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State Workers' Compensation

Funding shortfalls have depleted reserves and prevented settlements

Why we did this review

This special examination of state workers' compensation was requested by the Senate Appropriations Committee. Based on its request, we addressed the following questions:

- What are the trends in Georgia's workers' compensation claims history?
- What factors impact the state's financial liability for workers' compensation?
- Could the state increase its use of settlements to lower its workers' compensation costs?

About State Workers' Compensation

The 1920 Workers' Compensation Act provided for immediate medical and income benefits for workers injured "out of and in the course of" employment. It also fixed the amount of benefits paid. Georgia is an employer under the Act and is subject to its requirements. Covered employees include those employed by any state agency, instrumentality, or authority. In fiscal year 2017, approximately 122,300 employees were covered by the state's program.

The Risk Management Services Division of the Department of Administrative Services manages Georgia's workers' compensation program. In fiscal year 2017, 5,366 new claims were reported. Because claims can remain open for multiple years, in fiscal year 2017, the state paid $88.6 million in expenses for 11,138 claims.

What we found

As an employer, the State of Georgia is statutorily required to provide workers' compensation benefits to employees injured "out of and in the course of" employment. In fiscal year 2017, these medical and income benefits represented 84% ($84.6 million of $101 million) of the workers' compensation program's total expenses. Funding for the program comes from premiums the Department of Administrative Services (DOAS) bills to covered entities each year. However, the program has been consistently underfunded and has depleted its reserves. The lack of funding and reserves has hindered its ability to settle claims, which would offer an opportunity for long-term savings. It also puts the program at risk of being unable to pay out statutorily required benefits if a large-scale event occurred resulting in a significant increase in claims.

Premiums are the program's primary revenue source, representing 93% ($91 million of $98 million) of revenues in fiscal year 2017. However, since 2011, premiums have remained flat, even as the state's annual expenses have increased. The program has operated in a deficit for 7 of the last 10 fiscal years. The deficits were generally funded by using the cash and investments in the reserves of the Workers' Compensation Fund, which are now depleted.

Claim expenses are the largest portion of the program's expenses. As a result, using a sound methodology to estimate them is critical to developing an adequate premium level. However, DOAS has not established a standard policy or procedure for estimating claim expenses and ensuring that premiums cover program expenses. Our review found that DOAS currently budgets on a cash flow basis; under this approach, annual funding covers only the expenses the program expects to pay out in the upcoming fiscal

year. To operate in this manner, DOAS must ensure there are sufficient reserves in the Workers' Compensation Fund to address deficits if expenses exceed costs, which is possible, given that claim expenses can fluctuate. Additionally, premium levels should provide sufficient funding to allow for settlements when appropriate. It should be noted that, while DOAS is statutorily charged with setting reserves and premiums, these funding requests can be adjusted through the annual budget process.

Settlement savings result from cost avoidance. The state pays a smaller amount now than it anticipates paying over the full life of the claim. While settlements generate savings over the long term, they require more funding in the short term; therefore, the decision to offer settlements is largely based on funding availability. As annual expenses repeatedly exceeded annual revenues and the Workers' Compensation Fund's reserves fell, the program generally settled fewer claims. However, in fiscal year 2016, DOAS pushed to settle a large number of claims in an effort to reduce the state's outstanding liability and decrease the number of older open claims. The large settlement total that year helped deplete the Fund's reserves. The depletion of the Fund reserves and the insufficient premium funding have diminished the state's financial capacity to settle claims. As a result, the state is limited to paying the statutorily required benefits each year the claimant is eligible.

To manage the program effectively, DOAS must be able to identify trends in the number, frequency, and type of workers' compensation claims; analyze the costs and changes in these costs over time; and, identify claims for settlement. To do so, DOAS should collect additional data elements, aggregate data appropriately, and analyze the data to inform management decisions. By doing so, it can inform claim expense estimates and settlement decisions, as well as identify trends in workers' compensation claims.

What we recommend

This report is intended to provide answers to questions posed by the Senate Appropriations Committee. In addition, we made recommendations designed to address funding shortfalls and improve operations. We recommend DOAS establish policies and procedures for setting the annual premium level and estimating claim expenses to ensure it has sufficient funding to pay benefits and settle claims. As part of the determination, DOAS should identify a target funding level for the Workers' Compensation Fund. To improve transparency in the budgetary process, the General Assembly may wish to require DOAS to independently report its estimates of reserve and premium needs. In setting premiums, DOAS should also consider the impact of the December 2023 elimination of the Subsequent Injury Trust Fund, as it has provided additional revenues for the program for 9 of the last 10 years.

Regarding settlements, DOAS should establish a standard methodology for calculating exposure for settlement evaluations and track estimated savings for all claims settled. Along with the General Assembly, it should also ensure sufficient funds are available to allow for claim settlements that are financially beneficial to the state.

To identify potential opportunities to reduce workers' compensation losses and inform its management of the program, DOAS should ensure it collects additional data, aggregates the data appropriately, and analyzes the available data.

Finally, the General Assembly could consider additional financial incentives to covered entities such as allowing entities to keep a portion of the savings if their workers' compensation premiums fall.

See Appendix A for a detailed listing of recommendations.

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Purpose of the Special Examination

This review of the state's workers' compensation program was conducted at the request of the Senate Appropriations Committee. Based on the Committee's request, we addressed the following questions:

1. What are the trends in Georgia's workers' compensation claims history?
2. What factors impact the state's financial liability for workers' compensation?
3. Could the state increase its use of settlements to lower its workers' compensation costs?

A description of the objectives, scope, and methodology used in this review is included in Appendix B. A draft of the report was provided to the Department of Administrative Services for its review, and pertinent responses were incorporated into the report.

Background

Workers' compensation is a "no-fault" system that protects employers from unlimited liability and entitles employees to benefits without having to prove employer negligence. In the United States, the first workers' compensation laws were enacted in 1911. These laws were intended to ensure injured workers received proper and timely benefits with a minimum of disputes and litigation. Workers' compensation systems are designed to benefit both employees and employers. Employers are able to avoid costly litigation because workers' compensation claims are handled through an administrative rather than judicial process. Employees benefit by receiving immediate medical treatment for work-related injuries or illnesses and some financial compensation for lost income. Employers provide workers medical benefits and indemnity (income) benefits by purchasing workers' compensation insurance from private insurance carriers or by self-insuring.

State Workers' Compensation Statute

In 1920, the Georgia General Assembly enacted the Workers' Compensation Act ("the Act"), making it the 42nd state to adopt such legislation. Prior to the Act, workers were required to prove their injuries resulted from the negligence of the employer. Laws also excluded claims for job injuries resulting from natural conditions or from the strain of physical labor. Injured worker claims were difficult for employees to pursue because the laws at the time favored employers. However, claims that did result in a jury trial could financially ruin an employer because juries were typically sympathetic to the injured worker and awarded large settlements. To address these issues, the Act provided for immediate medical and income benefits for workers injured "out of and in the course of" employment, while fixing the amount of benefits paid by employers.

In the event of a workplace accident, benefits may be paid in one or both of the following categories:

- **Medical** – Medical care is provided to the injured[1] worker by a doctor from a list of physicians maintained by the employer or from a workers' compensation managed care organization.
- **Indemnity** – Indemnity, or income benefits, partially replace lost wages. If applicable, claimants may also receive indemnity payments for the loss of limb or physical ability. If the injury causes the worker's death, indemnity benefits are paid to the worker's dependent family members.

The State Board of Workers' Compensation (SBWC) is responsible for administering the Act. SBWC has jurisdiction over disputed claims, which are decided by administrative law judges in non-jury hearings. SBWC also publishes an annual medical fee schedule, which specifies maximum amounts employers and insurers pay for various medical procedures. The State of Georgia is considered an employer under the Act. As such, it is subject to statutory requirements and SBWC's oversight, as is any Georgia employer.

Under Georgia's workers' compensation law, the state is an employer subject to statutory requirements.

Because the system is designed to function with minimal litigation, most claims are handled between the employee and employer according to the guidelines set by law and SBWC. However, if an affected party disagrees with any of the decisions made, he or she can request a hearing before SBWC, which will rule on the dispute. Parties may appeal the administrative law judge's decision to SBWC's Appellate Division, and with some restrictions, may file subsequent appeals with the Superior Courts and the Court of Appeals. The law places restrictions on time frames for appeals to avoid lengthy delays in claim resolution.

State Workers' Compensation Program

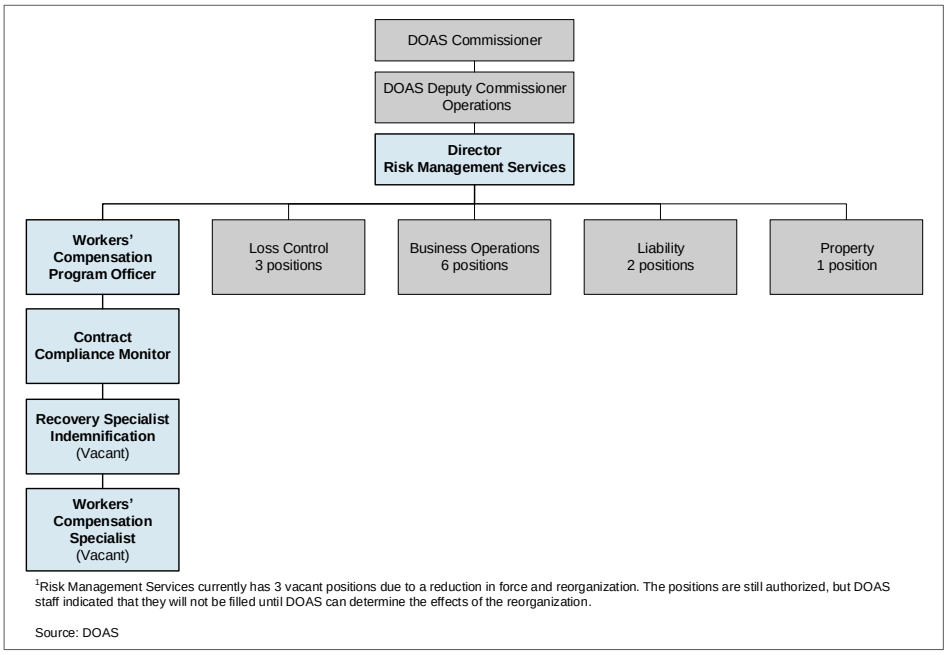
Under state law, employees covered under the State of Georgia's workers' compensation program include employees of any state agency, instrumentality, or authority, including the University System of Georgia. Covered employees also include county and district health agency employees, community service board employees, and members of the Georgia National Guard and the State Defense Force serving on state active duty. In fiscal year 2017, approximately 122,300 employees were covered by the state's workers' compensation program.

The state's workers' compensation program is managed by the Risk Management Services (RMS) Division of the Department of Administrative Services (DOAS). Under state law, DOAS is tasked with formulating "a sound program of self-insurance for workers' compensation benefits for all employees of the state." While the state pays most claim expenses (self-insurance), DOAS does purchase excess coverage for high-cost claims. This coverage currently pays when expenses exceed $5 million for an individual claim.

RMS is also responsible for managing the state's insurance coverage for property, liability, and indemnification. As shown in **Exhibit 1**, RMS directly employs two employees in the workers' compensation program and has two vacant positions. Most aspects of claims administration are outsourced to external vendors.

[1] The terms "injury" and "injured" in this report also include occupational illnesses, such as asbestosis, and illnesses that occur as a result of an accident.

Exhibit 1
RMS Organization Chart
July 2017



[1]Risk Management Services currently has 3 vacant positions due to a reduction in force and reorganization. The positions are still authorized, but DOAS staff indicated that they will not be filled until DOAS can determine the effects of the reorganization.

Source: DOAS

To pay workers' compensation expenses, DOAS bills covered entities for workers' compensation premiums each year. DOAS staff estimates the total funding amount needed for the upcoming fiscal year and then allocates this amount to each entity as premiums. Premiums are based on a combination of the entity's experience (80%) and exposure (20%) compared to the state as a whole, as shown in the formula in **Exhibit 2**. The experience component refers to the past three years of claim expenses for the entity divided by the sum of all claim expenses for the state. The exposure calculation for workers' compensation refers to the entity's salary total divided by the state's salary total.

Exhibit 2
Entity Premiums are Based on Experience and Exposure

Premium Formula

$$\left[0.80\left(\frac{\text{Sum of Claim Payouts for the Entity for the past 3 years}}{\text{Sum of Claim Payouts made by the State for the past 3 years}}\right) + 0.20\left(\frac{\text{Total Entity Salary}}{\text{Total State Salary}}\right)\right] \times \text{Approved Funding Level} = \text{Entity Premium}$$

(Experience) (Exposure) (Total State Funding)

Premium Example

$$\left[0.80\left(\frac{\$19,943,281}{\$273,908,143}\right) + 0.20\left(\frac{\$168,571,305}{\$6,234,813,668}\right)\right] \times \$91,100,000 = \$5,799,017$$

(Experience) (Exposure) (Total State Funding)

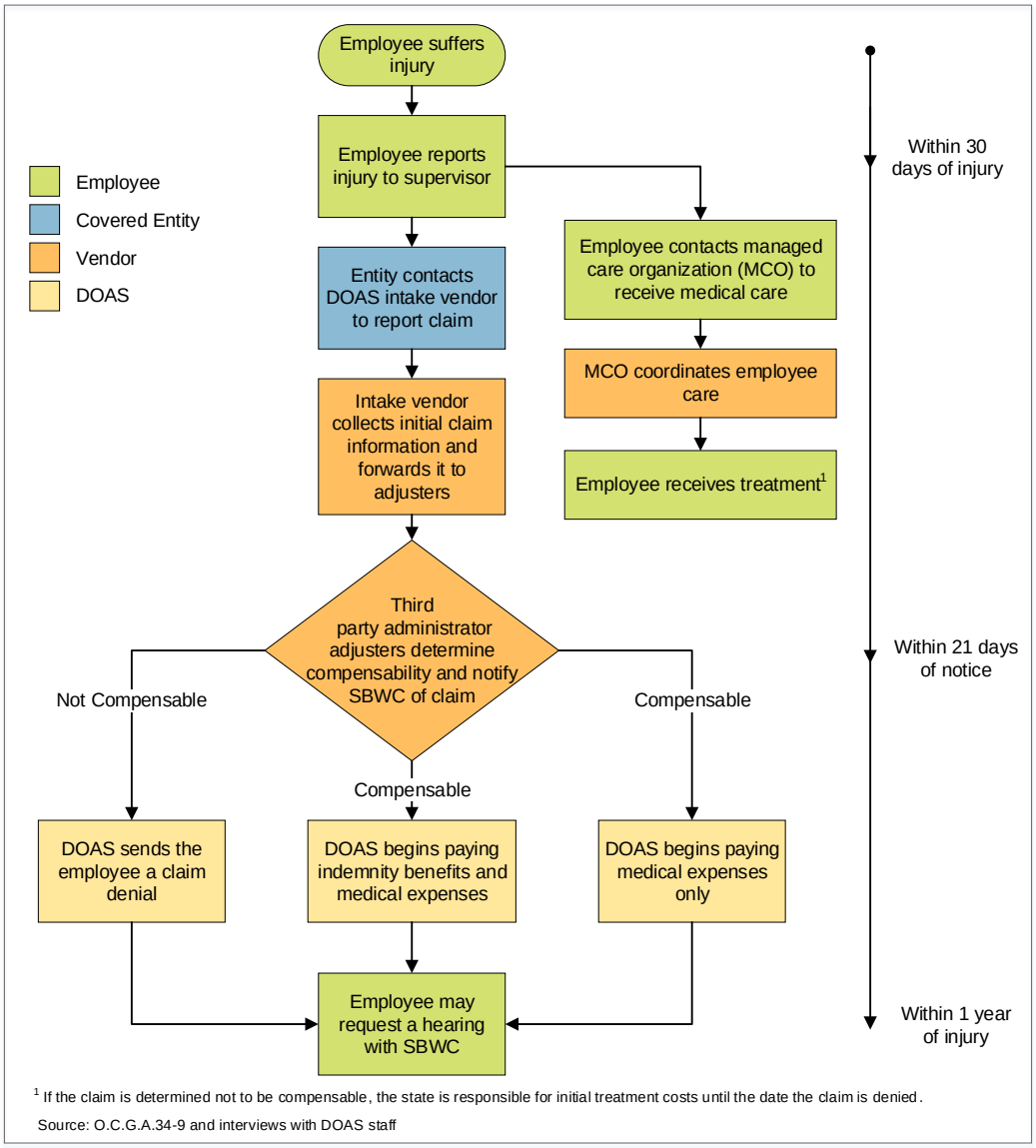
Source: DOAS Premium Calculations

While DOAS is responsible for estimating program expenses and premium amounts, these figures are subject to review through the regular budget process. DOAS submits both the total funding amount and the entity premium allocations to the Governor's Office of Planning and Budget (OPB). The funding request is subject to revision and must be approved by OPB prior to being included in the annual Governor's Budget Report and submitted to the General Assembly.

Claims Process

When an injury arises out of and in the course of employment, it falls under the state's workers' compensation law. An overview of the typical claims process for a state employee is shown in **Exhibit 3**.

Exhibit 3
Typical Workers' Compensation Claims Process for State Employees



[1] If the claim is determined not to be compensable, the state is responsible for initial treatment costs until the date the claim is denied.

Source: O.C.G.A.34-9 and interviews with DOAS staff

State law requires the injured employee, or claimant, to report the injury to his or her supervisor within 30 days of the occurrence. Unless emergency care is necessary, the supervisor instructs the claimant to contact the state's managed care organization, which coordinates the claimant's medical care. To begin the claim, the supervisor or other agency representative calls the state's intake vendor and provides initial information regarding the accident. This information is entered into DOAS' case management system, and the claim is forwarded to the third party administrator. The third party administrator provides claims adjustment services throughout the life of the claim. The claim is assigned to a claims adjuster, who reviews the claim, obtains additional information, and determines whether the claim is compensable (i.e., eligible for workers' compensation benefits). Once the compensability decision has been made, the claimant is notified, and a form is filed with SBWC within 21 days of the injury notification. This form details information on the claimant, the injury, and any benefits payable.

Benefits

Legislation passed in 2013 reduced the length of medical care from lifetime eligibility to a maximum of 400 weeks.

If the claim is deemed compensable, DOAS will begin to pay for benefits according to statutory requirements. Benefits are classified as medical or indemnity.

Medical

The state must provide injury-related medical care for all compensable claims. Medical benefits are generally payable for up to 400 weeks (approximately 7.7 years). However, if an injury is deemed catastrophic[2] or if it occurred prior to fiscal year 2014, injury-related medical care must be provided for the life of the claimant. It should be noted that the term catastrophic is statutorily defined and is related to the individual's ability to return to work. It is not a measure of injury severity, although these two factors may be related.

For any medical expenses, DOAS utilizes a vendor to review the bill, compare it to the medical fee schedule published by SBWC, and potentially negotiate lower rates with providers.

Indemnity

Depending on the impact of the injury, claimants may receive one of the following types of indemnity (income) benefits:

- **Temporary total disability** – Claimants unable to work for more than seven days receive weekly payments equal to two-thirds of their weekly wage, with a minimum of $50 and a maximum of $575, for up to 400 weeks.[3] For catastrophic injuries, the week limit is waived.
- **Temporary partial disability** – Claimants able to return to work in a limited capacity receive weekly payments equal to two-thirds of the difference between their weekly wages before and after the injury, with a maximum of $383, for up to 350 weeks after the injury.

[2] Catastrophic injuries include those causing severe paralysis, brain damage, or other factors that prevent the employee from being able to work.
[3] Claimants may elect to use sick or annual leave for lost time and forego applicable indemnity benefits.

- **Permanent partial disability** – Claimants who have lost a "member" (such as a limb or a finger) or the use of a member receive weekly payments equal to two-thirds of the weekly wage for a specified number of weeks, up to 300.

The type of indemnity benefits paid is subject to change if the claimant's condition changes. While temporary disability benefits are intended to replace lost wages, permanent partial disability is compensation for the loss and is not tied to the claimant's ability to work. As a result, permanent partial disability is generally paid after the completion of temporary disability payments.

Additionally, the state pays death benefits to the employee's dependents if the work-related injury or illness leads to the employee's death. These benefits are paid even if the death occurs many years after the accident. Death benefits of up to $230,000 include burial expenses of $7,500 and weekly income payments. The income payments are equal to temporary total disability for persons wholly dependent on the deceased employee, which may include a spouse and/or children.

Settlements

Due to statutory requirements, the state may pay benefits on some claims over a period of several years or for the life of the claimant. However, parties to a claim have the option to settle instead of continuing benefit payments over the long term. Under state law, both parties must agree to the settlement, and the settlement must be approved by SBWC. When claims are settled, claimants generally receive a lump sum payment and give up all rights to future compensation, even if their condition deteriorates. However, some claims may settle the indemnity portion only. In these partial settlements, the state is still responsible for future medical costs due under the law.

Loss Control

Loss control refers to efforts to reduce claim frequency and severity. DOAS currently employs two loss control officers who work on the state's workers' compensation, property, auto liability and physical damage, and general liability insurance programs. The officers conduct site visits, evaluations of loss data, ergonomic workplace evaluations, and training. These services are provided to covered entities free of charge and on a voluntary basis. The services provided and the voluntary participation were typical of the other states and entities we interviewed.

The Comprehensive Loss Control Program was implemented in October 2008 in response to Senate Bill 425. The purpose of the program was to incentivize agencies to reduce loss frequency and severity. The program addresses all insurance programs covered by DOAS loss control officers. Each participating entity agrees to specific requirements, such as implementing an accident prevention program, having a written workers' compensation return-to-work program in place, and providing employees with appropriate safety training. Senate Bill 425 authorized DOAS to charge differential premiums based on participation in loss control efforts, and DOAS originally planned to incorporate this concept into the Comprehensive Loss Control Program. Non-participants would be required to pay a 10% penalty on all premiums. However, DOAS staff indicated that differential premiums have not been utilized because so few entities do not participate in the program. Currently, only five entities do not participate, and these entities represented 0.1% of workers' compensation claims in fiscal years 2008 through 2017. Staff stated that, because these entities are

small and have few claims, the assessment of differential premiums would be an inefficient use of resources.

Subsequent Injury Trust Fund

The Subsequent Injury Trust Fund (SITF) was created "to encourage the employment of persons with disabilities." The SITF may reimburse any eligible Georgia employer for part of the workers' compensation benefits paid to a worker with a pre-existing permanent impairment if that worker suffers a subsequent compensable injury. Reimbursement is applicable when the subsequent injury would not have occurred without the pre-existing impairment, when the subsequent injury causes a greater disability than it would have without the pre-existing impairment, or when a death would not have been accelerated without the pre-existing impairment. For example, the state received SITF reimbursement for a claimant injured in an altercation with an inmate. The claimant had a pre-existing condition from an earlier slip and fall injury that exacerbated the injuries from the workers' compensation accident.

The SITF is funded by an assessment on workers' compensation insurers and self-insurers. In 2005, the SITF statute was amended to end the program, and the last date of injury eligible for reimbursement was June 30, 2006. However, the SITF will continue to pay reimbursement for eligible claims until it is eliminated on December 31, 2023.

Because the state is an employer subject to workers' compensation laws, it receives reimbursements from and pays an assessment to the SITF. DOAS works with an external vendor to obtain reimbursement for eligible claims from the SITF. In fiscal year 2017, the state received approximately $6 million in reimbursement from the SITF for 170 claims.

Self-Insurance

According to statute, the state is required to self-insure for the workers' compensation program. Self-insurance is a reasonable workers' compensation solution because benefit limitations and claim timelines lend themselves to some predictability in forecasting claim expenses. The use of self-insurance can help to reduce the program's costs by eliminating the insurance company, which can be expected to charge premiums covering its costs plus a profit.

However, self-insurance requires sufficient financial resources be allocated to the insurance program. A self-insuring employer trades a known risk (insurance premiums) for an unknown risk (direct claim expenses). Claim expenses can be expected to fluctuate from year to year. While the employer may be able to predict workers' compensation expenses with some accuracy over the long term, short-term expenses are less predictable. For this reason, the employer must maintain sufficient cash reserves to handle expense fluctuations. As a result, self-insurance is most frequently used by large employers with sufficient cash reserves.

Financial Information

The state's workers' compensation program operates through an internal service fund known as the Workers' Compensation Fund. This Fund collects revenues and pays expenses related to the workers' compensation program. Surplus funds are kept as reserves to pay future program expenses.

As shown in **Exhibit 4**, the primary expense for the Workers' Compensation Fund is the payment of claim expenses. Claims represented $87.7 million of the $100.5 million in expenses (87%) in fiscal year 2017. The primary source of revenue is premiums paid by covered entities.

Exhibit 4
Financial Summary of the Workers' Compensation Fund
Fiscal Years 2016-2017

Operating Revenue	**2016**	**2017**
Premiums	$89,123,352	$91,094,455
SITF Reimbursement	$9,324,236	$6,188,532
Other Revenue	$275,830	$784,075
Total Revenue	$98,723,418	$98,067,062
Operating Expenses		
Administrative Expenses	$10,819,931	$12,858,862
Claim Expenses		
Medical Expenses	$52,535,830	$52,990,492
Indemnity Benefits[1]	$49,713,779	$31,574,069
Other Claim Expenses	$3,158,740	$3,116,222
Total Claim Expenses	$105,408,349	$87,680,784
Total Expenses	$116,228,280	$100,539,646
Operating Deficit	*$17,504,862*	*$2,472,583*
Additional Revenue		
From Fund Reserves	$17,387,328	$0
From State Purchasing Division	$0	$2,590,117

[1]Indemnity Benefits include settlements, which fell by $15.8 million in fiscal year 2017.

Source: TeamWorks Reports provided by DOAS

As shown in **Exhibit 4**, for fiscal years 2016 and 2017, the Workers' Compensation Fund operated with a deficit. In fiscal year 2016, Fund reserves were depleted, and in fiscal year 2017, the program required a $2.6 million transfer from the DOAS State Purchasing Division to cover its expenses. According to DOAS staff, OPB approved the transfer. The depletion of the Workers' Compensation Fund is discussed in more detail, starting on page 25.

Requested Information

Trends in Georgia's Workers' Compensation Claims History

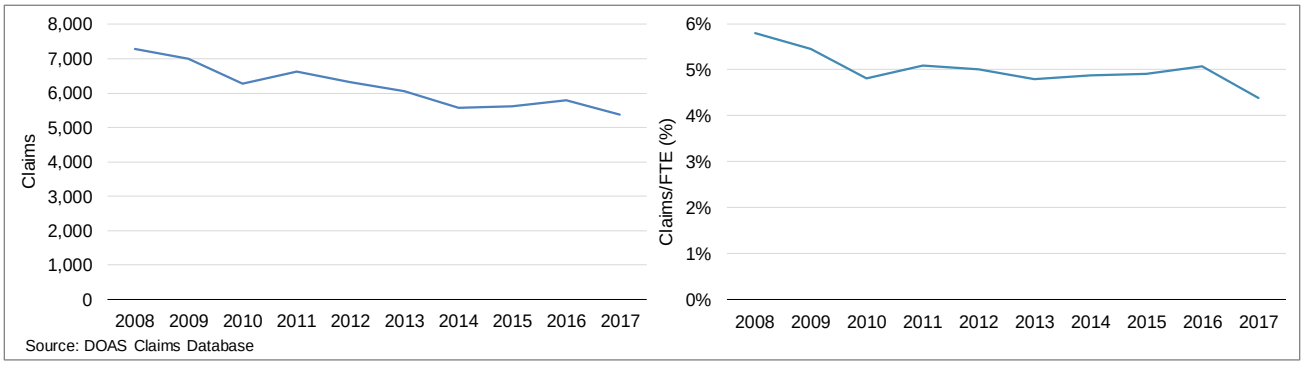
Both the number and frequency of workers' compensation claims have fallen over the last 10 years. This decline has helped to offset an increase in the average estimated per-claim cost. Because the state continues to pay benefits on claims incurred in prior years, annual expenses have also increased over fiscal years 2008-2017.

Claim frequency has fallen, but average costs have risen.

The number of workers' compensation claims has fallen over the last 10 years. As shown in **Exhibit 5**, 7,279 claims were reported in fiscal year 2008, and 5,366 claims were reported in fiscal year 2017, a decrease of 26%.

The number of state employees has decreased from its peak in 2010, which contributed to the decline in claims. Even after this decrease is considered, workers' compensation claims are still trending downward. The number of claims divided by the number of full-time equivalent employees (FTE) is known as claim frequency. As shown in **Exhibit 5**, claim frequency fell from 5.8% in fiscal year 2008 to 4.4% in fiscal year 2017. These percentages translate to one claim for every 17 employees in fiscal year 2008 and one claim for every 23 employees in fiscal year 2017.

Exhibit 5
Reported Claims Fell by 26% and Claim Frequency Also Declined
Fiscal Years 2008-2017



Source: DOAS Claims Database

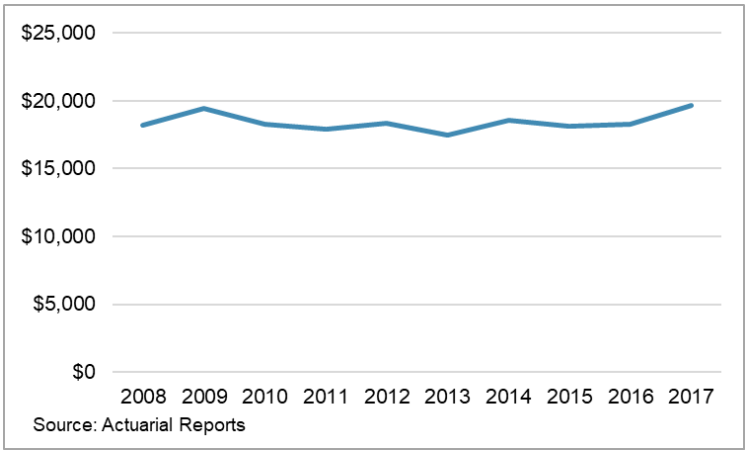
The state's workers' compensation claim frequency was similar to that of the five other states' governments we reviewed but was higher than other employers in Georgia. In fiscal year 2017, claim frequency in other states we reviewed averaged 4.1% (ranging from 2.4% to 5.7%). According to claim numbers reported by SBWC, claim frequency for all applicable employers[4] in Georgia was approximately 3.7% for calendar year 2014 (the most recent year available). In 2014, the state's claim frequency was 4.9%. State governments typically have higher incident rates than private industry, partially due to high-risk occupations such as public safety officers.

[4]Small businesses, defined as those employing fewer than three employees, are not required to have workers' compensation insurance. Certain industries, such as railroads and farm labor, are also excluded.

Claim severity is an estimate of all costs over the life of the claim, including medical, indemnity, legal, and other administrative claim costs.

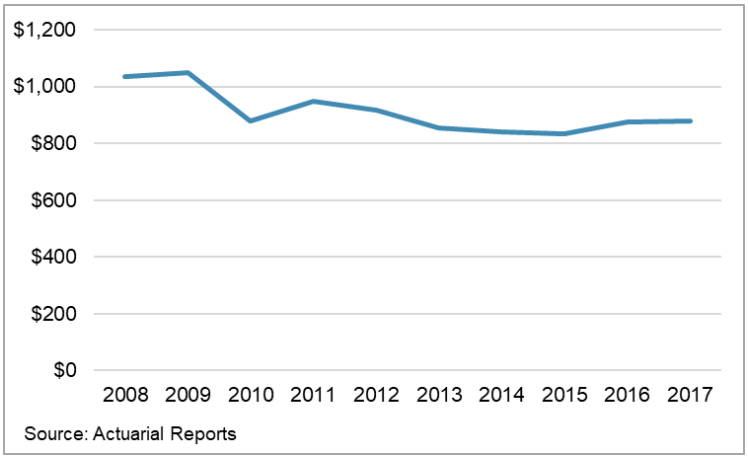
While the number of claims has fallen, the average cost of these claims has risen slightly. DOAS utilizes an actuarial firm to estimate claim severity, which is all expected costs over the full lifetime of the claim, including anticipated future expenses. The cost estimates are reported based on the year the accident occurred. As shown in **Exhibit 6**, the average estimated claim severity rose from $18,193 for fiscal year 2008 claims to $19,666 for fiscal year 2017 claims. This increase totaled 8% over 10 years, with most of the growth occurring since fiscal year 2013.

Exhibit 6
Average Claim Severity Grew by 8%
Fiscal Years 2008-2017



The actuarial firm also estimates the average loss per employee for each fiscal year's claims, which considers both claim frequency and claim severity. The average loss per employee is equal to the total ultimate loss estimate divided by the number of covered employees. The decrease in claim frequency was enough to offset the increase in claim severity. As a result, as shown in **Exhibit 7**, the average loss per employee has fallen from $1,034 in fiscal year 2008 to $878 in fiscal year 2017, a decrease of 15%.

Exhibit 7
Average Loss Per Employee Fell by 15%
Fiscal Years 2008-2017

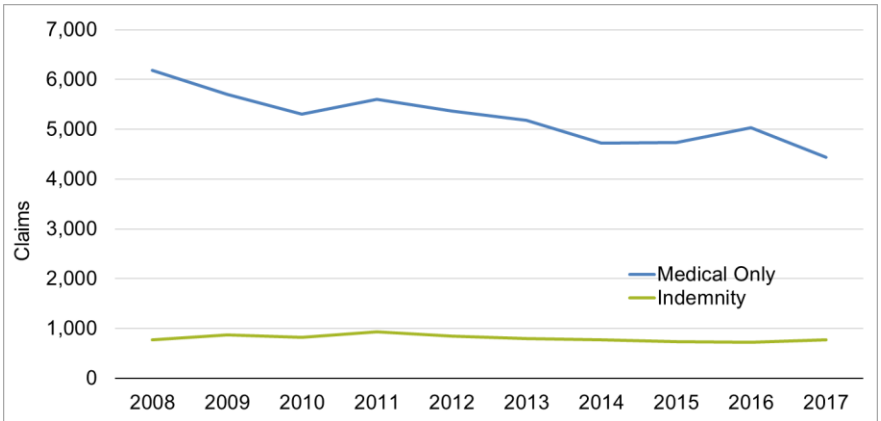


Trends varied by claim type.

Workers' compensation claims are divided into indemnity and medical-only claims. Indemnity claims involve income benefits[5] to help replace lost wages or to compensate for loss of limb or physical ability, in addition to any payments for medical expenses. Medical-only claims cover medical expenses but do not involve any income benefits. Typically, indemnity claims have higher costs than medical-only claims, due to the additional income benefits and significantly higher medical costs. This difference reflects the likelihood that a claimant will miss time from work if the injury is more severe.

Exhibit 8 shows the number of medical-only and indemnity claims for fiscal years 2008 through 2017. Medical-only claims fell by 28%. Indemnity claims were at essentially the same level in fiscal year 2017 as 2008, after peaking in fiscal year 2011.

Exhibit 8
Medical-Only and Indemnity Claims[1]
Fiscal Years 2008-2017



[1]Graph does not include a total of 1,625 claims we were unable to classify because they showed no incurred medical or indemnity costs. DOAS staff indicated that these claims may have been controverted or the claimant may not have responded to requests for information.

Source: DOAS Claims Database

Claim Severity vs. Injury Severity

Claim severity is a measure of the claim's total cost, while injury severity is related to the extent of the claimant's injury. While these two concepts could be related, a severe injury may not result in a severe (high-cost) claim. For example, if a claimant lost a limb in an accident, then it would be considered a severe injury. However, if the claimant recovers and returns to work quickly, claim costs may be relatively low, and therefore, the claim would not be considered severe. By contrast, a claimant with a less severe injury could develop complications that require additional medical care and prevent return to work, resulting in additional costs to the state. This claim would be considered severe because of its total cost.

[5] Indemnity benefits also include settlements and payments to a claimant's dependents when the injury leads to death.

DOAS claims data does not include a reliable indicator of injury severity. As a result, we were unable to assess whether new claimants' injuries are more or less severe than those of past claimants. Differences from year to year in injury severity would affect the benefit expenses.

However, DOAS data does indicate which claims have been designated catastrophic. Catastrophic claims are those where the nature of the injury permanently prevents the employee from being able to work. Examples of catastrophic injuries are spinal cord injuries that involve severe paralysis, severe brain injuries, and total blindness.

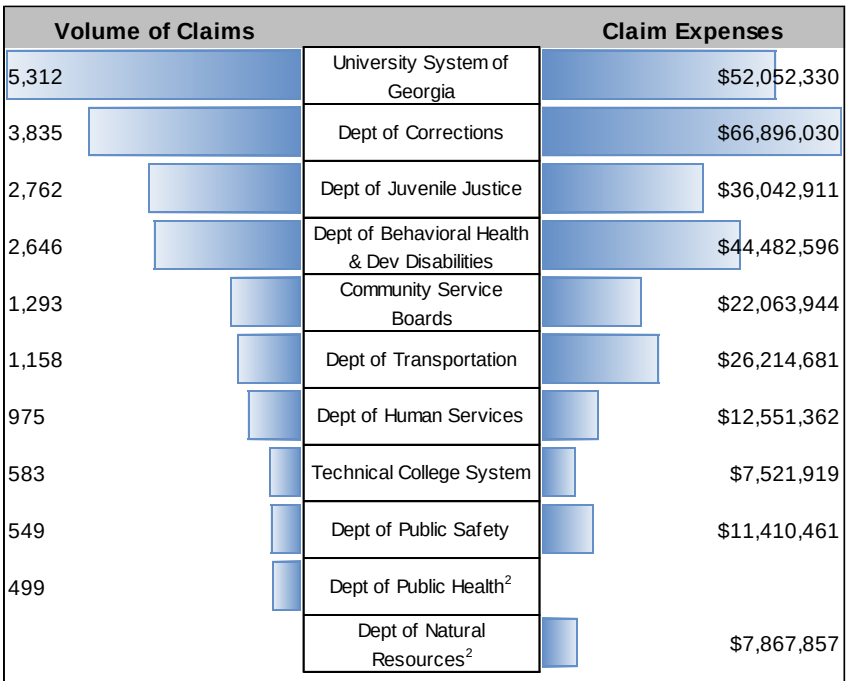
Due to the nature of catastrophic injuries and the resulting lifetime eligibility for benefits, catastrophic claims are likely to be among the most expensive claims. In fiscal year 2008, 55 of 7,279 reported claims (.8%) were designated catastrophic, and in fiscal year 2009, 39 of 7,011 reported claims (.6%) were designated catastrophic. The number of catastrophic claims for fiscal years 2010-2017 could not be reliably determined. Claim status can change over time; however, claimants without a catastrophic designation have little incentive to seek such a designation before the 400 weeks of temporary total disability and medical benefits expire. During this time, eligible benefits are essentially the same for all types of claims. At the time of this review, only claims reported prior to October 2009 would have passed the 400-week limit. As a result, the catastrophic claim numbers for fiscal years 2010 through 2017 are not reliable. Additionally, claimants may request a catastrophic designation up to two years after the last payment for temporary total or partial disability.

During fiscal years 2008 through 2017, workers' compensation injuries resulting in the employee's death averaged three per year and ranged from one to seven. Due to the relatively small number of claims, year-to-year changes do not show an identifiable trend. If a workplace injury results in the claimant's death, the state is required to pay burial expenses up to $7,500 and pay the claimant's dependents weekly compensation equal to temporary total disability benefits. These payments to dependents are considered indemnity benefits and are paid as long as the injury is the cause of the death, whether the employee dies immediately after the accident or later. Total death benefits are capped at $230,000, not including any medical expenses.

The number of claims by entity varies according to entity size and claim frequency.

The same entities tend to have a large number of claims reported each year, primarily due to the number of employees and the type of work being performed. For the same reason, these entities also have large claim expenses each year. **Exhibit 9** shows the top 10 entities by claims reported and by claim expense payments over fiscal years 2014 to 2017. During this time period, these 10 entities represented 87.8% of claims reported and 86.9% of claim expenses. Reported claims and claim expenses for the top 25 covered entities are included in Appendix C and Appendix D.

Exhibit 9
Top Entities for Claims and Expenses[1]
Fiscal Years 2014-2017



[1]Volume of Claims is the number of claims reported in FY 2014-2017. Claim Expenses are the expenses paid during FY 2014-2017, regardless of year claim was reported.

[2]Department of Public Health was not part of the top 10 by claim expenses. Department of Natural Resources was not part of the top 10 by volume of claims.

Source: DOAS Claims Management Database

We also calculated entities' claim frequency, which is the number of claims divided by the number of full-time equivalent employees. This measure provides comparable incident rates by accounting for entity size. The top 10 entities during fiscal years 2014 to 2017 are shown in **Exhibit 10**. Claim frequency for the top 25 covered entities is included in Appendix E.

Exhibit 10
Top Entities by Number of Claims Per 100 FTE
Fiscal Years 2014-2017

	Average Claims per 100 FTE
Dept of Juvenile Justice	19.3
Dept of Human Services	11.1
Dept of Behavioral Health & Developmental Disabilities	11.0
Georgia Agricultural Exposition Authority	10.6
Georgia Forestry Commission	8.0
Dept of Public Safety	7.8
Dept of Corrections	7.7
Dept of Veterans Service	6.9
Dept of Driver Services	6.8
World Congress Center Authority	6.6

Source: DOAS Claims Database

The Department of Juvenile Justice had the highest claim frequency, averaging 19.3% over fiscal years 2014 through 2017. This rate is equivalent to approximately one claim for every five employees. Overall, the state had an average claim frequency of 4.8% during this time period, equivalent to 1 claim for every 21 employees.

Due to data limitations, we were unable to conduct additional entity-level analyses. In fiscal years 2008 through 2013, there were significant organizational changes in state government. As a result, we were unable to ensure an accurate alignment between each entity's employee and claim counts.

Factors Impacting the State's Financial Liability for Workers' Compensation

The state's claims payable liability for workers' compensation has grown over time and can be expected to continue to grow. The state has not billed a sufficient level of premiums to cover the program's annual expenses. The inadequate funding resulted in depletion of the Workers' Compensation Fund's reserves and limitations on the amount of claims that can be settled to help lower the liability. Factors impacting liability are discussed on pages 15-34.

We compared the state's workers' compensation program with similar programs, including workers' compensation programs in five other states and two group self-insurance funds in Georgia. We also obtained research on the workers' compensation industry as a whole in Georgia. The state's program was generally similar to the other programs we reviewed. Where we identified opportunities for improvement through these comparisons, they are noted in the applicable sections.

Claims may remain open or be re-opened for many years; these older claims represent a significantly larger portion of the expenses.

Claim Status

Open – Claim is active, payments are being made or are anticipated, and the claim has not been closed.

Closed – No benefits are being paid or are anticipated for the claim.

Re-Open – Claim was closed but has been re-opened to pay additional benefits.

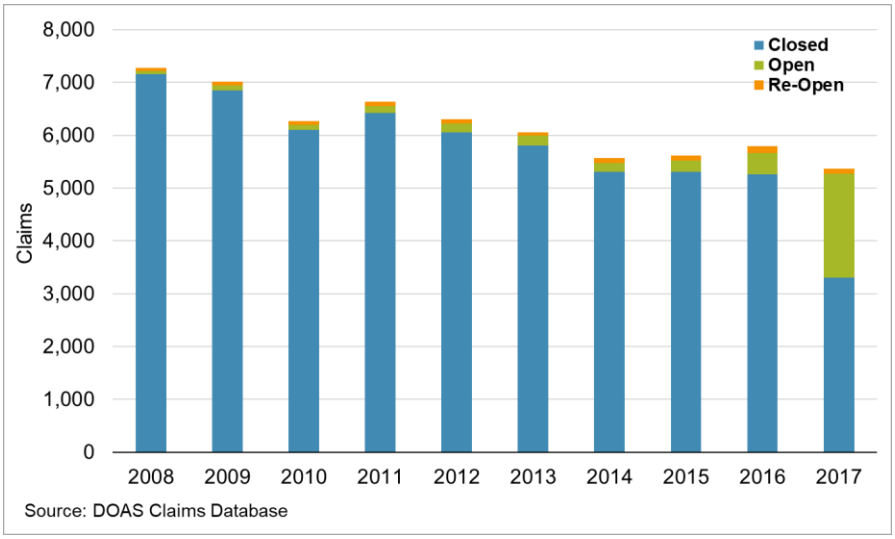
Claims remain open as long as the state is paying benefits or payments are anticipated. Claims are generally closed by the adjuster when the claimant reaches "maximum medical improvement"[6] and returns to work or when the claimant reaches the maximum week limit for indemnity benefits. While there are statutory limits on the benefits,[7] closed claims have the potential to be re-opened. A claim may be re-opened if the claimant is eligible for and requests additional medical treatment. Less severe injuries can be treated, and the claims can be closed, in a shorter period of time. As a result, claims that remain open for several years are likely to be the result of more severe injuries requiring more significant (and likely more expensive) treatments. Claims that remain open from previous years are also more likely to require indemnity benefits.

If the claimant and the state agree to settle the medical and indemnity portions of a claim, the amount paid is final, and the claim cannot be re-opened. **Exhibit 11** shows claims by status as of June 30, 2017, according to the fiscal year in which the claim was reported. As expected, fiscal year 2017 has the largest number (1,956) and percentage (37%) of claims with an open status.

[6] Maximum medical improvement is an industry term used to indicate full recovery or the point at which no additional improvement is expected.

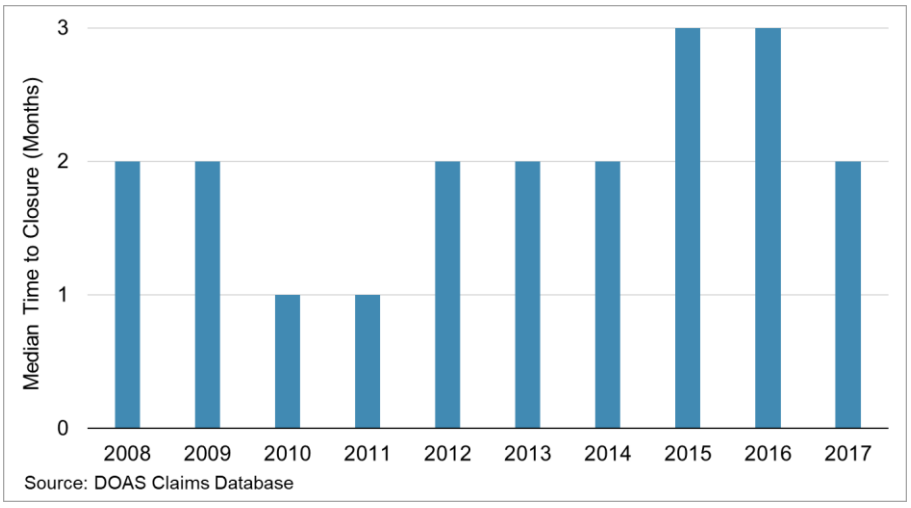
[7] Temporary total disability benefits have a time limit of 400 weeks (approximately 7.7 years), and temporary partial disability benefits have a time limit of 350 weeks (approximately 6.7 years). Medical benefits are not time limited if the accident occurred on, or before, June 30, 2013 or for catastrophic claims. Medical benefits are limited to 400 weeks for non-catastrophic claims occurring after June 30, 2013.

Exhibit 11
Number of Open Claims Falls as Claims Age
Fiscal Years 2008-2017



For claims that are closed, which means no benefits are being paid or anticipated, **Exhibit 12** shows the median number of months between the claim report date and the claim closure date, by the fiscal year in which the claim was reported. For example, half of the claims reported in fiscal year 2008 were open for less than two months and half were open for longer than two months. The median months to closure fluctuated over this time period, peaking in fiscal years 2015 and 2016. It should be noted that 38% of fiscal year 2017 claims remain open (classified as either open or re-open), so the median for this year may change. DOAS staff was unsure what caused the fluctuations, and the available claim data was not sufficient for us to determine the cause.

Exhibit 12
Median Months to Claim Closure Varied
Fiscal Years 2008-2017



Due to the larger number of claims, the median is driven by the time it takes to close medical-only claims. For fiscal years 2008 to 2017 the median time to closure was 12 months for indemnity claims and 2 months for medical-only claims.

As of June 30, 2017, the state's workers' compensation program had 4,974 open claims, including those that had been re-opened. These claims date back to fiscal year 1981 and include claims from every year from 1981 to 2017. **Exhibit 13** shows all open claims by the decade in which the claim was reported. Within the period 2010-2017, fiscal year 2017 had 2,059 (41.4%) of the 4,974 claims with a status of open or re-open.

Exhibit 13
Later Decades Represent More Claims with Open or Re-Open Status
As of June 30, 2017

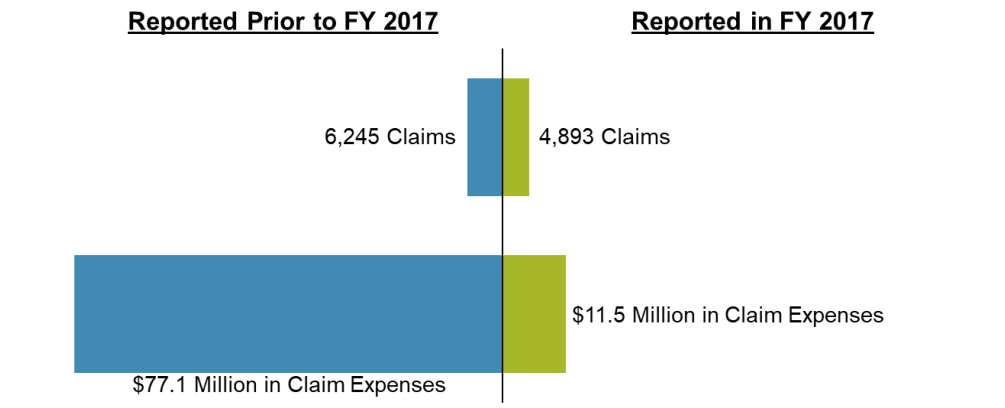
	# of Open[1] Claims	% of Open[1] Claims
1981-1989	47	1%
1990-1999	119	2%
2000-2009	761	15%
2010-2017	4,047	81%
Total	**4,974**	**100%**

[1]Includes claims with a status of "open" or "re-open."

Source: DOAS Claims Database

During fiscal year 2017, the state paid expenses for a total of 11,138 claims. As shown in **Exhibit 14**, 4,893 (44%) of these claims were reported in fiscal year 2017, and 6,245 (56%) were reported in earlier fiscal years. However, older claims represented a significantly larger portion (87%) of the claim expenses.

Exhibit 14
Old Claims Account for More Expenses
Fiscal Year 2017

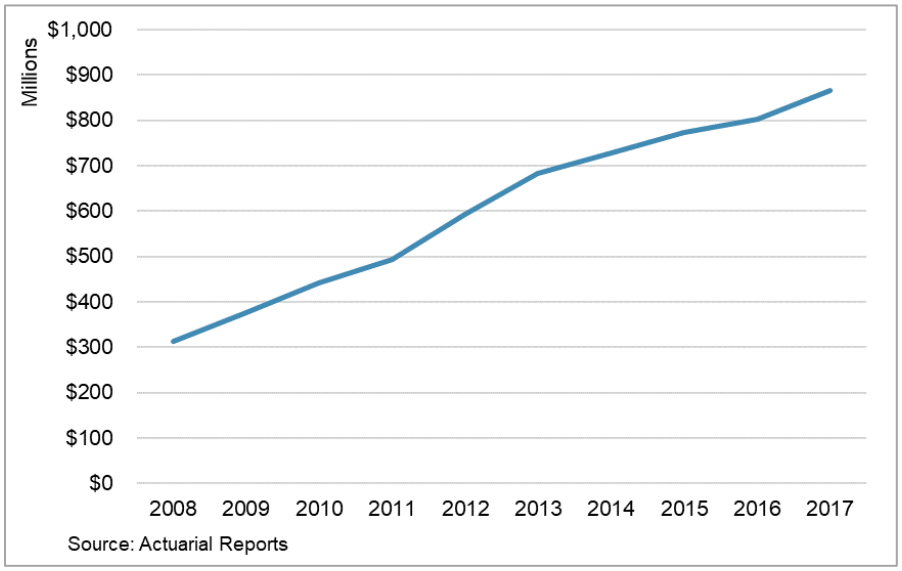


Source: DOAS Claims Database

The state's claims payable liability is growing.

The claims payable liability for the state's workers' compensation program has grown over time. **Exhibit 15** shows the state's liability at the end of each fiscal year from 2008 to 2017. The liability grew from $301 million to $866 million, an increase of 188%. The claims payable liability is the future claim expenses that the state must pay for accidents that have already occurred. The requirement that the state pay medical and indemnity benefits for its workers' compensation claimants for a period of time that may cover several years creates this liability.

Exhibit 15
State Workers' Compensation Claims Payable Liability Grew in Fiscal Years 2008-2017



Because the severity of a claimant's injury is not fully known at the time of injury, there is uncertainty around the amount of the liability. Adjusters estimate anticipated costs for each individual claim, but these amounts change continuously over the life of the claim. As a result of this uncertainty, DOAS hires an actuarial firm each year to provide an estimate of the state's total claims payable liability.[8] The actuarial estimate is reported in the state's Comprehensive Annual Financial Report (CAFR) in the Statement of Net Position for the Workers' Compensation Fund.

It should be noted that the amounts shown in **Exhibit 15** differ from amounts reported in the CAFR. **Exhibit 15** depicts the undiscounted liability estimate for each fiscal year. However, accounting standards allow for long-term liabilities to be presented in present value terms (discounted) in financial statements. According to governmental accounting standards, the discount rate used should consider both investment returns and inflation. As a result, the claims payable liability in the CAFR is lower than the undiscounted amount. For example, the undiscounted amount in fiscal year 2016 was $803 million, while the discounted amount shown in the CAFR was $540 million.

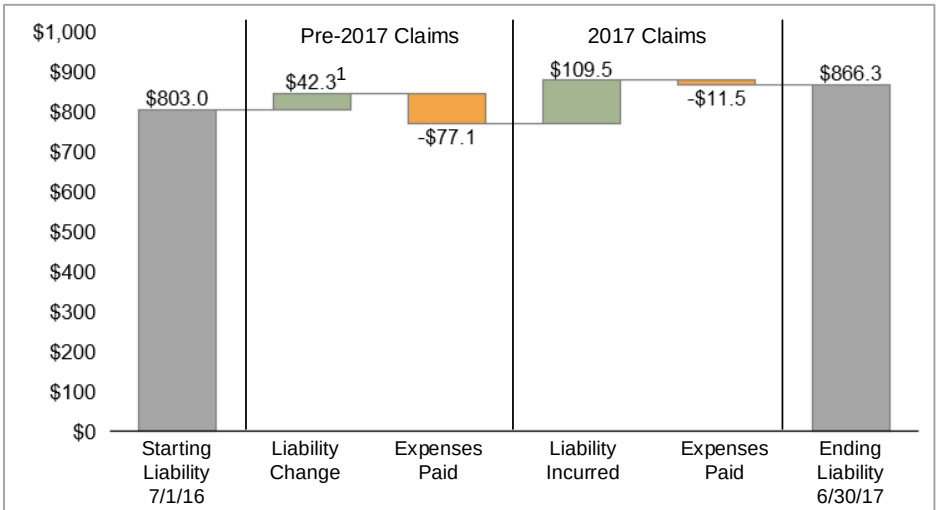
[8] The actuarial estimate includes claim benefits, such as medical and indemnity, as well as some administrative expenses, such as medical bill review and legal expenses. Administrative expenses are only included when they can be allocated to a specific claim.

As shown in **Exhibit 15,** the claims payable liability for the state's workers' compensation program grew steadily over fiscal years 2008 through 2017. The liability increases when the state accrues more new or additional liability than it pays out in claim expenses. **Exhibit 16** shows the change in the liability from $803 million at the end of fiscal year 2016 to $866 million at the end of fiscal year 2017.

The change in liability from one year to the next is a function of four factors, and **Exhibit 16** shows the estimated impact of each of these factors for fiscal year 2017.

- **Change in liability for pre-2017 claims** – Accidents occurring in fiscal year 2016 and earlier are included in the starting liability. However, cost estimates for these claims may change over time. The change may be positive or negative, but for the years we reviewed, the changes were generally positive, meaning costs were higher than earlier estimates and added to the liability growth.
- **Expenses paid for pre-2017 claims** – The state continues to pay expenses for claims incurred in prior fiscal years. These claims were included in the starting liability, and the expenses paid reduce the state's outstanding liability.
- **Liability incurred for 2017 claims** – The actuarial firm estimates costs for accidents occurring in the current fiscal year. The new liability represents the expected costs over the entire life of the claim. The liability for the new claims adds to the state's overall liability.
- **Expenses paid for 2017 claims** – The state also pays expenses for the 2017 claims incurred, with the effect of reducing the outstanding liability for these new claims.

Exhibit 16
Estimated Changes to Workers' Compensation Liability
Fiscal Year 2017



[1]This amount is an estimate based on the remainder of the liability change after all other factors were taken into account.

Source: DOAA Analysis of Actuarial Reports and TeamWorks Financial Reports

The change in liability is determined by the cumulative impact of all of these factors. If the state pays out more in expenses than it accrues new or additional liability, the

liability will decrease. Additionally, if the liability for older claims decreases, the overall liability may decrease as well.

Settlements can also impact the state's liability. Each individual claim's estimated outstanding liability contributes to the state's overall liability. If the state settles a claim for less than the expected lifetime cost, those projected savings would then decrease the state's overall liability. If the state were to increase its use of settlements over the long term, the actuarial analysis would take this change into consideration when projecting costs for new claims. As a result, future liability estimates would be lower.

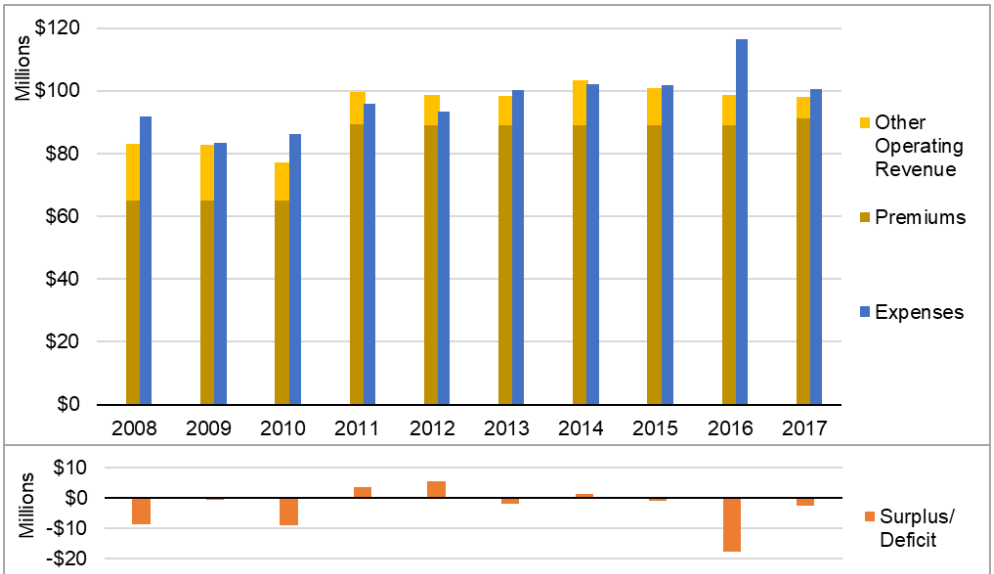
Premiums are not adequately set and have not covered program expenses.

According to DOAS, workers' compensation premiums and other revenue are intended to finance the anticipated expenses for the upcoming fiscal year. However, revenues have not been sufficient to cover program expenses. As a result, the program has repeatedly operated in a deficit. Premiums billed to covered entities are the primary revenue source. While the most critical component in setting premiums is estimating claim expenses, DOAS does not have an adequate process in place to estimate claim expenses and justify premium levels. These points are discussed in more detail in the following sections.

Insufficient Revenues and Premiums

As shown in **Exhibit 17**, the program has operated in a deficit for 7 of the last 10 fiscal years. The deficits have generally been funded by using the cash and investments in the reserves of the Workers' Compensation Fund. However, the Fund is now depleted. (The Fund depletion is discussed in more detail in the next finding.)

Exhibit 17
Workers' Compensation Expenses Exceeded Revenue
Fiscal Years 2008-2017

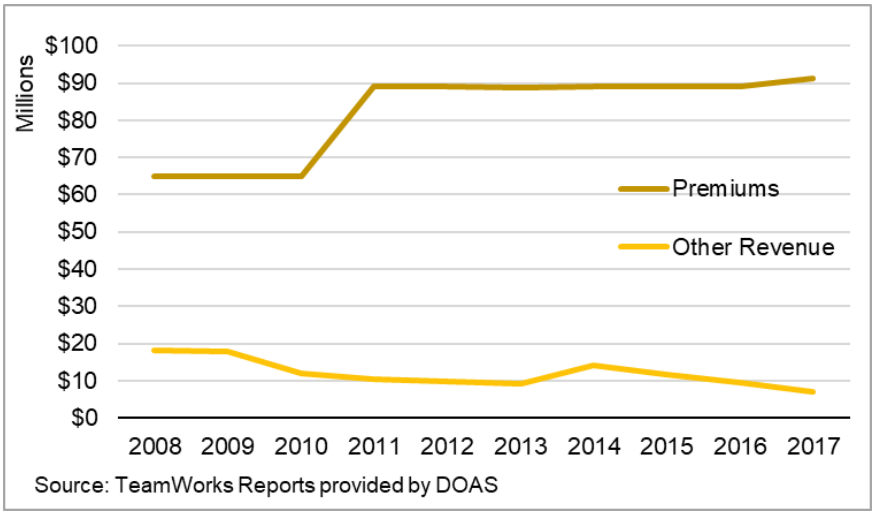


[1]These figures are based on actual revenues and expenses (cash flow basis of accounting) and not the liability incurred (accrual basis).

Source: TeamWorks Reports provided by DOAS

In fiscal year 2017, premiums represented 93% of revenue. As shown in **Exhibit 18**, premiums remained fairly stable over fiscal years 2008 to 2017, with the exception of a 37% increase in fiscal year 2011.[9] Other revenue, which is primarily SITF reimbursements, decreased over this time period. Other revenue also includes subrogation recoveries (when another party is at fault for an accident) and interest and gains on investments. The decline in the Workers' Compensation Fund reserves has had a negative impact on investment earnings as well.

Exhibit 18
Workers' Compensation Revenue
Fiscal Years 2008-2017



Source: TeamWorks Reports provided by DOAS

Premiums are allocated to the covered entities. Currently, the DOAS allocation method incorporates each entity's total payroll and its claim expenses over the prior three years. This consideration is intended to help align an entity's expenses/risk with its premiums and provide an incentive to lower claims. The other states we reviewed used varying methods to allocate premiums to state entities, but all incorporated payroll and claim history into the allocation method.

It should be noted that, while the state operates a loss control program, it does not adjust entities' premiums based on participation in the program. Practices in other states were similar. However, we identified two states that allow an entity to keep part of the savings if its premium decreases from one year to the next. Conversely, if the entity's premium increases, it is responsible for providing part of the increase from its budget. This incentive rewards or penalizes entities based on their workers' compensation costs. Implementing this practice would not impact the total premium amount required to fund the program; it would be a separate appropriation outside the workers' compensation premium-setting process.

Estimating Expenses to Set Premiums

To calculate the total funding level needed for the year, DOAS estimates the amount of claim expenses expected to be paid out that year and then adds administrative expenses. Administrative expenses include vendor contracts, program personnel, and

[9] According to staff, the increase in premiums was made to address cost increases and to avoid depleting the Fund reserves.

DOAS central administration. DOAS then subtracts an estimate for the revenue expected from SITF reimbursements. The net amount is the total funding level DOAS requests in premiums, which are approved through the annual budget process.

Claim expenses are the primary expense for the workers' compensation program, representing 87% of total expenses in fiscal year 2017. Therefore, accurately estimating claim expenses is critical to developing an accurate premium level. However, DOAS does not have a written policy or a clear procedure to estimate claim expenses and ensure that premiums fully cover program expenses. DOAS staff indicated that averages and trends from the past two to three years are used to estimate claim expenses. However, the staff was unable to provide the calculations or analysis used to estimate claim expenses.

It should be noted that while DOAS is statutorily charged with setting "…the necessary reserves needed [and] the premiums to be charged…," the funding request is subject to the annual budget process. As a result, DOAS does not have complete autonomy in setting premiums. For example, DOAS provided documentation from the fiscal year 2017 planning process showing a change in the premium amount of $4 million (from an original request of $93.1 million to $89.1 million). However, DOAS did not provide documentation for prior years, so we were unable to determine the frequency of these types of changes or what impact they may have had.

Setting Premiums: Liability Versus Cash Flow Methods

DOAS does not have a clear methodology for estimating claim expenses for the purpose of setting premiums; however, as part of its annual analysis, DOAS' actuarial firm estimates future workers' compensation claim expenses. The firm provides two perspectives on claim expenses that could be factored in to determining appropriate premium levels – liability and cash flow. The two perspectives differ in how they address expense timing when a claim's expenses stretch over multiple years.

- **Liability** – The actuarial firm estimates the total expected lifetime costs (liability) for claims incurred in the upcoming fiscal year. The liability amount is assigned based on the claim year and does not consider expenses from claims that occurred in previous years. If the state used the liability estimates, it would set premiums to cover the full lifetime costs for claims incurred during the year, and any surplus funds would be invested until needed.

- **Cash flow** – The actuarial firm also estimates expenses that are expected to be paid out in the upcoming fiscal year. These expenses may result from claims incurred during the year or in previous years. DOAS currently determines premiums based on a cash flow model, although premiums are based on DOAS estimates and not the actuarial estimates.

From a budget perspective, it may make sense for the state to utilize the cash flow approach instead of the liability approach. The same entities are covered by the state's workers' compensation program from year to year, so the same entities continue to pay for expenses even when claims stretch over multiple years. Under the cash flow approach, annual funding covers only the anticipated expenses for the upcoming fiscal year. As a result, DOAS must ensure that the premium funds are sufficient to cover program costs and that there are sufficient reserves in the Fund to address deficits if expenses exceed revenues.

Private sector insurance policies employ a liability approach by using premiums (and any subsequent investment income) to cover the full liability incurred for a policy year.[10] Covered entities may change from year to year as entities change insurers. By aligning premiums and liability, insurance companies can ensure that revenue earned in a year covers all incurred costs for that year. If DOAS billed annual premiums based on that year's expected liability, any surplus would remain in the Workers' Compensation Fund as reserves and be invested until needed. These reserves would allow DOAS to pay expenses as needed and to settle claims as beneficial. Only one of the five states we reviewed used liability as the basis for premiums; the other states operated on a cash flow basis.

It is important to note that any actuarial estimates are based on expected claim expenses. The actuarial firm provides central estimates based on long-term averages, and actual expenses may vary from these averages. Any funding approach must take into consideration the potential for fluctuations and ensure that an adequate cushion is built into the premium level so that the program will have sufficient funding.

Advantages of Billing Entities for Premiums

There are two benefits to billing premiums to fund workers' compensation instead of a direct state appropriation to the workers' compensation program – to aid in program budgeting and to maximize federal grant funding. The program budgeting concept requires all resources used for service provision be included in a program's budget to reflect the program's full cost over time. Workers' compensation premiums allow the state to align claim expenses with their respective programs. For example, the budget for the Department of Corrections' state prison program should include all costs for the prisons' correctional officers, including costs for workers' compensation claims. Additionally, premiums can be included in a program's budget as a reimbursable cost to help draw down applicable federal grant funding. If premiums do not cover the full cost of claims, programs show artificially low costs and may not be able to draw down the maximum federal funding for which the state is eligible.

RECOMMENDATION

1. To ensure DOAS requests sufficient funding for its workers' compensation program, it should establish a standard procedure for estimating claim expenses, which could include utilizing actuarial estimates. Additionally, it should ensure that the total funding request (i.e., the annual premium level) reflects additional amounts, as necessary, for claim settlements, unanticipated expenses, and the Workers' Compensation Fund reserves. These processes should be documented in a written policy.
2. To provide additional financial incentive to covered entities, the General Assembly should consider allowing entities to keep a portion of the savings when their workers' compensation premiums fall.
3. To fully understand the state's workers' compensation liability and to improve transparency in the budgetary process, the General Assembly should consider requiring DOAS to independently report its estimates of reserve and premium needs.

[10] It should be noted that private insurers may discount the liability incurred to account for investment income earned between when premiums are collected and claim expenses are paid.

DOAS Response: *In its response to the first recommendation, DOAS noted that it has a documented process for making recommendations to the various budget offices for setting annual premiums and that it bills agencies in accordance with the funding provided in the appropriations bill.*

In its response to the second recommendation, DOAS indicated it disagrees. It noted that "to ensure adequate funding is available to fund ongoing costs of the program, all savings related to the Workers' Compensation program should be retained in the trust fund." It also noted that entities with federal grants have to return excess funds and/or savings to the federal government.

Auditors' Response: *Regarding the first recommendation, the DOAS processes for making its annual funding request to OPB and for billing agencies are not at issue. Rather, the issue we identified is related to the methods used to develop the funding request (annual premium level), which involve estimating the claim expenses and including additional funds to cover unanticipated expenses, settle claims, and build a reserve. These methods and procedures are not documented or transparent. While its request is subject to change under the regular budget process, DOAS is statutorily responsible for ensuring that its funding request is sufficient to cover program expenses and its methodology for estimating the components, specifically the claim expenses, is justifiable.*

Regarding the second recommendation, implementation of this incentive is more related to how an individual entity's workers' compensation premium is funded by the General Assembly. For example, under the current process, if the Department of Corrections' premium declines by $100,000 from fiscal year 2016 to 2017, its overall budget appropriation in fiscal year 2017 would also decline by $100,000. If this incentive was put in place, the General Assembly could choose to appropriate an additional $50,000 in the Department of Corrections' 2017 budget as a reward for reducing its premiums. The state benefits, and the agency is incentivized to continue its loss control efforts. If the premium increased, the Department of Corrections would be responsible for funding part of the increase from its budget. In neither scenario is the workers' compensation total funding level impacted.

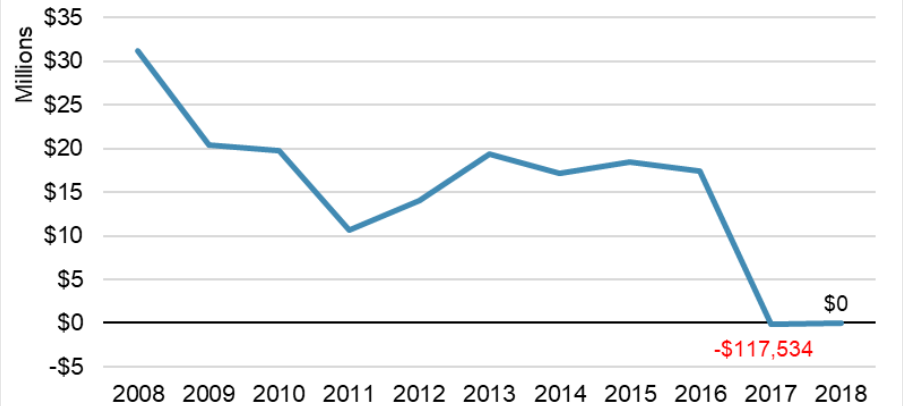
Fund reserves have been depleted.

If there is a significant increase in claims due to a large-scale incident, the program may be unable to make statutorily required payments because no reserves are available.

The program's repeated deficits have depleted its reserves, which hinders management of the program. Because of the depletion of the Workers' Compensation Fund, the program no longer has reserves to draw from if it were to experience a significant increase in the number of workers' compensation claims or if claim expenses were underestimated. Additionally, the lack of funding inhibits the use of settlements to close cases. If funding is available, the state can settle claims when financially beneficial. Any settlement savings are realized over the long term because the state pays more now to avoid higher costs in the future, over the life of the claim.

Historically, reserves from the program have been maintained in the Workers' Compensation Fund, where they are invested to generate additional funding for the program. As program expenses have exceeded revenue, Fund reserves have been used to cover the deficits. **Exhibit 19** shows the Workers' Compensation Fund reserves at the beginning of each fiscal year from 2008 to 2018. Reserves declined from a high of $31 million in fiscal year 2008 and were depleted during fiscal year 2016. In fiscal year 2017, the program again had a deficit, which was covered by a $2.6 million transfer from DOAS' State Purchasing Division.[11] DOAS expects the program to run a deficit again during fiscal year 2018. As a result, DOAS plans to request an additional $6 million in the amended fiscal year 2018 budget to address the deficit.

Exhibit 19
Fund Reserves Were Depleted During Fiscal Year 2016[1]
Fiscal Year 2008-2018



[1]Fund reserves are shown as of the beginning of the fiscal year.
Source: TeamWorks Reports provided by DOAS

Maintaining a target level of reserves in the Workers' Compensation Fund would help ensure the program has sufficient funding each year to withstand unexpected expense fluctuations. According to DOAS staff, the Fund does not have a target for the reserve level, and it has not had one in the past. As noted earlier, DOAS is statutorily

[11] According to DOAS, in June 2017, it requested and was granted authority by OPB to transfer these funds. Staff said that no documentation exists because approval was provided verbally.

responsible for determining the necessary reserve level. Staff stated they are currently working with OPB to develop a reserve target.

Our research did not identify a clear, single standard that the state should follow regarding the level of the Workers' Compensation Fund reserves. The state should set a target reserve level for the Workers' Compensation Fund that allows it to have sufficient funding for settlements and to withstand fluctuations in program expenses. The DOAS Risk Management Services policy manual states that staff shall make a recommendation for funding when the Workers' Compensation Fund balance drops below 75% of the discounted actuarial recommendation. However, DOAS staff indicated that this policy is not followed. At the end of fiscal year 2017, 75% of the discounted actuarial recommendation was $440.9 million.

One option would be to follow the security requirements of the Georgia Self-Insurers Guaranty Trust Fund (SIGTF). The SIGTF regulates private companies that self-insure for workers' compensation, so its security (and other) requirements do not apply to the state. The SIGTF requires self-insurers to file security that is the greater of the employer's reserves or twice the annual average of the employer's cumulative medical and indemnity benefits paid during the last three years. At the end of fiscal year 2017, the latter amount would have been approximately $182.7 million for the state's workers' compensation program.

RECOMMENDATION

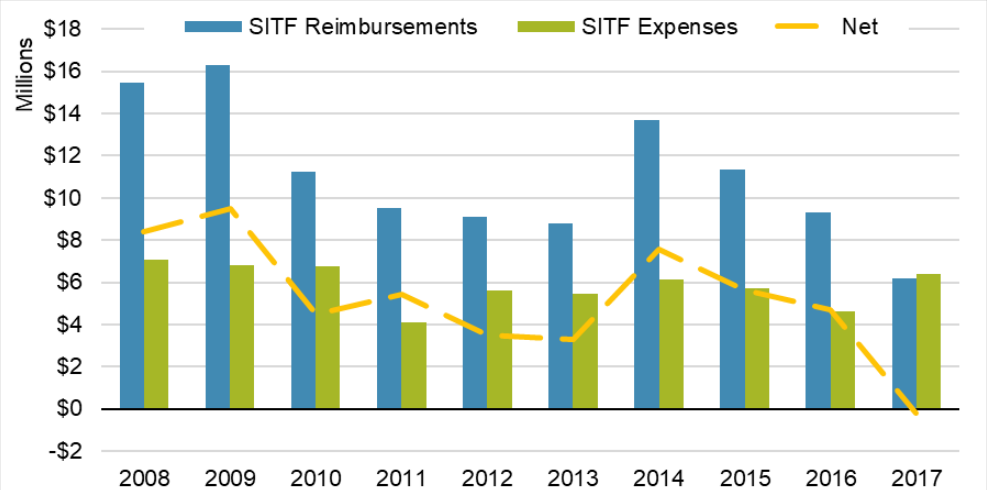
1. DOAS should establish a reasonable target reserve level for the Workers' Compensation Fund.

DOAS Response: *DOAS agreed with the recommendation to establish a target reserve level.*

Revenues from the Subsequent Injury Trust Fund have covered some of the shortfall but are declining.

As all employers subject to workers' compensation laws do, the state is eligible to receive expense reimbursements from, and must pay an assessment to, the Subsequent Injury Trust Fund (SITF). (Additional explanation of the SITF is included on page 7.) Program revenue includes SITF reimbursements for eligible claims. Program expenses include SITF assessments and fees paid to a vendor to assess claim eligibility and request reimbursements. As shown in **Exhibit 20**, SITF-related revenue exceeded expenses for fiscal years 2008 through 2016.

Exhibit 20
Net Income from SITF Is Declining
Fiscal Year 2008-2017



[1] Reimbursements are based on benefits paid for eligible claims, while assessments are based on all prior year benefits paid. The FY2017 assessment is higher due to higher settlement expenses in FY2016.

Source: TeamWorks Reports provided by DOAS

Because reimbursements have exceeded expenses, the net effect has been to contribute funding to the state's workers' compensation program. However, as shown in **Exhibit 20**, this source of funding has decreased over time, falling to -$219,151 in fiscal year 2017. The decrease is due to legislative changes. In 2005, the SITF statute was amended to end the program, and the last date of injury eligible for reimbursement was June 30, 2006. The SITF will continue to pay reimbursement for eligible claims until it is eliminated on December 31, 2023.

DOAS currently includes an estimate for the revenue from the SITF when setting workers' compensation premiums. As this source of revenue dissipates, it is increasingly important that workers' compensation premiums cover program expenses.

RECOMMENDATION

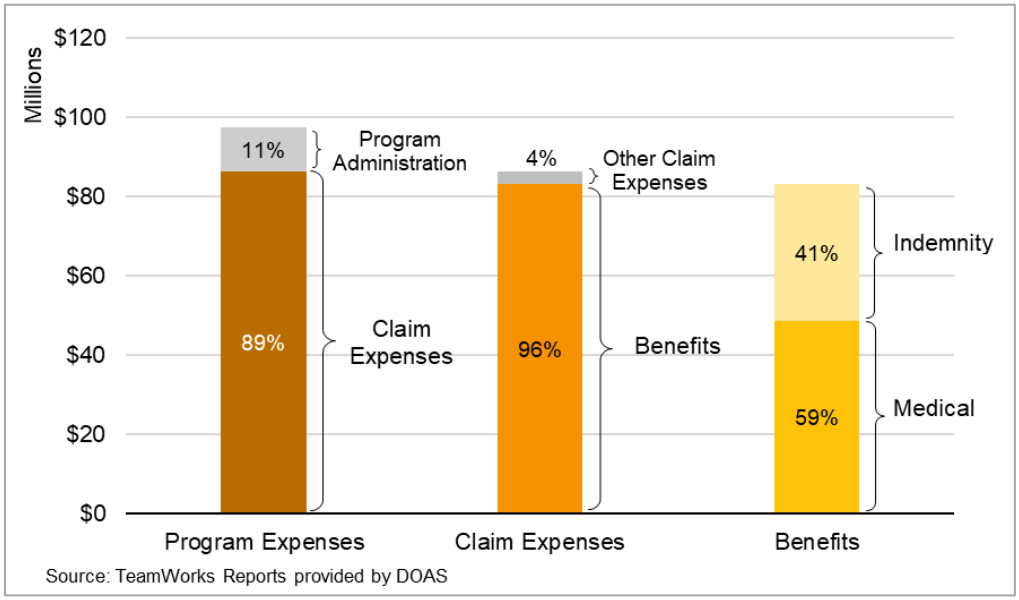
1. DOAS should consider the impact of the SITF elimination when setting premiums.

DOAS Response: *In its response, DOAS indicated it is aware of the sunset of the SITF program and the impact on current and future funding. It also indicated it is factoring the decline in SITF reimbursements into reserve projections.*

Medical and indemnity benefit expenses drive program costs.

Claim expenses are the largest driver of the workers' compensation program's costs. The primary components of the claim expenses are payments for medical care and income benefits. (See **Exhibit 21.**) Between fiscal years 2008 and 2017, claim expenses averaged 89% of program costs while program administration accounted for the remaining 11%.[12] During the same period, medical and indemnity benefits represented, on average, 96% of claim expenses. We found both medical and indemnity costs are increasing. Additional information on the cost drivers and trends related to medical and indemnity benefits are provided in the following sections.

Exhibit 21
Claim Expenses Are Primary Cost
Fiscal Years 2008-2017



Medical Benefits

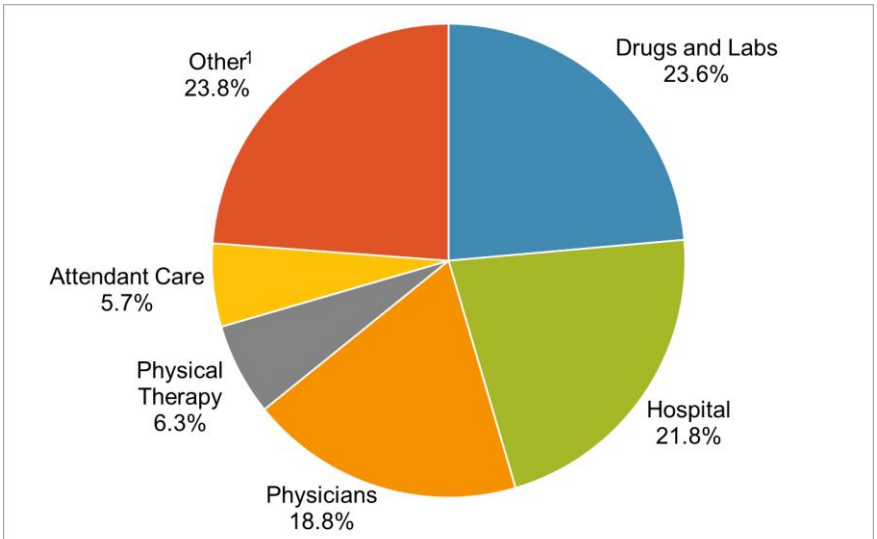
Medical care has been the largest benefit expense for the state, and these expenses have been primarily related to the provision of direct care. As shown in **Exhibit 21**, medical expenses averaged 59% of benefits paid for fiscal years 2008 through 2017, and ranged from 51% to 63%.

As shown in Ex**hibit 22**, the top three medical expenses are payments for drug and lab expenses, payments to hospitals, and payments to physicians. These three expense

[12] Expenses related to the third-party administrator providing adjustment services are included in program administration expenses. Expenses related to other vendors providing claim-specific work are included in claim expenses.

types made up 64.2% of medical costs in fiscal year 2017, and represented more than 60% of medical costs for each fiscal year from 2008 to 2017. The Other category in **Exhibit 22** includes items that each represent less than 5% of medical expenses, such as rehabilitation and medical case management.

Exhibit 22
Medical Expenses Are Driven by Three Expense Types
Fiscal Year 2017



[1]The Other category includes items that each represent less than 5% of medical expenses, such as rehabilitation and medical case management.

Source: TeamWorks Reports provided by DOAS

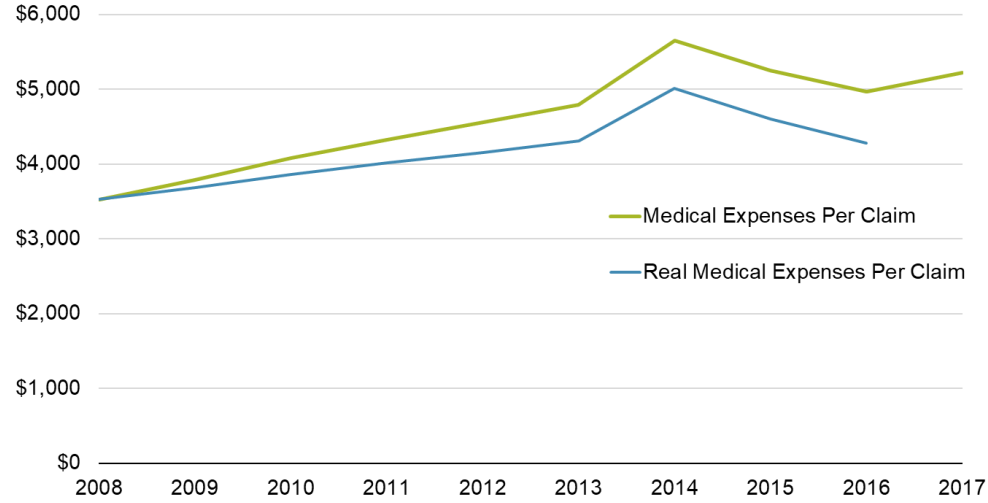
Under the workers' compensation law, the state is required to provide reasonable medical care prescribed by an authorized physician for the treatment of a claimant's injuries. Reasonable care is judged by the claims adjuster and the managed care organization nurse case manager who determine what treatments are medically necessary. Additionally, patient treatments go through an automated utilization review process to ensure they qualify. For example, a certain number of physical therapy treatments may be required prior to surgery being approved. It should be noted that if the claimant requests a medical treatment that the state denies, the claimant can appeal the decision to SBWC.

Individual treatment costs are governed by a fee schedule published annually by SBWC. The fee schedule includes the maximum amount that a medical provider can charge for each procedure, drug, or piece of medical equipment provided in the treatment for a workers' compensation claim. Additionally, DOAS utilizes a vendor that reviews each medical bill prior to payment. That vendor verifies the bill is within the amount allowed by the SBWC medical fee schedule. The vendor also provides access to its preferred provider network and its pharmacy network, allowing the state to access lower negotiated rates.

Costs for medical treatments increased between fiscal year 2008 and fiscal year 2017; however, general medical inflation does not appear to be the primary reason for this trend. We evaluated per-claim costs over this time period to assess the impact of

medical inflation. **Exhibit 23** shows the average medical expense for each claim with medical expenses in that year, on both a nominal and inflation-adjusted (real) basis.

Exhibit 23
Limited Impact of Medical Inflation
Fiscal Years 2008-2017



[1]The Personal Consumption Expenditures health index, published by the federal Bureau of Economic Analysis, was used to adjust for medical inflation. The index for 2017 is not yet available.

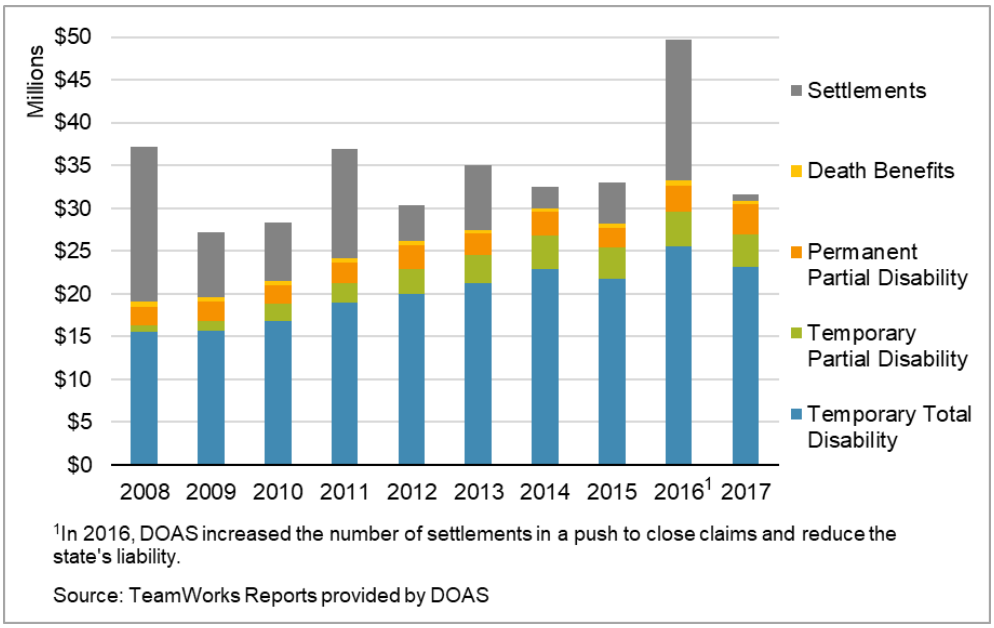
Source: TeamWorks Reports provided by DOAS and the DOAS Claims Database

If medical inflation were the only driver of medical cost changes, the inflation-adjusted medical expenses would appear as a straight, horizontal line in **Exhibit 23** because the inflation would explain all expense variations. The graph shows that the inflation-adjusted medical expenses are lower than the nominal values, indicating medical inflation did have an impact. However, the inflation-adjusted medical expenses still exhibit fluctuations and a general upward trend, following the nominal expense pattern. This pattern suggests that other factors, such as injury severity, have a significant impact on medical costs. DOAS staff indicated that medical expenses tend to be more volatile than indemnity expenses. For example, if more claimants require high-cost procedures in a given year, medical costs could fluctuate unexpectedly.

Indemnity Benefits

Indemnity benefits are the second largest workers' compensation expense after medical benefits. Indemnity represented an average of 40% of claim expenses over fiscal years 2008 to 2017. As shown in **Exhibit 24**, the largest component of indemnity costs is temporary total disability, which is equal to two-thirds of the claimant's wages and is paid when a claimant is unable to work due to his or her injury. Settlements were the second largest component of indemnity costs over fiscal years 2008 to 2017. DOAS staff indicated that claims are settled as funding allows, so settlements fluctuate from year to year.

Exhibit 24
Temporary Total Disability and Settlements Drive Indemnity Costs
Fiscal Year 2008-2017



[1]In 2016, DOAS increased the number of settlements in a push to close claims and reduce the state's liability.

Source: TeamWorks Reports provided by DOAS

When a claimant is able to work but only in a lower wage position, the claimant is paid temporary partial disability.[13] Expenses for temporary partial disability more than tripled over fiscal years 2008 to 2017, from $0.8 million to $3.8 million. However, temporary partial disability remains significantly smaller than temporary total disability, which was $23.1 million in fiscal year 2017.

We identified several factors that contribute to the overall increases in indemnity costs, including the number of claims receiving indemnity benefits each year, statutory changes to benefit amounts, and the length of time claimants receive indemnity benefits. We could not identify a primary cost driver, but instead, the combination of these factors is contributing to cost increases.

More claimants are receiving indemnity benefits than in the past, when older claims are included. **Exhibit 25** shows the number of claimants receiving indemnity benefits

[13] Temporary partial disability payments equal two-thirds of the difference between the claimant's original wage and the wage of the new position. The payments are limited to $383/week for up to 350 weeks.

in a given fiscal year, based on the date of the payment. In fiscal year 2008, the state paid indemnity benefits to 2,056 claimants, and in fiscal year 2017, the state paid indemnity benefits to 2,484 claimants, an increase of 21%. As noted on page 9, the number of claims reported each fiscal year has fallen over this time period. However, older claims remain open and continue to receive indemnity benefits as long as they are eligible under statute.

Exhibit 25
Claims Receiving Indemnity Has Grown
Fiscal Years 2008-2017

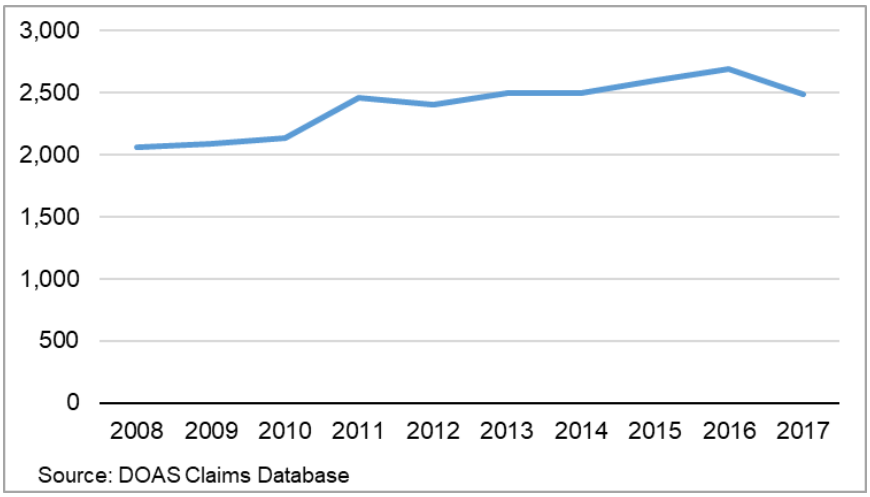
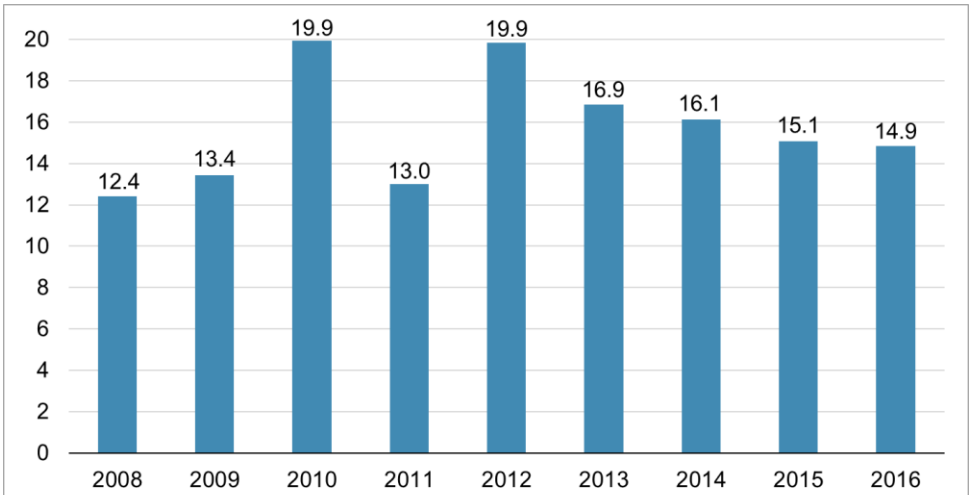


Exhibit 26 shows the median number of weeks claimants received temporary total and/or temporary partial disability payments, by the fiscal year in which the claim was reported to DOAS. These indemnity benefits provide replacement income to claimants who are unable to earn the same wage level as prior to the accident. The median number of weeks provides an estimate of the typical amount of time for claimants receiving these benefits to return to their prior earning capacity. As shown in **Exhibit 26**, the median number of weeks was higher for fiscal year 2016 claims than for 2008 claims. The median has declined from its fiscal year 2012 peak. Fiscal year 2017 claims were excluded due to the number that remain open.

Exhibit 26
Median Weeks Receiving Indemnity is Higher in 2016 than in 2008
Fiscal Years 2008-2016



[1]Graph is limited to temporary total and partial disability payments and is based on the fiscal year in which the claim was reported.

Source: DOAS Claims Database

State workers' compensation statute places limits on the maximum amounts paid for temporary total disability and temporary partial disability, and these limits were raised four times between fiscal years 2008 and 2017. While the statutory changes contributed to the increase in indemnity costs, these increases do not appear to be the primary indemnity cost driver because statutory changes do not apply to accidents that took place prior to the change. The workers' compensation law in place on the date of the claimant's injury determines the benefits paid, including indemnity amounts. For example, maximum weekly temporary total disability was $175 in fiscal year 1991, so a worker injured that year who was still receiving benefits in fiscal year 2017 would still receive up to $175 per week, or $9,100 per year. In contrast, a worker injured in fiscal year 2017, would receive up to $575 per week for as long as he or she received temporary total disability. In fiscal year 2017, 2,100 claimants were paid temporary total or partial disability payments, and 34 (1.6%) received the fiscal year 2017 maximum of $575 for total or $383 for partial. While statutory changes contribute to overall cost increases, the impact is limited by the small number of claimants receiving the maximum limits.

Data collection and availability inhibit the type of analysis that can be conducted.

In order to effectively manage the program, DOAS needs to collect and analyze additional information on cost drivers and trends, as well as claim characteristics. The claims management system has the capability to capture additional information at a detailed level for individual claims and aggregate this information in reports. However, as the system is currently being used, there are data elements that DOAS is not systematically collecting, elements that are captured but cannot be aggregated, and elements that are captured inconsistently. DOAS does not require adjusters to complete all available fields that could provide useful information.

As a result of the way the system has been implemented, claims data is not sufficient to inform management decisions. For example, DOAS cannot analyze factors such as how occupational risk affects claim frequency and severity. By conducting this type of analysis, DOAS could assess which factors impact program costs and may identify opportunities for savings. We identified three specific data points discussed below that DOAS could capture to improve its program management.

- **Injury severity** – DOAS does not collect information on injury severity. DOAS could use the *claimant type* field to capture this information. To do so, it would need to align the claimant type categories with a severity index and provide explicit instruction to users on selecting the category. Collecting this information would allow DOAS to evaluate trends (i.e., are injuries less or more severe than previously), which could inform loss control efforts and help identify cost drivers.
- **Return to work** – DOAS does not consistently collect information on whether claimants return to work and how long claimants are out of work. DOAS could require adjusters to use the date fields available in the data system to track this information and capture all claimants who missed time from work. Collecting this information would allow DOAS to identify entities that are not returning claimants to work, to evaluate trends, and to compare itself to similar programs.
- **Settlement potential** – DOAS relies on claims adjusters to identify candidates for settlement on a case-by-case basis but does not have a method for reporting on identified candidates. DOAS could make this identification part of adjusters' systematic case reviews using existing fields in the data system. Collecting this information would allow DOAS to quickly identify settlement candidates when funding is available. (Settlements are discussed in more detail in the next section.)

There are potentially other data points that could provide useful management information. It should be noted that whether DOAS begins tracking new data elements or not, it should review and revise its policies and procedures manual to ensure that claims are handled and documented consistently. The current manual is outdated. For example, it refers to the previous data system and provides insufficient instruction for some tasks. Staff indicated that they are in the process of revising the manual and anticipate it being completed by year end.

RECOMMENDATIONS

1. DOAS should ensure that it collects sufficient data to identify potential opportunities to reduce workers' compensation losses.
2. DOAS should review and revise its policies and procedures manual.

DOAS Response: *In its response to the report, DOAS indicated that it "agrees with and supports the report recommendation." It reported that it has begun to work with its third-party claims administrator vendor evaluating potential modifications of the claims administration systems that would enhance the evaluation of injury severity, return to work and settlement potential factors. It also noted that it has begun revising the existing policies and procedures manual and expects to complete the manual by December 31, 2017.*

Feasibility of Increasing Settlements to Lower Workers' Compensation Costs

Settlements have the potential to provide significant long-term savings to the workers' compensation program. However, DOAS has been limited in its ability to offer settlements due to financial constraints, which are discussed in the previous section.

It should be noted that both parties must agree to a settlement. If a claimant does not wish to settle the claim, DOAS must continue to pay for any benefits required by the state workers' compensation law.

Claims are identified and evaluated for settlement individually.

Claims are identified for settlement on a case-by-case basis. Settlements are generally identified one of three ways.

Claims may become harder to settle as they age. Industry representatives indicated that claimant willingness to settle is highest during the first two years.

1) The claimant or the claimant's attorney contacts DOAS or the claims adjuster to request a settlement. The claimant may request a specific amount to settle the claim and provide the starting point for negotiation.
2) The DOAS attorney from the Office of the Attorney General may identify a claim for settlement. The Attorney General is responsible for representing the state in any hearings before SBWC. The Office of the Attorney General may recommend the state settle these claims.
3) DOAS or the claims adjuster may determine that a claim is a good candidate for settlement. If claim characteristics indicate a risk of high long-term costs, DOAS may initiate settlement negotiations.

Once a claim is identified as a candidate for settlement, the adjuster or the DOAS attorney will complete a settlement evaluation that includes an estimate of anticipated future costs, also known as exposure. Based on this evaluation, DOAS will authorize a range of settlement values. The adjuster or attorney will then attempt to negotiate a settlement amount within this range. If the parties are able to reach an agreement, DOAS and the claimant sign a settlement contract, which is submitted to SBWC for approval. The contract generally prohibits the claimant from working for the state again in the future.

During our review of settled claims, we noted that DOAS policy regarding settlement evaluations does not specify the methodology for calculating exposure. Some of the evaluations we reviewed incorporated costs for legal and vendor expenses, while others included only medical and indemnity. Additionally, some evaluations calculated the present value of total costs, while others used the nominal value. Varying methods for calculating exposure could result in disparate settlement amounts for similar claims and inaccurate estimates of settlement savings.

Settlements are generally full and final, meaning that the settlement amount paid closes the claim, and the claimant will not receive any future benefits from DOAS, even if the claimant's condition continues or worsens. However, some settlements close only the claim's indemnity benefits. For these partial settlements, the state will continue to pay the claimant's medical expenses. A partial settlement may result when

a Medicare set-aside agreement[14] is required, and DOAS determines that the set-aside amount is too high for the state to fund.

RECOMMENDATION

1. To ensure consistency across claims, DOAS should establish a standard methodology for calculating exposure for settlement evaluations.

DOAS Response: *In its response, DOAS noted that it agrees with and supports the report recommendation. It indicated it has "begun to work with our third-party claims administration system vendor to evaluate current capabilities of the system that would enhance the evaluation and documentation of individual claims." It stated that it will "develop a standardized process of analyzing, reviewing and documenting the methodology within the system."*

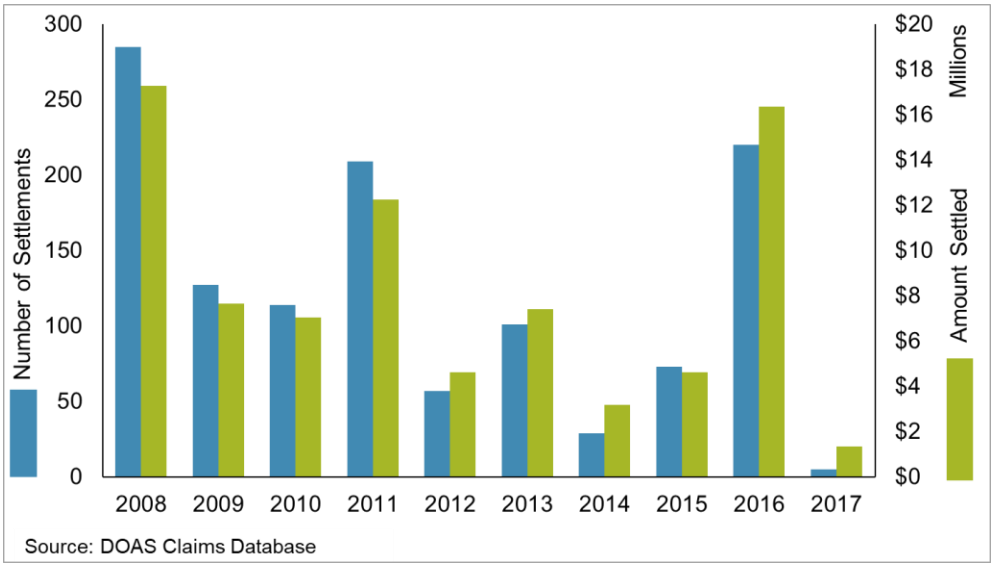
Settlements are limited by the lack of funding.

The Workers' Compensation Fund does not currently have any reserves to help fund settlements, and insufficient annual revenue puts the program at risk of depleting its funding for the year. As a result, DOAS is currently settling only claims eligible for SITF reimbursement. The SITF reimbursement limits the settlement's impact on the program's short term cash flow. Without sufficient funding, the state no longer has the option to settle other claims, and it must pay the statutorily required benefits each year the claimant is eligible.

Settlements have varied significantly over time. **Exhibit 27** shows the number and amount of workers' compensation settlements in fiscal years 2008 through 2017. During this time period, DOAS spent $81.7 million and reached 1,208 settlements. Because a settlement may close multiple claims, these 1,208 settlements closed 1,220 claims.

[14] A Medicare set-aside agreement is required when the claimant is a Medicare beneficiary or will enroll within 30 months. These settlements must set aside an amount for future injury-related medical costs, and the amount must be approved by the Centers for Medicare and Medicaid after an evaluation of the claimant's medical history and status.

Exhibit 27
Number and Amount of Settlements Have Varied
Fiscal Years 2008-2017



The decision to offer settlements is largely based on funding availability. As annual expenses repeatedly exceeded annual revenue, the Workers' Compensation Fund's reserves fell, and the state generally settled fewer claims. However, in fiscal year 2016, DOAS pushed to settle a large number of claims in an effort to reduce the state's outstanding liability and the number of older open claims. The large settlement total that year helped to deplete the remaining reserves in the Fund. After the reserves were depleted, the program had limited financial resources to settle claims.

While the state is settling some SITF claims, its revenue shortfalls can impact the number of these it can settle as well. SITF provides reimbursement for eligible claims as the state pays out expenses, once those expenses have exceeded thresholds specified in the law.[15] Therefore, when the state settles a claim, the SITF reimbursement offsets part, if not all, of the settlement expense, making the settlement possible. However, the state has to wait for reimbursement. Because the state has no reserves to provide the initial funds necessary to settle claims, this delay causes a cash flow problem. Further complicating this issue, the SITF is scheduled to sunset in December 2023. Once it ends, the state will no longer receive reimbursement for these claims. It is in the state's best interest to settle these claims prior to the SITF sunset to take advantage of the reimbursement. Otherwise, it can no longer utilize this source of revenue, but the state would still have to fund the claim expenses.

The state settles workers' compensation claims at a lower rate than other employers in Georgia but within the range of other states we reviewed. According to an industry publication, employers in Georgia settled 18% of indemnity claims within 12 months and 40% within 36 months.[16] During the same time period, the state settled 0% of

[15] The SITF reimburses for a claim's indemnity benefits after the employer has paid for 104 weeks (2 years) of benefits. The SITF also reimburses for 50% of medical and rehabilitation expenses between $5,000 and $10,000 and 100% above $10,000.

[16] Data cited was published by the Workers' Compensation Research Institute for claims occurring between October 2012 and September 2013.

indemnity claims within 12 months and 7% within 36 months. We also reviewed the number of settlements in five other states during fiscal years 2016 and 2017. Only North Carolina had a higher settlement rate than Georgia during this time period, due in part to additional funding appropriated specifically for settlements. Virginia and Tennessee each had settlement rates similar to Georgia's. The remaining two states settled no claims during this time period due to statutory restrictions.

RECOMMENDATION

1. The General Assembly and DOAS should ensure that the workers' compensation program has sufficient funding to allow claim settlements that are financially beneficial to the state.

Settlements generate long-term savings for the state.

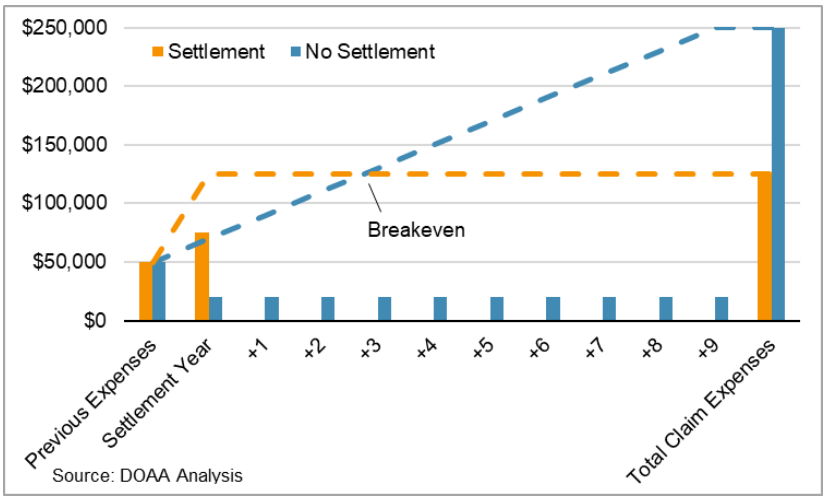
Because settlements are voluntary, DOAS can limit settlements to instances where it will be financially beneficial to the state. A settlement will result in savings to the state if the amount paid is less than future claim costs. Future costs are uncertain, but settlement savings can be estimated by comparing the settlement amount to the expected exposure.

Additionally, DOAS may settle if the claim or a portion of the claim is controverted. This situation may occur if DOAS has denied the claim or a portion of the claim (e.g., claimant alleges the accident affected multiple body parts, but DOAS disagrees), or if the claimant seeks catastrophic designation not granted by DOAS. If the claim or a portion of the claim is controverted and the claimant appeals the decision to SBWC, future claim expenses could vary based on the SBWC hearing outcome. In these instances, the state may settle to avoid the uncertainty and expense of a hearing.

Settlement savings result from cost avoidance. The state pays a smaller amount now than it anticipates paying over the full life of the claim. **Exhibit 28** shows a hypothetical scenario based on a typical claim settlement.[17] In this scenario, DOAS spent $50,000 on expenses for this claim prior to the settlement. DOAS anticipates spending an additional $200,000 over the next 10 years, or an average of $20,000 per year. If DOAS settles the claim for $75,000, it pays no additional expenses, and total claim expenses are $125,000. If DOAS does not settle the claim, it expects to spend a total of $250,000 on claim expenses. In this scenario, estimated settlement savings are $125,000 ($200,000 in future exposure minus the $75,000 settlement). Additionally, the state is able to eliminate the $200,000 in outstanding claims payable liability in the settlement year, versus a gradual elimination as the expenses are paid.

[17] To simplify the results, this analysis does not factor in the time value of money.

Exhibit 28
Example of a Claim's Settlement Savings Over 10 Years



It is important to note that a settlement generates savings over the long term but requires more funding in the short term. A single year of claim expenses is likely to be lower than the settlement amount because claim expenses can stretch over many years. In the scenario shown in **Exhibit 28**, the state does not break even until three years after the settlement. As a result, settlements can have a negative effect on the program's cash flow in the short term. This negative effect on cash flow has hampered DOAS' ability to offer settlements that would be financially beneficial to the state in the long term.

Settlement savings can be calculated using the exposure amount estimated during the settlement evaluation. However, the exposure estimate is not included in the claims database in a manner that can be aggregated. As a result, we were unable to calculate savings for a statistically significant number of settlements. DOAS staff indicated they do not track settlement savings on a regular basis, but they were able to provide savings estimates for a group of 250 settlements from fiscal years 2015 and 2016. For this group, savings ranged from $1,335 to $2,725,000 and averaged $152,680 per settlement. In total, DOAS spent $18.8 million and estimated the resulting savings at $37.9 million (202%). Due to data limitations, we were unable to validate these figures.

RECOMMENDATION

1. DOAS should track estimated savings for all claims settled.

DOAS Response: *In its response to the report, DOAS indicated it agrees with and supports the report recommendation. It noted it is working with the third-party claims administration system vendor to evaluate current capabilities of the system that would enhance the evaluation and documentation of individual claim costs and associated liability reductions when settlement agreements are executed.*

Appendix A: Table of Recommendations

Trends in Georgia's Workers' Compensation Claims History
Claim frequency has fallen, but average costs have risen. (p. 9)
No recommendation
Trends varied by claim type. (p. 11)
No recommendation
The number of claims by entity varies according to entity size and claim frequency. (p. 13)
No recommendation
Factors Impacting the State's Financial Liability for Workers' Compensation
Claims may remain open or be re-opened for many years; these older claims represent a significantly larger portion of the expenses. (p. 15)
No recommendation
The state's claims payable liability is growing. (p. 18)
No recommendation
Premiums are not adequately set and have not covered program expenses. (p. 20)
1. To ensure DOAS requests sufficient funding for its workers' compensation program, it should establish a standard procedure for estimating claim expenses, which could include utilizing actuarial estimates. Additionally, it should ensure that the total funding request (i.e., the annual premium level) reflects additional amounts, as necessary, for claim settlements, unanticipated expenses, and the Workers' Compensation Fund reserves. These processes should be documented in a written policy.
2. To provide additional financial incentive to covered entities, the General Assembly should consider allowing entities to keep a portion of the savings when their workers' compensation premiums fall.
3. To fully understand the state's workers' compensation liability and to improve transparency in the budgetary process, the General Assembly should consider requiring DOAS to independently report its estimates of reserve and premium needs.
Fund reserves have been depleted. (p. 25)
4. DOAS should establish a reasonable target reserve level for the Workers' Compensation Fund.
Revenues from the Subsequent Injury Trust Fund (SITF) have covered some of the shortfall but are declining. (p. 27)
5. DOAS should consider the impact of the SITF elimination when setting premiums.
Medical and indemnity benefit expenses drive program costs. (p. 28)
No recommendation

Data collection and availability inhibit the type of analysis that can be conducted. (p. 33)
6. DOAS should ensure that it collects sufficient data to identify potential opportunities to reduce workers' compensation losses.
7. DOAS should review and revise its policies and procedures manual.
Feasibility of Increasing Settlements to Lower Workers' Compensation Costs
Claims are identified and evaluated for settlement individually. (p. 35)
8. To ensure consistency across claims, DOAS should establish a standard methodology for calculating exposure for settlement evaluations.
Settlements are limited by the lack of funding. (p. 36)
9. The General Assembly and DOAS should ensure that the workers' compensation program has sufficient funding to allow claim settlements that are financially beneficial to the state.
Settlements generate long-terms savings for the state. (p. 38)
10. DOAS should track estimated savings for all claims settled.

Appendix B: Objectives, Scope, and Methodology

Objectives

This report examines the Department of Administrative Services' (DOAS), Risk Management Services Division's workers' compensation program. Specifically, our examination set out to address the following questions:

1. What are the trends in Georgia's workers' compensation claims history?
2. What factors impact the state's financial liability for workers' compensation?
3. Could the state increase its use of settlements to lower its workers' compensation costs?

Scope

This special examination generally covered activity related to the workers' compensation program that occurred from fiscal years 2008-2017, with consideration of earlier or later periods when relevant. Information used in this report was obtained by: reviewing relevant laws, rules, and regulations; reviewing workers' compensation vendor contracts and financial data; reviewing actuarial reports; interviewing DOAS staff and contractors; interviewing State Board of Workers' Compensation staff; reviewing professional organizations' information on workers' compensation; and surveying other states, as well as group self-insurance programs in Georgia.

Additionally, we analyzed data from DOAS' iVOS database, which is used to manage workers' compensation claims. We obtained data on claims reported in fiscal years 2008-2017, open claims as of June 30, 2017, and settlements and other payments made in fiscal years 2008-2017. DOAS also provided us with read-only access to the database to allow for additional review of individual claims. We assessed the reliability of this data and corrected obvious errors we identified, such as removing duplicate claim records. While we concluded that the information was sufficiently reliable for the purposes of our review, we did not independently verify the data. Although the data was subject to various sources of error, we believe it represents a credible estimate given the limitations of the data.

Methodology

To determine the trends in Georgia's workers' compensation history, we evaluated iVOS claims and payment data for fiscal years 2008 through 2017. However, we determined that the adjusters' estimates of claim severity (per-claim lifetime costs) in iVOS were not reliable for claims reported in recent years. Adjusters' estimates may develop over several years as the claimant's condition and related expenses become clearer. As a result, we utilized the actuarial reports provided by DOAS for fiscal years 2008-2017 to identify estimated claim severity and average loss per employee.

It should be noted that we defined indemnity claims by whether the claim data included any paid or anticipated indemnity benefits, and not whether the claimant missed time from work. Claimants do not qualify for wage replacement indemnity benefits unless they miss at least seven days of work. Additionally, the claimant may elect to use sick or annual leave for lost time and forego applicable indemnity benefits. As a result, the indemnity classification is not equivalent to a missed time classification, as some claimants classified as medical-only may have also missed time

from work. DOAS data does not currently track, in a manner that can be aggregated, which claimants miss time from work unless they also receive indemnity benefits.

Due to data limitations, we were unable to conduct entity-level analyses other than reported claims and claim expenses for fiscal years 2014 through 2017. In fiscal years 2008 through 2013, there were significant organizational changes in state government that led to the transfer of programs and personnel between covered entities. As a result, we were unable to ensure an accurate alignment between each entity's employee and claim counts. As noted above, we determined that the actuarial estimates of claim severity were more reliable than those in the DOAS claims database. However, the actuarial estimates were not available for the entity level. Therefore, we calculated entities' annual expenses for applicable fiscal years instead of claim severity for claims reported in those years.

To determine what factors impact the state's financial liability for workers' compensation, we interviewed DOAS staff and contractors about the claims process, premium setting, and cost drivers. We reviewed documents provided by DOAS, including the policies and procedures manual, actuarial reports, and financial reports generated from TeamWorks Financials. We also evaluated iVOS claims and payment data for fiscal years 2008 through 2017 and claims data for open claims as of June 30, 2017. We reviewed relevant laws, rules, and regulations to determine their impact on the liability and interviewed SBWC personnel for additional explanation of workers' compensation requirements.

To assess the difference between the actuarial estimates of the liability and the figures reported in the state's Comprehensive Annual Financial Report, we interviewed personnel from the State Accounting Office (SAO) and financial audit personnel from the Department of Audits and Accounts. We obtained documentation from SAO regarding the selection of the discount rate and reviewed applicable accounting standards.

To evaluate the impact of general medical inflation on workers' compensation medical costs, we used the Personal Consumption Expenditures health index, published by the federal Bureau of Economic Analysis. This index included the most comparable range of payers and goods and services in comparison to other indices we reviewed. To factor in the changing number of claimants, we divided all medical expenses for each year by the number of claims with medical expenses in that year to obtain an annual per-claim medical cost. The index was then used to adjust these costs for medical inflation.

As discussed on pages 33-34, the claims database does not include certain useful data points, or it collects the data in a manner that cannot be aggregated. This limitation prevented us from conducting additional analyses of the workers' compensation program, such as injury severity trends over time and the percent of claimants returning to work.

To compare the state's workers' compensation program with similar programs, we interviewed program staff in five other states – Arizona, North Carolina, Tennessee, Texas, and Virginia. We also contacted South Carolina but did not receive a response. These states were selected based on the size of the state's population and workforce, location in the Southeast, and a preliminary review of state law and program requirements. We also considered the level of public sector unionization in potential

comparison states, due to concerns that union contracts could result in dissimilar treatment of work-related injuries. We interviewed program staff in each of these states and reviewed documents to determine how premiums are set and allocated, what level of reserves are maintained, what loss control efforts are in place, and what incentives covered entities have to reduce claims. We also reviewed claim frequency, settlement frequency, and program expenses.

In addition to contacting other states, we also interviewed staff from the Association of County Commissioners of Georgia and the Georgia Municipal Association. These two organizations administer group self-insurance funds that provide workers' compensation insurance policies for local governments. We obtained similar types of information from these entities to what we obtained from other states.

To determine whether the state could increase its use of settlements to lower its workers' compensation costs, we interviewed DOAS staff and staff employed by the third party administrator regarding the process for identifying and evaluating claims for settlement. We interviewed staff in other states and at group self-insurance funds in Georgia to determine their settlement practices.

We used the settlement payment data that DOAS provided to determine the number and amounts of settlements during fiscal years 2008-2017. We reviewed a nonrandom sample of 14 of these claims in the iVOS database to better understand the settlement process. We also reviewed industry literature to identify a settlement rate for employers in Georgia and then evaluated iVOS settlement data to determine an equivalent rate for the state.

We were limited in our ability to calculate the estimated savings resulting from settlements because DOAS does not currently capture this information in iVOS in a manner that can be aggregated. We attempted to calculate settlement savings using adjusters' estimates for total claim estimates prior to the settlements. However, we determined that the data was not sufficiently reliable for this purpose. We also attempted to obtain the necessary data by reviewing relevant documents and adjuster notes within individual claim records in iVOS. However, we were unable to evaluate a statistically significant sample, given the timeframe in which the report was needed. As a result, we were unable to calculate savings for previous settlements and provide savings projections if DOAS were to settle additional claims. Although DOAS does not regularly track settlement savings, it did provide estimated savings for a group of 250 settlements from fiscal years 2015 and 2016. These settlements were part of the DOAS effort to reduce the state's outstanding liability. Due to the data limitations discussed above, we were unable to verify DOAS' savings estimates for these claims.

This special examination was not conducted in accordance with generally accepted government auditing standards (GAGAS) given the timeframe in which the report was needed. However, it was conducted in accordance with Performance Audit Division policies and procedures for non-GAGAS engagements. These policies and procedures require that we plan and perform the engagement to obtain sufficient, appropriate evidence to provide a reasonable basis for the information reported and that data limitations be identified for the reader.

Appendix C: Top 25 Entities by Claim Volume[1]

Entity	Fiscal Year 2014	Fiscal Year 2015	Fiscal Year 2016	Fiscal Year 2017	Total
University System of Georgia	1,338	1,350	1,344	1,280	5,312
Dept of Corrections	1,070	986	927	852	3,835
Dept of Juvenile Justice	532	596	893	741	2,762
Dept of Behavioral Health and Developmental Disabilities	791	680	600	575	2,646
Community Service Boards	316	314	336	327	1,293
Dept of Transportation	261	306	307	284	1,158
Dept of Human Services	210	264	273	228	975
Technical College System of Georgia	157	146	141	139	583
Dept of Public Safety	135	141	144	129	549
Dept of Public Health	124	124	133	118	499
Dept of Natural Resources	115	110	123	121	469
Dept of Driver Services	34	57	68	35	194
Georgia Forestry Commission	40	44	52	48	184
Georgia Bureau of Investigation	39	51	34	31	155
World Congress Center Authority	36	48	41	30	155
Georgia Ports Authority	41	40	37	36	154
Dept of Labor	31	48	28	34	141
Dept of Community Supervision[2]		3	47	81	131
Dept of Defense	33	24	20	45	122
Georgia Vocational Rehabilitation Agency	37	31	26	25	119
Dept of Revenue	22	35	23	28	108
Dept of Education	32	23	19	23	97
Dept of Agriculture	21	16	25	17	79
Dept of Community Health	13	21	13	17	64
Georgia Public Defender Council	7	8	22	9	46
State Total	**5,569**	**5,615**	**5,798**	**5,366**	**22,348**

[1]Claim volume is the number of claims reported in each fiscal year. The top 25 entities were identified based on the total number during this time period.
[2]While the Department of Community Supervision was not created until fiscal year 2017, earlier claims that were still open were transferred to the Department from the prior entity if the employee's position was transferred.

Source: DOAS Claims Database

Appendix D: Top 25 Entities by Claim Expenses[1]

Entity	Fiscal Year 2014	Fiscal Year 2015	Fiscal Year 2016	Fiscal Year 2017	Total
Dept of Corrections	$14,316,389	$17,589,607	$18,400,369	$16,589,664	$66,896,030
University System of Georgia	$10,718,486	$14,102,833	$14,079,174	$13,151,837	$52,052,330
Dept of Behavioral Health and Developmental Disabilities	$9,950,004	$11,494,661	$12,209,474	$10,828,457	$44,482,596
Dept of Juvenile Justice	$7,163,881	$8,754,616	$10,391,433	$9,732,981	$36,042,911
Dept of Transportation	$7,374,347	$5,809,430	$7,866,580	$5,164,324	$26,214,681
Community Service Boards	$4,293,252	$5,156,935	$6,154,344	$6,459,412	$22,063,944
Dept of Human Services	$2,529,702	$3,231,024	$3,814,997	$2,975,640	$12,551,362
Dept of Public Safety	$1,925,101	$3,441,375	$2,842,882	$3,201,104	$11,410,461
Dept of Natural Resources	$1,773,535	$2,052,096	$2,047,538	$1,994,688	$7,867,857
Technical College System of Georgia	$1,777,546	$2,187,405	$1,711,444	$1,845,523	$7,521,919
Georgia Ports Authority	$740,474	$1,142,485	$3,171,077	$1,542,640	$6,596,677
Dept of Public Health	$1,347,071	$1,516,794	$1,616,268	$1,263,517	$5,743,651
Dept of Labor	$794,731	$603,229	$1,408,169	$985,397	$3,791,526
Prosecuting Attorneys' Council of Georgia	$586,680	$727,502	$773,301	$665,697	$2,753,181
Georgia Forestry Commission	$559,427	$838,027	$552,510	$711,590	$2,661,554
Dept of Driver Services	$398,455	$687,706	$920,695	$533,092	$2,539,948
Dept of Defense	$684,306	$477,887	$450,031	$523,996	$2,136,220
Dept of Revenue	$323,071	$643,744	$472,960	$594,090	$2,033,865
Georgia Bureau of Investigation	$358,946	$547,488	$500,568	$503,760	$1,910,762
World Congress Center Authority	$362,544	$475,667	$449,549	$449,594	$1,737,353
Georgia Vocational Rehabilitation Agency	$357,454	$422,332	$456,982	$365,289	$1,602,057
Dept of Agriculture	$454,556	$356,391	$384,083	$396,273	$1,591,302
Georgia Military College	$429,069	$192,526	$232,168	$250,093	$1,103,856
Georgia Public Defender Council	$124,970	$144,914	$351,203	$354,235	$975,322
Dept of Education	$163,618	$156,972	$229,098	$229,570	$779,258
State Total	**$70,747,970**	**$84,013,288**	**$92,844,991**	**$82,961,669**	**$330,567,918**

[1]Amounts shown are the claim expenses paid out in a given fiscal year and not all expected expenses for claims reported that year. The top 25 entities were identified based on total expenses paid during this time period.

Source: DOAS Claims Database

Appendix E: Top 25 Entities by Claims per 100 FTE[1]

Entity	Fiscal Year 2014	Fiscal Year 2015	Fiscal Year 2016	Fiscal Year 2017	Average
Dept of Juvenile Justice	14.8	16.6	24.9	20.7	19.3
Dept of Human Services	6.4	17.7	18.1	2.3	11.1
Dept of Behavioral Health and Developmental Disabilities	13.2	11.4	10.0	9.6	11.0
Georgia Agricultural Exposition Authority	9.3	14.8	9.3	9.3	10.6
Georgia Forestry Commission	6.9	7.6	9.0	8.3	8.0
Dept of Public Safety	7.7	8.1	8.2	7.4	7.8
Dept of Corrections	8.3	7.7	7.2	7.5	7.7
Dept of Veterans Service	19.3	5.2	2.2	0.7	6.9
Dept of Driver Services	4.8	8.0	9.5	4.9	6.8
World Congress Center Authority	6.0	8.0	6.9	5.6	6.6
Dept of Transportation	5.9	6.9	6.9	6.4	6.5
Community Service Boards	5.8	5.8	6.2	6.0	6.0
Dept of Defense	6.0	4.3	3.6	8.1	5.5
Dept of Natural Resources	5.0	4.8	5.4	5.3	5.1
Georgia Bureau of Investigation	5.1	6.6	4.4	4.0	5.0
State Properties Commission	3.4	4.5	7.3	2.2	4.3
Georgia Ports Authority	4.2	4.1	3.8	3.7	3.9
Dept of Community Supervision[2]				3.9	3.9
Secretary of State	1.7	3.8	6.3	1.7	3.4
Dept of Agriculture	3.2	2.5	3.8	2.6	3.0
University System of Georgia	3.0	3.1	3.1	2.9	3.0
Dept of Early Care and Learning	1.7	3.8	4.3	1.7	2.9
State Accounting Office	3.8	0.0	3.1	4.6	2.9
Georgia Public Broadcasting	2.7	3.4	0.0	4.7	2.7
Dept of Education	3.5	2.5	2.1	2.5	2.7
State Total	**4.9**	**4.9**	**5.1**	**4.4**	**4.8**

[1]Rates shown represent the number of claims reported in a given fiscal year for every 100 full-time equivalent employees. The top 25 entities were identified based on the entity's average rate during this time period.

[2]The Department of Community Supervision was created in fiscal year 2017, so the average rate is equal to 2017's rate.

Source: DOAS Claims Database

The Performance Audit Division was established in 1971 to conduct in-depth reviews of state-funded programs. Our reviews determine if programs are meeting goals and objectives; measure program results and effectiveness; identify alternate methods to meet goals; evaluate efficiency of resource allocation; assess compliance with laws and regulations; and provide credible management information to decision makers. For more information, contact us at (404)656-2180 or visit our website at www.audits.ga.gov.