

# Business Insurance

\$100

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SPECIAL ISSUE: **TACKLING  
THE TOUGHEST**  
**WORKERS COMP CLAIMS**

crain

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NEWSPAPER

## DATA POSTER INSIDE

Returning injured workers to the job  
more quickly and at a lower cost



# YOU CAN'T PREDICT ACCIDENTS, BUT YOU CAN SEE COMPLICATIONS COMING A MILE AWAY.

**INDUSTRY:**  
MANUFACTURING

**CUSTOMER:**  
FURNITURE DESIGNER

**CASE OBJECTIVE:**  
MANAGE UNRELATED COMPLICATIONS  
OF AT-WORK INJURY

**CASE SPECIFICS:**

While working, an employee at one of our customers' furniture factories recently had an accident. What seemed like a fairly straightforward claim changed when our VantageComp™ predictive model alerted us early that the man had key triggers for type 2 diabetes. We were able to get our doctors and other medical staff involved early to craft a plan that treated the injury and helped the employee manage his diagnosis. By combining innovative data analytics with experienced talent, VantageComp led us to the best solution for today and tomorrow. To learn more, contact your agent or broker, or go to [libertymutualgroup.com/factory](http://libertymutualgroup.com/factory)



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# Fast action, solid resources stop comp claims spiralling

Experts recommend early intervention, constant monitoring

By **ROBERTO CENICEROS**

Failing to pay adequate attention to an employee immediately after he or she is injured can quickly result in expensive, tough-to-close workers compensation cases, veteran risk managers say.

Among other factors also blamed for average workers comp claims remaining open longer than expected while their costs balloon are the growing incidence of worker obesity and related co-morbidities, Medicare set-aside mandates that complicate settlements as well as litigation.

But failing to assign adequate

## COMPLICATING FACTORS

Issues that can extend the duration of a workers compensation claim include:

- Failing to quickly contact the injured worker
- Failing to investigate contributing factors
- Assuming the claim will not escalate
- Failing to assign adequate resources

resources to a newly reported claim, or assuming such claims will be appropriately handled, often is cited by experienced risk managers and other workers comp professionals as the major reason why otherwise typical employee injury

cases spiral into legacy claims that defy resolution.

"In many instances, it's claims that don't get the necessary full-court-press attention from Day 1 and they end up floundering without any specific direction," said Mike Kenitz, Midwest regional practice leader for strategic outcomes practices at Willis North America Inc. in Pittsburgh.

"Before you know it, time erodes and you lose control," Mr. Kenitz said.

Peggy Crook, McLean, Va.-based director of global claims risk management services for Hilton Worldwide Inc., said hiring an outside auditor 10 years ago to review workers comp cases helped her gain a better understanding of how claims escalate when assumptions are made that they will be a

See **AVOIDANCE** page 21

## Long-term claim costs escalate rapidly

By **ROBERTO CENICEROS**

While it's well known that costs mount the longer a workers compensation claim stays open, data from insurers, third-party administrators and pharmacy benefit managers shows that the increases are dramatic.

For example, claims that close within 30 days incur an average cost of just \$287. Ninety percent of such claims are medical-only cases, or cases in which no work time is lost, according to data provided by Sedgwick Claims Management Services Inc.

But the costs increase to \$722 when workers comp claims remain open for 31 to 90 days and when nearly 81% are medical-only cases.

The rapid rise in costs continues, reaching \$6,875 when such cases stay open 181 days to one year, which is

about 3.5 times more than their \$2,150 cost when they remain unresolved for 91 to 180 days, according Sedgwick's book of workers comp claims that closed during 2011.

The percentage of medical-only claims drops to a minority of all claims when they are unresolved from 181 days to one year, with only 37% in that category.

When comp claims close between one and two years, Sedgwick's data shows their average cost jumps to \$19,888, when only 21% are medical-only claims. Claims that close between two and three years incur average expenses of \$36,792, when the medical-only proportion drops to 13%. After three years, when fewer than 10% of cases are medical-only claims, the average cost is \$63,087.

Other data shows similar patterns.

Information provided by Lansing, Mich.-based Accident Fund Holdings Inc., for example, shows that claims closing at two years are 2.19 times more expensive than those closing at one year. Likewise, the insurer's data shows that claims closing after six years are seven times as expensive as claims that close at one year.

Several factors now contribute to delays resolving workers comp claims, said Scott P. Rogers, Boston-based executive vp of casualty operations for Sedgwick. They include an aging worker population, legislative changes and compliance with Medicare regulations.

But treating claims as simple medical-only cases when they actually need more aggressive attention and resources early on also is a significant factor.

See **COSTS** page 15

## Even seemingly minor injuries require informed follow-up

By **ROBERTO CENICEROS**

Workers compensation claims commonly categorized as "medical only" because a quick resolution is expected easily can deteriorate into costly indemnity or lost-time claims that drag on.

When that happens, the chance to conduct a helpful claims investigation diminishes, and modified duty or return-to-work efforts can end up exacerbating matters instead of helping employers control costs, say risk managers, brokers and consultants.

Often, medical-only claims are not properly monitored, said Debra Levy, workers compensation solution leader

in the Risk Consulting Resource Group for Wells Fargo Insurance Services USA Inc. in Atlanta.

"We see this over and over," injured employees with medical-only claims put on modified duty and then claims handlers fail to follow up to ensure that those employees receive a timely, full-duty release. Or, the claims adjusters fail to make sure those employees really comply with their medical restrictions, Ms. Levy said.

"Then people continue to get hurt and that is how those claims often grow bigger because the medical (management) is not handled properly on the front end," Ms. Levy said.

It is not unusual for medical-only

## MEDICAL-ONLY CLAIMS

To prevent claims for what appear to be minor injuries from becoming indemnity claims, experts recommend:

- Give insurers and third-party administrators specific information on handling medical-only claims
- Monitor medical treatment to make sure it is appropriate
- Properly monitor injured workers' progress and compliance with medical restrictions

claims to become longer-term problems in that way, because they often land on the desks of adjusters with minimal experience who are managing heavy case loads, several sources said.

See **MEDICAL** page 6

## SPECIAL ISSUE

### TACKLING THE TOUGHEST WORKERS COMP CLAIMS

An array of relatively new challenges has made it increasingly tougher for workers compensation payers to control claims costs.

Issues such as an aging and an increasingly obese workforce, Medicare set-aside demands and the liberal treatment of chronic pain with prescription pharmaceutical drugs have added to the traditional burdens of managing claims.

Failing to assign necessary resources early on to a new claim also can cause employee injury cases that seem typical on the surface to spiral into tough-to-manage "monster claims," according to risk managers.

Fortunately, as you will read in the stories within this special issue on managing workers compensation claims, there are strategies and tools to help risk managers and workers comp managers mitigate new and traditional claims-cost drivers.

Consider predictive modeling, for example. Proponents say its widespread application helps identify which claims will grow out of hand if necessary medical services are not provided early. Yet those same proponents say it is too early to provide data measuring the positive impact of predictive modeling on claims outcomes.

But it is clear that workers comp claims managers would welcome proven tools and strategies.

More than one-quarter of workers compensation claims handlers report seeing the cases they manage stay open longer, according to a survey conducted for *Business Insurance*. Many of those say they are very concerned about the trend.

Read on to learn more about the issues that have claims handlers concerned and what some of them are doing about it.

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# Increase in open claims worries claims handlers

By SHEENA HARRISON

More than one-quarter of workers compensation claims handlers say claims are staying open longer, and most of those claims handlers say they're "very concerned" about the trend.

That's according to a survey conducted in July for *Business Insurance* by Signet Research Inc., an independent research company based in Cliffside Park, N.J. The results are based on responses from 326 professionals who manage workers comp claims for public, private and nonprofit employers, as well as insurers, brokers and third-party administrators.

About 26% of survey respondents said workers comp claims are staying open longer now than five years ago. Of those claims managers, 42% say claims are staying open 90 days to one year longer compared with five years ago, while 32% see claims staying open 20 to 89 days longer.

Among those seeing longer claims, 69% said they're "very concerned" about the claims duration trend, while 31% said they're "somewhat concerned."

Insurance buyers reported similar findings. Among 203 employers who took the survey, 22% said they're seeing comp claims stay open longer compared with five years ago, and 63% said they're "very concerned" about longer durations.

The survey data correlates with a recent report from NCCI Holdings Inc., which said the average duration for temporary total disability claims benefits increased during the first half of 2011.

The Boca Raton, Fla.-based ratings and research organization

said the average duration for TTD indemnity benefits was 149 days in the first six months of last year. That compares with 147 days in 2010 and 144 days in 2008, the first full accident year after the Great Recession began.

NCCI said the increase in claims duration tracked an increase in unemployment rates nationwide during the recession.

Despite the trend, many employers still see claims durations holding steady. Nearly 58%

26%

The percentage of respondents who say workers compensation claims are staying open longer today than five years ago.

69%

The percentage of respondents who say they are very concerned that workers compensation claims are staying open longer today than five years ago.

said they do not see longer claims durations, while 17% said they didn't know or weren't sure.

Among those seeing longer claims, nearly half said litigation by claimants and economic conditions are contributing factors.

About one-third of that group said durations have been affected by an aging workforce nationwide and Medicare secondary-payer compliance issues, which can hinder the settlement of workers comp claims.

Insurance buyers also identi-

fied inadequate claims management as one of the top contributors to longer durations.

Many claims managers in *BI's* survey are attempting to address duration problems, with 41% saying they've used procedures and programs to identify claims that might stay open longer.

Half said they are relying more heavily on nurses and doctors to help claims close earlier. Of those managers, 89% said increased involvement has "definitely helped" or "helped in some cases" to close claims earlier.

Predictive modeling is an emerging resource allowing claims handlers to tackle claims duration. About 15% of claims managers said they're using predictive models to identify workers comp claims that are at risk of staying open longer or becoming more costly.

Of those, 58% said models have provided "some help" to identify problem claims, and 24% said they have provided a "great deal" of help.

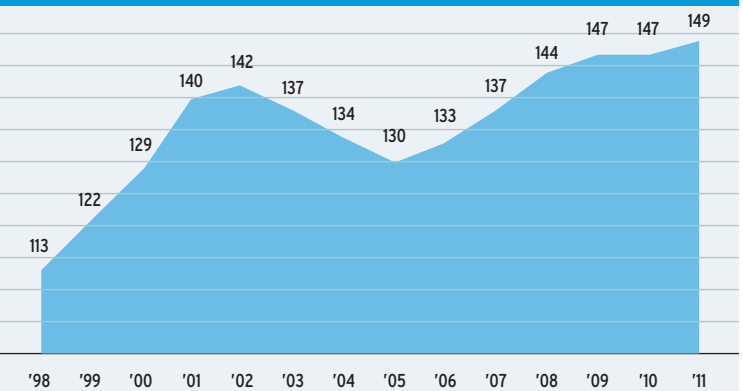
Nearly 85% of insurance buyers said they are using return-to-work policies that can help injured employees transition back into the workplace after an injury. And 24% said they are referring claimants to wellness programs when obesity has been identified as a complicating factor in a workers comp claim.

In spite of efforts to address longer claims, some employers said the problem is not receiving attention from C-suite executives.

More than 51% of insurance buyers who see increased claim duration said their upper management has not expressed concern about increased comp costs during the past 12 months.

## AVOIDING INDEMNITY CLAIMS

Informed, proactive steps can prevent minor injuries becoming more expensive indemnity claims, experts say. The length in days of claims for temporary total indemnity increased markedly during the Great Recession.



Source: NCCI Holdings Inc.

## Early contact limits severity of claims

Quick phone calls to injured workers speed return to work

By ROBERTO CENICEROS

Hours before her third-party administrator receives a new workers compensation claim, Laurie Ogsaen telephones employees injured at Evergreen International Aviation Inc. facilities across the United States.

Calling workers immediately after an injury to help them understand what to expect from the workers comp system and who else will be calling them—be it a TPA claims adjuster or a nurse case manager for more serious injuries—is the best practice she knows to keep injured employees from contacting attorneys, said Evergreen International's workers compensation manager in McMinnville, Ore.

"Since I am in corporate, the first thing I require of (field) managers is to make sure they get the

worker medical treatment and advise them of the process, Ms. Ogsaen said. "After they are all done treating and (injured workers) go home, I call them and make the first point of contact with them from corporate, which seems to mean a lot to a lot of them."

Taking such measures immediately after an injury helps maintain control of claims so they don't evolve into tough-to-resolve cases, experts say.

If employers or their representatives don't aggressively address a claim early in its life cycle, there is greater possibility it will drag out, said Mike Kenitz, Midwest regional practice leader for strategic outcomes practices at Willis North America Inc. in Pittsburgh.

"The bottom line is comp is money and time is money," Mr. Kenitz said. "The end result is the longer a case is open, the more it's going to cost. The less attention it gets up front, the more time it's going to take (to close) and the

See **EARLY** page 20

# Medicare Secondary Payer system can hinder comp settlements

Self-insured firms, insurers affected by federal requirements

By SHEENA HARRISON

Difficulties in the Medicare Secondary Payer system are continuing to hinder the settlement of

some workers compensation claims, say service providers who specialize in handling such cases.

The system requires self-insured employers, insurers and others to notify the Centers for Medicare and Medicaid Services of all workers compensation or liability settlements that involve Medicare recipients. Those beneficiaries are then obligated to use settlement

## IMPEDIMENTS

The Medicare secondary payer system, which requires Medicare recipients who receive workers compensation or liability settlements to repay the Centers for Medicare and Medicaid Services, has slowed resolution of some workers comp claims because of:

- Longer-than-expected CMS response times
- Higher-than-expected insurer set-asides
- Higher-than-expected CMS bills

## Errors & Omissions

■ The funding deficit of pension plans sponsored by large employers hit a record high in July, according to an analysis by Mercer L.L.C. A headline in an InBrief item in the Aug. 6 issue said the opposite.

■ A July 16 article, "M&A Activity Up, Focused on Middle-market Firms," should have said USI Holdings Corp. is looking to acquire boutique benefits operations serving employers with 100 to 2,000 covered lives.

funds to repay CMS for the cost of their treatment, but employers and insurers also can be held

responsible.

Although insurers understand that settlements can be used for Medicare reimbursement, sources say long response times and higher-than-expected bills from CMS are making it difficult to resolve claims.

"You've got cases that are ready to settle, but we just can't settle them because we can't get the information we need to get it resolved," said Michael Merlino, vp of Medicare compliance for Sedgwick Claims Management Services Inc. in Atlanta. "And that just creates frustration on everyone's part."

Settlements that involve Medicare beneficiaries, or those who will soon become beneficiaries, require parties to include reim-

bursement for medical care that occurred from the date of an injury to the date of a settlement. While parties work to anticipate how much Medicare is owed before a claim's closure, CMS sends a conditional payment letter only after settlement.

Letters usually are sent to parties in a case within 65 business days after Medicare is notified of a pending settlement, according to the Medicare Secondary Payer Recovery Contractor website. A study released in March by the U.S. Government Accountability Office showed that the contractor took an average of 76 business days to issue such notices in 2011.

That timeline has stretched as

See **SETTLEMENTS** page 20



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# Creative claims settling

*Some injured workers prefer alternatives to cash settlements*

By SHEENA HARRISON

Experts say workers compensation claims handlers need to think creatively to devise settlements that help injured workers resolve long-standing cases.

Gift cards, hot tubs and, in one case, a new boat, are examples of ways in which some difficult claims have been brought to a close.

While such offerings may seem peculiar in a workers comp setting, they can help resolve claims that otherwise could stretch on for years, said Kathryn Tazic, Chicago-based senior vp with Sedgwick Claims Management Services Inc.

"We've found a need industry-wide to start creating other opportunities for settlements that really

would be more innovative than traditional," Ms. Tazic said.

Greg Gitter, president of San Diego-based Gitter & Associates Inc., said the key to settling many difficult claims is listening closely to what an injured worker needs or wants.

"Sit down with the person, have a conversation and find out what's important," said Mr. Gitter, whose consulting firm works to resolve high-exposure workers comp claims.

Ms. Tazic said Sedgwick has seen an increase in injured workers who want gift cards to a preferred retailer as part of their workers comp settlements. At times, such cards can be loaded with as much as \$10,000, she said.

She said she believes the weak economy has prompted more claimants to accept settlements in gift card form.

"Depending on where or how the gift card's applied, it would (provide) the ability to meet

everyday needs," Ms. Tazic said. "So if it's a grocer, they know that they can feed their family."

Mr. Gitter's firm has devised several settlements that go beyond traditional cash offers. In one case, he worked with a claimant who was reluctant to accept a \$50,000 settlement.

In conversations with the worker and his attorney, the man mentioned that his dream was to spend his time fishing for bass in Oregon. Mr. Gitter used that information to offer the worker a \$38,000 bass fishing boat plus about \$8,000 in cash.

The worker accepted the offer almost immediately, he said.

"It didn't change the value of the case," Mr. Gitter said. "It didn't change anything about the case other than the manner that we approached the settlement."

Dave Dietsch, Kansas City, Mo.-based vp of claims for Lockton Cos. Inc., L.L.C. said the broker's claims managers at times have



By making alternative settlement offers, such as offering injured workers hot tubs, claims handlers can close tough claims.

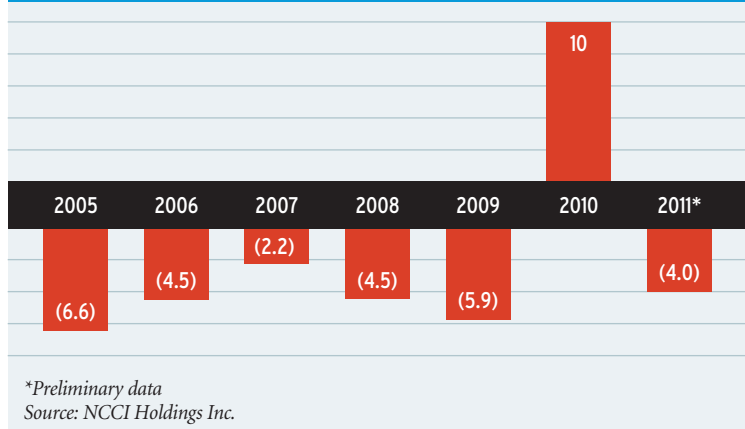
offered hot tubs or gym memberships in lieu of cash that would be used for an injured worker's physical therapy expenses.

Mr. Dietsch said he believes such settlements appeal to

See **CREATIVE** page 20

## FREQUENCY OF CLAIMS

Due in large part to factors related to the Great Recession, the frequency of lost-time workers comp claims increased in 2010 for the first time since 1997. Frequency went down again in 2011. Frequency is the number of lost-time claims per \$1 million in earned pure premiums. Percentage changes shown.



## Integrated safety plans cut claims frequency

*Firms focus on stopping injuries before they happen*

By LOUISE KERTESZ

"The least expensive claim is the one that doesn't happen," says Joyce Long, global workforce strategies practice leader for Marsh Risk Consulting in St. Louis.

And a safety program that's integrated into the organization is a key to preventing and mitigating workers comp claims, consultants say.

Too often, however, workplace safety, workers comp claims administration, and data and analytics operate in silos reporting to different parts of an organization, and valuable information about

cost drivers is not captured for use in safety programs.

"It's not just a problem with the separate reporting. Sometimes the safety or loss control people don't understand the workings of work comp and risk management and vice versa," said John Spath, senior consultant at Aon Risk Solutions' global risk consulting and casualty risk consulting unit in Boston. "There are a lot of opportunities to get training in these areas and understand some of the basics" from broker resources to professional organizations, including the American Society of Safety Engineers' Business of Safety Resource Center, he said. "The better organizations are integrating the functions now," he added.

See **INTEGRATE** page 21

## Medical: Informed follow-up needed

CONTINUED FROM PAGE 3

Severe injury cases, in contrast, get more immediate attention from veteran adjusters and nurse case managers who can enlist additional resources to obtain the best outcomes possible.

Those cases are expected to result in claims requiring focused medical management and indemnity benefit payments while the claimants lose time away from work to recuperate.

But when injuries are seemingly minor and expected to be resolved within 90 days or so, there may be less attention paid to them at the outset.

Sources disagree whether issues such as increased worker obesity and an aging workforce are driving more medical-only claims to turn into indemnity claims because of co-morbidity complications.

Although the issue has long been a concern, the topic of medical-only claims sliding into the indemnity category is gaining greater attention in the workers comp industry, said Hattie Cunningham, a claims cost expert for Lockton Cos. L.L.C. in Kansas City, Mo.

It could be that the "low-hanging fruit with regard to post-injury management" has been addressed with practices such as return-to-work programs and the selecting of preferred medical providers, Ms. Cunningham said.

"Now we are starting to look at other places where we might be missing the boat, and that is one of them—managing those claims so they don't turn into indemnity" cases, Ms. Cunningham added.

Sources agree, though, that lost-time claims morphing into indemnity cases is an issue that

employers must manage to control unnecessary costs and help injured employees return to work safely.

Doing so may require specific instructions and contract language on how third-party administrators or insurers are to handle medical-only claims.

Large third-party administrators say, however, that they have systems in place to assure that medical-only claims immediately receive proper evaluation and the resources needed to assure they do not stretch into lost-time claims.

Employers' internal claims management practices also can be a factor, said Peggy Crook, director of global claims risk management services for Hilton Worldwide Inc. in McLean, Va.

Because of budgetary issues, for instance, an employer's internal claims-management department may be too short-staffed to pay proper attention to medical-only claims while larger claims hold their attention, Ms. Crook said.

An audit conducted 10 years ago revealed that mismanagement of Hilton's medical-only claims caused them to mushroom into "monster claims," Ms. Crook added. The claims often involved workers placed on modified duty under a return-to-work program while they continued receiving medical treatment.

"But what we found were (TPA) medical-only claims handlers—which many times are nothing more than clerks (because) they have very little experience—were authorizing" extensive medical treatment, Ms. Crook said. "That kind of thing was being done on medical-only claims."

Hilton now has a dedicated medical-only claims unit within

its TPA, Ms. Crook said. That provides her greater control over the claims, as the TPA must follow her protocols.

The efforts help ensure, for example, that there is greater communication between claims adjusters and medical providers so that employees on modified duty do not re-injure themselves by failing to follow work restrictions.

It also helps assure the workers are moved from modified-duty status to full-duty status as soon as appropriate so they don't get discouraged thinking they are not getting better and their cases become lost-time claims, Ms. Crook said.

"Not managing medical-only claims can be a major flaw in many work comp programs," said Charles F. Martin, casualty operations consulting leader in the risk consulting practice at Marsh USA Inc. in Norwalk, Conn.

"Unfortunately too many (lost-time claims) just get processed (without) a lot of investigation or validation" that compensability is appropriate, Mr. Martin said. By the time employers and their claims adjusters realize that costs are mounting, the opportunity to properly investigate by interviewing witnesses, for example, may be lost.

The employer also has lost the opportunity to properly manage the employee's medical care to ensure they receive adequate treatment, Mr. Martin said.

"If you don't keep an eye on all of the medical-only claims, there are going to be a portion of those that transform into lost-time claims," Mr. Martin said. "Some of those are going to come back and bite you because now it is too late in the game."

# TPAs can help avoid costly lost-time cases

By **ROBERTO CENICEROS**

While observers say medical-only claims easily can fall between the cracks and spiral into costly lost-time cases when adjusters fail to properly manage them, several third-party administrators say they guard against that happening.

The problem arises because medical-only adjusters often have minimal experience and are relegated to processing large caseloads of claims that typically are expected to be resolved quickly because the injuries appear minor.

But merely processing claims, rather than carefully reviewing them to assure claimants receive the necessary level of medical management, can cause small problems to grow worse, sources said.

"Some of the worst cases you will see started out as medical-only," said Charles Martin, casualty operations consulting leader in the risk consulting practice at Marsh Inc. in Norwalk, Conn. "People didn't manage them (properly), and then down the road (they become) a lifetime case and you are spending hundreds of thousands of dollars."

Experts also say not paying proper attention to underlying health factors, such as co-morbid conditions stemming from obesity or aging, can complicate medical-only claims.

And when employers have established modified-duty return-to-work programs, claim handlers also may fail to assure that medical-only claimants comply with their work restrictions or return to their normal, full duties when released to do so.

Employees who do not comply with their work restrictions can exacerbate their injuries, while those who are not promptly returned to full duty when appropriate can become lost-time indemnity claimants, sources said.

But several TPAs say they have implemented practices to ensure from the outset that medical-only claims are thoroughly reviewed so additional medical resources are immediately called in when necessary.

ESIS Inc., for example, analyzed its claims data a few years ago to learn more about its medical-only claims outcomes, then implemented measures that would prevent unnecessary cost drivers, said Nancy DiVincenzo, ESIS vp of claims product management.

The data showed that the Philadelphia-based TPA could improve on its medical-only claims by "actually managing them, as opposed to just processing them," Ms. DiVincenzo said.

So ESIS created a unit dedicated to handling medical-only claims. In addition to medical-only claims supervisors and claims analysts, a dedicated team includes nurses who provide clinical guidance for managing the claims.

The unit's nurses evaluate incoming claims "at Day 1" as well as reviewing the medical

treatment provided to the claimant the entire time a case remains open, Ms. DiVincenzo said.

"They are evaluating the (current procedural terminology) codes and making sure that everything is in line with treatment guidelines for that injury," Ms. DiVincenzo said.

The nurses look for co-morbid conditions and any other factors that could prolong a claim.

They also help determine if a claim should be transferred to an indemnity adjuster rather than leaving it in the hands of a medi-

cal-only claims analyst.

"If anything seems like it's going to prolong treatment or it's going to drive up the cost of that claim, we are going to pull it right out of medical only," Ms. DiVincenzo said.

Several years ago, Gallagher Bassett Services Inc. also improved its claims management process by setting up "centralized medical-only units," said Emil Bravo, executive vp in Itasca, Ill.

The unit's goal is to ensure medical-only claims do not unnecessarily become lost-time cases, and the units have helped

## DIGGING DEEPER

Paying closer attention to underlying factors such as co-morbid conditions can reduce the duration and cost of a workers comp claim, experts say. While the average for all claims for injury years 1996-2007 was \$2,490, co-morbidities added significantly to that total for selected categories.

CATEGORY	CO-MORBIDITY RELATED	OTHER SERVICES	TOTAL
Diabetes	\$3,169	\$12,728	\$15,897
Hypertension	\$2,687	\$12,969	\$15,656
Chronic pulmonary	\$2,501	\$12,218	\$14,719
Drug abuse	\$2,999	\$10,718	\$13,717

Source: NCCI Holdings Inc.

reduce the average cost per claim and the average amount of time a claim stays open, Mr. Bravo said.

Gallagher Bassett also offers

See **EVOLVE** page 19

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# Opinions

## EDITORIAL

### High-cost comp claims can be avoided

**E**mployers in many states face tougher pricing conditions for workers compensation coverage, a situation that is unlikely to improve significantly anytime soon.

That's generally bad news for employers, but for workers comp professionals, these are the types of market conditions where they can prove their worth to their organizations.

And one way workers comp claims management staff can make a difference is by using their expertise to head off potentially costly problem claims.

As we report in this special issue of *Business Insurance*, seemingly routine claims quickly can become problem claims if they are not managed effectively. The longer the problem claims are allowed to fester, the more rapidly they escalate into catastrophic claims.

The reasons why claims are allowed to deteriorate often are simple to identify. Lack of communication, overworked and inexperienced claims staff, and poor controls are some of the more common reasons why the costliest workers comp claims develop.

While it's easy to spot the weaknesses, it's not always easy to fix the problems.

That is where the workers comp professionals come in.

By installing systems and procedures that flag potential problem claims such as early intervention programs; treating the injured workers and resolving the claims quickly, sometimes using creative settlement strategies; using sophisticated tools, such as predictive modeling; and getting the best out of their workers comp service providers, workers comp professionals can greatly reduce the potential for problem claims.

That, in turn, should put them in a better position when they have to negotiate with their insurers.

Lower spending on insurance premiums can add to an employer's bottom line, and that really grabs the attention of management.

## LETTERS

*Business Insurance* welcomes letters to the editor.

The section is intended to be a forum for readers' opinions and comments. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters.

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## SCHILLERSTROM



## COMMENTARY

### Prepare for price hikes in 2013

**C**hanging workers compensation insurance market conditions make it clear that risk managers must prepare their companies for a budget reality they haven't faced in years.

That goes for buyers of primary and excess workers comp coverage layers, too, as underwriters of both products are not bending easily when it comes to demanding price increases at renewal time.

Risk managers, meanwhile, have probably grown accustomed to lower or flat workers comp insurance prices after a years-long soft market trend.

But chances are good the next renewal will be different for many employers that haven't already experienced what I am talking about.

So risk managers need to prepare by considering how paying higher workers comp insurance premiums will impact their budgets and their company's overall cost of risk.

Some employers may no longer have the choice of purchasing low-deductible policies as insurers reduce their offerings. Still other employers may voluntarily decide to raise their retentions to offset increased premiums.

That alternative, however, also comes with hefty budget considerations.

Risk managers likely will need to huddle with the C-suite occupants to discuss issues such as funding the costly collateral insurers demand for securing claims payments when they provide employers with larger-deductible policies.

"We are telling clients to be aware that for

their 2013 budgets they need to be putting in increases" for premium expense, Paul Braun, Los Angeles-based managing director of casualty claims for Aon Global Risk Consulting, recently told me. "If they think they are going to take a higher retention, then they need to come up with security. In other words, it could impact their budgeting process."

Mr. Braun isn't the only one advising clients to budget for rising workers comp premium increases.

Workers comp insurers are paying out between \$1.18 and \$1.30 for every dollar they take in, said Kansas City, Mo.-based Julie Burgess, a senior vp and unit manager in national accounts for broker Lockton Cos. L.L.C.

"Whether we (as insurance buyers) have good experience or not, we all have to make up that 18 cents or 30 cents," Ms. Burgess said. "So yes, the cost of work comp is going up."

Beyond budget preparations, managing rising workers comp insurance prices will require greater attention to other risk management areas, such as loss prevention and claims management.

And risk managers who haven't had their policy-purchasing negotiation skills tested since the last hard market also may want to brush up on that aspect of the job.

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**ROBERTO CENICEROS**  
SENIOR EDITOR

# Perspectives

One of the biggest cost drivers in workers compensation is seemingly “average” claims that take a turn for the worst and result in several years of medical treatment and disability. Mark Walls, vp of claims for Safety National Casualty Corp. discusses the common threads of “creeping catastrophic” claims.

## Intervene early on claims

By Mark Walls

When people think of the types of claims that are reportable to an excess workers compensation carrier, they usually think of very serious injuries such as severe burns, brain injuries and spinal cord injuries resulting in paralysis, or even death claims.

However, the vast majority of the cases that breach the average retention are what we refer to as “creeping catastrophic” claims or “developmental” claims.

These claims start out like any other case, usually with a back, knee or shoulder injury. However, because of a series of events, they end up costing the employer hundreds of thousands of dollars. These developmental claims share many common characteristics that, if identified and addressed in a timely manner, can prevent significant adverse development of the claims.

I cannot emphasize enough the important role that a return-to-work program plays in controlling claims costs. It's a relatively simple way to prevent average claims from becoming developmental claims.

There is a strong correlation between duration of disability and the chances of ever returning to work. According to studies done by the Workers Compensation Research Institute and others, employees who are disabled for longer than six months have less than a 50% chance of ever returning to their job. If they are off work longer than a year, the chances for a successful return to work are less than 10%.

In addition to the direct cost of extended disability in terms of indemnity and medical benefits, there are also significant indirect costs. While you are paying the injured employee's disability, you're also paying another person to perform their job.

In spite of these statistics, an increasing number of employers are not providing modified duty for injured workers. The most common reasons I hear for this are the economy and the unions. Employers argue that, because of the economy, they are running lean operations and cannot afford to have a worker who is not productive. In addition, many unions have a “whole person or no person” rule,

which does not allow for accommodating any restrictions.

By returning injured employees to the workforce as soon as possible, the employer can significantly reduce the chances of adverse development on an average claim.

When comparing cases with the same diagnosis, the rates for surgeries, physical therapy and diagnostic testing are significantly higher in workers compensation than in group health, and the outcomes are much worse. Why is this? For starters, there are significant financial incentives for many of the stakeholders to over-treat. Medical providers look to workers compensation to make up for the lower reimbursement rates that Medicare and group health provide. The lack of deductibles makes the injured worker more likely to pursue the lengthy treatment that the doctor recommends. And finally, the quest for a large settlement can lead attorneys to refer their clients to medical providers who produce poor outcomes.

The common thread flowing through these different motivating factors is that the medical care being rendered is inappropriate based on the diagnosis and objective findings. At Safety National, we utilize Best Doctors Inc., a medical peer review organization, to assist in the management of our complex and catastrophic claims. According to the findings of Best Doctors, 29% of the cases that they review have been misdiagnosed. Even when the diagnosis is correct, a change in the treatment plan is recommended in 60% of cases.

When injured workers receive an incorrect diagnosis and inappropriate care, the costs on the claim skyrocket. That's why it is so important to focus on getting the injured worker the appropriate care from medical providers who produce superior outcomes. TPAs, carriers, and employers must be diligent in monitoring the medical treatment using case management, utilization review and independent medical exams to verify that the treatment is appropriate.

I have seen both ends of the spectrum: injured employees who are paraplegics successfully return to the workforce, and people with back strains who never work again.

The one element of developmental claims that cannot be controlled is the motivation of the injured worker. The mind is a pow-

erful healing tool. If a person accepts being disabled and truly believes they cannot improve, then they will indeed be disabled, and no amount of medical treatment will improve their condition.

While you cannot control motivation, an area that is getting increased focus is screening claims for certain psycho-social elements that can impact motivation. Most screening models focus on whether certain factors are present for the employee:

- Young children at home
- A disabled spouse
- A history of drug or alcohol abuse
- A high school education or less
- A low wage-earning capacity
- A history of discipline problems at the employer
- A history of psychological treatment, including for depression

If any of these red flags are present, special attention needs to be given to the claim to minimize the potential impact. Enhanced communication with the injured worker can make a significant impact, because fear of the unknown can drive mistrust and increased litigation rates. Although there is hesitancy in the industry to accept psychiatric conditions on the claim, a little bit of counseling early in the process may head off significant issues later on. If you ignore these psycho-social issues, they are certain to complicate the claim. It is imperative that you identify and address them as soon as possible.

Given that a significant percentage of the population is overweight, it is no surprise that obesity and its associated complications are significant contributors to workers compensation costs. Obesity, hypertension and diabetes are the most common co-morbidities seen on workers compensation claims. According to research presented in the report “Comorbidities in Workers Compensation” that was presented at the 2012 NCCI Annual Issues Symposium in Orlando, Fla., “Claims with comorbidity treatments have about twice the medical costs of otherwise comparable claims.”

While claims handlers cannot prevent the co-morbidities, it is important that they identify them early on.

The over-prescribing and abuse of opioid medications is not just a workers compensation problem—

it is a public health crisis that is costing our health care system billions of dollars every year.

Opioids commonly seen on workers comp claims include oxycodone and fentanyl. Another study presented at the 2012 NCCI Annual Issues Symposium was titled “Workers' Compensation Temporary Total Indemnity Benefit Duration.” This study found that the disability duration on claims receiving opioids was 50% greater than comparable claims.

A similar study by the California Workers' Compensation Institute found that higher levels of opioid use led to increased disability and medical costs, and poor outcomes for injured workers.

Opioids are designed for short-term use during the acute phase of an injury. On almost every developmental claim I have seen, the injured worker was taking a significant dosage of opioid medication for long-term pain management. Such long-term use of this medication not only renders the employee unable to work, it also can lead to other health complications.

It's very important for claims handlers to take immediate action when they see opioids prescribed. They should partner with a pharmacy benefit manager who will monitor the frequency and duration of the dosage to ensure they are proper. They also should insist on a monitoring program to ensure the drugs are being taken properly. Finally, they should work with the treating physician to identify pain management solutions that do not involve long-term opioid use.

The money spent on a comprehensive pain management program today can easily save you hundreds of thousands of dollars later in prescription drug costs. And the key to preventing an average claim from becoming a developmental claim is to diligently monitor for the first sign of potential problems. If red flags are identified, the claims handler must be proactive in addressing these issues before they spiral out of control.

It is important to use all tools available to assist in managing the claims early on. If we can spot the indicators that drive claims costs today, we can stop adverse development in the future.

*Mark Walls is vp of claims for Safety National Casualty Corp. and founder of the 15,000 member Work Comp Analysis Group on LinkedIn. He can be reached at [mark.walls@safetynational.com](mailto:mark.walls@safetynational.com).*



Mr. Walls

**The money spent on a comprehensive pain management program today can easily save you hundreds of thousands of dollars later in prescription drug costs.**

# Models flag potential tough comp claims

By SHEENA HARRISON

Predictive modeling is becoming a key tool for workers compensation claims handlers to identify and intervene in cases that could become high-dollar claims.

Insurers and workers comp service providers say the technology has helped reduce return-to-work times and claim costs. And they're optimistic that results will improve as more data is collected and used to analyze claims.

"We are really helping people avoid poor outcomes, which materially affect the quality of their lives," said George Neale, Boston-based executive vp and general claims manager for Liberty Mutual Group Inc. "And that's the real benefit of this modeling from a responsibility standpoint."

Still, companies that use predictive modeling are hesitant to quantify the effectiveness of models that are still in their infancy.

"I don't feel like we've got sufficient data yet in the industry, and I don't feel like the value proposition is strong enough," said Michael Gavin, chief strategy officer for Duluth, Ga.-based PRIUM, a medical cost management company that uses an "identification model" to intervene on workers

comp claims.

Liberty Mutual began using a predictive model last year as part of its VantageComp claims management program it uses past claims data to identify comp cases with complicating factors, such as obesity, smoking or mental health issues, that can hinder return-to-work efforts.

Mr. Neale said the model helps claims handlers assign early medical intervention for claims that could spin out of control.

"If it goes over that hill, think about how many resources and how much effort it would take at that point in time to try to get it back into the land of a good outcome," Mr. Neale said. "It's pretty darn near impossible."

Seattle-based SeaBright Insurance Co. uses a similar predictive model as part of its BrightCure PDQ program for complex workers comp claims.

Richard Seelinger, senior vp of policyholder services for SeaBright, said the model identifies difficult claims and assigns peer-to-peer counseling for physicians treating injured workers.

"The key to engaging that physician is to engage them early on the right claims" so they can affect the outcomes, said Mr.

Seelinger.

Paladin Managed Care Services Inc., a unit of SeaBright in Santa Ana, Calif., also uses the model. Chief Operating Officer Jeff Miller said the model has been particularly helpful in identifying prescribing and treatment trends that can prolong workers comp claims.

While companies tout the benefits of predictive modeling in workers comp claims, they are hesitant to say how well their predictive models are performing.

SeaBright's internal analysis has seen "very encouraging" results, Mr. Seelinger said.

Mr. Neale said Liberty Mutual's model is too new to provide concrete data about its effect on claims, but there has been a "material improvement" in claims flagged so far by the model. "So far, we're seeing a pretty significant impact of claims coming in less than the escalation risk would have suggested," he said.

PRIUM's Mr. Gavin said it's difficult to say whether the models are catching claims that otherwise would have resulted in high costs.

"It's just a harder story to tell," Mr. Gavin said of predicting the outcome of workers comp cases early in the claims cycle. "We've found that to be the case, and I

## COMP TOOL

*Predictive modeling is gaining usage among workers comp claims handlers, but the technology is still evolving.*

- While some insurers and service providers say modeling has speeded workers' return to their jobs and held down costs, others say the models have yet to prove long-term cost reductions.
- Experts generally agree that sufficient data is not yet available.
- Despite predictive models' advantages, experts say they will not replace experienced claims handlers' interpretation of a claim.

think a lot of our partners and competitors have found that to be the case, too."

PRIUM uses its Qualified Medical Intervention program to review workers comp claims that already appear troubled rather than trying to predict complications that could arise down the road, Mr. Gavin said.

Westerville, Ohio-based pharmacy benefit manager Progressive Medical Inc. is developing its own predictive model.

Joe Anderson, director of ana-

lytics, said Progressive Medical hopes such technology will augment the expertise of its staff.

"In some places, you'll see that decisions can be made better with a statistical model than what a human can do," Mr. Anderson said. "But I think it's too early to say in workers comp pharmacy (if that's the case here.)"

Sources agree that predictive models can't replace experienced claims handlers who can interpret workers comp cases. Still, they say it's an effective tool to lighten the workload of busy claims adjusters, as well as to provide assistance for less experienced staff.

"We feel like the model's going to get it right all of the time, and the adjuster—just because of the massive amount of information they have to deal with—they can't be that accurate on each and every claim that they are managing," Liberty Mutual's Mr. Neale said. "It's really a safety net."

Despite his skepticism, PRIUM's Mr. Gavin said he believes predictive models in workers comp will mature and become more "transparent" as companies hone their data. Still, he said the information will be valuable only if it's used to effectively guide recovery for injured workers.

"The mere identification of a potential high-dollar claim is necessary, but not sufficient to prevent the claim from becoming catastrophic," Mr. Gavin said.



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# Successful Workers Comp Programs Are More Than a Roll of the Dice



A workers comp claim investigation should answer six key questions:

**WHO, WHAT, WHEN, WHERE, HOW AND WHY?**

Source: WC Manual, 2008

Safety programs cut workers comp insurance costs by

**30%.**

Source: MMIA, 2009

**1** in every **5** companies experiences longer-than-average workers comp claims.

Source: BI Research

Injuries are expensive for workers, too: An injured worker can lose

**40%**

of wages, even after all benefits.

Source: MMIA, 2007

- ✗ Employers
- ✗ Insurance companies
- ✗ Third-party administrators
- ✗ Injured workers
- ✗ Medical providers



Avoiding missteps on the path to returning injured workers to the job **more quickly and at lower cost**

For selected injuries, claims with at least one opioid prescription have over **50% LONGER TTD DURATION** than claims without opioids.

Source: NCCI, 2012

**HIGH NARCOTICS USE** in the first quarter following injury indicates higher-than-average probability of narcotics use in subsequent quarters.

Source: NCCI, 2012

**CAP ON DOCTORS' CHARGES** when dispensing pharmaceuticals reduces workers comp costs without limiting patient access to Rx.

Source: WCRI, 2012

Major chronic conditions of an **AGING SOCIETY** have a negative impact on injured worker's recovery time and claim costs.

Source: NCCI, 2011

**EARLY RECOGNITION** of potentially difficult claims largely depends on **ADJUSTER JUDGMENT/ TRAINING** & supporting vendors.

Source: E&Y, 2012

**NARCOTIC ABUSE** is concentrated among **A SMALL PERCENTAGE OF COMP CLAIMANTS.**

Source: NCCI, 2012

Companies satisfied with their current workers comp claims management are more likely to have a **CONTINUOUS CLAIMS PROCESS IMPROVEMENT PROGRAM** than those unhappy with claims management.

Source: BI Research, 2012

**FREQUENT CONTACT** with injured employee and medical providers is essential to **GETTING EMPLOYEE BACK TO WORK AS SOON AS POSSIBLE.**

Primary losses—the most expensive dollars in every claim—are doubling from the current cap of **\$5,000 to \$10,000** in 2013, and eventually going up to **\$15,000** by 2015.

Source: NCCI, 2012

Medical claims costs per 100 workers with normal BMI are about **\$7,500 vs. \$51,000** per 100 severely obese workers.

Source: NCCI-ASI, 2011

The most obese workers file **TWICE AS MANY** workers comp claims as healthy-weight workers.

Source: AMA, 2007

The **SLOW ECONOMIC RECOVERY** puts upward pressure on claim frequency.

Source: NCCI-ASI, 2011

Complex case loads, increased administrative tasks **LIMIT THE TIME AND ANALYSIS** an adjuster can dedicate to a claim.

Source: E&Y, 2012

Improved technology and workplace safety contributed to a

**1% DECREASE** in lost-time claim frequency in 2011.

Source: NCCI, 2012

**ADVANCED ANALYTICS** can identify drivers of unexpected developments in a claim to reduce overall workers comp claims.

Source: NCCI, 2011

Primary losses are reduced by **70%** if a worker's return to work occurs **BEFORE INDEMNITY BEGINS.**

Source: NCCI, 2010

**PRIOR CLAIMS HISTORY** is highly predictive of the amount required to **SETTLE A CURRENT CLAIM.**

Source: E&Y, 2012

Using mitigation strategies in the early stages of a workers comp claim allows for capture and recovery of **25%-50%** of potential adverse developments.

Source: E&Y, 2012

Attorney or other representation is higher among long-duration workers comp claims **25%** than short-duration claims **7%.**

Source: Texas DOI, 2007

Claims of **SMALL EMPLOYERS** tend to remain active longer than the claims of **LARGER EMPLOYERS.**

Source: Texas DOI, 2007

Return-to-work programs that include **COMMUNICATION WITH INJURED WORKER**

during recovery show an overall reduction in claim length.

Source: NCCI, 2012

Medical costs associated with workers comp claims are projected to be **70%** of total claim costs by 2017 vs. **59%** in 2007.

Source: DOL Report, 2010

Delayed or inaccurate reporting to Medicare may result in **FINES** that will increase claim costs for Medicare-eligible injured workers.

Source: Medicare/Medicaid, 2007

**LUMP-SUM SETTLEMENTS** of workers comp claims encourage return to work.

Source: WCRI, 2010

The more the employer knows about **FUTURE MEDICAL CLAIMS**, the better the odds that they will be **SUCCESSFULLY RESOLVED.**

Source: Cal DOI, 2010



**OBESITY & RELATED MEDICAL PROBLEMS** are leading to increased workers compensation claims costs.

Source: NCCI-ASI, 2011

To gather the most accurate and objective information possible, **DOCUMENT EVERY WORKERS COMP CLAIM.**

Source: E&Y, 2012

**LAWYER DENSITY** in a geographic area leads to higher ultimate workers comp claim value.

Once changes from normal procedures are isolated, **CAUSES CAN BE IDENTIFIED** to prevent incidents from recurring.

Source: CA WC Manual, 2008

Accidents occur as a result of **UNEXPECTED DEVIATIONS FROM THE NORM.**

Sources: Business Insurance Proprietary Research, 2012; American Medical Association; California Department of Insurance, 2010; California Workers Compensation Manual, 2008; Labor Department Report, 2010; Medicare/Medicaid, 2007; Montana Municipal Insurance Authority; National Council on Compensation Insurance, Inc. (NCCI); NCCI-Annual Issues Symposium, 2011; "Predictive Modeling and Claims Analytics to Incorporate Leakage Analyses," Ernst & Young, 2012; Texas Department of Insurance, 2007; WC Management Program (RIMS); Workers Compensation Research Institute

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## Costs: Fast escalation for claims

CONTINUED FROM PAGE 3

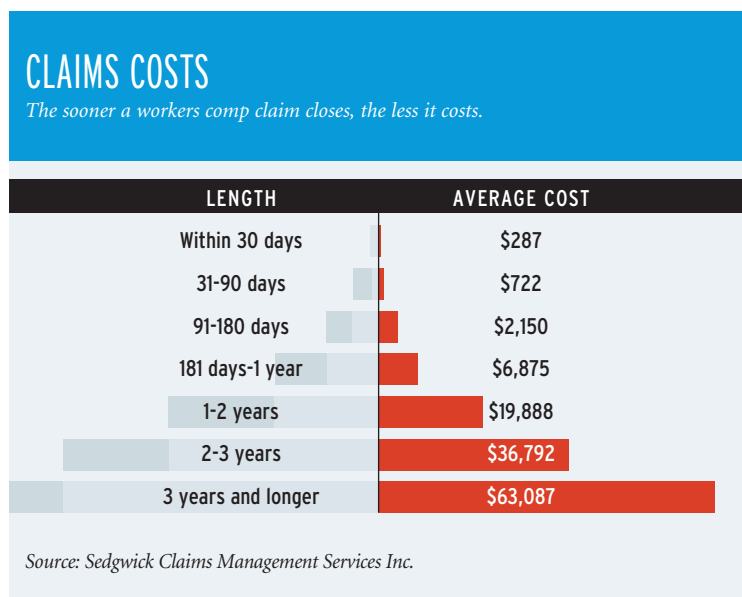
early on also is a significant factor. "A lot of these files start off as medical-only," Mr. Rogers said. "If those files are mishandled in a 'medical-only status,' by the time you realize (the mistake), it's almost too late" and costs will mount.

In addition, a significant part of the medical spending associated with claims that drag on results from pharmacy costs, Mr. Rogers said.

"You will see in the age-pending files a significant medical pharmacy spend issue on those claims," he said.

Because prescription costs often are significant, pharmacy benefit managers say workers comp payers are seeking more data to help manage drug expenses.

"We want to make sure that we are giving information back to our customers, allowing them (to select) the best strategy for their injured workers," said Jim Andrews, senior vp of pharmacy benefit management for Duluth, Ga.-based Health-



care Solutions Inc.

To that end, PBMs in the past two years have included information in their annual drug trend reports showing how much pharmaceutical costs increase as claims age.

Healthcare Solutions' "2012 Workers' Compensation Drug Trends Report," for instance, states that significant increases in the number of prescriptions and the prices of prescriptions occur during the first three years of a claim.

"The most significant increase occurs between the first and second service year, when a 65% increase in the number of prescriptions and a 76% increase in

the average price per prescription is observed," the report states. "Claims that have progressed to the second and third service years have likely found initial treatment unsuccessful and are utilizing second- and third-line medications," which are often single-source drugs that are more expensive.

In year four, claims often stabilize, with the number of prescriptions and their price not rising as rapidly as the first three years, Healthcare Solutions found. The increases that do occur often are "the result of additional medications being used either as adjunct treatment or prophylaxis for the side effects of other medications."

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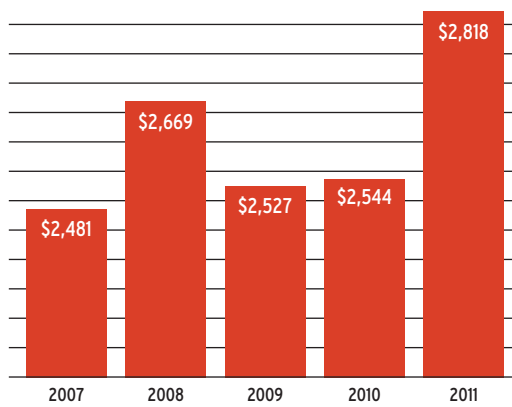
# DATA snapshot

## THIRD-PARTY ADMINISTRATORS

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### TPAs' REVENUES SINCE 2007

The 10 largest TPAs' revenue from self-insured clients in 2011.



Source: BI survey

## LARGEST THIRD-PARTY CLAIMS ADMINISTRATORS

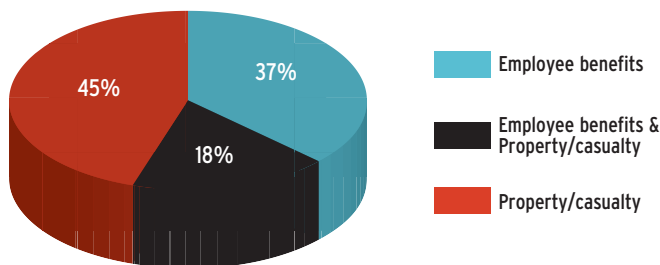
Ranked by 2011 revenues from claims handled for self-insured clients.

RANK	Company/address	Phone/website	2011 revenues from self-insured clients	2011 claims paid to self insurers	Total clients	Claims staff	Principal officer
1	Sedgwick Claims Management Services Inc. <sup>1</sup> 1100 Ridgeway Loop Memphis, Tenn. 38120	901-415-7400 <a href="http://www.sedgwick.com">www.sedgwick.com</a>	\$855,482,705	\$10,598,575,421	1,968	9,254	David A. North, president/CEO
2	Gallagher Bassett Services Inc. The Gallagher Centre 2 Pierce Place Itasca, Ill. 60143-3141	630-773-3800 <a href="http://www.gallagherbassett.com">www.gallagherbassett.com</a>	\$463,759,000	\$7,700,000,000	4,291	2,754	Scott Hudson, president/CEO
3	UMR Inc. 11 Scott St., Suite 100 Wausau, Wis. 54403	866-881-0800 <a href="http://www.umar.com">www.umar.com</a>	\$445,705,731	N/A	1,609	N/A	Jay M. Anliker, CEO
4	Broadspire Services Inc., a Crawford Co. 1001 Summit Blvd. Atlanta, Ga. 30319	866-625-1662 <a href="http://www.choosebroadspire.com">www.choosebroadspire.com</a>	\$228,492,000	\$2,333,000,000	825	1,596	Danielle Lisenbey, CEO
5	ESIS Inc. 436 Walnut St. Philadelphia, Pa. 19106	215-640-1000 <a href="http://www.esis.com">www.esis.com</a>	\$200,000,000	\$2,440,000,000	850	1,200	David Patterson, president
6	Meritain Health 300 Corporate Parkway Buffalo, N.Y. 14226	800-242-6226 <a href="http://www.meritain.com">www.meritain.com</a>	\$196,000,000	\$2,310,268,458	2,348	N/A	Mark Schmidt, head
7	York Risk Services Group Inc. <sup>2</sup> 99 Cherry Hill Road Parsippany, N.J. 07054-0253	877-927-2255 <a href="http://www.yorkrsg.com">www.yorkrsg.com</a>	\$171,349,000	\$4,026,528,000	6,506	1,751	Tony Galioto, president/CEO
8	HealthSmart Holdings Inc. <sup>3</sup> 222 W. Las Colinas Blvd., Suite 600 N. Irving, Texas 75039	214-574-3546 <a href="http://www.healthsmart.com">www.healthsmart.com</a>	\$93,100,000	\$1,977,712,054	306	526	James M. Pennington, president
9	CoreSource Inc. 400 Field Drive Lake Forest, Ill. 60045	800-832-3332 <a href="http://www.coresource.com">www.coresource.com</a>	\$88,000,000	\$2,390,848,586	631	339	Nancy Eckrich, president
10	Cannon Cochran Management Services Inc., dba CCMS 12 E. Main St., Suite 208 Danville Ill. 61832	800-252-5059 <a href="http://www.ccmsi.com">www.ccmsi.com</a>	\$75,650,000	\$1,060,500,968	540	770	G. Bryan Thomas, president/CEO

<sup>1</sup> Purchased Cambridge Integrated Service Group Inc. and Selective Settlements International Inc. in May 2011 and Nationwide Better Health's productivity solutions division in June 2011. <sup>2</sup> Purchased Avizent, the marketing name of Frank Gates Service Co./Attenta, and JI Cos. in December 2011. <sup>3</sup> Purchased Wells Fargo Third Party Administrators Inc. in December 2011.

### TYPES OF CLAIMS ADMINISTERED

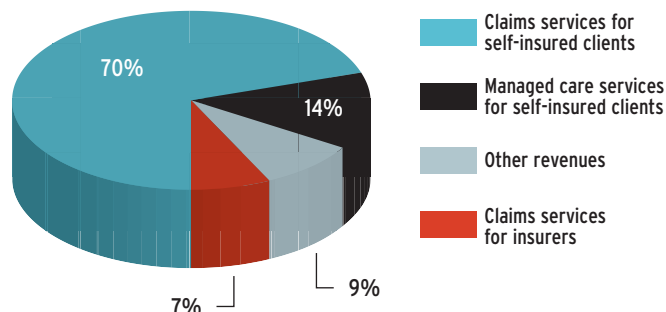
Types of claims handled by all companies listed in the Business Insurance directory.



Source: BI survey. Researched by Angelina Villarreal

### BREAKDOWN OF REVENUE FOR TPAs

Revenues for all companies listed in the Business Insurance directory.



### LARGEST PROPERTY/CASUALTY TPAs

TPAs that specialize in property/casualty claims administration, ranked by 2011 revenues from self-insured clients.

<b>RANK</b>	<b>1</b>
<b>Company</b>	GALLAGHER BASSETT SERVICES INC.
<b>Revenues</b>	\$463,759,000
<b>RANK</b>	<b>2</b>
<b>Company</b>	BROADSPIRE SERVICES INC., A CRAWFORD CO.
<b>Revenues</b>	\$228,492,000
<b>RANK</b>	<b>3</b>
<b>Company</b>	ESIS INC.
<b>Revenues</b>	\$200,000,000
<b>RANK</b>	<b>4</b>
<b>Company</b>	YORK RISK SERVICES GROUP INC.
<b>Revenues</b>	\$171,349,000
<b>RANK</b>	<b>5</b>
<b>Company</b>	CANNON COCHRAN MANAGEMENT SERVICES INC., DBA CCMSI
<b>Revenues</b>	\$75,650,000

### LARGEST TPAs BY CLIENTS

Ranked by number of clients in 2011.

<b>RANK</b>	<b>1</b>
<b>Company</b>	YORK RISK SERVICES GROUP INC.
<b>Clients</b>	6,506
<b>RANK</b>	<b>2</b>
<b>Company</b>	GALLAGHER BASSETT SERVICES INC.
<b>Clients</b>	4,291
<b>RANK</b>	<b>3</b>
<b>Company</b>	BERKLEY RISK ADMINISTRATORS CO. L.L.C.
<b>Clients</b>	2,358
<b>RANK</b>	<b>4</b>
<b>Company</b>	MERITAIN HEALTH
<b>Clients</b>	2,348
<b>RANK</b>	<b>5</b>
<b>Company</b>	SEDGWICK CLAIMS MANAGEMENT SERVICES INC.
<b>Clients</b>	1,968

### LARGEST EMPLOYEE BENEFIT TPAs

TPAs that specialize in employee benefit claims administration, ranked by 2011 revenues from self-insured clients.

<b>RANK</b>	<b>1</b>
<b>Company</b>	UMR INC.
<b>Revenues</b>	\$445,705,731
<b>RANK</b>	<b>2</b>
<b>Company</b>	MERITAIN HEALTH
<b>Revenues</b>	\$196,000,000
<b>RANK</b>	<b>3</b>
<b>Company</b>	HEALTHSMART HOLDINGS INC.
<b>Revenues</b>	\$93,100,000
<b>RANK</b>	<b>4</b>
<b>Company</b>	CORESOURCE INC.
<b>Revenues</b>	\$88,000,000
<b>RANK</b>	<b>5</b>
<b>Company</b>	HEALTHSCOPE BENEFITS
<b>Revenues</b>	\$69,811,000



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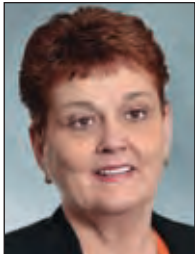
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# Perspectives

Anyone who manages workers compensation claims knows a routine claim can easily become a complex claim. The reasons are varied, but one driving factor is the use of narcotics in the treatment of chronic pain in injured workers. Deborah Gleason, clinical resources manager at ESIS Inc., discusses this growing problem and how to counter the trend.



Ms. Gleason

## Pain is the blame for claims complexity

By Deborah Gleason

Chronic pain affects about 100 million Americans, more than the number affected by heart disease, diabetes

and cancer combined, according to a June 2011 report from the Institute of Medicine's "Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research."

The prevalence of chronic pain is growing and is likely to continue to do so, according to the report. As the rate of reported chronic pain increases, it has been accompanied by a rise in the rate

of adults reporting the use of prescription drugs for pain, including opioids such as OxyContin, Percocet and oxycodone products.

Only 3.2% of Americans reported using opioids for pain during the seven-year period from 1988-1994, according to data from the National Health and Nutrition Examination Survey, which was cited in the report. But by the four-year period from 2005-2008, that increased to 5.7% of the population.

### Workers compensation

In workers compensation cases, spending on narcotic opioids far outpaces the spending in the group health market.

Narcotic analgesics comprise almost 34% of the total drug spending for workers comp payers as opposed to about 3% in the group health market, according to the IMS Institute for Healthcare Informatics, cited in the PMSI Annual Drug Trends Report for 2012.

Of the total medical expense for workers compensation claims, the cost of prescription medications accounts for 19%, according to the National Council on Compensation Insurance.

The impact on the cost of claims is also significant. When a workers compensation claim involved a narcotic, the claim cost averaged nearly \$20,000 more than claims without opioids, according to a report in the 2009 Journal of the International Assn. for the Study of Pain, which was cited in the PMSI report.

The use of narcotics also affected time lost from work. Odds of chronic work loss were six times greater when opioids were used, according to the Journal.

### Counter the trend

With the help of their third-party administrators, companies can play an important role in promoting the appropriate use of narcotics. This can mean early and appropriate returns to work to prevent an otherwise simple claim from converting into a legacy claim.

Companies should look for a third-party administrator that can offer several critical capabilities. These include:

- **EARLY INTERVENTION:** The first few hours after an employee is injured are critical. This is when

Continued on next page

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Record No. 2012 / 437 COS

IN THE MATTER OF:  
ICAROM plc (UNDER ADMINISTRATION)  
AND IN THE MATTER OF  
OMEGA GENERAL INSURANCE COMPANY  
AND IN THE MATTER OF  
EIFLOW INSURANCE LIMITED

AND IN THE MATTER OF:  
THE ASSURANCE COMPANIES ACT 1909,  
THE INSURANCE ACT 1989 AND  
THE EUROPEAN COMMUNITIES (NON-LIFE INSURANCE)  
FRAMEWORK REGULATIONS 1994

TAKE NOTICE that:

1. A Petition has been presented to the High Court of Ireland to seek the sanction by the Court pursuant to Section 13 of the Assurance Companies Act 1909 of, and to give effect pursuant to Section 36 of the Insurance Act 1989 to:

- an Assumption Reinsurance Agreement dated 19th April 2012 between Icarom plc ("Icarom") (formerly The Insurance Corporation of Ireland plc) and Omega General Insurance Company ("Omega") relating to the transfer to Omega of the discontinued insurance and reinsurance business of the Canadian Branch of Icarom; and
- a Scheme providing for the transfer to Eiflow Insurance Limited of the entire of the remaining discontinued insurance and reinsurance business of Icarom together with other ancillary relief.

2. Copies of the Scheme whereby the transfer is to be effected, the Petition and related documentation are available for inspection by any policyholder or shareholder of Icarom plc, Eiflow Insurance Limited or Omega General Insurance Company at the offices identified below between the hours of 9.00 a.m. and 5.00 p.m. Monday to Friday for fifteen days from the date of this notice.

3. The Petition is directed to be heard at the Four Courts, Inns Quay, Dublin 7 on Tuesday the 13th day of November 2012 at 10.45 a.m. Any person who wishes to support or oppose the making of an order on the said Petition may appear at the time of the hearing, in person or by counsel or solicitor for that purpose and a copy of the Petition will be furnished to any person who requires it by the undersigned.

4. Any person who intends to appear at the hearing of the said Petition should send by post written notice of such intention to, or serve such notice on, the Petitioner's solicitors, Whitney Moore, Wilton Park House, Wilton Place, Dublin 2 (quoting reference GMC/MBR) no later than 5.00 p.m. on 30th October 2012. The said notice must state the name and address of the person or, if a firm, the name and address of the firm and must be signed by the person or firm, or his or their solicitor (if any) (and must specify an individual at the firm (or firm of solicitors) who will be responsible for dealing with communications regarding such written notice) and must be sent by post in sufficient time to reach the above named solicitors for the Petitioner not later than 5.00 pm on the 30th October 2012 and should indicate whether such person supports or opposes the said Petition. A copy of the Petition is also available for inspection at the offices of the solicitors for the Petitioner identified above between the hours of 9.00 a.m. and 5.00 p.m. Monday to Friday from the date of this notice.

Dated this 13th day of 2012.

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Wilton Park House  
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initial decisions about treatment are made, including what to prescribe for pain. Look for a TPA with a clinical resource hot line to access nurses that can help assess injuries and direct employees to urgent care or an appropriate network doctor who are positioned to best handle the treatment of injured workers and have a proven track record of successful outcomes.

■ **APPLIED INSIGHT:** At specific junctures throughout the life of a claim, the use of narcotics should be evaluated. When narcotics are prescribed, there should be notations in the claim file and a mechanism in place to monitor the types of drugs and duration of use. Use of pharmacy benefit management with aggressive utilization review is critical. Because the treatment of chronic pain can be protracted, doctors and injured workers need to be supported over time. Decision points should be established to prompt reviews by a clinical pharmacist who will review the case and provide an opinion on whether the continued use of narcotics is appropriate. If narcotics are deemed no longer appropriate, then the TPA's pain management specialist can work with the treating physician to determine appropriate next steps.

■ **PREDICTIVE ANALYTICS:** Strong partnerships between companies and their TPAs are the result of ongoing and meaningful interaction. A TPA that uses predictive analytics can extract value from a company's claim experiences. This can help pinpoint problems and spur collaborative approaches to develop plausible solutions. Monitoring claims that involve the use of opioids can help identify claims trends and patterns that companies may want to address immediately or in the future.

■ **RETURN-TO-WORK PROGRAMS:** Any time an injured worker loses time from work, there is a risk that the individual will never return. When narcotics are involved, the odds of chronic work loss are significantly higher. Aggressive return-to-work programs, therefore, are critical. Employers should look for ways to provide employees with modified job duty whenever possible to get them back on the job.

Today, there is no such thing as a routine claim. With narcotic use and abuse on the rise, workers

compensation claims must be carefully managed.

Employers should partner with a TPA that can provide tools and resources specifically designed to monitor narcotic use throughout the life of a workers compensation claim.

Employers should be armed with information so they can access programs and services that provide better outcomes while promoting optimal pain management, early return to work, and improved quality of life for injured workers.

*Deborah M. Gleason is the Philadelphia-based Clinical Resources Manager for ESIS Medical Impact, part of ESIS Inc. She can be reached at 215-640-5232 or Deborah.gleason@esis.com.*

## Evolve: Avoid costly lost-time cases

CONTINUED FROM PAGE 7

customers the option of paying an additional fee for lost-time adjusters, who command higher wages, to manage medical-only claims instead of a medical-only adjuster handling them, Mr. Bravo said.

"They pay a little more up front, but when we look at their program in the aggregate...it shows that we reduced the cost of risk for them with an indemnity adjuster vs. a medical-only adjuster," Mr. Bravo said.

Overall, the management of

medical-only claims has improved, but they still can fall between the cracks, Marsh's Mr. Martin said.

To help keep that from happening, employers should stay engaged with the management of their claims by TPAs or insurers, said Debra Levy, workers compensation solution leader in the risk consulting resource group for Wells Fargo Insurance Services USA Inc. in Atlanta.

Employers also need to communicate directly with their injured employees to learn, for example, about their ability to

work in a modified-duty capacity and their ability to return to full duty, said Hattie Cunningham, a claims cost expert for Lockton Cos. L.L.C. in Kansas City, Mo. A TPA's or insurer's adjuster may not conduct those conversations, she said.

"Med-only adjusters generally have a very diverse claim load, and not every TPA/carrier on a medical-only claim is going to reach out to the employee and verify that the doctor has released them for return to work," Ms. Cunningham said.

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## Early: Contact limits claims severity

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more costly it's going to be."

Employers' early attention to claims, in addition to their insurer or TPA's management, also helps ensure that potential "red flags" warranting additional scrutiny are not overlooked, added Peggy Crook, director of global claims risk management services in McLean, Va., for Hilton Worldwide Inc.

Because employers know their company's culture and work practices, they are more likely than an outside claims adjuster to recognize warning signs that may mean a claim is not compensable or an outright fraud.

For example, Ms. Crook has seen housekeepers claim injuries from flipping hotel bed mattresses. But flipping mattresses is left to

a "houseman" and not within the course of a housekeeper's employment.

Therefore, such claims warrant further investigation. But an outside adjuster may not know the subtle distinctions in Hilton job roles and wouldn't scrutinize the claim further, Ms. Crook said.

"It could be a missed opportunity," to stem an unwarranted claim that would otherwise be challenging to resolve, Ms. Crook said.

Even when claims are legitimately compensable, navigating state workers comp systems is a "daunting process" for hurt employees who may be fearful because they don't understand what will happen next, Ms. Ogsaen said.

When making her first telephone contact with injured

employees, she discusses the information a claims adjuster will provide them, such as their claim number and where to go for any additional treatment, Ms. Ogsaen said.

"That way everything is so smooth," Ms. Ogsaen said. "Knowing that the employer does care and helps them through the process is huge. It can keep a claim from being litigated and the employee being disgruntled."

The attention doesn't end there.

Workers out on disability get a call from her several times a week to discuss the progress of their medical treatment and their nurse case manager's service level, for example, "just to make sure things are going the way they are supposed to go, because I am in Ore-

gon and a lot of times (the claimants) are in New York or 38 other states," Ms. Ogsaen said.

Ms. Ogsaen said she obtains TPA adjusting services through insurer C.V. Starr & Co. Inc., which contracts for the services.

Along with helping injured employees navigate the workers comp system, Ms. Ogsaen said her calls to workers help ensure that claims adjusters get the information they need.

"We all know that the adjusters have a caseload that probably isn't realistic," she said. "And if I can smooth the way by providing them every single thing they need," it helps produce a favorable outcome.

Aside from helping injured employees recover, the telephone contact also helps assure that the claim Evergreen Aviation is funding is not fraudulent, Ms. Ogsaen said.

## Settlements: Impediments

CONTINUED FROM PAGE 4

long as three to five months in recent years, depending on a backlog of cases being processed by MSPRC, said Martin Cassavoy, vp of strategic services for North Reading, Mass.-based Crowe Paradis Services Corp., a Medicare secondary payer compliance company.

In waiting for a response from CMS, insurers and employers continue to pay for claims that they had hoped to settle sooner rather than later, he said.

"You need to be able to obtain the information quickly, you need to be able to potentially work with Medicare to resolve any disputes associated with that amount, and you need to have a definitive answer provided by Medicare," said Mr. Cassavoy, who estimates that Medicare secondary payer issues affect 8% to 13% of all workers comp claims.

Because Medicare often continues to make medical payments as parties wait for a final demand letter, Mr. Merlino said the final amount owed to Medicare often can differ largely from what insurers expected to pay in a case.

"I know of one case where the estimated amount was \$800, and the final demand was \$8,000," he said.

Jennifer Jordan, general counsel with MEDVAL L.L.C. in Columbia, Md., said the discrepancy leaves workers comp case parties wondering who should pick up the additional costs.

While some settlements require claimants to pay Medicare for any additional costs that are billed after settlement, Ms. Jordan said insurers are often left holding the tab.

"A lot of times...carriers accept that they have to pay these conditional payments as sort of the scope of business," she said.

Mr. Merlino said conditional payments for Medicare treatment also can discourage some parties from wanting to settle their cases. That's because the reimbursement amount could take up most or all of a claimant's settlement, reducing the worker's incentive to close his or her case.

"Why would the claimant settle for \$30,000 instead of just walking away

because...they're going to have to pay it right back to the government," he said.

Further complicating matters is the issue of Medicare set-asides, where insurers place money into an account to pay for future medical expenses that otherwise would be covered by Medicare.

Experts contend that CMS is asking some insurers to pay larger-than-expected settlements by asking for set-asides that are much higher than the insurers' cost projections. In such cases, they say insurers sometimes opt to leave a claim open rather than put money into a Medicare set-aside fund.

Ms. Jordan said CMS estimates for Medicare set-asides usually are about 20% higher than what insurers or employers expect to pay for an injured worker's future medical costs, and can sometimes reach up to 150% higher.

For instance, she said she remembers a case in which an insurer expected to set aside \$50,000 for a claimant's medical expenses. However, she said, CMS required the insurer to pay \$150,000 toward the worker's future care, based on treatments and prescriptions that the beneficiary was expected to receive.

The difficulty, Ms. Jordan said, lies in formulas that CMS uses to predict a beneficiary's future care based on what they already have received.

CMS is "trying to figure out a way to ballpark a future of unknowns," she said.

Projected prescription costs create some of the largest leaps in set-aside costs, said Russell Whittle, senior staff counsel and vp of Medicare secondary payer compliance for consultant Gould & Lamb L.L.C. in Bradenton, Fla.

"You have to allocate for prescription drugs, but the methodology that Medicare uses isn't always consistent," he said. "The type of formularies they use and the rules that they apply to each of the (Medicare set-asides) are not necessarily as predictable as one would expect. So what we're seeing is drugs being prescribed over a lifetime which are either medically contraindicated or not appropriate for that type of condition."

Mr. Cassavoy said insurers and service providers are working to develop strategies that can simplify the Medicare recovery process. But he said the workers comp market has not yet been able to develop a one-size-fits-all solution.

"There's not really an easy silver bullet answer," he said.

## Creative: Alternative claims resolution

CONTINUED FROM PAGE 6

claimants' emotional side, providing them with benefits or amenities they may not otherwise have been able to afford. They also provide immediate, concrete benefits for injured workers who worry that cash may not cover their future expenses, he said.

"You tie it to a finite number, as opposed to having to negotiate something open-ended, where they may be more reluctant to accept the dollar figure because they're not sure it's sufficient," Mr. Dietsch said.

While claimants theoretically could use lump-sum settlements to make purchases or investments of their choosing, Sedgwick's Ms. Tazic said workers want to accept settlements that meet their unique needs.

"It depends on the individual, their psychological issues and...where they want to spend their money," she said.

Emil Bravo, Itasca, Ill.-based executive vp with Gallagher Bassett Services Inc., said the third-party administrator has used creative settlements. But he cautions that workers who receive unique settlements may inspire their co-workers to seek similar benefits if they suffer a comparable injury.

"If the person has a similar injury, their expectation is that they want the hot tub, plus a settlement, too," Mr. Bravo said. "You have to be prepared as the employer...to buy it for anybody else that asks for it."

Creative thinking in workers comp can help improve costs and case management for workers comp claims that aren't heading toward settlement, said George Neale, Boston-based executive vp and general claims manager with Liberty Mutual Group Inc.

One Liberty Mutual claim involved a Texas woman who lost use of her legs and one of her arms after suffering a work-related hand injury. Mr. Neale said the woman's paralysis was believed to be caused by a combination of psychological factors and a medical condition in which not using one limb gradually provokes paralysis in other areas of the body.

The claimant eventually asked Liberty Mutual for a new wheelchair to replace her existing one, even though she wasn't entitled to receive one, Mr. Neale said. Rather than turning down her request, a nurse case manager and claims adjuster offered the wheelchair as a condition of the woman going to a physical rehabilitation facility. In addition, the duo sent the woman flowers and called her regularly to motivate her to stay in treatment. Today, the woman is able to walk again, said Mr. Neale, who did not know the status of the woman's claim.

Mr. Neale said claims handlers should pay close attention to a claimant's requests and needs to find clues that can help move a claim toward resolution.

"You have to listen to them and you have to be able to empathize with them, and you have to create a little bit of a bond," he said.

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## Avoidance: Ways to avoid legacy claims

CONTINUED FROM PAGE 3

medical-only claim.

"One thing that was surprising to me...was they found that our monster claims, which is what we call them, started out as medical-only" injury cases, Ms. Crook said.

Medical-only claims result from injuries expected to require only limited medical attention without the employer having to pay indemnity benefits because the injured worker remains on the job while recuperating. The vast majority of workers comp claims—at least at the start—are medical-only claims, experts say.

"Medical-only claims tend to fall below people's radar," Ms. Crook said. "It is assumed that they will be closed within 90 days, that there is no lost time and (that such claims require only) nominal medical treatment."

But "you have to pay attention to medical-only claims," Ms. Crook said, "because if they are not managed properly (from the

start), they can turn into larger claims."

Not acting immediately can push injured workers down a path that turns otherwise ordinary claims into larger problems, others agree.

Employers that fail to personally contact workers immediately after they report an injury "is huge" and can cause claims to "go sideways quick," said Laurie Ogsaen, workers compensation manager in McMinnville, Ore., for Evergreen International Aviation Inc., an air freight and aviation services company that operates in 38 states.

Legitimately injured workers are often "in the dark" and possibly fearful of the workers comp system, Ms. Ogsaen said. Because they don't understand how workers comp operates, they may even fear that making a claim could cost them their job.

"Usually, the first thing they do is listen to their friends or their roommates at home who say, 'Oh, they are not calling you. You better call an attorney. I

think you have benefits due to you. You would be surprised what you can get,'" Ms. Ogsaen said.

"The first thing they do (then) is get an attorney and get a new doctor, or doctors, and get taken off work immediately, and it is usually immediately," Ms. Ogsaen said. "If they don't hear from the employer, they are going to get a temporary total disability slip."

"The clock starts ticking from the time the accident happens," Mr. Kenitz said of the potential for a typical workplace injury escalating into an expensive claim.

Failure to learn early on specific facts about an injured worker also can cause claims to remain open longer and "maybe not even close whatsoever," said Charles F. Martin, managing director in the risk consulting practice at Marsh USA Inc. in Norwalk, Conn.

A claimant's age; health conditions such as obesity, diabetes or heart problems; salary; and previ-

ous claims history are important factors to learn about early in a claim. Failing to get such information quickly diminishes the employer's chances of properly managing the claim, he said.

For example, health conditions may indicate that the worker's recovery will require managed care resources or nurse case management services as well as closer communications with the claims adjuster so the claim doesn't "turn sour," Mr. Martin said.

Similarly, failing to implement measures to identify potentially problematic claims earlier—by using tools such as predictive modeling—invites trouble, Mr. Martin said.

"Part of it is not having a plan up front and not being able to identify the claim as a potential problem up front," Mr. Martin said. "For example, if you didn't investigate it properly, then you likely came to a poor compensability decision; and if (the employer has) accepted a claim that is not compensable, or perhaps even fraudulent, then you probably are accepting a claimant that knows the system that knows how to be out on comp."

## Integrate: Programs keep claims at bay

CONTINUED FROM PAGE 6

Setting up a risk allocation process, where comp insurance costs are allocated to facilities based on their performance, is one way to get plant managers, risk managers and safety people to collaborate, Mr. Spath said.

"Safety people perceive risk differently than their claims peers," said Ms. Long. Safety professionals focus on measurements associated with Occupational Safety and Health Administration, such as the number of reportable incidents, while claims people are looking at the dollar value of the claims, she said. But they should have shared goals and use data to determine the return on investment of linking improved safety to workers comp, she said.

Facilitating tight integration at Newport News Shipbuilding, a division of Huntington Ingalls Industries Inc. in Newport News, Va., is that "we have a dense population in just two locations," said James Thornton, director of environmental health and safety for the maker of naval aircraft carriers and submarines. "Safety,

workers comp, environmental and our medical facility all sit equally and at the same level in the same organizational chain," he said. A data warehouse allows safety people to see accident trends and their impact on workers comp claims.

NNS safety personnel report accident statistics to operations on a weekly basis based on incident rate and time-loss goals set at the beginning of the year. "In order to really influence operations, it's a regular interaction as opposed to event-based. That's what integration is—it's continuous improvement," Mr. Thornton said.

In addition, the data warehouse sends out a daily electronic report of injuries seen at the clinic. "Safety is getting the information in real time. We have our own fire department and rescue squad, so if an ambulance is dispatched, we get an email," he said.

At a company with far-flung facilities like Ensign-Bickford Industries Inc., integration is more challenging. The diversified manufacturing company based

in Simsbury, Conn., has several subsidiaries making products from explosive materials to pet food additives.

"Differences come in how you treat safety at each site," said Richard Roberts Jr., corporate risk manager for Ensign-Bickford. Nevertheless, the company is working on making work comp data accessible to safety people so they can track injury trends and suggest areas for intervention. Once business unit leaders "see what their cost drivers are, they can focus safety folks and HR folks in areas that need to be addressed," he said.

"If a company is going to have a good system for detecting hazards, then there has to be communication between claims and safety," said Len Welsh, chief for workplace safety at State Compensation Insurance Fund in San Francisco. "There has to be an organized approach to capturing data. You have to look at loss trends over time—generate your own company statistics," he said. Successful integrated safety programs have been recognized by OSHA's Voluntary Protection

Program, he said. "Good dialogue and communication among a company's systems makes it good at manufacturing and selling its products—not just safety," he added.

Ophelia Galindo, national leader for Buck Consultants L.L.C.'s absence and productivity solutions unit in Orange, Calif., said she is seeing company departments "bridging across the divide." A single department may now cover leaves of absence, disability plans and work comp, whereas these historically were handled separately by HR, benefits and risk management, she said. Alternately, those three areas often now collaborate on a project such as developing a return-to-work strategy, she said.

The expansion of the Americans with Disabilities Act is spurring employers "to have a more comprehensive perspective" because they must accommodate an employee's return to work, Ms. Galindo added. With return to work being a main goal of workers compensation programs, safety professionals are called on to identify jobs that a person returning from disability can perform without re-injury, consultants said.

# inBrief

### Wells Fargo sues new broker ABD

Wells Fargo Insurance Services USA Inc. has filed suit against ABD Insurance & Financial Services Inc., citing trademark infringement on a similarly-named brokerage unit Wells Fargo acquired in 2007. The suit alleges the newly-launched ABD, which is led by former Wells Fargo employees, misappropriated the former ABD's trademark. ABD could not be reached for comment.

### P/C rates increase in July: MarketScout

Commercial property/casualty insurance rates continued to rise in July, increasing 4% on average compared with those of a year earlier, according to MarketScout. Commercial property rates registered the greatest increase at 6% compared with July 2011.

### NOAA foresees more named storms

The National Oceanic and Atmospheric Administration's Climate Prediction Center has increased the number of named storms it believes will form during this year's Atlantic hurricane season, which runs through Nov. 30. NOAA said it expects 12 to 17 named storms to form this season, up from the nine to 15 it predicted in May. Five to eight of those storms are expected grow to hurricane strength, according to NOAA.

### Retail, hospitality face biggest health care hikes

Employers in the retail and hospitality industries face the greatest cost increases when provisions of the health care reform law imposing financial penalties on employers that do not offer qualified coverage go into effect in 2014, according to Mercer L.L.C. Forty-six percent of employers in the retail and hospitality industries and 40% of employers in the health care services industry expect health care cost increases of at least 3% due to health care reform law requirements.



## Funding Employee Benefits: A Risk Manager's Guide

This white paper from Spring Consulting Inc. outlines the advantages to funding employee benefits in a captive arrangement and provides guidelines on how to structure this type of program. Companies who choose to fund their employee benefits through a captive have benefited from reduced and guaranteed premiums, reduced risk and fronting changes, custom plan designs and increased control over claims and cash flow. Given this environment, Risk Managers are now exploring the option of increasing their captive's capabilities to fund their employee benefits programs.

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## Cup of coffee packs a punch for worker

An Australian man who was punched in the arm by a coworker over a cup of hot coffee was denied workers compensation.

The Administrative Appeals Tribunal threw out Michael Ralser's claim for compensation for physical injuries resulting from the caffeinated confrontation because the injury did not occur during Mr. Ralser's employment, according to recent news reports.

In December 2009, Mr. Ralser and four colleagues at the Australian Taxation Office in Canberra went to a café for their midmorning coffee when an argument broke out with his then-colleague Dieter Tietz after both men tried to claim a mug of coffee.

Mr. Ralser reportedly stuck his finger in the mug and flicked coffee on Mr. Tietz, who subsequently punched him in the arm.

A workers comp claim was filed in 2010 by Mr. Ralser where he claimed mental and physical injuries and workplace bullying and harassment, according to the Canberra Times.

According to the news report, Mr. Ralser said he got "dead arm" from the incident along with persistent pain and a whiplash-type injury to the spine.

While the tribunal rejected the physical injury claim, they reportedly found that Mr. Ralser suffered psychologically after the incident because of his perception of being bullied in the workplace and should be compensated for that injury.

Morning lines at coffeehouses can be grueling, but you shouldn't have to beat them to the punch for your cup of joe.

CONTRIBUTING: Roberto Cenicerros, Matt Dunning, Sheena Harrison, Mike Tsikoudakis

# End Page



ABC/CARIN BAER

Contestants compete in a game as part of the TV show "Glass House." ABC is facing a trademark infringement lawsuit from CBS, which says the show copies "Big Brother."

## 'Big Brother' is watching ABC

Walt Disney Co.'s ABC is facing a trademark infringement lawsuit from CBS Broadcasting Inc. which says ABC's new television show "Glass House" is an "unabashed rip-off" of the hit reality series "Big Brother."

In an amended complaint filed last month in U.S. District Court in Los Angeles, CBS said that ABC's "Glass House" employs at least 32 former employees from "Big Brother" and is "an obvious attempt by (ABC) to capitalize on Big Brother's unique success."

Both reality TV shows involve contestants whose daily lives are filmed and broadcasted while living in a network-provided

house. The programs require participants to compete in challenges and vote their housemates off the show each week.

"Big Brother" first appeared in 2000, while "Glass House" debuted in June. CBS accuses ABC of hiring former "Big Brother" producers and using CBS' trade secrets to produce the new show.

CBS is seeking unspecified compensatory and punitive damages against ABC, Walt Disney and other defendants for copyright infringement, trade secret misappropriation and other claims.

## Psychic sees success in lawsuit's end

Consulting a crystal ball before taking action against a psychic reader might have helped the Mississippi city of Hattiesburg avoid a lawsuit settlement.

Hattiesburg agreed to pay \$7,500 to settle a federal lawsuit filed by a couple who shuttered their Marie: Psychic Reader business after receiving a city ordinance violation notice, according to recent news reports.

The violation notice stated that fortune telling was illegal in the city.

But the city should have seen trouble coming, considering the ordinance adopted in 1929 likely would have been ruled unconstitutional by a court.

The couple claimed in their lawsuit that city officials violated their right to due process under the Mississippi and U.S. constitutions, and they asked for a ruling that the ordinance amounts to restraint of free speech.

A district judge in November issued a preliminary injunction, restraining the city from enforcing the ordinance. Then in December, the Hattiesburg City Council repealed the ordinance.

The city's attorney reportedly told local media organizations it was prudent for the city to settle given the likelihood of an unfavorable court finding.



## MAN'S CLAIM SCHEME GOES UP IN FLAMES

A Staten Island man's alleged plan to collect on a fraudulent auto theft claim might have worked, if the burning remains of his car hadn't already been found a week before he reported the theft.

According to the New York Daily News, Arkady Suleymanov allegedly told his insurance company that his 2007 Maserati was stolen on Nov. 14, 2011, in Forest

Hills, Queens, where he was visiting his sister.

Authorities located Mr. Suleymanov's expensive sports car. Even more interesting is that authorities discovered that the car had been found on Nov. 9—five days before it was reported stolen—engulfed in flames in Sunset Park, Brooklyn.

The Daily News reported an FBI agent involved in the

case said investigators are not totally sure that the man in the recorded call to the insurance company was, in fact, Mr. Suleymanov. The person on the call sounded younger with greater English proficiency than Mr. Suleymanov, the agent told the newspaper.

Mr. Suleymanov was released last week on \$200,000 bond on the fraud charge.





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DECEMBER 4, 2012, NEW YORK CITY

**KEYNOTE SPEAKER:**



Photo: Deborah Feingold

**Suzy Welch,**  
 The best-selling author,  
 popular television  
 commentator, and  
 noted business  
 journalist will be the  
 keynote speaker at the  
 Leadership workshop.

**FULL DAY AGENDA**

7:30 - 11:30 a.m.	Leadership Workshop Registration Open
7:30 - 8:15 a.m.	Networking Welcome Breakfast & Registration
8:15 - 8:30 a.m.	Welcome Address
8:30 - 9:30 a.m.	Session 1: A Juggling Act: Achieving Effective Work Life Balance
9:30 - 10:00 a.m.	Keynote Speaker: Suzy Welch, author, "10-10-10"
10:00 - 10:30 a.m.	Coffee Break and Book Signing
10:30 - 11:30 a.m.	Session 2: Using Sponsorship to Break into the Executive Suite
11:30 - 12:00 p.m.	Registration for Awards Luncheon Open [for people only attending the luncheon]
11:30 - 12:30 p.m.	Session 3: Show Me the Money: Bridging the Wage Gap
12:30 - 2:55 p.m.	Women to Watch Awards Luncheon
1:00 p.m.	Luncheon Keynote: <i>Tweet This: How Social Media Can Make or Break Your Reputation</i>
3:00 p.m.	Final Comments & Program Closes

**CONFIRMED SPEAKERS:**

**Beth Bierbower,** President, Employer Group Segment, Humana

**Helene Fisher,** Commercial Head Underwriting Quality, Chartis

**Kathleen Savio,** Chief Administrative Officer, North American commercial, Zurich N.A.

**Carol Murphy,** Managing Director, Aon Risk Services

**Seraina Maag,** CEO, of XL North America

**Bonnie Boone,** Senior VP and Health Care Practice Leader, Alliant Healthcare Solutions

**Trevor Gandy,** Chief Diversity Officer, Chubb Corp.

**Tracy Schmidt,** Social Media Strategist, Crain Communications

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