

Tools to make MSA Pharmacy Allocations Last

means asking the right questions to be sure the company has credentials to provide the best service and savings.

Competency – Does the PBM have expertise in workers' compensation and does it have experience managing funds from MSA-structured settlements? Or, is the bulk of their business group health with only a small portion dedicated to workers' compensation? Is the company well-versed in Medicare fee schedules and Medicare regulations?

Utilization – Does the PBM have the ability to deliver the right medication to the right claimant at the right time? Does its process ensure that patients are taking the proper medication to prevent inappropriate or non-compensable medications?

Accountability – Does the PBM have advanced reporting systems that provide information in a manner and format easily understood for review by the claimant, custodial manager and, more importantly, by CMS?

Productivity – Is it easy for the custodial account manager or the claimant to access account information 24/7? Does it have knowledgeable service representatives on call around the clock to address questions and solve problems?

Home Delivery – Are patients offered the option of nationwide home delivery?

Prescription Card – Are personalized and customized pharmacy prescription cards available?

Network Penetration – Does the PBM have a large nationwide network of pharmacies to make access easier?

Security – Is the PBM's electronic access system secure? Does it monitor and record account access, have built-in password expiration protection and automatic password expiration notification for HIPAA compatibility?

Electronic claims management – Does the PBM use the most advanced online claims management technology that allows for real-time instant updates to claims processing?

No doubt, insurance payers and Medicare Set Aside allocation organizations will continue to be challenged with appropriately assessing the cost allocation of future medical needs and applying tools to maximize duration of the benefits. The task becomes less daunting when they can incorporate cost management tools – including pharmacy benefits management and preferred provider services – that have traditionally delivered these benefits.

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By Lisa Datelle Quarterman and Eileen Ramallo

Since 2001, when The Centers for Medicare and Medicaid Service (CMS) issued its accounting report of Medicare spending, CMS has aggressively focused on making the workers' compensation payer markets accountable for protecting Medicare's interest. The report stated that Medicare and other federal benefits programs were spending billions of dollars because of conditional payments in workers' compensation cases that should have been addressed by the workers' compensation carriers.

With the introduction of Medicare Part D in January 2006, and subsequent inclusion of pharmacy benefits in Medicare Set Aside Allocations prior to settling workers' compensation claims, the issue of accurately calculating pharmacy along with medical benefits and ensuring they last as long as anticipated has reached a new level of priority.

If legal action is taken to recover Medicare Secondary Payor (MSP) from the primary workers' compensation payer, Medicare may seek double the amount of issued payments plus interest. The exposure requires that workers' compensation payers not only properly identify claims that require MSA Allocations, but also address how the allocated funds will be managed following the settlement to maximize the duration of the funds through the life expectancy of the beneficiary.

Payers are recognizing that maximizing use of the allocated funds requires that services are managed with some degree of preferred payment structure to the providers rendering the medically necessary health care and prescription drug services.

Cypress Care, a leader in the workers compensation industry has expanded into the auto and Medicare Set-Aside markets by applying best practices and expertise - focused toward a single goal: Help our clients achieve the best financial and clinical outcome - to get back to work and get back to life.

We are committed to delivering end-to-end health cost management solutions and integrated strategies that thoughtfully address the needs of our clients.



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Older claims have higher drug costs

In its 2006 State of the Line Report, the National Council on Compensation Insurance Inc. (NCCI) looked at the distribution of medical service utilization based on the age of the claim. The study shows that prescription drug costs in new claims account for less than 20% of the total medical dollars spent for treatment of the injury. However, in claims where dates of injury exceed six years, the cost of drugs dramatically increases, accounting for over 50% of the medical dollars spent for treatment of work related injuries.

Considering that many claims meeting the criteria for MSA allocation will exceed six years from the date of injury, the probability is high that a large portion of these allocations will have future pharmacy needs exceeding 50% of the total settlement amount.

That's because the cycle of the common work-related injury starts with the acute phase, which generally includes surgery, followed by increased physical medicine, shifting to a prescription drug-focused maintenance mode.

One industry expert notes another trend that is increasing the pharmacy spend in some workers' compensation cases. "More and more, prescription therapies are being utilized as a key component of conservative treatment of work injuries and may even eliminate the need for invasive procedures," said Jean Feldman, vice president of care management operations at CHOICE Medical Management/Unisource Administrators.

As the injury cycle settles into long term-long-term pain management, prescription medication and doctor visits frequently become the norm over alternative methods for easing the pain to accommodate the activities of daily living. It is this chronic stage that medical dollars are absorbed by monthly visits to the doctor for new scripts, and supportive medical equipment such as tens units, supplies and other durable medical equipment.

An informal poll of 10 Medicare Set Aside allocation organizations shows that an estimated 90 percent of the allocations they arrange are managed by the individual claimant. The remaining 10 percent is being professionally administered or with some type of custodial management organization, either through an annuity or other structured settlement.

This means that vast numbers of claimants are being given the sole responsibility for managing their MSA allocated medical funds throughout their life expectancy without the tools to maximize the duration of the funds. More challenging is that CMS currently does not require consideration of inflation costs – all the more reason the money should be managed judiciously.

Considering the high number of MSA allocation settlements being managed by individual beneficiaries and the likelihood that more than half their medical dollars will be spent on pharmacy in later years, there is considerable incentive to implement responsible MSA funds management.

Confronting the challenge

Several custodial plan administrators are beginning to apply tried and true network provider strategies to address and manage the cost of medical and ancillary services rendered on settled workers' compensation claims.

Their strategy starts with recognizing that workers' compensation claims, once they are transferred into MSA settlement accounts, are no longer subject to workers' compensation regulation. There are no fee schedules established post claim care, thus exposing the fund to escalating prices and the chance that the costs associated with rendering the medical care and treatment on these settled claims can far exceed the allocations – especially for those claims with long benefit duration expectancy.

Adding to the challenge is that several programs focus on retrospective payment for medical service rendered. This can result in a lower per unit cost of care but, with no management of the medical necessity or

relatedness of the services rendered, the cost might be too high or unnecessary.

Regardless of how the funds are managed – professionally or beneficiary-managed – after the allocation amount is settled, the funds are no longer subject to regulations that provide the best avenue for cost savings. Favorable fee schedules and other means of cost controls, including network mandates on where the dollars are used and for what purpose, are out of reach. In either case, but especially for the individual claimant who lacks the buying power of a provider network, the allocated funds can be at risk of being depleted prematurely.

Accessing managed care tools

Some claims organizations are addressing the challenge by informing the claimant, MSA allocation companies and custodial managers that there are ways to access managed care tools to stretch the MSA allocated dollar. They point to programs offered by pharmacy benefits managers (PBM) or prescription card services as well as Preferred Provider Organizations (PPO) where medical rates are similar to what the carriers and payers access while the claim is active under workers compensation. In many instances they are providing the information as part of the documents shared during the claim settlement discussions.

Access to such managed care benefits, like formulary management with automatic brand to generic conversion, preferred provider rates and prescription cards are some examples of savings opportunities that will level the playing field and give the claimant the favored position enjoyed by the carrier. With an allocation based on a preferred provider rate, for example, the beneficiary can pay up to 20 percent below fee schedule, when retail rate for the same drug could be 120 percent.

By extending managed care tools that exist in a structured payment system like PPO and PBM services to the MSA beneficiary, the MSA dollar goes farther, Medicare's interests are protected, and claimants can continue to have their own

medical treatment needs met in a seamless process.

One company's approach

While MSA fund management represents only a portion of the custodial accounts administered by FARA Healthcare, the addition of pharmacy to MSA allocations has had a big impact on the size of the MSA accounts that FARA administers, according to Leta R. Sharkey, division manager of Settlement Options for FARA Healthcare. The size of the funds is changing the way her company helps negotiate and manage the settlements.

"I knew adding pharmacy to some settlements would triple or quadruple the allocation," she said. To protect the fund assets, "I wanted to create a structure that would be acceptable for all parties – the adjuster, claimant, defense and plaintiff attorney and Medicare."

Such was the case of a social security disability claimant whose decade-old work injury and high-priced pain medication created a multi-million dollar settlement with annual pharmacy costs in six figures. "Because the claimant chose to self administer the pharmacy allocation, we had to find the means to allow him to do this, but with assurance the funds would last."

By partnering with a PBM company with experience in workers compensation, a structured pharmacy management plan was tailored to this claimant's need. More importantly, the PBM was familiar with Medicare rules and fee schedules. CMS approved the plan in a matter of weeks.

Today, the claimant is saving money because of the PBM network discount, she said, and the system is set up to dispense only plan-approved drugs and to generate an account activity report that meets CMS' requirement for annual reporting. Moreover, the PBM created a debit payment system from the claimant's bank account so the funds are used appropriately.

Setting up pharmacy management process

Whether the PBM is brought into the process in the pre- or post-settlement

stage of the MSA allocation, custodial account managers would be wise to consider taking steps ahead of time so savings can be put into effect immediately, delays in service are minimized, and the benefits are not interrupted.

Obtain all the HIPAA compliant medical releases

Remembering that once the MSA case is settled and closed and it is no longer a workers' compensation claim, all transfer and dissemination of medical information falls under the HIPAA protection. To avoid obstacles to medical treatment and preferred rates, custodial and benefits managers should obtain Medical release and authorization forms signed by the claimant prior to settling the workers' compensation claim. This allows the medical vendor to request information from the beneficiary without infringing on HIPAA.

Establish a process for billing and collection

Establishing claimant billing information is fundamental to setting up a structured fund allocation management system. This allows the PBM and PPO to access the information needed to process claims easily. Whether the account is set up from the

individual claimant's bank account or through a custodial account, a payment system should be established. For automatic bank deposits and payment, a bank release form is required for access to the claimant or custodial manager's bank account to facilitate such processes as PBM card or home delivery medication sign up. This is done with an automatic bank draft through an ACH transaction.

To realize savings right away, the PBM or PPO needs the claimant's Medicare renewal date, so no time is lost transferring benefit services.

Annual accounting on use of allocation funds to CMS.

Whether the account is managed by the beneficiary or the custodial manager, an annual report must be submitted to CMS annually. Therefore, a process must be established with the PPO or PBM for submitting account information in a timely way to the claimant or the custodial manager to comply with CMS protocol.

PBM and MSA competency

Finding the right PBM for MSA pharmacy fund allocation management

Exhibit 13 Medical Payment Share by Service Group and Age of Claim

