Kennedy School of Government
Case Program

C107-96-1317.0

The Washington State Workers' Compensation Administration: Reforming a Culture of Despair (A)

In the early 1980s, Washington state's workers' compensation program, a publicly owned insurance system that paid workers who sustained injuries at their workplace for lost wages and medical expenses, was plagued by inefficiencies and huge deficits to a point that its continued existence was in doubt. In 1984, with business and labor at loggerheads over the program's future, a new governor was elected who promised to reform the insurance operation, which was part of the Washington's Department of Labor and Industries. To carry out his campaign pledge the governor asked an industry executive, Richard Davis--later succeeded by Bob McCallister--and a labor leader, Joseph Dear, to join the department. Hanging in the balance was not only the governor's political future but the very existence of the publicly-operated workers' compensation program, which had been established in the Progressive Era of the early 20th century to deliver better benefits to workers, at lower cost to employers, than would private insurance.

Immediately upon taking the Department's reins, Davis and Dear would stop the program's financial hemorrhaging with multi-million dollar financial fixes, many of which could be accomplished almost with the stroke of a pen. With the program's immediate financial and political crisis resolved, the department's new management would turn its attention to the day-to-day operations of its all-important Claims Administration section, which was itself in crisis, but where change would come more slowly. Here a demoralized and overworked staff processed claims using procedures that had been outmoded for a quarter century and which seemed to lack a direct relationship to the section's purpose—to return injured workers to gainful employment as soon as it was feasible and to assure that the department paid only for necessary and appropriate medical treatment.

This case was written by Harvey Simon for Linda Kaboolian, assistant professor of public policy, for the Innovations Program in American Government at the John F. Kennedy School of Government, Harvard University. Funds were provided by the Ford Foundation. (0696)

Background

In the early days of the 20th century, a time when new, power-driven machinery was causing numerous industrial accidents, the state of Washington pioneered the practice of providing financial benefits to the victims of work-related injuries. In 1911, Washington, along with four other states, adopted the nation's first workers' compensation laws. The new law entitled workers injured on the job to certain benefits; workers, in exchange, ceded the right to file civil suits against employers over work-related injuries. Until 1971 the law applied only to workers engaged in "extra-hazardous" employment but was then expanded to cover almost all workers.[1]

The Department of Labor and Industries, which administered the workers' compensation program, was a public sector analog of a private insurance company. It collected premiums and paid out benefits. Employers paid three types of premiums, two of which employees also paid, with the employer paying about 70 percent of the total cost of the combined premiums.[2] These premiums, their rates determined by the department, funded three types of legislatively mandated benefits: 1) Medical. The department paid all medical costs, whether for drugs, visits to the doctor, artificial limbs, surgery, or other services, so that the worker incurred no medical expenses. 2) Wage Replacement. Temporarily disabled workers were paid what were known as time-loss benefits, which amounted to a portion of the workers' salary. Injures that resulted in permanent, but not total, disability were compensated for with a lump sum payment. Workers whose injuries caused total and permanent disability were paid a lifetime pension. And in cases where workers died as a result of their injuries, the surviving spouse and dependent children received monthly payments. 3) Vocational Rehabilitation. Injured workers whose injury prevented them from pursuing their occupation were eligible for vocational rehabilitation services, which assisted them in learning new skills and finding a new job.

Until the early 1980s, the workers' compensation program operated in relative obscurity. Then benefit costs shot up and the Department of Labor and Industries began proposing a series of enormous premium increases, which pitted business against labor in an election year, and sent an unmistakable signal of an impending administrative and financial crisis within the insurance program. In 1982, Labor and Industries, which sets its own premium rates, said it would need a 37 percent increase for the coming year. It subsequently scaled its increase back to 17 percent in response to objections from the business community, but in 1983 the department said it would need a 55 percent adjustment. Again it settled for less: a premium adjustment of 30 percent after yet

---

1 "Casual" employees and certain kinds of "domestic" laborers are not covered. Benefits were also considerably expanded.

2 The accident fund premium, paid entirely by the employer, was set according to the nature of the employer's business and the accident rate in that industry as well as the employer's safety record. Employers and employees shared equally the cost of medical aid premiums, which also varied according to the nature of the business. Supplemental pension premiums, also divided equally between employer and employee, were set at the same rate for all employers. The employer collected the employee's share and sent it to Labor and Industries together with its own payment.

more protests from business. Still, in 1984, the department said it would need another large increase—30 percent. This time the Republican governor, John Spellman, who was seeking reelection in 1984, froze the premiums. By this point, however, the fund was running a $30 million deficit and further large premium increases were projected for the future.

The business community, which bore the brunt of these unprecedented increases, was incensed. Although it had succeeded in forcing rollbacks in the initial rate requests, it considered even the smaller premium increases too large. To find relief from the prospect of future premium hikes, business spearheaded a drive to end the state monopoly on workers' compensation insurance. The state's business leaders advocated legislation that would permit employers to buy their employees workers' compensation insurance from private carriers. A private company, business leaders believed, would operate more efficiently and offer lower premiums. As the law stood, only the state's largest employers were permitted to opt out of the state system. These employers could "self-insure," essentially setting up in-house insurance funds and either contracting out for the administration of their workers' compensation claims or administering their own claims.[3] In the mid-1980s, 30 percent of the workers in the state were employed at companies that self-insured.

The drive for a "three-way" system, as the addition of a private insurance option to the other two alternatives was known, was a call to arms for organized labor, whose rallying cry was that there should be no profit from the pain and suffering of injured workers. Labor leaders, who were prepared to go to the mat to block a three-way system, feared that private insurers would profit at their expense by paying fewer claims than the state fund and by offering to settle claims with tempting lump-sum payments that would eventually leave workers unable to pay their medical bills. Labor's only major complaint with the state workers' compensation system was that benefit levels were too low.

With premiums escalating, and with labor and business butting heads over the possibility of a three-way system, the administration of the state's workers compensation fund became a point of contention in the 1984 gubernatorial race. The Democrats, who were seeking to unseat the Republican incumbent, John Spellman, tagged Labor and Industries as the state's most mismanaged department and tried to hold the governor accountable. Spellman did not try to deny that there were problems with the workers' compensation program and, toward the end of his term, appointed a task force to investigate the program's failings and to recommend reforms.

But within a month of the release of the task force report, Spellman lost his bid for re-election and Booth Gardner, a Democrat, was elected to succeed him. By the time Gardner was sworn in, early the next year, the legislature had completed a second investigation of the department—with 73 recommendations for change. During the campaign Gardner had created an

---

[3] Legislation permitting self-insurance was passed in 1971. Employees working for self-insured companies did not pay into the medical aid or supplemental pension funds.

expectation among voters that he could reform the state's workers' compensation program; now that he was in office he would be judged by how well he fulfilled that promise. Moreover, if his administration failed to put Labor and Industries back on its feet, the legislature would surely allow private insurance companies to provide workers' compensation insurance. And if that happened the state's experiment in providing labor with non-profit, low-cost, no-fault industrial insurance would turn out to be a failure.

New Management

The new governor took seriously his authority to appoint the head of the department of Labor and Industries. The department had long been known as a dumping ground for patronage appointments but the new governor broke with tradition and appointed well-respected members of the business and labor community to run the agency. The governor hired a telephone company executive named Richard Davis as department director and tapped the research director for the Washington State Labor Council, AFL-CIO, Joseph Dear, to be Davis' deputy in charge of the Industrial Insurance Division, the unit specifically responsible for workers' compensation, which accounted for almost 84 percent of the department's total budget. A third key appointment came in late 1987 when Davis left the department and Dear became director. Bob McCallister, who had made a name for himself in the private sector as an expert on workers' compensation, was named to the deputy directorship that Dear had held under Davis. In the first two years of the Gardner administration other key management positions were also filled after Davis, who gained a reputation as a "hatchet man," cleared out what he considered to be the department's deadwood. Their goal was to rescue the department from financial ruin so that it could fulfill its potential to provide the state with a service that many people believed a private insurance company could never offer. The workers' compensation program, says Dear, was "conceived in the notion that … because it was a publicly owned, non-profit insurance organization it would treat workers better because there was no financial incentive to cheat anybody out of a benefit, but it would also be cheaper for employers because it had none of the overhead costs associated with a competitive insurance program—marketing expense, shareholder dividends, high salaries to executives." But in order for the workers' compensation program to achieve this noble goal, he somehow had to "make this system work."

Quick Fixes to Buy Time. The new management's first priority was to stem the department's huge financial losses. Davis and Dear feared that if they did not take quick action leading to major savings, political support for the department would collapse. But if they could resolve the department's immediate crisis, they would have the time they would need to work on one of the department's most important, and intractable, problems—the day-to-day operations of its claims units, where the potential existed to save millions of dollars a year.

Davis and Dear first sought immediate savings through benefit reductions. Such cuts, which the legislature would have to vote on, would not be popular with labor, but Dear's union

background and the department's serious financial problems—the deficit was now projected to hit $225 million by the end of the fiscal year—provided the new administration with rare political running room.

The biggest target was the vocational rehabilitation benefit, which Davis later said "was killing us financially." In 1982, under pressure from labor, the legislature had made vocational rehabilitation a mandatory benefit for injured workers, entitling any worker injured on the job to retraining. Also, injured workers did not have to return to work, and continued to receive benefits, unless they could find employment at a wage comparable to what they were earning before they were injured—a difficult proposition for loggers who might only have had a ninth-grade education but were earning $15 to $20 an hour. Supporters of vocational rehabilitation had believed that this type of counseling would be cost effective, in the long run, because the new skills workers would learn would make them more employable and reduce the amount of time they received time-loss benefits. But according to the state legislature's study of the workers' compensation system, the savings did not pan out, despite a 65 percent increase (between 1982 and 1983) in the number of vocational rehabilitation referrals.[4] There was also anecdotal evidence that injured workers were taking unfair advantage of these benefits. "Basically," says Davis, "if your son worked for you in your hardware store and he hurt his back and couldn't work, he could go to the department, he'd come under workers' comp., he would then go to four years of college paid for by the fund. That's not what the workers' comp. fund was intended to do."

Davis told legislators that premiums would have to jump 40 percent just to halt the growth of the industrial insurance fund's deficit unless they voted to roll back vocational rehabilitation benefits. Meanwhile, Dear, who had pushed for the 1982 increase in vocational rehabilitation benefits, was able to quell labor's opposition to a roll back, largely on the basis of the clout he carried as a former union official. Dear also promised that when the program became solvent again, that he would push for new benefit increases. The strategy worked and in 1985 the legislature voted to make vocational rehabilitation an option the department could provide an injured worker on an as needed basis, rather than a right to which every injured worker was entitled. Also, workers had to take whatever job they could get, even if it paid less than their previous employment. The next year the legislature passed other money-saving measures for the department, including reducing benefits by the amount of any federal Social Security benefits that injured workers might also receive. Also spouses of workers who died for causes unrelated to their industrial injury were made ineligible to receive the workers' compensation pension that their spouses had been receiving, saving $56 million.

Davis and Dear also made a number of one-time accounting changes that did not require legislative approval that contributed substantially to stemming the tide of red ink. Some of these, which were accomplished during the first two years of the Gardner administration, were what

4 "Report to the Legislature: Recommendations for Improving Washington State's Industrial Insurance System." By the Joint Select Committee on Workers' Compensation, January 14, 1985.

Davis liked to refer to as "smoke and mirrors." The one with the largest impact was increasing the discount rate or assumed future investment return that the department made from its invested trust funds. "In the stroke of a pen," says McCallister, "they made $140 million." The department also closed the claims of the thousands of people receiving vocational rehabilitation benefits. Although some people whose claims were closed protested the action, the vast majority of claimants did not object. "In the insurance business," says McCallister, "that's salvage—you salvage money off of the reserves and that ingested a considerable amount of money into the mix." The department also moved hundreds of millions of dollars out of a non-interest-bearing checking account and worked the bugs out of a computer system, designed to catch errors in medical bills. In the Medical Services Division (later renamed Health Services Analysis) there were numerous programs to control escalating medical costs while simultaneously assuring quality medical care. One major initiative, known as inpatient utilization review, aimed to cut back on the number of unnecessary hospital procedures, just as many private insurance companies had done. The Industrial Insurance Division also negotiated discounts with, and modified its accounting methods for providing payments to, hospitals; contracted with a firm to review the quality of service provided by individual physicians and chiropractors; instituted fee schedules, with maximum allowable charges for outpatient hospital services and for other charges; and set maximum fee levels where none had existed.

These legislative and accounting measures resolved the Labor and Industries' short-term financial and political crises, while the programmatic remedies promised future savings, freeing the department's senior managers to concentrate on the Insurance Division's daily operations. The division's internal problems would require years to correct, but promised to be the source, eventually, of significant additional savings.

A Broken Agency

Davis, Dear and McCallister, inherited an antiquated, dysfunctional organization that was not following even the most well accepted insurance industry practices to control its costs. Indeed the department did not even seem to be in the insurance field, where premiums are invested to generate income, expenses are controlled as much as possible and the interests of customers are served. In effect, the department was doing little more than writing checks—to medical providers and to injured workers—and not even doing that simple job efficiently. "Essentially, everything was broken," says Dear, who recalls his sheer terror that "every time you looked at something it was worse than you ever imagined."

In the 1970s and early '80s the cost of medical care in Washington, and the nation, had climbed rapidly, but Labor and Industries had not done anything to control these costs. Although the department was requiring prior authorization for non-emergency surgery and reviewing medical bills to determine if they conformed to the department's fee schedules, it was not scrutinizing medical bills for errors, inappropriate treatments or excessive charges. Nor was it

aggressively attempting to limit unnecessary hospital admissions or promote effective, but less costly, medical services. The department would, for instance, pay inflated bills for back surgery without question, though the bills might mask charges for unrelated cancer treatments. It even paid bills for services that were not provided.

At the Center of the Problem: Claims Management. When McCallister took over as head of the Industrial Insurance Division, in 1987, he found, he says, "an unbelievable mess." Although he had as much familiarity with the division as anyone outside the department, having served on a committee of outside advisors to the workers' compensation system, on Governor Spellman's task force on industrial insurance reform and as a public member to the legislature's Joint Select Committee on Workers' Compensation, he was nonetheless "flabbergasted" by the extent of the division's problems. Many of the division's worst problems, it seemed to McCallister, were in the Claims Administration section.[5]

Claims Administration, also known as Claims Management, which paid all medical bills and issued all the benefit checks that went directly to injured workers, was the heart of the Industrial Insurance Division. The 400 or so claims examiners, treatment authorizers and disability adjudicators (sometimes called claim managers) who worked in this section made the most important decisions about, and took actions that directly affected, workers and their claims. "The single most important person in the whole scheme of things in industrial insurance is the claims manager," says Clifford Finch, a lobbyist with the Association of Washington Business and an expert on workers' compensation. If run well, with each claim managed carefully and efficiently, with the aim of getting workers back on the job as soon as their medical conditions permitted, the section could minimize unnecessary or excessive benefit and medical payments.

The department's new management did not wish to deny workers any benefits to which they were entitled, but, by the same token, did not believe the department should pay benefits that went beyond what a liberal interpretation of the law required, or spend more money doing it than was necessary. A primary way to control costs was to get workers back on the job as quickly as possible, an objective that was in the workers' best interests and in the departments'. Evidence showed that injured workers who failed to return to work after two years of their injury were unlikely ever to return to work.[6] Even workers who stayed off the job more than six months "become professional couch sitters, they watch Oprah Winfrey and they become used to living on a reduced income," according to Dixon Bledsoe, a staff consultant in Labor and Industries' Office of Research and Development. "If you don't keep that mindset that work is good, … suddenly you get people who are chronically disabled." Nor was it always in the workers' best interests—and certainly not the departments'—to automatically approve requests for surgical procedures, as the

---

5 Claims Administration was a section of the Industrial Insurance Division. Within Claims Administration there were a number of different sub-sections, one of which was composed of the claims units. Initially there were 10 units; ultimately there were 21 units. Each unit had clerical and technical claims adjudication staff.

6 The chances a worker in such circumstances would return to work were less than 15 percent.

claims staff was wont to do. Some surgery was unnecessary and sometimes it was injurious. "Sometimes quality of care means *not* doing things that a service provider who's compensated on a fee-for-service basis might want to do because that's the economic incentive they have," says Dear.

But instead of carefully monitoring claims to control costs, Claims Administration rubber stamped virtually every request for medical and benefit payments that came in and incurred delays in every aspect of its operation. The forms and letters that flowed into the section, which were automatically approved, drove the operation and overwhelmed it too. At any one time each person processing claims had a backlog of 800 to 1,000 pieces of unopened mail—letters from doctors requesting approval to perform surgery, or notices from employers of a suitable job for an injured employee. Often times months passed before these time-sensitive notices were processed. In the meantime an injured worker might return to work—while still receiving time-loss benefits. In the rare cases when the department caught its error, its success at reclaiming these payments was poor.

Visiting the claims section McCallister had the feeling of traveling back in time a dozen years to witness claims processing procedures, and working conditions, that had atrophied years earlier. Walking through the section's single large room, one of the first things he noticed were tall stacks of papers on all the desks. The piles were so high McCallister could hardly see who was sitting behind the desks. Nor was it easy for him even to thread his way through the room. Boxes, filled with yet more papers and files, were littered about on the floor's ripped carpeting, and people were seated so close together the heat from their bodies sometimes set off the building's fire alarm. Desks were crowded up against each other, without even enough space for cubicle dividers and too close for the room to ever be adequately cleaned. "It was a sweatshop," says Janet Morris, who took over management of the division in 1987 and vividly remembers her early impressions of the office. "When I first arrived at the office the first thing that struck me when I got off the elevator was I'd see people in the hallway and nobody talked. Nobody. There was no laughter. It was incredible. … They just looked at the floor, and no one spoke." Morris, who worked directly for McCallister and, like him, had earned her stripes in the private sector, also noticed their clothes. "They dressed in clothes that I wouldn't work in the yard in. Very few people wore suits, men or women, they wore crummy clothes mostly because [the office] was such a mess you didn't want to ruin your good clothes."

Job Classifications and Processing Procedures. Claims were processed in assembly-line fashion, with no one person responsible for overseeing all of the many interrelated decisions that were made about each claim. Most of the staff fell into one of four major job classifications: The sole job of the section's **claim examiners**, which was an entry-level job—was to reject or approve claims when they were first filed with the department. **Disability adjudicators**, who were promoted into this position after starting as claim examiners, then took over the file and determined if the claimant had a permanent partial disability. These adjudicators—who were classified as level one, two, or three, depending upon their experience—were also responsible for reopening closed claims,

and for handling protests to the department's decisions. **Treatment authorizers**, in turn, who had the most experience in allowing medical payments but very little experience in claims management, approved, or declined, medical treatment.[7] **Medical aid adjusters** handled claims without time loss benefits that only involved reviewing and paying medical bills.

The claims section, located in Olympia, was composed of 10 individual units, which were assigned claims based on where the injured worker lived. One unit handled claims that required medical payments only, with no time-loss compensation. The nine other units, called compensable claims units, handled all the other claims. The average compensable unit had 12 claim processors comprising the various specialties—disability adjudicators, claims examiners, treatment authorizers and medical aid adjusters—who together handled all aspects of their claims. (See Exhibit 1 for a detailed description of the claims administration process.)

The production line method of claim processing left some of the section's staff with very few claims to handle and buried others in work. Even when the first person in the section that handled an incoming claim recognized a claimant needed a medical exam, approval for the exam—and the exam itself—would have to wait until a treatment authorizer made the same determination—a process that could take four months. "It was a hurry up and wait scenario; it was a non-accountability scenario," says Morris, who was the first person in memory to head claims who was knowledgeable about the profession.

The production line also diffused responsibility. With each person handling a piece of the process, no one who knew all the facts about any individual claim. Worse yet, the more a claim was mismanaged, the harder it was to tell who was responsible. As a claim got older, and the cost of the claim went up, it would be transferred to more senior staff members, with each one having to take the time to read a folder that could be four inches thick. So the claims that rose in cost the most passed through the most hands—so many that no one could be held accountable. "Claims were in the system forever because no one felt responsible to do anything about it," says Morris.

Morris and McCallister also inherited a section in which claims processors had grown accustomed to not initiating telephone or face-to-face contact with their clients—employers and their injured employees. The claims section instead conducted business mostly through the mail. McCallister and Morris believed that claims managers who initiated early, consistent and personal contact with claimants and employers could encourage employees to return to work earlier, on average, than those who were not contacted or brought together with their employer. But McCallister laments how the staff "had a culture that virtually ignored the people they were there to serve," adding:

---

7 The job of managing claims was separated into two different responsibilities--medical authorization and benefit paying.

> there was no basis on which they felt comfortable picking up the phone and calling the employer and saying, 'On your account we can reduce your costs [of experience-based premiums] if you do the following: go see the worker and work to get him back to work.' Maintaining the employer—employee relationship is a critical piece of successful claims management.

But managing claims, as McCallister conceived it, would have taken more time than merely processing claims and most claims staff were too overloaded with work to do more than merely glance at each file. Whereas in the private sector claims managers were each responsible for about 250 active claims, at Labor and industries each person in the claims section—some of them from families who had worked in the same type of job for three generations—handled more than 1,000 claims, compared to a claims load of 250 for the private sector.[8] Their phones rang constantly, many times with frantic calls from people whose injury was the most important event in their lives. The claim staff "would go home with a glazed look at night," says Morris. "It was like no one was home. … They worked real hard, they tried real hard, but it was an incredible environment, just an incredible environment."

When a staff member fell too far behind, a member of what Morris calls the "saviour squad" might come to the rescue. The saviour squad, also known as the SWAT team, or "floats," was comprised of about four staff members from the claims section who did not have their own case load. This squad would occasionally be used to work on old claims to relieve some of the backlog, work with people who were struggling with their work and had fallen far behind, and cover for employees who were on vacation or on leave. The saviour squad had been in existence, off and on, at least since 1976; claim section directors who came and went over those years had varying notions of the squad's usefulness and would disband it or reconstitute it accordingly.

Even where the section seemed to be performing reasonably well, apparent success masked failure. One measurement of processing time clocked the number of days it took the department to issue its first time-loss payment after the department received notice a worker was filing a claim. State law required the department to make these payments within 14 days. But instead of starting the 14-day clock at the point in time when this notice arrived, the department started counting the days when the paperwork landed on the desk of the person responsible for paying the claim. The department was ignoring the time it took to open and date the "report of injury." The doctor treating the injured worker was required to submit to the department a form outlining the injury and treatment rendered. The department then entered the information from the doctor's form into the computer, assigned the report a claim number, and microfilmed the correspondence. It was no surprise that the department started the 14-day clock when it did,

---

8 The numbers may not be directly comparable as private sector claims managers handle all aspects of a claim and their counterparts at Labor and Industries handle only a portion of the total claims processing function.

because this up-front processing alone took an average of eight days. If the department had used as a starting point the date its mailroom first received the report of injury, the claim examiner would have usually had insufficient time to do the minimal amount of work needed to get the check out and would be meeting the 14-day deadline only about a quarter or more of the time.[9] But even counting the days as it did, the department was missing the deadline 11 percent of the time. And when it missed, it sometimes missed by a huge margin—as long as 90 days after the injury.

Self-perceptions in Claims Management. Employees in Claims Management prided themselves on how well they knew and abided by the laws, regulations, rules and procedures that seemed to dictate their every move. Claim workers were proud of themselves for knowing these guidelines chapter and verse. And they were sticklers for detail. One such rule governed the reimbursement of travel expenses for injured workers going from their residence to a doctor's office for medical care. The department paid these expenses if the worker lived more than 10 miles from the doctor's office. Even if a claimant filing for a small travel expense reimbursement, which might be for only $30, lived just slightly less than 10 miles from his doctor's office, the claims examiner would proudly and defiantly reject the voucher. In such cases, where exact distances might be a judgment call, claimants often felt cheated. A claimant in this situation might be willing to go to great extremes to seek redress. "That $30 down the line will become maybe $30,000," says McCallister, "because now we have an adversarial relationship between the adjudicator and the worker, and the injured worker may … end up with an attitude that says, 'My God, I'll show that adjudicator.'" McCallister believed it was in the department's best interest to pay the $30 travel reimbursement request in such borderline cases, but his reasoning was at odds with the claims examiners' training. "Why did the claim adjudicator reject it? Because the person is only 9.98 miles from the office," says McCallister. "And I can remember I used to walk around a lot and I'd say to the claim adjuster, 'Why did you do that?' And they'd open the book and say, 'Right there, you look right there, that's the rule, I follow the rules.'"

Yet the claims processors did, occasionally, attempt to exercise reasonable discretion. A claims examiner, who joined the claims section in 1979, recalls having insisted, on one occasion, when vocational rehabilitation was still a mandatory benefit, that a vocational rehabilitation counselor should not be sent to visit a particular claimant, though the rules she was following stated that all injured workers were to receive this benefit. Since this particular claimant was comatose, the claims examiner decided the counselor was not needed. And after the law changed, when injured workers were no longer permitted to hold out for jobs at their old wages, "we weren't going to go out and make them all Pizza Hut drivers, which we could have," she says . "You learn common sense over the years."

---

9 This fraction is a rough estimate. In 1988 the department calculated that it met the 14 day requirement 26 percent of the time, but this number was derived by starting the 14-day clock on the first day the employee missed work as a result of the injury. According to McCallister, the record for 1984 would probably be similar to the 1988 performance, using a similar start time. No reliable estimate was available of how many days elapsed between the workers first lost time from work and the time the department received a report of injury.

The annual evaluations claims staff received from their supervisors did not pick up these exceptions, nor did they measure outcomes—such as how many claimants went back to work. They measured process. Medical treatment adjudicators were evaluated, therefore, according to the number of bills they paid, or, as McCallister says, "on the basis of how many files did they push across their desk." Performance reviews also measured, according to Morris, whether the claims staff "use state resources wisely" and "do you get along with other people." Morris says that "a very nice person could do very little, but get a great review." According to these measures, the staff was doing well. "It wasn't that they weren't doing a good job, it was that the job was wrong," concludes McCallister.

Although members of the claims staff believed they were good at their jobs, their performance had often been criticized over the years. However hard they tried, however expert they were at following the section's procedures, the department was, nonetheless, losing money, which had prompted many attempts to reform aspects of the claims operation. "They had been told they were not professionals and incompetent to do the job," says Morris. "The staff were constantly reminded of how large their case loads were and how impossible the task before them was."

During one of his many walks through the department to talk with the division's front-line employees McCallister discovered for himself just how many attempts at reform there had been. On one such foray he stopped to ask a supervisor what she thought the department should do about the problem of recovering the overpayments it made to medical providers and injured workers. "So what would this person answer? It was to pull out the [desk] drawer and say, 'Well, Bob, would you like the report from 1986, 1985, 1984, 1983?' They would go back years, all ideas about how to solve that problem. And I would say, 'Well, how about '83?' So out comes a folder and here is a plan—never saw the light of day. … Some were made by staff, some were made by consultants. Not one—not one—had been implemented."

To the claims staff the department's new administration, led by Dear, Davis and McCallister, looked like more of the same, and they were therefore extremely suspicious of these new Gardner administration appointees. McCallister et. al., they suspected, would be no different than their predecessors. They would hire consultants to write reports and solicit ideas from the staff to try to improve their section's performance but in a few years they would move on and the cycle would repeat itself. "The claims staff," says Morris, "basically had just been beat up and run over for years and [hadn't had] the support of upper management."

The staff, as captives of a dysfunctional claims processing system, had developed a siege mentality. A consultant working with the Industrial Insurance division described this as a culture of "food and despair." Employees were frequently popping popcorn or toting Tupperware to a potluck, rituals that served to bring them together and thereby fend off "all these folks who were putting pressure on them to do better [when] they couldn't do better because the system wouldn't allow them to do better," says McCallister. "The culture is almost like kind of sitting around the

campfire and being pretty sure they aren't going to be able to get out of the canyon but [there is] camaraderie among themselves … and despair because of this hopeless situation."

Nonetheless, Labor and Industries staff was not without a voice when it came to carrying out department policy. New polices and procedures were fully adopted only when there was a consensus; in the absence of consensus, everyone went his own way, implementing the policy or not as he saw fit. "If they didn't want to do it," says McCallister, "they didn't have to." This was one reason, according to McCallister, that change never happened. The other consequence, he adds, was an inconsistent application of department policy that, among other things, angered the department's customers, frequently leading them to contact the director's office or a legislator, or to hire an attorney.

Management's Own Despair. After about six weeks on the job, after he had pulled back the curtains to reveal the department's creaky administrative machinery, McCallister reached the same conclusion the deputy director he was taking over from—Joe Dear—had come to: that the Industrial Insurance Division's problems might just be intractable. "I thought [before becoming deputy director] I knew all their warts and all their frailties," McCallister says of the division, "and discovered that I did not. As Joe [Dear] said, it took him about three months to figure out that he may have made the largest career mistake that he had ever perpetrated—and it took me about 6 weeks to figure that out."

Exhibit 1

CLAIMS ADMINISTRATION PROCESS

REPORT OF ACCIDENT

After being injured at the place of employment, the injured worker reports to a physician of his choice and there completes the Report of Accident. The worker must file a report within one year of the date on which the injury occurred or within one year from the date on which the worker was advised by a physician that he had an occupational disease.

The Reports of Accident are mailed to the Department by the physician. The physician is required by statute to assist the claimant in filing the claim.

The physician mails the worker's and physician's sections to the employer. The employer completes the employer's section and mails it to the Department in Olympia.

The Report of Accident is received in the Department and immediately assigned a claim number and microfilmed. Notice of claim arrival is sent to worker and attending physician within 24 hours of Report of Accident receipt. A preliminary determination is made at this point as to whether the claim is compensable or noncompensable, i.e., whether the worker will lose more than three days of work as the result of the injury. Approximately 600 injury claims are received each day of which approximately 400 are non-compensable claims (medical only). Of the remaining 200 claims received each day, most do not include the employer's section of the Report of Accident. The employers are telephoned to determine: (1) certification of whether the worker did lose time from work because of the injury, (2) if the employer wishes to protest the claim and if so why, and (3) the worker's wages at the time of injury so accurate time loss compensation is paid. The physicians are also called to obtain certification of time loss or other information missing from the Report of Accident.

The firm number and rate class are assigned by Audit personnel.

The Accident Reports are then sent to the adjudication units where they are reviewed by the Claims Examiners to determine if benefits are to be allowed or denied.

CLAIM ALLOWANCE

After a Claims Examiner reviews the claim for compliance with the Act he verifies the time Loss rate, reviews certification of time loss by the physician and submits a payment request if indicated. For the initial payment the claims examiner also determines the starting date of compensation and entitlement to the three day waiting period. The Claims Examiner then signs the Report of Accident and sends it on for computer processing and microfilming.

If the Accident Report is incomplete, the information is questionable, or the claim has been protested, the Claims Examiner may call the appropriate party for further information, write a letter requesting additional information or explaining the Department's action, arrange a formal investigation through the Service Location or refer the claim to a higher lever adjudicator for review. The Claims Examiner may also reject the claim outright if appropriate. If further information is required prior to determination, the claim is coded as provisional and a provisional payment request is submitted if otherwise payable.

The Department is required to make first payment of time loss compensation within 14 days by law. An informational pamphlet is enclosed with the first payment warrant.

An examination may also be arranged prior to allowance by the Disability Adjudicator for clarification of medical problems.

If time loss is indicated on the Report of Accident but not certified medically, a time loss certification card is sent to the claimant to be completed by his physician. A certification card is sent out with all time loss payments where no release date or return to work date has been established to obtain certification for continued time loss compensation. These certification cards are completed by the claimant and the physician jointly and must be signed by them both. The claimant's portion of the card requests information on return to work, address changes, unemployment compensation and social security benefits received. The physician's portion requests information and release for work, whether or not the claimant's condition is medically stable and any further comments the physician cares to make.

When the cards are received by the Department they are referred to the Claims Examiner the same day. The Claims Examiner obtains the microfiche file and reviews the claim before taking appropriate action, such as: (1) submitting continued time loss payment requests, (2) terminating time loss compensation, (3) making a referral for vocational evaluation, (4) closing the claim with no permanent partial disability award, and (5) referring the claim to some other function for their action.

Continued time loss compensation may also be paid based on information received from letters or provided by the attending physician, claimant, and employer by telephone.

TREATMENT/MEDICAL

All medical bills which are incurred as a result of treatment of an injury are paid by the Department's Medical Adjudicator. A medical vendor may not bill a worker for services nor for additional payment if the Department pays less than the vendors usual fee. Payments are made in accordance with the Department's published maximum fee schedule.

The Department receives approximately 3,800 bills per day. Each Medical Adjuster processes, pays and/or adjusts approximately 124 medical bills each day. Before processing a bill the Medical Adjuster must take into consideration the allowed and denied medical conditions on the claim, if the treatment was authorized by the Department, if there is adequate medical information in the file to justify payment, and if the charges billed are proper.

The Treatment Authorizer monitors the medical management of the claim. Each ongoing claim is reviewed periodically by the Treatment Authorizer. If adequate medical reports are not received from the attending doctor the authorizer requests such information. The Treatment Authorizer reviews requests for treatment, surgery, medication, hospitalization, therapy, etc., to determine the appropriateness of same and letters of authorization or denial are written by the Treatment Authorizers.

Other items monitored by the Treatment Authorizers are the worker's drug intake, the worker's cooperation or non-cooperation with a treatment program, excessive treatment, unrelated condition, etc. The Treatment Authorizer also refers claims to other functions when appropriate.

REHABILITATION

Any worker who is disabled for more than 120 days is contacted by a vocational counselor to determine if the worker will require vocational services in order to return to work. Most of these referrals are presently referred automatically, that is, a listing is compiled by computer after a period of time loss compensation has been paid. In addition to this additional period of disability, a worker must be referred for vocational services within 30 days of the date we receive notice from a physician that vocational services will be required. Also, re-referrals for additional vocational contact must be made. The latter two items are not included in the automated referral system and are dependent on the Claims Examiner, Disability Adjudicator or Claims Consultant making such referral. The Department also maintains the Buckner Rehabilitation Center in Seattle. Some of the services offered are an amputee service, body mechanics, employment orientation, physical capacity evaluation, work evaluation, testing services and work readiness services.

The Department allows up to $3,000 per year for tuition, books, supplies, transportation and other training costs. A worker's job site can be modified and the Department can allow up to $5,000 for modification. Residence modification can be allowed up to an amount not exceeding the state's average wage and modification for a motor vehicle can be made up to 50 percent of the state's average wage. Last year's average state wage was $17,553.

After vocational evaluation a determination is made by the vocational specialist as to whether the claimant will benefit from or requires further services. A plan for these services is proposed by the specialists and reviewed by the Office of Rehabilitation Review. If the plan is approved as appropriate, the specialist is authorized to proceed with the services. Upon completion of the proposed services, a final report closing services is provided by the vocational specialist and reviewed again by the Office of Rehabilitation Review. An opinion is generally given in the report by the specialist as to whether they feel the worker is employable on a continuous basis. If the worker or some other interested party disagrees with the report, the findings are reviewed by the Supervisor of the Office of Rehabilitation Review and may be protested further to the Supervisor of Industrial Insurance and from there to the Board of Industrial Insurance Appeals in an expedited process.

CLAIM CLOSURES

When the attending physician advises that the claimant's condition is stable and no further curative treatment is indicated, the claim is referred to the Disability Adjudicator for review if there is any indication of possible permanent partial disability. The Disability Adjudicator will, if appropriate, arrange for a special examination with an independent medical examiner or examiners, or have the attending physician perform a comprehensive examination if qualified and willing to do so. The examination appointments are arranged through the local service locations who maintain a list of all specialists in their area willing, qualified and able to perform these examinations. There is sometimes a delay of anywhere from one to ten months in scheduling examination appointments due to the limited number of qualified examiners willing to perform examinations for the Department in any given area, particularly in the Eastern Washington area. Claims on which time loss compensation is currently being paid are given priority scheduling.

The Disability Adjudicator will request in his examination assignment that the examiner rate permanent partial disability based on the requirements of the Act and the Department's WAC regulations.

When the examiners report is received by the Department, the Disability Adjudicator reviews the report, the vocational information available, as well as the rest of the file. The Disability Adjudicator may close the claim with a permanent partial disability award if indicated or request further information or clarification of the examiner's opinion. If the examiners do not recommend closure of the claim, the report is referred back to the Treatment Authorizers for further medical management along with the examiners recommendations for treatment. If the examiners or the vocational specialists found the claimant to be unemployable the Disability Adjudicator refers the claim to the pension adjudicators who will review the claim.

Disability Adjudicators may also schedule examinations at the request of the employer, physician, claimant, or on their own if a review of the file indicates that an examination is needed. Over 2,400 examination reports were reviewed and acted upon by the Department in 1983.

The Disability Adjudicators also review requests for reconsideration of the Department's orders. They will correct obvious errors or injustices and they may also obtain additional information needed to resolve protests or to substantiate the Department's previous action.

REOPENING

Requests for reopening of claims due to aggravation are submitted to the Department by the claimant through his physician's office as the Courts have interpreted the law to require some objective medical evidence of a worsening of the claimant's condition prior to reopening.

These requests are reviewed by the Disability Adjudicators for compliance with the requirements of the Act. The Disability Adjudicator will reopen the claim if appropriate for further treatment and sometimes additional permanent partial disability. The Disability Adjudicator may require an examination of the claimant prior to a determination of reopening or the Disability Adjudicator may act based solely by the information provided by the attending physician and file.

Over Seven Year Reopenings: There is a legal limit for the filing of reopening applications of seven years (ten years for eye claims) since the last closing order or remain closed order issued by the Department became final and binding. Reopening requests filed over the seven year time limit can

be considered by the Director at his discretion but that determination by the Director is not appealable. Normally, a complete investigation and examination work-up of the claim is required by the Director prior to his decision and as a matter of course, claims which he reopens at least meet the normal requirements of a timely application.

The Department receives approximately 900 re-opening applications a month.

CLAIMS CONSULTANTS

Any party may protest a Department order within 60 days of the issuance of the order and a further order has been issued. If any party is still aggrieved of the decision he/she may appeal the decision to the Board of Industrial Insurance Appeals or protest to the Department's Claims Consultants. In fact, each appeal to the Board is first reviewed by a claims consultant and a claims consultant may reassume jurisdiction and enter a further order if he/she wishes to do so. The claims consultant has only ten days on which to reassume jurisdiction or let the issue go to the Board of Appeals. Many decisions at the claims consultant level are negotiated settlements between the consultants and the protesting party or the attorney for the protesting party.

PENSION DESK

The Department has two pension adjudicators who are responsible for reviewing all pension requests and placing on pension those claimants who meet the requirements of the act. They also handle or review all fatal claims and all claims filed for heart attacks, black lung disease, silicosis and cancer. They review fraud investigations and coordinate the Department's actions with the County Prosecutors and the investigation staff. They also make determinations regarding second injury for the relief of the employers with pension claims charged to their firm.

SUBROGATION

If an injury or disease is determined to have been caused by, or be the fault of, some party other than the worker's employer and co-workers, the Department has subrogation rights. If the injured worker sues for damages, the Department may recoup from any settlement received the amount that had been paid out previously in benefits. If the worker declines to pursue the claim with the third party, the Department may file suit on the worker's behalf. The worker would receive any money in excess of what the Department had paid out in benefits.

The Department maintains a Subrogation Section to handle these third-party actions, and to negotiate settlements. This section also handles benefit overpayments and collection.