Workers Compensation Update: October 2012

Market Update

- **Rate increase initially recommended … final decision is NO change!**

  In August 2012, the WCIRB recommended a **12.6%** pure premium rate increase for 1/1/2013 (as compared to 7/1/2012 rates). After SB 863 was approved (see below) and review of insurer experience through 6/30/12, the WCIRB indicated a **9.3%** rate increase would be appropriate.

  Based on the uncertainty of the reform estimates, the bureau decided to push aside the poor recent experience and their own reform estimates to file rates consistent with 7/1/2012 (i.e. **No *industry* rate change)**.

  - Note that rates by class are NOT consistent with July 2012, only rates at the *industry* level are consistent.
  - Why go through all the effort to calculate reform impacts if you are not going to use them? Politics, pure and simple.

  What does the future look like for rates?

  Very uncertain. Not only do disagreements on cost estimates exist, but certain reform measures need to be implemented by numerous parties and their impacts quantified.

  For the most part, insurance companies have stated that they expect costs to *increase* due to the reform, not decrease.

  We agree and expect to see premiums continue to increase in 2013, most likely upper single digits for the industry.

Updated Results

- **Medical Costs**

  Since 2005, average medical costs have increased over **48.4%**. Medical inflation has stabilized since 2009, with only modest increases in the last few years. Note that the WCIRB view of these costs has changed dramatically with each evaluation: the trends continue to get worse as the data develops over time. See graphs on the last page for detail.

- **Combined Ratio**

  The 2011 ultimate accident year combined ratio is estimated at **136%**. The combined ratio shows **6 percentage points** of deterioration since the last evaluation period (3 months ago!). We continue to expect further deterioration as results become more mature. See graphs on the last page for detail.

Reform Impact Summary

SB 863 was passed on August 31st, 2012. The bill is intended to increase benefits to injured workers phased in over a two year period (2013 – 2014). To counter the increase in benefits, several system adjustments were made with the intention of off-setting the benefit increases.

Our belief is that these adjustments will **NOT** offset the benefit increases and the overall cost for the system will increase, as shown below.

CA WC SB 863 Reform Summary			
Numbers in millions			
Reforms	**WCIRB (2013)***	**WCIRB (2014+)***	**Aon (2014+)**
Upward Changes to PD (Min/Max&AMA Mod)	510		
Downward changes to PD (Drop of Add-on's)	(170)		
Three Tiered Weekly PD Rates	(100)		
PD Revisions	**240**	**810**	**982**
Liens	(480)		(356)
IMR	(370)		(86)
Surgical Implant & ASC Fees	(190)		(132)
MPN	(190)		(57)
Ogilvie overlap	(210)		-
Total Savings	**(1,440)**	**(1,440)**	**(631)**
Total Industry Dollar Impact	**(1,200)**	**(630)**	**351**
Industry Loss & Loss Expense	19,000	19,000	16,011
Total Industry Percent Impact	-6.3%	-3.3%	2.2%

* Data from WCIRB Amended Jan 1, 2013 Pure Premium Rate Filing

We expect the permanent disability rates to *increase* higher than the WCIRB estimate, due to optimistic assumptions on the add-ons and greater utilization due to higher benefits. We also see optimistic assumptions on the Liens, IMR and MPN assumptions.

Our reasons why we view the WCIRB reform assumptions as too optimistic:

- Higher benefits mean greater utilization; the WCIRB uses a historical linear relationship to estimate this impact. We view the relationship as non-linear, and therefore believe the impact will be greater in our current economic climate.
- The impact of the add-on's assumes that no new add-on's are discovered. We find that very unlikely; as new add-on's will be found when the old ones are eliminated.
- Lien information ignores current medical reimbursement rates.
- IMR impacts are overly optimistic on future regulatory challenges.
- MPN impacts will not be recognized by most insurance companies.

Reform Change Summary

Below is a listing of significant changes in SB 863.

Strengthens Medical Provider Networks (MPN):

- Eliminates the requirement that a Medical Provider Network (MPN) have non-occupational medicine specialists constitute at least 25% of the physicians in the network.
- Requires an MPN to obtain a written acknowledgement from a physician that the physician agrees to be in the MPN.
- Requires all MPNs to have a "medical access assistant" staff person or persons, who need not be employees, but who must be located within the United States, to aid injured workers in obtaining appointments or referrals within the MPN.
- Limits the reasons that can be used to avoid obtaining treatment within an MPN, and establishes an expedited process to resolve any disputes about whether the injured worker is required to be treated within the MPN.
- Requires a physician who knows or should know that the patient is suffering from an occupational injury to notify the employer within 5 days that the injured worker is being treated outside the MPN, and prohibits payment by an employer or insurer for any treatment provided to the injured worker when the notice requirements have not been met.

Develop and Implement an Independent Medical Review process:

- Implements an Independent Medical Review (IMR) process, similar to what is found at the Department of Managed Health Care (DMHC), in order to provide independent medical review by doctors for health care disputes.
- Allows the employee to appeal a Utilization Review (UR) decision by requesting an IMR either immediately after the UR decision or after getting a second utilization review with addition information.
- Eliminates the Workers' Compensation Appeals Board's (WCAB) authority to adjudicate medical treatment disputes that are directed to the IMR process.
- Provides a timeline for approval of treatment after utilization review of 2-3 months, rather than the current judicial timelines which can take in excess of a year.
- Establishes a hierarchy of standards that are to be applied by IMR, with the Medical Treatment Utilization Schedule adopted by the Administrative Director as the highest source for evaluating the appropriateness of medical treatment, followed by the same ranked standards that apply to HMOs under the Knox-Keene Act.
- Makes the results of the IMR process binding on all parties, absent clear and convincing evidence of fraud or conflict of interest.
- Establishes penalties in the event an employer fails to notify an injured worker of his or her right to IMR, or fails to implement a decision by IMR favorable to the injured worker.

Develop and Implement an Independent Bill Review process:

- Establishes an Independent Bill Review (IBR) process to take medical billing disagreements under rules similar to the IMR process, limiting the need for liens filing.

- Provides for the AD to contract with qualified organizations to implement the IBR functions, subject to detailed conflict of interest rules and substantive responsibilities, as specified.

Workers' Compensation Medical Lien Reform:

- Prohibits the filing of a lien against an award for matters that is subject to IMR and IBR dispute resolution.

- Establishes a $150 filing fee in order to file a lien, recoverable if the lien claimant prevails.

- Establishes a $100 activation fee for legacy liens (unless the lien was previously subject to a $100 filing fee), recoverable if the lien claimant prevails.

- Adopts a statute of limitation within which liens must be filed.

Fee Schedules:

- Requires the AD to adopt a medical fee schedule methodology based on Medicare's Resource-Based Relative Value Scale (RBRVS) system, with specified modifications for California's workers' compensation system, including geographic adjustments.

- Adopts a fee schedule for Ambulatory Surgery Centers (ASC).

- Prohibits payment for home care services where the services were already being provided prior to injury, authorizes the AD to adopt a home care services utilization and fee schedule, and limits the re-opening of old cases where home care services are alleged to have been provided but were not authorized or ordered by a physician before the services were rendered.

- Authorizes the AD to adopt a fee schedule for copying services, interpreter services, vocational experts, and establishes substantive rules to govern these services.

Medical Care Reforms:

- Eliminates the pass-through for implantable surgical hardware.

- Repeals the requirement that a second opinion be obtained in cases of spinal surgery, and instead would resolve questions of appropriateness of spinal surgery in the IMR process.

- Streamlines the Agreed Medical Evaluator (AME) and Qualified Medical Evaluator (QME) process.

- Limits Chiropractic QMEs to individuals who are doctors of chiropractic and certified in California workers' compensation evaluation by a provider recognized by the administrative director.

- Provides that a chiropractor who has reached the 24-visit cap cannot serve as the injured worker's primary treating physician.

- Clarifies that an insurer or employer can pay for physical medicine treatments in excess of the 24-visit cap without that payment constituting a blanket waiver of the cap.

Permanent Disability:

- Increases aggregate Permanent Disability (PD) benefits by approximately $740 million per year, phased in over a two-year period, and adjusts the formula for calculating the benefit amount so that compensation amounts more accurately reflect loss of future earnings, and to ensure that no class of injured workers receive a lower award than under the present system.

- Eliminates sleep disorder and sexual dysfunction "add-ons" to primary injuries that do not include these injuries when calculating the level of Permanent Disability, but requires all appropriate medical treatment for these injuries.

- Limits psychological add-ons when calculating a PD rating to cases involving catastrophic injury or that involved a violent workplace incident, but requires all appropriate medical treatment for psychological injuries.

- Eliminates the diminished future earnings capacity (DFEC) from the determination of permanent disability, and instead provides that all permanent disability awards are increased by a multiplier of 1.4 for the loss of future earnings, comparable to the top available DFEC modifier.

- Limits the definition of permanent disability to include only a consideration of how occupation affects the overall classification of employment of the injured worker, rather than the individual injured worker's ability to compete in the open labor market or reduction of future earnings.

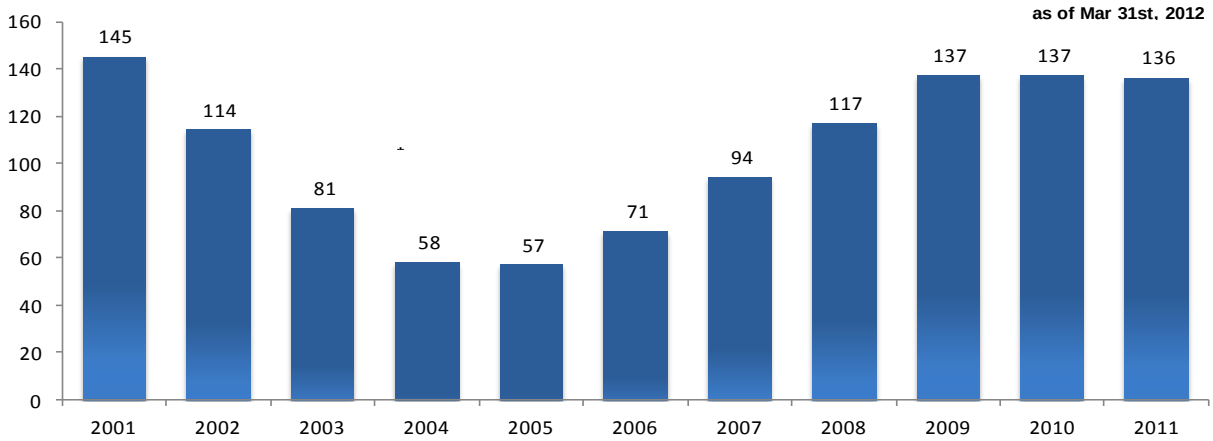
Return to Work:

- Creates a $120 million return-to-work program annually derived from the Workers' Compensation Administration Revolving Fund for making supplemental payments to workers whose permanent disability benefits are disproportionately low in comparison to their earnings loss. This approach was adopted in lieu of the "bump up" provisions in prior bill.

- Requires the Commission on Health and Safety and Workers' Compensation to conduct a study comparing average loss of earnings for employees who sustained work-related injuries with permanent disability ratings under the permanent disability rating schedule and evaluate the impact of increased payments made pursuant to the "bump up" provisions, and report to the Legislature before January 1, 2016.

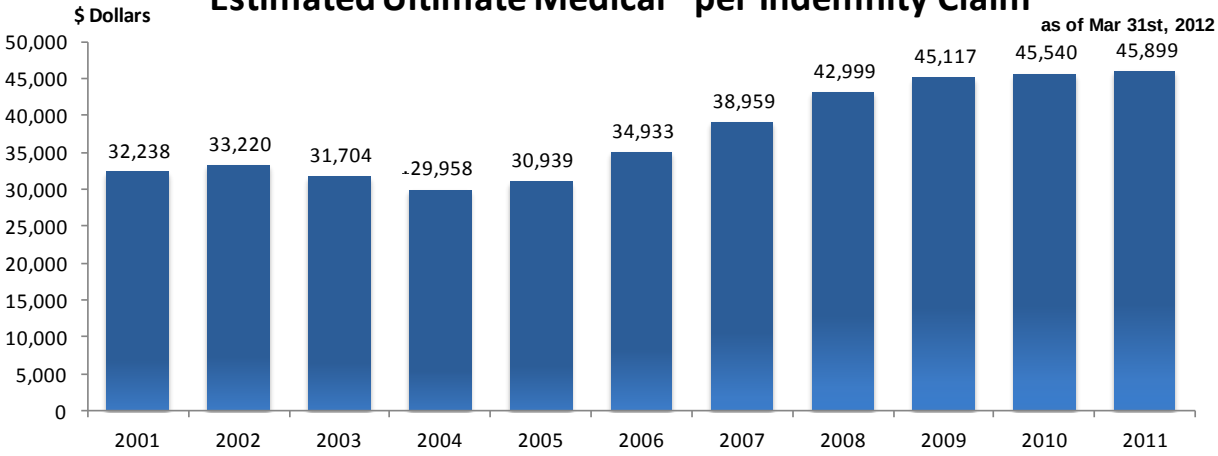
- Requires the Director to adopt regulations to establish eligibility for these payments, based on studies conducted by the Director in consultation with the Commission on Health and Safety and Workers' Compensation (CHSWC).

Accident Year Combined Loss and Expense Ratios



Information provided by the WCIRB of California and Reflects OAG adjustments

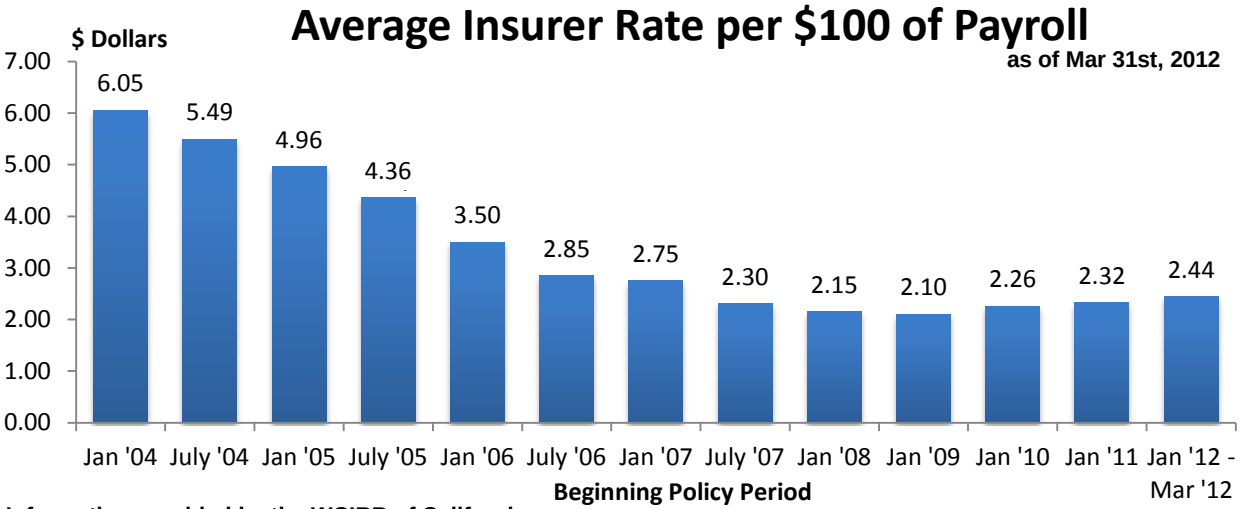
Estimated Ultimate Medical* per Indemnity Claim



Information provided by the WCIRB of California

* Excludes Medical Only, Includes OAG Adjustments

Average Insurer Rate per $100 of Payroll



Information provided by the WCIRB of California

Learn More

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