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The Time Has Come for a Decision on GATT Lump-Sum Distribution Rules

by Jeffrey R. Kamenir, A.S.A., E.A.

INSIDE THIS ISSUE

- Administrative Simplification and Privacy Issues for Health Plans
- Key Data Elements in Managed Workers' Compensation

New rules applicable to lump-sum payments from defined benefit plans came into existence as part of the 1994 General Agreement on Tariffs and Trade (GATT). Many pension practitioners are finding that using the new rules can result in lower lump-sum distributions, and that the reductions in many cases will be more than a *de minimus* amount, particularly for younger participants. As a result, some plan sponsors have delayed adopting the new GATT rules.¹

This article describes the minimum required lump-sum rules before and after GATT, compares the rules' effects on lump sums, and discusses some of the transitional issues confronting plan sponsors.

Pre-GATT Rules

For plans that have not yet adopted the GATT rules, the pre-GATT requirements for lump-sum distributions still apply. Thus, lump sums can be no less than the present value of the monthly benefit, determined by using interest rates published by the Pension Benefit Guaranty Corporation (PBGC) applicable at the date of distribution. If the lump sum exceeds \$25,000, a plan sponsor may reduce the amount by redetermining the minimum required lump sum based on 120% of the PBGC rates, assuming that the plan includes a provision to do so. However, in no case may such a redetermination result in a lump sum of less than \$25,000. Many plans do not avail themselves of this option, preferring to provide payments that are more than the legally required minimum distribution.

In calculating the minimum lump sums under the pre-GATT rules, plan sponsors:

- may use any unisex mortality table;
- may use the PBGC interest rates that are in effect either during the month of distribution or at the beginning of the plan year of distribution;
- need not reflect subsidized early retirement

benefits, subsidized joint-and-survivor annuities, or preretirement death benefits; and

- must reflect the normal form of annuity for single participants, which is typically either a single-life annuity or a certain-and-life annuity.

The last two items of the pre-GATT rules above are not modified by the new GATT rules.

GATT Lump-Sum Distributions

In general, minimum required lump sums are likely to be lower after the GATT rules are adopted. However, lump-sum distributions are likely to be greater if the plan has been using 120% of the published PBGC interest rates to determine lump sums exceeding \$25,000, or if the plan has been using a male mortality table for determining lump sums.

The GATT lump-sum rules set forth assumptions that must be used to determine minimum lump-sum benefits. A plan sponsor, however, may use other assumptions to calculate lump sums, as long their use does not result in a distribution that is smaller than that obtained by using the GATT assumptions.

Under the GATT rules, lump sums are calculated by using the 30-year Treasury rate applicable at the date of distribution and the blended 1983 Group Annuity Mortality (1983 GAM) table (i.e., a blend of 50% male and 50% female table rates). The objective of the new rules is to make the cost of lump-sum distributions from defined benefit pension plans more closely approximate the cost of an annuity purchase. If the blended 1983 GAM table is later updated by the IRS to reflect lower mortality rates, minimum required lump sums are likely to increase.

In determining the lump-sum benefit, the GATT rules allow a plan sponsor to choose whether the 30-year Treasury rate will fluctuate on a monthly, quarterly, or annual basis. Furthermore, the plan sponsor may choose the rate from one month to five months before the monthly, quarterly, or annual measurement period begins. Thus, a calendar



COMPARING THE MINIMUM REQUIRED LUMP SUMS

The examples below compare the effects of the GATT lump-sum rules with the old rules under four different sets of assumptions (see Exhibit I below for a description of the various assumption sets).

Exhibit I

ASSUMPTION SET	MORTALITY ASSUMPTION	INTEREST RATE ASSUMPTION	COMMENTS
Old Basis #1	UP-84	PBGC Immediate/Deferred Interest Rates for October of 1998 (i.e., 4%)	UP-84 is a common mortality table that has been used by defined benefit plans to determine lump sums under the old law. UP-84 is considered a blend of male and female mortality rates.
Old Basis #2	UP-84	120% of Old Basis #1 Rates (i.e., 4.8%)	Under the old law, the plan using assumption basis #1 redetermines lump sums greater than \$25,000 based on 120% of PBGC rates.
Old Basis #3	UP-84 with ages set forward one year	Same as Old Basis #1 Rates	UP-84 with a one-year set forward is a common male mortality table used by plans to determine lump sums under the old law.
Old Basis #4	UP-84 with ages set backward four years	Same as Old Basis #1 Rates	UP-84 with a four-year setback is a common female mortality table used by plans to determine lump sums under the old law.
GATT Basis	Blended 1983 GAM	30-Year Treasury Rate for August of 1998 (i.e., 5.54%)	

Assume two participants retired on 10/1/98, one at age 55 and the other at age 65 (see Exhibit II). Each elected a lump-sum distribution in lieu of an immediate single-life annuity. The figures shown are minimum immediate annuity factors used to determine each participant's lump sum under various bases.

For the participant retiring at age 55, the minimum required lump-sum payment is reduced following the plan's adoption of the GATT rules in all circumstances, except for the plan using the "Old Basis #2" assumption set. For the participant retiring at age 65, the minimum required lump-sum payment increases under the GATT rules in all circumstances, except under the plan using the "Old Basis #4" assumption set.

Assume two participants terminated employment on 10/1/98 with vested benefits at age 25 and age 45, respectively (Exhibit III). Each elected to receive a lump-sum distribution in lieu of a deferred monthly single-life annuity payable at age 65. The figures shown are minimum deferred annuity factors that would be used to determine the participant's lump-sum benefit under the various bases.

For the participant terminating at age 25, the minimum required lump-sum payment is reduced by adopting the GATT rules in all circumstances. For the participant terminating at age 45, the minimum required lump-sum payment is reduced under the GATT rules in all circumstances, except for the plan using the "Old Basis #2" assumption set.

Exhibit II

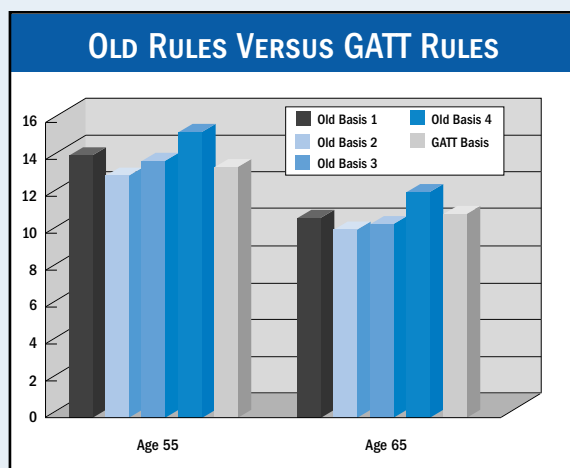
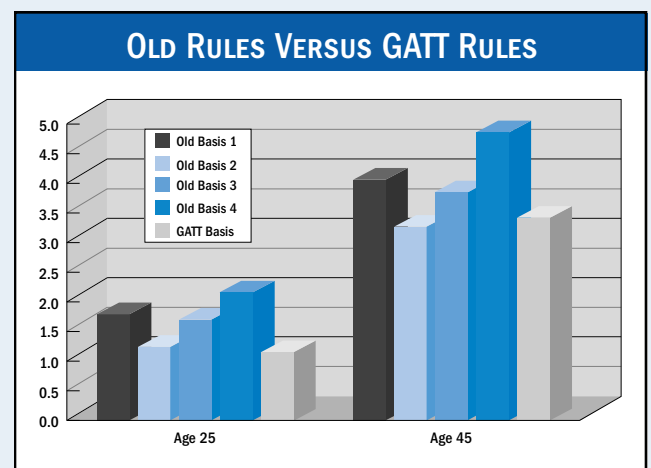


Exhibit III



year plan that uses an annual basis could select an applicable Treasury rate as far back as August of the prior year to calculate the lump sum that must be distributed to participants during the following calendar year.

As a practical matter, selecting the Treasury rate that is one month before a measurement period begins is not feasible because the rate is not published until early the following month (e.g., the rate for November 1998 is not available until early December). Time constraints would make payout within 30 days difficult, given that calculations and informed participant elections are required before the check can be cut.

Transition to GATT

Anti-Cutback Rules

To the surprise of many pension practitioners, the IRS rules specifically allow plans to switch from using the PBGC interest rates—which generally have been low, producing larger lump-sum benefits—to the new GATT rates without violating the “anti-cutback” rule that generally prohibits plans from reducing or eliminating a participant’s accrued benefit. For example, a plan is permitted to pay a participant \$20,000 if he or she retires after the GATT rules are adopted, even if the payout would have been \$21,000 under the pre-GATT rules. Moreover, the IRS regulations do not require such a plan to provide participants the usual 15-day advance notice of a benefit reduction when the GATT rules are adopted.

As plan sponsors contemplate the transition to the GATT rules, some thought should be directed at the possibility that the PBGC will discontinue calculating and publishing its lump-sum interest rates after 2001. This may create uncertainty for plans that want to provide lump sums based on the greater of the old rules or the GATT rules and have no desire to reduce lump-sum distributions under any circumstances.

Another issue for plan sponsors to consider is the application of the anti-cutback rules in those situations where, prior to the adoption of GATT, a plan determines lump sums by using a specified interest rate in addition to the PBGC interest rates. For example, if a plan specifies that lump sums will be determined by using the greater of 5% and PBGC rates, the 5% basis cannot be eliminated. Prospectively, the plan must make a distribution that is the greater of: a) the lump sum based on a 5% interest rate, with the accrued monthly benefit frozen as of the effective date of the GATT amendment; or b) the lump sum based on the required GATT assumptions. The plan may instead provide that, prospectively, the 5% lump sum will be based on the entire accrued monthly benefit rather than on a frozen accrued monthly benefit.

Reductions in lump sums after adopting the GATT rules can be minimized if the plan also specifies that payouts are to be based on its own interest rate and mortality table assumptions. If such interest rate and mortality assumptions were not stipulated in the plan before, they could be added when adopting the new GATT rules.

Timing for Interest Rate Selection

Plan sponsors may also wish to consider changing the timing for determining the applicable lump-sum interest rate (e.g.,

from an annual basis to a monthly basis). The IRS regulations allow plans to change the timing for determining the lump-sum interest rate, provided that each lump-sum distribution made within one year after adopting the GATT rules (or, if later, one year after the GATT amendment’s effective date) is the greater of the lump sum based on the old timing or the lump sum based on the new timing. A plan need not satisfy this one-year transition rule if the lump-sum interest rate measurement period is not changed (e.g., the plan maintains annual timing) and the 30-year Treasury rate is determined no more than two months before the measurement period begins.

For example, assume a plan sponsor adopts the GATT rules in October of 1998 with an effective date of January 1, 1999 and changes the lump-sum interest rate timing from annual to monthly. Under the one-year transition rule, the lump sum for each participant retiring in 1999 must be the greater of the lump sum calculated using the applicable 30-year Treasury rate at the beginning of the year or the amount based on the applicable monthly 30-year Treasury rate. In 2000 and thereafter, the distribution is determined using only the applicable monthly 30-year Treasury rate. However, if the plan continues to use the annual interest rate timing and determines 1999 lump-sum payouts based on the November 1998 30-year Treasury rate, the transition rule will not apply.

Conclusion

Traditionally, defined benefit plan sponsors have not offered a lump-sum option, in part due to their desire to protect participants and assure them of ongoing monthly retirement income. Under pre-GATT rules, plan sponsors also have been concerned about increasing plan costs by offering a lump-sum option, which historically has been more expensive than annuities. But the GATT rules might make lump-sum distributions less expensive, resulting in more defined benefit plan sponsors offering this option.

In defined benefit plans that offer participants lump-sum distributions in lieu of monthly annuities, most participants are likely to elect the single-sum amount at termination or retirement. The decision of how to make the transition to the GATT rules thus becomes critical, because, in many cases, the rules will materially affect lump-sum amounts. Plan sponsors should not wait until the last minute to make such an important decision and should thoroughly review all aspects and issues under the new rules—including participant communications—before amending their plans.

Note

¹ For a plan in existence prior to GATT, plan sponsors are not required to make the new rules effective until the first day of the plan year that begins after 12/31/99, although earlier adoption is permissible. According to IRS *Revenue Procedure 99-23*, for a calendar year plan (where the rules must be in place on 1/1/00), the plan must be amended by the end of 2000. However, calendar year plans that adopt the GATT rules after 1/1/00 must determine lump sums paid during the period beginning on 1/1/00 and ending on the GATT adoption date based on the greater of pre-GATT rules or the GATT rules.

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Administrative Simplification and Privacy Issues for Health Plans

By Stacey V. Muller, F.S.A.

With the enactment of the Health Insurance Portability and Accountability Act (HIPAA) in 1996, many employers face having to make administrative changes to their health plans. Although known more for its “portability” requirements, HIPAA also included a section directed at simplifying administrative transactions related to health insurance. The provisions look toward the future, outlining standard formats as more health plan transactions are conducted electronically. The law calls for national identifiers for providers, health plans, employers, and individuals, with the aim of increasing efficiency and assisting in fighting fraud.

The prospect of having a national identifier for each individual has started the necessary debate on individual privacy issues. Moreover, pressure from the international community is mounting, as the U.S. remains one of the few countries without a comprehensive privacy law in place. HIPAA places a deadline on Congress to enact privacy legislation by August of this year; otherwise, the Health Care Financing Administration (HCFA) is given the authority to issue regulations by February 2000. Privacy legislation or regulation will likely impact how medical claims adjudication, underwriting, and utilization review tasks are handled as restrictions are placed on access to individual medical records.

This article discusses the administrative simplification and privacy issues that employer-sponsored health plans will face as legislation and regulations are developed. Most of the issues will have indirect implications for group health plans and the efforts needed to address these issues generally will depend on the level of employer involvement in delivering benefits to employees.

Administrative Simplification

In an effort to address congressional concern that administrative costs are cutting into the potential funds available for medical services, HCFA has promulgated regulations that would establish standard formats for several common information exchanges that occur within the healthcare industry. HCFA in 1998 began to issue its “administrative simplification” regulations, which, when complete, will cover national standards for the identification of healthcare providers, health plans, employers, and individuals, as well as standards for electronic transactions and for security and electronic signatures.

HCFA has yet to publish the proposed regulations for the identifiers for health plans and individuals. Although the agency has prepared a paper discussing the issues sur-

rounding an individual identifier, proposed regulations in this area are not expected until comprehensive privacy legislation is enacted.

National Standard Identifiers

Having national standard identifiers could produce greater administrative efficiencies and accuracy in many health plan transactions. The identifier proposed for employers is the Employer Identification Number (EIN) that the IRS uses for tax purposes. Some healthcare providers have expressed concern that they will be unable to obtain the EIN from patients for use on electronically submitted claims. Some have suggested that the EIN be included on the health plan or insurance cards issued to employees. Adding the EIN might involve some additional costs for those employers that will have to modify and reissue such cards.

Transaction Standards

HIPAA does not require the collection or electronic submission of any health information, only that the published standards be followed any time a transaction is conducted electronically. However, given the expansion of interactive technology, these standards will affect all but the smallest health plan operations. The regulations proposed by HCFA to implement the transaction standards cover all types of health plans, including self-insured plans governed by the Employee Retirement and Income Security Act (ERISA). Thus, employers may be affected when transferring data to their insurers or third-party administrators (TPAs).

The proposed regulations outline standards for exchanging information about plan enrollment, premiums, and health claims. In general, use of standard transaction layouts is required for the electronic transmission of:

- health claims or equivalent encounter information;
- health claims and remittance advice;
- coordination of benefits;
- health claim status;
- enrollment and disenrollment in the health plan;
- eligibility for a health plan;
- health plan premium payments; and
- referral certification and authorization.

Security Standards

Security standards are required for all health information pertaining to an individual that is electronically maintained or transmitted. Although most employers do not directly handle individual health information, the security standards may affect interactions with health



plans or TPAs. At a minimum, security standards must be documented, kept current, and include:

- administrative procedures to guard data integrity, confidentiality, and availability (e.g., disaster plans, audit guidelines, personnel security, security incident procedures, etc.);
- physical safeguards to guard data integrity, confidentiality, and availability (e.g., protection from theft, fire, and other hazards, as well as security awareness training);
- technical security services to guard data integrity, confidentiality, and availability (e.g., access control through user identification numbers, passwords, etc.); and
- technical security mechanisms (e.g., processes, such as encryption, to secure data transmitted over a communications network).

HCFA's proposed regulations also address electronic signature standards, requiring a "digital signature." A digital signature is based on cryptographic methods that allow for the identification and verification of a unique signer. The regulations provide required and optional implementation features of this standard.

Privacy Issues

Currently, the U.S. has no law that addresses privacy for individual citizens for health or any other type of personal data. A network of private-sector initiatives and self-regulation provide what protection exists. By contrast, many other industrial countries have enacted laws to protect the privacy of personal data. In particular, the European Union issued a comprehensive privacy directive last October. The Directive on Data Protection prohibits the transfer of personally identifiable data to third countries that do not provide an "adequate" level of privacy protection. Because no formal protections exist in this country, there is a degree of uncertainty about whether the U.S. complies. The U.S. Department of Commerce and the European Commission continue to discuss the creation of a safe harbor for U.S. companies that choose voluntarily to adhere to certain privacy principles.

The goal of any privacy law is to restrict disclosure of individual data, enhance patients' rights, and punish those who misuse information. But it also must balance the need for patient confidentiality with the realities of several players in the healthcare system—including employers—that have a legitimate need for access to individual health information. In addition, important public health research and disease control efforts can take place if there is appropriate access to and use of medical information.

HCFA's Principles

HCFA has outlined five principles that make up the Administration's recommendations for health record priva-

cy. These principles will serve as the foundation for regulations if Congress fails to enact a law containing health information privacy standards. HCFA has indicated that its regulations would provide a minimum standard, allowing stricter state laws or regulations to override the federal requirements. The agency's principles specifically address electronically transmitted healthcare data:

- *Boundaries*—Healthcare information should only be used for healthcare purposes. Thus, there should be limitations on using data for non-healthcare purposes while minimizing the restrictions for healthcare uses.
- *Security*—Any law or regulation must require those who receive information for a legal purpose to take steps to protect that information.
- *Access*—Individuals should have access to their own health information and have the right to know who has access to the records and what those records contain, as well as the ability to change incorrect information.
- *Accountability*—Those with access to personal healthcare information must be held accountable by criminal penalties for misuse of the information.
- *Public Responsibility*—Privacy needs must be balanced with a public responsibility to protect the public health, allow research opportunities, encourage quality healthcare, and discourage healthcare fraud.

Federal and State Legislation

In 1998, several privacy bills were introduced in Congress with varying requirements. None was passed in 1998 but most are likely to be revisited in the current Congress. Many of the federal bills contain aspects of HCFA's principles, but the level of preemption by federal legislation does vary.

In addition, at least two models exist for state legislatures to consider. The National Association of Insurance Commissioners (NAIC) has issued model legislation directed at insurance company use of health information. A committee sponsored in part by the Centers for Disease Control has designed a model to address protection of health information held by public health agencies.

The potential differences in federal and state legislation may impact health plans and employers operating in several states. Opponents fear that separate federal and state privacy laws could hinder the claims-paying process and adversely affect employers, insurers, and claimants. Some proponents of privacy legislation, however, believe that proposals to date do not go far enough to protect individual rights. In particular, several areas indirectly connected to healthcare may initially be exempt from the privacy standards due to the wide variety of parties needing access to the data, such as in the case of



workers' compensation claims. Some advocacy groups for individual privacy rights contend that employers currently consider a person's prior workers' compensation claims history in making hiring decisions.

Conclusion

The healthcare environment has changed dramatically over the last 10 years. The movement from paper to electronic records increases the efficiency and usefulness of medical information but also reduces the control the patient has over disclosure of that information. This development tends to weaken the traditional methods of controlling access to this information.

The impact of administrative simplification requirements and potential privacy legislation on employers

will likely be indirect. Much of the debate in both areas centers on healthcare providers, health plans, and insurers, either in their role as providers of healthcare or administrators of healthcare claims. However, employer-sponsored health benefit plans, whether fully or self-insured, face at least some administrative disruptions. The extent of the changes and implications for each employer will depend upon the level of employer involvement in the delivery of healthcare to employees. All employers that sponsor health plans should monitor developments in these areas.

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Key Data Elements in Managed Workers' Compensation

by Patrick A. Gallagher, Ph.D., William L. Granahan, C.I.C., L.I.A., C.M.C., and Christine L. Morgan

Employers looking for a managed workers' compensation program to help control costs should look for the right service components and beyond the promotional material for this "product." In fact, employers need to realize that they are not really looking for a product, but an integrated set of medical management services and a claims management program that does more than simply track and monitor the cost of the claim. An occupational injury or illness should be managed not only as a financial incident but also as a medical process. A truly effective workers' compensation management system will contain a thoroughly integrated set of core component services that assists the employer in both reducing or avoiding workplace accidents (pre-loss services) and providing immediate and consistent medical services when claims do occur (post-loss services).

This article examines some of the continuing problems that workers' compensation managed care organizations (WCMCOs) have in measuring the effects of their interventions, and discusses the key data elements employers should demand from a WCMCO in their effort to improve the employee return-to-work rate and thereby reduce costs related to the workers' compensation program.

Data Lacking

One of the most striking findings of the *Fourth Annual Milliman & Robertson Survey: HMO Managed Workers' Compensation Strategies and Products* was that health maintenance organizations (HMOs) active in the workers' compensation field generally recognize the importance of carefully tracking the claimant through

their system. Equally striking was the revelation that most HMOs were struggling to match their ability to track with their objective to do so.

The study specifically found a continuing problem in tracking patient activity and in determining savings that the HMOs generated in the prior year. The study showed:

- About two-thirds of active HMOs listed tracking of patients and return-to-work results as important objectives, yet only 9% could provide data on the average duration of lost-time claims.
- One-half of the survey respondents reported their savings in medical costs in the prior 12 months, but only one-third provided estimates of indemnity savings on those same claimants. (Total program savings, from medical and indemnity expenses, tend to cluster around 30%, slightly higher than earlier survey results.)
- Only 9% of the HMOs reported having a data warehouse in operation, with an equal percentage looking to have one on line in the near future.

The lack of information in certain categories may result from software and hardware either not in place or not yet configured to systematically capture the data to track patient outcomes and determine program savings.

Other entities—such as workers' compensation carriers, case management firms, and third-party administrators—that are becoming increasingly involved in the workers' compensation arena also are grappling with the



difficult task of effectively tracking cases from the first report of injury to case closure.

Data Needs

Many areas of data collection are required when attempting to measure the effectiveness of a managed workers' compensation program. Process elements such as appropriate receipt of first reports of injury (FROI, detailed below) and timely provider payment are obviously critical and deserve ample attention from the managed care organization (MCO). Use of treatment guidelines and sophisticated workers' compensation-focused physician networks must be in place to reduce the time that injured employees remain out of work.

It is also important to have an advanced system of reporting and electronically transmitting data elements to the regulatory authority. If an MCO is to demonstrate its effectiveness in reducing workers' compensation costs to employers, however, it must have the capability to capture and measure data related to return-to-work efficiency. To measure the effectiveness of its program, an MCO must have the data capabilities to track appropriate injury codes, common procedural terminology codes, and return-to-work dates. MCOs that can effectively manage this data will be successful in proving their value to employers.

Employers searching for a WCMCO should look for an MCO that has adopted the same return-to-work focus that they as employers intuitively have. Many MCOs have experience in group health business and have traditionally been good at the medical management of group health cases. But they may have minimal experience dealing with the urgency and timely handling that are demanded in the treatment of work-related injuries. In addition to the direct and indirect costs employers face when a worker is injured, work-related injuries affect the morale of the injured employee and his or her coworkers. Both employers and MCOs often recognize the significance of returning an employee to his or her former position in the most timely fashion, because the odds of returning to work decline dramatically the longer a person is out of work.

An employer that is committed to reducing costs through a comprehensive managed workers' compensation approach must address several important data management and measurement issues. For example, in the pre-loss area, an employer can pinpoint problems by capturing and monitoring data on "near-miss" accidents and accident patterns on various work shifts. An employer also can get assistance from MCOs that develop func-

USEFUL WORKERS' COMPENSATION REPORTS

- Status of claimant—treatment and improvement to date
- Estimated date for return to work or prescribed transitional job program
- Cost of medical services to date by treatment
- Lost wages paid to date and estimate of claim duration
- Dates of contact by the case manager
- Aggregation of claims by injury type, location, and cause
- Reserves for lost-time claims (medical and indemnity)
- Incurred but not reported estimates
- State fee schedule (as appropriate)
- Verification of pre-certification for expensive services and hospital stays
- Prescription drug costs and services
- Vocational rehabilitation costs and services
- Durable medical equipment costs and services
- Litigation costs

tional job analyses and transitional duty programs, which can then be subjected to quantitative review to determine an MCO's effectiveness. In addition, an employer should systematically evaluate each component area (i.e., loss control and safety management; claims administration; medical and case management; return-to-work services) in terms of data capture and measurement to judge the effectiveness of the MCO's services.

Claims Data Elements

In the post-loss data area, one of the key issues is the timing of the first reports of injury (FROI). This is a concrete statistic that reflects the responsiveness of MCOs to the needs of the employer and injured worker. It represents a critical early step in the direction of prompt return to work. To some degree, employer involvement and oversight will affect the speed of FROI submissions, and the most effective MCOs will work closely with the employer on this. State regulations concerning responsibility for filings and filing deadlines may also affect the timing of FROI submissions. The state's regulations, however, will apply equally to all MCOs in that jurisdiction and should not be used as an excuse for slow performance. Ideally, the FROI should be submitted within 24 hours of the injury or recognition of an occupational illness. Many MCOs use electronic data submission to enhance FROI compliance, and it is reasonable for employers to expect average submission timing to be two to three days after an injury.

To facilitate managed workers' compensation claims, a competent MCO must have a medical management system as its base, as well as an automated claims system that is compliant with the unique requirements of the applicable states' workers' compensation systems. But once an employer is convinced that the MCO has these components, it is necessary to assess the provider's ability to measure and report its results.



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The employer should be able to look at each claim, as well as the injury that triggered it, and dissect how, when, and where it was managed by the MCO. Difficulties may arise when the MCO cannot adequately track and report this data internally, often due to use of claims systems that are not designed to interface with medical and case management, or to the use of subcontractors that do not capture or supply the appropriate data.

Other Key Elements

On a claim-by-claim basis, an MCO must be able to capture the following data to meet the employer's needs:

- diagnosis codes;
- treatment codes;
- claimant job classification;
- provider release date for return to work; and
- actual return-to-work date.

MCOs are beginning to develop data warehouse capabilities that will enhance the process of capturing, managing, and reporting the results of an employer's lost-time cases (typically 80% or more of total costs). While this resource is not yet widely used, an employer should review with the MCO how the MCO plans to manage this critical data.

Conclusion

MCOs should be able to market their managed workers' compensation services to employers by finding ways to differentiate themselves. Many MCOs offer a wide array of "pre-loss" and "post-loss" services that appear to be quite similar. However, employers must look beyond the surface of what MCOs profess to offer and recognize that some MCOs may not have the staff or resources to deliver the services they promise. Employers must not only search for a WCMCO that offers all of the service components, but also should carefully examine each component to verify that the services delivered are real and not merely described on paper. The services should be linked to one another in a logical pattern where claimants can be tracked at any point throughout the system, and connected with a data management system that leads to meaningful measurements and reports.

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