Leaderschoice
INSURANCE SERVICES

Leaders News Alert

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Workers' Comp

Agency Recommends 4.4% Rate Increase

THE AGENCY that helps set workers' comp rates is recommending they increase 4.4% at the start of next year.

The Workers' Compensation Insurance Rating Bureau in early August recommended that the average benchmark pure premium rates for all of the state's class codes increase to $2.62 per $100 of payroll for policies incepting on or after Jan. 1, 2014.

A good portion of the rate increase is due to increased claims filings, as well as rises in medical costs and permanent disability benefits that partly took effect this year and take full effect in 2014.

This year, benefit increases added another $620 million in system costs, the Rating Bureau has estimated. In 2014, the increases will add another $590 million in costs for all workers' comp payers in the state.

That said, cost increases are expected to be offset by savings from reforms contained in SB 863, which was signed into law in 2012 and took effect at the start of this year.

All told, the Rating Bureau projected the $1.2 billion in additional permanent disability benefits will be offset by $1.7 billion in savings, reducing overall costs by $520 million a year starting in 2014.

Changes in calculation method

You may be confused by different percentages being publicized regarding the rate increase in the coming weeks.

Because of changing methodologies and changes in the way the benchmark rate is expressed, calculating the exact amount of proposed rate increases has become more difficult.

Due to changes in the regulations, ushered in by the current insurance commissioner to reduce the appearance of rate increase magnitudes, the so-called pure premium benchmark rate increase is expressed in relation to the rates insurers currently have on file.

That's not the same, however, as the advisory rates that the Department of Insurance sets every year. This new filing will set new advisory rates.

The last time the benchmark was set was for the start of 2014, when it was $2.56 per $100 of payroll, and the average rates insurers had on file across all classes codes as of July 1 this year was $2.53 per $100 of payroll.

However, because of changes to the way rates are calculated, what was $2.56 per $100 of payroll at the start of this year is actually $2.51 under the new method for calculating rates (hence the 4.4% rate increase above).

The Rating Bureau makes the rate recommendation to the state insurance commissioner, who has the authority to either approve it or reject it and set another benchmark.

The pure premium benchmark rate is purely advisory and insurers use it as a guidepost to set their own rates. They do not have to follow the benchmark rates.

The rating agency has submitted the recommendation to the California Department of Insurance and the insurance commissioner has scheduled a hearing on the proposal for late September. ❖

INDUSTRY AVERAGE CHARGED RATE*

2003	$6.29
2005	$4.96
2007	$2.75
2009	$2.10
2011	$2.32
2013	$2.60

** Per $100 of payroll across all industries*

COSTLIER TREATMENT: *Medical costs for injured workers are still climbing, but inflation is slowing.*

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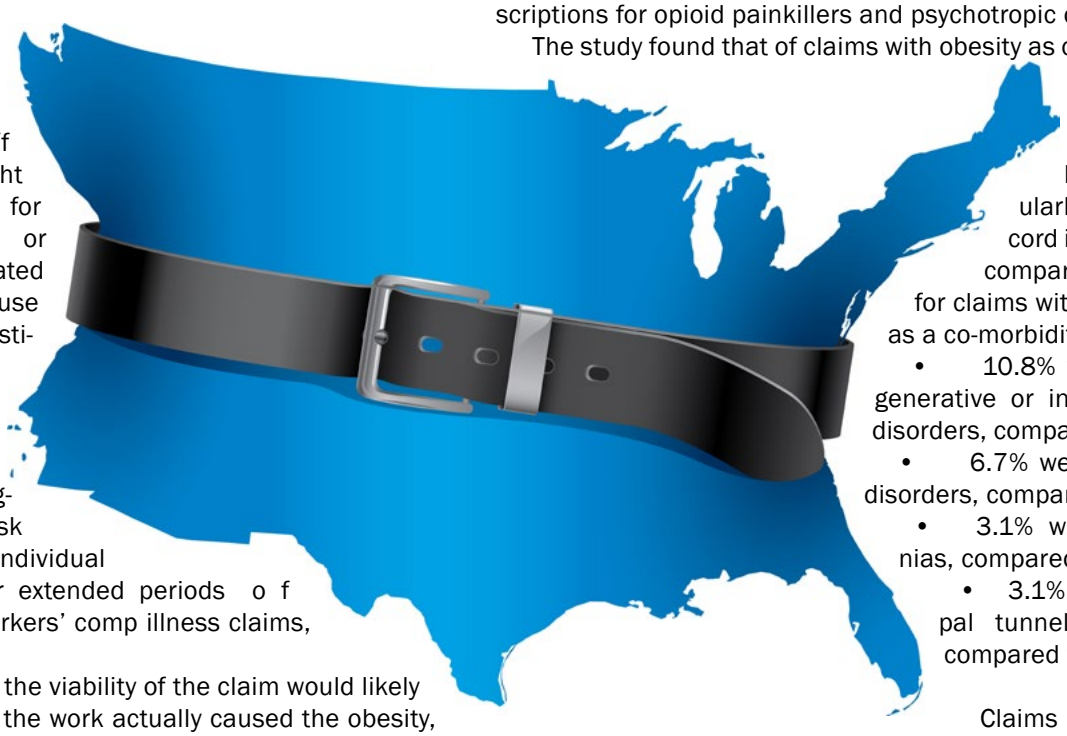
Workers' Comp Claims

Costs May Rise after Obesity Classified as Disease

THE AMERICAN Medical Association's recent decision to reclassify obesity as a treatable disease may have serious repercussions for workers' comp claims costs, according to a new report.

While obesity itself in most cases will not be compensable as a workplace illness, the condition will certainly play a role in the way obese claimants receive medical treatment. And it could result in obesity being considered an outgrowth of the original workplace injury if an injured worker gains weight during rehabilitation.

According to the California Workers' Compensation Institute, obesity may be deemed "a compensable consequence of injury, just as sleep disorders, sexual dysfunction and psychological disorders became common workers' compensation 'add-ons' prior to passage of last year's workers' comp reforms."



"For example, this could be the case in claims where the employee remains off work and gains weight after being inactive for extended periods, or where they are treated with drugs that cause weight gain," the institute wrote.

Not only that, but workers who gain weight in sedentary jobs, such as long-haul trucking or desk jobs that require an individual to remain seated for extended periods of time, may also file workers' comp illness claims, it wrote in its report.

"In such scenarios the viability of the claim would likely hinge on proving that the work actually caused the obesity, which would be an issue ripe for dispute and which could lead to additional litigation," the institute wrote.

"In light of the increasing evidence of genetic pre-disposition for various medical conditions, defining causation and relative causation will be critical in claims involving obesity, and also may arise in other employment areas such as pre-employment screening."

The change may end up significantly increasing the costs of claims for workers' comp claimants who are already obese. And such claims are already expensive, according to the institute.

The definition of obese is someone who has a body-mass index of 30 or more, and 35.7% of U.S. adults fall into this category.

BMI is measured as a ratio of your weight to your height (weight divided by height). It is an imperfect measurement, as muscular individuals and athletes may tend to have higher BMIs and may not be considered overweight or obese.

To date, obesity in workers' comp claims has been treated as a "co-morbidity" – a condition that occurs at the same time, but usually independent of the work-related compensable injury or illness.

"For example, obesity as a co-morbidity within a workers' compensation claim can complicate the treatment of a compensable back or joint injury," wrote the institute.

An earlier study by the institute of claims filed between 2005 and 2010 found that claims with obesity as a co-morbidity have had significantly higher rates of lost time from work, permanent disability and attorney involvement, and have been much more likely to involve additional co-morbidities and prescriptions for opioid painkillers and psychotropic drugs.

The study found that of claims with obesity as co-morbidity:

- 24% were for back problems, particularly with spinal cord involvement, compared to 14.1% for claims without obesity as a co-morbidity,
- 10.8% were for degenerative or infective joint disorders, compared to 2.5%,
- 6.7% were for spine disorders, compared to 1%
- 3.1% were for hernias, compared to 0.6%,
- 3.1% were for carpal tunnel syndrome, compared to 0.6%.

Claims with obesity as a co-morbidity:

- Had average medical payments of $68,468, compared to $35,091 for those without;
- Had average indemnity (wage replacement) payments of $47,970, compared to $29,140 for those without; and
- Averaged 35 weeks of lost time, or 80% more than the average of 19 weeks for claims without the obesity co-morbidity.

Keep in mind that these costs were for claims filed when obesity was not classified as a disease by the American Medical Association.

"To the extent that such disparities continue in the future, these results suggest that any increase in the volume of claims involving obesity treatments could have a significant impact on workers' compensation payments," the institute wrote. ❖

Insurance Marketplaces

Glitches, Scams Predicted for Exchange Websites

BESIDES THE continuing concerns about a rocky rollout for health insurance exchanges, one big worry is how the online exchanges will function properly.

A recent report by the *Wall Street Journal* predicts glitches in the technology, particularly in the various websites the federal government will run for the 33 states that have chosen not to operate their own exchanges. There are also growing concerns about fraudsters using so-called "near-miss" sites to not only extract money from unsuspecting individuals, but also to steal their identities.

Consultants involved in creating the websites for the various exchanges have predicted snags when the sites go live, according to the *Journal*.

"It will be full of issues, bugs and technological challenges," Dan Schuyler, a director at the consulting firm Leavitt Partners and a former director of technology for Utah's health insurance exchange, told the paper.

Likely the biggest issue will be effectively linking various databases that will be required to determine eligibility for subsidies and Medicaid. Developers have to design sites for each state that can communicate with the following:

- Databases run by the IRS and other government agencies to verify citizenship and legal immigrants working in the US,
- State Medicaid systems, and
- All the insurers participating in the exchanges in each state.

The *Journal* also reported that the recent move to reduce the number of pages in the applications for health care exchanges put developers in a bind, as they'd already been building the systems with the old application form in mind. That meant they had to go back and redesign portions of each website.

Fraudulent sites

Meanwhile, it will likely be extremely easy for scammers to create multiple websites that will trick consumers into thinking that they are legitimate sites, according to the Identify Theft Resource Center.

"Without known and reliable sources, there exists a great opportunity for gaming of the Internet search engines to attract consumers to websites intent on harming them by eliciting the fraudulent collection of personal identifying information," it writes.

It identifies two types of websites that will arise: legitimate businesses cutting corners and engaging in misleading tactics to secure new business, and outright scam websites, which are built to obtain personally identifiable information for malicious use.

Also, scammers have since last year been calling, faxing and e-mailing people across the country claiming to be with "Obamacare," Medicare, or another state agency.

They often say they need to "verify" some personal information (typically a bank account or Social Security number) to ensure you get the proper benefits. In some cases, the scammers tell victims they need to buy an insurance card to be eligible for coverage under the new program. ❖

Scammer alert

These tips, provided by consumer groups and government, will help individuals spot a fraud:

- There is no card associated with health care reform.
- There is no new Medicare card, and you don't have to update personal information.
- The health insurance marketplaces don't open until Oct. 1 , meaning you can't yet buy coverage.
- Don't respond to a cold call of any kind, especially one that asks for personal information or money..
- Don't let anyone rush you. The rates in the exchange have been preapproved for Oct. 1 to March 31. Anyone promising a "special price" or "limited time offer," is lying.

Affordable Care Act

How to Disburse Medical Loss Ratio Rebate Checks

IF YOUR company received a medical loss ratio (MLR) rebate check from its health insurer this year, you may be wondering how you can spend it.

Under the Affordable Care Act, health plans are required to pay back a portion of premium if they fail to spend a certain amount of the collected premium on medical benefits. For large group plans that minimum is 85%, and for small group plans the minimum is 80%. The MLR rebates were due by Aug. 1.

If a plan spends less than that on treatment, drugs and other covered services, they are required to send out rebate checks to plan sponsors. In turn, employers have certain requirements on how they can spend the rebate checks and if you receive one, you need to know the regulations.

Your plan should have language dictating how rebates received may be used. If not, make sure that you get it clearly stated. This may require an amendment to the plan, which should be done in accordance with the plan's amendment process.

Four steps for disbursing rebates

If your company receives a rebate, the Department of Labor has outlined the steps you need to take.

- **Determine the plan to which the rebate applies** – Typically, rebates apply only to a specific plan option. So the only ones benefiting from the rebate would be those that participated in the specific plan. If there are checks for two plan options, you need to apply the rebate separately based on the separate calculations of the insurer.
- **Determine what portion of the rebate applies respectively to the employer and employee contributions** – If your company contributed 80% of the premium and the employees 20%, then typically, your company can keep 80% of the rebate, while the rest must be used for the benefit of participants.
- **Determine to whom you will distribute the rebate** – You can chose to use an allocation method, as long as it is fair. It does not have to reflect the actual contribution amount of each employee. You can choose to provide a flat amount to each participant, or a percentage of their actual contribution.
- **Determine the method for distributing the rebate** – Regulations on the MLR include four possible methods for distributing rebates to enrollees:
  - Premium contribution reductions for enrollees,
  - Enhancing plan benefits or services,
  - A refund back to plan participants, either through cash or check, or
  - A premium holiday (essentially using the rebate to pay the employees' portion of the premium).

If the cost of distributing the refund by cash or check is not cost-effective, you should consider the other options available.

Although it's not stated in the regulations, the consensus is that rebates must be applied within three months of receipt.

DON'T FORGET!

Oct. 1 is the deadline to distribute exchange availability notices to your employees.
You can find sample notices here:
http://www.dol.gov/ebsa/

Tax treatment

The tax consequences of receiving an MLR rebate depend on whether the employees paid premiums on a pre- or post-tax basis. According to IRS guidance, in cases when the employee portion was paid for using pre-tax dollars:

- If the rebate is distributed as cash, it will be taxable.
- If the rebate is used to reduce current-year contributions, it will be "effectively" taxable – since the participants' pre-tax contribution toward current year benefits will decrease, their taxable income will increase by a like amount.

When employees pay their portion of a premium post-tax, the rebate will generally not be subject to federal income tax.

Rebate notices

You are not required to send a notice regarding the rebate to your employees. That's the insurance company's job. The notices sent by carriers will not include the amount of the rebate, but will state that the rebate was sent to the employer.

If you receive an MLR rebate, you may want to send a memo to your staff informing them if and how they may receive a portion of it. You may also want to point out that the rebate will usually be a relatively small amount on a per participant basis. That will counter an expectation of a huge windfall. ❖

ONE FOR ME, ONE FOR YOU: *Distribute the rebate based on the percentage employees pay into the plan.*