STATE OF CALIFORNIA EDMUND G. BROWN JR., *Governor*

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David M. Lanier, Secretary
California Labor and Workforce Development Agency
800 Capitol Mall, Suite 5000
Sacramento, CA 95814

Dear Secretary Lanier,

In May 2016, you directed the Department of Industrial Relations (DIR) to convene a working group of stakeholders to study and make strategic policy recommendations to strengthen anti-fraud efforts in the California workers' compensation system. I am pleased to provide you with this report detailing the Department's anti-fraud efforts, and in particular our efforts to reduce medical provider fraud and illegitimate liens, which were significantly bolstered by the passage of Assembly Bill 1244 (Gray and Daly) and Senate Bill 1160 (Mendoza). Our report also details the relevant research and data that will direct the next series of significant anti-fraud policies targeting premium fraud.

Senate Bill 863, the landmark reform of 2012, addressed the needs of injured workers and employers – the primary stakeholders in the workers' compensation system – by increasing benefits while lowering premiums through the elimination of friction costs. In particular, Senate Bill 863 took medical treatment and billing disputes out of the litigation system and redirected them into the evidenced-based, more timely, more transparent, and less costly Independent Medical Review and Independent Bill Review systems. While these reforms met the primary objectives of increasing benefits and reducing costs, they also generated new data on liens, which aided in exposing provider fraud schemes and fraudulent practices.

The high-profile provider fraud prosecutions by local district attorneys that were publicized in the past year involved investigative and funding support from the California Department of Insurance (CDI), and the expertise and data analysis provided by the DIR and its Division of Workers' Compensation (DWC). CDI and DWC chose to not publicize their involvement to preserve the integrity of the prosecutions by not revealing investigative methods and techniques. However, these efforts were key to ascertaining patterns of fraud, relationships among participants, the extent of fraudulent treatment and billing schemes, and how the schemes were perpetrated within the context of the workers' compensation system.

As directed, DIR in collaboration with CDI and the Commission on Health and Safety and Workers' Compensation convened meetings of stakeholders across the system to assess workers' compensation fraud. The departments moved quickly to help incorporate anti-fraud measures into Assembly Bill 1244 (Gray and Daly) and Senate Bill 1160 (Mendoza). In particular, these measures expressly require the automatic stay of lien claims of providers criminally charged with fraud, and for DWC to

suspend any medical provider, physician or practitioner convicted of fraud from participation in the workers' compensation system. Lien filing requirements were strengthened to ensure that the lien claimant was actually the provider who rendered the service.

Since the start of this year, the lien claims associated with approximately 75 providers currently facing criminal fraud charges were stayed pursuant to new Labor Code section 4615. More than 200,000 liens with a total claim value of over $1 billion have been stayed. DWC has adopted provider suspension regulations and now is issuing notices of suspension to convicted providers, who together account for at least another 100,000 liens in the system. Removing fraudulent providers and their lien claims from the workers' compensation system will enable the system to improve services to injured workers by improving the system's efficiency and ultimately reducing costs.

Premium fraud – through which unscrupulous employers seek to lower costs by underreporting payroll, misclassifying employees as independent contractors, or misreporting workers engaged in high-risk occupations as engaged in low-risk occupations – also warrants focused attention. Premium fraud is less impactful on overall system costs than provider fraud since premium costs are mostly redistributed to honest employers in the form of higher premiums.

The cost of the workers' compensation insurance premium is based on an employer's payroll total. By misreporting payroll costs, some employers avoid the higher premiums they would incur with accurate reporting of their payroll. Employers can also misreport total payroll or the number of workers in specific high-risk, high-premium occupation classifications by reporting them in lower-risk, lower-premium occupations. A 2009 study funded by CDI's Fraud Assessment Commission found that between $15 billion and $68 billion dollars of payroll is underreported annually.

As you know, DIR's ongoing work to combat workers' compensation fraud includes the creation of an Anti-Fraud Support Unit to share and track data from system participants, and obtaining the resources for the new responsibilities entrusted to DIR under Assembly Bill 1244 and Senate Bill 1160. We are also continuously looking into how we can combat fraud administratively and aid in similar efforts with other enforcement entities. DIR contracted with the Rand Institute for an independent evaluation and recommendations, including a review of fraud-detection in other federal and state health care programs, and we expect that study (which currently is in peer review) to be released this spring. We appreciate the interest the Legislature has shown in this area and look forward to continued cooperation between the Administration and Legislature in this mutual effort.

Sincerely,

Christine Baker

Christine Baker, Director
Department of Industrial Relations

cc: Dave Jones, California Insurance Commissioner
Steven Bradford, Chair of Senate Labor and Industrial Relations Committee
Tom Daly, Chair of Assembly Insurance Commission
Eduardo Enz, Executive Officer, Commission on Health and Safety and Workers' Compensation