STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

State Compensation Fund

REPORT
HIGHLIGHTS
PERFORMANCE AUDIT

Subject

Although a state entity, the State Compensation Fund (Fund) operates like, and competes with, private insurance carriers in providing workers' compensation insurance to Arizona employers. Workers' compensation pays lost wages and medical expenses to workers injured on the job. In 2007, the Fund provided workers' compensation insurance to 58 percent (55,000) of Arizona employers, covering more than 1 million employees.

Our Conclusion

The Fund has a high ratio of claims expenses to its premium income and should continue its efforts to improve this ratio. The Fund should also continue to improve its claims management by better aligning itself with recommended practices.

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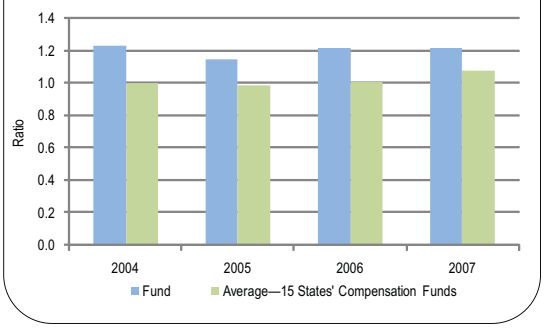
Fund has high claims expense-to-premium ratio

The Fund is required by law to be self-supporting. Therefore, like other insurers, it needs to receive enough premiums to pay claims expenses, which consist of lost wages benefits to injured workers, their medical expenses, and the Fund's other operating expenses, such as investigation, litigation, and employee expenses.[1] This comparison of expenses to premiums is called the claims expense-to-premium ratio. In calendar year 2007, the Fund's ratio was 1.22, indicating that for every $100 the Fund received in premiums, it paid out $122. Over the same period, the average ratio for a group of 15 states was 1.08.

The Fund makes up any gap between claims expenses and premiums with its investment income. The Fund's investments earned about $154 million and $206.8 million in 2007 and 2008, respectively.

Comparison of the Fund's Claims Expense-to-Premium Ratio to an Average of 15 States' Compensation Funds
Calendar Years 2004 through 2007



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Source: Courtesy of the State Compensation Fund.

The Fund's high claims expense-to-premium ratio has contributed to statewide premium increases although Arizona's premiums are still among the lowest in the nation. A national insurance-rating organization develops standard rates that all Arizona workers' compensation insurers must follow unless they receive permission from the Department of Insurance to charge higher or lower rates. These standard rates are based on the claims expense-to-premium ratios of all workers' compensation insurers in the State. Because the Fund insures more than half of all employers in the State, the Fund's high ratio has contributed to the national rating agency's recommending increases in Arizona's standard workers' compensation premium rate for every year between 2003 and 2008, except 2006.

Lowering the Fund's claims expense-to-premium ratio can potentially be accomplished by:

- Pricing insurance policies to better account for employer risk.
- Reducing operational expenses.

The Fund is taking action in both areas, but can do more.

1 The claims expense-to-premium ratio does not include investment income and dividend payments. State statute allows the Fund's Board of Directors to pay dividends to policyholders from a surplus of fund monies.

To improve premium pricing and better account for employer risk, the Fund is taking several actions.

Fund creating subsidiaries to improve pricing—The Fund is adopting an industry practice of creating subsidiary companies to allow it to better match its rates to policyholders' risk. By State law, an insurance company must charge the same premium for all employers within similar industries. However, by creating subsidiary insurance companies, policyholders can be assigned to different subsidiary companies based on the employer's risk. The Fund's first subsidiary, SCF Premier, began offering coverage in July 2007, and as of November 2008, had about 250 policyholders with a proven history of very low losses. Consequently, these employers received the best premium rates available. In March 2009, the Fund completed the process of creating three additional subsidiaries to provide additional rates for other employers based on their loss experience, with some planning to charge rates higher than the standard rate and some lower than the standard rate.

Fund should deny coverage to high-risk employers—Some employers' loss histories may make them too risky for even a subsidiary charging the highest premiums. Because workers' compensation insurance is statutorily required, these employers can become part of Arizona's assigned risk pool. They pay a 30 percent higher premium, and all workers' compensation insurers in the State share the cost of injured workers' benefits that exceed the premiums these employers pay.

However, Arizona has a smaller percentage of employers in its assigned risk pool than most states. Historically, the Fund has insured even the riskiest employers, refusing coverage only to those who refuse to take reasonable safety measures or fail to pay premiums. As a result, the Fund has some policyholders with very high losses. An internal analysis by the Fund found that in 2006, the 105 policyholders with the highest losses paid $7.1 million in premiums, but cost the Fund $60.2 million in benefits paid to injured workers.

The Fund should consider denying coverage to more of the riskiest employers. By doing so, more employers would be placed in the assigned risk pool and the risks would be spread among all of the State's insurers rather than falling so heavily on the Fund.

To reduce operational expenses:

Fund has acted to better control medical costs—Medical costs accounted for 67.3 percent of benefits paid to injured workers in 2006, and 66.2 percent in 2007. To help contain costs, the Fund pays benefits according to the Industrial Commission of Arizona's (ICA) fee schedule, which covers services by physicians, physical therapists, and occupational therapists, and pharmaceutical costs. In addition, the Fund has developed its own provider network, which has negotiated lower rates with about 2,900 physicians and healthcare providers, as well as many hospitals and ambulatory surgery centers. The Fund also uses a repricing service to determine reasonable and customary rates for healthcare services not covered by the ICA fee schedule or provided by the Fund's network providers.

However, about 30 percent of Arizona's hospitals and 60 percent of the ambulatory surgery centers are not part of the Fund's provider network. Because the ICA fee schedule does not cover these services, there are no external restraints on what the providers can charge, making it more difficult for the Fund to control these costs. The same applies to durable medical equipment such as wheelchairs. A possible remedy would be a statutory change establishing that any medical charge not covered by the ICA fee schedule be based on the usual and customary reimbursement rates in the community.

Recommendations

The Fund should:

- Consider denying coverage to more of the riskiest employers.
- Recruit additional providers to participate in its network.
- Work with the Legislature to develop legislation so that medical charges not covered under the ICA fee schedule will be based on usual and reasonable charges.

Better alignment with recommended practices could improve claims management

Timeliness and accuracy are two common measures used to evaluate claims management. The Fund generally meets the statutory standard for timely claims decisions and payments. For example, 99.6 percent of claims auditors analyzed met the statutory 21-day limit for acceptance or denial. However, the Fund's quality assurance (QA) reviews show both strengths and areas for improvement, measured against the Fund's internal criteria. The areas of opportunity for improvement involve timeliness of medical and lost-wages benefit payments and accuracy of lost-wages benefit payments. Because the QA review does not distinguish between cases that lacked documentation and cases that were actually inaccurate, the review likely underestimates the Fund's accuracy. The Fund needs to modify its QA process and tool to make the results more useful, and fund officials have already started making changes to the process.

Fund has taken steps to improve claims handling—The Fund contracted for an external review to help improve its claims management practices. It has reorganized its claims department so that one team handles a claim from beginning to end instead of transferring it between teams. The Fund has also implemented a new Best Practices Manual, which requires ongoing, active medical management.

Other recommended practices where the Fund can improve its claims handling include:

- Adopting additional claims assignment criteria beyond what it has already established in policy.
- Ensuring that its claims handlers contact the worker, employer, and medical provider within 24 hours of receiving the claim.
- Improving documentation of case strategy and action plans.
- Maintaining ongoing contact with injured workers to check on their work status and job search, where applicable.
- Improving its QA reviews so the results can be used to improve claims handlers' performance.

Once the Fund has implemented these changes, it should review their impact.

Recommendations

The Fund should:

- Follow recommended practices for claims handling, including contacting the worker, employee, and medical provider within 24 hours of receiving the claim, and maintaining ongoing contact.
- Modify its QA processes and tool to improve evaluation of timelines and accuracy of benefit payments.
- Review the implemented changes' impact.

TO OBTAIN MORE INFORMATION

A copy of the full report can be obtained by calling
(602) 553-0333

or by visiting our Web site at:
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