

I. BACKGROUND LEADING TO WORKERS' COMPENSATION REFORMS

Employer Options to Cover California Workers' Compensation Exposures

Labor Code Section 3700 specifies two methods for an employer to secure the payment of workers' compensation for their employees in California. These are:

1. By being insured against the liability to pay compensation by one or more insurers duly authorized to write workers' compensation insurance in this state; or
2. By securing from the Director of the Division of Industrial Relations a certificate of consent to self insure either as an individual employer or as one employer in a group of employers, whether the employer is a private employer or a governmental entity or district.

The State of California and its various agencies are exempted from securing the payment of compensation by either method, thus being the sole employer in the state that has "legally uninsured" status (Labor Code Section 3700). Regardless, some individual state agencies purchase insurance policies from carriers or have a certificate of consent to self-insure. Most State agencies, however, secure the payment of compensation as a legally uninsured employer.

There are employers that fail to secure workers' compensation coverage as required under Labor Code Section 3700. For the injured workers of these "illegally uninsured" employers, there is the Uninsured Employers' Fund (UEF) in the Department of Industrial Relations to pay benefits due and then attempt to collect the costs of the benefits provided from the uninsured employer.

For those employers electing to purchase workers' compensation coverage, (alternative #1 above), the insurance market has had two distinct periods. The first period was the "minimum rate" era which was in effect for 80 years, from the inception of the workers' compensation system in California until the advent of the "open rating" system. "Open rating" began in 1995 and continues to the present. Within the "open rating" period, there have been three very different market phases. A hard market began in 2000 and continued throughout 2003. However, with various reforms contained in AB 749 (Chapter 6, 2002) the market began its swing to a more competitive one in late 2003.

- Soft market: 1995 to 1999
- Hard market Pre-reform: 2000 to early 2003
- Post-Reform era: late 2003 to present

Each phase has resulted in major consequences to the insurance industry, the regulatory agencies governing the workers' compensation system, the employer community and their employees.

During the "minimum rate era", the state set a floor on the cost of workers' compensation rates. Insurance carriers could charge rates at or above the state-approved rates. Under "open-rating"

which began in 1995 and continues to the present – the state adopts pure premium rates which are advisory. Insurance companies that meet the state’s solvency standards are generally free to charge above or below the state-adopted rates. In addition, the state-adopted rates under open rating are called “pure premium” rates, meaning they only reflect anticipated loss and loss adjustment expense. Insurance carriers are expected to calculate their own adjustments for other items such as general overhead, business acquisition costs, and investment income.

Minimum Rate Era – 1915-1995

The Commission on Health and Safety and Workers’ Compensation (CHSWC) in April 2002 published a “Background Paper State of the Workers’ Compensation Insurance Industry in California” that summarized the minimum rate law and the workers’ compensation insurance market under it, as follows:

Until a few years ago, California’s workers’ compensation insurance rates were regulated by the Insurance Commissioner under the minimum rate law passed in 1915. Under this law, *an insurer could not issue, renew or continue workers’ compensation insurance at premium rates that were less than the rates approved by the Insurance Commissioner (emphasis added)*. The Commissioner, through its statistical agent, the Workers’ Compensation Insurance Rating Bureau (WCIRB), gathered and analyzed premium and losses data, classified businesses, did actuarial projections, and determined final, fully developed, premium rates that included all the costs of benefits and administrative overhead. The final premium could be lower depending on the dividends paid by insurers at the end of the policy period.

California workers’ compensation direct written premium peaked at nearly \$9 billion in 1993, the same year the legislature enacted a major overhaul of the system. Adoption of open rating, which took effect in January 1995, was a key provision of that reform. However, beginning in mid-1993, prior to the conversion to open rating, the legislature and the Insurance Commissioner approved a series of rate decreases. The first, mandated by the Legislature, called for a reduction of 7% in workers’ compensation rates. Then, with the state experiencing a major economic recession and workers’ compensation claim frequency and claim costs declining for the first time in years, the Insurance Commissioner followed the legislated rate reduction with a 12.7% reduction in January 1994 and a 16% reduction in October 1994, just before the minimum rate law was eliminated and open rating took effect. As a result, by 1994, statewide premium was down to \$7.7 billion, and by 1995 – the year open rating took effect – written premium was already down to \$5.7 billion – a decline of over 35 percent in 2 years.¹

Analysis of the California Workers’ Compensation Insurance System

In 1989 the California Legislature established the Workers’ Compensation Insurance Rate Study Commission (Commission) as part of workers’ compensation reform legislation passed that year (Chapter 892, Section 1989). The Commission was mandated to study and report on a number of issues. One of which was to evaluate the present workers’ compensation insurance ratemaking process and the relative effectiveness of similar rate making systems in other states. Included in this evaluation was “an analysis of all aspects of the current system by which minimum rates are established in California, including an analysis of the extent to which this system fosters or discourages competition between insurers”.²

In its March 1992 report, the Commission pointed out that the workers’ compensation insurance rate making process did not exist in isolation of broader issues affecting workers’ compensation

in California. The rate making process was inextricably interwoven with other aspects and important cost savings were well beyond the rate making mechanism. The Commission report went on to state benefits and costs that there is broad support...

in seeing increased benefits and the holding down of costs. Yet there seems to be little incentive in the system to attack the basic cost drivers. Most participants simply pass along cost increases...many players simply do not have the incentive to challenge cost drivers. In fact, some [participants] benefit from increased costs, either directly or in passing them along with more margin to themselves.³

The Commission Report tempered its findings and recommendations with one final statement on the cost drivers within the California workers' compensation system:

...any change in the ratemaking system in California is unlikely to produce significant cost savings compared to the savings that may be had by addressing the system's main cost drivers, those being medical costs, legal costs, broadness of coverage, fraud, and the shifting of costs for off-the-job injuries to workers' compensation.⁴

The Commission report identified a number of "cost drivers" in the California workers' compensation system that would need to be addressed, but that the "real cost containment opportunities lie outside the rate making process." The report identified these "outside-the-ratemaking-system" cost drivers as:

Medical costs that were increasing at an annual rate of 13%;

Broad coverage under workers' compensation more so than in most other states which contributes to higher incidents of indeterminate injuries and to higher overall costs than in states that do not compensate for some of these claims. Mentioned specifically were mental stress claims, mental with physical claims not separated from the physical claim, and vocational rehabilitation costs.

Litigation costs that have turned the system originally designed as a no-fault system, but it has evolved into a highly litigious one.

Fraud ... particularly as it related to stress and back injury claims.

Coverage gaps... A number of claims under workers' compensation are for off-the-job injuries. They are non-employment related, but end up receiving workers' compensation benefits.⁵

The "inside-the-ratemaking-system" cost drivers were identified as:

Insurance company expenses and profits.⁶

The Commission report summarized the challenge to reforming the California workers' compensation system as:

"The challenge then is to bring costs into some type of containment while at the same time providing injured workers with proper benefits."⁷

The report identified that "California and Missouri are alone among the states with a minimum rate provision" at the time of the Commission's report.⁸ With respect to how other states in 1992 regulated workers' compensation insurance rates, in general, the report added:

Many states allowed deviations from the bureau rates, either prospectively, or retrospectively. Some states encourage price and service competition among insurers by allowing individual carriers to request rates in some or all categories of work that were lower or higher than the bureau level. Several had always allowed deviations from the bureau rates if the insurer(s) wishing the deviation could give assurance that the rates were reasonable, and adequate, but not excessive. Some states recognized that it was administratively cheaper to write some risks than others, and allowed or mandated premium discounts or expense constants that were set according to the size of the account.⁹

Beginning in the 1980s, several states began to shift from administered pricing to various competitive rating mechanisms. These variations encouraged and/or allowed more market competition into rates. For example, the new laws often restricted cartel-like rating bureaus from filing fully developed rates, and many did away with requiring prior approval of the insurance regulator before the rates could be used...¹⁰

The Commission reviewed past studies of competitive workers' compensation insurance markets and concluded:

Regulation of the workers' compensation insurance industry is based on the premise that social welfare goals are not likely to be accomplished through competitive market forces. The Commission's analysis of the economics of the workers' compensation industry suggests that the *goals could be achieved efficiently in a more competitive market with a minimum of regulation* (emphasis added). Experience in other states (for example Michigan and Illinois) which have moved toward a more competitive market environment indicates that employer costs usually fall when regulatory constraints are eased; cutthroat competition resulting in widespread insurer insolvency and lack of availability *have not occurred* (emphasis added).

Among the goals that have been identified, the Commission believes that market stability, insurers' solvency and profitability have been overemphasized to the point of regulatory paternalism. Stable markets are not necessarily static, and insurance company managers are rational, profit maximizing individuals. Reasonable assurances of insurer solvency can be accomplished by less obtrusive means.

...a more competitive market would still provide incentives to encourage workplace safety to reduce loss costs for both carriers and employers even if employers choose policies based solely on price; for carriers to pass through improvements to claims servicing to its insurance policy prices; and to identify fraudulent claims. Price competition would permit carriers to compete on the basis of their own cost structures in pricing their policies. The Commission recommended against creating an exclusive State Fund, but rather a competitive market system with emphasis on "up-front pricing and [one that] relies on loss costs to set floor rates."¹¹

The Commission's report envisioned that competitive forces would be introduced into the California workers' compensation system:

Insurers are free to compete above the floor rate without prior approval from the Insurance Commissioner subject only to the limitations on unfair discrimination. Pricing below the floor are possible too, but requires prior approval. This is to guard against predatory pricing, yet allowing extremely efficient providers to compete even more aggressively.

The Rating Bureau retains its role for central data collection, development of loss costs and determination of rating classifications, but no longer would it produce fully developed rates. The State Fund is left to fend for itself in the competitive market, but the *establishment of a small assigned risk pool is recommended in order to handle the overflow of risks (businesses) that may not be able to buy workers' compensation insurance on the voluntary market* (emphasis added) except at exorbitant prices. ... Finally, the Insurance Commissioner is instructed to do an annual

study of how the system is working to accomplish its goals so that appropriate modification can be made, if needed, before major problems arise.¹²

Eleven (11) major recommendations were made in the Commission report, and are summarized below:

1. *“Abolition of the existing minimum rate law and replacing it by open competition with floor rates approved by the Insurance Commissioner (emphasis added) based on loss costs provided by the Workers’ Compensation Insurance Rating Bureau. Prior approval from the Insurance Commissioner would be necessary to price below the floor rate. Also recommended are:*
 - a. Reliance on a uniform classification system.
 - b. Insurance Code provisions applying to unfair discrimination be extended to workers’ compensation insurance.
All insurers shall report any individual risk rating plans and the rates used to the Insurance Commissioner.
 - c. In determining floor rates, the State Compensation Insurance Fund data be included in their entirety.
2. Along with abolition of the minimum rate law, establishment of an assigned risk pool. The costs would be allocated across all workers’ compensation insurers in California on the basis of prorated market share. Admission requirements and rates be designated so the percentage of total premium volume in this category is very low. The level and extent of self insured employers’ contribution to the pool be studied and an appropriate decision reached on self insurer contribution. A tiered assigned risk plan be used, similar to that of Michigan.
3. If an assigned risk pool is not adopted, premium level required for participation in experience and retrospective rating plans should be lowered to permit more employers to participate.
4. Workers’ Compensation Insurance Rating Bureau should continue in its role as a quasi independent organization for determining rating classifications and loss costs.

The Rating Bureau should initiate a more systematic approach to handling employer complaints, systematic records kept on each inquiry--its type, disposition, and speed of resolution-- with particular attention to the small employer; and consideration to use of an Ombudsman to help employers with problems.
5. Insurance Code be modified to permit self insured employers to purchase aggregate excess insurance from admitted California carriers; and that a study might be undertaken to consider requiring aggregate excess insurance be carried by certain self insurers.
6. Do not establish an exclusive state fund.
7. Availability of safety groups to provide group purchasing power to small firms should be expanded and publicized by the Department of Insurance; insurers should be encouraged to develop and promote such groups.
8. If Recommendation #1 is not adopted, then institute a system of premium rebates and/or deductibles plans for small firms.
9. An auditing process for quality of service should be used to ensure performance of statutory duties with provision of loss control/safety and benefit services explicitly evaluated and results disseminated.

10. Commissioner of Insurance issue an annual report evaluating state of competition in workers' compensation insurance market.
11. Workers' Compensation system be reevaluated on terms broader than the ratemaking system as cost savings in workers' compensation are beyond the scope of rate making process."¹³

Initial Phase of Open Rating – 1995 thru 2000

In 1993 the workers' compensation reform legislation repealed California's 80-year-old minimum rate law and replaced it beginning in 1995 with an "open-competition" system of rate regulation in which insurers set their own rates based on "pure premium advisory rates" developed by the WCIRB.

In a report issued by CHSWC in 2002, the workers' compensation insurance market under the open rating system was described in detail as follows:

Price Competition

While declining claim costs and the mandated premium rate reductions initiated the decline in the total California workers' compensation premium, open rating apparently spurred competition among insurers seeking to retain or add to their market share. Some insurers attempted to increase their market share by writing coverage at low prices that eventually proved to be below loss costs. This deregulated market kept premium rates near their historic lows throughout the latter half of the 1990s, even though losses were no longer declining.

In addition, the commercial market was able to solicit and quote public agencies for the first time. Prior to open rating, a public agency could either insure with State Fund, or self insure. Since so few public agencies were insured previously, the WCIRB data on them was very scant and probably not representative, especially in urban areas. This caused some significant under pricing, which led public agencies, especially school districts to go back to full insurance.

Total premium volume did begin to edge up after 1995, as California's booming economy added many new jobs, driving up covered payroll. By 1997, however, industry-wide losses exceeded premiums, and the situation for many insurers was deteriorating. As the link between the price of insurance and loss costs became more and more tenuous, some insurers left the state, others ceased writing workers' compensation, or merged with or were acquired by other carriers. Still others, including several of the largest insurers in the state, became insolvent and had to be taken over or supervised by the state. As a result, the workers' compensation market became much more concentrated than in the past, with only a few insurers primarily the State Fund, and large, national carriers, accounting for the lion's share of statewide premium.

Changing Insurers

WCIRB identified some trends in employers changing insurers prior to and after open rating. WCIRB estimates that before open rating, about 25% of California employers with experience-modifications (x-mods) changed insurance carriers each year. Post open rating, about 35% of the employers did so, and the first quarter of 2001 shows that half of the employers changed carriers. It should be noted, however, that in many open rating cases employers had no choice but to change insurers as the market had deteriorated to the point that many carriers – including several of the largest workers' compensation insurers in the state -- ceased to exist or stopped writing workers' compensation in California.

Reinsurance

After open rating, many carriers shifted the risk of their workers' compensation claims to other insurance companies, some of whom were inexperienced with the California workers' compensation insurance market. Many carriers used reinsurance aggressively in order to mitigate the risk of having to make large future payoffs. Backed by reinsurance treaties that lowered the reinsurance level to \$50,000 or less from the more typical \$500,000 to \$1 million, some primary workers' compensation carriers offered extremely low rates that proved to be inadequate in the face of soaring losses. Some reinsurance companies also sold off their risk to other reinsurers in a process called "retrocession." During 1999, several major reinsurance pools experienced financial difficulty and ceased operations.

Profitability of Insurance Companies

Profitability of insurance companies as measured by the National Association of Insurance Commissioners decreased with deregulation. In the late 1980s, workers' compensation insurers in California had profit levels of nearly three times the national average. With open rating, California insurers have lower than average profit margins, and during the late 1990s had the lowest return in the nation. Several indicators pointed to a decrease in the profitability of the insurance industry.

Premiums

Immediately after the reform and the elimination of the minimum rate law, in part from reasons previously discussed, workers' compensation insurance premiums continued to decline. The total written premium declined from a high of \$8.9 billion in 1993 to a low of \$5.7 billion (\$5.1 billion net of deductible) in 1995. The written premium grew slightly from 1996 to 1999 due to growth of insured payroll, an increase in economic growth, movement from self-insurance to insurance and other factors, rather than increased rates. But even with well over a million new workers' covered by the system, the total premium paid by employers remained below the level seen at the beginning of the decade.

At the end of 1999, the insurance commissioner approved an 18.5% pure premium rate increase for 2000 and the market began to harden after five years of open rating, though rates remained less than two-thirds of the 1993 level. Since then, the market continued to firm, with the insurance commissioner approving a 10.1% increase in the advisory rates for 2001 and a 10.2% increase for 2002. Rates continued to move up, and with the expansion of covered payroll. The WCIRB estimated total written premium would end up at or near its all-time high in 2001."¹⁴

Combined Loss and Expense Ratios

The accident year combined loss and expense ratio, which measures workers' compensation claims payments and administrative expenses against earned premium increased greatly from 1993 to 2000. In accident year 2000, insurers' claim costs and expenses amounted to \$1.50 for every dollar of premium they collected. And that was an improvement over the record high of \$1.70 noted in 1999. In fact, the ratios from 1996 to 2000 were the highest ever recorded by the industry since WCIRB began collecting data in 1972.

Under-Reserving

Furthermore, inadequacy of financial reserves for incurred claims was noted. As of December 31, 2000, the WCIRB estimated that the amount of statewide reported financial reserves were \$7.1 billion below the estimated ultimate cost of incurred claims.

According to many, these unprecedented results are explained, at least in part, by inadequate pricing due to an extremely competitive insurance market. According to WCIRB, for most of the

second-half of the 1990's insurers were, on average, pricing their policies well below the pure premium rate level. (Pure premium rates provide only for losses and loss adjustment expenses and include no provision for other insurer expenses.)

Average Claim Costs

At the same time that premiums and claim frequency were declining, the total amount insurers paid on indemnity claims jumped sharply due to increases in the average cost of an indemnity claim, which rose dramatically during the late 1990s. According to the WCIRB, "both average indemnity and medical claim costs have shown increases over the last several years. ... The WCIRB predicts that the average cost of a 2000 indemnity claim will be \$38,397, which is an up 4% since 1999 and 100% since 1993".¹⁵

Hard Market Phase of Open Rating – 2000-2003

The CHSWC report goes on to describe the current state of the workers' compensation market in California and summarized the workers' compensation insurance market after the 1993 reform to the date of the report, as follows:

A number of California insurers left the market or reduced their writings as a result of the decrease in profitability, contributing to a major redistribution of market share among insurers since 1993... According to the Workers' Compensation Insurance Rating Bureau, California companies (excluding the State Compensation Insurance Fund) insured seven percent of the California workers' compensation market in 2000, compared with 33% of the market in 1993.

The industry recent problems in the reinsurance market caused by the events of September 11 have significantly affected the cost and availability of catastrophe reinsurance and, correspondingly, have a significant effect on the cost of workers' compensation insurance. This extends to more than acts of terrorism and is a critical component of any evaluation of the California workers' compensation insurance marketplace.

Currently [2002], several insurance companies are experiencing problems with payment of claims. According to WCIRB, fifteen independent insurer/insurer groups, which collectively wrote over one-quarter of the total California market in 1994, are under regulatory action by the Department of Insurance."¹⁶

Compounding the effects of the hard market was the industry's unprecedented number and size of insurer insolvencies, most directly related to negative workers' compensation experience and inadequate pricing.

The following exhibit shows the workers' compensation insurance carriers which became insolvent since 2000. The employers insured by these carriers had to find new coverage elsewhere.

Exhibit I-1. Workers' Compensation Carrier Insolvencies 2000-2004		
	Company Name	Liquidation Date
2000	LMI Insurance Company	5/23/2000
	California Compensation Insurance Company	9/26/2000
	Combined Benefits Insurance Company	9/26/2000
	Commercial Compensation Casualty Ins. Co.	9/26/2000
	Superior National Insurance Company	9/26/2000
	Superior Pacific Insurance Company	9/26/2000
	Credit General Indemnity Company	12/12/2000
2001	Credit General Insurance Company	1/ 5/2001
	Great States Insurance Company	5/ 8/2001
	HIH America Compensation & Liability Ins. Co.	5/ 8/2001
	Amwest Surety Insurance Company	6/ 7/2001
	Sable Insurance Company	7/17/2001
	Reliance Insurance Company	10/ 3/2001
	Far West Insurance Company	11/ 9/2001
	Frontier Pacific Insurance Company	11/30/2001
2002	PHILCO	2/ 1/2002
	National Auto Casualty Insurance Co.	4/23/2002
	Paula Insurance Company	6/21/2002
	Alistar Insurance Company	11/ 2/2002
	Consolidated Freightways	9/ 2/2002
2003	Western Growers Insurance Company	1/17/2003
	Legion Insurance Company	3/25/2003
	Villanova Insurance Company	3/25/2003
	Home Insurance Company	6/16/2003
	Fremont General Corporation	7/ 2/2003
	Pacific National Insurance Co.	8/ 5/2003
2004	Casualty Reciprocal Exchange	8/18/2004
	Protective National Insurance Company	2/12/2004

2004 Annual Report, Commission Health Safety and Workers' Compensation", February 2005, pg 15-16.

Under California Insurance Code Section 1063.1(c), the entire unpaid balance of the workers' compensation insurance policy liabilities in California of an insolvent workers' compensation carrier is guaranteed as a "covered claim" by the California Insurance Guarantee Association (CIGA). Thus, the remaining unpaid California workers' compensation liabilities of the 28 insolvent carriers listed above were transferred following the carriers' liquidation date to CIGA for payment. (Insurance Code Section 1063.1(c).)

Need for Fundamental System Changes

Ten years after the legislation passed which moved the California workers' compensation insurance system into "open rating"; it was evident that there remained underlying and unaddressed problems in the California workers' compensation system. The evidence included (1) the insolvency of over 28 workers' compensation carriers from 2000 to 2004; (2) financial difficulties at both the State Compensation Insurance Fund (SCIF) and the CIGA; (3) workers' compensation insurance rates that were the highest or second highest in the nation; and (4)

benefits levels for injured workers' which were among the lowest. Two studies in 2003, one conducted by Hays Companies for CHSWC and the other by the State Auditor, pointed to significant problems involving basic cost drivers within the California workers' compensation system.

Hays Report

The CHSWC retained the Hays Companies of Minneapolis, Minnesota, to conduct a study of the workers' compensation insurance market. The draft report entitled "Study of the California Workers' Compensation Insurance Market," dated September 2003 was submitted to the Commission.¹⁷ The report states it was intended to discuss four major areas:

1. Recommend ways to stabilize the market.
2. Identify impacts on insurers and employers.
3. Analyze the effects of market consolidation.
4. Reduce system costs and improve benefit delivery.¹⁸

A discussion of major cost drivers in the workers' compensation system found that:

One of the main cost drivers we found was the extreme pressure from medical costs, especially the amounts due to permanent partial [disability] cases in the California system. As we also demonstrate later, development of medical costs for PD cases tends to be developing later in the cycle. As this change is occurring over time, it throws off the ability of the WCIRB to catch the trend sooner in the ratemaking process.

Medical costs have long been identified as a challenge for California. In the 1992 Workers' Compensation Research Institute (WCRI) California Administrative Inventory, medical costs were identified as a major cost factor driving inflation in system costs. None of the cost-control mechanisms implemented in the ensuing decade have had a lasting effect on controlling costs.

In fact, many of the issues and challenges to the California system identified in that WCRI inventory (high number of PD cases, lack of comprehensive fee schedules, utilization, litigation, and inconsistency) have not been effectively addressed and remain a factor coloring current perceptions of the system.¹⁹

The Hays report discussed the system cost drivers and made various recommendations to address problems noted. In the discussion on medical cost controls, the report stated:

Unless those [medical] costs are addressed through a comprehensive fee schedule and treatment protocol system, we believe there is little hope for costs to abate....

Medical costs continue to be the major cost driver for the California workers' compensation market. Estimates from the WCIRB indicated that medical benefit inflation has increased an average of 12% annually since 1994. National inflation rates as recently measured by the NCCI show annual medical inflation also at the 12% annual rate. WCRI measured national trends for workers' compensation medical costs as growing at an annualized rate of 7.5%.

The challenge is that California has a much different frequency and development of medical costs associated with PD cases ... as one of the main system cost-drivers.

In July 2003, the WCIRB reported that medical costs and services now comprise the majority (51%) of total loss payments in the California – insured market segment for calendar year 2002. This occurred as total medical costs increased 28% from \$3.2 billion to \$4.1 billion.²⁰

The Hays report went on to recommend the adoption of fee schedules for all treatment segments to a 100% or 120% level of Medicare using a fee schedule based on a Resource Based Relative Value Scale model tied to the Medicare or Medical fee schedule.²¹ This was followed by a discussion and recommendation to adopt meaningful guidelines on utilization control:

These [treatment] guidelines would be just that, guidelines which are refutable by the provider. Frequency limitations and a treatment plan to actually improve the injured worker's condition or enhance a return-to-work are important elements...

The 1998 WCRI report "The Anatomy of Workers' Compensation Medical Cost and Utilization" provides some excellent insights into the medical utilization rates of California compared to seven other states (Massachusetts, Connecticut, Florida, Georgia, Minnesota, Pennsylvania and Texas).

California ... utilization is 120% of the median state based on information from the eight states.

Medical treatment frequency and costs in California averages are significantly higher than the national average. The WCRI found that frequency of medical visits was two times higher than the national average, 31.2 visits per injury. The median treatment duration was 241 much more than any other state measured.

Although, on average, injured workers' receive higher numbers of visits and treatments that does not translate to an earlier return-to-work for those workers' and their employers.

Interestingly, studies (WCRI, Rhode Island and Texas Research and Oversight Council on Workers' Compensation (TROC), and the Medicare Payment Advisory Commission on Protocols) have not shown that access to care nor quality is adversely affected by implementation of fee or treatment parameters.²²

The report further recommended that injury treatment plans be required for injuries to show cure and relief as a result of the treatment; that objective improvement is planned and progress toward the objectives is being shown as part of the treatment plan.²³

The report also discussed a second system "cost driver" on the indemnity side to be permanent disability, in part, as follows:

In reviewing the indemnity portion of claims, the predominance of permanent partial claims in California is startling. The average state has 58.8% of its total costs in permanent partial cases. In California, total costs from the system attributable to permanent partial claims are 82.6%.

This phenomenon is clear from the frequency of permanent partial claims per 100,000 workers'. California has almost three times the number of permanent partials per 100,000 workers' as the countrywide average.²⁴

In other words, these statistics show 81% of the entire system costs are driven by less than 15% of the entire claims population.²⁵

The report went on to recommend the adoption of a more consistent and predictable permanency schedule to improve predictability and consistency in ratings as a cost control tool.²⁶

The report concluded that the workers' compensation marketplace was "in crisis" with several symptoms significantly impacting the insurance market as follows:

As many participants in the California workers' compensation system have stated and numerous reports and articles show, the current [2003] California workers' compensation marketplace is in crisis. There are a number of system design factors affecting the future viability of the workers' compensation system and marketplace. The symptoms we identified as significantly impacting the current market are:

The lack of predictability in cost drivers and claims outcomes.

- The level of current assessments and uncertainty of future additional assessments to support the guaranty fund and the regulatory process.
- The large number of carrier liquidations in the past four years.
- The current split of the market in California between self-insurance, State Compensation Insurance Fund and private carriers, and reinsurance availability, retention levels, and costs.
- The system of penalties for payer mistakes or actions.

These symptoms have all contributed to the current crisis state of the workers' compensation market in California. No one issue is primarily responsible for the current condition in the market place. The interaction of these issues has created a challenging and non-competitive market for workers' compensation.²⁷

State Auditor Report

At the same time the Hays Report was being written, the California State Auditor conducted an audit of the medical payment system in the workers' compensation system and issued a report entitled "California Worker's Compensation Program: The Medical Payment System Does Not Adequately Control The Costs to Employers to Treat Injured Workers or Allow for Adequate Monitoring of System Costs and Patient Care," which focused on the major cost driver—escalating medical costs.²⁸ The report included the following "Audit Highlights":

Rising medical costs are contributing to the increasing costs of the workers' compensation system—costs California's employers are required to pay.

Fee schedules intended to control the amounts paid for medical services are outdated or nonexistent. The medical payment system lacks enforceable treatment guidelines that can help contain medical costs and streamline the delivery of medical care to injured workers'. Researchers point to inadequate control over treatment utilization as a primary cause of escalating costs in the workers' compensation system.

Although the division (DWC) could adopt fee schedules developed by other entities, such as Medicare, it would first have to decide on how to adjust those fee schedules to best meet the needs of the workers' compensation system.

The division (DWC) lacks a data collection system that allows it to monitor medical costs and measure the effectiveness of reforms made to the system.²⁹

The State Auditor's Report made two broad recommendations.

[1] "Regardless of how the State modifies its workers' compensation medical payment system, it will need to improve its controls to allow it to better administer the system

[2] ...and to monitor the effects of policy changes so that it can respond more quickly to changing conditions in the system , including pressures on the costs of providing medical services and injured workers' access to care...

Legislative Reforms of 2002, 2003 and 2004

AB 749 (Chapter 6, Statutes of 2002)

Assembly Bill 749 in 2002 was the first of four recent workers' compensation reform measures that are the subject of this study. The bill is generally considered to be primarily a benefit increase measure, but a number of other reforms were made in the bill as well. Generally, the provisions of AB 749 became effective on January 1, 2003. Key components of the bill included the following:

Medical Matters

The presumption of correctness applied to the pre-designated personal physician or chiropractor only. While primary treating physicians who were not pre-designated remained responsible for treating, coordinating care and report writing, their opinions no longer carried presumptive weight. Carriers and employers could obtain a report from a Qualified Medical Evaluator (QME) to assess treatment and disability issues.

An unrepresented injured worker may obtain additional medical legal reports after retaining an attorney. In such circumstances, the employer may also obtain a QME.

Fee schedules for outpatient surgery services and prescribed medicines were authorized.

Medical liens became subject to a statute of limitations under one of three conditions (six months from a final order; five years from date of injury; or, one year from date services were rendered – whichever is later). Exceptions exist for a provider to overcome the statute if, as a lien claimant, he/she provided care on a non-industrial basis and had no knowledge that the condition may be work-related.

Disability Benefit Matters

Temporary Total Disability and Permanent Total Disability benefits were increased for 2003 – 2005 with adjustments to occur in subsequent years based on the State Average Weekly Wage (SAWW).

A Return to Work program is to be developed with rebates payable to employers. The rebates will vary depending on the size of the employer. The program applies only to those with injuries on or after July 1, 2004.

Permanent Partial Disability benefit rates when less than 70% were increased each year from 2003 – 2006.

Permanent Partial Disability (PPD) benefits when equal to or greater than 70% but less than 100% were to have the same minimum weekly benefit as lower PPD, but higher maximums with annual increases from 2003 – 2005.

The number of weeks of permanent disability to be paid by percentage range increased the number of weeks for PPD ratings in the under 10% through 19.75% starting in 2004.

For life pension benefits, maximum earnings were defined at \$515.38 effective January 1, 2006. An annual benefit recalculation for cases with life pension exposures would be required for injuries occurring on or after January 1, 2003 beginning January 1, 2004 and tied to the SAWW.

A \$10,000 cap on vocational rehabilitation settlements was established for settlements to be approved by the Rehabilitation Unit. The Rehabilitation Unit may only disapprove a settlement if it believes that only through the provision of vocational services will the injured employee be able to find suitable gainful employment.

Surviving parents are presumed to be dependent if no other dependents exist, and a \$250,000 lump sum is to be paid to the decedent's estate when the decedent leaves no dependents. An incapacitated child is entitled to death benefits for life.

Penalties

Multiple penalties may be awarded pursuant to Labor Code Section 5814. In addition, applicant attorney fees will be paid in situations where penalties occur following the issuance of an award.

Health Care Organizations (HCOs)

HCO's must disclose when a carrier owns them.

Employers are not required to offer more than one HCO.

Employers may control the choice of medical provider for 90 days if they do not offer group healthcare. For employers who offer group healthcare, medical control exists for 180 days.

An HCO may only provide services on a capitated basis if licensed under a Knox-Keene Service Plan.

DWC Audit

The first level of audit is a Profile Audit Review. If a carrier or administrator meets the standards for this level of review, then no penalties are due. Instead, the carrier or administrator is only obligated to pay unpaid compensation, interest or certain automatic penalties pursuant to Labor Code Section 4650(d).

The second level of audit is a Full Compliance Audit. The payment requirements mimic those of a Profile Audit Review. In addition, carriers and administrators will have to pay penalties for

failure to pay or to pay timely compensation benefits. If the carrier or administrator fails the Full Compliance Audit, then all penalties will be assessed.

A summary of the benefit increases contained in AB 749 is included in the following exhibit.

Exhibit I.2 AB749 AT A GLANCE								
California Workers' Compensation Changes as of 1.1.03 and Beyond								
BENEFIT INCREASES								
TEMPORARY DISABILITY WEEKLY RATES- Minimums/Maximums								
Temporary Disability	2002	2003	2004	2005	2006	2007 --->		
Minimum*/Maximum	Actual wages/ \$490	\$126/\$602	\$126/\$728	\$126/\$840	\$126/\$840 or SAWW**	Minimum and maximum TD rates**		
*Applies also to volunteers and prisoners. **Increased by percentage increase in State Average Weekly Wage (SAWW)								
PERMANENT DISABILITY WEEKLY RATES - Minimums/Maximums								
Permanent Disability	2002	2003	2004	2005	2006 --->			
Below 15%	\$70/140	\$100/185	\$105/200	\$105/220	\$130/230			
14-24.75%	\$70/160	\$100/185	\$105/200	\$105/220	\$130/230			
25-69.75%	\$70/170	\$100/185	\$105/200	\$105/220	\$130/230			
70-99.75%	\$70/230	\$100/230	\$105/250	\$105/270	\$130/270			
Life Pension	2002	2003 - 2005*			2006* --->			
Maximum	\$257.69	\$257.69			\$515.38			
100% PTD*	PTD is payable at the TTD rate applicable on DOI for life (LC4659(b))							
*LP and PTD indemnity payments for injuries in 2003 and beyond are adjusted by the percentage increase in State Average Weekly Wage (SAWW)								
ADDITIONAL WEEKS OF PERMANENT DISABILITY								
PD %	2002 - 2003		2004 --->					
0-9.75	3		4					
10-19.75	4		5					
20-99.75%	No change							
DEATH BENEFITS								
<ul style="list-style-type: none"> Incapacitated Child is to receive death benefits for life (1.1.03). Death Benefit of \$25 0,000 is payable to estate if no total or partial dependents (1.1.04). 								
DEATH Benefits								
Number of dependents	2002-2005			2006 --->				
Single Total	\$125,000			\$250,000				
No total, 1 + partial	\$125,000			\$250,000				
Single total, 1+ partial	\$145,000			\$290,000				
2 total dependents	\$145,000			\$290,000				
3+ total	\$160,000			\$320,000				
AWE and TD Rate Maximums - Chart to Test Eligibility for the LC4661.5 2-Year Bump								
Dates of Injury	1.1.91 - 6.30.94	7.1.94 - 6.30.95	7.1.95 - 6.30.96	7.1.96 - 12.31.02	2003	2004	2005	2006 --->
AWE Maximum	\$504	\$609	\$672	\$735	\$903	\$1,092	\$1,260	\$1,260 or 1.5 x SAWW*
TD Rate Max./wk	\$336	\$406	\$448	\$490	\$602	\$728	\$840	\$840 or SAWW**
*Increased by State Average Weekly Wage (SAWW)							**Whichever is higher	
LC4661.5 2-Year Bump Action Guide								
If any of these benefits are to be paid two or more years from DOI, review whether AWE on DOI raises the TD Rate. If so, pay when the benefit increase takes effect and the claim is 2 or more years old from DOI.								
Needs LC4661.5 Reserve Review:			Needs No LC4661.5 Reserve Review:			Payment Procedures		
TTD			PD Supplement to VRMA			1. Adjust TD benefit rate		
Self-imposed penalty on TD			Death benefits to dependents (non-minors)			2. Pay benefit at increased rate		
VRMA paid at TD Rate						3. Send DWC500F notice and		
Death benefits to dependent minors						send copy to app attorney if any		
Note: Retro TD benefits may be payable at higher rates under AB749.								
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This document is for informational purposes only and should not be construed as or relied upon as legal advice. You should contact your attorney to obtain advice with respect to any particular issue or problem.								

AB 227 (Chapter 635, Statutes of 2003)

The effective date of AB 227 was January 1, 2004. Key provisions of the bill are:

Vocational Rehabilitation

The bill repealed Vocational Rehabilitation benefits for all injuries and repeals LC5405.5, which defined the period to request vocational rehabilitation as one year from date of last finding of permanent disability or Compromise and Release of other issues.

The bill enacted a Supplemental Job Displacement Benefit (Vouchers) for injuries occurring on or after January 1, 2004, that does the following:

- a. A voucher is payable up to \$10,000 where permanent partial disability (between 1% and 99% PPD) is awarded to an injured worker who has not returned to work within 60 days from the end of temporary disability (TD), or who has not been offered modified or alternative work within 30 days from the end of TD.
- b. The voucher pays for education-related retraining or skill enhancement at state approved or accredited schools. No more than 10% of voucher moneys may be used for vocational or return-to-work counseling.
- c. The amount of the voucher is tied to the percentage of permanent partial disability as noted in the following table.

PPD	Voucher Amount
< 15%	Up to \$4,000
15% - 25%	Up to \$6,000
26% - 49%	Up to \$8,000
50% - 99%	Up to \$10,000
100%	No voucher

- d. The voucher is payable to the educational institution, to the return-to-work counselor, or to reimburse injured workers' who pay the educational institution or counselor directly. The voucher is non-transferable.
- e. Unlike vocational rehabilitation, the voucher does not compensate for wage loss while the injured worker participates in retraining, nor pay for additional living expenses. The employer or insurer is not required to administer the voucher, nor provide workers' compensation benefits in the event that an injured worker sustains an injury while participating in voucher-related activities.
- f. The statute is silent regarding whether the voucher benefit may be settled.

Other Provisions

- 1. Requires that employer assessments fund 100% of the cost of the Division of Workers' Compensation, rather than 20%.
- 2. Provides CIGA with an alternative funding mechanism for up to \$4.5 billion in bonds to be issued before January 1, 2007. CIGA is not required to pay LC5814 penalties incurred by an insolvent insurer.

3. Increases the maximum fine from \$50,000 to \$150,000 for making a false or fraudulent statement regarding any workers' compensation claim.
4. Requires the Insurance Commissioner to take into account projected savings due to changes enacted in the 2003 Legislative Session in determining the advisory pure premium rates for policies incepted on or after January 1, 2004, and to post an on-line rate comparison of the top 50 insurance companies writing the highest volume of business during the two preceding years.
5. Exempts State Compensation Insurance Fund from hiring freezes and staff cutbacks otherwise required by law.
6. Expands the definition of "common trade or business" to include specified types of manufacturing facilities.

SB 228 (Chapter 639, Statutes of 2003)

The effective date of SB 228 was January 1, 2004. Key provisions of the bill were:

Medical Matters

1. The Official Medical Fee Schedule (OMFS) sets maximum fees for patient services:

Services Included in the OMFS:	Reimbursement Rates as of 1.1.04
Physician services	5% off current OMFS, frozen until 2006
In-Patient Hospital	120% Medicare
Out-Patient Facility*	Not to exceed 120% Medicare
DME – equipment and supplies	120% Medicare
Out-Patient Laboratory	120% Medicare
Pharmacy	100% Medi-Cal
Ambulance	120% Medicare

* Includes services provided in Emergency Room Departments

Services excluded from the OMFS:
Inpatient skilled nursing facility care
Home Health Agency services
Inpatient services from exempted facilities, such as free-standing psychiatric hospitals or rehabilitation hospitals
Outpatient renal dialysis services

2. Chiropractic treatment and physical therapy visits are limited to 24 visits for injuries occurring on or after January 1, 2004, for the lifetime of the claim, including self-procured care. Employers/carriers may authorize more than 24 visits per injury.

3. Medical utilization guidelines are mandatory effective January 1, 2004, for all injuries.
 - a. Establishes a Utilization Review (UR) procedure is established to approve, delay, modify or deny treatment plans in whole or in part, based on whether the proposed treatment is medically necessary to cure and relieve the effects of the injury.
 - b. The employer's UR policy must be in writing, consistent with ACOEM Guidelines or the Administrative Director's medical utilization schedule, filed with the Administrative Director, and made available upon request.
 - c. Only qualified physicians, including the UR plan's Medical Director, can make decisions to delay, modify or deny treatment.
 - d. Employers may request pre-authorization of non-emergency treatment or diagnostic services and conduct reasonably necessary utilization review.
 - e. There are three levels of UR: Concurrent or prospective reviews, retrospective reviews, and reviews not to exceed 72 hours from receipt where an injured worker faces serious or imminent threat to his or her health.
 - f. Strict procedures and timeframes must be followed to assure that treatment requests are peer-reviewed and responded to promptly.
 - g. Penalties can be pursued for an unreasonable delay in completion of the UR process.
4. The Administrative Director is required to adopt a medical treatment utilization schedule on or before December 1, 2004.
 - a. Until new medical utilization guidelines are adopted, the American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines are deemed presumptively correct on extent and scope of treatment as of March 22, 2004.
 - b. ACOEM Guidelines may be rebutted by a preponderance of evidence establishing that variance from the guidelines is reasonably required to cure and relieve the employee from the effects of the injury.
 - c. Where ACOEM guidelines are not sufficient, other evidence-based medical treatment guidelines shall be used that are generally accepted by the healthcare community.
 - d. The Industrial Medical Council (IMC) is eliminated and IMC treatment guidelines are repealed as of January 1, 2004.
5. The treating physician presumption of correctness was modified. Where treating physicians and chiropractors are properly pre-designated for injuries occurring on or after January 1, 2003, the treating physician opinion is presumed correct for issues other than extent and scope of treatment. For injuries prior to 2003, the treating physician opinion is presumed correct for issues other than extent and scope of treatment.

6. A second opinion process for spinal surgeries was required. Employers that dispute the need to authorize a spinal surgery must object to the DWC Medical Unit within 10 days of the treatment request, regardless of date of injury, effective January 1, 2004.
 - a. Only a California licensed board-certified or board-eligible orthopedic surgeon or neurosurgeon can be a second opinion physician. Physical examination is optional. The second opinion physician report must be served on the parties within 45 days of receipt of the treating physician's report.
 - b. The employer is not liable for medical costs or temporary disability resulting from a disputed spinal surgery procedure that is performed prior to completion of the second opinion process. Where the second opinion physician determines surgery is required, the employer must provide the surgery immediately. Where the second opinion physician determines surgery is not required, the employer must file a Declaration of Readiness to resolve the issue, even if the injured worker is unrepresented.
7. Employers must pay medical bills within 45 working days instead of 60 calendar days. Requires payers to accept electronic bills by July 1, 2006 and pay such bills within 15 days under certain circumstances.
8. Self-imposed penalties for late medical payments were increased from 10% to 15%.
9. The dispensing of generic drugs from any source, not just pharmacies was mandated, unless the treating physician prescribes otherwise.
10. A \$100 fee for initial filing of medical liens was required. The Veterans Administration, Medi-Cal, and public hospitals are exempt.

Other Provisions

1. Every employer must maintain an effective injury and illness prevention program. Requires every workers' compensation insurer must obtain an independent review of the injury and illness prevention programs of its insureds within four months of the beginning of the initial policy term.
2. The timber and aerospace carve outs were repealed. New requirements for Alternative Dispute Resolution programs for any industry other than construction were established.

AB 227/SB 228 Commentary

AB 227 and SB 228 were enacted with expectations that significant savings would be realized from these bills. Specifically, the California legislature stated, "employers in this state need reasonably priced workers' compensation insurance."

The Legislative Conference Committee estimated a one-time savings of \$5.3 billion from the Official Medical Fee Schedule (OMFS), out-patient surgery facility fee schedule, and repeal of the Primary Treating Physician (PTP) presumption. The Committee projected \$1 billion to \$1.7 billion ongoing savings from the use of medical treatment guidelines and \$1.2 billion from the

“repeal” of vocational rehabilitation. The Committee summary provided a roadmap of anticipated savings from the following factors:

- a. Official Medical Fee Schedule
- b. New out-patient surgery facility fee schedule
- c. Pharmaceutical fee schedule
- d. Current treating physician’s presumption of correctness “repealed”
- e. Chiropractic and physical therapy visits limited to 24 per injury
- f. New treatment protocols, including American College Of Occupational And Environmental Medicine Practice Guidelines (ACOEM)
- g. Second opinion process for spinal surgeries
- h. Repeal of vocational rehabilitation

This package of cost-containment approaches provided the initial framework for reduced workers’ compensation costs for carriers and employers.

SB 899 (Chapter 34, Statutes of 2004)

CHSWC prepared a nine page, “SB 899 Topic Summary Report” in 2004 that lists and briefly summarizes the nature of the reforms included in this legislation.³⁰ An excerpt from that report listing major features of SB 899 is shown below.

Exhibit I.3. List of Workers’ Compensation Subject Matters Addressed in SB 899 (Chapter 34, s 2004)	
Funding	User Funding [workers’ compensation program]
Vocational Rehabilitation	Supplemental Job Displacement Benefits
Integrated Benefits in Carve-Outs	Liberal Construction [burden of proof]
Return to Work Incentives	RTW Site Reimbursements for Worksite Modifications
Provision of Medical Benefits	<ul style="list-style-type: none"> Repeal of Treating Physician Presumption Medical Treatment Defined and Pre-designation of Physician Medical Billing Treatment Guidelines Medical Networks Patient Rights in Networks IMR to Resolve Dispute with Network Organizations Deemed Approved as Networks Early Medical Treatment
AME/QME	<ul style="list-style-type: none"> QME System and Report Writing AME/QME and Medical Dispute Resolution
Payment of Benefits	<ul style="list-style-type: none"> Timing of Payments TD Limit to 2 Years
Permanent Disability	<ul style="list-style-type: none"> PD Indemnity Chart, Including Tiered PD Benefit Definition of Modified and Alternate Work PD Rating Schedule
Apportionment	<ul style="list-style-type: none"> Apportionment [Based on Causation] Apportionment {Employer Liability} Lien filing Fees Admissible Evidence
Penalties	<ul style="list-style-type: none"> Private Attorneys General Exception Penalties for Unreasonable Delay Penalty for General Business Practice of Delays
Injury and Illness Prevention Program	
Fraud	Fraud Reporting
Study Effects of Reform	
SB 899 Effective dates	<ul style="list-style-type: none"> Prospective from 4-19-2004 Retrospective unless otherwise specified.
Source: CA Commission on Health and Safety and Workers’ Compensation, SB 899 Topic Summary Report, 2004	

The effective date of SB 899 was April 19, 2004, although some provisions in the bill take effect at a later point in time. The bill applies prospectively from date of enactment, regardless of date of injury, unless otherwise specified, but is not cause to reopen or rescind, alter or amend an existing order, decision or award of the Appeals Board. Key provisions included in the bill are listed below:

Medical Matters

1. Limits the amounts paid for medical services to the reasonable maximum amounts in the Official Medical Fee Schedule in effect on date of service. Medical providers are to submit an itemization of medical services provided and would be paid according to the fee schedule.
2. Fully repeals the treating physician's presumption of correctness on all issues, regardless of date of injury.
3. Revises procedures to obtain qualified medical evaluations (QMEs) that, prior to enactment of SB 899, were not used to address determination of claim liability.
 - a. Requires claims administrators to initiate the QME panel process where liability for the claim is questioned within the first 90 days and injured workers' do not timely request a QME panel, unless the treating physician comments upon claim liability.
 - b. For injuries occurring in 2005, represented employees must seek a QME panel to resolve disputes of claim liability, permanent disability, and other medical issues where the parties do not agree to Agreed Medical Evaluations (AMEs).
4. Requires employers to authorize medical treatment within one day of receipt of a signed claim form. Treatment is limited to \$10,000 until liability for the claim is accepted or denied. Authorized treatment shall be consistent with ACOEM Practice Guidelines.
5. Amends the second opinion spinal surgery process so that injured workers' may obtain a QME panel evaluation.
6. Defines medical treatment as reasonably required to cure or relieve the injured worker from the effects of the injury, not all medical services reasonably required. Definitions of medical treatment contained in the medical utilization schedule and utilization review enacted by SB 228 are better integrated with existing medical treatment statutes.
 - a. Strengthens the presumption of correctness of ACOEM Practice Guidelines or the medical utilization schedule, to be controverted by a higher standard of "a preponderance of scientific medical evidence."
 - b. Requires medical guidelines to be evidence and scientifically based, nationally recognized and peer-reviewed.
 - c. Authorizes the Appeals Board to receive medical guidelines as evidence.
 - d. Limits occupational therapy visits to no more than 24 per industrial injury.

Permanent Disability

1. Requires the Administrative Director to adopt a permanent disability rating schedule before January 1, 2005 for determining permanent disability to promote consistency, uniformity and objectivity. The goal is for adjustment factors in the new schedule to result in very similar disability ratings for similar types of injuries.
 - a. Determines the nature of physical injury or disfigurement by incorporating descriptions and measurements contained in the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition. The former schedule relies on medical evaluation of work restrictions and subjective factors.
 - b. Replaces diminished ability to compete in the open labor market with diminished future earning capacity as a factor of permanent disability in the schedule.
 - c. Defines an employee's diminished future earning capacity by using a numeric formula based on empirical data from a 2003 Rand report and other empirical studies.
 - d. Applies to injuries occurring on or after January 1, 2005, and some pre-2005 injuries.
 - e. Requires the Administrative Director to update the schedule at least once every 5 years.
2. Replaces present law on apportionment with a statement that apportionment of permanent disability is based on causation.
 - a. Makes the employer liable only for portion of disability directly caused by injury.
 - b. Requires physicians evaluating permanent disability to assess percentage of disability due to work and the percentage caused by other factors, including prior industrial injuries.
 - c. Conclusively presumes that an injured worker's prior PD awards exist at the time of subsequent injury.
 - d. Requires employees to disclose all previous permanent disabilities or impairments.
 - e. Restricts accumulated percentage of disability for any body region to 100% over lifetime.
3. Requires the employer to begin payment of reasonable estimates of permanent disability at the time the last temporary disability has been made, regardless of whether the extent of permanent disability can be determined at that time.

Temporary Disability

SB 899 limits temporary disability payments to 104 weeks within a two year period from the first payment of temporary disability benefits for injuries occurring on or after April 19, 2004. There are nine specified exceptions for which temporary disability is capped at 240 weeks within a period of five years from date of injury.

Medical Provider Networks

SB 899 authorizes insurers and self-insured employers to establish Medical Provider Networks (MPNs) to improve treatment provided to injured workers' beginning in 2005.

- a. Requires the Administrative Director to approve MPN plans and to establish a statewide list of Independent Medical Reviewers (IMRs).
- b. Requires networks to provide treatment in accordance with medical utilization controls established by the Administrative Director.
- c. Requires that networks be established with consistent standards, which provide procedures for injured workers' to obtain care for common occupational injuries and work-related illnesses through the networks. Standards describe adequate numbers and types of physicians and provide sufficient access to physicians based on geography and need for specialty medical treatment. Employers have the exclusive right to determine provider members of the network.
- d. Allows for physician pre-designation so that employees can opt out of the network before a work injury occurs.
- e. Establishes policies for transfer of care so that workers' injured prior to establishment of approved MPNs may continue to receive treatment from existing physician(s) if the worker is scheduled for surgery or if the worker's condition is acute, serious and chronic, or terminal.
- f. Provides procedures for injured workers' to obtain second and third opinions by other MPN physicians where the injured worker disagrees with the diagnosis or treatment offered by the treating network physician.
- g. Requires the Administrative Director to establish a statewide list of eligible physicians to perform an Independent Medical Review (IMR) where a dispute remains after a third opinion within the network is obtained. The IMR physician shall determine whether the requested health care service is consistent with the injured employee's specific medical needs and consistent with the ACOEM Practice Guidelines or the utilization schedule established by the Administrative Director. Where the IMR physician finds that the disputed services are so consistent, the injured worker may seek the services from a physician of his or her choice, either inside or outside the network.
- h. Establishes policies for continuity of care, including procedures for providers terminated from the network. Physician compensation may not be structured to reduce, delay or deny medical treatment or restrict access to treatment (economic profiling).
- i. Health Care Organizations and Health Maintenance Organizations are deemed approved as Medical Provider Networks if they have reasonable numbers of physicians in occupational and non-occupational medicine.

Other Provisions

1. Limits penalty amounts in cases of unreasonable delay or denial of care or benefits to 25% of the amount delayed or denied, or \$10,000, whichever is less, effective June 1, 2004. A two year statute of limitations is established for claiming penalty after payment due date. At time of settlement, any accrued penalties are conclusively presumed resolved unless the issue is presented in the settlement or at trial. Administrative

penalties of up to \$400,000 are provided for employers who knowingly violate delay/denial laws as a general business practice.

2. Requires all workers' compensation findings of fact to be interpreted impartially such that all parties are considered equal before the law.
3. Provides that the \$100 initial medical lien-filing fee will also be collected from those filing medical liens on behalf of providers.
4. Repeals duplicate Supplemental Job Displacement Benefit language; restores vocational rehabilitation benefit for pre-2004 injuries, subject to sunset in 2009.
5. Requires that insurers conduct reviews of injury illness and prevention programs of all new injured employers with experience modification factors of 2.0 or more.
6. Restores user funding of the Return-to-Work Program and specifies eligibility to reimburse employers of up to 50 employees with available funds.
7. Gives civil immunity to those that appropriately report suspected fraudulent claims.
8. Authorizes collectively bargained projects on health care integration for delivery of medical and disability benefits.
9. Requires study of insurance marketplace and rate effects from legislative reform.

Uncertainties Related to Reforms

Process for Clarification of Workers' Compensation Reforms

The reforms enacted collectively by these four legislative bills have significantly revised the California workers' compensation system they focus on "outside the system cost drivers" that the Commission identified in 1992 as both "inextricably interwoven" with the California workers' compensation system, and also "important cost savings that are well beyond the [workers' compensation insurance]rate making mechanism". As previously mentioned, the Commission Report in 1992, the Hays Report in 2003 and the State Auditor's Report in 2003 all made recommendations suggesting that significant savings could be had by addressing the California workers' compensation system cost drivers.

As is the case in most legislation affecting a subject area as complicated as workers' compensation, legislative bills do not address every aspect in complete detail. This is left to the regulatory agencies, the Courts, or future legislation. These reforms have left many uncertainties that potentially will affect the workers' compensation system and, thereby, the rate making process for workers' compensation insurance carriers.

The development of legal issues in the workers' compensation arena typically follows a pattern of legislation, adoption of rules by the Administrative Director (AD) or the Workers'

Compensation Appeals Board (WCAB) (for primarily procedural changes) for implementation. Finally there are legal challenges by the interested parties to the system to clarify the interpretation of the legislation and or regulations adopted to implement the legislation. Some legislation does not require adoption of regulations for implementation and can move immediately into the legal challenge mode to obtain clarification.

An example of legislation that required rules by the AD is the implementation of the Medical Provider Networks (MPN) authorized under Labor Code § 4616. Since the Labor Code required the AD to promulgate regulations and approve the networks, nothing could happen until the regulations had been adopted. The regulations were adopted to implement the MPN program and have since been revised and updated.

An example of legislation that does not require adoption of regulations is Labor Code § 4663 on apportionment. The interpretation of this statute would be made by the WCAB as parts of its duty to interpret the labor code and the administration of benefits to employees. The same is true of Labor Code § 5814 on penalties, as the WCAB is the primary judicial interpreter of when such penalties apply and how to apply the statutes to specific fact patterns presented to it.

In a sense both the process of adopting regulations and the process of obtaining clarification through legal challenges allow for input from different sources to be considered by a neutral party interested in providing a specific implementation of a statutory directive from the legislature into the overall scheme of workers' compensation.

The regulation adoption process requires the AD to solicit and consider information, opinions and argument from the public, including the various interest groups, into the regulations that will be used to implement the legislative directives.

In the litigation system the parties present their arguments on the interpretation of the law as it applies to specific facts to a neutral party, the Workers' Compensation Administrative Law Judge (WCJ). This process relies on the adversarial process of litigation to provide the WCJ with available options and sufficient information and analysis to make a decision on how to apply the legislative directives to the facts of a specific case. The decision of the trial judges can then be challenged at increasingly higher levels of judicial authority until ultimately the California Supreme Court can be asked to rule on the lower court's interpretation. Typically the process of obtaining clarification of legal principles in the litigation process takes a number of years as cases must work their way to trial and decision by a WCJ, followed by an appeal to the WCAB itself, possibly followed by appeal to the Courts of Appeal and finally consideration by the California Supreme Court. At each succeeding level the review becomes more legally refined and the likelihood of a party obtaining review becomes increasingly less likely. In general, the higher the court that issues a decision, the more significant the decision has as legal precedent to bind lower courts to follow the decisional law.

Legal Uncertainty

Two areas that are likely to involve significant increased litigation over the next several years are Permanent Disability (PD), specifically the litigation over rebuttal to the newly adopted PD Schedule and apportionment to causation.

One of the specific directives in the adoption of the schedule was to create “consistency, uniformity and objectivity” (LC 4660). The purpose of efforts to sidestep the schedule and litigate the issue of wage loss is to avoid the very purpose of the schedule, to reduce litigation of PD by making the schedule more consistent and objectively based. This effort could end up being substantially eroded with the current efforts to introduce evidence to avoid application of the PD Rating Schedule.

Apportionment has traditionally been fertile ground for litigation. The reform legislation has changed the prior rules on apportionment and therefore a completely new set of rules, developed through case law, will have to emerge to clarify the application of the new statutes. It is probably impossible to completely change the statutes on apportionment and not expect a substantial amount of litigation, requiring years of developing case law to be the result. The case law before SB 899 took almost 30 years to fully develop. One can anticipate a good deal of litigation on the issue of apportionment. If the current decisional case law holds up in the Gallo Glass Co v WCAB (Dykes), case, and if this concept is expanded to cases beyond those specifically identified in Dykes, then the employer community may find much of the effort to obtain the benefit of apportionment to prior awards of PD to be a hollow victory.

The following is a summary of thirty significant issues resulting from AB 749/AB486, SB 228/AB 227 and SB 899 in order of importance as defined by potential costs saved or to be incurred by the overall system. A more comprehensive discussion of each issue, organized by the reform measure that addressed the issue is contained in Appendix A.

1. Impact of the Utilization Review time limits in applying Utilization Review decisions to medical care.

This issue has been pending at the Court of Appeals for several months in Sandhagen v WCAB. Given the very tight time frames for completing and communicating UR decisions, strict interpretation of the UR timeframes will result in increased costs to implement UR.

2. Application of ACOEM Guidelines to injuries beyond 90 days.

The WCAB has generally applied ACOEM regardless of how long after the injury. Trial judges tend to issue findings that ACOEM does not apply beyond 90 days. The WCAB is developing case law that suggests that while the guidelines will still apply beyond 90 days that the applications is more flexible and less structured thereby allowing more treatment than is generally identified in ACOEM. In general, the further the employee gets from the date of injury, the less significant the ACOEM guidelines become. Adoption of the Medical Treatment Guidelines by the Administrative Director, as required by statute, could help to resolve this issue and provide treatment guidelines that cover a longer time frame from the date of injury.

- 3. Presumption for American College of Occupational and Environmental Medicine Medical Treatment Guidelines Application Date.**
This issue is currently pending at the Court of Appeals. This issue involves use of ACOEM to review, approve and or deny treatment provide before the effective date of the presumption on March 22, 2004. A decision can be expected sometime before mid 2006.
- 4. Retroactive Application of provisions of SB 899.**
The appellate courts have provided a very solid basis to apply all of the provisions of SB 899 that do not have a separate implementation date to all aspects of Workers' Compensation. This issue is now settled
- 5. Ability to transfer existing claims into MPNs.**
The Administrative Director's rules make transfer into the MPN for existing cases a reality. It is anticipated that legal challenges will be made to the Administrative Director's authority to allow transfer of existing cases into an employer or carrier's MPN.
- 6. Effective date of repeal of presumption for primary treating physician.**
The PTP presumption was identified as one of the primary cost drivers of medical care from 1994 to 2003 when the presumption was substantially modified. Given the language in Section 46, the application of the repeal of this section was mandated for existing cases. This was confirmed by the WCAB in and *en banc* decision.
- 7. Interpretation of "existing Order, Decision or Award of the Workers' Compensation Appeals Board.**
This issue helped to determine how many existing cases will be affected by SB 899. The courts have used the rule of "finality of decisions" to apply SB 899 provisions to all cases without a final decision. This issue is substantially settled.
- 8. Ability to rebut the Permanent Disability Rating Schedule (PDRS) that went into effect on January 1, 2005.**
The ability to rebut the PDRS and obtain ratings based on wage loss concepts is just being explored but has the potential to significantly increase the exposure for PD benefits. Cases are currently pending where this issue is being raised. Has the potential to substantially increase litigation costs and Permanent Disability benefits in some cases.
- 9. New definition of apportionment to "causation".**
WCAB has provided expensive definition of what "causation" means in Labor Code § 4664. Anticipate much more litigation over details of application of how to develop record to prove apportionment
- 10. Calculation of apportionment to pre-existing Awards.**
Current case law authority is conflicting. Has the potential to wipe out apportionment under Labor Code § 4664 as a meaningful issue for employers.

- 11. Application of revised statutes on apportionment to existing cases.**
Kleemann v WCAB provided for application of apportionment to existing cases that are not final. This issue is now settled.
- 12. Application of amended Labor Code § 5814.**
Case authority now holds that amended Labor Code § 5814 applies to all claims as for effective date June 1, 2004. System has already experienced a dramatic drop in claims for penalty.
- 13. Effective date of use of the new Permanent Disability Rating Schedule under Labor Code § 4660.**
Which claims, where injury occurred prior to January 1, 2005, will be evaluated using the pre-January 1, 2005, PDRS and which will use the AMA Guides? Use of AMA Guides will generally result in significant overall savings in Partial Permanent Disability Awards.
- 14. Apportionment under Labor Code § 4664 for a prior Award where the new Award is under AMA guides.**
Since the old and new systems use both different methodology for calculation of PD and different standards, how will prior awards be credited against new awards?
- 15. Prospective application of Vocational Rehabilitation Settlement.**
This issue is final and was resolved in favor of being able to settle VR benefits for all claims regardless of the date of injury.
- 16. Ability to settle Supplemental Job Displacement Benefits.**
Since use of SJDB is not anticipated to be widespread, that ability to conclude liability is important for employers to be able to close files completely. Current rules allow for settlement of this benefit.
- 17. Lack of a Permanent Disability Award on entitlement to supplemental job displacement benefits.**
If and how to calculate the value for SJDB vouchers where there is no PD award. Labor Code only requires payment of voucher where there is an award of PD and there is no procedure for requesting a determination of WCAB on PD after case is settled by Compromise and Release.
- 18. Amendment to Labor Code § 3207 Removing Vocational Rehabilitation.**
Definition of compensation no longer includes Vocational Rehabilitation. Has potential impact in application of penalty statutes to VR benefits as Labor Code § 5814 provides for penalty to be awarded for delay in payment of “compensation”.
- 19. Pre-designation limitation to Primary Care Physician.**
Proposed regulations limit use of pre-designation to small pool of physicians and prevents injured workers’ from pre-designation of non primary care physicians. Has potential to increase number of employees to be treated in MPN

- 20. Obtaining medical-legal evaluations in represented cases for injuries prior to January 1, 2005.**
Two cases on this issue are currently pending in Appellate Courts. Potential to reverse existing case law and require more restrictive medical legal process for obtaining medical legal examinations in existing cases not just claims of injury after January 1, 2005.
- 21. Administration of vocational rehabilitation when portions of the statutory provisions have been repealed.**
The subject to a WCAB Significant Panel decision with instructions to use now repealed statutes in Labor Code § 4635 to 4646.
- 22. Definition of 50 employees for purposes of Labor Code § 4658(d) (2).**
Will define application of 15% adjustment to PD.
- 23. 15% Increase/Decrease of Permanent Disability Award: Identification of Permanent and stationary dates.**
Since many times the P & S opinion is received long after the actual date, the ability to offer alt/mod/regular work within 60 days will be affected. Current proposed rules to do not provide any guidance to this issue.
- 24. Calculation of Retroactive or Delayed Vocational Rehabilitation Maintenance allowance benefits.**
Issue is whether repeal of Labor Code § 4646 and adoption of Labor Code § 139.5 will eliminate payment of past due and delayed VR benefits at TTD rate (maximum rate of \$840) v VRMA rate (maximum rate of \$246)
- 25. Ability to pre-designate a chiropractor or acupuncturist pursuant to Labor Code § 4601 where employer has MPN.**
This could result in significant additional leakage from MPNs if allowed. Proposed rules limit designation of personal chiropractor to non MPN situations.
- 26. Ability of chiropractor to remain as primary treating physician after completion of 24 visits.**
What happens to chiropractor as primary treating physician when 24 visit cap (applicable only to post January 1, 2004 injuries) is reached?
- 27. Obtaining medical-legal reports in multi-party cases and multi-injury cases.**
None of statutory rules address issue of medical legal examinations in multi-party cases, contribution issues etc.
- 28. Commencement of Increases in Life Pension Benefits for Permanent Total Disability Cases.**
Technical question for calculation of benefits where life pension is awarded when to include COLA for calculating increases.

29. Extension of Dependency Benefits for Mentally or Physically Incapacitated Child of Any Age for Life.

Clarification of how to identify those might qualify for this benefit

30. Dependency Benefits Payable to Estate of Injured Worker.

Potential constitutional issue on whether legislature has power to direct payment of benefits to estate of deceased worker.

Actuarial Uncertainty

It takes a significant amount of time to accurately estimate changes that occur in the workers' compensation system. The reason for this is that payments associated with workers' compensation claims are often stretched over many years. For example, the WCIRB estimates that less than 21% of the total medical and indemnity costs associated with injuries occurring in 2004 had been paid out as of June 30, 2005. The 79% of costs which had not yet been paid are estimates, and they are subject to changes in inflation, medical cost increases, utilization, loss development, and many other factors.

Our analysis of the historical accuracy of the WCIRB recommended and CDI approved pure premium rates (section VII of this report) highlights an example of actuarial uncertainty. We note that both the WCIRB and CDI underestimated the cost of claims for policies incepting January 1, 1998 through June 30, 2001. We do not believe that this underestimation is in any way a reflection on the WCIRB or CDI. We believe that the underestimation of claims costs was primarily due to changes that were occurring in the workers' compensation system that neither the WCIRB, CDI, workers' compensation research organizations, nor insurers were able to accurately estimate. In other words, dynamic changes within the system introduced a high level of actuarial uncertainty.

The recent reforms have introduced many basic changes to the workers' compensation system, and this again has introduced a great degree of actuarial uncertainty. The impact of some changes, such as the alterations to medical fees or the number of weeks in the PD schedule, can be systematically analyzed. The effects of other changes, such as the repeal of the presumption of correctness of the primary treating physician as well as the introduction of the use of the AMA Guides and ACOEM Guidelines are much more difficult to quantify. Almost all of the research organizations and insurance companies interviewed in connection with this study have stressed to us the current uncertainty of the ultimate impact of the reforms on claims costs. This current uncertainty is based on workers' compensation's long payout pattern. It will take several years for there to be data that is sufficiently mature for the analyses to be more accurate and reliable.

It is important to recognize that each insurance carrier, as part of its own rate setting process, is going to evaluate the reform legislation and make its own determinations on how significant any unresolved issue may be and how certain the carrier is that each individual reform will stand. Their analysis will be one of the factors that influence how far each carrier will be willing to adjust their rates on the basis of the reform legislation alone.

Legislative Uncertainty

The width and breadth of the workers' compensation reforms enacted have had far reaching effects. As a consequence, individuals and organizations that experienced adverse financial impacts from the reforms may seek to roll back or modify the reforms through remedial legislation or through the voter initiative process. Employee advocate groups who feel that the reforms resulted in inappropriate reductions in benefits to injured workers may also seek changes. The 2006 legislative session will likely contain workers' compensation bills that will seek either to make minor adjustments or major revisions to the previous reforms. Three voter initiatives have already been filed with the Secretary of State to be placed on the November 2006 ballot, each one proposing major changes to the workers' compensation system and elimination of various aspects of the previous reforms.

Employers, employer groups, and insurers may be supportive of the new utilization guidelines, apportionment by causation, and fee schedules, there are others who oppose these same reforms. As a result, there is substantial uncertainty as to whether some of the basic provisions in the reforms will remain in place. This uncertainty impacts estimated cost savings due to reforms and insurance market competition, both of which are analyzed in this study.

Chapter 1 Endnotes

- ¹ Commission on Health and Safety and Workers' Compensation; Background Paper Workers' Compensation Insurance Industry in California, April 2002, page 3
- ² 1992 Rate Study Commission Report; page I-1.0-1
- ³ 1992 Rate Study Commission Report; page I-i
- ⁴ 1992 Rate Study Commission Report, page I-1.0-7
- ⁵ 1992 Rate Study Commission Report, page I-I to I-iii
- ⁶ 1992 Rate Study Commission Report, page II to I-iii
- ⁷ 1992 Rate Study Commission Report, page I-iii
- ⁸ 1992 Rate Study Commission Report, page I-1.0-3
- ⁹ 1992 Rate Study Commission Report, page I-1.0-4
- ¹⁰ 1992 Rate Study Commission Report, page I-1.0-4
- ¹¹ 1992 Rate Study Commission Report, page I-1.0-6
- ¹² 1992 Rate Study Commission Report, page I-1.0-7
- ¹³ 1992 Rate Study Commission Report, page I-1.0-8 to I-1.0-10
- ¹⁴ Commission on Health, Safety and Workers' Compensation; April 2002, page 3-5
- ¹⁵ Commission on Health, Safety and Workers' Compensation; April 2002, page 6-8
- ¹⁶ Commission on Health, Safety and Workers' Compensation; April 2002, page 8-10
- ¹⁷ Hays Companies; Study of the California Workers' Compensation Insurance Market, September 2003
- ¹⁸ Hays Companies; September 2003, page 5
- ¹⁹ Hays Companies; September 2003, page 6-7
- ²⁰ Hays Companies; September 2003, page 47
- ²¹ Hays Companies; September 2003, page 48-49
- ²² Hays Companies; September 2003, page 49-50
- ²³ Hays Companies; September 2003, page 51
- ²⁴ NCCI Annual Statistical Bulletin; 2003, page 326
- ²⁵ Hays Companies; September 2003, page 52-53
- ²⁶ Hays Companies; September 2003, page 52-53
- ²⁷ Hays Companies; September 2003, page 7-8
- ²⁸ California State Auditor; California Workers' Compensation System Audit Report; 2003-108.1, August 2003
- ²⁹ California State Auditor; August 2003, page 3
- ³⁰ Commission on Health, Safety and Workers' Compensation; SB 899 Topic Summary Report, 2004, 9 pages