

Workers' Compensation Reform:

**Employers Save,
Insurers Profit,
Injured Workers Suffer**



Prepared by the California Labor Federation, AFL-CIO
March 28, 2007

Cover photo: Greg Otto, a 14-year veteran of the San Luis Obispo City Fire Department, was diagnosed with pancreatic cancer in Fall 2004. Cancer commonly affects firefighters and is considered a job-related hazard due to the carcinogenic chemicals routinely used in their work. Following a seven month battle to win workers' compensation benefits, Greg was finally awarded his benefits. He passed away on March 26, 2005, just days after winning his case.



California Labor Federation, AFL-CIO

Headquarters:
600 Grand Av., Suite 410
Oakland, CA 94610-3561

Legislative Office:
1127 11th Street, Suite 425
Sacramento, CA 95814-3809

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EXECUTIVE SUMMARY

Much public attention has recently been focused on California's multi-billion workers' compensation system. But Governor Schwarzenegger's reform has failed in its intended goals. Instead, it has resulted in historic insurer profits, generous employer savings, slashed benefits, and denied treatment for workers. The effect has been increased pain and misery for injured workers in California.

In 2000, skyrocketing premiums focused the Legislature's attention on reforming the system. In 2002 and 2003, former Governor Gray Davis signed two reform packages that changed the rules for medical treatment, reduced vocational rehabilitation costs and increased benefits.

Despite significant medical reforms, insurance companies resisted lowering rates while employers cried out for cost containment, creating the backdrop for Arnold Schwarzenegger, then candidate for Governor, to call for further reforms. Schwarzenegger campaigned vigorously on the workers' compensation issue and, once elected, actively supported signature-gathering efforts to place a draconian anti-worker initiative on the ballot. Employers raised over \$5 million to back the measure, further pressuring the Legislature to act in 2004.

In 2004, Governor Schwarzenegger introduced a harsh "reform" measure (SB 899 Poochigian) that was modified and improved in negotiations with then President Pro Tem John Burton.

Governor Schwarzenegger committed that he would not cut benefits for injured workers. Instead, the reforms of 2004 were meant to create more consistency and less friction and litigation in the system. Savings were supposed to come from fewer rubs in the system, not from a reduction in injured workers' benefits. For example, permanent disability (PD) benefits based on empirical wage loss were expected to ease litigation over PD ratings. Employer-chosen doctors were supposed to decrease the disputes over appropriate medical care. Incentives to return injured workers back to work were meant to create more harmonious transitions.

This is the brokered deal over SB 899 that the Legislature overwhelmingly passed in 2004 and on which Labor stood neutral against the backdrop of the draconian ballot measure alternative.

Despite the Governor's commitment, the regulations implementing SB 899 have slashed indemnity benefits for injured workers, delayed and denied medical treatment, and failed to provide much increase in the number of injured workers returning to work. Schwarzenegger reneged on his promise to not take away benefits from injured workers and the result is that injured workers are suffering.

Employers have enjoyed significant savings in workers' compensation costs, and insurers are making historic profits. In 2005, the insurers' loss ratio was 30%; that is, for every dollar in premium collected from employers, only 30 cents were paid out in benefits. Injured workers are inappropriately paying the price for the financial success of insurers.

As seen in the workers' compensation system, when insurers in a system of mandatory coverage were left unregulated, they took advantage of the changes in the system to increase their profits. As the Governor and the Legislature consider negotiating a significant health care reform proposal this year, policymakers should not consider workers' compensation reform a model.

KEY FINDINGS

- Frequency of workers' compensation claims has dropped almost continuously over the last 15 years. Workers' compensation changes that have made it harder for injured workers to access benefits has pushed the frequency of claims even lower.
- Deregulation of the insurance market caused the crisis in workers' compensation. The repeal of the minimum rate law in 1993 resulted in predatory pricing and the insolvency of 32 insurance companies. Employers skyrocketing costs, beginning in 2000, resulted from insurers' irresponsible pricing after deregulation.
- Insurers are now making historic profits. In 2005, their loss ratio was 30%. That is, for every dollar collected in premiums, insurance companies are only paying out 30 cents in benefits. Companies have never enjoyed such large profit margins.
- Employers are saving \$11-12 billion a year in workers' compensation costs out of a total system cost of \$29 billion.¹
- Permanently disabled workers face 50% cuts in permanent disability (PD) benefits. Total PD dollars have been slashed by two-thirds.
- Temporarily disabled workers face strict time limits on their benefits. They are being forced to rely on group health insurance and state disability insurance (SDI) – a benefit they pay for themselves.
- Medical treatment is being delayed and denied by insurance companies applying utilization review and strict interpretations of medical treatment guidelines. These reviews of employer chosen doctors are creating more friction and costs for the system and delaying care for workers.
- Incentives to return injured workers back to work are inadequate. The law needs a stick that will encourage employers to keep injured workers on the job.

¹The estimated savings are represented in incurred dollars and include both the insured and self-insured employers. The savings are based on data from the Workers' Compensation Insurance Rating Bureau.

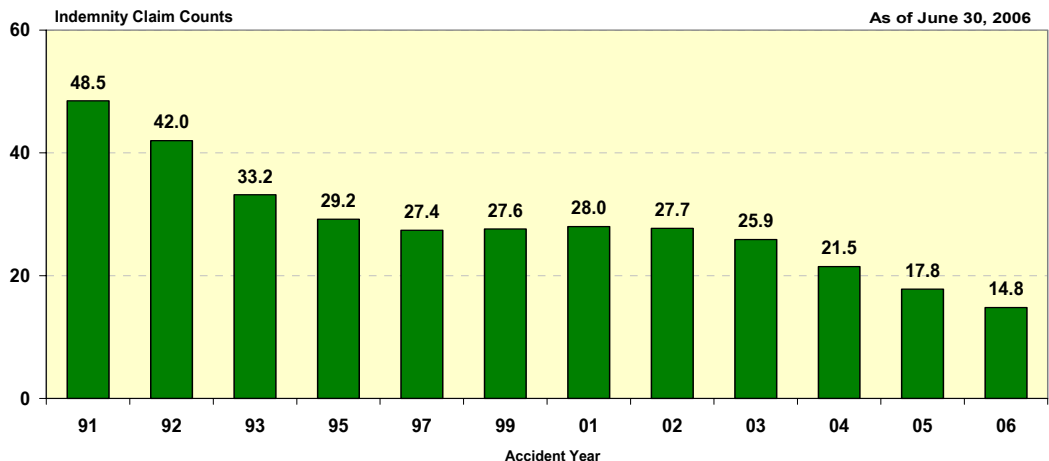
BACKGROUND ON WORKERS' COMPENSATION

California's workers' compensation system provides benefits for injured workers and shields employers from most tort liability. Workers' compensation is a "no-fault" system in which injured workers must show that their injury is work-related, but they do not have to prove that their employer's negligence caused the injury. Benefits available to injured workers include medical care, partial wage replacement for work time missed due to injury, permanent disability (PD) benefits, vocational rehabilitation services or supplemental job displacement benefits, and death benefits.

In exchange for these benefits, workers have relinquished their rights to sue an employer for injuries that occur on the job. Employers that fund the workers' compensation system, either by purchasing insurance on the market or self-insuring, are shielded from most tort liability for workplace injuries.

About 780,000 workers' compensation claims are filed each year in California. Most claims (around two-thirds) are for medical care only, with no cash indemnity payments.² Approximately 20 percent of claims are for temporary disabilities. Permanent partial disability claims account for about 14 percent of total claims – 10 percent are minor disabilities and four percent are major disabilities. Death benefits and permanent total disability benefits each account for about one-half of one percent of total workers' compensation claims.

Ultimate Indemnity Claim Counts Per Estimated 1,000 Full-Time Employee Equivalents



Data Source: WCIRB

The frequency of workers' compensation claims filed has dropped almost continuously over the past 15 years.

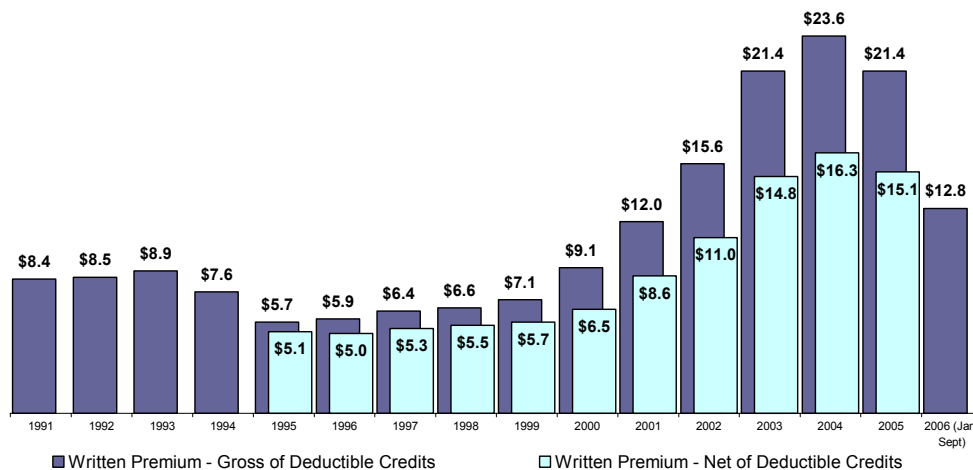
² Total claims reported in 2005 per DWC presentation at 2/23/07 CHSWC meeting, other figures from e-mail correspondence with Dave Bellusci, WCIRB., based on policy year 2000.

Safer worksites, better worker safety programs, and improved worker protections do not fully explain this dramatic drop in claims frequency. It is no coincidence that some of the sharpest drops have occurred in the years when legislative “reforms” have made it more difficult for injured workers to obtain their workers’ compensation benefits. As our system becomes more tattered and difficult to navigate, workers suffering injuries and illnesses are turning elsewhere.

DEREGULATION OF INSURANCE MARKET CAUSED THE CRISIS

Total premium costs have resembled a roller coaster over the past decade. In 1993, the repeal of the minimum rate law, the floor for workers’ comp rates, deregulated the workers’ compensation system resulting in drastic rate cuts. Insurers priced products too low to cover losses. Twelve insurers withdrew from the market between 1993 and 1997. Other companies relied on investment returns to make up for underwriting losses. When the investment bubble burst, companies became insolvent. From 2000 through 2006, a total of 32 companies became insolvent, with the largest insolvencies occurring from 2000 through 2003.³

Workers' Compensation Written Premium
(in billion\$, as of September 30, 2006)



Data Source: WCIRB

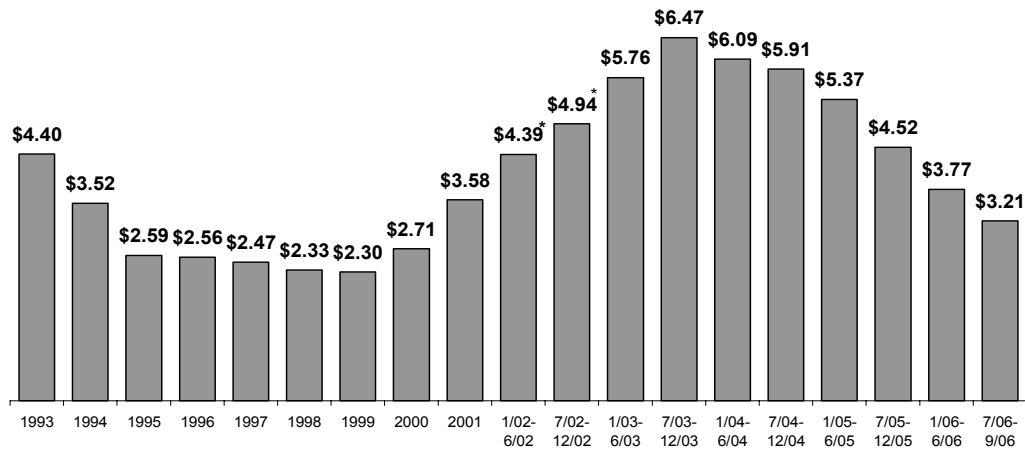
In 2000, insurers created a skyrocketing trend of premium increases to make up for the cutthroat under-pricing. What employers experienced as astronomical workers’ compensation rates was really the market

³ Insolvencies as reported by Wayne Wilson, Executive Director of CIGA, at 2/23/07 meeting of CHSWC.

response to deregulation, rising medical costs, and a crashing investment market.

Three years of continuous reforms have resulted in California employer costs decreasing from a high in 2003 of \$6.47 per \$100 of payroll to \$3.21 in 2006. This rate is lower than rates prior to deregulation in 1993.

Average Workers' Compensation Insurer Rate Per \$100 of Payroll as of September 30, 2006



Data Source: WCIRB

* Excludes the impact of the adopted changes to outstanding policy year 2002 pure premium rates effective January 1, 2003

INJURED WORKERS SUFFERING UNDER NEW SYSTEM

Regulatory cuts in indemnity benefits and medical treatment for injured workers have produced high employer savings and record insurer profits. Two of the main goals of SB 899, to decrease frictional costs and increase consistency, have failed. Instead, the result has been more challenges and litigation.

Low PD benefits have pushed applicants' attorneys to find creative ways to augment benefits. Judges who think benefits are too low find judicial ways to adjust them upwards. The point of the new schedule, to achieve consistency and predictability, has been lost.

Treatment guidelines and employer-controlled medical networks were supposed to deliver timely and appropriate medical care. Utilization review – the process by which insurers challenge doctors' decisions – has built up the workload on treatment decisions at the Workers'

Compensation Appeals Board. The effect is that more medical decisions are being referred to judges through the litigation process.

INDEMNITY BENEFITS

Injured workers who are unable to return to their usual jobs may qualify for indemnity cash benefits. Workers who will never recover completely or will always be limited in the work they can do may be eligible for PD benefits. Temporary disability (TD) benefits may be available for workers while they are recovering from their injuries.

The 2004 Schwarzenegger reforms enacted an overhaul of indemnity benefits.

Permanent Disability

SB 899 reduced PD benefits in four ways, and it delegated the revision of the PD rating schedule to the Administrative Director of the Division of Workers' Compensation (DWC). The Administrative Director's schedule reduces benefits even more.

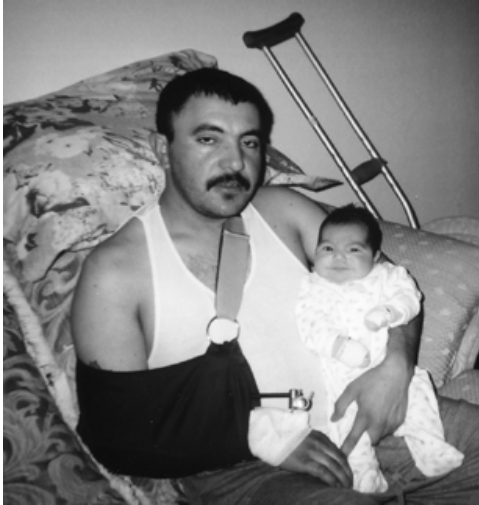
The four ways SB 899 specifically reduced PD benefits are:

1. *It reduced the number of weeks of benefits for most ratings.* Permanent disability benefits are payable for a number of weeks that depends on the percentage of permanent disability. SB 899 reduced the number of weeks for all but the most severe injuries. **The change in weeks reduces PD benefits paid to injured workers by approximately 16%.**
2. *It bumped the weekly PD benefit payment up or down by 15% depending on whether the employer offers the injured worker a job.* The weekly amount of the PD benefit is \$230 for most full time workers. This weekly rate is reduced by 15% if the employee can return to work for the employer or increased by 15% if the employer cannot return to work for the employer. **The net effect is about a 3% reduction in the average benefit paid to a permanently injured worker.**
3. *It permitted apportionment by causation of disability.* PD benefits are now apportioned to causation, that is, the cause of the injury. Doctors are now allowed to attribute percentages of disabilities to injuries suffered off the job. For example, a worker who suffers a serious toe injury and later has to have his leg amputated due to infection, could lose a substantial percentage of disability because he had diabetes which



"My [appeals] case hasn't been settled or tried; I'm left in limbo. I'm 100% disabled but the insurance carrier repeatedly denies needed care. They violate court orders to provide care, and it takes 10 months to get another court order for care."

- Dolores "Dee" Turner, deputy district attorney; injured at work when an escalator stopped suddenly



“Under the old schedule, I would have been rated 97% disabled. PD compensation was supposed to replace my lost future earnings due to my injury’s long-term effects. But my compensation under Gov. Schwarzenegger’s rating schedule is cut by more than 75%.”

- Gustavo Ortiz, steelworker; injured at work when a roof collapsed and he fell 50 ft. to the ground

contributed to the spread of the infection. **Apportionment determinations have cut PD benefits by a total of 5.8%.⁴**

4. *It required ratings to be based on the American Medical Association Guides (AMA), which exclude many disabilities that used to be covered.* PD ratings are now tied to the AMA Guides to the Evaluation of Permanent Impairment. Almost a third of all injured workers who would have had a PD rating under the previous California system will no longer receive any PD rating under the AMA Guides. **As a consequence, one-third of injured workers who would have had PD awards under the pre-2005 schedule will receive no PD benefits at all.**

The deepest cuts in PD did not come from the language of SB 899. The deepest cuts are a result of a new Permanent Disability Rating Schedule adopted through regulations. The goal of the Legislature in enacting the new PDRS (Labor Code Section 4660⁵) was to tie benefits to wage loss, or the percentage of wages a worker would lose as a result of the injury. The RAND study on wage loss would provide the empirical data needed to calculate loss of wages. The law can be no clearer on this matter.

Yet, Schwarzenegger’ Administrative Director adopted regulations that did not properly consider the empirical data and, instead, made her own policy determinations on what the PDRS should look like. The result of the Schwarzenegger Administration’s PDRS has been an additional 50% cut in PD benefits.

⁴ Memo by Frank Neuhauser dated 2/24/07, as reported at 2/23/07 CHSWC meeting,.

⁵ “... The administrative director shall formulate the adjusted rating schedule based on empirical data and findings from the Evaluation of California’s Permanent Disability Rating Schedule, Interim Report (December 2003), prepared by the RAND Institute for Civil Justice, and upon data from additional empirical studies. ...”

Average PD award under 2005 Permanent Disability Rating Schedule through January 17, 2007, compared to average pre-2005 schedule ratings.⁶

	2005 PDRS	Pre-2005 PDRS	Difference
Summary*	\$10,592	\$22,508	-52.9%
Consults	\$20,840	\$42,514	-51.0%

With about 30% of what used to be PD claims now dropping out completely due to the AMA Guides, an 11% drop in benefits due to the change in weeks, a 5.8% cut from apportionment, a 3% drop due to return-to-work adjustments, and another 50% cut in benefits due to the rating schedule, **the total dollar amount spent on PD has dropped by two-thirds, or about \$1.75 billion dollars a year.**

Recommendations:

- *Adjust the Permanent Disability Rating Schedule.* The new schedule became effective January 1, 2005, and, since then, over 30,000 injured workers have faced 50% cuts in their benefits. Regulations to implement the new schedule required 18 months of data collection and an adjustment if the data reflected a need. In February 2007, the Division of Workers' Compensation issued the first of two studies, measuring return-to-work rates under the new schedule. A wage loss study is expected March 2007. These studies are nine months late and, with every day that passes, more injured workers are facing severe cuts in benefits. An adjustment to the schedule, based on wage loss, must be completed as quickly as possible.
- *Adopt new future earnings capacity (FEC) factors.* The Schwarzenegger regulations created FEC numbers in the rating schedule to translate AMA impairments into disability percentages that are supposed to reflect wage loss. Yet, these numbers did not rely on RAND's wage loss data. The FECs should be recalculated to more closely tie PD benefits to wages. These recalculations can be done without legislation and, instead, by modifying regulations.

⁶ Adapted from Frank Neuhauser memo dated February 24, 2007

* Summary ratings are cases without attorney representation; consult ratings involve an applicant attorney.

- *Increase weekly benefit amounts.* The weekly PD benefit rate no longer reflects earnings. A worker earning \$8 an hour would receive the same weekly benefit as a worker earning \$18 an hour. The weekly benefit amount should be tied to TD benefits that do reflect wage loss.

Temporary Disability



“Workers’ compensation is supposed to provide medical treatment to help me heal and get back to work, and compensation for my disability. I’m stuck between a rock and a hard place. I can’t get back to work because I’m not healed.”
- Sandra Wilfley, sales representative; injured at work during a business trip

Temporary disability benefits are intended to replace part of a worker’s lost earnings while recovering from a job-related injury. TD benefits are two-thirds of pre-injury earnings and indexed to changes in the statewide average weekly wage. For 2007, the minimum TD benefit is \$132.25 and the maximum is \$881.66 per week. TD benefits end when the employee goes back to work or reaches maximum medical improvement, whichever is first. Benefits may be payable for broken periods if a worker tries to go back to work for a while and has to go off again, all before reaching maximum medical improvement.

Until 1979, TD was limited to an aggregate of 240 weeks within five years of date of injury. Beginning in 1979, there was no limit on the duration of total TD benefits available as long as the worker remained continuously disabled.

The Schwarzenegger reforms limited TD benefits to 104 weeks of benefits within two years of the first payment of TD benefits.

The existing time limit on TD benefits discourages injured workers from trying to go back to work if they might need more time off later. While they wait for the insurance company to approve a doctor’s decision, the TD clock continues to tick. Injured workers are punished while insurance companies fight doctors’ decisions.

What happens when workers hit the TD limit? They may rely on State Disability Insurance, benefits that they have paid out of their own paychecks. Their recovery and return to work is compromised and, potentially, unachievable.

Recommendations:

Adjust the TD benefits cap. Adjustments should include:

- The window of eligibility should be more than two years. Injured workers should get up to five years to utilize the benefits.
- The TD limit should be extended beyond 104 weeks.
- Delay in accepting a claim or in receiving needed medical care should not count against the TD time limit.

MEDICAL TREATMENT

Employers are now allowed to choose doctors that their injured employees will see by creating their own medical provider networks (MPNs). The only way for injured workers to see their own doctors is to pre-designate their physicians prior to injury. All other workers are now subject to treatment by an employer-selected doctor.

Providers are required to follow medical treatment guidelines established by the American College of Occupational and Environmental Medicine (ACOEM). ACOEM guidelines are meant for chronic, not acute, injuries and illnesses. They pay little attention to suffered pain and, as a result, must be augmented by other evidence-based medical treatment guidelines. Most recent regulations have incorporated guidelines for acupuncture with the use of ACOEM guidelines. But to date, no other guidelines have been adopted.

Insurance companies are allowed to review doctors' decisions by sending them through utilization review. During early implementation of reform, one major insurer was sending every doctor decision through utilization review.

Sending cases to utilization review has become the way for insurance companies to delay and deny needed medical treatment. Out-of-state doctors, paid for by the insurance companies, work out of their specialty area, and review the decisions of California doctors. The vast majority of doctors' requests for treatment authorization are approved. Utilization review has become a costly process that merely confirms the original doctor's medical decision in most cases.

Utilization review has provided insurance companies a new tool to hang on to their premium dollars a little longer. But what may be good for the insurers is definitely harmful to injured workers.

Over 1,000 employer-controlled MPNs have been approved by the Administration's Division of Workers' Compensation (DWC) since January 1, 2005. The law requires MPNs to maintain certain standards including the number of primary care and specialty doctors that must be available, the access injured workers have to doctors, and the process for second and third opinions within the MPN. The DWC is not required to review the MPNs for any of these quality standards once they are approved.

Injured workers have complained that doctors listed in the MPN whom they have contacted do not accept workers' compensation cases. Doctors have reported that they have been included in MPNs without their knowledge. Others report that they are forced to take discounted



“The insurance company took away my nurse case manager, denied payment to my spinal surgeon and denied prescriptions, pain management specialists, orthopedists and physical therapy. I am in constant pain.”

- Linda Vierling, retail store clerk; injured at work when she fell from a ladder and two TV sets landed on top of her

rates of pay for workers' compensation cases or face getting kicked out of a group health network.

To avoid a company doctor, workers have increasingly been trying to pre-designate their treating physicians. The right to see one's own physician has been routinely stymied by employers who want to exert control over medical treatment. Some employers have simply thrown away pre-designation forms filed with them, arbitrarily imposed limits on the number of employees who can pre-designate, and refused to honor prior pre-designation forms.

Taken together, these reforms have created unnecessary delays and denials of medical treatment. As the workers' compensation medical treatment system deteriorates, injured workers who have group health insurance will increasingly be more likely to rely on their employer-based health coverage to treat their injuries. Costs will shift from workers' compensation to group health insurance and, as a result, injured workers will have to pay co-pays and deductibles out of their own pockets.

Recommendations:

- *More stringent review of MPNs.* The DWC must conduct regular audits of MPNs to guarantee that they still offer required access to medical care.
- *Educate employers and employees about the right to pre-designate.* The DWC should issue more information and clarification about a worker's right to see her/his own doctor. Stronger enforcement and penalties on employers who curtail this key right should be levied.
- *Augment ACOEM treatment guidelines.* No one treatment guideline is comprehensive enough to treat all injured workers. Other evidence-based medical guidelines must be incorporated to supplement the ACOEM guidelines.
- *Limit the use of utilization review on MPN-approved doctors.* Employers now get to choose which doctors their injured workers will see. Because they selected them, they should not have an additional right to review their decisions. MPN doctor decisions should not be subject to utilization review.
- *Continually monitor and evaluate access to and quality of medical care.* The medical treatment system has been fundamentally altered to the employers' control. Such a significant change should be accompanied by a significant investment in its evaluation. The cost shift from workers' compensation to group health care should be documented.

RETURN TO WORK

Labor unions believe the best outcome for injured workers is for them to return to work when they are ready and able. SB 899 created incentives for employers to take injured workers back on the job. Under the bill, employers who return an injured worker back to work pay 15% lower PD benefits; employers who don't return an injured worker back to work pay a 15% higher PD benefit. A funding source was created to help small employers pay for the workplace modifications needed for an injured worker to return to the job.

Because PD benefits are now so low, the 30% swing in PD benefits doesn't amount to much of an incentive. Reports from injured workers and their representatives declare that employers are pushing employees to PD benefits as a way to rid themselves of older workers. Workers who have been on the job longer have likely accrued higher wages, more vacation days, and better benefits. It may be cheaper for the employer to replace these older workers with younger, healthier, and lower-paid new workers.

Injured workers who have been cleared by their doctors to return to their jobs are facing increased barriers. In some situations, after being cleared to go back to work by their treating doctors, workers are required by their employers to submit to a final examination by company doctors, further delaying the return to work by months.

These dynamics have increased friction and conflict between employees and employers. More injured workers have to rely on lawyers to file anti-discrimination lawsuits on their behalf, based on both state and federal laws. Union members have to grieve and arbitrate decisions that keep them off the job.

Recommendations:

- *Penalize employers who refuse to take injured workers back to work.* Financial incentives for return to work have been tried and are failing. Financial disincentives now need to be explored. Once an injured worker has been cleared to return to work, an employer should be required to take them back or pay them their full wages.
- *Allow a doctor's release back to work to stand.* Once a doctor has released a worker back to work, that decision should be implemented. Insurer or employer interference on this decision should be minimized.
- *Create a penalty against employers who refuse to take an injured worker back to work.* The state's declared policy is that injured



"My surgery and therapy were denied. They cut off my temporary disability. Now, the company has fired me because I can't do the job. With surgery and therapy, I could!"

- Adrienne Patterson, forklift operator; injured at work when four cases of juice fell onto her shoulder

workers should not be discriminated against. This policy should be enforced against employers who choose not to take an injured worker back to work.

INSURANCE MARKET REFORMS

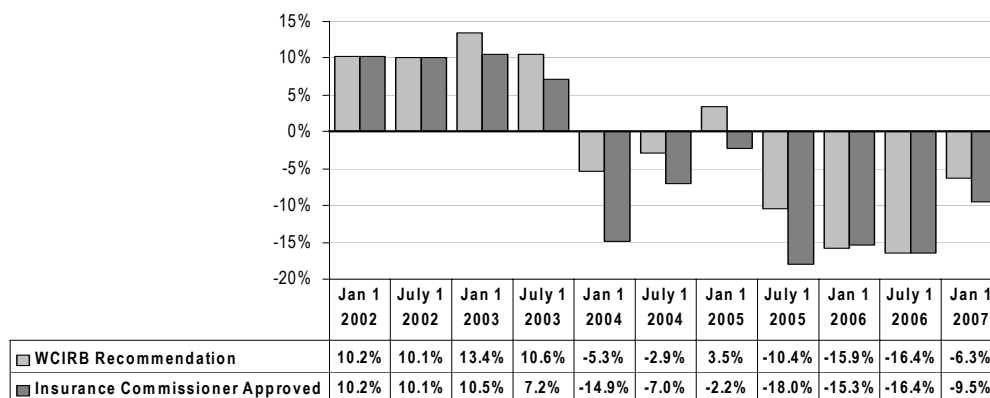
Over the past 15 years, the workers' compensation insurance market has been like the Wild Wild West. Deregulation in 1993 caused rates to drop below the cost of paying out benefits. Skyrocketing prices beginning in 2000 reflected the need for adjustments post deregulation.

Most recent reforms have required everyone in the system – medical providers, lawyers, vocational rehab counselors, injured workers, and employers – to face some type of regulation or suffer some economic loss. Only the insurance companies have gotten away with no new oversight or economic sacrifice.

The actuarial arm of the insurance industry, the Workers' Compensation Insurance Rating Bureau, provides the State's Insurance Commissioner with its recommended advisory rate once or twice a year. Then the Insurance Commissioner puts forth his/ her own advisory premium rates following a public hearing and its own actuarial review. But the insurance companies are not required to follow this guidance and, ultimately, they set their own rates. Workers' compensation insurance is the only line of property casualty insurance that is unregulated.

As the chart below indicates, the WCIRB's advisory rate nearly always differs from that of the Commissioner. They will, on behalf of the industry, almost always call for bigger rate increases and slower savings.

**Changes in Workers' Compensation Advisory Premium Rates
WCIRB Recommendation v. Insurance Commissioner Approval**

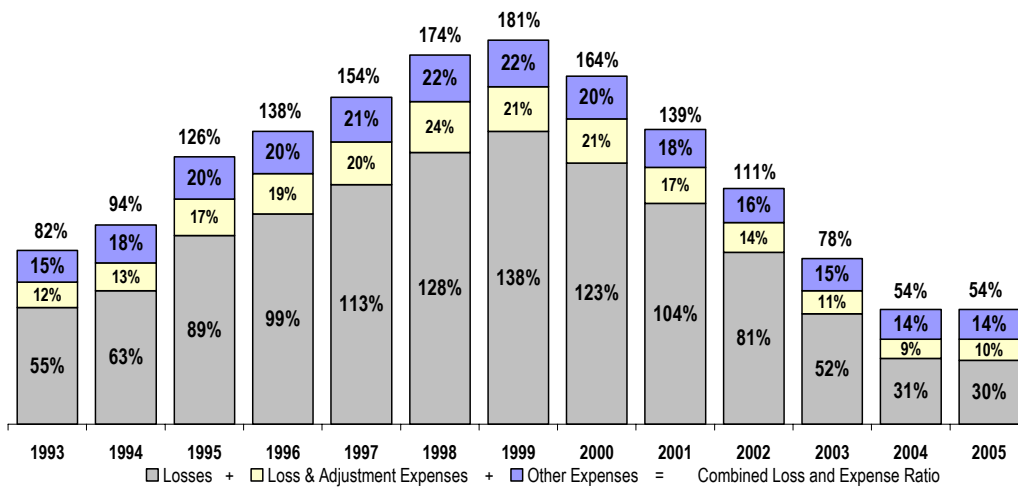


Data Source: WCIRB

The Insurance Commissioner's advisory rates for workers' compensation insurance costs is just an advisory, and has no legal bearing on what the insurance companies can actually charge. The result of such an arrangement is historic profit rates for the insurers.

As the chart below indicates, 2005 proved historic for the insurers. Their loss ratio was at 30%. That is, for every dollar collected in premium, 30 cents was paid out in benefits. The remaining 70 cents of every dollar went to administrative costs and profits.

California Workers' Compensation Combined Loss and Expense Ratios
 Reflecting the Estimated Impact of AB 227, SB 228 & SB 899
 (as of September 30, 2006)



The workers' compensation insurance market works only if all covered employers participate in the system. When insurance costs fluctuate so dramatically, employers' coverage will as well. Even though state law requires all employers to have workers' compensation insurance coverage, nine percent of employers are estimated to have no coverage.⁷ The consequences of employers going bare are twofold: 1) other employers are competing unfairly with these illegally operating businesses, and 2) other employers have to pay the costs of their injured workers.

More publicly accessible information about employers' workers' comp coverage will assist in enforcing the law.

⁷ In the CHSWC 1998 study on Illegally Uninsured Employers, the rate of uninsured employers was found to be 9% of the system as a whole. For new employers and in the targeted industry of auto/truck repair, 15% and 20%, respectively, were uninsured.

Recommendations:

- *Regulate insurance rates.* Workers' compensation is the only property casualty insurance line that does not require prior approval for rate increases from the Insurance Commissioner. The advisory rate issued by the Commissioner should have more bearing on what insurers are allowed to charge. And, the Insurance Commissioner should have the authority to set the rates charged for workers' compensation insurance.
- *Limit the loss ratio.* Governor Schwarzenegger, in his health care reform package, proposes to limit HMOs to an 85% loss ratio. For every dollar collected in health care premium, at least 85 cents must be spent on medical care. The same loss ratio should be applied to workers' compensation insurers. Their current benefits payments at 30% are outrageous for a mandatory insurance product.
- *Create a publicly accessible database of employers' workers compensation coverage.* A searchable database will assist injured workers, other employers, medical providers, and government enforcement agencies to file claims and enforce the law.

CONCLUSION

California's workers' compensation system has undergone dramatic changes over the past five years. Employers have enjoyed over \$12 billion in savings per year. Insurance companies are reaping historic profits. Their loss ratio is at 30%, that is, for every dollar in premium they collect, they are only paying out 30 cents in benefits.

These employer savings and insurer profits come at the expense of injured workers.

Permanently injured workers have had their benefits slashed by over 50%. Temporarily disabled workers face unfair time limits on their benefits. Medical treatment is delayed and denied and injured workers aren't returning to work when they heal.

Cost savings were supposed to come from less friction and less litigation in the system. Instead, savings have come off the backs of injured workers. Workers today have to fight every step of the way to get adequate treatment and benefits. And, with these fights, the original goals of reform are fleeting.

The pendulum has swung too far. California's unions are committed to restoring fairness for injured workers by pursuing legislative and regulatory changes. We will pursue legislation that restores benefits, provides timely and appropriate medical care, and creates oversight on insurance companies.

As the Legislature and the Governor look to enact a major health care reform proposal, workers' compensation reform cannot be the model. Today insurers and employers benefit by slashing benefits and denying medical care. And laws passed by the Legislature are effectively ignored during the regulatory process. We can and we must do better for our health care system.

RECOMMENDATIONS

Permanent Disability:

- *Adjust the Permanent Disability Rating Schedule.* The new schedule became effective January 1, 2005, and, since then, over 30,000 injured workers have faced 50% cuts in their benefits. Regulations to implement the new schedule required 18 months of data collection and an adjustment if the data reflected a need. In February 2007, the Division of Workers' Compensation issued the first of two studies, measuring return-to-work rates under the new schedule. A wage loss study is expected March 2007. These studies are nine months late and, with every day that passes, more injured workers are facing draconian cuts in benefits. An adjustment to the schedule, based on wage loss, must be completed as quickly as possible.
- *Adopt new future earnings capacity (FEC) factors.* The Schwarzenegger regulations created FEC numbers in the rating schedule to translate AMA impairments into disability percentages that are supposed to reflect wage loss. Yet, these numbers did not rely on RAND's wage loss data. The FECs can and should be adjusted through regulatory changes.
- *Increase the weekly benefit amount.* The weekly PD benefit rate no longer reflects earnings. A worker earning \$8 an hour would receive the same weekly benefit as a worker earning \$18 an hour. The weekly benefit amount should be tied to temporary disability (TD) benefits that do reflect wage loss.

Temporary Disability:

- *Adjust the TD benefits cap.* Adjustments should include:
 - The window of eligibility should be more than two years. Injured workers should get up to five years to utilize the benefits.
 - The TD limit should be extended beyond 104 weeks.
 - Delay in accepting a claim or in receiving needed medical care should not count against the TD time limit.

Medical Treatment

- *More stringent review of MPNs.* The DWC must conduct regular audits of MPNs to guarantee that they still offer the required access to medical care.

- *Educate employers and employees about the right to pre-designate.* The DWC should issue more information and clarification about a worker's right to see her/his own doctor. Stronger enforcement and penalties on employers who curtail this key right should be levied.
- *Augment ACOEM treatment guidelines.* No one treatment guideline is comprehensive enough to treat all injured workers. Other evidence-based medical guidelines must be incorporated to supplement the ACOEM guidelines.
- *Limit the use of utilization review on MPN-approved doctors.* Employers now get to choose which doctors their injured workers will see. Because they selected them, they should not have an additional right to review their decisions. MPN doctor decisions should not be subject to utilization review.
- *Continually monitor and evaluate access to and quality of medical care.* The medical treatment system has been fundamentally altered to the employers' control. Such a significant change should be accompanied by a significant investment in its evaluation. The cost shift from workers' compensation to group health care should be documented.

Insurance Market Reforms

- *Regulate insurance rates.* Workers' compensation is the only property casualty insurance line that does not require prior approval for rate increases from the Insurance Commissioner. The advisory rate issued by the Commissioner should have more bearing on what insurers are allowed to charge.
- *Limit the loss ratio.* Governor Schwarzenegger, in his health care reform package, proposes to limit HMOs to an 85% loss ratio. For every dollar collected in health care premium, at least 85 cents must be spent on medical care. The same loss ratio should be applied to workers' comp insurers. Their current benefits payments at 31% are outrageous for a mandatory insurance product.
- *Create a publicly accessible database of employers' workers compensation coverage.* A searchable database will assist injured workers, other employers, medical providers, and government enforcement agencies to file claims and enforce the law.