ALABAMA SELF-INSURERS
— A S S O C I A T I O N —

VOLUME 1 SPRING 2014

ASIA Objectives

ASIA is committed to a workers' compensation program that:

- Adequately compensates the employee with a work-related injury
- Recognizes fair limitations on employer responsibility
- Provides for an appropriate distribution of the compensation dollar
- Reduces litigation
- Is dedicated to eliminating abuses within the system
- Operates within the bounds of reasonable and necessary regulations

Summer Conference

August 10-12, 2014
Hilton Sandestin Beach Golf Resort & Spa
Destin, Florida

Winter Workshop

Date to be determined
Sheraton Birmingham
Birmingham, Alabama

INSIDE THIS ISSUE:

Medication Use and Patient Safety Concerns: The Dark Side of Drugs

By: Dane Higgins, M.B.A., Pharm.D. and Tim Covington, M.S., Pharm.D.
Covington Healthcare Associates

All too often we focus on the benefits, but neglect the dark-side of drug therapy. It is estimated that prescription medications cause 140,000 to 180,000 deaths annually. If it were monitored as a cause of death, drug therapy would represent the third-leading cause of death in the U.S., well ahead of stroke (135,000 deaths), chronic lower respiratory diseases (128,000), and diabetes (71,000). In 2000, it was estimated that the U.S. spent $177.4 billion annually due to medication-related adverse events/problems. The total cost of pharmaceuticals was $133 billion in 2000. Other estimates have suggested that for every $1 spent on purchasing prescription medications, as much as $2 is spent managing the complications of medication therapy. Unfortunately the healthcare system is doing little to address preventable drug-related morbidity (or drug-induced disease) and mortality (or drug-related death). All too often the doctor diagnoses and prescribes, the pharmacist dispenses and after that patient care is left to chance.

WHAT ARE MAJOR CAUSES OF MEDICATION-RELATED MORBIDITY AND MORTALITY?

Far too many factors are responsible for medication-related morbidity and mortality to list in a single review; however, an overview of selected factors involving key players (e.g., physician, patient, pharmacy) is provided below:

- Physician: The physician's index of suspicion regarding the dark side of drugs is often too low. Many physicians are educated about new drugs by sales representatives from brand-name pharmaceutical companies. Physicians simply do not have adequate time to keep up-to-date and objectively evaluate the vast amount of drug information that is being published on a daily basis.

- Pharmacist: The dispensing pharmacist is typically unaware of the patient's diagnoses and laboratory data. If the patient is filling prescriptions at multiple pharmacies, the pharmacist may not have the patient's complete drug regimen. Pharmacists operating in busy pharmacies may be consumed with drug dispensing and not have adequate time to keep up with newly published drug information.

- Patient: Patients often underappreciate the risks of medications, especially when mixed. This includes the use of over-the-counter medications and herbal remedies.

continued on page 5

The Alabama Self-Insurer is a quarterly publication of the Alabama Self-Insurers Association:
Post Office Box 240757 • Montgomery, AL 36124-0757
(800) 366-3439 • Fax (334) 272-7128
E-mail: asia@gmsal.com
www.asiaal.org

A Word from the President...

Doug Kitchens

I don't know about those of you who are reading this but as for me, I AM CERTAINLY GLAD WE ARE APPROACHING SPRING! What a brutal winter we have had. Your ASIA Board has been very active working indoors to continue protecting the interests of our membership. From planning the Summer Conference, to monitoring Legislative issues and even working to address two Board vacancies.

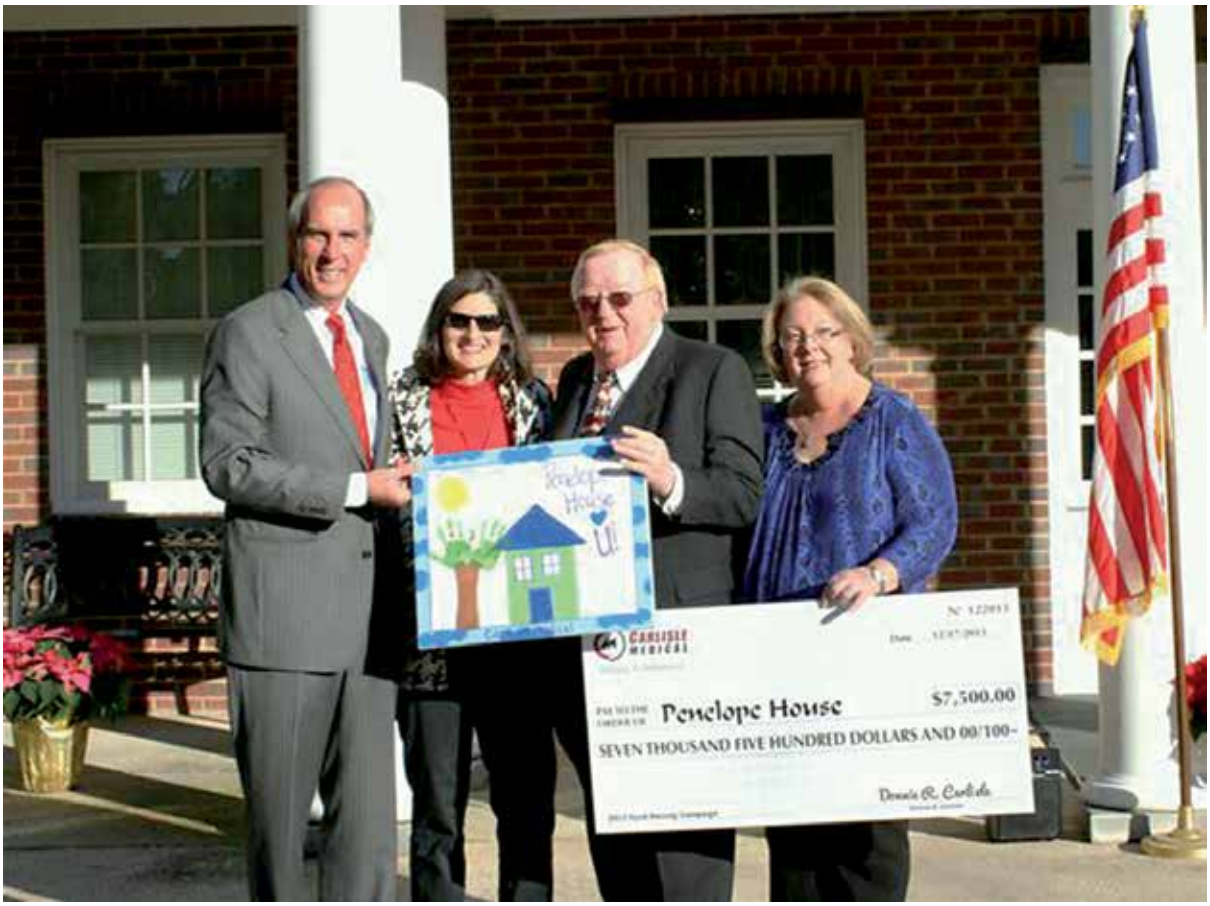
On behalf of the ASIA Board of Directors, I want to welcome the latest two additions to our Board. Carol Davis joins the ASIA Board and serves as a medical specialist with experience in management of workers' compensation cases since 1996 with Mercedes Benz US International in Vance, Alabama. We also welcome Stewart Civils to the ASIA Board. Stewart is an attorney with Vulcan materials and manages the workers' compensation programs for his company. We look forward to the fresh ideas of these new Board members. The corporate representation of Mercedes Benz and Vulcan provides additional strength to our organization. I am sure many of you know both Carol and Stewart but for those of you who are not familiar with them, please make a point to welcome them to our Board as you meet them during our conference in August.

In any organization, we are often reminded that there is no place for "I". As the ole saying goes, "there is no I in Team". Believe it or not, I am going to take issue with that for a moment to present each of you with a challenge. I would like to ask each of you to ask yourself, "what can I do for the benefit of the ASIA organization". The best answer is for each of us to individually take steps to recruit members to our organization. Yes, "I" has a place in our organization! Give some thought to friends you may have within the self-insured community and reach out to them for membership in the Alabama Self-Insurer's Association. Enhanced membership will provide more employers with an opportunity to experience the benefits of ASIA. From educational enhancement, to an improved clout within the legislative community. From a broadening of what ASIA can offer, to a benefit for our vendors who provide our financial support. You see, growth in our organization helps everyone who is involved. Accept your role in becoming an important "I" for the coming weeks and months.

Serving ASIA as your president for the past several months has been very rewarding. I want to push our membership, both active and associate members, to help us grow as we reach out to broader opportunities.

Thank you all for your participation and commitment to a better ASIA!

Doug



Carlisle's 2013 Fund Raising Finale – The Carlisle companies celebrated the 2013 fund raising effort by holding a finale event. This event was attended by the recipient of the Carlisle companies' 2013 fund raising effort—Penelope House—represented by Executive Director, Tonie Ann Torrans, the Mayor of Mobile, Sandy Stimpson, and Carlisle staff. At the event, Donnie and Deborah Carlisle presented Penelope House with a check for $7,500. During the year, the Carlisle staff raised approximately $3,000 from raffles, donations and other special events. An additional $2,000 was raised through "Casting for the Kids" raffle. This raffle was a partnership effort between the Carlisle companies and Penelope House, with prizes donated by local fishing Captain, Bobby Abascato, custom rod building legend, Ross Hutchisson, and local businessman, Mark Travis. An additional donation was given by Donnie and Deborah Carlisle. Over the last five years, the Carlisle companies have raised over $27,000 to support local charities. Penelope House was created to provide safety, protection and support to the victims of domestic violence and their children.

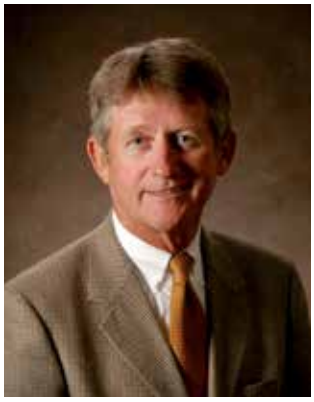
ASIA Calendar of Events

AUGUST 10-12, 2014	**ASIA Summer Conference** Hilton Sandestin Beach Golf Resort & Spa • Destin, FL
JANUARY/FEBRUARY, 2015	**ASIA Winter Workshop – Date to be determined** Sheraton Birmingham • Birmingham, AL

continued on page 4

Executive Director's Report... The Clock is Ticking

Charles Carr



Every now and then it hits me. It always hits me in the most peculiar ways. It has been a much longer time than I realize since 1968.

I graduated from high school in 1968. I still feel young and young at heart. I can still remember exactly what Jimmy & Johnny Bowden's 1968 Chevrolet SS 396 looked like. The reason I feel it wasn't that long ago is that every time I think of that SS 396, I know every detail about it. The wheels, the curves, the tail lights, that beautiful yellow color, and the knowledge that the Bowdens were cool and I was not because I was driving a 1964 Chevrolet Corvair.

The difference between a 1964 Chevrolet Corvair and a 1968 Chevrolet SS 396 is more than just 4 years. In total coolness, they are light years apart. There is no way that I could ever expect to feel good driving around in my Corvair. It was just a thing that got me from point A to point B. The Bowden's SS 396 got them from A to B quickly and with every cute girl in Enterprise, Alabama looking at them as they drove by.

I digress. This is not a reflection on cars, it is to let you know how quickly time has passed from 1968 to 2014. Sometimes, I have to do the math in my head. That is 46 years ago. Yet when I think of my classmates at Enterprise High School and that SS 396, it seems as though it was only yesterday.

This year, Mardis Devore retires from Wal-Mart. Around 1982, I received a call from Mardis Devore. Mardis called me because I was the only person working at 6 pm on a Friday. She asked me if I did comp work. I told her I did. She asked me if I had ever heard of Wal-Mart. I confessed that I hadn't. Imagine that. In 1982, I had never really heard of Wal-Mart. She told me they had a few stores and we bonded right away. Over the next 14 years, I did everything in my power to please Mardis and Wal-Mart. For a while Mardis was my boss in Alabama. Later she passed Alabama off to others as she moved up the ladder handling more and more important stuff for Wal-Mart.

During the course of that 14 years (1982-1996), Mardis was indirectly responsible for my kids getting educated and for me progressing up the ranks of partnership to my then law firm Rives & Peterson.

In 1997, when Carr Allison was formed Mardis was the very first client who came with us. Others followed suit. Though I seldom did any comp work with Wal-Mart after that (though many in our firm did), I have never forgotten Mardis and all the loyal friends she introduced me to who stood by us for so long. As this is Mardis Devore's last year with Wal-Mart, I totally dedicate this Executive Director's report to her and to the loyalty and dedication that she exhibited. I offer a toast to her unshakeable Christian principles and for believing in me and our firm. I also offer my heartfelt appreciation and want her to know she left an imprint that will never be forgotten.

Beyond this, the clock is ticking. I am now 63 years of age. When I was 16, everyone that was 63 was old and was surely scoping out the best nursing home in Enterprise. 65 meant social security and wrinkles. It meant no longer looking cute to anyone other than your dog. No one worked past 65.

Let me tell you what else I can remember. I can remember 1977 when a 10% impairment rating from the doctor meant a 10% impairment settlement approved by the judge. Always. I can remember 1977 when the only lawyer other than me that was handling workers' compensation cases on the defense side was Jay Clark and maybe John Civils. We were like Crawford & Company. If Jay, John and I had started a law firm in 1977 we probably would have had all the comp work today. Not because we were any good (they were, I wasn't), but because no one else wanted it. We were like Crawford & Company in 1977. Was there any other TPA in 1977 other than Crawford & Company..

In 2014, none of the original work comp lawyers still do comp work. But there are a million lawyers that do. There is a real question as to whether there are more work comp lawyers or more TPA's? Or surveillance companies? Or Physical therapists? If we had an ASIA meeting in 1977, Donnie Carlisle would have been the only other "vendor" to help sponsor our organization. It was not until Mark Davis started doing his work comp seminar in Mobile and Brown & Hudges started doing their USS Alabama Battleship party AND the court of Civil Appeals announced the first lump sum attorneys' fees that everything changed. Now every lawyer who graduates from law school wants to do comp work.

What does this all mean? Your Executive Director is getting old. You've known it a long time. I haven't. Every time I look in the mirror, I see the same guy that looked at that 1968 SS 396. It's God's gift to all of us. We don't see how old we are getting when we look in the mirror.

It's been a really fun ride. There have been so many of you that have made the ride fun, I can't begin to thank you all. For the most part, though, its those of you that are reading this old man's rant. If you made it this far, God Bless you!!

THE CLOCK IS TICKING.

Medication... CONTINUED FROM PAGE 1

• Insurer/Payer: Payers (e.g., insurers, employers) often focus on the cost of prescription drugs and do not consider the additional cost prescription drugs inflict on medical cost due to drug-induced adverse events that result in emergency room visits, hospitalizations and other adverse outcomes. The price of the medication is only a small part of the total cost of drug therapy.

• Healthcare System: Pharmacy is separated into its own "silo". Pharmacy data, costs and outcomes are separated from medical data, cost and outcomes. Too often, little is done to integrate this information.

Clearly, many other factors are present, some of which include….

- A lack of long-term safety data supporting the use of medications for more than just a few months to a year in duration; therefore, we often do not know much about the long-term effects of medications.
- Lack of risk data when combining 3, 4 or more drugs in a single patient.
- Lack of data about individual or combination drug use in certain co-morbid medical conditions (such as declining liver or kidney function).
- ….and much more.

WHAT DRUGS ARE ASSOCIATED WITH MEDICATION-RELATED MORBIDITY AND MORTALITY?

Every medication approved by the Food and Drug Administration (FDA) contains a package label. The label provides physicians, pharmacists and other healthcare professionals information on the drug. Typically, 90% or more of package labeling addresses the negative effects of drugs. This includes black-box warnings, contraindications, warnings, precautions, drug interactions, and adverse reactions. Typically less than 10% of the product label addresses the beneficial effects of the drug, which is generally limited to indications, the clinical trials section of labeling, and administration and dosing guidelines. Unfortunately, healthcare professionals often focus on the positive aspects of drug therapy and minimize the fact that drugs and drug combinations can cause significant harm in many individuals.

All drugs have a risk of causing adverse events. The severity of which can range from minor adverse events (drowsiness, constipation, etc) to severe life-threatening adverse events (arrhythmias, liver toxicity, respiratory depression, internal bleeding, etc). However, certain drug classes are more often associated with causing drug-related hospitalizations than others. The classes of drugs in the chart below are more frequently responsible for drug-related hospitalizations:

While the drugs above are the individual agents most often associated with hospitalization, a more frequently encountered issue is how drugs negatively interact with one another and/or the patient's other medical conditions. While a drug may not cause an adverse reaction severe enough to cause a medical emergency or hospitalization, drugs commonly cause negative effects that reduce quality of life, complicate other medical conditions, and/or result in the use of additional drug therapies to manage the adverse events due to the original medication. These issues are extremely common and represent a significant cost inflicted on the healthcare system. Some commonly encountered examples include the following:

- Multiple Central Nervous System (CNS) Depressants: Numerous classes of drugs suppress the CNS, such as opioid narcotics (e.g., morphine, OxyContin®, Duragesic®),

DRUG CLASS	DRUG EXAMPLES	COMMON REASONS FOR HOSPITALIZATION
Anti-diabetics	Insulin, glyburide, glimepiride	Low blood sugar, which could cause loss of consciousness and coma.
Cardiovascular Agents	Diuretics, Digoxin, anti-arrhythmia drugs	Kidney failure, low blood pressure, fainting, heart arrhythmias.
Psychotropics	Anti-psychotics, Anti-depressants, Anti-anxiety agents	Confusion, falls and fracture, movement disorders, stroke, heart attack.
Gastrointestinal Drugs	Metoclopramide, Dicyclomine	Confusion, falls and fracture, movement disorders, depression/suicide.
NSAIDs	Naproxen, Ibuprofen, Celebrex®	Gastrointestinal bleeding, kidney failure and heart disease.
Anticonvulsants	Carbamazepine, Phenytoin	Seizures, skin reactions, confusion.
Antineoplastics	Methotrexate, Doxorubicin	Blood, liver, and kidney toxicity.
Corticosteroids	Prednisone, Dexamethasone	Infections, psychosis.
Antibiotics	Penicillin, Cephalexin	Rash

hypnotics (e.g., Ambien®, Lunesta®), muscle relaxants (e.g., Soma®, Flexeril®), anti-anxiety drugs and some antidepressants. Individually, these medications can cause significant CNS depression, resulting in sedation, dizziness, and mental confusion. When combined, their effects can be synergistic in nature. It is not uncommon to find patients prescribed 5 to 6 CNS depressants chronically. These combinations can cause profound daytime sedation, increasing one's risk for accidents and diminishing quality of life. The CNS depression can be severe enough to have doctors prescribe a CNS stimulant, such as Provigil® or Nuvigil®. These agents are highly expensive and are of questionable efficacy in drug-induced sedation.

- Antipsychotic Use in Depression: Antipsychotics, such as Abilify®, Seroquel® and Zyprexa® are increasingly being used in the management of depression. These medications produce very negative cardiovascular adverse events. They often cause significant weight gain, increased blood sugar/diabetes, and increased cholesterol. When used chronically, these agents can increase one's risk of heart attacks and strokes. While the antipsychotics can be considered in serious treatment-resistant depression following the failure of numerous safer treatment strategies, they are often being employed far too early (sometimes after the failure of only one antidepressant). Unfortunately, many prescribers are also not regularly checking blood sugar, weight, cholesterol, and other recommended monitoring parameters when prescribing the antipsychotics. These agents also often cost $300 to $500 per prescription, far more than generic antidepressants, which can be purchased for as little as $5 to $20 per prescription.

- NSAID Use in Heart Disease: NSAIDs, such as naproxen, ibuprofen, Celebrex® and meloxicam, are commonly used to manage pain and inflammation. These medications cause significant cardiovascular, gastrointestinal and renal toxicity. Vioxx® and Bextra® were NSAIDs removed from the market due to negative cardiovascular effects, such as an increased risk of heart attacks and strokes. While all NSAIDs appear to increase cardiovascular risk, some agents are associated with more risk. Risk is also dose-related with higher doses causing greater increases in risk. Despite their well-documented risks, it is not uncommon to find patients with heart failure, previous heart attacks, uncontrolled diabetes, etc, receiving high-doses of NSAIDs chronically. This further increases one's risk for a heart attack or stroke.

- Chronic Use of Oral Corticosteroids: Oral corticosteroids, such as prednisone, are commonly used for short periods of time to treat severe asthma, poison ivy, arthritis, and various other inflammatory conditions. When used for very short periods of time, these drugs can be highly effective and generally well tolerated. However, when used for chronic periods of time, prednisone and other oral corticosteroids can cause weight gain, increased blood sugar (diabetes), increased blood pressure, stomach ulcers, osteoporosis, cataracts, and immune suppression (increasing one's risk for infections). The chronic use of oral corticosteroids can often be minimized or avoided.

- Aging Issues and Rx Use: As we age, our bodies change with respect to how we handle medications. The absorption of medications is slowed, the rate at which we eliminate (by kidneys

and liver) medications is also slowed, and our bodies become more sensitive to the effects of many medications. Ultimately, these age-related changes result in the necessity to use lower and lower medication dosages as patients age from 60-65 years of age and on through life. Additionally, many medications are not recommended in people over 65 years of age because the risk associated with these therapies exceeds their potential benefits. Failure to recognize these issues can result in elderly individuals experiencing falls and fractures, gastrointestinal bleeding, confusion, severe constipation, increased heart attack/stroke risk, etc.

The examples listed above only represent a small sample of medication-related morbidity and mortality issues. While medications can represent miraculous cures for disease, they can also cause adverse events that result in hospitalizations, reduce quality of life, and cause or complicate other diseases.

WHICH PATIENTS ARE AT HIGHEST RISK?

Anyone being prescribed medications or taking OTC drugs/herbal remedies is at risk of developing an adverse event from drug-therapy. However, patients at the highest risk for developing drug-induced complications include the following…

- Use of Multiple Medications: The greater the number of medications used, the more likely that one will develop drug-related adverse events and/or interactions. Patients prescribed 5 or more medications are at a greater risk of developing drug-related adverse events/interactions than those prescribed two to three medications. When patients are being prescribed 10 or more prescriptions, there are nearly always issues of unnecessary drug use, inappropriate drug use, questionable dosing, drug interactions, and drug-induced morbidity.

- Multiple Co-Morbid Conditions: The more co-morbid conditions a patient has, the more likely he/she will have multiple prescribers and many medications. A medication used for one condition may complicate the treatment of another co-morbid condition. Some medications should not be used in patients with certain medical conditions, such as heart failure, liver disease, renal impairment, heart attack, stroke, etc.

- Multiple Prescriber/Pharmacies: While having multiple physicians can be necessary and appropriate for patients with multiple medical conditions, it can also present communication issues, duplicative therapies, drug-drug interactions, and other issues.

Patients at high-risk for developing drug-related morbidity and mortality typically possess all of the risk factors listed above. Patients being prescribed 7 to 10 medications, or more, from multiple prescribers to treat numerous co-morbid conditions are at very high-risk for being prescribed unnecessary drugs, drugs that have interactions with other drugs or other medical conditions, and drug-induced morbidity.

WHAT IS THE HEALTHCARE SYSTEM DOING TO MITIGATE PATIENT RISK?

Unfortunately, the healthcare system is fragmented and complex. Information technology, care integration and coordination of efforts, and various other factors are intended to mitigate patient risk. However, little is actually being done to identify and resolve drug-related morbidity and mortality. For example, the increased use of e-prescribing may reduce drug dispensing errors; however, little is being done to reduce overprescribing and/or inappropriate prescribing. Insurers and PBMs are generally more concerned with the cost of purchasing the drug and less about the value derived from drug therapy, whether positive or negative.

WHAT CAN ORGANIZATIONS DO TO MITIGATE PATIENT RISK?

Organizations such as employers, TPAs and insurers should not just consider drug therapy in a silo. While the drug therapy benefit may be administered by a pharmacy benefits manager (PBM), this does not mean that everything should be left up to the PBM. PBMs are typically concerned primarily about the cost of purchasing the drug and not your return-on-investment (ROI) obtained from drug therapy. For every dollar you spend on prescription drugs, what is your ROI? Are you spending less on medical cost due to pharmaceuticals? Or are you spending $2 managing the complications of mismanaged drug therapy for every $1 you spend on pharmaceuticals? Are your beneficiaries with chronic medical conditions (such as diabetes and hypertension) even taking their medications on a daily basis as prescribed? About 50% of people with diabetes, hypertension and other medical conditions are non-adherent to prescribed drug therapy, resulting in higher and unnecessary medical cost. Is your PBM monitoring and reporting on medication non-adherence? Are they performing interventions to foster medication adherence in diabetics, hypertensives and patients with other chronic medical conditions? What is your PBM and/or insurer doing to address drug-induced morbidity and mortality? What are they doing to identify and resolve drug-related issues involving unnecessary or inappropriate drug use, overutilized medications, drug interactions, and drug-induced morbidity?

Employers, TPAs and other organizations must take a more active role in pharmaceutical care to achieve an ROI on their medication expenditures. This will require organizations to ask questions of the PBM and/or insurer. This will also require organizations to demand programs that foster the safe, effective and economical use of prescription drugs. Programs may include, but are not limited to, the following…

- Formulary/Utilization Management Programs: The drug formulary (a list of drugs covered by the PBM/insurer) is the cornerstone of drug benefit management. However, a drug formulary clearly does not substantially address drug-related morbidity and mortality problems. In fact, despite PBMs having drug formularies in place, drug-induced mortality is still the third leading cause of death. This clearly suggests that far more is needed than what is currently being provided by PBMs/insurers.

- Medication Adherence Programs: The World Health Organization has estimated that adherence to long-term therapy for chronic illness averages only 50%. This costs payers billions every year in medical cost due to medication non-adherence in diabetics, hypertensives, and other chronic health conditions. Payers should be utilizing medication adherence programs to identify patients who are non-adherent to drug therapy. Various levels of intervention (e.g., patient letter/message, physician letter/message, incentives) could then be enacted to foster medication adherence.

- Pharmacotherapy Review Programs: The pharmacotherapy review program targets patients at the highest risk for drug-induced morbidity and mortality. This includes patients who are receiving 7 to 10 medications, or more, from multiple prescribers to treat numerous co-morbid conditions. An evidence-based pharmacotherapy review should be conducted by a PharmD-level (Doctor of Pharmacy) clinical pharmacist. The review should evaluate and report on all areas of drug therapy, both clinical and financial. This process provides nurse case managers with intellectual "ammunition" to present to prescribers in the form of an evidence-based report. Ultimately, the goal of the pharmacotherapy review program is to optimize health outcomes while preventing drug-related morbidity/mortality and avoiding unnecessary pharmacy cost.

- Numerous other programs are available, such as pharmaceutical quality assurance programs, specialty drug programs, and medication therapy management programs, just to name a few.

CONCLUSIONS

Unfortunately the healthcare system and payers of health care bills are doing little to address preventable drug-related morbidity and mortality issues. For every $1 spent on purchasing prescription medications, as much as $2 is spent managing the complications of medication therapy. Payers of healthcare benefits must take a more active role in pharmaceutical care to foster an ROI on their medication expenditures. This will require organizations to ask questions of the PBM and/or insurer and demand more accountability. Numerous pharmaceutical programs are available that attempt to prevent drug-related morbidity and mortality.

AUTHORS

Dane A. Higgins, M.B.A., Pharm.D.; Tim R. Covington, M.S., Pharm.D.

Covington Healthcare Associates, LLC
3800 Colonnade Parkway
Suite 110
Birmingham, AL 35243
Phone: 205-970-3939
Fax: 205-910-2836

BIBLIOGRAPHY:

- Drug-induced diseases: prevention, detection and management. 2nd Edition.

- Facts and Comparisons. Wolters Kluwer Health. 2013.

CARR ALLISON

ALABAMA | FLORIDA | MISSISSIPPI | TENNESSEE

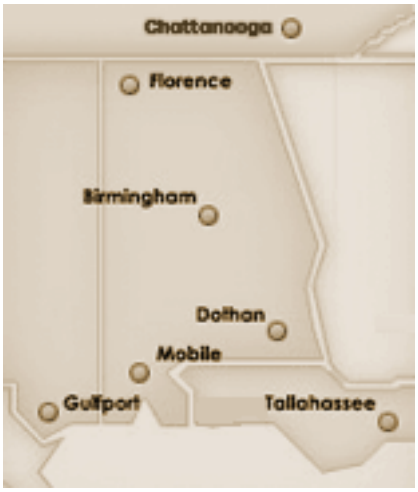
Proudly Serving the Legal Defense Needs
Of the Business Community Throughout

ALABAMA , FLORIDA, MISSISSIPPI and TENNESSEE

CARR ALLISON

Proud to Support

The Alabama Self Insurers Association



www.carrallison.com

ASIA Summer Conference...

AUGUST 10-12, 2014
HILTON SANDESTIN BEACH GOLF RESORT & SPA
DESTIN, FLORIDA

GO TO ASIAAL.ORG IN MAY TO REGISTER!

Transportation for Your Injured Worker

Know the Facts About Liability & Service

By Mel Nehleber

Transportation is made available when injured workers cannot facilitate the function themselves. It will help facilitate a faster return to work of the claimant by:

- Insuring that safe, reliable transportation is available to the claimants to get them on time to significant appointments.
- Eliminate the excuse of missed appointments due to not having reliable transportation, thus prolonging the claim.
- Limit additional risk of people outside the claim becoming injured in facilitating the transportation.
- Documenting claimant's compliance.

The most often type of transportation requested is ambulatory transportation (80%). Wheelchair is estimated at 10% and all other modes (stretcher, ambulance) at 10%.

THERE ARE KEY CONSIDERATIONS WHEN RETAINING A COMPANY TO PROVIDE TRANSPORTATION SERVICES.

- Quality of the organization being contracted with from both a service and financial perspective.
- How are the services delivered (eg: via a provider network)?
- What are the initial and on-going credentialing / contracting processes?
- How does the provider perform quality assurance on their network vendors?

What is the insurance program that the provider has in place, coverage amounts, how does it work, and what does it cover?

PROVIDING NATIONWIDE COVERAGE

Beyond these basic questions, there is one that has surfaced over the last several years. How should the role of Independent Drivers be considered when performing ambulatory transportation?

For a nationwide footprint, companies that perform these services in many cases are "brokers", not owning their own vehicles and utilizing a credentialed network of vendors.

Independent Drivers are vendors that are recruited to perform ambulatory transportation services. They are individuals who typically should go through an extensive credentialing process that should include background check, drivers' license check, vehicle registration; vehicle should meet certain specific criteria, insurance confirmation to comply with the legal requirements in their operating jurisdiction, and then a contract that outlines requirements, confidentiality, etc.

But, they are not commercially licensed to transport people.

COMMERCIAL COMPANIES AND INDEPENDENT CONTRACTORS

Independent Driver or Commercial companies. Knowing the facts about using one or the other is important.

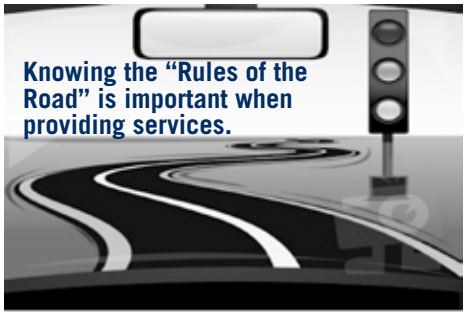
Commercial companies include taxi, car service, PUC licensed operators. These vendors are required to comply with the laws associated with the licensing requirements of their locality, city, county and/or state.

It has been asserted that Independent Drivers may provide a better and more attentive service than a commercial company vendor, but there is a question of liability. Not so much from the injury perspective, as long as the proper insurances is in place, but from the legality of the use of the Independent Driver.

The provider you utilize should carry insurance coverage that layer on top of the network vendor to assure coverage that would meet the levels that insulate the client that retains the services.

This normally is a policy referred to as "Hired and Non-Owned" that covers only the injured worker being transported for liability related to injuries incurred and for the other vehicle involved if applicable.

It layers on the commercial vendor's coverage and starts at "dollar-one" for the Independent (their insurance is personal and therefore would not cover "for hire" services).



But, what of the liability of the use of a non-commercially licensed provider? What of vehicle failure where the Independent Driver may not have to comply with regular maintenance and inspections of the vehicle in contrast to the Commercial Vendor who is required to comply with such based on the license maintenance requirements?

What about the legal liability of a legal action for utilizing a vehicle/ driver where they do not possess the licensure to transport persons of the public?

There are many questions that arise in the utilization of Independent Drivers. AccessOnTime has taken the conservative approach to use a 99% plus commercial network, only using independents in remote areas where a commercial vendor may not be reasonably available.

It is our position that this best protects the injured worker, our company and the clients that retain our company to provide the service. This helps address the potential non-covered liability.

You as the client have to look to your organization's risk management to answer the question of what is in the overall best

Melven (Mel) Nehleber is President and CEO of AccessOnTime and is responsible for overseeing all aspects of business operations and development. The company provides virtually every mode of transportation services internationally.

For more information visit their website at www.accessontime.com.

News from the National Council of Self - Insurers

From: wenholt@aol.com
Subject: Registration for Meeting of National Council of Self-Insurers
Date: February 3, 2014 11:40:02 AM CST

Dear NCSI Member:

The 2014 annual meeting of the National Council of Self-Insurers will occur from Sunday, June 1 to Wednesday, June 4 at the new Tropicana Las Vegas.

The following documents can be found on 2014 Annual Meeting Page of the National Council of Self-Insurers website. Please check this website http://www.natcouncil.com/meet.html.

The Meeting Registration fee for a conferee or a spouse/companion includes the cost of the President's Reception and Buffet Dinner on Sunday evening, the Luncheon on Monday, the Dinner-Entertainment on Tuesday evening, the Adjournment Breakfast on Wednesday, Continental Breakfasts on Monday and Tuesday and the Hospitality Room.

Please register for the meeting and communicate with the Tropicana Las Vegas to make your room reservation as soon as possible.

If you have any questions at all, please feel free to contact me by e-mail at natcouncil@aol.com or by phone at 908-665-2152.

Larry Holt
Executive Director

Members of the National Council of Self-Insurers:

The following is a summary of an article, in Risk and Insurance, which examines a significant question faced by the workers' compensation community. The article was written by Anthony Ireland.

With the Terrorism Risk Insurance Act set to expire on December 31, 2014, Congress has the difficult task of deciding whether the U.S. insurance industry needs federal protection from a major terrorist act.

Opinion is divided over the future of this federal backstop.
Most believe the Act should be renewed, albeit with amendments. Yet there remains a valid argument that TRIA has served its purpose and is no longer necessary. Terrorism risk, some say, is no different than any other catastrophe peril and should be insured entirely by the private market.

Under the existing TRIA program, a federal payout would be triggered by a terrorism loss of $100 million or more – a scenario fortunately yet to be tested, since the Act was first implemented in 2002 and subsequently extended in 2005 and 2007.

Corporate insurance buyers and their brokers are certainly in favor of a federal backstop remaining in place in some form or other – after all, without TRIA, there is no way terrorism insurance would be as accessible and affordable as it is today.

Peter Beshar, general counsel of Marsh & McLennan and a vocal advocate for TRIA, says, "We have already begun to see the uncertainty over TRIA prompt some workers' compensation carriers to pull back from certain parts of the market, where they feel they have aggregated risk – large urban areas with high concentrations of buildings and employees."

Indeed, while the U.S. insurance industry now boasts a healthy surplus of Property & Casualty capacity, there is less confidence in the ability of the industry to foot potentially enormous workers' compensation losses. Workers' compensation coverage is mandatory and does not exclude terrorism. As such capacity is stretched in dense urban areas containing many employees.
Self-insured companies are not exempt from this economic danger, as they carry excess workers' compensation insurance.
But there are vocal quarters of the insurance and academic communities that say TRIA has run its course and should be removed altogether.
Professor Robert Rhee of the Cato Institute, which conducted a detailed policy analysis of TRIA, says the following:
"If there was some ambiguity about the program's need before, there is none now. Terrorism risk is no more severe than other insurable risks such as natural catastrophes. The private market is capable of underwriting the risk."

Natural catastrophes cost the U.S. insurance market $45.7 billion in losses between 2003 and 2012. Terrorism cost just $433 million.

There is agreement that the current $100 million trigger for TRIA appears disproportionately low given the market's ability to absorb multibillion dollar natural catastrophes each year with few problems.

Despite some compelling economic arguments for the removal or scaling down of TRIA, the very nature of terrorism breeds extreme caution – fear of the scale and nature of the next attack; fear among politicians of appearing complacent; fear among insurance buyers how the insurance market will respond to life without the TRIA safety blanket.

Indeed, psychology – perhaps even more so than economic risk itself – will be crucial in determining whether and in what form TRIA endures.

Larry Holt
Executive Director

From: wenholt@aol.com
Subject: Flat Fee for TPA Bill Review Services
Date: March 11, 2014 10:01:40 AM CDT

Members of the National Council of Self-Insurers:

More employers wanting predictability in the fees they pay workers' comp third-party administrators are negotiating to pay a single, flat fee for bill review services. The arrangements follow from criticisms some employers and brokers have placed on TPAs, saying traditional TPA charges for bill review services obscure the ultimate cost of those services.

Under traditional arrangements, a TPA might charge an employer on a per-bill basis for each medical-provider bill reviewed. Or, they might charge on a per-line basis, tallying a fee for each expense line on a bill.

TPA executives have countered that their billing measures are transparent, at times arguing that brokers stir the controversy to attract consulting business.

Svrivatsan Sridharan, senior vice president, product development for TPA Gallagher Bassett Services, a National Council of Self-Insurers member, says more large employers are negotiating to pay a consistent flat, per-bill fee for all bill-review-related services for each claim. The employer then pays additional amounts for claims handling and all of the other TPA services required to resolve a claim, although the charges for these other services have tended to be more predictable than the bill-review fees.

Data collection has made it possible for TPAs to model an employer's expected claims management expenses and accommodate flat-fee deals.

In a similar vein, brokers have recently been asking TPAs about their willingness to charge one, all-inclusive fee for an employer's entire book of claims business, says Joe Picone, chief claim officer for Willis of North America and a speaker at an annual meeting of the NCSI.

Ultimately, employers want to know the "true cost" of managing their claims and this "could be the next evolution of TPA pricing," Mr. Picone said. "Why don't we just say, 'Instead of paying $1,500 per claim, my whole contract is worth $1 million or $500,000.' "

The mountain of workers' comp claims data that TPAs collect could help make the broader flat-fee arrangement possible, at least theoretically, because TPAs could mine the data to predict the claims management costs an employer will generate when operating in a specific region and industry, with certain employee demographics and exposure differences.

The above is a summary of a recent article in Risk and Insurance magazine, written by Senior Editor, Roberto Ceniceros.

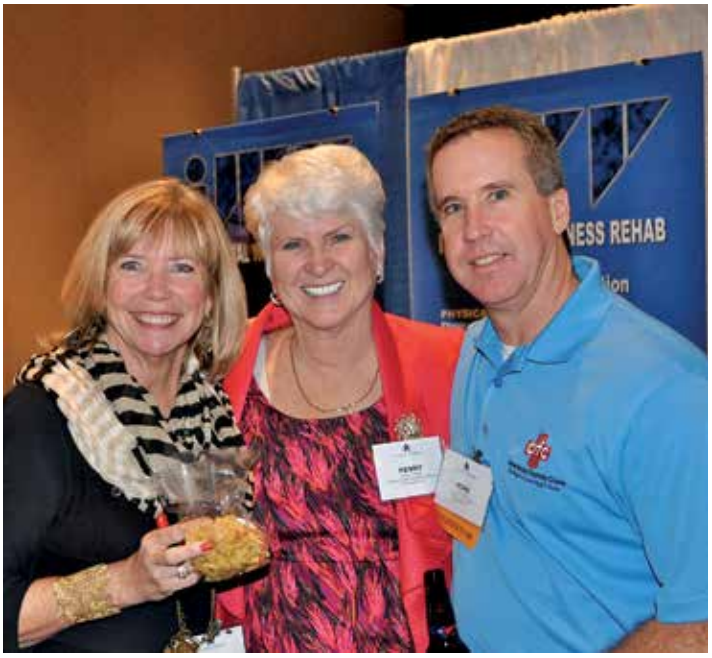
WINTER WORKSHOP IN REVIEW...

Attorney Johnathan Berryhill and Dr. Chip Thuss spoke on Drug & Alcohol Defense

Randal Ward, Terry Young and Greg Wilkes

Bethany Sweatt, Terri Connell and Harriett McQueen enjoy the tradeshow

Karl Rayborn, Tracy Webster and Mark Miller visit between speakers



Mary Holden, Penny Nichols and Mike Perley talk shop at tradeshow

Attorney John Webb Explains Graben Pain Exception

SPECIAL THANKS
TO ASIA SPONSORS AND EXHIBITORS

EXHIBITORS

Access on Time
Alabama Artificial Limb & Orthopedic Service, Inc.
Alabama Healthcare Exchange
Alabama Orthopaedic Clinic
Alabama Orthopaedic Surgeons
AlaMed Holdings
American Family Care
American Health Imaging
Biotech Limb and Brace
Brentwood Services Administrators, Inc.
Brookwood Medical Center
CareMaster Medical Services
Carlisle Medical, Inc.
Carr Allison
Catastrophic Medical Excess
Center for Pain
Comp1One
Corvel Corporation
Coventry Health Services
D & D Case Management
D1 Sports Medicine & Orthopedics
Direct Pay Provider Network
Directions Management Services
Drayer Physical Therapy
EBSCO Creative Concepts
Encore Rehabilitation
Fourroux Prosthetics
Genex
Greystone Neurology & Spine Center
HealthMed, Inc.
ICM
Industrial Wellness Rehab
Industrial Medical Clinic of Mobile
Jefferson Neurobehavioral Group
Jett Medical
Johnston & Associates
Managed Health Care Administration
MRM
MTI America
NeuroLife, LLC
Occupational Health Center
One Call Care Management
OrthoSports Associates, LLC
PMA Companies
PMOA
Preferred Medical Network
Prium
Rehab Associates - Champion Sports Medicine
Restore Neurobehavioral Center
Shelby Baptist Medical Center
Southern Orthopaedic Surgeons
Southlake Orthopaedics Sports Medicine & Spine Center
Southside Pain Specialists
Spain Rehabilitation Center
SportsMed
St. Vincent's Occupational Medicine
St. Vincent's Orthopedics
Tennessee Valley Pain Consultants
The Orthopaedic Center
The Orthopaedic Group, PC
The Workplace
UAB Orthopaedic Surgery
University Orthopaedic Clinic
Vernis & Bowling

2014 Winter Workshop Sponsors

Platinum Sponsors

Carr Allison

Silver Sponsors

Carlisle Medical
Center for Pain
D1 Sports Medicine & Orthopedics
MTI America
OrthoSports Associates
Southlake Orthopaedics Sports Medicine

Gold Sponsors

AlaMed Holdings
Blue Cross & Blue Shield of AL
Brentwood Services Administrators, Inc.
Southside Pain Specialists
UAB Orthopedic Surgery

Bronze Sponsors

Alabama Bone and Joint Clinic
Encore Rehabilitation
HealthMed, Inc.
MRM, LLC
Southern Orthopaedic Surgeons

The *Self-Insurer*
is a quarterly
publication of the
Alabama Self-Insurers
Association
Post Office Box 240757
Montgomery, AL 36124-0757
(800) 366-3439
Fax (334) 272-7128

PRSRT STD
U.S. POSTAGE
PAID
MONTGOMERY, AL
PERMIT #275