Exhibit A

Milwaukee County
2012 WC CLAIM AUDIT

Conducted By
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Milwaukee County

By – Gary A. Hayek and Glenn Mittelstadt

TPA Claim Audit Overview

An audit of 49 selected Workers' Compensation (WC) claim files was conducted during the weeks of June 18th and 25th, 2012. The purpose was to determine if the County's self administration of their WC claims was in compliance with their own internal guidelines, as well as comparing it to industry Best Practices for WC claims administration.

The claims to be audited were identified in advance. In addition to the physical files, the auditors also had access to the Riskmaster system in order to view all financial and transactional information as well as the adjusters claim notes. The files were reviewed to evaluate the technical attributes as a component of Best Practices claim handling procedures as outlined in the attached Audit Matrix (Page 3).

The claim files were reviewed at the County's Office of Risk Management in Milwaukee, WI. Following the review, the preliminary findings were discussed with Cynthia VanPelt, the Director of Risk Management.

The detailed audit reports are contained later on in this document (Page 4).

Summary Findings

The overall audit score was 54%. No files scored higher than 80%. 3 files scored 80%; 12 files scored between 70%-79%; 13 files scored between 60-69%; 3 files scored between 50-59%; 5 files scored between 40-49%; 7 files scored between 30-39%; 2 files scored between 20-29%; 3 files scored between 10-19% and 1 file scored 0%.

The individual audit category scores (% satisfactory) and findings were:

- CONTACTS (0%) – There were no 3 point contacts made on any of the files (100% failure). Claimant contact was initiated in the form of a contact letter. In most instances, it was days or weeks before there was any initial conversation with the claimant(s).
- INVESTIGATION (83%) – As every claims person is taught (or should know), an immediate and thorough investigation is paramount to the successful file management and ultimate controlling of claim costs. While most investigations/discussions were adequate in order to make a decision, several cases clearly reflected and lack of "curiosity" in determining and/or verifying the alleged circumstances of the particular case.
- RECOVERY/SUBROGATION (8%) – Generally, subrogation opportunities were identified. However, in several instances, while the potential had been identified, follow up work needed to be done but had not been addressed at the time of the audit.
- RESERVES (59%) – One adjuster scored 92% while the other only scored 28%. Bulk reserving seems to be the norm and stair-stepping was clearly evident. There was no reserve rationale documented.
- INDEMNITY BENEFITS (57%) – One adjuster scored 87% while the other only scored 26%. In a number of instances, the Indemnity benefits were paid late with no explanation provided for the delay. In several other instances, benefits were paid, but the claims were subsequently denied later on, thereby resulting in potential significant overpayments. It was also noted that there were several late payment penalties assessed by the State.
- MEDICAL BENEFITS (93%) – Most bills appear to have processed and paid on a timely basis.
- DISABILITY/MEDICAL MANAGEMENT (65%) – There was only scattered evident of any proactive claim handling. IMEs were not used with any great frequency. UR opportunities existed on many files, but did not appear to have been used at any time. RTW discussions were not documented. NCM intervention was appropriate on a number of files, but was only used sporadically. There was also limited use of Surveillance.

- DOCUMENTATION (57%) – One adjuster scored 84% while the other only scored 32%. Some areas of concern were the lack of documented conversations, follow up items and action plans were non-existent.
- REPORTING (78%) – One adjuster scored 96% while the other only scored 59%. State reporting was either late and/or not properly documented.
- LITIGATION MANAGEMENT (45%) – Corporation Counsel handles all litigation. There was little evidence of the extent (if any) of communication between the adjusters and Counsel. Nothing was documented to reflect how the litigation was being managed.
- DIARY (0%) – There was nothing in the files or in the claim notes to reflect diary frequency and what was being done. There is an automated diary function in Riskmaster, but is not being used. It is our understanding that diaries were being kept on a paper calendar. That is not considered to be a Best Practice within the industry.
- SUPERVISION (47%) – One adjuster scored 100% while the other only scored 16%. In many cases, the guidance, directions and/or recommendations that were being given were largely ignored.

Recommendations

While the County does have a set of guidelines (Required Workers' Compensation File Activities) for the handling of WC claims, overall, it does not meet the level of industry standards for Best Practices.

In order to effectively manage the WC claims and achieve the best possible outcomes, including financial results, it is essential that a uniform set of Best Practices be implemented. Best Practices are generally a mirror of those areas outlined in the next section of this report (Audit Matrix) on pages 4-5.

Included within Best Practices are some other areas that should receive additional focus, including:

- Creating templates to capture investigation, reserves, wage information, etc.
- Adjuster communication with department heads, supervisors, witnesses, during the pendency of the investigation.
- Electronic diary to be set in tandem with meaningful action plans focused on file resolution.
- Roundtable discussions of complex or potentially complex claims.
- Medical canvass and background checks on questionable red flag claims.
- IME and 2nd Opinion utilization be implemented on a proactive, not reactive, basis.
- More opportunistic use of Nurse Case Management.
- More frequent and/or documented communication between Corporation Counsel and Risk Management as to the status and/or strategy for handling the defense of WC claims.
- Data integrity is an important piece. Use of RTW fields and pay dates (to-from) are important, as is proper accident/injury coding, i.e., changing the coding when a strain/sprain becomes a tear and requires surgical intervention.

Another consideration should be to purchase Index Bureau services. Although the RiskMaster system does provide a claim history for injured workers, the Index Bureau would also provide information on any other "accident" related information, such as Auto or GL claims that might involve the specific employee. The cost is nominal, usually about $6 or $7 per submission for Indemnity claims.

Continued education for the staff is important. Most carriers, TPAs, medical management vendors and defense firms provide webinars and/or seminars, in addition to having e-newsletters available that provide jurisdictional updates.

Another significant consideration is the fact that, in our opinion, the current and historical claim volume does not support the current staffing levels. Industry average pending caseloads for Indemnity adjusters runs around 160-180 and for Medical Only adjusters, is around 250-300. Your current caseloads really only supports the need for 1 Indemnity adjuster and 1 Med Only representative. The Med Only representative could also be trained to take on additional claim duties, such as handling some of the very

small or simple Indemnity claims, i.e., the ones that only have minimal lost time, no PPD, no extended medical treatment and no litigation.

Finally, based on the deficiencies as identified by this audit, it is our opinion that there is probably in the area of 10-15% "leakage" in the overall payment of benefits and/or medical expenses.

If there are any questions or concerns about the results of this audit, please feel free to contact either of the undersigned for discussion and/or clarification.

Thank you for this opportunity to have been of service.

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Prepared August 3, 2012