Workers Compensation Small Medical-Only Claims:

Should an employer pay them or turn them in to the insurance company?

The most common question an insurance agent gets from employers is whether or not they should pay (or continue to pay) small medical bills on Workers Compensation claims rather than submitting them to the insurance carriers for payment. The answer to this question is not simple. It can depend on several factors including:

1. Whether or not the state has approved the Experience Rating Adjustment (ERA) in their Experience Modification formula.

2. Whether or not the employer has expertise in paying according to the state fee or reasonable and customary schedule and/or has access to discounted medical networks as insurance carriers do.

3. Whether or not a small deductible to handle small medical claims might be more appropriate and assist in complying with state rules.

4. Understanding the state rules and penalties where the employer is located.

5. Whether or not the state of operation has a favorable alternative option for handling small medical claims.

6. How organized and detailed the employer is.

Experience Rating Adjustment (ERA)

For years, insurance agents recommended that employers pay small Workers Compensation medical claims out-of-pocket and not submit them to their insurance carrier. The rationale for this recommendation was that frequency impacted the experience modification formula greater than severity, leading to a higher Experience Modification and increased costs. It is true the experience modification is designed to put more emphasis on frequency than on severity.

When the experience rating formula was created, assumptions were built into it. One assumption is one single large claim should not have as much effect as a number of smaller claims that total the same amount. For example, a single $90,000 claim should not have the same impact as five $18,000 claims. One large claim may not be reflective of the insured's overall operations. However, five $18,000 claims indicate a problem with the frequency of claims. It can be evidence of safety or other issues. In addition, studies have shown frequency often leads to severity.

This practice of employers not reporting small claims in an attempt to keep their experience modification low troubled many of the Workers Compensation stakeholders (insurance companies, actuaries, OSHA, National Council of Compensation Insurance [NCCI] and other state independent Advisory Organizations for Workers Compensation). By not reporting these claims, the database of loss experience was not complete and could lead to poor statistical analysis.

An Experience Rating Adjustment (ERA) was introduced in the formula. Medical-only claims, (injury code 6 claims), are reduced by 70% in states where ERA is approved before it is utilized in the experience rating process. Also, the expected loss rate and discount ratio, used to compute expected losses and expected primary losses, have been changed to reflect that medical-only claims will be reduced by 70%.

Many feel the incentive to not report medical-only claims has been eliminated in states where ERA is approved.

ERA Approved States

Alabama, Arkansas, Arizona, Connecticut, Colorado, District of Columbia, Florida, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Maine, Maryland, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, North Carolina, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, West Virginia and Wisconsin.

ERA Pending/Recommended States
(To all intents and Purposes – Disapproved)

Alaska, California, Delaware, Georgia, Iowa, Missouri, New York, North Dakota, Ohio, Washington, Wyoming and Texas

ERA Disapproved States

Louisiana, Massachusetts, New Jersey, New Mexico, Oregon and Pennsylvania,

I have performed several "what if" scenarios on employers either reporting to the carrier or paying medical-only claims on their own in ERA states and its impact on the Experience Modification and the employer's overall costs. The studies are conclusive that the employer did not save money by paying medical-only claims itself in an ERA state particularly if the employer does not know how to apply the state fee schedule and/or has no access to discounted networks like those developed by insurance carriers. Here is an example.

Illustration 1 No State Fee Schedule or Discounted Insurance Carrier Network Applied			
	Premium	**Experience Modification**	**Adjusted Premium**
Cost (premium) where all claims were reported	$40,790.00	1.275	52,007.25
Cost (premium) where employer did not report medical-only claims	$40,790.00	1.18	48,132.20
Premium Savings due to reduction in experience modification for not reporting medical-only claims.			3,875.00
Premium savings over three years due to the reduction in the experience modification for not reporting medical-only claims			11,625.15
Medical Claims cost paid by the employer			13,981.00
Additional cost to employer due to not reporting medical-only claims			2,355.85

Illustration 2 State Fee Schedule or Reasonable and Customary Percentage Decrease & Insurance Carrier Network Discounts			
Total Medical Bills	State Fee Schedule reduction for the Treatment/Procedure	Insurance Carrier Network Discounts	Final medical bills cost due to state fee schedules and carrier network discounts
$13,981 (gross)	$9,787	$7,829	$6,152 (net)

Illustration 2 is representative of the reduction that would be realized on the $13,981.00 in medical bills had they been applied against the state fee schedule and insurance company network discounts. Now the total claims in the modification formula at 30% would be $6,152 reducing the modification from 1.275 to 1.20 versus the 1.18 experience modification without reporting medical-only claims. No question reporting no medical claims produces a lower modification; however, many employers have no knowledge on how to apply the WC state fee schedules and will not have access to insurance carrier discount networks. This often results in the employer paying higher medical costs.

Employers could arrange with a third party fee schedule company to assist with state fee schedules but this would depend on the volume of work. It may be awkward to engage a fee schedule company without a formalized program to allow the employer to pay their own medical claims under a small or large deductible program. Alternatively, the employer can look up the fee schedule amount by procedure code and fee schedule. The employer will have to know how to create an “explanation of benefits” for the medical provider. In summary, some knowledge is required if an employer is going to take advantage of state fee discounts in paying their own medical claims.

Illustration 3 State Fee Schedule and Discounted Insurance Carrier Network Applied			
	Premium	**Experience Modification**	**Adjusted Premium**
Cost (premium) where all claims were reported	$40,790.00	1.20	48,948.00
Cost (premium) where employer did not report medical-only claims	$40,790.00	1.18	48,132.20
Premium Savings due to reduction in experience modification for not reporting medical-only claims.			816.00
Premium savings over three years due to the reduction in the experience modification for not reporting medical-only claims			2,448.00
Medical Claims cost paid by the employer			13,981.00
Additional cost to employee due to not reporting medical-only claims			11,533.00

Potential Risks and Penalties

Clearly, an employer paying their own medical claims in non-ERA states presents a more attractive option than doing so in ERA states, as the impact on the Experience Modification is greater. However, there are several factors to consider. There is always a risk the claim could become more serious. Many states have distinct periods of time that allow for a claim denial. If the claim becomes problematic or significant medical is needed, or if an employee becomes disgruntled or disabled (and the condition can bean be tied back to the original medical claim) the employer may lose their ability to have the claim denied at a later date due to the state's statutes.

In addition, many states have penalties that apply if the employer does not report the claim to the carrier or the state. Other states require all incidents must be reported even if "notice only". Other states such as Florida and California, the doctor reports the claim to the state with a copy to the carrier of record so the opportunity to pay your own medical claims is reduced or certainly more challenging. An employer must also be aware of penalty situations in their states regarding timeliness of payment. For instance, in Michigan, as in many other states, the bill must be paid within 30 days of receipt.

Deductible Programs

Currently 36 states (Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota and Tennessee) have state-approved small deductible rules ranging from $100 to $25,000 for medical and indemnity. In some states, an insurer is not required to offer a deductible if the employer's ability to make payment of the claims under the deductible is in doubt. In Arizona, Idaho, Louisiana, Michigan and Mississippi insurers are permitted to file small deductible programs.

When a deductible is in place, the employer receives a premium credit on the policy for assuming a deductible on every claim. These plans are extremely popular as a cost cutting tool for many employers, especially contractors. Sometimes insurance carrier underwriters use deductibles as a defensive underwriting tool or the employer reluctantly accepts a deductible, as it may have been the only way to obtain a competitive premium. A deductible is simple to manage from the employer's standpoint. Claims are submitted to the carrier. The carrier pays the claims after applying the state fee schedules and other network discounts. The employer is billed at the end of the month for reimbursement of the claims under the deductible amount.

Whether or not the claims under the deductible go into the Experience Modification depends on the state the employer is located in. Some states require insurers to report losses on a gross basis, which is the full amount paid by the insurer, irrespective of deductible reimbursements received from the employer. Other states allow reporting on a net basis, after deduction of the employer's reimbursement. (With the expanded format of the unit statistical report approved in most states, losses are reported on both a gross and net basis. Thus, insurers report the same information in all states regardless of whether gross or net losses are used to calculate experience modifiers.) Net reporting of losses may allow an employer to receive a premium discount up front and favorably affect its experience modification factor by eliminating all losses below the deductible from experience rating.

For instance, in Kentucky, the employers get a premium credit for the deductible and the medical claims under the deductible do not go into the Experience Modification. An employer will have to check with their insurer and state to see how the claim under the deductible will affect their modification.

In states where there is no approved Workers Compensation deductible, some insurers will consent to the development of a first-aid folder that allows the employer to pay all medical-only claims up to a stated amount, e.g., $250. Medical-only payments are made by the employer directly. The insurer becomes aware of such payments only on advisement by the insured in a report "for information only." There is no provision for any reduction in the Workers Compensation premium. However, such claim payments made by the insured are not included in the loss data filed for experience rating. Subject to the insurer's consent, the employer's election of a plan to pay small medical-only claims reduces insurers' claim handling charges associated with small yet frequent claims. This plan also removes some loss dollars from the experience rating procedure. As previously discussed, since experience rating is primarily frequency-driven rather than severity-driven, the effect of such an arrangement can be advantageous to the employer.

State Specific Variances

There is usually a reason why a state did not approve ERA. They may have a mechanism in place to handle employers paying small medical claims. As an example, Missouri allows any employer to pay the first $1,000 of any medical-only claim. The bill is submitted to the carrier. The carrier re-prices the medical bill according to the state fee schedule and network discounts. This is true even if a bill is $1,200 but ends up being $800 after re-pricing. The claims under $1,000 do not get reported on the Experience Modification. Some carriers operating in Missouri that have a higher deductible plan (i.e., $2,500) in place with an employer will allow the employer to reimburse the bill and not report the entire bill to the Experience Modification. They count the first $1,000 under the Missouri law and the balance of the deductible as subrogation. Any lost time claim or a claim where it is known that a permanency rating will apply (i.e., fracture) must be reported even if under $1,000.

The Missouri system has worked well for employers. It is an example of how an employer may have a different approach to paying small medical claims or decide not to pay them at all depending on the state they are located in.

Advanced Monitoring of the Experience Modification

It is important to note that the 70% reduction applied to medical claims for the Experience Modification in ERA states is only for a *medical-only* claim. As soon as an indemnity (lost wages) payment is included, the entire medical portion of the claim goes into the Experience Modification formula. Once the waiting period has passed to collect lost wages (anywhere from 3 to 7 days depending on the state) lost wages are paid back to day one. There are occasions when a claim may result in only 5 or 7 days off or $300 to $900 of indemnity payment but the medical is high (i.e. $10,000). Hernia operations are an example of short time off but large medical expense. If the employer were to continue to pay this individual for the week or two off and report only the medical to the carrier, only $3,000 of the medical would apply to the Experience Modification. This feature of the formula highlights the importance of returning employees to work as soon as medically possible and when not medically possible, managing that one-to-three-week period of wages. Modmaster could be used to run a variety of "what ifs" to determine the cost saving advantages to paying close attention to this issue.

Conclusion

As we have seen, the variances among states dictate that there is no one, simple answer to the employer's quandary of whether to pay small medical-only claims or turn them in to the insurance carriers for payment. An employer must weigh the advantages and disadvantages of paying small medical claims after obtaining a complete understanding of their state's rules and laws, evaluating their staff's ability to effectively manage their own medical bills and reviewing the insurance alternatives available that take paying small medical claims into consideration.