ANALYSIS OF CONNECTICUT SUBSTITUTE SENATE BILL 907
Amended With LCO No. 5560

Connecticut Substitute Senate Bill (SB) 907, if enacted in its current form, may increase the inflation rate of workers compensation medical costs up to 10% per year in Connecticut. Since medical benefits represent half of total benefits, this translates to an additional rate of growth in overall (medical and indemnity) benefit costs of approximately +5% (+$34[1]M) each year. After five years, the cumulative impact on costs could be as much as +30% (+$204M). The magnitude of the increase will depend upon how the proposed provisions are interpreted and applied in practice. In addition, SB 907 may result in increased duration of claims and litigation costs, further increasing overall system costs.

If enacted, SB 907 would apply to dates of service on or after October 1, 2013. Hence, its provisions would apply to claims that occurred prior to its enactment. This would result in a retroactive impact since claims stemming from policies written prior to October 1, 2013 would be affected. Premiums on these policies would not have contemplated the proposed changes. As there is no mechanism to assess all employers for such additional claim costs that may result from a subsequent change to the statutes, a change of this nature may be considered to be retroactive, and will result in an unfunded liability for the workers compensation system.

Summary of Connecticut SB 907 – As Amended

SB 907 would add requirements for employers and insurers in order to discontinue, reduce, or deny medical treatment deemed reasonable or necessary by a physician or surgeon:

- Requires an employer or insurer to notify the Connecticut Workers Compensation Commissioner ("commissioner"), physician or surgeon and the employee when proposing to discontinue, reduce, or deny a course of treatment which a physician deems reasonable or necessary.

- Precludes the employer or insurer from discontinuing, reducing, or denying medical treatment if it fails to provide such notice.

- Specifies that such notice shall include an opinion from a physician that the course of treatment recommended by the attending physician is not reasonable or necessary. Alternatively, the employer may schedule an independent medical examination (IME), which must occur within thirty days after the employee's receipt

[1] Overall system costs are based on NAIC Annual Statement data as provided by A.M. Best. The estimated dollar impact is the percentage impact(s) displayed multiplied by A.M. Best 2011 written premium of $680M for Connecticut. This figure does not include self-insurance, the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs. The dollar impact on overall system costs inclusive of self-insurance is estimated to be between $44M, where data on self-insurance is approximated using the National Academy of Social Insurance's August 2012 publication "Workers' Compensation: Benefits, Coverages, and Costs, 2010"

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of notice. However, if the IME is not conducted in a timely manner, the employer or insurer is precluded from disputing, discontinuing, or reducing treatment.

- The employer has the burden of proving that the medical care is unreasonable.
- Requires the commissioner's written approval prior to discontinuing, reducing, or denying medical treatment.
- Provides a timeline for the employer and employee in such cases.
- The employer is not subject to these provisions if treatment is of "limited duration".
- The employer is not subject to these provisions if it provides accident and health insurance to the majority of its employees "pursuant to section 31-284b of the general statutes." Since this statute concerns accident or health insurance provided by employers but has been deemed inapplicable to private employers by court decision, the apparent intent is to make this exemption applicable to state and municipal government employers, but not to private employers.

Actuarial Analysis of SB 907 – As Amended

Currently in Connecticut, an employer or insurer may file a Form 43, "Notice to Compensation Commissioner and Employee of Intention to Contest Employee's Right to Compensation Benefits," when contesting any aspect of a claim, including medical treatment. When a medical treatment is contested, no payment by the insurer or employer is required. In such cases, the burden of proof is on the employee to show the course of medical treatment is necessary.

Under the provisions of SB 907, an employer or insurer would need to provide notification to the injured employee for a proposed discontinuation or reduction in medical treatments. The employer would have the burden of proving that the medical care is unreasonable. Written approval by the commissioner would be needed in order to discontinue, reduce, or deny medical treatment. The employer or insurer would be precluded from changing treatment if it fails to issue the notification, or fails to conduct the IME within the required timeframe, if applicable. Due to the increased requirements for an employer or insurer to discontinue, reduce, or deny medical treatments, these provisions would be expected to result in an increase in the number of medical treatments and informal hearings. This could also result in growth in frictional costs and loss adjustment expenses due to increased litigation. In addition, increased utilization of medical treatments and pending litigation could delay an employee's return to work, resulting in increased overall system costs.

Discussions with system stakeholders revealed that employers or insurers are currently required by statute to pay for care that is curative in nature, with no such requirement for providing palliative care. Since SB 907 would make it more difficult for employers to deny such care when deemed appropriate, this could be interpreted so as to include palliative

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care as "reasonable or necessary" medical treatment, thereby resulting in increased costs to the system.

Additionally, this provision would appear to give the presumption of correctness to the treating physician, creating a situation similar to that experienced by California in the late 1990's as a result of the *Minniear* decision.[2] The 1996 *Minniear* decision in California changed the rules governing disputes over medical treatment. *Minniear* changed the balance by giving a legal presumption of correctness to the opinion of the primary treating physician (PTP) against all other opinions when the issue was medical treatment. In addition, it defined a higher standard of what was required to rebut the PTP's opinion. This decision sparked unprecedented medical cost escalation in the California workers compensation system—upwards of two to three times the historical medical inflation rate[3]. Should SB 907 be enacted in its current form, it could result in a similar presumption of correctness given to the opinion of the physician or surgeon, and potentially result in an escalation in medical costs similar to what was experienced in California in the late 1990's.

While conditions in Connecticut are not identical to those in 1990's California, the proposal provides a strong enough parallel to suggest that average cost increases similar to those experienced in California could possibly be realized in Connecticut.

SB 907, if enacted in its current form, may result in an increase in the inflation rate of workers compensation medical costs in Connecticut by up to an additional 10% per year. Since medical benefits represent half of total benefits, this translates to an additional rate of growth in overall (medical and indemnity) benefit costs of approximately +5% (+$34 M) each year. After five years, the cumulative impact on costs could be as much as +30% (+$204M). The magnitude of the increase will depend upon how the proposed provisions are interpreted and implemented.

Other Considerations

- Under SB 907, after receiving notice of treatment, an employer or insurer would have ten days to issue a notice to discontinue, reduce or deny medical treatment. If the notice does not include a physician opinion, the employer or insurer would then have thirty days to perform an independent medical examination (IME). The treatment recommended by the treating physician or surgeon may not be discontinued, reduced, or denied until the results of the IME are considered at informal hearing. Based on discussions with system stakeholders, the proposed timeframe may not be sufficient for scheduling and completing an IME.

- Based on the wording of SB 907, it is unclear if the physician determining the "reasonable or necessary" course of treatment would need to be the treating physician or surgeon. To the extent that multiple practitioners could recommend

[2] Minniear v. Mount San Antonio Community College District (1996), 61 Cal. Comp. Cases 1055 (Appeals Board en banc opinion)

[3] Smoothing Out the Roller Coaster Ride: The California Workers Compensation Experience by Robert G Mike and Dave Bellusci, Workers' Compensation Insurance Rating Bureau of California

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"reasonable or necessary" medical treatment where the insurer or employer would need to notify the commissioner to discontinue, reduce, or deny such treatments, there would likely be an increase in medical costs, informal hearings and frictional costs.

- In Connecticut, insurance carriers and employers can negotiate a settlement for future medical payments in order to extinguish their liability and close a claim file. These provisions of SB 907, if enacted in its current form, may lead to an increase in the number of lump sum medical settlements requested by insurers due to the increased uncertainty associated with the impact from these provisions on the future medical costs of claims. Additionally, higher settlement amounts may be demanded from claimants since they may have more leverage in claim negotiations due to the inherent uncertainty associated with these provisions.

- Under SB 907, the employer is not subject to the stated provisions if treatment is of "limited duration". This term is undefined and will likely be the subject of litigation. Therefore, it is unclear how many claims would be exempted from the proposed restrictions on the discontinuance, reduction, or denying of medical treatment.

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