A REPORT
TO THE
ARIZONA LEGISLATURE

Performance Audit Division

Performance Audit and Sunset Review

State Compensation Fund

April • 2009
REPORT NO. 09-05

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

Debra K. Davenport
Auditor General

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STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

DEBRA K. DAVENPORT, CPA
AUDITOR GENERAL

WILLIAM THOMSON
DEPUTY AUDITOR GENERAL

April 20, 2009

Members of the Arizona Legislature

The Honorable Janice K. Brewer, Governor

Donald Smith, President and Chief Executive Officer
SCF Arizona

Transmitted herewith is a report of the Auditor General, A Performance Audit and Sunset Review of the State Compensation Fund. This report is in response to an October 5, 2006, resolution of the Joint Legislative Audit Committee. The performance audit was conducted as part of the sunset review process prescribed in Arizona Revised Statutes §41-2951 et seq. I am also transmitting with this report a copy of the Report Highlights for this audit to provide a quick summary for your convenience.

As outlined in its response, the State Compensation Fund agrees with all of the findings and plans to implement all of the recommendations.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on April 21, 2009.

Sincerely,

Debbie Davenport
Auditor General

Attachment

cc: Jim Weeks, Chairman
SCF Arizona Board of Directors

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SUMMARY

The Office of the Auditor General has conducted a performance audit and sunset review of the State Compensation Fund (Fund) pursuant to an October 5, 2006, resolution of the Joint Legislative Audit Committee. This audit was conducted as part of the sunset review process prescribed in Arizona Revised Statutes (A.R.S.) §41-2951 et seq.

Workers' compensation insurance provides injured workers with coverage for their job-related medical expenses, and if they are injured for a sufficiently long period, with payments to compensate for lost wages. The employer pays the insurance premium, and under state law, all employers must provide coverage. Employers have the option of obtaining this insurance through the Fund, but they can also obtain it through a private insurance carrier, or if they have sufficient financial resources, by self-insuring a compensation program. However, the Fund remains the largest single source of workers' compensation insurance in Arizona. As of 2007, the Fund reported that it provided workers' compensation insurance to more than 55,000 businesses with more than 1 million employees, representing 58 percent of Arizona's employers. That same year, the Fund collected 55 percent of total state-wide workers' compensation insurance premiums, according to Arizona Department of Insurance records. In 2007, the Fund processed more than 47,000 injury claims for medical bills, compensation for lost wages, and lifetime or death benefits. In that same year, the Fund paid $216 million for medical services and $101 million in payments for lost wages.

The Fund operates as a separate, self-supporting organization established under state statutes to provide workers' compensation insurance to Arizona employers. The Fund pays claims and other operational expenses entirely from its own revenues. It receives no state appropriations, and statutorily, must be administered without liability to the State of Arizona.

Fund should continue and enhance efforts to improve its claims expense-to-premium ratio (see pages 13 through 23)

The Fund pays out more in claims and related expenses than it receives in premiums paid by employers. Although the Fund has been able to rely on investment income to make up the difference, its ratio of claims expenses to income from premiums is higher than the national average for state compensation funds. A 2008 report from Oregon's Department of Consumer & Business Services ranked state workers' compensation premium rates and showed Arizona was the seventh-lowest nationwide in 2008.[1] Yet, because the Fund insures more than half of all employers in the State, its high ratio affects the overall ratings for the State and has resulted in increased premiums for all Arizona employers. Medical costs are the largest component of the Fund's claims expense.

Improving the claims expense-to-premium ratio can come from improving both the premium pricing structure and claims cost reductions.

- To improve its premium pricing, the Fund is changing its pricing policies and standards in ways that take risk into greater account in setting the premiums that employers pay. Specifically, the Fund has begun to adopt the industry practice of creating subsidiary companies that can offer different rates that more closely match the risk level of specific policyholders. This is expected to improve the Fund's claims expense-to-premium ratio as well as create a more equitable pricing structure. In addition, the Fund is reassessing its traditional approach of acting as the insurer of last resort, regardless of an employer's risk. Although statute does not require the Fund to cover all employers regardless of risk, under direction from its Board, the Fund has traditionally only refused coverage if an employer met specific criteria, such as refusing to take reasonable safety measures or failing to pay premiums. The Fund has some policyholders with very high loss histories. For example, according to the Fund's internal analysis, in 2006, the 105 most adverse policyholders insured by the Fund paid $7.1 million in premiums but cost the Fund $60.2 million in benefits paid for those policyholders' injured workers. If the Fund denied coverage to such employers, they would need to find coverage from another insurer or the State's Assigned Risk Pool.[2]

- To decrease claims costs, the Fund can consider making greater use of measures it already has in place for containing medical costs. Arizona has a fee schedule that has been effective in containing medical costs but does not include some high-cost services, such as facility charges by hospitals or

1 Department of Consumer & Business Services. (2008). *2008 Oregon workers' compensation premium rate ranking summary*. Retrieved February 11, 2009, from http://www.cbs.state.or.us/imd/rasums/2082/08web/08_2082.pdf

2 The Arizona Department of Insurance contracts with the National Council of Compensation Insurance to administer Arizona's Assigned Risk Pool, which provides workers' compensation insurance to employers who have been denied by the Fund and at least two private carriers.

outpatient surgery centers. The Fund should work with the Legislature to revise statutes to address these high-cost services. Also, the Fund may be able to further control medical costs by increasing the use of its medical services provider network. The Fund could do more to encourage policyholders to direct injured workers to network providers for their first treatment, and should continue its efforts to add new providers to the provider network.

Fund should continue to improve claims management by better aligning itself with recommended practices (see pages 25 through 35)

By better aligning its procedures with recommended practices, the Fund can continue to improve its processing of claims filed by injured workers. Although claims management can be evaluated in many ways, two common measures with readily available data are timeliness and accuracy—that is, whether medical bills and lost-wages benefit payments are made on a timely basis, and whether they are accurately determined. Auditors reviewed the Fund's own internal assessments of compliance with timeliness and accuracy requirements and supplemented this with additional analyses of lost-wages claims data. Both reviews showed areas where some challenges exist and areas where there are opportunities to improve, particularly with regard to claims for lost wages. For example, analysis of this data indicates that the Fund pays medical bills accurately, but can improve the timely payment of medical bills. Also, although the Fund generally meets statutory standards for lost-wages claims decisions and timely benefits payments, it can take some additional action to improve the accuracy and timeliness of lost-wages benefit payments and do more to ensure claims handlers actively obtain medical documentation.

In 2009, the Fund completed a reorganization of its claims processing functions, and although this reorganization has yielded improvements, it can do more. The most significant change was reorganizing the Claims Services Division so that a manager with claims experience supervises the teams and one team manages a claim from "cradle to grave" instead of transferring claims between teams when changes occur in the claim's status. According to fund officials, the new team structure, which was substantially implemented in August 2008 and completed in January 2009, should improve claims management and oversight continuity. However, improvements can be made in areas such as claims assignment, three-way contact, action plans, supervisory review, and obtaining medical documentation. Specifically, the Fund should re-examine its criteria used to assign claims, take actions to ensure claims handlers complete the three-way contact in a timely manner, require documented action plans for all claims with significant costs, develop and implement an effective review process, and develop and implement policies regarding actively obtaining

medical documentation necessary for timely payment of lost-wages claims. The Fund should also take steps in the future to evaluate the results of the reorganization it completed in January 2009 by performing an internal audit or commissioning another external claims review to measure progress against statutory compliance and recommended practices in claims management.

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INTRODUCTION & BACKGROUND

The Office of the Auditor General has conducted a performance audit and sunset review of the State Compensation Fund (Fund) pursuant to an October 5, 2006, resolution of the Joint Legislative Audit Committee. This audit was conducted as part of the sunset review process prescribed in Arizona Revised Statutes (A.R.S.) §41-2951 et seq.

Mission and purpose

The Arizona Legislature created the State Compensation Fund in 1925 as part of Arizona's original Workman's Compensation Act. Workers' compensation insurance provides workers who suffer job-related injuries with coverage for their medical expenses, and payments to compensate for lost wages if they are injured for a sufficiently long period. The insurance premium is paid by the employer, not the worker. A.R.S. §23-961 requires all employers to provide workers' compensation coverage to their employees.

The Fund's primary purpose has remained virtually the same since 1925: to provide Arizona businesses with a means for obtaining workers' compensation insurance. Arizona employers have the option of obtaining workers' compensation insurance through the Fund, but they can also obtain this insurance by purchasing it through a private insurance carrier, or by self-insuring a workers' compensation program if they have sufficient financial resources. However, the Fund remains the largest single source of workers' compensation insurance in Arizona. As of 2007, the Fund reported that it provided workers' compensation insurance to more than 55,000 businesses with more than 1 million employees, representing 58 percent of Arizona's employers. That same year, according to Arizona Department of Insurance (Department) records, the Fund collected 55 percent of total state-wide workers' compensation insurance premiums.

The Fund provides benefits for two major types of claims—those involving medical benefits only and those involving both medical benefits and payments for lost wages (see textbox, page 2). In 2007, the Fund processed more than 47,000 injury claims for medical bills and compensation for lost wages. In that same year, the Fund paid $216 million in medical service provider bills and $101 million in payments for lost wages.

Fund Provides Benefits for Two Major Types of Claims

Medical only: The Fund pays for the injured employee's medical services by directly paying the medical provider(s).

Lost wages: In addition to paying for medical services, the Fund directly pays the injured employee a portion of his/her wages for the duration of lost time, if the employee cannot return to work within 7 days or cannot return to his/her previous duties. Lost-wages claims are likely to be more complicated and time consuming than medical-only claims and require planning, monitoring, and ongoing contact with the injured worker, policyholder, and medical provider(s).

Injured workers have a legal right to have all of their medical bills paid by the insurance carrier on an accepted claim. Under state statute, an injured worker is not responsible for payment of any portion of a medical bill for services on an accepted claim.

Source: State Compensation Fund Arizona. (2007). *Benefits guide: Information for the injured worker* [Electronic version]. Phoenix, AZ: Author., and Auditor General staff analysis of A.R.S. §§23-1062.01(D) and 23-1062(B).

The Fund was originally formed as part of the Industrial Commission of Arizona (ICA). In 1968, the Legislature enacted workers' compensation reforms that separated the Fund from the ICA, effective January 1, 1969. Since that time, the Fund has operated as a stand-alone entity with its own enabling statutes.[1] In essence, it competes with other insurers to provide workers' compensation insurance. However, unlike private insurance carriers, the Fund historically has provided a ready market for workers' compensation insurance, insuring nearly all employers who apply regardless of claims history, size, or accident history, including employers who otherwise would not be able to self-insure or obtain workers' compensation insurance coverage from private insurance carriers.[2] As of November 2008, the Fund was structured as two corporate entities, "SCF Arizona" and "SCF Premier," to provide workers' compensation insurance to Arizona employers.[3]

State regulation of Fund

Over the years, the Fund's ties to the State have been reduced, so that it now acts more like a private insurance carrier, although it retains some statutory obligations to the State. Since 1990, the primary changes have come from statutory changes that exempted the Fund from various state government agency requirements, and from a state court's decision that determined the Fund's assets are not public monies. Specifically:

- **Legislative actions exempting Fund from state government agency requirements**—In 1990, the Legislature amended A.R.S. §23-986 in the Fund's enabling statutes to exempt the Fund from various state agency requirements such as using the state personnel system, purchasing, risk management, motor pool, property management, and telecommunications services and following

1 The majority of the Fund's enabling statutes are found at A.R.S. §§23-981 through 23-1006.

2 In limited circumstances, the Fund refuses coverage to certain high-risk employers. Employers who are denied coverage by the Fund and two other insurance carriers are eligible to obtain workers' compensation insurance through Arizona's Assigned Risk Pool. See Finding 1, pages 13 through 23, for more information about increased use of the Pool as a cost-saving measure for the Fund.

3 In March 2006, the Fund registered the trade name "SCF Arizona" with the Secretary of State's Office and has since used that name as its official corporate name. In June 2006, the Fund received approval from the Arizona Corporation Commission to launch "SCF Premier" as a subsidiary company. SCF Premier offers lower premium prices to larger companies with strong safety records. See Finding 1, pages 13 through 23, for more information about the Fund's efforts to create additional subsidiaries to offer different premium rates to its policyholders.

the state salary schedule. The Legislature enacted these changes partly in response to the Office of the Auditor General's 1988 sunset review, which recommended that the Legislature consider steps to curtail benefits the Fund received from its relationship with the State in order to reduce the Fund's competitive advantage over private insurers (see Report No. 88-10). In 2002, the Legislature exempted the Fund from all statutory requirements set forth in Title 41, Chapter 39, associated with the disclosure of state and local government information on government agency Web sites. As part of these changes, the Legislature specifically noted that the term "state agency" did not apply to the Fund. More recently, in 2007, the Legislature statutorily exempted the Fund from the Administrative Procedures Act (APA) at A.R.S. Title 41, Chapter 6. The APA generally covers state agency requirements pertaining to the publication of administrative rules, the executive agency rulemaking process, state licensing time frames, administrative hearing procedures, and other administrative procedure requirements that state agencies must meet.

Although various legislative enactments have exempted the Fund from some statutory requirements imposed on state agencies, the Fund still retains some benefits that apply to state agencies and public entities. For example, the Fund still participates in the Arizona State Retirement System (ASRS), although it pays the employer portion of the contribution from its own assets. According to fund officials, the statute that requires the Governor to appoint the Fund's Board of Directors also allows the Fund to continue its participation in ASRS. In addition, in accordance with A.R.S. §12-820.04, the Fund and its employees remain protected from punitive damage lawsuits. According to the Arizona Court of Appeals, the exemptions the Legislature has approved under Title 23 do not change the Fund's status as a public entity, as defined in Title 12.[1]

- State Court ruling that Fund's assets not public monies—In December 2003, the Fund filed *State Compensation Fund v. Petersen,* in response to a 2003 legislative attempt to transfer $50 million from the Fund to the State General Fund in exchange for $50 million of state assets.[2] The Fund argued that such a transfer violated the Arizona Constitution. In April 2004, the Court concurred and the Fund won a Motion for Summary Judgment. In its ruling, the Court stated that the monies and assets held by the Fund are not public monies, but are instead assets held in trust by the Fund for the employer, injured workers, and their families.[3]

1 *State Compensation Fund v. Superior Court (EnerGCorp, Inc.),* 190 Ariz. 371, 948 P.2d 499 (APP. 1997).According to the 1997 Arizona Court of Appeals decision in this case, the Fund was a public entity subject to notice-of-claim and a 1 year limitations period governing suits against public entities as defined by A.R.S. §12-820.

2 *State Compensation Fund v. Petersen*, CV2003-011970 (Maricopa County Super. Ct. filed June 20, 2003).

3 The 2004 court ruling also affected how the State of Arizona presented the Fund's financial information in its annual financial report and basic financial statements. Specifically, the State's fiscal year 2004 annual financial report noted that the Fund had been reclassified to a "related organization" of the State rather than a "component unit" of the State. Due to the reclassification, the State would no longer present the Fund's financial information in its basic state-wide financial statements, and the State's independent auditor noted that the Fund was "no longer financially accountable to the State."

As a state entity, the Fund has one benefit that other insurers do not—it qualifies for a federal tax exemption. As of January 2009, the Fund was the only workers' compensation insurance carrier in Arizona that qualifies for this federal tax exemption because it is the only carrier that has a state-appointed board. The Internal Revenue Code found at 26 U.S.C.A. §501(c)(27) allows organizations that provide workers' compensation insurance to claim a federal tax exemption under two scenarios: (1) any organization created by a state prior to June 1, 1996, that operates as a state's exclusive provider of workers' compensation insurance, or (2) any organization, including a mutual insurance company, that operates as a state compensation fund under specific state legal requirements, including state appointment of the organization's Board of Directors. The Internal Revenue Service has exempted the Fund from federal tax on corporate income under 26 U.S.C.A. §501(c)(27)(B). According to the federal statute, workers' compensation insurance organizations, such as the Fund, which have a majority of their board members appointed by the State, are eligible for the federal tax exemption. However, the Fund pays other federal taxes such as social security taxes and the federal excise tax on telecommunications. In addition, the Fund pays Arizona state property taxes, sales taxes, and automobile registration on the vehicles it owns, and does not have authority to use state-owned vehicles. In addition, state statute requires the Fund to pay the State's tax on insurance premiums at the same rate as private insurers.

Although the Fund benefits from not having to pay federal income taxes, its enabling statutes also impose certain restrictions that are not imposed upon private insurance carriers. For example, A.R.S. §23-981 limits the Fund to covering only Arizona employers, and it also limits the Fund to offering only workers' compensation insurance.[1] These restrictions prevent the Fund from offering workers' compensation insurance to employers who operate outside of Arizona and offering other lines of insurance. Further, A.R.S. §23-981 requires the Fund to be administered without any state liability, and A.R.S. §23-983 requires the Fund to be "neither more nor less than self-supporting."[2]

As of January 2009, the Fund remained subject to some executive branch and legislative branch oversight. For example, the Fund remained subject to the Governor's appointment of board members, Joint Legislative Budget Committee budget review and approval, and the legislative sunset review.

The Fund also must meet the same statutory requirements and state regulations set forth by the ICA and the Arizona Department of Insurance for all private insurance carriers that offer workers' compensation insurance. Several of these requirements are directly related to issues addressed in this audit. Specifically:

- Requirements imposed by ICA—Although it was separated from the ICA in January 1969, the Fund remains subject to various ICA requirements that apply to all Arizona workers' compensation insurers. For example, the Fund must

1 A.R.S. §23-981 states that the Fund can hold Arizona employers harmless against workers' compensation liabilities under other states' laws for Arizona employees who temporarily work outside of the State, if the Fund insures the employer's other employees who work within the State.

2 See, specifically, A.R.S. §§23-981(C) and 23-983(A).

comply with state statutes and regulations that set forth time frames for the timely delivery of services to injured workers, and the ICA's regulation of certain medical services fees. By statute, the ICA must be notified when an employee has experienced a work injury and when an insurance carrier has made a claims decision (See Finding 2, pages 25 through 35, for more information on the Fund's performance with respect to claims decisions). The Fund also must follow the processes that the ICA has put in place to adjudicate claims disputes between an injured worker and the insurance company, and follow procedures the ICA has put in place to investigate any bad faith claims' complaints. The Fund also is subject to state statutes that require the ICA to monitor the Fund's and other insurance carriers' compliance with the State's lost-wages benefits formula.

One statutory function of the ICA is establishing a fee schedule governing the fees that all workers' compensation insurers pay for physicians, physical therapists, occupational therapists, and prescription medicines. The ICA fee schedule sets forth reimbursement rates that medical providers are obligated by law to charge for their services, and the ICA is required by statute to review the fee schedule annually. Although the fee schedule covers many types of payments, it does not cover such major medical services as hospitals, outpatient surgery centers, and durable medical goods, which constitute approximately 30 percent of the medical costs of claims for the Fund (See Finding 1, pages 13 through 23, for more information on how the Fund uses the fee schedule).

- Requirements imposed by Department—The Fund, like all Arizona workers' compensation insurance carriers, unless otherwise provided by law, must meet the Department's statutory and regulatory requirements for workers' compensation insurance, including requirements for reserves and surpluses. In addition, the Fund must limit its investment types to those prescribed in Title 20 insurance statutes.

  Among its many duties, the Department also regulates and approves the rates that employers pay the Fund and other Arizona insurers for workers' compensation coverage. By statute, the Department bases insurance premium rates on advisory information supplied by an insurance rating organization. The Department relies on the National Council on Compensation Insurance (NCCI) to establish the recommended insurance premium rates for Arizona. For workers' compensation insurance, NCCI develops a standard premium rate by compiling information from all Arizona workers' compensation insurance carriers, including the Fund's premium information.

  However, once a rating organization such as NCCI establishes this rate recommendation, A.R.S. §20-359 allows an insurance provider to apply for, and the Department to approve, a deviation from it (See Finding 1, pages 13 through 23, for more information on rate setting and rate deviations).

Organization and staffing

The Fund is overseen by a five-member Governor-appointed Board of Directors (Board). In addition, a six-member executive team provides leadership, and a 16-member senior management team drives the day-to-day operations. As of December 31, 2008, the Fund had a total of 576 full-time equivalent positions, and as of that time, a total of 6 staff positions were vacant. The Fund has a main office located in central Phoenix and offices in six other Arizona cities. As of December 31, 2008, 517.5 staff positions were assigned to the Fund's central Phoenix office, and 58.5 staff positions were assigned to locations outside of Phoenix. The Board's duties, executive and senior management duties, and the Fund's organization are as follows:

- Governor-appointed Board of Directors' Duties—One of the Board's statutory duties is to appoint the Fund's Chief Executive Officer (CEO) to manage the Fund's daily operations, including, specifically, personnel management and formulation of an investment policy and supervision of the Fund's investment activities in accordance with Department of Insurance requirements, and also to monitor the CEO's performance. Statutorily, only the Board can approve whether the Fund can issue an annual dividend payment to policyholders. Other board activities include: (1) keeping the Fund's policyholders and Arizona employers and employees informed of the Fund's activities, (2) developing written policies for the CEO to follow that prescribe organizational ends to be achieved and organizational situations to be avoided, governance, and board-management delegation policies, (3) approving substantive revisions in the Fund's investment policies, and (4) identifying or seeking legislative changes as appropriate that affect the Fund. The Fund's Board has various committees, including an audit committee, finance, investment and dividend committee, and community outreach giving committee. Also, the Board and all of its committees must comply with the State's open meeting laws.

- Executive Management (12 FTE, 0 vacancies)—This division includes the Fund's executive management team and their administrative staff. A six-member executive management team provides leadership by setting strategies, policy and priorities, and performance metrics. The Fund's CEO reports to the Board of Directors. The other five members of the team include a Chief Operating Officer, Chief Financial Officer, Chief Business Development Officer, the Senior Vice President of Communications and Public Affairs, who also serves as Chief of Staff, and a Vice President of Enterprise Strategy and Customer Insight.

A 16-member senior management team drives the Fund's day-to-day operations. Some key positions include Senior Vice President of Claims Management, Vice President of Strategic Projects and Talent, Vice President of Information Technology and Chief Information Officer, Vice President of Investments, and Corporate Counsel and Chief Compliance Officer.

As of December 31, 2008, the Fund allocated its remaining staff positions, which include its senior managers, among the following divisions:

- Operations Division (430.5 staff positions, 2 vacancies)—The Fund's Executive Vice President and Chief Operating Officer (COO) oversees the Fund's operational core. This is the largest of the Fund's divisions, and its major sections include:

    - Claims Management (233 staff positions, 1 vacancy)—Four key activities take place within the Fund's claims management section:

        - *Claims Management* processes claims for injured workers. Prior to August 2008, claims operated in a decentralized environment, but as of August 2008, the Fund centralized most claims handling to its central Phoenix office.

        - *Claims Medical Management* develops, implements, and measures the Fund's claims medical management and medical costs containment policies. The unit has a medical review team, and a utilization review team, and also rehabilitation counselors who focus on return-to-work efforts. This area also is responsible for managing the Fund's provider network, which is called the "Preferred Connection Network."

        - *Training, Reserving, Audit and Compliance Unit (TRACS)* trains claims managers and claims handlers and conducts monthly compliance quality assurance reviews of actual claims to monitor claims handlers' compliance with applicable claims' management statutes and regulations as prescribed by the ICA and the Fund's internal policies.

        - *Claims Legal* educates claims handlers, defends the Fund against claim protests or allegations of bad faith, investigates fraud, and pursues third parties who may be responsible for a worker's injuries.

    - Sales and Customer Relations (117 staff positions, 0 vacancies)—This section works to generate new business and periodically audits policyholders' payroll records. Some of the employees in this unit work in the Fund's main central Phoenix office, while others work in field offices outside of Phoenix. The section has four regional managers and a small business center manager.

- Other Operational (80.5 staff positions, 1 vacancy)—Three other units that report directly to the COO include the (1) Customer Contact Center and e-Solutions, (2) Underwriting Services, and (3) Web Services Development. The customer contact center provides direct customer service through a call center. Staff assist with both claims-related issues and insurance policy issues.

Two other major divisions report indirectly to the COO, specifically:

- Strategic Projects and Talent (14 staff positions, 2 vacancies)—Manages the Fund's strategic projects by overseeing systems and processes, and ensuring effective and compliant Human Resources operations.

- Information Technology (IT) Division (43 staff positions, 2 vacancies)—IT Services defines IT policies and standards, maintains IT systems and major applications such as PowerSuite for claims processing, tests information technology security, and designs special projects and metrics reports to inform executive management.

In addition to the Board, executive management, and the divisions that report to the COO, the Fund's organizational structure includes:

- Finance (23.5 staff positions, 0 vacancies)—The Fund's Chief Financial Officer (CFO) oversees the Fund's accounting, finance, investment, management, actuarial, and financial reporting and analysis activities. It is also responsible for developing the financial reports that the Fund submits to the Arizona Department of Insurance.

- Enterprise Strategy and Customer Insight (3 staff positions, 0 vacancies)—The Fund's Vice President for Enterprise Strategy and Implementation leads the Fund's strategic planning process, evaluates resource needs, helps align the organization's strategies and goals with its vision and agenda, and implements the tools and processes to help the Fund become a more customer-focused organization. This division develops the Fund's Strategic Plan and annual Business Plan, and develops and monitors corporate goals and a Quarterly Business Review process that aims to close the gaps between the Fund's strategic goals and the execution of those goals.

- Business Development (1 staff position, 0 vacancies)—The Fund's Executive Vice President and Chief Business Development Officer oversees this division. The Fund created the division in July 2007 to look at new investment opportunities, such as private equity, solar energy projects, real estate, software development, optics, aerospace investments, and research business expansion opportunities. In addition, the Fund would also like to expand the types of services it offers to small businesses to potentially include workers' compensation-related services, such as employee wellness programs. Fund officials reported that they would like the Legislature to consider amending state

statute to allow the Fund to provide related insurance products outside of Arizona (See Sunset Factors, pages 37 through 45, for more information).

- Communications and Public Affairs (43 staff positions, 0 vacancies)—The Fund's Senior Vice President and Chief of Staff oversees this division. The Fund's Chief of Staff oversees the Fund's buildings, and approves all new hires, in collaboration with the Chief Operating Officer. The Chief of Staff also plays a role in setting the Fund's legislative agenda, and acts as a liaison to the Board of Directors. The division also develops the Fund's official publications and on-line communication materials.

- Legal/Corporate Counsel (6 staff positions, 0 vacancies)—The Fund's Corporate Counsel and Chief Compliance Officer provides broad-based legal representation for the Fund, including contracting, review of procedures, and corporate defense. The Fund's Corporate Counsel also interacts with the Fund's Internal Audit unit, although the Fund's internal auditors report directly to the Board of Directors' audit committee.

Fund's financial operations

The Fund operates as a separate, self-supporting organization established under state statutes to provide workers' compensation insurance to Arizona employers. The Fund pays claims and operational expenses entirely from its own revenues. It receives no state appropriations, and statutorily, must be administered without liability to the State of Arizona.

As shown in Table 1 (page 10), the Fund's total premiums earned (that is, paid by participating employers) increased from $426 million in 2006 to $492 million in 2007, and then decreased to $406 million in 2008. However, during the same years, the Fund's total operating expenses increased from $517.2 million to $605.1 million, and then decreased to $583.7 million. These operating expenses consisted primarily of claims expenses (that is, expenses for injured workers' medical services and lost wages), employee-related expenses such as fund employees' salaries and benefits, and various taxes and fees.[1] Investment gains of $139.9 million, $154.1 million, and $206.8 million in 2006, 2007, and 2008, respectively, allowed the Fund to partially offset some of its losses. Nonetheless, the Fund incurred net losses in 2006 and 2007.

The Fund would have realized a net positive income in 2006 and 2007 if the Board had elected not to pay dividends to employers purchasing its insurance policies. State statute allows the Fund's Board to pay dividends to policyholders from a surplus of fund monies. According to the Fund's officials, the Board has issued a dividend every year since 1971. The Fund's Board makes year-end dividend

[1] Even though the Fund is exempt from paying federal corporate income tax, it pays various state taxes, including premium taxes as required by state statute, and state and local taxes on real and personal property owned by the Fund. In 2006, 2007, and 2008, the Fund paid $20.4 million, $24.2 million, and $14.1 million in taxes, respectively.

Table 1: Statutory-Basis Statement of Operations[1]
(In Thousands)
Calendar Years 2006 through 2008
(Unaudited)

	2006	2007	2008
Net premiums earned	$426,597	$492,383	$406,282
Operating expenses:			
Losses incurred[2]	402,866	487,519	458,357
Loss expenses incurred[3]	62,642	38,736	43,289
Underwriting and administrative	31,277	54,604	67,992
Taxes and fees	20,402	24,217	14,107
Total operating expenses	517,187	605,076	583,745
Net underwriting loss	(90,590)	(112,693)	(177,463)
Net investment income	140,487	148,476	151,496
Net realized capital gain (loss)	(613)	5,631	55,336
Net investment gain	139,874	154,107	206,832
Other income (expense)	(36)	3,037	6,469
Net income before policyholders' dividends	49,248	44,451	35,838
Provision for policyholders' dividends[4]	70,000	50,000	21,440
Net income (loss)	$ (20,752)	$ (5,549)	$ 14,398

1 The financial statements are prepared on a statutory basis in accordance with accounting practices prescribed or permitted by the Department. The Department recognizes only statutory accounting practices prescribed or permitted by the State of Arizona for determining and reporting an insurance company's financial condition and results of operations, and for determining its solvency under the State of Arizona Insurance Laws. *The National Association of Insurance Commissioners' Accounting Practices and Procedures Manual* (version effective January 1, 2007) has been adopted as a component of prescribed or permitted practices by the State of Arizona.

2 Consists of expenses for injured workers' medical benefits and lost wages.

3 Consists of expenses associated with specific claims such as investigation and litigation costs.

4 The Fund's Board of Directors can declare a provision for dividends to be paid to policyholders, based on the Fund's overall experience and anticipated future results. Dividends are paid to policyholders who meet premium volume and loss experience criteria established by the Board.

Source: Auditor General staff analysis of the Fund's *Statutory Financial Statements and Supplementary Schedules with Independent Auditor's Report Thereon* report for calendar years 2006 and 2007, audited by McGladrey & Pullen, Certified Public Accountants, and the Fund's annual statements submitted to the Arizona Department of Insurance for calendar year 2008.

payments only to policyholders enrolled in SCF Arizona. Eligible policyholders who enroll in the newer SCF Premier subsidiary cannot receive an annual dividend payment because they agree to receive up-front savings in the premiums they pay. With these payments factored in, the Fund's net loss was $20.8 million in 2006 and $5.5 million in 2007. In contrast to those 2 years, the Fund realized a net gain of $14.4 million in 2008 after it paid out dividends.

Scope and objectives

This performance audit and sunset review focused on gathering information about efforts that the State Compensation Fund can employ to improve premium pricing and control claims costs, and how well it manages claims processing. In addition, the report includes responses to the 12 sunset factors specified in A.R.S. §41-2954.

This audit was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The Auditor General and staff express appreciation to the State Compensation Fund's Board of Directors, Chief Executive Officer, and staff for their cooperation and assistance throughout the audit.

FINDING 1

Fund should continue and enhance efforts to improve its claims expense-to-premium ratio

The State Compensation Fund (Fund) pays out more in claims and other expenses than it receives in premiums paid by employers. Although the Fund has been able to rely on investment income to make up the difference, its ratio of claims expenses to income from premiums is higher than the national average for state compensation funds. This high ratio has contributed to increased premiums for Arizona employers, regardless of whether they use the Fund or some other insurance carrier. To adequately cover its expenses, the Fund is taking steps to both improve premium pricing practices and control costs. Several additional steps, however, would help. These include being more selective in the employers it covers, working with the Legislature to amend state statute to establish reasonable charges for various high-cost medical services, and expanding the network of medical providers with whom the Fund has negotiated preset prices.

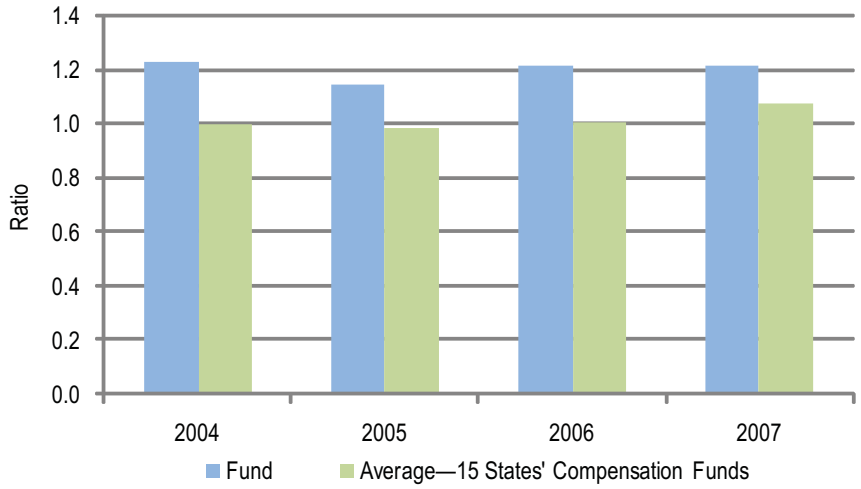
Fund has high claims expense-to-premium ratio

The Fund's ratio of claims expenses to premium income is higher than the national average for state compensation funds and private insurance carriers.[1] Because the Fund insures more than half of all employers in Arizona, its high ratio has resulted in increased premiums for Arizona employers, regardless of whether they are insured with the Fund or with a private company, although, compared to other states, Arizona premiums remain among the lowest in the country.

Expense-to-premium ratio exceeds national average—To ensure that it can continue paying benefits to injured workers, the Fund needs to maintain a ratio of benefits and other claims expenses to premium income that allows it to remain financially solvent. As Figure 1 shows (see page 14), the Fund has had a higher ratio of claims expenses to premium income than an average of 15 states' funds

[1] The claims expenses included in the claims expense-to-premium ratio are medical and lost-wages benefits paid out; other claims expenses, such as investigation and litigation costs; and underwriting costs, such as salaries, employee benefits, advertising, and taxes. Dividend payments and investment income are not included in calculating this ratio. The insurance industry uses several ratios to include the financial strength of insurance companies including a loss ratio, an expense ratio, a dividend ratio, and a combined ratio, which is the sum of the first three ratios.

Figure 1: Comparison of the Fund's Claims Expense-to-Premium Ratio to an Average of 15 States' Compensation Funds[1,2]
Calendar Years 2004 through 2007



1 A ratio greater than 1.0 means the total claims expenses paid (benefits to injured workers, loss adjustment expenses, and underwriting expenses) are greater than the premiums charged to participating employers for the year. A ratio less than 1.0 means the total claims expenses paid are less than the premium revenues. Dividend payments and investment income are not included in the calculation of this ratio.

2 The average for the 15 states' compensation funds includes AZ, CA, CO, HI, ID, KY, LA, MO, MT, NM, OK, OR, RI, TX, and UT.

Source: To calculate the Fund's ratio, auditors reveiwed the Fund's annual statements submitted to the Arizona Department of Insurance for calendar years 2004 through 2007. For the average of 15 states' compensation funds, auditors reviewed Kokulak, D. & Daley, T. (2008). *State Advisory Forums 2008, Arizona August 21, 2008*. [Power Point slides] retrieved August 27, 2008, from https://www.ncci.com/documents/SAF_AZ.pdf and used data that excluded polichyholder dividends provided by NCCI in March 2009.

In 2007, the Fund paid out 22 percent more in claims expenses than it collected in premiums.

during calendar years 2004 through 2007. For example, in calendar year 2007, the Fund's ratio was 1.22, indicating that for every $100 in premiums collected, $122 was paid out in expenses. In contrast, the average of the ratios for a group of 15 states' compensation funds was 1.08.[1] Although the Fund has other operating expenses, such as salaries and taxes, medical and lost-wages payments for injured workers comprise the majority of operating expenses. In 2007, for example, benefits payments were approximately 81 percent of total claims expenses, and payment of these benefits alone nearly equaled the Fund's premium income.

1 Kokulak, D. & Daley, T. (2008, August 21). State advisory forums: Arizona [PowerPoint slides]. Retrieved August 27, 2008, from https://www.ncci.com/documents/SAF_AZ.pdf

To meet its statutory mandate to be self-supporting, the Fund supplements its premium income with investment income. The Fund receives no State General Fund appropriations and cannot draw upon state monies if its income is insufficient to pay its expenses. In 2007 and 2008, the Fund's investments earned approximately $154.1 million and $206.8 million, respectively. Because statute also requires the Fund to be neither more nor less than self-supporting, the Fund's overall income and expenses should be closely aligned. At year-end, any net gain that the Fund does not need to pay claims or other administrative costs is returned to policyholders as dividends.

The Fund receives no State General Fund appropriations.

Fund's high ratio has led to state-wide premium rate increases—The Fund's high claims expense-to-premium ratio has contributed to state-wide premium increases in 2003 through 2008. Even with these increases, Arizona employers still pay lower premiums than employers in most other states, according to a 2008 Oregon report.[1] Oregon's Department of Consumer and Business Services ranked state workers' compensation premium rates and showed Arizona was the seventh-lowest nation-wide in 2008. The National Council of Compensation Insurance (NCCI) makes premium recommendations to the Arizona Department of Insurance (Department) based on claims expense-to-premium ratios of all reporting Arizona workers' compensation insurance carriers. However, because the Fund accounted for more than half of Arizona's workers' compensation insurance market in 2006 and 2007, its claims expense-to-premium ratio has affected NCCI's calculation for the State's rates. In policy years 2004 through 2007, Arizona's overall claims expense-to-premium ratio, although not as high as the Fund's ratio alone, remained considerably higher than the national average. NCCI recommended increases to Arizona's standard workers' compensation premium rates every year between 2003 and 2008, except for 2006. In August 2008, Arizona was one of only eight states, out of the 37 states NCCI works with, for which NCCI recommended a premium increase.

These premium increases apply to all insurance carriers that provide workers' compensation insurance in Arizona, and therefore all of Arizona's employers. However, statute allows carriers to charge lower premiums than the standard rate by filing a request with the Department. The number of carriers filing such requests increased from 38 in 2003 to 51 in 2008.

Improving the claims expense-to-premium ratio can come both from increases on the premium side or from reductions on the claims expense side. As discussed next, the Fund is taking steps on both sides of the equation but can do more in both areas.

1 Department of Consumer & Business Services. (2008). *2008 Oregon workers' compensation premium rate ranking summary*. Retrieved February 11, 2009, from http://www.cbs.state.or.us/imd/rasums/2082/08web/08_2082.pdf

Fund is changing policies to account for employer risk but could do more

To improve its ratio of claims expenses to premium revenues, the Fund is changing its premium pricing policies and standards. Because Arizona statute provides limited options for applying different premium rates for different policyholders, the Fund has begun to adopt the industry practice of creating subsidiary companies that can offer different rates that more closely match the risk level of specific policyholders. However, the Fund should also reassess its traditional approach of acting as the insurer of last resort regardless of risk and consider denying coverage to the riskiest employers so that their coverage could be shifted to the State's Assigned Risk Pool, where rates even more adequately reflect the degree of risk.

Fund creating subsidiaries to adequately cover expenses and remain competitive—Arizona statute provides insurance carriers limited leeway in adjusting premium rates to reflect risk. Arizona Revised Statutes (A.R.S.) §20-344 requires workers' compensation carriers to follow department-approved state-wide uniform plans, meaning that insurance carriers must charge the same premium for all policyholders within similar industries. The standard premium for a policyholder's industry is modified for eligible policyholders by an experience rating factor, which is based on the policyholder's accident history compared to the average for the same industry.[1] NCCI, which is Arizona's rate-setting organization, computes both the standard rates and the employer-specific experience ratings. However, insurance carriers may also obtain the Department's permission to charge a higher or lower rate than the standard rate, but must change the rate for all policyholders by the same percentage. For October 1, 2008 through September 30, 2009, the Fund filed and received the Department's approval to use a 10 percent discount from the standard rates (See the textbox for an illustration of how a premium is typically calculated with uniform rating.)

NCCI computes standard rates and employer-specific experience ratings.

Although the Fund has used uniform rating, there are other alternatives. An insurance company may follow a schedule rating plan by which an insurer establishes premium rates that reflect each policyholder's individual risk characteristics or loss ratio. If the schedule rating option is chosen, a carrier must use it for all policyholders.

Workers' Compensation Premium Calculation Illustration (Simplified)

Classification	Rate[1]	Payroll total		Premium
Carpentry	11.30	X 100,000	X .01	$11,300.00
Clerical	0.24	X 25,000	X .01	$ 60.00
		Subtotal premium based on standard rate		$11,360.00
		Experience modifier for employer		X .90
				$10,224.00
		Department-approved deviation from standard rate		X .90
		Total Premium		$ 9,201.60

1 Rate is per $100 of payroll.

Source: Auditor General staff simplified summary of the Fund's instructions to employers.

1 Experience ratings are mandatory for all companies in business for at least 4 years, but apply only to employers that have a premium above a threshold amount.

The rate-setting procedures are designed to account for potential risk of policyholders. In uniform rating, the standard rates differentiate the risks of industries, and the experience rating augments this, accounting for policyholders' different risks. However, experience ratings may not always be sufficient to account for policyholders' risk because the experience rating calculation uses 2-year-old data and may not reflect an employer's current circumstances. Further, individually determining premiums under schedule rating allows a carrier to increase or decrease a policyholder's rates to reflect the individual risk, but this is time-consuming and very costly to use for large numbers of small policyholders, according to fund officials.

To offer different rates to policyholders with different levels of risk, insurance groups in Arizona create subsidiary carriers and assign policyholders to the appropriate carrier by risk. According to department records for 2006-2007, of the top 25 workers' compensation carriers by premium, only the Fund and one other carrier were not a subsidiary of an insurance group.

In 2006, the Fund began creating its own subsidiaries to handle different levels of risk and charge policyholders different premium rates that reflect the degree of risk. Specifically:

SCF Premier offers lower premiums to the Fund's safest customers.

- In June 2006, the Fund created a subsidiary, SCF Premier, which uses schedule rating to offer lower premiums to its safest customers. SCF Premier began offering coverage in July 2007 and, according to fund staff, as of November 2008, SCF Premier had 251 policyholders, accounting for approximately $27 million in premiums.

- In July 2008, the Fund's Board of Directors approved plans to begin taking steps toward establishing three additional subsidiaries to offer different rates based on policyholders' risk factors. The Fund filed the required documents with the Arizona Corporation Commission in November 2008 and with the Department in December 2008 for SCF Western, SCF General, and SCF Casualty. In March 2009, the Department issued Certificates of Insurance to transact workers' compensation insurance.

As Table 2 (see page 18) shows, the premium rates charged by each subsidiary would vary considerably and reflect risk factors, such as the extent of past losses, and other requirements, such as participation in accident-reduction programs. Policies shifted to SCF Western would receive a 20 percent discount from the standard premium rate, compared to the Fund's regular discount of 10 percent. In contrast, policies shifted to SCF General would not receive any discount, and policies shifted to SCF Casualty would pay 25 percent more than the standard rate. Based on a consultant's study, the Fund expects these changes to improve its expense-to-premium ratio. The Fund retained an insurance-consulting company to help develop the pricing strategy for the subsidiaries and to develop

Table 2: Fund's Proposed Structure As of December 2008

Policyholder Characteristics of Each Subsidiary	Premium Rate Deviations From Standard Rates
SCF Casualty (proposed)	
• History of high losses compared to premiums • Cooperate with SCF to reduce workplace accidents	25%
SCF General (proposed)	
• Been in business less than 3 years • May have experienced some losses	Standard rate[1]
SCF Arizona (existing)	
• Participating members of an SCF's Association Safety Program • History of acceptable losses	-10%[2]
SCF Western (proposed)	
• History of very low losses • Proven safety record	-20%[2]
SCF Premier (launched July 2007)	
• $50,000 and above in annual premium • Proven history of very low losses	Schedule rating[3]

1 The standard rate, or "manual rate" as it is commonly known in the insurance industry, refers to Arizona workers' compensation insurance rates recommended by the National Council on Compensation Insurance, reviewed and approved by the Arizona Department of Insurance.

2 Represents a deviation from the standard rate, which must be applied to all of a carrier's policies when the carrier uses uniform rating. Uniform rating is one of two methods that insurance carriers can use to calculate insurance premium rates and by which a carrier charges the same premium for all policyholders with the same loss and risk experience.

3 Schedule rating is an alternative rating plan by which an insurer increases or decreases premiums to reflect each policyholder's individual risk characteristics.

Source: Auditor General staff analysis of documents from a September 16, 2008, fund staff presentation to the Fund's Board of Directors and an actuarial report prepared for the Fund in November 2008.

criteria to categorize policyholders into the appropriate subsidiary. This included evaluating the potential changes to total premiums as a result of the different rates for each company. According to the consulting company's study, these changes are projected to improve the Fund's loss and loss adjustment expense ratio (see textbox) by approximately 1 percent once the plan is fully implemented, as well as create a more equitable pricing structure so that lower-risk policy holders will pay less while higher-risk policy holders will pay more for their coverage.

Loss and loss adjustment expense ratio—The ratio of medical and lost-wages benefits paid out (called "losses" in the insurance industry), as well as other expenses associated with specific claims such as investigation and litigation costs ("loss adjustment expenses"), to premium revenues.

Source: Auditor General staff analysis of A.M. Best glossary of insurance terms. (n.d.) Retrieved March 25, 2009, from http://www.ambest.com/resource/glossary.html#L, and Kokulak, D. & Daley, T. (2008, August 21). State advisory forums: Arizona [PowerPoint slides]. Retrieved August 27, 2008, from https://www.ncci.com/documents/SAF_AZ.pdf

Fund should consider denying coverage to very high-risk policyholders—Some employers' loss histories may make them too risky for even a subsidiary with the highest premium. Because workers' compensation insurance is statutorily required, employers denied coverage from the Fund must become part of Arizona's Assigned Risk Pool (Pool) unless they can obtain coverage from another carrier. The Department contracts with NCCI to administer Arizona's Pool, which provides workers' compensation insurance to employers who have been denied by the Fund and at least two private carriers.

Employers that cannot obtain coverage become part of the State's Assigned Risk Pool.

Because of its mission to provide a ready market for workers' compensation insurance, the Fund has traditionally not considered an employer's loss history in determining whether to issue a policy. Although statute does not require the Fund to cover all employers regardless of risk, under direction from its Board, the Fund refused coverage only if an employer met specific criteria, such as refusing to take reasonable safety measures or failing to pay premiums. The Fund has some policyholders with very high losses. For example, according to the Fund's internal analysis, in 2006, the 105 most adverse policyholders insured by the Fund paid $7.1 million in premiums but cost the Fund $60.2 million in benefits paid for those policyholders' injured workers.

The Fund is already taking some steps to better manage its high-risk policyholders. On June 18, 2008, the Board adopted a policy resolution whereby the Fund may deny coverage to an employer who does not meet reasonable safety standards. Fund officials reported that they plan to use the new subsidiary tier model, through SCF Casulaty, to allow the Fund to cover some of its high-risk employers that will work to improve their safety programs, with help from the Fund.

The Fund plans to use SCF Casualty to cover some high-risk employers.

With the Board's new policy in place, the Fund should consider becoming more aggressive in denying coverage to the riskiest employers, who would then need to find coverage from another insurer or the Pool. According to the Fund's staff analyses, some employers' loss histories may make them too risky even for SCF Casualty, which has the highest premium, and some may not improve their safety records even while insured with SCF Casualty. The Fund should consider applying stricter standards of coverage so it provides insurance only to those companies with loss histories within reasonable industry standards.

There are indications that, relative to other states, Arizona makes less use of its assigned-risk pool. In 2006, NCCI reported that Arizona had only 1.1 percent of employers covered by the Pool, the second lowest market share in the 29 states administered by NCCI. As of 2008, premiums in the Pool were set at 30 percent above the standard premium rate for a given industry. A.R.S. §23-1091(C) requires all workers' compensation insurance carriers to contribute to the administrative cost of administering the Pool, according to the carrier's share of the market.

Fund can reduce claims expenses by better controlling medical costs

On the cost side of the equation, high medical costs contribute to the Fund's high claims expenses. The Fund can make greater use of measures it already has in place for containing medical costs. Arizona has a fee schedule that has been effective in containing medical costs but does not include some high-cost services. Some of these high-cost services include facility charges by hospitals or outpatient surgery centers. The Fund should continue to work with the Legislature to revise statutes to address these high-cost services. Also, the Fund may be able to further control medical costs by increasing the use of its medical services provider network.

High medical costs contribute to Fund's high claims expenses—

Medical costs are a large component of the Fund's expenses, accounting for 67.3 percent of the total amount paid out in benefits for 2006 and 66.2 percent for 2007. The other component of benefits, employees' lost wages payments, accounts for a smaller share of the total.[1] Both nationally and in Arizona, workers' compensation medical costs increased at a faster rate than overall health system medical costs between 1997 and 2007. Specifically, although the Medical Consumer Price Index, a national measure of healthcare costs, increased by an average rate of 4.1 percent between 1997 and 2007, the average annual increase in workers' compensation medical costs per claim was 8.4 percent during those years, according to NCCI. To contain some medical costs, the Fund uses third-party vendors to review medications, physical and occupational medicine utilization, and other medical services to help ensure that therapies are appropriate and necessary.

Nation-wide workers' compensation medical costs per claim increased an average of 8.4 percent per year between 1997 and 2007.

In addition, the Fund uses three mechanisms to contain the prices it pays for medical services.

- **ICA fee schedule**—A.R.S. §23-908 requires ICA to develop and annually update a fee schedule for workers' compensation medical services charged by physicians, physical therapists, and occupational therapists, as well as the cost of pharmaceuticals. This schedule sets forth fees to be charged by physicians, physical therapists, and occupational therapists attending injured employees, as well as the cost of pharmaceuticals. All healthcare providers governed by the fee schedule must accept payment at the fee schedule amount.

- **Repricing service**—To determine the appropriate price to pay for out-of-network hospital and ambulatory surgery center services, which are not covered by the schedule, the Fund uses repricing contractors. These

[1] Laws 2007, Ch. 271, §1, amended A.R.S. §23-1041 to increase the maximum lost-wages benefit starting January 1, 2008, with annual adjustments thereafter to reflect increases in the Arizona average annual wage.

contractors use proprietary data to determine the reasonable and customary rate for a billed service, and the Fund pays that amount.[1]

- **Provider network**—According to the Fund's Web site, as of February 20, 2009, the Fund had enrolled 2,901 healthcare providers and physicians servicing 4,019 locations in its Preferred Connection Network (Network). The Network includes 70 of Arizona's 98 licensed hospitals and 63 of Arizona's 161 ambulatory surgery centers. Providers in the Network agree to accept a predetermined price for their services. Altogether, over half of the Fund's medical bills came from network providers in 2008.

Auditors identified ways, discussed below, in which the Fund could make even greater use of these mechanisms.

Revising workers' compensation statutes to address some high-cost services could help contain medical costs—To the extent it has been applied, the ICA fee schedule has worked well in controlling costs. A.R.S. §23-908 requires ICA to develop and annually update a fee schedule for workers' compensation medical services charged by physicians, physical therapists, and occupational therapists, and in 2004, the Legislature approved expanding it to include pharmaceuticals. ICA added a schedule for pharmaceuticals effective March 2005. A December 2007 NCCI report found that Arizona's workers' compensation fee schedule rates were 98 percent of the prices paid by group health insurers for the same services to treat nonoccupational injuries. According to NCCI, fee schedules are an effective medical cost containment strategy, and NCCI identified Arizona's existing fee schedule as one of the five most effective in the United States at containing medical costs.[2]

NCCI identified Arizona's medical services fee schedule as one of the five most effective in the U.S.

However, Arizona's fee schedule still has some notable omissions. Specifically, the fee schedule excludes hospitals, ambulatory surgery centers, and durable medical equipment, such as wheelchairs. From May 2007 through April 2008, costs for these services accounted for approximately 30 percent of the Fund's total medical costs. Specifically, facility payments for hospital inpatient and outpatient services and ambulatory surgery centers accounted for 19 percent of the Fund's total medical payments, and durable medical equipment accounted for 11.1 percent of total medical payments.

Statutory changes could help to mitigate the cost impacts of services that are not on the ICA fee schedule. One way to address this would be through a statutory change establishing that any medical charges not covered under the ICA fee schedule be based on the usual and customary reimbursement rates that prevail in the same community for that medical service. To mitigate the cost impacts of services that are not on the ICA fee schedule, in January 2009, the Fund worked

1 In 2003, the Fund was sued by a provider who contested the reasonableness of the repriced amount the Fund paid, claiming instead that the billed charges from the provider were reasonable. The court found that the repriced amount paid by the Fund was reasonable.

2 Robertson, J., & Corro, D. (2007). *NCCI research brief: Making workers compensation medical fee schedules more effective*. Retrieved August 26, 2008 from, https://www.ncci.com/documents/WC_Medical_Fee_Schedule.pdf

with legislators to introduce Senate Bill 1262. If the bill is passed in its original form and becomes law, it would add a new statute to Title 23, Chapter 6, Article 9, related to reimbursement costs for medical, surgical, and hospital procedures and would apply to services not already on the fee schedule and not from a medical provider in a carrier's provider network. The Fund already uses repricing contractors to determine the reasonable and customary rate for billed services from providers not covered by the fee schedule and not in the Fund's provider network. Another option is for the ICA to develop a fee schedule for hospitals, ambulatory surgery centers, durable medical equipment, and all other medical services that are not covered under the existing fee schedule. A statutory change is necessary to accomplish this because statute stipulates the services that the ICA fee schedule may include.

Research has found that cost savings can be achieved with both of these options. Specifically, the December 2007 NCCI study found that states that regulate medical costs through fee schedules based on usual and customary reimbursement rates have lower workers' compensation medical costs than states with no fee regulation. In addition, between 2002 and 2004, California made comprehensive changes to its workers' compensation system, including changes to fee schedules for hospital inpatient and outpatient services and ambulatory surgery centers. As a result of these reforms, California had approximately a 39 percent reduction in hospital outpatient charges, and a 4 percent reduction in hospital inpatient charges, according to a 2008 study by California's workers' compensation insurance rating organization.[1]

Increased use of network providers could help contain costs—Like the fee schedule, the network has cost-saving advantages. According to fund officials, many of the network providers whose services are covered by the ICA workers' compensation fee schedule accept the Fund's standard contract terms of rates 10 percent below the ICA fee schedule maximum amount. According to the Fund's materials and officials, providers benefit from joining the network because they build stronger relationships in the community by belonging to a network of other medical providers in their area, and they receive prompt payment from the Fund. However, measuring network cost savings is difficult because although some providers bill their typical charges and allow the Fund to reduce the payment, others simply bill the Fund for the reduced rate. Despite that, based on billed amounts, the Fund has calculated that its savings attributed to network reductions totaled approximately $61.5 million in 2006 and approximately $65.9 million in 2007.

Many network providers accept rates 10 percent below fee schedule rates.

The Fund could take steps to increase provider network usage and membership. According to the Fund's records, in 2007, approximately 24 percent of providers that submitted bills were network providers. Further, 53.8 percent of its medical

1 Workers' Compensation Insurance Rating Bureau of California. (2008). 2008 Legislative cost monitoring report. Retrieved November 14, 2008, from https://wcirbonline.org/wcirb/Home.aspx

bills, accounting for 65.5 percent of medical charges, were from network providers. Pursuant to A.R.S. §23-908, an employer can choose to require one medical examination by a provider of the employer's choice, but beyond that, the injured worker can select a provider of his or her choice. The Fund could do more to encourage policyholders to direct injured workers to network providers for their first treatment. The Fund's approximately 2,900 network providers include 70 of Arizona's 98 hospitals. Ten of the hospitals not in the network are specialized, such as children's, transplant, or heart hospitals. Further, some nonnetwork bills come from out-of-state medical suppliers and other providers. Fund staff reported working actively to recruit hospitals into the network and have begun work to identify areas of the State with greater opportunity for recruiting new providers. However, according to fund officials, it can be difficult to recruit providers in rural areas where providers have few competitors and therefore do not perceive a benefit for contracting for discounted prices. Still, the Fund should continue working to make improvements to its provider network in order to reduce its costs by recruiting additional providers and identifying areas of the State in need of additional providers.

The Fund's network includes most Arizona hospitals.

Recommendations:

1.1 The Fund should consider applying stricter standards of coverage so it provides insurance to only those companies with loss histories within reasonable industry standards and where reasonable safety improvement efforts are effective.

1.2 The Fund should continue to work with the Legislature to develop legislation to change state statutes to establish that any medical charges not covered under the ICA fee schedule and not from a medical provider within a carrier's medical network shall be based on the usual and customary reimbursement rates that prevail in the same community for that medical service.

1.3 The Fund should continue to encourage policyholders to direct injured workers to the Fund's network providers, when appropriate, for their first medical treatment.

1.4 The Fund should continue working to make improvements to its provider network through efforts to recruit additional providers and identifying areas of the State in need of additional providers.

FINDING 2

Fund should continue to improve claims management by better aligning itself with recommended practices

By better aligning its procedures with recommended practices, the State Compensation Fund (Fund) can improve how it processes claims filed by injured workers. Case reviews and claims data analyses show that claims processing—especially claims for injured workers who receive payments for lost wages as well as medical services—face some challenges with timeliness and accuracy. Such issues are indications that processing can be strengthened. In 2008, the Fund partially implemented reorganization of its claims-processing functions, and full implementation of the reorganization was achieved in January 2009. This reorganization has yielded improvements, and the Fund can continue to improve its claims management by better aligning itself with recommended practices.

Reviews show areas of opportunity for improvement on claims management

Although claims management can be evaluated in many ways, two common measures with readily available data are timeliness and accuracy—that is, whether decisions and payments are made on a timely basis, and whether payments are accurately determined. Auditors reviewed the Fund's own internal assessments of timeliness and accuracy, and supplemented these assessments with additional analyses of lost-wages claims. Both the review and the analyses showed areas where some challenges exist, particularly with regard to lost-wages claims.

Internal quality assurance reviews show both strengths and weaknesses—Auditors' analysis of the Fund's own Quality Assurance (QA) reviews showed the Fund has timeliness problems related both to medical bills and lost-wages benefits, as well as accuracy problems for lost-wages benefits.

Accuracy for medical benefits appears strong (see textbox, page 27, for a description of QA reviews). As shown in Table 3 below, for timeliness, the percentage of claims meeting the Fund's own criteria was between 77.9 percent and 80.4 percent for payment of medical bills and was 74 percent for payment of lost-wages benefits.[1] For accuracy, the percentage of claims meeting the Fund's scoring for medical benefits was much higher—at 94.5 percent—but was only 57.1 percent for lost-wages benefits. Auditors' analysis of 73 lost-wages claims failing to meet the Fund's QA criteria found that the two most common errors were that claims handlers miscalculated the average monthly wage or claims handlers failed to obtain or document the information necessary to justify their benefit decisions.

Table 3: Results of Fund's Quality Assurance Reviews of Medical-Only and Lost-Wages Claims August 2007 through August 2008

Quality Assurance (QA) Review Claim Type and Question	Claims Meeting QA Review Criteria	Percentage Meeting Criteria
Total Medical-Only Claims Reviewed: 289		
QA Question		
Were medical bills paid timely?	225	77.9%
Were medical benefits paid/processed accurately?	273	94.5
Total Lost-Wages Claims Reviewed: 693[1]		
QA Question		
Were lost-wages benefits paid timely?	513	74.0
Were lost-wages benefits paid accurately?	396	57.1
Were medical bills paid timely?	557	80.4
Were medical benefits paid/processed accurately?	653	94.2

1 The QA review of lost-wages claims for the period August 2007 through August 2008 was for only 10 rather than 13 months of data because, according to fund staff, the Fund's compliance auditors did not perform lost-wages claims audits in April, June, and July 2008.

Source: Auditor General staff analysis of the Fund's QA compliance reviews of medical-only claims for the months of August 2007 through August 2008, and QA compliance reviews of lost-wages claims for the months of August 2007 through March 2008, May 2008, and August 2008.

However, the QA review likely understates the Fund's actual timeliness and accuracy. The QA review does not differentiate between actual late payments or inaccuracies and cases that lacked documentation needed to measure timeliness and accuracy. Further, the senior vice president of claims management disagreed with approximately 28 percent of QA reviewers' conclusions on the QA question pertaining to accuracy of lost-wages payments when she examined 77 lost-wages

1 These criteria include, for example, whether the first lost-wages check was issued within the statutory time frame of 21 days after being notified by the Industrial Commission of Arizona (ICA) about a worker's injury. For timeliness of medical payments, the Fund's QA standard allows up to 30 days from the receipt of billing, whereas the statutory requirement at A.R.S. §23-1062.01 allows up to 60 days. For accuracy, the standards include calculating the average monthly wage in accordance with statutory requirements and providing correct documentation to support the benefit amount.

cases the reviewers had scored as unacceptable. Other indicators of accuracy suggest a higher rate than the QA reviews found. Specifically, according to fund officials, their review of approximately half of the QA review cases auditors analyzed determined that, in 97.6 percent of the cases, the ICA agreed with the Fund's wage calculation. In addition, the Fund reported that less than 2 percent of claims are protested in court, which fund officials believe suggests that claimants also agree with the Fund's wage calculations. To enable it to better use the results of its QA reviews to assess and improve its performance, the Fund should modify its QA processes and tool. According to fund officials, now that the claims reorganization has been implemented, they intend to review the QA process in a way that will allow them to improve the evaluation of timeliness and accuracy of lost-wages benefit payments.

Fund generally meets statutory standard for claims decisions and payments—Because lost-wages claims are generally more complicated than medical-only claims and statutes establish mandatory time frames for them, auditors performed additional analyses of the timeliness of processing lost-wages benefits. These analyses included determining whether the Fund met the statutory requirements of paying lost-wages claim benefits or denying a claim within 21 days of being notified of the claim by the Industrial Commission of Arizona (ICA) and, for accepted claims, making the initial lost-wages payment within 21 days of the ICA notification. As shown in Table 4 (see page 28), auditors' analysis of lost-wages claim data found that more than 99.6 percent of lost-wages claims met the 21-day standard for making a decision to accept or deny a claim.

Although only about 78 percent of lost-wages claims met the statutory standard for issuing benefits within 21 days of the ICA notification, this figure likely understates the Fund's timeliness. Injured workers are eligible for compensation only if they cannot work for more than 7 days because of the injury, and Arizona courts have determined that carriers do not have to pay benefits until they receive supporting medical documentation that confirms the employee's medical disability. The Fund reviewed 100 of the claims identified as paid more than 21 days after the ICA notification date in auditors' analysis and found that, in 77 percent of the cases, the claims were paid within 21 days of receiving documentation justifying payment for compensation.

Quality Assurance (QA) Reviews

The Fund monitors statutory compliance with QA reviews conducted by an internal claims audit unit. The Fund's compliance auditors evaluate medical-only claims for compliance with six performance questions, such as:

- Was a thorough investigation completed to determine benefit entitlement?
- Were medical bills paid timely?
- Were medical benefits paid and processed accurately?

Auditors' evaluations of lost-wages claims include two additional questions, specifically:

- Were lost-wages benefits paid timely?
- Were lost-wages benefits paid accurately?

A claim must satisfy all criteria related to each question to receive an acceptable score for that question, according to the claims audit unit director. Although the criteria include statutory requirements, the criteria also contain applicable Arizona Administrative Code rules and fund policies related to the question. Therefore, if a claim fails to receive an acceptable score for a specific question, it does not always represent a violation of statute, such as inaccurate payment, but may indicate that although the claims handler made an accurate payment, he/she relied on the wrong information to justify a decision or failed to provide necessary justification.

Source: Auditor General staff analysis of the Fund's quality assurance compliance review criteria and interviews with fund management.

Table 4: Timeliness of Lost-Wages Claims Processing
August 1, 2007 through October 17, 2008

Claim Type/Statutory Timeline	Number of Claims[1]	Percentage Meeting Processing/ Payment Timelines
Decision to accept/deny lost-wages claim from Industrial Commission of Arizona (ICA)		
Statutory requirement within 21 days of ICA notification of a new claim	5,661[2]	99.6%
Lost-wages benefit payment from ICA notification date		
Statutory requirement before or within 21 days of ICA notification date for valid and accepted claims	2,871[3,4]	77.6

1 The Fund decided 7,371 lost-wages claims during this period. However, not all claims were evaluated against the performance standards measured because the Fund does not receive ICA notification for all claims.

2 Excludes lost-wages claims that did not have an ICA notification date.

3 Excludes lost-wages claims that the Fund denied, claims that did not receive a lost-wages benefit payment, and claims that the Fund and the ICA have exempted from the statute.

4 Out of 2,871 claims tested, 612 claimants received a payment prior to the ICA notification date, and 1,615 received a payment within 21 days.

Source: Auditor General staff analysis of fund lost-wages claims data for August 1, 2007 through October 17, 2008, and Arizona Revised Statutes §§23-1061(M) and 23-1062(B).

Fund has taken steps to improve claims handling, but can do more to ensure good claims practices

Although timeliness and accuracy are only two aspects of claims handling, challenges in these areas are indications that improvements can be made. The Fund has recognized the need for improvement with claims handling, including timeliness and accuracy issues, and has taken a number of steps to address them, but further action is recommended.

Actions taken stem from external review and concern about compliance with recommended practices—As part of its efforts to improve its claims service, in 2007, the Fund commissioned an external claims review to establish a benchmark for claims handling prior to reorganizing the

function. Based on a review of 215 cases, the external consultant found that the Fund was not in line with several recommended practices.[1] (See Table 5, page 30, for a list of recommended practices.[2])

The Fund has used the external review as a tool to improve its claims management practices. Since 2007, the Fund has implemented a number of changes consistent with the consultant's recommendations. Most significantly, it has reorganized its Claims Services Division so that a manager with claims experience supervises the teams. Previously, the Fund assigned lost-wages claims to multifunction account service teams that also contained nonclaims personnel and a manager responsible for the quality of claims handling who did not necessarily have a claims background. In the new claims structure, the teams manage a claim "cradle to grave" instead of transferring claims between teams when changes occur in the claim's status, and claims managers must have claims-handling expertise. According to the claims management director, if a claim was converted from medical-only to lost-wages in the old structure, it could be reassigned to a different team, which could result in a lack of effective oversight and diminished continuity of service for the injured worker. Fund officials stated that the new claims managers and team structure, which was substantially implemented in August 2008, and completed in January 2009, should improve claims management and oversight.

The Fund has reorganized its Claims Services Division to provide better claims management and oversight.

In addition to the reorganization, the Fund has implemented new processes. For example, beginning in May 2008, the Fund requires manager approval for all denied claims and in February 2009 completed a new *Best Practices Manual* for claims handlers, which requires "evidence of ongoing active medical management," among other requirements consistent with recommended practices. According to fund officials, the Fund completed manager training on the July 2008 version of the manual in November 2008 and plans to have team leaders begin the best practice reviews previously conducted by the Fund's compliance auditors. Additionally, according to the claims management director, the Fund plans to institute new performance "score cards" for use in claims handlers' performance evaluations that will reflect both the best practice reviews and results of the compliance auditors' work.

Additional steps would bring about better compliance with recommended practices—Although the changes made to date are important, auditors identified several opportunities to better align current procedures with industry-recommended practices and improve the Fund's claims-handling procedures. Specifically, as shown in Table 5 (see page 30), the Fund should improve in five of the six recommended practices areas:

1 The external consultant's sample was intended to be a representative sample of open and recently closed claims activity, but it was not intended to be a statistically valid sample. The consultant's findings cannot be extrapolated to the total claims population.

2 Recommended practices were derived from Auditor General staff analysis of *SCF Arizona workers' compensation best practices claim review*, November 9, 2007, performed by an insurance consulting firm, and National Council on Compensation Insurance, Inc. (1999). *2000 servicing carrier performance standards* [Electronic version]. Boca Raton, FL: Author. In addition, the Auditor General's 1988 report on the Fund identified similar recommended practices (see Report No. 88-10).

Table 5: Comparison of Recommended Practices in Workers' Compensation Claims Management to the Fund's Practices
As of January 2009

Recommended Practice	Fund's Practice
New claim assignment: Assign claim to claims handler with appropriate skill level based on initial claim information and complexity of claim.	In 2007, the Fund initiated a "triage" process to assign claims to claims handlers based on disability status. However, the Fund should reconsider its consultant's recommended criteria for when to assign claims to lost wages claims handlers.
Three-way contact and claim investigation: Contact injured worker, policyholder, and medical provider within 24 hours of receiving claim and complete quality investigation on every new lost-time claim within 10 to 14 days.	Less than 45 percent of lost-time claims reviewed met the QA review criteria for a good investigation. The majority of errors involved incomplete three-way contacts. The Fund requires a completed investigation prior to accepting or denying a claim, but should update its policy to require completed investigations within 10 to 14 days of receiving the claim.
Case strategy/action planning: Complete a documented strategy to get the injured employee back to work and bring the case to satisfactory conclusion.	In its 2007 review, the external consultant stated that claims handlers usually did not document formal strategy steps and that a lack of strategy and steps could result in late or delayed treatment and under- or over-payments. QA reviewers do not consistently review claims for good case strategy and the Fund's team leaders and managers have not conducted best practices reviews, which would evaluate case strategy, since June 2007.
Case reserving: Conduct thorough analysis of available information to assess and document expected claim cost; specifically, claim file should be clear as to how many weeks of temporary disability.	The Fund's external consultant stated that case reserving is a closely supervised process in the claim processing operation, resulting in outcomes closer to best practices. Claims handlers continue to forward case reserve estimates beyond their authority to the QA team for feedback and approval.
Medical/disability management: Claims handler or nurse case manager should maintain contact with injured worker, especially following doctor appointments and while worker is disabled.	The external consultant stated it rarely found interaction between the assigned claims handler and the injured employee.
Oversight: Perform and document claims reviews and provide direction on cases of defined durations, incurred amounts, or specific nonroutine issues.	Although the Fund performs QA compliance reviews, it does not perform the three per handler, per month required by fund policy. Further, the Fund is not effectively using the results to improve its practices. The Fund has not been conducting best practice claims reviews since June 2007, but plans to reinstate them in 2009 based on new criteria and an examination of claims review policy.

Source: Auditor General staff analysis of *SCF Arizona workers' compensation best practices claim review*, November 9, 2007, performed by an insurance consulting firm, NCCI *2000 servicing carrier performance standards*, the Fund's QA reviews of lost-wages claims for the period August 2007 through August 2008, and fund policies and interviews with fund management and staff between August 2008 and January 2009.

- Claims assignment—Although the Fund has some specific criteria for when to assign claims to lost-wages claims handlers, it should re-examine the external consultant's recommendations regarding additional criteria to help avoid payment delays. In August 2007, the Fund adopted a new claims initiation policy that provided, for example, that any claim involving certain types of fractures should be classified as a lost-wages claim. However, the external consultant suggested several additional criteria that could be adopted. When auditors determined that some claims in August 2007 through October 2008 did not meet payment timeliness standards, fund officials stated that one reason was that the claims had to be reassigned from being a medical-only claim to a lost-wages claim. The Fund should re-examine the consultant's recommendations and adopt additional criteria, such as assigning claims where medical treatment exceeds $2,500 or is expected to extend beyond 6 months' duration, to lost-wages claims handlers, if it determines that doing so would help avoid payment delays.

The Fund should re-examine and adopt more of its consultant's recommended criteria to avoid payment delays.

- Three-way contact and claims investigations—The Fund's claims handlers do not meet the Fund's own standards for initial contact with the injured worker, the policyholder, and the medical provider. Less than 45 percent of the claims in the Fund's QA reviews from August 1, 2007 through August 31, 2008, met the Fund's internal standards for investigations. These standards require, among other things, that three-way contact be completed within 24 hours of receiving the claim. The majority of investigation errors identified in the QA reviews involved noncompliance with three-way contact criteria, such as timeliness or lack of contact with all three parties. The Fund should examine its policies, training, and oversight functions to determine why claim adjusters fail to adequately complete three-way contacts and modify its oversight and training practices accordingly.

- Case strategy and action planning—The Fund needs to improve its oversight and policies for documenting case strategy and action plans for the management of claims. According to the National Council on Compensation Insurance (NCCI), lost-wages claims require a good strategy for medical/disability management and a follow-up plan to get the injured worker back to work. However, in the 2007 review, the Fund's external consultant stated that claims handlers usually did not document a formal case strategy with specific next steps. The lack of a strategy with next steps or issues for followup can cause treatment to be late or stalled, benefits to be over- or underpaid, or claims to be open too long. According to fund officials, the Fund does prepare documented action plans for claims with significant costs. However, because it defines "significant costs" differently for each claims handler depending on his or her experience level, workers with similarly severe injuries may not receive equivalent case management. Further, auditors could not determine whether claims handlers' performance had improved because the Fund does not review case strategy as part of its QA reviews, and it has

not conducted its own best practices reviews, which would include a review of case strategy and action plans, since June 2007. To help ensure effective case management, the Fund should require action plans for all claims with significant costs and include a review of the plans in its best practices reviews.

- Medical/Disability Management—The Fund should update its practices and policies on medical management and implement the changes. The Fund's external consultant stated that it rarely found interaction between the assigned claims handler and the injured employee and that the employees had trouble understanding their new responsibilities related to job searches and income reporting after the medical provider released them to light duty. In this phase, injured workers receive reduced and less-frequent lost-wages benefits and must conduct a job search and report their income to the Fund.[1] Further, NCCI recommends a team approach to disability management with ongoing contact with the injured worker. The Fund's external consultant found ongoing contact especially important when injured workers were released to light duty and needed to understand the process. Fund officials elected not to implement the consultant's recommendation that the Fund's call center refer more calls from the injured worker directly to his/her claims handler to improve claims management. According to fund officials, they elected not to implement this recommendation because the Fund's call center efficiently and effectively handles routine calls from injured workers, which helps to free claims handlers for more important tasks. However, the Fund should take some steps to ensure effective interaction between injured workers and their claims handlers, such as implementing its consultant's recommendation to contact injured workers by phone, in addition to the required letter, to check on their work status and job search when applicable.

Workers released to light duty need help understanding their new responsibilities.

- Oversight—The Fund does not meet its own standards for reviewing claims handlers' work, and it does not fully use the results of its reviews to improve its performance. According to NCCI, insurance carriers should provide documented review and supervisory direction and control of claims handling consistent with the injury severity and the extent of disability. According to fund management, because of limited staffing, the Fund's compliance auditors have only been reviewing one claim per claims handler per month, instead of the three per claims handler required by the Fund's policy. Similarly, in 2007, the Fund's external consultant reported that it found almost no documentation of claims reviews by team leaders. Further, the Fund's compliance auditors stopped conducting best practices reviews in June 2007, at which time claims teams were intended to take over the reviews. These reviews compared claims handling against recommended practices in addition to the ongoing QA reviews that check for compliance with statutory, regulatory, and policy requirements. However, according to fund officials, these best practices reviews have not occurred since the compliance auditors stopped conducting them. According to the claims management director, the Fund expects to

[1] Payments are made at 66 2/3 percent of the difference between the average monthly wage and any reported earnings.

reinstate these reviews in the first quarter of 2009 with claims managers conducting the reviews, although the Fund wants to re-examine their review policies to determine the most effective review schedule considering claim type or claims handler experience. The Fund should examine its review policies and develop and implement an effective, documented review process that provides fund management with trends in claims management and can be used to improve claims handlers' performance.

In addition to reviewing claims handlers' work, oversight should include informing claims handlers of their review results and providing direction for improving their performance. However, although the claims management director states that the compliance auditors e-mail results to claims handlers and managers, there is no documentation showing that the managers discuss the results with the claims handlers.

The Fund should also take a couple of steps to better ensure timely payment of lost-wages claims. First, it should develop and implement policies regarding actively working to obtain medical documentation. According to the Fund's review of 100 of the claims auditors identified as paid late, missing documentation explained most of the delays. However, the Fund lacks a standard for how long to wait before taking steps to obtain documentation, and the Fund's external reviewer found that, claims handlers generally did not make proactive efforts to obtain medical documentation. Second, the Fund should establish an internal standard for payment timeliness when eligibility for lost-wages compensation cannot be determined within 21 days of an ICA notification date. Statutes do not specify when claims should be paid in this situation. Once it establishes these policies and this standard, the Fund should modify its QA review to evaluate whether claims handlers are following the policies and meeting the internal standard.

The Fund should ensure that its claims handlers proactively seek medical information.

Fund should evaluate changes to ensure progress—Now that the Fund has completed its remaining reorganization activities, it should review the impact of these changes. To do this, the Fund could commission another external claims review to obtain the specialized expertise available from external consultants. As previously noted, the Fund's internal claims audit unit focuses on evaluating claims for compliance with statutory, regulatory, and policy requirements rather than recommended practices. In addition, according to the senior vice president of claims management, the 2007 external review was obtained to establish a benchmark prior to the reorganization, and because the Fund's other internal auditors, who report directly to the Board of Directors' audit committee, did not have the expertise to conduct claims reviews. Alternatively, the Fund could conduct a review using its own staff to determine whether its performance has improved since the 2007 consultant's review and this audit.

Recommendations:

2.1 The Fund should re-examine its consultant's recommended criteria for when to assign claims to lost-wages claims handlers and adopt additional criteria, if it determines that doing so would help avoid payment delays arising from reassigning claims.

2.2 The Fund should examine its policies, training, and oversight functions to determine why claims handlers fail to adequately complete three-way contact. Based on the results of its findings, the Fund should modify its oversight and training practices accordingly and ensure that the three-way contact and claims investigations are completed in a timely manner.

2.3 To help ensure effective case management, the Fund should:

a. Require documented action plans for all claims with significant costs, and

b. Review documented action plans as part of its best practices reviews.

2.4 The Fund should implement the external consultant's recommendation that it contact injured workers by phone, in addition to the required letter, to check on his/her work status and job search when applicable.

2.5 To help insure QA reviews are used to improve statutory compliance, the Fund should:

a. Examine its review policies, and develop and implement an effective review process that provides fund management with trends in claims management and that can be used to improve claims handlers' performance;

b. Provide documentary evidence of this supervisory review; and

c. If appropriate, develop an action plan for improvement based on the results.

2.6 To better ensure timely payment of lost-wages claims, the Fund should:

a. Develop and implement policies regarding actively working to obtain medical documentation;

b. Establish an internal standard for payment timeliness when eligibility for lost-wages compensation cannot be determined within 21 days of an ICA notification date; and

c. Modify its QA review to evaluate whether claims handlers are following the policies and meeting the internal standard.

2.7 To ensure the Fund's reorganization efforts are on target and effectively bringing the Fund in line with recommended practices in claims management, the Fund should perform an internal audit or commission another external claims review to measure progress against statutory compliance and recommended practices in claims management.

SUNSET FACTORS

In accordance with Arizona Revised Statutes (A.R.S.) §41-2954, the Legislature should consider the following 12 factors in determining whether the State Compensation Fund (Fund) should be continued or terminated.

1. The objective and purpose in establishing the Fund.

   The Arizona Legislature created the Fund in 1925, the same year in which it made workers' compensation insurance mandatory in Arizona. The Fund was originally part of the Industrial Commission of Arizona (ICA), but in 1968, the Legislature removed the Fund from the ICA and established it as a separate entity effective January 1, 1969. Since this time, the Fund has operated as a stand-alone entity with its own enabling statutes.[1]

   The primary purpose of the Fund has remained virtually the same since 1925: to provide Arizona businesses with workers' compensation insurance. Arizona employers may obtain workers' compensation insurance through the Fund, through self-insurance, or through a private insurance carrier.

   The Fund is Arizona's dominant workers' compensation insurance provider. As of 2007, the Fund reported that it provided workers' compensation insurance to more than 55,000 businesses with more than 1 million employees, representing 58 percent of Arizona's employers. That same year, the Fund collected 55 percent of total state-wide workers' compensation insurance premiums, according to Arizona Department of Insurance records. Further, in 2007, the Fund paid nearly $216 million in medical service provider bills for injured workers and nearly $101 million in lost-wages payments to workers.

2. The effectiveness with which the Fund has met its objective and purpose and the efficiency with which it has operated.

   The Fund has been generally effective in providing workers' compensation coverage in competition with private insurance companies. As of 2007, the Fund insured approximately 55 percent of the Arizona workers' compensation insurance market by total premiums, according to Arizona Department of Insurance records. In addition, it has effectively managed its operations, enabling it to pay benefits for its policyholders' injured workers and return dividends to its policyholders. The Fund's officials reported that the Fund has paid a dividend every year since 1971.

1 The majority of the Fund's enabling statutes are found at A.R.S. §§23-981 through 23-1006.

However, as discussed in Finding 1 (see pages 13 to 23), the Fund can take steps to improve its claims expense-to-premium ratio. Improving the claims expense-to-premium ratio can come both from increases in premiums or reductions in expenses. The Fund is taking steps in both areas but can do more. To improve premium pricing, the Fund is changing its pricing policies and standards in ways that take risk into greater account in setting the premiums that employers pay. Specifically, the Fund has begun to adopt the common Arizona insurance industry practice of creating subsidiary companies that can offer different rates that more closely match the risk level of specific policyholders. However, the Fund should also consider reassessing its traditional approach of acting as the insurer of last resort, regardless of a policyholder's risk. Denying coverage to very high-risk employers could shift them to the State's Assigned Risk Pool, where rates even more adequately reflect the degree of risk. On the expense side, the Fund can make greater use of measures it already has in place for containing medical costs. To mitigate the cost impacts of services that are not on the ICA fee schedule, in January 2009, the Fund worked with the Legislature to introduce Senate Bill 1262 related to reimbursement costs for medical, surgical, and hospital procedures. This bill, if passed in its original form, would establish that any medical charges not covered under the ICA fee schedule and not from a medical provider within a carrier's medical network shall be based on the usual and customary reimbursement rates that prevail in the same community for that medical service. Also, the Fund may be able to further control medical costs by increasing the use of its medical services provider network.

Additionally, as discussed in Finding 2 (see pages 25 to 35), the Fund can continue to improve its claims management. By better aligning its practices with industry recommended practices, the Fund can improve its processing of claims filed by injured workers. Auditors reviewed the Fund's own internal assessments of timeliness and accuracy and supplemented these assessments with additional analyses of lost-wages claims. Both the review and the analyses showed areas where some challenges exist, particularly with regard to claims for lost wages. For timeliness, the percentage of claims meeting the Fund's own criteria was between 77.9 percent and 80.4 percent for medical bills payments and was 74 percent for lost-wages benefit payments. For accuracy, the percentage of claims meeting the Fund's criteria for medical benefits was higher at 94.5 percent, but was only 57.1 percent for lost-wages benefits.

In addition, although the Fund generally meets a statutory requirement regarding timely lost-wages benefit payments in most cases, it should establish an internal standard for payment timeliness when eligibility for lost-wages compensation cannot be determined within 21 days of an ICA notification date. A.R.S. §23-1062(B) requires workers' compensation insurance carriers to make the first lost-wages benefit payment within 21 days from the ICA notification. However, because workers are only eligible for payment if the injury causes them

to be unable to work for more than 7 days, Arizona courts have concluded that carriers do not have to pay benefits until they receive medical documentation that the employee was unable to work. Auditors' analysis of claims found that the Fund met the 21-day standard in approximately 78 percent of the claims, including approximately 21 percent that were paid before the ICA notification date. According to the Fund's review of 100 of the 662 claims auditors identified as paid late, missing documentation explained most of the delays.

Although timeliness and accuracy are only two aspects of claims handling, challenges in these areas are indications that improvements can be made. The Fund has recognized the need for improvement with claims handling, including timeliness and accuracy issues, and has taken a number of steps to address them, such as an external review that it commissioned in 2007, claims reorganization efforts, and the implementation of new claims processes. However, further action is needed in areas such as claims assignment, three-way contact, action plans, supervisory review, and obtaining medical documentation. Specifically, the Fund should re-examine its criteria used to assign claims, take actions to ensure claims handlers complete the three-way contact in a timely manner, require documented action plans for all claims with significant costs, develop and implement an effective review process, and develop and implement policies regarding actively obtaining medical documentation necessary for timely payment of lost-wages claims. The Fund should also take steps in the future to evaluate the results of the reorganization it completed in January 2009 by performing an internal audit or commissioning another external claims review to measure progress against statutory compliance and recommended practices in claims management.

3. The extent to which the Fund has operated within the public interest.

The Fund has operated within the public interest by providing a market for workers' compensation insurance. It has also provided dividends to policyholders. Arizona's workers' compensation premiums are the seventh-lowest in the nation, according to a recent report by Oregon's Department of Consumer & Business Services.[1]

The Fund has also operated within the public interest by promoting workplace safety. The Fund provides safety information to Arizona businesses through safety events, expositions, the Internet, symposia, and seminars around the State. The Fund also reported that it provides some safety information directly to workers through the Internet, television, and radio, including Spanish-language television and radio. In addition, the Fund rewards the safety efforts of policyholders that are enrolled in one of the Fund's Association Safety programs. The Fund may award bonus dividends to policyholders, in addition to the individual dividends, based on the safety success of the association to which the policyholder belongs.

1 Department of Consumer & Business Services. (2008). *2008 Oregon Workers' Compensation Premium Rate Ranking Summary*. Retrieved February 18, 2009, from http://www.cbs.state.or.us/imd/rasums/2082/08web/08_2082.pdf

4. The extent to which rules adopted by the Fund are consistent with the legislative mandate.

Pursuant to A.R.S. §41-1005(A)(27), the Fund is exempt from the Arizona Administrative Procedures Act and therefore is not subject to rulemaking requirements.

5. The extent to which the Fund has encouraged input from the public before adopting its rules and the extent to which it has informed the public as to its actions and their expected impact on the public.

The Fund is exempt from the Arizona Administrative Procedures Act and therefore is not subject to rulemaking requirements. However, the Fund informs the public as to its actions. Pursuant to A.R.S. §38-431, the Fund complies with the Arizona open meeting laws requirements to post its meeting notices and meeting agendas, including notices of executive session, with at least 24 hours' notice in the specified locations. The Fund also records meeting minutes and makes copies available to the public. In addition to informing the public about the Board's actions and decisions, the Fund issues press releases and a quarterly magazine, which include information about some decisions made by the Board of Directors.

6. The extent to which the Fund has been able to investigate and resolve complaints that are within its jurisdiction.

This factor is not applicable because the Fund is not a regulatory agency and therefore, has no need to investigate and resolve complaints regarding regulated persons or entities. However, it does receive disputes about its own actions from injured workers, and it takes steps to resolve them. If an injured worker wishes to file a dispute against the Fund, he/she must file a complaint with the ICA. According to fund counsel, the Fund attempts to resolve these disputes prior to the hearing. Previously, claims handlers were responsible for attempting to resolve disputes. However, in 2007, the Fund's legal division established within it a pilot Dispute Resolution Unit (Unit), with two dedicated dispute resolution specialists, to provide better service and to free claims handlers to focus on claims management. According to the Unit's Best Practices manual, dispute resolution allows the Fund to maintain amicable relations with injured workers and ensures them that they receive all benefits to which they are legally entitled. Further, officials stated that the unit saves the Fund time and money by promptly addressing medical and lost-wages issues and reducing litigation costs. According to unit reports, it has been meeting its internal goals to resolve 25 to 30 percent of disputes since the project's inception.

7. The extent to which the Attorney General or any other applicable agency of state government has the authority to prosecute actions under the enabling legislation.

The Fund has authority to sue and be sued. In addition, under A.R.S. §20-466(G), insurers, including the Fund and other workers' compensation insurers, must report fraud to the Arizona Department of Insurance (Department). If the department director finds that "fraud, deceit or intentional misrepresentation of any kind has been committed in the submission of a claim," the director may report the violations to the appropriate county attorney or the Attorney General for prosecution.

According to the Department, in 2008, it received 198 workers' compensation fraud referrals from Arizona insurance companies with 112 of these submitted by the Fund. According to the Fund's legal division officials, when the Fund's attorneys receive a referral about potential fraud, such as from a claims handler's routine check for fraud, the legal division's attorneys do the necessary research and investigation to fully prepare the case for prosecution by the Attorney General.

8. The extent to which the Fund has addressed deficiencies in its enabling statutes, which prevent it from fulfilling its statutory mandate.

Fund officials reported that, since the 1998 sunset review, they have directly initiated two statutory changes, which were both enacted in 2007 and did the following:

- Exempted the Fund from the Arizona Administrative Procedures Act (Act). In 2003, the Fund was sued by a vendor who maintained that the Fund must follow the Act in adopting a new system of pricing and reimbursement. The court determined that the Fund was performing a business function common to private workers' compensation carriers and was not in violation of the Act. This court case, however, led the Fund to seek legislation on the issue, and the Legislature specifically exempted the Fund from the Act by adding A.R.S. §41-1005(A)(27).

- Clarified the time limit for the Fund to seek reimbursement from a third party that may bear some responsibility for a worker's injury. The Fund has the statutory authority to impose a lien on the amount collectable if an injured employee pursues a lawsuit against a third party. The Legislature clarified A.R.S. §23-1023 to state that if the injured worker does not file a case within the first year of the injury, then the Fund may do so within the second year of the injury.

The Fund's Board of Directors has identified other statutory changes it believes are necessary to improve the Fund's ability to compete with private insurance companies. Statutes exempt the Fund from many requirements that apply to other state agencies, such as using state personnel and purchasing services, and from the Arizona Administrative Procedures Act. The Legislature enacted some of these exemptions to remove the Fund's competitive advantage over private insurance companies. However, fund officials and board members determined that the Fund should pursue additional legislative changes to allow it to be more competitive in the private market. During its September 16, 2008, meeting, the Board decided to pursue changes to several statutes in 2009, including:

- A.R.S. §23-966—Administration of Insolvent Carrier Claims—This statute requires the ICA to assign claims to the Fund if an insurance carrier or self-insured employer does not comply with requirements to pay compensation or medical benefits, and provides for the Fund to be reimbursed from the State's Special Fund established in A.R.S. §23-1065. The Fund plans to propose that it should no longer be required to process the claims of insolvent insurance carriers that have been assigned to the State's Special Fund. Rather, it proposes that the ICA should assume these claims and then contract with outside claims administrators to administer insolvent carrier claims. Fund officials indicated that if the statute were amended, the Fund might be willing to contract with the ICA to process these claims. However, they no longer want to be statutorily required to administer these claims.

- A.R.S. §23-981—Fund's Statutory Purpose—The Fund would like the Legislature to amend its statutory purpose to remove the requirement that it can offer insurance only to Arizona employers. According to fund officials, the Fund's inability to offer insurance outside Arizona reduces its ability to spread its risks, makes it vulnerable to any catastrophic event that occurs in Arizona, and also limits the Fund's ability to fully serve its Arizona-based customers. However, according to fund officials, obtaining legislative authority to operate outside of Arizona could potentially affect the Fund's eligibility for a federal tax exemption under 26 U.S.C.A. §501(c) 27(B).

- A.R.S. §23-981.01—Fund's Board of Directors Appointment and Powers of Fund's Manager—The Fund proposes a change from five board members to nine. In addition to the five governor-appointed members, the Fund proposes that its policyholders should elect an additional four members for 3-year terms. Because the Governor would still appoint the majority of the Fund's board members, the Fund believes that the change would not jeopardize its eligibility for a federal tax exemption under 26 U.S.C.A. §501(c)27(B).

- A.R.S. §23-986—Application of Title 20 to the Fund and Statutory Exemptions—This statute identifies various Title 20 insurance statutes that apply to the Fund, as well as various exemptions from statutory provisions including all of Title 35; Title 38, Chapter 4; Title 39, Chapter 1, Article 1; and various chapters in Title 41 pertaining to State Government. The Fund plans to propose that the Legislature amend the statute to completely exempt the Fund from Title 41. Specifically, the Fund would like the Legislature to remove the requirement that it be subject to sunset review and contends that this would be accomplished by completely exempting the Fund from Title 41. If this change were to take effect, the Fund would still be subject to Joint Legislative Budget Committee budget review and the Governor's appointment of board members, as those requirements are set forth in Title 23.

As of March 2009, the Fund had not introduced any of the proposals submitted to the Board at its September 16, 2008, board meeting related to the four statutes discussed above.

9. The extent to which changes are necessary in the laws of the Fund to adequately comply with the factors in the sunset law.

As discussed in Finding 1 (see pages 13 to 23), to mitigate the cost impacts of services that are not on the ICA fee schedule, in January 2009, the Fund worked with the Legislature to introduce Senate Bill 1262 related to reimbursement costs for medical, surgical, and hospital procedures. If passed in its original form, this legislation would add a new statute to Title 23, Chapter 6, Article 9, to establish that any medical, surgical, and hospital charges, not covered under the ICA fee schedule and not from a medical provider within a carrier's medical network, shall be based on the usual and customary reimbursement rates that prevail in the same community for similar services.

In addition, the Fund requested a change in rate-setting statutes to address a statutory discrepancy regarding when premium rates become effective. Specifically, statutes establish an October 1 effective date for premium rate changes and deviations from premium rates are effective through the following September 30, but there is a January 1 effective date for changes in maximum lost-wages benefits. The discrepancy means that insurance companies must prorate the January 1 increase for policies that begin in October through December, and could have to refund the prorated amount to employers that cancel policies during those months. In January 2009, the Legislature introduced House Bill 2146 dealing with rate filing dates. The bill, if passed, would amend A.R.S. §20-357 to require new premium rates to become effective on January 1 and change A.R.S. §23-359 to make deviations from premium rates effective through the following December 31.

10. The extent to which the termination of the Fund would significantly harm the public's health, safety, or welfare.

Terminating the Fund would not significantly harm the public's health, safety, or welfare, but it would affect Arizona employers' choice of workers' compensation insurers. Employers are required by state law to have workers' compensation coverage through an insurance carrier or through self-insurance. According to the Fund's 2007 Annual Report, it is Arizona's largest provider of workers' compensation insurance, serving 58 percent of Arizona's employers. Additionally, although not required, the Fund historically has acted as an insurer of last resort, accepting all employers regardless of accident history or who otherwise would not be able to self-insure or obtain coverage from private carriers. Terminating the Fund would require these employers to obtain workers' compensation insurance elsewhere. Finally, because the Arizona Superior Court has determined that the Fund's assets are not public monies but, rather, private monies held in trust for the benefit of the employers and employees, terminating the Fund would require establishing a mechanism to carry on the services to fulfill the employers' and employees' vested rights.

11. The extent to which the level of regulation exercised by the Fund is appropriate and whether less or more stringent levels of regulation would be appropriate.

Because the Fund is not a regulatory agency, this factor does not apply.

12. The extent to which the Fund has used private contractors in the performance of its duties and how effective use of private contractors could be accomplished.

The Fund uses private contractors for a number of purposes and auditors did not identify any additional opportunities for the Fund to use private contractors. The Fund has contracts with more than 200 vendors, ranging from one-time trainers on specific topics, to full-time security personnel with specialized training for the protection of the Fund's employees and tenants of the Fund's main office building, to human resource benchmarking. In addition, the Fund's attorneys report using private contracts for legal services that should not or cannot be performed by the Fund's legal staff. For example, some of the Fund's claims involve injuries to employees who are temporarily out of state. Because, according to the Fund's attorneys, an Arizona employee injured in another state may elect to be covered under the laws of that state, and because workers' compensation laws are state-specific, the Fund's attorneys reported contracting with counsel who are admitted to other states' state bars to litigate these claims. Also, the Fund's attorneys reported that the Fund contracts with third parties to handle commercial litigation, such as disputes over reimbursement levels between the Fund and medical providers, because these cases are too time-consuming for their staff and the workload is variable.

The Fund has contracts with several companies to review and adjust submitted medical bills. These companies perform various cost-savings services, such as reviews determining reasonable reimbursement for out-of-network providers' medical charges, processing prescription drug charges, and reviews of physical medicine services.

The Fund's attorneys also reported using private contracts to perform functions essential to meeting its fiduciary responsibilities and statutory reporting requirements. For example:

- The Fund contracts with an outside vendor for actuarial services. The need for high-quality, independent, expert actuarial review is fundamental, in the Fund's view, to meeting the company's fiduciary duty to its insured employers and the injured workers who rely on the Fund's ability to pay long-term claims.

- Pursuant to A.R.S. §23-982, the Fund is required to use independent, outside auditors to review its financial statement and report to the Arizona Department of Insurance annually. The Fund contracts with a Certified Public Accountant firm to review the financial statement.

APPENDIX A

Methodology

- **Finding 1**—To establish benchmarks of workers' compensation loss ratios against which the State Compensation Fund's (Fund's) expense to premium ratio could be compared, auditors reviewed reports from the National Council on Compensation Insurance (NCCI). In addition, auditors reviewed the Arizona Department of Insurance's (Department) annual reports on workers' compensation carrier filings. The Fund's data was obtained from the Fund's financial statements submitted to the Department for 2004 through 2007 and the ratios were calculated according to NCCI's formulas. To determine premium rate information, auditors reviewed NCCI reports on rates, a report from Oregon's Department of Consumer and Business Services, and the Department's reports on changes in rates and carrier deviations. To understand the proposed business structure, auditors attended the Fund's board meetings where the new subsidiaries were discussed. Auditors also reviewed a consultant's reports on the effect of the new subsidiaries on the Fund's financial projections and expected loss ratios. To understand the impact of rising medical costs, auditors reviewed NCCI reports of medical cost data in workers' compensation and the Fund's cost data. To understand the impact of fee schedules and assess the need for statutory change, auditors reviewed a 2007 NCCI research brief related to the effectiveness of medical fee schedules; a 2008 Workers' Compensation Insurance Rating Bureau of California report regarding the impact of legislation in that state, including changes to fee schedules; the Industrial Commission of Arizona (ICA) fee schedule statute at A.R.S. §23-908; and the ICA fee schedule. Auditors also reviewed the Fund's proposed legislative agenda for the 2009 legislative session, including Senate Bill 1262 related to medical, surgical, and hospital charges.

- **Finding 2**—To gather information about claims processing, auditors interviewed the Fund's management and staff, and reviewed fund policies, Arizona statutory requirements, and various performance audits and reports. To understand the Fund's performance in claims processing, auditors also analyzed Compliance Quality Assurance reports conducted by the Fund's Training, Reserving, Audit

and Compliance Unit for the period August 1, 2007 through August 31, 2008, and performed analyses of lost-time claims data for the period August 1, 2007 through October 17, 2008. To understand recommended practices in claims handling, auditors reviewed performance standards for servicing carriers compiled by the NCCI, reviewed recommended practices identified in an external claims review that an insurance consulting firm conducted on the Fund in September 2007, which the Fund received in November 2007, and recommended claims management practices identified in the Auditor General's 1988 report on the Fund (Report No. 88-10).

- Introduction and Background—To develop information for the Introduction and Background section, auditors compiled information from federal and state laws, organization charts, annual reports, strategic planning documents, the Board of Directors' governance policies, and other fund-provided documents, including the Fund's audited financial statements for calendar years 2006 and 2007, and financial statements prepared for the Department for 2008. Auditors also reviewed court documents associated with *State Compensation Fund vs. Petersen*, and information from the Arizona Department of Administration's General Accounting Office's Comprehensive Annual Financial Report for the State of Arizona for fiscal years 2003 and 2004.

- Sunset Factors—To respond to the sunset factors, auditors relied on work conducted to complete the audit report background and findings. In addition, auditors used information obtained from the Department and from the Fund, such as information about the Fund's legal division, legislative proposals approved by the Fund's Board of Directors in September 2008, and contracts for companies that the Fund uses to reprice medical service fees to determine fair and reasonable reimbursement rates for service fees that are not listed on the ICA's fee schedule.

AGENCY RESPONSE

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SCF Arizona™
At work for you

April 15, 2009

Ms. Debbie Davenport
Auditor General
Office of the Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85018

Dear Ms. Davenport,

SCF Arizona is pleased to respond to the Auditor General's draft performance audit and sunset review of the State Compensation Fund.

I want to state that we have been very pleased by the depth of understanding and comprehension of the staff of the Auditor General's Office regarding the operations of SCF Arizona. We are a complicated business and your staff was always inquisitive, professional and responsive as we worked through the audit and review. We congratulate you on a very impressive review document.

Finding 1: Fund should continue and enhance efforts to improve its claims expense-to-premium ratio.

Recommendations:

1.1 The Fund should consider applying stricter standards of coverage so it provides insurance to only those companies with loss histories within reasonable industry standards and where reasonable safety improvement efforts are effective.

This finding of the Auditor General is agreed to and the audit recommendation will be implemented.

1.2 The Fund should work with the Legislature to develop legislation to change state statutes to establish that any medical charges not covered under the ICA fee schedule and not from a medical provider within a carrier's medical network shall be based on the usual and customary reimbursement rates that prevail in the same community for that medical service.

This finding of the Auditor General is agreed to and the audit recommendation will be implemented in the sense that SCF will continue to offer legislation with the intent expressed in the finding. While we agree entirely that legislation directed towards implementing medical cost containment focused on allowing carriers to direct care in some manner and implement evidence-based treatment guidelines and allowing greater utilization review is needed, we must acknowledge that accomplishing this goal is not within SCF's power. Legislative changes in this arena may prove to be difficult to achieve due to opposition from various interest groups that oppose efforts to control medical costs under any circumstances.

1.3 The Fund should encourage policyholders to direct injured workers to the Fund's network providers, when appropriate, for their first medical treatment.

This finding of the Auditor General is agreed to and the audit recommendation will be implemented.

1.4 The Fund should continue working to make improvements to its provider network through efforts to recruit additional providers and identifying areas of the State in need of additional providers.

This finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Finding 2: Fund should continue to improve claims management by better aligning itself with recommended practices.

Recommendations:

2.1 The Fund should re-examine its consultant's recommended criteria for when to assign claims to lost-wages claims handlers and adopt additional criteria, if it determines that doing so would help avoid payment delays arising from reassigning claims.

This finding of the Auditor General is agreed to and the audit recommendation will be implemented.

2.2 The Fund should examine its policies, training, and oversight functions to determine why claims handlers fail to adequately complete three-way contact. Based on the results of its findings, the Fund should modify its oversight and training practices accordingly and ensure that the three-way contact and claims investigations are completed in a timely manner.

This finding of the Auditor General is agreed to and the audit recommendation will be implemented.

2.3 To help ensure effective claims management, the Fund should:

a. **Require documented action plans for all claims with significant costs, and**
b. **Review documented action plans as part of its best practices reviews.**

This finding of the Auditor General is agreed to and the audit recommendation will be implemented.

2.4 The Fund should implement the external consultant's recommendation that it contact the injured worker by phone, in addition to the required letter, to check on his/her work status and job search when applicable.

This finding of the Auditor General is agreed to and the audit recommendation will be implemented.

2.5 To help insure QA reviews are used to improve statutory compliance, the Fund should:

a. **Examine its review policies, and develop and implement an effective review process that provides fund management with trends in claims management and that can be used to improve claims handlers' performance,**
b. **Provide documentary evidence of this supervisory review; and**
c. **If appropriate, develop an action plan for improvement based on the results.**

This finding of the Auditor General is agreed to and the audit recommendation will be implemented.

2.6 To better ensure timely payment of lost-wages claims, the Fund should:

a. Develop and implement policies regarding actively working to obtain medical documentation;

b. Establish an internal standard for payment timeliness when eligibility for lost-wages compensation cannot be determined within 21 days of an ICA notification date; and

c. Modify its QA review to evaluate whether claims handlers are following the policies and meeting the internal standard.

This finding of the Auditor General is agreed to and the audit recommendation will be implemented.

2.7 To ensure the Fund's reorganization efforts are on target and effectively bringing the Fund in line with recommended practices in claims management, the Fund should perform an internal audit or commission another external claims review to measure progress against statutory compliance and recommended practices in claims management.

This finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Again, thank you for the opportunity to respond to this report. We will be prepared to provide your office, as required by the Joint Legislative Audit Committee, a written explanation of the status of all recommendations within six months after the published date of this audit report.

Sincerely,

Don Smith
CEO

Performance Audit Division reports issued within the last 24 months

07-02 Arizona Department of Racing and Arizona Racing Commission
07-03 Arizona Department of Transportation—Highway Maintenance
07-04 Arizona Department of Transportation—Sunset Factors
07-05 Arizona Structural Pest Control Commission
07-06 Arizona School Facilities Board
07-07 Board of Homeopathic Medical Examiners
07-08 Arizona State Land Department
07-09 Commission for Postsecondary Education
07-10 Department of Economic Security—Division of Child Support Enforcement
07-11 Arizona Supreme Court, Administrative Office of the Courts—Juvenile Detention Centers
07-12 Department of Environmental Quality—Vehicle Emissions Inspection Programs
07-13 Arizona Supreme Court, Administrative Office of the Courts—Juvenile Treatment Programs
08-01 Electric Competition
08-02 Arizona's Universities—Technology Transfer Programs
08-03 Arizona's Universities—Capital Project Financing
08-04 Arizona's Universities—Information Technology Security
08-05 Arizona Biomedical Research Commission
08-06 Board of Podiatry Examiners
09-01 Department of Health Services, Division of Licensing Services—Healthcare and Child Care Facility Licensing Fees
09-02 Arizona Department of Juvenile Corrections—Rehabilitation and Community Re-entry Programs
09-03 Maricopa County Special Health Care District
09-04 Arizona Sports and Tourism Authority

Future Performance Audit Division reports

Gila County Transportation Excise Tax