Employee Benefits & Workers' Comp News

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Getting the Best Outcome from a Workers' Comp Incident

The definition of what is the best outcome has become more expansive in recent years.

First, let's define what we mean by best outcome. It's where the injured employee's discomfort is ®minimized, recovery is maximized, and the well-being of both the firm and employee suffer as little as possible. In the past, the employer's focus has often been primarily on minimizing cost and settling the claim as quickly and economically as possible.

But in recent years the focus has shifted in a more holistic direction toward the well-being of the employee. In addition to creating a more positive work environment, the employer benefits from reduced litigation costs and a more productive workforce because employees return to being productive members of the firm sooner.

The first step in the process is making sure in-

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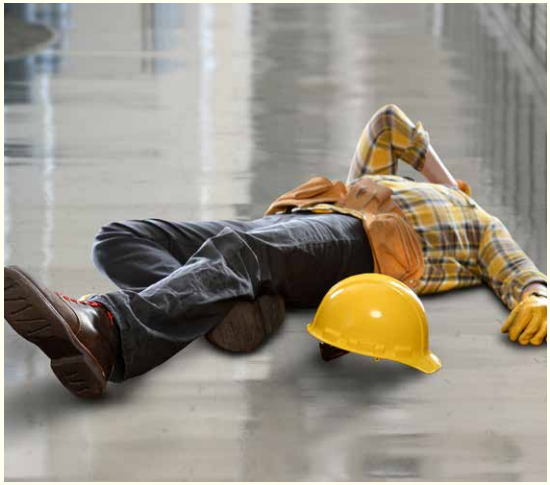

Future of the Cadillac Tax Running on Fumes

There's interest on both sides of Capitol Hill for the Cadillac Tax to be repealed and never enacted.

The Cadillac Tax was created as part of the Affordable Care Act to help fund benefits for uninsured Americans. Beginning in 2022, plan sponsors and insurers must pay a 40 percent excise tax on any employer-sponsored health plan costing more than $11,100 for employees-only or $29,750 for family coverage. Those costs likely will be passed on through copays and deductibles.

Although the name implies that the tax is only for rich benefit plans, many of the plans are modest and have high costs due to conditions that include geog-

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jured employees get help immediately with a quick evaluation of the injury. They also need answers to their questions, and most importantly, compassion. An empathetic representative of the employer, such as a registered nurse, should set the tone by making sure that not only does the injury get promptly attended to but also help the employee manage the paperwork and gain access to additional resources that may be necessary to ensure the employee's full recovery. It's important to be prepared to answer questions about job security, how the injured employee will get paid, how long they can expect recovery to take and so on in a caring, compassionate way.

Some of the other people with resources, capabilities and responsibilities who may be important in making the claims outcome more positive for everyone include:

Nurse Case Managers

- To monitor and guide occupational injury care
- To provide guidelines for managing effective treatment utilization.
- To act as a patient advocate
- To provide a non-threatening, friendly, professional relationship with the injured employee. Such support can identify and deal with any personal concerns and help reduce the risk of litigation. It can also help minimize any barriers to returning the injured employee to work, such as childcare issues or financial worries. These are all concerns that may impact the outcome.

Vocational Specialists

- To provide return to work strategies that fit the injured worker's individual claim circumstances.
- To help employees who have restrictions in their ability to perform work by setting up modified duty for them.
- To intervene when providers are not following sound guidelines related to returning to work.

Surgery Nurse Services

- To help injured employees facing surgery be better prepared physically and mentally, including instilling in them the confidence to achieve a faster recovery. This innovative approach is designed to focus specifically on the needs of patients dealing with surgery, which has historically been a significant driver of high-cost claims.

Physician Advisors

- To ensure that the appropriate treatments are provided based on the injury
- To support other key decisions regarding treatments, procedures, and other facets of injury management that can significantly impact a claim.
- To enhance the utilization review process,
- To provide medical and pharmaceutical expertise to ensure clients and their injured employees continue on the right path to achieve the best possible outcomes.

raphy, the number of female, older workers or dependents.

House lawmakers introduced legislation (H.R 748) this year to repeal the Cadillac tax, and during the 2017-2018 congressional session, more than 300 members from both parties in the House co-sponsored repeal legislation.

Lawmakers have already delayed implementation of the tax twice. Congress passed and President Barack Obama signed a delay of the Cadillac tax in 2015, changing the effective date from 2018 to 2020. Congress passed and President Donald Trump signed a delay of the tax in 2018, changing the effective date from 2020 to 2022.

Prescription Drug Management Advisors

- To help control the use of narcotics, opioids and other appropriate drugs prescribed to treat work-related injuries. This role, regardless of who performs it, is especially important because of the growing concern over misuse of pain medications.

Many if not all of these people and the functions they perform may be critical in getting the best outcome in a workers' comp incident. But it all starts with an empathetic listener to set the stage with the injured worker in a way that is comforting, positive and reflects the goodwill of the employer.

Please contact us if you have questions about how to improve your workers' compensation incidents claims handling. ■

Hospital Prices Now Must be Published Online – But is it a Game Changer?

Want to know how much a procedure is going to cost you at a particular hospital or medical facility? Look no further than the Internet.

The Centers for Medicare and Medicaid Services (CMS) previously required hospitals and other health care providers to make a list of their standard charges available to the public. New CMS regulations mandate that the pricing information for procedures and services also be posted online. Hospitals can use any format, as long as the information is accessible on the Internet and machine readable. The regulations went into effect at the beginning of the year.

A hospital's list of prices for billable items and services is called a Charge Description Master or chargemaster. Hospitals use the list to negotiate prices with insurers — therefore the list is more of a bargaining tool and not a realistic reflection of the actual cost of delivering a service.

The federal rule is intended to increase transparency and make it easier for patients to compare costs between facilities. The prices, however, only tell patients what a procedure will cost if the hospitals and insurance companies are out of network or do not have contract agreements.

Advocates for transparency point out that consumers would never buy anything at a grocery store or restaurant without knowing the price. Why would they want to get a medical procedure without knowing the costs or being able to compare prices?

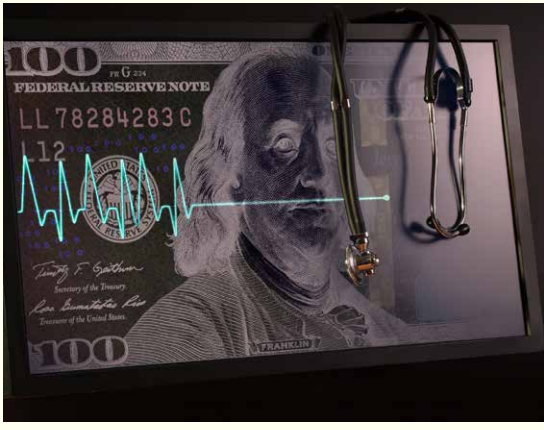
Challenges to Overcome

Patient advocates point out that the data alone might not necessarily achieve the goal of transparency.

Usually, only those who are uninsured pay the listed price. Individuals who have private health insurance pay a discounted rate for procedures if they go to a medical facility that is considered "in network." The facility charges a lower price and the insurance company covers part of the cost. The final bill depends on the patient's plan's co-pays, coinsurance and deductibles. Therefore, the list price won't tell a patient how much they'll really have to pay.

However, if a patient goes to a medical provider that is out-of-network, they might be "balance billed" the difference between what the chargemaster lists and what the insurance company pays.

Sometimes hospitals will use the threat of lists prices and balance billing a policyholder as a way to get insurers to negotiate with them and include them in their network.



Price shopping works best for elective, non-emergency procedures. For example, Lasik eye surgery prices have steadily decreased because of competition driving down the price more than three-quarters over 15 years. In 2017, Sen. Rand Paul, R-KY, pointed out that the average consumer wanting Lasik surgery calls four different doctors to compare costs.

Consumers also can check the prices for elective procedures such as physician office visits, lab and diagnostic tests and non-emergency surgery.

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However, price alone should not be the determining factor. Quality of work is also very important, along with how many procedures the facility performs; patient satisfaction rates; and recommendations of physicians and friends.

In addition, medical-industry pricing can be complicated when a patient doesn't understand medical terms. For instance, if your doctor wants you to have an MRI, you also would need to know whether the test will be done with or without "contrast."

Going Forward.

Since the price of a procedure often depends on the discount negotiated by an insurance company, many insurance companies have started to offer price comparison tools. However, these tools have their limitations. It's not always possible to compare prices ahead of time, particularly when there's an emergency. Also, other attributes such as location or a doctor's reputation are not accounted for.

There is also concern that the price comparison tool does not help at all. *The Journal of the American Medical Association* surveyed employees at two large companies in 2016 and learned that use of price comparison tools did not seem to lower health care spending for the companies' employees.

Keep in mind that even if you do look at the list prices to compare costs between medical facilities, they may not be be completely accurate. For example, Cartersville Medical Center in Cartersville, Ga., notes on its website that it doesn't guarantee the accuracy of the pricing information online. ■

How Workers' Compensation Claims Reserves Are Set

It's in your interest to make sure reserves are set as accurately as possible.

When a workers' compensation claim is filed with an insurance company or third-party administrator, the claims professional will try to establish the eventual cost to pay all expenses related to the claim. This is not only prudent business practice but required under insurance state and federal regulations, including the Sarbanes-Oxley Act of 2002.

In most situations most of the detail involving costs, such as medical, indemnity payments and legal expenses, if any, will not be available at the time the claim is submitted.

Nevertheless, a figure must be determined. There are two primary approaches to this. One (the "guesstimate") is based on previous similar claims. The second involves making a statistical reserve based on the average cost of all previous claims. Regardless of what the initial reserve is or how it was determined, claims examiners will regularly revisit the reserve and revise it based on information obtained about actual or reliable estimates of the actual costs.

For each claim the claims professional will set up a reserve worksheet where costs are itemized in three categories — medical, indemnity and expense (some insurers and TPAs break the expense category into legal expenses and non-legal expenses).

Medical

To establish the medical reserve, the claims professional will analyze reports to determine an estimate of the cost in the following sub-categories:

- Physicians
- Specialists
- Diagnostic Testing
- Hospitals
- Physical Therapy / Occupational Therapy
- Pharmacy
- Transportation (to/from medical care)
- Attendant Care

Most work comp claims will not require an estimated amount in every medical reserve category.

Indemnity

To establish the indemnity reserve, the claims professional will analyze the medical reports and discuss with the employer possible modified duty options to get an informed estimate of the claim cost in these sub-categories:

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- Temporary Total Disability
- Temporary Partial Disability
- Permanent Partial Disability
- Permanent Total Disability
- Vocational Rehabilitation
- Death Benefits
- Dependent Benefits

Seldom will the claims professional have a dollar amount of reserves in every indemnity category. Most files will have reserves in only two or three of the indemnity sub-categories. For example, one case file might include only reserve amounts for temporary total disability and permanent partial disability, while another file might show only the category of death benefits completed.

Expense

Expense reserve sub-categories include:

- Defense Attorneys
- Court Costs
- Court Reporters
- Experts
- Surveillance
- State Filing Fees
- Peer Reviews (some insurers and TPAs put this in the medical reserve)
- Independent Medical Examinations (some insurers and TPAs put this in the medical reserve)
- Medical Reports (some insurers and TPAs put this in the medical reserve)
- Medical Management Cost (medical fee schedule reviews, nurse case managers, triage nurses, etc.)
- Any Other Expense

Completing the Reserve Worksheet

To calculate the total reserve for the workers' compensation claim, the dollar amounts for medical, indemnity and expenses are combined.

But adding up the result on the reserve worksheet is the final step for reserving the claim. As new medical information or legal information becomes available that changes the medical prognosis, extent of the indemnity payment or the legal responsibility on the claim, the claims professional will review the reserves in all categories and make the necessary corrections, increasing or decreasing the reserve amount.

Goal: Make Claim Reserves Match Final Settlement

As attorney Rebecca A. Shafer points out in her workbook, *Workers' compensation Management: How to Reduce Costs 20% – 50%,* "The goal of reserving is to have the ultimate (final) value of the claim stated as soon as practical, with the understanding that the ultimate value of the claim is subject to change."

Rarely will the amount set for the total reserve and the final amount paid be the same when the claim file is closed. However, the goal of the claims professional is to strive to constantly ascertain as accurately as possible what the final settlement amount will be. It's an ongoing task that requires consistent, conscientious updating.

"Accurate reserving of the claim file is very important to the employer," says Shafer. "If the claim file reserves are too high, the dollar amounts the underwriter uses to calculate future insurance premiums are overstated causing the insurance premiums to be higher than it should be. When the reserves are set too low, an upward adjustment in the reserve amount has to be made in order to pay the correct amount when the claim is settled/concluded."

It's important to monitor your reserve adjustments. If your loss runs reflect large reserve adjustments of 10% or more to the total claim reserve, either up or down at the time of the claim conclusion, you should ask your insurer or third-party administrator to provide details. It's in your interest to make sure reserves are set as accurately as possible.

If you have questions about your workers' compensation reserves, please contact us. ■

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How to Determine Whether Your Voluntary Plans Fall Under Safe Harbor

Your benefit programs can have an exemption to ERISA if they meet certain requirements.

Don't assume you're in compliance with the Voluntary Plans Employee Retirement Income Security Act (ERISA) safe harbor rules just because you don't contribute to the cost of your employees' voluntary benefits. ComplianceBug, LLC, a provider of online risk assessment and compliance monitoring tools, reported that more than 80 percent of worksite and voluntary benefits plans are actually subject to ERISA. This is despite employers believing the plans were exempt from compliance requirements under the safe harbor rules.

Most employee benefit plans offered through a private employer are subject to ERISA. The requirements provide minimum standards for retirement plans, group health plans and other welfare benefit plans.

There is a safe harbor exemption (DOL Reg. § 2510.3-1(j)) from ERISA for certain voluntary plans such as life, vision, dental, disability, critical-illness and accident insurance. However, these programs can be subject to ERISA if the employer fails to meet these requirements:

1. Employee participation is voluntary.
2. The benefit plan must be completely employee paid. Salary contributions made on a pre-tax basis through a Cafeteria/Section 125 plan are employer contributions, so all employee contributions must be after-tax to meet the safe harbor.
3. The employer cannot endorse, educate or market the plan to employees. The insurer can collect premiums through payroll deductions.
4. Employers receive no compensation or profit from the program, although they can be compensated for administrative services.

Most employers have difficulty with the third rule. To be in compliance, employers must ensure that all documents or explanations of voluntary benefits are removed from the materials you give your employees about their benefits. For instance, you must have one packet for employer-provided plans and one for voluntary benefits in order to comply with Safe Harbor protection.

Talk to your broker or counsel if you have questions whether your voluntary benefit plans are subject to ERISA regulations. ■