

COMPENDIUM


PacificCompSM

California's Workers' Comp Specialist

www.pacificcomp.com

Broker news from Pacific Compensation Insurance Company

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Issue 1



Medicare set-asides – the next major cost driver

Many in workers' compensation today are wringing their hands over Medicare Set-Aside (MSAs) arrangements and their impact on increased claims costs. MSAs are negotiated with Medicare to set-aside a portion of a workers' compensation settlement to pay for future medical costs that otherwise would be paid by Medicare. These allocations add significant expense to an already overburdened system. Risk and insurance professionals must be fully informed and prepared to minimize the impact.

WHAT IS AN MSA? WHO IS AFFECTED?

An MSA is best described as an account set up to cover future workers' compensation medical costs for a claimant who is either receiving Medicare or soon will be. But because of the common misunderstanding about who may become a Medicare beneficiary, the downside risk extends far beyond individuals who are aged 65 or older and still in the workforce.

In fact, MSA allocations can involve three populations of claimants:

- Medicare beneficiaries aged 65+ who are still working when they are injured.

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EXECUTIVE VIEWPOINT



There's nothing old fashioned about the concept that "knowledge is power."

James E. Little

Chairman, President & CEO

The old line says "A little knowledge is a dangerous thing." If that's true, how much more competitive could a whole *compendium* of knowledge make a smart and savvy broker about workers' comp?

You probably know that *Compendium*, the name of PacificComp's new broker newsletter, isn't a made-up word. Derived from Latin, it means "a concise, yet comprehensive compilation of a body of knowledge." We chose this name to emphasize that one of the most useful added values you'll get from PacificComp is current, in-depth information and analysis about the most important legislative and regulatory issues in California workers' comp. Our intent is to bring you information and perspective that will raise your knowledge level and help your clients. Because it's true that knowledge is power.

Here's a preview of what you're going to find in our first issue:

- A major article on Medicare Set-Asides, or MSAs, the outcome of massive cost shifting for Medicare recipients still being

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EXECUTIVE VIEWPOINT

Knowledge is Power.

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treated for old, or not-so-old, workplace injuries. A statute in place since 1981, it was never enforced until the potential revenue stream back to Medicare appeared to be a “painless” way to address Medicare deficits. A national issue with far-reaching implications for insureds and insurers alike, it is one that we believe brokers and their clients need to be knowledgeable about and prepared for.

- PacificComp was honored late in 2010 by two different organizations for its technology innovations, at a time when we were on hiatus. Jon Siglar writes about how that came about, and how keeping our brokers’ interests front and center was the driver that earned those awards.
- Mark Webb, PacificComp’s legislative and regulatory expert, shares his views and analysis of the trends and developments in 2011 that he believes will affect workers’ comp, for better or worse.
- In each issue, we will feature a column by a different PacificComp senior manager or expert sharing some useful, current insight and information about the area he or she knows best. The first is from Joyce Schulman, Pacific Comp’s Vice President of Claims. Joyce talks about what PacificComp does on many levels to guard against negative outcomes. These range from actively listening to the injured worker from the beginning to better guide their recovery expectations, to our deliberate movement toward a “sports medicine” treatment model, which focuses on what can be done to get a valued team member back in the game quickly and safely.

We’d like to know what you think about *Compendium* and what topics you’d like to know more about. E-mail me at jlittle@pacificcomp.com or Jon Siglar at jsiglar@pacificcomp.com.

MEDICARE SET-ASIDES

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- Claimants aged 62-1/2 or older who will become eligible for Medicare within 30 months of a settlement.
- People of *any age* who are receiving Social Security Disability Insurance (SSDI) benefits, and will automatically qualify for Medicare after two years. In many cases, these individuals may be decades younger than 65.

WHAT’S THE IMPACT?

When extended medical treatment is required, the industry must use an MSA to protect Medicare’s future interests against the impending medical expenses. Now, new guidelines have stepped up efforts to ensure amounts “set-aside” are appropriate—in many cases, enough to cover injury-related care for the duration of the worker’s life. The biggest concern about MSAs is that the settlement must take into account Medicare’s exposure and not the costs associated with workers’ compensation benefits. For example, Medicare wants protection against average wholesale price (AWP) of prescription medications associated with the future medical costs of a workers’ compensation claim and not the costs that would be

charged under California’s workers’ compensation fee schedule.

Here’s one example: Previously, we might have settled a case at \$45,000 based on permanent disability rates and anticipated future medical exposure. Today, that same claim might have an MSA allocation alone of \$75,000, bringing the total potential settlement to \$120,000.

“Most troubling, once CMS makes a decision, it’s final. There is currently no appeals process or any other form of redress to ensure decisions are fair.”

DECISIONS ARE NON-NEGOTIABLE

Although MSAs affect a relatively small number of claims currently, the financial repercussions are significant. Regional offices of Centers for Medicare and Medicaid Services (CMS) review MSA allocations on a case-by-case basis. So far, industry reports say CMS offices have been overly conservative, aggressive, inconsistent, and inexperienced in estimating costs for long-term medical claims—increasing MSA amounts by 10 to 20 percent on average, and in some cases, by substantially more. Most troubling, once CMS makes a decision, it’s final.

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There is currently no appeals process or any other form of redress to ensure decisions are fair.

SOLUTIONS ON THE HORIZON

PacificComp is at the forefront of these critical MSA issues, helping to educate the industry about key requirements, challenges, and best practices. On January 1, 2011, we successfully launched our mandatory reporting process to CMS. With our industry-leading expertise in this area, we've pioneered the establishment of best practices to ensure Medicare-related claims are strategically managed. MSA amounts are accurately determined and settlement arrangements procured optimally to save costs. This may mean that the future medical payments will not be resolved by a Compromise and Release if Medicare's demands are patently unreasonable. Finally, we've led the charge in proposing legislative reforms, which, if successful, will make the MSA settlement process

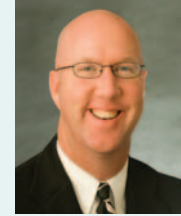
more streamlined and equitable.

PacificComp's comprehensive MSA strategy ensures a cost-effective and proactive approach for our policyholders:

- Accurate Medicare reporting.** Legislation recently added mandatory reporting requirements with respect to Medicare beneficiaries who receive settlements. With most policies, PacificComp assumes claims-paying responsibilities, and as a result, we comply with reporting requirements on our policyholders' behalf. The penalty for failing to report to CMS is \$1,000 a day per claim. Less savvy payers incur significant penalties and pass these costs to clients. At PacificComp, we successfully initiated our reporting process the first day of this year — which has allowed us to get ahead of the game. We've put advanced technology in place to support our reporting process and ensure an optimal level of accuracy, timeliness, and efficiency.

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INSIGHTS & UPDATES



PacificComp is officially declared "cool" and "innovative." But how will that help you?

Jon P. Siglar, ARM
Vice President/Chief Sales & Field Services Officer

At the end of last year, PacificComp was honored and delighted to be singled out by Novarica in its inaugural "Cool Capabilities Report" highlighting the development and implementation of our state-of-the-art agency management system, a result of our successful partnership with FirstBest® Systems. Only days later, *Insurance Networking News* handed PacificComp one of only nine 2010 INNovator Awards; ours was in Enterprise Technology. These awards were given to companies that "led or contributed to a business application or project that uses innovation to successfully drive business impact, technical impact or the innovation itself."

These would have been kudos at any time, but they were particularly welcome for their timing. As PacificComp has spent the last year retooling its business model to be broker-exclusive and taking a hiatus, we used the time not only to make an investment, but a commitment to technology specifically to make our brokers' lives easier. It's one thing for a company to make promises and shout them from the rooftops; it's quite another when respected third parties announce that not only is the promise in fact a reality, but an innovation that will make a difference for the brokers they do business with.

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PERSPECTIVE: CLAIMS



An Ounce of Prevention

Joyce S. Schulman
Vice President, Claims

There are many factors currently affecting the claims environment, ranging from consistently escalating healthcare costs and worry over Medicare Set-Asides (MSAs) to historically predictable increases in claims costs during the current economic downturn.

The escalating loss costs result from multiple factors. For example, it is no secret that the American population has grown increasingly more obese. It is well documented that obese individuals are more prone to accidents, more likely to have complications if they are injured and also more likely to have a slower recovery.

Regardless of whether a claimant is 25 or 65, slender or overweight, it is extremely important to know someone's state of health at the time of their injury. Conditions such as hypertension and diabetes can significantly influence the appropriate medical treatment and speed of recovery.

THE OBJECTIVE IS ALWAYS A POSITIVE OUTCOME

Once a claim is filed, we take specific steps to project its likely outcome. At the same time, we work with the medical team to optimize a treatment approach that will get the employee back to work as quickly as possible. We maintain close three-point contact with the physician, nurse/case manager and injured worker and believe that informed choices by the employee lead to better outcomes.

Part of the PacificComp three-point contact protocol is an interview with the claimant

on a psycho-social level conducted by a nurse/case manager staff consultant who is a workers' comp specialist. This interview, conducted as early in the life of the claim as possible, provides important indicators on how the claim should be managed to achieve the best possible outcome. The goal is not just to provide the appropriate medical treatment from the beginning of the claim, but also prepare the employee for reentering the workforce at the earliest possible time.

It's also vital to explore their expectations of medical care, which were formed from past events having nothing to do with the injury. In our extensive workers' comp claims experience, it is at the beginning, the inception of the claim, when the worker is likely to be the most candid and forthcoming about their current health status.

A SUBTLE SHIFT IN APPROACH AND TREATMENT FROM "INJURED WORKER" TO "VALUABLE TEAM PLAYER"

In terms of the medical evaluation, PacificComp is at the forefront of a movement in workers' comp toward a "sports medicine model" which differs both philosophically and clinically from the traditional approach. Historically, the protocol favored traditional evaluation and diagnosis of the injured worker leading to a treatment plan. The sports medicine model (as a point of reference, envision a valuable professional athlete with a sidelining injury) is geared toward both prevention and outcomes. How do we get this employee back to work, comfortable, in a manner that does not risk further damage, and also get the claim closed? The intent is to respond quickly when an injury occurs, assess its root cause, and implement a game plan that fosters a clearer path to recovery. It also incorporates the flexibility of closely monitoring the patient's progress so that if some aspect of the treatment is not working, it can be addressed and changed quickly.

MEDICARE SET-ASIDES

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- **Significant Medicare/MSA expertise.** With the complexities of Medicare and MSAs, your clients may wonder if they need additional expertise. At PacificComp, we not only serve as the Responsible Reporting Entity (RRE) on your clients' behalf, but we also have the medical expertise to properly advise, evaluate, and secure accurate MSAs.

Claims involving Medicare beneficiaries are typically very costly. Identifying these claims upfront is the first critical step to anticipating and managing potential Medicare liabilities. After the date of injury, we collect key data elements—such as the claimant's date of birth and Social Security number—and regularly submit eligibility queries to CMS to accurately identify Medicare beneficiaries.

We also have a Medicare specialist in-house, who provides quarterly training and ongoing direction to our claims staff regarding MSA issues.

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- Diligent and accurate negotiation and settlement process. PacificComp performs careful analysis of all proposed MSAs. For example, we've established best practices to ensure amounts are not only appropriate, but also clearly documented—which increases the likelihood for CMS approval. CMS bases its decisions on the physician's medical report. We work with our providers to ensure their reports explicitly delineate future medical care needs appropriate for the injury claimed by the injured worker. When possible, they must specify duration of care or any level of care that is deemed necessary and/or unnecessary for a case.

For example, the injured worker may require a prescription, but only for three years. Or the physician may believe surgery is unwarranted. Without noting these types of stipulations in the medical report, CMS may take a more conservative and aggressive approach by anticipating and including costs for lifetime use of a prescription drug or a surgical procedure into the MSA amount.

Our team also advocates for settlement options that maximize


savings. For example, we often propose structured settlements that leverage interest-bearing accounts to help pay for long-term care. With some cases, we know a proposed MSA amount is significantly higher than the claimant's future medical care will cost. Rather than a global settlement, we'll negotiate an arrangement in which the future medical component remains open, so we can continue to manage and control these costs.

- Support for legislative reform. The Medicare Secondary Payer (MSP) program requires significant reform. In 2010, PacificComp sponsored a California resolution, AJR 42 (Solorio), which called upon Congress and the President to enact H.R. 4796, the MSP Enhancement Act (MSPEA) of 2010. The objective of H.R. 4796 was to establish a fair and prompt process for Medicare-related settlements, so there are no unnecessary delays in the resolution of workers' compensation claims.

Key facets of the bill included the ability to create safe harbors for good faith reporting of claims to Medicare so as not to trigger substantial penalties, establish sensible recovery thresholds, provide payers with a right of appeal, and clarify the statute of limitations on Medicare recovery efforts.

H.R. 4796 did not get to the President in 2010. New legislation will shortly be introduced in Congress in 2011. Our hope is that every insurance professional will support MSP reform in order to get it high on the list of public policy goals in 2011. To learn more about reform, visit the Medicare Advocacy Recovery Coalition website at www.marccoalition.com.

As we move into the future, a growing number of people will likely fall into one of the MSA-affected populations we've defined: an aging workforce with both Medicare beneficiaries and those who will soon be eligible (44 million beneficiaries today, nearly doubling to 80 million seven years from now), and an increasing number of people who receive SSDI benefits and consequently will receive Medicare benefits. With these demographic factors, along with a lagging economy that historically results in a surge of workers' comp claims, the use and average amount of MSA allocations is expected to expand significantly.

PacificComp has implemented a comprehensive strategy to deal with the MSA challenge. Our brokerage partners and their clients can rest assured that we use an assertive, cost-effective approach to optimally control MSA-related costs—now and into the future. 



INSIGHTS & UPDATES


PacificComp is “Cool”

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So what does this “cool” capability and “innovation” mean for you? For one thing, we are determined to demonstrate to our brokers with actions and not just words that we’ve put our money where our mouth is. PacificComp has made technology investments to prove to our brokers beyond a doubt that we’re easy to do business with. In a competitive marketplace, if we don’t make your life and the lives of your producers and support staff easier, you may dial someone else’s number. So we put our broker hats on, put our management team in your shoes, and concluded there were three things we could do quickly that would make us stand out:

- Speedy and client-sensitive quote turnaround for both straight-through accounts and those requiring underwriting
- Direct access to human beings empowered to answer questions and solve problems, which means no unlisted numbers and no voicemail dead-ends. If the right person is not there or on another call, you won’t have to wait for the next snowstorm to hear back from them.
- Finding every way we can to reduce or eliminate “administrivia” for our brokers.

Those goals are at the heart of our business strategy and our desire to form a successful business partnership with each of you.

To read more about PacificComp’s recognition from Novarica and for the complete article about PacificComp’s award from *Insurance Networking News*, be sure to visit our website at www.pacificcomp.com, select the “News” tab and click on “In the News.” 

SACRAMENTO REPORT



Crystal ball + common sense: Likely and unlikely developments in 2011

by Mark Webb
*Vice President,
Assistant General Counsel*

Predicting is always a perilous process. The best information available, and a few hunches, can either prove prophetic or embarrassing when actual events unfold. This early in 2011, there are a few things we already know.

- The first is that the focus of policymakers in Sacramento is on the budget, and that enormous task relegates many issues to the back burner. A major workers’ compensation proposal, with increases in the amount of permanent disability (PD), would be difficult to enact given the current condition of the economy and the dire fiscal condition of local governments and school districts.
- We also know that there are a number of issues that were close to resolution in 2010 that are likely to reemerge in 2011.
- Even if a major workers’ compensation legislative package is not forthcoming this year, there is a possibility that progress can be made in helping to reduce the complexity of the system and address some of the emerging cost drivers that are driving up medical expenses.



CONSENSUS ISSUES WILL BE VISIBLE

Regardless of the timing of major workers’ compensation legislation, there will be opportunities to address consensus issues that drive significant administrative costs. The Commission on Health & Safety & Workers’ Compensation (CHSWC) and the Division of Workers’ Compensation (DWC) have been working for some time on a better benefit notice system. Legislation has already been introduced that would remove notices currently mandated by statute and vest discretion in the DWC to develop more rational notices. Assembly Bill 335, by Assembly Insurance Committee Chairperson José Solorio, is in response to this effort. In addition, the CHSWC published a major work on liens earlier this year, including recommended statutory changes. Whether this can fall into a “consensus” category, however, remains to be seen.

REINTRODUCTION OF LEGISLATION TO CURB COMPOUND MEDICATION ABUSES, CONTAIN COSTS

At the close of the 2010 session, legislation was introduced to try to curb the abuses evident in the use of compound medications. Compound

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SACRAMENTO REPORT

Crystal ball

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medications are supposed to be drug formulas that address specific needs of a patient who may be resistant to regular strength prescriptions. Because of loopholes in the pharmacy fee schedule adopted by the DWC, however, the use of compound drugs is increasing at a significant rate and is a major medical cost driver. Following a recent report by the CHSWC, expect legislation to be reintroduced in 2011 to address this issue.

“SURGERY” POSSIBLE ON OFFICIAL MEDICAL FEE SCHEDULE

Regulatory agencies, most notably the DWC, still have major rule-making initiatives that have yet to be completed. The most significant of these is changes to our antiquated Official Medical Fee Schedule (OMFS). There remains considerable debate over how best to update the OMFS. It is clear, however, that many costs associated with liens and bill review are driven by the difficulty in managing this schedule. Efforts to update the schedule and bring it more in line with the Medicare Fee Schedule are ongoing, but have been met with strong resistance from certain specialty medical providers. Also, the DWC was mandated to revise the permanent disability rating schedule (PDRS) by 2005. This long overdue revision could be a priority for the new Administration, even if it results in increased awards.

LIEN BACKLOG POINTS TOWARD LIEN CONSOLIDATION

The Courts also play a significant role in the system. In Los Angeles, the Workers' Compensation Appeals Board (WCAB) is attempting to address the considerable lien backlog problem through consolidation of liens that have common issues of fact and law. PacificComp is in the forefront of these efforts relating to interpreter liens. Resolution of lien issues can free up much


needed judicial resources at the local Appeals Board offices to resolve cases more expeditiously.

COURT DECISIONS COMPLICATE DETERMINATION OF PERMANENT DISABILITY

In addition, the Court of Appeal, First Appellate District, has before it the Ogilvie decision. This case, which has added considerable uncertainty to the PD rating process, has been fully briefed and oral arguments are set for April 13. Last year, the Court of Appeal, Sixth Appellate District, upheld the WCAB's decision on the use of the AMA Guides in the *Guzman* case. In November, 2010, the California Supreme Court declined review of the *Guzman* decision. The companion case to *Guzman*, *State Compensation Insurance Fund v. WCAB (Almaraz)* is pending review at the Court of Appeal, Fifth Appellate District. It remains uncertain whether *Almaraz* will be accepted for review. What is certain, however, is that these three decisions have

added considerable expense to the process of determining permanent disability, one of the main factors driving the increased severity in PD awards.

ADDRESSING FEDERAL MSA ENFORCEMENT A PRIORITY FOR PacificComp

PacificComp will also continue to support the efforts of the Medicare Advocacy Recovery Coalition (MARC) in Washington D.C. to bring about changes in the way Medicare enforces its rights as a secondary payer. The costs associated with Medicare set-aside agreements (MSAs) are exploding. As our workforce ages, this will be an increasingly important driver of medical severity. In 2010, Pacific Comp sponsored AJR 42 (Solorio), memorializing the support of the California Legislature for these efforts. As we start the 112th Congress, we will continue to work with all interested parties to move this issue to the President's desk. 



PERSPECTIVE: CLAIMS

An Ounce of Prevention

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The Claims staff at PacificComp is 100% certified and undergoes monthly training on business, legal and medical issues provided by a range of experts, including attorneys and physicians. All claims involving temporary disability are reviewed at a management level twice a month, typically resulting in faster resolution and less litigation.

PacificComp's claims strategy can be expressed in some fundamental steps:

1. Get the injured worker the right medical care as soon as possible.
2. The goal is always a speedy and healthy return to work.
3. Recognize when there is likely to be a problem with the claim as early as possible to mitigate the potential downside risk.
4. Address the medical vs. legal issues quickly, thoroughly and proactively.

In the long run, a commitment to good claims planning and management by your carrier is one huge preventive measure that can help your clients avoid having a worst-case scenario turn into a reality. 