Employee Benefits & Workers' Comp News

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Opioids and Workers' Comp: A Blessing and a Curse

Deaths from prescription painkiller overdose have skyrocketed over the last decade. This epidemic is triggering a reexamination of how medical providers and insurers handle chronic pain management in workers' compensation cases.

Consider the following facts:

15,000

Nearly 15,000 people die every year of overdoses involving prescription painkillers.

1 in 20

In 2010, 1 in 20 people in the US (age 12 or older) reported using prescription painkillers for nonmedical reasons in the past year.

1 Month

Enough prescription painkillers were prescribed in 2010 to medicate every American adult around-the-clock for a month.

Source: Centers for Disease Control

Opioids are medications that relieve pain. They reduce the intensity of pain signals reaching the

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This Just In

With its state partners, the Occupational Safety and Health Administration (OSHA) has approximately 2,200 inspectors responsible for the health and safety of 130 million workers. In Fiscal Year 2015, OSHA and its state plan partners conducted 79,291 inspections.

The following were the top 10 most frequently cited standards by Federal OSHA in fiscal year 2015:

1. Fall protection, construction (29 CFR 1926.501)
2. Hazard communication standard, general industry (29 CFR 1910.1200)
3. Scaffolding, general requirements, construction (29 CFR 1926.451)
4. Respiratory protection, general industry (29 CFR 1910.134)
5. Control of hazardous energy

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brain and affect those brain areas controlling emotion, which diminishes the effects of a painful stimulus. Medications that fall within this class include hydrocodone (e.g., Vicodin), oxycodone (e.g., OxyContin, Percocet), morphine (e.g., Kadian, Avinza), codeine, and related drugs. Hydrocodone products are the most commonly prescribed for a variety of painful conditions, including dental and injury-related pain.

The nature of workers' compensation claims makes the possibility of opioid abuse a real risk. Many workers' comp claims involve back injuries, one of the most common conditions for which doctors prescribe opioids. While effective for short-term pain management, long-term opioid use can lead to abuse and addiction. In fact, opioids may be the real "gateway drug"—a 2010 study found that 14 percent of people who abused or were dependent on pain medications used heroin.

Current guidelines recommend using opioids for only a short time—typically 30 days or less. After that point, the effectiveness of these drugs diminishes. This can lead to an increase in dosing, which also increases the possibility of abuse and addiction.

In addition to being an ineffective long-term treatment for pain, opioid overuse is costly. The Express Scripts 2013 Workers' Compensation Drug Trend Report, says opioid painkillers account for 32 percent of pharmacy costs in workers' compensation injuries, making them "the costliest therapy class for work-related injuries." A report in Insurance Journal, citing WCRI research, said "opioids make up to three percent of cost in shorter claims and between 15 and 20 percent of all medical costs on longer-term claims." Further, claims involving opioid painkiller prescriptions are "almost four times as likely to have a total cost of $100,000 or more compared with claims without any prescriptions," according to research by Lansing, Mich.-based Accident Fund Holdings. ("Opioid Epidemic Plagues Workers' Comp," by Denise Johnson and Don Jergler, May 17, 2013)

Researchers, employers, workers' compensation insurers, physicians and other stakeholders have begun to look at solutions to the problem of opioid overuse and abuse in workers' compensation claims. For longer-term or chronic pain management, other therapies may prove more effective. These include physical therapy, alternative medicine (such as acupuncture) and other, non-opioid pharmaceuticals.

To ensure workers' compensation claimants receive treatment for pain without overuse of opioids, the Centers for Disease Control guidelines and other experts recommend:

- Encouraging treating physicians to follow current prescribing guidelines.
- Setting up prescription claims review programs to identify and address improper prescribing and use of painkillers.
- Increasing coverage for other treatments to reduce pain, such as physical therapy, and for substance abuse treatment.
- Counseling patients on the benefits and risks of opioid use.
- Psychological screening and drug testing for individuals using opioids on a long-term basis.
- Drug testing of individuals using opioids on a long-term basis.
- Referring individuals whose productivity or behavior changes to the employer's employee assistance program (EAP) for evaluation and referrals if drug abuse is suspected.

For more information on controlling costs in your workers' compensation claims, please contact us.

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(lockout/tagout), general industry (29 CFR 1910.147)

6 Powered industrial trucks, general industry (29 CFR 1910.178)

7 Ladders, construction (29 CFR 1926.1053)

8 Electrical, wiring methods, components and equipment, general industry (29 CFR 1910.305)

9 Machinery and machine guarding, general requirements (29 CFR 1910.212)

10 Electrical systems design, general requirements, general industry (29 CFR 1910.303)

If any of these standards could raise concerns for your business, you can find links to OSHA's relevant Safety and Health Topics page here. Or contact us for more information—we're happy to conduct a safety review at your workplace.

Which Health Plan Applies?

When your employees are covered by more than one health plan, you'll want to know which plan is "primary," insurance jargon for the one that pays claims first. Here's some guidance.

Let's consider two situations where dual — and dueling — coverage might occur. They both involve someone covered by two plans, but in one case, both plans are group plans, and in the second, one plan is group medical and the other is Medicare.

Situation One: Two Group Health Plans

The rules that regulate the coordination of benefits and define the primary payer in a situation where two policies cover one person are set by the state where the insured resides. The regulations vary from state to state.

The National Association of Insurance Commissioners (NAIC) has developed a model regulation for coordination of benefits. States have no obligation to use the NAIC model, but many do or have written regulations that closely resemble it.

According to NAIC, states that either have taken no action on the topic or have established regulations that differ significantly from the model are Alaska, Florida, Hawaii, Maine, Maryland, Mississippi, New Mexico, Pennsylvania and Vermont. Washington, D.C., is also on that list.

Here are some nuggets from the NAIC model regulation:

- If a policyholder is also covered as a dependent on a second policy, the policy he or she holds is primary and the policy that lists that person as a dependent is secondary.
- A dependent child of parents who both hold policies that cover the child and are living together is covered first by the policy of the parent whose birthday (month and day) falls earliest in the calendar year. If they have the same birth date, the plan that went into effect first is primary.
- A dependent child of parents who are not living together is covered first by the policy of the parent who is under court order to provide health coverage. If that parent has no coverage, coverage of the second

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parent is primary. If both parents have a court decree declaring them responsible, the rules are the same as for parents living together. If there is no court order, primary coverage is determined in this order: the plan of the custodial parent, the plan of the custodial parent's spouse, the plan of the non-custodial parent, the plan of the non-custodial parent's spouse.

The NAIC model suggests that claims should be filed with each insurance plan, regardless of which coverage is primary. However, the important thing is to understand the regulations in your state and clearly explain the benefits to employees.

You can order a complete copy of the NAIC model regulation by visiting www.naic.org/prod_serv_model_laws.htm.

Situation Two: When Medicare Is Involved

The good news is that uniform rules apply nationwide to employees with Medicare.

In most cases, Medicare is primary, meaning Medicare will pay claims for covered individuals first; then you can submit any balance remaining to another policy (the secondary policy).

Some of the most common situations where Medicare becomes the secondary payer are:

- The individual or his/her spouse is currently employed/working and covered under an employer group health plan as a result of current employment.
- The company has 20 or more employees or participates in a multiple-employer or multi-employer group health plan where at least one employer has 20 or more employees.
- The individual in question is entitled to Medicare as a result of a disability; the company has 100 or more employees, or participates in a multi-employer group health plan where one employer has 100 or more employees.
- The individual in question is Medicare-entitled due to end-stage renal disease. Medicare is the secondary payer to a group health plan until a 30-month coordination period has ended.

Risk note: Eligible employees of small employers sometimes do not buy optional Medicare Part B coverage, because they have group coverage. Part B covers doctors' services and outpatient care. Group plans for small employers often assume that the company's Medicare-eligible workers carry Part B and pay accordingly, leaving these workers underinsured.

Administering a group health plan is a complicated task that requires knowledgeable and dedicated staff. For more information, please call us. ■

Asthma and Allergies: How Companies Can Breathe Easier

From dust mites, mold spores, cockroaches and animal dander, to cotton fibers, acid anhydrides, formaldehyde and latex, the modern workplace is a veritable minefield of substances that trigger asthma, allergies and associated workers' comp claims.

According to the Asthma and Allergy Foundation of America (AAFA), more than 200 substances found in the workplace can cause asthma. An estimated 11 million workers are exposed to these gases, vapors and organic and inorganic dusts every year, causing 15 million lost work days, according to a 2002 study by the Centers for Disease Control (CDC). Millions more workers are exposed to substances that can cause allergic reactions and other respiratory problems. But using proper diagnoses and management, the vast majority of these expensive problems can be avoided or eliminated.

Asthma Impact

In 2006, the AAFA estimated that asthma cost business $18 billion annually. According to the CDC study, asthma triggered:

- 12.7 million doctor visits,
- 1.2 million hospital outpatient visits,
- 1.9 million emergency department visits,
- 484,000 hospitalizations, and
- 4,261 deaths.

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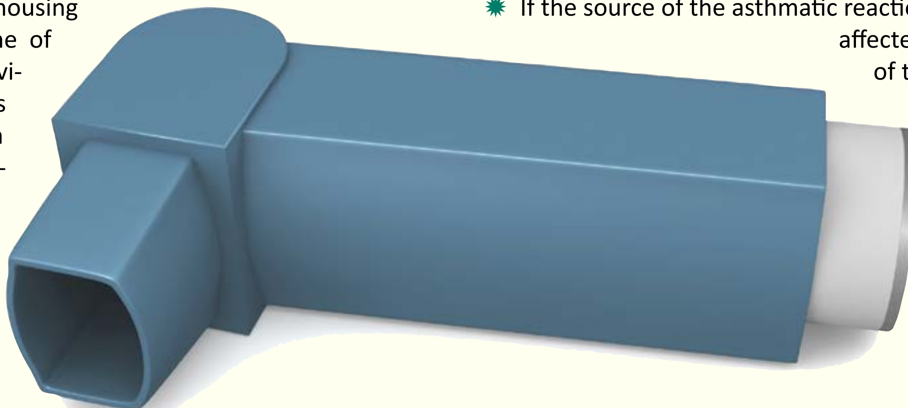
Asthma was identified as the fourth leading cause of work absenteeism or presenteeism and caused some $3 billion in lost productivity. Prescription drugs were the largest single direct medical expenditure at over $5 billion. Medical costs reached an average of almost $5,000 per patient and represented 2.5 times as much as for workers without a history of asthma. For asthmatic employees with disability claims, the figures were much worse. They cost employers three times as much as other disability claimants —$14,827 vs. $5,280, according to a 2002 article in the *Journal of Allergy and Clinical Immunology.*

Asthma and allergies can hit any business, and any occupation within that business. But according to the CDC, some of the worst cases occur in general merchandise stores, food stores, the furniture and lumber industries, banking, schools, trucking, warehousing and metal industries. Some of these sectors have no obvious exposures to dangerous substances — asthma can easily be caused by something as innocuous as poor indoor environmental quality. That helps explain why computer operators and financial record processors had the highest prevalence of asthma in the CDC study.



Asthma Prevention

There's no single strategy to prevent asthma. But a good place to start is in getting the proper diagnosis. Consult a medical professional who specializes in asthma to determine whether the asthma symptoms are an irritant reaction or the much more serious allergic reaction. Armed with that information, an industrial hygienist can help you identify the source of the irritant. An industrial hygienist can also help redesign your workspace or manufacturing processes to eliminate some of the irritants.

Often the simplest prevention steps yield the greatest results:

- Get workers to keep their work areas uncluttered and, if appropriate, have them dust and use HEPA-type tabletop air purifiers. Alternatively, if dust is a pervasive problem, hire a cleaning crew to regularly maintain your premises. Ensure they use nontoxic, non-irritating cleaners.
- Give workers dust masks or even better, fully enclosed respirators.
- Check that the air exchange system in your building is functioning properly.
- If the source of the asthmatic reaction has been identified move affected workers to different parts of the building, especially in severe cases where staying in contact with the substance can be life-threatening.

In some cases it may pay to use asthma disease management vendors who define, evaluate and measure health care quality, and who will educate workers on dealing with asthma. In work-related asthma cases, your workers' compensation carrier might recommend one. But if your company contracts directly, make sure the vendor is accredited with an agency such as the NCQA (National Committee for Quality Assurance), URAC (Utilization Review Accreditation Commission) or the JCAHO (Joint Commission on Accreditation of Healthcare Organizations).

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How Pharmacy Benefit Managers Control Your Drug Costs

Pharmacy benefit managers, or PBMs, have nine basic tools to control the cost of prescription drugs:

1. Volume discounts. PBMs negotiate volume discounts with certain pharmacies, then steer plan members to these pharmacies.
2. Generic substitutions. PBMs can encourage plan members to use less-expensive generic substitutions by paying a higher percentage of a generic drug's cost.
3. Rebates. PBMs often negotiate rebates from drug manufacturers. Whether they share rebates with their employer clients is something you might want to ask.
4. Copayments. Most plans require members to pay a small, fixed amount, such as $20, each time they fill a prescription. Some plans waive copayments for people who opt to take a generic prescription for a chronic condition.
5. Coinsurance. Some plans require members to pay a percentage, or coinsurance, of the total cost of their prescription. Some require a smaller coinsurance percentage for generic drugs or drugs that meet certain efficacy standards.
6. Formularies. A formulary is a list of prescription drugs covered by a health or prescription drug plan. PBMs usually evaluate the drugs they include on a formulary for efficacy and cost effectiveness.
7. Disease management. This integrated care approach to managing illness includes screenings, check-ups, monitoring and coordinating treatment, and patient education. It can reduce costs for people with chronic conditions.
8. Mail order fulfillment. Mail order fulfillment of refills can save money.
9. Drug utilization review. Systems review drug claims to identify problems such as therapeutic duplication, drug/disease contraindications, incorrect dosage or duration of treatment, drug allergy and clinical misuse or abuse. PBMs examine individual claims to identify problems such as contraindications, incorrect dosage or duration of treatment, drug allergy and clinical misuse or abuse. They also look for patterns of fraud, abuse, gross overuse or medically unnecessary care.

For more information on PBMs, please contact us.

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THE INSURANCE 411
What you need to know about insurance

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