

# Insurance Issues



## Workers' Compensation

### Contents

Chronic Pain—The Not So Quiet Epidemic That is Lurking in Your Loss Experience <i>by Michael Shor, MPH, Best Doctors Occupational Health Institute</i>	2
Nanotechnology—Is This Exposure on the Minds of Workers' Compensation Underwriters and Claim Executives? <i>by Charlie Kingdollar, Gen Re</i>	8
Physician-Dispensing of Repackaged Drugs <i>by Diane Brown, Gen Re</i>	10

#### About This Newsletter

Created for our clients, our *Insurance Issues* publication provides an in-depth look at timely and important topics on insurance industry issues.

### Emerging Issues in Workers' Compensation

The Workers' Compensation line had a tough 2010, and 2011 is looking only marginally brighter. Employment is picking up, and construction and manufacturing declines are leveling off. Insurers are working hard to keep the good business on their books, maintain rates and manage costs. The last thing on your minds may be emerging issues.

In this edition of *Emerging Issues in Workers' Compensation*, we selected topics that are relevant from three perspectives: On the everyday issues you face, is there anything new that can help you improve results? Are there any issues on the horizon that merit attention now, even if they have not yet developed into problems? Lastly, are there any state-specific developments that might help your bottom line? The articles on these topics include:

**Chronic Pain Management**—Michael Shor, MPH, of the Best Doctors Occupational Health Institute, shares the Institute's approach to chronic pain management and how his organization helped a New England workers' compensation insurer achieve successful outcomes. Attentive claim executives can work with medical professionals to make big improvements in quality of care and reduce unnecessary costs for this challenging population.

**Nanotechnology**—Gen Re's Emerging Issues specialist Charlie Kingdollar revisits nanotechnology to highlight the latest developments and what they mean to our industry. It's all about preparation today in the event nanotech becomes

tomorrow's claim problem. Are your insureds protecting their employees? Do you know?

**Physician-Dispensing of Repackaged Drugs**—This cost issue is red-hot for insurers, and some states are making major progress on containing costs. Gen Re's Diane Brown discusses the latest efforts in Florida, Georgia and other states to help employers and insurers reduce unnecessary expense. A related topic on "percentage of savings" practices may also be of benefit.

As always, we welcome discussion on these issues—and any topics important to your Workers' Compensation business.



## Chronic Pain—The Not So Quiet Epidemic That is Lurking in Your Loss Experience

by Michael J. Shor, MPH, Managing Director,  
Best Doctors Occupational Health Institute

NCCI has reported that within the last decade claim frequency has moved down and severity up. This is reportedly driven by medical and wage inflation as well as an increase in the number and kinds of medical treatments.<sup>1</sup> What has been less well understood is precisely why, and what specifically to do about it. The purpose of this article is to provide C-suite leaders with some critical experience and insights on how to begin addressing this very important issue.

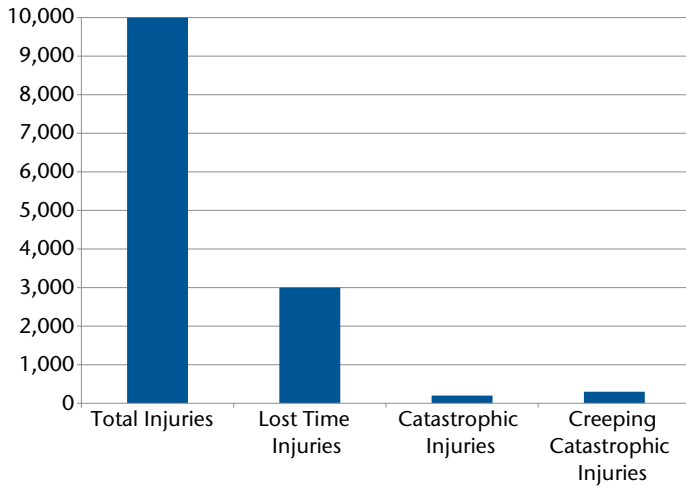
Let's start with a few reasonable assumptions. Going forward, over 50% of incurred losses will be for medical services, and the typical workers' compensation claim organization will be under-resourced with internal medical expertise. In addition, the traditional approaches to managing medical care may cost almost as much as they reportedly save. Consider those comments editorial opinion from more than one industry expert who specialize in the clinical component of work-related injury.

Approximately five years ago, staff of the Best Doctors Occupational Health Institute and Associated Industries of Massachusetts Mutual Insurance Company (A.I.M. Mutual), a regional mono-line workers' compensation insurer, formed an enterprise partnership to better understand precisely what was driving medical severity within their insured population. According to Michael Kelley, Vice President of Claims at A.I.M. Mutual, "Our traditional tools for managing medical care were simply not working on cases involving chronic pain. We knew we were good at managing claims, but needed a very different approach to improving medical care."

That effort was triggered by a growing concern about the dramatically rising level of costs associated with the brand-name extended-release narcotic Oxycontin™. A quick look at your own loss experience will likely demonstrate this medication or another narcotic is your largest pharmaceutical expense. The effort itself included a very rigorous review of the small number of claims that were thought to be driving overall loss experience. The partnership continues today and the very interesting findings are discussed below.

Depending on whose data you look at, it has been estimated that about 15% of all injured workers will account for 85% of total costs. In our research, we find that 60% to 75% of workers' compensation losses are incurred by 3%–5% of all injuries. When one digs just a bit deeper, one finds that almost 60% of the top 3%–5% are insidious injuries. These are typically relatively minor clinical injuries that do not respond as expected and, over two or three years, blossom into what we refer to as "creeping catastrophic" events. *Creeping*, because the nature of the injury does not set off the usual immediate alarms for the claim adjustor, and *catastrophic*, because the associated expenses and reserves have pierced the stop-loss limit with no obvious end in sight. A look at the top 100 pharmaceutical users for the past three years, including their date of loss, will tell you exactly who these injured workers are, what is being prescribed and who is doing the prescribing. What they won't tell you is how and why they got there, how much more will have to be spent or what to do about it.

### Typical Distribution of Injuries Based on 10,000 Total Reported Events

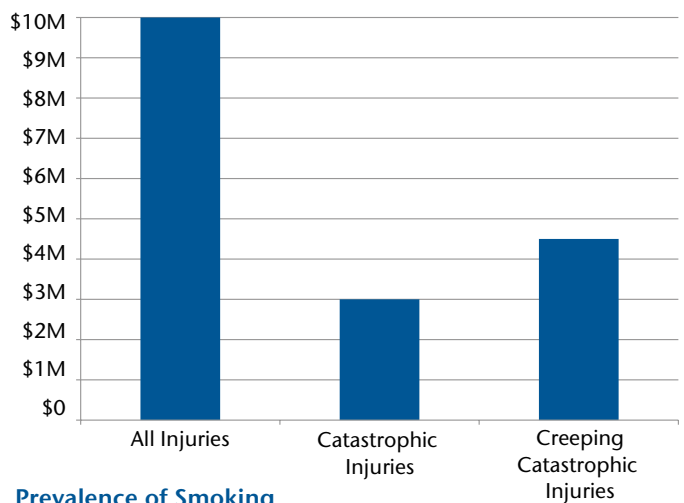


Typically, by the time an injury has become a “creeping catastrophic,” the working diagnosis for the injured worker has literally morphed from such relatively simple conditions as lumbar strain, fractured ankle, and shoulder strain, to failed back surgery syndrome, fibromyalgia, chronic regional pain syndrome or neuropathic pain, all of which are simply descriptions of chronic pain without a clear attribution or cause. A closer look at the claim file will typically reveal a series of expensive failed surgical interventions, multiple MRIs and CT scans, injections, implantation of a spinal cord stimulator, removal of a spinal cord stimulator, a virtual buffet of pharmaceuticals, including extended release narcotics, breakthrough pain immediate-release narcotics, anti-convulsants being used to treat neuropathic pain,<sup>2</sup> anti-depressants, and hypnotics for sleep and medications to treat the side effects of the medications. A look at the incurred expenses will show numbers ranging from \$250,000 to \$500,000. And unfortunately, it is not at all uncommon for patients to report that their pain still precludes any type of meaningful employment.

Simply put, these are the “chronic pain” injuries that have workers’ compensation underwriters, adjusters and reinsurers lying awake at night wondering how much worse it is going to get (note to board: if we do nothing, a lot worse) and trying to figure out what, if anything to do about it.

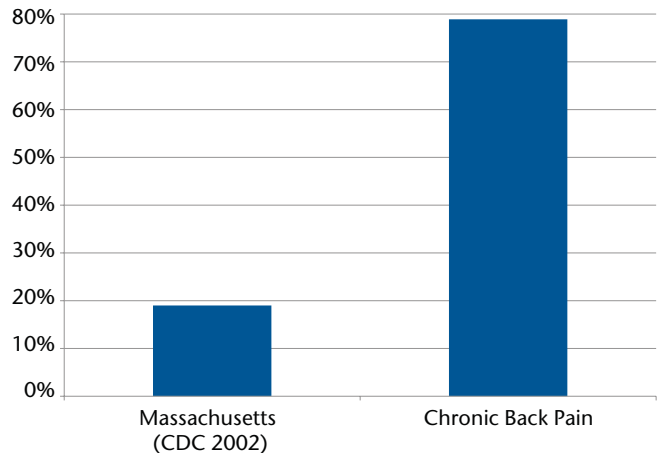
First, there aren’t any simple solutions. The treatment of chronic pain is as frustrating for clinicians and injured workers as it is for insurers. However, we do now have a very good understanding of the characteristics of individuals who are more likely to develop chronic pain conditions. And that

### Costs Associated with Creeping Catastrophic and Catastrophic Injuries

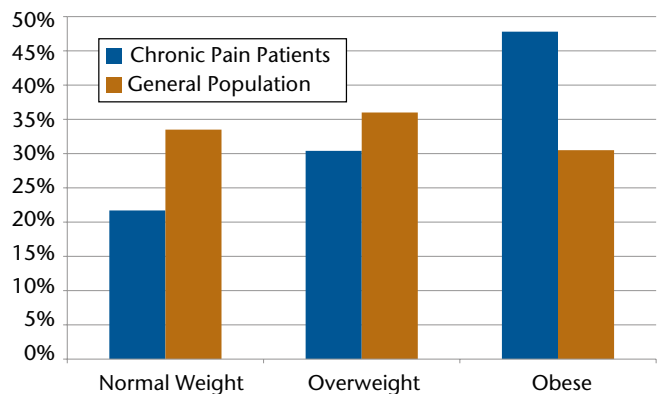


### Prevalence of Smoking

*The percentage of population that smokes in Massachusetts vs. chronic pain patients that smoke*



### Prevalence of Overweight and Obesity



“Our traditional tools for managing medical care were simply not working . . . We were very good at managing claims, but needed a very different approach to improving medical care.”



Research conducted at Best Doctors Occupational Health Institute and by others has clearly demonstrated that there are specific variables that put injured workers at much higher risk for the development of chronic pain.

understanding can provide the trigger to encourage claim executives to move from the “claim processing” mode of thinking to a “claim management” mindset.

Research conducted at Best Doctors Occupational Health Institute<sup>3</sup> and by others has clearly demonstrated that there are specific variables that put injured workers at much higher risk for the development of chronic pain. Some of the more obvious include a history of cigarette smoking,<sup>4</sup> a body mass index (BMI) over 30,<sup>5</sup> history of depression, history of emotional or physical abuse, history of workers’ compensation injuries, an unskilled position with heavy labor demands, and nature of the relationship between the injured worker and their supervisor, to name just a few. As these factors add up, the risk increases exponentially. Much of this information can be readily attained at the time of injury or from the initial medical exam.

Medical evidence is also showing that injured workers with the above-described risk factors are at greater risk for therapeutic failures than those without. All other things being equal, the results of a spinal fusion being successful in a habitual smoker are far lower than a non-smoking counterpart.<sup>6</sup>

Medical experts are also beginning to seriously question the therapeutic value of many of the standard procedures that are used in the treatment of chronic pain. A very recent study published in *Spine* showed that injured workers who received a spinal fusion for one of three specific diagnoses used more narcotics, suffered greater disability and returned to work less frequently than those treated non-operatively.<sup>7</sup> While the study itself is very interesting, our own review suggests interpretive caution. What the study did not do is match injured workers in the surgical and non-surgical populations for levels of reported pain. It’s quite possible the surgical population reported much higher levels of pain and the surgical intervention was the equivalent of the “Hail Mary” touchdown pass.

Another recently released study has called into serious question the therapeutic value of long-term narcotics in the treatment of chronic back pain. To quote, “In comparison with placebo, it is uncertain whether the long-term application of any analgesic drug produces any clinically meaningful improvements in pain or day-to-day function, which drug class is most effective, and to what degree patients are compromised by adverse effects.”<sup>8</sup>

One frequently used procedure in the treatment of chronic pain is the Spinal Cord Stimulator, or SCS. The SCS is frequently used as a last resort when all other efforts, such as surgery, seem to have been exhausted. A 2008 study funded by the State of Washington State Department of Labor and Industries found that the long-term benefits at 12 and 24 months were no better than those referred to a multidisciplinary pain clinic or usual care, and that the risk of complications was much higher. As a result, on October 22, 2010 the decision was made to no longer cover SCS as a treatment.<sup>9</sup>

The facts are that, yes, there is abuse out there, but most injured workers suffering with chronic pain do want help.



The bottom line for decision-makers is that the medical evidence for many of the most common and costly procedures utilized in the treatment of chronic pain is of very questionable value for the injured worker and for the workers' compensation insurer.

The question then becomes, What does work for chronic pain? The current medical evidence strongly supports the use of multi-disciplinary programs that focus on functional reconditioning, the provision of emotional and psychological support, and engaging the injured worker as an active participant in decision-making.

The table to the right, which is extracted from information published by the British Medical Journal, shows the level of medical evidence that supports very common procedures in the treatment of chronic low back pain.<sup>10</sup> The challenge for workers' compensation insurers is that it is very difficult for claims specialists to identify excellent multi-disciplinary programs. Part of the reason is that most "pain clinics" prefer to focus on procedures like injections or pharmaceutical management which tend to be well reimbursed. Another part is that it is easier for a busy claim executive to approve an injection, narcotic or spinal cord stimulator than try to find and approve a multi-week program that includes multiple clinical professionals focusing on improving function and how an injured worker perceives their pain experience. The economics do tell the story: procedures such as surgery, injections and diagnostics pay very well; trying to help injured workers become better stewards of their own care, not so much.

Effectiveness of Different Types of Interventions for Chronic Low Back Pain Based on Current Medical Evidence	
<b>Beneficial</b>	Back Exercises
<b>Likely to be Beneficial</b>	Acupuncture Behavioral Therapy Intensive Multi-Disciplinary Treatment Programs Spinal Fusion in carefully selected patients Spinal Manipulative Therapy Massage
<b>Unknown Effectiveness</b>	Artificial Disc Replacement Intradiscal Electrothermal Therapy Radiofrequency Denervation Back Schools Electromyographic Biofeedback Lumbar Supports TENS Traction Epidural Steroid Injections Facet Joint Injections Local Injections Analgesics Antidepressants
<b>Trade off Between Benefit and Harm</b>	Muscle Relaxants NSAIDS

The facts are that, yes, there is abuse out there, but most injured workers suffering with chronic pain do want help. And they will seek that help from the resource they believe is working in their best interest. What we have learned is that if you are willing to provide clinical resources that reach out to “at risk” injured workers very early in the life of an injury, and help them get access to clinical resources that are focused on functional reconditioning and the maintenance of productivity, very good things can happen. We have also learned that you can do the very same things with those injured workers who are already suffering with chronic pain and achieve a very similar result. And you know what? Injured workers will thank you for the help. Does it work all the time? Absolutely not! There is far more we do not understand about chronic pain than we do. But for the C-suite executive, the real questions are very simple:

1. Do we have the genuine internal expertise to address this cost driver?
2. Are our current approaches to the issue delivering results in which we have confidence?
3. If we decide not to decide, what are the consequences?

## And you know what? Injured workers will thank you for the help.

What it all means for C-suite executives interested in addressing the issue is a rethinking of the claims process. As stated earlier:

1. Injured workers at risk for developing chronic pain can be identified almost literally at the time of injury.
2. Assisting the injured worker to identify and access clinical resources that understand “risk factors,” and have a therapeutic focus on both healing and return to productivity, is paramount.

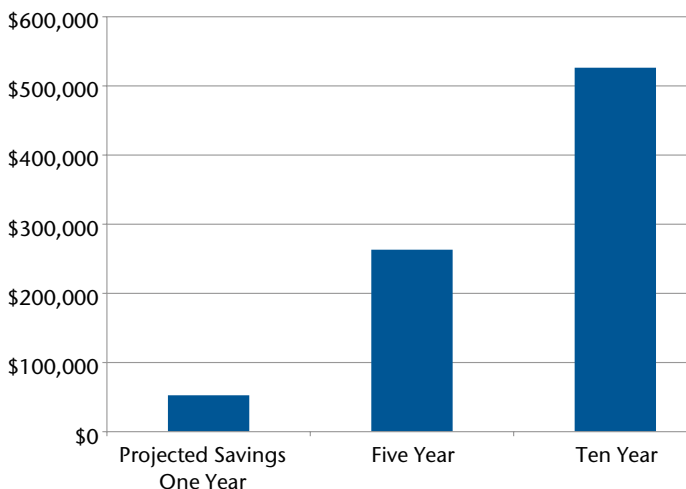
We have also learned that even after an injured worker has developed chronic pain, there are very real steps that can be taken to improve function and reduce cost. The chart below shows the cost saving achieved by working very closely with the injured worker and his or her treating physician over a period of several months. While the sample (“N”) is small, with an average intervention date of 51 months from date of injury and a range between 8 and 129 months, the results were clearly directionally correct. The facts are really quite simple. The long-term ability to provide competitively priced workers’ compensation insurance will be a function of:

1. The level and quality of medical expertise available to the claim executive for critical decision-making
2. The ability of the claim executive to make those expert resources available to the injured worker

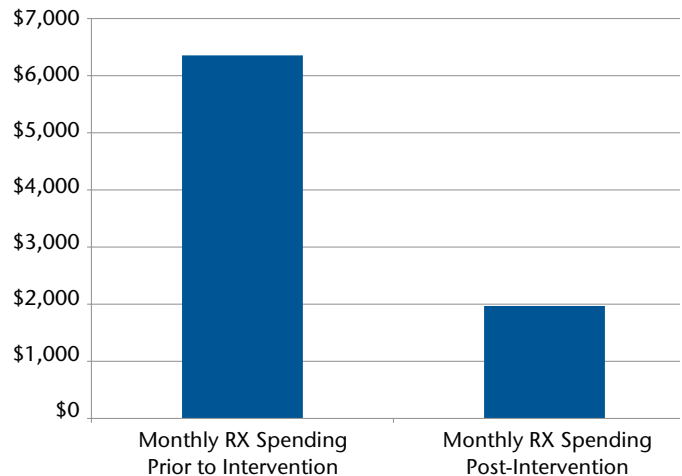
The opportunity is as simple. A very small percentage of all injuries drive claim experience. A very high percentage of this small number of claims can literally be identified at the time of injury. It’s what happens next that that decides the outcome of these claims.

The challenges presented by the costs and frustrations associated with chronic pain can simply be thought of as a very anxious canary in a rather deep coal mine. ■

**Projected Reduction in RX Expenses Over Time (N=11)**



**Results of a Pilot Patient Centered Narcotic Reduction Effort (N=11)**



## Endnotes

- <sup>1</sup> Shuford H, "What Does Recession Mean for Workers Compensation?," Workers Compensation Issues Report, 2009.
- <sup>2</sup> Neuropathic pain is pain caused by a dysfunction in the way the nervous system perceives pain, not by the original injury.
- <sup>3</sup> Shor, et al., "An Assessment of Chronic Pain Treatment and Management," A report for the AIM Mutual Insurance Companies, 2005.
- <sup>4</sup> Vogt M, "Influence of Smoking on the Health Status of Spinal Patients," *Spine* 2002.
- <sup>5</sup> Fanuele J, "Association between Obesity and Functional Status in Patients with Spine Disease," *Spine* 2002.
- <sup>6</sup> SD Glassman et al. "The effect of cigarette smoking and smoking cessation on spinal fusion," *Spine* 2000;25:2608-2615.
- <sup>7</sup> Nguyen T et al. "Long-term outcomes of lumbar fusion among workers' compensation subjects: a historical cohort study." *Spine* 2011;36(4):320-31.
- <sup>8</sup> Stein C et al., "Opioid use in chronic non-cancer pain: Guidelines revisited," *Current Opinions in Anesthesiology*, 2010;23:598-601.
- <sup>9</sup> Health Technology Clinical Committee Findings and Coverage Decision, Spinal Cord Stimulation, Washington State Healthcare Authority, Health Technology Assessment, October 10, 2010.
- <sup>10</sup> Chou R, Low Back Pain (Chronic), *Clinical Evidence* 2010;10:1116.



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*He is a prolific writer and speaker on contemporary medical care cost and quality issues. His professional writings have appeared in the Journal of Workers Compensation, and Annals of the American Orthopedic Association, among others.*

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# Nanotechnology—An Exposure on the Minds of Workers’ Compensation Underwriters and Claim Executives?

by Charlie Kingdollar, Gen Re

Let’s start by reviewing the numbers and the research. Several interesting developments, including the adverse health effects that may arise from occupational exposure to nanomaterials, have come to light since we highlighted the issue in our first Emerging Issues in Workers’ Compensation publication (*Gen Re Viewpoint*, September 2009).

## Nanotechnology Update

> **Number of Affected Businesses**—How many U.S. companies employ workers exposed to nanomaterials? The federal government’s National Nanotechnology Initiative (NNI), which includes 25 federal agencies working to develop nanotechnologies, provides funding for over 1,000 small nanotechnology firms. These firms have fewer than a dozen employees. In addition to these small firms, there are an unknown number of nanotechnology firms with 25 to 50 employees, and many Fortune 500 companies have nanotechnology divisions.

According to a speaker from the National Institute of Occupational Safety and Health (NIOSH) at the NNI’s Washington D.C. summit in December 2010, the agency has no official estimate for the number of workers occupationally exposed to nanomaterials. We also know that many employees at secondary industries add nanomaterials to an array of products. By simple conservative estimates, there are likely millions of workers occupationally exposed.

> **Status of Health Studies**—As a Workers’ Compensation insurer, you want to know what employers need to protect their employees. NIOSH has published draft recommendations to limit occupational exposures to nanomaterials, particularly carbon nanotubes and carbon nanofibers. While “there are no scientific reports of ‘adverse health effects in workers producing or using carbon nanotubes...or carbon nanofibers,’ NIOSH is concerned because some studies have shown that the potential for worker exposure exists. Additionally, some in vivo inhalation studies have shown adverse reactions to carbon nanotubes in rodents, including pulmonary inflammation and fibrosis. Further, other in vitro and in vivo studies have led researchers to theorize that inhalation of certain carbon nanotubes in large doses may potentially cause asbestos-type exposure effects.”<sup>1</sup>

> **Early Government Recommendations**—NIOSH’s draft recommendations include:

- Minimizing work-related exposures “through a hierarchy of measures, instituting appropriate medical screening programs, and educating workers on sources and job tasks that may expose them to these types of nanomaterials.”
- An “exposure limit of 7 micrograms of each material per cubic meter of air as an eight-hour, time-weighted average, respirable mass concentration—the concentration that can be most reliably measured with current instrumentation.”

While admitting that the recommended exposure limit might not be completely health protective, the draft document says it “should help lower the risk of developing work-related lung disease and assist employers in establishing an occupational health surveillance program that includes elements of hazard and medical surveillance.”<sup>2</sup> Noting that these recommendations are not conclusive, they can serve as a starting point for loss control to engage your insureds in dialog about this potential exposure and, as NIOSH suggests, to assist in establishing health surveillance programs.

## Many Unknowns

Trying to gauge the potential for adverse health effects is increasingly difficult. Thousands of engineered nanomaterials are already being produced in the U.S. and elsewhere.

Sheer numbers pose a formidable challenge for scientists attempting to determine the potential toxicity of nanomaterials. “Different coatings, sizes, surface charges, functionalizations, or manufacturing processes can drastically alter the toxicity and behavior of a given engineered nanomaterial [ENM], and companies are constantly developing new materials. By one estimate there are [already] 50,000 different permutations of carbon nanotubes alone... Moreover, there can be a great deal of inconsistency between batches made by the same manufacturer.”<sup>3</sup> In one study of two different batches of the same nanomaterial made by the same manufacturer, “the two different types of particles would behave completely differently inside the lungs... So, notionally [they were] the same material, [but] in reality the types of particles being released were like night and day.”<sup>4</sup> So great is

the diversity and variation of ENMs that one report estimated it would take more than 50 years to conduct traditional studies on the nanomaterials currently in commerce at a cost of upwards of \$1 billion.<sup>5</sup>

Some researchers are concerned that existing personal protective gear may be inadequate to protect those with occupational exposures to nanomaterials. One researcher explains that “current regulations and standards testing for protective clothing and equipment are almost devoid of references to nanomaterials specifically. Moreover, although some researchers have concluded that certified respirators offer an appropriate level of protection against nanoparticles, there remain large uncertainties, for example, due to the increased potential of leaks at face seal because of the very small size of nanoparticles, a few billionths of a meter.”<sup>6</sup>

## Developments

Nanotechnology developments are not all bad news. In our September 2009 *Viewpoint*, we also highlighted the spread of Methicillin-resistant Staphylococcus Aureus (MRSA), not only in hospital settings but also in the workplace. A recent study found that certain nanostructures “are physically attracted to infected cells like a magnet, allowing them to selectively eradicate difficult-to-treat bacteria without destroying healthy cells around them. These agents also prevent bacteria from developing drug resistance by actually breaking through the bacterial cell wall and membrane, a fundamentally different mode of attack compared to traditional antibiotics.”<sup>7</sup>

## Asking Questions

What is absolutely certain is the growing number of U.S. workers exposed to a variety of nanomaterials in a growing number of industry sectors, and this trend will continue for the foreseeable future. How can insurers get their arms around the exposures? Perhaps a starting point for any analysis can be with your producers. Ask them about the companies they are talking to, find out which companies are producing or manufacturing nanomaterials and which ones are buying the nanoparticles to incorporate into secondary products, such as

cosmetics, food, semiconductors, or clothing. The answers will be interesting; they may even be surprising.

**Nano Tip:** *ISO has developed General Liability class codes for nano manufacturers. Can this information help you and/or your producers find out more about the risk?*

## Endnotes

- <sup>1</sup> “NIOSH Recommends Exposure Limit of 7mg/m3 for Carbon Nanotubes,” *Nanotechnology Law Report*, <http://www.nanolawreport.com/2010/12/articles/carbon-nanotubes/niosh-recommends-exposure-limit-of-7-igm-3-for-carbon-nanotubes/>, 12/22/10.
- <sup>2</sup> “Nanotechnology is focus of draft recommendations,” *Risk & Insurance*, <http://www.riskandinsurance.com/story.jsp?storyId=533328821&query=carbon%20nanotubes>, 1/17/11.
- <sup>3</sup> “Engineered Nanoparticles in Consumer Products,” *Environmental Health Perspectives*, March 2011.
- <sup>4</sup> *Ibid.*
- <sup>5</sup> *Ibid.*
- <sup>6</sup> “Current safety equipment may not be adequate for nanoprotection,” *Nanowerk*, [www.nanowerk.com/news/newsid=13054.php](http://www.nanowerk.com/news/newsid=13054.php), 10/13/09.
- <sup>7</sup> “IBM and The Institute of Bioengineering and Nanotechnology Find Breakthrough for MRSA Treatment,” *PR Newswire*, 4/4/11.



**Charlie Kingdollar** is a Vice President in the Emerging Issues Unit of Gen Re's Treaty department. Charlie is responsible for tracking and analyzing developments that create new or changing exposures, and assessing their potential impact on insurers. Charlie speaks on Nanotechnology and other Emerging Issues at industry events across the country. He may be reached at 203 328 5756 or [ckingdol@genre.com](mailto:ckingdol@genre.com).



## Physician-Dispensing of Repackaged Drugs

by Diane Brown, Workers' Compensation Business Development Specialist, Gen Re

Why should we care about this? Don't doctors always prescribe and dispense drugs? The NCCI reports that, as a group, physicians selling repackaged drugs charge two or three times more than pharmacies selling the same drugs purchased from the original manufacturers. That's a problem, and a few states are taking action.

**Florida**—The Workers' Compensation Research Institute (WCRI) reported last spring that Florida's drug costs were 38% above the median in a 16-state study. The NCCI projects that capping the price of repackaged drugs would reduce annual workers' compensation costs by \$62 million in Florida alone. On May 6, 2011 both houses of the Florida legislature unanimously passed a bill that would stiffen penalties for physicians who overprescribe medications and would prohibit them from dispensing painkillers from their offices or clinics. The bill's goal is to stop the spread of Florida's "pill mills" that have made the state the focus of many prescription drug-sales studies. Governor Scott is expected to sign the measure. We are keeping a close watch on any potential delay or debate surrounding the governor's signing of this bill.

**Georgia**—Effective April 1, 2011, Georgia implemented a cap on repackaged drugs. The language is similar to that employed in a price cap bill adopted in Mississippi in 2010.

**Texas**—The Texas State Legislature is now considering a measure that would allow physicians to dispense repackaged drugs in the state. Knowledgeable observers have concerns about higher utilization of drugs, particularly narcotic medications. They also anticipate that higher drug costs will develop in Texas as it has in other states. No physician explanation of patient-convenience can justify a charge that is two to three times greater than what a pharmacy would

The NCCI reports that, as a group, physicians selling repackaged drugs charge two or three times more than pharmacies selling the same drugs purchased from the original manufacturers.

charge for the same medication.

Insurers in Texas may want to provide commentary on Senate Bill 546 or at least alert area legislators about the impact.

**Maryland**—Public opinion is being sought for Maryland's proposed regulation establishing uniform reimbursement rates for pharmaceuticals (COMAR 14.09.03). The AIA published a letter to the Maryland WC Commission where they cite data from the NCCI and WCRI studies mentioned above. They go on to say, "Physicians have a right to fair and adequate reimbursement for their services; they do not have a right to gouge employers who pay the bills because of loopholes in reimbursement rules." We concur.

Other states on our radar screen include California and Louisiana.

### Saving Claim Dollars— A Practical Tip

We offer a closing note on reimbursement loopholes—"Percentage of Savings." Most of you are already familiar with this practice, but for others we bring it to your attention. In "Percentage of Savings" states, a bill review company can take a stated share of the savings they "discover or find" on your claimants' invoices. This percentage of savings charge is over and above the bill review company's fees. Often this percentage of savings is calculated on an amount that was actually an adjustment to a bill based upon a mandated fee schedule.

Consider this example: A medical provider bills \$75,000 for a procedure for which the fee schedule allows \$50,000. The bill review agency would adjust your bill to the lower \$50,000 amount. Then, based upon some contractual figure your

company has agreed to (somewhere between 10% – 25%), the agency applies a percentage of the “savings” to add to their normal charge. Let’s say the contractual amount is 10%. In this example, your percentage of savings charge on an amount you should have paid is 10% of the \$25,000—or \$2,500.

In states such as Illinois where this “Percentage of Savings” practice exists, ask your bill review company for a “flat rate” per bill. You can make sure that the rate is reasonable and avoid getting gouged. That can save you real claim dollars.

By the way, this “savings” issue also exists on the General Liability side of the insurance business. Trial lawyers are lobbying for bills that allow juries to determine damages based on the amounts initially billed by medical providers, rather than the lower amount actually paid for care. Using our same example, the \$75,000 bill would be added to damages instead of the lower \$50,000 ultimately paid. The issue has been heard by several state high courts, and is now on the docket for argument in several more. The bottom line is, again, higher insurance costs. Our GL brethren and their industry trade groups are fighting the trend, just as we battle on the Workers’ Compensation issues reported here.

## Conclusion

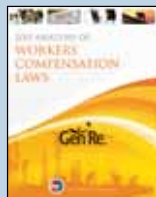
So much of our discussion is about arming people with knowledge or perspectives to improve company results. Our industry has fabulous underwriters and claim professionals. I have the privilege of meeting many of them at industry and company events. The challenges they face day in and day out are enormous, and only a few of those challenges have been outlined in this publication. I hope that the insights presented here will help in your daily efforts.

Let’s hope that 2011 is still brighter when we reach year-end, and that the recovery continues into 2012 and beyond. ■



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## Other Workers' Compensation Publications

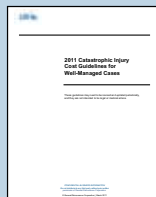


### Analysis of Workers' Compensation Laws—2011 Update

*This publication by the U.S. Chamber of Commerce will be available soon. If you would like more information, please contact your Gen Re representative.*



### Emerging Issues for the Workplace—*Insurance Issues*, March 2010



### 2011 Catastrophic Injury Cost Guidelines for Well-Managed Cases

*This publication is only available to Gen Re clients.*



### Drywall Update: New Defendants Add to the Insurance Exposures—*E-News GL/Umbrella*, January 27, 2010



### 2010 Medicare Secondary Payer Act Seminar

*Contact your Gen Re representative for seminar material.*



### Medicare Recipients Litigation—*E-News Multiline*, January 27, 2010



### For Workers' Compensation, It's All About the Economy—*Gen Re Viewpoint*, June 2010



### Workers' Compensation—Emerging Issues Ahead—*Gen Re Viewpoint*, September 2009

If you want to talk more about Emerging Issues for Workers' Compensation, please contact one of our Treaty or Facultative representatives in this line:

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