WORKERS' COMPENSATION INSURANCE RATING BUREAU
of California

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WCIRB Preliminary Estimate of the Cost Impact of Assembly Bill 227 and Senate Bill 228 As Adopted by the Legislature September 12, 2003

September 15, 2003

Assembly Bill No. 227 (AB 227) and Senate Bill No. 228 (SB 228), recently passed by the Legislature, involve complex multi-dimensional changes to the Workers' Compensation system in California. The WCIRB is in the process of preparing a formal evaluation of the cost effect of these bills by September 29, 2003. However, in view of the interest expressed in the impact of these bills, a preliminary assessment of those provisions of the bills that are relevant to pure premium rates is provided herein to the extent there is relevant credible information currently available.

Some of the preliminary estimates contained herein may, and are likely to, change as a result of the formal evaluation which will be prepared after the WCIRB (1) convenes a panel of professionals with appropriate expertise to assess the fiscal impact of the provisions contained in the bills, (2) more thoroughly reviews relevant existing research, and (3) performs additional analysis as needed and appropriate.

Medical Cost Provisions

A number of the provisions of AB 227 and SB 228 involve medical costs. The WCIRB currently estimates that the total statewide cost of medical on injuries occurring in 2004 will be $13.8 billion.

1. **Changes to the Official Medical Fee Schedule Values for Physician Services**. Amendments to Section 5307.1(k) provide that calendar year 2004 and 2005 rates for physician services are set at 5% below the current fee schedule, with the exception that the Administrative Director will not reduce a rate for a procedure with a current schedule value below that of Medicare. Amendments to Labor Code Section 5307.1(l) provide that on or after January 1, 2006, the Administrative Director will have the authority to adopt a fee schedule for physician fees. Beginning in 2006 until such time as a schedule is adopted, physician fees will revert to the existing medical fee schedule.

   There are several ambiguities regarding these statutory provisions. Labor Code Section 5307.1(k) is not clear as to how to apply the requirement that no current physician schedule values that are below the Medicare value will be reduced. Also, Labor Code Section 5307.1(l) is not completely clear as to the fee schedule that will apply to physician fees after January 1, 2006. The provisions related to physician fees have been evaluated based on our understanding of the legislative intent that overall physician schedule fees will be 5% less in 2004 and 2005 despite having no decreases for services at levels currently below the Medicare level, and that in 2006 the current fee schedule will apply until such time as the Administrative Director adopts a new physician schedule. If this legislation is ultimately interpreted in another manner, actual costs may vary from our estimates.

   Of the $13.8 billion of medical costs estimated for 2004 injuries, it is estimated that 50%, or $6.9 billion will be paid to physicians for medical treatment. For 2004 and 2005 injuries, it is estimated that a portion (approximately 30% for 2004 and 10% for 2005) will be paid prior to January 1, 2006, and therefore, will be at the lower level. A 5% reduction for physician services provided in 2004 and 2005 corresponds to cost savings of $0.1 billion for 2004 injuries and $35 million for 2005 injuries. There is no cost impact for 2006 and later injuries until such time as the Administrative Director promulgates a new schedule.

   Changes to fee schedules apply to all medical services provided after the effective date of the change, including services on injuries that occurred prior to the effective date of the change. The WCIRB currently estimates that the total statewide cost of unpaid medical losses on injuries that have occurred prior to January 1, 2004 is approximately $40 billion. If the proportion of total

medical costs subject to the aforementioned schedule changes on pre-2004 injuries is the same as estimated on 2004 injuries (an hypothesis that has not yet been evaluated), the total cost of unpaid amounts on pre-2004 injuries is approximately $20 billion for physician services. Of the $20 billion in unpaid physician amounts, we estimate that 22%, or $4.4 billion will be paid in the next two years and will therefore be subject to the 5% reduction. Assuming a 5% reduction from current levels on medical services provided before 2006, and no change in costs on medical services provided after 2006, corresponds to a potential one-time reduction in liabilities for future medical costs on pre-January 1, 2004 injuries of approximately $0.2 billion.

2. **Changes to the Official Medical Fee Schedule for Inpatient Procedures**. Amendments to Labor Codes Section 5307.1(a) also provide that effective January 1, 2004 and until such time as the Administrative Director adopts an official fee schedule in accordance with the structure and rules of the Medicare fee schedule, maximum reasonable fees for inpatient procedures are set at 120% of Medicare. The language in Labor Code Section 5307.1(a) is not clear as to which services are excluded from the schedule. The provisions related to inpatient facilities have been evaluated based on our understanding of the legislative intent that these fees will be set at 120% of the Medicare Schedule. If this legislation is ultimately interpreted in another manner, actual cost impact may vary from our estimates. Of the $13.8 billion of medical costs estimated for 2004 injuries, it is estimated that 12.3%, or $1.7 billion is attributable to hospital inpatient charges. The Commission on Health & Safety and Workers' Compensation (CHSWC) has published information on potential cost impacts of adopted fee schedules based on certain percentage loadings of Medicare.[1] The CHSWC report suggests that moving to 120% of Medicare would increase inpatient costs by 8.1%. This corresponds to additional annual inpatient costs on 2004 injuries of +$0.1 billion. The CHSWC report also indicates that a significant portion of the additional costs will be offset by savings with respect to procedures that are treated as outliers in the current system. The potential cost impact of the provisions related to the treatment of outliers has not yet been evaluated.

   In addition, if the proportion of total medical costs subject to the aforementioned schedule changes on pre-2004 injuries is the same as estimated on 2004 injuries (an hypothesis that has not yet been evaluated), the total cost of unpaid amounts on pre-2004 injuries subject to the inpatient fee schedule is approximately $4.9 billion. As a result, the percentage increases based on the CHSWC study would correspond to potential one-

1 "Workers' Compensation Medical Payment Systems – A Proposal for Simplification and Administrative Efficiency", The California Commission on Health and Safety and Workers' Compensation, April 2003.

time additions in liabilities for future inpatient costs on pre-January 1, 2004 injuries of approximately +$0.4 billion. The CHSWC report also indicates that a significant portion of those additional costs will be offset by savings with respect to procedures that are treated as outliers in the current system. The potential cost impact of the provisions related to the treatment of outliers has not yet been evaluated.

3. **Pharmaceutical Fee Schedule**. Amendments to Labor Code Section 5307.1(a) establish a schedule for pharmaceuticals using the Medi-Cal Schedule. As noted above, the language in Labor Code Section 5307.1(a) is not clear as to which services are excluded from the schedule. The provisions related to pharmaceuticals have been evaluated based on our understanding of the legislative intent that these fees be set at 100% of the Medi-Cal schedule. Additionally, amendments to Labor Code Section 4600.1 provide that any party dispensing medicines dispense a generic drug equivalent, unless no generic drug equivalent is available or the prescribing physician specifically provides that a non-generic drug must be dispensed. (Currently, the requirement to dispense generics is limited to pharmacies.) The WCIRB estimates pharmaceutical costs on 2004 injuries are $0.9 billion. (This estimate reflects reductions in pharmaceutical costs expected to occur as a result of enactment of AB 749.[2]) CHSWC, based on a 2000 study,[3] has indicated that, considered independently, the pharmaceutical fee schedule provisions would result in savings of approximately 37%. If the provisions of AB 227 and SB 228 were to be interpreted independently of the provisions of AB 749, the estimated 37% reduction based on the CHSWC report would correspond to annual savings of approximately $400 million. However, the WCIRB has estimated that the provisions of AB 749 will reduce the average cost of pharmaceuticals by 21% by 2005. As a result, the estimated reduction of 37% based on the CHSWC report corresponds to a reduction of approximately 20%, or $0.2 billion on 2004 injuries after consideration of the estimated impact of AB 749.

   These amendments apply to all pharmaceuticals provided after the effective date of the change, including services on injuries that occurred prior to the effective date of the change. If the proportion of pharmaceutical costs to total medical costs on pre-January 1, 2004 injuries is the same as estimated on 2004 injuries (an hypothesis that has not yet been evaluated), the estimated

[2] The WCIRB's January 1, 2004 pure premium rate filing, submitted to the Insurance Commissioner on July 30, 2003, reflected a decrease in pharmaceutical costs of 9% in 2003, an additional 6% in 2004 and an additional 6% in 2005 from what they would otherwise be due to AB 749 provisions related to generics and pharmacy networks.

[3] Neuhauser, Frank, Alex Swedlow, Laura Gardner and Ed Edelstein, "Study on the Cost of Pharmaceuticals in Workers' Compensation," Report to the Commission on Health and Safety and Workers' Compensation, June 2000.

total future pharmaceutical costs on pre-2004 injuries is approximately $2.9 billion. As a result, the percentage reductions based on the CHSWC study would correspond to potential one-time savings in reduced liabilities for future pharmaceutical costs on pre-January 1, 2004 injuries of approximately $0.6 billion.[4]

4. **Outpatient Surgery Center Fee Schedule.** Amendments to Labor Code Section 5307.1(c) provide that the maximum facility fee for services performed in an ambulatory surgical center may not exceed 120% of the Medicare fee for the same service performed in a hospital outpatient facility. As noted above, the language in Labor Code Section 5307.1(a) is not clear as to which services are excluded from the Schedule. The provisions related to outpatient facilities have been evaluated based on our understanding of the legislative intent that outpatient fees be set at 120% of Medicare. If this legislation is ultimately interpreted in another manner, the actual cost impact may vary from our estimates.

   It is estimated that total outpatient costs on 2004 injuries will be approximately $2.0 billion. Cost estimates provided by the California Department of Insurance (CDI), CHSWC, and the RAND Institute are based on a 2001 Kominski and Gardner Report to CHSWC,[5] which compared actual payments to outpatient facilities to Medicare values. With a standard set at 120% of the Medicare Ambulatory Payment Classification Group (APC) values, the percentage estimates based on the data underlying the report would correspond to annual savings of 41%, or $0.8 billion on 2004 injuries. However, these estimates do not reflect any potential changes in utilization (e.g. movement to more costly inpatient procedures). The cost impact of the potential changes in utilization has not yet been evaluated.

   If the proportion of total future medical costs represented by outpatient costs on pre-2004 injuries is the same as estimated on 2004 injuries (an hypothesis that has not yet been evaluated), the total cost of unpaid outpatient costs on pre-January 1, 2004 injuries would be approximately $5.8 billion. As a result, the percentage reductions based on the data underlying the Kominski and Gardner Report referenced above would correspond to potential one-time reductions in needed liabilities for future outpatient costs on pre-January 1, 2004 injuries of approximately $2.4 billion.

[4] If the 37% change in average cost was to be applied independently of the estimated effect of the changes in AB No. 749, the potential one-time savings in reduced unpaid liabilities would be $1.1 billion.

[5] Gardner, Laura and Gerald Kominski, "Inpatient Hospital Fee Schedule and Outpatient Surgery Study," Report to the Commission on Health & Safety and Workers' Compensation, December 2001.

5. **Process for Reimbursement of Medical Payments**. Amendments to Labor Code Section 4603.2(b) reduce the period to pay medical bills from 60 to 45 working days and increase the penalty on late medical payments from 10% to 15%. Amendments to Labor Code Section 4603.4(c) provide that an electronic billing system shall be adopted by January 1, 2005 and that employers must be able to accept bills in this format by July 1, 2006. Bills for medical services at or below the level of the fee schedule that are submitted electronically must be paid in 15 days. Finally, Labor Code Section 4903.05 provides for a filing fee of $100 for medical liens. The WCIRB, at this time, has no basis to assess the effect of these provisions on (a) the cost of medical benefits, (b) paid penalty amounts, or (c) the administrative cost of processing claims.

6. **Prohibition on Outpatient Self-Referrals**. Amendments to Section 139.3 of the Labor Code, with some exceptions, prohibit doctors from referring their workers' compensation patients to outpatient surgery centers that they own. Due to a lack of information on the percentage of outpatient costs that is incurred on self-referred procedures, or what percentage of these costs will be eliminated by the change, there is no basis to assess the effect of these provisions on the cost of medical benefits at this time. However, we estimate that total outpatient costs on 2004 injuries will be approximately $2.0 billion

7. **Limitations on Chiropractor Visits**. Amendments to Labor Code Section 4604.5(d) cap chiropractic visits at 24 per claim. The WCIRB estimates that chiropractic costs on 2004 injuries will be approximately $1.2 billion. Information from the California Workers' Compensation Institute (CWCI) ICIS database suggests that if chiropractic visits were limited to 24 per claim without exception, the approximate reduction in chiropractic costs would be 45%. A 45% reduction in costs corresponds to annual savings of approximately $0.6 billion on 2004 injuries. It is likely that in some instances, due to employer authorization or other factors, there will be additional chiropractic visits beyond 24. We are unable at this time to quantify to what extent this exception and/or increases in the number of visits due to the establishment of a specified maximum number of permitted visits could erode potential savings.

8. **Limitations on Physical Therapy Visits**. Amendments to Labor Code Section 4604.5(d) also cap physical therapy visits at 24 per claim. The WCIRB estimates that the cost of payments to physical therapists on 2004 injuries will be approximately $0.9 billion. Information from the CWCI ICIS database on physical therapy costs suggests that limiting physical therapy visits to 24, without exception, will save 40% of physical therapy costs. A 40% reduction in costs corresponds to annual savings of approximately $0.3 billion on 2004 injuries.

It is likely that in some instances, as a result of employer authorization or other factors, there will be additional physical therapy visits beyond 24. We are unable at this time to quantify to what extent this exception and/or increases in the number of visits due to the establishment of a specified maximum number of permitted visits could erode potential savings.

9. **Utilization Review**. Amendments to Labor Code Section 5307.27 provide that by December 1, 2004 the Administrative Director is to establish an Official Medical Utilization Schedule meeting specified criteria. Amendments to Labor Code Section 4604.5 provide that the official utilization schedule adopted by the Administrative Director is presumed to be correct and can only be rebutted by a preponderance of medical opinion. This section also provides that by July 1, 2004 and continuing until such time as the Administrative Director establishes an Official Utilization Schedule, the standards of the American College of Occupational and Environmental Medicine Medical Practice Guidelines are presumed correct. Also, amendments to Labor Code Section 4610 provide that employers are required to utilize a utilization review process meeting specified criteria. Finally, amendments to Labor Code Section 5703 provide that relevant portions of medical protocols published by medical societies are admissible in disputes before the Appeals Board.

   As previously indicated, the estimated total cost of medical on 2004 injuries is $13.8 billion. Excluding the cost of medical-legal and medical cost containment, it is estimated that total medical treatment cost on 2004 injuries is $12.5 billion. The proposed amendments to Labor Code 4604.5(d) include specific caps for chiropractor and physical therapy visits. Excluding WCIRB estimates of the total costs of these services, which for the most part are being addressed through these caps, it is estimated the total remaining cost of medical treatment on 2004 injuries is $10.4 billion. The actual impact of utilization standards will of course depend on the specific standards established and how these standards will ultimately affect medical treatment practices in workers' compensation. Given (a) the complexity of the medical process for workers' compensation in California, (b) the relative lack of specificity of utilization standards such as that proposed, (c) the nature of the medical dispute resolution process within the WCAB, and (d) that the effect of the AB 749 repeal of the primary treating physician presumption on injuries occurring after January 1, 2003 has not yet been reflected in medical loss experience,[6] the WCIRB is unable at this time to estimate the cost effects of

[6] The WCIRB's January 1, 2004 pure premium rate filing, submitted to the Insurance Commissioner on July 30, 2003, reflected a cumulative decrease in medical costs from what they otherwise would be of approximately 9% (more than $1 billion) by accident year 2005 due to the partial repeal of the primary treating physician presumption effective January 1, 2003

these provisions related to medical utilization.[7] However, a number of studies have documented differences in treatment costs of similar injuries between group health and workers' compensation. As a result, to the extent treatment levels through these standards and procedures are made more consistent with group health levels, potential savings could be significant. Given the fundamental differences between the two systems, it is not likely that the entire treatment cost differential between the two systems can be eliminated by a system of utilization controls. However, assuming a 50% differential between group health and workers' compensation treatment levels,[8] the range of potential savings at alternative proportions of the assumed 50% differential being eliminated are as follows:

Percentage of Group Health/ WC Differential Eliminated	Potential Corresponding Savings
5%	$0.2 bb.
10%	$0.3 bb.
15%	$0.5 bb.
20%	$0.7 bb.
25%	$0.9 bb.
30%	$1.0 bb.
35%	$1.2 bb.
40%	$1.4 bb.
45%	$1.6 bb.
50%	$1.7 bb.

10. **Medical Dispute Resolution for Spinal Surgeries**. The proposed amendments to Labor Code Section 4062 provide for a special process related to resolving disputes over medical treatment related to spinal surgeries. (Although, the statutory language currently in the AB 227 and SB 228 could be interpreted more broadly, it is our understanding that the intent is to clearly limit its application to spinal surgeries.) Specifically, the provisions provide for a second opinion by a qualified medical evaluator or an agreed upon medical evaluator, when there is a medical dispute. It is estimated that inpatient costs on 2004 injuries are approximately $1.7 billion. Of the inpatient cost amount, it is estimated that approximately 40% or, $0.7 billion, is attributable to spinal surgeries. The WCIRB is unable at this time to estimate the cost effects of these provisions as neither the data nor a sound basis upon which to predicate an estimate of the cost impact of the proposed

[7] It is possible that these provisions may also have an impact on indemnity costs such as temporary disability duration. While this impact is potentially significant, we are unable to quantify such an impact based on the information available.

[8] It is our understanding that estimates developed by the Commission on Health and Safety and Workers' Compensation and the California Department of Insurance were based in part on this assumption.

process to resolve medical disputes related to spinal surgeries is available. However, a range of potential savings at alternative percentages of spinal surgery costs eliminated by the proposed changes is provided below.

Percentage of Spinal Surgery Costs Eliminated	Potential Corresponding Savings
5%	$35 mm.
10%	$70 mm.
15%	$105 mm.
20%	$140 mm.
25%	$175 mm.

11. **Repeal of the Primary Treating Physician Presumption for Pre-2003 Injuries**. AB 749 repealed the presumption given to the primary treating physician effective on injuries occurring on or after January 1, 2003. The WCIRB has estimated that, by accident year 2005, this repeal will reduce medical costs by 9%.[9] This estimate was derived by reducing the indicated excess rate of medical inflation applicable to 2003 and later injuries by 50%. Amendments to Labor Code Section 4062.9(b) extend the repeal of the treating physician presumption, except when there is predesignation, to injuries that occurred prior to January 1, 2003. It is estimated that the amount of statewide unpaid medical losses on injuries from 1994 through 2002 (the years in which the presumption currently applies) is approximately $25 billion. Although we are unable at this time to estimate the precise impact of extending the repeal to open claims, if, for example, the WCIRB's projected rate of growth in loss development is reduced by 50% on the 1994 through 2002 injury years (an hypothesis that has not yet been tested), estimated unpaid liabilities would be reduced by approximately 8%, or $2.0 billion on 1994 through 2002 injuries.

Other Provisions

1. **Vocational Rehabilitation.** AB 227 and SB 228 repeal mandatory vocational rehabilitation and add Labor Code Section 4658.5 which provides for non-transferable education vouchers to be provided to injured workers who are not back at work within 60 days after the termination of temporary disability benefits and have not received a qualified offer of modified work. Of the $11.1 billion in indemnity costs estimated for 2004 injuries, it is estimated that vocational rehabilitation benefits comprise 12%, or $1.3 billion. Information

[9] The WCIRB's January 1, 2004 pure premium rate filing, submitted to the Insurance Commissioner on July 30, 2003, reflected a cumulative decrease in medical costs from what they otherwise would be of approximately 9% (more than $1 billion) by accident year 2005 due to the partial repeal of the primary treating physician presumption contained in AB 749.

from the RAND Institute study on permanent disability completed for CHSWC suggests that approximately three-quarters of workers with permanent partial disabilities return to work. Based on this information and information from the CHSWC vocational rehabilitation survey on the percentage of workers who refuse offers of modified work, approximately one-eighth of permanently disabled workers would be eligible for the additional benefits. The net result of (a) eliminating all vocational rehabilitation costs (we are unable at this time to estimate what percentage of vocational rehabilitation costs would continue to be paid not withstanding the repeal of mandatory benefits) and (b) providing the additional benefits of Labor Code Section 4658.5 to one-eighth of all workers with permanent partial disability claims who would be eligible based on RAND and CHSWC information (an hypothesis that has not yet been evaluated), is that total system costs on 2004 injuries would be reduced by approximately $1.2 billion.

2. **Expansion of Carve-Outs**. Amendments to Labor Code Section 3201.7 provide for an expansion of "carve-out" programs. Due to a lack of information on the potential increase in the utilization of carve-outs as a result of this provision or the savings in benefit costs that can be expected when carve-outs are utilized, we are unable at this time to estimate the cost effects of this provision.

3. **Other Proposals**. AB 227 and SB 228 amendments include provisions related to the IMC, fraud, CIGA, and other areas. The WCIRB is unable at this time to estimate the cost effects of these provisions due to a lack of information regarding the impact these provisions on system costs.

Please note that these preliminary estimates are based on (a) WCIRB's staff's initial review of the statutory language provided and (b) the data and information readily available at this time. The preliminary estimates contained herein may, and are likely, to change as additional information becomes available and the full implications of the statutory language are reviewed by a panel of professionals with detailed expertise in the areas affected.

