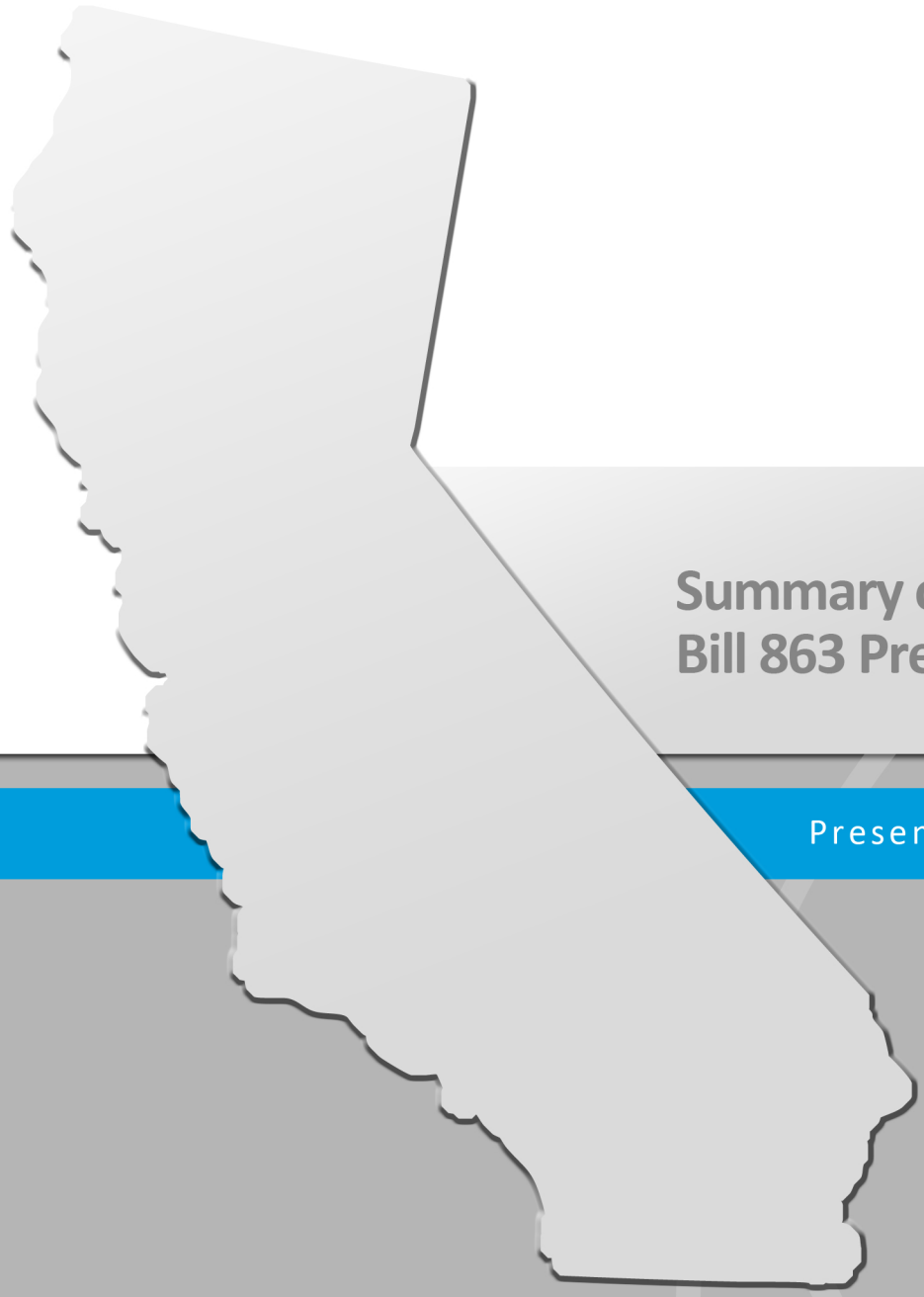

Summary of Sedgwick Senate Bill 863 Presentation

Presented November 2012

sedgwick®

Summary of Sedgwick Senate Bill 863 Presentation

PRESENTED NOVEMBER 2012

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Introduction and Overview

Speaker: Jay Ayala, Senior Vice President, Managing Director, Sedgwick

With the recent volatile political season, California's uncertain economy and a myriad of other issues, Senate Bill 863 (SB863), the landmark legislation promising to revolutionize California's broken workers' compensation system, has taken many employers by surprise. As with any legislation, there are those who applaud the bill and those with reservations. However, overall, the SB863 was passed with unprecedented support from labor and management.

While that could easily be a topic for another forum, what we at Sedgwick recognize is that everyone involved in the workers' compensation industry in California must now learn, implement, and comply with the new regulation.

And that can be difficult. It's also why on November 13, 2012 we brought together some of the state's leading experts on SB863 – including those aligned with labor, employers, as well as top state officials, to provide insights, direction, and guidance.

At Sedgwick, we take our responsibility as the nation's leading provider of claims management services seriously. We are the largest third party administrator in the state – and we believe we offer the greatest resources, as well as experts in California's complex and always dynamic workers' compensation marketplace.

There is still much to be done – indeed some estimate the majority of work and refinement for this legislation still lies ahead. While the next few years will be challenging, as employers, participants, and leaders in the workers' compensation system, we all have a great opportunity to influence and shape an evolving process.

We know it takes a "world of resources" to meet the challenges of workers' compensation today – especially when new legislation is passed.

Our pledge to our customers is that we will do all we can to aggressively manage the cost implications of SB863, and work to make sure the legislation achieves its desired goal – to create a system that is more efficient and more effective for all stakeholders.

SB863 at-a-glance

Signed in September of 2012, SB863 has been heralded as landmark legislation for California's workers' compensation industry. Key features of the bill include increasing permanent disability by 30%, decreasing litigation, and lowering overall costs by $1 billion.

Background and History

How did we get here? The background and history of the latest California workers' compensation legislation

Speakers: *Martin Brady, Commission on Health, Safety and Workers' Compensation*
Jason Schmelzer, Shaw, Yoder, Antwih, Inc.

Given the political makeup of California, and with the significant differences of opinion and motivations when it comes to workers' compensation, it's a truly remarkable achievement that our legislature and governor came together to pass Senate Bill 863 (SB863) earlier this year.

Understanding SB863 begins with grasping the realities of the current political landscape in California. Prior to 2012, we were in a state of perpetual partisan gridlock. However, with the November election, California is now a decidedly "blue" state; Democrats have a 2/3 super majority. The good news is that it will translate into decidedly less gridlock.

Of course, it also presents concerns for some employers. Some fear that the new democratic legislature will favor labor. However, if past experience is any indication, Governor Brown has taken a balanced approach to workers' compensation, with many rulings now much more favorable for employers, while also making sound appointments to key departments and boards.

What really changes the work comp landscape for employers – and what creates a strong need for advocacy – are several key political reforms, many unrelated to work comp, including 12-year term limits and redistricting.

We are entering a period of high turnover in the legislature, resulting in less experienced legislators and a loss of "institutional memory." As we start the new legislative session, not a single assembly member will have been present when we passed SB899 in 2004. More than 1/3 will not have been in the legislature when SB863 was passed. That means there is considerable education to be conducted on even the basics of workers' compensation.

The need for reform

There is one simple reality that those on either side of the political aisle can agree upon: California's work comp system has become far too complex and there has been an erosion of gains made with reforms passed in 2003 – 2004. Benefit notices to unrepresented workers have become literally as high as a phone book.

Despite its best intentions, Senate Bill 899 (SB899)[i] created the circumstances for the next wave of crisis for the work comp industry. Today, indemnity costs have increased and the insurance market ratio has soared to more than 130%, resulting in some carriers, especially those providing excess coverage, leaving the state. According to a recent Workers' Compensation Insurance Rating Bureau (WCIRB) study, costs are up 41% since 2005 (when costs were at their lowest level) and 14% above the highest level prior to the reforms.

There was a real sense of urgency for employers – and labor and state politicians took note of the reality facing businesses as well.

- Work comp costs in the state were 155% of the national median.
- 1 out of every 9 work comp dollars nationally was being spent in California.
- $6 for every $100 in payroll went to work comp – no other state had rates even close to what California was spending on work comp.

BACKGROUND AND HISTORY (CONTINUED)

How did we get here? The background and history of the latest California workers' compensation legislation

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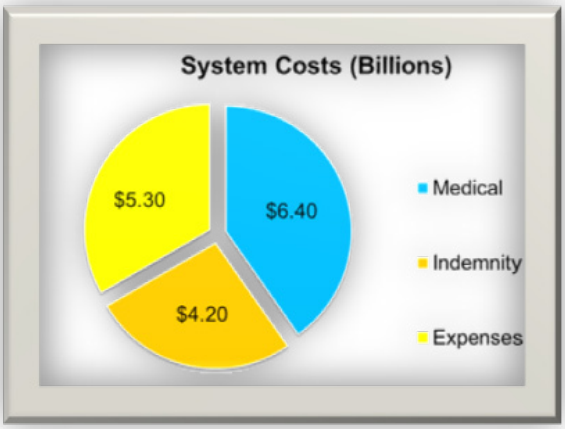
The findings led many to recognize that we needed to avoid our own version of the "fiscal cliff." It's clear we needed to streamline the system, eliminate redundancies in language, and simplify the overall process so that we weren't, in essence, creating work for attorneys.

To prevent further problems, leaders in the state's work comp industry built a coalition that included employers and labor dedicated to averting the crisis and to working cooperatively to understand the core issues on both sides.

California's work comp system was created to provide for medical care and benefits for injured workers. Currently, a huge slice of the work comp benefit pie is going to the machine – not to those who need it most – there are simply "too many straws in the trough."



In order to restore benefits to workers in a way that was acceptable to labor and employers, and to bring balance to the work comp "pie," we had to pull some of those dollars off of the plates of others. What's more, we needed to become more accountable for the dollars being spent.

With that in mind, work began on Senate Bill 863. There was also a real effort to address the needs of labor, employers, and the injured worker. There was also a commitment to ensuring benefits did not come from payroll; more specifically that any benefit increases would be offset by savings in an effort to ensure that employers already struggling with the recession were not further penalized.

Representatives from key constituents were brought in to develop the new legislation, including the California Department of Industrial Relations, the Department of Workers' Compensation, and the Commission on Health, Safety and Workers' Compensaton; as well as representatives from labor and management, covering both large and small public and private employers.

The result is what even jaded politicos note is a balanced package, with approximately $800 million in annual benefits and $1 billion in annual savings.

While there is clearly much to do – and there will be considerable ongoing debate and litigation about some components of the bill – the next phase in the process is implementation with initial programs slated to begin 1/1/13.

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OVERVIEW OF SPECIFIC PROVISIONS IN SENATE BILL 863

Speakers: *Richard Jacobsmeyer, Shaw Jacobsmeyer Crain and Claffey*
Michael Sullivan, Michael Sullivan & Associates

Senate Bill 863 (SB863) is the most massive workers' compensation reform the state has seen to date. It touches on far more than individual code sections and has a bigger impact than anything we have seen in the past.

Prior to 1990, most work comp legislation was applicant focused. Beginning in 1990, we began to see the impact of employers and labor on the system. California's workers' compensation system is both revolutionary and evolutionary as we strive to bring the system back to employers and labor.

To understand the specific provisions of SB863, it helps to look at the major statutory changes, including:

- Permanent Disability (PD) benefit rates and schedule changes
- Return to work/supplemental job displacement voucher modifications
- Independent Medical Review (IMR) for medical treatment disputes
- Independent Bill Review (IBR) for medical bill payment disputes
- Lien reform
- Medical Provider Network (MPN) reform
- Medical treatment/fee schedules
- Litigation/procedural changes

Permanent disability benefits

One of the key issues addressed in SB863 was permanent disability. According to Sullivan, "Under the new law, applicants get more permanent disability and employers get the benefits of many reforms. Changes were made to eliminate questionable claims of disability related physical injuries making it more difficult to reach the same percentage of permanent disability."

PD is paid out every two weeks to injured workers and paid for a certain number of weeks at a determined rate. New LC 4658 establishes the number of weeks for injuries on or after 1/1/13 – the weeks were not changed by SB863. However, the amount of weekly PD has been increased.

PD is 2/3 of earnings within the limits set in the legislation. However, there are now statutory minimums and maximums for the weekly rate.

We anticipate that with all the changes, there should be more than a 50% increase in filings for PD over the next few years.

There is good news for employers:

- Add-ons for sleep dysfunction, sexual dysfunction, and compensable psychiatric disorders have been eliminated. However, there are explicit exceptions to the rule. For example, if the worker is a victim of a violent act, or in the event of a catastrophic injury, "including but not limited to loss of a limb, paralysis, severe burn or severe head injury."
- The Diminished Future Earning Capacity (FEC) modifier has been eliminated, and replaced with a simple modifier and a new PD rating schedule, which is similar to what is being used now.

The new PD modifier takes AMA guidelines – age, occupational modifiers, etc., eliminates the FEC modifier, or the loss of earning capacity, and adds a 1.4 multiplier or 40% – for all ratings. This is a major change and represents a significant benefit increase – up to 30% – for injured workers.

OVERVIEW OF SPECIFIC PROVISIONS IN SENATE BILL 863 (CONTINUED)

Speakers: Richard Jacobsmeyer, Shaw Jacobsmeyer Crain and Claffey
Michael Sullivan, Michael Sullivan & Associates

Under the new structure, the applicant in every case receives what was previously the maximum possible adjustment. And while the specifics are debatable, the goal is to ensure that all workers and all injuries will be treated equally.

We anticipate that applicant attorneys will try to rebut the fee schedule. In addition, questions remain about the use of vocational experts. However, overall the new law should reduce litigation.

Return to work and supplemental job displacement

As SB863 was being finalized, there was concern that some applicants would not receive adequate PD, primarily because the 15% adjustment to partial PD was eliminated. Labor was concerned that provision, as well as changes in ratings for return to work issues, would hurt some workers.

In an effort to close the gap, a special return-to-work fund was created. Overseen and administered by the director of industrial relations, the program is funded by employers to an annual total amount of $120 million.

In essence, the new fund restructures the supplemental job displacement voucher. It provides:

- A single level voucher valued at $6,000
- Makes it harder for employers to make job offers to avoid the liability voucher
- Ensures more employees are eligible for the fund; requires the voucher to be offered earlier and enacts a statute of limitations on its use
- Mandates that expenses have to incur within five years

Good news for employers – And while employers pay for the fund, they will not have to administer or litigate it – that will all be done by the state.

As of now, many specifics of the fund are still undetermined and we expect litigation on several key points. What we do know is that the appeals board has ultimate discretion over this fund.

Independent medical review

While IMR may be revolutionary for California, it is not unique in other states; most already have a system for resolving disputes with injured workers and their physicians over payment for treatment denied, delayed, or modified under the employers utilization review (UR) program.

IMR provides an administrative system for resolving disputes over the amount of payment due pursuant to fee schedules adopted by the Administrative Director (AD). It also replaces the jurisdiction of the Workers' Compensation Appeals Board (WCAB) to resolve such disputes and it prohibits lien claims from being filed prior to completion of the IBR.

Under our new IMR system, litigation is pulled out of the system – the decision making process will be taken away from the work comp board and put in the hands of independent physicians.

The way the system will work is relatively straightforward. The AD will contract with one or more IMR companies to review appeals from UR decisions. If the injured worker appeals his or her adverse UR determination within 30 days, a review is conducted by an independent IMR consultant.

In addition, the AD will create a fee based system to cover IMR and system costs, with the fee to be paid by the claims administrator.

OVERVIEW OF SPECIFIC PROVISIONS IN SENATE BILL 863 (CONTINUED)

Speakers: Richard Jacobsmeyer, Shaw Jacobsmeyer Crain and Claffey
Michael Sullivan, Michael Sullivan & Associates

The new fee schedule will apply to all fee scheduled services, including:

- Interpreters
- Medical legal expense
- Copy services
- Home health care
- Vocational evaluations

In short, IMR will be the exclusive process to challenge a UR determination; disputes may not be referred to an AME, QME, or any other doctor where IMR is applicable. However, IMR determinations are deemed decisions of the AD and may be appealed to the WCAB. Decisions are presumed correct and may be set aside only by clear and convincing evidence, such as the AD acted without or in excess of the administrative director's powers; the IMR was subject to a material conflict of interest in violation; or the determination was the result of bias.

The new system eliminates many of the current bad motivations in the system. Plus, if there are appeals, whoever wins doesn't pay.

Lien reform

Lien reform is an area where employers had been asking to "stop the madness" for years.

Under the old system, some physicians would send a bill at three or four times the RVS value, include some creative coding, and basically hope the adjuster would pay all or part of their inflated bill. If not, we'd go to court, fight, and back and forth it would go. It was costly, wasteful, and a highly litigious process. Liens have been especially burdensome in southern California. Luckily, that can now change.

Lien reform under SB863 includes:

- Electronic filing requirements (with some exceptions)
- Lien filing and activation fees
- New statute of limitations for filing liens
- New time limit for filing liens
- Notification requirements for representation
- Restrictions on entitlement to medical information
- Restrictions on assignment of liens

HOW LIEN REFORM WILL WORK

- NOTIFICATION REQUIREMENTS FOR REPRESENTATION:
  - MUST PROVIDE WRITTEN NOTICE TO PARTIES WITHIN FIVE DAYS OF REPRESENTATION
- RESTRICTIONS ON ENTITLEMENT TO MEDICAL INFORMATION:
  - NON-PHYSICIAN LIEN CLAIMANTS ARE NOT ENTITLED TO COPIES OF ALL MEDICAL RECORDS
- RESTRICTIONS ON ASSIGNMENT OF LIENS:
  - ASSIGNMENT ONLY PERMITTED UNDER SPECIFIC STATUTORY DEFINE CIRCUMSTANCES

There are several points about the legislation related to liens that are particularly attractive to employers.

- There is a $150 filing fee for most medical providers and medical legal liens filed after 1/1/13, regardless of dates of injury.
- There is an "activation fee" of $100 for most medical/medical legal liens filed prior to 1/1/13.

OVERVIEW OF SPECIFIC PROVISIONS IN SENATE BILL 863 (CONTINUED)

Speakers: Richard Jacobsmeyer, Shaw Jacobsmeyer Crain and Claffey
Michael Sullivan, Michael Sullivan & Associates

- There is a statute of limitations – no more than three years from date of service beginning 1/1/13; and after 7/1, claims must be filed no more than 18 months from date of service provided.
- The practice of a vendor "buying and bundling" liens from providers will be eliminated – the doctor has to be the claimant and if lien is assigned, that person or entity has to be identified.

Under the new guidelines, we believe a lot of frivolous liens and so-called zombie liens (e.g., those we thought were settled, but come back years after date of service) will be eliminated. Plus, there are restrictions on who is entitled to medical information and what information they can receive – this will prevent plaintiffs from over-reaching, save money on copy services, and help protect workers' medical privacy.

Medical Provider Network reform

Statutes regulating MPNs were revised under SB863 for several reasons. Some of the most contentious and debated issues related to MPNs are now being addressed. First, labor wanted improved access to quality providers as well as to care coordination in the event an appropriate provider could not be found within the network. Conversely, employers wanted to plug holes in workers' ability to escape MPN control and to restrict litigation.

Several small but important changes were made to the MPN legislation passed in 2004.

- How the MPN is set up and administered
  - The changes discussing the establishment and AD enforcement of MPNs apply as of 1/1/14
- What happens in litigation/medical control
  - The changes which primarily involve litigation over MPNs applies 1/1/13

Most technical changes related to MPNs will go into effect 1/1/14. One important adjustment is that the network may be established by a physician network services provider, such as Sedgwick, not just the carrier or employer (1/1/13). This will significantly streamline the current review process, resulting in cost savings for the state.

For employers, MPN control has been tightened. Key changes include:

- DWC approval of MPN is conclusive evidence of valid MPN; as long as approved, they don't have to jump through hoops
- Failure to provide MPN notice or posting notice is not a basis to escape network absent a denial of care

More good news: Employers have no liability for self procured treatment obtained prior to a determination by IMR that the treatment is necessary, unless that treatment is deemed necessary in IMR.

Medical treatment and fee schedules

Employers are pleased with a number of the changes to the guidelines for treatment and fee schedules. There are new definitions for medical treatment, including home health. For example, if an applicant has back surgery and a spouse says they provided care and then seek $100,000 in reimbursement, under new guidelines, that claim would require prescriptions from a physician and surgeon. The spouse can be compensated based only upon approved fee schedules. Services provided by the spouse prior to the injury are not compensable.

There are also limitations on designating chiropractors as primary care providers. After 24 visits, the chiropractor cannot be listed as a primary care provider.

Overview of Specific Provisions in Senate Bill 863 (continued)

Speakers: *Richard Jacobsmeyer, Shaw Jacobsmeyer Crain and Claffey*
Michael Sullivan, Michael Sullivan & Associates

There are also new fee schedules coming for several areas, including RVS to RBRVS, interpreters, home health care, ambulatory surgery centers, and medical legal costs such as copy services.

In short, new changes will help to . . .

- Fix procedural issues with the medical legal exam process
- Limit the ability of the injured worker to obtain an award of benefits with a physician hand-selected by an attorney
- Reduce expenses associated with the applicant's attorney obtaining vocational/rehabilitation (VR) expert reports (and rebuttal reports)

Plus, expedited hearing changes allow for more prompt resolution of treatment control and medical legal exam issues for the injured worker.

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CHANGES FOR SELF-INSURED EMPLOYERS

Speaker: Marilee Robinson, Supervising Workers' Compensation Compliance Officer, Office of Self Insured Plans

Currently, in California there are more than 7,900 employers, covering four million workers. The Office notes its primary goal is to establish best practices – and to help address solvency issues. There are three primary areas that will impact self-insured employers with regard to Senate Bill 863 (SB863).

1. Calculation of security deposits will change

- Unless otherwise permitted by regulation, the deposit shall be an amount equal to the self-insurer's projected losses, net of specific excess insurance coverage, if any, and inclusive of incurred but not reported (IBNR) liabilities, allocated loss adjustment expense, and unallocated loss adjustment expense, calculated as of December 31st of each year. The calculation of projected losses and expenses shall be reflected in a written actuarial report that projects ultimate liabilities of the private self-insured employer at the expected actuarial confidence level to ensure that all claims and associated costs are recognized. The written actuarial report shall be prepared by an actuary meeting the qualifications prescribed by the director of regulation.

There is also no longer a minimum security deposit requirement and the actuarial report will be due after the March 1st annual report filing deadline; the date will be determined by regulation, as will actuary qualifications. It is believed that providing solvency affirmation and financial information will not present a burden for employers as they are preparing similar information for annual reports.

2. Specific employers will no longer be issued certificates of consent to self-insure

- A certificate of consent to self-insure shall not be issued after 1/1/13 to any of the following:
  - A professional employer organization
  - A leasing employer, as defined in Section 606.5 of the Unemployment Insurance Code
  - A temporary services employer, as defined in Section 606.5 of the Unemployment Insurance Code
  - Any employer, regardless of name or form of organization, which the director determines to be in the business of providing employees to other employers
- A certificate of consent to self-insure that has been issued to any employer described in subdivision (a) shall be revoked by the director not later than 1/1/15

Changes were made in this area because of recent PEO defaults as well as employer bankruptcies due to significantly underfunded liability. The new provision should bring greater stability to the state's work comp program.

3. Reporting requirements for public self-insured employers will change

- All self-insured employers shall file a self-insurer's annual report in a form prescribed by the director. Public self-insured employers shall provide detailed information as the director determines necessary to evaluate the costs of administration, workers' compensation benefit expenditures, and solvency and performance of the public self-insured employer workers' compensation programs, on a schedule established by the director. The director may grant deferrals to public self-insured employers that are not yet capable of accurately reporting the information required, giving priority to bringing larger programs into compliance with the more detailed reporting.

For additional information, visit http://www.dir.ca.gov/osip/sip.html.

***Click here* to access this recorded presentation.**

VIEW FROM THE DEPARTMENT OF INDUSTRIAL RELATIONS

Speaker: Christine Baker, Director of California Department of Industrial Relations (DIR)

Senate Bill 863 (SB863) started toward the end of Governor Arnold Schwarzenegger's administration. Once Governor Brown was elected in 2010, legislation to plug the holes in earlier work comp legislation began in earnest. A key impetus was the recognition that the Almarez/Guzman[ii] case could mean the undoing of the PD legislation put together under SB899 in 2004.

Despite initial concerns, labor and employers have found Governor Brown to be very supportive of efforts to bring fairness and balance to California's current workers' comp system. Governor Brown acknowledged that labor wanted benefit increases, but stressed that to do so, there had to be real quantifiable savings for employers.

The "guiding light" laid forth by the Governor's Office for efforts to improve the system was a recognition that labor and management had to agree to all key decisions. The process has not always been easy. We have had to examine the true cost of a benefit and how to offset those costs. In addition, there has been a constant process of trading one provision for another in the hopes of fixing the system, reducing litigation, and most importantly, ensuring benefits are delivered efficiently and effectively.

As a first step, the DIR recognized it needed to hear from labor, management, and workers. The department staged a number of "listening tours." One of the often repeated problems was with medical benefit delivery. The chief complaint was that it was costly and decisions were often delayed.

In addition, labor believed that PD benefits had been cut too severely and employers believed IMR was necessary.

To address those problems, the PD system was revised under SB863 to:

- Eliminate the FEC
- Add a 1.4% modifier to all claims
- Do away with add-ons for sleep disorders, sexual dysfunction and psychiatric claims
- Require authorized schools for vocational-rehabilitation
- Limit the ability to appeal IMR and ensuring determinations are not over-turned by judges, but based on the medical review process

Another key change led by the DIR was IMR –

The DIR will contract with Maximus, which is currently providing IMR for MediCal. Maximus has a large cadre of MDs, outside of the Qualified Medical Evaluator (QME)[1] designation, to ensure files are reviewed independently. By piggybacking on what is already being done for MediCal, the DIR believes it can save significant dollars. It is estimated that with the new legislation, it will cost $500 to $600 per IMR vs. the current cost of $1,000 to $10,000 per claim.

The DIR has modeled IMR after current independent review programs for group health. The ultimate goal of the department is to see those two benefits integrated, an aspiration now reasonable and feasible under healthcare reform.

Addressing liens

The DIR is also pleased with current changes to California's historically convoluted approach to liens. The department estimates that by incorporating a provision for a filing fee, lien claims will be reduced by 50%.

VIEW FROM THE DEPARTMENT OF INDUSTRIAL RELATIONS (CONTINUED)

Speaker: Christine Baker, Director of California Department of Industrial Relations (DIR)

Baker notes that there is a current backlog of five million liens and that there are more than 765,000 lien claims per year. However, there are only about 100,000 new injuries reported each year – meaning there are seven times more liens than people.

Clearly, something had to be done to reduce liens. Said Baker, "Liens are a problem to our department, but more importantly they are a problem for employers who are often paying an inordinate amount of money to resolve often frivolous claims that bog down our system and inhibit judges' abilities to best serve injured workers."

Additional items on the agenda for the DIR include:

Medical fee schedules

Determining the official medical fee schedule has long been a bone of contention between providers and payers. The new Resource Based Relative Value Scale (RBRVS) is a needed enhancement to California's system. In most parts of the country, the RBRVS is used for group health and work comp. California is the only state that defines fees based on "back room deals." Under SB863, fee schedules will be updated regularly and capped at 120% of Medicare.

The DIR is also striving to ensure there are proper fee schedules for copy services, home health, vocational rehabilitation, and other related services. The goal is to ensure the research is conducted before the 1/1/13 default trigger and to ensure early IBR efforts are more effective.

Medical provider networks

The overall goal of the MPN program is to ensure access to a high quality network of providers, speed up the delivery of care, and get people back to work.

Under SB863, several rules governing MPNs were tightened. One important new ruling is that QME office locations will be limited. Under old guidelines, some providers claimed more than 100 locations. Under new guidelines, only 10 office locations are allowed. The DIR believes this new provision will reduce MPN backlogs and that a full 1/3 of the existing case load will be moved to IMR.

The DIR also is looking forward to changes in MPN guidelines, specifically so that workers who can't find treatment within the network have options. As of 1/1/14, SB863 requires access to care coordinators to assist injured workers with finding treatment within the MPN.

New guidance needed

Many of these provisions will require new regulations. The DIR has a team of 20 people working on regulations and has contracted with Rand on several aspects of the bill including the Return to Work Fund as well as on studies related to home health to ensure that areas prone to abuse are addressed.

Baker notes they are anxious to hear from employers regarding concerns – as well provisions that employers view as beneficial. "We need to know what works, as well as where there are missteps as we want to make sure there are savings for employers as well as benefits for workers," stated Baker.

For information and updates, interested parties are invited to visit the DIR website at www.dir.ca.gov.

Click here to access this recorded presentation.

[1] A qualified medical evaluator (QME) is a physician who evaluates you when there are questions about what benefits you should receive. A physician must meet educational and licensing requirements to qualify as a QME. They must also pass a test and participate in ongoing education on the workers' compensation evaluation process. If you have an attorney, you and your claims administrator might agree on a doctor to resolve medical disputes. This doctor is called an agreed medical evaluator (AME). An AME or a panel QME will be used to resolve medical disputes in your workers' compensation case. Source: California DIR - http://www.dir.ca.gov/dwc/medicalunit/faqiw.html.

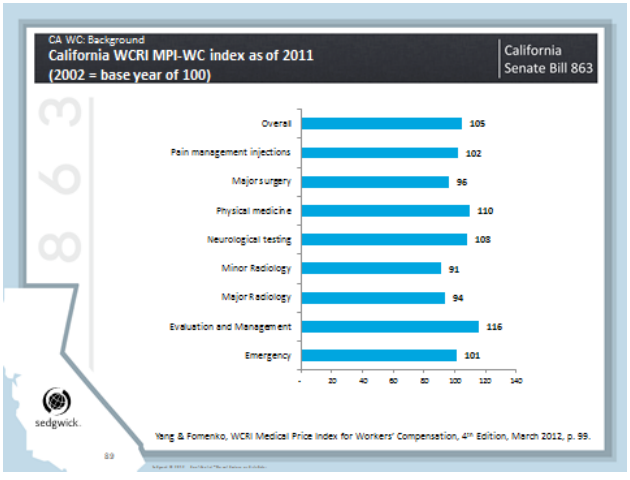
COST AND SAVINGS: A LOOK AT FACTORS IMPACTING WORK COMP COSTS TODAY

Speaker: Mark Priven, Director, Regulatory and Alternative Risk Consulting, Bickmore Risk Services

Senate Bill 863 (SB863) was created to address the many inequities and imbalances in California's workers' compensation system.

A key question for employers, as well as legislators, is what will it cost? To determine potential savings, actuaries at leading consulting firms, the Workers' Compensation Insurance Rating Bureau (WCIRB), and other state experts have been looking at past experiences to determine baselines, and are conducting analysis to determine potential future savings.

One important finding for employers is that while medical expenses within the work comp industry are increasing, it's not inflation driving cost, its utilization. People are simply going to the doctor more frequently, and getting more treatments, than in past years.



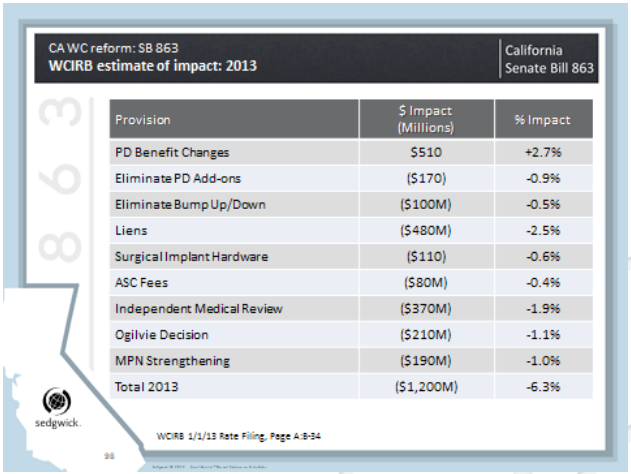
Here are other key findings from California's actuarial analysis.

- We are slow to pay and treat.
  - The rate at which California pays medical costs is much slower than other states. California is the slowest to pay medical bills in the first and second year of injury, and the ability for injured workers to obtain medical treatments also takes longer than other states.
- Medical cost containment ratios are unsustainable
  - Medical cost containment is increasing at 23% and 24% annually.
- Litigation costs have been increasing statewide; especially in Southern California
  - Allocated Loss Adjustment Expenses in 2011 were $11,302 vs. $7,093 in 2005.
- Litigation rates are increasing
  - 91% of all major PD claims now have attorney representation.
- California is one of the least generous states when it comes to PD benefits
  - We are one of the bottom five states when it comes to PD claims, while our system itself is one of the most expensive in the nation. Even employers acknowledge the state's PD system was often inadequate.

Addressing the savings question

One of the top questions on employers' minds is what SB863 will cost and if there will be any savings.

Overview of savings as per California-based actuaries:



Provision	$ Impact (Millions)	% Impact
PD Benefit Changes	$510	+2.7%
Eliminate PD Add-ons	($170)	-0.9%
Eliminate Bump Up/Down	($100M)	-0.5%
Liens	($480M)	-2.5%
Surgical Implant Hardware	($110)	-0.6%
ASC Fees	($80M)	-0.4%
Independent Medical Review	($370M)	-1.9%
Ogilvie Decision	($210M)	-1.1%
MPN Strengthening	($190M)	-1.0%
Total 2013	($1,200M)	-6.3%

COST AND SAVINGS: A LOOK AT FACTORS IMPACTING WORK COMP COSTS TODAY (CONTINUED)

Speaker: Mark Priven, Director, Regulatory and Alternative Risk Consulting, Bickmore Risk Services

There is considerable debate about actual savings. In the savings overview chart developed by Priven, savings for 2013 are projected at 6.3%. However, Priven notes that this is not the savings employers will see from this year to next.

Without any reform, the California Ratings Bureau projected workers' compensation costs would increase by 15% in 2013. That figure needs to be factored in to the projected savings, giving an actual estimated savings with inflation of 9% to 10% with SB863.

"There will be a savings in 2013 and beyond," notes Priven. "But when you look at the net against the backdrop of inflation in the work comp system, initial savings may be hard to pinpoint." Priven also notes that projected costs exclude employer expenses for the Return to Work Fund and that several areas of reform are still to be quantified. As noted earlier in this summary, those include:

- Fee schedules for photocopy service, home health
- Medical-legal changes to QME
- Interpreter regulations, etc.

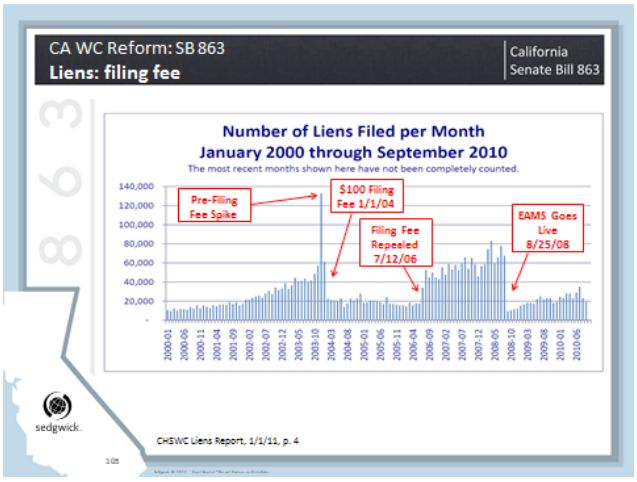
Priven predicts several more updates on savings in the coming months, and notes that the Department of Insurance will hold rate hearings and post its own reports on the Department website in the coming months.

PD will continue to be an issue to examine for cost and potential savings

Under the previous PD system, many workers quickly hit their max. Under SB863, potential PD savings, and when and if the max will be hit, will vary significantly by wages, industries, and locations. Current PD cost and savings projections are based on average wages. For employers outside the norm, Priven recommends checking with your own internal actuaries to determine how you will deviate from the California average.

There is potentially significant savings from lien reforms

An analysis of the impact of lien reform shows the potential for significant savings:



Currently, about 1/3 of California liens have a lag time of two or more years. This is good news for employers because under reform, within the next few years, no liens over 18 months can be filed. This new ruling could quickly eliminate almost 1/3 of liens.

The chart above also highlights the value of the proposed filing and activations fee in helping to reduce the total number of liens.

Determining IMR savings difficult, but some good news in projections

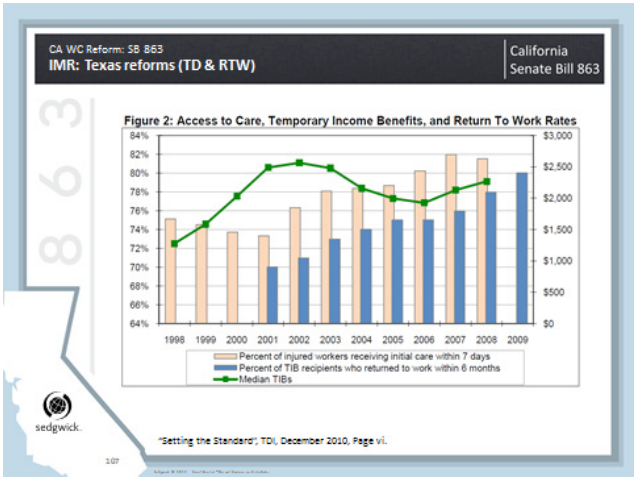
IMR is difficult to determine as the procedure is new to the state. To get a general idea, California actuaries looked at the experience Texas had with IMR.

COST AND SAVINGS: A LOOK AT FACTORS IMPACTING WORK COMP COSTS TODAY (CONTINUED)

Speaker: Mark Priven, Director, Regulatory and Alternative Risk Consulting, Bickmore Risk Services

Analysis showed significant potential savings in medical costs, temporary disability, and dispute resolutions. For example, the analysis showed:

- 15% decrease in TD
- Higher return to work rates (which is important to California)
- Faster medical treatment and payments to providers
- Decrease in medical costs
- Decrease in disputes

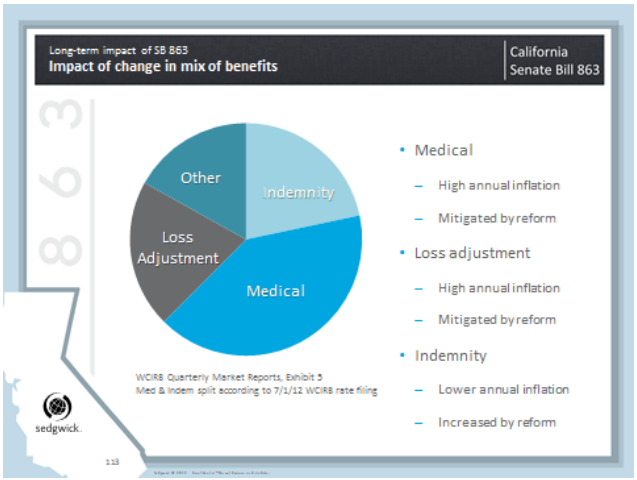


Strengthening MPN key to success

The ability to provide a strong MPN was important to employers and was a key concession won during SB863 discussions. Actuarial data shows when workers go outside the network, costs go up. When we look at what would happen if those same claims stayed in the network, we see that costs go down. Out-of-network PD claims are 22.6% higher than those in-network.

Changing the pie

One of the important achievements in work comp reform is that it is shifting money from the part of the work comp pie – medical expenses, which tends to inflate quickly – and putting more emphasis on pieces of the pie that inflate more slowly, such as indemnity.



Liability will go down

Another key point according to Priven is that to date, much of the discussion surrounding SB863 looks at savings going forward. It's important to note that some of these provisions take effect on all claims – even those with dates of injuries prior to 1/1/13.

To generalize, those provisions that impact the claims prior to 1/1/13 will reduce costs for employers. The ones that cost employers only take effect on injuries occurring after 1/1/13. That's all good news for employer liability.

COST AND SAVINGS: A LOOK AT FACTORS IMPACTING WORK COMP COSTS TODAY (CONTINUED)

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Parting words

Priven closed out his presentation with a quick summary of key findings. He reminds California's employers that . . .

- 2013 is a transition year
- There will be net savings in 2013 and 2014
- Specific savings will vary considerably based on employer size, location, wages, etc.
- Liens will likely spike somewhat at the end of 2012; however new fees should limit the amount somewhat
- A decrease in liabilities should help to mitigate overall work comp inflation rates
- There is still much to do – but it will get done

And an important assurance: "After all our intense research and analysis, I'm optimistic about SB863 . . . I think this overall package should decrease the rate at which the entire pie of workers' comp costs inflates over time."

***Click here* to access this recorded presentation.**

The Sedgwick Strategy and Approach to Senate Bill 863

The 170 pages in the recently passed Senate Bill 863 (SB863) legislation will bring more than 70 changes to California's workers' compensation system, as well as many opportunities and challenges to those of us who must implement and comply with the latest reforms.

Sedgwick's leadership has been heavily involved in the ongoing discussions and development of the law; and in fact, were frequently tapped by state officials, management, and labor for our advice and input.

At Sedgwick, we are approaching the challenges presented by SB863 with a combination of resources, including our Practice Group, Sedgwick University, Defense Attorney Partners, and IT Group, as well as with our dedicated and highly informed colleagues.

We bring our clients unparalleled expertise and a commitment to continually learn and adjust to the changing marketplace. On October 1, 2012, we started a weekly series of emails to colleagues entitled SB863 "In Focus" to provide overviews of the key aspects of the bill. In addition, noted California attorney and workers' compensation expert Mike Sullivan has provided his comprehensive and insightful overview "Special Report: A First Look at SB863" to our California claim colleagues.

Phase one of our internal training, the SB863 overview, also took place in October, soon after the Governor signed the bill into law. Mr. Sullivan again assisted by providing two, three-hour sessions for our designated Subject Matter Experts (SMEs). The SMEs have access to recorded presentations and they are, in turn, informing and educating their office staff.

Phase two of our internal training implementation and strategy is scheduled for mid-January, and is designed to reinforce all the changes required with the new legislation and to provide an update on new provisions. We have also established work groups in all offices to develop our own internal workflows for key areas, including:

- Independent medical review
- Independent bill review
- Liens and fee schedules
- MPN
- Advancement of PE benefits
- Supplemental job displacement voucher
- Interpreting

To bring it all together, all training materials, including the Sullivan book, are available on Sedgwick's intranet site for fast and convenient access. We will be following changes, implementations, and lessons from colleagues and peers as the law unfolds, and passing on those insights to our colleagues and clients.

We are committed to ensuring a smooth transition, optimal compliance, and minimal costs. Our goal is to make certain that the full benefits promised to employers by SB863 are achieved by all our clients.

If you have additional questions, require further training for your staff, or simply want to discuss issues related to the bill, do not hesitate to contact us at Sedgwick@sedgwick.com.

QUESTIONS AND ANSWERS WITH THE SEDGWICK PANEL OF EXPERTS

Sedgwick Panel: *Edward Canavan, Head of Workers' Compensation Practice Group*
Joann Munch, Vice President of Client Services
Cindy Parker, Vice President of Operations

Following is a list of questions asked by attendees at Sedgwick's Senate Bill 863 presentation held on November 13, 2012.

Q: What does Sedgwick think is the most impactful change brought forth by SB863?

A: "One of the most impactful areas of this reform is going to be PD. SB863 will increase PD costs by $510 million in the next few years. However, there are positive aspects that will likely offset those increases. One is the elimination of the bothersome add-ons that were often used to increase the overall award. As we know, most applicant attorneys automatically include sleep, psychiatric, and sexual dysfunction in PD claims. Now that practice is eliminated and it should help us to offset other costs, minimize litigation, and save examiners' time. We've also eliminated that 15% increase or decrease for PD – when an injured worker retires, is terminated, or resigns, California's State Audit unit wanted employers to increase PD by 15%. That provision never worked as intended, and it's a good thing it was eliminated. Another interesting aspect of the bill is that we will no longer have to pay advance PD benefits if a worker returns to their job. In the past, we've advanced the entire PD award amount. The difficulty with this approach is that when we went to ask the injured worker to sign a settlement, they had nothing to win and many opted not to settle. Now, we can go to the worker and say, 'if you sign, we can give you a lump sum payment for the PD benefits you are due.' We are hopeful that change will help us get more claims settled and closed." *Ed Canavan*

"To me, the big impact is going to be on liens. As we know, liens are crippling California. We've heard about the backlog; it's bringing the system to a standstill. It's horrible for our clients. The claims costs are crazy. But there's another cost – liens make it difficult for us to close claims as quickly as we'd all like. I'm the most optimistic about that provision in the bill. If it reduces the number of liens as projected, we should certainly be able to close claims much more quickly reducing our clients' claims and administrative costs." *Cindy Parker*

"I think a key benefit will be the cost containment opportunities. Today, we have no opportunities to manage costs for interpreters, ambulatory service centers, copy services, and home care; so as we know, when you have an application of controls you see changed behaviors." The new legislation should help us better address costs that before had no controls." *Joann Munch*

Q: Do you think there are any provisions in the bill that may be deemed unconstitutional at a later date?

A: There is a provision related to IMR and IBR that states that the decision is binding, meaning it can't be appealed to the WCAB unless there is a finding of bias or conflict of interest, or some sort of factual error. Many people are discussing concerns that the provision could be argued that it is unconstitutional to not allow applicants the right to litigate the issue before the WCAB. The spirit of IMR and IBR is to leave those issues with the experts to alleviate judges reviewing claims where they may not have expertise, and we hope to have this provision upheld.

Q: Can an injured employee be transitioned back to the MPN if the claim is denied but later accepted?

A: No. Refusal to provide care that is later found necessary by the WCAB will jeopardize the employers' ability to require the employee to

QUESTIONS AND ANSWERS WITH THE SEDGWICK PANEL OF EXPERTS (CONTINUED)

receive medical care with an MPN provider. In this circumstance, the employee will be able to continue treatment with a non MPN physician indefinitely. The choice to accept or deny a claim will now have longstanding consequences on the cost of the claim due to medical control.

Q: Why was the 2004 lien filing fee implemented and then removed a year later?

A: Administratively, there were problems in 2004 securing and getting the filing fee processed from the individual filer. These difficulties led to the abandonment of the effort. We are hopeful this time around that there is a tighter process in place, so there is a method to accept the activation and filing fee.

Q: How will Sedgwick assist clients with determining if SB863 is reaping any cost savings?

A: As we have heard from industry experts, it will be hard to determine initial savings. Most of us believe there will be long-term opportunities for cost savings. Your client services team will work with you, and all of our work rules will now be geared toward those areas clients want to manage and measure. We want to give our clients this information and we'll look for opportunities on how to trend those areas from year to year.

Q: If the IMR finds the treatment is not reasonable and necessary, how is this used to terminate temporary disability?

A: We can still go through the QME process for disputes per Labor Code 4062 that do not pertain to medical. If an IMR comes back indicating no further treatment is required, our recommendation is to go through the medical/legal process and have that reviewed by QME or AME. It would then be admitted into evidence and you could then argue as no further treatment is required, the only reasonable outcome is permanent stationary status or MMI. However, we would caution that likely what will go to the IMR is an individual treatment request such as for surgery that may then be decertified. It does not mean that the treating physician will not come up with another strategy or approach. As has been found in the experience of Texas with IMR, a lot of TD went down. There appears to be a change in physician behavior with IMR. We are hopeful that this will happen here. However, physicians may just come up with other treatments to recommend. Perhaps if it is the final treatment request, the doctor will determine it is time to note the patient is permanent and stationary, and that will stop the clock. Again, we are hopeful, but based on past experience, remain somewhat skeptical.

Q: What is Sedgwick's plan to ensure their MPN partners will be compliant with SB863?

A: We are already working closely with our MPN partners to ensure compliance. Luckily the effective date is 2014, giving us time to properly educate and inform. But we are focusing now on providing education in areas related to medical access assistance and confirmation of physicians. We are also awaiting the inevitable fine tuning of the regulations, so that we can provide timely updates and guidance to our MPNs.

Q: When will program managers be working with work groups on individual client programs to see how reform can be implemented?

A: Program managers and client services managers are not waiting; we are having discussions about processes and procedures now. Many of the details of SB863 will be finished by January; so our conversations with clients will be ongoing for the next several months. These discussions will be highly customized, and based on client needs and areas of interest. Program managers will bring back what they hear from clients to the corporate level, giving us the opportunity to further develop and enhance system-wide approaches related to claim systems,

QUESTIONS AND ANSWERS WITH THE SEDGWICK PANEL OF EXPERTS (CONTINUED)

tracking, etc. We anticipate that in the years to come, we will have many opportunities to discuss developing new claim fields, tracking in JURIS, lien modules, and other features our clients may request.

Q: Are there any provisions of SB863 that are effective immediately?

A: Unlike SB899, most of the provisions are effective as of 1/1/13 for all dates of injury. Some of the MPN factors will be effective 1/1/14, and many of the provisions dealing with permanent impairment will be effective on or after 1/1/13. We recommend reviewing the Sullivan book as it outlines all the aspects of the bill and when they are effective. If you do not yet have a copy of the book, you can obtain one by emailing mike@mikeslaw.net.

Q: Currently, we are able to settle claims without an MMI report at the WCAB, will that change?

A: Based on everything we've seen and read to date, we don't think that will change. As long as you have your argument and evidence in place, you should still be able to try the case.

Q: A defense attorney commented to adjusters at a recent presentation, "welcome to your nightmare." Does Sedgwick see the bill as creating new challenges and complications for adjusters?

A: Our adjusters learned a lot from the implementation of SB899 in 2004–2005, such as UR, MPN, 15% increase/decrease, second opinion, etc. The good news is, with this bill, many things will be administered by the Administrative Director (AD). For example, IMR and IBR as well as the RTW Fund are sent to the AD. In this bill, some things that were procedurally difficult were eliminated and given to the state. We think SB863 will have a shorter learning curve than SB899. It is still difficult to be an adjuster in California, but there is help coming.

Q: Will SB863 help slow down the increases we are seeing in cost containment?

A: There are a lot of areas that we think will impact loss adjustment costs in a positive way. Liens cost a lot of money to defend; SB863 essentially eliminates the ability to file a lien, especially on an accepted case. That will greatly help. The current remedy for IMR is to go through the AME and/or QME process. AME is not an ideal solution; reports can take months to secure; you may have to get multiple reports, etc. With IMR now binding on all parties as well, you are taking that prolonged litigation process out of the system, eliminating or at least slowing down the inflation of loss adjustment costs.

Q: What is Sedgwick's plan to assist adjusters with the anticipated spike in the lien resolution process that we anticipate prior to the end of 2012?

A: We have a number of resources, including a dedicated California-based Lien Resolution Unit. With almost one million liens in the system, we don't think it will get that much more difficult. What we do think is that claimants are going to want to escalate settlements because they don't want to pay the activation fee. What we hope is that people become more reasonable and less interested in spreading it out to the WCAB because it will now cost them. We also had a campaign in the month of August for our examiners called, "All Things Lien." This included self-paced modules and general tips on how to negotiate liens in various circumstances. Those training modules are assisting our examiners now with some of the similar activities they are seeing with SB863. We will also be tracking the number of incoming calls that come in post 1/1/13 to see how and if it drops off.

Click here to access this recorded presentation.

END NOTES

[i] SB899 reforms focused on controlling escalating medical costs, which by 2004, accounted for 51% of every dollar and indemnity benefits, which account for 49% of every workers' comp dollar spent. SB899 tried to mitigate the problem of escalating costs by providing prompt, effective medical treatment to injured workers so they recover from injuries and return to work; Medical Provider Networks (MPNs) provided a framework for effective medical treatment; medical treatment guidelines determined whether proposed medical treatment is necessary and will be effective; new permanent disability rating schedule (PDRS) provides objective and consistent methodology to determine disability rating; and return to work provision supplies incentive for employers to return injured workers to the job. More information is available on the California Division of Workers' Compensation website at http://www.dir.ca.gov/dwc/sb899/sb899Review2005.htm.

[ii] The California Workers' Compensation Appeals Board (WCAB) has issued a unanimous en banc ruling that allows physicians to bypass American Medical Association Guidelines (the AMA Guides) in making impairment determinations in permanent disability cases. Critics of the decision foresee a rush of arbitrary appeals, breakdowns in the consistency and objectivity of PD determinations, and higher costs for employers. At stake are the gains achieved through the implementation of a cornerstone provision of SB899, California's 2004 workers' compensation reform legislation.