

## I. BACKGROUND

This report, produced by the UCLA Center for Health Policy Research (CHPR) under contract to the California Division of Workers' Compensation (DWC), Department of Industrial Relations, and mandated pursuant to California Labor Code (LC) § 5307.2, examines access to quality medical care for injured workers. The study was conducted following multiple recent changes in the way that medical care for industrial illnesses and injuries is accessed and delivered. Workers' Compensation (WC) legislative reforms enacted in 2003 and 2004 followed a period of rapidly rising WC premiums. From 1999 to 2003, WC aggregate premiums rose by more than 200 percent (from \$7.1 billion to more than \$25 billion), while premiums per \$100 of payroll increased from \$2.30 to slightly more than \$6.00.<sup>1</sup> During this same period, WC premiums declined slightly across the nation. In response to the crisis in WC premiums, the state legislature enacted several WC reforms in 2002, 2003, and 2004. Assembly Bill (AB) 749 was signed into law on February 15, 2002, amended by AB 486 in September, and was effective starting January 1, 2003. In 2003, the legislature adopted two pieces of legislation – AB 227 and Senate Bill (SB) 228 – that both went into effect on January 1, 2004. In 2004, SB 899 was enacted as an urgency bill and thus made effective immediately upon the Governor's signature on April 19, 2004.

The remainder of the report is organized as follows. Section I provides a brief chronological overview of the evolution of WC reform in California, and a summary of the legislative history and content of WC reform bills AB 749, AB 227, SB 228, and SB 899. Section II presents the goals of the evaluation study conducted by CHPR. Section III describes the unique features of this study, and how this study differs from other recent efforts to assess the impact of the WC reforms on access to quality care. Section IV presents a review of the relevant scientific literature related to quality of care and access to care in both the general health care and WC health care sectors. Section V provides an overview of the three surveys – of injured workers, providers, and payers – conducted as part of this evaluation, including sampling frames, sample sizes, survey design, and survey administration. Detailed information on each of the surveys is also included in the Appendices. Sections VI, VII, and VIII analyze the responses from the surveys of injured workers, providers, and payers,

respectively, to determine the adequacy of quality medical care for injured workers. Section IX presents conclusions drawn by the CHPR research team regarding the impact of WC reform on access and quality, and presents directions for future research and for legislative action to ensure continued access.

## **CALIFORNIA'S PROMISE OF MEDICAL TREATMENT IN WORKERS' COMPENSATION**

California was among the first states to adopt WC legislation early in the 20<sup>th</sup> century. California's first WC law was established under the Compensation Act in 1911 (known as the Roseberry Act), *1911 Cal. 399*, which established a WC insurance system with voluntary participation by employers. This voluntary system was replaced two years later with a compulsory system as part of the Workers' Compensation, Insurance and Safety Act of 1913 (known as the Boynton Act), *1913 Cal. 176*. The fundamental role of California's WC system is signified by its embodiment in California's Constitution, which grants the legislature express authority to "create and enforce a complete system of workers' compensation...[that] includes full provision for such medical, surgical, hospital and other remedial treatment as is requisite to cure and relieve from the effects of such injuries..." (Art. XIV, s. 4). The specific definitions of medical and hospital treatments provided under California's WC system are specified in LC § 4600.

Because of the above language in the state Constitution, WC insurers prior to recent reforms could not deny payment for medically necessary care provided to injured workers. In contrast, non-occupational treatments that are medically necessary are often excluded or limited by insurers because they are outside the scope of coverage of the insurer's contract with the insured. California's WC system therefore allowed for a broad range of treatment modalities. For example, the definition of physician "includes physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law" (LC § 3209.3). Prior to the enactment of SB 899 in 2004, California's WC system also provided a broad definition of medical treatment for injured workers. Under SB 899, effective April 19, 2004, LC §

4600(b) was amended to provide for “medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his or her injury means treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27 or, prior to adoption of those guidelines, the updated American College of Occupational and Environmental Medicine’s Occupational Medicine Practice Guidelines,” as discussed further below.

### **THE CONTEXT FOR REFORM: AB 749, AB 227, AND SB 228**

Premiums for WC insurance nationally remained relatively constant during the period from 1999-2003. In California, however, WC premiums increased by about 200 percent during this same period. This rapid increase in premiums was not due to more injuries or illnesses among California workers; in fact, workplace injuries and illnesses actually continued to decline during this period.<sup>1</sup> Instead, premiums appear to have increased rapidly during this period because of increasing medical costs and increasing rates of permanent partial disability cases.<sup>1</sup> Furthermore, premiums also appear to have increased based on insurer expectation that medical costs and permanent partial disability cases would continue to rise.

In response to the crisis in WC premiums, the state legislature enacted several WC reforms in 2002 and 2003. AB 749 was signed into law on February 15, 2002, amended by AB 486 in September, and was effective starting January 1, 2003. AB 749’s most significant impact on access was the elimination of the treating physician’s presumption of correctness, except where an employee had predesignated a personal physician or personal chiropractor for WC care. For injuries occurring on or after January 1, 2003, AB 749 stated that the presumption of correctness was rebuttable by a preponderance of medical evidence. AB 749 also required the adoption of a pharmaceutical fee schedule and gave DWC the authority to adopt an outpatient surgical fee schedule.

In 2003 legislative hearings were held on unnecessary medical treatment and treatment costs in the WC system. Three bills to reform WC were introduced during this session (SB 228 by Senator Alarcon, AB 227 by Assembly Member Vargas, and SB 899 by Senator

Poochigian). SB 228 and AB 227 were actually introduced as complimentary pieces of legislation, with each bill containing language that its provisions would only go into effect if the other bill was passed, and were both passed during the 2003 regular legislation session. SB 899 was referred to conference committee after it passed the Senate in the 2003 session, and was passed out of conference in 2004.

Because of the intense legislative interest in WC reform during the 2003 legislative session, several relevant studies were also published during this period. The Commission on Health and Safety and Workers' Compensation (CHSWC) contracted with RAND to produce a report analyzing the implementation issues related to adopting Medicare fee schedules to pay WC providers in California for all services.<sup>7</sup> The RAND report built on three previous studies. One was done for the Industrial Medical Council (IMC) in 1999 examining the implementation issues related to the adoption of Medicare's fee schedule by California as the basis of WC payments to physicians.<sup>8</sup> Another was conducted in 2001 for CHSWC analyzing the cost savings associated with adopting Medicare fee schedules as the basis for WC payments to outpatient surgery and ambulatory surgery centers.<sup>9</sup> A third was conducted in 2002 for the IMC to assess the impact of and strategies for adopting an adjusted Medicare-based fee schedule for physicians.<sup>10</sup> The goals of these studies were to propose a system for increasing the accuracy of payments to providers of WC care while ensuring access to quality care for California's injured workers. In addition, the California Bureau of State Audits produced a report in 2003 at the request of the Joint Legislative Audit Committee with a number of recommendations, including the adoption of Medicare-based fee schedules for physicians and outpatient surgical centers and treatment guidelines.<sup>11</sup>

AB 227 and SB 228 were signed into law by Gov. Gray Davis on September 30, 2003, just one week before the recall election that led to his departure from office. These bills represented a fundamental departure from the way medical treatment had been viewed under California's WC system, although the provisions of SB 228 were much broader in scope than those in AB 227. Prior to the enactment of these bills, medical care and treatment, with the exception of hospital inpatient care, was largely unlimited fee-for-service (FFS) treatment based on the legal standard of "reasonable and necessary to cure or relieve"

industrial injury (Cal. Constitution, Art. XIV, s. 4; LC § 4600). Treatment guidelines adopted by the IMC, which was comprised of physicians, were advisory only (as specified in LC § 139). SB 228 abolished the IMC, repealed LC § 139, transferred all its remaining responsibilities to the Administrative Director (AD) of DWC, and directed the AD to adopt, after consultation with CHSWC, a medical treatment utilization schedule that incorporates the “evidence-based, peer-reviewed, nationally recognized standards of care” recommended by CHSWC and that addresses the “frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers’ compensation cases” (LC § 5307.27).

SB 228 also retroactively repealed the presumption of correctness for treating physician decisions regarding the extent and scope of medical treatment, except where the primary treating physician (PTP) was predesignated by an employee, for all injuries regardless of when they occurred (LC § 4062.9). Rather than presuming that a physician’s proscribed treatment was correct, it established that treatment consistent with the medical treatment utilization schedule to be adopted by the AD was now presumed to be the correct course of treatment, and until then, treatment consistent with the American College of Occupational and Environmental Medicine (ACOEM) guidelines, or other evidence-based medical treatment guidelines for injuries not covered by the ACOEM guidelines, would constitute the correct treatment schedule (LC § 4604.5). Furthermore, SB 228 placed a cap of 24 chiropractic visits and 24 physical therapy visits for injuries occurring on or after January 1, 2004 for the life of the claim (LC § 4604.5(d)), unless the employer authorized additional visits. SB 228 required all employers to adopt a utilization review (UR) system in which only a licensed physician in the appropriate scope of practice may deny, delay, or modify treatment recommended by the PTP (LC § 4610). SB 228 also established new fee schedules for WC payment, equal to: (1) 100 percent of Medi-Cal for pharmaceuticals; (2) 120 percent of Medicare for hospital inpatient care; and, (3) 120 percent of the Medicare hospital outpatient payment schedule for both hospital outpatient department care and for ambulatory surgery centers (LC § 5307.1). It also reduced rates for physician services by 5 percent off the existing Official Medical Fee Schedule (OMFS) rates, except where the fee for the

procedure was currently reimbursed at a rate equal to or below the Medicare rate for the same procedure.

AB 227 was much narrower in scope than SB 228. It repealed the vocational rehabilitation mandate contained in Article 2.6 (starting with Section 4635) of Chapter 2, Part 2, Division 4 of the Labor Code, and replaced this mandate with a new requirement that employers provide vocational rehabilitation with a new supplemental job displacement benefit consisting of fixed dollar payments based on the percentage of the injured worker's permanent partial disability (LC § 4658.5). It also required the Insurance Commissioner to consider projected savings from all bills passed during the 2003 session (including SB 228) in determining advisory pure premium rates for WC policies effective on or after January 1, 2004.

#### **FURTHER REFORM: SB 899**

SB 899 was passed by both houses of the legislature on April 16, 2004, and signed April 19, 2004 by Gov. Schwarzenegger as an urgency bill, which meant that the bill was effective immediately, with some provisions retroactive to January 1, 2004. SB 899 completely repealed the presumption of correctness of the PTP, making the repeal apply to all cases, regardless of the date of injury and whether the employee had predesignated a personal physician or chiropractor (LC § 4062.9). It explicitly tied the definition of medical treatment to the utilization schedule or treatment guidelines adopted by the AD, such that “medical treatment that is reasonably required to cure or relieve...from the effects of ...injury” (LC § 4600) means treatment that is based upon the guidelines adopted by the AD pursuant to LC § 5307.27 or, until then, the ACOEM guidelines (LC § 4600(b)). Although SB 228 established the authority of the AD to adopt treatment guidelines, SB 899 strengthened the “rebuttable presumption” by requiring all parties in legal disputes to meet the evidentiary burden of proof instead of simply the burden of producing evidence. The effect of this change is that guidelines must be rebutted in court proceedings by scientific medical evidence.

One of the unique features of SB 899 was the creation of Medical Provider Networks (MPNs). As of January 1, 2005, the law now permits employers to control the medical treatment of an injured employee for the life of the claim in WC if contracted with an MPN that meets statutory requirements, but otherwise is not regulated by the state (LC § 4616; 4600(c)). Specifically, employers can now require an injured employee to seek all care within the MPN, although injured employees retain the right to select their own provider within the MPN after the first visit (LC § 4616.3). Previously, the employer controlled only the first 30 days of treatment (LC § 4600) or the first 90-180 days where the employer contracted with a DWC-approved Health Care Organization (HCO) (LC § 4600.3). SB 899 also required a new schedule for rating permanent disability be adopted by January 1, 2005 (LC § 4660(e)), replacing a “diminished ability to compete” with a “diminished future earning capacity” and requiring the rating of permanent impairment to follow the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment.<sup>12</sup> It also imposed a cap of 24 visits on occupational therapy visits, unless the employer authorized additional visits, in addition to the 24-visit cap on chiropractic care and physical therapy imposed by SB 228. SB 899 restored the vocational rehabilitation requirement on the part of employers, repealed by SB 228, for a period of five years. Finally, SB 899 now requires employers to authorize up to \$10,000 in medical treatment after an injured employee files a WC claim until the date the WC claim is accepted or rejected (LC § 5402(c)).

#### **LEGISLATIVE REQUIREMENT FOR AN ANNUAL SURVEY OF ACCESS TO MEDICAL TREATMENT FOR INJURED WORKERS (LC § 5307.2)**

As mentioned above, this report was authorized pursuant to LC § 5307.2, which was revised by SB 228 to require the AD to “contract with an independent consulting firm...to perform an annual study of access to medical treatment for injured workers.” The primary goal of this annual survey is to “analyze whether there is adequate access to quality health care and products for injured workers and make recommendations to ensure continued access.” Furthermore, if the AD determines based on this study “that there is insufficient access to quality health care or products for injured workers,” the AD may make appropriate adjustments to medical and facilities fee schedules. Specifically, if the AD determines that “substantial access problems exist,” he or she may revise fee schedules by adopting fees “in

excess of 120 percent of the applicable Medicare payment system fee for the applicable services or products.”

## **EVALUATING THE IMPACT OF WORKERS’ COMPENSATION REFORM ON INJURED WORKERS, PROVIDERS, AND PAYERS**

SB 228 and SB 899 have fundamentally changed the nature of WC medical treatment by establishing a new standard regarding the presumption of correctness regarding medical treatment of industrial injuries. These bills replaced the judgment of individual physicians with guidelines adopted by the AD that are evidence-based, nationally recognized, and peer reviewed. Many of these guidelines include explicit limits on the number and types of services that are appropriate for treating specific injuries. As a result, the adoption of guidelines, whether those produced by ACOEM or by other organizations, represents a major shift in the legal definition of medical treatment for WC care. DWC is currently in the process of rule-making regarding adoption of a Medical Treatment Utilization Schedule that provides for treatment that goes beyond what is addressed by ACOEM, per LC § 5307.27.

These bills also imposed caps on the number of visits for occupational therapy, physical therapy, and chiropractic care in addition to imposing employer control on who an injured worker can receive treatment from, as result of implementation of MPNs, for the life of a claim. By explicitly limiting medical care available to injured workers through the use of guidelines, lifetime caps, and employer control of treating physician, WC reform established mechanisms for controlling the growth of medical expenditures in California’s WC system.

The purpose of this evaluation is to assess the adequacy of access to quality medical care and products for injured workers in the context of WC reform and to establish a baseline for access and quality of care against which future studies on access and quality can be measured. To address these goals, we conducted surveys of injured workers, physicians authorized to treat WC cases as defined by law (LC § 3209.3), and payers. The next section explains these goals in more detail, while Section V explains the survey methods in more detail.