The California Commission on Health and Safety and Workers' Compensation

CHSWC Summary of System Changes in California Workers' Compensation

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Background

Workers' Compensation in California originated in 1913. The workers' compensation system is intended to provide benefits for injuries arising out of and occurring in the course of employment, without regard to fault. As a social contract, workers give up the right to sue employers for injuries that may be due to the negligence of the employer, and in return the workers receive assurance of benefits for all such injuries without the delay and uncertainty of trying to prove negligence.

Over the decades, the system has become increasing formalized. Judicial interpretations have generally expanded the range of conditions that are covered for workers' compensation, propelled in part by a statutory mandate for liberal construction of the law in favor of extending benefits for workers. The Legislature has occasionally intervened to narrow the scope of eligibility for workers' compensation and occasionally to broaden it. Over the same period, inflation has continually eroded the dollar value of indemnity benefits, and legislation has been enacted sporadically to increase these payments. This summary will outline broad generalizations and provide background for future discussions. Many important details are omitted, and this summary must not be used to answer any individual question about any particular case.

Eligibility for Benefits

The statutory criteria for eligibility for compensation have changed little over the years. Beginning around the 1970s, there was increasing medical and judicial acceptance of work-related psychiatric injury and illness, making this an increasingly costly component of the case mix. Legislation was enacted to establish and later to raise the threshold of causation, so that now the actual events of employment must be predominant as to all causes combined of the psychiatric injury. For other types of injury, an employee is entitled to full benefits if there is any degree of occupational causation for the injury or illness. Permanent disability benefits are the only type of benefits that may be reduced or apportioned for non-occupational contributions.

Types of Benefits

There are five major types of compensation benefits:

- Medical treatment to cure or relieve from the effects of an injury or illness accounts for nearly 65% of all workers' compensation benefit payments incurred on new claims. [1]
- Temporary disability indemnity benefits, payable while a worker is recovering and unable to work, are the next largest share, at 17%.
- Permanent disability indemnity payments, payable for the permanent residuals of an injury, account for about 16% of all benefit payments. These include permanent partial disability (9%), life pensions for permanent partial disabilities rated 70% or higher (2%), and permanent total disability benefits (5%)
- The supplemental job displacement benefit, which has replaced the former vocational rehabilitation benefit, accounts for about 1% of all workers' compensation benefits.
- Death benefits comprise less than 1% of the total, which is a testament to the improvements in workplace safety in the past century.

Medical Treatment

Medical treatment is perhaps the most important benefit furnished by workers' compensation, at least for workers who lack other medical coverage. It is certainly the most costly for employers. The legislature has attempted to control the cost while assuring adequate care.

Fee Schedules

Most medical services are subject to fee schedules, and the breadth of the fee schedules has been expanded so that there are few exceptions. The choice of services to render, however, was largely in the discretion of the treating physician. Until recently, the employer ordinarily had the right to select the treating physician for the first 30 days after an injury, and the employee had free choice of physicians after that period.

Managed Care

Beginning in the 1990s, employers or their insurers were given the option to adopt a managed care system modeled after the health maintenance organization (HMO) system. The health care organizations under that system would retain the control of the employee's medical care for a longer period of time, but never for more than one year. Employer interest in this option was limited for a number of reasons so that no more than 2% or 3% of the workforce was ever covered by these arrangements. Beginning in 2005, employers or their insurers could establish medical provider networks, or MPNs, and workers could be required to select their treating physicians from within those networks

[1] Source: Correspondence with WCIRB, 2/26/2008

for the life of the claim. Now more than half of all workers are covered by MPNs. Employees who pre-designate a personal physician are not subject to the employer's 30 day control or to an HCO or MPN. Eligibility for predesignation was significantly narrowed in 2004 and slightly amended in 2006.

Utilization Review and Treatment Guidelines

An even more profound change in the relationship among patients, doctors, and insurers occurred in 2004, when the 2003 legislation took effect and utilization review (UR) became the only permissible way for a claims administrator to delay or deny a doctor's request for authorization for treatment. The significance was not just the UR process, but also the fact that was required to apply evidence-based medical treatment guidelines specified by the statute or by the Administrative Director. Furthermore, hard caps were imposed on chiropractic and physical therapy treatments. Medical costs fell sharply beginning in 2004. Temporary disability durations began to drop. Patient satisfaction held steady, based on a survey two years after adoption of these new rules compared to a study a decade earlier. While there are many instances where medical benefits are not being provided appropriately, the shift to decision-making based on scientific medical treatment guidelines appears to be fundamentally sound.

Temporary Disability

Temporary disability (TD) benefits are payable while an employee is recovering from injury and is unable to return to work. Weekly benefits are generally two-thirds of the employee's weekly wages at the time of injury, but there are minimum and maximum limits on the amount of the employee's actual weekly wages that will be used for the calculation. The maximum weekly benefit is therefore two-thirds of the maximum weekly wage that is statutorily recognized. Most attention is on changes in the maximum as illustrated in the chart below. The standard set by the National Commission on Workers' Compensation Laws (U.S. Government Printing Office, 1972) is that the maximum weekly benefit should be 100% of the state's average weekly wage. California now meets this standard. The latest state average weekly wage is $914.60, and the maximum weekly TD rate for 2008 is $916.33.[2] The TD rate is now indexed for inflation without the need for periodic updating by the Legislature. Other important changes to the law of TD dealt with the maximum duration of TD benefits:

- Prior to 1979, TD was limited to 240 weeks of benefits within five years of date of injury.

[2] DWC Newsline Bulletin No. 66-07, http://www.dir.ca.gov/dwc/dwc_newslines/2007/Newsline_66-07.pdf

- In 1979, the limitation was removed for temporary total disability, so long as the disability remained uninterrupted after the first five years.
- Effective April 19, 2004, new cases became limited to 104 weeks of benefits within two years of first payment.
- Effective January 1, 2008, the limitation for new cases is 104 weeks of benefits within five years of date of injury.

Phased-In Increases on Minimum and Maximum Temporary Disability Payments

Temporary Disability	Pre-2003	Injuries in 2003	Injuries in 2004	Injuries in 2005	Injuries in 2006[3]	Injuries in 2007	Injuries in 2008
Minimum Payment	*$126*[4]	*$126*	*$126*	*$126*	*$126*	*$132.25*	*$137.45*
Maximum Payment	$490	$602	$728	$840	$840	$881.66	$916.33

Permanent Disability

Permanent disability may be either total or partial. The great majority of permanent disabilities are partial, and unless otherwise specified, the terms "permanent disability" or "PD" are generally used to mean permanent partial disability. PD is determined based on a medical evaluation, followed by a calculation of a disability rating derived from that evaluation according to a permanent disability rating schedule.

Rating PD

The method for evaluating and rating PD changed dramatically in 2005 with the adoption of the AMA Guides for the Evaluation of Permanent Disability as the foundation for a new rating schedule. The new rating schedule also considers diminished future earning capacity. Both before and after that change, the disability rating process produced a percentage rating. The number of weeks of benefit payments depends on the percentage rating, and the conversion from percent to weeks has been revised from time to time. The conversion now produces 3 weeks of payments for each additional percentage point in a rating in the range from 0.25% to 9.75%, but 16 additional weeks of benefits for each additional percentage point in the range of 70% to 99.75%. The weekly amount is two-thirds of the employee's weekly earnings, but with maximum limits set much lower than for TD. Like TD, the maximum

[3] Beginning in 2006, both the maximum and the minimum weekly payment is increased annually by the percentage of increase in the state's average weekly wage (SAWW). Under the formula, no adjustment was required for 2006.

[4] The lesser of $126 or the employee's average weekly earnings from all employers

weekly PD benefit has been revised from time to time, and different maxima have been adopted for different ranges of ratings. The following chart illustrates the increases in the minimum and maximum ratings.

Phased-In Increases on Minimum and Maximum Permanent Partial Disability Payments

Permanent Disability Rating	Pre-2003	Injuries in 2003	Injuries in 2004	Injuries in 2005	Injuries in 2006	Injuries in 2007	Injuries in 2008
Below 15% *Minimum Payment* Maximum Payment	*$70* $140	*$100* $185	*$105* $200	*$105* $220	*$130* $230	*$130* $230	*$130* $230
15%-24.75% *Minimum Payment* Maximum Payment	*$70* $160	*$100* $185	*$105* $200	*$105* $220	*$130* $230	*$130* $230	*$130* $230
25%-69.5% *Minimum Payment* Maximum Payment	*$70* $170	*$100* $185	*$105* $200	*$105* $220	*$130* $230	*$130* $230	*$130* $230
70%-99.75%[5] *Minimum Payment* Maximum Payment	*$70* $230	*$100* $230	*$105* $250	*$105* $270	*$130* $270	*$130* $270	*$130* $270

[5] Awards in this range also include life pensions, not shown here. The weekly rate for life pensions for injuries after 2005 was doubled.

Phased-In Increases on Minimum and Maximum Permanent Total Disability Payments

Permanent Disability Rating	Pre-reform	Injuries in 2003	Injuries in 2004	Injuries in 2005	Injuries in 2006[6]	Injuries in 2007	Injuries in 2008
Permanent Total							
Minimum Payment	*$126*[7]	*$126*	*$126*	*$126*	*$126*	*$132.25*	*$137.45*
Maximum Payment	$490	$602	$728	$840	$840	$881.66	$916.33

Apportionment

Before leaving the topic of PD, it is important to touch on the question of apportionment. Apportionment is the process of assigning responsibility for a permanent disability among two or more causes. It may apply where an employee sustains successive injuries, each of which adds to the employee's cumulative disability. It may apply where the employee has a non-occupational condition that results in a disability greater than the occupational injury alone would produce. Without attempting to explore the nuances of this complex topic, the law prior to April 19, 2004 may be summarized as allowing a PD award to be reduced by apportionment only if some portion of the PD would have existed even in the absence of the occupational injury. In 2004, the statutes were changed to require apportionment by causation. The interpretation of that change is beyond the scope of this summary.

Vocational Rehabilitation / Supplemental Job Displacement Benefit

Vocational rehabilitation (VR) was a program designed to provide individualized counseling, return to work guidance, job training if necessary, and job placement if necessary for injured workers who could not return to their usual occupations. As the costs of the program grew and the results were often unsatisfactory, legislation was enacted to limit the costs and eventually to repeal the VR system entirely. It was replaced by two benefits. One is a program that offers limited reimbursements to small employers for the cost of equipment or worksite modifications to accommodate their injured workers. The other, available to all workers who sustain permanent partial disability and are not offered a return to work with the at-injury employer, is a supplemental job displacement benefit. This is a voucher of $4000 to $10,000,

[6] Beginning in 2006, both the maximum and the minimum weekly payment is increased annually by the percentage of increase in the state's average weekly wage (SAWW). Under the formula, no adjustment was required for 2006.

[7] The lesser of $126 or the employee's average weekly earnings from all employers

depending on the PD rating, that can be used to pay expenses for education-related expenses or skill enhancement.

Death Benefit

Death benefits and burial allowances have been increased from time to time, and the benefits have been extended to continue as long as a child of the deceased employee remains under the age of 18. Further details of the changes in this area may be found in Labor Code Sections 4700 and following.

Workers' Compensation Reform Legislation

The attached memorandum by former WCAB Commissioner C. L. Swezey describes highlights of specific reforms subsequent to 1980 in chronological sequence.

The major reforms of the past five years and most of the related bills passed in 2007 are summarized in the following table.

2002	AB 749	TD weekly rate increase phase-in, , then indexed for inflation PD weekly rate increase PD weeks increased for first 20 points of each rating Presumption in favor of treating doctor's opinion is narrowed. Medical fee schedules may be extended to outpatient surgery centers. Increased penalty assessments on uninsured employers. Increased civil penalties for fraud.
2003	SB 228	Hospital fee schedules set at Medicare + 20%. Outpatient surgery centers are same as hospital fee schedule. Physician fee schedule may be revised on or after 1/1/06. Pharmaceutical fee schedule based on Medi-Cal. Medical treatment to be provided per evidence-based guidelines, initially ACOEM, and later as adopted by AD after CHSWC study. Authorization for treatment to be determined by Utilization Review, applying guidelines. 24-vist caps on chiropractic and PT treatments. Spinal Surgery Second Opinion process adopted.

		Filing fee to discourage unnecessary lien filings. Physician conflict of interest includes ownership of outpatient surgery facility.
	AB 227	Repeal of vocational rehabilitation. Establishment of supplemental job displacement benefit. Increase fines for fraud. CIGA not liable for penalty for delay by insolvent insurer. Online publication of rates for 50 largest insurers. DWC 100% user-funded by assessments on employers.
	AB 1262	Insurance Commissioner to adopt standards for claims adjusters. (Insurance Code Section 11761)

2004	SB 899	Medical treatment may be contained indefinitely within Medical Provider Network (MPN) established by employer or insurer. Employee eligibility to predesignate a personal physician is restricted to employees covered by employer-provided health coverage, and physician must consent to be pre-designated. Medical treatment to be provided after a claim is filed until the claim is either accepted or denied, up to $10,000. Parties must use a single AME or QME instead of separate medical evaluators for each side. Treating physician's presumption repealed entirely. TD limited to 104 weeks of benefits within 2 years of first payment. PD weeks of benefits reduced for first 15 percentage points of every rating. PD rating to be based on evaluation per AMA Guides with consideration for diminished future earning capacity, change applicable to all cases that have not reached specified stages by the time revised schedule is adopted, due 1/1/2005. Apportionment of PD rating to be based on causation of disability, and previously awarded disability is conclusively presumed to continue. Limitation on individual award of penalty for delay; adoption of administrative penalty for business practice of delay.
2006	AB 2068	Employee may pre-designate a medical group or an individual physician.
2007	AB 338	TD benefits up to an aggregate of 104 weeks may be received up to five years from date of injury.
	AB 1073	24-visit cap on physical medicine services may be exceeded in post-surgical cases under guideline to be adopted by AD.
	SB 316	Revision of solvency regulation of insurers, study of recent insolvency crisis
	SB 869	Labor Commissioner to use data mining to identify illegally

		uninsured employers.

The following attachment is a memorandum by former WCAB Commissioner C. L. Swezey describing highlights of specific workers' compensation reforms subsequent to 1980 in chronological sequence.

COMMISSION ON HEALTH AND SAFETY AND WORKERS' COMPENSATION

MEMORANDUM

Date: December 12, 2007
To: Christine Baker, Executive Officer
From: C. L. Swezey, Consultant

Subject: Reform Acts Subsequent to 1980

Background

Compulsory Workers' Compensation began in California with the adoption of the Boynton Act in 1913. Based on experience under that act, the Workmen's Compensation Insurance and Safety Act was adopted in 1917. That act, as subsequently amended, was codified in 1937. Amendments increasing benefits were adopted from time to time, and operative January 15, 1966, substantial procedural amendments were adopted including replacement of the Industrial Accident Commission with the Workers' Compensation Appeals Board.

Margolin-Bill Greene Reform Act of 1989

The next major change was brought about by the *Margolin-Bill GreeneWorkers' Compensation Reform Act of 1989,* as amended in 1991 and 1993. The 1993 amendments eliminated 1989 provisions that appeared unworkable or impractical. The major substantive changes in addition to increases in compensation consisted of limitations on compensability of psychiatric injuries and administrative penalties for substandard claims administration. Payment of an injured worker's attorney fees by defendant was required under certain circumstances, and attorneys, in turn, were required to provide the injured worker with a disclosure form advising him or her, among other things, how to get benefits without hiring an attorney. Standards for medical-legal reports were established with penalties for violations. A provision limiting expenses of vocational rehabilitation to $16,000 was added.

Organizational changes renamed the Division of Industrial Accidents as the Division of Workers' Compensation, assigned additional duties to the Administrative Director of the division, and increased the terms of members of the Workers' Compensation Appeals Board from four to six years. An Industrial Medical Council was created with extensive powers with respect to the new disability evaluation system created by the Act including appointment and

discipline of qualified medical evaluators. A Workers' Compensation Revolving Fund, to be partially financed by assessments on insurers and self-insured employers, and a Health and Safety Commission were created.

The principal procedural change was the establishment of an extensive pre-litigation administrative procedure that was required before the adjudication services of the Workers' Compensation Appeals Board could be used. Injuries were presumed compensable if they were not denied within 90 days. Provision was made for evaluation by an agreed or qualified medical evaluator if injury was denied and when temporary disability terminated. If the report of the AME or QME called for payment of compensation, the claims administrator (insurer or self-insured employer) was required to pay or file an application for adjudication of the issue by the WCAB.

After litigation commenced, a mandatory settlement conference was required before a formal hearing before a Workers' Compensation Judge could be held. Provision for priority hearings on limited issues such a temporary disability, medical treatment, and rehabilitation was made. Arbitration of certain issues was permitted and required for insurance coverage and contribution.

Minor Amendments During 1994-2001

The next several years minor amendments, mostly providing increased benefits for public safety employees, were made to the workers' compensation law. Comprehensive reform bills, including many CHSWC recommendations, were passed in 1999 (*SB 320*), 2000 (*SB 996*), and 2001 (*SB 71*) but vetoed by the governor. In vetoing *SB 71*, the governor said that to meet his approval a bill would have to encourage return to work, increase benefits, contain medical costs, and to target benefits to maximize outcomes for injured workers.

AB 749

Finally early in 2002, when unions and applicant's attorneys were threatening ballot measures, the governor signed *AB 749* which increased benefits, cut fees for medical treatment, established the position of court administrator, added labor members to Fraud Assessment Commission, increased penalties for fraud and failure to secure payment of compensation, assigned additional functions to CHSWC, increased audit penalties, required return to work program, limited treating physician's presumption of correctness, required fee schedules for drugs and ambulatory surgical facilities, limited arbitration provisions but expanded carve outs,

provided time limitations on filing liens, and limited penalties for multiple delays in payment of compensation.

AB 227 and SB 228

Several workers' compensation bills were introduced during the 2003 regular session and emerged from conference committee as *AB 227* and *SB 228. AB 227* had several provisions relating to insurance, tripled the fine for fraud, eliminated vocational rehabilitation, and substituted provisions for job displacement benefits. *SB 228* eliminated the Industrial Medical Council, transferred the IMC functions to the administrative director, expanded carve outs, gave CHSWC additional functions, further restricted treating physician presumption, increased penalty for late payment of medical bills, established process for resolving disputes over necessity for back surgery, limited chiropractic and physical therapy treatments to 24 for each injury, and provided for utilization review.

SB 899

After an unproductive extraordinary legislative session called to solve "the workers' compensation problem," employer interests proposed a comprehensive initiative measure and were starting to collect signatures. In reaction, the Legislature on April 19, 2004, adopted and the governor signed an urgency statute (*SB* 899) that became effective immediately and amended, repealed, reenacted, or added over 60 Labor Code sections. The principal provisions of the statute provided:

(1) system totally funded by employer surcharges,
(2) vocational rehabilitation services only available for pre 2004 injuries,
(3) carve outs broadened to allow means of delivery of benefits negotiated,
(4) all parties "equal before the law" on burden of proof.
(5) immunity for persons reporting fraud,
(6) procedure for selecting qualified medical evaluator if worker not represented,
(7) procedure for selecting qualified medical evaluator if worker represented,
(8) QME or AME required for all medical issues not subject to utilization review,
(9) no other medical evaluations allowed,
(10) access to WCAB barred until evaluation by AME, QME, or treating doctor,
(11) administrative director provides educational material for treating doctors,
(12) treating physician presumption abolished,

(13) medical treatment must be based on guidelines (AD or ACOEM),
(14) free choice of physician after 30 days only if no medical provider network,
(15) predesignation of treating physician markedly limited,
(16) medical provider networks authorized,
(17) except for certain disabilities, temporary disability limited to two years,
(18) permanent disability compensation adjusted according to work offer,
(19) permanent disability compensation increased for greater disabilities,
(20) PD rating schedule based on *AMA Guides to Evaluation of Permament Impairment,*
(21) PD apportionment may be based on causation,
(22) PD previously found conclusively presumed to continue,
(23) upon filing of claim. employer must provide treatment up to $10,000 until liability accepted or denied,
(24) penalties for unreasonable delay increased to 25% but application limited,
(25) claim for penalty must be made within two years of delay, and
(26) administrative penalty up to $400,000 for general business practice of delaying or refusing compensation.

Subsequent Legislation

In 2005, workers' compensation legislation was limited to minor amendments related to fraud and insolvent insurers. In 2006, the State Compensation Insurance Fund was made subject to audit and apportionment of public safety officers' PD was limited.

Bills designed to correct problems created by *SB 899* were vetoed.

It can probably be concluded that the governor intends to give *SB 899* a fair trial before mending it.