, we are recommending Labor & Industry spearhead the study. This report only identifies the areas which we believe warrant further examination. We believe it is more appropriate for Labor & Industry to identify the specifics of how any such study should be conducted.

Many of the potential bottleneck areas identified by stakeholders involved the medical community. Medical treatment providers are only peripheral players in the workers' compensation process; medical treatment is their primary objective. Therefore, it may be that treatment providers are unable to allocate their limited resources to facilitating the present claims process. As such, we believe it is imperative that any study conducted examine those areas in the claims process which involve the medical community and analyze methods of improvement. However, we strongly believe without dialogue with the medical treatment providers, no suggested reforms will be successful.

Virtually all of the stakeholders who responded to the survey expressed frustration with the delays that routinely occur in the process of obtaining relevant medical records from treatment providers. Any study undertaken to streamline the claims process should examine alleviating this problem.

The process of obtaining relevant medical records in New Hampshire is facilitated by eliminating the authorization form altogether; no medical authorization is required to obtain the records in the workers' compensation claims context. For those medical providers who remain reluctant to release records without a specific patient authorization, the New Hampshire Department of Labor & Industry issues an explanatory letter, referencing the appropriate statute and offering the necessary reassurance. The study

should assess ways to streamline this part of the process including the possibility of placing the Medical Authorization form with the first notice of injury.

Another area that was identified as a bottleneck was the scheduling of hearings and conferences with Labor & Industry. The Department should study ways in which these scheduling issues could be alleviated, such as additional staffing, allowing further use of telephone conferences, or otherwise streamlining the scheduling process.

RECOMMENDATIONS

The following summarizes the recommendations discussed in the body of this report.

Recommendation 1: Eliminate the need for the injured worker's signature on the forms that document the benefits to be paid.

Current Vermont process requires that the indemnity benefits due an injured worker for either temporary or permanent disability be paid in accordance with a "Compensation Agreement." The Agreement must be signed by both the adjuster and the injured worker, and then submitted to the Department of Labor & Industry for its approval.

Many stakeholders commented on the bottlenecks that occur because of the injured worker's unfamiliarity with the Compensation Agreement form, and his or her reluctance to sign it as a result, regardless of whether any disagreement exists as to the form's contents.

What is important is that the injured worker receives timely and comprehensible notice of an adjuster's determination as to what benefits are due, in what amounts, and at what times. Provided that the injured worker has adequate time to dispute or otherwise respond to an adjuster's determination of benefits due, it is not necessary that he or she actually sign the form before it can become valid and enforceable.

As discussed above, we recommend Vermont adopt a procedure incorporating a form similar to Maine's Memorandum of Payment. The Memorandum of Payment does not require the injured worker's signature to become effective and trigger benefits, but it allows the injured worker sufficient explanation of the adjuster's benefits analysis as well as sufficient time for the injured worker to determine whether or not he or she agrees with

the adjuster. If the claimant agrees with the adjuster, he or she takes no action. If the claimant disagrees, he or she must notify the adjuster and Labor & Industry. In this way, the claims process is not slowed down as a claimant analyzes their situation and is only impacted if there is an actual dispute about benefits due.

- **<u>Action required</u>: Amend Department of Labor & Industry Rules to substitute "Memorandum of Payment" process in place of current "Compensation Agreement" process.**

<u>Recommendation 2</u>: Implement mandatory ten-day response time for adjusters to respond to inquiries.

Various stakeholders, including claimants' attorneys and employers, commented that it was sometimes difficult to get adjusters to respond to claims inquiries. Under the present regulatory system, workers' compensation adjusters are subject to the same general requirements of the Insurance Trade Practices Act as are adjusters of other types of claims. The Insurance Trade Practices Act requires that adjusters respond "reasonably promptly." 8 V.S.A. § 4724(9)(B). However, workers' compensation adjusters are exempt from the more specific claims settlement requirements included in BISHCA's regulations because workers' compensation claims are primarily regulated by Labor & Industry Rules.

Adjusters handling claims other than workers' compensation claims are required respond to claimants' inquiries within ten days. We recommend that a similar requirement be imposed on adjusters of workers' compensation claims. This should alleviate some of the concerns voiced by stakeholders relating to adjusters' responsiveness.

- **<u>Action required</u>: Amend Department of Labor & Industry Rule 1-46 to include a ten day mandatory response time to inquiries.**

Recommendation 3: **Refrain from imposing caseload maximums.**

The state should refrain from imposing caseload maximums on individual adjusters. An adjuster's caseload handling ability depends in large part on individual characteristics such as training, education, experience and work habits. The type of workers' compensation claims and other work assigned also impacts the number of claims an adjuster reasonably can be expected to manage. The support staff available to assist in the claims adjusting process – data entry clerks, medical case managers, supervisors – further impacts caseload volume considerations. Given these variants, imposing an arbitrary caseload maximum on all adjusters and adjusting entities would be ill-advised. Focusing instead on underlying compliance requirements – timely and accurate benefit payments, for example – is a more effective way of ensuring adequate claims handling.

- **Action required:** **No action required.**

Recommendation 4: **Undertake a pilot program to monitor adjusting entity performance relating to three verifiable events during the claims process.**

The Department of Labor & Industry should implement a program to monitor adjusting entities' performance in the following areas:

- Timely acceptance or denial of claims;
- Timely first indemnity payment, for accepted temporary and permanent disability claims; and
- Timely discontinuance of indemnity benefits.

The monitored areas represent important moments in any workers' compensation claim, for the following reasons:

- Administrators, injured workers, medical providers and employers all need to know in a timely manner whether an adjuster intends to accept or deny a claim for benefits, so that each can plan accordingly.
- Once a claim is accepted, the injured worker needs to receive the first benefit payment without delay.
- When information is received that should lead to benefits being discontinued, this should occur promptly as well so that claim costs are not increased unnecessarily.

This program should be tested as a one-year pilot project initially. This will allow Labor & Industry to ascertain whether its data collection, retrieval and analysis systems are adequate to capture and monitor the necessary information effectively and accurately. Labor & Industry should work closely with adjusting entities to ensure that the monitoring process is not unduly cumbersome and that it fairly measures compliance.

Presently, we do not know how timely these events are occurring on a systems-wide basis. It may be that the vast majority of these events occur in approximately the same period of time. Or it may be that there is a wide variance in how timely certain adjusting entities accomplish these events. By monitoring these events through a pilot program, Labor & Industry can establish a baseline of what is occurring in the present claims environment. Once such a baseline has been established, Labor & Industry can assess whether it is prudent to monitor these events on an on-going basis, whether it makes sense to define acceptable compliance benchmarks and whether Vermont wants to

implement some other aspects of certain state regulatory programs (such as routine fines, audits or publishing compliance reports).

- **Action required: Labor & Industry should design and implement a monitoring system in order to establish the existing claims environment baseline. Legislative and/or regulatory amendment will be necessary in order to implement a permanent compliance program based on Labor & Industry's recommendations.**

Recommendation 5: Investigate ways in which the claims adjusting process can be streamlined.

Outside of adjuster entity performance standards, our survey revealed there were certain areas where most, if not all, of the stakeholder groups felt there could be improvement. These included communicating with the claimants' treatment provider, obtaining medical records, clarifying the injured workers current work capacity, scheduling independent medical evaluations, and scheduling delays by the Department of Labor & Industry for hearings and information conferences.

Labor & Industry should conduct a study of the claims process which identifies areas where processes could be eliminated or otherwise made more efficient to address the concerns voiced by the stakeholders in response to our survey. Many of the areas identified as potential bottlenecks involved medical treatment or treatment records. As such, it is imperative that any study of the claims process involve the medical community.

Medical providers hold the key to the most critical moments in an injured worker's claim for benefits: what treatment is necessary, when it is appropriate to return to work, whether the injured worker needs vocational rehabilitation and whether there is any permanent impairment. Labor & Industry should engage the medical community in

an ongoing discussion as to how best to streamline the communication process so that information flows more freely between medical providers and adjusters.

Virtually all of the stakeholders who responded to the survey expressed frustration at the delays that routinely occur in the process of obtaining relevant medical records from treatment providers. Anything that can be done to streamline this process will help alleviate the problem.

Vermont law already provides that when a claim for workers' compensation benefits is filed, the injured worker waives his or her right to privilege as to relevant medical records. Workers' Compensation Rule 3.0800 The waiver is automatic, and there may be no need, therefore, for the claimant to sign a separate form authorizing the release of medical records. A copy of the First Report of Injury, and/or an explanatory letter to the medical provider from the Department of Labor & Industry might suffice.

The process of obtaining relevant medical records in New Hampshire is streamlined in this way. No medical authorization is required. For those medical providers who remain reluctant to release records without a specific patient authorization, the Department of Labor & Industry issues an explanatory letter, referencing the appropriate law and offering the necessary reassurance. Vermont's Department of Labor & Industry should investigate whether it can do likewise consistent with both state and federal law.

- **Action required: Convene a study committee involving adjusters and medical community to identify additional areas of improving the critical flow of medical information in workers' compensation claims and analyzing other areas where identified bottlenecks can be eliminated or minimized.**

APPENDIX A

Phyllis Severance-Phillips is an attorney and consultant on workers' compensation and related employment matters. From 1995 until 2003 she was co-owner of Workers Risk Services, Inc., a Vermont-based workers' compensation insurance company. Her experience in workers' compensation also includes three years as the workers' compensation director for the Vermont Department of Labor & Industry, as well as a private law practice focusing primarily on workers' compensation representation for employers, insurance carriers and injured workers. Ms. Severance-Phillips was a member of the 2003 Workers' Compensation Advisory Committee convened by the Vermont Department of Labor & Industry. She has testified before the Vermont Legislature and frequently speaks to professional groups on workers' compensation issues.

Ms. Severance-Phillips received her B.A. from the University of Vermont and her J.D. from the University of California, Hastings College of the Law. She resides in Williston with her husband.

The following is a list of the activities Ms. Severance-Phillips performed to assist BISHCA with this report:

- Researched insurance industry efforts to develop carrier and/or adjuster performance standards, and conducted telephone interviews with numerous industry representatives, including the Property Casualty Insurers Association of America (PCIA), American Society of Workers' Compensation Professionals (AMCOMP), International Association of Industrial Accident Boards & Commissions (IAIABC), Workers' Compensation Research Institute (WCRI) and National Council of Compensation Insurers (NCCI);

- Researched efforts to implement carrier and/or adjuster performance standards, and conducted telephone interviews with numerous administrators in a variety of states, including California, Texas, Wisconsin, Maine, Florida, Oregon, Colorado and Minnesota;

- Developed the workers' compensation adjusting process chart and Steps in Adjusting Process questionnaire; administered questionnaire and collated responses from claims adjusters, managers, attorneys and Department of Labor & Industry administrators;

- Conducted telephone interviews with numerous claims adjusters and attorneys as to perceived bottlenecks in workers' compensation system;

- Assisted with the initial drafting of the preliminary report.

Charles Piasecki, CPCU, CIC is the current Market Conduct Chief for the State of Vermont's Insurance Division. His major responsibilities include acting as examiner in charge of the market conduct exams conducted by BISHCA. He has been employed with BISHCA for three years. Prior to working for BISHCA he was the owner of the Bristol Insurance Agency of Bristol, Vermont. As a licensed agent he sold and serviced workers' compensation policies in Vermont for twenty years. Mr. Piasecki served on the Board of Directors of the Vermont Independent Insurance Agents' Association for eight years. In 1993 he served as President of the Vermont Independent Insurance Agents' Association. In addition to having experience as an agent, Mr. Piasecki also was a licensed insurance adjuster and worked for an independent adjusting firm.

Mr. Piasecki received his B.A. degree from Bowdoin College and a M.A. degree from the University of Oklahoma. He holds the insurance professional designations of Chartered Property and Casualty Underwriter, CPCU, and Certified Insurance Counselor, CIC. He resides in Ferrisburgh, VT.

APPENDIX B

"Steps in Adjusting Process" Survey

SURVEY CODES (use with chart on following page)

COLA - Cost of Living Adjustment
EE – Employee
EMR - End Medical Result
ER - Employer
FRI - First Report of Injury
IME - Independent Medical Evaluation
IWRP - Individualized Written Rehabilitation Plan
MD - Medical Provider
med tx - medical treatment
NCM - Nurse Case Manager
PPD - Permanent Partial Disability benefit
RTW - Return to Work
TPD - Temporary Partial Disability benefit
TTD - Temporary Total Disability benefit
VR - Vocational Rehabilitation

	Steps in Adjusting Process		Rate Bottleneck Potential		What would help?		Other
	First Report of Injury received						
1	Claim data entered						
2	Claim assigned to adjuster						
3	Coverage confirmed						
4	Claim Indexed						
	Investigate claim						
5	Contact employer						
6	Contact injured worker						
7	Contact medical provider						
8	Contact witness(es)						
9	Identify/investigate fraud flags						
10	Identify/monitor outstanding issues						
	Obtain necessary forms						
11	Wage statement						
12	Medical authorization						
13	Certificate of Dependency						
	Obtain medical records						
14	Current injury						
15	Prior injuries						
	Determine compensability						
16	Identify/resolve legal issues						
17	Identify/resolve factual issues						
18	Obtain IME if necessary						
19	Issue denial if appropriate						

	Develop action plan						
	Monitor medical treatment						
20	Assign NCM?						
21	Obtain IME?						
	Monitor work status						
22	Investigate modified-duty work						
23	Set reserves						
	Calculate TTD/TPD						
24	Form 21signed/approved						
25	Pay weekly benefits						
26	Calculate COLA/file Form 28						
	Maintain contact						
27	With injured worker						
28	With employer						
29	With treatment provider(s)						
	Review ongoing medical treatment						
30	Obtain medical records						
31	Audit/pay medical bills						
32	Obtain IME if necessary						
	Obtain release to RTW						
33	Clarify claimant's work capacity						
34	Monitor claimant's work search						
35	Obtain IME if necessary						
36	Assign surveillance if necessary						
	Obtain EMR determination						

37	Obtain IME if necessary						
	Discontinue benefits						
38	Form 27 filed/approved						
	Provide voc rehab services						
39	Determine entitlement						
40	Develop IWRP						
41	Monitor progress						
42	Obtain closure						
	Rate/pay PPD						
43	Obtain impairment rating						
44	Obtain IME if necessary						
45	Form 22 signed/approved						
46	Pursue subrogation						
	Resolve disputes						
47	Informal conference						
48	Formal hearing						
49	Refer to attorney?						
50	Initiate settlement negotiations						
51	Identify loss control issues						
	Respond to telephone inquiries						
52	Explain issues to claimant						
53	Explain issues to employer						
54	Close claim						