How Convoluted Contracts Produce Costly Claims

An explosive expose of the problem with fixed fees, hidden fees and the other problems with most workers' comp contracts. Here's how both employers and vendors are to blame, but how employers need to take charge to fix the situation.

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Insiders in the workers' compensation arena have known for some time about a festering problem that has hurt corporations with higher than necessary claims costs. Claims administration contracts between employers and their insurance companies or third-party administrators have created a cycle of misaligned incentives and unintended consequences.

Many employers have lost sight of what a workers' compensation program is supposed to do, and vendors have created products and services that often drive costs up instead of down. There is plenty of blame to go around, but rather than affix the blame, it is long past time to fix the problems.

EMPLOYERS' BLAME

First, let's look at the role that employers play. The request for proposal and engagement process is problematic because it focuses on the wrong things. Employers tend to focus on the fixed costs of claims administration because the variable costs are so, well, variable. They're trying to keep things simple, and it seems reasonable to put quotes from several claims administrators on a spreadsheet and select the least expensive.

Employers also "spread-sheet" the fixed cost for adjudicating an indemnity claim or a medical-only claim and feel good about negotiating a $1,500 indemnity claim fee down to $1,250, or a medical-only claim fee from $150 to $100.

However, this obsession with fixed costs causes employers to overlook the more expensive, less controllable costs of claims administration.

Fixed costs generally cover taking the first report of injury, filling out the state-mandated forms, channeling the injured worker to a medical provider, setting up appointments, filing compliance forms with the state and paying the bills on the claim.

Variable costs, also known as allocated loss adjustment expenses, usually include: medical provider networks, bill review, telephonic and field nurse case management, utilization review and peer review.

VENDORS' BLAME

The truth is that claims administrators cannot profitably adjudicate workers' comp claims if they have been beaten down on their fixed costs, so they make up their loss on the ALAEs.

Naturally, they don't tell clients this. No one comes back to the employer and says, "If we lower the indemnity claim fee, as you have requested, then we will have to, in a murky, convoluted and nontransparent way, make up that money somehow."

That conversation doesn't happen, but employers pay dearly for their fixed-cost fixations.

To make up its loss on the fixed cost, the claims administrator hands off parts of claims management and then bills the file extra fees. Instead of the adjuster setting the reserve, an attorney does it--and bills the file. A nurse case manager discusses work restrictions with the employer--at an hourly rate of $95 or $100. Can't adjusters do this? Yes, they can, but not within that extremely low fixed fee the employer was so intent on achieving.

In addition, claims administrators generate additional fees for such services as bill repricing, utilization review and peer review. Are these services even necessary? If so, how are the fees determined? Can a return of investment be demonstrated?

Bill repricing is a critical function in the claims payment process. Medical providers and other vendors typically do not bill for their services according to a previously agreed-upon fee because they know the bill will be adjusted before payment. There is no dispute that this service is necessary. However, the fee arrangements for this important service are often absurd.

Utilization review is another fee-based service that is offered when it appears the medical provider is not following evidence-based treatment guidelines or delivering more services than reasonable. The explosion of utilization review service fees has likely been precipitated through the flawed method of pressuring the medical providers to accept lower fees. Doctors who have discounted their fees are also under pressure to provide additional services. Are you seeing a pattern?

Utilization review services are a profit center for the claims administrator. If they fix the underlying problem of paying doctors fairly and rewarding them for better outcomes, then the profit center goes away.

Peer review is when the conversation with the treating doctor is ramped up to a higher level. The idea is that a doctor-to-doctor conversation will reap greater rewards. However, surgeons often don't regard a doctor who is not a surgeon as their peer. An employer is frequently charged for peer review services when in fact there is not even a real peer-to-peer relationship.

HOW CAN EMPLOYERS FIX IT?

Most employers have no process to determine their true claims administration costs or if there is a return on investment for all of the additional fees. After driving a hard bargain with their claims administrator, they are lulled into complacency with the feeling that they have sufficiently addressed the issue. Most are shocked to learn that their $1,250 indemnity claim fee was just a minor percentage of their cost to adjudicate the claim.

To solve the problem of workers' comp contracts, employers need to identify their real goals and benchmarks for injured employee care management and RFPs need to state the employer's objectives and call for solutions that address them.

When writing a new RFP with the end in mind, employers need to ask themselves:

--What do we want?

--What are our ultimate objectives?

--How will we know if we are successful?

--How will we measure and enforce that our objectives are met?

--How do we build a mutually beneficial relationship with our claims administrators?

Bringing clarity to the contracts is the next step. Too many contracts focus more on the financial, legal and administrative relationship between the employer and their claims administrator rather than on describing the specific and measurable quality of care and performance standards. Done right, contracts provide a fair, tangible and enforceable mechanism to deliver what both sides want.

Contract language can help turn quality-of-care expectations into reality, or undermine all other employer driven, cost reduction and productivity improvement processes. The evidence suggests that few contracts ensure that the employer's objectives are met in a cost-effective and efficient way.

Following is an actual example of imprecise contract language that does not address the employer's objectives:

"The claims administrator will administer workers' compensation services for covered persons in accordance with our standards and procedures."

That basically says the claims administrator will do what it wants to do according to its own standards. Who knows what those standards or processes are, what they cost or if they are any good?

Following is an example of a greater level of precise contract language: "The claims administrator will adopt practice guidelines promulgated by the American College of Occupational and Environmental Medicine, or other appropriate existing guidelines."

Agreements can be built into the contract as to what percentage of medical treatments provided are consistent with evidence-based guidelines.

The workers' compensation system is intended to get injured workers prompt and appropriate medical treatment, return the employee to pre-injury status as best it can, and to maintain a healthy and productive workforce. Given a choice, most claims administrators would rather be transparent, but a seriously flawed engagement process and business relationship that is built on the wrong measures has muddied the waters.

Employers need to take the lead in a mutually beneficial relationship that has transparency on all sides. Both sides need to change, but employers need to lead the charge.

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