



ANALYSIS OF SB 899 WORKERS' COMPENSATION REFORM PACKAGE

The Workers' Compensation System

Workers' Compensation, implemented in California in 1913, is a no-fault system entitling workers to compensation for illness or injury arising out of and in the course of work duties, regardless of the cause which might be otherwise attributed to the employer or the employee.

The workers' compensation system is premised on a bargain between the employers and the employees: employees are to receive benefits for employment-related injuries and, in return, these benefits are the exclusive remedy for the injured employees against their employer, even when the injury is caused by the negligence of the employer.

There are five (5) basic types of workers' compensation benefits available to injured employees depending on the nature and severity of the injury:

1. Medical Care
2. Temporary Disability
3. Permanent Disability
4. Vocational Rehabilitation Services
5. Death Benefits

Analysis of SB 899 Major Changes (By Category)

MEDICAL CARE

Medical Provider Networks

Beginning January 1, 2005, SB 899 allows employers and insurers to establish medical provider networks. By providing networks, the legislature intends to improve medical care for injured employees by providing them with a choice of physicians. Networks are to be established consistent with standards detailed in the bill and certified by the Administrative Director (AD). The standards would incorporate patient protection provisions from existing health and safety and labor code sections to ensure adequate numbers and types of physicians as well as sufficient access. Networks

Making a Difference

The reforms passed by the Legislature and signed by the Governor were intended to provide tools to employers and claims administrators that will impact the cost of workers' compensation claims. Savings will be achieved by those employers who work in tandem with their claims administrators to fully utilize the tools available under the new law. As an employer, here are some things that you can do to make a difference:

1. **Report all injuries or possible injuries to your claims administrator immediately:** Although historical studies have shown that injuries reported late cost more than those reported in a timely manner, it has never been more important than now. Under the new law, treatment must be provided immediately upon an employee's claim of injury, regardless of whether the injury is questionable. It is imperative that employers report any possible claims to the claims administrator immediately so that they can make a compensability determination as quickly as possible and mitigate costs.
2. **Maintain medical control:** The 30-day period of employer-controlled medical care is still in effect until 1/1/05 when the new provider networks will be established. Now that medical treatment is to be provided immediately upon a claim of injury, it is vital that employers direct employees to the company-designated physicians and work with the claims administrator to maintain this control for the full 30 days.
3. **Establish and Maintain an active Return-to-Work program:** Bringing employees back to work in a modified capacity can substantially reduce temporary disability costs for a workers' compensation claim. Temporary disability benefits is one of the greatest costs in a workers' compensation claim and is one that the employer can help to control. It is a known fact that injured employees that are performing work, even in a reduced or modified capacity, recover more fully and more quickly.

InterWest will continue to keep you abreast of the reform changes and its impact on your workers' compensation costs.

would be required to provide treatment in accordance with the Utilization Controls set by the Division of Workers' Compensation (DWC).

SB 899 provides that physician compensation may not be structured in order to achieve goals of reducing, delaying or denying medical treatment or restricting access to medical treatment. In developing a medical provider network an employer or insurer shall have the exclusive right to determine the members of their network. SB 899 requires that there are procedures for continuity of care which are submitted to the Administrative Director and to employees. The procedures will be drafted by the employer or insurer in accordance with the regulations set forth by the Administrative Director in consultation with the State Department of Managed Health Care.

The networks will be primarily comprised of occupational medicine specialists with a goal of at least 25% of physicians who primarily treat non-occupational injuries. An employee will be able to see three different doctors within the network and then can seek an independent medical review (IMR) from a doctor appointed by the Administrative Director and paid for by the employer. If the IMR agrees with the injured worker, the injured worker can receive necessary treatment either within or outside the network at the employer's expense.

The network of doctors must ensure adequate and appropriate care, including sufficient geographical coverage, an adequate number of specialists, the availability of a specified percentage of non-occupational physicians, and continuity of care, among other things. Health Care Service plans (Knox-Keene plans) and certified Health Care Organizations shall be deemed "approved" if they have reasonable numbers of physicians with competency in occupational and non-occupational medicine as determined by the Administrative Director (AD).

Pre-designation of Physician

Under SB 899, the injured worker is allowed to receive care from his or her group HMO or PPO or from the employer's network if the employer provides group health insurance and the injured worker pre-designated his or her treating physician within the group. Any physician pre-designated after April 19, 2004 must agree to be designated. Workers who pre-designate their physician must not exceed 7% of the total employees. Insurers must approve referrals to specialists, and such treatments must be from within the HMO or PPO. Insurers may require prior authorization of non-emergency treatments or diagnostic services. An employee who pre-designates a physician is bound by all the rules of group health insurance. The Division of Workers' Compensation will study pre-designation to see whether it is cost-effective. The right to pre-designate will sunset in three years.

Immediate Medical Care

The employer still has 90 days to determine compensability but as of April 19, 2004, the employer is responsible to provide initial medical treatment within one working day after an employee files a claim form for a declared work-related injury until the claim is accepted or denied up to a limit of \$10,000.

Limits on Occupational Therapy

In addition to physical therapy and chiropractic treatment, SB 899 limits occupational therapy to 24-visits. The requirement of written authorization for treatments beyond 24 visits has been clarified.

Repeal of the Treating Physician Presumption of Correctness

Effective April 19, 2004, SB 899 repeals the treating physician presumption of correctness for pre-designated physicians. The repeal applies in all cases, regardless of the date of injury but it shall not constitute good cause to reopen or rescind, alter, or amend any existing order, decision, or award of the Workers' Compensation Appeals Board. SB 899 repeals the presumption of correctness of any treating physician in accordance with the above.

Medical Disputes

SB 899 creates new medical-legal processes for resolving such disputes for unrepresented and union workers.

Unrepresented Workers: SB 899 allows either party to request a med-legal evaluation and to choose the Qualified Medical Evaluator's (QME) medical specialty. If they can't agree on a physician, the employee has ten (10) days to select a QME from a list of three, schedule an appointment and inform the employer. Otherwise,

the employer selects a QME.

Represented Workers: For injuries after January 1, 2005, either party may request a med-legal exam and suggest at least one (1) physician to act as an Agreed Medical Evaluator (AME). If there is no agreement within ten (10) days, either party may request a QME panel. The requesting party notifies the Administrative Director of their preferred specialty, the other party's preferred specialty and the treating physician's specialty. The DWC medical director will assign a panel of three (3) QME's and the parties have ten (10) days to agree on a QME. If they fail, each party strikes one name from the panel.

For both Unrepresented and Represented Workers: Additional medical-legal exams are prohibited if the worker's representation status changes.

TEMPORARY DISABILITY (TD)

For injuries after April 19, 2004, temporary disability benefit payments are capped at 104 weeks within a period of two (2) years from the first payment by an employer. TD awards may exceed the 104 week/2 year "cap" for injuries such as acute and chronic Hepatitis, amputations, severe burns and certain chronic diseases which will be capped at 240 weeks within 5 years of the first TD payment.

PERMANENT DISABILITY (PD)

Permanent Disability Benefits

Within sixty (60) days of becoming permanent and stationary, injured workers who do not receive an offer from their employer to return to work (regular, modified or alternate work lasting at least 12 months) will have their permanent disability benefits increased by 15%. For injured workers who receive an offer to return to work, permanent disability benefits are decreased by 15%. This provision applies only to those employers with fifty (50) or more employees.

In addition, SB 899 increases the number of weeks of permanent disability compensation for disabilities with ratings over 70% and decreases the number of weeks for those rated 15% or below.

Permanent Disability Determination

Beginning January 1, 2005, SB 899 will require PD determinations to be based on a formula that reflects the injured worker's future loss of earning capacity rather than their ability to compete in the open labor market. The formula will incorporate data from RAND and other studies showing the average percentage of long term income loss by injury type. SB 899 provides that in determining percentages of permanent disability, account shall be taken of the nature of the physical injury, age and occupation of the injured employee and consideration given to the employee's diminished future earnings capacity. Procedures for determining diagnosis and treatment have to be in accordance with the American College of Occupational and Environmental Medicine (ACOEM) guidelines

Causation and Apportionment

SB 899 states that the employer is only liable for that portion of the disability directly caused by the work-related injury. For a report to be admissible on the issue of permanent disability the physician must determine the approximate percentage of the permanent disability that was caused by the present work-related injury and what portion is due to other factors (including prior industrial injuries). Employees claiming a work-related injury must disclose all previous permanent disabilities or physical impairments. Any prior permanent disability awards to the employee are conclusively presumed to exist at the time of the subsequent injury. Accumulation of all permanent disability for any region of the body shall not exceed 100% over the employee's lifetime except if injury or illness is deemed to be "total" per Labor Code 4662. Body regions include: hearing, vision, mental disorders, spine, upper extremities, lower extremities, head, face, cardiovascular, respiratory and all other systems. No single injury may accumulate more than 100% disability.

VOCATIONAL REHABILITATION

Effective on signature, SB 899 reinstates old Labor Code Section 139.5, specifically providing that employees

injured prior to 1/1/04 are eligible for rehabilitation benefits. The rehabilitation must be completed no later than 12/31/2009, at which time Labor Code Section 139.5 expires.

RETURN TO WORK PROGRAM

This bill establishes and funds a return to work program that provides up to \$2500 to small employers (those with less than 50 employees) who need to make workplace improvements or modifications in order to return injured workers to their jobs. The program is to be funded from “user funding” and administrative penalties collected for patterns of unreasonable behavior in delaying or denying workers’ compensation payments.

LITIGATION

Penalties Arising From Labor Code Section 5814

effective June 1, 2004, SB 899 revises LC 5814 which requires a 10% penalty for unreasonable delay or refusal of payment. The penalty will now be based on the amount of the late payment, not on the entire species of benefit. The penalty is capped at 25% or \$10,000, whichever is less. SB 899 allows claims administrators who discover a potential violation before the employee claims a penalty to self-correct the error by paying any amount due plus a 10% self-imposed penalty. Any LC 5814 penalty will be reduced by the amount of the self-imposed penalty paid and there is now a 2-year statute of limitations from the date the payment was due. The bill establishes a \$400,000 penalty for any employer or insurer who is found to incur 5814 penalties to the degree that it is considered a business practice.

Statutory Construction

The term “liberal construction” now is to be interpreted in an impartial and balanced manner in order that all parties are considered equal before the law. While SB 899 does not alter Labor Code Section 3202, it makes clear that the courts now are to interpret evidence in an equally balanced fashion and not construe with the intent to expand benefits, as they were required under Section 3202.

INJURY AND ILLNESS PREVENTION PROGRAM (IIPP)

SB 899 reduces the scope of IIPP requirements in AB 227 and SB 228 enacted last year. Specifically, the requirement that every workers’ compensation insurer conduct a review of the injury and illness prevention program of each insureds within four months of the initial insurance policy term is restricted to employers with an experience modification factor of 2.0 or greater and is extended to within six months of the initial policy term. The review may be done by a licensed California professional engineer, certified safety professional, certified industrial hygienist, or another person working under the direction of such a professional.

INSURANCE RATE STUDY

After intense months-long debate in and out of the media spotlight, SB 899 requires the Division of Workers’ Compensation in consultation with the Department of Insurance to contract for a report on the impact that the cost savings from this bill and AB 227 and SB 228 of last year have on rates. This bill also requires the study to address the appropriateness of rate regulation. The insurance industry will pay for the study, up to \$1,000,000, proportionately allocated by each insurer’s share of the California workers’ compensation market.