Senate Bill No. 863
WCIRB Cost Monitoring Report – 2015 Retrospective Evaluation

Released: November 16, 2015

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I. Executive Summary

On September 18, 2012, the Governor signed Senate Bill No. 863 (SB 863) into law. SB 863 increased benefits effective January 1, 2013 and January 1, 2014 and provided for a number of structural changes to the California workers' compensation benefit delivery system. The WCIRB's prospective evaluation of the cost impact of SB 863 was published on October 12, 2012.

The WCIRB's plan to retrospectively monitor the cost impact of SB 863 based on emerging post-reform costs was published on March 27, 2013. The WCIRB released retrospective evaluations pursuant to this plan in 2013 and 2014. This report includes an updated retrospective evaluation of the cost impact of a number of SB 863 provisions based on data emerging through the third quarter of 2015.

In total, based on the most current information available, the WCIRB estimates the impact of SB 863 is an annual net savings of $770 million, or 4.1%, of total system costs. However, there remain several other components of SB 863 for which it is too early to make an initial assessment. As a result, it is possible that later SB 863 cost assessments may differ significantly from this estimate.

The WCIRB's principal findings based on emerging post-SB 863 costs are summarized below.

1. The impacts of increases to weekly permanent disability (PD) minimums and maximums for 2013 and 2014 injuries are emerging consistent with initial projections.

2. Changes to PD ratings related to the elimination of the future earning capacity (FEC) and PD add-ons were projected to increase average PD ratings by approximately 6% (prior to any impact from the Ogilvie[1] decision). This is generally comparable to data on early 2013 PD ratings from the California Disability Evaluation Unit (DEU) which suggests increases in average PD ratings 3% to 8% above the pre-reform rate of growth.

3. The changes to PD related to FEC were estimated to eliminate any increases to PD for the Ogilvie decision and included significant savings to frictional costs resulting from the elimination of Ogilvie. While specific information related to Ogilvie adjustments to PD ratings is not available, average PD ratings from WCIRB unit statistical data, the estimated proportion of claims involving Almaraz/Guzman[2] adjustments based on DEU information, and changes in total indemnity costs per claim do not suggest any significant post-SB 863 increases to average PD ratings. However, since the implementation of SB 863, average allocated loss adjustment expense (ALAE) costs per claim have not declined and, in fact, have increased significantly, suggesting no savings to ALAE from the elimination of Ogilvie are emerging.

4. Indemnity claim frequency was projected to increase modestly from 2012 to 2014, in part due to SB 863 changes to indemnity benefits. Indemnity claim frequency for accident years 2013 and 2014 is emerging generally consistent with projections. Although indemnity claim frequency did increase significantly in 2012, it had been increasing prior to the enactment of SB 863 in the third quarter of 2012.

5. The number of lien filings was projected to decrease by approximately 41% as a result of the SB 863 lien filing fee and statute of limitations. Although filings in 2013 and 2014 decreased by approximately 60% annually when compared to 2011 levels, the number of liens filed increased significantly in 2015 and are projected to be only 20% lower than 2011 levels. However, some of this increase may be a result of temporary increases in lien filings due to the transition of the

[1] Ogilvie v. City and County of San Francisco.
[2] Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School District.

statute of limitations on filing liens from three years to eighteen months for dates of service on or after July 1, 2013. As a result, it is not clear at this time whether the SB 863 lien provisions will produce saving more or less than originally projected.

6. SB 863's elimination of the duplicate payment for spinal surgical implants was estimated to save approximately $20,000 per procedure, while WCIRB Medical Data Call (MDC) data shows a decrease of over $25,000, or 28%, reduction in the average cost of these procedures since 2013.

7. SB 863's reduction in maximum ambulatory surgical center (ASC) facility fees was estimated to reduce those costs by 25%, which is consistent with the reductions observed based on WCIRB medical transaction data comparing post-January 1, 2013 reimbursements to pre-SB 863 levels. In addition, the proportion of post-January 1, 2013 services performed in outpatient hospitals compared to ASCs is consistent with pre-reform levels, suggesting no cost-shifting to outpatient hospitals is occurring.

8. The frequency of independent medical review (IMR) requests through the third quarter of 2015, even after eliminating duplicate and ineligible requests, is far above the levels initially projected. As a result, fees paid for IMRs are expected to increase ALAE costs by approximately 2.4%, as compared to a 1% increase prospectively estimated in 2012.

9. Expedited hearings related to medical treatment disputes were expected to be substantially eliminated by the new IMR process, while approximately 5,500 more expedited hearings have been held per year since the implementation of SB 863.

10. While average unallocated loss adjustment expenses (ULAE) declined from 2012 to 2014, medical-legal costs, utilization review (UR) costs, and litigation costs have continued to emerge at pre-reform levels and average ALAE costs increased significantly through 2014, suggesting the prospectively estimated significant savings to frictional costs from IMR and other SB 863 provisions are not materializing.

11. Temporary disability (TD) duration was projected to decrease by 5% as a result of SB 863 provisions related to IMR and medical provider networks (MPNs). California Workers' Compensation Institute (CWCI) information on average TD duration for accident year 2013 shows an increase of approximately 2% at 12 months and average TD duration for accident year 2012 also shows an increase. However, other measures of TD do not suggest an increase in TD duration. Since the issuance of IMR decisions has experienced significant delays during the initial transition period due to a far greater than anticipated volume of requests, the extent to which IMR may ultimately impact TD duration remains uncertain.

12. Preliminary estimates of MPN usage through 2014 show that network utilization in 2013 and 2014 is continuing at pre-reform levels and the impact of network utilization on cost levels is generally consistent with that for prior years.

13. Relatively few independent bill review (IBR) requests have been filed when compared to IMR filings, with information suggesting that the majority of decisions favor the provider and result in additional payments. However, as with IMR, MPNs, and other SB 863 provisions, the IBR process may be having an impact on recent declines in overall medical severities.

14. The changes to convert the physician fee schedule to a Resource-Based Relative Value Scale (RBRVS) basis were estimated to increase physician costs by 2.4% for services provided in 2014 and by 1.6% for services provided in 2015. Estimates of medical payments through the first six months of 2015 suggest a 4.8% decrease in physician payments per claim for the 2014 service

year, which is largely being driven by a decline in the number of special services and reports transactions, and a modest increase for the 2015 service year that is generally consistent with the WCIRB's prospective estimate.

15. SB 863 changes to liens, IMR, IBR, MPNs, and other areas could significantly impact medical treatment levels, and overall medical claim severities declined in 2013 and 2014 with clear indications of reduced utilization levels particularly in 2014. While it is very difficult to attribute changes in medical treatment levels to specific components of SB 863, the WCIRB estimates the SB 863 changes have resulted in an overall 5% decline in medical treatment costs.

Table 1 presents a summary of the WCIRB's prospective cost estimates of SB 863's cost components along with the potential impact on savings estimates based on the most recent information and any updated cost estimates if applicable.

Table 1: November 2015 Evaluation of SB 863 Cost Impact

	WCIRB Prospective Evaluation		November 2015 Retrospective Evaluation		
	Total Cost Impact ($millions)	Total % Impact	Preliminary Impact on Cost Savings[3]	Adjusted Cost Impact ($millions)[4]	Adjusted Total % Impact
Indemnity Cost Components					
Changes to Weekly PD Min & Max	+$650	+3.4%	=	—	—
SJDB Benefits	($10)	-0.1%	TBD	—	—
Replacement of FEC Factor	+$550	+2.9%	=	—	—
Elimination of PD Add-ons	($170)	-0.9%	TBD	—	—
Three-Tiered Weekly PD Benefits	($100)	-0.5%	TBD	—	—
Ogilvie Decision	($210)	-1.1%	-	**($130)**	**-0.7%**
Medical & LAE Cost Components					
Liens	($480)	-2.5%	=	—	—
Surgical Implant Hardware	($110)	-0.6%	+	**($140)**	**-0.7%**
ASC Fees	($80)	-0.4%	=	—	—
IMR – Impact on Frictional Costs	($180)	-0.9%	-	**+$70**	**+0.4%**
IMR – Impact on TD Duration	($210)	-1.1%	-	—	—
MPN Strengthening	($190)	-1.0%	=	—	—
IBR	N/A	N/A	+	—	—
RBRVS Fee Schedule	+$340	+1.8%	+	**($10)**	**-0.1%**
Indemnity Claim Frequency	Small Increase	—	=	—	—
Indemnity Severities (Incl. Trend)	Increases	—	=	—	—
Medical Severities (Incl. Trend)	Increases	—	+	**($520)**	**-2.7%**
ALAE & ULAE Severities	Signif. Declines	—	-	—	—
Total Estimate – All Items	**($200)**	**-1.1%**		**($770)**	**-4.1%**

[3] A "+" implies additional savings above those prospectively estimated by the WCIRB, a "-" implies less savings (or additional costs) and a "=" implies savings (or cost) estimates generally consistent with prospective estimates. "TBD" implies that it is too early to retrospectively evaluate the cost component at this time.

[4] Reflects the total impact on system costs for components for which the WCIRB has enough information to make a revised estimate. Amounts not shown imply total cost impacts equal to the prospective estimates.

II. Background

SB 863, which was enacted on September 18, 2012, increased benefits effective January 1, 2013 and January 1, 2014 and provided for a number of structural changes to the California workers' compensation benefit delivery system. Following the enactment of SB 863, the WCIRB reviewed the impact of SB 863 on the cost of losses and LAE underlying 2013 advisory pure premium rates. On a prospective basis, the WCIRB estimated that the net impact of the provisions of SB 863 quantifiable at the time of its prospective evaluation, once fully implemented in 2014, was a 2.7% reduction in the total cost of losses and LAE.[5] (SB 863 also included a number of amendments which the WCIRB was not able to prospectively evaluate at the time.)

On October 2, 2013, the Division of Workers' Compensation (DWC) adopted a new fee schedule for physician services based on a Resource-Based Relative Value Scale (RBRVS). The WCIRB's prospective evaluation of the RBRVS changes was included in its Amended January 1, 2014 Pure Premium Rate Filing. In total, the WCIRB estimated the new fee schedule would increase policy year 2014 costs by 1.8%.

These estimates of the cost impact of SB 863 were in part based on judgmental assumptions that may or may not materialize. In addition, a number of SB 863 provisions that could not be evaluated at the time of the WCIRB's prospective evaluation may ultimately have a significant impact on costs. As a result, the WCIRB developed a plan to proactively monitor and quantify post-SB 863 costs as they emerge. The *Senate Bill No. 863 WCIRB Cost Monitoring Plan* was submitted to the California Department of Insurance (CDI) on March 27, 2013.

The WCIRB cost monitoring plan involves a multi-year retrospective measurement of the cost impact of key provisions of SB 863 and identifies the cost components to be measured, the data elements needed to measure these cost components, the general methodology used to measure these cost components, and the scheduled timeframe by which each of the cost components will be measured. As noted in the monitoring plan, the ultimate cost impact of many provisions of SB 863 will not be known for many years. The WCIRB published earlier reports on the impact of SB 863 based on emerging post-SB 863 costs in 2013 and 2014. This report represents the WCIRB's third retrospective evaluation of emerging post-SB 863 costs pursuant to the monitoring plan and reflects emerging experience through the third quarter of 2015.

[5] *WCIRB Evaluation of the Cost Impact of Senate Bill. No 863*, WCIRB, updated October 12, 2012.

III. Cost Components Evaluated – Changes to Indemnity Benefits

A. Minimum and Maximum Permanent Disability Benefits

SB 863 provided for increases in the minimum and maximum weekly PD benefits for workers with injuries occurring on or after January 1, 2013, with an additional increase to maximum weekly PD benefits for injuries occurring on or after January 1, 2014. In total, the WCIRB's prospective evaluation estimated that these changes, after the estimated impact on claim frequency, would increase overall system costs by 3.5%. These estimates were primarily based on the WCIRB's legislative evaluation model, which estimates changes in indemnity benefits using distributions of claim costs by claim type and PD rating.[6]

In 2013, the most significant changes were to weekly PD benefit minimums, which increased for all PD claims regardless of PD rating, with increases to weekly PD benefit maximums only for claims with very high ratings. In 2014, increases to weekly PD benefit maximums became effective for the majority of PD claims. Table 2 shows the changes to weekly PD benefit minimums and maximums by PD rating interval.

Table 2: SB 863 Changes to Weekly PD Benefits

PD Rating Interval	Pre-SB 863		Effective 1/1/2013		Effective 1/1/2014	
	Min.	Max.	Min.	Max.	Min.	Max.
1 to 54.75	$130	$230	**$160**	$230	$160	**$290**
55 to 69.75	$130	$230	**$160**	**$270**	$160	**$290**
70 to 99.75	$130	$270	**$160**	**$290**	$160	$290

The WCIRB has compiled preliminary information on accident year 2013 and 2014 PD claims based on unit statistical reports at first report level. Based on the reported weekly wage and PD rating for each claim, the estimated incurred PD benefits were computed under the 2013 or 2014 level and pre-SB 863 (2012) statutory benefit level. The estimated change in average PD benefits using this approach is compared to the WCIRB's prospective estimates by PD rating interval in Tables 3 and 4. The results for the 2013 changes (Table 3) are generally comparable to prospective estimates while the initial very preliminary results for the 2014 (Table 4) changes show a slightly lower impact when compared to prospective estimates. However, this data is based on early identifiable PD claims and may change over time as PD claims are often late-developing.

Table 3: Changes in Average PD Benefits for AY 2013 Based on WCIRB Unit Statistical Data

PD Rating Interval	Prospective Estimate[7]	Retrospective Estimate[8]	Percent of 1st Report Claims
1 to 14.75	+1.2%	+1.1%	70.8%
15 to 24.75	+1.0%	+1.6%	21.7%
25 to 69.75	+2.7%	+3.3%	7.3%
70 to 99.75	+7.0%	+6.4%	0.2%

[6] The model is based on WCIRB unit statistical data and other sources of claim characteristic information and the parameters underlying the model are periodically reviewed and updated by the WCIRB's Actuarial Committee.

[7] Based on 200,000 indemnity claims that occurred on policies incepting in 2008 and 2009, restated to 2013 wage and benefit levels.

[8] Based on 40,000 accident year 2013 PD claims.

Table 4: Changes in Average PD Benefits for AY 2014 Based on WCIRB Unit Statistical Data			
PD Rating Interval	Prospective Estimate[9]	Retrospective Estimate[10]	Percent of 1st Report Claims
1 to 14.75	+20.8%	+19.0%	73.9%
15 to 24.75	+21.4%	+18.3%	20.5%
25 to 69.75	+20.1%	+18.5%	5.4%
70 to 99.75	+0.0%	+0.0%	0.2%

B. Supplemental Job Displacement Benefits

SB 863 provided that a supplemental job displacement benefit of up to $6,000 shall be offered to an injured worker who has not received a qualified return-to-work-offer. SB 863 also modified the basis upon which the supplemental job displacement benefit is paid and the types of expenses that are reimbursed. These changes are effective on injuries occurring on or after January 1, 2013. The WCIRB's prospective evaluation estimated that these changes would reduce costs by 0.1%.

Table 5 shows calendar year paid vocational rehabilitation-related benefits—which include supplemental job displacement benefits—that are reported on the WCIRB's annual Aggregate Indemnity and Medical Costs Call through 2014. While vocational rehabilitation-related benefits paid in calendar year 2013 are consistent with that of the immediate prior years, benefits paid in 2014 are somewhat lower than the pre-reform level. Although supplemental job displacement benefits are paid well into the life of a PD claim and will be evaluated in more detail in subsequent cost monitoring reports, the lower vocational rehabilitation benefits paid in 2014 are generally consistent with prospective estimates.

Table 5: Calendar Year Paid Vocational Rehabilitation Benefits		
Calendar Year	Voc. Rehab. Paid ($millions)	% of Total Indemnity Paid
2010	$32.0	1.1%
2011	$32.3	1.1%
2012	$36.2	1.1%
2013	$37.2	1.1%
2014	$29.9	0.9%

C. Changes in Permanent Disability Ratings

SB 863 provided that the PD impairment produced in accordance with the American Medical Association (AMA) Guides will not be modified for FEC as in the 2005 Permanent Disability Rating Schedule (PDRS).[11] In addition, SB 863 provided that a uniform adjustment factor of 1.4 will be applied to the whole person impairment determined pursuant to the AMA Guides. Additionally, by eliminating the application of the FEC factor, SB 863 in effect eliminates the impact of PD adjustments made in accordance with the 2009 Workers' Compensation Appeals Board (WCAB) decision in Ogilvie.[12] These changes to PD ratings were effective on injuries occurring on or after January 1, 2013. The WCIRB's prospective evaluation estimated that these changes, after the estimated impact on claim frequency, would increase costs by 1.8%. These estimates were primarily based on analysis of PD ratings issued by the DEU and judgmental assumptions.

[9] Based on 200,000 indemnity claims that occurred on policies incepting in 2008 and 2009, restated to 2014 wage and benefit levels.

[10] Based on 15,000 accident year 2014 PD claims from policies incepting in 2013.

[11] Prior to SB 863, the FEC factor ranged from 1.1 to 1.4 depending on the injury.

[12] Ogilvie allowed for the PD rating on a claim to be adjusted based on a finding that the FEC component of the PD rating did not appropriately describe the loss of future earning capacity.

The WCIRB has compiled the latest information on PD ratings based on claims available from the DEU through mid-2015. Exhibit 1 shows average PD ratings by accident year and age of rating based on the DEU database. Prior to SB 863, PD ratings had been increasing at rate of 2% to 4% per year. PD ratings issued within the first 15 months after the injury increased by approximately 11% for 2013 injuries and remained relatively consistent for 2014 injuries. However, PD ratings issued between 15 months and 27 months after the date of injury increased by approximately 7% in 2013, which is generally consistent with the WCIRB's prospective estimates.[13]

Using the information in the DEU database, the WCIRB is able to estimate the impact of the elimination of the FEC factor and the additional 1.4 adjustment factor directly by restating the ratings from 2013 and later injuries using the pre-SB 863 FEC factor. For each claim, the PD rating was calculated based on the FEC factor implied by the 2005 PDRS and compared to the actual rating determined for the claim. Table 6 shows the average PD ratings based on this approach, which are generally comparable to the WCIRB's prospective estimates.

Table 6: Average DEU Ratings with Changes to FEC

Estimate	Accident Years Used	Number of Ratings	Average Rating w/ FEC Factor (Pre-SB 863)	Average Rating w/ 1.4 Factor (Post-SB 863)	Impact of Change
Prospective	2005-2012	20,000	21.1	22.9	+8.5%
Retrospective	2013-2014	8,300	14.8	16.2	+9.5%

Adjustments to PD for Ogilvie are typically not reflected in the DEU database. However, the WCIRB can review the DEU data and other PD data to assess whether the elimination of Ogilvie as well as other SB 863 provisions has an indirect impact on PD ratings, such as an increase in adjustments for the Almaraz/Guzman WCAB decisions. Table 7 shows the estimated prevalence of Almaraz/Guzman adjustments in the DEU database pre- and post-SB 863 based on information identified by the DEU rater, which have been overall fairly consistent since the enactment of SB 863 in 2013.

Table 7: Percentage of Ratings Involving Almaraz Adjustments

Period	Quarter Final Rating was Issued	"Almaraz"[14]	"Potential Almaraz"[15]	Combined
Pre-SB 863	4Q 2011 to 4Q 2012	10.8%	7.7%	18.5%
Post-SB 863	1Q 2013 to 2Q 2015	8.1%	10.2%	18.3%

The WCIRB's evaluations of the cost impact of the Ogilvie decision reflected the significant litigation costs associated with the WCAB decision. Specifically, the WCIRB judgmentally estimated that ALAE would reduce by 3% with SB 863's effective elimination of the Ogilvie adjustments. Exhibit 2 shows changes in ultimate ALAE per indemnity claim by accident year, which increased significantly in 2013 and 2014. The impact of Ogilvie on ALAE costs cannot be isolated from other factors affecting ALAE. However, since overall ALAE severities have increased rather than declined as projected, the WCIRB has in this retrospective evaluation of SB 863 eliminated any savings to ALAE costs related to the Ogilvie decision, which was prospectively estimated at 0.4% of total costs.

[13] The WCIRB projected an additional 6% increase in average PD ratings as a result of the SB 863 changes to the FEC factor in addition to the elimination of PD add-ons.

[14] Refers to ratings where Almaraz/Guzman is cited directly in the rating notes.

[15] Refers to ratings where terms related to Almaraz/Guzman are cited in the rating notes, such as "per AMA Guides."

D. Permanent Disability Add-Ons

SB 863 eliminated increases in impairment ratings for psychiatric impairment, sleep disorder and sexual dysfunction arising out of a compensable physical injury, with the exception of psychiatric add-ons for catastrophic injuries or injuries that resulted from a violent act. These changes became effective for injuries occurring on or after January 1, 2013. The WCIRB's prospective evaluation estimated that these changes, after the estimated impact on claim frequency, would decrease costs by 0.9%. This projection included an estimated 10% offset to the estimated savings for psychiatric add-ons as a result of catastrophic injuries or injuries that resulted from a violent act.

PD ratings computed by the DEU include the impairment information to determine if the claim included a PD add-on. Exhibit 3 shows the proportion of claims in the DEU database that included an add-on for psychiatric impairment, sleep disorder, or sexual dysfunction by age of rating. Although the proportion of accident year 2013 and 2014 claims involving these add-ons is declining, ratings involving add-ons typically do not appear until much later and only approximately 1% of ratings issued before 27 months after the date of injury involve these add-ons. At this time, it is uncertain the extent to which the add-ons for post-SB 863 claims through 27 months identified in the DEU database are those intended to be eliminated by SB 863. As a result, the WCIRB will not be able to retrospectively assess the impact of the SB 863 provisions eliminating the PD add-ons until later monitoring reports.

A potential indirect impact of SB 863 is the increased use of other types of PD add-ons in lieu of those eliminated by SB 863 such as pain, gastrointestinal disorder, diabetes, or hypertension. DEU data suggests that prevalence of these add-ons in post-SB 863 claims through 27 months is consistent with the pre-reform level and affects approximately 1% of final ratings in this period. However, since ratings involving add-ons typically do not appear until later in the life of a claim as discussed above, the extent to which additional add-ons will emerge in post-January 1, 2013 injuries is uncertain at this time.

Exhibit 4 shows average PD ratings based on WCIRB unit statistical data. Although unit statistical data include all PD claims including those not rated by the DEU and should reflect the impact of all the SB 863 changes related to PD ratings, PD ratings reported at earlier report levels are typically claim adjuster estimates since the majority of final PD ratings are not determined for several years. For these reasons, the WCIRB has in recent years relied upon the DEU data rather than unit statistical data to evaluate the cost impact of changes to the PD rating process. Nevertheless, contrary to the information provided by the DEU, this data shows significant declines in average PD rating in 2013 and 2014. However, given the immaturity of PD information for accident years 2013 and 2014 as discussed above, the WCIRB believes it is still premature to make any adjustments to the prospective estimates of the SB 863 changes related to PD benefits.

E. Indemnity Claim Frequency

The WCIRB's prospective evaluation of SB 863 included provisions for changes in indemnity claim frequency (utilization) as a result of the changes to PD benefits and other types of indemnity benefits since frequency changes have historically accompanied changes in indemnity benefit levels. These provisions were based on a WCIRB econometric analysis of the effect of a number of economic, demographic and claims-related variables on the frequency of indemnity claims.[16] The study showed that changes in indemnity claim frequency are related, in part, to indemnity benefit changes. Specifically, the model shows that for every 1% change in average indemnity benefits, the frequency of indemnity claims changes by approximately 0.2%.[17] In total, the WCIRB's prospective evaluation estimated that the changes in frequency as a result of SB 863 changes to indemnity benefits would increase costs by 1.1%.

[16] Brooks, Ward, *California Workers' Compensation Benefit Utilization – A Study of Changes in Frequency and Severity in Response to Changes in Statutory Workers Compensation Benefit Levels*, Proceedings of the Casualty Actuarial Society, Volume LXXXVI, 1999, pp. 80-262.

[17] This utilization provision is assumed to apply to TD and permanent partial disability claims but not to medical-only, permanent total disability, death, or vocational rehabilitation claims.

Exhibit 5 summarizes the WCIRB's latest estimates of accident year indemnity claim frequency changes through June 30, 2015. Table 8 compares the changes from 2012 through 2014 with those projected based on the WCIRB's econometric claim frequency model.[18] While current estimates for accident years 2013 and 2014 are generally consistent with the changes projected by the WCIRB's frequency model, the actual frequency for accident year 2012 is significantly higher than projected. However, the WCIRB estimated a 4% increase in indemnity claim frequency for 2012 based on data through six months which was prior to SB 863 and is generally consistent with the current estimate. As a result, it is likely that the higher-than-projected accident year 2012 indemnity claim frequency change is primarily driven by factors other than SB 863.[19]

Table 8: Indemnity Claim Frequency Changes

Accident Year	WCIRB Model Projected Indemnity Claim Frequency Change[20]	Current Estimate of Actual Indemnity Claim Frequency Change[21]
2012	-1.9%	+3.3%
2013	+0.3%	+0.5%
2014	+1.1%	+0.0%

Claim frequency patterns can be influenced by many diverse factors including changes in benefit levels. Exhibit 6 shows the distribution of PD claims by the injured worker average weekly wage reported in WCIRB unit statistical data. Wages are adjusted to a common (accident year 2014) basis. In 2013 and 2014, there does not appear to be a significant increase in the proportion of PD claims which would have received increases in minimum or maximum weekly PD benefits (see Table 2).

[18] The indemnity benefit level in the WCIRB's econometric frequency model is a leading variable. That is, a change in indemnity benefit levels for a year is assumed to also impact indemnity claim frequency for the prior year. In addition to changes in indemnity benefit levels, the WCIRB's frequency model also projects frequency changes based on a number of economic and other claims-related factors.

[19] For more information regarding the WCIRB's analysis of the 2012 indemnity claim frequency change, see *Analysis of Changes in Indemnity Claim Frequency—January 2015 Update Report*, WCIRB, January 14, 2015.

[20] See Section B, Appendix B, Exhibit 2 of the WCIRB's January 1, 2016 Pure Premium Rate Filing submitted on August 19, 2015. Frequency changes include the projected impact of shifts in the classification mix. The estimated impacts of class mix shifts on indemnity claim frequency are -1.1% for 2012, -0.5% for 2013 and +1.5% for 2014.

[21] See Exhibit 4. The 2012 and 2013 estimates are based on indemnity claim counts compared to payroll adjusted to a common wage level from WCIRB unit statistical data. The 2014 estimate is based on a comparison of changes in reported aggregate indemnity claim counts on WCIRB data calls to changes in statewide employment.

IV. Cost Components Evaluated – Changes to Medical Benefit Delivery System

A. Liens

SB 863 included a number of provisions related to liens. Liens filed on or after January 1, 2013 are required to be filed with the WCAB using an approved form and be filed with a $150 filing fee. In addition, no liens may be filed more than three years from the date of service for services provided before July 1, 2013 or 18 months from the date of service for services provided on or after July 1, 2013. The WCIRB's prospective evaluation of the impact of SB 863 on lien-related costs estimated a 1.8% reduction in medical costs and a 7.8% reduction in LAE, resulting in a 2.5% reduction in total costs.[22] In the WCIRB's 2014 SB 863 Cost Monitoring Report, the estimate of the impact of the SB 863 lien provisions was adjusted based on initial cost monitoring results showing a greater-than-projected number of liens reduced after SB 863, which resulted in an additional 1.1% reduction in total costs as a result of these provisions.[23]

In the WCIRB's prospective evaluation, it was assumed that approximately 41% of liens would be eliminated by the SB 863 lien filing fee and statute of limitations. This estimate was updated to 60% in the WCIRB's 2014 SB 863 Cost Monitoring Report based on initial cost monitoring results through the third quarter of 2014. The DWC maintains lien filing information in its Electronic Adjudication Management System (EAMS). Exhibit 7 shows the number of liens filed by region and type of lien through the third quarter of 2015 based on DWC EAMS data. Following the passage of SB 863 in the third quarter of 2012, lien filings in the remainder of 2012 increased dramatically in anticipation of the implementation of the lien filing fee. In 2013 and 2014, the number of liens filed decreased by approximately 60% when compared to pre-reform levels. However, in 2015, the number of liens filed has increased significantly in each quarter, and the number of liens filed in the first three quarters of 2015 is 87% higher than the first three quarters of 2014. A significant proportion of this increase may be attributable to the 18-month statute of limitations on liens filed for services performed on or after July 1, 2013, which began to affect those liens starting January 1, 2015. If these trends continue in the fourth quarter of 2015, the number of liens filed will be approximately 20% lower than the 2011 level compared to a 41% reduction projected and a 60% reduction experienced for 2013 and 2014. However, some of this trend may reverse once the three-year statute of limitations on liens for pre-July 1, 2013 services expires completely on June 30, 2016. As a result, the WCIRB will closely monitor lien filing activity in subsequent quarters to determine if the higher 2015 lien filings will continue into the future.

The WCIRB's prospective estimate of lien demand, settlement and administrative costs was based on its 2012 Lien Survey of a random sample of 1,000 PD claims. In 2013 and 2014, the WCIRB issued subsequent Lien Surveys on 1,000 additional PD claims for information on liens active in 2013 or 2014.[24] The results of the WCIRB's Lien Surveys are shown in Exhibits 8 through 14 and summarized below:

1. Approximately 24% of claims surveyed from Southern California regions[25] had lien activity during the first half of 2013 or 2014, compared to 38% of claims with lien activity during the first half of 2012. Similarly, claims from Northern California regions saw a reduction in the proportion of claims with lien activity during the first six months of the year from 16% in 2012 to 6% in 2013 or 2014 (Exhibit 8).

[22] The WCIRB's prospective evaluation did not include any estimated impact of the lien activation fee since the lien activation fee is only effective on outstanding liens and would not affect post-January 1, 2013 injuries.

[23] This updated estimate of the cost impact of SB 863 lien provisions has been reflected in the January 1, 2015 and subsequent pure premium rate filings.

[24] The 2013 and 2014 Lien Surveys were conducted on accident year 2008 and 2009 claims, respectively. The 2012 Lien Survey was conducted on accident year 2007 and prior claims.

[25] Claims were mapped to Northern or Southern California based on the zip code reported on the workers' compensation policy.

2. The average number of active liens per claim with an open lien was fairly consistent across the Surveys (Exhibit 9).

3. The average delay between the accident date and the lien filing date was 3.0 years for liens active during the first six months of 2013 or 2014 compared to 2.5 years for liens active during the first six months of 2012. The average delay between the lien filing and the lien resolution was 1.7 years for liens resolved during the first six months of 2013 or 2014 compared to 2.0 years for liens resolved during the first six months of 2012 (Exhibit 10).

4. The distribution of liens by lien claimant type was fairly consistent across Surveys (Exhibit 11).

5. The median settlement amount for liens resolved during the first half of 2013 or 2014 was $900, compared to $525 for the first half of 2012 (Exhibit 12). The increase in median settlement amounts were experienced for almost all types of lien claimant.

6. The average lien defense cost per Southern California claim[26] with a lien was fairly consistent across the Surveys, regardless of when the lien was active (Exhibit 13).

7. Exhibits 8 through 13 reflect liens active in the first six months of the survey year regardless of when the lien was filed. Although fewer liens have been filed after January 1, 2013, the WCIRB has compiled preliminary information on the cost of liens filed after the effective date of SB 863. Exhibit 14 shows, for each survey year, the average demand and settlement amounts for liens based on the year the lien was filed. From this survey sample, liens filed after January 1, 2013 appear to be for amounts consistent with liens filed prior to the effective date of SB 863.

During the initial implementation of SB 863, there were concerns that some liens would be replaced by "petitions for costs" filings in an attempt to avoid payment of the lien filing or activation fees – particularly in areas such as interpreter and copy service fees. However, in mid-2013, the WCAB published an *en banc* decision clarifying that a claim for medical-legal expenses may not be filed as a petition for costs.[27]

As a result of the higher-than-projected lien filings in 2015 and questions as to when the lien filing rates will stabilize, the WCIRB believes it is premature to adjust its original estimates that were based on a reduction in liens of 41% until the lien filing counts begin to stabilize.[28]

B. Surgical Implant Hardware

SB 863 eliminated the separate reimbursement for implantable medical devices, hardware and instrumentation for spinal surgeries, beginning with services provided on or after January 1, 2013. Additionally, SB 863 required the Administrative Director to adopt a regulation specifying an additional reimbursement for certain diagnostic-related groups (DRGs) pertaining to spinal surgery to ensure that aggregate reimbursement is sufficient to cover costs, including implantable hardware.[29] On a prospective basis, the WCIRB estimated that the elimination of the multiple reimbursements would reduce total medical costs by 1% for a 0.6% reduction in total costs. (The WCIRB's prospective estimate did not include any provision for a potential change to the utilization of spinal implant procedures.)

[26] Due to the sparseness of the data, average defense costs for Northern California claims could not be credibly estimated. However, the defense cost on observed claims was small.

[27] Martinez v. Terrazas (2013) 78 Cal. Comp. Cases 444.

[28] This reduces some of the savings indicated in the WCIRB's 2014 SB 863 Cost Monitoring Report, which was predicated on a reduction in lien filings of 60% based on the volume of lien filings in 2013 and 2014.

[29] The regulation was repealed on January 1, 2014.

The WCIRB's prospective estimate was, in part, based on a CWCI study estimating the savings from eliminating the multiple reimbursements on claims with spinal surgeries.[30] The study found that the duplicate payment for spinal instrumentation on these claims added an estimated $20,000 to each procedure.

The WCIRB has compiled information on spinal surgical implants performed through the first half of 2015 based on its MDC data. Specifically, surgical implant services provided after January 1, 2013 were compared to the same services provided in 2012. The number and cost of surgical episodes involving these services[31] are shown on Table 9. The reduction in the average cost of these episodes was over $25,000, which is approximately 25% greater than the $20,000 per procedure reduction projected in the WCIRB's prospective estimate. In addition, the number of these types of procedures has been relatively consistent with pre-SB 863 levels.

Table 9: Number and Cost of Surgical Episodes Involving Spinal Implants Based on WCIRB MDC Data

Dates of Service	SB 863 Targeted DRGs[32]		
	Total Paid ($millions)	Total Episodes[33]	Average Paid per Episode
Pre-1/1/2013	$34.2	361	$94,722
Post-1/1/2013	$33.1	486	$68,065
Change	—	—	-$26,657

As a result of the higher-than-projected reduction in the average cost of these types of surgeries, the WCIRB has increased its estimated SB 863 savings to these procedures by 25%, resulting in an additional 0.2% reduction in total costs.

C. Ambulatory Surgical Center Fees

SB 863 provides that the maximum facility fee for services performed in an ASC should not exceed 80% of the Medicare fee for the same service in a hospital outpatient department (the prior cap was set at 120% of the Medicare rate for hospitals). These amendments would have resulted in a one-third reduction in ASC facility fee payments if it was assumed that the change in the maximum fee schedule allowance would translate directly to ASC facility fee costs. However, many ASC fees are reimbursed under contract at levels different from those contemplated in the fee schedule. The WCIRB's prospective evaluation estimated the reduction in ASC facility fees would reduce total medical costs by 0.8% based on a judgmental reduction of 25% in ASC facility fees rather than the one-third indicated if the fee schedule reduction would be fully reflected in reduced costs, resulting in a 0.4% reduction in total costs. (The WCIRB's prospective estimate did not include any potential change to the utilization of ASCs or outpatient hospital services.)

[30] *Preliminary Estimate of California Workers' Compensation System-Wide Costs for Surgical Instrumentation Pass-Through Payments for Back Surgeries*, CWCI, June 2012.

[31] Includes payments for DRGs, the implant specific revenue code (0278), and other revenue codes on the same hospital bill (e.g., radiology, lab, pharmacy, supplies and physical training).

[32] Spinal implant DRGs include: 028, 029, 030, 453, 454, 455 and 456.

[33] Episode is defined as a unique surgical event with defined "from and through" days of service.

In 2014, the WCIRB in conjunction with CWCI released a comprehensive report detailing post-SB 863 outcomes for ASCs.[34] A follow-up study was published earlier this year.[35] These reports showed that ASC costs in 2013 and 2014 are generally consistent with the WCIRB's prospective estimates and there is no evidence of cost shifting from ASCs to outpatient hospitals.

The WCIRB has compiled updated information on ASC facility fees paid on services provided through the first half of 2015 based on its MDC data. Table 10 shows the paid cost related to ASC facility fees on services provided after January 1, 2013 compared to the reimbursements on claims with pre-SB 863 dates of service. The average reimbursement to ASCs in 2013 and later is 24% lower than the average reimbursement on services provided prior to the implementation of SB 863, which is consistent with the WCIRB's prospective estimates.

Table 10: ASC Facility Fee Results Based on WCIRB MDC Data

Date of Service	Number of Episodes	Total Paid ($millions)	Average Paid per Episode
Pre-1/1/2013	22,517	$44.4	$1,973
Post-1/1/2013	66,999	$100.9	$1,507
Change	—	—	**-24%**

Table 11 shows ASC costs compared to costs on outpatient hospital services for the same procedures provided both before and after SB 863. The proportion of total episodes utilized by outpatient hospitals has remained generally consistent after the implementation of SB 863, suggesting that no significant shift from ASCs to outpatient hospital facilities has occurred. Table 11 also shows that the relative cost per outpatient episode compared to the average ASC cost has increased significantly after SB 863 and, as a result, outpatient hospitals represent a larger share of the total paid amounts after January 1, 2013.

Table 11: ASC and Outpatient Hospital Episodes Based on WCIRB MDC Data

	Pre-1/1/2013 Services[36]	Post-1/1/2013 Services
ASC Episodes	22,517	66,999
Outpatient Hospital Episodes (% of All Episodes)	5,635 **(20%)**	15,304 **(19%)**
ASC Paid ($millions)	$44.4	$100.9
Outpatient Hospital Paid ($millions) (% of All Paid)	$14.0 **(24%)**	$42.0 **(29%)**
ASC Avg. Paid/Episode	$1,973	$1,507
Outpatient Hospital Avg. Paid/Episode (Difference vs. ASC)	$2,483 **(+26%)**	$2,746 **(+82%)**

[34] *Ambulatory Surgical Center Cost Outcomes: The Impact of California SB 863 Workers' Compensation Reforms*, WCIRB and CWCI, February 26, 2014.

[35] *Ambulatory Surgical Center Cost Outcomes: Follow Up Study on the Impact of California SB 863 Workers' Compensation Reforms*, WCIRB and CWCI, March 11, 2015.

[36] Reflects services in the third and fourth quarters of 2012.

D. Independent Medical Review

SB 863 created a new IMR process for handling medical treatment disputes. IMR became effective on January 1, 2013 for new injuries and on July 1, 2013 for all injuries regardless of accident date. The WCIRB's prospective evaluation of the cost impact of IMR was segregated into several components, including savings attributable to lien costs, medical-legal reports, expedited hearings, TD duration and litigation costs. In total, the WCIRB estimated these IMR components would result in a 2.1% reduction in system costs. IMR also has the potential to significantly affect medical treatment costs. However, given the uncertainty as to how IMR will impact medical treatment, the WCIRB did not prospectively estimate the impact of IMR on medical treatment costs.[37] In the WCIRB's 2014 Cost Monitoring Report, based on initial cost monitoring results showing a greater-than-projected number of IMR filings and no reductions in frictional costs or other LAE after the effective date of SB 863, the WCIRB updated its estimate to remove any savings to frictional or litigation costs from the IMR process (0.9% of total costs).[38]

Table 12 shows the number of IMRs requested through the third quarter of 2015 based on information received from the DWC through the IMR vendor. Once IMR became effective for all injuries regardless of the accident date starting on July 1, 2013, the number of IMR requests increased significantly in the second half of 2013. The number of IMRs again escalated in the second quarter 2014. While the number of IMR requests has generally increased at a modest rate since that time, the number of requests in the third quarter of 2015 is consistent with the prior quarter. However, a number of requests have been identified as duplicate requests or requests ineligible for IMR. Exhibit 15 shows the number of IMRs requested to date and those identified to be duplicate or ineligible by the IMR vendor. Although eliminating almost 40% of IMRs due to duplicate or ineligible requests significantly reduces the estimated number of IMRs performed per year, it still remains two to three times greater than that projected by the WCIRB in its initial assessment of SB 863 cost impacts.[39]

Table 12: IMR Filings

Year & Quarter	IMRs Filed
2013 1Q & 2Q	878
2013 3Q	31,950
2013 4Q	51,092
2014 1Q	49,928
2014 2Q	59,983
2014 3Q	61,793
2014 4Q	56,500
2015 1Q	61,142
2015 2Q	65,410
2015 3Q	65,875

The fees for IMR requests are paid by the insurer or self-insured employer and are a component of ALAE. Table 13 shows the WCIRB's prospective estimate of annual IMR costs in ALAE and the IMR fees incurred on requests made after SB 863 was enacted. While the number of eligible IMR requests has increased in 2015, there have been reductions in the average fee for an IMR resulting in an estimated total incurred cost of $60 million for both 2014 and projected for 2015. As a result, the WCIRB has updated its SB 863 cost estimate to reflect an annual cost of $60 million for IMR fees, which results in an approximate 0.3% increase in total costs.

[37] The CDI's decision on the January 1, 2013 and Premium Rate Filings reflected a projected 2.5% reduction in medical costs coming from the impact of IMR on medical treatment.

[38] This updated estimate of the cost impact of IMR on frictional costs has been reflected in the January 1, 2015 and subsequent pure premium rate filings.

[39] The WCIRB prospectively estimated approximately 51,000 IMR requests to be filed per year when the SB 863 IMR process is fully in effect.

Table 13: Cost of IMRs					
Application Year	Eligible Requests (A)	Paid IMRs (B)	Total IMR Fees Paid (C)	Avg. Paid per IMR (D) = (C) / (B)	Total IMR Fees Incurred (E) = (D) x (A)
Prospective Estimate	51,000	—	—	$500	$25.5M
2013[40]	52,563	48,172	$24.7M	$514	$27.0M
2014	141,703	132,800	$56.7M	$427	**$61.0M**
2015 (2 Quarters)	84,300	35,757	$13.1M	$367	$31.0M
2015 (Proj. Annual)	168,600	—	—	$367	**$62.0M**

The WCIRB's prospective evaluation of SB 863 assumed that liens related to UR disputes would be replaced by IMR reports. Although the number of liens filed decreased dramatically after the effective date of SB 863 (see Exhibit 7), it is uncertain as to what proportion of the eliminated liens were a result of IMR compared to other SB 863 provisions impacting liens. As shown on Exhibit 11 based on WCIRB Lien Survey data, a significant number of liens related to medical treatment disputes were still active in 2013 and 2014.

The WCIRB's prospective evaluation of SB 863 also assumed that Qualified Medical Evaluator (QME) reports related to medical treatment issues would be replaced by IMR reports. Table 14 shows the number and average cost of medical-legal reports based on WCIRB MDC data. Even after IMR became effective on all injuries starting in the second quarter of 2013, the number and cost of medical-legal reports has not shown any decline.

Table 14: Number and Cost of Medical-Legal Reports		
Service Year & Half	% of Claims with Med-Legal Payments	Average Paid per Med-Legal Report[41]
2012 2H	9.3%	$1,036
2013 1H	8.5%	$1,021
2013 2H	8.7%	$1,141
2014 1H	9.2%	$1,225
2014 2H	9.1%	$1,233
2015 1H	9.3%	$1,221

The WCIRB's prospective evaluation of SB 863 assumed that expedited hearings related to medical necessity would be eliminated by IMR. Table 15 shows the number of expedited hearings by year. After SB 863 was enacted in 2013, the number of expedited hearings increased rather than decreased and has remained at the higher level through the first three quarters of 2015. On average, 5,500 more expedited hearings were held annually after the implementation of SB 863 than in the years immediately prior to SB 863. As a result, based on an estimated $1,500 in administrative and legal costs per hearing that were approximated in the WCIRB's prospective evaluation of SB 863, the WCIRB updated its estimate of SB 863 to reflect an increase of approximately 0.1% in total costs for the increase in the number of expedited hearings.

[40] IMR did not go into effect for all open claims until July 1, 2013.
[41] Includes all claims with a medical-legal report regardless of payment.

Table 15: Number of Expedited Hearings	
Calendar Year	Expedited Hearings Held
2011	9,502
2012	11,464
2013	15,217
2014	16,606
2015 (3 Quarters)	12,110
2015 (Proj. Annual)	16,147

IMR requests follow execution of a valid UR. Exhibit 16 shows preliminary estimates of the proportion of medical payments (including medical cost containment program (MCCP) costs) related to UR, IMR and IBR based on information from CWCI. The proportion of these costs has remained relatively consistent after the implementation of SB 863. Exhibit 16 also shows calendar paid MCCP costs as a percentage of other medical costs based on WCIRB aggregate data calls. The increase in the proportion of MCCP costs in 2014 likely in part a result of IMR fees included in MCCP costs, which were not paid in significant volumes until 2014.[42]

The WCIRB's prospective evaluation of SB 863 estimated significant savings in LAE as a result of fewer frictional costs (as discussed above) in addition to reduced litigation related to medical treatment disputes. Exhibit 17 shows the estimated percentage of PD claims represented by an attorney based on the WCIRB's PD Claim Survey. Preliminary information from accident year 2012 claims evaluated as of first survey level (approximately 28 months) shows representation rates remain at high levels for claims in both Northern and Southern California regions.

Table 16 compares projected changes from 2012 to 2014 in average ULAE and ALAE costs per indemnity claim based on the WCIRB's prospective SB 863 estimates, projections based on current estimates of SB 863 costs and LAE severity trends, and what has actually emerged. While actual ALAE costs have emerged significantly greater than current projections, average ULAE costs have emerged lower than projected. As discussed in the WCIRB's prospective evaluation of SB 863, for many SB 863 provisions impacting frictional costs, it is difficult to separate the impact on ALAE or ULAE. In total, LAE costs are emerging greater than projected.

Table 16: Change in Calendar/Accident Year LAE Costs Per Indemnity Claim from 2012 to 2014		
	ULAE	ALAE (Excl. MCCP)
Prospective Estimate[43]	-7.6%	-2.6%
Updated Projection[44]	-0.6%	+3.5%
Actual Emergence	-6.3%	+16.4%

[42] Beginning with IMRs paid in 2016, these costs will no longer be reported as MCCP costs but will continue to be reported as a component of ALAE.

[43] Includes the WCIRB's prospective estimates of the impact of SB 863 on calendar/accident years 2013 and 2014 in addition to the projected severity trends for 2013 and 2014 reflected in the WCIRB's January 1, 2013 Pure Premium Rate Filing.

[44] Includes the WCIRB's current estimates of the impact of SB 863 (see Table 1) in addition to the projected severity trends for 2013 and 2014 reflected in the WCIRB's January 1, 2016 Pure Premium Rate Filing.

The WCIRB's prospective evaluation of SB 863 assumed the new IMR process would reduce delays in medical treatment and as a result reduce the duration of TD payments. Exhibit 18 shows the average number of paid days of TD based on CWCI data. The number of paid TD days for accident year 2013 at 12 months and accident year 2012 at 24 months continues to increase at approximately the pre-reform rate. However, data from the WCIRB's PD Claim Survey (also shown on Exhibit 18) in addition to WCIRB annual reports on calendar year paid costs[45] suggest that TD is stable or declining. Given the mixed indications related to TD duration and since the issuance of IMR decisions experienced significant delays during the initial transition period due to a far greater-than-anticipated volume of requests, the extent to which IMR may ultimately impact TD duration remains uncertain.

As discussed above, IMR has the potential to significantly affect medical treatment costs. As shown in Exhibit 20, medical severities have declined following the implementation of SB 863. However, it is very difficult to isolate the direct impact of the IMR process on medical treatment levels from other SB 863 provisions affecting medical treatment such as those related to liens, MPNs and IBR. The WCIRB's analysis of the impact of SB 863 on the overall utilization of medical services is discussed in Section H below.

E. Medical Provider Networks

SB 863 made changes to MPNs to provide that reports prepared by a consulting or attending physician chosen by the injured worker and outside the MPN should not be the sole basis of compensation. In addition, SB 863 provided that the employer is not liable for treatment or the consequences of treatment obtained outside a valid MPN. The WCIRB's prospective evaluation estimated these changes to MPNs would reduce total costs by 1.0%, which included savings to PD costs, TD costs and medical costs.

As discussed in the WCIRB's SB 863 Cost Monitoring Plan, the WCIRB will retrospectively monitor the utilization of MPNs before and after the SB 863 changes to assess whether any changes in the utilization of networks has occurred. Exhibit 19 shows the percentage of visits and medical payments made to MPNs through 2014 based on CWCI data compared to the proportion of visits and payments for prior years. Network penetration since 2013 has continued at a rate consistent to that of the immediate prior years.

As discussed in the WCIRB's SB 863 Cost Monitoring Plan, the WCIRB will also monitor cost differentials related to MPNs to assess if any change in the cost of services provided within an MPN compared to out-of-network services has occurred. CWCI estimates the average medical cost per MPN managed claim is approximately $500, or 4%, less than a non-network claim through 24 months based on services provided through 2013.[46] This is generally consistent with estimates from prior years.

F. Independent Bill Review

SB 863 created a new process of IBR to handle bill payment disputes effective on medical services provided on or after January 1, 2013. Specifically, for disputes not resolved after the employer's second review, the provider may request an IBR within 30 days of the second review or the bill will be deemed satisfied. The WCIRB did not include a prospective cost estimate for IBR in its SB 863 evaluation since, at the time, there were a number of outstanding issues related to the IBR process that needed to be resolved through regulation.

[45] The WCIRB reports show that despite increases in the number of claims involving TD, injured worker average wage levels, and TD maximums, total paid TD benefits have been relatively stable over the last several calendar years suggesting that some decreases in TD duration may be occurring.

[46] *Analysis of Medical and Indemnity Benefit Payments, Medical Treatment and Pharmaceutical Cost Trends in the California Workers' Compensation System*, CWCI, July 2014.

Information on the number of IBRs requested through mid-2015 are available from the DWC through the IBR vendor and summarized on Table 17. While the total volume of IBRs has increased each year, it still remains relatively low. Information on IBR decisions suggests that the majority of the decisions favor the provider and result in additional payments. Although the total volume of IBRs is low, the IBR process may be having an impact on the overall utilization of medical services (discussed in Section H below).

Table 17: IBR Filings

Year	IBRs Filed
2013	991
2014	2,004
2015 (2 Quarters)	1,554
2015 (Proj. Annual)	3,108

G. Conversion of the OMFS to a RBRVS Basis

SB 863 provided that the DWC Administrative Director shall adopt a fee schedule based on a Resource-Based Relative Value Scale (RBRVS) basis for physician services, with the maximum reasonable fees paid set at a level not to exceed 120% of Medicare. The amendments adopted by the Administrative Director provide for a four-year transition period beginning in 2014. The WCIRB's prospective evaluation of the RBRVS changes were included in the WCIRB's Amended January 1, 2014 Pure Premium Rate Filing. Once fully implemented in 2017, the WCIRB estimated that the RBRVS changes would increase physician costs by 8.5% resulting in a 2.1% increase in total costs. As noted in the WCIRB's January 1, 2016 Pure Premium Rate Filing, information on paid physician costs for the 2014 service year suggested that while for most components of the physician fee schedule costs were emerging at a level generally consistent with the WCIRB's initial prospective estimates, the significant reduction in the cost of special services and reports was not initially projected. As a result, the WCIRB attributed significant savings to the first year of the four-year phase-in of the new RBRVS-based fee schedule that substantially offset the estimated cost increases in subsequent years.

The WCIRB's 2015 retrospective evaluation of the RBRVS changes based on data through the first six months of 2015 is included as Attachment A. As discussed in Attachment A, the RBRVS changes were initially estimated to increase physician costs by 2.4% on 2014 services and by 1.6% on 2015 services.

As discussed in Attachment A, the WCIRB retrospectively estimates physician payments per claim on 2014 services decreased by approximately 4.8% (compared to a decrease of 4.1% reflected in the WCIRB's January 1, 2016 Pure Premium Rate Filing). This change was primarily driven by greater-than-anticipated decreases in payments for special services and reports, and the WCIRB has reflected this information in its overall cost estimate of SB 863. Based on data through the first half of 2015, the WCIRB estimates physician payments per claim on 2015 services increased by approximately 0.8%, primarily driven by increases in the utilization of physical medicine services which offset the decreases in laboratory and pathology services. In total, this increase is generally consistent with the WCIRB's prospective estimate for service year 2015. As a result and since the evaluation of service year 2015 is based only on data through the first six months of 2015, the WCIRB is not changing its prospective cost estimate of the impact of the RBRVS-based fee schedule on 2015 services at this time.

H. Impact of SB 863 on the Utilization of Medical Services

Many of the provisions of SB 863 affected medical treatment costs. For a number of SB 863 components including the elimination of duplicate reimbursements for spinal implant hardware, MPN strengthening, fee schedule reductions for ASCs, provisions related to liens, and the physician fee schedule transition to a RBRVS basis, the WCIRB was able to prospectively estimate the impact of the SB 863 provisions on average medical costs and those estimates have been reflected in the WCIRB's subsequent pure premium rate filings and have been separately re-assessed as part of this report and earlier SB 863 cost monitoring efforts.

Other provisions of SB 863 impact medical costs, including those that address the utilization of medical services rather than the average cost of services. The potential cost impact of these provisions was heavily dependent on future regulations required by the legislation, how the WCAB interprets certain new provisions, the result of potential legal challenges to components of the legislation, and changes in medical treatment and other system practices and patterns. As a result, the WCIRB did not reflect estimates for these provisions in its initial prospective evaluation of SB 863, but indicated that cost evaluation of these components would require additional time and data. In particular, the WCIRB did not include a prospective evaluation of the impact of IMR on medical treatment levels in its prospective evaluation of SB 863.

Now, more than two years have elapsed since IMR and other SB 863 provisions impacting medical costs have been implemented. Prior to SB 863, medical treatment costs per indemnity claim had risen by approximately 45%, or approximately 6.5% per year since 2005.[47] A CWCI report in 2013 analyzed increases in medical severities based on detailed medical transactional payment data through December 31, 2012.[48] The CWCI analysis showed sharp increases in medical payments per claim following the full implementation of the reforms of 2002 through 2004 in 2005 in a broad range of medical treatment categories such as pharmaceutical costs, costs of medical cost containment programs, and medical-legal costs. These increases were attributable to increases in the number of visits per claim, the number of procedures per visit, and the average cost of procedures.

Exhibits 21 through 27 summarize post-SB 863 medical cost trends by type of service for services performed in six month periods at six month payment intervals. Theses exhibits summarize the average cumulative paid per claim, the average number of transactions per claim, and the average cumulative paid per transaction. The data is shown for all medical services in Exhibit 21 and separately for physician services (Exhibit 22), pharmaceuticals (Exhibit 23), inpatient hospital services (Exhibit 24), outpatient hospital services (Exhibit 25), procedures coded under the Health Care Procedure Coding System (HCPCS) (Exhibit 26), and medical-legal (Exhibit 27). Exhibits 21 through 27 are based on the WCIRB's analysis of its medical transaction data covering services from July 2012 through June 2015. These data, from over 40 insurer groups representing approximately 90% of statewide premiums, include 1.3 million unique claims, 57 million paid medical transactions and $7.4 billion in paid medical services.

As shown in Exhibit 21, rather than increasing at anywhere near the pre-SB 863 rate of inflation, medical costs per claim have generally declined from the pre-SB 863 levels as represented by the second half of 2013 medical amounts. The decline in medical costs per claim in 2013 was driven in part by the reductions in the average cost of procedures, as many of the SB 863 reforms took effect (e.g., ASC fee schedule reductions, elimination of duplicate reimbursement for spinal implants). However, with the implementation of IMR on a broad basis as well as RBRVS in late 2013 through 2014, the continued reduction in medical cost levels was driven by significant reductions in the number of procedures per claim. Exhibits 22 through 27 show that this pattern was generally consistent for most components of medical treatment. As shown in Exhibit 23 for pharmaceuticals in particular, which had been growing at a

[47] See the Executive Summary of the WCIRB's January 1, 2013 Pure Premium Rate Filing submitted on August 21, 2012.
[48] *Analysis of Medical and Indemnity Benefit Payments, Medical Treatment and Pharmaceutical Cost Trends in the California Workers' Compensation System*, CWCI, July 2013.

double digit annual rate of inflation prior to SB 863,[49] there were significant reductions in the average cost per claim in 2014 and the first half of 2015 driven by significant reductions in the number of pharmaceutical transactions by claim. (Pharmaceuticals have been subject to IMR more frequently than other medical components.)

It is not possible to isolate the impact of IMR on the utilization of medical services from the impact of other components of SB 863, as well as other phenomena impacting medical costs such as a general slowing of medical inflation countrywide. However, as discussed above, it is clear that IMR as well as the other SB 863 components have had a significant impact on medical treatment levels and medical costs.

I. Changes to Overall Claim Severities

As discussed above, there have been significant reductions in in the utilization of medical services producing post-SB 863 medical levels well below those reflected in the WCIRB's initial prospective evaluation of SB 863. As shown on Exhibit 20, projected ultimate medical severities for accident years 2012 through 2014 also show declines.

Table 18 compares projected changes from 2012 to 2014 in average indemnity and medical costs per indemnity claim based on the WCIRB's prospective SB 863 estimates and projections based on current estimates of SB 863 costs and severity trends to what has actually emerged. As discussed above, the majority of SB 863 provisions impacting indemnity benefits only affect PD claims occurring after January 1, 2013 or January 1, 2014, and PD claims are often late-developing. As a result, after reflecting the WCIRB's most recent cost estimates for SB 863 and estimated residual indemnity severity trends, the WCIRB believes overall indemnity claim severities are emerging generally consistent with projections. However, even after reflecting the most current estimates of the impact of the various SB 863 provisions affecting medical costs (which were typically on a date of service basis), overall medical severities are still emerging at a level approximately 5% lower than projected. Given the impact of SB 863 on medical utilization levels discussed above, the WCIRB believes it is reasonable to assume this differential represents the approximate impact of SB 863 on overall medical treatment levels. As a result, the WCIRB has reflected an estimated 5% decrease in overall medical severities as a result of changes to medical utilization levels resulting from SB 863, which represents an approximate 3.0% decrease in total costs.

Table 18: Change in Accident Year Claim Severities from 2012 to 2014

	Indemnity	Medical
Prospective Estimate[50]	+15.7%	+13.7%
Updated Projection[51]	+8.3%	+0.6%
Actual Emergence	+10.3%	-4.5%

J. Other System Components

In addition to the areas discussed above, the WCIRB's SB 863 Cost Monitoring Report includes a number of other system components that will likely be affected by SB 863 for which data is not yet available including several fee schedules that have recently been adopted (copy services) or are expected to be adopted in upcoming months (home health and interpreter services). The WCIRB will continue to monitor post-SB 863 costs and provide updates on the items identified as well as any other affected components as more information becomes available.

[49] *Analysis of Medical and Indemnity Benefit Payments, Medical Treatment and Pharmaceutical Cost Trends in the California Workers' Compensation System*, CWCI, July 2013.

[50] Includes the WCIRB's prospective estimates of the impact of SB 863 on accident years 2013 and 2014 in addition to the projected severity trends for 2013 and 2014 reflected in the WCIRB's January 1, 2013 Pure Premium Rate Filing.

[51] Includes the WCIRB's current estimates of the impact of SB 863 (see Table 1, excluding the estimated changes to overall medical severities) in addition to the projected severity trends for 2013 and 2014 reflected in the WCIRB's January 1, 2016 Pure Premium Rate Filing.

Average Permanent Disability Ratings Based on DEU Data
Claims with Final Rating Before June 1, 2015

Average Final Rating

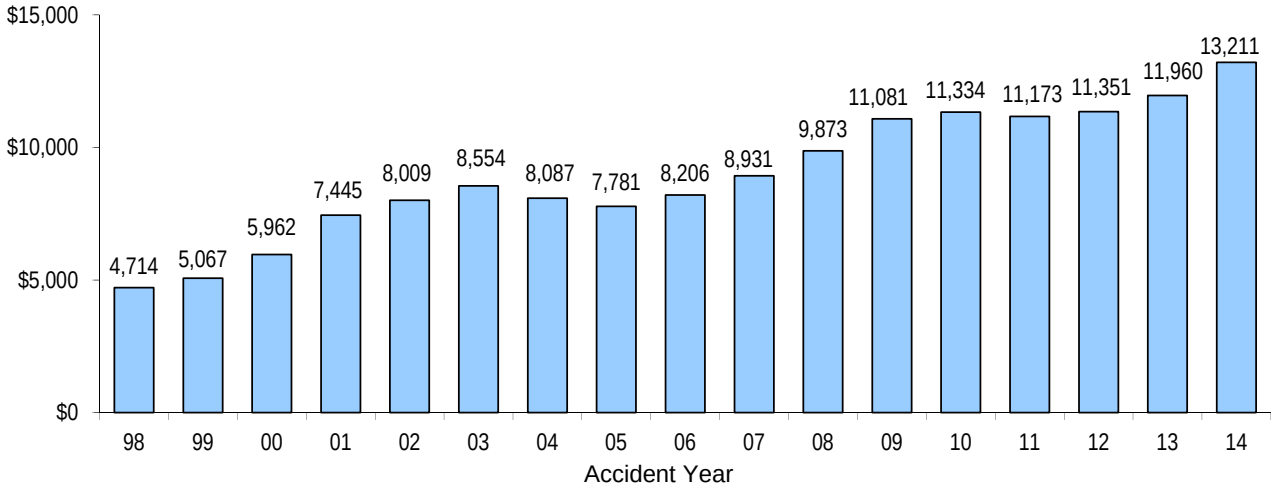
Age at Final Rating (Months)		Accident Year									
		2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
0	15	11.6	12.1	12.4	12.6	12.7	13.4	13.4	13.7	15.2	15.0
15	27	14.7	15.2	15.8	16.2	17.0	18.1	18.5	19.0	20.3	
27	39	18.8	19.8	20.6	22.3	22.6	23.8	23.8	23.8		
39	51	23.0	24.0	25.7	26.7	28.2	28.5	27.4			
51	63	26.7	28.6	30.4	31.7	31.6	29.9				
63	75	29.8	31.5	32.3	33.7	30.9					
75	& Over	35.2	35.4	34.1	32.6						

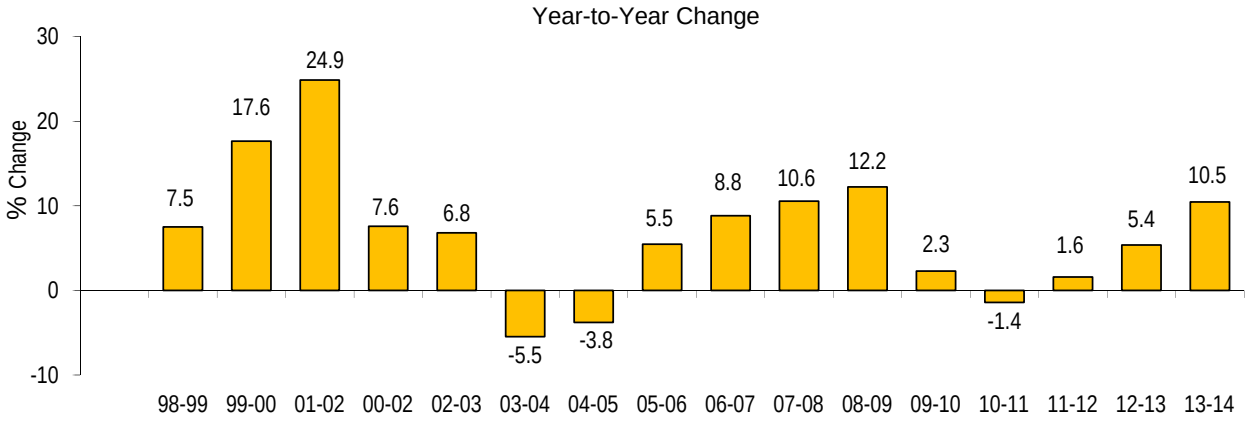
Change in Average Rating

Age at Final Rating (Months)		Accident Year									
		2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
0	15	---	3.7%	2.4%	2.0%	0.7%	5.6%	-0.4%	2.8%	11.0%	-1.4%
15	27	---	3.5%	3.9%	2.4%	5.2%	6.7%	2.1%	2.6%	7.0%	
27	39	---	5.1%	4.4%	7.9%	1.8%	5.2%	0.1%	-0.3%		
39	51	---	4.3%	7.1%	4.1%	5.5%	1.0%	-3.7%			
51	63	---	7.3%	6.2%	4.1%	-0.2%	-5.4%				
63	75	---	5.6%	2.6%	4.3%	-8.4%					
75	& Over	---	0.4%	-3.7%	-4.2%						

Source: DEU database. 2014 data is preliminary.

California Workers' Compensation
Estimated Ultimate ALAE per Indemnity Claim[1] by Accident Year
As of March 31, 2015





[1] Based on data submitted by private insurers only.

Percentage of DEU Ratings Involving Add-ons
Claims with Final Rating Before June 1, 2015

Add-on for: Psychiatric Impairment, Sleep Disorder, or Sexual Dysfunction

Age at Final Rating (Months)		Accident Year									
		2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
0	15	0.2%	0.4%	0.6%	0.7%	0.6%	0.5%	0.7%	0.8%	0.7%	0.5%
15	27	0.8%	1.3%	1.4%	1.1%	1.6%	1.6%	1.6%	1.4%	0.7%	
27	39	3.0%	2.6%	2.8%	3.8%	3.6%	4.4%	3.3%	3.0%		
39	51	4.4%	4.1%	5.2%	6.5%	6.5%	6.4%	4.7%			
51	& Over	6.9%	9.8%	10.9%	10.7%	9.0%	7.2%				

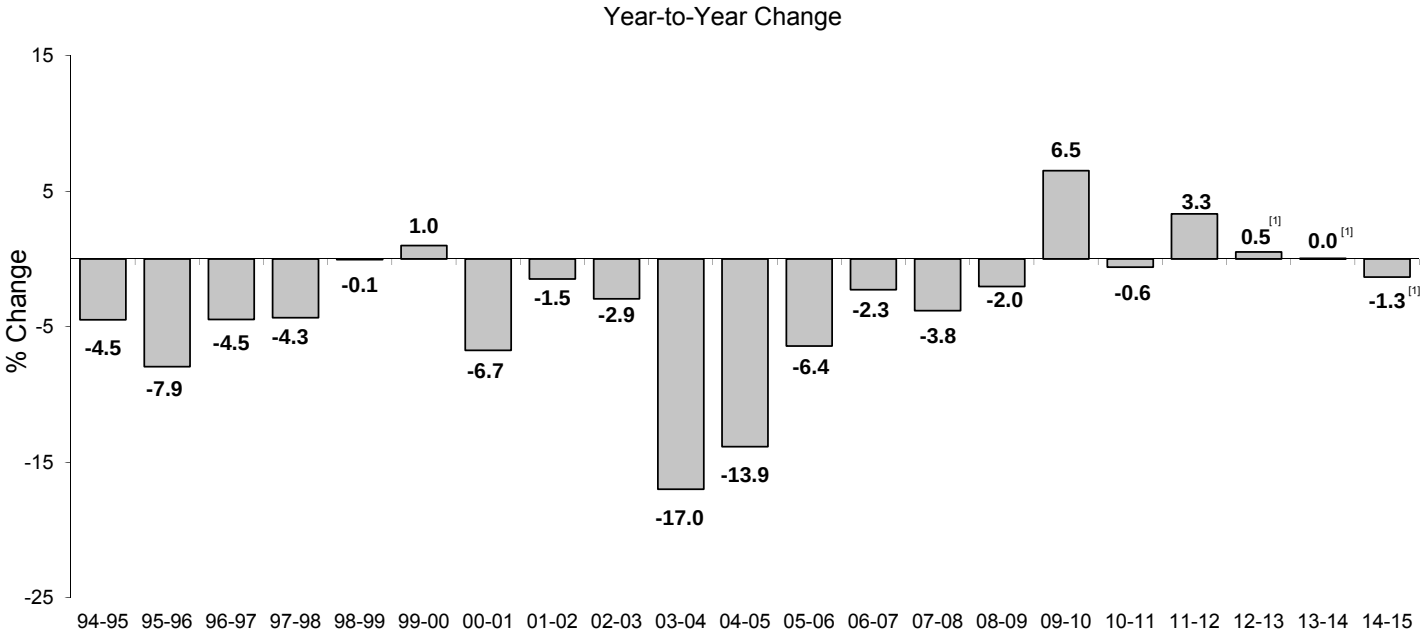
Source: DEU database. 2014 data is preliminary.

Average Permanent Disability Rating Based on WCIRB Unit Statistical Data

Accident Year	Report Level 01	02	03	04	05	06	07	08	09
2005	13.0	15.1	15.9	16.3	16.8	17.2	17.4	17.5	17.5
2006	12.0	14.3	15.7	16.5	17.2	17.6	17.7	17.6	*17.7*
2007	11.9	14.5	16.2	17.3	17.8	18.1	18.0	*17.7*	
2008	12.4	15.1	17.1	18.1	18.4	18.3	*18.3*		
2009	12.6	15.4	17.0	17.8	17.7	*18.0*			
2010	12.5	15.0	16.3	16.5	*17.0*				
2011	12.7	14.6	15.2	*15.8*					
2012	12.1	13.6	*15.0*						
2013	11.2	*12.4*							
2014	*10.6*								

Note: Latest diagonal (italics) is preliminary and is based on a partial accident year. For example, the average PD rating for accident year 2014 at 1st report level is based on policies incepting in 2013.

California Workers' Compensation
Estimated Indemnity Claim Frequency by Accident Year



[1] The 2012-2013 estimate is based on partial year unit statistical data. The 2013-2014 and 2014-2015 estimates are based on comparison of claim counts based on WCIRB accident year experience as of June 30, 2015 relative to the estimated change in statewide employment. Prior years are based on unit statistical data.

Distribution of Indemnity Claims by Average Weekly Wage
Based on WCIRB Unit Statistical Data at 1st Report Level

Permanent Disability Claims

Average PD Wage* Interval		Accident Year						
Lower	Upper	2008	2009	2010	2011	2012	2013	2014
[$0	$160]	6.4%	8.2%	9.0%	9.8%	10.5%	10.4%	*11.6%*
($160	$230)	5.8%	6.3%	7.3%	10.2%	11.4%	12.1%	*11.7%*
[$230	$270)	9.0%	9.1%	11.0%	8.8%	9.5%	9.8%	*11.8%*
[$270	& Up	78.8%	76.4%	72.7%	71.2%	68.6%	67.7%	*64.9%*

All Indemnity Claims

Average PD Wage* Interval		Accident Year						
Lower	Upper	2008	2009	2010	2011	2012	2013	2014
[$0	$160]	18.9%	19.1%	20.0%	21.1%	21.0%	18.0%	*15.2%*
($160	$230)	5.7%	6.4%	7.3%	9.7%	10.7%	11.7%	*11.4%*
[$230	$270)	8.1%	8.1%	9.8%	8.2%	8.6%	8.6%	*10.3%*
[$270	& Up	67.3%	66.4%	62.9%	61.0%	59.7%	61.7%	*63.1%*

*PD wage is 2/3 the reported average weekly wage. Wages are adjusted to a 2014 wage level.

Note: 2014 (italics) is preliminary and is based on policies incepting in 2013.

Liens Filed Counts*

Counts by Region

Region**	Calendar Year 2011	1st Quarter 2012	2nd Quarter 2012	3rd Quarter 2012	4th Quarter 2012	1st Quarter 2013	2nd Quarter 2013	3rd Quarter 2013	4th Quarter 2013	1st Quarter 2014	2nd Quarter 2014	3rd Quarter 2014	4th Quarter 2014	1st Quarter 2015	2nd Quarter 2015	3rd Quarter 2015
Bay Area	18,723	5,490	5,467	6,434	10,397	1,232	1,450	1,607	1,928	1,841	1,697	1,941	1,690	2,071	2,370	2,428
Central Coast/Valley	24,414	7,245	8,970	15,289	25,730	2,193	1,562	1,795	2,025	2,029	2,306	1,996	2,371	3,058	4,218	4,977
Los Angeles County	283,774	97,245	122,040	207,639	342,549	46,830	18,947	25,999	29,537	25,668	29,417	29,665	34,772	45,827	54,147	61,619
Remainder of LA Basin	114,554	38,034	44,065	85,152	123,129	17,032	6,917	9,855	10,893	10,117	11,942	12,198	12,469	18,016	22,198	24,827
Remaining CA Zip Codes	2,535	895	1,102	698	1,119	230	211	247	276	239	265	239	249	270	318	393
Sacramento	3,934	1,248	1,322	1,407	1,557	268	339	410	358	384	354	424	384	488	500	526
San Diego County	15,922	4,936	4,991	6,611	8,523	1,312	684	991	1,136	1,165	1,263	1,378	1,488	2,133	2,787	3,047
Total	**463,856**	**155,093**	**187,957**	**323,230**	**513,004**	**69,097**	**30,110**	**40,904**	**46,153**	**41,443**	**47,244**	**47,841**	**53,423**	**71,863**	**86,538**	**97,817**

Region Percentage of Total

Region**	Calendar Year 2011	1st Quarter 2012	2nd Quarter 2012	3rd Quarter 2012	4th Quarter 2012	1st Quarter 2013	2nd Quarter 2013	3rd Quarter 2013	4th Quarter 2013	1st Quarter 2014	2nd Quarter 2014	3rd Quarter 2014	4th Quarter 2014	1st Quarter 2015	2nd Quarter 2015	3rd Quarter 2015
Bay Area	4.0%	3.5%	2.9%	2.0%	2.0%	1.8%	4.8%	3.9%	4.2%	4.4%	3.6%	4.1%	3.2%	2.9%	2.7%	2.5%
Central Coast/Valley	5.3%	4.7%	4.8%	4.7%	5.0%	3.2%	5.2%	4.4%	4.4%	4.9%	4.9%	4.2%	4.4%	4.3%	4.9%	5.1%
Los Angeles County	61.2%	62.7%	64.9%	64.2%	66.8%	67.8%	62.9%	63.6%	64.0%	61.9%	62.3%	62.0%	65.1%	63.8%	62.6%	63.0%
Remainder of LA Basin	24.7%	24.5%	23.4%	26.3%	24.0%	24.6%	23.0%	24.1%	23.6%	24.4%	25.3%	25.5%	23.3%	25.1%	25.7%	25.4%
Remaining CA Zip Codes	0.5%	0.6%	0.6%	0.2%	0.2%	0.3%	0.7%	0.6%	0.6%	0.6%	0.6%	0.5%	0.5%	0.4%	0.4%	0.4%
Sacramento	0.8%	0.8%	0.7%	0.4%	0.3%	0.4%	1.1%	1.0%	0.8%	0.9%	0.7%	0.9%	0.7%	0.7%	0.6%	0.5%
San Diego County	3.4%	3.2%	2.7%	2.0%	1.7%	1.9%	2.3%	2.4%	2.5%	2.8%	2.7%	2.9%	2.8%	3.0%	3.2%	3.1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Counts by Type

Type	Calendar Year 2011	1st Quarter 2012	2nd Quarter 2012	3rd Quarter 2012	4th Quarter 2012	1st Quarter 2013	2nd Quarter 2013	3rd Quarter 2013	4th Quarter 2013	1st Quarter 2014	2nd Quarter 2014	3rd Quarter 2014	4th Quarter 2014	1st Quarter 2015	2nd Quarter 2015	3rd Quarter 2015
Interpreter	28,721	12,937	17,162	46,095	47,427	2,397	831	484	378	421	275	140	156	143	152	134
Medical	292,982	85,152	106,336	182,474	317,241	45,631	22,480	32,356	37,515	33,105	38,534	39,750	45,381	60,066	73,919	84,094
Medical-Legal	39,569	22,931	37,440	64,912	80,916	11,411	587	653	537	397	320	178	159	216	267	190
Copy Service	539	139	65	91	62	11	20	23	8	16	10	7	4	18	7	7
Other***	102,045	33,934	26,954	29,658	67,358	9,647	6,192	7,388	7,715	7,504	8,105	7,766	7,723	11,420	12,193	13,392
Total	**463,856**	**155,093**	**187,957**	**323,230**	**513,004**	**69,097**	**30,110**	**40,904**	**46,153**	**41,443**	**47,244**	**47,841**	**53,423**	**71,863**	**86,538**	**97,817**

Type Percentage of Total

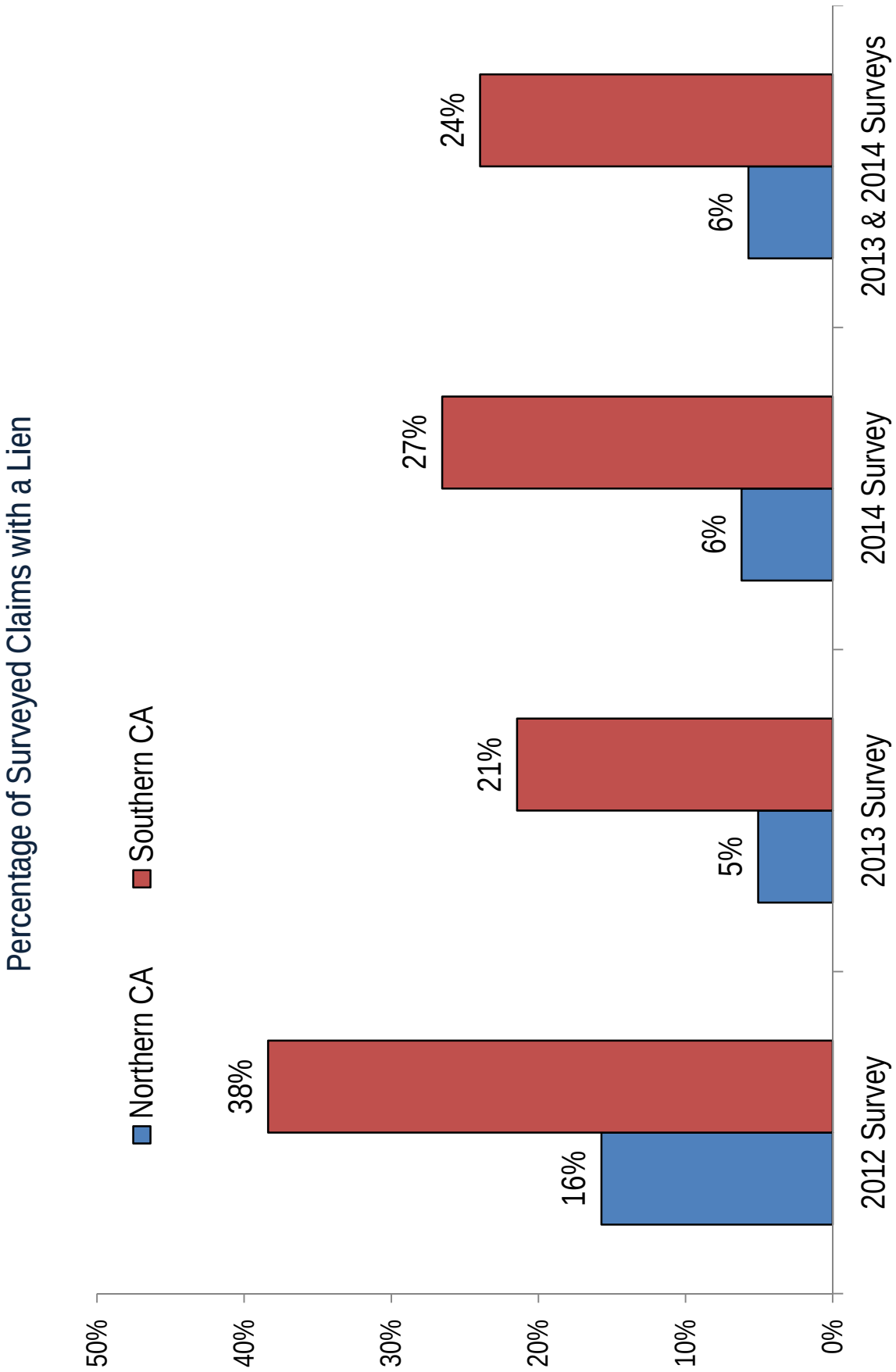
Type	Calendar Year 2011	1st Quarter 2012	2nd Quarter 2012	3rd Quarter 2012	4th Quarter 2012	1st Quarter 2013	2nd Quarter 2013	3rd Quarter 2013	4th Quarter 2013	1st Quarter 2014	2nd Quarter 2014	3rd Quarter 2014	4th Quarter 2014	1st Quarter 2015	2nd Quarter 2015	3rd Quarter 2015
Interpreter	6.2%	8.3%	9.1%	14.3%	9.2%	3.5%	2.8%	1.2%	0.8%	1.0%	0.6%	0.3%	0.3%	0.2%	0.2%	0.1%
Medical	63.2%	54.9%	56.6%	56.5%	61.8%	66.0%	74.7%	79.1%	81.3%	79.9%	81.6%	83.1%	84.9%	83.6%	85.4%	86.0%
Medical-Legal	8.5%	14.8%	19.9%	20.1%	15.8%	16.5%	1.9%	1.6%	1.2%	1.0%	0.7%	0.4%	0.3%	0.3%	0.3%	0.2%
Copy Service	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other***	22.0%	21.9%	14.3%	9.2%	13.1%	14.0%	20.6%	18.1%	16.7%	18.1%	17.2%	16.2%	14.5%	15.9%	14.1%	13.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

* Lien Counts exclude SDI/EDD Liens

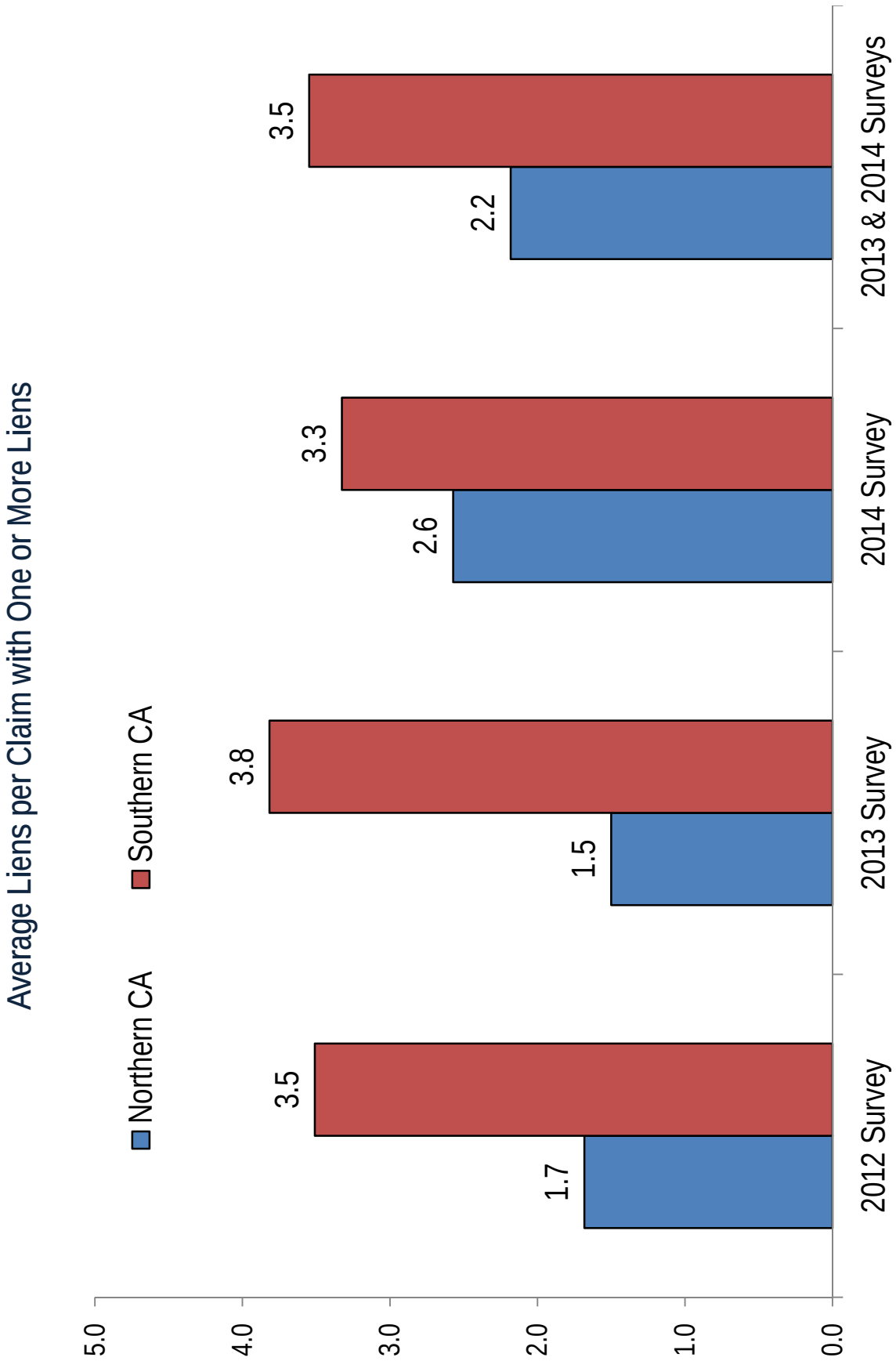
** Regions reflect the following WCAB Office mapping: Bay Area - Oakland, San Jose, San Francisco; Central Coast/Valley - Bakersfield, Fresno, Goleta, Grover Beach, Salinas, Stockton; Los Angeles County - Long Beach, Los Angeles, Marina Del Rey, Pomona, Van Nuys; Remainder of LA Basin - Anaheim, Oxnard, Riverside, San Bernardino, Santa Ana; Remaining CA Zip Codes - Eureka, Redding, Santa Rosa; Sacramento - Sacramento; San Diego County - San Diego

***Other includes Attorney Fees, Family Support, Living Expense, PFL, Transport, Wage Replace Liens

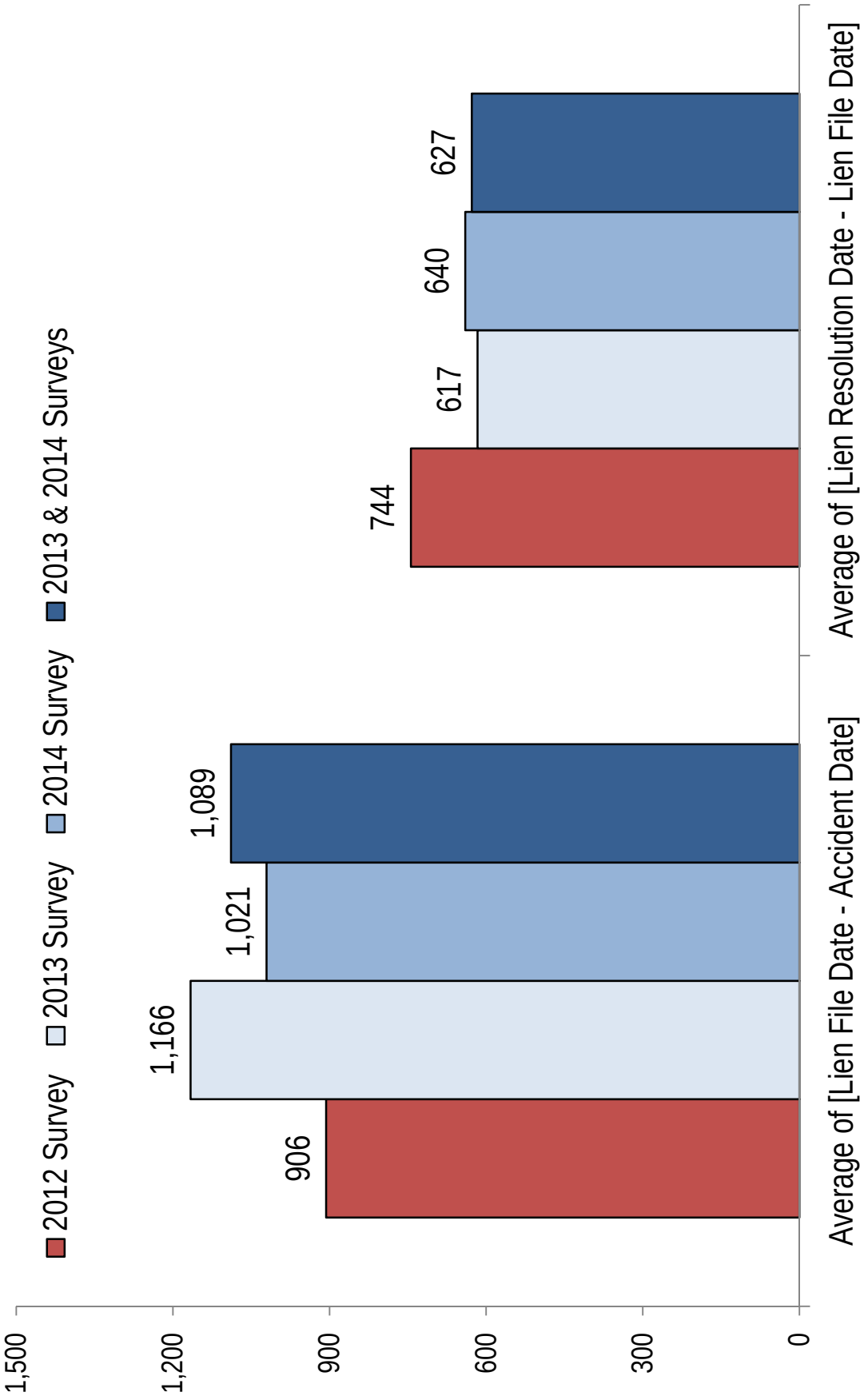
Source: EAMS Liens Data



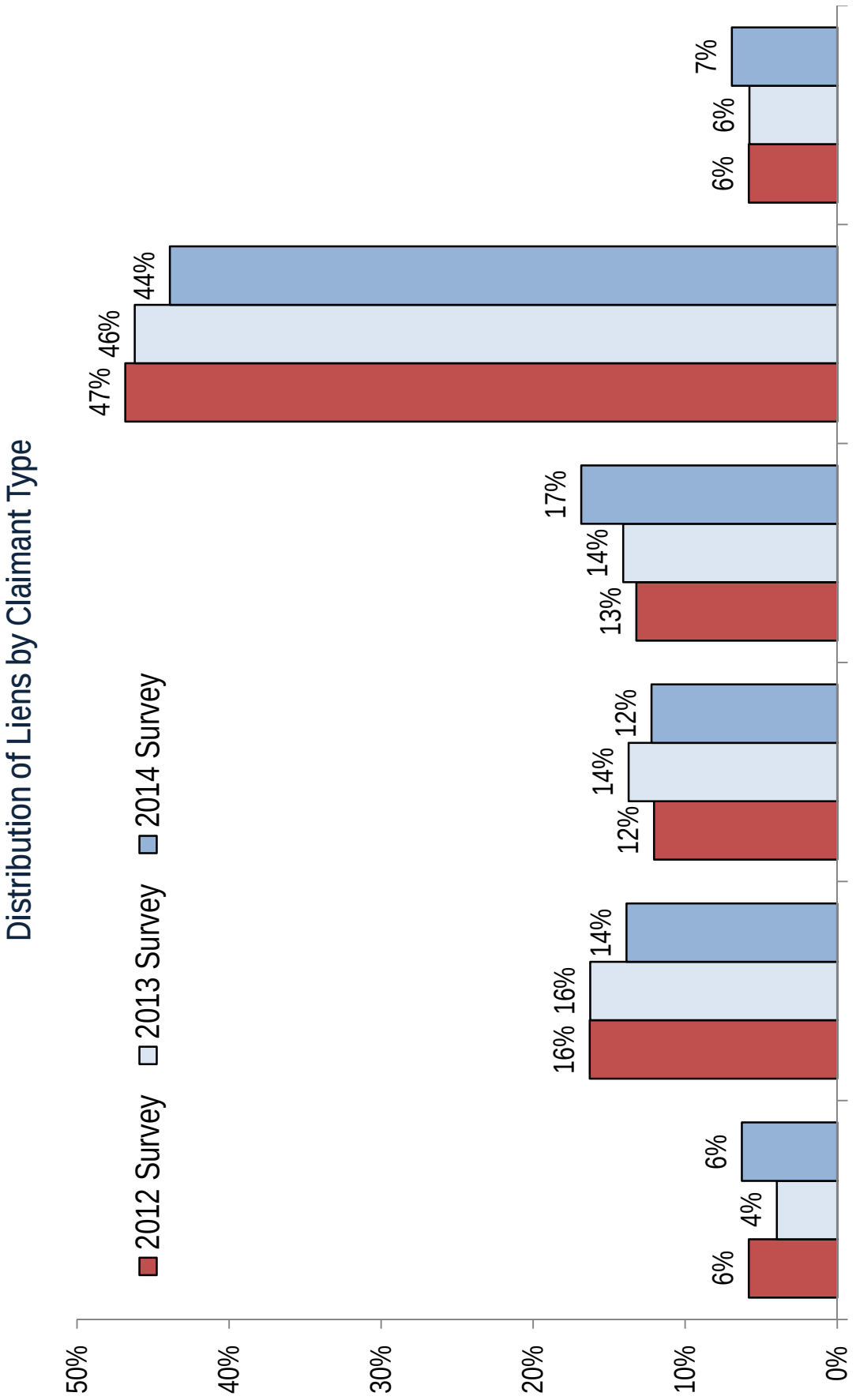
Source: WCIRB Liens Survey. Figures represent liens active during the first six months of the survey year.



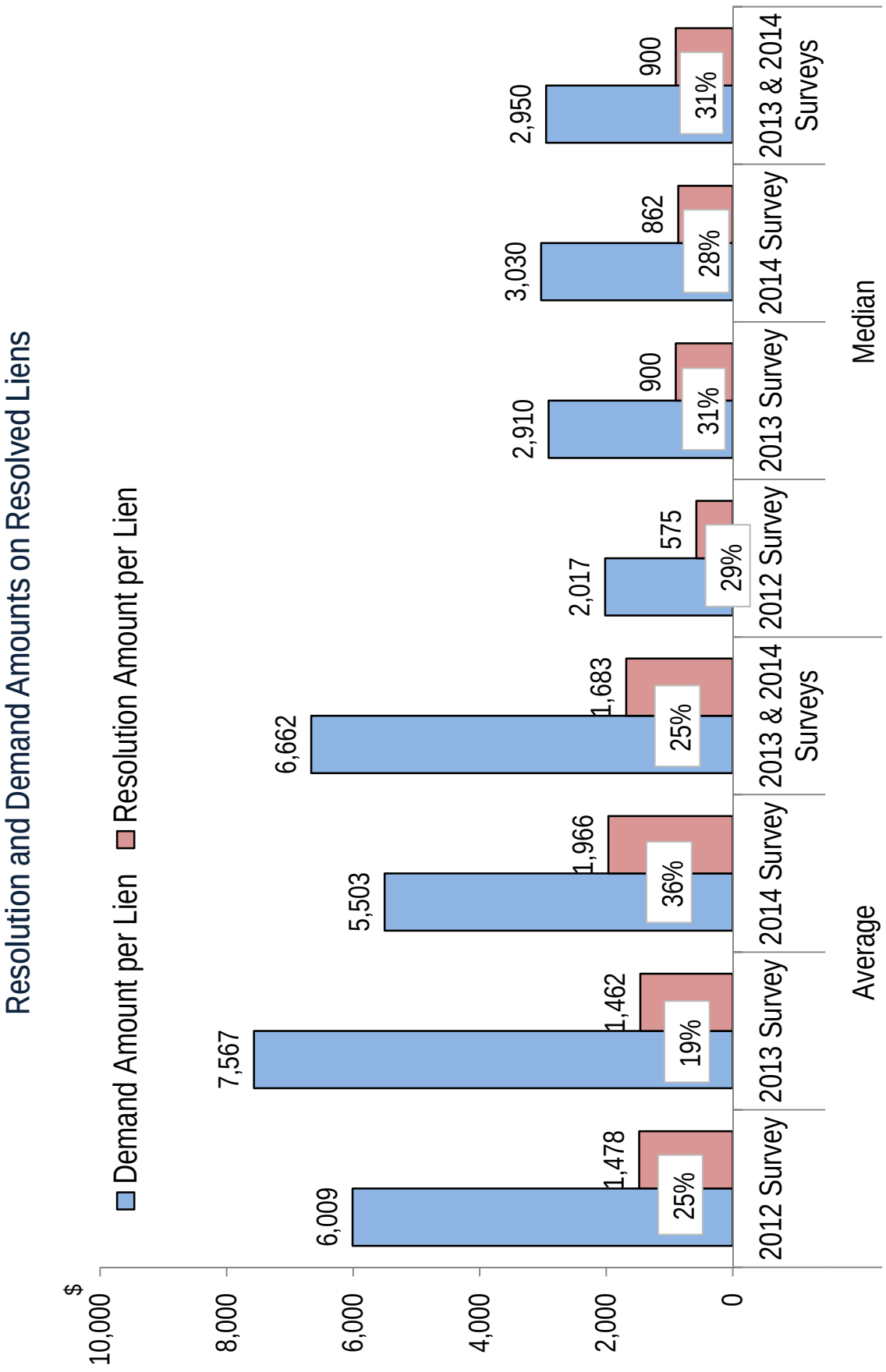
Source: WCIRB Liens Survey. Figures represent liens active during the first six months of the survey year.



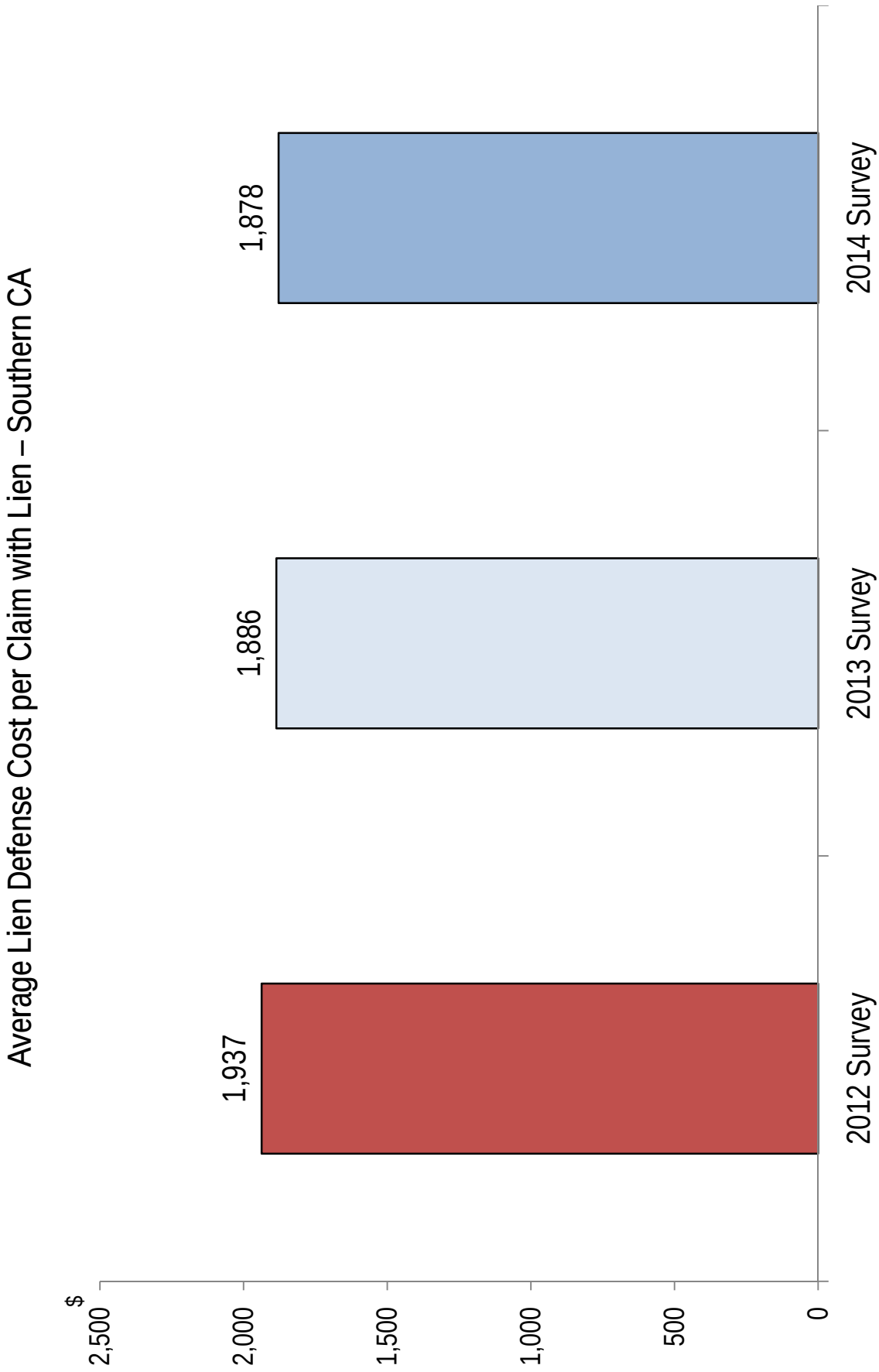
Source: WCIRB Liens Survey. Figures represent liens active during the first six months of the survey year.



Source: WCIRB Liens Survey. Figures represent liens active during the first six months of the survey year. Excludes SDI/EDD liens.



Source: WCIRB Liens Survey. Figures represent liens resolved during the first six months of the survey year.



Source: WCIRB Liens Survey. Figures represent total lien defense costs on claims with at least one lien active during the survey year.

WCIRB Lien Survey Results by Survey Year & Year Lien was Filed

Number of Surveyed Liens with a Lien Demand Amount

Survey Year	Lien Filing Year 2007	2008	2009	2010	2011	2012	2013	2014
2012	43	118	120	142	118	58		
2013		6	19	45	64	102	12	
2014			10	34	59	105	36	34

Median Lien Demand Amount

Survey Year	Lien Filing Year 2007	2008	2009	2010	2011	2012	2013	2014
2012	1,590	2,449	1,812	2,273	1,538	3,118		
2013		4,402	1,885	2,764	2,901	2,872	2,432	
2014			3,400	2,244	1,831	2,250	4,508	2,226

Number of Surveyed Liens with a Lien Resolution Amount

Survey Year	Lien Filing Year 2007	2008	2009	2010	2011	2012	2013	2014
2012	6	16	26	16	27	21		
2013		4	7	15	32	35	5	
2014			0	8	14	30	21	11

Median Lien Resolution Amount

Survey Year	Lien Filing Year 2007	2008	2009	2010	2011	2012	2013	2014
2012	225	855	550	1,191	400	500		
2013		1,773	800	800	1,200	1,000	450	
2014				525	750	500	1,159	400

Percentage of Liens Resolved

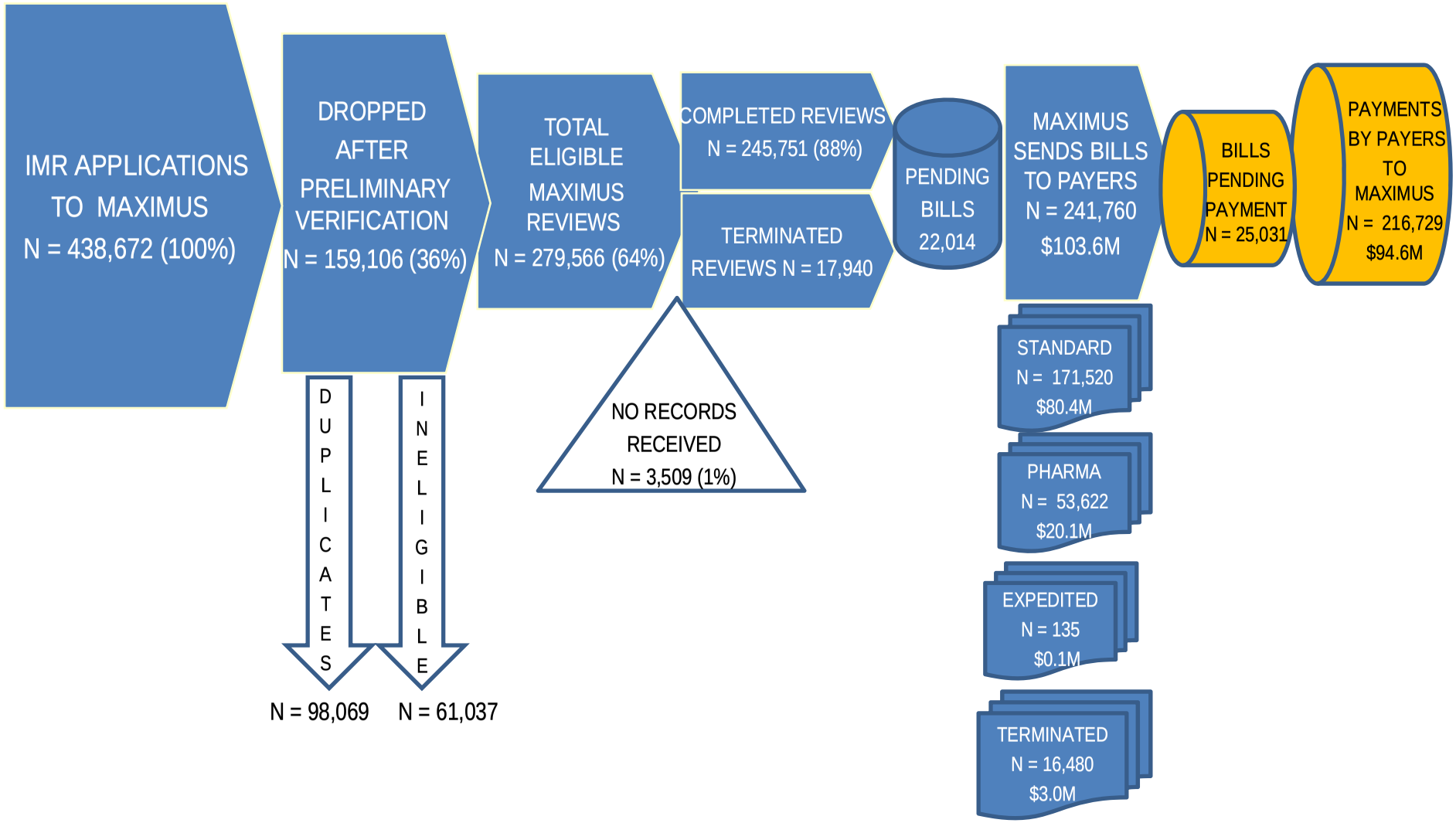
Survey Year	Lien Filing Year 2007	2008	2009	2010	2011	2012	2013	2014
2012	14%	14%	22%	11%	23%	36%		
2013		67%	37%	33%	50%	34%	42%	
2014			0%	24%	24%	29%	58%	32%

Median Lien Resolution Amount as a Percentage of Median Lien Demand

Survey Year	Lien Filing Year 2007	2008	2009	2010	2011	2012	2013	2014
2012	14%	35%	30%	52%	26%	16%		
2013		40%	42%	29%	41%	35%	19%	
2014				23%	41%	22%	26%	18%

Source: WCIRB Liens Survey.

IMR Process Flow – All Applications As of 6/30/2015



Source: DWC from IMR vendor.

Utilization Review Costs as a Percentage of Medical Payments
Based on CWCI 2015 Claims Monitoring Report

	Percent of Medical Cost Containment Payments by MCC Type			Medical Cost Containment as a Percentage of Medical Payments			UR/IMR/IBR* as a Percentage of Medical Payments		
	(1)	**(2)**		**(3)**	**(4)**	**(5)**	**= (3) X (1)**	**= (4) X (1)**	**= (5) X (1)**
Transaction Year	UR/IMR/IBR*	Medical Bill Review/PPO/MPN	Accident Year	9 Months	12 Months	24 Months	9 Months	12 Months	24 Months
2005	40.4%	59.6%	2005	11.7%	11.9%	11.2%	4.7%	4.8%	4.5%
2006	45.8%	54.2%	2006	14.4%	14.2%	12.5%	6.6%	6.5%	5.7%
2007	50.2%	49.8%	2007	15.2%	15.0%	13.6%	7.6%	7.5%	6.8%
2008	50.8%	49.2%	2008	16.4%	16.4%	14.6%	8.3%	8.3%	7.4%
2009	51.1%	48.9%	2009	16.8%	16.6%	14.8%	8.6%	8.5%	7.6%
2010	52.7%	47.3%	2010	16.6%	16.6%	14.7%	8.7%	8.7%	7.7%
2011	51.7%	48.3%	2011	17.3%	16.6%	14.1%	8.9%	8.6%	7.3%
2012	50.9%	49.1%	2012	16.5%	16.4%	14.2%	8.4%	8.3%	7.2%
2013	51.0%	49.0%	2013	17.0%	17.0%		8.7%	8.7%	
2014	54.7%	45.3%	2014	16.3%			8.9%		

Paid MCCP Costs as a Percentage of Paid Medical Costs
Based on WCIRB Aggregate Data

Calendar Year	
2007	7.1%
2008	9.6%
2009	9.1%
2010	9.2%
2011	9.4%
2012	9.2%
2013	9.2%
2014	10.1%

*IMR and IBR did not become effective until 2013 and few payments for IMR or IBR were made in 2013.

Percentage of Represented and Unrepresented Permanent Disability Claims by Region
First and Second Report Level

First Survey Level

	Northern California				
	AY2008	AY2009	AY2010	AY2011	AY2012
% Represented	60.9%	61.4%	62.5%	63.3%	63.2%
% Unrepresented	39.1%	38.6%	37.5%	36.7%	36.8%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

	Southern California				
	AY2008	AY2009	AY2010	AY2011	AY2012
% Represented	78.9%	77.3%	78.8%	76.8%	80.6%
% Unrepresented	21.1%	22.7%	21.2%	23.2%	19.4%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Second Survey Level

	Northern California				
	AY2007	AY2008	AY2009	AY2010	AY2011
% Represented	61.4%	61.6%	65.6%	64.1%	65.6%
% Unrepresented	38.6%	38.4%	34.4%	35.9%	34.4%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

	Southern California				
	AY2007	AY2008	AY2009	AY2010	AY2011
% Represented	79.6%	79.1%	79.4%	79.4%	78.7%
% Unrepresented	20.4%	20.9%	20.6%	20.6%	21.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Note: Claims are assigned to Northern and Southern California regions based on the WCAB office code reported on the Permanent Disability Claim Survey forms. If the WCAB office code was not reported, the zip code of the claimant's residence was used.

Source: WCIRB Permanent Disability Claim Survey at first survey level for each accident year (AY)

Temporary Disability Outcomes

Accident Year	Average Duration of TD Payments in Days Based on CWCI ICIS Data		Average Duration of TD in Weeks Based on WCIRB PD Claim Survey
	12 Months	24 Months	First Survey Level
2005	75.5	108.0	42.4
2006	79.6	112.4	44.2
2007	78.4	111.5	47.2
2008	80.4	117.5	50.4
2009	83.0	129.6	48.5
2010	91.8	132.8	46.2
2011	84.2	128.5	44.6
2012	91.0	137.1	43.9
2013	92.4		

Annual Change

Accident Year	Average Duration of TD Payments in Days Based on CWCI ICIS Data		Average Duration of TD in Weeks Based on WCIRB PD Claim Survey
	12 Months	24 Months	First Survey Level
2006	5.4%	4.1%	4.2%
2007	-1.5%	-0.8%	6.9%
2008	2.6%	5.4%	6.8%
2009	3.2%	10.3%	-3.8%
2010	10.6%	2.5%	-4.7%
2011	-8.3%	-3.2%	-3.6%
2012	8.1%	6.7%	-1.5%
2013	1.5%		

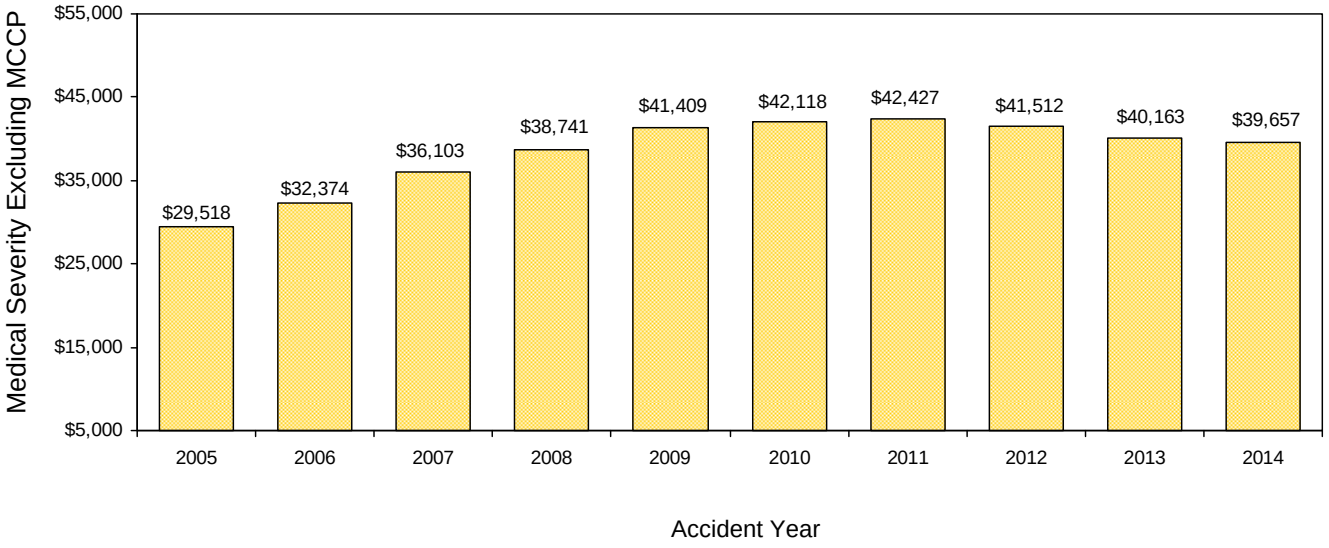
Note: First Survey Level is valued at approximately 28 months.

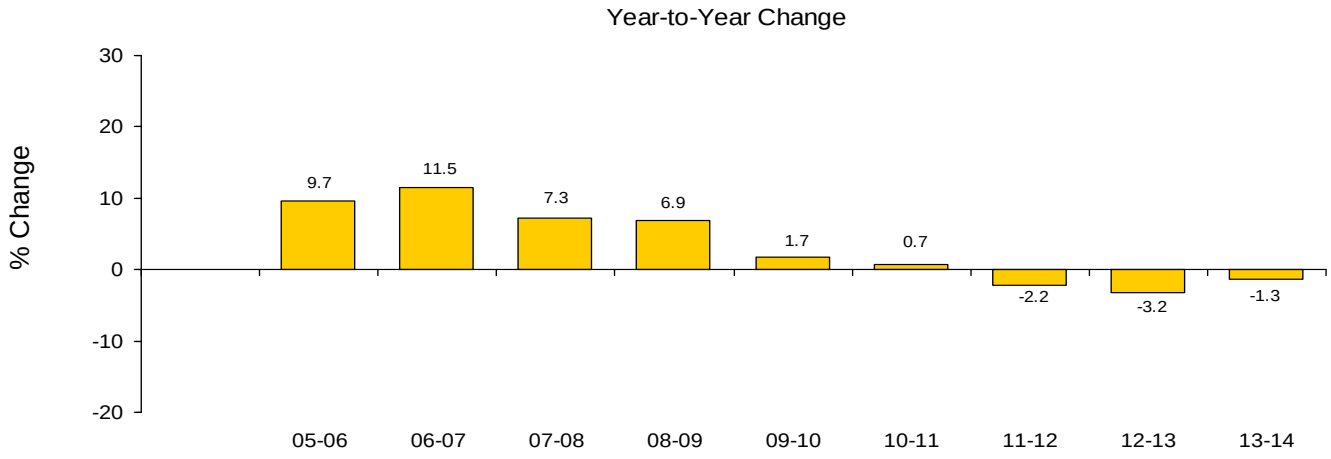
MPN Utilization Based on CWCI ICIS Data

Accident Year	Percentage of First Year Visits to Network Providers		Percentage of First Year Payments to Network Providers	
	Total	% Change	Total	% Change
2005	68.7%	---	57.0%	---
2006	70.9%	3.2%	59.4%	4.2%
2007	72.3%	2.0%	60.4%	1.7%
2008	74.9%	3.6%	62.7%	3.8%
2009	76.2%	1.7%	65.2%	4.0%
2010	78.3%	2.8%	67.1%	2.9%
2011	79.8%	1.9%	69.1%	3.0%
2012	80.4%	0.8%	69.0%	-0.1%
2013	80.1%	-0.4%	69.7%	1.0%
2014*	80.4%	0.4%	68.7%	-1.4%

Preliminary: AY 2014 based on the change in visits within the first 30 days from AY 2013 to 2014.

California Workers' Compensation
Estimated Ultimate Medical* Excluding MCCP per Indemnity Claim**
as of June 30, 2015





Source: WCIRB quarterly calls for experience
* Estimated ultimate severities for all accident years were derived by dividing ultimate medical losses on indemnity claims by ultimate indemnity claim counts.
** MCCP excluded from accident years 2010 and prior is estimated based on WCIRB's Annual Calls for Direct California Workers' Compensation Aggregate Indemnity and Medical Costs.

Changes in Medical Treatment Levels – All

Table 19: All: Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	2,084		2,758		2,864		2,909		2,934		2,947
1H2013	2,119	1.02	2,783	1.01	2,862	1.00	2,890	0.99	2,910	0.99	
2H2013	2,122	1.02	2,685	0.97	2,750	0.96	2,777	0.95			
1H2014	2,108	1.01	2,680	0.97	2,740	0.96					
2H2014	1,999	0.96	2,510	0.91							
1H2015	2,106	1.01									

Table 20: All: Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	20.23		24.23		24.74		24.94		25.04		25.12
1H2013	20.41	1.01	24.94	1.03	25.35	1.02	25.49	1.02	25.63	1.02	
2H2013	20.32	1.00	24.14	1.00	24.51	0.99	24.71	0.99			
1H2014	17.99	0.89	22.25	0.92	22.62	0.91					
2H2014	18.25	0.90	21.36	0.88							
1H2015	17.81	0.88									

Table 21: All: Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	103		114		116		117		117		117
1H2013	104	1.01	112	0.98	113	0.98	113	0.97	114	0.97	
2H2013	104	1.01	111	0.98	112	0.97	112	0.96			
1H2014	117	1.14	120	1.06	121	1.05					
2H2014	110	1.06	118	1.03							
1H2015	118	1.15									

Changes in Medical Treatment Levels – Physician Services

Table 1: Physician Fee Schedule: Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	1,082		1,364		1,403		1,417		1,429		1,433
1H2013	1,067	*0.99*	1,367	*1.00*	1,396	*1.00*	1,409	*0.99*	1,419	*0.99*	
2H2013	1,054	*0.97*	1,308	*0.96*	1,336	*0.95*	1,351	*0.95*			
1H2014	1,033	*0.95*	1,297	*0.95*	1,324	*0.94*					
2H2014	1,024	*0.95*	1,236	*0.91*							
1H2015	1,083	*1.00*									

Table 2: Physician Fee Schedule: Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	16.00		19.14		19.52		19.66		19.74		19.81
1H2013	16.06	*1.00*	19.66	*1.03*	19.96	*1.02*	20.07	*1.02*	20.19	*1.02*	
2H2013	16.15	*1.01*	19.23	*1.00*	19.52	*1.00*	19.68	*1.00*			
1H2014	13.52	*0.84*	16.93	*0.88*	17.20	*0.88*					
2H2014	14.35	*0.90*	16.73	*0.87*							
1H2015	14.10	*0.88*									

Table 3: Physician Fee Schedule: Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	68		71		72		72		72		72
1H2013	66	*0.98*	70	*0.98*	70	*0.97*	70	*0.97*	70	*0.97*	
2H2013	65	*0.97*	68	*0.96*	68	*0.95*	69	*0.95*			
1H2014	76	*1.13*	77	*1.08*	77	*1.07*					
2H2014	71	*1.06*	74	*1.04*							
1H2015	77	*1.14*									

Changes in Medical Treatment Levels – Pharmaceuticals

Table 4: Pharmacy Fee Schedule: Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	685		748		766		776		782		785
1H2013	736	*1.07*	799	*1.07*	811	*1.06*	818	*1.05*	823	1.05	
2H2013	714	*1.04*	772	*1.03*	783	*1.02*	789	*1.02*			
1H2014	701	*1.02*	733	*0.98*	744	*0.97*					
2H2014	596	*0.87*	626	*0.84*							
1H2015	565	*0.82*									

Table 5: Pharmacy Fee Schedule: Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	6.57		7.09		7.18		7.22		7.24		7.26
1H2013	6.74	*1.03*	7.24	*1.02*	7.29	*1.02*	7.31	*1.01*	7.32	*1.01*	
2H2013	6.57	*1.00*	7.04	*0.99*	7.06	*0.98*	7.08	*0.98*			
1H2014	6.17	*0.94*	6.47	*0.91*	6.49	*0.90*					
2H2014	5.43	*0.83*	5.66	*0.80*							
1H2015	5.18	*0.79*									

Table 6: Pharmacy Fee Schedule: Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	104		106		107		107		108		108
1H2013	109	*1.05*	110	*1.05*	111	*1,04*	112	*1.04*	112	*1.04*	
2H2013	109	*1.04*	110	*1.04*	111	*1.04*	111	*1.04*			
1H2014	114	*1.09*	113	*1.07*	115	*1.07*					
2H2014	110	*1.05*	111	*1.05*							
1H2015	109	*1.04*									

Changes in Medical Treatment Levels – Inpatient Hospital

Table 7: Inpatient Services: Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	20,107		25,101		26,222		26,944		27,292		27,425
1H2013	20,374	*1.01*	24,295	*0.97*	24,946	*0.95*	24,997	*0.93*	25,129	*0.92*	
2H2013	22,166	*1.10*	25,119	*1.00*	25,533	*0.97*	25,625	*0.95*			
1H2014	23.553	*1.17*	26,032	*1.04*	26,158	*1.00*					
2H2014	25,604	*1.27*	28,253	*1.13*							
1H2015	27,682	*1.38*									

Table 8: Inpatient Services: Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	11.38		13.11		13.58		13.78		13.86		13.90
1H2013	11.26	*0.99*	12.85	*0.98*	13.21	*0.97*	13.33	*0.97*	13.39	*0.97*	
2H2013	11.23	*0.99*	13.04	*0.99*	13.27	*0.98*	13.34	*0.97*			
1H2014	13.67	*1.20*	14.80	*1.13*	14.86	*1.09*					
2H2014	14.18	*1.25*	14.80	*1.13*							
1H2015	14.12	*1.24*									

Table 9: Inpatient Services: Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	1,768		1,914		1,930		1,955		1,969		1,974
1H2013	1,809	*1.02*	1,890	*0.99*	1,888	*0.98*	1,876	*0.96*	1,877	*0.95*	
2H2013	1,974	*1.12*	1,926	*1.01*	1,924	*1.00*	1,921	*0.98*			
1H2014	1,723	*0.97*	1,759	*0.92*	1,760	*0.91*					
2H2014	1,805	*1.02*	1,909	*1.00*							
1H2015	1,961	*1.11*									

Changes in Medical Treatment Levels – Outpatient Hospital

Table 10: Outpatient Services: Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	2,785		3,134		3,202		3,231		3,242		3,249
1H2013	2,619	*0.94*	2,758	*0.88*	2,764	*0.86*	2,770	*0.86*	2,792	*0.86*	
2H2013	2,325	*0.83*	2,503	*0.80*	2,533	*0.79*	2,542	*0.79*			
1H2014	2,649	*0.95*	2,758	*0.88*	2,766	0.86					
2H2014	2,284	*0.82*	2,551	*0.81*							
1H2015	2,818	*1.01*									

Table 11: Outpatient Services: Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	4.75		5.26		5.35		5.37		5.39		5.39
1H2013	4.87	*1.03*	5.37	*1.02*	5.39	*1.01*	5.39	*1.00*	5.38	*1.00*	
2H2013	4.83	*1.02*	5.32	*1.01*	5.37	*1.00*	5.37	*1.00*			
1H2014	5.07	*1.07*	5.40	*1.03*	5.44	*1.02*					
2H2014	4.79	*1.01*	5.23	*1.00*							
1H2015	4.79	*1.01*									

Table 12: Outpatient Services: Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	587		596		599		601		602		603
1H2013	537	*0.92*	514	*0.86*	513	*0.86*	513	*0.85*	519	*0.86*	
2H2013	481	*0.82*	470	*0.79*	472	*0.79*	473	*0.79*			
1H2014	522	*0.89*	511	*0.86*	509	*0.85*					
2H2014	477	*0.81*	487	*0.82*							
1H2015	589	*1.00*									

Changes in Medical Treatment Levels – HCPCS

Table 13: HCPCS Schedule: Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	520		620		638		651		655		657
1H2013	497	*0.96*	594	*0.96*	628	*0.98*	633	*0.97*	634	0.97	
2H2013	511	*0.98*	590	*0.95*	601	*0.94*	604	*0.93*			
1H2014	438	*0.84*	497	*0.80*	511	*0.80*					
2H2014	401	*0.77*	480	*0.77*							
1H2015	466	*0.90*									

Table 14: HCPCS Schedule: Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	4.11		4.53		4.61		4.67		4.69		4.70
1H2013	4.06	*0.99*	4.55	*1.00*	4.66	*1.01*	4.69	*1.00*	4.70	*1.00*	
2H2013	3.98	*0.97*	4.32	*0.95*	4.37	*0.95*	4.39	*0.94*			
1H2014	4.74	*1.15*	5.36	*1.18*	5.42	*1.18*					
2H2014	4.52	*1.10*	5.06	*1.12*							
1H2015	4.60	*1.12*									

Table 15: HCPCS Schedule: Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	126		137		138		140		140		140
1H2013	122	*0.97*	131	*0.96*	135	*0.97*	135	*0.97*	135	*0.97*	
2H2013	129	*1.02*	137	*1.00*	138	*0.99*	138	*0.99*			
1H2014	92	*0.73*	93	*0.68*	94	*0.68*					
2H2014	89	*0.70*	95	*0.69*							
1H2015	101	*0.80*									

Changes in Medical Treatment Levels – Medical-Legal

Table 16: Medical-Legal Schedule: Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	1,799		2,082		2,105		2,108		2,110		2,113
1H2013	1,841	*1.02*	2,129	*1.02*	2,149	*1.02*	2,154	*1.02*	2,157	*1.02*	
2H2013	1,896	*1.05*	2,170	*1.04*	2,189	*1.04*	2,193	*1.04*			
1H2014	2,068	*1.15*	2,358	*1.13*	2,377	*1.13*					
2H2014	1,989	*1.11*	2,236	*1.07*							
1H2015	2,079	*1.06*									

Table 17: Medical-Legal Schedule: Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	1.35		1.45		1.46		1.46		1.46		1.46
1H2013	1.31	*0.97*	1.41	*0.97*	1.42	*0.97*	1.42	*0.97*	1.42	*0.97*	
2H2013	1,30	*0.96*	1.39	*0.96*	1.40	*0.96*	1.40	*0.96*			
1H2014	1.30	*0.96*	1.40	*0.97*	1.41	*0.97*					
2H2014	1.26	*0.93*	1.35	*0.93*							
1H2015	1.32	*0.98*									

Table 18: Medical-Legal Schedule: Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2H 2012	Paid through SH + 1	Ratio to 2H 2012	Paid through SH + 2	Ratio to 2H 2012	Paid through SH + 3	Ratio to 2H 2012	Paid through SH + 4	Ratio to 2H 2012	Paid through SH + 5
2H2012	1,330		1,439		1,445		1,444		1,443		1,444
1H2013	1,402	*1.05*	1,512	*1.05*	1,515	*1.05*	1,514	*1.05*	1,514	*1.05*	
2H2013	1,458	*1.10*	1,557	*1.08*	1,562	*1.08*	1,562	*1.08*			
1H2014	1,589	*1.20*	1,680	*1.17*	1,681	*1.16*					
2H2014	1,575	*1.18*	1,658	*1.15*							
1H2015	1,575	*1.18*									

Analysis of the Impact of RBRVS on Medical Payments — 2015 Report

Released November 13, 2015

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Notice

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Executive Summary

The new Resource-Based Relative Value Scale (RBRVS) physician fee schedule pursuant to Senate Bill No. 863 (SB 863) is being phased in over a four-year period. The first phase of the transition became effective January 1, 2014. The fee schedule encompasses approximately 40% of all workers' compensation medical payments. The WCIRB studied comparable periods in 2013, 2014 and 2015 to determine the impact of this new fee schedule.

This study indicates that the financial impact of the new fee schedule on 2014 physician payments was less than originally forecast as there was a significant reduction in the cost of special services and reports that was not initially projected. Preliminary information on the 2015 services suggests that physician costs in 2015 may be emerging at a level generally consistent with projections. In general, as expected, a greater share of total workers' compensation medical payments has shifted to primary care providers.

Background

SB 863 directed the Administrative Director of the Division of Workers' Compensation (DWC) to adopt a physician fee schedule based on a resource-based relative value scale (RBRVS) with the maximum reasonable fees not to exceed 120% of Medicare fees, adjusted for inflation. In late 2013, the Administrative Director adopted a physician fee schedule (California fee schedule) that began the four-year transition to an RBRVS-based fee schedule effective January 1, 2014. In 2015, the California fee schedule was again modified to reflect the second year of the four-year transition to the RBRVS-based fee schedule.

The RBRVS fee schedule which underlies the California fee schedule is maintained and updated by the Centers for Medicare & Medicaid Services (CMS). The CMS fee schedule includes relative value units for each medical service associated with the physician's work and conversion factors that convert the relative value units into a maximum amount to be paid for the service. Physician services covered under the CMS fee schedule encompass approximately 40% of all California workers' compensation medical costs.

On November 14, 2014, the WCIRB published its *Preliminary Analysis of the Impact of RBRVS on Medical* Payments as an attachment to the *Senate Bill No. 863 Cost Monitoring Report – 2014 Retrospective Evaluation.* The report noted that early indications of the impact of RBRVS based on data through June 30, 2014 on payments to physicians for services in 2014 suggested that rather than increasing physician costs in 2014 as initially projected, RBRVS was reducing the total cost of payments to physicians. This decrease was primarily attributable to reduction in the costs of Special Services and Reports. The *Analysis of the Impact of RBRVS on Medical Payments — 2015 Report* is intended to update the preliminary findings in the 2014 report based on medical transaction data collected by the WCIRB with services through June 30, 2015.

Estimated RBRVS Cost Impacts

The use of RBRVS as the basis of California's physician fee schedule has long-term financial implications for the California workers' compensation system. As part of the Amended January 1, 2014 Pure Premium Rate Filing, the WCIRB evaluated the potential cost impact of the transition to RBRVS.[1] In this filing, the WCIRB estimated that the impact of the new fee schedule on policy year 2014 physician payments was +7.3%, which had an estimated impact on overall policy year 2014 medical costs of +3.6%. With respect to services provided in 2014, the WCIRB originally estimated a +2.4% impact on physician services. The WCIRB originally estimated that the impact of RBRVS on 2015 physician services would be +1.6%.

As part of its SB 863 cost monitoring plan, the WCIRB evaluates its prospective assessment of SB 863 components against the post-SB 863 data actually emerging. Currently, the WCIRB has collected eighteen months of post-RBRVS experience from its medical transaction database. In this report, the WCIRB used this data to answer the following questions:

1. What is the overall financial impact of RBRVS?
2. How did the impact of RBRVS compare to the WCIRB's projections?
3. What were the differential impacts by fee schedule section?
4. Did RBRVS shift the share of total payments from specialists to primary care providers?
5. Which types of procedures and services increased or decreased most in frequency and cost?

[1] Section B of the WCIRB's Amended January 1, 2014 Pure Premium Filing submitted on October 23, 2013.

What is the Overall Financial Impact of RBRVS?

To determine the overall impact of RBRVS based on the information through June 30, 2015, the WCIRB compared medical services and payments from 2013 (pre-RBRVS) to 2014 and from the first two quarters of 2015 (post-RBRVS). Table 1 shows provider services delivered and paid by six-month service intervals, allowing comparability in payment development over these periods. For services in the first two quarters of 2014 compared to the first two quarters of 2013, the data show a 6.0% decrease over an 18-month payment period. In the first half of 2015, payments increased by approximately 1.5% over the first six months of 2014.

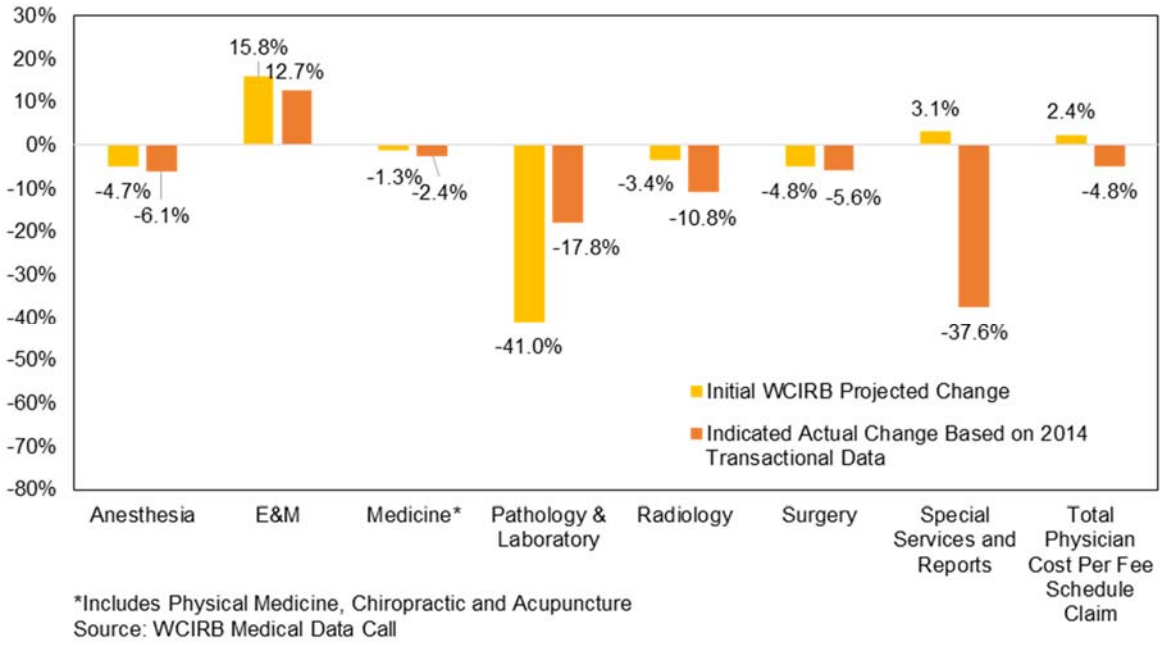
Table 1: Fee Schedule Payments by Service and Payment Half (in millions)

Service Half	Paid within 1H 2013 OMFS	Paid within 2H 2013 OMFS	Paid within 1H 2014 RBRVS	Paid within 2H 2014 RBRVS	Paid within 1H 2015 RBRVS	Total
1H 2013	$302.2	$160.3	$18.5	$8.5	$7.5	$496.9
2H 2013		$310.6	$136.7	$17.0	$10.5	$474.8
1H 2014			$291.9	$142.7	$17.7	$452.2
2H 2014				$299.4	$120.2	$419.5
1H 2015					$296.2	$296.2

How Did the Impact of RBRVS Compare to the WCIRB's Projections?

Projections for 2014
The WCIRB's Amended January 1, 2014 Pure Premium Rate Filing projected a 2.4% increase on a per claim basis for 2014 physician fee schedule services compared to 2013. Table 2 shows that actual payments per claim for calendar year 2014 decreased by 4.8% compared to 2013. This decrease was driven by a 37.6% reduction in payments for Special Services and Reports. All other fee schedule sections experienced declines in 2014, except for Evaluation & Management (E&M) which increased by 12.7% over 2013, and is consistent with WCIRB projections.

Table 2: Projected vs. Actual Change in Physician Fees – 2013 to 2014
Impact of RBRVS on Physician Fees for Service Year 2014

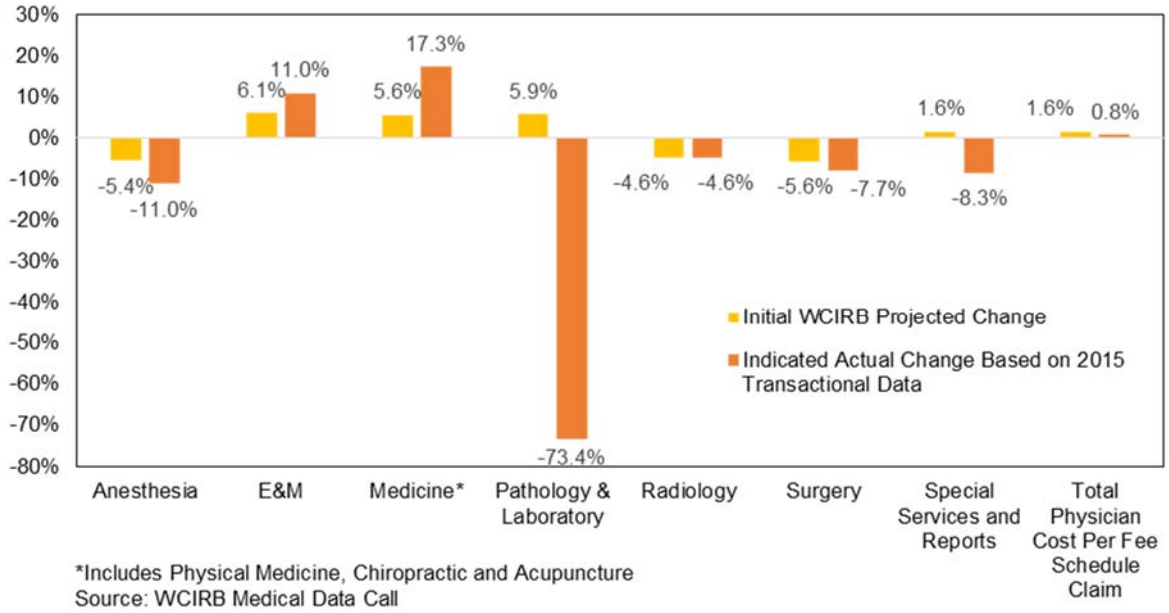


*Includes Physical Medicine, Chiropractic and Acupuncture
Source: WCIRB Medical Data Call

Projections for 2015

The WCIRB's Amended January 1, 2014 Pure Premium Rate Filing projected a 1.6% increase on a per claim basis for 2015 California fee schedule services compared to services provided in 2014. Table 3 shows an overall 0.8% increase for services through the first six months of 2015 compared to the first six months of 2014. Increases in E&M and Medicine services exceeded WCIRB projections. These results were offset by greater-than-expected decreases in other fee schedule services, especially Pathology and Laboratory services.

Table 3: Projected vs. Actual Change in Physician Fees – 2014 to 2015
Impact of RBRVS on Physician Fees for Service Year 2015



*Includes Physical Medicine, Chiropractic and Acupuncture
Source: WCIRB Medical Data Call

Cumulative 2013 to 2015 Projections

The WCIRB forecasted the impact of the cumulative service year 2015 RBRVS changes by section in its Amended January 1, 2014 Pure Premium Rate Filing. As shown in Table 4, WCIRB's forecasts for 2015 projected a 22.9% increase for E&M codes for the 2013 to 2015 period compared to the actual increase of 25.6%. Medicine was projected to increase by 4.2% compared to its actual 10.0% rise. For Surgery, the WCIRB forecasted a 10.1% drop in 2015 compared to the actual 11.1% decline. Other specialty sections such as Anesthesia and Radiology decreased somewhat more than projections. The widest diverergences were for Special Services and Reports for which costs declined by 34.2% from 2013 and for Pathology and Laboratory services which showed a 73.7% drop in costs from 2013.

Table 4: Actual Fee Schedule Changes in Paid Medical From 2013 to 2015 Compared to WCIRB Forecast (in $000s)

Type of Service	1st Half 2013 Paid Medical	1st Half 2013 Paid per Transaction	1st Half 2015 Paid Medical	1st Half 2015 Paid per Transaction	% Change in Paid Medical 2013 to 2015	WCIRB Forecasted Change from 2013 to 2015
Anesthesia	$6,485	$347	$5,497	$324	-15.2%	-9.8%
Evaluation & Management	$84,136	$87	$105,699	$113	+25.6%	+22.9%
Medicine	$73,851	$34	$81,240	$39	+10.0%	+4.2%
Radiology	$31,545	$129	$26,859	$110	-14.9%	-7.8%
Surgery	$57,890	$372	$51,435	$407	-11.1%	-10.1%
Pathology & Laboratory	$15,907	$54	$4,170	$25	-73.7%	-37.5%
Special Services & Reports	$32,349	$43	$21,281	$53	-34.2%	+4.7%
Total Physician Fee Schedule	$302,163	$66	$296,181	$75	-2.0%	+4.0%

What Were the Differential Impacts by Fee Schedule Section?

2013 to 2014

Table 5 examines each section of the fee schedule for 2014 compared to 2013. These findings show that there were reductions in the volume of total paid transactions for most categories, except Pathology and Laboratory. The total number of Special Services and Reports paid transactions dropped by 25%. This change appears to be the result of the new RBRVS-based fee schedule's elimination of reimbursements for most progress reports starting in 2014. Instead, these reports appear to have been bundled into E&M codes, which increased significantly under the 2014 RBRVS adjustments. The decline in Special Services and Reports and the rise in E&M services was borne out by the findings.

- **Evaluation & Management**
  Paid amounts for E&M increased by 12% in 2014. This increase was primarily driven by the 25% upward adjustment in RBRVS for E&M payments, which more than offset a 10% decline in paid E&M transactions.

- **Medicine**
  Medicine (including physical therapy, psychiatry, acupuncture, chiropractic, and office-based procedures) declined in total payments by 3% in 2014. Reflecting the RBRVS upward adjustment for these services, the paid amount per transaction increased by 9% in 2014. Medicine services, however, experienced an 11% drop in paid transactions, resulting in an overall reduction in payments compared to the previous year.
- **Surgery**
  Total reimbursements for Surgery declined by 6% in 2014 compared to 2013. This reduction was primarily generated by a 15% drop in paid transactions, reflecting less utilization. However, the paid per transaction for Surgery increased by 10% in 2014, despite a downward adjustment for these services in RBRVS. This suggests that more highly reimbursed procedures were provided in the Surgery category more than offsetting the general reduction in values for Surgery procedures under RBRVS.
- **Anesthesiology**
  Anesthesiology payments declined by 6% in 2014, consistent with the Surgery trends. This change was driven by the 2014 RBRVS adjustment for these services which led to a 1% decline in paid per transaction with a 6% decline in the number of Anesthesiology transactions.
- **Radiology**
  Radiology payments declined by 11% in 2014.This change reflected a 2% drop in paid transactions and a 10% decline in average paid amount per transaction. This change was consistent with the January 2014 average fee schedule adjustment for these Radiology services.
- **Pathology and Laboratory**
  Pathology and Laboratory payments declined by 18% in 2014. The 26% drop in paid per transaction was generally consistent with RBRVS adjustments for these services. However, a 10% increase in 2014 in paid Pathology and Laboratory transactions somewhat offset the impact of the fee schedule value reductions for these services.
- **Special Services and Reports**
  Special Services and Reports payments declined 38% in 2014, accounting for the majority of overall indicated California fee schedule savings in 2014. The number of transactions for Special Services and Reports decreased by 25% in 2014 and the paid per transaction declined by 18%. The amounts shown for Special Services and Reports in 2014 reflect the cost of reports that were reimbursed using the new DWC set of reporting codes introduced in 2014.

Table 5: Fee Schedule Payments by Section
Calendar Year 2013 vs. Calendar Year 2014 (in $000s)

Type of Service	CY 2013 Paid Medical	CY 2013 Paid Trans.	CY 2013 Paid per Trans.	CY 2014 Paid Medical	Diff. CY 2014-2013	CY 2014 Paid Trans.	Diff. CY 2014-2013	CY 2014 Paid per Trans.	Diff. CY 2014-2013
Anesthesia	$16.2	47.0	$345	$15.1	-6.3%	44.3	-5.7%	$342	-1 %
Evaluation & Management	$211.4	2,404.3	$88	$237.6	+12.4%	2,157.4	-10.3%	$110	+25.0%
Medicine	$188.6	5,437.9	$35	$183.5	-2.7%	4,837.1	-11.0%	$38	+8.6%
Radiology	$79.0	624.7	$126	$70.3	-11.0%	615.0	-1.6%	$114	-9.5%
Surgery	$141.9	392.3	$362	$133.6	-5.9%	335.1	-14.6%	$399	+10.2%
Pathology & Laboratory	$41.8	752.7	$55	$34.2	-18.0%	826.2	+9.7%	$41	-25.5%
Special Services & Reports	$94.2	1,885.6	$50	$58.7	-37.8%	1,418.2	-24.8%	$41	-18.0%
Total Physician Fee Schedule	$773.1	11,544.5	$67	$733.1	-5.1%	10,233.3	-11.4%	$72	+7.5%
# of Claims with Fee Schedule Payments	445,887			444,583	-0.3%				

2014 to 2015
Table 6 compares the changes in fee schedule sections for the first six months of 2015 to the first six months of 2014. On a combined basis, all measures for the first half of 2015 including total paid amounts, total transactions and paid per transaction increased by approximately 1%. However, there were significant changes by fee schedule section.

- **Evaluation and Management**
  Reflecting the annual RBRVS adjustments, paid amounts for E&M services increased 12% in 2015, consistent with the 2014 increase. The number of E&M transactions increased 8% in 2015 and the average paid amount per E&M transaction increased 4%.
- **Medicine**
  Medicine (including physical therapy, psychiatry, acupuncture, chiropractic and office-based procedures) fee schedule values also were adjusted upward in 2014 and 2015 by RBRVS. Although payment increases were not observed in 2014, the first half of 2015 did show significant increases. Total paid amounts for these services increased by 18% in the first half of 2015, compared to a 2.7% decrease in calendar year 2014. This change was primarily generated by a sharp rise in physical therapy utilization which, when combined with the upward RBRVS unit paid cost adjustments, led to a 24% increase in physical medicine payments in the first half of 2015.
- **Surgery**
  Total reimbursements for Surgery declined by 7% in in the first half of 2015, primarily reflecting a 5% drop in the number of transactions. The paid amount per transaction remained relatively flat, indicating that more highly reimbursed surgical procedures were provided in 2015 despite generally lower fee schedule values.
- **Anesthesiology**
  Total Anesthesiology paid amounts declined in the first half of 2015 with reductions both in the

number of transactions and in the average paid per transaction. These reductions continued the trend starting in 2014, with the RBRVS fee schedule adjustments for this specialty.

- **Radiology**
  Radiology payments declined 4% in the first half of 2015. This reduction was driven by a 6% drop in the average paid per transaction which more than offset a 2% increase in the number of paid transactions.
- **Pathology and Laboratory**
  Total payments for Pathology and Laboratory services declined 73% in the first half of 2015. This reduction was driven by sharp drops in utilization (as measured by paid transactions) and amounts paid per transaction. Although significant Pathology and Laboratory fee schedule value reductions were part of the 2014 introduction of RBRVS, these declines were not observed until 2015. Two factors related to the RBRVS appear to have driven this decline. First, many Pathology and Laboratory procedures are governed by Medicare's Clinical Laboratory Fee Schedule (CLFS) and appear as codes under the Health Care Procedure Coding System (HCPCS), which are captured elsewhere by the WCIRB. Second, consistent with Medicare procedures, payers appear to be more frequently rejecting bills that are generated on a per-assay basis and, instead, are paying for bills reflecting any or all assays occurring at a single patient visit.
- **Special Services and Reports**
  Total payments for Special Services and Reports declined 10% in the first half of 2015, continuing a trend that began with the introduction of RBRVS in January 2014. The transactions for Special Services and Reports decreased by 27% in in the first half of 2015, which was comparable to the rate of reduction in 2014. These services experienced a 23% increase in the average paid per transaction in the first half of 2015, likely reflecting less frequent submission of low value "boiler plate" progress reports and the use of the new the DWC reporting codes.

Table 6: Comparison of Physician Services by Fee Schedule Section
1st Half 2014 to 1st Half 2015 (in $000s)

Type of Service	1st Half 2014 Paid	1st Half 2014 Paid Trans.	1st Half 2014 Paid per Trans.	1st Half 2015 Paid	Diff. from 1st Half 2014	1st Half 2015 Paid Trans.	Diff. from 1st Half 2014	1st Half 2015 Paid per Trans	Diff. from 1st Half 2014
Anesthesia	$6,133	18	$340	$5,497	-10%	17	-6%	$324	-5%
Evaluation & Management	$94,549	869	$109	$105,699	+12%	935	+8%	$113	+4%
Medicine	$68,782	1,806	$38	$81,240	+18%	2,079	+15%	$39	+3%
Radiology	$27,958	240	$117	$26,859	-4%	244.	+2%	$110	-6%
Surgery	$55,331	133	$416	$51,435	-7%	126.	-5%	$407	-2%
Pathology & Lab	$15,569	313	$49	$4,170	-73%	166	-48%	$25	-48%
Special Services & Reports	$23,604	550	$43	$21,281	-10%	404	-27%	$53	+23%
Total Physician Fee Schedule	$291,926	3,929	$74	$296,181	+1.4%	3,971	+1.1%	$75	+1%
# of Claims with Fee Schedule Payments	268,812			270,791	+0.9%				

Did RBRVS Shift the Share of Total Payments from Specialists to Primary Care Providers?

The RBRVS methodology involves major changes in the way specific services are reimbursed. The adjustments in fee schedule factors were expected to shift more of the total payments to primary care and less to physician specialists. WCIRB results based on the initial eighteen months of post-RBRVS experience suggest that this objective was achieved. As shown in Table 7, the share of paid services defined as Primary Care (E&M and Medicine) increased by 9.4% from 2013 to 2015.The share of Specialty Care (Anesthesia, Pathology, Radiology and Surgery) declined by a corresponding 9.4%.

Table 7: Share Paid Medical to Primary Care vs. Specialists
First Halves of 2013, 2014 and 2015

Type of Service	1st Half 2013 % of Total Medical Paid	1st Half 2014 % of Total Medical Paid	Change from 2013	1st Half 2015 % of Total Medical Paid	Change from 2013
Evaluation & Management	31.2%	35.2%	+4.0%	38.4%	+7.2%
Medicine	27.4%	25.6%	-1.8%	29.6%	+2.2%
Total Primary Care	58.6%	60.8%	+2.2%	68.0%	+9.4%
Radiology	11.7%	10.4%	-1.3%	9.8%	-1.9%
Surgery	21.5%	20.6%	-0.9%	18.7%	-2.8%
Pathology & Laboratory	5.9%	5.8%	-0.1%	1.5%	-4.4%
Anesthesia	2.4%	2.4%	-0.0%	2.0%	-0.4%
Total Specialist	41.4%	39.2%	-2.2%	32.0%	-9.4%
Total Physician Fee Schedule*	100%	100%		100%	

Which Types of Procedures and Services Increased or Decreased Most in Frequency and Cost?

Two sections of the fee schedule, Pathology and Laboratory, and Medicine, showed very significant changes in 2015. Table 8 shows the changes in the first six months of 2015 for Pathology and Laboratory services relative to the first six months of 2014. The table indicates that the three most highly reimbursed codes (qualitative chromatography, quantitative chromatography and assay of opiates) accounted for 80% of the decline in Pathology and Laboratory payments in 2015. As noted above, this decrease was driven, in part, by reimbursing on a bundled per-visit basis rather than on a per-assay basis. As shown in Table 8, only 20% of the submitted transactions for these codes were paid in the first half of 2015, compared to 34% in the first half of 2014. In addition, some services are more frequently billed using Medicare's HCPCS "G" codes. (These payments are collected by the WCIRB in its overall tracking of medical costs.)

Table 8: Changes in Payments for Top 3 Pathology Codes-
First Halves 2014 and 2015 (in $millions)

Procedure Code	Description	1st Half 2014			1st Half 2015		
		2014 Paid	% of Submitted Trans. Paid	Paid per Trans.	2015 Paid	% of Submitted Trans. Paid	Paid per Trans.
82486	Qualitative Chromatography	$6.0	35.6%	$262	$1.6	17.3%	$265
82491	Quantitative Chromatography	$4.8	18.6%	$486	$1.4	14.6%	$265
83925	Assay of Opiates	$4.4	43.6%	$122	$1.7	23.7%	$92
	Total Paid – Top 3 codes	$15.2	34.4%	$221	$4.7	20.0%	$157
	Annual Change – Top 3 codes	-$.3			-$10.5		
	Total Paid – All Path/Lab	$28.4	52.4%	$54	$14.3	39.1%	$37
	Annual Change All Path/Lab				-$14.1		-$17

Table 9 shows the changes in 2015 for services classified as Medicine. These services include physical therapy, acupuncture, chiropractic, psychiatry and various physical testing procedures. Virtually the entire 2015 increase in medicine payments was driven by physical therapists, chiropractors and acupuncturists. Although the values for the RBRVS codes for these services rose by approximately 3% in 2015, the 18% annual increase was largely driven by increased utilization by the three groups of medicine providers. Physical therapists, in particular, generated a 24.3% increase in payments in the first six months of 2015 over the first six months of 2014 accounting for the majority of the increase in medicine payments. The average cost per physical therapy transaction rose by 6.2% in the first half of 2015 suggesting that most of this increase in services was driven by an increase in the number of transactions.

Table 9: Changes in Payments to Medicine Section of Provider Fee Schedule
First Halves 2014 and 2015 (in $000s)

Type of Procedure	1st Half 2014 Paid	1st Half 2014 Paid Per Trans.	1st Half 2015 Paid	Difference from 2014	1st Half 2015 Paid per Trans.	Difference from 2014
Physical Therapy	$49.8	$33	$61.9	+24.3%	$35	+6.2%
Testing & Physical Procedures	$5.1	$118	$5.1	-0.6%	$116	-1.9%
Psychiatry	$4.2	$100	$4.2	+0.3%	$111	+11.3%
Acupuncture	$3.0	$35	$4.0	+33.3%	$35	+0.4%
Chiropractic	$2.7	$43	$3.1	+14.8%	$45	+6.5%
Other, Misc.	$4.0	$74	$2.9	-26.0%	$76	+2.2%
	$68.8	$38	$81.2	+18.1%	$39	+2.6%

Summary of WCIRB Findings

The WCIRB's assessment, based on the medical transactions paid through the first eighteen months after the introduction of RBRVS, indicates:

1. The financial savings generated by the RBRVS schedule are reflected in payment development for services delivered in 2014 compared to 2013. Payments declined by 6% for these services, which have been solely governed by the RBRVS schedule. The cost of physician services delivered in the first half of 2015 have increased by 1.5% compared to the first half of 2014.

2. The RBRVS fee schedule transition has had an impact on each section of the California fee schedule. In 2014, the first year of the four-year transition to RBRVS, payments for Special Services and Reports experienced a sharp decline from the prior year. As intended by the fee schedule, E&M payments increased in 2014 and again in 2015. Medicine payments, which were subject to upward fee schedule adjustments in 2014, did not experience a sharp increase until 2015. Payments for Surgery, Radiology, Anesthesiology, and Pathology and Laboratory all experienced declines during the 18 months since the introduction of RBRVS.

3. The overall impact of the RBRVS schedule has not increased costs as projected by the WCIRB in its initial prospective evaluation. Instead of a 4% overall cumulative increase from 2013 to 2015, physician fee schedule payments have declined by 2% during that period. This decrease was driven primarily by a reduction in utilization (as measured by paid transactions) particularly with respect to Special Services and Reports. This change offset the RBRVS scheduled increases in unit price for primary care transactions (as measured by paid per transaction). In the first half of 2015, overall costs subject to the fee schedule were emerging at a level generally consistent with initial WCIRB projections.

4. As expected, RBRVS shifted the total share of medical payments from specialists to primary care providers. The share of payments for primary care (E&M and Medicine) increased by 9.4% from 2013 to 2015 while the payment share for specialty care (Pathology and Laboratory, Surgery, Anesthesiology and Radiology) correspondingly declined.

5. Specific sections of the fee schedule experienced dramatic changes in 2015. Pathology and Laboratory services declined sharply in 2015, driven in part by changes in the application of

Medicare reimbursement rules authorized by RBRVS. Medicine services, including physical therapy, acupuncture and chiropractic procedures sharply increased in 2015, largely driven by an upsurge in utilization.

This assessment is based on eighteen months of medical services and payment data subsequent to the initial year of the four-year transition to RBRVS. As such, WCIRB will regularly update these findings to determine if these initial trends persist.

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