

**CHSWC Staff Estimates  
for Labor and Employer Discussions**

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## SUMMARY CHART OF SAVINGS FOR PROPOSED WORKERS' COMPENSATION REFORMS

The estimated savings in this document have been updated to include data from the most recent publication of the Workers' Compensation Insurance Rating Bureau of California (WCIRB) Losses and Expense report dated June 25, 2009.<sup>1</sup>

Proposed Reform	Estimated Range of Savings (Includes Administrative Savings) <sup>2</sup>
<b>I. Clarification of PDRS Intent</b>	<b>\$250 million - \$864 million per year</b>
<b>II. Lien Proposal</b>	<b>\$100 million - \$164 million per year after initial surge in costs for old liens</b>
<b>III. Improved QME Process</b>	<b>Increased efficiency and reduced delays. Unable to quantify</b>
<b>IV. Elimination of Tiered PD Benefit</b>	<b>\$192 million per year</b>
<b>V. Elimination of SJDB</b>	<b>\$86 million per year</b>
<b>VI. Deferral of PD Advances</b>	<b>Small savings, improved match of benefits to worker's time of need</b>
<b>VII. Straight-line Translation from Percent PD to Weeks of Payments</b>	<b>Impact up or down depends on choice of number of weeks per point of PD and interaction with other changes</b>
<b>VIII. Elimination of Duplicate Payment for Spinal Implants</b>	<b>\$55 million to \$103 million per year</b>
<b>IX. Ambulatory Surgical Center (ASC) Fees at 120% of Medicare</b>	<b>\$109 million per year</b>
<b>X. Elimination of the RTW Program Labor Code Section 139.48</b>	<b>\$0.8 million (Estimated User Funding)</b>
<b>ESTIMATED TOTAL SAVINGS</b>	<b>\$793 MILLION - \$1.5 BILLION PER YEAR</b>

<sup>1</sup> WCIRB 2008 California Workers' Compensation Losses and Expenses report June 25, 2009.

<sup>2</sup> Estimates of savings presented in the document begin with either incurred or paid dollars.

Per WCIRB, the incurred and paid costs are similar. These are direct impacts extended to reflect the fully loaded impact to employers.

## Note on Methodology

The impact of changes on the workers' compensation system can be measured in several different ways. To injured workers, direct benefits are the measure of what they receive. To insurance companies, incurred losses include the projected cost of delivering those benefits for the life of the claim plus the loss adjustment expenses that are involved in administering the claim. To employers, the cost of the workers' compensation system is what is paid for insurance or for self-insurance programs, which generally means the incurred losses plus loading for such things as overhead, marketing, taxes and profit.

In this paper, we are evaluating costs or savings to employers. The fully loaded impact of a change to a direct benefit is about 158% of the direct benefit alone. This is based on WCIRB data<sup>3</sup> showing incurred losses of \$6.9 billion for direct benefits in 2008 and earned premium of \$10.9 billion. This loading is applied to direct benefits such as payments to injured workers and payments to medical providers. For changes that are focused on administrative costs such as the lien proposals, as opposed to changes in direct benefits, we do not add any additional loading in the estimates of impacts on employers.

When the estimates are based on loss data from insurers, the estimates are extrapolated to include the self-insured sector by applying a multiplier of 1.43. This is based on the relative sizes of the insured sector and the self-insured sector (including the State) as shown by claims counts. It is likely that this multiplier is accurate for the cost of direct benefits, but the loading for expenses is probably different for self-insured employers than for insured employers. Data on self insured employers are insufficient to support a separate estimate of the loading; therefore a straight extrapolation is the best estimate in the absence of more data on the self-insured sector. When the estimates are based on loss data from system-wide sources, such as hospital discharge data from the Office of Statewide Health Planning and Development (OSHPD), no additional extrapolation is required to include the self-insured sector.

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<sup>3</sup> WCIRB, 2008 California Workers' Compensation Losses and Expenses, released June 25, 2009. p. 31.

## I. CLARIFICATION OF PDRS INTENT

### Background

#### Problem

California has a highly litigious permanent disability (PD) rating system. Workers who litigate their PD ratings generally obtain higher awards than those who do not litigate, so the system creates incentives for litigation. Litigation drives up systemwide costs with only a part of that increased cost actually going into increased awards received by injured workers. The 2005 Permanent Disability Rating Schedule (PDRS) was intended to reduce the need for litigation by making PD awards more consistent, uniform and objective. The 2005 PDRS has not achieved those goals, in part because the schedule is only “prima facie” evidence of the percentage of PD attributable to each injury covered by the schedule and it is not clear what constitutes acceptable rebuttal to that evidence.

#### Solution

The Governor and the Legislature could clarify the intent of Senate Bill (SB) 899 to preclude rebuttal by means of impairment evaluations that are contrary to the American Medical Association (AMA) *Guides* as a whole or by individualized evaluations of diminished future earning capacity.

### Cost Impact of Almaraz/Guzman and Ogilvie

Two February 2009 decisions by the Workers’ Compensation Appeals Board (WCAB) have substantially unraveled the efforts of the 2004 reforms to promote consistency, uniformity and objectivity in the PDRS. The Labor Code provides for a rating schedule that is only prima facie evidence of the percentage of PD in each case. In an effort to interpret that statute and explain what other evidence might be considered, the decisions known as Almaraz/Guzman and Ogilvie have opened the door to subjectivity and uncertainty as each case is evaluated by what a doctor or judge perceives to be a fair and reasonable rating. The consequences are an expected increase in litigation, an increase in PD benefit awards, and overload of the dispute resolution process at the WCAB. The evaluation of individual cases following these new precedents will greatly increase the time needed for medical evaluations, expert witness reports and testimony, and trial time at the WCAB.

The Workers’ Compensation Insurance Rating Bureau (WCIRB) has estimated a 5.8% increase in pure premium (the amount required to pay benefits and adjustment expenses) as a result of these cases. WCIRB admits that this is a low estimate that will probably have to be increased over time. Given the range of assumptions that must be made to arrive at an estimate, this is the lowest reasonable estimate that could be made. The estimate does not include any allowance for the deterioration of the WCAB dispute resolution system under the increased load created by these decisions. Although pure premium is not the sole factor determining the cost of the workers’ compensation system, changes in pure premium provide a reasonable approximation of

the impact of these cases on the system as a whole. WCAB has granted reconsideration of its decisions in these cases. As of early August 2009, it is not known whether the eventual decisions will be substantially different or merely revised in some technical details. The issues are not likely to be finally resolved until these decisions and others like them work their way through the appellate courts and probably the California Supreme Court.

### **Impact on Insured and Self-Insured Employers**

The written premium for insured employers is: = \$10.4 billion (2008)<sup>4</sup>

Total system size for insured and self-insured employers is \$10.4 billion \* 1.43<sup>5</sup> = \$14.9 billion

Almaraz/Guzman and Ogilvie decisions will result in a 5.8% price increase in the pure premium component of the price of insurance per WCIRB.<sup>6</sup> Extrapolating this to the entire system, the estimated cost of these decisions is:

\$14.9 billion X .058 = **\$864 million per year additional cost to the system for all employers combined**, if the decisions are affirmed without substantial change.

While the Almaraz/Guzman and Ogilvie decisions are being reconsidered by WCAB, additional costs are being incurred by the system to estimate ratings taking these decisions into account. These costs are estimated at about \$250 million.

Therefore, the savings from a statutory change to Labor Code Section 4660 which would clarify the intent of SB899 and repudiate the Almaraz/Guzman and Ogilvie decisions would range from: \$250 million to \$864 million per year.

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<sup>4</sup> WCIRB, Summary of December 31, 2008 Insurer Experience, Exhibit 1, April 7, 2009.

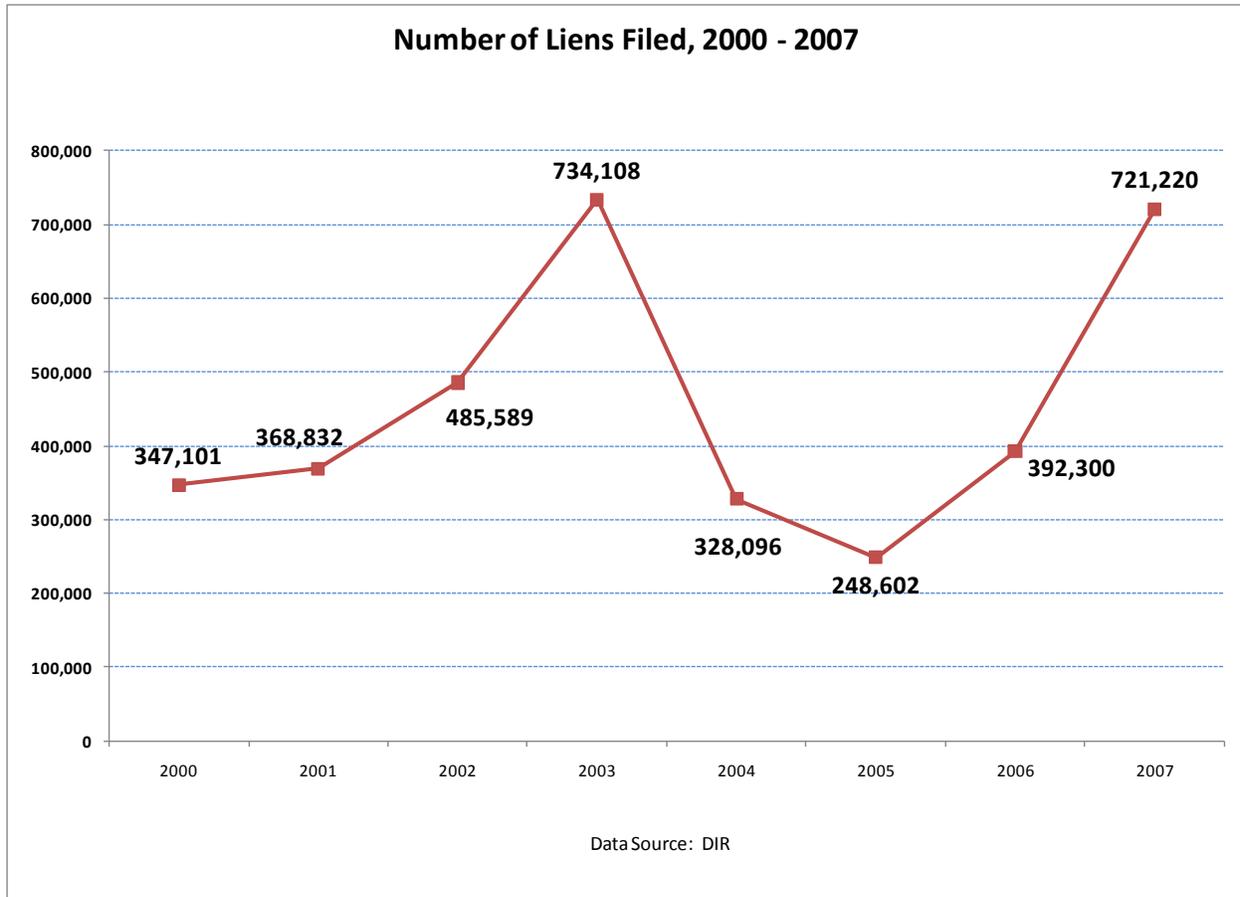
<sup>5</sup> The multiplier to estimate systemwide performance is based on Workers' Compensation Information System (WCIS) data on the number of claims filed by employees of insured employers, self-insured employers and the legally uninsured State agencies. Self-insured employers and the State of California are estimated to comprise 30 percent of all California workers' compensation claims.

<sup>6</sup> WCIRB, Regulatory Filing, [https://wcirbonline.org/wcirb/resources/rate\\_filings/pdf/2009\\_07\\_01\\_filing.pdf](https://wcirbonline.org/wcirb/resources/rate_filings/pdf/2009_07_01_filing.pdf), July 1, 2009, p. 2.

## II. SAVINGS FROM LIEN PROPOSAL

### Estimate of lien savings with multi-pronged approach to include reduction of liens through the Assigned Qualified Medical Examiner (QME) process with Quality Oversight.

As shown in the chart below, the number of liens has increased by 111% between 2000 and 2003, decreased by 47% between 2003 and 2006, and increased again by 84% between 2006 and 2007.



The number of lien decisions regarding liens filed on Workers' Compensation Appeals Board (WCAB) cases has grown by over 130% between 2000 and 2007, resulting in an expenditure of Division of Workers' Compensation (DWC) staff resources on the resolution of those liens. Filing, processing, and adjudicating liens place an enormous unfunded burden on the already strained workers' compensation courts.

A sample of data obtained from DWC indicates that 82 percent of the liens filed are for medical issues.<sup>7</sup> These may include medical-legal, medical treatment on denied claims and on accepted

<sup>7</sup> Data provided by DWC. Edex Filings.

claims where the doctor was not authorized or treatment was not authorized, and billing disputes over items such as outpatient costs.

For purposes of this estimate, we believe medical liens could be cut in half by an aggressive multi-pronged effort. The multi-pronged effort includes:

- Lien statute of limitations of one year from date of the service for which lien is claimed [similar to SB 403 (Benoit) as amended].
- Lien disqualification for unauthorized and unapproved treatment.
- Reinstating the \$100 filing fee as a disincentive for frivolous lien disputes.
- Discouraging the assignment and selling of medical liens by requiring payment only to the medical provider.
- Administrative billing resolution, where Official Medical Fee Schedule (OMFS) experts in DWC will provide summary determinations of fee schedule issues and serve as expert resources to the WCAB.

Using 400,000<sup>8</sup> as the average number of liens filed over the past 4 years and 82 percent of those liens being medical liens, we estimate 328,000 medical liens are filed per year. Half of those estimated medical liens (164,000) can be eliminated through the above proposed processes; then we estimate that savings will range from **\$100 million to \$164 million per year**.

Note: Calculation based on conservatively estimating that it takes 1,000 dollars to handle a lien<sup>9</sup> (litigation only may not include administrative costs).

We may expect a one-time surge of over half of the liens, similar to the surge in 2003 before a \$100 filing fee took effect in 2004 (see chart above). Therefore, the savings may be reduced in the early years as these liens are processed through the system.

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<sup>8</sup> For years 2004-2007.

<sup>9</sup> Based on discussions with experts.

### **III. SAVINGS FROM IMPROVED QME PROCESS**

#### **Background**

Existing law provides that medical issues of compensable injury, nature and extent of injury, capacity for return to work, permanent impairment, and apportionment are all addressed by medical-legal evaluations. Issues of appropriateness of particular medical treatments are addressed first by utilization review (UR), with recourse to medical-legal evaluation if the worker disputes a UR decision to delay, modify, or deny authorization for treatment. A medical-legal evaluation is performed by an agreed medical evaluator (AME) if the worker is represented and the parties agree, otherwise by a Qualified Medical Evaluator (QME) selected from a panel of three assigned by DWC.

Problems exist due to delays in selecting evaluators, obtaining examinations, and producing the evaluation reports. Problems also exist with deficiencies in the content of reports that fail to comply with the legal standards or omit necessary components and thus necessitate supplemental reports. All of these problems contribute to increased frictional costs and delays in resolving disputes and delivering benefits to injured workers.

#### **Proposal**

Proposals to improve the medical-legal evaluation process include:

- Reduce delays by allowing either party to request QME panel:
  - a. Employer need not wait 10 days for unrepresented employee to submit request.
  - b. Represented parties need not wait while attempting to agree on an AME.
  
- Remove access to barrier to WCAB when QME report is defective by allowing employer to file an application in an unrepresented case without incurring liability for workers attorney fees:
  - a. Amend Labor Code to provide for attorney fees if employer files Declaration of Readiness (DOR) in an unrepresented case, as statute originally intended.

#### **Effects on Costs**

We expect that systemwide savings due to improved efficiency resulting from implementing improvement to the QME process. We are unable to quantify savings from reduced delays and improved efficiency.

#### IV. SAVINGS FROM THE ELIMINATION OF TIERED PERMANENT DISABILITY BENEFIT (“Bump Up/Bump Down”)

According to Workers Compensation Insurance Rating Bureau (WCIRB),<sup>10</sup> the tiered Permanent Disability (PD) benefit/Return-to-Work Adjustments is costing \$100 million per year (see Table A below) for insured employers.

The following table shows an excerpt of WCIRB estimates of post-reform savings due to Assembly Bill (AB) 749, AB 227, Senate Bill (SB) 228 and SB 899 by major benefit components. Only the PD benefit components are shown here. The information is derived from WCIRB’s Legislative Cost Monitoring Report published October 9, 2008.

**Table A. October 2008 Evaluation of Post-Reform Costs by Major Cost Component (Excerpt)**

	Projected Pre-Reform Annual Cost in millions <sup>11</sup> (Insured employers only)	Estimated Annual Reform Impact			
		WCIRB Prospective Evaluation <sup>12</sup>		October 2008 Retrospective Evaluation	
		%	Million\$	%	Million\$
Permanent Disability Benefits:	\$3,700				
Apportionment		-10%	-\$400	-6% <sup>13</sup>	-\$200
Change in # of Weeks		-10%	-\$400	-13%	-\$500
<b>Return-to-Work Adjustments</b>		<b>-3%</b>	<b>-\$100</b>	<b>+2%</b>	<b>+\$100</b>
January 1, 2005 PDRS		-38% <sup>14</sup>	-\$1,400	-60%	-\$2,200

WCIRB, when calculating the \$100 million per year for insured employers, includes a 17%<sup>15</sup> loss adjustment expense but does not include other underwriting expenses such as commission

<sup>10</sup> WCIRB, Legislative Cost Monitoring Report, October 2008.

<sup>11</sup> Based on pre-AB 227 and pre-SB 228, \$20.8 billion estimate (insured employers only) of statewide pre-reform indemnity and medical losses and loss adjustment expenses (with loss adjustment expenses assumed to be 17 percent of losses).

<sup>12</sup> Based on various prospective evaluations of benefit costs reflected in WCIRB’s pure premium rate filings.

<sup>13</sup> Based on the average of the estimate based on the University of California (UC), Berkeley Study and the estimate based on WCIRB PD claim survey date.

<sup>14</sup> See WCIRB’s January 1, 2006 pure premium rate filing. The July 1, 2005 pure premium rate filing evaluation reflected a lesser estimate. The July 1, 2007 and January 1, 2008 pure premium rate filing evaluations reflected greater savings estimates.

<sup>15</sup> WCIRB, Legislative Cost Monitoring Report,

[https://wcirbonline.org/wcirb/resources/data\\_reports/pdf/2008\\_cost\\_monitoring\\_report.pdf](https://wcirbonline.org/wcirb/resources/data_reports/pdf/2008_cost_monitoring_report.pdf), October 2008, p. 3. See also footnote 1.

and brokerage fees and other expenses. To include these costs in the savings that employers will realize from the repeal of the tiered benefits, we calculated the following:

- 1)  $\$100\text{Million}/1.17 = \$85$  million equals savings for insured employers in direct benefits, not including loss adjustment expenses.
- 2) Per WCIRB, in 2008, the last year for which data were available on direct benefit costs, the total medical and indemnity costs were  $\$6.9^{16}$  billion. The insured earned premium, which includes both direct and administrative costs, in 2008, was  $\$10.9$  billion.<sup>17</sup>
- 3)  $\$10.9$  billion is 1.58 times the direct benefit costs ( $\$10.9$  billion/ $\$6.9$  billion).
- 4) Therefore, the Tiered PD costs to insured employers, including loss adjustment expenses and other administrative and overhead costs:  $\$85$  million  $\times$  1.58 =  $\$134$  million.
- 5) To estimate the total cost for insured and self-insured employers, we would multiply  $\$134$  million  $\times$  1.43 =  **$\$192$  million per year.**

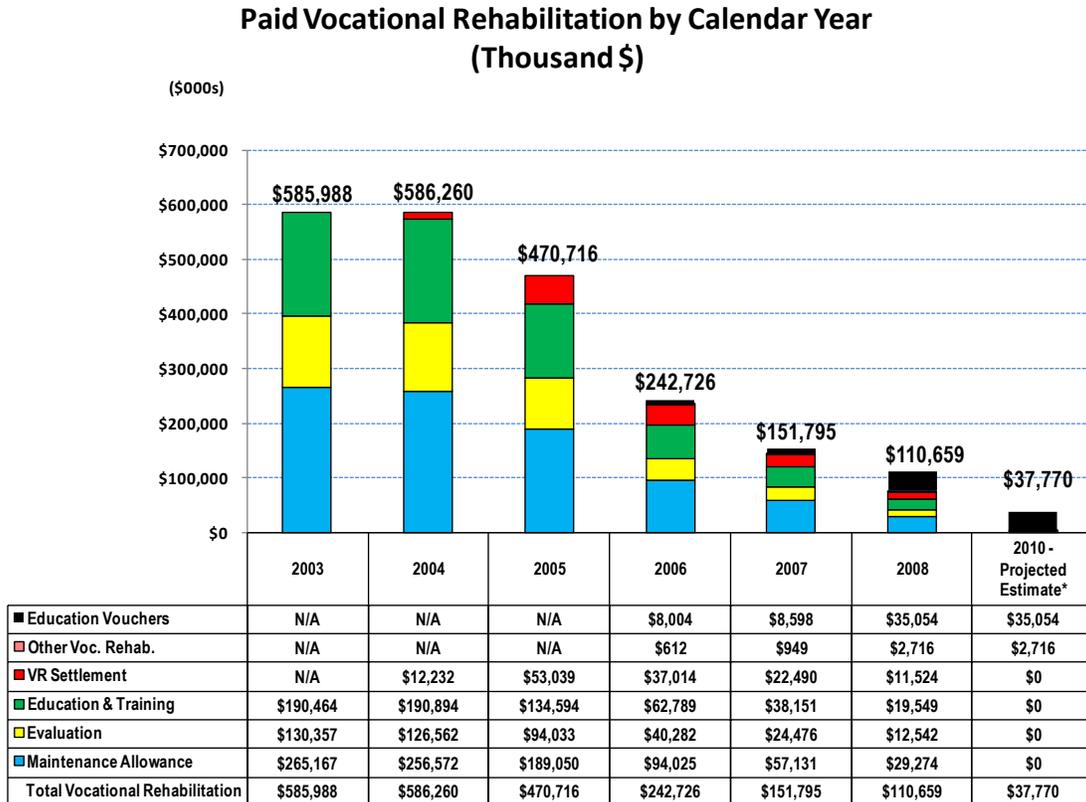
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<sup>16</sup> WCIRB, Losses and Expenses Report, June 25, 2009, p. 31.

<sup>17</sup> WCIRB, Losses and Expenses Report, June 25, 2009, p. 31.

## V. SAVINGS FROM REPEAL OF SUPPLEMENTAL JOB DISPLACEMENT BENEFIT

The chart below shows insured Vocational Rehabilitation (VR)/Supplemental Job Displacement Benefit (SJDB) direct benefit costs from 2003 to 2008. In looking at the costs from the chart below, we project that insured VR/SJDB direct benefit costs in 2010 will be about \$38 million for insured employers.



Data Source: WCIRB, 2008 Losses and Expenses Report, June 2009, Exhibit 17.1

\* The direct benefit cost of SJDB in 2010 will be \$38 million for insured employers. We arrived at this estimate through the following assumptions:

- In 2010, the following components will be zeroed out due to the elimination of VR in January 2009: Education and Training, Evaluation, Maintenance Allowance, and VR Settlement.
- We assumed that the costs for Educational Vouchers and other VR for 2010 would be the same as for 2008. The costs for Educational Vouchers will be \$35 million, and the costs of other VR will be \$2.7 million.

- Therefore, the total SJDB direct benefit costs in Year 2010 are estimated to be \$38 million for insured employers.

#### Calculations of SJDB costs, including administrative and overhead costs

Per WCIRB, in 2008, the last year for which data were available on direct benefit costs, the total medical and indemnity costs were \$6.9<sup>18</sup> billion. In 2008, the insured earned premium, which includes both direct and administrative costs, was \$10.9 billion.<sup>19</sup>

\$10.9 billion is 1.58 times the direct benefit costs (\$10.9 billion/\$6.9 billion).

Therefore, the SJDB costs in Year 2010 which include administrative and overhead costs = \$38 million (projected direct benefit costs for insured employers in 2010) X 1.58 = \$60 million.

To include self-insured employers and the State of California, we would multiply \$60 million by 1.43 = \$86 million system-wide.

Total cost, including administrative and overhead costs, of SJDB = \$86 million per year.

#### Savings from Repeal of SJDB

Therefore, total savings from the elimination of SJDB = **\$86 million per year.**

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<sup>18</sup> WCIRB, Losses and Expenses Report, June 25, 2009, p. 31.

<sup>19</sup> WCIRB, Losses and Expenses Report, June 25, 2009, p. 31.

## **VI. SAVINGS FROM DEFERRAL OF PD ADVANCES WHILE WORKING**

Existing law requires employers or insurers to begin paying Permanent Disability (PD) benefits when temporary disability (TD) ends, even in advance of any award, up to the amount that the employer or insurer estimates the ultimate award will be. Therefore, a worker is entitled to PD advances even if the worker is back at full duty or light duty or transitional job without loss of pay. When the disability becomes permanent, the employer may not be able to provide a permanent job accommodation, and the worker could be out of work. The PD benefit may have already been advanced while the person was working, leaving no further benefits, or at least leaving less available to pay to the worker when it is needed most.

In addition, the payment of advances and the deduction of those advances can lead to misunderstandings and occasional claims for overpayment of advances if the adjuster's estimate was higher than the ultimate award.

Deferring pre-award advances as long as the worker remains employed by the employer would preserve the available funds for the time when workers are more likely to need the money, avoid some misunderstandings and overpayments, and create a small savings for employers or insurers by delaying the time when payments must begin. Payment would not be delayed once an award is issued, even if the employee is still working for the employer.

The same awards would ultimately be paid; therefore, there is no direct cost or savings from this change in the timing of payments. There could be minor savings in some loss adjustment expenses.

## **VII. SAVINGS FROM STRAIGHT-LINE TRANSLATION FROM PERCENT OF PD TO WEEKS OF PAYMENTS**

The amount of Permanent Disability (PD) compensation paid in any case is the product of three primary factors:

- The disability rating expresses the percent of PD caused by the injury.
- The number of weeks for each percent of disability produces the overall duration of the award.
- The rate of dollars per week determines the final amount of the award.

The number of weeks of benefits for each percent of disability has been amended over time as a way to change overall benefits. Most of the changes have been increases, and they have been disproportionately added to the highest (and least frequent) ratings. At one time, four weeks of benefits were payable for each one percent of disability. Now there are seven steps, or ranges, beginning with three weeks for each one percent below 10% and going up to 16 weeks for each one percent in the range of 70% to 99%.

This progressive (almost exponential) structure permits the payment of relatively generous benefits to the small number of workers with high ratings without proportionately driving costs for the four-fifths of workers who have ratings under 25%. This structure also introduces an anomaly where a worker gets different amounts of compensation for the same disability, depending on whether the disability is caused by a single injury or a combination of injuries. This structure places so much value on each percent of disability in the very high ranges that it provides an incentive for litigation over minor differences in ratings and apportionment.

The progressive number of weeks for each percentage point is not justified by empirical evidence on the relationship between disability rating and earnings loss, and it generates litigation and contributes to the complexity of the system. The system could be simplified by adopting a uniform number of weeks for each percent of disability across the entire range of severity.

To make this change cost-neutral, the number would be between 4 and 5 weeks for each percent. Depending on the intended overall level of compensation and the interaction with other benefit changes, California could adopt 4 weeks or 5 weeks or some other convenient number for the translation from disability percentage to weeks of disability payments.

The direct impact of any change depends on the number chosen and its interaction with other components. The indirect impact of simplifying the system has not been quantified, but it would eliminate a share of the litigation over apportionment. Also not quantified is the value of a more consistent relationship between average losses and average compensation across the range of severity of injuries.

A change to 4 weeks of PD benefits for each percent would reduce the duration of the average PD award from 91.1 weeks to 80.8 weeks. The savings from this 11.3% reduction would be partially offset by the fact that the life pensions for workers with ratings over 70% would begin

earlier, so the net effect of a change to 4 weeks per point would be about a 6% reduction in the permanent partial disability benefits including life pensions.

See Section XI for estimates of the impact on benefits and costs if California were to adopt either 3 weeks per point or 4 weeks per point together with an increase in maximum weekly benefits to any of several possible levels.

## VIII. SAVINGS FROM ELIMINATION OF DUPLICATE PAYMENT FOR SPINAL IMPLANTS

Existing law permits a duplicate payment for implantable devices or hardware used in certain spinal surgeries. Several analyses have concluded that this arrangement results in unnecessary costs.

Labor Code Section 5318 provides that for certain spinal surgical procedures, the direct cost plus an allowance for overhead cost of implantable devices are separately reimbursable in addition to the reimbursement of facility fees at 120% of Medicare. The Medicare reimbursement already includes an average cost for these devices in the diagnosis related group (DRG), including cases in the same DRG but not using hardware. To the extent that the cost of hardware is already included, plus 20% under the California workers' compensation fee schedule, the cost of the hardware is being double-paid. There is no reduction of the DRG reimbursement in cases where hardware is not used.

The duplicate reimbursement, generally called a "pass through," was adopted based on the premise that reimbursements for these procedures were so low that patients were being denied access to needed treatments. That premise was argued but never proven, and the statute allows the Administrative Director (AD) to adopt a regulation to change or eliminate the pass-through.

A 2003 RAND report, "[Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program](#)," prepared for the California Commission on Health and Safety and Workers' Compensation (CHSWC), found that the pass-through payments result in the workers' compensation program paying twice, once in the DRG fee schedule and again in the additional payment for the hardware costs.

A 2005 RAND working paper, "[Payment for Hardware Used in Complex Spinal Procedures under California's Official Medical Fee Schedule for Injured Workers](#)," again found that "the data analyzed in this study do not support a continuation of the pass-through."

A January 2009 RAND working paper, "[Inpatient Hospital Services: An Update on Services Provided Under California's Workers' Compensation Program](#)," reiterated that "the pass-through for the cost of hardware used during complex spinal surgery is problematic and should be re-evaluated." It is estimated that payments at 120% of Medicare are already reimbursing hospitals for 166% of the costs of these procedures *before* consideration of the pass-through payments.

### Calculation of Direct Costs of Duplicate Payment for Spinal Implants

The cost of the duplicate payment cannot be readily identified from available data. According to a third-party intermediary supplier of spinal hardware, the average hardware cost in cases using hardware is in the range of \$21,647 to \$22,875. There were 5,825 procedures performed in these DRGs in 2003, per the 2005 RAND report. If half that number is performed with hardware annually, the pass-through's direct cost could be \$65 million. If the average cost per claim were exaggerated, if the number of procedures were reduced, or if some of the eligible costs were not getting billed, the actual cost could be lower.

Accordingly, the savings from eliminating the duplicate payment of spinal hardware are estimated at \$35 million to \$65 million annually.

Calculation of Duplicate Payment for Spinal Implants, Including Administrative and Overhead Costs

The cost of the pass-through including administrative and overhead savings would be:

- 1) \$35 million x 1.58 = \$55.3 million.
- 2) \$65 million X 1.58 = \$102.7 million

No additional extrapolation is required for the self-insured sector because this calculation began with the total number of procedures performed in a year, not limited to insured cases. Therefore, the savings from the elimination of duplicate payment for spinal implants, including administrative and overhead costs, is: **\$55 million to \$103 million per year.**

## **IX. SAVINGS FROM AMBULATORY SURGICAL CENTER (ASC) FEES AT 120% OF MEDICARE**

### Background<sup>20</sup>

Existing law arguably requires that ASC fees and hospital outpatient department fees in the Official Medical Fee Schedule both be 120% of Medicare fees for hospital outpatient department services. At the time this law (Labor Code Section 5307.1(c)) was adopted, Medicare did not have an up-to-date fee schedule for ASCs. Under the revised Medicare payment system, most ASC services are paid at about 67% of the hospital rate. Now that a separate ASC fee schedule is available under Medicare, it is possible to revise the ASC fees in workers' compensation to take advantage of the lower costs of ASCs. This may be possible by regulation, but a statutory change could preempt any challenge to the regulatory authority.

Payors (insurers and self-insured employers) under California's workers' compensation program generally pay for medical services on a fee-for-service basis. The Administrative Director (AD) of the Division of Workers' Compensation (DWC) maintains an Official Medical Fee Schedule (OMFS) that establishes the maximum allowable fees for most medical services. The OMFS amounts apply unless the payor and provider have contracted for a different price. Prior to 2004, fees for facility services furnished in connection with ambulatory surgery were exempt from the OMFS; payments for these services were based on rates the payor negotiated with the provider. SB 228 eliminated the exemption for these facility services effective January 1, 2004. As amended, Section 5307.1 of the California Labor Code requires that the OMFS for ambulatory surgery be based on the fee-related structure and rules of the Medicare program. Ambulatory surgery can be performed in either a hospital or a freestanding ASC. The Labor Code requires that the same rates apply to hospital ambulatory surgery and procedures performed in freestanding ASCs.

The OMFS limits allowable fees for ambulatory surgery facility services to 120 percent of the amounts payable under the Medicare program for comparable services furnished to hospital outpatients. Medicare assigns hospital outpatient procedures to ambulatory payment classification (APC) groupings of clinically coherent procedures with similar costs. Each APC has a relative weight reflecting the costliness of the median procedure in the group relative to the median cost for a mid-level clinic visit. To determine payment, the relative weight is multiplied by a conversion factor and geographic adjustment factor. Additional payments are made for high-cost outlier cases. To determine the OMFS allowance, the Medicare payment is multiplied by 1.20. The 1.20 multiplier is intended to compensate for any higher costs attributable to workers' compensation patients and to provide a reasonable profit.

Consistent with the Labor Code, the OMFS allows the same fees for surgical services provided in hospital and ASC settings. At the time when Senate Bill (SB) 228 became effective, Medicare rates for ASC services were outdated in 2004 but were updated in 2008 and tied to the outpatient rate but at a percentage of that payment. Under the revised Medicare payment system, most

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<sup>20</sup> Wynn, Barbara and Griffin, Beth Ann. "Ambulatory Surgery Facility Services Provided to California's Injured Workers." RAND Working Paper. March 2009.

ASC services are paid under a system that parallels the payment system for hospital outpatient services but at a lower rate (about 67% of the hospital rate).

## Estimates of Savings

1. Total maximum allowable facility fees for ambulatory surgery in 2007: \$258,694,547
2. ASC share of relative weights for ambulatory surgery in 2007:  $2,530,973/3,820,999 = 66.2\%$
3. ASC share of payments =  $\$258,694,547 \times .662 = \$171,255,790$
4. Update for inflation =  $1.033$  (2008)  $\times 1.036$  (2009)  $\times 1.021$  (est. 2010) =  $1.093 \times 171,255,790 = \$187,124,685$
5. Difference in conversion factors (CF) =  $\text{ASC CF} \times \text{rel wgt adj}/\text{OMFS CF}$  for 2009 =  $41.303 \times .9751 / 63.92 = .63$
6. 2010 savings =  $\$187,124,685 \times (1-.63) = \$69.2$  million.

The estimate assumes 2007 ASC volume and mix of cases and that ASCs and hospital outpatient services are similarly distributed throughout the State. The ASC wage-index adjustment is based on a lower labor-related share that would also impact the savings (probably a slight increase). The difference in conversion factors (CF) is based on the difference between the ASC 2009 CF and the OMFS 2009 CF. In projecting out additional years, a 3 percent annual rate increase should be assumed. This estimate also does not account for paying “office-based” procedures at the physician fee schedule rate, but only a small percentage of encounters will be affected.<sup>21</sup>

## Calculation of Setting Ambulatory Surgical Center Fees at 120% of Medicare ASC Fees Including Administrative and Overhead Costs

$\$69.2$  million  $\times 1.58 = \$109.3$  million

No additional extrapolation is required for the self-insured sector because this calculation began with the total number of procedures performed in a year, not limited to insured cases. Therefore, the savings from the elimination of duplicate payment for spinal implants, including administrative and overhead costs is: **\$109 million per year.**

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<sup>21</sup> Calculations of savings by Barbara Wynn, Rand Corporation.

**X. SAVINGS FROM ELIMINATION OF THE RETURN-TO-WORK (RTW) PROGRAM LABOR CODE SECTION 139.48**

The Commission on Health and Safety and Workers' Compensation (CHSWC) "Report on the Return-To-Work Program Established in Labor Code Section 139.48" found that:

- The California workplace modification program has been underutilized, probably because most small employers who qualify for the program were unaware of it. In a two-year period from January 2007 to December 2008, 11 applications were approved.<sup>22</sup>
- More than two-thirds of the employers that applied were denied.
- The average amount received per employer was less than \$800.00.
- To date, the program has not been cost-effective.
- The costs to process applications and administer the program far exceeded the amounts paid out.

Estimated savings from the elimination of the RTW program are about **\$824,554 per year.**<sup>23</sup>

Expense	Amount
Salaries	\$185,581
Personnel Benefits	\$62,170
Operating Expenses & Equipment	\$59,460
Indirect	\$17,343
Total	\$324,554

The program also includes an additional \$500,000 in reimbursement costs.

<sup>22</sup> CHSWC Report on the Return-To-Work Program Established in Labor Code Section 139.48, April 2009.

<sup>23</sup> Based on annual staffing cost of the Return-To-Work Reimbursement Program. Figures provided by the Division of Workers' Compensation.

## **XI. SCENARIOS FOR INCREASED WEEKLY PD BENEFITS**

The University of California at Berkeley estimated a range of possible options for increasing permanent disability payments. The basic parameters used to model the impact were:

- 4 weeks per percentage point of rating
- 2005 PDRS
- Life pension (LP) rules remain the same
- Minimum PPD payment per week remains \$130
- Maximum PPD payment per week scenarios
  - Unchanged -- \$230 for ratings under 70%, \$270 for ratings 70%-99%
  - \$270
  - \$300
  - \$360
  - \$390
  - \$420

The same analysis was done for 3 weeks per percentage point of rating and weekly rates of:

- \$360
- \$390
- \$420
- \$450
- \$480
- \$510
- TD rate

Increasing the weekly maximum improves the equity of the PPD system by making the compensation more proportional to the earnings losses of workers whose pre-injury earnings were appreciably above the minimum wage.

Moving from the current step-wise graduated number of weeks per percentage point of rating to a single number of weeks (in this case 4 weeks) greatly simplifies the system, avoids complications of combining multiple injuries, reduces disproportionate impacts of apportionment, and improves the equity by evening out the wage replacement rates between more and less severely impaired workers.

The impact on life pensions (LPs) of moving to a straight 4 weeks is an increase of 39%, because the PPD payouts would be completed earlier and the LPs would then commence earlier. However, the overall impact is small because LPs are involved in only about 1% of PPD claims. We include the impact of LPs in each of the estimates.

**Total dollar impact of benefit change – 4 weeks**

The chart below shows a range of estimates of the proposed benefit changes using the current estimate of PPD plus LPs (\$1.7 billion). The direct benefit changes were multiplied by 1.5<sup>24</sup> to take into account potential utilization effect as estimated by the Workers’ Compensation Insurance Rating Bureau (WCIRB).

**Total dollar impact of proposed benefit changes— 4 Weeks per Rating Point <sup>25</sup>**

Weekly Maximum	Direct Change (%)	Total dollar impact (\$millions)	
		Direct Benefit Change	Anticipated Impact (including utilization effect)
\$270	9.4%	\$162	\$242
\$300	16.7%	\$288	\$432
\$330	23.6%	\$407	\$611
\$360	30.1%	\$518	\$777
\$390	36.2%	\$622	\$933
\$420	41.8%	\$719	\$1,079

<sup>24</sup> Conversation with David Bellusci, Chief Actuary and Senior Vice President, WCIRB.

<sup>25</sup> Dollar impact of proposed benefit changes calculated with technical assistance from UC Berkeley. Memo from Frank Neuhauser to Christine Baker August 13, 2009.

### Total dollar impact of benefit change—3 Weeks

The results of the impact of using a straight 3 weeks per percentage point of rating are shown in the table below.

<b>Total dollar impact of proposed benefit changes—3 Weeks per Rating Point<sup>26</sup></b>			
Weekly Maximum	Direct Change (%)	Total dollar impact (\$millions)	
		Direct Benefit Change	Anticipated Impact (including utilization effect)
\$360	0.7%	\$12	\$18
\$390	5.9%	\$100	\$149
\$420	9.7%	\$165	\$248
\$450	14.2%	\$242	\$363
\$480	18.1%	\$307	\$461
\$510	21.4%	\$364	\$546
@TD Rate	77.1%	\$1,310	\$1,965

<sup>26</sup> Dollar impact of proposed benefit changes calculated with technical assistance from UC Berkeley. Memo from Frank Neuhauser to Christine Baker August 13, 2009.