icare
Insurance and Care NSW

# Board Briefing

## Nominal Insurer (NI) Claims Strategy Update

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| Strategic Purpose | To provide the Board with an overview of our claims portfolio performance, the perceived drivers for notable changes relative to 2015 and the implications of these insights for our strategy and operating model going forwards |

## Recommendation and Actions

1. **Note** the lessons learned and management's hypotheses for the core drivers of deterioration in the performance of NI claims management relative to 2015
2. **Note** our approach to leveraging these lessons learned in current and future strategy
3. **Note** our proposed operating model principles guiding future design and management.

## Background and Context

At the Board meeting in August 2021 (**item 4.4**), management laid out the process and plan to work through the various issues and design phases with respect to the NI Claims model prior to a market-based RFP late in 2021 or early 2022. This paper is the first of the discussion pieces with respect to that design process.

icare and third parties have completed a number of reviews of the NI, and especially claims management performance within the NI. These include (but are not limited to) the Dore Report, the McDougall Review, the EY Review of The Nominal Insurer (on behalf of SIRA), the PwC Guide Segment Deep Dive (on behalf of icare) and the PwC Post Implementation Review (on behalf of icare and included as **item 4.4.1**)

Following these reviews, management has undertaken an analysis of our claims data, with the support of Finity, to understand the material shifts in performance since 2015. This analysis includes a quantitative assessment combined with qualitative review based on input from our management team and from key resources within claims service providers (CSPs) with in-depth knowledge of frontline operations. This report is a work in progress and the current draft is included at **item 4.4.2**

Combining this work with the previous reviews, management has considered the performance shifts in the context of our lessons learned to inform the development of our strategy, operating model principles and our approaches to operational management of the NI. This paper provides a summary of those observations.

## Issues and Analysis

Since 2015, total break even premium (BEP) within the NI has increased approximately $800m after normalising for exposure growth and occurring in the following areas:

- **$350m attributable to return to work (RTW) deterioration** – occurring across all cohorts including weekly payments, medical costs and occupational rehabilitation.

Document tendered by Hon Daniel Mookhey
Received by Mrs Kate Bogatova
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Resolved Yes / No

- **$190m attributable to superimposed medical inflation** – increasing almost 50% from 2016 – 2018 across all aspects of treatment (the root cause of which is yet to be fully understood and is a core focus of other work);
- **$130m attributable to the increase in psychological claims frequency and duration –** with frequency increasing by 2.4 times from a relatively low base at 2015 levels. Psychological claims now represent 20% of total claims cost and 6% of volume;
- **$70m attributable to higher than assumed assessments of injured workers exceeding whole person impairment WPI (>21%)** - returning to pre-2012 levels (based on assumptions inherent within BEP and the subject of ongoing monitoring); and
- *$30m attributable to changes in PIAWE legislation in 2018*

Analysis of our data assessed in the context of previous reports, the observations of icare's management and our claims service providers' management suggests a confluence of factors have compounded to drive the observed deterioration.

## 1. Management conclusion on the high-level drivers of deteriorated performance in the NI

### The 'cost-plus' remuneration model did not incentivise good performance against icare's objectives

Between 2017 and 2020 the remuneration model appears to have incentivised more active claims that ran for longer. The cost-plus approach created clear incentives to accept more claims, agitate for higher budgets and to approve requests rather than take on the additional overhead of the actions required to determine liability, reduce or cease benefits under the scheme.

Between 2015 and 2020 we observe that the scheme has a higher number of active claims and they have run for longer. Through this period, we also observe a materially higher claims acceptance rate and a material reduction in the completion of actions available to dispute liability, reduce or cease benefits under the scheme. We also note that the remuneration and operating models implemented sought to reduce administration costs and Claims Handling Expenses (CHE) as a key focus. It appears this focus has been achieved at the cost of significantly increased liability.

Following the observed effects, icare imposed greater focus on specific operational processes such as disputes and assessments resulting in Work Capacity Decisions (WCDs). However, performance deteriorated following the reduction of this oversight. We conclude that CSPs will not tend to act without direct financial incentives.

For the CSP there were limited financial implications for poor performance. This represented a disincentive for the CSP to invest in improved performance. An investment to improve performance would come out of CSP profit.

An amended remuneration model was implemented in 2020 which includes a slightly increased performance incentive linked to revised standards and measures. However, the overarching mechanism is the same and the degree of incentives 'at risk' remains significantly below what was the case under pre-2017 contracts.

### icare's culture of prescription and a lack of performance management focus further undermined performance incentives

icare provides the central system and prescribed the claims process to an extent that it disempowered case managers. This combined with the effects of the remuneration model left little

space for genuine continuous improvement. Further, this enabled CSPs to attribute inadequacy to icare, with no incentive to overcome it.

As performance deteriorated icare's response was to increase prescription, exerting greater control and oversight over specific aspects of the day to day operation of the scheme. This was not accompanied by a sufficient increase in performance management rigor, monitoring or reporting.

icare lacked a robust performance management capability, both in terms of people and the system functionality to effectively oversee the scheme. This manifested in a lack of clear accountability within icare, ineffective use of relationships between the organisations and a lack of a clear performance management strategy. This led to distributed, reactive and inconsistent management of the CSP.

## The segmentation approach is not delivering the anticipated benefits and has been diluted to a risk delineation approach rather than a differentiated support model

Though icare has exerted great control in specific areas, other areas of the service model have been inconsistently executed, opaquely refined or abandoned in favour of CSP approaches. An example is the triage approach which although implemented as intended, does not result in broad scale differentiated support within the Support and Specialised segments (representing the majority of claims expense).

The original icare triage and segmentation approach was built on the premise that injured workers have differentiated needs based on their associated risk, as determined by a number of factors relating to the worker and their employer. This is a standard industry approach and dictated four segments being, from lowest to highest risk: Empower, Guide, Support and Specialised.

It was determined that there was no discernible difference in the management of Empower and Guide claims which were subsequently combined. It was also found that the original risk threshold between Guide and Support was too high and the Guide segment was refocussed to lower complexity claims.

Over time, the service differentiation between the Support and Specialised segments also appeared in the most part to be non-existent. The specialised segment now represents a cohort of very complex or specific claim types such as psychological (not including secondary), fatalities, industrial deafness and complex medical cases.

The current approach is now effectively focussed on two segments, Guide and Support. The Guide segment is 'low complexity' claims with no or limited time away from normal duties, the Support segment is everything beyond that threshold, and the Specialised segment represents 'special case' cohorts based on specific attributes (rather than an assessment of multiple factors to determine risk).

The triage model appears to be effectively delineating against the revised segments. There are opportunities to continuously improve the risk factors and their use, as expected for any triage model. However, CSPs do not appear to be providing significantly differentiated case management in the Support segment based on the risk factors identified by the triage process – a key component of the service model.

The approach was largely 'injured worker focussed' with limited appreciation of the differentiated needs of employers. Larger employers will have many claims per year, mid-size employers may experience anything from two claims per year upwards and very small employers may only experience one claim throughout their career if at all (on average one claim per 25 years for employers under $30k premium).

Further, very small employers' claims (less than $30k premium) represent approximately 40% of total physical claims but approximately 50% of physical claims over 52 weeks duration (and 31% vs 35% for psychological claims). This effect, and the assumed difference in knowledge of the workers

compensation claims process, strongly suggests a need for differentiated service based on the size of the employer.

Challenges arose for larger employers who found it more difficult to manage a portfolio of claims distributed across multiple case management teams. CSPs have now implemented employer aligned models that allow an employer's claims to be managed by the same team(s). This could come at the cost of differentiated support for injured workers, though as previously noted this is not occurring anyway.

Further, the current employer aligned approach in effect only applies to approximately 50% of the NI's claims, as the other 50% are unlikely to have more than one open claim at one time. With regards to smaller employers, it is unclear whether EML (being the only CSP servicing this cohort) are delivering differentiated services to cater for the needs of this cohort. Though we note that if they are, the approach would appear ineffective as claims performance in these segments continues to deteriorate.

The shifts made to the approach over time appear to be risk management of icare's design, rather than a continuous improvement focus. In this context it is not clear whether the current operation is realising the benefits of either a prescriptive model or a CSP driven continuous improvement approach.

## icare's model appears to have contributed to a broad-based increase in active claims and duration and failed to effectively understand and manage psychological claims

Reiterating our observations surrounding the remuneration model and the increased number of active claims, their increased duration and the correlation of this with claims acceptance rates and the frequency of actions required to dispute liability, reduce or cease benefits.

This effect appears to have been driven in part by icare's service model, which focussed heavily on a customer service focus. This was further supported by our rhetoric and ethos of that time, which focussed on being a 'social insurer' that delivered 'a fairer scheme' based on 'collaborative non-adversarial approaches'. These drivers combined with the effects of the remuneration model appear to have resulted in more active claims that have run for longer.

icare's service and segmentation model has been particularly unsuccessful in managing psychological claims. The acceptance rate for psychological claims has increased significantly relative to 2015 and is significantly higher than all other states (though the root cause of this difference is not yet understood).

The service model dictated that these claims be managed exclusively by specialised teams. The intent was to recruit staff with previous experience in mental health rather than focussing on upskilling staff with existing experience in workers compensation. The recruitment and retention of this skill set at the scale and speed required proved challenging for EML. Additionally, the intensity of these roles presented challenges for the well-being of case managers. CSPs have since transitioned to enabling those case managers to manage a mixture of psychological and lower complexity claims.

Notwithstanding the need to ensure the safety of case managers, it appears that the model provides limited differentiation in the service of psychological claims. Further, case managers appear to be particularly reluctant to take actions available under the legislation to dispute liability, reduce or cease benefits in relation to these claims.

These challenges have likely been exacerbated by high attrition and a lack of incentives for the development and retention of talent discussed later in this paper.

## A lack of higher-level market forces further reduced performance incentives and reduced icare's ability to control the scheme

In a single-CSP model, the question of ongoing involvement became a binary 'yes or no', as opposed to a multi-CSP model in which each CSP can have greater confidence of ongoing involvement. This, combined with a 3-5 year term, removed investment incentives for further horizons over which investments could be realised.

CSPs do not underwrite the scheme, as such there is no overarching 'natural' performance incentive. The lack of a market model with a degree of competition (plausible potential to lose market share based on performance) meant there was no systemic protection against poor performance.

A lack of comparable CSP performance made it impossible to distinguish CSP performance from the performance of the icare system and the value (or lack thereof) of icare's design. Consequently, performance management and budget discussions focussed on each organisation attributing blame to the other one.

Further, the single provider model rendered many risk management and contingency options unavailable and provided further protection for poor performance for the CSP. icare had no higher-level levers beyond the contractual performance management framework agreed. In the absence of an ability to control the scheme from a higher level, such as the allocation of claims between CSPs, icare exerted a great deal of control over the day-to-day operation of aspects of the scheme.

In February 2020 icare implemented the Authorised Provider (AP) model to address large employer concerns and redress this balance in part, enabling large employers over $500k Base Tariff Premium (BTP) to choose their own CSP. However, the vast majority of claims relate to employers under the $500k Base Tariff Premium, meaning the AP model only moderately relieves this challenge.

## Low case manager capability is a systemic issue combining with remuneration incentives to drive higher claim numbers with longer durations

It is perceived that a lack of development pathways for all experience levels and more attractive prospects elsewhere is driving high turnover and attrition. Consequently, case manager tenure is considered to be significantly lower than before the current operating model was implemented.

Anecdotally our workforce are increasingly inexperienced and perceived to either not understand the steps required to fulfil critical case management actions or are unwilling to complete them due to the emotional toll associated with making determinations they perceive as detrimental to the injured worker.

Though case management capability is of paramount importance and must be protected and fostered going forward, we reiterate the effects of the remuneration model with regards to this point, which we perceive to be a more significant driver.

Other industries such as CTP and Life Insurance command salaries up to 25% higher (as observed in the Hays FY21/22 Salary Guide), for roles perceived to be less onerous. This, combined with the perceived disempowering impact of icare's prescriptive model, appears to create a compelling case for individuals to leave the industry.

icare's focus on reducing CSP remuneration may have effectively imposed a salary cap, misaligning case management salaries with other industries (if salary is the principal driver). Work is ongoing to understand whether this is the case or whether CSPs have paid less than the market via a strategy of attracting relatively lower skilled resources (or a combination of both drivers).

Considering these factors, it appears that icare either does not sufficiently value the craft of case management or has assumed that case managers will work for purpose, an assumption that appears incorrect.

The turnover rate for frontline resources since the implementation of a single CSP model has been enduring and significant (compared to historic levels, other jurisdictions and similar industries). This constant cycling of resources has reduced overall experience and driven notable case management instability which is perceived to have had significant impact on performance. This has been the subject of continuous discussion between icare and EML, though we conclude these discussions have been largely ineffective in resolving what seems to be a systemic issue.

Further, the remuneration model has not incentivised the development or retention of talent. If low talent equates to more claims that run for longer this would represent a financial gain for CSPs under the past remuneration model.

The 2020 extension negotiation resulted in a $20m co-investment in retention. These funds have predominantly been used to reduce case-loads which EML assert enables development of capability. This may be the case, however icare has not specifically monitored this expenditure or the business case behind it. As such, and noting the recent implementation of the investment, it is not clear whether this investment has resulted in improved capability or not. Notwithstanding the effectiveness of this investment, we conclude that the model would ideally incentivise the development and retention of talent, rather than require that icare negotiate to achieve it.

As a result of recruitment and attrition challenges, there has been a degree of cannibalisation between CSPs. This may have driven further case management instability, impacting performance. However, it may also allow for the retention of some case managers who may have otherwise left the industry, mitigating potential further performance deterioration. Further, this is a positive effect in an effective market as it distributes knowledge and sets a price for capability.

## 2. The future focus of our strategy to build on our lessons learned

### The remuneration model will demonstrably align CSP incentives with icare objectives

From a risk management perspective, we will assume that CSPs will act in the sole interest of financial gain. Our models will be aligned to the key determinants of RTW and health outcomes and incentivise the collaborative achievement of appropriate valuation outcomes.

Work is ongoing to gain an in-depth understanding of inherent complexities surrounding incentivising CSPs to achieve an appropriate balance across our objectives. The approach will leverage complementary remuneration and operating models working together to provide direct and overarching incentives.

Our remuneration models and contracts will also be established with a degree of flexibility to enable optimisation and an ability to adapt to undesirable effects as they are identified.

### We will leverage the ability of claims service providers to optimise claims and injury management, while understanding we must incentivise the right objectives

Claims service providers will always have more in-depth knowledge of how best to optimise their operation. Our job is to ensure that objectives and expectations are clear, to establish a model that promotes desirable behaviour, and to protect against undesirable effects.

Uplifting our performance management capability is essential. As part of our role we will focus on understanding what drives performance within the scheme and distributing knowledge across the

scheme (ensuring CSP investment incentives are not eroded by this action). This will be enabled by our centralised system and data.

We will shift to remove ourselves as prescriptive operational managers and become orchestrators of the claims management market and scheme (taking care not to impact performance during transition). Our focus will become the effective performance management of CSPs rather than overseeing and inserting ourselves into CSP processes.

Noting the broader and long-lasting scheme implications that can be associated with particular processes or actions, work is ongoing to understand icare's level of involvement or risk management approach to specific processes in any new or refined models. Further, we are considering the strategic and procurement advantages of options to engage third party service providers as part of this model.

This means that we will not prescribe to CSPs that they must differentiate service based on risk or how to do it. As an example of the model shift, we would set an expectation that we believe differentiated service is likely valuable and establish a model that incentivises differentiate service in the areas where it is proven to be valuable by the CSPs. Critically, we will support the CSPs through our data, systems, and processes to achieve the effectiveness and efficiency opportunities they identify.

Analysis supports the need to differentiate the approach to support employers based on their size or other attributes. The model will incentivise CSPs to identify these differences and develop solutions to service them most effectively. However, where the most advantageous approach requires enabling employers to choose CSP (or not), this requires icare to design and set the thresholds enabling the model.

Initial analysis suggests that choice is a strategic advantage for icare and larger employers. However, this does not appear to be the case for smaller employers where an allocation based on demonstrated CSP performance against specific segments may be more advantageous. Work is ongoing to understand how best to meet the differentiated needs of employer and injured worker segments in the design of the operating and remuneration models.

The proposed model and icare single system dictate that we must play a role in the allocation of claims between claims service providers. This is a capability that we do not perform in this way today and the development of our approach and capability is a key focus of our strategy.

Beyond this we must provide the data capture and functionality that enables claims service providers to triage, allocate and differentiate claims service within their own operation as they see fit. This is a notable shift in culture and capability for icare which would see parts of our organisation need to operate (to an extent) in a similar fashion to a service provider for the CSP.

Within reason, we must serve CSPs as best we can to enable their objectives in the context of all the demands and priorities we face. These considerations are complicated by the multi-CSP competitive model in which CSPs are to an extent reliant on icare to achieve their objectives in competition with each other. The cultural and capability shifts required are a key focus of ongoing design.

## We will introduce market forces positioning ourselves to protect our objectives and guard against systemic challenges

There is no such thing as a perfect remuneration model and in the absence of an underwriting incentive, higher level incentives are required to protect the scheme. For icare, the added protection is delivered via a multi-CSP model in which CSPs are rewarded with greater volume or specific claim types based on demonstrated performance in line with icare's objectives.

Within this model icare will enable CSPs to manage their operations as they see fit, incentivising the CSPs to continuously improve to maintain and grow their business. Critically, rather than prescribing service models to CSPs, icare will retain a stake in CSP approaches by establishing a model in which the most beneficial approach is for CSPs to work collaboratively with icare.

icare will provide to employers, injured workers, CSPs and any other interested parties, transparent performance data on all CSPs operating within the scheme. This will empower employers to make informed decisions about their claims portfolios. Further, it will enable the CSPs to manage their performance, continuously improve, identify opportunities to grow, and drive increased CSP ownership of their performance.

icare will protect against detrimental 'big bang' changes by incentivising CSPs to transition to new models over time and via a test, prove and shift approach which the model is designed to accommodate and encourage.

Work is ongoing to understand the optimal number of CSPs, how they are distributed and whether interim states are required. As part of this work we are considering how contract lengths within the NI claims space can be best used to support icare's objectives and the sustainability of the scheme. Management intends to share the progress of this work with the Board at a subsequent Board session.

### We will focus on fostering capability through all aspects of our strategy

Case management capability is a key foundation for performance in any model. Our focus is to ensure all aspects of our strategy support the development of case management talent. As an example, our transition strategy will focus on capability as a key determinant of the approach and pace. Further, our remuneration model will be designed to incentivise the attraction, development, and retention of good talent.

To overcome previous focus on reduced administration and claims handling expenses, increased remuneration may be required. This strategy (if required), would be implemented with sufficient performance focus and market effects to prevent the uplift being used to increased profit without the required improvement in performance. In line with this, work is ongoing to understand appropriate levels of remuneration that represent a positive commercial outcome in the balance of remuneration and achieving improved results.

We are focussing on the development of industry standards and qualifications for case management, leveraging our scale and government position to partner with education providers to enable qualification pathways. Critically, this focus will not be executed by prescribing to CSPs what we think they need, rather working collaboratively with CSPs to understand what is required.

As an overarching focus, we aspire to drive a cultural shift within icare and across the insurance industry that brings into focus the value of personal injury case managers. We will promote appreciation of the skill and experience required to be a great case manager and further establish the profession as a respected and fulfilling career.

## 3. The principles that will guide the development of our claims model

The starting point of our operating model review and (re)design process commenced with consideration of the principles which guided development of the current model (**item 3.1, March 2017**). This ensures we understand the original logic to inform a considered approach to change, retaining what we determine to be valuable while making shifts.

The original model design was predicated on an end state outcome where 'claims management [would] effectively be insourced (either directly or through a heavily controlled entity)'. Noting this, the original design and principles sought a high degree of control over the delivery and optimisation of the

customer experience. Specifically, the intent was to drive towards icare needing to 'own' the customer relationship, systems, and processes.

In consideration of this, our learnings described above, and the context of where we are today - our philosophy has shifted materially. Our strategy is shifting to focus on creating a CSP market that drives performance and gives icare increased influence over the scheme without a requirement to prescribe process. This shift clearly requires an associated shift in the principles that will guide our model.

These 7 claims management model principles will guide our design and management going forwards:

1. **We will create a market that rewards and provides confidence to the participants which deliver the best performance**
   - Service contract periods will give confidence to invest and reward long term outcomes
   - Transparent outcome and performance data will drive market reward
2. **We will deliver claims services through third parties unless there is demonstrable strategic value and/or a demonstrable performance advantage in icare delivering the service(s)**
   - Engage third parties to provide services, guided by common icare-defined scheme principles
   - We will govern, performance manage and orchestrate
   - icare will only operate where there is demonstrated strategic value
3. **We will retain process control only where beneficial to the scheme**
   - A single/common core system
   - Central scheme data infrastructure and management
   - icare will retain limited decision rights to protect against material risks to scheme sustainability
4. **We will promote and reward service that facilitates optimal employment and health outcomes**
   - Deliver to legislative and regulatory requirements with empathy
   - Align customer service focus with the achievement of return to work and health outcomes for employers and injured workers
5. **We will equip our customers and service providers with data, information and transparency**
   - Share information to remove power imbalance between injured workers, employers and CSPs
   - Drive market performance by making outcome and performance data transparent
   - Empower customers with the information they need to make more informed decisions if they wish
6. **We will limit disruption through transition, shifting in incremental considered stages**
   - Large scale transitions will be managed over time to minimise risk
7. **We will prioritise long term sustainable performance and financial sustainability over short term operating cost management**
   - Claims outcomes will be valued over unit operating cost

## *1. Strategy Implications*

N/A – Paper relates specifically to the development of strategy

## 2. Financial Implications

N/A – Part of ongoing and further work

## 3. Risk Analysis

The shifts described in the future focus of our strategy and our seven claims management model principles present a number of risks. These risks are a core focus of the ongoing work to further define our strategy and the models that will operationalise our intent.

- Failure to shift icare's culture to support the strategy could result in flawed execution and further deterioration in performance
- Failure to uplift icare's capability to support the strategy could result in flawed execution and further deterioration in performance (especially with regards to the continuous improvement of the model and the performance management of CSPs);
- Failure to implement in line with the required uplifts to icare technology, data and reporting could result in flawed execution and further deterioration in performance.
- Failure to establish the model and icare's technology with sufficient flexibility to enable the model may drive a high frequency of requests for technology changes and development, exceeding our capacity and making icare a barrier to competition and improved performance.
- Failure to appropriately design operating and remuneration models (and optimise over time), may result in sub-optimal customer and claims performance outcomes;
- Failure to effectively design the remuneration model and performance manage it may lead to increased CSP remuneration without the desired performance improvement intended;
- Insufficient understanding of our objectives and / or inadequate development of the operating model, remuneration model or setting of clear expectations may result in unintended and undesirable CSP behaviours;
- Insufficient understanding of the allocation of decision rights may result in lasting scheme impacts if not effectively risk managed (via the retention of those decision rights or other risk management approaches);
- Insufficient consideration and management of transition risk drivers may result in loss of front-line capability and / or deteriorated scheme performance as a result of transition; and
- Shifts made in response to current challenges without sufficient consideration may represent an over-rotation resulting in undesirable or unforeseen effects and / or the reintroduction of challenges pre-dating icare

## 4. Governance Assurance

N/A – Part of ongoing and further work

**Submitted By**

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