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David M. Bellusci
Executive Vice President, Chief Operating Officer & Chief Actuary

October 28, 2013

By Email Only

Christina Carroll
Staff Counsel
California Department of Insurance
Government Law Bureau
300 Capitol Mall, 17th Floor
Sacramento, CA 95814

RE: January 1, 2014 Pure Premium Rate Filing – CDI File No. REG-2013-00012 – Cost Monitoring Report

Dear Ms. Carroll:

On March 27, 2013, the WCIRB submitted its comprehensive plan to monitor the impact of Senate Bill No. 863 (SB 863). As discussed, at the California Department of Insurance (CDI) October 28, 2013 public hearing on the WCIRB's January 1, 2014 Pure Premium Rate Filing, the WCIRB has completed its 2013 report monitoring the impact of SB 863.

Attached is the WCIRB's 2013 SB 863 Cost Monitoring Report, which was prepared in conformance with the monitoring plan submitted to you earlier this year.

Please let me know if you have any questions or if there is any additional information we can provide.

Sincerely,

David M. Bellusci
Executive Vice President,
Chief Operating Officer & Chief Actuary

Enclosures
cc: Bryant Henley, CDI
Giovanni Muzzarelli, CDI
Bill Mudge, WCIRB
Brenda Keys, WCIRB

Workers' Compensation Insurance Rating Bureau of California®

Senate Bill No. 863
WCIRB Cost Monitoring Report — Initial Retrospective Evaluation

Released: October 28, 2013

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Notice

This *Senate Bill No. 863 WCIRB Cost Monitoring Report — Initial Retrospective Evaluation* was developed by the Workers' Compensation Insurance Rating Bureau of California (WCIRB) for the convenience of its users. The WCIRB has made reasonable efforts to ensure the accuracy of this Report. You must make an independent assessment regarding the use of this Report based upon your particular facts and circumstances.

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I. Executive Summary

On September 18, 2012, the Governor signed Senate Bill No. 863 (SB 863) into law. SB 863 increases benefits effective January 1, 2013 and January 1, 2014 and provides 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. Pursuant to this plan, this report summarizes the WCIRB's initial retrospective evaluation of the cost impact of a number of SB 863 provisions based on data emerging through the third quarter of 2013.

The WCIRB's principal findings based on early emerging post-SB 863 costs include the following:

1. Indemnity claim frequency was projected to increase by 1% in 2013, in part due to SB 863 changes to indemnity benefits, while emerging frequency through June 30, 2013 indicates a 6.2% increase.
2. The number of lien filings was projected to decrease by approximately 40% as a result of the SB 863 lien filing fee and statute of limitations, while filings through the third quarter of 2013 have decreased by approximately 60% when compared to 2011 levels.
3. The SB 863 lien filing fee was projected to eliminate relatively smaller liens. WCIRB Lien Survey information indicates a much smaller proportion of liens under $500 active in 2013 when compared to liens active in 2012.
4. SB 863's elimination of the duplicate payment for spinal surgical implants was estimated to save approximately $20,000 per procedure. Very preliminary estimates based on WCIRB Medical Data Call (MDC) data show a $15,000, or over 50%, reduction in the average cost of these procedures in 2013 when compared to pre-2013 levels.
5. SB 863's reduction in maximum ambulatory surgical center facility fees was estimated to reduce those costs by 25%, which is consistent with the reductions observed based on preliminary WCIRB MDC estimates comparing 2013 reimbursements to pre-SB 863 levels.
6. Early estimates of independent medical review (IMR) requests show that the frequency of IMRs in recent months is far above the levels initially projected. If the higher volume of August and September IMR requests are indicative of filing rates for subsequent months, the number of IMRs requested per year would be over three times greater than that projected in the WCIRB's prospective cost estimate potentially eliminating any savings in administrative costs due to IMR and also potentially negatively impacting medical treatment costs.
7. Preliminary estimates of medical provider network usage in 2013 show that network utilization in the first six months of 2013 is fairly consistent with that for prior years.
8. Although relatively few independent bill review (IBR) requests have been filed when compared to IMR filings, early estimates of IBR decisions show 60% of decisions favoring the provider for amounts significantly less than the IBR filing fee.

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 loss adjustment expenses (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.[1] (SB 863 included a number of amendments which the WCIRB was not able to prospectively evaluate at the time.)

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 emerged. The *Senate Bill No. 863 WCIRB Cost Monitoring Plan* was submitted to the California Department of Insurance (CDI) on March 27, 2013 and is included as Attachment A.

The monitoring plan included as Attachment A 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 Attachment A, the ultimate cost impact of many provisions of SB 863 will not be known for many years. This report represents the initial preliminary evaluation of emerging post-SB 863 costs for the cost components identified in Attachment A which can be measured by the fourth quarter of 2013. In particular, this report includes updated information on indemnity claim frequency, liens, surgical implant hardware, ambulatory surgical centers, independent medical review, medical provider networks, and independent bill review.

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

III. Cost Components Evaluated

A. Indemnity Claim Frequency

SB 863 enacted increases to permanent disability (PD) weekly benefit minimums and maximums, changes to the process of determining final PD ratings, and other changes impacting indemnity benefits. The WCIRB's prospective evaluation of SB 863 included provisions for changes in indemnity claim frequency (utilization) that 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.[2] 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%.[3] 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%.

Exhibit 1 summarizes the WCIRB's latest estimates of accident year indemnity claim frequency changes through June 30, 2013. As shown, current estimates for the 2012 and 2013 accident years indicate moderate to significant increases in indemnity claim frequency, particularly when compared to the typical long-term decline experienced in earlier years. Also, as shown in Table 1, the indicated indemnity claim frequency increases for those years are much greater than the changes projected based on the WCIRB's econometric claim frequency model.[4]

Table 1: Indemnity Claim Frequency Changes

Accident Year	WCIRB Model Projected Indemnity Claim Frequency Change[5]	Estimated Actual Indemnity Claim Frequency Change[6]
2012	-0.8%	+3.3%
2013	+1.0%	+6.2%

Claim frequency patterns can be influenced by many diverse factors including changes in benefit levels. It is unclear the extent to which this higher than projected indemnity claim frequency change is due to the increased SB 863 benefits and the extent it is due to economic factors, other components of SB 863, or other claims related factors. The WCIRB will continue to study recent changes in indemnity claim frequency and provide updated information and estimates as they become available.

B. 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 Workers' Compensation Appeals Board (WCAB) using an approved form and be charged a $150 filing fee. In addition, no liens may be filed more than three years from the date of service for liens filed before July 1, 2013 or 18 months from the date of service for liens filed on or after July 1, 2013. The WCIRB's prospective evaluation of the impact of SB 863 on lien-related costs estimated

[2] Brooks, Ward, *California Workers' Compensation Benefit Utilization – A Study of changes in Indemnity 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.

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

[4] 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.

[5] See Part A, Section B, Exhibit 14.1 of the WCIRB's January 1, 2014 Pure Premium Rate Filing submitted on September 13, 2013.

[6] See Exhibit 1. These estimates are based on a comparison of changes in reported aggregate indemnity claim counts on WCIRB data calls to changes in statewide employment.

a 1.8% reduction in medical costs and a 7.8% reduction in loss adjustment expenses (LAE), resulting in a 2.5% reduction in total costs.

In the WCIRB's prospective evaluation, it was assumed that approximately 40% of liens would be eliminated by the SB 863 lien filing fee and statute of limitations. The Division of Workers' Compensation (DWC) maintains lien filing information in its Electronic Adjudication Management System (EAMS). Exhibit 2 shows the number of liens filed by region and type of lien through the third quarter of 2013 based on DWC EAMS data. As shown, following the passage of SB 863 in the third quarter of 2012, lien filings in the remainder of 2012 increased dramatically. However, during the first three quarters of 2013, the number of liens filed has decreased significantly in all regions and for all types of lien. In fact, the number of liens filed through the first three quarters of 2013 is approximately 60% less than the number of liens filed through the comparable period in 2011.

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. Earlier this year, the WCIRB issued its Lien Survey on 430 additional PD claims for information on liens filed or activated during the first half of 2013.[7] The results of the 2013 Lien Survey are shown in Exhibits 3 through 10 and summarized below:

1. Approximately 21% of claims surveyed from Southern California regions had lien activity during the first half of 2013, 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 5% in 2013 (Exhibit 3).
2. The average number of active liens per claim with an open lien was 3.7 during the first half of 2013 compared to 3.3 during the first half of 2012 (Exhibit 4).
3. The average delay between the accident date and the lien filing date was 3.2 years for liens active during the first six months of 2013 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 compared to 2.0 years for liens resolved during the first six months of 2012 (Exhibit 5).
4. The distribution of liens by lien claimant type was fairly consistent between the 2012 and 2013 Surveys (Exhibit 6).
5. The average lien demand amount was $7,567 and the average settlement amount was $1,462 for liens resolved during the first half of 2013, resulting in a settlement rate of 19%. Comparatively, the average demand and settlement amounts for liens resolved during the first half of 2012 was $6,089 and $1,478, respectively, resulting in a settlement rate of 24%. The median settlement amount for liens resolved during the first half of 2013 was $900, compared to $525 for the first half of 2012, as 2013 had a much lower proportion of settlement amounts below $500 and a much higher proportion between $1,000 and $2,500 (Exhibits 7 and 8). The increases in median settlement amounts were experienced for almost all types of lien claimant (Exhibit 9).
6. The average lien defense cost per Southern California claim[8] with a lien was fairly consistent between the 2012 and 2013 Surveys, regardless of when the lien was active (Exhibit 10).

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

[7] The 2013 Lien Survey was conducted on accident year 2008 claims. The 2012 Survey was conducted on accident year 2007 and prior claims.

[8] 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 very small.

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.[9]

C. 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.[10] On a prospective basis, the WCIRB estimated that the elimination of the multiple reimbursements would reduce total medical costs by 1%.

The WCIRB's prospective estimate was, in part, based on a California Workers' Compensation Institute (CWCI) study estimating the savings from eliminating the multiple reimbursements on claims with spinal surgeries.[11] 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 2013 based on its Medical Data Call (MDC) data. Specifically, surgical implant services provided in 2013 were compared to the same services provided prior to the effective date. The results are shown on Table 2. While there are relatively few instances of spinal surgeries affected by SB 863 that are reflected in the WCIRB MDC data through June 30, 2013, the average cost of these services is approximately $15,000 less, or more than 50% below the cost of similar surgeries provided prior to the implementation of SB 863.

Table 2: Surgical Implant Hardware Results Based on WCIRB MDC Data

Date of Service	Number of Episodes	Total Paid	Average Paid per Episode
Pre-1/1/2013	214	$5,870,125	$27,430
Post-1/1/2013	52	$628,504	$12,087
Change			**-56%**

D. Ambulatory Surgical Center (ASC) 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.

The WCIRB has compiled information on ASC facility fees paid on services provided through the first half of 2013 based on its MDC data. Specifically, the paid cost related to ASC facility fees on services provided in 2013 were compared to the reimbursements on claims with pre-SB 863 dates of service. The

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

[10] The regulation would be repealed January 1, 2014 unless extended by the Administrative Director.

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

results are shown in Table 3. As shown, the average reimbursement to ASCs in 2013 is 26% lower than the average reimbursement on services provided prior to the implementation of SB 863.

Table 3: ASC Facility Fee Results Based on WCIRB MDC Data			
Date of Service	Number of Episodes	Total Paid	Average Paid per Episode
Pre-1/1/2013	11,435	$37,628,741	$3,291
Post-1/1/2013	5,497	$13,430,373	$2,443
Change			**-26%**

E. Independent Medical Review (IMR)

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, temporary disability 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.[12]

Early information on the number of IMRs requested and results of IMR decisions through September 2013 are available from the DWC through the IMR vendor. This information is summarized in Table 4. As shown, a relatively small number of IMRs were filed during the first half of 2013. However, once IMR became effective for all injuries regardless of the accident date starting on July 1, 2013, IMR requests have increased significantly. If the higher volume of August and September IMR requests are indicative of filing rates for subsequent months, the number of IMRs requested per year would be over three times greater than that projected in the WCIRB's prospective cost estimate, potentially eliminating any savings in administrative costs due to IMR and also potentially negatively impacting medical treatment costs.[13] Based on DWC information on early IMR decisions, approximately 75% of decisions have upheld the initial utilization review determination. The WCIRB will continue to monitor IMR filing and decision activity as more information becomes available.

Table 4: IMR Filings in 2013	
Months	IMRs Filed
January to June	870
July	4,410
August	15,731
September	14,990

As discussed above, IMR has the potential to significantly affect medical treatment costs. As discussed in the SB 863 Cost Monitoring Plan (Attachment A), the WCIRB will retrospectively monitor changes in overall medical cost levels based on accident year paid medical severities from WCIRB quarterly aggregate financial data calls. Table 5 shows paid medical per indemnity claim severities through the first six months of 2013 compared to that for 2012. As shown, this preliminary estimate of 2013 severities shows paid medical per indemnity claim fairly consistent with the prior year.

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

[13] The WCIRB prospectively estimated approximately 60,000 IMR requests to be filed per year when SB 863 IMR process is fully in effect.

Table 5: Paid Medical Loss per Indemnity Claim	
Accident Year	At 6 Months
2012	$2,088
2013	$2,102
Change	+0.7%

F. Medical Provider Networks (MPNs)

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%, which included savings to PD costs, temporary disability costs, and medical costs.

As discussed in Attachment A, 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 11 shows the percentage of visits and medical payments during the first six months made to MPNs through 2013 based on CWCI medical transaction data compared to the proportion of first year visits and payments for prior years. As shown, preliminary network penetration for 2013 appears to follow a fairly consistent pattern with that of the prior years.

G. Independent Bill Review (IBR)

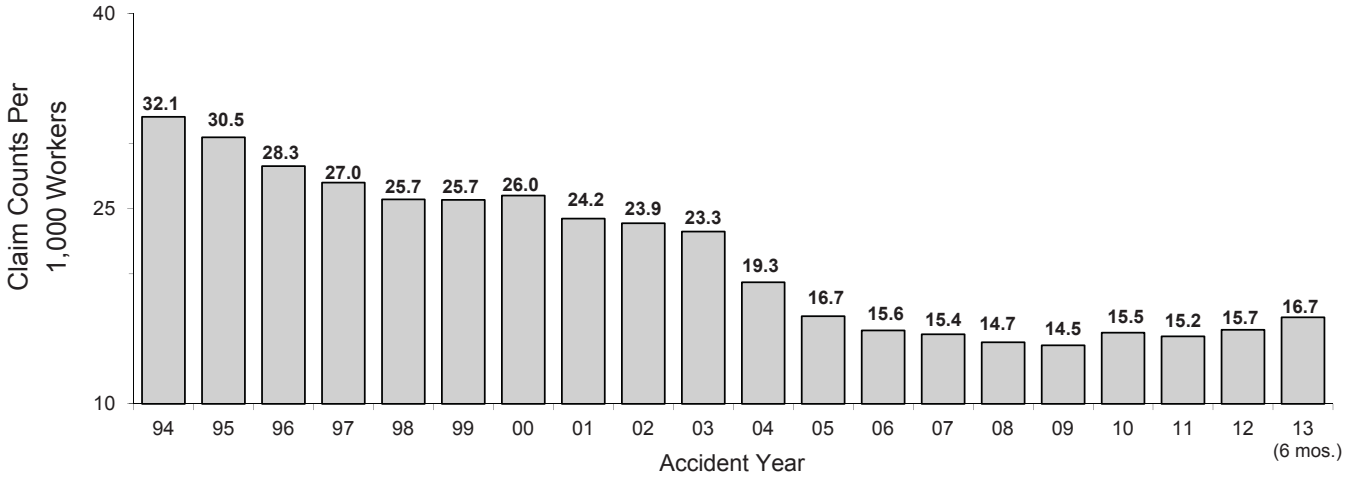
SB 863 created a new process of IBR to handle bill payment disputes, effective on medical services provided on or after January 1, 2013. Specifically, for disputes not resolved after the employer's second review, the provider may request an IBR within 30 days of the second review or the bill will be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

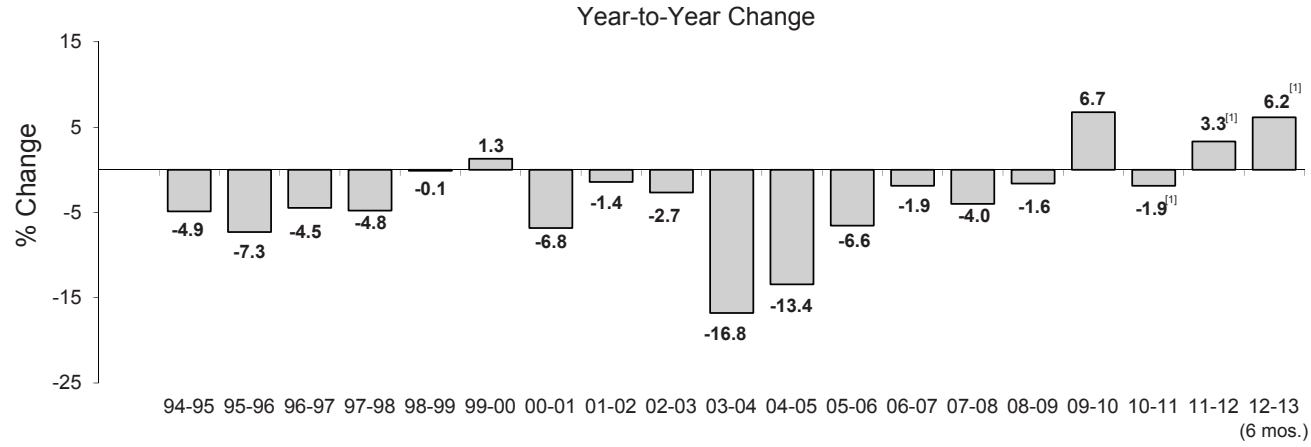
Early information on the number of IBRs requested and results of IBR decisions through the third quarter of 2013 are available from the DWC through the IBR vendor. This information is summarized on Exhibit 12. As shown, after a ramp up at the start of the year, IBR requests have been fairly consistent by month. Based on early IBR decisions in 2013, approximately 60% of the decisions have favored the provider, while the median decision amount of $111 is significantly less than the $335 IBR filing fee. The WCIRB will continue to monitor IBR filing and decision activity as more information becomes available.

H. Other System Components

In addition to the areas discussed above, the monitoring plan in Attachment A includes a number of other system components that will likely be affected by SB 863 for which data is not yet available. 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. In particular, future WCIRB SB 863 cost monitoring reports will assess the impact, based on post-January 1, 2014 emerging costs, of the recent amendments by the Division of Workers' Compensation to the physician fee schedule to change to a resource-based relative value scale (RBRVS).

California Workers' Compensation
Estimated Indemnity Claim Frequency by Accident Year
As of June 30, 2013





[1] The 2010-2011 estimate is based on partial year unit statistical data. The 2011-2012 and 2012-2013 estimates are based on comparison of claim counts based on WCIRB accident year experience as of June 30, 2013 relative to the estimated change in statewide employment.

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
Bay Area	18,723	5,492	5,467	6,437	10,397	1,267	1,464	1,618
Central Coast/Valley	24,414	7,248	8,974	15,298	25,757	2,279	1,616	1,834
Los Angeles County	283,774	97,246	122,047	207,673	342,627	47,285	19,157	26,158
Remainder of LA Basin	114,554	38,038	44,074	85,157	123,137	17,215	7,006	9,966
Remaining CA Zip Codes	2,535	903	1,106	700	1,127	232	212	247
Sacramento	3,934	1,248	1,323	1,407	1,557	272	346	444
San Deigo County	15,922	4,943	4,994	6,622	8,527	1,315	688	993
Total	**463,856**	**155,118**	**187,985**	**323,294**	**513,129**	**69,865**	**30,489**	**41,260**

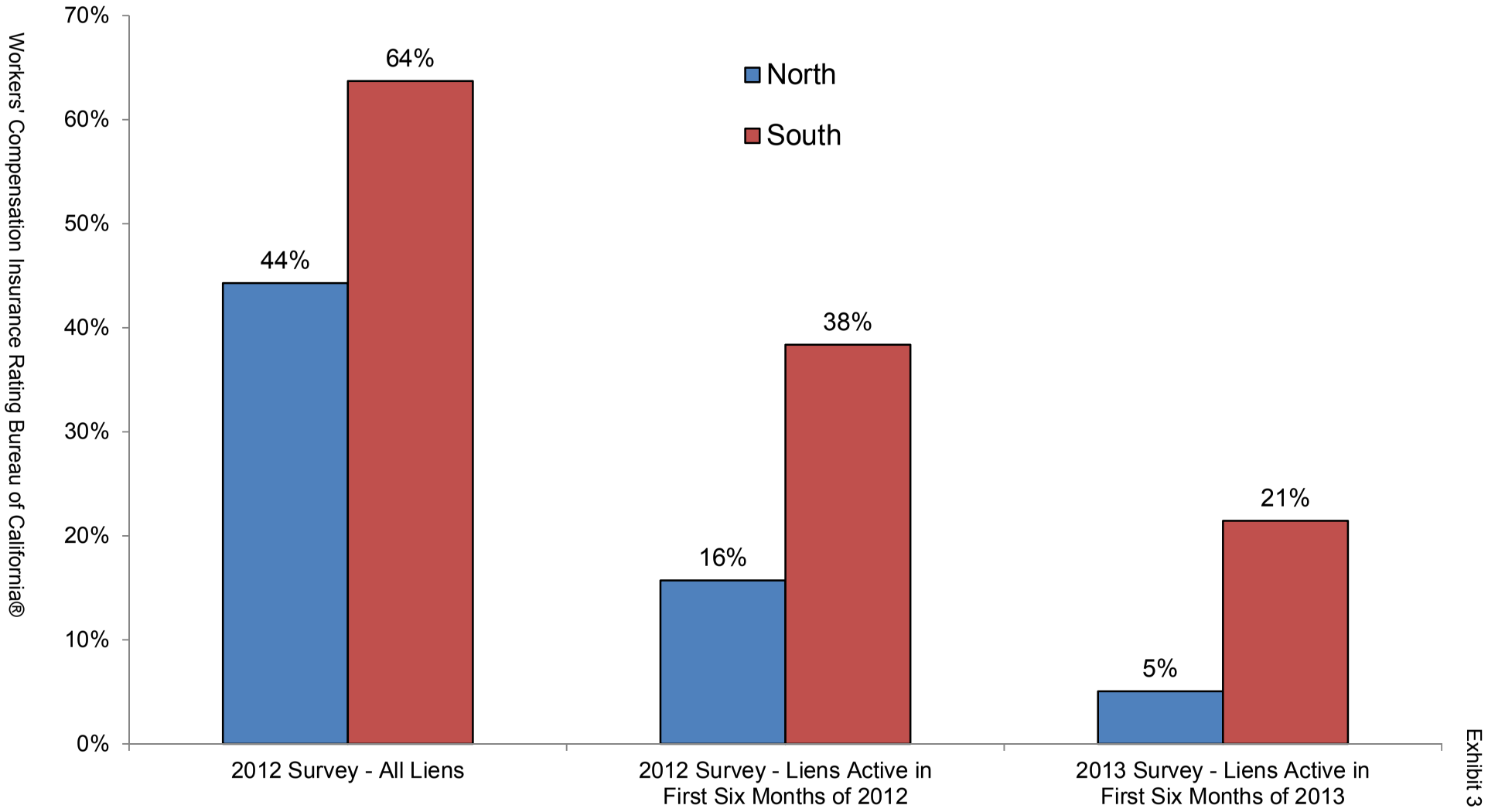
Counts by Type

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
Interpreter	28,721	12,937	17,162	46,095	47,427	2,303	831	484
Medical	292,982	85,152	106,336	182,474	317,241	45,798	22,480	32,356
Medical-Legal	39,569	22,931	37,440	64,912	80,916	11,530	587	653
Other	102,584	34,098	27,047	29,813	67,545	10,234	6,591	7,767
Total	**463,856**	**155,118**	**187,985**	**323,294**	**513,129**	**69,865**	**30,489**	**41,260**

* 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

Source: EAMS Liens Data

WCIRB Lien Survey Results
Percentage of Surveyed Claims with a Lien



WCIRB Lien Survey Results
Statewide Distribution of Liens per Claim with One or More Liens

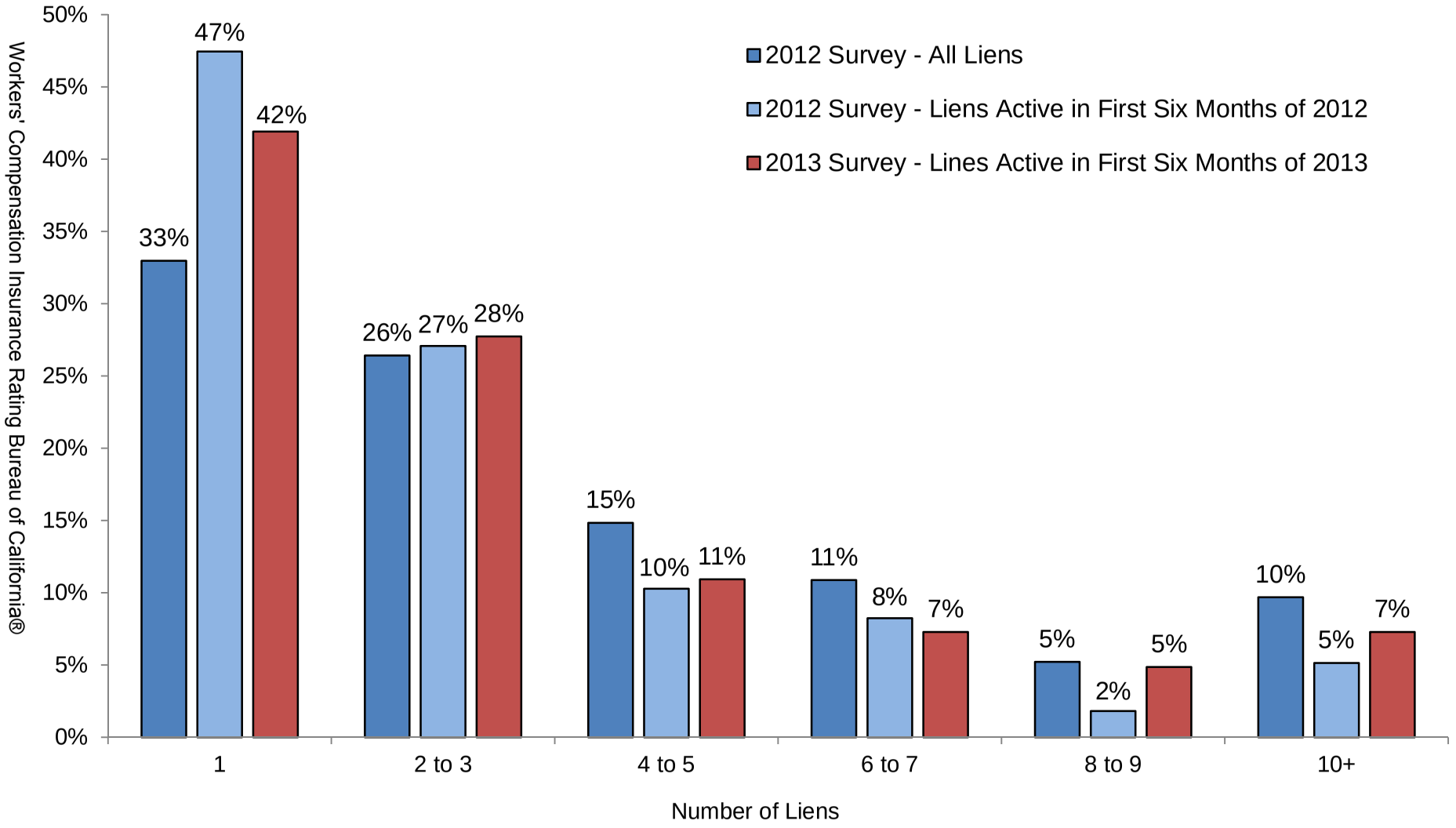


Exhibit 4

Notes

- Claims are weighted to adjust survey North-South claim count distribution to statewide distribution.
- Unadjusted average liens per claim for claims with a lien are 4.7, 3.3, and 3.7 for 2012 Survey – All Liens, 2012 Survey – Liens Active in First Six Months of 2012, and 2013 Survey – Liens Active in First Six Months of 2013 respectively.

WCIRB Lien Survey Results
Average Number of Days until Lien Filed or Resolved

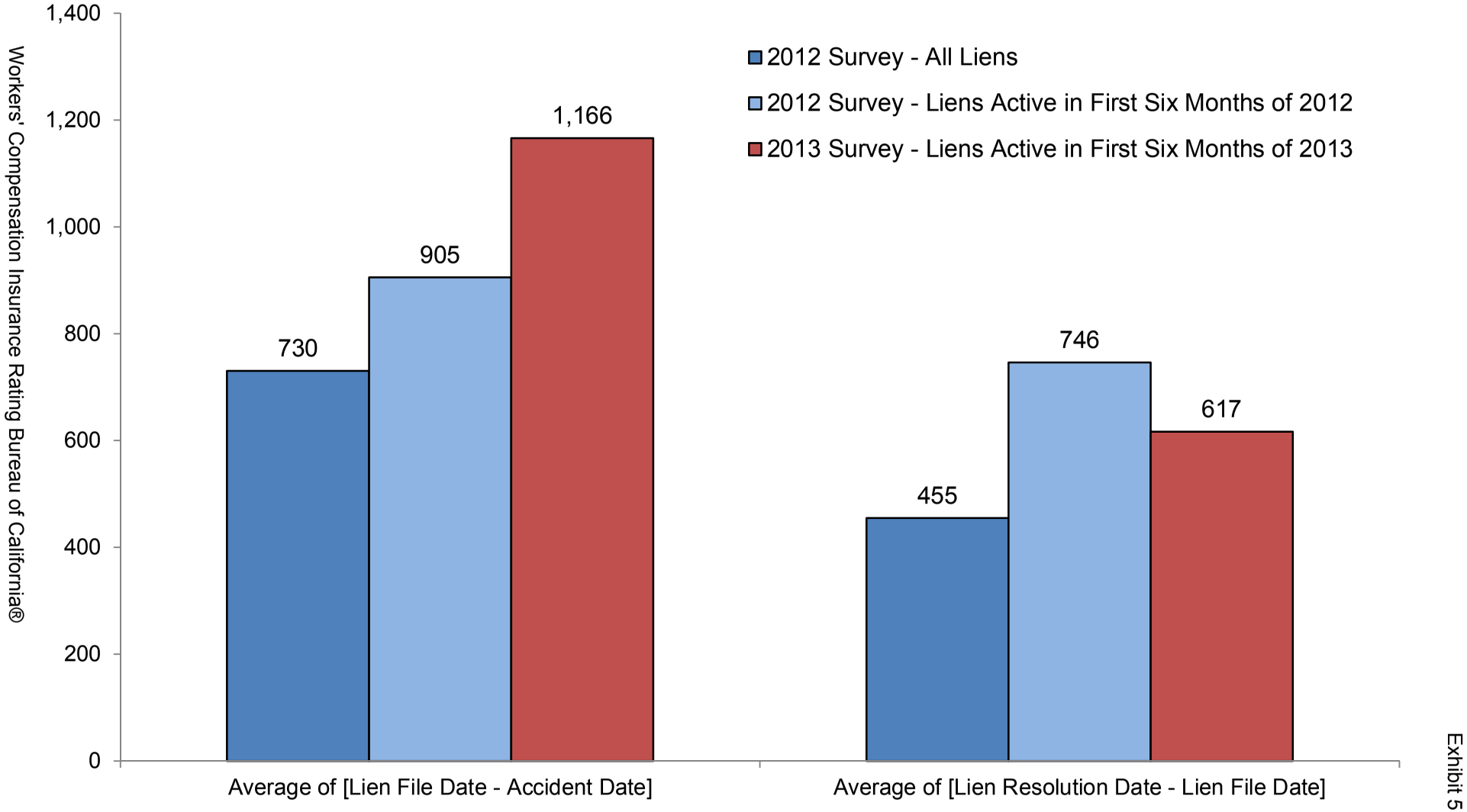


Exhibit 5

WCIRB Lien Survey Results
Distribution of Liens by Lien Claimant Type

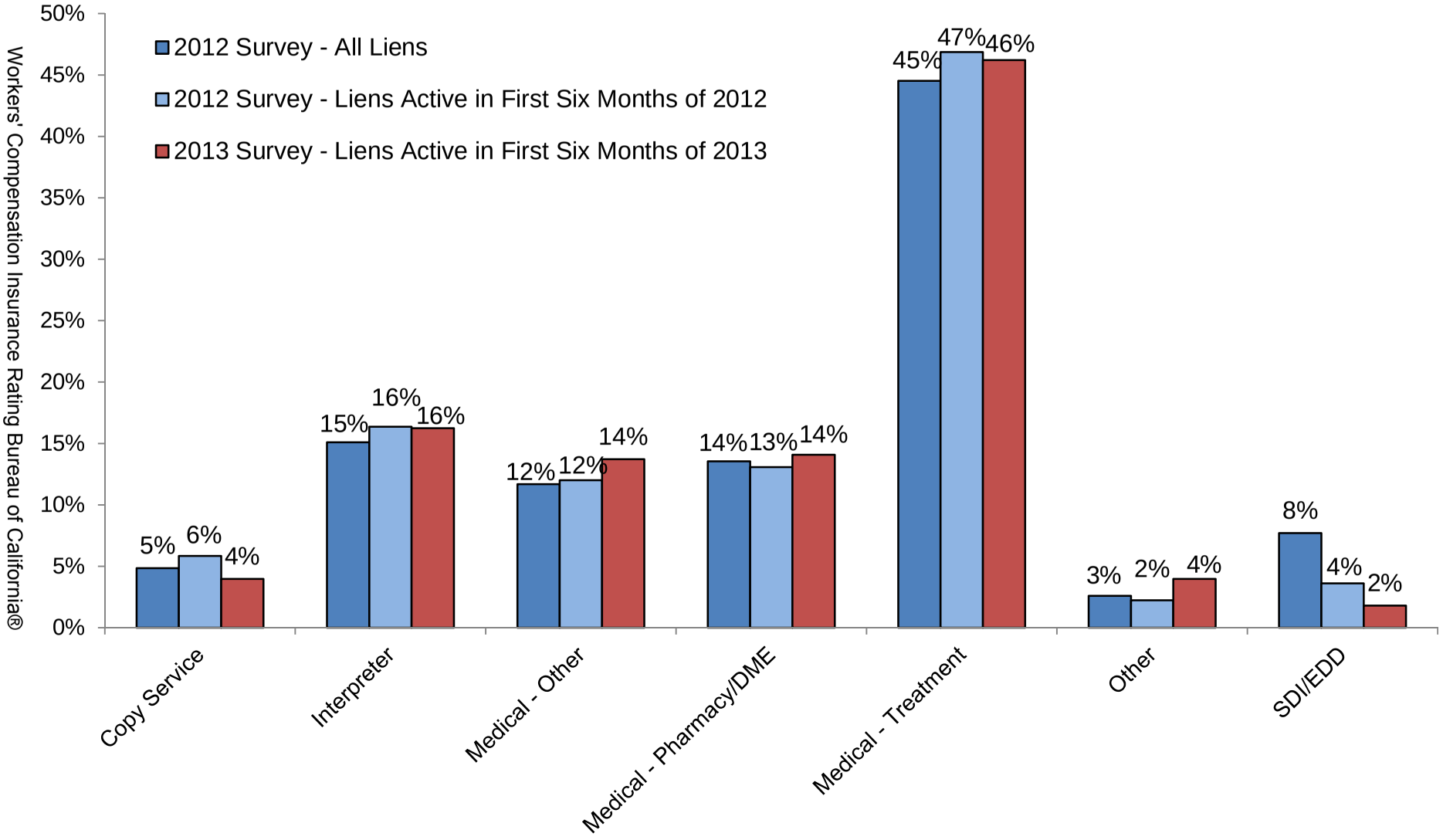


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Exhibit 6

WCIRB Lien Survey Results
Settlement and Demand Amounts on Resolved Liens
(Excluding SDI/EDD)

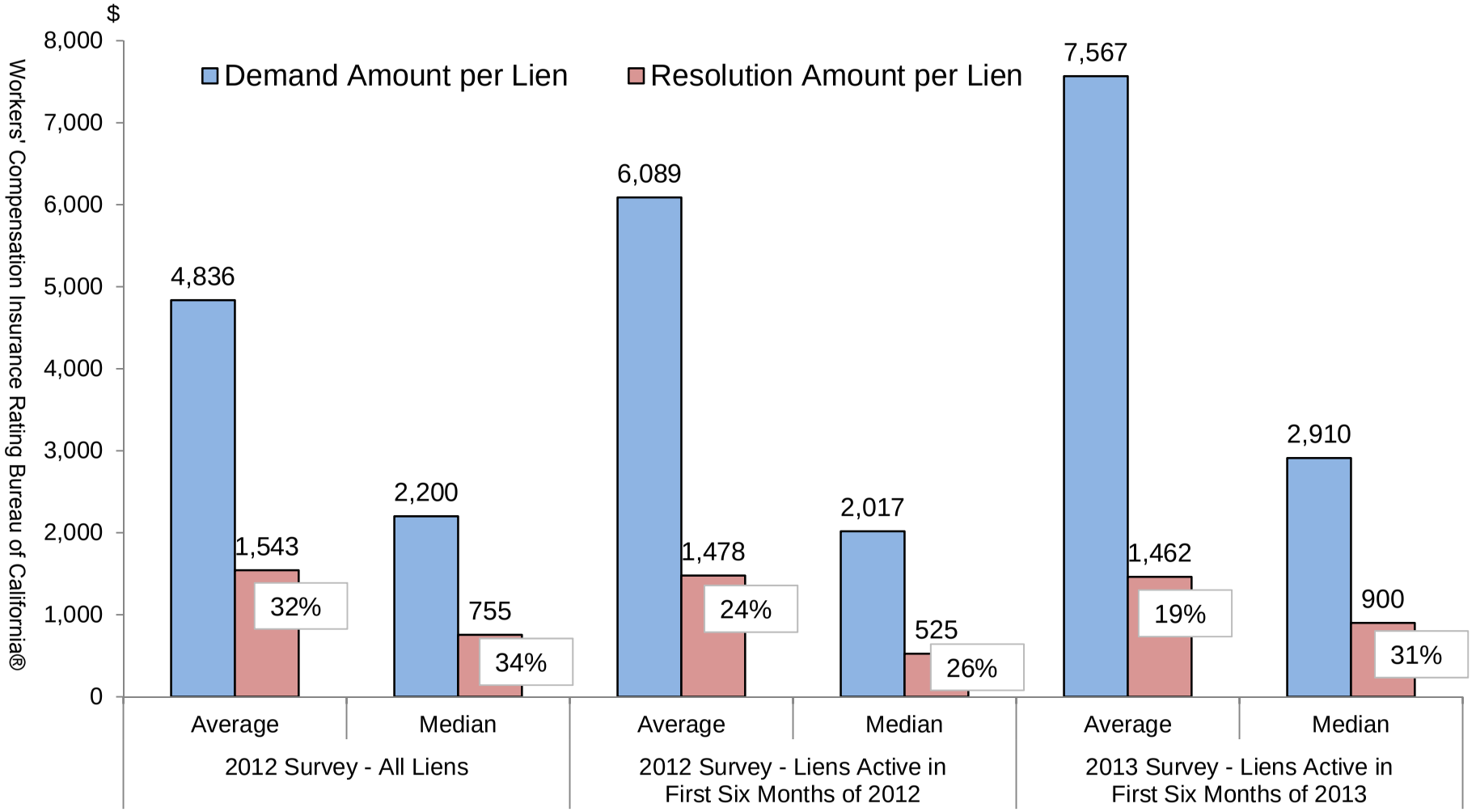

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Exhibit 7

WCIRB Lien Survey Results
Distribution of Liens by Settlement Amount
(Excluding SDI/EDD)

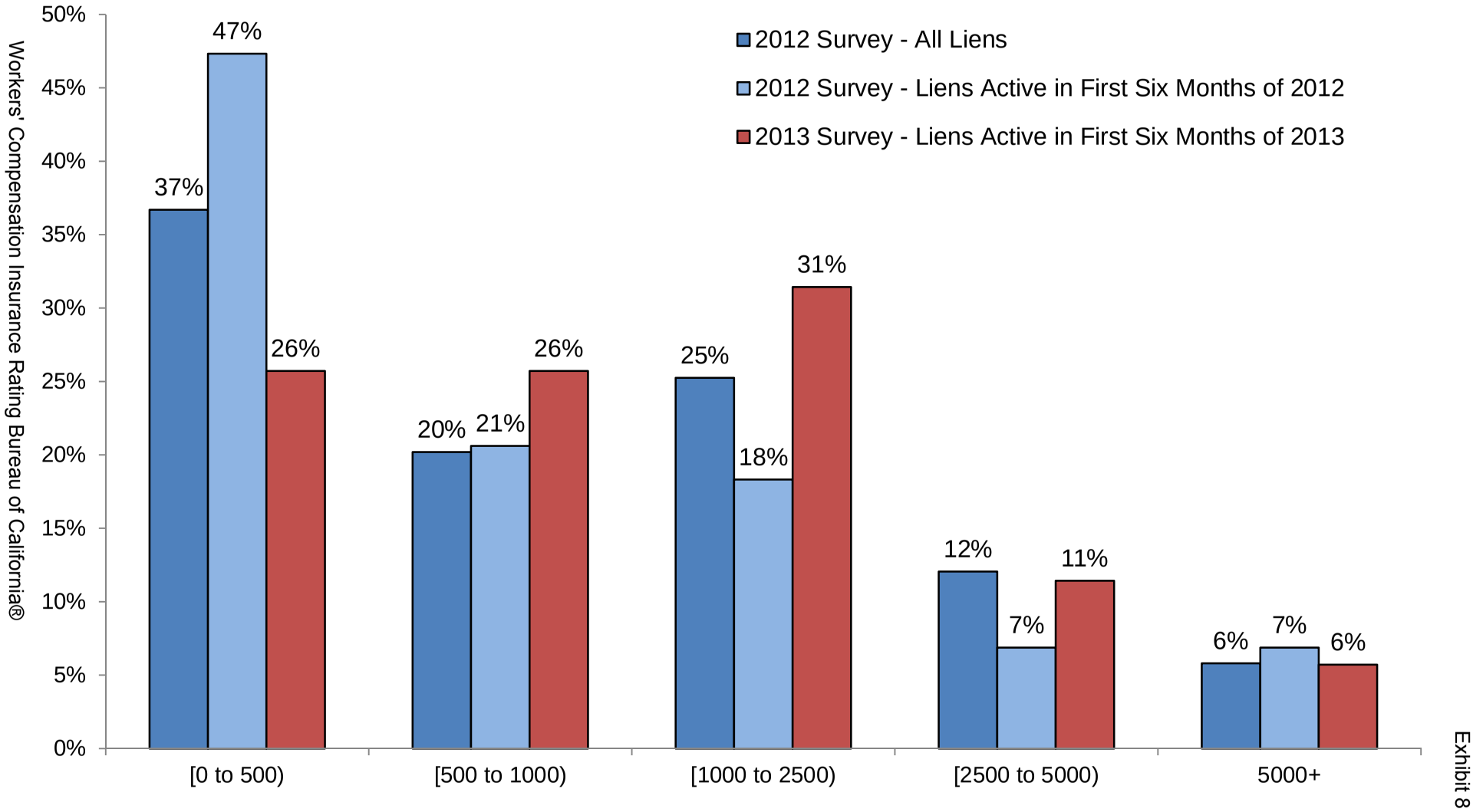

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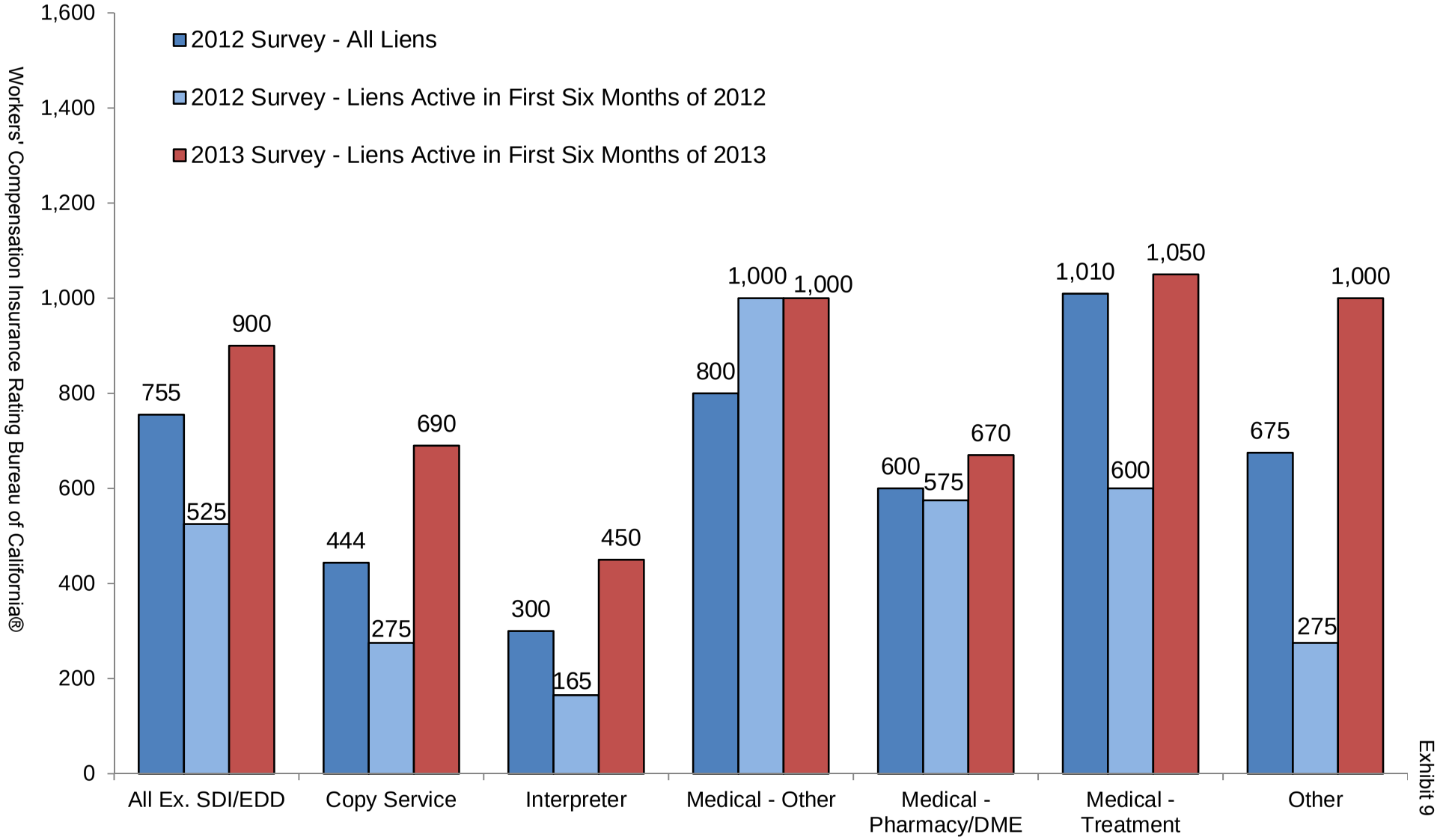
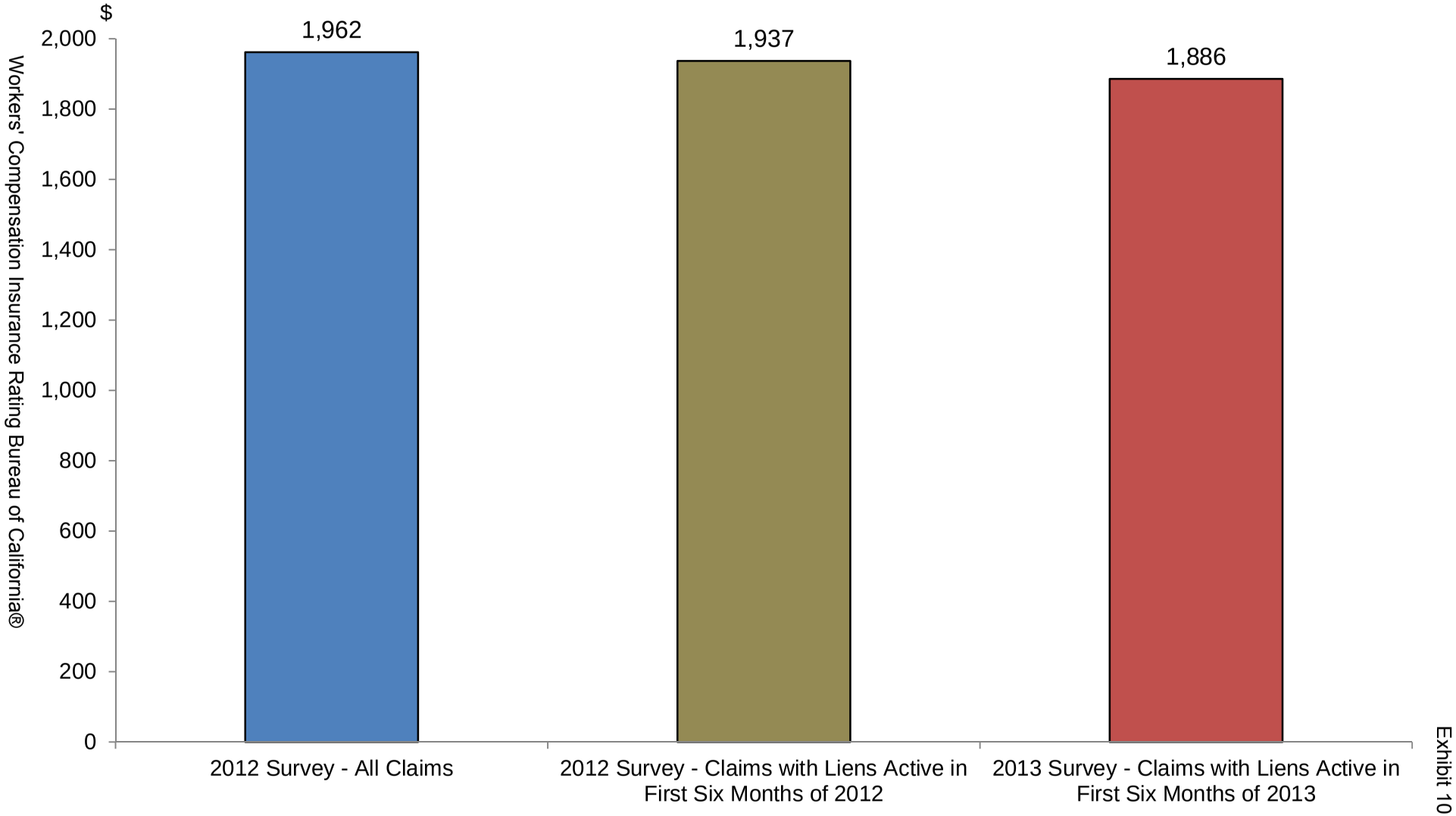
Exhibit 8

WCIRB Lien Survey Results
Median Settlement Amount by Lien Claimant Type



WCIRB Lien Survey Results
Average Lien Defense Cost per Claim with Lien – Southern CA



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	68.0%	---	56.9%	---
2006	70.5%	3.7%	59.6%	4.7%
2007	72.3%	2.6%	61.7%	3.5%
2008	75.2%	4.0%	64.4%	4.4%
2009	76.9%	2.3%	66.8%	3.7%
2010	80.0%	4.0%	70.3%	5.2%
2011	81.4%	1.7%	72.0%	2.4%
2012*	82.4%	1.2%	74.2%	3.1%
2013*	82.1%	-0.4%	76.7%	3.4%

*Preliminary: AY 2012 includes claims through June 2012. AY 2013 includes claims through March 2013.

Independent Bill Review Results

Counts of IBRs

Month	Number of IBRs Requested
Jan-13	0
Feb-13	1
Mar-13	4
Apr-13	29
May-13	67
Jun-13	95
Jul-13	113
Aug-13	113
Sep-13	126

Median IBR Decision Amounts

Median Amount	All Decisions	Reversed Decisions
Disputed Amount	218	262
Decision Amount	---	111
Decision + Filing Fee	---	446

Source: 50 IBR Decisions from the DWC
(30 of 50 are Reversed Decisions)

Workers' Compensation Insurance Rating Bureau of California®

Senate Bill No. 863
WCIRB Cost Monitoring Plan

Released: March 27, 2013

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Attachment A

Notice
The *Senate Bill No. 863 WCIRB Cost Monitoring Plan* was developed by the Workers' Compensation Insurance Rating Bureau of California (WCIRB) for the convenience of its users. The WCIRB has made reasonable efforts to ensure the accuracy of this Plan. You must make an independent assessment regarding the use of this Plan based upon your particular facts and circumstances.

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I. Background

Senate Bill No. 863 (SB 863) was passed by the Legislature on August 31, 2012 and signed by the Governor on September 18, 2012. SB 863 increases benefits effective January 1, 2013 and January 1, 2014 and provides 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 loss adjustment expenses (LAE) underlying 2013 advisory pure premium rates. The WCIRB's evaluations included a cost estimate for SB 863 amendments to permanent disability (PD) minimum and maximum weekly benefit levels; the burial allowance; supplemental job displacement benefits; the adjustments to the PD rating corresponding to future earning capacity (FEC); PD impairment "add-ons" for psychiatric impairment, sleep disorder or sexual dysfunction; the three-tiered system of PD weekly benefits based on return-to-work status; liens; reimbursements for spinal implant hardware; fee schedule values for ambulatory surgical centers (ASCs); the process for resolving medical treatment disputes through independent medical review (IMR); and provisions related to services provided outside a valid medical provider network (MPN). Attachment 1 is the WCIRB's most current prospective evaluation of SB 863, which was released on October 12, 2012. The WCIRB estimated that, in total, SB 863 will reduce the cost of losses and loss adjustment expenses on 2013 policies by 4.4%.[1]

Additionally, SB 863 included amendments which the WCIRB was not able to evaluate at the time. These include provisions related to MPN procedures and processes; independent bill review (IBR); IMR as it relates to medical treatment; fee schedules for interpreters, home health services and copy services; conversion of the California Official Medical Fee Schedule (OMFS) to a Resource Based Relative Value Scale (RBRVS) basis; and the proposed return-to-work program for the purpose of making supplemental payments to workers whose PD benefits are disproportionately low in comparison to their earnings loss; and PD advances.

The WCIRB's estimate of the impact of SB 863 on 2013 policies was reflected in its amended January 1, 2013 Pure Premium Rate Filing. Further, the January 1, 2013 advisory pure premium rates approved by the Insurance Commissioner reflected estimated savings of approximately 5.8% due to the impact of SB 863 on 2013 policies.[2]

These estimates of the cost impact of SB 863 on 2013 policies 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 may ultimately have a significant impact on costs. As a result, the WCIRB plans to closely monitor post-SB 863 costs as they emerge and propose further adjustments to advisory pure premium rates as appropriate based on those emerging costs. Accordingly, the WCIRB has developed this SB 863 Cost Monitoring Plan that details the process by which the WCIRB will monitor and quantify emerging post-SB 863 costs.

[1] In total, the WCIRB estimated that by the 2014 injury year, the quantifiable provisions of SB 863 will decrease total system costs by 2.7%, or $0.5 billion, annually.

[2] Department of Insurance Decision and Order on File Number REG-2012-00016, issued on November 30, 2012.

II. Summary of Cost Monitoring Plan Schedule

Shown below is a summary of the cost components detailed in this Plan to be measured and the timeframe by which they will initially be measured.[3] Table 1 shows the schedule for cost components related to indemnity benefit changes (see Section IV of the Plan) and Table 2 shows the schedule for cost components related to the medical benefit delivery system (see Section V of the Plan).

Table 1: Changes to Indemnity Benefit Levels

Cost Component	Initial Valuation to be Published By
A. Minimum and Maximum PD Benefits	
Change in Average Incurred PD Benefits	Third Quarter 2014
B. Supplemental Job Displacement Benefits	
Change in Vocational Rehabilitation-Related Costs	Third Quarter 2014
Change in Supplemental Job Displacement Benefits	Fourth Quarter 2015
C. PD Ratings	
Change in Average PD Rating Due to SB 863 Changes Related to FEC	Third Quarter 2014
Change in Average PD Rating Based on Unit Statistical Data	Third Quarter 2014
Change in Average PD Rating Based on DEU Data	Third Quarter 2014
D. PD Add-ons	
Impact of PD Add-ons on PD Ratings	Third Quarter 2014
E. Three-Tiered Weekly PD Benefits	
Frequency of Return-to-Work Offers	Fourth Quarter 2015
F. Indemnity Claim Frequency	
Accident Year Indemnity Claim Frequency Changes	Third Quarter 2013
Indemnity Claim Frequency Changes by Wage Level Interval	Third Quarter 2014
G. DIR Return-to-Work Program	TBD

[3] Valuations to be published in the third and fourth quarter of a particular year are anticipated to be available for consideration in the annual WCIRB advisory pure premium rate filing proposed to be effective the subsequent January 1.

Table 2: Changes to Medical Benefit Delivery System	
Cost Component	**Initial Valuation to be Published By**
A. Liens	
The Number of Lien Filings and Lien Activations	Fourth Quarter 2013
Average Lien Costs	Fourth Quarter 2013
Petitions for Costs	Fourth Quarter 2013
B. Surgical Implant Hardware	
Change in Spinal Implant Hardware Costs	Fourth Quarter 2013
C. Ambulatory Surgical Centers	
Change in the Cost of Ambulatory Surgical Center Facility Fees	Fourth Quarter 2013
Change in the Cost of Hospital Outpatient Services	Fourth Quarter 2013
D. Independent Medical Review	
Liens Related to Medical Treatment Disputes	Fourth Quarter 2014
Changes in the Number of Expedited Hearings	Third Quarter 2014
Frequency and Cost of IMRs	Fourth Quarter 2013
Change in the Duration of TD	Third Quarter 2014
Change in the Cost of Medical-legal	Fourth Quarter 2014
Paid ALAE per Indemnity Claim	Third Quarter 2014
Paid ULAE per Indemnity Claim	Third Quarter 2014
Changes in Litigation	Fourth Quarter 2014
Paid Cost of Medical Cost Containment Programs	Third Quarter 2014
Utilization Review Costs	Third Quarter 2014
Changes in Medical Treatment Patterns	Third Quarter 2014
Paid Medical per Indemnity Claim	Third Quarter 2013
E. Medical Provider Networks	
Percentage of Medical Treatment Provided within MPNs	Fourth Quarter 2013
Cost Differentials Related to MPNs	Third Quarter 2014
F. Independent Bill Review	
Frequency and Cost of IBRs	Fourth Quarter 2013
G. Conversion of the OMFS to RBRVS Basis	
Average Physician Payment per Procedure	TBD
H. New Fee Schedules	
Average Medical Payment per Affected Procedure	TBD

III. Plan Objective

The principal objective of this Plan is to detail the WCIRB's anticipated process to monitor the cost effects of the provisions of SB 863 as implemented as those cost effects emerge in loss and loss adjustment expense experience. Specifically, the Plan will include the following:

1. The cost components to be measured;
2. The data elements needed to measure these cost components;
3. The general methodology used to measure these cost components; and
4. The scheduled timeframe by which each of the cost components will be measured.

IV. SB 863 Cost Monitoring Plan – Changes to Indemnity Benefits

A. Minimum and Maximum PD Benefits

SB 863 amended Labor Code Section 4453 to provide 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.

The WCIRB's prospective evaluation of the estimated cost impact of the SB 863 changes in the minimum and maximum weekly PD benefits was based on information from approximately 200,000 lost-time claims that occurred on policies incepting in 2008 and 2009 and were reported to the WCIRB in accordance with the requirements of the *California Workers' Compensation Uniform Statistical Reporting Plan—1995* (USRP). (Certain information on death claims, vocational rehabilitation, and supplemental job displacement benefits was based on survey information.) Injured worker wage information on these claims was adjusted to reflect the level of wages anticipated for 2013 and 2014 injuries, based on wage level growth estimates using wage information published by the UCLA Anderson School of Management Business.

The changes in PD minimums and maximums were evaluated in conjunction with SB 863 changes in PD ratings, the death benefit burial allowance[4] and the supplemental job displacement benefit. The incurred cost of each of the approximately 200,000 lost-time claims was restated at the 2013 cost level after reflecting the changes to (a) weekly PD benefit maximums and minimums, (b) the burial allowance, (c) the supplemental job displacement benefit, and (d) the changes in PD ratings. The restated cost of these claims was then compared to the estimated cost of these claims under the current schedule of benefits. This process was repeated for injuries occurring in 2014 to estimate the cost impact of the SB 863 amendments to the weekly PD benefit maximums effective for injuries occurring in 2014.

The WCIRB will retrospectively measure the impact of the SB 863 changes to weekly minimum and maximum PD benefits based on unit statistical reports on 2013 and 2014 accident year claims. Specifically, based on the reported weekly wage and PD rating for each claim, the PD benefits can be restated at the pre-SB 863 statutory benefit level and compared to the incurred cost under SB 863.

Cost Components to be Measured and Schedule for Valuation

1. Change in Accident Year Average Incurred PD Benefits

    a. Data Elements — PD rating and weekly wage for each PD claim reported on WCIRB unit statistical reports.

    b. General Methodology — An estimate of the changes in accident year incurred PD benefit costs due to the SB 863 changes in PD minimum and maximum weekly benefits can be computed by comparing (1) the incurred PD benefit derived based on the reported PD rating, the weekly wage and the SB 863 statutory benefit level with (2) the incurred PD benefit derived based on the pre-SB 863 schedule of minimum and maximum weekly benefits. The initial computation can be made based on the first unit statistical reports of 2013 injuries on 2012 policies and repeated for later accident periods.

    c. Schedule — The initial valuation based on the first report of 2013 injuries on 2012 policies can be made on a preliminary basis by the third quarter of 2014. The analysis can be updated regularly as more mature information becomes available.

[4] SB 863 increased the death burial allowance from $5,000 to $10,000 effective on injuries occurring on or after January 1, 2013.

B. Supplemental Job Displacement Benefits

SB 863 added Labor Code Section 4658.7 which 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. For example, Labor Code Section 4658.7 provides that up to $1,000 of the benefit can be used for computer equipment and up to $500 can be used for miscellaneous expenses without requiring documentation. These changes are effective on injuries occurring on or after January 1, 2013.

The WCIRB's evaluation of the estimated cost impact of the SB 863 changes to the amount of the supplemental job displacement benefit was computed in conjunction with the change in minimum and maximum weekly PD benefits and was based on information from approximately 200,000 lost-time claims that occurred on policies incepting in 2008 and 2009. The WCIRB could not prospectively estimate the impact of the SB 863 provisions related to the basis upon which the supplemental job displacement benefit is paid and the types of expenses that will now be reimbursed.

The WCIRB will retrospectively measure the impact of the SB 863 changes to the supplemental job displacement benefit based on the calendar year paid vocational rehabilitation-related benefits that are reported on the WCIRB's annual call for indemnity and medical costs and the paid amount of supplemental job displacement benefits collected annually through the WCIRB PD Claim Survey. (Attachment 2 is a copy of the WCIRB PD Claim Survey issued in 2012.) Specifically, the impact of the SB 863 changes can be measured by comparing the average cost of paid supplemental job displacement benefits on injuries occurring in 2013 and later with those occurring prior to when SB 863 became effective.

Cost Components to be Measured and Schedule for Valuation

1. Change in Calendar Year Payments for Vocational Rehabilitation-Related Benefits

    a. Data Elements — Cost of vocational rehabilitation-related benefits paid in each calendar year from the WCIRB's annual call for calendar year indemnity and medical costs.

    b. General Methodology — An estimate of the changes in vocational rehabilitation-related benefits paid in calendar year 2013 will be made by comparing those benefit payments to those paid in prior calendar years.

    c. Schedule — Aggregate payments made in a calendar year segregated into indemnity and medical components is collected in the second quarter of the following year. As a result, the initial estimate of the SB 863 changes in the supplemental job displacement benefits can be made on a preliminary basis during the third quarter of 2014. The analysis can be updated regularly as more mature information becomes available.

2. Change in Accident Year Average Supplemental Job Displacement Benefits Paid

    a. Data Elements — Cost of supplemental job displacement benefits paid on each claim reported on the WCIRB PD Claim Survey.

    b. General Methodology — An estimate of the changes in accident year average supplemental job displacement benefits paid on 2013 and later injuries will be made by comparing the average cost of those benefits paid on claims reported on the PD Claim Survey to the average cost of supplemental job displacement benefits paid on pre-SB 863 injuries. The initial computation can be made based on claims reported on the PD Claim Survey on 2013 injuries relative to those on 2012 and prior injuries. This analysis can be updated at later survey report levels and for subsequent accident years.

c. Schedule — In the PD Claim Survey, accident year claims are initially valued, on average, at 28 months. One year later, open claims are resurveyed with an evaluation at 40 months. The initial retrospective estimate of the SB 863 changes in the supplemental job displacement benefits on 2013 injuries can be made on a preliminary basis during the fourth quarter of 2015. The analysis can be updated regularly as more mature information becomes available.

C. Changes in Permanent Disability Ratings

SB 863 added Labor Code Section 4660.1 to provide that the PD impairment produced in accordance with American Medical Association (AMA) Guides will not be modified for FEC as in the 2005 Permanent Disability Rating Schedule (PDRS). Instead, 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.[5] 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 WCAB decision in Ogilvie v. City and County of San Francisco.[6] These changes to the PD rating process were effective on injuries occurring on or after January 1, 2013.

The WCIRB's prospective evaluation of the direct impact of the changes to PD ratings based on Labor Code Section 4660.1 was based on a WCIRB analysis of approximately 20,000 claims available from the Disability Evaluation Unit (DEU) database that had PD ratings computed by the DEU between June of 2011 and March of 2012. Using the DEU database, the estimated change in average rating by percentage of PD rating point was determined and the rating for each claim in the WCIRB database of approximately 200,000 lost-time claims previously discussed was adjusted accordingly. Using this information, the incurred cost of each of these claims at the 2013 cost level was restated and compared to the estimated cost of these claims based on their current PD ratings.

As noted in the WCIRB's evaluation of SB 863, there is no information segregating the impact of an Ogilvie adjustment to PD from that of an Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School District (Almaraz/Guzman) adjustment or other factors impacting the final PD rating. The WCIRB's prospective evaluation of the elimination of the impact of the Ogilvie decision on PD ratings reflected a judgmental percentage of the WCIRB's estimate of the combined impact of the Almaraz/Guzman and Ogilvie decisions on PD benefit costs.[7]

The WCIRB will retrospectively measure the impact of the SB 863 changes to the PD rating process based on updated DEU data on PD ratings issued on 2013 and later injuries. Using this information, the WCIRB will be able to re-compute the actual DEU PD rating under the pre-SB 863 process. Additionally, to measure the impact of the provisions related to Ogilvie and as well as other issues impacting the PD rating, the WCIRB will also monitor the change in the average PD ratings beginning with 2013 injuries based on the PD ratings reported on unit statistical reports. Finally, although Ogilvie adjustments are typically not reflected in the DEU database, the WCIRB will review DEU data on post-SB 863 PD ratings to assess whether the elimination of Ogilvie as well as other SB 863 provisions may have an indirect impact on PD ratings (e.g., an increase in Almaraz/Guzman adjustments).

Cost Components to be Measured and Schedule for Valuation

1. Change in Accident Year Average PD Rating Due to SB 863 Changes Related to FEC

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

[6] 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.

[7] The WCIRB judgmentally estimated that 20% of the combined estimated impact of the Almaraz/Guzman and Ogilvie decisions on PD benefits and 33% of the combined impact on allocated loss adjustment expenses would be eliminated by the SB 863 provisions that eliminate the FEC adjustments.

a. Data Elements — The PD rating and other related descriptive information, such as disability category and impairment rating, are available from the DEU database on a relatively contemporaneous basis.

b. General Methodology — The rating on each claim rated by the DEU on 2013 injuries can be compared to the average rating re-computed using the pre-SB 863 process. The average PD rating over all DEU claims under both approaches can then be compared.

c. Schedule — DEU data on PD ratings is available on a relatively contemporaneous basis. However, given the PD claim process, PD ratings on 2013 injuries will not become available in significant volumes until 2014. An initial preliminary evaluation of ratings on 2013 injuries can be completed in the third quarter of 2014. The analysis can be updated regularly as more mature information becomes available.

2. Change in Statewide Average PD Rating Based On Unit Statistical Data

a. Data Elements — The PD rating is reported on unit statistical reports.

b. General Methodology — The average PD rating on 2013 injuries reported on 2012 policy year unit statistical reports can be computed in 2014 and compared to the average PD rating on similarly aged pre-SB 863 claims. This annual change should be compared to the average annual change in PD rating during the pre-SB 863 period. The process will be repeated for later evaluations and later accident years.

c. Schedule — Unit statistical reports are initially valued at 18 months and submitted 20 months from policy inception. Subsequent reports at annual increments are required on all open claims. First reports of accident year 2013 claims on 2012 policies can be preliminarily summarized in the third quarter of 2014. Updates can be made on a regular basis using more mature information and later accident years.

3. Change in Statewide Average PD Rating Based On DEU Data

a. Data Elements — The PD rating and other related descriptive information, such as disability category and impairment rating, are available from the DEU database on a relatively contemporaneous basis.

b. General Methodology — Based on DEU data, the final PD rating and whether an Almaraz/Guzman adjustment was applied can be determined for each claim rated by the DEU on 2013 injuries. These results can then be compared to the analogous results in the pre-SB 863 environment to assess the potential SB 863 impact.

c. Schedule — DEU data on PD ratings is available on a relatively contemporaneous basis. However, given the PD claim process, ratings on 2013 injuries will not become available in significant volumes until 2014. An initial preliminary evaluation of ratings on 2013 injuries can be completed in the third quarter of 2014. Updates can be made on a regular basis using more mature information and later accident years.

D. PD Add-ons

SB 863 amendments to Labor Code Section 4660.1 eliminated increases in impairment ratings for sleep disorder, sexual dysfunction or psychiatric impairment arising out of a compensable physical injury. However, psychiatric add-ons to permanent disability impairments are allowed for catastrophic injuries or if the injury was the result of a violent act. These changes are effective on injuries occurring on or after January 1, 2013.

The WCIRB's prospective evaluation of the SB 863 elimination of PD add-ons was based on the WCIRB analysis of approximately 20,000 claims available from the DEU database that had PD ratings computed by the DEU between June of 2011 and March of 2012. Using the DEU database, the rating on each claim that had a PD add-on for sleep disorder, sexual dysfunction or psychiatric impairment was re-computed excluding the effect of the add-ons. The DEU database of ratings did not, however, allow for the identification of claims with psychiatric add-ons associated with catastrophic injuries or injuries arising from violent acts. As a result, the WCIRB approximated the percentage of permanent disability add-ons that will not be eliminated for catastrophic injuries or injuries resulting from a violent act based on the underlying injury characteristics of reported permanent disability claims from WCIRB unit statistical data. Based on these re-computations, the impact on average PD rating was determined and the PD rating for each claim in the WCIRB database previously discussed was adjusted accordingly.

The WCIRB will retrospectively measure the impact of the SB 863 changes related to PD add-ons based on updated DEU data on PD ratings issued on 2013 and later injuries. Using this information, the WCIRB will assess the impact of the SB 863 changes by comparing the impact of the remaining add-ons for psychiatric injuries, sleep disorder and sexual dysfunction on PD ratings with their impact on pre-2013 injuries. This database can also be used to identify any new types of add-ons that are emerging in the post-SB 863 environment.

Cost Components to be Measured and Schedule for Valuation

1. Impact of PD Add-ons on PD Ratings

    a. Data Elements — The PD rating, coding for impairment add-ons and other related descriptive information, such as disability category and impairment rating, are available from the DEU database on a relatively contemporaneous basis.

    b. General Methodology — The volume and average impact of add-ons for psychiatric injuries, sleep disorder and sexual dysfunction on PD ratings can be determined from the DEU database of PD rating information on 2013 injuries. These measures can be compared to the analogous measures from DEU data on similarly-aged claims from pre-2013 injuries. In addition, the DEU database can be reviewed to assess if there is significant growth in new types of add-ons in the post-SB 863 environment.

    c. Schedule — DEU data on PD ratings is available on a relatively contemporaneous basis. However, given the PD claim process, PD ratings on 2013 injuries will not become available in significant volumes until 2014. An initial preliminary evaluation of ratings on 2013 injuries can be completed in the third quarter of 2014. The analysis can be updated regularly as more mature information becomes available.

E. Three-Tiered Weekly PD Benefits

SB 863 amendments to Labor Code Section 4658 repealed the provision for a 15% increase or decrease in weekly PD benefits depending on whether the employer provides a qualified return-to-work offer to an injured worker. These changes are effective on injuries occurring on or after January 1, 2013.

The WCIRB's prospective evaluation of the SB 863 amendments to Labor Code Section 4658 was based on the WCIRB's PD Claim Survey which collects information on the proportion of weekly PD benefits paid at each of the three tiers.

Since the three tiers of weekly PD benefits are being eliminated by SB 863, the WCIRB is unable to directly measure the post-SB 863 PD benefits that would have been paid at different tiers if not for the enactment of SB 863. However, the WCIRB PD Claim Survey does collect information as to whether a qualified return-to-work offer was made by the employer. The proportion of survey claims on which a qualified return-to-work offer was made for accident year 2013 injuries can be compared to the proportion on pre-SB 863 injuries to assess whether the elimination of the three-tiered system has impacted the frequency of return-to-work offers.

Cost Components to be Measured and Schedule for Valuation

1. Frequency of Return-to-Work Offers

    a. Data Elements — The number and proportion of claims reported on the PD Claim Survey in which there is a qualified return-to-work offer.

    b. General Methodology — The proportion of PD claimants receiving a qualified return-to-work offer can be estimated for 2013 injuries based on PD Claim Survey information received in late 2015 and the proportion compared to that of similarly aged pre-2013 injury claims.

    c. Schedule — In the PD Claim Survey, accident year claims are initially valued, on average, at 28 months. One year later, open claims are resurveyed with an evaluation at 40 months. The initial retrospective estimate of the SB 863 changes on the frequency of return-to-work offers on 2013 injuries can be made on a preliminary basis during the fourth quarter of 2015. The analysis can be updated regularly as more mature information becomes available.

F. Indemnity Claim Frequency

SB 863 enacted increases to PD weekly minimums and maximums, changes to the process of determining final PD ratings and other changes impacting indemnity benefits. The WCIRB's prospective evaluation of SB 863 included provisions for changes in indemnity claim frequency that have historically accompanied changes in indemnity benefit levels. These provisions were based on a WCIRB econometric analysis[8] of the effect of a number of economic, demographic and claims-related variables on the frequency of indemnity claims. 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%.[9]

Once post-SB 863 experience becomes available, the WCIRB can compare estimates of frequency changes based on the WCIRB model to actual changes in indemnity claim frequency based on accident year experience. Also, since benefit changes impact workers at different wage levels in different ways, frequency changes by wage level intervals based on unit statistical data can also be reviewed.

Cost Components to be Measured and Schedule for Valuation

1. Accident Year Indemnity Claim Frequency Changes

    a. Data Elements — WCIRB accident year indemnity claim counts from quarterly WCIRB aggregate financial data calls.

[8] Brooks, Ward, "California Workers Compensation Benefit Utilization – A Study of Changes in Indemnity 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.

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

b. General Methodology — The change in reported aggregate indemnity claims to exposure from one accident year to another will be measured at quarterly evaluations and compared to the changes forecast by the WCIRB frequency model and changes in recent pre-SB 863 accident years.

c. Schedule — The initial report for the frequency change by accident year can be made on a preliminary basis shortly following the beginning of the accident year. The first preliminary evaluation of the accident year 2013 frequency change based on six months of experience can be made by the third quarter of 2013. Regular updates can be made on a quarterly basis.

2. Accident Year Indemnity Claim Frequency Changes by Wage Level Interval

a. Data Elements — Claim counts by type of injury, accident year and wage level from WCIRB unit statistical reports.

b. General Methodology — Changes in accident year indemnity claim counts by wage intervals will be estimated based on unit statistical data. Changes in claim counts at wage intervals affected by the SB 863 benefit changes will be compared to changes at wage levels that were unaffected.

c. Schedule — The first preliminary evaluation of changes in an accident year's indemnity claim counts by wage level interval can be made within one year from the end of the accident year. The first preliminary evaluation of accident year 2013 changes can be made, based on a comparison of 2013 accidents reported on 2012 policies to similarly valued earlier accident years, by the third quarter of 2014. Updates can be made on a regular basis.

G. Department of Industrial Relations (DIR) Return-to-Work Program

SB 863 added Labor Code Section 139.48, which authorized the establishment of a return-to-work program funded at $120 million annually from the non-General Funds of the Worker's Compensation Administrative Revolving Fund for the purpose of making supplemental benefit payments to workers whose PD benefits are disproportionately low in comparison to their earnings loss. Labor Code Section 139.48 also provides that determinations of the DIR shall be subject to review at the trial level at the Workers' Compensation Appeals Board (WCAB) upon the same grounds as petitions for reconsideration.

As noted in the WCIRB's prospective evaluation of SB 863, this provision, once adopted through regulation, will have a significant impact on employer costs as reflected in direct employer assessments. However, those assessments do not directly affect the costs underlying pure premium rates. As a result, the WCIRB did not include any cost assessment of this provision in its prospective evaluation. Also, while it is possible that administration of this new program may have an impact on LAE costs, the WCIRB noted that it was premature to assess the cost impact of this program until such time as the program has been developed.

Once the regulations are developed and, in particular, the potential impact of the new program on LAE costs are better understood, the WCIRB will augment its monitoring program to retrospectively assess the impact of the new program on costs.

V. SB 863 Cost Monitoring Plan – Changes to Medical Benefit Delivery System

A. Liens

SB 863 included a number of provisions related to liens. Section 4903.05 was added to the Labor Code to provide that every lien claimant is required to file its lien with the WCAB using an approved form and be charged a filing fee of $150. In addition, amendments to Labor Code Section 4903.5 provided that no liens may be filed more than three years from the date of service for liens filed before July 1, 2013 or 18 months from the date of service for liens filed on or after July 1, 2013.

The WCIRB's prospective evaluation of the impact of SB 863 on lien-related costs was based primarily on information from a 2011 report[10] published by the Commission on Health and Safety and Workers' Compensation (CHSWC) that provided information on the volume of liens as well as lien characteristics by size, type and maturity and the WCIRB's 2012 lien study that provided information on the frequency of lien filings per PD claim as well as lien demand and settlement cost information. (Attachment 3 is a copy of the WCIRB 2012 Lien Survey form.) Based on this information, the WCIRB estimated the number of liens to be eliminated by SB 863 and the average settlement cost and loss adjustment expenses related to those liens.

The WCIRB will retrospectively measure the impact of SB 863 on lien costs based on information from the DWC on lien filings and activations in 2013 and beyond in addition to updated information on lien costs from the WCIRB Lien Survey. Further, to assess concerns that some lien costs will be replaced by "petitions for costs" filings — particularly in areas such as interpreter and copy service fees, the volume and cost of petitions for costs filings will also be monitored through information from the WCIRB Lien Survey.

Cost Components to be Measured and Schedule for Valuation

1. The Number of Lien Filings and Lien Activations

    a. Data Elements — Counts of lien filings and lien activations based on DWC data from the Electronic Adjudication Management System (EAMS).

    b. General Methodology — An estimate of the changes in the number of lien filings in 2013 can be made by comparing filings for the first half of 2013 with the comparable number of lien filings made in the first half of 2012. The total number of active liens can be approximated by the number of new lien filings in the first six months of 2013 with information on lien activations from the DWC EAMS database.

    c. Schedule — An initial preliminary evaluation based on the lien activity in the first six months of 2013 can be completed by the fourth quarter of 2013. The analysis can be updated regularly based on later time periods.

2. Average Lien Costs

    a. Data Elements — The average cost of lien demands and settlements by type of lien and lien defense costs from WCIRB Lien Survey data.

    b. General Methodology — The average demand and settlement cost by type of lien and lien defense costs for liens filed and activated in the first six months of 2013 can be compared to the comparable amounts for liens filed and activated in the pre-SB 863 period to estimate the impact of SB 863.

[10] *Liens Report*, CHSWC, January 2011.

c. Schedule — The WCIRB will issue its Lien Survey in the beginning of the third quarter of 2013 for information on liens filed and activated in the first half of 2013. The preliminary analysis based on that information can be completed by the fourth quarter of 2013. The analysis can be updated at regular intervals based on later time periods.

3. The Number and Cost of "Petitions for Costs"

   a. Data Elements — The number and cost of settlements on "petitions for costs" from WCIRB Lien Survey data.

   b. General Methodology — The number, average demand and settlement cost for "petitions for costs" by type for petitions filed in the first six months of 2013 can be determined to help estimate the impact of the SB 863 lien provisions.

   c. Schedule — The WCIRB will issue its Lien Survey for information on liens filed and activated and petitions for costs filed in the first half of 2013 in the beginning of the third quarter of 2013. The preliminary analysis based on that information can be completed by the fourth quarter of 2013. The analysis can be updated at regular intervals based on later time periods.

B. Surgical Implant Hardware

SB 863 repealed Labor Code Section 5318, which provided for separate reimbursement for implantable medical devices, hardware and instrumentation. These changes are effective on dates of service on or after January 1, 2013. Additionally, SB 863 added Labor Code Section 5307.1(m), which requires that on or before July 1, 2013 the Administrative Director adopt a regulation specifying an additional reimbursement for certain diagnostic-related groups pertaining to spinal surgery to ensure that aggregate reimbursement is sufficient to cover costs, including implantable hardware.[11]

The WCIRB's prospective evaluation of the provisions of SB 863 related to surgical implant hardware was based on a California Workers' Compensation Institute (CWCI) estimate of the cost of duplicate reimbursements for spinal implant hardware in California workers' compensation injuries.[12] No adjustment was made to the WCIRB estimate to reflect potential future adjustments to the fee schedule pursuant to Labor Code Section 5307.1(m).

The WCIRB will retrospectively measure the impact of the SB 863 changes related to spinal implant hardware based on medical transaction records from WCIRB medical data call (MDC) or CWCI Industry Claim Information System (ICIS) data by comparing the paid cost related to spinal implant hardware on 2013 and later dates of service with those on pre-SB 863 dates of service. The initial evaluation based on dates of service in early 2013 can be completed in late 2013 with updates in subsequent periods based on later dates of service.

Cost Components to be Measured and Schedule for Valuation

1. Change in Spinal Implant Hardware Costs

   a. Data Elements — Paid amounts related to spinal implant hardware based on medical transaction data from WCIRB and CWCI.

[11] The regulation would be repealed January 1, 2014 unless extended by the Administrative Director.

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

b. General Methodology — An estimate of the changes in average reimbursements for spinal implant hardware on 2013 and later dates of service can be made by comparing those costs based on medical transaction data from the WCIRB and CWCI with the costs paid on pre-2013 dates of service.

c. Schedule — The initial evaluation based on the dates of service in early 2013 can be completed by the fourth quarter of 2013. The analysis can be updated regularly based on later time periods.

C. Ambulatory Surgical Center Fees (ASC)

SB 863 amendments to Labor Code Section 5307.1(c) provide that the maximum facility fee for services performed in ASC should not exceed 80% of the Medicare fee for the same service in a hospital outpatient department. Currently, maximum ASC facility fees are set at 120% of the Medicare rate for hospitals.

The amendments to Labor Code Section 5307.1(c) 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 of the provisions of SB 863 related to ASC fees was based on a RAND Corporation analysis that estimated the cost of ASC facility fee payments.[13] The estimate also reflected a judgmental reduction of 25% in ASC facility fees rather than the one-third indicated based on the change in maximum fee schedule allowances inasmuch as review of WCIRB medical transaction data indicated that prior to SB 863, a significant number of ASC facility fees were being reimbursed at contract amounts that were well below the maximum allowed under the fee schedule.

The WCIRB will retrospectively measure the impact of the SB 863 changes related to ASC facility fees, based on a sample of medical transaction records from the WCIRB or the CWCI, comparing the paid cost related to ASC facility fees on 2013 and later dates of service to both the SB 863 fee schedule amounts and the actual reimbursements on claims with pre-SB 863 dates of service. The initial evaluation based on dates of services in early 2013 can be completed in late 2013 with updates in subsequent periods based on later dates of service. The WCIRB will also monitor outpatient hospital costs to assess if there has been any potential shift to outpatient hospital services with the new schedule for ASC facility fees.

Cost Components to be Measured and Schedule for Valuation

1. Change in the Cost of ASC Facility Fees

   a. Data Elements — Paid amounts related to ASC facility fees based on medical transaction data from WCIRB and CWCI.

   b. General Methodology — An estimate of the changes in the cost of ASC facility fees for 2013 and later dates of service can be made by comparing those costs, based on a sample of medical transaction data from the WCIRB or the CWCI, to both the SB 863 fee schedule amounts and the actual average reimbursements on claims with pre-SB 863 dates of service.

[13] *CHSWC Staff Estimates for Labor and Employer Discussions,* CHSWC, November 2009.

c. Schedule — The initial evaluation based on the dates of service in early 2013 can be completed by the fourth quarter of 2013. The analysis can be updated regularly based on later time periods.

2. Change in the Cost of Hospital Outpatient Services

   a. Data Elements — Paid amounts related to outpatient fees based on medical transaction data from WCIRB and CWCI.

   b. General Methodology — An estimate of the changes in the cost of hospital outpatient fees for 2013 and later dates of service can be made by comparing those costs based on medical transaction data from the WCIRB or the CWCI to outpatient costs during the pre-SB 863 period. If there is a significant shift in outpatient costs, the data can be analyzed by type of diagnosis to assess whether this change may be due to a shift in services from ASC facilities to outpatient hospital services.

   c. Schedule — The initial evaluation based on the dates of service in early 2013 can be completed by the fourth quarter of 2013. The analysis can be updated regularly based on later time periods.

D. Independent Medical Review (IMR)

SB 863 added Labor Code Sections 139.5, 4610.5, and 4610.6 and amended Labor Code Sections 4061, 4062, 4062.2, 4610.1, and 4903 to provide for a newly-created process of IMR. The SB 863 provisions related to IMR are effective on January 1, 2013 for injuries occurring on or after January 1, 2013 and on July 1, 2013 for all injuries.

The WCIRB's prospective evaluation of the SB 863 provisions related to IMR was segregated into several components. The WCIRB evaluated the impact of the IMR provisions on lien costs based on CHSWC data on liens related to medical treatment and WCIRB data on medical treatment lien costs. The WCIRB evaluated the impact of the SB 863 IMR changes related to Qualified Medical Evaluator (QME) reports based on CHSWC data on the number of QME reports and WCIRB data on the cost of medical-legal reports. The WCIRB evaluated the impact of the changes on the number of expedited hearings based on CHSWC data on the number of expedited hearings and WCIRB survey information on the cost of expedited hearings. The WCIRB evaluated the impact on temporary disability duration based on a judgmentally assumed reduction in the post-2005 deterioration in temporary disability duration based on WCIRB and CWCI data on temporary disability duration. Similarly, the estimated impact of the SB 863 IMR provisions on litigation costs was judgmentally estimated by assuming a percentage reduction in the post-2005 deterioration of allocated loss adjustment expense (ALAE) costs per indemnity claim based on WCIRB data.

The WCIRB's prospective evaluation of SB 863 noted that the SB 863 IMR provisions had the potential to significantly affect medical treatment costs. However, given the uncertainty as to how often IMR will be utilized, how often the IMR process will overturn utilization review decisions, and how the IMR process will ultimately affect medical treatment practices, the WCIRB did not reflect a cost estimate for the impact of IMR on medical treatment costs. The approved January 1, 2013 advisory pure premium rates did, however, reflect a judgmental estimate of potential savings in medical treatment costs due to the SB 863 IMR provisions based on the savings that resulted in Texas following a series of reforms impacting medical treatment.

The WCIRB will retrospectively measure the impact of the SB 863 IMR changes by analyzing post-SB 863 experience related to a number of components impacted by the bill. These components include liens related to medical treatment, expedited hearings, frequency and cost of IMRs, temporary disability

duration, medical-legal reports, ALAE, unallocated loss adjustment expenses (ULAE), litigation, medical cost containment program costs, utilization review costs, medical treatment levels, and average medical severities. Since SB 863 provisions regarding IMR become effective for all injuries on or after July 1, 2013, the WCIRB's initial preliminary evaluation of most to these components based on services provided in the second six months of 2013 will not occur until 2014. These preliminary evaluations can be updated as appropriate based on later information.

Cost Components to be Measured and Schedule for Valuation

1. Liens Related to Medical Treatment Disputes

    a. Data Elements — Liens filed on or after July 1, 2013 on medical treatment issues and their cost based on WCIRB Lien Survey data.

    b. General Methodology — To estimate the change in the number and cost of liens for medical treatment issues, the WCIRB will compare the number and cost of liens on medical treatment issues for services provided on or after July 1, 2013 based on WCIRB Lien Survey information with those from prior periods. (See Section V-A.)

    c. Schedule — The WCIRB will issue its Lien Survey for information on liens filed and activated in the second six months of 2013 and the first six months of 2014 in the beginning of the third quarter of 2014. The preliminary analysis based on that information can be completed by the fourth quarter of 2014. The analysis can be updated at appropriate intervals based on later time periods.

2. Changes in the Number of Expedited Hearings

    a. Data Elements — Counts of expedited hearings from DWC EAMS data.

    b. General Methodology — Most expedited hearings relate to medical treatment disputes. The number of expedited hearings in quarters subsequent to the July 1, 2013 effective date of the application of the IMR provisions to all injuries from EAMS data can be compared to the totals for prior periods when the IMR process was not in effect.

    c. Schedule — DWC information on expedited hearings in the second six months of 2013 and the first six months of 2014 will be available in the third quarter of 2014. The analysis can be updated at appropriate intervals based on later time periods.

3. Frequency and Cost of IMR

    a. Data Elements — The number, cost, decisions and related information from the IMR records provided to the DWC by the IMR vendor.

    b. General Methodology — The number, cost and typical outcomes of IMRs subsequent to SB 863 from DWC data on the individual IMR occurrences can be compared to similar information on the expedited hearing process gathered in the pre-SB 863 environment in part from a special WCIRB survey being issued in the first quarter of 2013.

    c. Schedule — Quarterly DWC information on IMRs should be available shortly following the end of the quarter. A preliminary summary of the IMR process in the first six months of 2013 as compared to similar information on expedited hearings in the pre-SB 863 period can be made by the fourth quarter of 2013. The analysis can be updated regularly for subsequent periods.

4. Changes in the Duration of Temporary Disability

a. Data Elements — ICIS transactional level data on the distribution of the duration of temporary disability by type of injury and accident year.

b. General Methodology — The distribution of the duration of temporary disability benefits by type of injury for 2013 and later injuries from ICIS data can be compared to the distributions for comparably aged pre-SB 863 accident years.

c. Schedule — CWCI anticipates collecting ICIS transactional data through year-end 2013 in 2014. As a result, preliminary estimates of any change in average temporary disability duration can be made by the third quarter of 2014. The analysis can be updated for subsequent periods.

5. Change in the Cost of Medical-Legal

a. Data Elements — The number and average cost of medical-legal reports by physician specialty is available from the WCIRB's annual PD Claim Survey.

b. General Methodology — The number and average cost of medical-legal reports by specialty and requesting party is determined for each accident year from the WCIRB's PD Claim Survey. The number and average cost of reports for periods subsequent to SB 863 can be compared to those for earlier periods. To the extent there are significant changes, further analysis will be considered.

c. Schedule — In the PD Claim Survey, accident year claims are initially valued, on average, at 28 months. One year later, open claims are resurveyed with an average evaluation at 40 months. The initial estimate of the number and average cost of medical-legal reports on 2012 injuries can be made during the fourth quarter of 2014. Updates can be made on an annual basis.

6. Paid ALAE per Indemnity Claim by Accident Year

a. Data Elements — Accident year paid ALAE per indemnity claim from WCIRB quarterly aggregate financial data calls.

b. General Methodology — The change in the average paid ALAE for accident years 2013 and later can be compared to the change in comparably aged average paid amounts for prior years to assess the extent to which trends in ALAE appear to be changing subsequent to SB 863. While changes in overall ALAE cost trends subsequent to SB 863 can be determined, it will likely not be possible to attribute specific changes in ALAE cost trends to IMR or any other specific SB 863 reform component.

c. Schedule — Paid ALAE by accident year for each quarter is available within ninety days subsequent to the end of the quarter. The WCIRB will prepare an analysis of paid ALAE for the 2013 accident year by the third quarter of 2014. This analysis can be updated in subsequent years.

7. Paid ULAE per Indemnity Claim by Calendar Year

a. Data Elements — Calendar year paid ULAE per indemnity claim based on the WCIRB's annual call for calendar year expenses and quarterly accident year experience calls.

b. General Methodology — The calendar year paid ULAE per indemnity claim subsequent to SB 863 can be compared to that of prior years. While changes in overall ULAE cost trends can be determined, it will likely not be possible to attribute specific changes in ULAE cost trends to IMR or any other specific SB 863 reform component.

c. Schedule — Calendar year expense payments are collected and summarized by June of the following year. As a result, an initial estimate of the effect of SB 863 on ULAE in 2013 based on this aggregate information can be made by the third quarter of 2014. This analysis can be updated in subsequent years.

8. Changes in Litigation

   a. Data Elements — The rate of attorney representation on PD claims is available from the WCIRB's annual PD Claim Survey.

   b. General Methodology — The rate of attorney representation will be determined for each accident year from the WCIRB's PD Claim Survey. The rate of representation for periods subsequent to SB 863 can be compared to that for earlier periods. While changes in overall trends in representation can be determined, it may not be possible to attribute specific changes in those trends to IMR or any other specific SB 863 reform component

   c. Schedule — In the PD Claim Survey, accident year claims are initially valued, on average, at 28 months. One year later, open claims are resurveyed with an average evaluation at 40 months. The initial estimate of the rates of attorney representation on 2012 injuries can be made during the fourth quarter of 2014. Updates for subsequent periods can be made on an annual basis.

9. Calendar Year Paid Cost of Medical Cost Containment Programs

   a. Data Elements — The annual amount of paid costs of medical cost containment programs by calendar year from the WCIRB's annual call for calendar year indemnity and medical costs and by accident year from WCIRB quarterly calls for experience.

   b. General Methodology — Compare the changes in the calendar year cost of medical cost containment in years subsequent to SB 863 to those costs in pre-SB 863 periods.

   c. Schedule — Aggregate calendar year payments for medical cost containment programs are collected and summarized by June of the following year. As a result, an initial estimate of the effect of the legislation on the cost of medical cost containment programs in 2013 based on this information can be made by the third quarter of 2014. This analysis can be updated in subsequent years.

10. Utilization Review Costs

    a. Data Elements — The amount of utilization review costs by accident year can be determined from CWCI ICIS data.

    b. General Methodology — Compare the cost of utilization review for post-SB 863 accident years to that for pre-SB 863 accident years to assess whether the introduction of IMR has impacted the use of utilization review.

    c. Schedule — ICIS medical transaction data through year-end 2013 should be available by the middle of 2014. As a result, a preliminary estimate of any changes in the cost and use of utilization review can be made by the third quarter of 2014. This analysis can be updated in subsequent periods as more information becomes available.

11. Changes in Medical Treatment Patterns

    a. Data Elements —WCIRB MDC and CWCI ICIS transaction level data on a number of utilization measures, such as the number of visits and number of procedures by type (e.g., physical medicine, chiropractic, evaluation and management) and by diagnosis

(e.g., lower back injury without radiculopathy) for different durations of treatment (e.g., the first 90 days, the first 180 days) for both pre-SB 863 and post-SB 863 injuries.

b. General Methodology — For a number of the key diagnoses that generate significant workers' compensation costs, compare the changes in various average utilization measures at comparable treatment intervals for later injuries impacted by the SB 863 reforms with the patterns on pre-SB 863 injuries to assess the extent to which treatment patterns have changed. This procedure will be updated as additional transaction level data becomes available.

c. Schedule — Medical transaction data through year-end 2013 should be available by the middle of 2014. As a result, a preliminary estimate of any changes in utilization patterns can be made by the third quarter of 2014. This analysis can be updated in subsequent periods as more information becomes available.

12. Accident Year Average Paid Medical per Indemnity Claim

a. Data Elements — Accident year paid medical per indemnity claim by quarter from WCIRB quarterly aggregate financial calls.

b. General Methodology — The change in the average paid medical per indemnity claim by accident year for quarters in 2013 can be compared to the change in comparably aged average paid medical amounts for prior years to assess if trends in medical severities appear to be changing subsequent to the effective date of SB 863.

c. Schedule — The WCIRB can prepare an initial analysis of medical paid severities for the first and second quarters of 2013 by the third quarter of 2013. This analysis can be updated in subsequent quarters.

E. Medical Provider Networks(MPNs)

SB 863 amended Labor Code Section 4605 to provide that reports prepared by a consulting or attending physician chosen by the injured worker and outside the MPN shall not be the sole basis of compensation. These amendments address the Valdez[14] decision, which relates to the admissibility of reports completed outside a valid MPN. In addition, SB 863 amendments to Labor Code Section 4603.2 provided that the employer is not liable for treatment or the consequences of treatment obtained outside a valid MPN.

The WCIRB's prospective evaluation of the impact of the SB 863 provisions related to treatment provided outside a valid MPN was based on judgmental assumptions that were predicated on CWCI data on cost differentials between costs incurred within a valid MPN to those incurred outside a valid MPN. Separate estimates were developed for medical treatment, temporary disability and permanent disability.

The WCIRB will retrospectively measure the impact of the SB 863 changes related to treatment provided outside a valid MPN based on CWCI data on utilization of networks as well as information on the changes in cost differentials between services provided within a valid MPN and those based on services provided outside a valid MPN. As with the WCIRB's prospective evaluation, cost differentials will be analyzed separately for medical treatment, temporary disability and permanent disability. An initial preliminary evaluation based on services provided in the first six months of 2013 can be completed by the fourth quarter of 2013. Updates can be completed on a regular basis.

[14] Valdez v. WCAB (Demo Warehouse). The WCAB, in an en banc decision issued on April 20, 2011, held that if the injured worker obtains unauthorized treatment outside a validly established and properly noticed MPN, the reports from any non-MPN doctors are inadmissible in court. The California 2nd District Court of Appeals, in a published decision issued on May 29, 2012, overturned the decision of the WCAB, holding that the Labor Code does not prohibit the admission of medical reports from non-MPN doctors. The case is now pending before the California Supreme Court.

Cost Components to be Measured and Schedule for Valuation

1. Percentage of Medical Treatment Provided within MPNs

    a. Data Elements — The percentage of medical procedures provided within a MPN can be obtained from CWCI's ICIS database.

    b. General Methodology — The proportion of services provided within a MPN for post-SB 863 periods can be compared to the proportion of services for periods prior to SB 863 based on ICIS data.

    c. Schedule — ICIS medical transaction data for the first six months of 2013 should be available by the fourth quarter of 2013. As a result, an initial preliminary analysis of the change in the volume of services provided within a valid MPN can be completed by that time. The analysis can be updated for subsequent periods.

2. Cost Differentials Related to MPNs

    a. Data Elements — The average cost differential in medical treatment, temporary disability and permanent disability for claims with medical services provided within a valid MPN compared to those with services provided outside a valid MPN from ICIS data.

    b. General Methodology — The average post-SB 863 cost differentials in medical treatment, temporary disability, and permanent disability for claims with medical services provided within a valid MPN from that on services provided outside a valid MPN can be compared to similar measures for pre-SB 863 periods. The analysis can use appropriate controls for differences in claim types.

    c. Schedule — An analysis of ICIS medical transaction data for 2013 injuries should be available by the third quarter of 2014. The analysis can be updated on a regular basis based on more mature information.

F. Independent Bill Review (IBR)

SB 863 added Labor Code Section 4603.6 to create a new process for IBR when there is a bill payment dispute. Specifically, Labor Code 4603.6 provided that if there is a dispute on the amount of payment and that dispute was not resolved by the employer's second review, the provider may request an independent bill review within thirty days of the second review. If the provider fails to request IBR within thirty days, the bill will be deemed satisfied. These provisions are effective on medical services provided on or after January 1, 2013.

In the WCIRB's prospective evaluation of SB 863, it was noted that there were a number of outstanding issues related to the IBR process that needed to be resolved through regulation. As a result, the WCIRB did not include a cost estimate for the impact of the new IBR provisions in its SB 863 evaluation.

The WCIRB's retrospective evaluation of the SB 863 provisions related to liens (see Section V-A) will incorporate the impact of the IBR provisions on reduced lien costs. The WCIRB will also retrospectively measure the frequency and cost of IBR as well as prepare an analysis of their results based on information to be provided by the DWC. An initial summary of IBR related costs in the first six months of 2013 can be prepared by the fourth quarter of 2013. The analysis can be updated regularly based on more current information.

Cost Components to be Measured and Schedule for Valuation

1. Frequency and Cost of IBR

    a. Data Elements — The number, cost, decisions and related information from the DWC IBR records provided to the DWC by the IBR vendors.

    b. General Methodology — The number, cost and typical outcomes of IBRs subsequent to SB 863 from DWC data on individual IBRs can be compiled. The costs of the IBR process will be reviewed in the context of reduced lien costs in part that may be attributable to fewer bill disputes being resolved by the lien process.

    c. Schedule — Quarterly DWC information on IBRs should be available shortly following the end of the quarter. A preliminary summary of the IBR process based on the first six months of 2013 can be made by the fourth quarter of 2013. The analysis can be updated regularly for subsequent periods.

G. Conversion of the OMFS to RBRVS Basis

SB 863 amended Labor Code Section 5307.1 to provide 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 provide for a four-year transition period beginning in 2014.

The WCIRB's prospective evaluation of SB 863 did not include an estimate for the impact of this change inasmuch as it was believed premature to assess the cost impact of fee schedule revisions until such time as the specific revisions have been promulgated. Once the revised schedule values are promulgated, the WCIRB will assess their cost impacts and, to the extent appropriate, reflect those cost impacts in proposed advisory pure premium rates.

The WCIRB's retrospective evaluation of the SB 863 provisions related to RBRVS will be based on medical transaction data from the WCIRB's MDC database. The impact of the new schedule can be assessed by comparing the average per procedure cost for the affected procedures with dates of service subsequent to the effective date of the new schedule with those with effective dates prior to the new schedule. The data will also be reviewed for significant shifts in the types of services that may be attributable to the changes in the schedule.

Cost Components to be Measured and Schedule

1. Average Physician Payment per Procedure

    a. Data Elements — WCIRB MDC data on the paid cost of physician services by procedure by date of service.

    b. General Methodology — The average cost of physician services per procedure provided in the six months following implementation of the new schedule can be compared with those provided in the prior twelve-month period. The analysis will also review any potential shifts in the type of physician services provided that may be attributable to the new schedule.

    c. Schedule — MDC data for a particular quarter is required to be reported by ninety days from the end of the quarter. The WCIRB can compute an initial retrospective estimate of the impact of the new RBRVS-based fee schedule based on the services provided in the first six months following implementation of the new schedule. This can be completed within one year

of the new schedule's effective date. Updates based on later information can be made on a regular basis.

H. New Fee Schedules

SB 863 added Labor Code Section 5307.8 to authorize the DWC Administrative Director to adopt a fee schedule for home health services by July 1, 2013 and adds Labor Code Section 5307.9 to authorize the DWC Administrative Director to adopt a fee schedule for copy services by December 31, 2013. In addition, SB 863 amendments to Labor Code Section 5307.7 and Labor Code Sections 4600(g) and 5811 authorize the DWC Administrative Director to adopt changes to the fee schedules for vocational services and interpreters, respectively.

The WCIRB's prospective evaluation of SB 863 did not include an estimate for the impact of these new fee schedules and fee schedule changes inasmuch as it was premature to assess the cost impact of fee schedule revisions until such time as the specific revisions have been promulgated. Once the revised schedule values are promulgated, the WCIRB will assess their cost impacts and, to the extent appropriate, reflect those cost impacts in proposed advisory pure premium rates.

The WCIRB's retrospective evaluation of the SB 863 provisions related to the new fee schedules will be based on medical transaction data from the WCIRB's MDC database. The impact of the new schedules can be assessed by comparing the average per procedure cost for the affected procedures with dates of service subsequent to the effective date of the new schedule with those with effective dates prior to the new schedule. The data will also be reviewed for significant shifts in the types of services that may be attributable to the new schedules and schedule changes.

Cost Components to Be Measured and Schedule for Valuation

1. Average Medical Payment per Affected Procedure

    a. Data Elements — MDC data on the paid cost of medical services by procedure by date of service period.

    b. General Methodology — For each of the new schedules adopted, the average cost of services per procedure provided in the six months following implementation can be compared with those provided in the prior twelve-month period. The analysis will also review any potential shifts in the type of services provided that may be attributable to the new schedules.

    c. Schedule — MDC data for a particular quarter is required to be reported within ninety days from the end of the quarter. The WCIRB can compute an initial retrospective estimate of the impact of new schedules based on the services provided in the first six months following implementation of the new schedule. This evaluation can be completed within one year of the new schedule's effective date. Updates based on later information can be made on a regular basis.

VI. Conditions and Limitations

A. Other System Components

In addition to the areas discussed above, the costs of other system components may well be affected by SB 863. Although not specifically addressed in this Plan, to the extent the WCIRB becomes aware of the potential of other significant impacts on costs resulting from SB 863 in areas not specifically addressed in this Plan, we will implement additional cost monitoring procedures.

B. Subsequent Legislation

Future legislation or unrelated regulation may affect cost components that were impacted by SB 863. It may be difficult to differentiate the impact of the enumerated bills from that of subsequent legislation.

C. Other Factors Affecting Benefit Costs

The California workers' compensation benefit delivery system is a complex, multi-dimensional system impacted by many economic, demographic, societal and claims-related factors, including legislative changes. In many cases, it can be very difficult to distinguish the specific impact of legislation from other influences on the cost of benefits.

D. Interpretation

The WCIRB's prospective cost evaluation of SB 863, as well as this Cost Monitoring Plan, is based on the WCIRB's interpretation of the legislation as written. If legislation is subsequently interpreted differently in regulations or by the courts, those interpretations may not be reflected in the WCIRB's initial cost evaluation or in this Cost Monitoring Plan.

Attachment A

Workers' Compensation Insurance Rating Bureau of California®

WCIRB Evaluation of the Cost Impact of Senate Bill No. 863

Updated: October 12, 2012

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WCIRB Evaluation of the Cost Impact of Senate Bill No. 863

Senate Bill No. 863 (SB 863) was passed by the Legislature on August 31, 2012 and signed by the Governor on September 18, 2012. SB 863 increases benefits effective January 1, 2013 and January 1, 2014 and provides for a number of structural changes to the California workers' compensation benefit delivery system.

The WCIRB has reviewed the impact of SB 863 on the costs of losses and loss adjustment expenses (LAE) underlying 2013 advisory pure premium rates. The WCIRB has provided a cost estimate for SB 863 amendments to permanent disability (PD) minimum and maximum weekly benefit levels; the burial allowance; supplemental job displacement benefits; the adjustments to the PD rating corresponding to future earning capacity (FEC); PD impairment "add-ons" for psychiatric impairment, sleep disorder or sexual dysfunction; the three-tiered system of PD weekly benefits based on return-to-work status; liens; reimbursements for spinal implant hardware; fee schedule values for ambulatory surgical centers (ASCs); the process for resolving medical treatment disputes through independent medical review (IMR); and provisions related to services provided outside a valid medical provider network (MPN). The SB 863 amendments which are not quantifiable at this time include provisions related to MPN procedures and processes; independent bill review; IMR as it relates to medical treatment, fee schedules for interpreters, home health services and copy services; conversion of the California Official Medical Fee Schedule (OMFS) to a Resource Based Relative Value Scale (RBRVS) basis; and PD advances. In addition, the WCIRB's cost estimate does not reflect the costs associated with the proposed return-to-work program for the purpose of making supplemental payments to workers whose PD benefits are disproportionately low in comparison to their earnings loss as this program is to be funded by direct assessments to employers and does not directly affect the costs underlying pure premium rates.[1]

In addition to percentage estimates of the impact of SB 863 on underlying costs, the WCIRB has provided estimated dollar impacts. These dollar estimates, while based primarily on data from insured employers, have been extrapolated to the entire market based on the relative sizes of the insured and self-insured markets.

In evaluating the cost implications of SB 863, the WCIRB (a) reviewed the provisions which potentially impact the costs reflected in advisory pure premium rates; (b) consulted with other professionals with expertise in evaluating the impact of the legislation;[2] (c) reviewed relevant research; and (d) performed additional analysis, as appropriate, given the available data and time constraints.

The WCIRB estimates the impact of the SB 863 provisions effective on injuries occurring on or after January 1, 2013 that are quantifiable at this time, including the impact on claim frequency (utilization), is an overall cost reduction of **5.8%, or $1.1 billion**, based on an estimated statewide cost of indemnity and medical losses and loss adjustment expenses (LAE) of $19 billion on injuries occurring in 2013.[3] In addition, the increased PD benefit provisions effective on injuries occurring on or after January 1, 2014, including the impact on claim frequency (utilization), are estimated to increase total system costs by **3.1%, or $0.6 billion**. In total, by the 2014 injury year, the currently quantifiable provisions of the legislation, including the impact on claim frequency (utilization), is estimated to decrease total system costs by **2.7%, or $0.5 billion**, annually.

Policies incepting in 2013 will be fully impacted by the SB 863 amendments effective January 1, 2013 and partly impacted by the SB 863 amendments effective on injuries occurring on or after January 1, 2014.

[1] The program created in Labor Code Section 139.48 is funded by $120 million annually through appropriation from non-General Fund revenues of the Workers' Compensation Administration Revolving Fund.

[2] These professionals include a number of insurer representatives with expertise in claims, legal, and actuarial matters; representatives of the California Department of Insurance; the Commission on Health and Safety and Workers' Compensation; the Department of Industrial Relations (DIR); the California Workers' Compensation Institute; and the University of California at Berkeley.

[3] The WCIRB's estimated system size is based on the estimated cost of indemnity and medical losses and loss adjustment expenses as reflected in the WCIRB's January 1, 2013 Pure Premium Rate Filing, with adjustments for statewide employment growth through 2013 based on UCLA forecasts and an estimated 50% loading for self-insured experience. The $19 billion estimate consists of $4.9 billion in indemnity benefits, $10.4 billion in medical benefits, and $3.7 billion in loss adjustment expenses.

The WCIRB estimates that, on average, SB 863 will reduce the cost of losses and loss adjustment expenses on 2013 policies by 4.4%.

While the information summarized below reflects the WCIRB's current estimate of the cost impact of SB 863, the actual cost impact will depend, in part, on the development and implementation of future regulations required by the legislation, how the Workers' Compensation Appeals Board (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. The WCIRB will regularly reassess the cost impact of this legislation as more information and data become available.

The WCIRB's estimated cost impact of SB 863 is summarized in Table 1.

Table 1: Estimated Cost Impact of SB 863

SB 863 Provisions	Direct Impact on Claim Costs ($ millions)		Indirect Impact on Claim Frequency (Utilization) ($ millions)		Total Impact on Claim Costs ($ millions)	Total % Impact on Claim Costs
	Loss	LAE	Loss	LAE		
2013 Benefit Level Changes[4]	$350	—	$220	$50	$620	+3.3%
Elimination of PD Add-ons[5]	($100)	—	($60)	($10)	($170)	-0.9%
Three-Tiered Weekly PD Benefits	($60)	—	($30)	($10)	($100)	-0.5%
Liens	($190)	($290)	—	—	($480)	-2.5%
Surgical Implant Hardware	($110)	—	—	—	($110)	-0.6%
ASC Fees	($80)	—	—	—	($80)	-0.4%
IMR[6]	($160)	($140)	($70)	($20)	($390)	-2.1%
Ogilvie Decision	($70)	($80)	($50)	($10)	($210)	-1.1%
MPN Strengthening	($130)	—	($50)	($10)	($190)	-1.0%
Total Estimated Impact of 2013 Changes	**($550)**	**($510)**	**($40)**	**($10)**	**($1,110)**	**-5.8%**
Estimated Impact of 2014 Benefit Changes[7]	**$340**	—	**$200**	**$50**	**$590**	**+3.1%**
Combined Estimated Annual Impact of SB 863 on 2014 Injuries	**($210)**	**($510)**	**$160**	**$40**	**($520)**	**-2.7%**

The basis of the WCIRB's evaluation of the cost impact of the various provisions of SB 863 is summarized below.

Section I: SB 863 Benefit Provisions for Which WCIRB Can Provide an Estimate

SB 863 amends Labor Code Section 4453 to provide 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. Effective January 1,

[4] This includes changes to the weekly PD benefit maximums and minimums, the supplemental job displacement benefit, the burial allowance, the elimination of the future earning capacity (FEC), and the application of a uniform factor adjustment of 1.4 to each impairment.

[5] This includes the elimination of the rating add-ons for psychiatric impairment, sleep disorder and sexual dysfunction, with a 10% offset to account for psychiatric add-ons that arise from a catastrophic injury or violent act.

[6] This includes the estimated impact of IMR on frictional costs, temporary disability duration, and litigation, but does not include any estimate for the impact of IMR on medical treatment.

[7] These 2014 amendments include changes in weekly PD benefit maximums.

2013, SB 863 adds Labor Code Section 4658.7 which provides 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 adds Labor Code Section 4660.1 to provide that the PD impairment produced in accordance with American Medical Association (AMA) Guides will not be modified for FEC as in the 2005 Permanent Disability Rating Schedule (PDRS); instead, a uniform adjustment factor of 1.4 will be applied to the whole person impairment determined pursuant to the AMA Guides. Finally, amendments to Labor Code 4701 increase the burial allowance from $5,000 to $10,000.

The evaluation of the estimated cost impact of the SB 863 statutory benefit level changes on injuries occurring on or after January 1, 2013 is based on information from approximately 200,000 lost-time claims that occurred on policies incepting in 2008 and 2009 and were reported to the WCIRB in accordance with the requirements of the *California Workers' Compensation Uniform Statistical Reporting Plan—1995*. (Certain information on death claims, vocational rehabilitation, and supplemental job displacement benefits is based on survey information.) Injured worker wage information on these claims was adjusted to reflect the level of wages anticipated for 2013 injuries, based on wage level growth estimates using UCLA published wage information.[8]

To evaluate the cost impact of the changes to PD ratings based on Labor Code Section 4660.1, the WCIRB analyzed approximately 20,000 claims available from the Disability Evaluation Unit (DEU) database that had PD ratings computed by the DEU between June 2011 and March 2012. While not all PD claims are rated by the DEU, the DEU database does provide sufficient detail to allow for the evaluation of the effect on the average rating of the elimination of the FEC and the application of the 1.4 adjustment factor. While the DEU database may not be fully representative of all PD ratings, there is no indication of significant bias for the purpose of this evaluation.

Using the DEU database, the estimated change in average rating by percentage of PD rating point was determined and the rating for each claim in the WCIRB database previously discussed was adjusted accordingly. Using this information, the incurred cost of each of the approximately 200,000 lost-time claims at the 2013 cost level was restated after reflecting the changes to (a) weekly PD benefit maximums and minimums, (b) the burial allowance, (c) the supplemental job displacement benefit, and (d) the FEC factor. The restated cost of these claims was then compared with the estimated cost of these claims under the current schedule of benefits. This process was repeated for injuries occurring in 2014 to estimate the cost impact of the SB 863 amendments to the weekly PD benefit maximums effective for injuries occurring in 2014.

With changes in benefit levels, not only is the cost of average weekly benefits changed, but the frequency of claims is also affected. This evaluation includes a provision to reflect the historical impact of changes in temporary total and permanent partial disability benefits on claim frequency. The estimates of the impact of the statutory benefit changes on claim frequency are based on a WCIRB econometric model of the effect of a number of economic, demographic and claims-related variables, including changes in indemnity benefit levels, on the frequency of indemnity claims in California.[9] In essence, the model shows that for every 1% change in average indemnity benefit costs due to changes in statutory benefit levels, there is an approximate 0.2% change in indemnity claim frequency.[10] (The utilization factors are not applied to changes in permanent total or death benefit levels, and no provision is reflected for the potential impact of benefit level changes on claim duration.)

Exhibit 1 shows the estimates of the cost impact of the SB 863 statutory benefit level changes effective for injuries occurring in 2013, both before and after the adjustment for changing frequency (utilization). Exhibit 2 shows the estimates of the cost impact of the SB 863 benefit level changes for injuries occurring in 2014.

[8] See Part A, Section B, Exhibit 5.1 of the WCIRB's Amended January 1, 2013 Pure Premium Rate Filing.

[9] 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.

[10] The medical loss factor is adjusted to reflect the assumption that some of the newly generated indemnity claims may not incur additional medical costs since they were medical-only claims in the past.

Changes in statutory indemnity benefit levels do not necessarily impact the cost of LAE. However, to the extent the number of indemnity claims is impacted by the benefit level changes, LAE cost will also be affected. The WCIRB's estimate of the cost impact of the SB 863 changes to the statutory benefit levels, as reflected in Table 1, assume that the change in LAE costs is proportional to the indicated change in claim frequency.

In total, including the impact of the changes in benefit levels on claim frequency (utilization), the WCIRB estimates that the SB 863 changes to statutory benefit levels will increase the total statewide cost of losses and loss adjustment expenses by 3.3%, or $620 million, for 2013 injuries and by 3.1%, or $590 million, for 2014 injuries.

Section II: SB 863 Provisions for Which WCIRB Can Provide a Judgmental Estimate

A. Elimination of Permanent Disability Add-ons

SB 863 amendments to Labor Code Section 4660.1 provide that there shall be no increases in impairment ratings for sleep disorder, sexual dysfunction or psychiatric impairment arising out of a compensable physical injury. However, psychiatric add-ons to permanent disability impairments would continue to apply to catastrophic injuries or if the injury was the result of a violent act.

The previously discussed DEU database of PD ratings allows for identification of add-ons for psychiatric injury, sleep disorder and sexual dysfunction. The DEU database of ratings does not, however, allow for the identification of claims with psychiatric add-ons associated with catastrophic injuries or injuries arising from violent acts. The WCIRB has approximated the percentage of permanent disability add-ons that will not be eliminated for catastrophic injuries or injuries resulting from a violent act based on the underlying injury characteristics of reported permanent disability claims from WCIRB unit statistical data. Exhibit 3 shows the WCIRB's estimated savings from the elimination of the permanent disability add-ons — including the estimated impact of the exception pertaining to psychiatric add-ons rising from catastrophic injuries or injuries resulting from violent acts. As shown in Table 1, the WCIRB estimates that these SB 863 provisions, including the commensurate impact on claim frequency, will reduce total system costs on 2013 injuries by 0.9%, or $170 million, based on a total statewide estimate of the cost of losses and loss adjustment expenses of $19 billion.

Note that this estimate assumes no adjustment to reflect the impact of any legal challenge to this restriction on PD add-ons which may occur. Additionally, no estimate has been reflected for any potential impact on medical costs of specifying in the Labor Code the intent to not limit the ability of the injured worker to obtain medical treatment for psychiatric impairment, sleep disorder or sexual dysfunction arising out of an industrial injury.

B. Elimination of Three-Tiered Weekly Permanent Disability Benefits

Amendments to Labor Code Section 4658 in effect repeal the provision for a 15% increase or decrease in weekly PD benefits depending on whether the employer provides a qualified offer to return to work to an injured worker. The WCIRB collects information on the proportion of weekly PD benefits paid at each of the three tiers through its annual PD claim survey. The WCIRB's survey information indicates that approximately 7.5% of the weeks of PD benefits on accident year 2006 through 2009 claims were paid at the lower benefit level that reflected the 15% reduction and approximately 30.6% of the weeks were paid at the higher benefit level that reflected the 15% increase. As a result, the WCIRB estimates that eliminating these tiered PD benefit adjustments and paying weekly PD benefits at the standard rate would reduce PD benefits by approximately 3%.

Exhibit 4 shows the cost impact of eliminating the three-tiered system of PD benefits based on the status of a qualified return-to-work offer. The WCIRB estimates that this provision, including the commensurate impact on claim frequency, as shown in Table 1, will reduce total system costs on 2013 injuries by 0.5%, or $100 million, based on a total statewide estimate of the cost of losses and loss adjustment expenses of $19 billion.

C. Liens

SB 863 includes a number of provisions related to liens, including those in Labor Code Sections 4603.2, 4603.3, 4603.4, 4603.6, 4622, 4903, 4903.1, 4903.6, 4903.8, 4904 and 4905. Labor Code Section 4903.05 is added to the Labor Code and provides that every lien claimant is required to file its lien with the WCAB using an approved form and be charged a filing fee of $150. In addition, the amendments to Labor Code Section 4903.5 provide that no liens may be filed more than three years from the date of service for liens filed before July 1, 2013 or 18 months from the date of service for liens filed on or after July 1, 2013.

There is relatively limited information available on the cost impact of liens. A 2011 report published by the Commission on Health and Safety and Workers' Compensation (CHSWC) indicated that the number of medical lien filings has increased sharply since 2005.[11] The report suggested that approximately $1.5 billion per year is claimed in lien disputes, and the average cost of defending and settling a lien is approximately $1,000.

The WCIRB has recently issued a special claim survey gathering lien information from insurers on a random sample of 1,000 permanent disability claims from 2007 and 2002 through 2004.[12] Exhibit 5.1 shows the computation of the estimated impact of the new lien filing fee on costs while Exhibit 5.2 shows the cost impact of the new provisions related to the time limitations for filing a lien.[13] The key assumptions underlying the WCIRB estimates developed in Exhibits 5.1 and 5.2 are summarized as follows:

1. The total number of liens for 2013 injuries, based on Division of Workers' Compensation (DWC) data and WCIRB frequency change forecasts, is estimated at 640,000.
2. Based on the distribution of lien settlements by size from the WCIRB lien survey, it was assumed that 30% of the liens would be eliminated by the filing fee. (This corresponds to an average lien settlement demand of approximately $1,000 and an average lien settlement amount of approximately $300, which is twice the $150 filing fee.)
3. Based on WCIRB lien survey data on individual liens by size, the average size of the liens with settlements below $300 that are projected to be eliminated by the lien filing fee is estimated to be $150.
4. The average savings in administrative cost per lien on the liens projected to be eliminated by the $150 filing fee is estimated at $400.[14]
5. The percentage of liens related to medical and medical-legal issues that were filed more than two years[15] from the date of service and were above the $1,000 lien demand threshold that was estimated to reflect liens eliminated by the new lien filing fee was estimated at 11% based on WCIRB survey data on lien demands and CHSWC data on the timing of lien filings.
6. The average lien claim based on WCIRB lien survey information for the liens that would be eliminated by the statute of limitations was assumed to be $7,500, with an assumed 30% settlement rate and $3,000 in legal and administrative costs.[16]

Based on the assumptions summarized above, as shown in Table 1, the WCIRB estimates that the SB 863 lien provisions will reduce total system costs by 2.5%, or $480 million, based on a total statewide estimate of the cost of losses and loss adjustment expenses of $19 billion.

[11] *Liens Report*, CHSWC, January 2011.

[12] These included a sample of 2002 through 2004 permanent disability claims that had recently reopened.

[13] Preliminary WCIRB estimates were based largely on the assumptions reflected in the Bickmore Risk Services' August 23, 2012 preliminary evaluation of the proposed legislation for the Department of Industrial Relations, which pre-dated the availability of the WCIRB lien survey data. Overall cost estimates based on the two sets of assumptions are very close.

[14] Estimates of the cost of loss adjustment expenses per lien have ranged from $1,000 in the 2011 CHSWC lien study to $1,500 based on CWCI's preliminary results from its 2012 lien survey (as discussed at the July 30, 2012 WCIRB Claims Working Group meeting). The WCIRB estimate is based on WCIRB lien survey information, which suggests $150 in legal costs per lien for smaller liens plus an approximate $250 provision for insurer administrative costs.

[15] The analysis reflected a two-year timeframe rather than the 18 months in SB 863 in that it was assumed that some liens that would otherwise be filed after 18 months will be filed earlier due to the establishment of the 18-month statute of limitations.

[16] WCIRB lien survey data suggests that the average cost of lien legal fees for these larger medical-related liens is approximately $1,400 with an assumed additional $1,600 in other claims administrative costs.

D. Surgical Implant Hardware

SB 863 repeals Labor Code Section 5318, which provides for separate reimbursement for implantable medical devices, hardware and instrumentation. Earlier this year, the California Workers' Compensation Institute (CWCI) preliminarily estimated that the savings from eliminating the multiple reimbursements for spinal implant hardware in California workers' compensation injuries was approximately $67 million.[17] Based on the WCIRB's estimate of total insured medical costs paid in 2010[18] adjusted to reflect the total statewide system, this would equate to approximately 1% of total paid medical costs. As a result, the WCIRB estimates that the repeal of the separate reimbursement for surgical implant hardware would reduce medical costs by 1% and total system costs by approximately 0.6%, or $110 million, based on a total statewide estimate of the cost of losses and loss adjustment expenses of $19 billion.

Additionally, SB 863 adds Labor Code Section 5307.1(m), which provides that on or before July 1, 2013, the Administrative Director shall adopt a regulation specifying an additional reimbursement for certain diagnostic-related groups pertaining to spinal surgery to ensure that aggregate reimbursement is sufficient to cover costs, including implantable hardware.[19] While this has the potential to affect the savings resulting from the repeal of Labor Code Section 5318, the WCIRB has not reflected any cost impact from Labor Code Section 5307.1(m) pending review of any regulations that may be adopted by the Administrative Director.

E. Ambulatory Surgical Center (ASC) Fees

SB 863 amendments to Labor Code Section 5307.1(c) provide that the maximum facility fee for services performed in ASCs should not exceed 80% of the Medicare fee for the same service in a hospital outpatient department. Currently, maximum ASC facility fees are set at 120% of the Medicare rate for hospitals. As result, these amendments would result in a one-third reduction in ASC facility fee payments if it is 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 current fee schedule. The WCIRB's review of a sample of medical transactions suggests that a significant portion of ASC fees are being reimbursed at amounts well below the current fee schedule. Savings of approximately 20%, rather than one-third, is indicated if it is assumed that the fee schedule change will have no impact on these contracted rates and these procedures will, in the future, be reimbursed at the lesser of the current contract rate and the new fee schedule value. However, some contract rates may be impacted by the new schedule and lower reimbursements may occur. The WCIRB has assumed savings of approximately 25% in ASC facility fees due to SB 863, which is the approximate average of the indicated savings assuming all fees are reduced by the change in schedule value and the indicated savings if it is assumed that the lower contracted values would be unaffected.

The CHSWC, based on information provided by the RAND Corporation, estimated that ASC facility fee payments in 2010 were $187 million.[20] A reduction in ASC facility fees of 25% would generate savings of approximately $50 million in 2010. This equates to approximately 0.8% of total medical costs based on the WCIRB's estimate of total insured medical costs paid in 2010[21] adjusted to reflect the total statewide system. As a result, the WCIRB estimates the reduction in ASC facility fees would reduce medical costs by 0.8% and total system costs by approximately 0.4%, or $80 million, based on a total statewide estimate of the cost of losses and loss adjustment expenses of $19 billion.

F. Independent Medical Review

SB 863 adds Labor Code Sections 139.5, 4610.5, and 4610.6 and amends 4061, 4062, 4062.2, 4610.1, and 4903 to provide for a newly-created process of independent medical review (IMR). In particular, the

[17] *Preliminary Estimate of California Workers Compensation System-Wide Costs for Surgical Instrumentation Pass-Through Payments for Back Surgeries*, CWCI, June 2012.
[18] *2010 California Workers' Compensation Losses and Expenses,* WCIRB, June 2011.
[19] The regulation would be repealed January 1, 2014 unless extended by the Administrative Director.
[20] *CHSWC Staff Estimates for Labor and Employer Discussions,* CHSWC, November 2009.
[21] *2010 California Workers' Compensation Losses and Expenses,* WCIRB, June 2011.

impact of these SB 863 provisions on indemnity and medical benefits is difficult to evaluate inasmuch as their ultimate impact is dependent upon the regulatory structure used in its implementation, any judicial interpretations of the new review process, and the practices and procedures used by the parties involved.

The SB 863 provisions related to IMR potentially impact a number of system cost components. The assessment of the cost impact of IMR on each of these components is discussed below:

1. Liens. The total number of liens for 2013 injuries, based on DWC data and WCIRB frequency change forecasts, is estimated at 640,000, prior to any adjustment for the impact of other SB 863 provisions. CHSWC data suggests that 62% of the liens are for medical and 11.3% relate to utilization review disputes. Judgmentally assuming that one-third of these liens were to be eliminated by other SB 863 provisions suggests that 30,000 liens related to utilization review disputes would remain in the system.[22] Assuming that the administrative and legal cost related to these issues is $3,000 based on WCIRB lien survey data[23] and those costs would be replaced with a $500 IMR report, estimated savings in loss adjustment expenses are $75 million (30,000 liens x ($3,000 - $500).

2. Qualified Medical Evaluations. CHSWC data indicates that there were 116,000 Qualified Medical Evaluator (QME) reports in 2010, with 18% or 21,000 related to medical treatment issues. WCIRB data indicates that the average cost of a medical-legal report in 2009 is $1,662.[24] Assuming an annual trend of 5%, the WCIRB estimates that the average cost of a medical-legal report for 2013 injuries would be approximately $2,000. As a result, assuming each of these QME reports will be replaced by an IMR report at a cost of $500 each would produce savings of approximately $32 million (21,000 QME reports x ($2,000 - $500)).

3. Expedited Hearings. CHSWC data suggests that there are approximately 12,000 expedited hearings, of which approximately 75% or 9,000 are related to medical necessity. Based on an informal survey of insurer claims departments, it is suggested that the legal and administrative costs related an expedited hearing is approximately $1,500. As a result, eliminating the costs related to these expedited hearings would suggest savings of approximately $14 million (9,000 expedited hearings x $1,500).[25]

4. Medical Treatment Costs. Medical treatment costs per indemnity claim have risen by approximately 45% since 2005.[26] Also, based on CHSWC data on liens and QME reports and WCIRB data on medical treatment lien demands, it is estimated that there are approximately 65,000 utilization review disputes — with approximately $400 million in dispute. However, at this time it is not clear how often utilization reviews are overturned under the current system and how often it will be overturned under SB 863's IMR system. Nor is it clear how often IMRs will be utilized and how the system might eventually affect treatment patterns. Given these uncertainties, the impact of SB 863's IMR system on medical treatment is not clear at this time. The WCIRB plans to actively monitor treatment costs subsequent to implementation of SB 863 and, to the extent appropriate, modify its pure premium rate projections based on emerging medical treatment cost information.

5. Temporary Disability Duration. WCIRB and CWCI data shows that temporary disability duration has increased by approximately 20% since the reforms of 2002 through 2004 were fully implemented in 2005.[27] Also, information from the Workers' Compensation Research Institute

[22] These assumptions are reflected in the August 23, 2012 Bickmore Risk Services report to the DIR evaluating potential reform savings.
[23] WCIRB lien survey data suggests that the average cost of lien legal fees for these larger medical-related liens is approximately $1,400 with an assumed additional $1,600 in other claims administrative costs.
[24] See Exhibit TR-S11 of Agenda Item AC12-08-01 of the August 2, 2012 WCIRB Actuarial Committee meeting.
[25] Since the cost of the IMR reports related to these disputes was already reflected in the evaluation of the impact of SB 863's IMR provisions on QME reports, no additional offset for the cost of IMR was reflected.
[26] See the Executive Summary of the WCIRB's January 1, 2013 Pure Premium Rate Filing submitted on August 21, 2012.
[27] See Exhibits LD-P7.1 and LD-P7.2 of Agenda Item AC12-08-01 of the August 2, 2012 WCIRB Actuarial Committee meeting.

(WCRI)[28] suggests that temporary disability duration in California is considerably higher than in most other states. It is not possible to isolate the impact of medical treatment delays from the impact of the economy, prior legislative changes impacting temporary disability duration, and issues related to permanent disability on increasing temporary disability duration. However, inasmuch as delays related to medical treatment are generally believed to be a significant component in the 20% deterioration in temporary disability duration since 2005 and it is generally believed that SB 863's IMR process should reduce delays related to medical treatment, the WCIRB believes some cost level adjustment is appropriate. The WCIRB believes it is reasonable to judgmentally assume that one-fifth of the recent deterioration in temporary disability duration will be eliminated by SB 863's IMR provisions. This results in a reduction of temporary disability benefits of 4% and a total cost reduction, including the estimated impact of changes in indemnity benefit levels on claim frequency utilization, of 1.1%, or $210 million, assuming a total system size estimate of $19 billion.

6. Litigation. Paid allocated loss adjustment expenses (ALAE) have increased by approximately 96% since 2005.[29] Also, WCRI information suggests that temporary benefit delivery expenses in California are significantly higher than in other states.[30] It is not possible to isolate the impact of medical treatment issues on litigation or ALAE from the impact of lien, permanent disability and other issues. However, inasmuch as disputes over medical treatment issues are generally believed to be a significant component in the deterioration of ALAE per claim since 2005 and it is generally believed that SB 863's IMR process should reduce litigation related to medical treatment, the WCIRB believes some cost level adjustment is appropriate.

   Other SB 863 reforms reflected in this evaluation are estimated to reduce ALAE costs by 15%, or approximately $400 million. The WCIRB believes it is reasonable to judgmentally assume that the estimated reduction in ALAE as a result of SB 863's IMR provisions is approximately proportional to the estimated 2.4% reduction in indemnity benefits as a result of the projected reduction in temporary disability duration discussed above. This assumption results in estimated total cost reduction of 0.3%, or $60 million, assuming a total system size estimate of $19 billion.

Based on the assumptions summarized above, as shown in Table 1, the WCIRB estimates that the currently quantifiable SB 863 provisions relating to the IMR process will reduce total system costs by 2.1%, or $390 million, based on a total statewide estimate of the cost of losses and loss adjustment expenses of $19 billion.

G. Elimination of the Impact of the Ogilvie Decision on PD Rating Adjustments

The 2009 WCAB decision in Ogilvie v. City and County of San Francisco allowed for the PD rating to be adjusted based on a finding that the FEC component of the PD rating did not appropriately describe the loss of FEC. As discussed in Section I above, under SB 863, FEC will not be used as a basis to determine the PD rating on injuries occurring on or after January 1, 2013 and, as a result, these ratings will not be subject to amendments based on the Ogilvie decision.

In 2009, the WCIRB projected the combined impact of the Ogilvie and Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School District WCAB decisions on cost levels to be an increase of 5.8%.[31] PD benefits, excluding the impact of changes in claim frequency, were estimated to increase by approximately 20% as a result of these WCAB decisions. The WCIRB has since reviewed a wide range of information on costs emerging subsequent to the WCAB decisions. This information shows costs emerging at a level generally consistent with the initial estimates reflected in the WCIRB's earlier

[28] *How California Compares Prior to SB 863: CompScope Benchmarks for California, 13th Edition*, Workers' Compensation Research Institute, October 2012.
[29] See the Executive Summary of the WCIRB's January 1, 2013 Pure Premium Rate Filing submitted on August 21, 2012.
[30] *How California Compares Prior to SB 863: CompScope Benchmarks for California, 13th Edition*, Workers' Compensation Research Institute, October 2012.
[31] See Part A, Section B, Appendix C of the WCIRB's July 1, 2009 Pure Premium Rate Filing for a complete discussion of the WCIRB's estimate of the cost impact of the Ogilvie and Almaraz/Guzman decisions on costs.

pure premium rate filings.[32] In particular, a WCIRB analysis of claim settlement data from the DWC suggested that total claim settlements increased by approximately 12% following the decisions, which corresponds to an approximate 25% increase in PD benefits.[33] The WCIRB has also reviewed information on ratings from the DEU which suggest that the increase in PD benefits due primarily to the Almaraz/Guzman decision could range from 8% to 17%.[34]

Given this information, the WCIRB believes that the initially estimated impact of Ogilvie and Almaraz/Guzman decisions on PD costs of an increase of 20% appears reasonable. However, the WCIRB is not aware of any information segregating the impact of Ogilvie from that of Almaraz/Guzman. The WCIRB's Claims Working Group has indicated that Ogilvie adjustments to PD are significantly rarer than Almaraz/Guzman adjustments, although they do impact claim settlements — particularly in Northern California.[35] The WCIRB judgmentally estimates that one-fifth of the increase in PD benefits collectively attributed to Ogilvie and Almaraz/Guzman is attributable solely to Ogilvie and, as a result, PD benefits on 2013 injuries is estimated to be reduced by 4% (one-fifth of 20%) by the effective elimination of the Ogilvie adjustments.

In the 2009 evaluation of the impact of the Ogilvie and Almaraz/Guzman decisions, the WCIRB estimated that ALAE would increase by 9% due to the WCAB decisions.[36] Although the impact of the WCAB decisions on ALAE costs cannot be isolated from other factors impacting ALAE (e.g., liens), ALAE costs did escalate following the WCAB decisions at a level relatively consistent with the estimate.[37] As noted earlier, Ogilvie adjustments to PD are significantly rarer than adjustments based on the Almaraz/Guzman decision. Nevertheless, Ogilvie cases do involve significant frictional costs. As a result, the WCIRB judgmentally estimates that one-third of the 9% increase in ALAE estimated to reflect the combined impact of Ogilvie and Almaraz/Guzman is attributable solely to Ogilvie and, as a result, ALAE on 2013 injuries is estimated to be reduced by 3% by the effective elimination of the Ogilvie adjustments. This would reduce statewide LAE by approximately $80 million based on a total system cost estimate of $19 billion.

As shown in Table 1, the WCIRB estimates that the elimination of the Ogilvie adjustments to PD will reduce total system costs by 1.1%, or $210 million, based on a total statewide estimate of the cost of losses and LAE of $19 billion.

H. Provisions Related to Medical Services Provided by a Valid MPN

SB 863 amends Labor Code Section 4605 to provide that reports prepared by a consulting or attending physician chosen by the injured worker and outside the MPN shall not be the sole basis of compensation. These amendments appear to address the Valdez[38] decision, which relates to the admissibility of reports completed outside a MPN. In addition, Labor Code Section 4603.2 provides that the employer is not liable for treatment or the consequences of treatment obtained outside a valid MPN. The WCIRB believes that, in particular, the SB 863 amendments to Labor Code Section 4603.2 should significantly strengthen the impact of the MPNs.

[32] See Agenda Item AC09-03-07 of the August 2, 2012 WCIRB Actuarial Committee meeting for a more complete discussion of this information.
[33] See Agenda Item AC09-03-07 of the August 3, 2011 WCIRB Actuarial Committee meeting.
[34] See Agenda Item AC09-03-07 of the August 2, 2012 WCIRB Actuarial Committee meeting.
[35] See Agenda Item AC09-03-07 of the August 2, 2012 WCIRB Actuarial Committee meeting.
[36] See Part A, Section B, Appendix C of the WCIRB's July 1, 2009 Pure Premium Rate Filing for a complete discussion of the WCIRB's estimate of the cost impact of the Ogilvie and Almaraz/Guzman decisions on costs.
[37] See Agenda Item AC09-03-07 of the August 2, 2012 WCIRB Actuarial Committee meeting for a more complete discussion of this information.
[38] Valdez v. WCAB (Demo Warehouse). The WCAB, in an en banc decision issued on April 20, 2011, held that if the injured worker obtains unauthorized treatment outside a validly established and properly noticed MPN, the reports from any non-MPN doctors are inadmissible in court. The California 2nd District Court of Appeals, in a published decision issued on May 29, 2012, overturned the decision of the WCAB, holding that the Labor Code does not prohibit the admission of medical reports from non-MPN doctors.

It is difficult to precisely estimate the cost impact of these provisions related to services provided outside a MPN. However, recent CWCI analyses have shown that costs are impacted by the use of MPNs.[39] The WCIRB's projected cost impact of the SB 863 provisions related to MPN strengthening on medical costs, temporary disability benefits and PD benefits is based on the assumptions reflected in the Bickmore Risk Services' August 23, 2012 report to the DIR on potential reform savings. The key assumptions underlying the estimates are as follows:

1. Based on WCIRB and CWCI data, it is estimated that 76% of PD claims are within network and 70% of claims are litigated.
2. One-fifth (20%) of in-network litigated PD claims will obtain medical services outside the networks.
3. Based on CWCI data, approximately 75% of medical payments and 76% of temporary disability payments are assumed to occur on PD claims.
4. Based on CWCI data on cost differences within and outside networks, medical costs procured outside of network are estimated to be approximately 10% higher than in-network costs, temporary disability costs are estimated to be approximately 14% higher, and PD costs are estimated to be approximately 23% higher.
5. Based on WCIRB data, 68% of medical costs are unpaid at 24 months and assumed to be affected by the changes related to MPNs.

Based on these assumptions, a savings of approximately $60 million in medical costs, $30 million in temporary disability costs and $40 million in PD costs is estimated prior to the impact of the temporary disability and permanent disability benefit reductions on claim frequency utilization. In total, based on these assumptions, the WCIRB estimates that SB 863 provisions related to strengthening MPNs, including the impact of the reduction in temporary disability and permanent disability benefits on claim frequency, will reduce total system costs by 1.0%, or $190 million.

Section III: SB 863 Provisions for Which No WCIRB Estimate is Provided

SB 863 included a number of provisions for which the WCIRB is not able to provide an estimated cost impact. These include the following:

1. New Return-to-Work Program. SB 863 adds Labor Code Section 139.48, which authorizes the Administrative Director to develop a return-to-work program funded at $120 million annually from the non-General Funds of the Worker's Compensation Administrative Revolving Fund for the purpose of making supplemental benefit payments to workers whose PD benefits are disproportionately low in comparison to their earnings loss. Labor Code Section 139.48 also provides that determinations of the Administrative Director shall be subject to review at the trial level at the Workers' Compensation Appeals Board (WCAB) upon the same grounds as petitions for reconsideration. While this provision, once adopted through regulation, will have a significant impact on employer costs as reflected in direct employer assessments, it does not directly affect the costs underlying pure premium rates. As a result, the WCIRB has not included any cost assessment of this provision in this evaluation. While it is possible that administration of this new program may have an impact on LAE costs, any estimate of this cost impact is premature until such time as the programs enabling regulations have been promulgated.
2. Medical Provider Networks. SB 863 amends Labor Code Sections 4061, 4062, 4062.3, 4616, 4616.1, 4616.2, 4616.3 and 5502 to address MPNs. These provisions are intended to improve communication and quality assurance and streamline the entire MPN process in California. The WCIRB is not aware of any statistical basis upon which to predicate an estimate of the cost impact of these changes.
3. Independent Bill Review. SB 863 adds Labor Code Section 4603.6 to create a new process for independent bill review when there is a bill payment dispute. Specifically, Labor Codes 4603.6 provides that if there is a dispute on the amount of payment and that dispute was not resolved by

[39] *Analysis of Medical and Indemnity Benefit Payments, Medical Treatment and Pharmaceutical Cost Trends in the California Workers' Compensation System*, CWCI, July 2012. See the Minutes for Item AC12-06-03 of the August 2, 2012 WCIRB Actuarial Committee meeting.

the employer's second review, the provider may request an independent bill review within thirty days of the second review. If the provider fails to request an independent bill review within thirty days, the bill will be deemed satisfied. There are a number of outstanding issues related to the independent bill review to be resolved through regulation. At this time, the WCIRB is not aware of any statistical basis upon which to predicate an estimate of the cost impact of these changes.

4. IMR. As discussed in Section II, Paragraph F, the WCIRB was able to estimate an impact of the SB 863 provisions related to IMR on frictional costs, temporary disability duration and litigation. However, given uncertainties as to how the IMR program will be implemented and utilized and how it may affect medical treatment patterns, the WCIRB was unable to quantify the impact of IMR on medical treatment costs at this time. The WCIRB will actively monitor treatment costs subsequent to implementation of SB 863 and, to the extent appropriate, modify its pure premium rate projections based on emerging medical treatment cost information.

5. New Medical Fee Schedules. SB 863 adds Labor Code Section 5307.8 to authorize the Administrative Director to adopt a fee schedule for home health services by July 1, 2013 and adds Labor Code Section 5307.9 to authorize the Administrative Director to adopt a fee schedule for copy services by December 31, 2013. The SB 863 amendments to Labor Code Section 5307.7 and Labor Code Sections 4600(g) and 5811 pertain to fee schedules for vocational services and interpreters, respectively. It is premature to assess the cost impact of new fee schedules until such time as the fee schedules are adopted. Once the new schedules are adopted, the WCIRB will assess their cost impacts and, to the extent appropriate, reflect those cost impacts in proposed pure premium rates.

6. Conversion of OMFS to RBRVS Basis. SB 863 amends Labor Code Section 5307.1 to provide that the Administrative Director shall adopt a fee schedule based on the RBRVS for physician services, with the maximum reasonable fees paid set at a level not to exceed 120% of Medicare. The amendments provide for a four-year transition period beginning in 2014. It is premature to assess the cost impact of fee schedule revisions until such time as the specific revisions have been promulgated. Once the revised schedule values are adopted, the WCIRB will assess their cost impacts and, to the extent appropriate, reflect those cost impacts in proposed pure premium rates.

7. Advances to Permanent Disability. SB 863 revisions to Labor Code Section 4650(b) provide that the advances to PD are not required if the employer has made a qualified offer of return-to-work. Typically, the WCIRB does not reflect changes affecting only the time value of money in pure premium ratemaking. However, inasmuch as the typical PD advance is believed to be well less than one year and current interest rates are low, the WCIRB believes this provision will not have a significant impact on total system costs.

Estimated Cost Impact On Accident Year 2013 - SB 863

Changes in Statutory Benefit Levels[1]

Type of Injury	Distribution of Incurred Losses	Impact Prior to Utilization Adjustments	Impact Subsequent to Utilization Adjustments
Death	0.0063	2.5%	2.5%
Permanent Total	0.0108	0.0%	0.0%
Major 70-99.75	0.0077	10.5%	12.3%
Major 25-69.75	0.1669	10.2%	11.9%
Serious	0.1917	9.4%	11.0%
Minor 15-24.75	0.0265	5.2%	6.9%
Minor 0.25-14.75	0.0655	4.9%	6.6%
Temporary	0.0373	0.0%	1.6%
Non-Serious	0.1293	3.6%	5.2%
Indemnity (Serious & Non-Serious)	0.3210	7.0%	8.7%
Medical	0.6790	0.0%	1.4%
Total	**1.0000**	**2.3%**	**3.7%**

[1] This includes change to the permanent disability weekly benefit maximums and minimums, change to the supplemental job displacement benefit, increase of the burial allowance, elimination of the FEC, and the application of a 1.4 adjustment to each impairment but prior to the elimination of the rating add-ons for psychiatric impairment, sleep disorder and sexual dysfunction.

Estimated Cost Impact On Accident Year 2013 - SB 863
Changes in Statutory Benefit Levels[1]

	(1) Benefit Effective 1/1/2013 Present	(2) Benefit Effective 1/1/2013 Proposed[1]
Death		
1. Effect of amendment on death	$196,955.94	$201,955.94
		1.025
Permanent Total		
2. Average compensation	$1,048.62	$1,048.62
3. Effect of amendment on permanent total		1.000
Major 70-99.75		
4. Average duration, temporary disability	98.8	98.8
5. Average compensation, temporary disability	$632.33	$633.28
6. Average duration, permanent disability	530.6	577.5
7. Average compensation, permanent disability	$273.21	$293.29
8. Average duration, life pension	967.2	908.1
9. Average compensation, life pension	$187.85	$219.49
10. Average cost of education vouchers	$3,382.91	$2,560.04
11. Average total cost: (4)x(5)+(6)x(7)+(8)x(9)+(10)	$392,552.00	$433,841.63
12. Effect of amendment on major 70-99.75		1.105
Major 25-69.75		
13. Average duration, temporary disability	75.7	75.7
14. Average compensation, temporary disability	$530.46	$535.65
15. Average duration, permanent disability	189.9	208.9
16. Average compensation, permanent disability	$229.59	$237.81
17. Average duration, life pension	---	1,075.0
18. Average compensation, life pension	---	$2.56
19. Average cost of education vouchers	$2,339.19	$1,893.27
20. Average total cost: (13)x(14)+(15)x(16)+(17)x(18)+(19)	$86,111.32	$94,875.71
21. Effect of amendment on major 25-69.75		1.102

[1] This includes change to the permanent disability weekly benefit maximums and minimums, change to the supplemental job displacement benefit, increase of the burial allowance, elimination of the FEC, and the application of a 1.4 adjustment to each impairment but prior to the elimination of the rating add-ons for psychiatric impairment, sleep disorder and sexual dysfunction.

Estimated Cost Impact On Accident Year 2013 - SB 863
Changes in Statutory Benefit Levels[1]

	(1) Benefit Effective 1/1/2013 Present	(2) Benefit Effective 1/1/2013 Proposed[1]
Minor 15-24.75		
22. Average duration, temporary disability	61.8	61.8
23. Average compensation, temporary disability	$476.13	$481.40
24. Average duration, permanent disability	69.9	77.8
25. Average compensation, permanent disability	$226.77	$229.33
26. Average cost of education vouchers	$1,135.95	$1,247.65
27. Average total cost: (22)x(23)+(24)x(25)+(26)	$46,387.99	$48,820.71
28. Effect of amendment on minor 15-24.75		1.052
Minor 0.25-14.75		
29. Average duration, temporary disability	40.6	40.6
30. Average compensation, temporary disability	$455.06	$457.26
31. Average duration, permanent disability	23.6	27.6
32. Average compensation, permanent disability	$221.28	$223.99
33. Average cost of education vouchers	$501.69	$623.32
34. Average total cost, (29)x(30)+(31)x(32)+(33)	$24,188.54	$25,374.27
35. Effect of amendment on minor 0.25-14.75		1.049
Temporary		
36. Average compensation	$456.26	$456.26
37. Effect of amendment on temporary		1.000

[1] This includes change to the permanent disability weekly benefit maximums and minimums, change to the supplemental job displacement benefit, increase of the burial allowance, elimination of the FEC, and the application of a 1.4 adjustment to each impairment but prior to the elimination of the rating add-ons for psychiatric impairment, sleep disorder and sexual dysfunction.

Attachment A

Estimated Cost Impact On Accident Year 2014 - SB 863

Change in Statutory Benefit Levels[1]

Type of Injury	Distribution of Incurred Losses	Impact Prior to Utilization Adjustments	Impact Subsequent to Utilization Adjustments
Death	0.0063	0.0%	0.0%
Permanent Total	0.0106	0.0%	0.0%
Major 70-99.75	0.0070	0.0%	1.6%
Major 25-69.75	0.1730	10.1%	11.9%
Serious	0.1969	8.9%	10.5%
Minor 15-24.75	0.0271	7.1%	8.8%
Minor 0.25-14.75	0.0676	4.6%	6.2%
Temporary	0.0368	0.0%	1.6%
Non-Serious	0.1315	3.8%	5.4%
Indemnity (Serious & Non-Serious)	0.3284	6.9%	8.5%
Medical	0.6716	0.0%	1.3%
Total	**1.0000**	**2.3%**	**3.7%**

[1] This includes the change to the permanent disability weekly benefit maximums.

Estimated Cost Impact On Accident Year 2014 - SB 863

Change in Statutory Benefit Levels[1]

	(1) Benefit Effective 1/1/2014 Present	(2) Benefit Effective 1/1/2014 Proposed
Death		
1. Effect of amendment on death	$203,808.05	$203,808.05
		1.000
Permanent Total		
2. Average compensation	$1,078.89	$1,078.89
3. Effect of amendment on permanent total		1.000
Major 70-99.75		
4. Average duration, temporary disability	98.8	98.8
5. Average compensation, temporary disability	$652.29	$652.29
6. Average duration, permanent disability	540.1	540.1
7. Average compensation, permanent disability	$279.57	$279.57
8. Average duration, life pension	957.7	957.7
9. Average compensation, life pension	$195.37	$195.37
10. Average cost of education vouchers	$2,387.15	$2,387.15
11. Average total cost: (4)x(5)+(6)x(7)+(8)x(9)+(10)	$404,964.77	$404,964.77
12. Effect of amendment on major 70-99.75		1.000
Major 25-69.75		
13. Average duration, temporary disability	75.7	75.7
14. Average compensation, temporary disability	$546.37	$546.37
15. Average duration, permanent disability	193.2	193.2
16. Average compensation, permanent disability	$228.10	$273.93
17. Average cost of education vouchers	$1,887.60	$1,887.60
18. Average total cost: (13)x(14)+(15)x(16)+(17)	$87,323.81	$96,176.76
19. Effect of amendment on major 25-69.75		1.101

[1] This includes the change to the permanent disability weekly benefit maximums.

Estimated Cost Impact On Accident Year 2014 - SB 863

Change in Statutory Benefit Levels[1]

	(1) Benefit Effective 1/1/2014 Present	(2) Benefit Effective 1/1/2014 Proposed
Minor 15-24.75		
20. Average duration, temporary disability	61.8	61.8
21. Average compensation, temporary disability	$489.34	$489.34
22. Average duration, permanent disability	70.2	70.2
23. Average compensation, permanent disability	$222.81	$270.53
24. Average cost of education vouchers	$1,150.02	$1,150.02
25. Average total cost: (20)x(21)+(22)x(23)+(24)	$47,015.46	$50,364.77
26. Effect of amendment on minor 15-24.75		1.071
Minor 0.25-14.75		
27. Average duration, temporary disability	40.6	40.6
28. Average compensation, temporary disability	$467.95	$467.95
29. Average duration, permanent disability	24.6	24.6
30. Average compensation, permanent disability	$222.29	$268.61
31. Average cost of education vouchers	$600.40	$600.40
32. Average total cost, (27)x(28)+(29)x(30)+(31)	$25,072.72	$26,214.30
33. Effect of amendment on minor 0.25-14.75		1.046
Temporary		
34. Average compensation	$468.97	$468.97
35. Effect of amendment on temporary		1.000

[1] This includes the change to the permanent disability weekly benefit maximums.

Estimated Cost Impact on Accident Year 2013 - SB 863

Effect of Removal of Add-ons for Psychiatric Impairment, Sleep Disorder, and Sexual Dysfunction

Removal of All Add-Ons

			Without Utilization Effects		With Utilization Effects	
Add-On	% of Ratings Affected (a)	Change in Average Rating (a)	% Impact on Total Losses	Loss Dollar Impact (in $MM) (b)	% Impact on Total Losses	Loss Dollar Impact (in $MM) (b)
Psychiatric Impairment	2.6%	-2.1%	-0.5%	($77)	-0.8%	($121)
Sleep Disorder	1.7%	-0.7%	-0.2%	($23)	-0.2%	($36)
Sexual Dysfunction	0.5%	-0.2%	0.0%	($7)	-0.1%	($11)
Total All Add-ons	4.1%	-2.7%	-0.7%	($107)	-1.1%	($168)

Removal of Add-Ons with 10% Offset for Psychiatric Impairments (c)

			Without Utilization Effects		With Utilization Effects	
Add-On	% of Ratings Affected	Change in Average Rating	% Impact on Total Losses	Loss Dollar Impact (in $MM) (b)	% Impact on Total Losses	Loss Dollar Impact (in $MM) (b)
Psychiatric Impairment	---	---	-0.5%	($69)	-0.7%	($109)
Sleep Disorder	---	---	-0.2%	($23)	-0.2%	($36)
Sexual Dysfunction	---	---	0.0%	($7)	-0.1%	($11)
Total All Add-ons	---	---	-0.6%	($99)	-1.0%	($156)

Source: Approximately 20,000 permanent disability claims rated by the Disability Evaluation Unit from June 2011 to March 2012.

(a) Due to interactive effects, the sum of the individual components may not equal the total.

(b) Loss dollar impacts are re-weighted so that the sum of the individual components equals the total.

(c) An estimated 10% of the savings from the removal of psychiatric add-ons is offset for catastrophic injuries or injuries that were a result of a violent act based on the injury description characteristics reported on permanent disability claims from unit statistical data.

Estimated Cost Impact On Accident Year 2013 - SB 863

Removal of Three-Tiered Weekly PD Benefits[1]

Type of Injury	Distribution of Incurred Losses	Impact Prior to Utilization Adjustments	Impact Subsequent to Utilization Adjustments
Death	0.0063	0.0%	0.0%
Permanent Total	0.0106	0.0%	0.0%
Major 70-99.75	0.0071	-1.8%	-2.1%
Major 25-69.75	0.1760	-1.8%	-2.0%
Serious	0.1999	-1.6%	-1.9%
Minor 15-24.75	0.0273	-1.0%	-1.3%
Minor 0.25-14.75	0.0677	-0.2%	-0.5%
Temporary	0.0368	0.0%	-0.3%
Non-Serious	0.1318	-0.3%	-0.6%
Indemnity (Serious & Non-Serious)	0.3317	-1.1%	-1.4%
Medical	0.6683	0.0%	-0.2%
Total	**1.0000**	**-0.4%**	**-0.6%**

[1] This is the impact of eliminating the 15% adjustment up and down in weekly PD benefits related to qualified return-to-work offer.

Estimated Cost Impact On Accident Year 2013 - SB 863

Removal of Three-Tiered Weekly PD Benefits[1]

	(1) Benefit Effective 1/1/2013 Present	(2) Benefit Effective 1/1/2013 Proposed[1]
Death		
1. Effect of amendment on death	$201,955.94	$201,955.94
		1.000
Permanent Total		
2. Average compensation	$1,048.62	$1,048.62
3. Effect of amendment on permanent total		1.000
Major 70-99.75		
4. Average duration, temporary disability	98.8	98.8
5. Average compensation, temporary disability	$618.31	$618.31
6. Average duration, permanent disability	514.3	514.3
7. Average compensation, permanent disability	$285.21	$272.41
8. Average duration, life pension	909.1	909.1
9. Average compensation, life pension	$172.73	$172.73
10. Average cost of education vouchers	$2,400.39	$2,400.39
11. Average total cost: (4)x(5)+(6)x(7)+(8)x(9)+(10)	$367,209.62	$360,628.59
12. Effect of amendment on major 70-99.75		0.982
Major 25-69.75		
13. Average duration, temporary disability	75.7	75.7
14. Average compensation, temporary disability	$532.29	$532.29
15. Average duration, permanent disability	200.4	200.4
16. Average compensation, permanent disability	$236.88	$228.68
17. Average duration, life pension	1,074.4	1,074.4
18. Average compensation, life pension	$2.23	$2.23
19. Average cost of education vouchers	$1,861.61	$1,861.61
20. Average total cost: (13)x(14)+(15)x(16)+(17)x(18)+(19)	$92,046.96	$90,403.45
21. Effect of amendment on major 25-69.75		0.982

[1] This is the impact of eliminating the 15% adjustment up and down in weekly PD benefits related to qualified return-to-work offer.

Estimated Cost Impact On Accident Year 2013 - SB 863
Removal of Three-Tiered Weekly PD Benefits[1]

	(1) Benefit Effective 1/1/2013 Present	(2) Benefit Effective 1/1/2013 Proposed[1]
Minor 15-24.75		
22. Average duration, temporary disability	61.8	61.8
23. Average compensation, temporary disability	$481.03	$481.03
24. Average duration, permanent disability	77.0	77.0
25. Average compensation, permanent disability	$229.26	$222.67
26. Average cost of education vouchers	$1,238.41	$1,238.41
27. Average total cost: (22)x(23)+(24)x(25)+(26)	$48,608.55	$48,101.03
28. Effect of amendment on minor 15-24.75		0.990
Minor 0.25-14.75		
29. Average duration, temporary disability	40.6	40.6
30. Average compensation, temporary disability	$457.24	$457.24
31. Average duration, permanent disability	27.6	27.6
32. Average compensation, permanent disability	$223.99	$221.96
33. Average cost of education vouchers	$622.56	$622.56
34. Average total cost, (29)x(30)+(31)x(32)+(33)	$25,361.96	$25,305.89
35. Effect of amendment on minor 0.25-14.75		0.998
Temporary		
36. Average compensation	$456.26	$456.26
37. Effect of amendment on temporary		1.000

[1] This is the impact of eliminating the 15% adjustment up and down in weekly PD benefits related to qualified return-to-work offer.

Estimated Cost Impact of SB 863

Lien Filing Fee

1. Projected Number of 2013 Liens[1]	640,000
2. Projected Reduction in Lien Filings[2]	30%
3. Number of Liens Avoided: (1) x (2)	192,000
4. Average Lien Settlement Cost Savings[3]	$150
5. Total Lien Settlement Cost Savings: (3) x (4)	$29,000,000
6. Average Administrative and Legal Cost per Lien[4]	$400
7. Total Administrative and Legal Cost Savings: (3) x (6)	$77,000,000
8. Total Savings: (5) + (7)	$106,000,000

[1] *Bickmore Risk Services August 23, 2012 Projected Impact of Changes to CA Workers' Compensation*
Exhibit 7, Page 1 projected 2013 liens filed based on reported DWC lien counts.

[2] 2012 WCIRB Liens Survey proportion of lien settlements of $300 or less.

[3] 2012 WCIRB Liens Survey average lien settlement for lien amounts settling for $300 or less.
This amount reflects the filing fee and provision for expense the lien claimant incurs for preparing the lien filing.

[4] 2012 WCIRB Liens Survey lien legal cost of $150 plus provision for insurer administrative costs.

Estimated Cost Impact of SB 863

Lien Statute of Limitations

1.	Projected Number of 2013 Liens[1]	640,000
2.	Percentage of Medical/Medical-Legal Liens Eliminated[2]	11%
3.	Number of Liens Avoided: (1) x (2)	70,000
4.	Average Lien Amount[3]	$7,500
5.	Average Lien Settlement Rate[4]	30%
6.	Average Lien Settlement Cost: (4) x (5)	$2,250
7.	Total Lien Settlement Cost Savings: (3) x (6)	$158,000,000
8.	Average Administrative and Legal Cost per Lien[5]	$3,000
9.	Total Administrative and Legal Cost Savings: (3) x (8)	$210,000,000
10.	Total Savings: (7) + (9)	$368,000,000

[1] *Bickmore Risk Services August 23, 2012 Projected Impact of Changes to CA Workers' Compensation* Exhibit 7, Page 1 projected 2013 liens filed based on reported DWC line counts.

[2] The product of the proportion of liens filed two years or more from the service date from the *CHSWC 2011 Liens Report (23%)* , the proportion of liens that are medical from the WCIRB Liens Survey (70%) and the proportion of liens not eliminated by the lien filing fee (70% from Exhibit 5.1).

[3] 2012 WCIRB Liens Survey average lien amount for medical/medical-legal lien types excluding those liens eliminated by the lien filing fee.

[4] 2012 WCIRB Liens Survey average lien settlement rate for medical/medical-legal lien types.

[5] 2012 WCIRB Liens Survey lien legal cost of $1,400 plus provision for insurer administrative costs.

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WORKERS' COMPENSATION INSURANCE RATING BUREAU OF CALIFORNIA
PERMANENT DISABILITY CLAIM SURVEY

GROUP NAME:
INSURER NAME:

INSURED:
POLICY NUMBER:
POLICY PERIOD:

SURVEY ID NUMBER:
BUREAU NUMBER:

CLAIM NUMBER:
ACCIDENT DATE:
RUN DATE:

Area for insurer notes

1. (a) Date claim reported: _____ / _____ / _____ (MM / DD / YY)

   (b) Has this claim been resolved?

   _____ Yes ⟶ what is the date of claim resolution? _____ / _____ / _____ (MM / DD / YY)

   _____ No

3. Complete the following if the claim involves the use of medical-legal reports. If there were none, please write "NONE" on the first line. If more than eight reports are involved, please include requested information on additional reports on a separate sheet. PLEASE DO NOT INCLUDE REPORTS WHERE NO PAYMENTS HAVE BEEN MADE.

Report Number	Specialty of Provider (see A below)	Fee Schedule Code (see B below)	Requested by (see C below)	Cost of Report (answer only if payments have been made)	Date of Service
1					/ /
2					/ /
3					/ /
4					/ /
5					/ /
6					/ /
7					/ /
8					/ /

(A) Use the following codes to indicate Specialty of Provider:
- "**O**" for Orthopedics,
- "**I**" for Internal Medicine & Cardiology,
- "**N**" for Neurology,
- "**P**" for Psychiatry, or
- "**A**" for All Others

(C) Use the following codes to indicate Requestor:
- "**P**" for Primary Treating Physician,
- "**Q**" for QME
- "**W**" for Worker,
- "**E**" for Employer/Insurer, or
- "**A**" for AME/IME

(B) Use the following medical-legal Fee Schedule Codes:
- "**A**" for ML101,
- "**B**" for ML102,
- "**C**" for ML103,
- "**D**" for ML104,
- "**E**" for ML105,
- "**F**" for ML106, or
- "**Z**" for All Other

(Answer Question 2 **ONLY IF** Question 1(b) equals "Yes".)

2. (a) Method of resolution: (Select only one of the following.)

   _____(1) Compromise & release
   _____(2) Stipulated award
   _____(3) Take nothing
   _____ (4) Findings & award
   _____ (5) Dismissal
   _____ (6) Voluntary payments

   (b) If the claim is settled through a single sum amount, please provide the single sum amount:

   _____

4. (a) Permanent disability rating (prior to apportionment): _____ % (Nearest whole percent)

   (b) If this claim involves apportionment, what is the permanent disability rating after apportionment? (leave 4(b) blank if apportionment does not apply) _____ % (Nearest whole percent)

5. Zip code of injured worker's place of residence: _____

6. Total incurred (ALL PAID PLUS OUTSTANDING RESERVE) claim cost:

   (a) Incurred indemnity **(see "Note" below)** _____

   (b) Incurred medical _____

Note: Incurred indemnity should include amounts from Questions 10(a), 12 and 13 together with other indemnity costs.

7. (a) Is there a Medicare Set-aside arranged for this claim? ____ Yes ____ No

   (b) If Yes to (a), please provide the Medicare Set-aside amount: _____

8. Injured worker's date of birth: _____ / _____ / _____ (MM / DD / YY)

PLEASE CONTINUE TO QUESTION # 9 ON THE REVERSE SIDE

Attachment A

Attachment 2

9. (a) Has the claimant been represented by an attorney or other authorized representative?

_____ Yes _____ No

(b) Enter the 3-character WCAB Office Code: _____

10. (a) Worker's legal costs **(see Note in Question 6)** AMOUNTS PAID

i) Applicant attorney fees _____

ii) Applicant expert testimony related to PD _____

iii) Other _____

(b) Allocated loss adjustment expenses: AMOUNTS PAID

i) Defense attorney fees _____

ii) Surveillance/investigation fees _____

iii) Defense expert testimony related to PD _____

iv) Other _____

11. Indicate which of the dispute mechanisms listed below have thus far been involved in the claims process. (If appropriate, indicate more than one.)

_____ (1) Continuance

_____ (2) Mandatory settlement conference

_____ (3) Arbitration/mediation pursuant to carve-out agreements

_____ (4) Expedited hearings on medical issues

_____ (5) Expedited hearings on other than medical issues

_____ (6) Formal hearings

_____ (7) Other dispute mechanism(s)

_____ (8) No formal mechanism involved

12. Nontransferable education voucher and other vocational rehabilitation-related costs: **(see Note in Question 6)**

	PAID	INCURRED
(a) Nontransferable education voucher pursuant to Labor Code Sections 4658.5 and 4658.6	_____	_____
(b) Other vocational rehabilitation-related costs	_____	_____

13. Temporary disability incurred (ALL PAID PLUS OUTSTANDING RESERVE) claim cost: **(see Note in Question 6)**

_____

14. Prior to injury, did the worker designate a personal physician pursuant to Labor Code Section 4600(d)?

_____ Yes _____ No

15. Has the employer made a qualified offer of regular, modified or alternative work expected to last for at least twelve months?

_____ Yes _____ No

16. Please enter the estimated total number of weeks of permanent disability benefits at the following statutory levels:
(use whole numbers)

Number of Weeks

_____ (a) Number of weeks at statutory level without adjustment for return to work

_____ (b) Number of weeks at statutory level with 15% upward adjustment due to lack of qualified return-to-work offer, pursuant to Labor Code 4658

_____ (c) Number of weeks at statutory level with 15% downward adjustment due to presence of qualified return-to-work offer, pursuant to Labor Code 4658

Form completed by:

Name: _____

Telephone No.: (_____) _____ - _____

Date: _____ / _____ / _____
MM DD YY

Attachment A

Attachment 3
WCIRB California®

CALIFORNIA WORKERS' COMPENSATION LIENS CLAIM SURVEY

PLEASE RETURN SURVEY TO: **WCIRB Actuarial Department**
525 Market Street, Suite 800, San Francisco, CA 94105
email: actuarial@wcirbonline.org Fax: 415-778-7007

Insurer Name: _____ Policy Number: _____
Insurer Code: ____ Effective Date: _____
Insured Name: _____ Claim Number: _____
Accident Date: _____

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR CLAIM NUMBER:

A. How many lien claimants have filed against this claim? _____
B. Lien legal defense for this claim: $ _____
C. Number of lien hearing appearances on this claim: _____

Please complete the following for each lien claimant:	**Lien #1**
1. Please select from the drop-down box the type of lien claimant:	Select Type
2. *If Source selected is "Medical-Other" or "Other", specify here:	
3. Date of original lien filing for this lien claimant:	
4. Total original amount of lien demand for this lien claimant:	$
5. Has the lien claimant been resolved (Y/N):	
6. If the lien claimant has been resolved, what was the settlement amount for the lien? (Enter $0 if the lien was resolved without any payment or dismissed)	$
7. Date this lien claimant was resolved:	
8. Please select the WCAB Office from the drop-down box:	Select WCAB Office
9. Comments (if any):	

Name of Person Completing Survey Form: _____

Title: _____ Company: _____

Telephone Number: (___) _____ Email Address: _____

Date Completed: _____

Attachment A

WCIRB California®
Objective.Trusted.Integral.

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