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California's Workers' Compensation System since SB 863: A Background Paper on California's Century Long Experiment in Equity for Injured Workers

Senate Committee on Labor and Industrial Relations
March 25, 2015

California's workers' compensation system is one of the most-discussed and most controversial areas in the Senate Labor Committee's jurisdiction. Nowhere is this more true than with the 2012 workers' compensation reform bill, Senate Bill 863 (DeLeon) (Statutes of 2012, Chapter 363). On March 25th, this Committee will conduct oversight on how SB 863 is being implemented, in what areas the reform has achieved success, and areas where further efforts are needed. The purpose of this background is to give a brief overview of the history of California's workers' compensation system, recent efforts at reform, and a rough overview of the benefit increases and cost savings at the core of SB 863.

A Brief History of the Creation of California's Workers' Compensation System

The first workers' compensation system in modern history was created by Bismarck in Prussia in 1884, largely as a way to address labor unrest in Prussia due to worker-led political unrest. At its core, Prussia's workers' compensation system was a grand compromise between employers and injured workers: injured workers receive necessary treatment (and an award if the injury is permanent), but lose the right to sue--- meaning workers' compensation becomes the exclusive remedy for all workplace injuries. Employers, on the other hand, do not need to worry about workplace injury liability in the courts, but they are liable for the medical treatment for injured workers (as well as an indemnity award if the injury is permanent).

This grand compromise between labor and employers was at the core of California's decision to create a workers' compensation system in 1913 (replacing a voluntary workers' compensation system created in 1911). Key to this compromise was that California's system was a no-fault workers' compensation system--- the injured worker received treatment and benefits for

occupational injuries, irrespective of the cause of the injury.[1] Prior to 1913, California followed English Common Law on workplace injuries, which held that, because employees know more about the hazards in a given worksite as a result of working there, the employee was liable for workplace injuries.[2]

Size of California's Workers' Compensation System

Based on estimates from the 2014 Commission on Health and Safety and Workers' Compensation (CHSWC) annual report, employers incurred approximately $21.4 billion in system wide costs by California's workers' compensation system. This included more than $5 billion in indemnity benefits[3], more than $7.8 billion in medical benefits, and nearly $10 billion in reserve costs and administrative expenses. For more than a decade, medical costs have been the single largest expense for employers and insurers in the workers' compensation system.

Legal Structure of California's Workers' Compensation System

Article XIV, Section 4 of the California State Constitution reads (in part):

The Legislature is hereby expressly vested with plenary power, unlimited by any provision of this Constitution, to create, and enforce a complete system of workers' compensation, by appropriate legislation .... A complete system of workers' compensation includes adequate provisions for the comfort, health and safety and general welfare of any and all workers ... to the extent of relieving from the consequences of any injury or death incurred or sustained by workers in the course of their employment, irrespective of the fault of any party... the administration of such legislation shall accomplish substantial justice in all cases expeditiously, inexpensively, and without incumbrance of any character; all of which matters are expressly declared to be the social public policy of this State, binding upon all departments of the state government....

This broad article serves as the foundation of California's workers' compensation system, and it was originally passed in 1911 by a vote of the people (Senate Constitutional Amendment No. 32, Article XX, Section 21).

The primary Labor Code Sections largely echo the constitutional requirements. Labor Code §4600 provides that medical, surgical, chiropractic, acupuncture, and hospital treatment that is reasonably required to cure or relieve the injured worker from the effects of his or her injury shall be provided by the employer. Similarly, Labor Code §5402 provides that employers must

[1] Exceptions to this include if the employee purposely hurt himself or herself, was intoxicated, or if the injury was due to a fight at the worksite.

[2] While it may be apocryphal, one story about this period that is repeatedly told is that of a worker who lost his hand in an industrial accident involving a conveyor belt--- and the employer sued the injured employee for damages due to halting production.

[3] Indemnity benefits are also known as Temporary Disability (TD) or Permanent Disability (PD) benefits. Both will be discussed in more detail below.

initially provide up to $10,000 in medical treatment for a claim – even if that claim is later rejected.[4]

Indemnity Benefit Structure of California's Workers' Compensation System

As was discussed above, the cost of medical benefits is significantly higher than indemnity benefits. However, indemnity benefits are an important benefit for injured workers and are frequently what people reference of when discussing benefits in the workers' compensation system. The different forms of indemnity benefits are discussed below.

Temporary Disability (TD) benefits are benefits the worker receives when the occupational injury results in lost time and wages. The purpose of this benefit is wage replacement: TD replaces 2/3rds of an injured worker's wages, with a ceiling set at $1095.70/week for 2015.[5] The benefit lasts for up to 104 weeks, except for certain serious injuries. TD is the most common type of indemnity benefit, and is generally not a significant friction point in the system.

Permanent Disability (PD) benefits are, as the name suggests, benefits awarded in the event that the injury results in permanent reduced earning capacity. The two types of PD indemnity benefits are Permanent Partial Disability (PPD) and Permanent Total Disability (PTD). PTD is very rare; it would generally occur in very serious injuries such as blindness, amputation of limbs, or paralysis. Generally, when one is discussing PD, one is discussing PPD.

As per Labor Code §4660.1 states, "*determining the percentages of permanent partial or permanent total disability, account shall be taken of the nature of the physical injury or disfigurement, the occupation of the injured employee, and his or her age at the time of injury.*" A physician does this analysis once the injured worker is permanent and stationary (P&S), or when the nature and degree of disability has reached a point where it is neither worsening nor improving. The physician must refer to the American Medical Association's Guides to the Evaluation of Permanent Impairment in order to determine disability. Once this is done, the physician can determine the permanent disability rating using the Permanent Disability Ratings Schedule (PDRS), which is created by the Administrative Director. This rating is communicated through a percentage – eg. PD rating of 15%.[6]

In the event of a dispute, the case would then be referred to a Qualified Medical Examiner (QME).[7] QMEs are physicians who have passed a Division of Workers' Compensation (DWC) test that certifies them as qualified to resolve medical disability disputes. QMEs are selected

[4] The $10,000 cap came from SB 899, which will be discussed in detail later. Prior to this, liability was basically uncapped.
[5] The TD ceiling increases every year based on the State Average Weekly Wage (SAWW).
[6] For a worker who is found to be totally disabled (PTD), the rating would be 100%.
[7] It is also possible for both parties to skip/avoid the QME process and agree to a single medical evaluator. This would be an Agreed Medical Evalulator (AME).

from a panel; basically, either side disputes the PD rating, requests a panel, receive a list of three QMEs that meet the appropriate criteria, and then each side gets to reject one QME, leaving the remaining QME as the QME to resolve the rating dispute.[8]

If an injured worker's injuries are severe enough to result in a PD rating of 60% or more (including PTD), the worker would be awarded a life pensions as well as a "traditional" PD benefit. As the name suggests, this is a cash award that would continue for the life of the injured worker. As a PD rating of 60%+ would suggest, injured workers eligible for a life pension would be the most seriously injured workers and is relatively rare.

California's Workers' Compensation Reform Prior to SB 863 (DeLeon) of 2012

Prior to 1995, the Insurance Commissioner regulated workers' compensation premium rates. The goal of this regulation, also known as the Minimum Rate Law, was to ensure that no one insurer cut their rates so low that they achieved a monopoly, which would destroy the entire workers' compensation insurance market in the event of the monopolistic carrier's insolvency. In 1995, insurance rates were deregulated, which effectively allowed insurance companies to set their own rates.

What followed was a period of incredible volatility in California's workers' compensation insurance market. While average rates dropped from about $4.00 per $100 of payroll in 1993 to a bit more than $2.00 per $100 of payroll in 1995[9], this reduction in costs for employers was short lived. By 2002, the average rates had risen to $6.00 of payroll, and many employers and insurers were facing insolvency.[10] Moreover, a market largely populated by local monoline workers compensation carriers was replaced with large national multiline insurers with significant capitalization.

The most famous reform in response to this crisis was SB 899 (Poochigian) of 2004, which was the product of a campaign promise made by Arnold Schwarzenegger in the recall campaign of Governor Gray Davis. While SB 899 contained many significant adjustments to California's workers' compensation system, one of the most significant changes was in the permanent disability (PD) schedule. Structured through regulation by Andrea Hoch, the Administrative Director of the Division of Workers' compensation, the newly created schedule was expected to reduce PD benefits for some injured workers. However, in short order, stakeholders began reporting far lower than expected permanent disability awards, leading to controversy. In 2007,

[8] As with many things in workers' compensation, the QME process is more complicated than it appears.

[9] Workers' compensation insurance rates are assessed as a percentage of payroll, depending on the industry and the injury experience of the employer (e.g. how frequently the employer reports industrial injuries). This is generally shown as a dollar figure per $100 of payroll. For clerical employees, the figure will be low, while for high-risk injuries the figure will be high (e.g. $2.20 per $100 of payroll vs. $30 per $100 of payroll).

[10] In fact, more insurers went insolvent or left California's workers' compensation market in 2003 (28) than went insolvent in 1935, at the height of the Great Depression (18).

a Commission on Health and Safety and Workers' Compensation (CHSWC) report definitively showed that benefit award dollars were cut by more than 50%, far more than was intended by the Legislature and workers' compensation stakeholders.

Despite this, the Schwarzenegger administration refused to revisit SB 899 and address the new PD schedule. In 2009, despite the fact that SB 899 itself required that the PD schedule be revised, the administration made no significant moves towards revising the schedule. Due to this inactivity, injured workers continued to see significantly diminished PD awards.

On the employer/insurer side, the early implementation of SB 899 was an incredible boon. Low rates, paired with diminished costs on both past[11] and present claims, led to a return of a healthy workers' compensation market. However, with the collapse of the financial and stock markets in 2008, as well as a return to less stringent underwriting standards, rates began to increase on employers. Paired with several Workers' Compensation Appeals Board (WCAB) decisions that significantly increased the cost of PD claims, these headwinds led to a rapid deterioration of California's workers' compensation market and to the employer community seeking legislative reforms.

Senate Bill 863's Primary Reforms: Benefit Increases

With stakeholders in the workers' compensation system unsatisfied with the operation of the workers' compensation system, it was inevitable that reform legislation would be introduced when Governor Schwarzenegger termed out in 2010. In preparation for this, both labor and employers began meeting over several months to hammer out a compromise bill. This bill eventually became SB 863 (DeLeon) of 2012, which was overwhelmingly passed by both houses and signed by Governor Brown.

The concepts behind what eventually became SB 863 were a decade in the making and almost entirely drawn from Commission on Health and Safety and Workers Compensation (CHSWC) studies, which highlighted administrative inefficiencies that created significant costs for employers. By trading these administrative savings for a benefit increase, SB 863 promised to accomplish a counterintuitive feat: increasing permanent disability benefits by 30% (on average) and lowering system costs at the same time.

According to Workers' Compensation Insurance Rating Bureau (WCIRB) estimates, SB 863 increased PD indemnity payments to injured workers overall by **<u>$1.1 billion</u>**, as well as an additional **<u>$120 million</u>** in the newly-created Return to Work (RTW) fund for injured workers who cannot return to work.

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[11] Unlike past workers' compensation reforms, SB 899 contained retroactive components. These retroactive components were upheld by the court, which suggests that retroactive application of workers' compensation reforms is not automatically unconstitutional. See *Green v. WCAB* (2005), Cal.App.4th 1426.

Senate Bill 863's Primary Reforms: Cost Savings

The primary savings that achieved this were the elimination of the double reimbursement of spinal surgery hardware, socializing PD "Add-Ons" and the *Ogilvie* decision costs, workers' compensation liens reform, and the creation of Independent Medical Review (IMR). These reforms, as well as the creation of medical fee schedules, will be discussed below.

Spinal Hardware Double Reimbursement:

In 2003, the Legislature created an additional reimbursement for spinal hardware used in spinal surgeries for injured workers, which was commonly known as the spinal pass-through. At the time, the belief was that an additional reimbursement was necessary due to the new nature of spinal fusion hardware technology. However, it quickly became apparent that such a pass-through effectively doubled the cost of spinal surgery hardware and incentivized such surgeries--leading to unnecessary spinal surgeries and at least one death of an injured worker.

SB 863 eliminated the spinal pass-through, bringing spinal surgery reimbursements appropriately in-line with reimbursements in other areas. While spinal surgeries are still available to injured workers in need, this reform saved $110 million per year, according to the WCIRB, and also help to ensured that injured workers were not victims of unnecessary spinal surgeries.

Socializing PD "Add-Ons" and the *Ogilvie* Decision costs:

In structuring SB 863, stakeholders targeted several practices where, through litigation, indemnity benefits could be increased, but the systemic costs exceeded the cost of the benefit itself. For example, the 2009 decision *Ogilvie v. City and County of San Francisco* allowed for a represented injured worker to argue that he or she should receive a larger PD award as the PD rating he or she received did not reflect the actual impact of their injuries on their future earning capacity. While the *Ogilvie* decision resulted in $70 million in additional benefits, the administrative and legal costs were $80-140 million, making the systemic cost far greater than the benefit award.

Similarly, PD "add-ons" such as claiming psychological distress, or sexual or sleep disorders resulted in increased indemnity awards of $100 million for injured workers, but frictional costs were $70 million. These systemic costs were shouldered by employers and essentially required employers to pay $170 million to provide $100 million in benefits (or, in the case of Ogilvie, $140 million for $70 million in benefits). This extra cost, however, did not result in higher indemnity payments or increased medical treatment.

SB 863, in essence, closed off the legal avenues for pursuing high systemic cost remedies, and instead socialized the benefit amount for all workers, which both raised average benefit amounts

and lowered costs. **However, it is worth noting that these reforms only impacted indemnity costs – they did not impact any treatment options of the underlying disability**. The WCIRB estimates the savings from restructuring indemnity benefits at $380 million.

Workers' Compensation Liens Reform:

Another example of administrative savings achieved by SB 863 was in reforming the lien process in California's workers' compensation system. Prior to SB 863, there was no filing fee to file a lien, allowing medical providers to place liens on injured workers' cases, preventing employers from closing the cases. In many cases, the treatment was poorly documented or not approved, leaving employers paying for care they didn't feel was appropriate or necessary.[12] This problem was further magnified with the growth of third-party lien filers who purchased liens from doctors, sometimes at inflated prices, in order to settle for $0.20-0.50 on the dollar.

SB 863 addressed this by creating both an activation and filing fee for lien holders, necessitating that the lien holder pays $100 or $150 (respectively) to move forward with their liens, unless they settle the lien. In filing these liens, the WCAB also requires documentation of the lien and that the documentation is shared with the employer. This encourages lien holders to only move forward with liens that are well-documented and of merit. Additionally, third party lien filers were prohibited from pursuing liens filed after January 1, 2013.

While the initial figures suggested both the activation fee and filing fee were effective in curbing lien abuses, both the activation and filing fees are currently being challenged in federal court. As such, approximately $480-690 million in savings is currently in jeopardy.

Independent Medical Review:

SB 863 also created administrative processes for both bill disputes and medical disputes: Independent Bill Review (IBR) and Independent Medical Review (IMR)[13]. Prior to SB 863, disputes on bill coding and what was appropriate medical care were adjudicated by the WCAB.

[12] In some cases, there was even a question of if the treatment had actually occurred on not. Even in these cases, it was generally easier for employers to settle the claim than to pay attorneys for time-intensive hearings before the WCAB.

[13] The Independent Medical Review process draws heavily from the IMR process for the Department of Managed Healthcare (DMHC) and private group health, including the anonymity of the reviewing independent doctor. IMR services are contracted for by the Department of Industrial Relations(DIR), and the current contracted vendor for IMR services is Maximus Federal Services.

As judges are neither medical doctors nor bill adjusters, this placed them in the untenable position of ruling on issues in which they had no expertise.

With SB 863, these disputes will now go through their respective administrative processes: billing disputes will be sent to IBR and settled by bill reviewers and medical treatment disputes will be sent to IMR and settled by independent doctors. While IBR is relatively non-controversial, IMR continues to be a source of controversy, including constitutional challenges, perceived delays in treatment, and lack of competition from IMR vendors.

From the perspective of cost savings, IMR was estimated to save $390 million – but the WCIRB has subsequently found that IMR *created cost pressures* due to the large volume of IMR requests, which the employer must pay for and which vary between $123 and $515 per request. When the WCIRB created cost savings estimate, the believed volume of IMR requests was 51,000 requests per year. Between January 1, 2013 and August 31, 2014 alone, nearly 189,000 IMR requests were filed, many of which were duplicates. Needless to say, this volume dramatically exceeds the estimated volume of IMR requests, and there is little evidence to suggest that this increased volume will abate. While cost savings may still be possible, IMR request volume poses challenges for the Division of Workers' Compensation (DWC) and workers' compensation stakeholders.

Medical Fee Schedules:

As was noted above, both the constitution and statute require employers to provide necessary medical treatment and services. Similar to Medicare and private medical systems, the Division of Workers' Compensation promulgates fee schedules that set the prices for medical treatment and services. These fee schedules are of paramount importance to stakeholders – they set the market for payors and service providers, letting payors know that they're to pay and service providers what they will receive for services rendered. Without fee schedules, payment disputes are far more common, leading to frictional costs, such as litigation and payment delays.

While none of the fee schedules were scored as cost savings when structuring SB 863, some stakeholders have reported savings from fee schedules. One notable exception to this is in the creation of the physician fee schedule, which is based on Medicare's Resource Based Relative Value Scale (RBRVS) fee schedule, which the WCIRB prices out at $340 million. However, noting the possible increase in participation by general practitioners in the workers' compensation system, possibility for savings may remain.

While the vast majority of fee schedules have been completed by the Division of Workers' Compensation due to incredible work by DWC staff, several fee schedules have yet to be finished by the DWC. These include the home health care fee schedule and the vocational expert fee schedule, both of which have been reported by stakeholders as areas where a fee schedule would reduce friction in the system.

Realizing the Promise of Senate Bill 863

SB 863 was a marriage of a concrete indemnity benefit increase for California's most seriously injured workers and a complicated mix of savings designed to reduce frictional costs. As with any marriage, time will be the final arbiter of success. Yet, even noting the uncertainty, a March 18, 2015 report from Workers' Compensation Executive predicts a drop in premiums later this year, following several years of premium increases. In short, SB 863 remains a work in progress that will require additional oversight from this Committee for several years to come.