STATEMENT OF GREGORY KROHM
EXECUTIVE DIRECTOR
INTERNATIONAL ASSOCIATION OF INDUSTRIAL ACCIDENT BOARDS AND COMMISSIONS
BEFORE THE
SENATE SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT, THE FEDERAL WORKFORCE, AND THE DISTRICT OF COLUMBIA

July 26, 2011

Mr. Chairman and Members of the Subcommittee,

My name is Gregory Krohm. I am the Executive Director of the International Association of Industrial Accident Boards and Commissions (in short the IAIABC). The IAIABC was founded in 1914 by a group of civil servants who recognized a need to share information about workers' compensation laws and administration. Our mission is to advance the efficiency and effectiveness of workers' compensation systems throughout the world, and we accomplish this mission through a variety of education and research activities. Thus, it is very mission appropriate for me to testify on the functioning of state workers' compensation systems.

I appreciate the opportunity to discuss legislative reforms to FECA. My area of expertise is in state workers' compensation programs, and not FECA. As such, I have been asked to describe the current state of compensation benefits by state systems. A secondary contribution I hope to make is to discuss how a claim is typically handled within a private insurance system. In particular, I would like to sketch the typical patterns of claims handling that would be practiced by workers' compensation insurers for common types of claims. You may then, if you wish, contrast these with the practices of the Department of Labor, Office of Workers' Compensation Programs (OWCP).

For the record, let me state that my remarks have not been reviewed or approved by the Executive Committee of the IAIABC. While I am here in my capacity as Executive Director, these remarks should not be construed as an official statement of my organization, nor of its member states.

I would like to begin by comparing and contrasting state benefits with the FECA program. I will focus on four benefit categories: medical, temporary disability, and permanent partial and permanent total disability. In the second part of my remarks, I will focus on the goal, techniques and benefits of disability management.

The first thing that one learns about state workers' compensation is that each state is different. Hardly any aspect of state law on workers' compensation follows a national model. Terms are different and the administrative details in coverage, claims criteria, and benefits are always different to some degree. Yet, it is possible to see some common elements that might be compared fairly with FECA.

Medical Payments are very similar across states in the following features: 1) any medical care necessary to cure and relieve the consequences of work injury or illness is covered, 2) a wide variety of commonly licensed medical professionals can treat workers' compensation claimants, and 3) the injured worker is not subject to copayments or balance billing. States differ on the rights of the employer or payer to manage and direct care and on the maximum payment available to providers.

As I understand it, FECA allows the claimant unlimited choice of medical providers, and does not have guidelines on treatment. Only a handful of states would be comparable to this.

Temporary Total Disability (TTD) benefits are the second most common claim category in workers' compensation. This is the most uniform of the state indemnity benefits. Generally, states pay 66.6 % (36 states) of pre-injury wages. Four states pay larger percentages of wages, e.g., Texas, New Jersey and Oklahoma at 70%, and Ohio at 72%; a few states use a higher percentage on "spendable" or after tax income. TTD is usually paid for the length of the temporary disability (until maximum medical improvement), although several states have weekly limits in the range of 100-700 weeks. TTD amounts are usually capped at about the State Average Weekly Wage (SAWW); 21 states are at 100% of SAWW and most of the others are within +/- 25% of the SAWW. Complicating features include how wages are calculated and whether a cap is put on the number of weeks. While the percentage of wage replacement varies across states, the percentage is almost always uniform within a given state, i.e., no sliding scale or schedule of percentages.

The income continuation feature of FECA is without any counterpart in state workers' compensation law. Some employers attempt to ease case flow interruption for their employees through sick leave or short term disability insurance, but this is outside of workers' compensation. Another unusual feature of FECA is the increase of the percentage of wage replacement to 75% for workers with at least one dependent. A few states make a minor allowance for dependents but nothing of this magnitude.

Permanent Partial Disability (PPD) benefits are paid by all but a few states; those that do not recognize this benefit continue to pay lost wages. In compensating for Permanent Partial Disability, approximately 44 states pay compensation on a schedule basis, and 45 states on a non-schedule basis (some states use both methods). Scheduled benefits refer to a system for attaching specific benefits or a benefit formula to a loss of a body part, organ, or the impaired function of these body parts. Most commonly this impairment to the body is quantified in degree by a physician. The percentage loss of a body part or body as a whole is then converted to weeks of indemnity compensation. The amount of PPD compensation per week is usually a fixed dollar amount that is some fraction of the state average weekly wage. In 29 states the weekly amount based on impairment is adjusted to reflect factors that would make the wage loss from that impairment higher or lower than for the typical worker, e.g., age or occupation. 45 states place limits on the number of weeks payable or total dollar payout for PPD.

Permanent Total Disability (PTD) benefits are perhaps the most difficult to summarize across state systems. There is much variation in how permanent disability is determined and how benefits are paid. As of 2010, 33 states offered lifetime PTD payments, 21 had some form of automatic or formula based cost of living escalator. Many states eliminate PTD benefits if the claimant resumes gainful employment.

Some possible differences with FECA are: 1) there is a relatively unstructured and undefined criterion for Permanent Total Disability in FECA, 2) few states offer the high upside potential for PTD benefits from FECA's combined offering of PTD for life and annual CPI adjustment.

By way of comparison, I thought it might be useful to sketch some characteristics of state workers' compensation systems. The NCCI data is for 37 states that NCCI collects data from.

- The frequency of compensable injuries has declined 12 of the last 13 years. In most states, lost time injuries per hundred employees are probably as low as they have been since records were first kept. This frequency decline has much more to do with changes in the economy and technology than to workers' compensation law.
- According to NCCI, the percentage of insurance benefits paid that go to medical providers has been rising steadily for a decade and in 2009 was about 58% of the total insurance company payout.
- According to the Bureau of Labor Statistics, in 2010 workers' compensation was about 1.6% of total wage and benefit compensation paid by private employers.
- According to NCCI, the duration of Temporary Total Disability (TTD) indemnity benefits increased from about 92 days to 129 days between 1996 and 2001 and has remained fairly constant from 2001 to 2007. Average countrywide TTD

ultimate duration in 2010 was about 125 days; median ultimate duration is about 42 days.

- Roughly 85 percent of all lost time claims are closed by the end of the first year after injury date.

Next, I would like to touch upon an issue that often arises in discussion of state workers' compensation reform legislation: the relationship between benefit design and claims duration and cost. There is significant empirical evidence that benefit "richness" and duration of disability are positively related. This should not surprise us because as a general tendency of human nature, if the cost of reporting a work injury and staying out of work go down, more claims will be reported and more people will accept workers' compensation in lieu of their normal wages. However, one must be careful to assume that there is an ease, lock step relation between changing any benefit feature to produce a lower length of disability and low cost of claims.

The chart below is taken from a 2010 NCCI report in which they nicely compare the benefit features of 37 states and the median days of duration of lost time claims. I have studied this and can find no positive correlation between increasing the Maximum TTD benefit ceiling and duration. One might also suspect that increasing the waiting period might affect duration, but here the connection is a bit counter-intuitive. By increasing the waiting period one cuts off more short duration claims, and hence the median duration might be expected to increase. This does seem to be the case in the exhibit below; 7 day states tend to have higher duration than 3 day states. However, the average cost of claims in 7 day states will be lower because injuries with durations under 7 days are paid wage indemnity.

The above discussion is not intended as an actuarial estimate of claims cost as a function of benefit change, but rather a warning against making rash assumptions about the savings and cost of particular adjustments to waiting periods or maximum weekly benefits.

Table 1
Benefit Provisions and Median Durations by State

STATE	Waiting Period	TTD Benefits Retroactive After	Max TTD Benefits as % of SAWW	Max PPD Benefits as % of SAWW	Median Days Duration AY 2001 @12/31/2007
AK	3 Days	28 Days	120%	**	29
AL	3	21	100%	31%	28
AR	8	14	85%	64%	42
AZ	7	14	100%	100%	42
CO	3	14	91%	29%	40
CT	3	7	100%	78%	28
DC	3	14	100%	100%	28
FL	7	21	100%	75%	42
GA	7	21	100%	100%	52
HI	3	**	100%	100%	14
IA	3	14	200%	184%	24
ID	5	14	90%	55%	29
IL	3	13	133%	133%	37
IN	7	21	100%	100%	36
KS	7	21	75%	75%	42
KY	7	14	100%	100%	42
LA	7	41	75%	**	66
MD	3	14	100%	75%	27
ME	7	14	90%	90%	42
MO	3	14	105%	55%	32
MS	5	13	67%	67%	48
MT	4	**	100%	50%	47
NC	7	21	110%	110%	52
NE	7	41	100%	100%	32
NH	3	13	150%	150%	17
NM	7	28	100%	100%	46
NV	5	5	150%	**	31
OK	3	**	100%	50%	49
OR	3	14	133%	100%	24
RI	3	**	115%	115%	38
SC	7	14	100%	100%	56
SD	7	7	100%	100%	32
TN	7	14	110%	100%	45
TX	7	14	100%	70%	94
UT	3	14	100%	67%	29
VA	7	21	100%	100%	41
VT	3	10	150%	150%	29

Source: Barry Lipton et al, NCCI, 2010

The central feature of reducing the length of disability is the quality of claims handling and the ability of the claims process to get injured workers back to work on modified duty. In the remainder of my testimony I would like to address claims handling and return to work issues.

Based upon my knowledge of the private insurance industry, I would characterize the handling of a typical lost time workers' compensation case as follows:

1) The claim is reported to the employer who fills out some type of first report of injury and forwards it on to their insurer (web, phone, or fax).

2) Immediately upon receipt a claims file is opened and an adjuster (often assisted by a nurse case manager) is assigned. The adjuster is under strong incentive to make contact with the employer, claimant, and treating physician within 24-48 hours of receiving the claim.
3) If the discussion with the parties and the written report seem complete and the claim valid, the adjuster focuses on ensuring that the worker is getting prompt, competent medical care.
4) Soon after treatment begins, the adjuster will want a diagnosis, prognosis, and treatment plan from the treating provider. The adjuster is trained to get full and complete reports, especially duty restrictions relevant to return-to-work.
5) Unless the physician recommends immediate return to work with few limitations, the adjuster will want to ensure that the employer strongly considers a plan to get the worker back on the jobsite within the limits imposed by the physician.
6) If the physician seems to be protracting treatment or imposing unreasonable duty limits, the adjuster is trained to advocate for an approach consistent with treatment guidelines and disability parameters.
7) Adjusters handle 200 or more lost time claims at once and are under compulsion to move claims to closure as quickly as possible given the facts of the case.

Let us consider a non-surgical low back sprain to illustrate how a claim would be handled by a competent private insurance adjuster. The claim would be open and come to the attention of the adjuster within a day or two of the injury report to the employer. The adjuster would contact the worker, obtain information from him/her about the incident, and get their plans for medical treatment. The adjuster would be eager to see the medical report to obtain the physician's statement of the apparent facts of the case and the return-to-work date and restrictions. Often the medical report is vague or incomplete, so the adjuster must contact the doctor's office to "dig in" and get a specific statement of functional limitations during the projected healing period. With the medical facts in hand, the adjuster can then approach the employer about return-to-work, possibly with modified duty and ongoing therapy. The adjuster is trained and obliged to be proactive and make meaningful contact with the claimant, employer, and medical provider at all critical stages of the claim, and to close the claim with dispatch. Of course, if the claim seemed to have complications, that would have to be noted and communicated to claims supervision for possible special handling.

In my final remarks, I would to turn to disability management as a discipline with workers' compensation. My remarks in this area are less descriptive of state systems and more of my personal judgments on ideal features of a well-functioning workers' compensation system.

The system should not exist to pay indemnity for work injuries, but to reduce the social and personal costs of work injuries. I believe that it is time for workers' compensation to

embrace the goals and techniques of what has come to be characterized as “disability management.” Disability management as I understand it is not a cost cutting tool or a trendy management fad. It boils down to using techniques that good claims adjusters and employers have learned and practiced for years. If you will, its common sense dressed up with a new title and more cache.

The American College of Occupational and Environmental Medicine (ACOEM) has partnered with my organization on a number of medical issues related to workers’ compensation. In that partnership, the IAIABC has frequently promoted the work of the ACOEM Guidance Statement, “Preventing Needless Work Disability by Helping People Stay Employed.” I would like to summarize the ACOEM work disability prevention report as follows:

I. Adopt a disability prevention model. The model should have the support of all stakeholders, i.e., legislators, regulators, policymakers, and benefits program designers and should agree that much work disability is preventable, and that successful reintegration to work requires collaboration among several parties. While the OWCP could provide leadership and coordination, the other stakeholders need to genuinely accept the new model of disability management.

II. Address behavioral and circumstantial realities that create and prolong work disability. These factors include age, marital status, and psycho-social conditions affecting the claimant (e.g., chemical addiction or mental health problems). Psycho-social issues are difficult to manage, but when done properly, disability days drop sharply. Another very important factor is the claimant’s attitude about their supervisor and workplace generally.

III. Acknowledge the powerful contribution that motivation makes to outcomes and make changes that improve incentive alignment. Financial and administrative incentives to employers, insurers, doctors and claimant do affect their behaviors. Wage replacement has been shown empirically to have an inverse relation to return to work. Another harmful disincentive is paying medical providers relatively low fees without regard to quality of care or outcomes. One indirect incentive for employers to game the system is the structure of the charge back mechanism to federal agencies for their claims cost.

IV. Invest in system and infrastructure improvements. This includes training and special tools and forms for communicating among the parties.

These are simple, common sense principles, but putting them into action requires great skill. The first step in disability management is to break down suspicion and communication barriers between the claims handler, the injured worker, and the treating physician.

The notion of disability management strikes a bad feeling in the minds of many advocates for workers' rights. I believe they suspect that it is a plot to deprive workers of rights and benefits that they truly deserve. I am sympathetic to the need to protect workers from uncaring and clumsy management practices. Some employers are indeed inept at managing return to work. They lack motivation or imagination to create suitable light duty or alternate jobs or accommodations. They sometime ignore the duty limitations and therapy orders of treating physicians. Having said this, I believe that the majority of employers are supportive of disability management principles. Critics of early return to work abuses should not oppose disability management, but work to make it operate properly according an accepted model. It's worth the struggle to overcome the difficult challenges of disability management because getting workers back to work is good for them, both economically and physically. Returning to work is the best way to minimize the disruption to careers and earning from injury. Finally, in most cases, it complements and enhances the healing process.

Finally, I commend three good documents as objective sources of support for the benefits of disability management to injured workers : 1) *A Physician's Guide to Return to Work* by Drs. James Talmage and Mark Melhorn, 2nd Edition (forthcoming), AMA Press, 2011; 2) ACOEM Guidance Statement, "Preventing Needless Work Disability by Helping People Stay Employed" June 2006; and 3) *Is Work Good for Your Health and Well-being?* by Drs. Gordon Waddell and A. Kim Burton, UK Dept. of Work and Pensions, 2006.