January 8, 2013

Fact Sheet: Senate Bill 863

On September 18, 2012, Governor Jerry Brown signed a package of legislative reforms (SB 863 – De Leon) designed to increase benefits paid to injured workers while improving operation of the state's $16 billion workers' compensation system. According to the Workers' Compensation Insurance Rating Bureau (WCIRB), the proposal will result in increased Permanent Disability (PD) benefit costs of approximately $1.2 billion, but includes provisions that will reduce costs by up to $1.7 billion, resulting in a projected "net" savings to California employers of $520 million – or 2.7% in system-wide savings.

California's workers' compensation system is among the most expensive of U.S. states. The average cost per claim increased by 43% since 2005 to a record-high $66,922 in 2011. Aggregate system costs increased $1.4 billion just between 2010 and 2011, and system costs are projected to reach $19 billion in 2013. Insurance Commissioner Dave Jones has advised workers' compensation insurers to increase average pure premium rates by 2.8% to pay for higher projected claims costs in 2013, even after accounting for savings from SB 863.

California officials estimate that there is up to 30% of accumulated cost increases that have not been passed on to employers in the form of higher premiums to date, and insurers report losing $1 billion last year on workers' compensation policies. As such, estimated cost savings generated may offset the cost of the benefit increases contained in the bill and some portion of future projected cost increases rather than reverse the trend of increasing costs. Realizing these cost savings will depend, however, on timely implementation of various provisions through regulations by the Division of Workers' Compensation and key provisions of the bill being able to withstand legal challenges.

1. Increases Permanent Disability (PD) Benefits

PD benefits are designed to replace a portion of wages an injured worker will lose over time as a result of permanent disability. The proportion of injured workers' lost wages being replaced by PD benefits declined after the passage of SB 899 in 2004 and the rating schedule had not been updated since it was adopted in 2005, although the law required an update in 2009. SB 863 increases the weekly minimum and maximum PD rates for injuries occurring after January 1, 2013 and provides a second increase for injuries occurring after January 1, 2014. The weekly minimum rate will increase from $230 to $290 and the maximum weekly rate will increase from a current high of $405 to $435.[1] The bill would also create a $120 million fund to provide supplemental payments to injured workers whose PD benefit payments are disproportionately low compared to their earnings losses.

2. Streamlines the Formula for PD Ratings

In adopting SB 899 in 2004, the California Legislature declared that the Permanent Disability Rating Schedule (PDRS) should promote consistency, objectivity and predictability.

[1] Total benefits are arrived at by multiplying these figures by a number of "weeks" provided for each percentage point of an injured workers disability under the Permanent Disability Rating Schedule.

Since the adoption of the 2005 PDRS, court rulings (*Almaraz-Guzman* and *Ogilvie*) have made ratings less objective and predictable and increased litigation over the component rating "factors," which drives additional costs. SB 863 simplifies the PDRS by deleting one of these factors (Diminished Future Earning Capacity), which will eliminate legal challenges under the *Ogilvie* standard. In its place, every injured worker will have their rating multiplied by a uniform factor of 1.4, which was the highest multiplier available under the previous DFEC. It would also restrict the addition of secondary conditions, such as sleep, sexual and psychological disorders to the original PD claim and the need for associated testing, which has become an expensive cottage industry in workers' compensation. These disorders will continue to be entitled to medical treatment, and benefits may be awarded for psychological disorders that result from a catastrophic injury or violent workplace event. SB 863 also eliminates the current process for increasing or decreasing PD payments by 15% depending on whether an offer to return to work is made to the injured worker, a provision that has been difficult to administer and resulted in increased litigation costs since its adoption in 2004.

3. Speeds and Improves Medical Dispute Resolution

Resolving medical disputes in California's workers' compensation system is inefficient and costly, typically requiring adjudication from an administrative law judge who is not required to have any medical training or background. Injured workers, meanwhile, are forced to wait much too long to receive an examination from an Agreed Medical Evaluator or Qualified Medical Evaluator. SB 863 replaces the current process with an "Independent Medical Review" unit overseen by the Division of Workers' Compensation (DWC). The unit will be staffed by medical professionals who will issue decisions within 30 days based on the existing medical reports and evidence-based medicine. The bill will also eliminate the current process for seeking second opinions for spinal surgery.

4. Reduces and Resolves Medical Billing Disputes

Treatment provided without authorization or without a controlling fee schedule gives rise to disputes between medical providers and payors and results in liens filed with the Workers' Compensation Appeals Board. Liens over medical payments are estimated to cost employers hundreds of millions of dollars annually and command an increasing proportion of judge's time in place of resolving issues for injured workers. The proposal would require payors to provide an "Explanation of Review" with payment to providers to explain differences between the charged amounts and paid amounts. Providers would still be able to appeal payment, but within a limited amount of time to prevent "zombie liens." The proposal would also establish an "Independent Bill Review" unit within the Division of Workers' Compensation to resolve payment disputes.

When liens are filed, the proposal would require that they be accompanied by a $150 filing fee and be filed within 18 months of service, as well as other requirements.

The proposal would establish new rates for medical treatment reimbursement by adopting Medicare's Resource-Based Relative Value Scale, as well as the Medicare reimbursement rate for outpatient surgery centers. It also directs the DWC establish fee schedules for services that frequently become the subject of liens and disputes, including copy, translation and home health care services.

5. Enhances Performance of Medical Provider Networks

The ability of Medical Provider Networks (MPN) to treat injured workers according to evidence-based medicine guidelines has been eroded in recent years. Attorneys frequently direct their clients out of the MPNs to doctors who provide unauthorized treatment without the employer's knowledge, but at the employer's expense. Certain requirements for certifying MPNs, meanwhile, increase administrative costs without providing better treatment for injured workers. The proposal would allow employers to receive an expedited hearing (14 days) when challenging treatment outside the MPN and hold that an employer is not liable for non-MPN treatment or its consequences prior to Independent Medical Review or when an injured worker is not entitled to treat outside the MPN. It would also limit the role of medical reports from non-MPN doctors (*i.e.* self-procured) in making determinations over disability awards and make it more difficult for attorneys to invalidate MPNs for non-substantive, technical reasons. It also eliminates current administrative requirements that MPNs contain a certain percentage of non-occupational doctors and that the same MPN be repeatedly certified by the DWC.

To help injured workers locate medical providers within MPNs and schedule appointments the proposal would require MPNs to establish a "Medical Access Assistance" program.

6. Addresses Other Cost-Drivers and Areas of Abuse

The proposal would enact a series of other changes designed to curb perceived abuses, such as double billing for spinal surgery hardware and ownership of ancillary services, such as attorneys with ownership interest in copy service vendors. It would also address the number of locations a QME can claim to have an office (limit to 10 locations) and clarify when the services of a QME or AME can be requested by either party.