Insurance Newsletter
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Opioid Abuse and WC Insurance Costs

The problem of opioid abuse, much in the news recently, has reached epidemic proportions. The human and social cost of opioid abuse is severe and highly visible and affects all levels of society, but there is a dollar cost to employers, too, which is sometimes visible, often not.

You may have already seen some costs related to drug abuse reflected in your health insurance program costs. Another, much less visible cost is in your workers compensation claims, which directly affect your premiums. In general, workers compensation claims adjusters at larger and more sophisticated insurance companies are pretty sensitive to the potential for higher costs and less successful outcomes from treatments for work injuries that involve excessive opioid use, and combat that wherever they can within the context of the applicable state WC statutes. If you ever sit in on a review of your open WC claims with your insurance company's claim adjuster (which you should do periodically), that's something to watch for. Good adjusters are alert to potential overuse of painkillers; the problem is that not all adjusters are good, and not all insurance companies are as diligent in managing this aspect of claims, and where that's true, you can end up writing bigger premium checks.

A recent report from the Workers Compensation Research Institute (WCRI) highlighted another area where opioids can surreptitiously hit your pocketbook. When a workers compensation claim approaches resolution, adjusters are required to notify CMS (Centers for Medicare and Medicaid Services) for any claimant near retirement age or potentially eligible for social security disability. The operating principal here is that if future medical expenses can be expected from a work injury, they should be the responsibility of the workers compensation system, not Medicare. Claim adjusters are required to submit such claims to CMS, who determines how much money needs to be included in any claim settlement for future medical expenses. This is known as the Medicare Set Aside, and these dollars are added directly to the final settlement value of a claim.

There are a lot of problems with how this works in practice, but one common one is how anticipated future prescription drug costs are calculated. A recent WCRI (Workers Compensation Research Institute) report highlighted this. Here's the problem: the WCRI did a study of almost 8,000 recent closed claims for which workers compensation Medicare set asides were established. They found that the average amount set aside for prescription drugs was $48,986 and the average allocation for other future anticipated medical expenses was $54,407, for a combined total of $103,393 for these claims, all of which was added to the final claim settlement. Of those drug costs, opioids were the most commonly prescribed drug for set asides; the study noted they represent "significantly higher proportions than in the general workers compensation population."

It gets worse. The researchers also looked at the doses approved, and found that for set-aside settlements that included opioids, injured workers were on average approved not only for high daily doses, but some 70% of settlements required funding for decades of opioid use, with an average duration of use of 20.9 years. Moreover, 10% of set-aside plans included opioids at levels that actually represented a medical indicator of elevated risk to the patient. Many of the set asides that included opioids also had concurrent prescription reserves for other sedative-hypnotics and muscle relaxant prescriptions, further imperiling claimants if they actually used the amount of medication included in the set aside.

Claimants attorneys like big settlements for obvious reasons, but including dangerous levels of highly addictive drugs does not help the claimant, and increases the employer's costs. Fortunately, there are mechanisms to contest these set-asides and appeals based on medical facts have good chances of success. But, as mentioned earlier, don't assume your insurance company or claims adjuster is actually looking at

these amounts or pushing back. When claims approach closure and a Medicare set-aside becomes a possibility, you need to be keeping an eye on your claims and your claims adjuster. Remember, all these excess claims costs may not necessarily benefit the injured worker, but they all ultimately find their way into your workers compensation premiums.

EPL Insurance for Sexual Harassment

The subject of sexual harassment in the workplace is much in the news right now, but while a rash of revelations and charges against high profile individuals may be bringing much attention to the issue, it's a problem that has simmered along quietly for years.

These days employers of any size will carry employment practices liability (EPL) insurance as part of their general insurance portfolio, and any well written EPL insurance contract will cover sexual or workplace harassment claims. In fact, it was a highly publicized sexual harassment case that drove the initial spurt of interest in EPL insurance as far back as the early 1990's.

In Harris vs. Forklift Systems, Teresa Harris, a manager at a Tennessee forklift dealer, alleged that she was subjected to persistent and unwanted sexual innuendos and advances at work. She sued…and lost in district court. She appealed, and lost again at the appeals level. The case was ultimately taken up by the U.S. Supreme Court, where in 1993 she won, in a unanimous decision. The court's clarification of the definition of the terms "hostile" or "abusive" work environment was a shot across the bow for employers, and a clear warning that there were financial consequences for ignoring this issue. Another consequence was that EPL insurance, which from the beginning always covered these types of claims, gained increased visibility as an important part of employers insurance portfolios.

Claims of this type have percolated along for years. The EEOC reports that of the 91,500 complaints it received in 2016 almost 30% included an accusation of sex-based workplace harassment. They also note that those numbers may barely scratch the surface; the EEOC estimates that three-fourths of people who are sexually harassed on the job don't tell anyone. With all the recent publicity given to this subject, one might reasonably surmise that these numbers might change in the future, and not for the better.

Obviously the victims of such conduct may suffer significant emotional, psychological and economic harm, but there are also substantial legal and financial costs for businesses. EPL insurance can cover many of these costs, but the current crop of highly publicized cases raises other serious risk management issues as well. EPL insurance is most effective and worthwhile for lower level harassment cases. Think of common and obvious cases of lower level managers or line supervisors, seeking to extort sexual favors in exchange for better hours, overtime, promotions and such. These are, if you will, routine cases of harassment, and insurance can adequately cover most costs from them; a business suffers little in the way of other effects.

Recent cases making the headlines illustrate different problems. What happens when the harasser is a high level executive, a creative leader, a top talent or major producer or dealmaker? When the offender is someone who contributes in significant ways to the top or bottom line of an enterprise, the stakes change. Contracts, deals, even employment are abruptly terminated, projects shelved, ongoing business relationships damaged or destroyed, all with significant financial consequences to the business and owners. The Weinstein case is a prime example; recent news reports indicate that the company is about to be sold, for a price that, after debt assumption and other obligations, will leave equity holders with nothing. A few months ago they owned a piece of a thriving and successful company; in the blink of an eye, they are wiped out. There is no insurance to cover that, and as current headlines have shown, such financial hits can be immediate and often devastating.

For these reasons the risks of sexual harassment claims pose one of the most difficult and vexing

risk management challenges faced by any enterprise. The closer to the top of the organizational chart an offender is, the more severe the risk faced by an organization. Not only will any judgement or settlement be bigger, significant uninsured financial consequences can also be expected.

While a well written EPL insurance policy is obviously necessary, these are the types of claims any employer will particularly want to avoid. Businesses are familiar with the concept of loss prevention and there is lots of good advice and information on how to minimize and mitigate risks of sexual harassment claims available from other sources, so we won't belabor details here. Just remember that while a well written EPL policy is an important part of any modern commercial insurance portfolio, insurance can only cover part of the costs of such claims, and the higher up the perpetrator is, the greater the likelihood that uninsured costs will be the bigger part of any fallout from such incidents. Preventing and minimizing them is the preferred strategy to avoid significant uninsured loss.

Insurance Applications

In the minds of most insurance buyers a policy, once bought and paid for, is pretty much a settled issue. If a claim is presented most folks expect, rightfully, that it will be paid under the terms of the policy. And most times, that's pretty much what happens. There are exceptions, though.

Insurance policies are contracts, and have the same elements as any contract, offer and acceptance, consideration (the premium) and legal purpose. At bottom, they are contracts that say that in return for payment of the premium by the policyholder the insurance company agrees to pay money to the policyholder in the future, under specific defined circumstances when a covered claim is presented, and subject to all the terms and conditions of the insurance contract. If you think about it, the policyholder is actually at a disadvantage in this type of arrangement. The policyholder performs first, by payment of the premium, and must rely on the good faith of the insurance company to perform in the future, when a claim is submitted. An unscrupulous insurance company, having collected the premium, may not be highly motivated to pay back anything for a claim subsequently presented. This is not about routine disagreements between claimant and adjuster about amounts to be paid or interpretation of the terms of a policy, which are pretty common, but about an insurance company refusal to pay just because, well, they think they can.

Situations where things like that happened were perhaps more frequent in the past but these days there is a well-developed and rigorous body of law and precedent governing insurance companies, and it can be a pretty costly proposition for any insurance company who fails to deal with a policyholder/claimant in good faith. The principal of good faith dealing with claimants by insurance companies is backstopped by some pretty hefty financial penalties against insurance companies who don't do that.

Good faith goes both ways, though, and there is another side of the coin that policyholders need to keep in mind. When an underwriter entertains an application for insurance he needs to obtain enough information to determine if he wants to offer a policy to that applicant, what the limits, terms and conditions will be, and what premium he wants to charge for the risk he's assuming. He'll typically ask for an application, which requests information from the applicant the underwriter thinks he'll need to make a decision.

For this reason the application carries a fair bit of weight. The underwriter will assume that the applicant is answering questions and providing information on the application that is honest and accurate. He has to; in this case the advantage lies with the applicant. All an underwriter can hope for is enough information to make an informed underwriting decision, but the applicant will always know his own affairs better than any underwriter possibly could. Since the underwriter is necessarily dealing with limited information, he must rely on the good faith of the applicant, and assume that the information being provided by the applicant is

complete, accurate and honest. Incorrect or omitted information can drastically affect a carrier's acceptance or rejection of the risk. That's why insurance applications are so important and carry so much weight.

They are so important, in fact, that an insurance company can decline coverage and void the policy for incorrect information. Most applications that you will sign will state somewhere near the space for your signature that the underwriter is relying on the information provided. Often unstated is the corollary, that if the applicant misrepresents or omits material information and the insurance company discovers it either at the time of loss or after the policy is bound, they can seek to deny coverage and void the policy.

Material misrepresentation is the failure to disclose a fact that would change the carrier's mind about issuing a policy. For one simple example, consider an applicant for a homeowners policy who fails to mention that he owns a pit bull with a history of attacking people without provocation. Most underwriters would not want to offer a policy if they knew that risk existed. An applicant who thought they could get a policy by concealing such a material fact could be unpleasantly surprised if they ever submitted a dog bite claim, but so too could an applicant who just hastily dashed off a signature on an application without reading it and noticing the omission. Whether deliberate or accidental, the information is material, and failing to disclose it could be a problem.

So, word to the wise: next time you have to sign an insurance application, take a couple of minutes to read it first and make sure it's right.

2017 Catastrophe Loss Update

2017 will go down as the costliest year ever for losses from natural disasters in the U.S. There were sixteen events that resulted in more than one billion dollars in damages and most recent reports indicate that the U.S. suffered over $300 billion in total economic damages from all sources. Insurance companies will pay out more than $135 billion in covered claims from all these events, with the balance paid for by government grants, loans and aid, or out of pocket by those suffering the uninsured loss.

None of these totals include damage from the December wildfires in southern California, one of which, the Thomas fire, was officially counted as the worst fire in state history. And 2018 is continuing in a similar vein, with a massive winter storm hitting the east coast as far south as Florida to start the first week of the new year.

So what does this mean to you? There is likely to be some impact on insurance costs, especially property insurance, as underwriters seek to recoup some of that $100 billion or so they paid. Most of that will be in the form of a hit to earnings, with only a few insurers actually seeing any impairment to capital, but either way there will be some pressure to get some of it back. Some caveats: any pricing changes will likely filter in slowly over the first few months of the year as underwriters get a handle on their recent experience. There is also counter pressure on rates from still ample capacity and competition in the reinsurance market from alternative capital sources. January reinsurance renewals did not see any significant upward spikes.

Upshot? Except for catastrophe exposed property risks expect only low single digit rate increases at worst. There may also be some minor spill over to liability lines as underwriters attempt to spread increases over other lines. At minimum, there are unlikely to be further rate decreases, at least for a while.

Except for auto, which continues its own slow, rolling catastrophe. Auto insurance experience continues to be unfavorable in general, for both personal and commercial segments. On top of that a large part of the insured claim totals mentioned above were also in auto lines; remember, there is no flood exclusion in an auto comprehensive policy, so flood claims from hurricanes also contributed to poor auto loss experience.

If you've seen your own personal auto policy renewal lately you likely noticed the effect of poor auto claim experience first hand; auto underwriters, both personal and commercial, want more money. Mid-single digit increase will likely be the norm, and for heavy commercial accounts and those with losses, it could be much worse.