Protecting Reforms Can Maintain System Balance, Provide Timely Benefits, Minimize Employer Costs

Background

Created in 1913, the California workers' compensation system constitutionally guarantees workers the right to compensation for workplace injuries, including coverage of medical treatment required to "cure and relieve" the injury. When injured workers are unable to work or suffer severe injuries, they also may receive indemnity benefits in the form of temporary or permanent disability payments.

Over the last 25 years, California's workers' compensation system has been in a cyclical state of reform and re-reform. In the late 1990s, the system began to experience massive cost increases. These increases resulted from overutilization of medical services, higher-than-normal indemnity benefit costs, and increased litigation. At the height of the workers' compensation crisis in 2003, employers faced double-digit insurance premium increases, resulting in California having the most expensive workers' compensation premiums in the nation.

In the 2002–2004 legislative sessions, broad reforms were presented to reduce medical care and indemnity benefit costs in the system. The reforms focused on delivery management and treatment cost containment while also ensuring appropriate delivery of quality care. These reforms proved successful and, for the next few years, medical costs and costs per claim declined sharply. This decline was reflected in employers' insurance rates, which dropped by more than 60%, according to the Workers' Compensation Insurance Rating Bureau (WCIRB).

This trend began to reverse in 2008 when system costs started rising once again. Data from the Commission on Health and Safety and Workers' Compensation (CHSWC) revealed that the average cost per indemnity claim was much higher than before implementation of the 2003 reforms. Specifically, costs per claim increased 43% from the post-reform low in 2005 and were up approximately 14% from the pre-reform all-time high in 2003.

In addition, overall system costs rose by almost $1 billion per year, making California the third most costly workers' compensation system in the nation, according to the biennial national study conducted by the Oregon Department of Consumer and Business Services. Numerous cost drivers throughout the system share responsibility for these increasing costs. Not only had savings from the 2004 reforms been diluted or undercut by incomplete implementation, judicial activism, and exploitation by system vendors, but medical and frictional costs (such as litigation) also had increased since 2005.

As system costs trended up, so did insurance premiums. According to the WCIRB, workers' compensation insurance rates have climbed every year since 2009 due to rising claims costs. The average rates filed with the Department of Insurance increased by 19% between January 2009 and January 2010, and by 3% between January 2010 and June 2011 when the estimated rate per $100 of payroll was $2.37. The rise in claims costs also had an impact on employers that self-insure. The California Workers' Compensation Action Network estimated that between 2005 and 2011, the claims costs for public entities that self-insure increased by 32%—even though the number of claims remained essentially unchanged.

The post-2004 reform issues within California's workers' compensation system were not limited to employers as many injured workers were receiving inadequate permanent disability benefits. These benefits were reduced during the prior round of reform in response to higher-than-normal costs. As part of the 2004 reform deal, however, these benefit reductions were to be re-evaluated and adjusted within five years. This evaluation never occurred and the gap between injured workers' wage loss and the benefits they received in permanent disability payments widened. All system stakeholders acknowledged that permanent disability benefits needed proper augmentation.

2012: Balanced Reform

In September 2012, Governor Edmund G. Brown Jr. signed into law a workers' compensation reform package negotiated by employers and labor that sought to address both system costs and permanent disability benefits. The goal of this reform legislation was to offset an increase in permanent disability benefits with cost-saving proposals. On paper, SB 863 (de León; D-Los Angeles, Chapter 363, Statutes of 2012) struck this balance. It increased benefits to injured workers through direct increases in permanent disability benefits and through the creation of a $120 million fund for injured workers whose permanent disability award inadequately reflects wage loss. The total level of increase was estimated at just under $1 billion a year. These benefit increases were projected to be offset by reforms that should reduce frictional costs, decrease litigation, stem abuses by vendors within the system, speed up the claims administration process, and make delivery of benefits more efficient.

Challenges Remain Despite Positive Trends for Reform Savings

The most recent analysis of the reforms brings cautious optimism for employers. Overall, the 2016 WCIRB Cost Monitoring Report (Report) now projects $1.3 billion in yearly net system savings—a 7% total reduction in system costs and a 3% increase in savings over the 2015 projections. Initially, when SB 863 was passed, WCIRB projected 1% in savings and that projection matched the 2014 Report. The jump in system savings over the last two years is largely attributed to a decrease in medical costs, which were not initially "priced" by the WCIRB because too many variables and unknowns existed about regulatory implementation when SB 863 passed.

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The medical savings broke down into two areas: reduced medical costs; and reduced use of medical services. Together, these reductions resulted in approximately $1.3 billion in yearly system savings. While the Report determined that it is impossible to isolate the specific effect of any individual reform component of this savings, together they "have had a significant impact" on medical costs.

Although this is encouraging news, it is important to note that the system experienced significant medical cost savings after the 2004 reforms and soon saw those savings replaced by significant inflation as stakeholders adjusted to the new cost containment laws and courts issued rulings altering the initial intent of the laws. Additionally, medical cost inflation is down countrywide and this phenomenon is not expected to continue. In short, the history of medical savings is tenuous and likely cannot be exclusively relied upon for long-term structural savings.

The Report illuminated two other broad positive system trends beyond a reduction in medical costs:

• First, **lien reforms continue to match expectations**. The filing fees and statute of limitations have reduced lien filing by 34% compared to 2011 levels and are on pace to hit the estimated $480 million in system savings. This positive news is bolstered by the dismissal of constitutional challenges to the new lien laws (discussed below).

One note of caution on lien savings, however, is the uptick in liens filed throughout 2015 and the beginning of 2016. Some of the increased filings can be attributed to the statute of limitations, which drove lien filings at the deadlines during the time period. Additionally, loopholes were found in some of the lien rules and there was some change in vendor behavior. A bill introduced and signed in 2016— SB 1160 (Mendoza; D-Artesia)—should address some of these issues (discussed below).

• Second, the **cost side of the reforms is currently on track to meet expectations** after concerns that the initial projection had underestimated the number of indemnity claims—claims where injured workers receive disability benefit payments. At the beginning of 2014, the increase in indemnity claims outpaced the initial estimate which, coupled with the increase in amount of benefits per claim provided by the reforms, threatened to unbalance the reform. New WCIRB estimates now show indemnity claim frequency stabilizing and costs from the benefit increases meeting projections.

It is not all positive news, however. Concerns still exist over the long-term stability of the savings, which were initially premised on a reduction in system friction. Most alarming has been the performance of Independent Medical Review (IMR)—a cost-saving anchor of the reform. The purpose of IMR is to resolve medical disputes in a timely manner, reducing the timeframe for dispute resolution from up to a year down to 30 days. In doing so, frictional savings are derived from a reduction in lien costs, medical-legal reports, expedited hearings, temporary disability duration, and litigation costs. The Report found that IMR has had no effect in reducing costs associated with any of these areas and, in fact, IMR has actually created $70 million in new system costs. These costs are due primarily to unexpected IMR volume—more than three times initial projections.

Most stakeholders believe that achieving long-term structural savings requires reducing frictional costs which, by extension, requires a well-functioning IMR process. It is important to keep this in mind as system stakeholders, regulators and policymakers continue to identify, evaluate and address IMR process issues. Reform history suggests it is unlikely that medical savings alone can continue to mitigate the increased IMR costs and the costs associated with increased benefit levels.

Insurance Rates Stabilize But System Remains Most Expensive

The initial reform savings have been accompanied by stabilization of the workers' compensation insurance rates. California Insurance Commissioner Dave Jones recently issued a recommended 13.8% rate reduction, which comes on the heels of a 10.5% reduction earlier in 2016.

Although the Insurance Commissioner's rate is purely advisory, it reflects the trends of insurance rates actually paid by employers, which have largely stabilized or slightly decreased. It is important to note that there are a number of factors that go into determining insurance rates. Both the Insurance Commissioner and the WCIRB, however, attributed much of the rate stabilization to the initial reform savings.

It also should be noted that both the advisory rate and the rates paid by employers are aggregate numbers that represent a snapshot of the system as a whole. There still remain certain industries and geographical regions where employers continue to see rates increase.

In contrast to the news on insurance rates, California employers continue to pay for the most expensive workers' compensation system in the country. The Oregon Department of Business and Consumer Services released its biennial national study that compares each state's workers' compensation costs. The study revealed that California remained in the top spot with employers paying 176% more in workers' compensation costs than the national median and 18 percentage points more than the second most expensive state (New Jersey). Despite California remaining the most expensive state, there were some marginal improvements compared to the 2014 report: a 12 percentage point decrease in cost compared to the median. Some of this decrease can be attributed to reform savings.

Legal Attacks on Reforms Continue

Four years after the reform, a number of legal challenges have made it through to the Workers' Compensation Appeals Board (WCAB) and the Court of Appeals. These challenges align with the historical trends: opponents undertake legal and legislative efforts to undercut, dilute, and completely unravel the reforms.

California Workers' Compensation Costs Compared to Other States, National Median

Year	2000	2002	2004	2006	2008	2010	2012	2014	2016
Rank by Most Expensive	3	1	1	2	13	5	3	1	1
% of National Median	148%	216%	236%	166%	121%	131%	155%	188%	176%

Source: Oregon Department of Consumer and Business Services, *2016 Oregon Workers' Compensation Premium Rate Ranking Summary* (October 2016).

Lien Litigation

In 2015, the Ninth Circuit Court of Appeals issued the first major decision on the constitutionality of the reforms. *Angelotti Chiropractic v. Baker (Angelotti)* involved a challenge to lien activation fees put in place by the Legislature to reduce the number of frivolous liens filed with the WCAB.

Before 2012, the high volume of liens created significant strain on the workers' compensation system—reducing injured workers' access to the courts and costing employers hundreds of millions of dollars in administrative and settlement costs. In response, the Legislature created lien filing fees as part of the reform. Specifically, SB 863 contained two types of filing fees: a $100 fee on all liens filed after SB 863 took effect; and a $150 "activation fee" on all existing liens filed before the law took effect. The goal of these fees was to discourage the filing of liens that lacked merit in order to reduce the backlog. To date, this policy change has proven successful.

A group of providers challenged the constitutionality of the "activation fee" in federal court on the grounds that it violated the takings clause, the due process clause and the equal protection clause of the U.S. Constitution. The district court dismissed the takings and due process claims. But it found that plaintiffs had established a probability of prevailing on the equal protection claim on the grounds that there was no rational basis for the Legislature exempting large institutional lien holders from the filing fee. The district court issued a temporary injunction that prohibited the Department of Industrial Relations from enforcing the lien activation fee and/or dismissing the liens.

This decision was appealed to the Ninth Circuit Court of Appeals, which reversed the district court's ruling on the equal protection clause, vacated the injunction, and, in an unusual step, dismissed the equal protection claim. The appellate court found that the filing fees were constitutional because the Legislature had a rational basis to create filing fee exemptions—the fees were targeted on lien holders that most frequently file liens.

Angelotti was a resounding win for employers. First, as a practical effect, the "activation fee" was reinstated—lien holders had to pay the fee by December 31, 2015 or their lien was dismissed by operation of law. Many lien holders had awaited the resolution of the *Angelotti* case before either paying the fee or resolving the lien. Reinstating the lien fee should continue to clear the backlog of liens in the system. Second, *Angelotti* likely will serve as precedent for other challenges to the lien reform statutes. Other pending cases challenge these statutes and more may be filed in the future. *Angelotti* provides employers a level of certainty that the lien filing fees are constitutional and that savings derived from these laws will not be undermined.

Independent Medical Review Litigation

There also have been a number of constitutional challenges to the IMR process. In *Stevens v. Workers' Compensation Appeals Board (Stevens)*, the petitioner contended that the process violated the California Constitution's separation of powers clause, due process principles, and Article XIV, Section 4 requirements (Section 4) that the workers' compensation system allow for review of decisions and "accomplish substantial justice," as well as the U.S. Constitution's due process rights. The *Stevens* court rejected the state constitutional claims, finding that the plenary powers vested in the Legislature by the Constitution to create and enforce the entire workers' compensation system superseded the separation of powers and due process clauses, and that the IMR process does not conflict with Section 4.

The court also found that the IMR process did not violate federal due process rights. In its analysis rejecting this claim, however, the court may have opened the door to increased WCAB review of medical decisions. Amongst other arguments rejected by the court, petitioners contended that the IMR process did not allow for meaningful appeal of medical treatment decisions. The court countered that there were sufficient avenues of review under the IMR statutes. Specifically, the court cited the section of the Labor Code that allows the WCAB to determine whether the Administrative Director acted outside of his or her authority or whether the IMR determination was plainly erroneous. In interpreting these sections of the Labor Code, the court determined that the WCAB has "considerable" grounds to review IMR determinations and could evaluate whether a medical treatment request was permitted by the Medical Treatment Utilization Schedule (MTUS).

The Legislature designed the IMR process to increase efficiency for treatment disputes and to ensure physicians, not judges, make medical decisions. The language used by the *Stevens* court may have undermined these goals by broadening the WCAB's authority to review IMR determinations and substitute its judgment for the physician's. But this is not completely clear. The court also stated that the WCAB could review only decisions based on plainly erroneous facts that were not a matter of expert opinion. Presumably, nearly all decisions regarding the MTUS would necessitate an expert opinion, meaning that the WCAB's review of the IMR process may remain limited.

Overall, the *Stevens* decision cuts both ways for employers.

On one hand, the court found the IMR process constitutional, which is encouraging news. On the other hand, the language in the case will likely encourage more IMR appeals, thereby increasing system litigation and costs. *Stevens* will not be the last word on IMR's constitutionality as a number of challenges are pending in other districts. Workers' compensation legal experts believe that these issues will be decided eventually by the California Supreme Court, which declined to review the *Stevens* decision early in 2016.

2016 Legislative Activity

In 2016 the Legislature passed the most significant workers' compensation legislation since the 2012 reforms—SB 1160 (Mendoza; D-Artesia; Chapter 868). This legislation primarily modified the treatment dispute process by placing new limitations on utilization review (UR). It also implemented "clean-up" to the SB 863 lien reforms.

UR was created as part of the 2003/2004 reforms to reduce the unnecessary, ineffective, and often dangerous treatment in the system. UR requires providers to use nationally recognized, evidence-based treatment guidelines and permits employers to review treatment requests to ensure they comply with guidelines.

SB 1160 was driven largely by labor organizations to reduce frequency of UR. They have repeatedly argued that employers conduct too much UR, resulting in delayed treatment for injured workers and increased frictional cost in the system.

SB 1160 reduces frequency by barring UR for the first 30 days of an injury. There are exceptions to the "no UR" rule, including treatment requests for surgery, some medications such as opioids, diagnostic testing and expensive durable medical equipment. Also, employers can conduct retrospective UR, allowing them to review treatment requests during the first 30 days and determine whether there is a "pattern and practice" of a physician failing to render treatment pursuant to the state-developed standards. If this determination is made, employers can revoke the "no UR" rule with respect to that physician or remove the physician from their Medical Provider Network.

The policy underpinning this legislation was to adopt employer and insurer "best practices" for claims handling and statutorily apply them systemwide in order to increase speed of care and reduce system costs.

Employers remain skeptical, however, about this legislation and the existence of a UR problem. System data does not support organized labor's claims that UR has any large-scale deficiencies. The most recent reports reveal that when employers' UR decisions are appealed to the Division of Workers' Compensation (DWC), 9 out of 10 are upheld. This demonstrates that the issue is not UR frequency, but rather a failure by many physicians in the system to prescribe evidence-based treatment. When physicians miss the mark on the treatment standards developed by the state, employers are forced to engage in the UR process in order to ensure safe and effective care.

Despite the skepticism and lack of data demonstrating an issue, most employers and insurer organizations did not oppose SB 1160 because minimal UR is conducted in the first 30 days of a claim—system data reveals it is a little as 2% of all UR. Physicians generally request conservative care during this period and these are not the type of complex treatment requests that create appropriateness debates or pose risks to injured workers.

SB 1160 also provided millions of dollars of system cost savings through additional lien reforms. As mentioned above, SB 863 lien reforms continue to outpace initial saving projections. There were troubling signs, however, that these savings were beginning to erode due to unintended loopholes and alterations in vendor behavior leading to lien abuse. SB 1160 addressed this by creating additional lien filing requirements and fully barring the assignment of liens.

Combining the lien savings with the minimal restriction on the UR process kept employers and insurers (and the California Chamber of Commerce) from opposing SB 1160. It is expected, however, that legislative efforts will continue in the future to undercut or eliminate UR. Indeed, on the first day of the 2017 legislative session, a bill was introduced that would completely ban UR for certain types of claims. It is important to defend against these type of significant UR attacks as it remains a critical system process to ensure safe and effective care.

Other significant legislation introduced in 2016 included:

• **AB 1244 (Gray; D-Merced)** requires the Director of the Department of Health Care Services (DHCS) to notify the DWC when a physician has been suspended from participation in the Medi-Cal program for conviction of a felony, fraud, or patient abuse. Upon notification, AB 1244 requires DWC to promptly suspend the physician from participating in the workers' compensation system in any capacity. This bill was a first step in addressing almost $1 billion statewide in systemic fraud within the workers' compensation system. The CalChamber supported this bill and it was signed into law by the Governor (Chapter 852).

• **AB 1643 (Gonzalez; D-San Diego)** would have required employers to compensate some injuries that occurred outside of the workplace. California's workers' compensation system was designed to cure and relieve industrial injuries or, more simply put, injuries that occur at work. As such, when making permanent disability determinations, physicians may apportion between industrial and nonindustrial causes of the disability. AB 1643 would have eliminated apportionment for certain conditions, thereby expanding workers' compensation beyond industrial injuries. The CalChamber worked with coalition partners to stop this bill and it ultimately was vetoed by the Governor.

• **AB 2230 (Chu; D-San Jose)** would have increased system friction by mandating that injured workers, and not employers, choose an interpreter for medical-treatment appointments, medical-legal evaluations, depositions and mandatory settlement conferences. In doing so, AB 2230 would have effectively eliminated the ability of claims administrators to lower costs and streamline the administrative processes by contracting

for interpreting services. The CalChamber led an opposition coalition of employers and insurers, and the author eventually dropped the interpreter provisions from the bill before it was signed into law (Chapter 314).

• **AB 2407 (Chávez; R-Oceanside)** attempted to effectively roll back the soft caps on physical therapy and chiropractic care for certain types of injuries. Historically, these types of treatment modalities had been widely abused and implementation of the soft caps eliminated much of the abuse. The CalChamber opposed this bill and it failed to move out of the Assembly Insurance Committee.

• **SB 482 (Lara; D-Bell Gardens)** required health care providers to consult the Controlled Substance Utilization Review and Evaluation System (CURES) databases before prescribing a Schedule II, III or IV controlled substance to a patient for the first time, and at least once every four months thereafter if the medication continues to be prescribed. The CalChamber supported this bill in an effort to combat the opioid epidemic in the workers' compensation system. This bill was signed by Governor Brown (Chapter 708).

Looking to the Future

Opioids

Controversy has arisen regarding opioid misuse and abuse by patients suffering from chronic pain within the California workers' compensation system, highlighting the need for reform. This issue is not unique to California or the workers' compensation system as fatal and nonfatal opioid overdoses (the majority resulting from legal prescriptions) have risen dramatically over the last decade throughout the United States. The Prescription Drug Monitoring Program Center for Excellence states that emergency department visits related to the abuse of oxycodone rose 242%, hydrocodone 124%, and all pharmaceuticals 98% over the last several years. Since 2002, the number of opioid prescriptions increased six-fold in California's workers' compensation system.

According to the California Workers' Compensation Institute (CWCI), only 3% of the roughly 10,000 physicians in this system are responsible for just more than half of all Schedule II opioid prescriptions. CWCI noted that injured workers who receive high doses of opioids for injuries (such as back strains) take nearly three times as long to return to work compared to workers with similar injuries who were prescribed low doses. These statistics demonstrate a need to create stronger uniform guidelines for opioid prescriptions. Some of the issues that need to be addressed are:

• Determining under what circumstances it is absolutely necessary to use opioids as treatment;

• Refocusing treatment goals more broadly, rather than using pain reduction as the sole purpose;

• Developing opioid abuse screening tools that explore patient histories of substance abuse, psychiatric conditions, and prolonged disability;

• Committing to a careful process of monitoring a patient using opioids; and

• Planning how to achieve a patient's pain management with minimal opioid use.

California has initiated certain efforts to combat opioid abuse by chronic users through monitoring and regulatory controls. Within the last few years, the state has implemented an online prescription monitoring database as well as regulations released by the Division of Workers' Compensation in its Medical Treatment Utilization Schedule. Legislation was passed in 2015 to provide a constant stream of funding for the CURES database. The state Department of Justice plans to use this new funding to update the database and create CURES 2.0, an integrated approach that combines accurate and easy-to-access information technology with the oversight of medical professionals and the efforts of law enforcement. Also, as discussed above, legislation was passed in 2016 requiring physicians to consult the CURES database before prescribing certain medications.

Another possible tool to address the opioid problem is adopting drug formularies into the California workers' compensation system. Formularies are lists of approved drugs that can be prescribed for different therapeutic categories and are utilized by group health plans, Medicare and workers' compensation systems in other states, primarily to contain pharmaceutical costs. Formularies, however, have also proven effective in restricting opioid access. CWCI examined other states' workers' compensation systems that utilize formularies and found that if California adopted a similar model, there would be a significant restriction in Schedule II opioid prescriptions and a moderate restriction in Schedule III, IV and V opioid prescriptions.

In 2015, the Governor signed legislation that directed the DWC to create a prescription medication formulary for California's workers' compensation system. This is an important first step in developing this tool. The bulk of the formulary, however, will be developed through the regulatory process. The formulary's ability to curb inappropriate opioid prescribing practices will be largely a product of program design through this process. To date, the DWC continues work on the draft regulations that will create the formulary.

Finally, the DWC enacted updates to the *Chronic Pain Medical Treatment Guidelines* and created a separate *Opioids Treatment Guidelines* that will provide treatment protocols for appropriate use of opioids across the workers' compensation system.

Combating the opioid epidemic is a complex and serious problem that will continue to require thoughtful input and effort on both the state and national levels by all system stakeholders, government regulators and the medical community in order to develop a comprehensive solution.

Cumulative Trauma

Both anecdotal and statistical evidence show that the

frequency of cumulative trauma claims has been increasing in California's workers' compensation system in recent years. The nature of cumulative trauma creates difficulties for determining clear eligibility rules and policy surrounding these claims. Because cumulative trauma derives from a "continued event," it is more difficult to evaluate the appropriateness of a claim compared to workers' compensation claims that occur as the result of a "singular event," such as a slip-and-fall accident or an acute injury, such as a broken arm. Thus, it is difficult to delineate the cumulative trauma attributable to the current job, previous jobs, or other outside factors, such as natural aging or nonwork-related activities.

The WCIRB has documented a continued increase in cumulative trauma claims. Since 2005, these claims have increased by more than 50% as a portion of all indemnity claims. The rating bureau reported that in 2012 nearly 40% of cumulative trauma claims were "permanent indemnity injury types," meaning that there was some level of permanent disability payment. In addition, the WCIRB found that increase in cumulative trauma claims is spread across multiple sectors of the economy, including manufacturing, finance and clerical.

These numbers, paired with anecdotes of employees filing cumulative trauma claims post-employment, indicate that a worrisome trend may be emerging in which costs are shifting from the realm of unemployment insurance or retirement benefits to that of workers' compensation. Accordingly, injured workers, insurers and employers must come together to formulate a balanced approach to evaluating the appropriateness of cumulative trauma claims before misuse becomes unmanageable.

CalChamber Position

Workers' compensation costs for California employers must decrease to become more competitive with employer costs in other states. The CalChamber-supported cost-saving reforms were designed to both increase benefits and reduce overall system costs. These reforms must be protected from any attempts to dilute or undercut savings through subsequent legislation or judicial activism. The ultimate goal is a balanced workers' compensation system that efficiently provides timely and fair benefits to injured workers and minimizes administrative and frictional costs to employers.

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